Table Of Contents

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress

Online Forms

Program Narrative

Additional Information to be Submitted

Proof of Filing

1. SF-424 Application for Federal Assistance Version 2
   - (Upload #1): AttachmentForm_1_2-ATT1-1238-Navajo 2018 appendices combined.pdf
   - (Upload #2): SF424_2_1-1237-Service Areas and Congressional Districts - current.pdf
   - (Upload #3): ProjectNarrativeAttachments_1_2-Attachments-1235-AFHP Navajo Program Narrative 2018.pdf
   - (Upload #4): SF424_2_1-1236-Service Areas and Congressional Districts - current.pdf
   - (Upload #5): BudgetNarrativeAttachments_1_2-Attachments-1234-AFHP Navajo Budget Narrative and Supporting Documents.pdf
   - (Upload #6): Form AttachmentForm_1_2-V1.2.pdf
   - (Upload #7): Form BudgetNarrativeAttachments_1_2-V1.2.pdf
   - (Upload #8): Form ProjectNarrativeAttachments_1_2-V1.2.pdf
   - (Upload #9): Form SFLLL_1_2-V1.2.pdf
2. SF-424A Budget Information - Non-Construction
3. SF-424B Assurances - Non-Construction
4. SF-LLL Disclosure of Lobbying Activities
5. Project Abstract Summary
6. Key Personnel
7. Budget Narrative
8. Program Narrative
9. Exhibits/Tables/Attachments
10. Negotiated Rate Agreement
11. Copy of By-Laws
12. Proof of Non-Profit Status

Note: Upload document(s) printed in order after online forms.

OMB Approval No. 4040-0006
Expiration Date: 01/31/2019

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. N/A				$477,000.00	(b)(4)	
2.						
3.						
4.						
5. Totals				$477,000.00		

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) N/A	(2)	(3)	(4)	Total (5)
a. Personnel	(b)(4)				(b)(4)
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual					
g. Construction					
h. Other					
i. Total Direct Charges *(sum of 6a-6h)*					
j. Indirect Charges					
k. TOTALS *(sum of 6i and 6j)*					
7. Program Income					$ (b)(4)

Authorized for Local Reproduction

Standard Form 424A (Rev. 7-97)
Prescribed by OMB Circular A-102

Previous Edition Usable

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8			(b)(4)	
9.				
10.				
11.				
12. TOTAL *(sum of lines 8-11)*				

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$477,000.00	(b)(4)			
14. Non-Federal		(b)(4)			
15. TOTAL *(sum of lines 13 and 14)*					

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.	(b)(4)			
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$			

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks:	

Authorized for Local Reproduction

OMB Number: 0980-0204
Expiration Date: 04/30/2015

Project Abstract Summary

Program Announcement (CFDA)
93.217

*** Program Announcement (Funding Opportunity Number)**
PA-FPH-18-001

*** Closing Date**
05/24/2018

*** Applicant Name**
Arizona Family Health Partnership

*** Length of Proposed Project** 4

Application Control No.
PA-FPH-18-001-061595

Federal Share Requested (for each year)

* Federal Share 1st Year	* Federal Share 2nd Year	* Federal Share 3rd Year
$ 477,000.00	(b)(4)	
*** Federal Share 4th Year**	*** Federal Share 5th Year**	
(b)(4)	$ 0.00	

Non-Federal Share Requested (for each year)

* Non-Federal Share 1st Year	* Non-Federal Share 2nd Year	* Non-Federal Share 3rd Year
$ (b)(4)		
*** Non-Federal Share 4th Year**	*** Non-Federal Share 5th Year**	
$ (b)(4)	$ 0.00	

*** Project Title**
Arizona Family Health Partnership application for Title X service in the Navajo Region

Project Abstract Summary

*** Project Summary**

The Arizona Family Health Partnership (AFHP) is a private non-profit organization that has served as a Title X Arizona grantee since 1983 and the Title X Navajo Nation grantee since July of 2014. All direct services through the Navajo Nation grant are provided by (b)(4) and (b)(4) both federally qualified health centers, with a total of seven health centers. If funded, a minimum of (b)(4) clients will be served per year and at least 75% of clients will be at or below 100% of the Federal Poverty Level. Family planning services are provided by both sub-recipients which encompass a broad range of family planning methods including abstinence (sexual risk avoidance), natural family planning, and fertility awareness based methods, pregnancy testing and counseling, achieving pregnancy, basic infertility services, preconception and interconception health, and STD/HIV testing and treatment. Both (b)(4) and (b)(4) provide on-site comprehensive primary care, other preventive health, dental, and behavioral health services. AFHP promotes parental involvement all the while providing confidential services to minors and complying with all Title X, Arizona, and Utah legal requirements regarding mandatory reporting. Abstinence (sexual risk avoidance) and counseling related to coercive relationships is also provided to all adolescent clients and others as appropriate. (b)(4) establishes partnerships with community-based and faith-based organizations to enhance the client's ability to achieve optimal health outcomes. As the leading expert on family planning service delivery in Arizona and the Navajo Nation, AFHP is dedicated to a holistic approach to reproductive health, focusing on the overall well-being of each individual. AFHP is the only agency with the capacity, staff, and expertise to administer Title X funds with integrity and without a gap in services on the Navajo Nation.

*** Estimated number of people to be served as a result of the award of this grant.** (b)(4)

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
____ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	____ a. bid/offer/application b. initial award c. post-award	____ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: 93.217
8. Federal Action Number, *if known*:	**9. Award Amount**, *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____
Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

Approved by OMB
0348-0046

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: _____ Page 2 of 2

OMB Approval No.: 4040-0007
Expiration Date: 06/30/2014

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681- 1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93- 205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

*** SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL**	*** TITLE**
Manuel E Ferreiro	Chief Executive Officer
*** APPLICATION ORGANIZATION**	*** DATE SUBMITTED**
Arizona Family Health Partnership	05/21/2018

Standard Form 424B (Rev. 7-97) Back

Key Personnel

Name	Position Title	Annual Salary	No.Months Budget	% Time	Fed Amount	Non-Fed Amount	Total Amount Requested

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application:	*If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

*3. Date Received:	4. Applicant Identifier:
05/21/2018	AFHP Title X Navajo

5a. Federal Entity Identifier:	*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name: Arizona Family Health Partnership

*b. Employer/Taxpayer Identification Number (EIN/TIN):	*c. Organizational DUNS:
86-0289607	8272040820000

d. Address:

*Street1:	3101 N Central Ave
Street2:	Suite 1120
*City:	Phoenix
County:	
*State:	Arizona
Province:	
*Country:	UNITED STATES
*Zip / Postal Code:	85012-2642

e. Organizational Unit:

Department Name:	Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:	Ms.	*First Name:	Brenda
Middle Name:	Layle		
*Last Name:	Thomas		
Suffix:			

Title: Chief Executive Officer

Organizational Affiliation:
Arizona Family Health Partnership

*Telephone Number:	6022585777	Fax Number:	6022523708

*Email: bthomas@arizonafamilyhealth.org

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (specify):

*** 10. Name of Federal Agency:**

Office of the Assistant Secretary for Health

11. Catalog of Federal Domestic Assistance Number:

93.217

CFDA Title:

Family Planning Services

*** 12. Funding Opportunity Number:**

PA-FPH-18-001

*Title:

FY 2018 Announcement of Anticipated Availability of Funds for Family Planning Services Grants

13. Competition Identification Number:

PA-FPH-18-001-061595

Title:

FY 2018 Announcement of Anticipated Availability of Funds for Family Planning Services Grants

14. Areas Affected by Project (Cities, Counties, States, etc.):

See attached file: 1236-Service Areas and Congressional Districts - current.pdf; Mime Type: application/pdf; Location: 929843.SF424_2_1_P2.optionalFile1;

*** 15. Descriptive Title of Applicant's Project:**

Arizona Family Health Partnership application for Title X service in the Navajo Region

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant: AZ 9

*b. Program/Project: AZ 1

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

*a. Start Date: 09/01/2018

*b. End Date: 08/31/2022

18. Estimated Funding ($):

*a. Federal	477000
*b. Applicant	0
*c. State	0
*d. Local	0
*e. Other	(b)(4)
*f. Program Income	
*g. TOTAL	

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

☐ Yes ☒ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

**The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	Ms.
*First Name:	Brenda
Middle Name:	Layle
*Last Name:	Thomas
Suffix:	
*Title:	Chief Executive Officer
*Telephone Number:	6022585777
Fax Number:	6022523708
*Email:	bthomas@arizonafamilyhealth.org
*Signature of Authorized Representative:	Manuel E Ferreiro
*Date Signed:	05/21/2018

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

Application for Federal Assistance SF-424 Version 02

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

Upload #1

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress
Document Title:	AttachmentForm_1_2-ATT1-1238-Navajo 2018 appendices combined.pdf

Appendix 1

AFHP AGENCY HEALTH CENTER REPORT

Agency Name : (b)(4)

Grant Name: NAVAJO GRANT

Revised Date : 04/06/2018

Date : 05/15/2018

Name	Address	Office Hours	Clinic Hours	Number of Clients	Status	Applied Years
(b)(4)		Monday - 07:00 AM to 07:00 PM Tuesday - 07:00 AM to 07:00 PM Wednesday - 07:00 AM to 07:00 PM Thursday - 07:00 AM to 07:00 PM Friday - 07:00 AM to 07:00 PM Saturday - 07:00 AM to 07:00 PM Sunday - 07:00 AM to 07:00 AM	Monday - 07:00 AM to 07:00 PM Tuesday - 07:00 AM to 07:00 PM Wednesday - 07:00 AM to 07:00 PM Thursday - 07:00 AM to 07:00 PM Friday - 07:00 AM to 07:00 PM Saturday - 07:00 AM to 07:00 PM Sunday - 07:00 AM to 07:00 AM	485	Opened	2014, 2015, 2016, 2017, 2018
		Monday - 08:00 AM to 06:00 PM Tuesday - 08:00 AM to 06:00 PM Wednesday - 08:00 AM to 06:00 PM Thursday - 08:00 AM to 06:00 PM Friday - 08:00 AM to 06:00 PM	Monday - 08:00 AM to 06:00 PM Tuesday - 08:00 AM to 06:00 PM Wednesday - 08:00 AM to 06:00 PM Thursday - 08:00 AM to 06:00 PM Friday - 08:00 AM to 06:00 PM	540	Opened	2014, 2015, 2016, 2017, 2018
		Monday - 07:30 AM to 06:30 PM Tuesday - 07:30 AM to 06:30 PM Wednesday - 07:30 AM to 06:30 PM Thursday - 07:30 AM to 06:30 PM	Monday - 07:30 AM to 06:30 PM Tuesday - 07:30 AM to 06:30 PM Wednesday - 07:30 AM to 06:30 PM Thursday - 07:30 AM to 06:30 PM	175	Opened	2014, 2015, 2016, 2017, 2018

Agency Health Center Proposed Service Report

Appendix 1

Level of service provided : 1=Service Provided, 2=Referral Provided, 3=Service Not Provided & Referral Not Provided.

Grant Name : NAVAJO GRANT

Proposed Year : 2018

Services	Name of Health Centers		
	(b)(4)		
1) Family Planning Services			
1. Client Education and Counseling			
1.1. Pregnancy Prevention	1	1	1
1.2. Pregnancy Achievement	1	1	1
2. Family Planning Methods			
2.1. Male Condom	1	1	1
2.2. Oral Contraceptives	1	1	1
2.3. Injectables (Depo-Provera)	1	1	1
2.4. IUD without Hormones (ParaGard)	1	1	1
2.5. IUD with Hormones (Mirena, Skyla, Liletta, Kyleena)	1	1	1
2.6. Vaginal Ring (NuvaRing)	1	1	1
2.7. Emergency Contraception	1	1	1
2.8. Patch	1	1	1
2.9. Spermicide (Foams, Films, Suppositories)	1	1	1
2.10. Cervical Cap/Diaphragm	1	1	1
2.11. Sponge	1	1	1
2.12. Female Condom	1	1	1
2.13. Natural Family Planning (Fertility Awareness Based Methods)	1	1	1
2.14. Lactational Amenorrhea	1	1	1
2.15. Sexual Risk Avoidance (Abstinence Education)	1	1	1
2.16. Implant (Nexplanon)	1	1	1
2) Pregnancy Testing and Counseling as Indicated	1	1	1
3) Basic Infertility Services for Men			
1. Sexual History	1	1	1
2. Medical History/Family History	1	1	1
3. Reproductive History	1	1	1
4. Physical Exam	1	1	1
5. Semen Analysis	2	2	2
6. Further Diagnosis	2	2	2
4) Basic Infertility Services for Women			
1. Sexual History	1	1	1
2. Medical History/Family History	1	1	1
3. Reproductive History	1	1	1
4. Physical Exam	1	1	1
5. Further Diagnosis	2	2	2
5) Preconception Health Screening, Counseling and Education			

1. Intimate Partner Violence	1	1	1
2. Alcohol And Other Drug Use	1	1	1
3. Tobacco Use	1	1	1
4. Immunization Status	1	1	1
5. BMI	1	1	1
6. Blood Pressure	1	1	1
7. Diabetes	1	1	1
6) Sexually Transmitted Infection Testing			
1. Chlamydia	1	1	1
2. Gonorrhea	1	1	1
3. Syphilis	1	1	1
4. Herpes	1	1	1
5. Hepatitis C for High Risk Populations	1	1	1
6. HIV	1	1	1
7) Sexually Transmitted Infection Treatment			
1. Chlamydia	1	1	1
2. Gonorrhea	1	1	1
3. Syphilis	1	1	1
4. Herpes	1	1	1
5. Hepatitis C for High Risk Populations	2	2	2
6. HIV	2	2	2
8) Related Preventive Health Services			
1. Clinical Breast Exam as Indicated	1	1	1
2. Pelvic Exam as Indicated	1	1	1
3. Cervical Cytology with HPV Testing as Indicated	1	1	1
4. Genital Exam as Indicated	1	1	1
9) Other Preventive Health Services			
1. Other specify			
2. Other specify			
3. Other specify			
4. Other specify			

AFHP AGENCY HEALTH CENTER REPORT

Agency Name : (b)(4)

Grant Name: NAVAJO GRANT

Revised Date : 04/25/2018

Date : 05/15/2018

Name	Address	Office Hours	Clinic Hours	Number of Clients	Status	Applied Years
(b)(4)		Monday - 09:00 AM to 06:30 PM Tuesday - 08:00 AM to 06:30 PM Wednesday - 08:00 AM to 06:30 PM Thursday - 08:00 AM to 04:30 PM	Monday - 09:00 AM to 06:30 PM Tuesday - 08:00 AM to 06:30 PM Wednesday - 08:00 AM to 06:30 PM Thursday - 08:00 AM to 04:30 PM	100	Opened	2017, 2018
		Monday - 08:00 AM to 04:30 PM Tuesday - 08:00 AM to 04:30 PM Wednesday - 08:00 AM to 04:30 PM Thursday - 08:00 AM to 04:30 PM Friday - 08:00 AM to 04:30 PM	Monday - 08:00 AM to 06:30 PM Tuesday - 08:00 AM to 06:30 PM Wednesday - 08:00 AM to 06:30 PM Thursday - 08:00 AM to 06:30 PM Friday - 08:00 AM to 04:30 PM	150	Opened	2017, 2018, 2019
		Monday - 08:00 AM to 05:00 PM Tuesday - 08:00 AM to 05:00 PM Wednesday - 08:00 AM to 05:00 PM Thursday - 08:00 AM to 05:00 PM Friday - 08:00 AM to 04:00 PM	Monday - 08:00 AM to 07:30 PM Tuesday - 08:00 AM to 07:30 PM Wednesday - 08:00 AM to 07:30 PM Thursday - 08:00 AM to 07:30 PM Friday - 08:00 AM to 04:30 PM	300	Opened	2017, 2018, 2019

(b)(4)	Monday - 08:00 AM to 04:30 PM Tuesday - 08:00 AM to 04:30 PM Wednesday - 08:00 AM to 04:30 PM Thursday - 08:00 AM to 04:30 PM Friday - 08:00 AM to 04:30 PM Saturday - 08:00 AM to 04:30 AM	Monday - 08:00 AM to 07:30 PM Tuesday - 08:00 AM to 07:30 PM Wednesday - 08:00 AM to 07:30 PM Thursday - 08:00 AM to 07:30 PM Friday - 08:00 AM to 04:30 PM Saturday - 08:00 AM to 04:30 PM	250	Opened	2017, 2018, 2019

Agency Health Center Proposed Service Report

Level of service provided : 1=Service Provided, 2=Referral Provided, 3=Service Not Provided & Referral Not Provided.

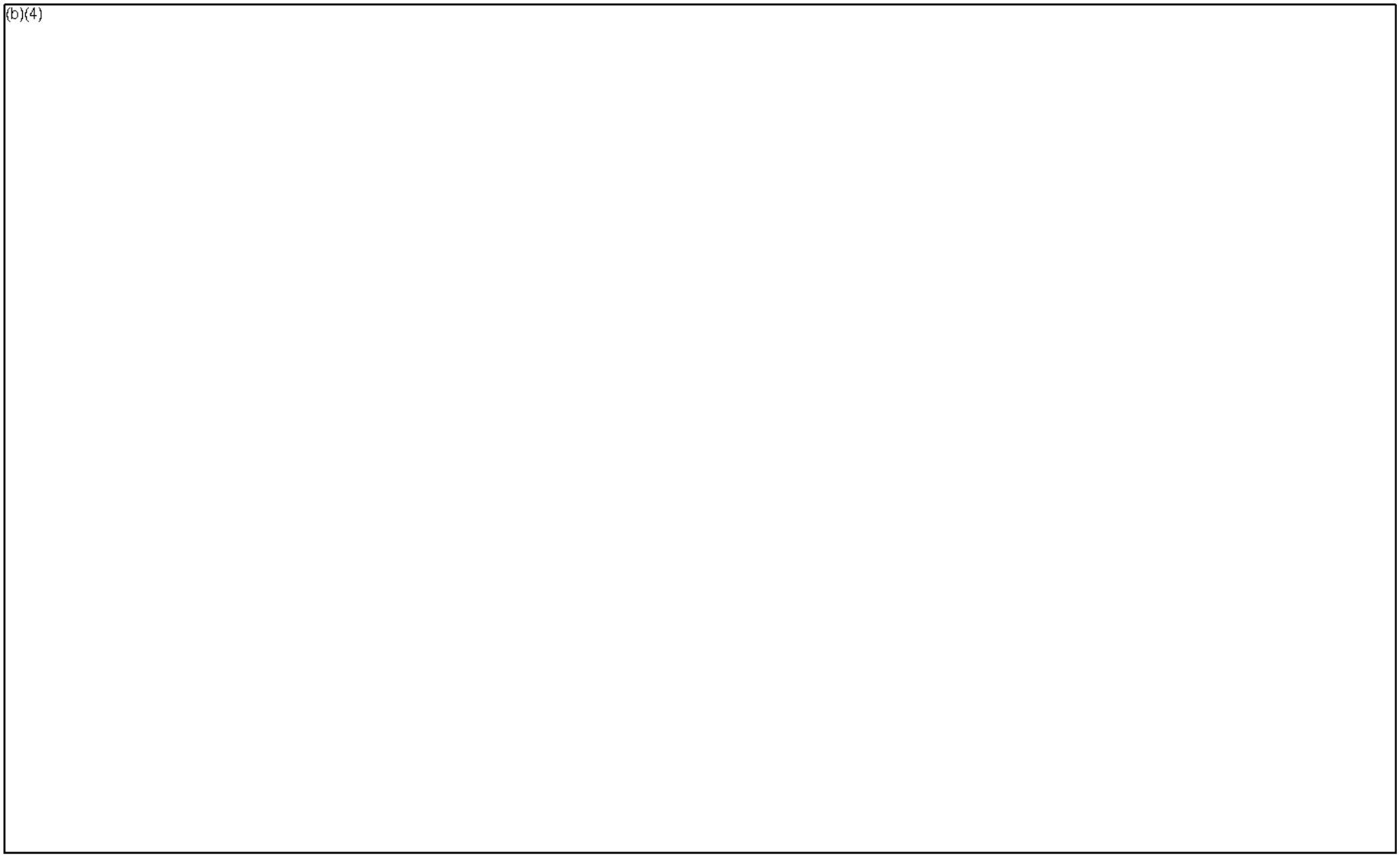
Grant Name : NAVAJO GRANT

Proposed Year : 2018

Services	Name of Health Centers			
	(b)(4)			
1) Family Planning Services				
1. Client Education and Counseling				
1.1. Pregnancy Prevention	1	1	1	1
1.2. Pregnancy Achievement	1	1	1	1
2. Family Planning Methods				
2.1. Male Condom	1	1	1	1
2.2. Oral Contraceptives	1	1	1	1
2.3. Injectables (Depo-Provera)	1	1	1	1
2.4. IUD without Hormones (ParaGard)	1	1	1	1
2.5. IUD with Hormones (Mirena, Skyla, Liletta, Kyleena)	1	1	1	1
2.6. Vaginal Ring (NuvaRing)	1	1	1	1
2.7. Emergency Contraception	1	1	1	1
2.8. Patch	2	2	2	2
2.9. Spermicide (Foams, Films, Suppositories)	2	2	2	2
2.10. Cervical Cap/Diaphragm	2	2	2	2
2.11. Sponge	2	2	2	2
2.12. Female Condom	2	2	2	2
2.13. Natural Family Planning (Fertility Awareness Based Methods)	1	1	1	1
2.14. Lactational Amenorrhea	1	1	1	1
2.15. Sexual Risk Avoidance (Abstinence Education)	1	1	1	1
2.16. Implant (Nexplanon)	1	1	1	1

2) Pregnancy Testing and Counseling as Indicated	1	1	1	1
3) Basic Infertility Services for Men				
1. Sexual History	1	1	1	1
2. Medical History/Family History	1	1	1	1
3. Reproductive History	1	1	1	1
4. Physical Exam	1	1	1	1
5. Semen Analysis	2	2	2	2
6. Further Diagnosis	2	2	2	2
4) Basic Infertility Services for Women				
1. Sexual History	1	1	1	1
2. Medical History/Family History	1	1	1	1
3. Reproductive History	1	1	1	1
4. Physical Exam	1	1	1	1
5. Further Diagnosis	2	2	2	2
5) Preconception Health Screening, Counseling and Education				
1. Intimate Partner Violence	1	1	1	1
2. Alcohol And Other Drug Use	1	1	1	1
3. Tobacco Use	1	1	1	1
4. Immunization Status	1	1	1	1
5. BMI	1	1	1	1
6. Blood Pressure	1	1	1	1
7. Diabetes	1	1	1	1
6) Sexually Transmitted Infection Testing				
1. Chlamydia	1	1	1	1
2. Gonorrhea	1	1	1	1
3. Syphilis	1	1	1	1
4. Herpes	2	2	2	2
5. Hepatitis C for High Risk Populations	2	2	2	2
6. HIV	2	2	2	2
7) Sexually Transmitted Infection Treatment				
1. Chlamydia	1	1	1	1
2. Gonorrhea	1	1	1	1
3. Syphilis	1	1	1	1
4. Herpes	1	1	1	1
5. Hepatitis C for High Risk Populations	2	2	2	2
6. HIV	2	2	2	2
8) Related Preventive Health Services				
1. Clinical Breast Exam as Indicated	1	1	1	1
2. Pelvic Exam as Indicated	1	1	1	1
3. Cervical Cytology with HPV Testing as Indicated	1	1	1	1
4. Genital Exam as Indicated	1	1	1	1
9) Other Preventive Health Services				
1. Other specify -- Colposcopy	1	1	2	2
2. Other specify				
3. Other specify				
4. Other specify				

Arizona Family Health Partnership
2018 Title X Navajo Coverage Map



AFHP 2018
Program Standards and Policy Manual

Table of Contents

INTRODUCTION 5
TITLE X 5
AFHP 5
PROGRAM MONITORING AND EVALUATION 6
Program Standards and Policy Manual (PSPM) 6
Helpful Links 7
DEFINITIONS 8
ACRONYMS 9
COMMONLY USED REFERENCES 10
8. PROJECT MANAGEMENT AND ADMINISTRATION 11
Title X Requirement - 8.1 Voluntary Participation 11
Title X Requirement - 8.1.1 11
Title X Requirement - 8.1.2 12
Title X Requirement - 8.1.3 13
Title X Requirement - 8.2 Prohibition of Abortion 13
Title X Requirement - 8.2 13
Title X Requirement - 8.3 Structure and Management 14
Title X Requirement - 8.3.1 14
Title X Requirement - 8.3.2 15
Title X Requirement - 8.3.3 15
Title X Requirement - 8.3.4 16
Title X Requirement - 8.3.6 16
Title X Requirement - 8.4 Charges, Billing, and Collections 17
Title X Requirement - 8.4.1 17
Title X Requirement - 8.4.2 18
Title X Requirement - 8.4.3 18
Title X Requirement - 8.4.4 19
Title X Requirement - 8.4.5 19
Title X Requirement - 8.4.6 20
Title X Requirement - 8.4.7 20
Title X Requirement - 8.4.8 21
Title X Requirement - 8.4.9 21
Title X Requirement - 8.5 Project Personnel 22

Title X Requirement - 8.5.1 22
Title X Requirement - 8.5.2 23
Title X Requirement - 8.5.3 23
Title X Requirement - 8.5.4 24
Title X Requirement - 8.5.5 24
Title X Requirement - 8.6 Staff Training and Project Technical Assistance 25
Title X Requirement - 8.6.1 25
Title X Requirement - 8.6.2 26
Title X Requirement - 8.6.3 27
Title X Requirement - 8.7 Planning and Evaluation 28
9. PROJECT SERVICES AND CLIENTS 28
Title X Requirement - 9.1 29
Title X Requirement - 9.2 29
Title X Requirement - 9.3 30
Title X Requirement - 9.4 31
Title X Requirement - 9.5 32
Title X Requirement - 9.6 32
Title X Requirement - 9.7 34
Title X Requirement - 9.8 35
Title X Requirement - 9.9 36
Title X Requirement - 9.10 36
Title X Requirement - 9.11 37
Title X Requirement - 9.12 38
10. CONFIDENTIALITY 39
Title X Requirement - 10 39
11. COMMUNITY PARTICIPATION, EDUCATION, AND PROJECT PROMOTION 41
Title X Requirement - 11.1 41
Title X Requirement - 11.2 42
Title X Requirement - 11.3 42
12. INFORMATION AND EDUCATION MATERIALS APPROVAL 44
Title X Requirement - 12.1 44
Title X Requirement - 12.2 44
Title X Requirement - 12.3 45
Title X Requirement - 12.4 45

Title X Requirement - 12.5 46
Title X Requirement - 12.6 46
13. ADDITIONAL ADMINISTRATIVE REQUIREMENTS 47
Title X Requirement - 13.1 Facilities and Accessibility of Services 47
Title X Requirement - 13.1.1 47
Title X Requirement - 13.1.2 49
Title X Requirement - 13.2 Emergency Management 49
Title X Requirement - 13.2 49
Title X Requirement - 13.3 Standards of Conduct 50
Title X Requirement - 13.3 50
Title X Requirement - 13.4 Human Subjects Clearance (Research) 50
Title X Requirement - 13.4 50
Title X Requirement - 13.5 Financial and Reporting Requirements 51
Title X Requirement - 13.5 51
14. ADDITIONAL CONDITIONS 53
AFHP Requirement - 14.1 Advancement of Title X Funds 53
AFHP Requirement - 14.2 Client Grievances 54
AFHP Requirement - 14.3 Record Retention 54
AFHP Requirement – 14.4 Closeout 54
PROGRAM POLICY NOTICES 55
OPA Program Policy Notice: Confidential Services to Adolescents 55
OPA Program Policy Notice: Integrating with Primary Care Providers 56
APPENDIX 1a 59
APPENDIX 1b 60
APPENDIX 2 61
APPENDIX 3 62
APPENDIX 4 65

INTRODUCTION

TITLE X

To assist individuals in determining the number and spacing of their children through the provision of affordable, voluntary family planning services, Congress enacted the Family Planning Services and Population Research Act of 1970 (Public Law 91-572). The law amended the Public Health Service (PHS) Act to add Title X, "Population Research and Voluntary Family Planning Programs." Section 1001 of the PHS Act (as amended) authorizes grants "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 (including natural family planning methods, infertility services, and services for adolescents)."

The Title X Family Planning Program is the only Federal program dedicated solely to the provision of family planning and related preventive health services. The program is designed to provide contraceptive supplies and information to all who want and need them, with priority given to persons from low-income families. All Title X-funded projects are required to offer a broad range of acceptable and effective medically (U.S. Food and Drug Administration (FDA)) approved contraceptive methods and related services on a voluntary and confidential basis. Title X services include the delivery of related preventive health services, including patient education and counseling; cervical and breast cancer screening; sexually transmitted disease (STD) and human immunodeficiency virus (HIV) prevention education, testing, and referral; and pregnancy diagnosis and counseling. By law, Title X funds may not be used in programs where abortion is a method of family planning.

The Title X Family Planning Program is administered by the Office of Population Affairs (OPA), Office of the Assistant Secretary for Health (OASH), within the U.S. Department of Health and Human Services (DHHS).

The Title X Family Planning Guidelines consist of two parts, 1) *Program Requirements for Title X Funded Family Planning Projects* (hereafter referred to as *Title X Program Requirements*) and 2) *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* (hereafter referred to as the QFP).

AFHP

Arizona Family Health Partnership (AFHP) is an Arizona non-profit 501(c) (3) agency, incorporated in 1974 (as the Arizona Family Planning Council). Since 1982, AFHP has been designated as a Title X ("ten") grantee and awarded federal family planning funds to provide services in Arizona. AFHP has also been the Navajo Nation grantee since July 2014.

As the grantee, AFHP performs a variety of roles in the oversight of the Title X Family Planning Program, including: grant administrator, monitor, partner, facilitator, technical advisor, educator and payer. AFHP responds to requests from the Regional OPA Office and from other Federal DHHS Offices. As the grantee, the AFHP is responsible to the funding

source for the following: quality, cost, accessibility, acceptability, and reporting for the Program and the performance of all delegate agencies.

(b)(4)

Page 029 of 199

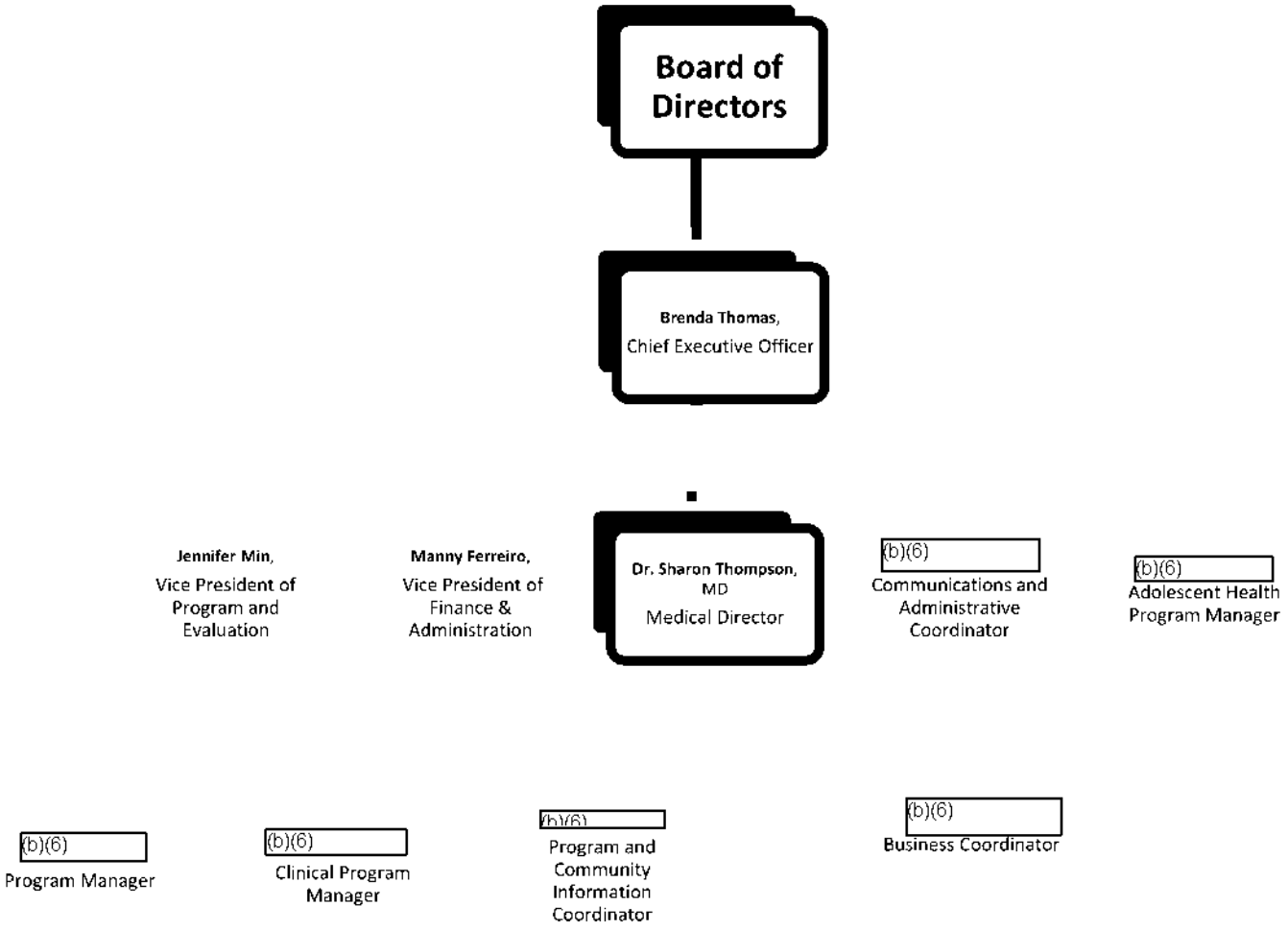
Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Appendix 4

Organizational Chart



Brenda L. "Bré" Thomas, MPA

PROFILE

More than 25 years of dynamic and proven leadership experience working in non-profit organizations, the Executive, Agency and Legislative Branch of state government as well as electoral campaigns. Expertise includes building lasting relationships and partnerships all while prioritizing competing responsibilities.

SPECIALIZED SKILLS

Knowledge and expertise in the areas of:

- Reproductive and public health
- Coalition building and management
- Communication and marketing
- Contract management and budgeting
- International policy experience
- Complex policy development and analysis
- Fundraising for campaigns & non-profits
- Prioritization of competing responsibilities
- Conversant in German
- Staff supervision

PROFESSIONAL EXPERIENCE

ARIZONA FAMILY HEALTH PARTNERSHIP (b)(6)

Chief Executive Officer

- Successfully lead non-profit agency with a $5 million annual budget and two Title X grants from US Department of Health and Human Services to contract with six sub-recipients throughout Arizona and the Navajo Nation including southern Utah
- Lead and retain a dynamic staff with three direct reports (eight staff total) to monitor sub-recipients all while improving outcomes and ensuring compliance with complex program guidelines and regulations
- Provide leadership and support to empower an informed and engaged Board of Directors
- Implement and monitor a program awareness campaign to increase services to teens by up to 16% utilizing social media, Cox and Pandora digital platforms
- Enhance community's awareness of and act as the spokesperson for agency to the media, print, TV and radio on all topics of reproductive health care with consistent messaging
- Develop and maintain collaborative relationships with private and public sector partners to increase access to contraception methods and to improve health outcomes for women
- Awarded an additional $250,000 for Zika prevention training, outreach and the purchase of contraception as well as almost 300,000 condoms for distribution state-wide

(b)(6)

Brenda L. "Bré" Thomas, MPA

(b)(6)

EDUCATION

Master of Public Administration, (b)(6) Arizona State University
- Member of Pi Alpha Alpha, National Honor Society

Bachelor of Arts in Political Science, (b)(6) Arizona State University
The University of London, Semester Abroad (b)(6) London, England
Kreis Gymnasium Halle, (b)(6) Halle, Germany
- (b)(6)

COMMUNITY ACTIVITIES

(b)(6)

Curriculum Vitae

Sharon R. Thompson, M.D., MPH

(b)(6)

Education

(b)(6)

Chief Resident for Teaching
Department of Obstetrics, Gynecology and Reproductive Medicine
Brigham and Women's Hospital, Massachusetts General Hospital
integrated Residency Program, Boston Massachusetts

Post Graduate- Years I-IV
Department of Obstetrics, Gynecology and Reproductive Medicine
Brigham and women's Hospital, Boston Massachusetts

Mount Sinai School of Medicine
New York NY
Degree: Doctor of Medicine

University of California, Berkeley
Berkeley California
Degree: Masters of Public Health (Maternal and Child Health)

Los Angeles Unified School District Teacher Credentialing Program
Los Angeles, California
Certificate: Secondary, Life Science Teaching Credential

Vassar College
Poughkeepsie New York
Degree: Bachelor of Arts in Biology

Employment

(b)(6)

Medical Director, Arizona Family Health Partnership

(b)(6)

(b)(6)

Honors and Awards

(b)(6)

Appendix 4

Curriculum Vitae

Sharon R. Thompson, M.D., MPH

(b)(6)

(b)(6)

Curriculum Vitae

Sharon R. Thompson, M.D., MPH

(b)(6)

(b)(6)

Publications

1. Thompson S. *Complementary Medicine*; Med-Challenger OBGYN Comprehensive Review [computer program]. Challenger Corporation, 2004.

2. Thompson S. *Sexuality and Sexual Counseling*; Med-Challenger OBGYN Comprehensive Review [computer program]. Challenger Corporation, 2004.

3. Thompson S. Becoming a Feminist Doctor. In: Women, Images and Realities: A Multicultural Anthology. New York, NY: McGraw Hill 2002

4. Thompson Sharon, Swartz Mark, Rose Suzanne. Taking a Sexual History: an Interactive Workshop Seminar. Poster Presentation, American Association of Medical Colleges, Washington DC, 2002

Personal and professional references available upon request

Manuel E. Ferreiro

(b)(6)

SUMMARY

Senior Financial Executive with more than twenty years of experience in nonprofit and for profit environments. Excellent analytical, business planning and forecasting skills along with a successful record of strategic financial and capital planning. Supportive team builder and team player with strong personal values and impeccable integrity.

PROFESSIONAL EXPERIENCE

(b)(6)

Arizona Family Health Partnership. - Phoenix, AZ
Vice President of Finance and Administration
Multi-delegate Title X funded, organization providing family planning services, prevention and education to over 35,000 patient

(b)(6)

EDUCATION

Bachelor of Science, Business Administration
Boston University
Diploma, Financial Planning
Boston University

(b)(6)

PROFESSIONAL / COMMUNITY AFFILIATIONS

(b)(6)

JENNIFER MIN, MSPH

(b)(6)

EDUCATION:

UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER, Denver, CO
Master of Science in Public Health
Graduated: (b)(6)

UNIVERSITY OF COLORADO, Boulder, CO
Bachelor of Arts
Major: Biological Sciences - Environmental, Populational, and Organismic
Graduated: December (b)(6)

EXPERIENCE:

(b)(6)

(b)(6)

COMPUTER SKILLS:

(b)(6)

LANGUAGES:

Kristin Stookey, CRNP

(b)(6)

Current Position, Clinical Program Manager, Arizona Family Health Partnership

Operational responsibilities include program development and evaluation of family planning services; management of Title X funded family planning services for the Navajo Nation; oversight of medically-related activities within the scope of the Arizona Family Health Partnership (AFHP) projects; provision of technical assistance in the areas of quality assurance and medically related issues; communication of pertinent clinical information to other staff directly involved with the agencies funded through AFHP to provide family planning services; program and fiscal monitoring of subcontractors; community collaboration; preparation of reports; and other duties as assigned.

Education

- (b)(6) Master in Nursing credits, University of Phoenix
- (b)(6) Bachelor of Science in Nursing, University of Phoenix
- (b)(6) Harbor UCLA Women's Health Care Nurse Practitioner Program
- Iowa Methodist School of Nursing, Des Moines, IA

Relevant Experience

(b)(6)

(b)(6)

Other Experience

(b)(6)

Certifications/Licensure

(b)(6)

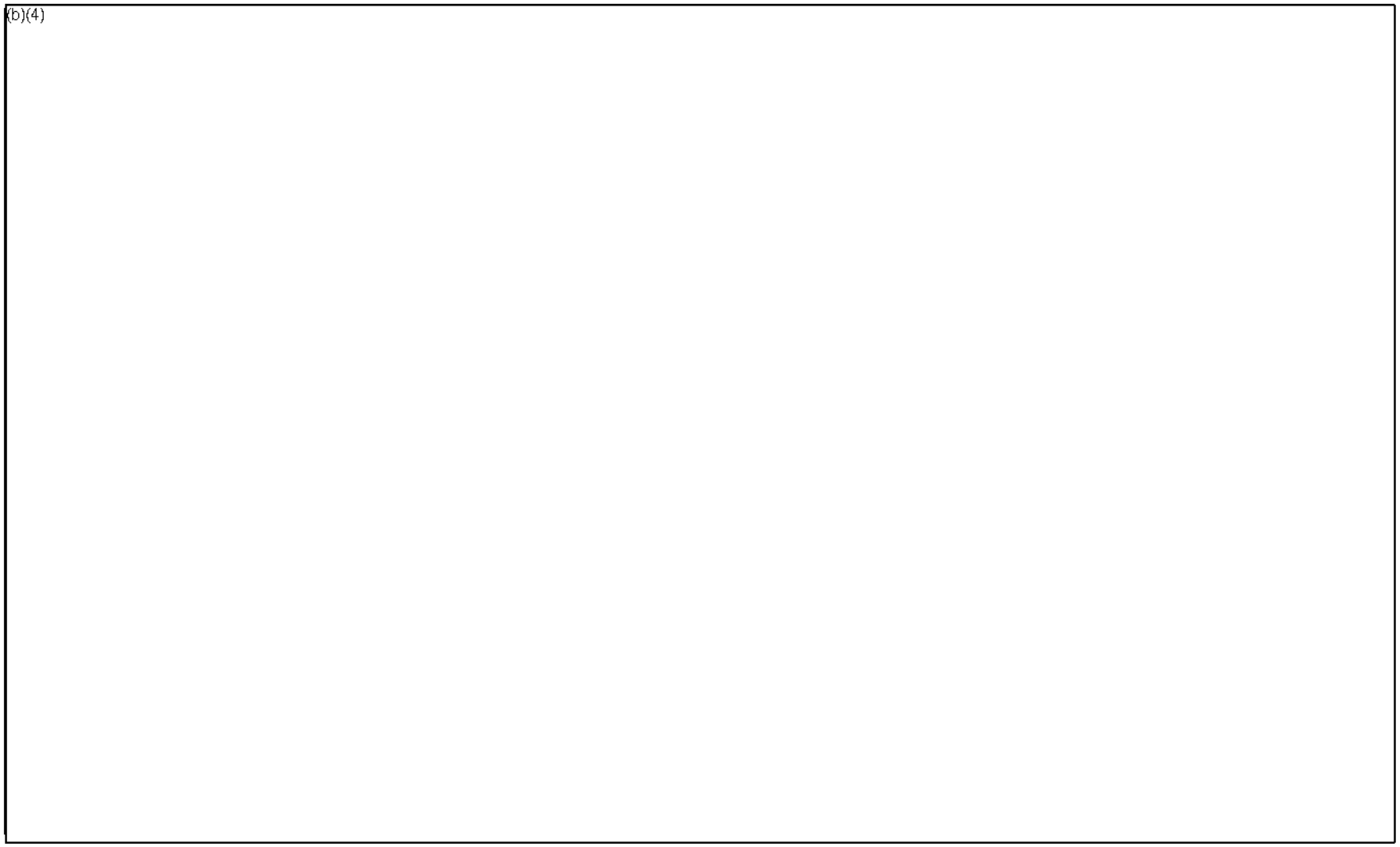
References Available upon Request

Arizona Family Health Partnership
Program Work Plan – Navajo Grant
September 1, 2018 through August 31, 2022

(b)(4)

(b)(4)

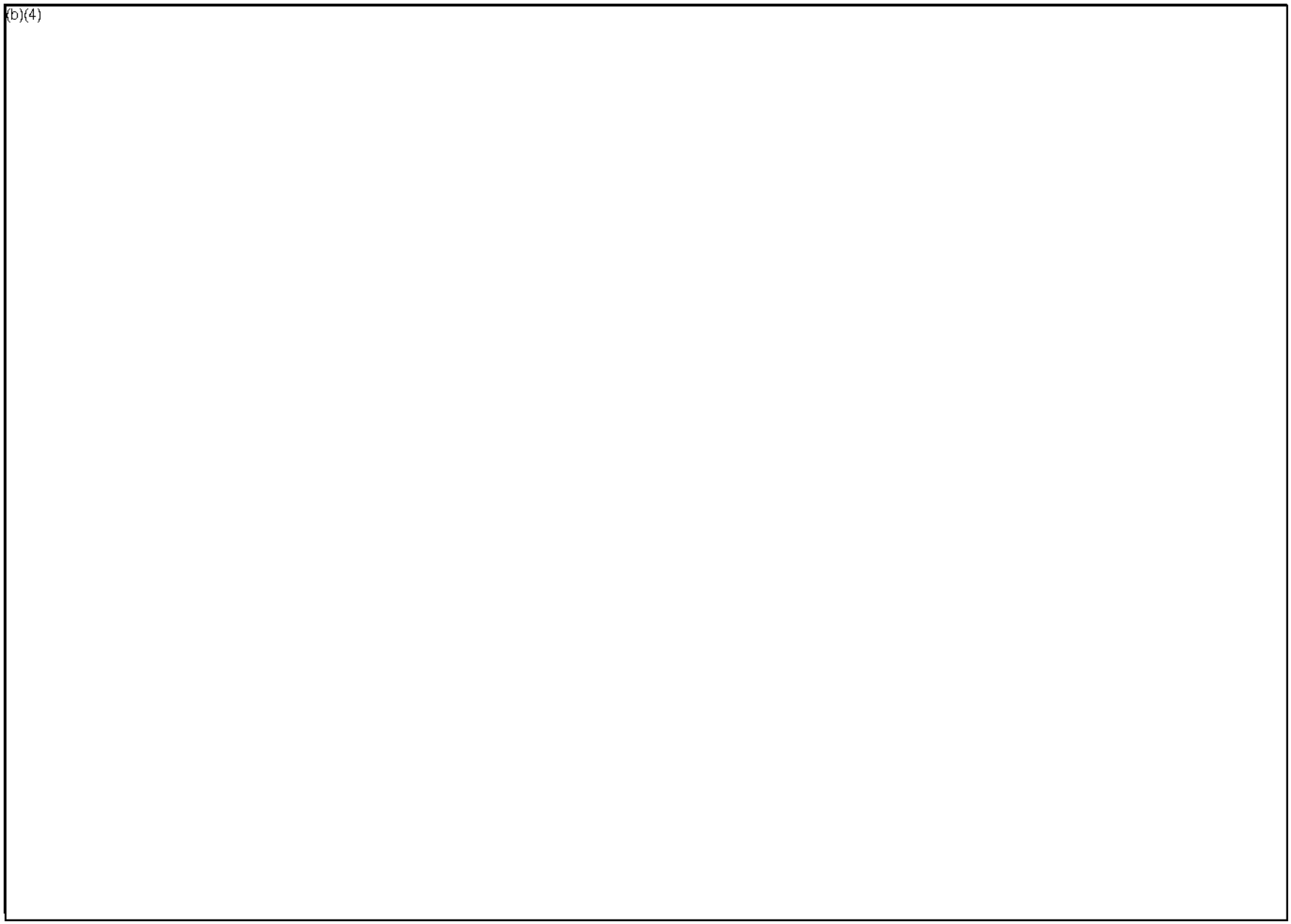

(b)(4)


(b)(4)


(b)(4)


(b)(4)

(b)(4)


(b)(4)

(b)(4)


(b)(4)


(b)(4)


(b)(4)

(b)(4)


(b)(4)

(b)(4)

2018 Key Issues

1. Efficiency and effectiveness in program management and operations;
2. Management and decision-making and accountability for outcomes;
3. Cooperation with community-based and faith-based organizations;
4. Meaningful collaboration with subrecipients and documented partners in order to demonstrate a seamless continuum of care for clients;
5. A meaningful emphasis on education and counseling that communicates the social science research and practical application of topics related to healthy relationships, to committed, safe, stable, healthy marriages, and the benefits of avoiding sexual risk or returning to a sexually risk-free status, especially (but not only) when communicating with adolescents;
6. Activities for adolescents that do not normalize sexual risk behaviors, but instead clearly communicate the research informed benefits of delaying sex or returning to a sexually risk-free status.
7. Emphasis on the voluntary nature of family planning services;

8. Data collection (such as the Family Planning Annual Report (FPAR) for use in monitoring performance and improving family planning services.

Appendix 6

(b)(4)

(b)(4)

(b)(4)

Title X Requirement - 8.4 Charges, Billing, and Collections

The grantee is responsible for the implementation of policies and procedures for charging, billing, and collecting funds for the services provided by the projects. Clients must not be denied project services or be subjected to any variation in quality of services because of inability to pay.

Projects should not have a general policy of no fee or flat fees for the provision of services to minors, or a schedule of fees for minors that is different from other populations receiving family planning services

Title X Requirement - 8.4.1
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)).

Within the parameters set out by the Title X statute and regulations, Title X grantees have a large measure of discretion in determining the extent of income verification activity that they believe is appropriate for their client population Although not required to do so, grantees that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on clients self-report.

Additional AFHP Requirement

(b)(4)

QFP Recommendation

None

Evidence Requirement is Met

1. Delegate has policies and procedures assuring that clients whose documented income is at or below 100% FPL are not charged for services.
2. Delegate has policies and procedures assuring that 3rd party payers are billed.
3. Financial documentation indicates clients whose documented income is at or below 100% FPL are not charged for services.
4. Financial documentation indicates that if a third party is authorized or legally obligated to pay for services, the project has billed accordingly.

5. Delegate has a written policy and procedure for verifying client income that is aligned with Title X requirements.
6. Delegate policy for verifying client income does not present a barrier to receipt of services.

Title X Requirement - 8.4.2
A schedule of discounts, based on ability to pay, is required for individuals with family incomes between 101% and 250% of the FPL (42 CFR 59.5(a)(8)).

Additional AFHP Requirement

(b)(4)

QFP Recommendation
None

Evidence Requirement is Met

1. Delegate has policies and procedures indicating that a schedule of discounts has been developed and is updated periodically to be in line with the FPL.
2. Service site documentation indicates client income is assessed and discounts are appropriately applied to the cost of services.

Title X Requirement - 8.4.3
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).

Additional AFHP Requirement

(b)(4)

QFP Recommendation
None

Evidence Requirement is Met

1. Delegate has policies and procedures that demonstrate there is a process to refer clients (or financial records) to the service site director for review and consideration of waiver of charges.

2. Documentation onsite demonstrates a determination is made by the service site director, is documented and the client is informed of the determination.

Title X Requirement - 8.4.4
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)).

Additional AFHP Requirement
None

QFP Recommendation
None

Evidence Requirement is Met
1. Delegate has a documented process, with a sound rationale, for determining the cost of services.
2. Financial records indicate client income is assessed and that charges are applied appropriately to recover the cost of services.

Title X Requirement - 8.4.5
Eligibility for discounts for unemancipated minors who receive confidential services must be based on the income of the minor (42 CFR 59.2).

Additional AFHP Requirement
None

QFP Recommendation
None

Evidence Requirement is Met
1. Delegate policies, procedures, and other documentation demonstrate that there is a process for determining whether a minor is seeking confidential services.
2. Delegate policy stipulates that charges to adolescents seeking confidential services will be based solely on the adolescent's income.
3. Client records indicate appropriate implementation of policy.

Title X Requirement - 8.4.6
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.

Additional AFHP Requirement

(b)(4)

QFP Recommendation
None

Evidence Requirement is Met

1. Delegate policies and procedures indicate that the project bills insurance in accordance with Title X regulations.
2. The delegate can demonstrate that it has contracts with insurance providers, including public and private sources.
3. Financial records indicate that clients with family incomes between 101%-250% FPL do not pay more in copayments or additional fees than they would otherwise pay when the schedule of discounts is applied.

Title X Requirement - 8.4.7
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)].

Additional AFHP Requirement
None

QFP Recommendation
None

Evidence Requirement is Met
Delegate maintains written agreements and ensures they are kept current as appropriate.

Title X Requirement - 8.4.8
Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.

Additional AFHP Requirement

(b)(4)

QFP Recommendation
None

Evidence Requirement is Met

1. Delegate policies addressing collection include safeguards that protect client confidentiality, particularly in cases where sending an explanation of benefits could breach client confidentiality.
2. Documentation demonstrates that clients' services remain confidential when billing and collecting payments.

Title X Requirement - 8.4.9
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.

Additional AFHP Requirement

(b)(4)

QFP Recommendation
None

Evidence Requirement is Met

1. Delegate policies and procedures indicate if the program requests and/or accepts donations.

Page 062 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 063 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 064 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 065 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 066 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 067 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 068 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 069 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 070 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 071 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 072 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 073 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Linkages

AFHP's outstanding network of organizations provide a wide-range of services to our target population. AFHP possesses positive relationships with these valuable agencies and we frequently collaborate with them on projects that benefit the clients we serve. Our linkages allow us to more broadly disseminate information about Title X services and expand our services to hard to reach populations. AFHP enjoys linkages with the following organizations.

Alliance of Arizona Nonprofits – The Alliance of Arizona Nonprofits is a trusted resource and advocate for Arizona's nonprofit sector. AFHP is member of this organization and utilizes best-practices shared for the management of AFHP.

American Cancer Society (ACS) - AFHP and the American Cancer Society (ACS) partner to advance Human Papilloma Virus (HPV) vaccination efforts. Together, AFHP and ACS work to reduce cancers caused by HPV through education. The priority areas include amplifying existing impactful efforts through sharing best practices, establishing new or strengthening state level relationships to facilitate HPV vaccination related activities, state level systems changes and increasing external organizations prioritization of HPV vaccination.

American Congress of OB/GYN Arizona Section (ACOG) - The Congress provides education to improve health care for women through practice and research, lead advocacy for women's health care issues nationally and internationally, and provides organizational support and services for members. ACOG is one of many partners that AFHP is working with on a coalition to increase access to postpartum contraception.

Arizona Association of Community Health Centers (AACHC) - AACHC is the primary care association and facilitates affordable and accessible primary healthcare for underserved Arizonans. The work includes collaboration with Federally Qualified Health Centers, Rural

Health Clinics, and Tribal organizations to provide education on services available. Through peer networking committees, AACHC brings together health care professionals from across the state to share best practices as well as to discuss a variety of health center priorities, challenges and success stories. AFHP is an active associate member of AACHC and as a member AFHP participates in their annual conference as well as on their peer networking community for outreach and communications.

Arizona Center for Economic Progress - The Center engages a diverse group of partners in advancing thoughtful analysis and effective solutions to generate economic growth shared by all Arizonans. They work toward a long-term vision that builds economic opportunity and quality jobs through great education, balanced tax and budget policies, as well as robust infrastructure. AFHP relies on their budget acumen to provide information on the State of Arizona's budget and the budget process.

Arizona Collation to End Sexual and Domestic Violence (ACESDV) - ACESDV unites professionals and community members to increase public awareness about the issues of domestic violence and sexual assault, enhance the safety of victims, provide resources, and reduce the incidence of domestic violence among Arizona's families. AFHP and ACESDV present at each other's meetings, and share information and best practices.

Arizona Community Action Association (ACAA) - ACAA unites communities to end poverty through community-based initiatives and solutions. ACAA and AFHP work together to increase awareness about the connection between poverty and access to family planning services.

Arizona Community Foundation (ACF) - ACF is Arizona's premier charitable partner trusted by thousands of generous Arizonans. Each fund has a unique purpose, as each was created by a visionary individual, family or organization. AFHP meets with ACF to update the

project officers on the needs of the community served by AFHP to increase services and education.

Arizona Department of Health Services (ADHS) – AFHP partners with a number of different programs at ADHS including the Title V program, WIC, the Preconception Health Alliance, Health Start, Home Visitors, the STD Control Program as well as the State Health Improvement Plan-Maternal and Child Health Committee. AFHP is the recipient of the Adolescent Health Initiative grant from ADHS and is working to implement the Adolescent Champion Model from the University of Michigan in Arizona.

Arizona Department of Economic Security (DES) – DES works with families, community organizations, advocates and state and federal partners to realize our collective vision that every child, adult, and family in the state of Arizona will be safe and economically secure. AFHP nurtured a relationship with the office of community engagement and the effort results in innovative referrals in each direction.

Arizona Foundation for Women (AFW) - AFW advances the vision to create a better life for Arizona's women and children. The work to mobilize the community's power and resources to meet the unmet needs of Arizona's women and their children, and empower long-term solutions by focusing on safety, health, and economic empowerment. The intersection of safety, health and economic empowerment match nicely with AFHP's work on access to family planning services.

Arizona Health Care Cost Containment System (AHCCCS) - AHCCCS is the state's Medicaid program and AFHP enjoys an advantageous relationship with their leadership team.

The Arizona Local Health Officers Association (ALHOA)- ALHOA is an affiliate of the Arizona Association of Counties and provides a vehicle for the county health officers from

around the state to convene and discuss matters of importance. AFHP presents on the Title X program as well as on special topics like Zika as requested.

The Arizona Partnership for Immunizations – (TAPI) hosts monthly community awareness meetings and bi-monthly provider meetings, generating a venue for the discussion of the importance of vaccines, including the HPV vaccine. TAPI also provides the billing and contracting for two of our county health department sub-recipients well as immunization updates at AFHP delegate meetings. AFHP, ACS & Arizona Cervical Cancer Organization recently received the "Big Shot's" award from TAPI for our collaborative work to increase access to the HPV vaccine.

Arizona Public Health Association (AzPHA) AzPHA is a non-profit organization that collaborates with health care professionals, state, and county health employees, health educators, community advocates, doctors, nurses, students, and faculty to provide education and professional development in Arizona. For the past 88 years, AzPHA has been influential in improving the health of Arizona's communities. AFHP staff are active members in AzPHA and recently won the Elsie Eyer Commitment to Underserved People (CUP) award.

Banner University Family Care (Banner) - AFHP partnered with Banner, a new AHCCCS Complete Care (ACC) provider, to conduct family planning trainings with their providers and develop pilot projects to increase testing and treatment of STD's for their clients. This will begin after 10/1/2018.

Basic Needs Coalition (BNC) BNC is a network of statewide safety net providers that come together to address poverty, food insecurity, violence against women, employment, child care, and other basic needs. AFHP is a formal and active partner with the coalition's work.

CDC – Zika - AFHP collaborated with the CDC at the outset of the Zika crisis to bring the latest information to Arizona healthcare providers, FQHCs, and Departments of Health. AFHP received supplemental grant from OPA for our work on this effort.

Children's Action Alliance (CAA) - CAA conducts research, produces publications, develops media campaigns, and provides advocacy for Arizona's children and families. Their programs provide information for the prevention of child abuse and neglect, they offer programs to help teens to become responsible adults, provide advocacy for children involved in the immigration process, strive to prevent hunger and poverty in Arizona and they work to help all children and families obtain health insurance. CAA convened the Healthy Children Coalition to support Arizona's CHIP program of which AFHP is an active member.

The Florence Immigrant Refugee Project - The Florence Immigrant Refugee Project is a nonprofit legal service organization dedicated to providing free legal services to men, women, and unaccompanied children in immigration custody in Arizona. AFHP works with The Florence Immigrant Refugee Project to provide basic reproductive healthcare training to the legal and social service professionals.

Postpartum Contraceptive Coalition AFHP, ACOG, OB/GYN residency programs, Doctor of Nurse Practioner students, and March of Dimes and various elected officials formed a Coalition to increase the availability of postpartum contraception.

March of Dimes (MOD) - MOD provides information to mothers to help prevent birth defects, premature birth and infant mortality. MOD partners with AFHP to improve birth outcomes for healthy mothers and healthy babies as well as on post-partum depression. Currently MOD is participating in the postpartum contraception coalition hosted by AFHP and is a leader on the postpartum depression work mentioned below.

Maricopa County Public Health Department – AFHP participates in the Maricopa County Collective STEPS for Youth, a community advisory board for positive youth development and the Health Improvement Project of Maricopa County (HIPMC). The Community Health Improvement Plan (CHIP) of Maricopa County is a community wide action plan to address the five public priorities determined by the 2012 Community Health Assessment. AFHP is an active participant and a CHIP strategist addressing the health priority of linkage and access to health care.

Maternal, Infant and Early Childhood Home Visiting Program AFHP provides numerous trainings in the community and at annual meetings to home visitors. Separate trainings designed for clinical (nurses) and nonclinical (case managers, health educators, managers) staff are also available. The home visiting program frequently refer clients to AFHP funded services site for family planning services.

Mobilizing for Positive Futures – AFHP is a member of this community advisory board with the aim of training teachers in primarily health and science departments abstinence-based sexuality education in the Sunnyside Unified School District.

Mountain Park Health Center (MPHC) MPHC is an FQHC in the Phoenix area that provides services to clients from surrounding regions. AFHP contracts with MPHC to provide tubal ligations for uninsured clients according to federal guidelines.

National Family Planning and Reproductive Health Association (NFPRHA) - For over 47 years, NFPRHA provides advocacy, education, and training for administrative and clinical family planning providers working with low-income and uninsured clients. AFHP staff are active on a number of NFPRHA work groups and present at NFPRHA meetings.

Non-profit Women CEOs – Twice a year women from local non-profit organizations meet to discuss important aspects to the non-profit community.

Phoenix Children's Hospital (PCH) Adolescent Medicine Department – PCH's Adolescent Medicine Department works with AFHP to ensure adolescents have access to high quality, confidential services by referring to our network. PCH is also a key partner for the implementation of the Adolescent Health Initative and is the clinical lead for the champions of this project.

Protecting Arizona's Family Coalition (PAFCO) - PAFCO is an inclusive and nonpartisan alliance of health and human service agencies, faith-based communities, and advocacy networks. AFHP is an active member of PAFCO.

Rural Women's Health Network (RWHN) – RWHN cultivates and promotes innovative policies and practices that improve the health of women in Arizona. Currently, the Network's focus is on sexual assault and domestic violence. AFHP is a member of RWHN, attends their meetings, and disseminates relevant information to networks.

Save the Family – Save the Family is a social services agency serving homeless families. AFHP provides quarterly trainings to the clients at Save the Family. AFHP presents information on reproductive health topics that include reproductive life planning, contraceptive methods, and STDs. In addition, AFHP regularly participates at Save the Family sponsored resource fairs.

Teen Outreach Pregnancy Services (TOPS) – AFHP provides training to case managers working directly with clients specifically on reproductive life planning, contraceptive methods and client centered counseling and education. TOPS has reciprocated by presenting at AFHP meetings on the program and services available to community by TOPS. TOPS is one of the funded agencies in this application.

Postpartum Depression Network – AFHP is a partner in the effort led by the Chairwoman of the Arizona House of Representatives Health Committee, Representative Heather Carter and ACOG to increase awareness of postpartum depression.

United Methodist Church, Desert Southwest Conference AFHP presents to the Health and Caring Committee on the work and resources provided by our network and we are actively seeking collaboration opportunities for the future.

Vitalyst – Vitalyst is a local healthcare foundation, on a mission to connect, support and inform efforts to improve the health of individuals and communities in Arizona. AFHP utilizes the information and networks from Vitalyst while connecting with the project officer to support AFHP's work.

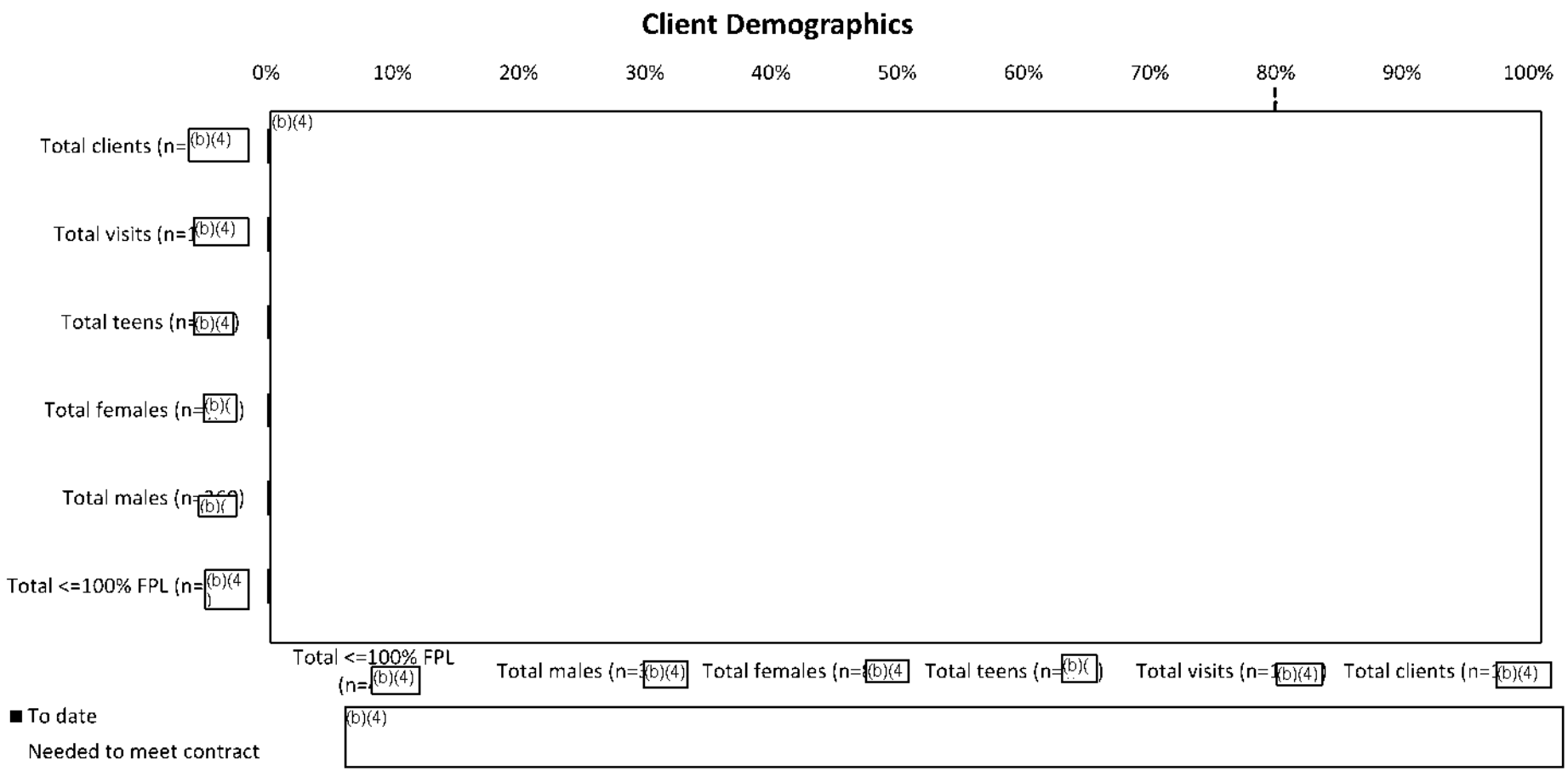
Navajo Linkages

Navajo Area Indian Health Service The Navajo Area Indian Health Service (NAIHS) delivers health services to a user population of over 244,000 American Indians in five Federal services units on and neat the Navajo Nation. Comprehensive health care is offered through inpatient, outpatient, contract, and community health programs centered in four hospitals, seven full-time health care centers, and five part-time health stations.

Navajo Department of Health – The Navajo Department of Health has 14 different programs funded by various agencies. With headquarters in Window Rock, the Navajo Department of Health serves approximately 300,000 members of the Navajo Nation. Covering an area of over 27,000 square miles, the Department of Health delivers a variety of health services in the areas of nutrition, aging, substance abuse, outreach, and emergency medical services, working in close partnership with state, federal, and local partners.

Navajo - July 1, 2017 through March 31, 2018
Dashboard Report

Client Demographics:



Visits per client: 1.41
Average age per client: 26 years

Clients with Race = American Indian/Alaska Native: 68%
Clients with Race = Unknown: 9%

Navajo - July 1, 2017 through March 31, 2018
Dashboard Report

Top Five Primary CPT Codes

Primary CPT Code	Description	Percentage
	(b)(4)	

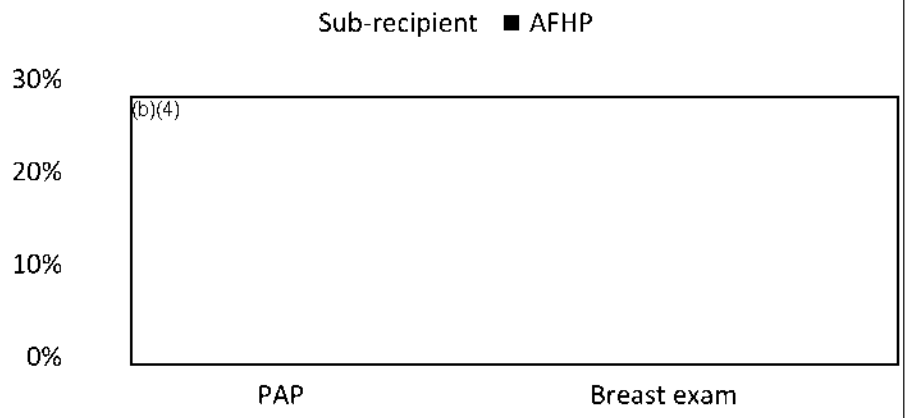
Percent of females <=24 years of age tested for Chlamydia: (b)(4)

(b)(4) Jan-Dec)

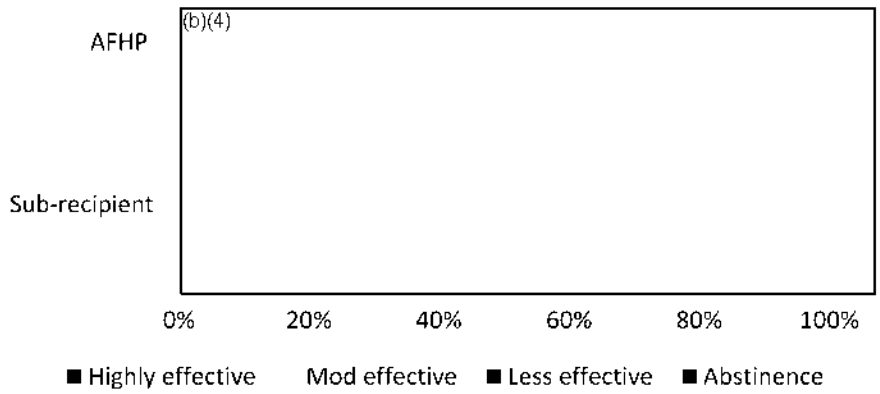
Chlamydia positivity rates

Females <=24	(b)(4)
Females >24	
All males	

Percent of female clients 21 and over with type of service

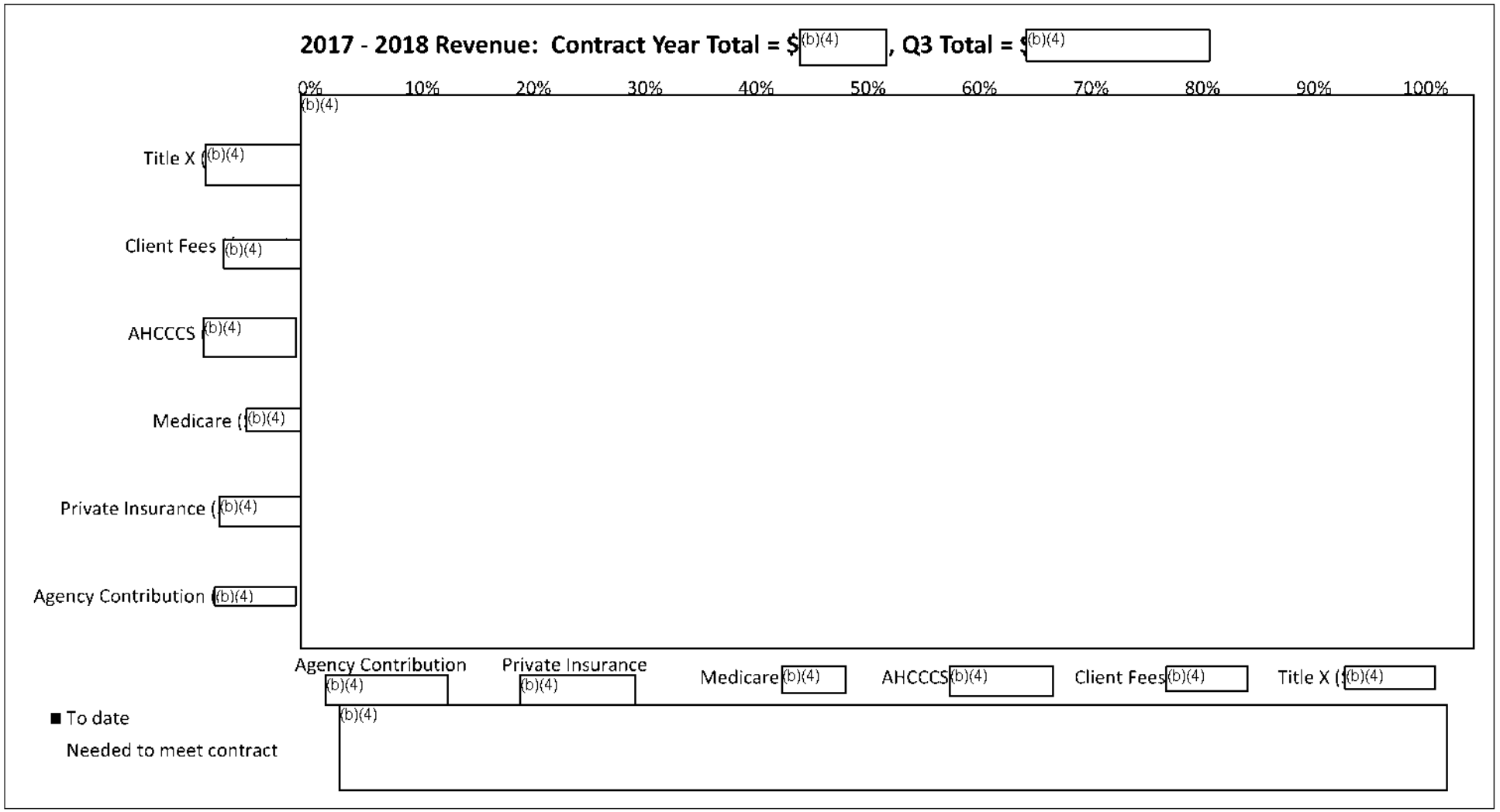


Female Primary Method

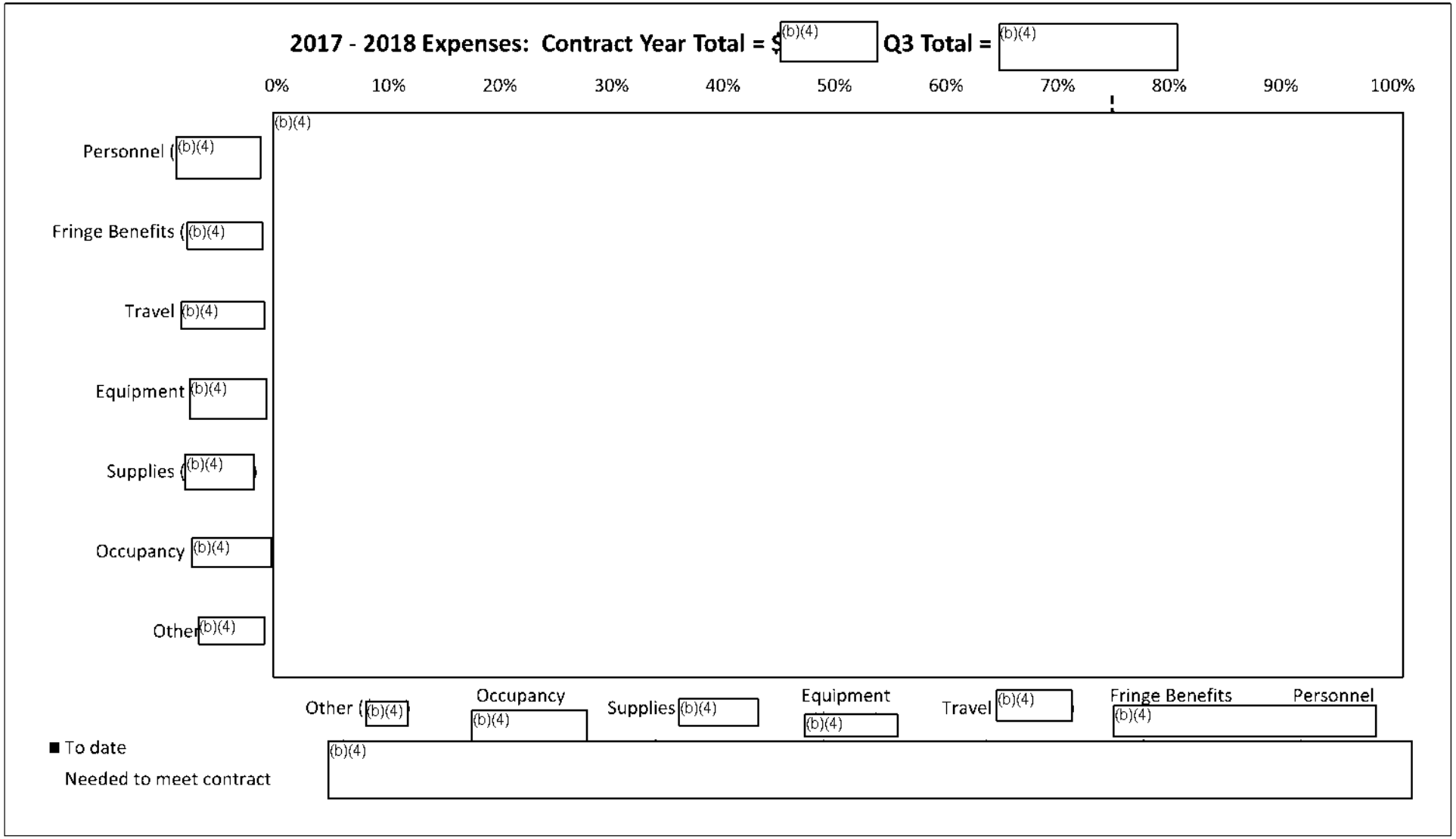


Navajo - July 1, 2017 through March 31, 2018
Dashboard Report

Fiscal:



Navajo - July 1, 2017 through March 31, 2018
Dashboard Report



Page 086 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 087 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 088 of 199

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Endnotes for 2018 Navajo Application

[1] Navajo Area. (2017). *Indian Health Service*. Retrieved January 4, 2018, from https://www.ihs.gov/navajo/index.cfm?module=nao_navajo_nation

[2] Navajo People - The Diné. (2011). *Navajo People*. Retrieved January 4, 2018 from http://navajopeople.org/navajo-nation.htm

[3] Navajo Nation. (2017). *Indian Health Service*. Retrieved January 4, 2018, from https://www.ihs.gov/navajo/navajonation/

[4] American Community Survey Profile (ACS) for the Navajo Nation Reservation and Off-Reservation Trust Land, AZ--NM--UT 2008-2012 ACS 5 Year Estimates. (2013). Retrieved December 6, 2016, from https://gonm.biz/uploads/documents/NavajoACSProfile.pdf

[5] Demographic Analysis of the Navajo Nation Using 2010 Census and 2010 American Community Survey Estimates. Retrieved January 4, 2018 from https://gotr.azgovernor.gov/sites/default/files/navajo_nation_0.pdf

[6] Navajo Indian Language (Dine). Retrieved December 6, 2016, from http://www.native-languages.org/navajo.htm

[7] Navajo Culture. (2017). *Navajo Tourism Department*. Retrieved January 4, 2018, from http://www.discovernavajo.com/navajo-culture.aspx

[8] Report to Congress on the Feasibility of a Navajo Nation Medicaid Agency. (2014, May). Retrieved January 4, 2018, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Downloads/Navajo-Nation-Medicaid-Agency-Feasibility-Report-to-Congress.pdf

[9] Navajo Population Profile 2010 U.S. Census. (2013, December). Retrieved January 4, 2017, from http://www.nec.navajo-nsn.gov/Portals/0/Reports/NN2010PopulationProfile.pdf

[10] Navajo Epidemiology Center Update Vol. 1, May 2016. (2016). *Navajo Epidemiology Center*. Retrieved January 4, 2018, from http://www.nec.navajo-nsn.gov/Portals/0/Announcements/Navajo%20Epidemiology%20Center%20Update%20May%202016.pdf

[11] Navajo Nation Comments to New Mexico Human Services Department on the Centennial Care: Ensuring Care for New Mexicans for the Next 100 Years and Beyond. (2012, April). *New Mexico Legislature*. Retrieved January 4, 2018 from http://www.nmlegis.gov/lcs/handouts/LHHS%20062512%20Navajo%20Nation's%20Comments%20to%20NMHS%20on%20Centennial%20Care.pdf

[12] 2008-2012 American Community Survey 5-Year Estimates: Arizona – DP05 "ACS Demographic and Housing Estimates." (2012). *U.S. Census Bureau*. Retrieved January 4, 2018, from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[13] 2008-2012 American Community Survey 5-Year Estimates: Utah – DP05 "ACS Demographic and Housing Estimates." (2012). *U.S. Census Bureau*. Retrieved January 4, 2018, from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[14] 2008-2012 American Community Survey 5-Year Estimates: Arizona – S1501 "Educational Attainment." (2012). *U.S. Census Bureau*. Retrieved January 4, 2018, from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[15] 2008-2012 American Community Survey 5-Year Estimates: Utah – S1501 "Educational Attainment." (2012). *U.S. Census Bureau*. Retrieved January 4, 2018, from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[16] 2008-2012 American Community Survey 5-Year Estimates: United States – S1501 "Educational Attainment." (2012). *U.S. Census Bureau*. Retrieved January 4, 2018, from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[17] Bishaw, A. (2012, September). Poverty: 2010 and 2011, American Community Survey Briefs. Retrieved January 4, 2018, from https://www.census.gov/prod/2012pubs/acsbr11-01.pdf

[18] 2008-2012 American Community Survey 5-Year Estimates: Arizona S1701 "Poverty Status in the Past 12 Months." (2012). *U.S. Census Bureau*. Retrieved January 4, 2018, from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[19] 2008-2012 American Community Survey 5-Year Estimates: Utah S1701 "Poverty Status in the Past 12 Months." (2012). *U.S. Census Bureau*. Retrieved January 4, 2018, from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[20] 2008-2012 American Community Survey 5-Year Estimates: Arizona DP03 "Selected Economic Characteristics" (2012). *U.S. Census Bureau*. Retrieved January 4, 2018, from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[21] 2008-2012 American Community Survey 5-Year Estimates: Arizona DP03 "Selected Economic Characteristics" (2012). *U.S. Census Bureau*. Retrieved January 4, 2018, from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

[22] State Facts About Unintended Pregnancy: Arizona. (2017). *Guttmacher Institute*. Retrieved January 4, 2018, from https://www.guttmacher.org/sites/default/files/factsheet/up-az.pdf

[23] State Facts on Publicly Funded Family Planning Services: Arizona. (2016). *Guttmacher Institute*. Retrieved January 4, 2018, from http://www.guttmacher.org/sites/default/files/factsheet/fp-az.pdf

[24] Healthcare Services on the Navajo Nation. (2014). *Navajo Nation Division of Economic Development*. Retrieved January 4, 2018 from http://www.navajobusiness.com/infrastructure/Healthcare.htm

[25] Arizona Health Professional Shortage Area (HPSA) Application and Scoring Process. (2009). *Arizona Department of Health Services*. Retrieved January 4, 2018, from http://www.azdhs.gov/documents/prevention/health-systems-development/shortage-designation/hpsa-designations.pdf

[26] Navajo Nation Primary Care Area (PCA) Statistical Profile - 2016. (May 3, 2016). *Arizona Department of Health Services*. Retrieved January 4, 2018, from http://www.azdhs.gov/documents/prevention/health-systems-development/data-reports-maps/primary-care/navajo/8.pdf

[27] Total Professionally Active Physicians. (October, 2017). *Kaiser Family Foundation*. Retrieved January 4, 2018, from https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[28] Arizona Physician Workforce Profile. (2017). *Association of American Medical Colleges*. Retrieved January 4, 2018, from https://www.aamc.org/download/484514/data/arizonaprofile.pdf

[29] Utah Physician Workforce Profile. (2017). *Association of American Medical Colleges*. Retrieved January 4, 2018, from https://www.aamc.org/download/484598/data/utahprofile.pdf

[30] Hospital Beds per 1,000 Population by Ownership Type. (2015). *Kaiser Family Foundation*. Retrieved January 4, 2018, from http://kff.org/other/state-indicator/beds-by-ownership/?currentTimeframe=0

[31] National Vital Statistics Report Vol. 67, No. 1.- Births: Final Data for 2016 (January 31, 2018). *Centers for Disease Control and Prevention*. Retrieved March 12, 2018, from http://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf

[32] Arizona Health Status and Vital Statistics Report: 1B. Natality: Maternal Characteristics and Newborn's Health. (2016). *Arizona Department of Health Services*. Retrieved January 4, 2018, from http://pub.azdhs.gov/health-stats/report/ahs/ahs2016/pdf/text1b.pdf

[33] Percentage of Babies Born Low Birthweight by State (2016). *Centers for Disease Control and Prevention*. Retrieved January 4, 2018, from https://www.cdc.gov/nchs/pressroom/sosmap/lbw_births/lbw.htm

[34] Table 1B-12 Live Births According to Selected Maternal, Prenatal Care, and Delivery Characteristics, Birthweight, Plurality, Child's Sex, Birth Order, and Birth Complications, Arizona, 2006-2016 (American Indian or Alaska Native Mothers). (2016). *Arizona Department of Health Services*. Retrieved January 4, 2018, from http://pub.azdhs.gov/health-stats/report/ahs/ahs2016/pdf/1b12.pdf

[35] Preterm Birth Rate. (2016). *CDC*. Retrieved January 4, 2018, from https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm

[36] Table 1B-2 Live Births According to Selected Maternal, Prenatal Care, and Delivery Characteristics, Birthweight, Plurality, Child's Sex, Birth Order, and Birth Complications, Arizona, 2006-2016 (All Race/Ethnic Groups). (2016). *Arizona Department of Health Services*. Retrieved January 4, 2018, from http://pub.azdhs.gov/health-stats/report/ahs/ahs2016/pdf/1b2.pdf

[37] Infant Mortality Rates by State. (2016). *CDC*. Retrieved January 4, 2018, from https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm

[38] Table 2C-3 Number and Rate of Infant Deaths by Race/Ethnicity and Age Group, 2006-2016. (2016). *Arizona Department of Health Services*. Retrieved January 4, 2018, from http://pub.azdhs.gov/health-stats/report/ahs/ahs2016/pdf/2c3.pdf

[39] Table 1B-13 Low-birthweight (LBW) Births According to Selected Maternal, Prenatal Care and Delivery Characteristics, Birthweight, Plurality, Child's Sex, Birth Order, and Birth Complications, Arizona, 2006-2016 (American Indian or Alaska Native Mothers). (2016). *Arizona Department of Health Services*. Retrieved January 4, 2018, from http://pub.azdhs.gov/health-stats/report/ahs/ahs2016/pdf/1b13.pdf

[40] Teenage Pregnancy Arizona, 2005-2015. (2016). *Arizona Department of Health Services*. Retrieved January 4, 2018, from http://www.azdhs.gov/plan/report/tp/2015/teenpregnancy2015.pdf

[41] Utah Vital Statistics Births and Deaths 2015, Table 16. Pregnancies, Pregnancy Rates, and Populations by Specific Age Groups Under 20 Years, Residents: Utah, 2000 and 2010-2015. (2016). *Utah Department of Health Center for Health Data and Informatics - Office of Vital Records and Statistics*. Retrieved January 4, 2018, from https://vitalrecords.utah.gov/wp-content/uploads/Births-and-Deaths-2015-Utah-Vital-Statistics.pdf

[42] 2011 Navajo Nation High School Youth Risk Behavior Report. (2012). *Navajo Nation Division of Health, & Navajo Area Indian Health Service*. Retrieved January 4, 2018, from http://www.nec.navajo-nsn.gov/Portals/0/Reports/2011%20NYRBS%20HS%20Report%20-%20Final.pdf

[43] Arizona, High School Youth Risk Behavior Survey, 2015. (2016). *Centers for Disease Control and Prevention*. Retrieved January 4, 2018, from https://nccd.cdc.gov/Youthonline/App/Results.aspx?LID=AZB

[44] State Facts About Unintended Pregnancy: Arizona. (August 2017). *Guttmacher Institute*. Retrieved January 4, 2018, from https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-arizona

[45] State Facts About Unintended Pregnancy: Utah. (August 2017). *Guttmacher Institute.* Retrieved January 4, 2018, from https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-utah

[46] Unintended Pregnancy in the United States. (September 2016). *Guttmacher Institute.* Retrieved January 4, 2018, from https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states

[47] Health Benefits and Cost Savings of Publicly Funded Family Planning. (2017). *Guttmacher Institute Data Center.* Retrieved January 4, 2018, from http://data.guttmacher.org/calculator

[48] Mosher WD, Jones J, Abma JC. "Intended and unintended births in the United States: 1982 2010." National health statistics reports; No. 55. (July 24, 2012). *Centers for Disease Control and Prevention.* Retrieved January 4, 2018, from http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf

[49] Sexually Transmitted Diseases 2012 Annual Report. (January 2014). *Arizona Department of Health Services.* Retrieved January 4, 2018, from http://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/disease-integrated-services/std-control/reports/2012-std-annual-report.pdf

[50] Sexually Transmitted Diseases 2016 Annual Report. (February 2018). *Arizona Department of Health Services.* Retrieved March 12, 2018, from http://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/disease-integrated-services/std-control/reports/2016-std-annual-report.pdf

[51] Chlamydia - CDC Fact Sheet. (October 4, 2016). *Centers for Disease Control and Prevention.* Retrieved January 4, 2018, from http://www.cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm

[52] Taylor, M., & Peterson, B. (2009, January). Expedited Partner Therapy for Chlamydia and Gonorrhea in Arizona - A Clinical Tool to Increase Partner Treatment and Decrease Re-infection. Retrieved January 4, 2018 from http://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/disease-integrated-services/std-control/ept-public-health-update.pdf

[53] "Navajo Confront an Increase in New H.I.V. Infections". (May 19, 2013). *New York Times.* Retrieved January 4, 2018, from http://www.nytimes.com/2013/05/20/us/navajo-confront-increase-in-new-hiv-infections.html

[54] 2017 Arizona HIV/AIDS Epidemiology Annual Report. (2017). *Arizona Department of Health Services.* Retrieved January 4, 2018, from http://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/disease-integrated-services/hiv-epidemiology/reports/2017/annual-report.pdf

[55] 2013 Arizona HIV/AIDS Epidemiology Annual Report. (2013). *Arizona Department of Health Services.* Retrieved January 4, 2018, from

http://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/disease-integrated-services/hiv-epidemiology/reports/2013/hiv-arizona-stats.pdf

[56] Sexually Transmitted Disease Surveillance 2016. (September 2017). *Centers for Disease Control and Prevention.* Retrieved January 4, 2018, from https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf

[57] HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2016. (2017). *Centers for Disease Control and Prevention.* Retrieved January 4, 2018, from https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf

[58] Contraceptive Needs and Services, 2014 Update. (September, 2016). *Guttmacher Institute.* Retrieved January 3, 2017, from https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update

[59] National Needs of Family Planning Among US Men Aged 15 to 44 Years (April, 2016). *American Journal of Public Health.* Retrieved January 4, 2018, from http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2015.303037?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&

[60] Title X Family Planning Annual Report 2016 National Summary (August, 2017). *Office of Population Affairs*. Retrieved January 4, 2018, from https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf

Upload #2

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress
Document Title:	SF424_2_1-1237-Service Areas and Congressional Districts - current.pdf

Current Delegate	Clinic	County	Congressional District
	(b)(4)	Navajo	1
		Coconino	1
		Coconino	1
		San Juan	UT 3
		San Juan	UT 3
		San Juan	UT 3
		San Juan	UT 3

Upload #3

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress
Document Title:	ProjectNarrativeAttachments_1_2-Attachments-1235-AFHP Navajo Program Narrative 2018.pdf

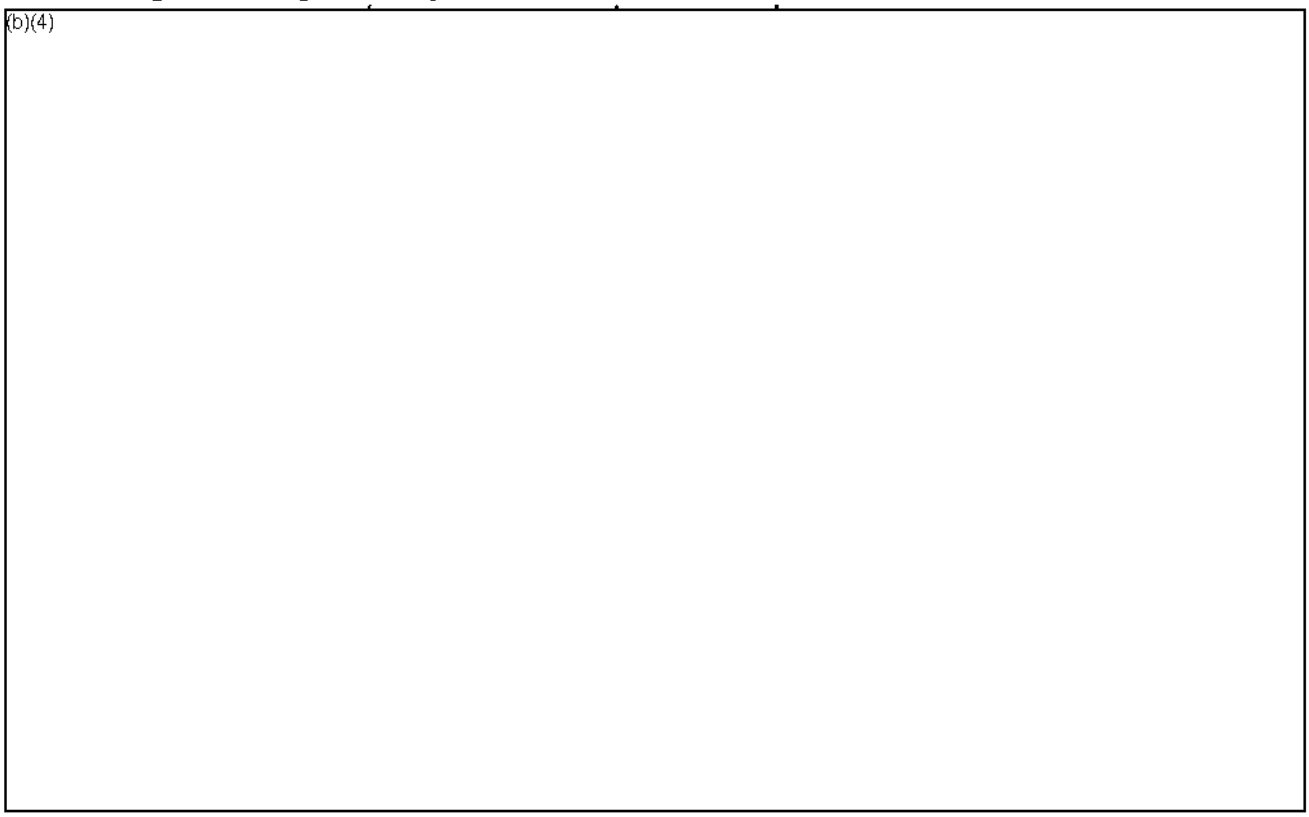
Arizona Family Health Partnership (AFHP) Title X Navajo Project Narrative

The Arizona Family Health Partnership (AFHP) is proposing to provide Title X family planning services throughout the Navajo Nation via its network of (b)(4) federally qualified health centers. AFHP is the current recipient of the Arizona service area grant and the Navajo Nation service area grant. This proposal for the Navajo Nation service area meets the requirements set forth in 42 CFR part 59, subparts A and B as well as the Program Priorities and Key Issues addressed in the 2018 Funding Opportunity Announcement. Through the current network of (b)(4) sub-recipients whose (b)(4) health centers are located in rural areas of northern Arizona and southern Utah, AFHP will serve (b)(4) family planning clients annually. Throughout the following application, AFHP will demonstrate the need for uninterrupted family planning services, as well as its ability to efficiently and effectively leverage federal funds so low-income women, men and adolescents continue to receive the confidential, quality family planning services and comprehensive client education that are the hallmark of the Title X program.

1. **Description of Need for Services Provided and Description of Geographic Area and Population Served**

Geography - The Navajo Nation is the largest American Indian reservation in the United States (U.S.). It encompasses portions of Arizona, New Mexico and Utah, and spans more than 25,000 miles as seen in Figure 1.[1] This makes it roughly the size of West Virginia and as large as 10 of the 51 states. The Navajo Nation is home to some of the most photographed scenery in the U.S. including Monument Valley and Canyon de Chelly. It is also home to three distinct climates. Eight percent of the Navajo Nation is classified as humid, 37% as steppe (with extreme temperatures in both winter and summer), and 55% as desert.[2]

Figure 1. Map of Navajo Nation

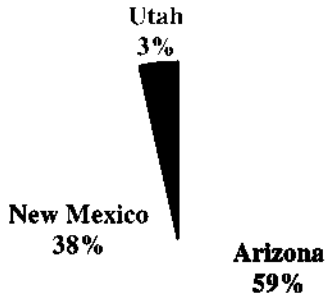


Geographically the Navajo Nation is considered rural, with many communities being miles away from the nearest city or hospital. In some areas, it can take hours to travel from one's home to the nearest store. Because of non-existent public transportation on the reservation, a lack of personal vehicles, and high fuel costs, Navajo families often require coordination of travel for shopping and health care needs. However, transportation can still be a challenge as a majority of the roads are unpaved dirt and become impassable in times of heavy rains and rough weather.

Population - The terms American Indian, Native American, and Alaska Native refer to one of the smallest racial minority groups in the U.S., a group that consists of descendants of the original people indigenous to the North American continent. Anthropologists believe the Navajos arrived in the Southwest probably between 800 and 1,000 years ago, having traveled south across the Bering Strait land bridge. The Navajo people call themselves the Diné, literally translating to

"The People."[3] The American Community Survey data indicates that there are now 172,695 people living on the Navajo Nation.[4] This represents a 4.3% decrease from the 2000 census. Nearly 6 in 10 residents of the Navajo Nation reside in Arizona while just 3% live in Utah. Figure 2 below shows the breakdown of the percentage of the population by state.[5]

Figure 2. Percentage of Navajo Nation Population by State of Residence, 2010



The Navajo Nation strives to preserve the Diné culture, in part by ensuring that instruction is provided to school children in the Navajo language. About 82% of residents of the Navajo Nation speak Navajo in their home, making it the most spoken Native American language in the U.S.[4,6] When looking at healthcare, this presents a unique barrier given healthcare providers typically offer services and educational materials in English.

The Navajo have a strong culture that influences the way they perceive and utilize health care services, and interact with Western medical systems. Some Navajo will utilize the local hospitals and clinics for healthcare while others pursue the tradition of seeking a Medicine man, who heals with herbs, songs, prayers, and ceremonies.[7] Access to adequate healthcare presents challenges for the majority of Navajo people due to remote areas where families live, transportation barriers, and a lack of healthcare providers in the area. With the downturn of the

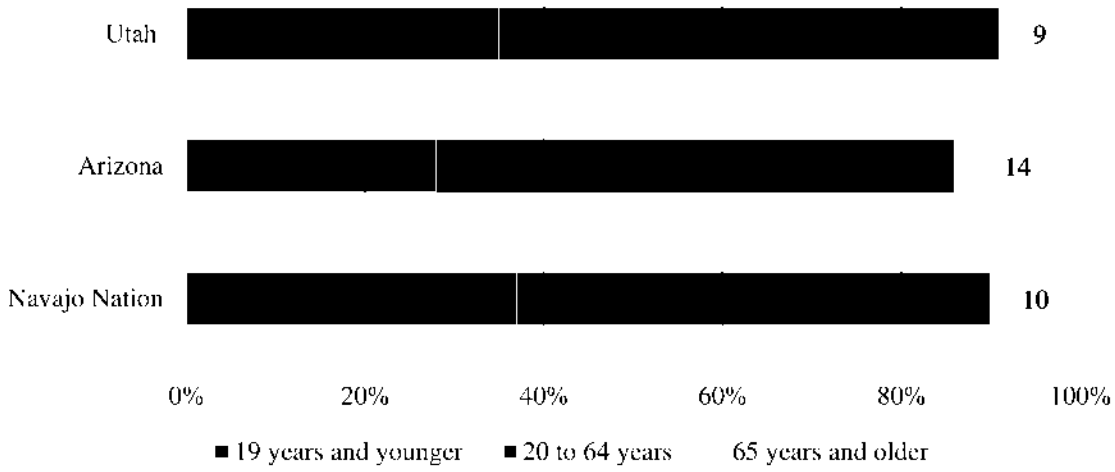
economy and slow recovery, Navajo individuals and families have even fewer employment resources.[5] Additionally, 60% of Navajo people do not have telephones, which makes it difficult to schedule appointments.[8] Thus, offering walk-in or same day opportunities is essential for this community. Ensuring clients receive care for their acute and chronic health care needs at the time of service is crucial to serving the Navajo Nation. Integrating family planning services into primary care has the potential to reduce barriers to receiving family planning services. This service delivery model is extremely important in the delivery of culturally appropriate health care to this special/hard-to-reach population.

Regarding the health care needs of the Navajo people, it is important to recognize the effect alcoholism has on the provision of health services. Alcoholism is the most widespread and severe problem in the Native American community, contributing to the fifth leading cause of death for the Navajo population (chronic liver disease and cirrhosis of the liver) compared to the 12th leading cause of death in the U.S.[9,10] Alcohol abuse is a major mental health issue and contributes to unintentional injury, chronic liver disease, cirrhosis, suicide, domestic violence, fetal alcohol syndrome, teen pregnancy, sexually transmitted diseases, and homicide. The risk for diabetes related deaths is also increased among the Navajo population with rates about three times higher than the U.S. rate (35.9 per 100,000 people compared to 13.5 for U.S.).[11]

Gender and Age - As seen in Arizona and Utah, population gender differences are slight on the Navajo Nation and the population is split almost evenly between males (84,524) and females (88,171).[4] When looking at age group distributions as seen in Figure 3, the Navajo Nation is more similar to Utah than Arizona. According to the American Community Survey data, over one third (37%) of all tribal members of the Navajo Nation are 19 years of age and younger.[4] In contrast, 28% of Arizonans and 35% of Utahns are in this age group.[12,13] The

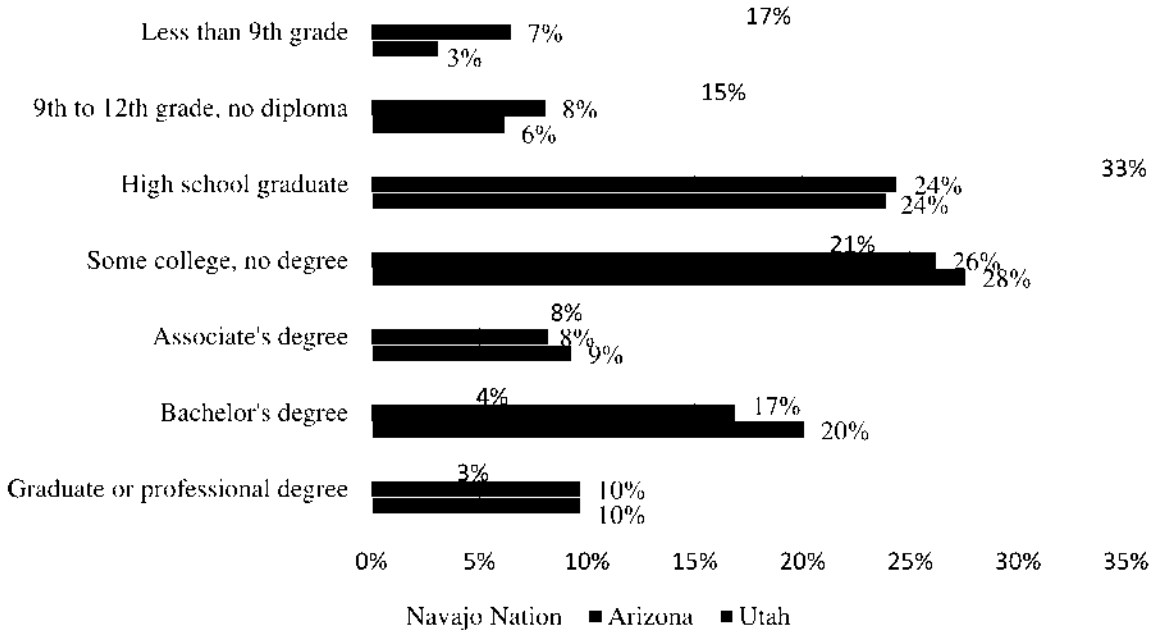
Navajo Nation is home to a smaller proportion of those age 65 and older. While 14% of Arizonans are 65 and older, just 10% of residents on the Navajo Nation and 9% of Utahns fall into this category.[4,12,13] The 2010 US Census reports that there were 35,316 women of reproductive age (15 – 44) living on the Navajo Nation.[9]

Figure 3. Percentage of Population by Age Group, 2008-2012



Education - While educational attainment for adults living in Arizona is similar to the U.S., educational attainment on the Navajo Nation lags far behind. Overall, 85% of Arizona residents and 91% of Utah residents age 25 and older are high school graduates (compared to 86% nationally).[14,15,16] On the Navajo Nation, just 69% of residents have graduated high school. Perhaps even more striking is that the 2012 American Community Survey estimates that 17% (or nearly one in six) of adults on the Navajo Nation completed less than ninth grade.[4] Figure 4 shows the distribution of educational attainment status for Arizona, Utah and Navajo Nation residents age 25 and older.[4,14,15]

Figure 4. Educational Attainment for Residents age 25 and older, Arizona, Utah, & Navajo Nation, 2008-2012



Poverty - Poverty is rampant on the Navajo Nation. Due to many people living in poverty, 32% of Navajo people lack plumbing, 28% lack complete kitchen facilities, and many others do not have electricity in their homes.[8] While 38% of those living on the Navajo Nation (compared to 17% in Arizona and 13% in Utah) have household incomes that place them at or below 100% of the federal poverty level (FPL), 44% of children (compared to 24% in Arizona and 14% in Utah) are considered to be living in poverty.[4,17,18,19] In 2012, 20% of those living on the Navajo Nation were unemployed compared to 10% of Arizonans and 7% of Utahns. An even more striking comparison is that of persons over the age of 65; 8% of Arizonans and 7% of Utahns in this age group live in poverty compared to 39% on the Navajo Nation.[4,18,19] The discrepancy in mean household income for those residing on the Navajo Nation compared to Arizona and Utah are also notable. The mean household income of those on the Navajo Nation in

2012 was about half of that for Arizonans and Utahns; $67,444 in Arizona and $73,002 in Utah compared to $37,890 on the Navajo Nation.[4,20,21]

For women living in poverty, there is an increased risk of unintended pregnancies and an increased need for publicly funded family planning services like Title X. Women ages 15-44 with incomes below 100% FPL have more than five times the unintended pregnancy rate of women at or above 200% FPL.[22] In 2014, the largest group of women needing publicly supported family planning services were those who were <100% FPL, with around double the rate of need than those in other income categories.[23] This disparity could stem from reduced access to reproductive health care, leading to a higher rate of unintended pregnancies among this population and other unforeseen but linked outcomes such as fewer opportunities for educational and economic achievement, less stable marriages, and challenges setting their children up for success. However, with access to free and affordable contraceptives through AFHP Title X funded health centers, low-income clients have a better chance of overcoming these hurdles and bridging the gap.

Insurance and the Health Care Delivery System - The Navajo Nation is home to two private hospital (Sage Memorial and Blue Mountain), a number of private clinics including a safety net facility run by (b)(4) (an FQHC), and facilities run by the Indian Health Service (IHS), which is by far the largest provider of health care on the Navajo Nation.[24] While Native Americans living on the Navajo Nation (96% of residents) are entitled to health care at no cost through the IHS and are also entitled to enroll in Medicaid (known as AHCCCS in Arizona), many members of the Navajo Nation still go without comprehensive medical care for a number of reasons.[5]

In a paper prepared for the New Mexico Medicaid agency,[11] the Navajo Nation identified a number of challenges facing the health care delivery system for Native Americans on the Navajo Nation including:

- High unemployment and poverty rates leading to chronic anxiety, frustration and depression with the ultimate result of high rates of chronic disease.
- IHS spends $1,600 per person per year for health services which is about 50% below per person expenditure by public and private health insurance plans.
- The Navajo Area IHS provides health care services at $1,187 per person and receives federal funding that only met about 55% of the health care needs for the patient population served.
- The U.S. Commission on Civil Rights reported in 2003 that the federal government's rate of spending on health care for Native Americans is 50% less than that of prisoners.
- Federal funding for IHS has been inadequate and has not kept pace with the rising cost of health care, such as the increased cost of prescription drugs, specialty care, competitive salaries to attract health professionals, and changes to health information technology.

In summary, lack of sufficient funding, geographic barriers, linguistic barriers, issues surrounding cultural competency, and health care provider shortages all contribute to a dearth of services in an area that has a higher need due to high rates of chronic illness and poverty.

Professional Healthcare Providers - Federal regulations establish Health Professional Shortage Areas (HPSA) as locations of high medical need based on geographic area, population groups served, or types of facilities available for care. Criteria for HPSA designation includes:

that an area must be rational for the delivery of health services, that there are more than 3,500 people per physician or 3,000 people per physician if the area has high need, and that healthcare resources in surrounding areas must be unavailable because of distance, over-utilization, or access barriers.[25] Members of federally-recognized American Indian tribes are automatically designated as population group HPSAs, making the Navajo Nation a HPSA under these criteria. Table 1 details the dramatic difference between the ratio of primary care providers and hospital beds in Arizona compared to the Navajo Nation.

Table 1. Providers and Hospitals, Utah & Arizona compared to Navajo Nation, 2016 - 2017

	Number of Primary Care Providers[26,27]	Population to Provider Ratio, [26,28,29]	Hospital Beds per 1,000 Residents[26,30]
Navajo Nation (Arizona)	64	1,556:1	0.3
Arizona	8,240	236:1	2
Utah	2,890	209:1	1.8

Reproductive Health Indicators

Birth Rates and Birth Outcomes - At the time of this writing, the most recent birth outcomes statistics available are for births occurring in 2016 and the most recent infant mortality statistics are for 2015. Table 2 provides low birth weight, preterm birth, and infant mortality rates for the U.S., Arizona, Utah, and Native American women residing in Arizona. Birth rates per 1,000 women in the U.S. and Arizona were remarkably similar (12.2 in the U.S. and 12.3 in Arizona) while Utah and Native American birth rates were higher (16.5 and 17.3 respectively).[31,32] Both Arizona as a whole and Native American women residing in Arizona had better outcomes for both low birth rate and preterm births than the nation. However, infant deaths were higher among Native American women.

Table 2. Birth, Low Birth Weight, Preterm Birth, and Infant Mortality Rates, Arizona, Utah, and U.S., 2016				
	Birth Rate (per 1,000 women) [31,32]	**Low Birth Weight Rate* (per 100 live births)** [31,33,34]	**Preterm Birth Rate (per 100 live births)** [31,34,35]	**Infant Mortality Rate** (per 1,000 live births)** [37,38]
U.S.	12.2	8.2	9.9	5.4
Arizona	12.3	7.3	9.1	5.4
Utah	16.5	7.2	9.6	5.4
Native Americans in Arizona	17.3	7.2	9.9	8.3

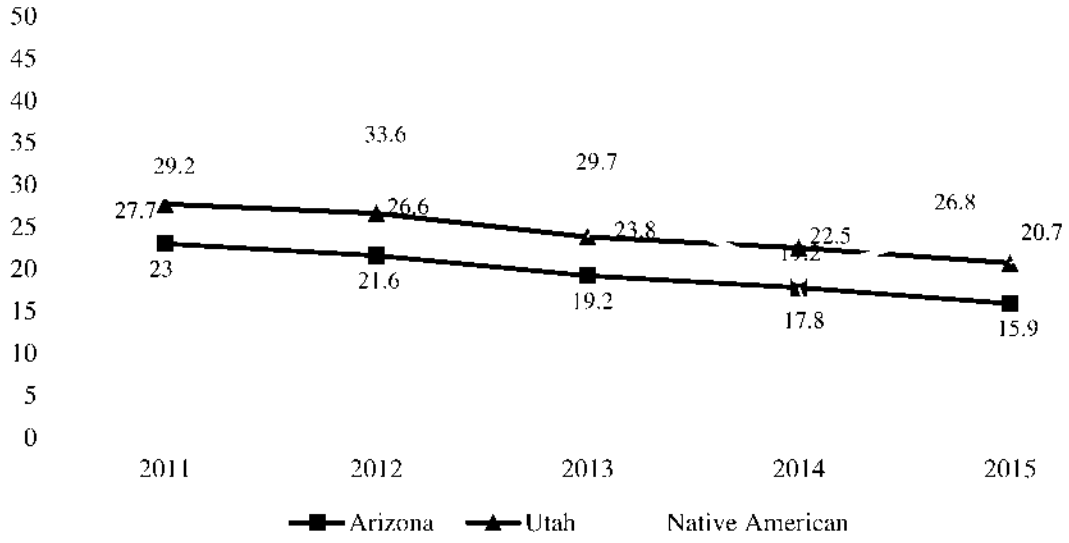
* Low Birth Weight: Less than 2,500 grams (5 pounds, 8 ounces) at birth
** Infant Mortality: Any death from birth through 364 days

The Arizona Department of Health Services (ADHS) provides statistics that track the proportion of births to mothers with medical risk factors such as anemia, diabetes, hypertension, or kidney disease. All of these risk factors can contribute to serious pregnancy complications and infant death if not treated properly. Compared to all Arizonan women, Native American women have higher rates of medical risk factors during pregnancy. In 2016, 41% of births in Arizona were to mothers with medical risks.[36] The percentage of births to Native American mothers with medical risk was 71%, which may indicate that the higher infant mortality rate in this population is associated with maternal medical risks.[39] This may be exacerbated by the fact that fewer Native American women in Arizona receive prenatal care during their first trimester of pregnancy than Arizonans in general (54% compared to 69% respectively).[36,39]

Teen Pregnancy - Unfortunately, data on teen pregnancy and birth rates were not available for the Navajo Nation. And while, generally speaking, birth rates are a more reliable measure than pregnancy rates when comparing groups (due to challenges in reporting abortions and differences in how fetal loss is reported), birth rates for Native Americans in Arizona were also not available to AFHP. Due to these limitations, AFHP is using Native Americans residing

in Arizona as a proxy for those living on the Navajo Nation. Figure 5 compares teen pregnancy rates for 10-19-year-old females living in Arizona and Utah to Native Americans of the same age living in Arizona from 2011 to 2015.[27,28] This figure demonstrates that teen pregnancy rates are consistently higher for Native American teens than for Arizonans and Utahns.[40,41]

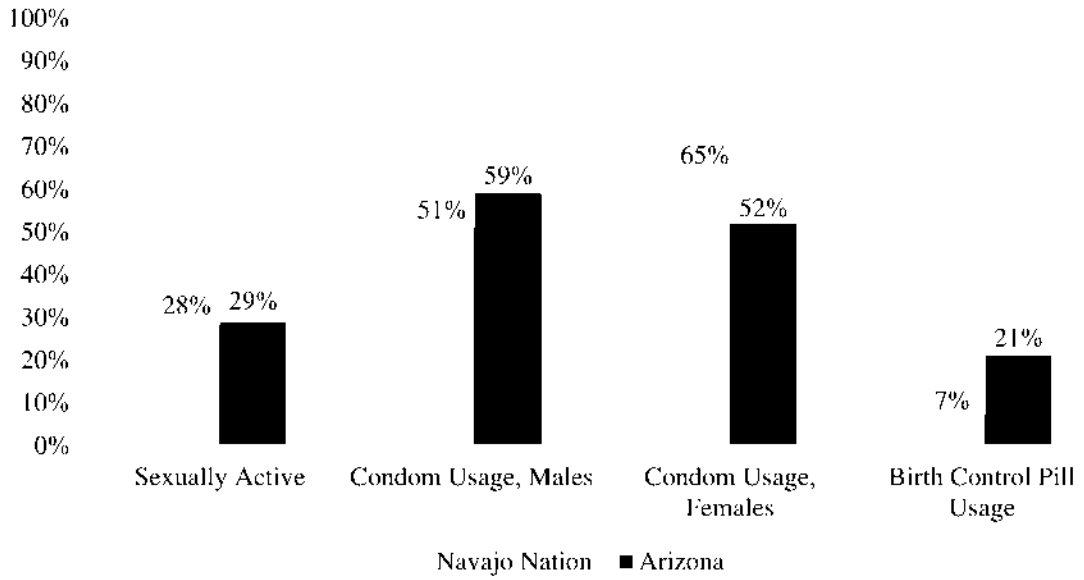
Figure 5. Teen Pregnancy Rates, Arizona & Utah vs. Native American, 2011-2015



Data from the 2015 Youth Risk Behavior Survey (YRBS) for Arizona and the 2011 YRBS for Navajo youth outline differences in the behaviors of these high school students when looking at rates of sexual activity (having had sexual intercourse with at least one person in the three months prior to the survey), condom use rates, and the rates of birth control usage. Unfortunately, Utah does not participate in the sexual behavior portion of this survey, so there is no data to compare. Figure 6 below outlines the results of these surveys, and found that Navajo teens were as likely as Arizona teens to be sexually active (28% compared to 29% for Arizona) and around three times less likely to be using birth control pills (7% compared to 21% for Arizona). Navajo males were less likely to use a condom at last sex when compared to Arizona

males (51% vs 59%) and Navajo teen girls were more likely to have used a condom than Arizona teen girls (65% vs 52%).[42,43]

Figure 6. YRBS Results, Navajo (2011) & Arizona (2015)



Unintended Pregnancy - Unintended pregnancy is defined as a pregnancy that is mistimed, unplanned, or unwanted at the time of conception. Arizona only recently began participating in the CDC's pregnancy Risk Assessment Monitoring System (PRAMS) and data collection began in April 2017. AFHP is an active member of the Arizona PRAMS Steering Committee and is looking forward to the results that will be available in 2019. Therefore, only estimates on unintended pregnancies in the state are currently available. About 52% of Navajo mothers reported that they did not intend to get pregnant which is comparable to 51% of all pregnancies in Arizona.[10,44] However, the unintended pregnancy rate in Utah is lower at 36%.[45] In the U.S., the majority (75%) of adolescent pregnancies are unintended. Unintended pregnancy rates are highest among poor and low-income women, women aged 18-24, cohabitating women, and minority women.[46]

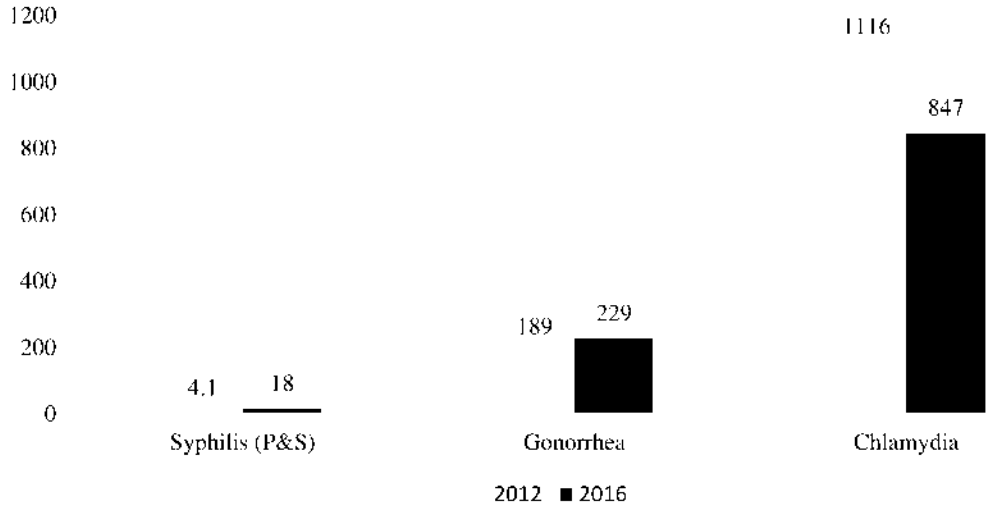
Unintended pregnancy has costly economic implications. In 2010, 65% of unintended births in Arizona were publicly funded, compared to 68% nationally. In Arizona in 2010, over $670 million was spent on unintended pregnancies; of this, over $509 million was paid by the federal government and over $161 million was paid by the state government.[23] In 2017, AFHP Title X funded services on the Navajo Nation prevented an estimated (b)(4) unintended pregnancies, which would have resulted in (b)(4) unplanned births.[47]

About 60% of women who had an unintended birth were not using contraception at the time of conception. Thirty-six percent of these women indicated that they did not think they could get pregnant, 14% were worried about the side effects of birth control, and another 17% did not expect to have sex.[48] Therefore, in addition to accessing and providing clinical services, Title X funding is leveraged to provide education and counseling that prioritizes optimal health and life outcomes for every individual and couple as well as offering a broad range of family planning methods including natural family planning (also called fertility awareness based methods).

Other Need Indicators – Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) can cause a number of health problems. The presence of high STD rates is increasingly used as an indicator of the need for family planning and reproductive health services. As with teen birth and pregnancy rates, data comparing STD rates on the Navajo Nation to Arizona was not available to AFHP at the time of this writing. Therefore, AFHP is utilizing Native Americans residing in Arizona as a comparison to all Arizonans to approximate the differences in the burden of STDs. Figure 7 shows the STD rates for Native Americans in Arizona during 2012-2016.[49,50]

Figure 7. Chlamydia, Gonorrhea, and Primary & Secondary Syphilis Rates per 100,000 in Native Americans in Arizona, 2012-2016



Chlamydia - Chlamydia is the most frequently reported infectious disease in the U.S. and the most common cause of preventable infertility. It is estimated that only about 10% of men and 5-30% of women with laboratory-confirmed chlamydial infection develop symptoms.[51] The Native American population in Arizona has historically had the highest rates of chlamydia. However, in the last four years there has been a 24% decline in chlamydia rates among Native Americans from 1116 per 100,000 in 2012 to 847 per 100,000 in 2016.[49,50]

In an effort to reduce chlamydia rates, the CDC supports chlamydia screening and surveillance activities in STD clinics, family planning health centers and other venues. Since the late 1990's, AFHP has been the recipient of CDC funding through ADHS for the Chlamydia Screening Project. Currently, the Chlamydia Screening Project provides funds annually for universal screening of sexually active women 24 years of age and younger to all AFHP Title X funded health centers as well as three new partners that are FQHCs. The Chlamydia Screening Project includes a performance improvement component that each agency designs, implements, and monitors. In addition, all AFHP Title X funded health centers provide chlamydia treatment

for all clients, testing for male clients receiving family planning services, and women 25 and older with signs, symptoms, or risk factors.

AFHP continuously monitors chlamydia screening in the target population (females 24 and younger) and positivity rates. For June 2016 to July 2017, positivity rates for AFHP Title X Navajo-funded health centers were (b)(4) for females 24 and younger, (b)(4) for females 25 and older, (b)(4) for males 24 and younger, and (b)(4) in males 25 and older. AFHP monitors the progress of all sub-recipient chlamydia screening rates, with a goal of 85% for each agency and AFHP as a whole. Although the goal has not been met yet, there has been progress among the two agencies that have recently become sub-recipients for AFHP's Navajo grant. (b)(4) (b)(4) became a sub-recipient in 2016, and saw a (b)(4) increase from 2016 to 2017 ((b)(4) . (b)(4) has been a sub-recipient since 2015 and saw a (b)(4) increase in screening rates from 2015 to 2017 (b)(4)

Gonorrhea - The consequences of untreated gonorrhea infection are similar to those of chlamydia infection and include pelvic inflammatory disease in women. Infection with gonorrhea is much less common than chlamydia; however, reported cases have increased in Arizona over the last few years. As with chlamydia, Native Americans have disproportionately higher gonorrhea rates. In 2016, the gonorrhea rate in Arizona for White, Non-Hispanics was 63 per 100,000 while in Native Americans it was four times that of White, Non-Hispanics at 229 per 100,000.[50] Between 2012 and 2016, Native Americans in Arizona experienced a 21% increase in gonorrhea rates (from 189 in 2012 to 229 in 2016).[49,50]

Expedited Partner Therapy – Both Arizona and Utah state laws allow clinicians, including nurse practitioners, to prescribe antimicrobial medications to partner(s) of clients with certain communicable diseases without requiring an intervening health assessment.[52] The

application of these laws, for STds such as gonorrhea and chlamydia, is referred to as expedited partner therapy (EPT). AFHP encourages sub-recipients to provide EPT to reduce barriers and increase access for treating partner(s) who may also be infected.

Syphilis - In 2016, the primary and secondary syphilis rate in Arizona was 11 cases per 100,000, which was a significant increase from 2012 (3.1 cases per 100,000). Native Americans in Arizona had the second highest rate of syphilis among all ethnicities in 2016, with a rate of 18 cases per 100,000, which was over four times the rate in 2012 (4.1 per 100,000)).[50]

HIV - The Navajo Nation has seen a five-fold increase in the number of HIV cases since 1999.[53] In 2016, the estimated prevalence rate of HIV/AIDS in Arizona was 255.7 per 100,000, while the prevalence rate for Native Americans in Arizona was slightly lower at 237.4 cases per 100,000.[54] This rate has increased since 2012, with the Arizona prevalence rate at 233.3 cases per 100,000 and the prevalence rate for Native Americans at 194.1.[55] All AFHP Title X funded health centers provide HIV testing and have referrals in place for HIV care and treatment.

Table 3 shows STD rates for the U.S., Arizona, Utah, and Native Americans in Arizona.

Table 3. Sexually Transmitted Disease Rates, Arizona, Utah, and U.S., 2016

	Chlamydia Rate per 100,000[50,56]	**Gonorrhea Rate per 100,000[50,56]**	**Syphilis Rate (Primary and Secondary) per 100,000[50,56]**	**HIV/AIDS Prevalence Rate per 100,000[54,57]**
U.S.	497.3	144.4	8.74	362.3
Arizona	512	151	11	255.74
Utah	315.7	70.1	3.1	116.4
Native Americans in Arizona	847	229	18	237.4

Target Population and Publicly-Funded Health Centers

For the purposes of reviewing unmet need for publicly funded contraceptive services and supplies, the target population is defined as women ages 13 to 44 (sexually active, fecund and

not pregnant or trying to become pregnant) who meet the Title X sliding fee scale criteria (up to 250% of the FPL). The most recent study was conducted to estimate the proportion of these women in need of publicly funded contraceptive services and supplies in the U.S. and by state during 2014.[58] To estimate the total number of women who had at least one visit for contraceptive services during the 12-month period, data was analyzed from publicly funded family planning clinics (Title X and non-Title X) and Medicaid funded contraceptive services from private physicians (National Survey of Family Growth). This analysis does not include data from the Indian Health Service, low-income women who are privately insured, or those insured through military health plans.

Table 4 provides an estimate of the proportion of the target population in need of contraceptive services and supplies in counties that have an AFHP Title X Navajo-funded health center. In 2014, 59% and 58% of the target population was in need of contraceptive services and supplies for Arizona and Utah respectfully.

Table 4. Proportion of the Target Population in Need of Contraceptive Services and Supplies, Arizona and Utah 2014

	Total Number of Women Ages 13-44	Total Number of Women in Need of Contraceptive Services and Supplies	Percent of Target Population in Need of Contraceptive Services and Supplies
Coconino County, AZ	34,360	21,370	62%
Navajo County, AZ	21,600	10,490	49%
Arizona Total	1,399,190	819,550	59%
San Juan County, UT	3,300	1,590	48%
Utah Total	687,150	399,100	58%

Table 5 provides an estimate of the proportion of the need for publicly funded contraceptive services that is met by all publicly funded health centers. In 2015, only 18% of the need for publicly funded contraceptive services was met in Arizona and 22% met in Utah.

Looking at the different counties, the percent of the need met ranged from a high of 56% in San Juan County, UT to a low of 27% in Coconino County, AZ.

Table 5. Proportion of the Need for Publicly Funded Contraceptive Services Met by All Publicly Funded Health Centers, Arizona and Utah 2015			
	Total Number of Women ≤250% FPL in Need of Publicly Funded Contraceptive Services and Supplies	**Total Number of Female Contraceptive Clients Served at Publicly Funded Health Centers**	**Percent of Need Met by Publicly Funded Health Centers**
Coconino County, AZ	14,640	3,990	27%
Navajo County, AZ	8,060	2,420	30%
Arizona Total	465,450	84,190	18%
San Juan County, UT	1,130	630	56%
Utah Total	207,350	46,410	22%

There is a substantial cost benefit to publicly funded contraceptive services. Every $1.00 of public funding spent on contraceptive and preventive health services saves the U.S. $7.09 and Arizona $11.27 in Medicaid costs for pregnancy and infant care.[44,45] In 2017, AFHP-provided Title X services on the Navajo Nation saved over $2.2 million in maternal and birth related costs, over $9,000 from STD testing, and nearly $2,000 from Pap and HPV testing.[47]

Although there is no state or local data on the need for family planning among men, national data indicates that 60% of men aged 15 to 44 years were in need of family planning.[59] In July 2016 through June 2017, (b)(4) of clients served at an AFHP Title X Navajo-funded health center were male which is on par with the national average of 11%.[47,60]

2. Evidence that the proposed project will address the family planning needs of the full population in the service area to be covered

As demonstrated in the Needs Assessment (Section 1), Arizona and Utah have high unmet need for family planning services for low-income women, men, and adolescents. Provider shortages, rural areas with limited access to resources, wide geographic spread, lack of public

transportation, and high poverty rates all make family planning service provision difficult in the Navajo Nation. While these obstacles present barriers to care, AFHP is uniquely positioned to provide publicly funded family planning services to those in need. In 2017, AFHP Title X services on the Navajo Nation helped prevent an estimated (b)(4) unintended pregnancies and saved taxpayers an estimated $2.2 million in maternal and birth related costs.

Currently, AFHP has a robust network of providers that are located in areas of high need on the Navajo Nation. AFHP is proposing to continue partnering with current sub-recipients, (b)(4) (b)(4) both FQHCs. If awarded the full amount for this service area, AFHP is proposing to serve (b)(4) unique family planning clients annually and at least 75% of clients will be low-income (at or below 100% FPL). Details of current sub-recipients, locations, hours, and projected number of clients are provided in Appendix 1 and a Coverage Map is provided in Appendix 2.

3. Evidence of experience in the particular service area and community to be served

Currently, AFHP funds two sub-recipient agencies (with seven health centers), each with decades of experience providing services in their communities throughout the Navajo Nation. Each agency provides a wide array of services to a unique and diverse population to ensure overall health and well-being. Both (b)(4) (b)(4) offer Saturday and evening hours and accommodate walk-in clients. A brief description of each sub-recipient follows:

- (b)(4) (b)(4)
  (b)(4) (b)(4) is a FQHC founded in 1973, and a sub-recipient for both AFHP's Arizona and Navajo Nation Title X grants. (b)(4) provides comprehensive medical, dental, and behavioral health services at three health centers in the rural areas of Page and Chilchinbeto. In 2017, (b)(4) of (b)(4) family planning clients were American Indian or Alaska Native and (b)(4) were at or

below 100% FPL. (b)(4) is sensitive to the needs of the Navajo Nation and has staff that provide services in both English and Navajo, depending on the clients' preference. (b)(4) is a health care home for a well-established client base within small and remote towns where travel can be a barrier. (b)(4) provides services to approximately (b)(4) family planning clients annually. (b)(4) utilizes (b)(4) for their E.H.R. and successfully contracts and bills both private and public insurance.

- (b)(4)

(b)(4) is a FQHC started in 2000 and provides medical, dental, and behavioral health care in neighborhoods throughout the northern portion of the Navajo Nation (Southeastern Utah in San Juan County) regardless of citizenship status, nationality or ability to pay. (b)(4) has "tribal organization" status with the Navajo Nation and as such holds a P.L. 93-638 contract with IHS to provide services for American Indian/Alaska Native people. In 2017, 88% of (b)(4) family planning clients were American Indian or Alaska Native and (b)(4) were at or below 100% FPL. (b)(4) is sensitive to the needs of Navajo residents and has staff that speak both English and Navajo. (b)(4) (b)(4) provides family planning services to about (b)(4) clients annually at four health centers; Navajo Mountain, Montezuma Creek, Blanding, and Monument Valley. (b)(4) uses Athena for medical record keeping, is proficient at billing insurance companies, and has contracts with Medicaid and commercial health plans.

4. Evidence of experience in providing clinical health services, qualified to deliver family planning services, and has capacity to undertake family planning and related health services required in statute and regulation

AFHP was incorporated as a private non-profit agency in 1974 (as the Arizona Family Planning Council) and served as a training and resource agency for family planning providers in

Arizona until 1983. For the past 35 years, since 1983, AFHP has been the designated Title X grantee for Arizona. In 2014, AFHP also became the Title X grantee for the Navajo Nation.

AFHP has the administrative infrastructure to successfully administer this grant. Critical resources make us well-positioned to undertake this project including the Centralized Data System (for encounter data), Project Information Management System (for fiscal data and comprehensive sub-recipient applications), sub-recipient meetings three times a year, in-house expertise to provide on-site and webinar trainings on all Title X related topics, Program Standards and Policy Manual (see Appendix 3), Site Monitoring Tool (modeled after the federal tool), and a 501(c)(3) Board of Directors. AFHP also has administrative policies and procedures to ensure compliance with Title X and standard operating procedures. As a Title X grantee, AFHP has systems and processes in place to implement contracts immediately upon Notice of Award and will successfully make rapid use of Federal funds by processing reimbursements typically within five business days. AFHP excels by abiding non-profit rules and regulations as evidenced by clean fiscal audits and successful federal site reviews. AFHP has innovative and strategic executive leadership, experienced program staff, and a dedicated, voluntary Board of Directors.

AFHP is governed by a community-based Board of Directors. There are a minimum of 11 and a maximum of 20 voting members, representing various areas of the community. As of May 2018, the Board consists of 13 voting members, 69% female and 31% male. Thirty-one percent of Board members are Hispanic/Latino and the remainder are White, Non-Hispanic. Corporations, academia, civic organizations, the non-profit community, and the public/behavioral health community are represented on the Board.

AFHP is currently comprised of nine full-time staff members. The Chief Executive Officer (CEO) serves at the pleasure of the Board of Directors and has overall administrative responsibility for the agency and the Title X grant. The CEO oversees the Communications and Administrative Coordinator who is responsible for communications, maintaining the website, and coordinating Board activities. The CEO also manages the Adolescent Health Program Manager and the two Vice Presidents. The Vice President of Finance and Administration maintains overall responsibility for fiscal accountability and oversees the Business Coordinator, responsible for fiscal and administrative compliance. The Vice President of Program and Evaluation maintains overall responsibility of program activities and oversees the Program Manager, Clinical Program Manager (a Certified Registered Nurse Practitioner), and Program and Community Information Coordinator. The Program staff serve as primary liaisons with sub-recipients as well as monitor fiscal and program compliance. On a part-time basis, AFHP contracts with a practicing Obstetrician/Gynecologist with a Masters of Public Health degree, who serves as the Medical Director and is a consultant to AFHP and sub-recipient staff for clinical issues. Please see Appendix 4 for AFHP's organizational chart and key staff resumes.

AFHP is considered an expert within the National Title X grantee network regarding the implementation and monitoring of the Title X program as demonstrated by participation in learning collaboratives and peer learning groups hosted by the Family Planning National Training Center (FPNTC). Currently, AFHP is one of two grantees leading the Primary Care Peer Learning Group of over 15 participating agencies and sharing expertise related to the integration of family planning and primary care within FQHCs. In addition, AFHP staff provides on-site technical assistance and training to other Title X grantees such as the Marshall Islands and Puerto Rico. AFHP regularly performs quality improvement activities and is often asked to

share results and best practices at national and state conferences. AFHP's CEO serves on the FPNTC Leadership Council to develop leadership training activities for all Title X grantees across the country.

Per the contract with AFHP, each sub-recipient must provide family planning services comprised of sexual health assessments, tools for reproductive life plans, health screenings, health education and counseling, referral services, infertility services, services for adolescents, and a broad range of family planning methods including abstinence (sexual risk avoidance), natural family planning, and fertility awareness based methods. For a complete list of the family planning methods and services offered by (b)(4) (b)(4) please see Appendix 1.

Both (b)(4) (b)(4) have on-site dispensing capabilities that offer clients access to 340B pricing that lowers costs, decreases barriers to care, and allows for better customer service. Both sub-recipients adhere to federal and state laws that regulate the prescribing and dispensing of pharmaceuticals. In addition, a master log of all inventory is maintained at all health centers and medication expiration dates along with lot numbers of the medications are logged by designated staff. During formal site visits, AFHP verifies that pharmacy protocols and procedure manuals are current to ensure rapid response to medication recalls and monitor appropriate use of funds for inventory control.

5. Evidence of familiarity with, and ability to provide services that include:

A. Family planning and related health issues

Family planning services are provided by both sub-recipients which encompass a broad range of family planning methods including abstinence (sexual risk avoidance), natural family planning, and fertility awareness based methods, pregnancy testing and counseling, achieving pregnancy, basic infertility services, preconception and interconception health, and STD/HIV

testing and treatment. AFHP sub-recipients also provide related preventive health services such as screening for breast and cervical cancer and many other preventive health services. Both (b)(4) (b)(4) (b)(4) provide comprehensive primary care on-site; thus, having both primary health care services and family planning services available at the same location increases incentives for individuals in need of care to choose a Title X provider.

Additional services include laboratory testing, services to males and adolescents, minor gynecological issues, and health promotion and disease prevention. Sub-recipients ensure that all clients are provided services in a voluntary, client-centered and non-coercive manner that includes a holistic approach to client education and counseling with optimal health outcomes as a desired goal emphasizing prevention. AFHP and sub-recipient staff are required to sign statements that they will not coerce a client to undergo an abortion or sterilization procedure and that they may be subject to prosecution.

B. Services that are consistent with standards of care related to family planning, adolescent health, and general preventive health measures for HIV, STDs, etc

AFHP issues an updated Program Standards and Policy Manual (PSPM) on an annual basis to establish written standards and guidelines consistent with the Title X statute and regulations. In 2015, AFHP engaged sub-recipients in a series of input sessions to update the PSPM to ensure that sub-recipients provide services that are consistent with current, nationally recognized standards of care. Technical assistance and trainings are conducted at sub-recipient meetings as well as on-site to reinforce the importance of maintaining up-to-date clinical protocols. AFHP's sub-recipients continuously improve service delivery using nationally recognized standards of care and quality improvement including:

- U.S. Preventive Services Task Force

- American College of Gynecology
- Center for Disease Control and Prevention
- American Cancer Society
- U.S. Medical Eligibility Criteria
- Selected Practice Recommendations
- World Health Organization
- Advisory Committee on Immunization Practices

During formal site visits, AFHP ensures that sub-recipients have and follow all required Title X administrative policies and clinical protocols. (b)(4) follow policies for client notification and treatment after a case or suspect case is diagnosed, detected, and treated. (b)(4) follows Arizona Administrative Code R9-6-202 that requires Communicable Disease Reports to be submitted within five working days. Utah adheres to Communicable Disease Reporting Act 26-6-1 that requires Confidential Morbidity Reports to be submitted within three days. Both sub-recipients follow the CDC STD Testing and Treatment Guidelines to ensure clients are screened and treated appropriately.

To ensure services provided meet best practice guidelines, AFHP encourages professional development opportunities to sub-recipient clinical staff. AFHP was recently recognized as an "AZ Big Shot" for collaborating with the American Cancer Society and The Arizona Partnership for Immunizations to educate clinical staff on communication skills with families and how to increase cancer prevention.

C. Compliance with State laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, intimate partner violence, human trafficking, or incest

AFHP's PSPM includes requirements related to mandated reporting laws and annual trainings. (b)(4) must fully comply with Arizona and Utah State laws in regards to reporting to the appropriate local authorities (Arizona Revised Statute §13.3620 and Utah Code Ann. 76-5-406) and are advised to consult with legal counsel to ensure that their policies are in compliance with State laws. Sub-recipients must have written policies regarding reporting of child abuse or neglect and assessing whether minors are in a coercive relationship. AFHP's sub-recipients are equipped to respond to the needs of victims and survivors by following trauma-informed reporting procedures. Sub-recipients must also have a mechanism to track reports submitted to appropriate authorities. Compliance with the legislative mandate related to State reporting laws is guaranteed through the activities described above.

Reporting activities are monitored through formal and informal site visits as detailed in the Work Plan (see Appendix 5). Additionally, AFHP ensures that sub-recipients are doing their due diligence in reporting through a data grooming process. Every quarter, AFHP sends each sub-recipient a list of clients age 13 and younger and asks that the sub-recipient review the client's medical record to confirm if the client was sexually active. If the client was sexually active, the sub-recipients must confirm that the client was reported to the appropriate agency. (b)(4)

(b)(4)

Individual screenings take place for intimate partner violence, sexual violence, and human trafficking through medical and sexual health assessments conducted with each client privately and confidentially. (b)(4) are informed of Arizona and Utah statewide

resources and referral agencies should a victim or survivor of human trafficking, intimate partner and sexual violence need assistance. Additionally, sub-recipients attend annual trainings sponsored by AFHP or other social service agencies regarding intimate partner violence, sexual violence, and human trafficking that include victim testimonials and assessment of client's readiness for intervention. AFHP staff are also required to attend mandatory reporting, human trafficking, and intimate partner violence trainings annually.

Other activities related to compliance of mandatory reporting include AFHP staff serving on a task force to update the 2015 Consent & Confidentiality in Adolescent Health Care: A Guide for Arizona Health Care Practitioners. This was a joint venture with the Arizona Medical Association and The American Academy of Pediatrics, Arizona Chapter. The task force was convened due to the need for updated adolescent consent and confidentiality guidelines in the delivery of health care to this population. Lack of information in this area is a barrier to optimal health care. Studies have shown that many physicians and other clinicians who deal with these issues on a daily basis are unsure of the management guidelines established for confidential care for adolescents. During 2017, the Guide was reviewed and updated including topics such as the law, exceptions to the law, consent based on status and service, HIPAA, human trafficking, and clinical guidelines. Client scenarios were developed and reviewed focusing on the practical, ethical and legal status of each client. Through these efforts, the Consent & Confidentiality in Adolescent Health Care: A Guide for Arizona Health Care Clinicians launched in the spring of 2018.

D. Counseling techniques that encourage family participation, incorporate resistance skills for minors to avoid exploitation and/or sexual coercion

Each AFHP sub-recipient signs a contract that contains and references the Title X regulations, certifying that the agency must encourage family, guardian, and /or parent participation in the decision of the minor seeking family planning services and provide counseling to minors on how to resist coercive attempts to engage in sexual activities. In addition to providing confidential services, sub-recipients must provide education and counseling specific to adolescents consistent with OPA's Title X Program Policy Notice on Confidential Services to Adolescents. Each adolescent medical record must contain documentation of counseling regarding abstinence (sexual risk avoidance), family involvement, and avoiding sexual coercion. Counseling includes helping adolescents build practical skills associated with healthy decision making and developing healthy relationships as well as learning the benefits of delaying sexual activity. Abstinence (sexual risk avoidance) must be discussed as a family planning method. The discussion should emphasize that it is the only method that provides 100% protection against pregnancy and STDs including HIV.

AFHP provides sub-recipients with training on how to approach these sensitive topics. Additionally, at formal site visits, AFHP reviews each sub-recipient's policies and procedures and conducts observations of staff counseling adolescent clients to ensure that they are encouraging family, guardian, and/or parent participation and teaching resistance skills. AFHP also conducts medical record reviews to ensure that all education and counseling topics are covered for adolescents.

Enhancing efforts to encourage family participation and develop resistance skills, (b)(4) (b)(4) (b)(4) provide adolescents with linkages to local community partners that support their safety and well-being. These community partners teach sexual risk avoidance strategies that empower youth to make healthy decisions and provide tools and resources to resist sexual

coercion and normalize sexual delay. Programming is age-appropriate and may include interactive peer group experiences, community service learning, role-playing, and learning from mentors that emphasizes healthy relationships, academic achievement, and goal setting related to personal success. Many of these health promotion programs provide the knowledge and skill building needed to achieve optimal health. Engaging adolescents in more consistent and long-term opportunities that reinforce social science research and practical application of these skills and knowledge can lead to the prevention of risk behaviors.

In an effort to engage minors in healthy behaviors, (b)(4) offers a Family Spirit Program within the We Are Navajo Program that focuses on Native American mothers between the ages of 12 to 19. Mothers enter the program during their third trimester of pregnancy and conclude at the child's 3rd year of life. The lessons taught are structured around the developing age of the child along with life skills enhancing maternal knowledge on how to strengthen their bond with the child. The desired outcome of the program is that both the mother and child will be empowered to achieve an optimal level of health both physically and emotionally.

AFHP will also secure an annual presenter certified in sexual risk avoidance to educate sub-recipient staff and share strategies for applying sexual risk avoidance in their organizations. Scholarships will be offered to sub-recipient staff interested in attending more advanced training to become a certified Sexual Risk Avoidance Specialist for their agency.

E. Counseling techniques that encourage family participation for all clients, including involvement of parents, spouses or family where practicable, mindful of the health, safety, and best interest of the client

AFHP provides training to all Title X clinicians that includes motivational interviewing techniques to enhance the shared decision making process. Promoting family participation in a

family planning visit provides for a safe place to address relationships and physical health concerns. AFHP's sub-recipients assess all clients to ensure they are in safe, healthy, and non-coercive relationships with partners, friends, and family members. Although most think sex education only occurs during school-aged years, sex education is beneficial for adults as they progress through their life-span of relationships, parenthood, and further adulthood. During a family planning visit, clinicians counsel on how to effectively: listen and communicate; manage conflicts and stress; identify unhealthy relationships and early warning signs of abuse as well as safe and helpful ways in ending unhealthy relationships. By ensuring healthy relationships within a family planning visit, the goal is to decrease the incidence of negative consequences associated with premature sexual activities and unintended pregnancies including financial stressors, inadequate support systems, increased risk for substance abuse, and emotional instability.

(b)(4) counsel clients on the importance of family participation in family planning decisions. Clients who express their desire to include their partner, friends or family with their health decisions are encouraged and supported by clinical staff. By involving family members in the family planning visit, the goals are to strengthen relationships and families and communication skills; increase knowledge of reproductive health; and decrease at-risk behaviors for STDs/HIV as well as anxiety and stigma. When methods such as condoms and fertility awareness based methods are utilized, the cooperation of the partner is critical to the success of the chosen method. Effective utilization of family planning methods is more successful when partners choose and agree upon a method together. Family participation also encourages discussions on the importance and benefits of family planning and birth spacing. The following questions are asked to assess family member/spouse participation:

- Do you have a family member/spouse with you today?

- Have you talked with your family member/spouse about your family planning method? Do they support the method you are utilizing?
- Would you like to have your family member/spouse in the room with you?
- Do you feel comfortable talking with your family member/spouse about family planning, STDs, HIV, and medical decisions?

Both sub-recipients provide opportunities to discuss healthy behaviors and habits such as seat belt use, diet, and exercise to promote prevention and wellness. Assessment of tobacco, alcohol, and substance use are also conducted and education is provided to prevent development of disease, illnesses, and other adverse health outcomes. Education and counseling is provided to clients based upon individual needs and best interest in a holistic manner optimizing physical, emotional, and social health outcomes that is the ultimate goal of client-centered care.

6. Schedule of discounts

(b)(4) collect family size and income from clients to assess their income status which is documented in their medical record. AFHP's PSPM Section 8.4 details sub-recipient responsibilities in regards to charges, client fees, and schedule of discounts that are consistent with Title X regulations (see Appendix 7). Section 8.4.2 states that a "schedule of discounts, based on ability to pay, is required for individuals with incomes between 101% and 250% of the FPL." Clients with an income status between 101% and 250% FPL must be charged for required services in accordance with AFHP-approved schedule of discounts and sliding fee schedules, unless another funding source exists that will cover the cost for the service at no cost to the client such as public and private insurance. Both sub-recipients ensure that clients who are at or below 100% FPL for visits where only family planning services are provided are not charged an administrative fee and that their services slide to $0. Also, for clients receiving only family

planning services, sub-recipients have schedule of discounts that go up to 250% FPL with those over 250% FPL being responsible for the full fee. Clients who receive both family planning and primary care are charged according to the FQHC schedule of discounts that goes up to 200% FPL which is consistent with OPA's Title X Program Policy Notice on Integrating with Primary Care Providers.

When a third party payer is authorized to pay for services, every effort will be made by the sub-recipient to obtain payment. Income status is assessed before determining whether copayments or additional fees are charged. For insured clients, sub-recipients ensure that those with incomes at or below 250% FPL do not pay more (in copayments or deductibles) than what they would otherwise pay when the schedule of discounts is applied. Additionally, reasonable efforts to collect charges are made without jeopardizing a client's confidentiality.

In regards to evaluating a minor's income, if the minor is un-emancipated and parents/guardians are aware that the minor is seeking family planning services, the family's income is assessed. When a minor requests confidential services, without the awareness of parents/guardians, the minor's income is assessed. Charges are always based on the minor's income if the minor's confidentiality would be breached in seeking the full charge or billing insurance.

Charges are based on a cost analysis of all required services provided by the sub-recipient. Each sub-recipient determines charges based on an analysis of the cost of their services and prevailing rates in the target service areas. At formal site visits, AFHP monitors the cost structure and conducts medical record reviews to ensure clients are appropriately charged according to the schedule of discounts. Programs cannot deny services to clients or subject clients to any variation in quality of services because of inability to pay. Sub-recipients must

provide services to persons from low-income households as the highest priority, with low-income defined as at or below 100% FPL. Within a few weeks of the Department of Health and Human Services issuing annual poverty guidelines, sub-recipients are required to submit their schedule of discounts to AFHP for approval.

7. Evidence that proposed services are consistent with Title X statute

AFHP provides sub-recipients with a PSPM which establishes written standards and guidelines to ensure services are consistent with the Title X statute and program regulations. The PSPM is updated on an annual basis to ensure that sub-recipients are informed of recent federal, contractual requirements, and program priorities and key issues. The PSPM identifies required service components of the Title X program including clinical, education and counseling, informed consent, confidentiality, and parental involvement as well as administrative, financial, and reporting requirements.

Formal site visits are conducted for each sub-recipient every three years to evaluate the sub-recipients' compliance with federal and local laws and requirements, Title X statute and program regulations, and other contractual agreements. A standardized Site Monitoring Tool is used, which covers administrative, clinical, financial, and educational aspects of the program. This tool largely mirrors the tool used by the OPA federal site review team. Formal site visits include review of policies, protocols and materials, fiscal documentation, medical record review, interviews with staff at all levels, and observation client-staff interactions and facilities. AFHP also conducts informal site visits with each sub-recipient including six-month follow-up to formal site visits, to review sub-recipient-specific concerns and provide technical assistance. If a sub-recipient is out of compliance, AFHP issues a corrective action plan and monitors sub-recipient's progress toward completing required actions.

8. Evidence that Title X funds will not be used in programs where abortion is a method

Per federal law, AFHP's contract (see Appendix 8 for sample contract) with sub-recipients contains a declaration that the agency will not use Title X funds to perform abortions. Additionally, AFHP's PSPM Section 8.2 states that "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." In compliance with CFR Part 200 and 45 CFR Part 75, AFHP sub-recipients must ensure that Title X funds will not be used to perform abortions or facilitate abortion referral processes.

(b)(4) (b)(4) do not perform abortion services at any of their health centers. At formal site visits, medical record reviews are conducted including clients who had a positive pregnancy test to confirm the counseling was done in a non-directive manner and at the client's request. Additionally, medical records are reviewed and observations of health center staff are conducted to ensure staff do not assist with scheduling a termination appointment if requested by the client.

9. Evidence that Title X activities are separate from non-Title X activities

The majority of AFHP's activities are related to Title X, therefore, AFHP is responsible for compliance with grantee financial management administration as identified in Title X statute and regulations, the OMB Super Circular, and other related federal government supplements and requirements. AFHP maintains a financial management system that meets program standards in safeguarding the use of Title X funds; establishes appropriate policies and procedures for funds to be used for allowable costs; and uses an accounting system that assures financial information is reported accurately and timely. (b)(4) submit annual budgets and quarterly financial

reports identifying Title X project revenue and expenses which are reviewed and approved by AFHP program staff.

AFHP keeps detailed records to ensure segregation of Title X and non-Title X activities and expenses for its general accounting and financial procedures. AFHP uses full accrual basis accounting in accordance with generally accepted accounting principles. AFHP has a chart of accounts which lists the title of all accounts used in the journals and ledgers, describes the type of item (revenues, expenses, assets, etc.) to be recorded in each account, and identifies whether revenue and expense accounts are for Title X or non-Title X activities. AFHP uses a system of procedures for reporting income and expenses by designating cost centers to maintain separation of federal Title X funds from other operating funds. In addition, Title X funds are tracked in a specified account that is reconciled on a monthly basis. AFHP consistently receives clean audits and complies in all material respects with the OMB Super Circular.

Section 8.2 of the PSPM states that the sub-recipient must have systems "in place to assure adequate separation of any non-Title X activities from the Title X project." Many of AFHP's sub-recipients provide other services beyond family planning and are required to keep Title X project activities separate from non-Title X activities. Through formal site visits, AFHP monitors sub-recipients to ensure a separate inventory of medications and family planning methods that can be tracked separately. Sub-recipients must have policies and procedures for record keeping, inventory, and dispensing in accordance with Title X statute and regulations. In addition, financial management of the family planning program must be separate from other lines of businesses. Distinct revenue and expense codes or cost centers must be established to manage Title X program activities. AFHP also reviews a sample of superbills by looking at CPT and ICD codes on the medical claims submitted to payers, explanations of benefits, and periodic

statements for outstanding balance sent to insurance companies and self-pay clients. Finally, each sub-recipient must submit to AFHP a copy of their annual audited financial statements and Single Audit Report if federal funds exceeds $750,000.

10. Plan for providing community information and education programs which promote understanding about the availability of services

AFHP and sub-recipients conduct a variety of community information and education activities that are focused on the communities served. Sub-recipients utilize a variety of modes to inform potential clients about the services that are available including websites, social media, internet and local radio spots, health fairs, and collaborative partnerships with social service agencies and other public health programs. (b)(4) has a well-established program promotion plan and actively promotes the Title X program including tabling at the high school in Page during parent-teacher conference night, participating in back to school events at the charter high school in Page, and presenting at the Chapter Houses on the Navajo Nation. (b)(4) diligently establishes collaborations with community members supportive of the family planning program including the Coconino County Public Health Services District. (b)(4) provides educational presentations on family planning including sexual risk avoidance and information about available services, locations, and hours of operation at the (b)(4) In addition, (b)(4) reaches out to Chapter Houses and local high schools in San Juan County. In 2017, AFHP collaborated with (b)(4) to develop an internet video promotion campaign to inform the communities within the Navajo Nation about the availability of services provided through the Title X program. AFHP works diligently with (b)(4) to ensure a culturally competent Navajo individuals are selected to deliver the information.

During formal site visits, AFHP reviews each sub-recipient's community information and education plan to ensure that the agency develops, implements, and monitors goals, objectives, and an evaluation process. All materials distributed at community events have been approved by each sub-recipient's Information and Education (I & E) Committee. Clear information outlining the services provided, clinic locations, hours of operation, indication of the sliding fee scale and acknowledgement of the funding source are required on all materials distributed to community members.

At the grantee level, AFHP promotes the Title X program in several ways. Social media is an excellent way to connect with women, men, and adolescents interested in the Title X program. AFHP is active on Facebook, Twitter, Instagram, and provides up-to-date information on the AFHP website, in both English and Spanish, for anyone searching for family planning services. AFHP manages a program education campaign to deliver information on Title X family planning services and locations. The campaign includes internet video and radio spots, printed materials as well as a website that educates users on family participation, sexual risk avoidance, and returning to a sexual risk free status. If funds are available, AFHP will continue to develop and promote internet spots to encourage optimal health outcomes to potential clients based on best practices and social science research. Additionally, AFHP was recently awarded funds to develop a resource information website to connect professionals serving youth to local opportunities for professional development, funding opportunities, events, partners, and services.

AFHP actively participates in the community promoting the Title X program and services including college, high school and community resource fairs, professional conferences and community coalitions. Annually, AFHP produces a community events calendar that includes historic and upcoming events to ensure that resources are utilized effectively and that a wide and

varied audience is reached. AFHP tracks and monitors attendance, audience, cost, location, and dates. In 2017, AFHP reached nearly (b)(4) individuals through information and education efforts to promote the Title X program.

As a result of AFHP's active program education efforts in the community, AFHP has strong partnerships with various community based agencies, including those that serve homeless families and youth, parenting families, victims of sexual and domestic violence, as well as behavioral health providers and home visitors. A list of the organizations AFHP collaborates with can be found in Appendix 9. Additionally, these partnerships create new opportunities for professional development and community presentations as well as increased awareness for potential clients. Through these efforts, AFHP presented to over 260 community members and professionals in 2017. Moving forward, AFHP will continue to meet training requests from community agencies interested in learning more about the Title X program and related family planning topics.

11. Plan for an information and education advisory committee that ensures all information and education materials are current, factual, and medically accurate as well as suitable for the community

AFHP established a process for assuring that printed client education and information materials (including clinical information sheets) distributed to family planning clients are culturally and linguistically appropriate. The review process includes staff, medical, and community reviews. As a grantee, AFHP conducts its own I & E activities on materials developed in house or in collaboration with a partnering agency. The outcome and feedback from AFHP's review committee is documented and approved materials are shared with sub-recipients to enhance program promotion. During formal site visits, AFHP reviews sub-recipient

I & E policies and procedures, evaluation of community review activities, and advisory committee minutes. AFHP frequently provides sub-recipients with technical assistance in the development of I & E policies and procedures and maintaining documentation of activities.

(b)(4) follow national standards issued by the U. S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) for culturally and linguistically appropriate services (CLAS). These standards include provision of culturally competent care, language access service and organizational supports for cultural competence. (b)(4) serve a substantial number of clients who primarily speak the Navajo language. It is important to emphasize the Navajo language is not a common written language. Many clients that need translation into Navajo, also have limited English proficiency and generally cannot read the English alphabet used to write out the language. Both sub-recipients make efforts to provide clients a comfortable and welcoming environment to access health care services. This is evidenced by Navajo speaking staff on-site and provision of annual training for all employees as to the importance of cultural competence.

Each sub-recipient must ensure that the review process reflects the needs of the local community. Sub-recipient agencies use different approaches to recruit community advisory members. Some utilize ad hoc committees or partner with other programs or agencies within their community to recruit members that are reflective of their target population. Recruiting and retaining community members who are broadly representative of the clients, to serve on this type of committee at times is challenging for sub-recipients. Innovative approaches to this challenge include soliciting community members at community events and health centers.

Additionally, AFHP received feedback from sub-recipients requesting assistance in developing a process in which materials could be approved for use on a statewide basis, thus

reducing the burden on each individual sub-recipient. In response to this feedback, AFHP established the I & E Task Force to assist sub-recipients with the I & E requirements. The goal is to create a master inventory list of approved materials that sub-recipients have the option to select from and implement at their respective agencies. The Task Force is comprised of representatives from each sub-recipient and AFHP program staff. The Task Force created a procedure in which sub-recipient representatives identify priority topics, submit materials for consideration, and select materials in a voting process. The materials selected are then submitted for the entire I & E review process led by AFHP. To date, approximately 50 materials in both the English and Spanish language were selected and approved by the I & E Task Force. The I & E Task Force convened at the end of 2017 and unanimously voted to continue activities in 2018.

12. Evidence that Title X program priorities and key issues are addressed

Directly following this Program Narrative is a detailed Work Plan (see Appendix 5) for September 2018 through August 2022. To ensure that program priorities are addressed, the Work Plan is built around OPA's 2018 program priorities with key issues listed under each priority in which the key issue is addressed. As demonstrated in the Work Plan, each priority incorporates objectives related to training, monitoring, and formal site visits to ensure sub-recipients follow Title X statute and regulations and nationally recognized standards of care. Each key issue is aligned with the priorities and enhances AFHP's collaboration with sub-recipient agencies. The Work Plan demonstrates AFHP's expertise and ability to oversee the Title X program efficiently and effectively in response to the needs of the community.

13. Description of the process and selection criteria used to select service sites and providers

AFHP was one of the first Title X grantees to issue a competitive Request for Proposals (RFP) that was open to the community, for the whole Arizona Title X delivery system. AFHP's innovative approach to selecting sub-recipients utilizes a scoring criteria with specific categories including administration, fiscal, clinical services (including adherence to Title X regulations and nationally recognized standards of care), facilities, data, E.H.R/billing, geographic location and need, proposed budget and number of clients, and either past performance or startup plans. The review process starts with a technical review to ensure all required documents are submitted. Each application is reviewed by multiple teams comprised of five reviewers including AFHP staff and outside consultants familiar with the Title X program. Each reviewer independently scores the applications and assigns a maximum of 100 points based on the scoring criteria. Scoring instructions ensure consistency and reliability so reviewers objectively evaluate each application and assign accurate scores. After being individually scored, each team meets to discuss scores and comes to a consensus (within 10 points of each other) for each application. The scores are averaged to determine the applicant's final score. Once all scores are finalized, all agencies are listed from highest score to lowest score. Recommendations are taken to AFHP's Board of Directors, which authorizes AFHP's CEO to negotiate contracts based upon funding availability and proposed clients to the top scoring agencies.

14. Staffing plan for clinical services

Clinical care at each sub-recipient agency is provided under the direction of each agency's medical director with special training or experience in family planning. It is the Medical Director's responsibility to ensure that family planning services are delivered effectively and are consistent with nationally recognized standards of care. Oversight responsibilities by the Medical Director include developing and approving protocols, conducting medical record

reviews, observing clinicians, leading the agency's quality assurance activities, and providing consultation for clinical staff. During formal site visits, AFHP interviews the Medical Director and reviews his/her curriculum vitae (CV), contract and malpractice insurance.

Client-centered clinical care at (b)(4) (b)(4) is provided by advanced practice clinicians (nurse practitioners and physicians assistants) as well as medical doctors and doctors of osteopathic medicine. Education and counseling is conducted by either clinicians or medical assistants/nurses (i.e. RNs, LPNs) in collaboration with clinicians. During formal site visits, AFHP reviews clinical protocols and observes clinical staff to ensure that personnel work within the scope of practice per Arizona and Utah State laws and Title X regulations. Additionally, sub-recipient policies and procedures for credentialing and licensing provider staff are evaluated by AFHP. The actual certification and current licenses of family planning staff are also reviewed. Family planning providers are screened prior to hire for verification of medical credentials and documentation of clinical license verification is maintained in the credentialing files.

15. Goal statement(s) and related outcome objectives are specific, measureable, achievable, realistic, and time-framed (SMART)

AFHP's Title X Work Plan for 2018 through 2022 (see Appendix 5) uses a SMART plan template providing a structure for articulating goals and objectives. AFHP incorporates the OPA 2018 program priorities as the overarching goals. Under each of the OPA program priorities/goals, the Work Plan contains SMART objectives, description of the activities which will support achievement of the objectives, the person(s) responsible for carrying out the activities, the timeframe for conducting the activities, and a description of how success or failure will be evaluated. Additionally, key issues are addressed in each objective.

16. Evidence, including signed referral agreements with relevant referral agencies and has a plan to facilitate access to the following:

A. Required clinical services;

B. Comprehensive primary care services, if not provided; and

C. Other needed health and social services for clients served in the Title X funded family planning project

(b)(4) provide required clinical services that include family planning services, pregnancy testing and counseling, services to help clients achieve pregnancy, basic infertility services, STD services, preconception health services, and breast and cervical cancer screening. These clinical services are provided according to a schedule of rates that are reasonable and necessary (see Section 6 for more detail on the schedule of discounts). In addition to providing family planning services, both (b)(4) provide a broad spectrum of primary, preventative and enabling services to these medically underserved populations. Services include family medicine, pediatrics, obstetrics, internal medicine, behavioral health, dental, emergency medical, laboratory, and pharmaceutical.

Both sub-recipients partner with other service providers in their communities to facilitate social services and specialized health care through formal and collaborative agreements. (b)(4) (b)(4) (b)(4) provide referrals to medical specialists, experts in substance abuse and mental health, and other services designed to assist clients in establishing eligibility for and gaining access to Federal, State, tribal, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services.

(b)(4) collaborates with other service providers in Page to facilitate social services referrals such as domestic violence shelters and specialized health care. Referrals for specialty

care are provided through a wide range of providers depending on the client's clinical need. (b)(4) has a signed referral agreement with Coconino County Public Health Services District for social services such as WIC, smoking cessation, food assistance, and HIV care. (b)(4) offers care management services with trained care coordinators following the Patient Centered Medical Home (PCMH) model. Care coordinators assist clients with referrals and appropriate follow-up care. (b)(4) also collaborates with other social service providers in San Juan County to link clients to social services including WIC. (b)(4) has a written agreement with the University of Utah for both physical and psychosocial care and with Blue Mountain Hospital for specialty medical care.

(b)(4) is part of the Community Resource Group with the Coconino County Public Health Services District and works with faith-based organizations to provide social services that include grief counseling, food assistance and city beautification projects including Sheppard of the Desert Lutheran, St. David's Episcopal, the Church of Jesus Christ of Latter Day Saints, and Lake Powell Nazarene. (b)(4) is affiliated with a Navajo Native Medicine Man with a background in behavioral health.

17. Evidence of capability to collect and report required program data for FPAR

AFHP uses an internet based data system called the Centralized Data System (CDS) to collect required fields for the FPAR. AFHP also maintains a Data Manual, Submission Guidelines, and Codebook that provides detailed CDS instructions for sub-recipients. The Manual includes guidelines on submission of encounter-level data, definitions of data fields, and proper coding for data submission. AFHP's sub-recipients are required to submit encounter-level data for all family planning visits on a monthly basis into CDS. Authorized users from each agency can either enter individual records or upload a batch of records.

AFHP's CDS only allows entry of visits that meet logic and range check criteria to ensure data integrity. For example, a visit for a male receiving a pap smear or an invalid code/date cannot be entered into the system. In addition to these safeguards to ensure clean data, AFHP performs quarterly grooming activities. Each quarter, sub-recipients are sent a list of visits with sex and birthdate discrepancies, women over the age of 55, sterilized clients, and clients on a non-FDA approved method. Sub-recipients return the list noting corrections that need to be made such as deletions of entire visits or edits to certain fields.

AFHP requires sub-recipients to have written policies and procedures for compilation of encounter data reports and submission to CDS. Sub-recipients must have a written process describing how reported data is assessed for accuracy, completeness, and logic and consistency checks. During formal site visits, written procedures are reviewed and sub-recipient staff are interviewed to ensure that data is reported accurately and consistently.

Each CDS user has a unique username and password to ensure data security. Each sub-recipient is required to appoint a Permissions Manager who is responsible for the quality of the data entered into CDS. The Permissions Manager approves any changes to encounter data and assures that all individuals who have been granted access to CDS are active employees in good standing with the sub-recipient. Only AFHP staff is able to make changes to the encounter data to ensure data integrity.

CDS reporting capabilities include FPAR tables and additional information for AFHP program monitoring. Encounter-level data can also be extracted from CDS for further data analysis and special reports. AFHP monitors the data in CDS on a quarterly basis for program management and quality assurance activities. Quarterly dashboard reports are produced to

monitor client numbers and services, and assess contract compliance (see Appendix 10 for a sample dashboard report).

Quality assurance is conducted at formal site visits to monitor accuracy of the data by comparing medical records to encounter data submitted for FPAR. AFHP monitors the accuracy of data fields such as family size and income, insurance type, race and ethnicity, as well as family planning methods. Additionally, AFHP staff reviews CPT and diagnosis codes, reimbursement, and timely filing for third party billing to confirm the accuracy of sub-recipient's financial reports. Through these concordance studies, AFHP is able to improve the quality of the data received from sub-recipients to ensure that the FPAR and fiscal reports submitted to OPA are accurate and complete.

18. Evidence of a system for ensuring quality family planning services, including:

A. Process for ensuring compliance with program requirements

As discussed in Section 7, AFHP updates the PSPM on an annual basis to ensure that the program requirements are reflected including Title X statute and regulations as well as nationally recognized standards of care. AFHP also updates the Site Monitoring Tool annually to include current standards and requirements consistent with the PSPM. The Site Monitoring Tool is used during formal site visits to evaluate the sub-recipients' compliance with federal and local laws and requirements, Title X statute and regulations, and other contractual agreements. Following a formal site visit, AFHP produces a comprehensive report that details observations, findings, required actions, and recommendations. After receipt of the final report, the sub-recipient must submit a corrective action plan (CAP) addressing required actions. The CAP is monitored by AFHP to ensure that the corrective actions are implemented.

In addition, AFHP conducts informal site visits with each sub-recipient to review specific concerns and provide technical assistance. Both sub-recipients submit quarterly financial reports and monthly encounter data. On an annual basis, AFHP also receives and monitors each sub-recipient agency's audited financial statements. AFHP produces quarterly dashboard reports to monitor contract compliance as well as summarize finance and encounter data. Dashboard reports reflect client numbers and services as well as the revenue and expenses of each sub-recipient's total family planning program. When revenue and expense line items have a variance of 10% for each quarter, sub-recipients are asked to provide justification for these variances. AFHP staff hold quarterly meetings to review each sub-recipient's dashboard report and variance justifications.

B. Defined performance measures including process for systematically assessing quality of services provided and methodology for ensuring practitioners have knowledge, skills and attitudes necessary to provide effective, quality family planning

AFHP's team includes an epidemiologist with strengths in creating and monitoring performance measures and conducting quality assurance and improvement activities. Many of AFHP's quality improvement efforts have been recognized nationally. AFHP staff have presented findings from successful quality improvement projects at Title X grantee and National Family Planning and Reproductive Health Association (NFPRHA) meetings. Examples of quality improvement projects that AFHP has conducted include increasing Chlamydia screening in women 24 and younger, improving the quality of encounter level data, and increasing access to family planning methods. AFHP utilizes the Plan, Do, Study, Act (PDSA) model for improvement when conducting quality improvement activities. AFHP has also participated in the Performance Measure Collaborative and Increasing Client Numbers Learning Collaborative

conducted by the FPNTC. Recently, AFHP was featured in a Quality Improvement Case Study video describing how AFHP effectively uses data for quality improvement. During Year 2 of the project period, AFHP plans to implement a performance improvement project (PIP) identified from the performance measure results in Year 1 as detailed in the Work Plan (see Appendix 5).

Quarterly dashboard reports are created for each sub-recipient. The dashboard reports contain a number of performance measures including contract compliance measures such as the number of clients, visits, adolescents, and clients at or below 100% FPL. Additionally, dashboard reports include Chlamydia screening rates in women 24 and younger, the proportion of clients using abstinence (sexual risk avoidance) and other family planning methods, the proportion of female clients 21 and older receiving pap and breast exams, and the proportion of revenue from third party payers. AFHP was asked to share a sample dashboard report for the FPNTC's Quality Improvement Community of Practice webpage as a model reporting tool for other grantees to replicate.

AFHP's standards for sub-recipients ensure that all staff have adequate training to provide quality and effective family planning services. Sub-recipients are responsible for providing orientation for new staff and on-going in-service training to all Title X program staff. AFHP supports sub-recipients by providing training opportunities through various approaches such as on-site and webinar trainings. Several key topics are required to ensure that family planning staff are qualified and have a working knowledge of Title X requirements. During formal site visits, training logs are reviewed and clinic observations are conducted. At a minimum, sub-recipient staff must receive training according to the schedule in Table 6:

Table 6. AFHP Training Requirements		
	Clinical Staff*	**Non-Clinical Staff****
Title X Orientation Upon Hire	Yes	Yes
Introduction to Family Planning Upon Hire	Yes (except clinicians)	No
Title X Clinical Training– Upon Hire	Yes (clinicians only)	No
Mandatory Reporting Upon Hire and annually	Yes	Yes
Family involvement and sexual coercion (for adolescents) Upon Hire and annually	Yes	Yes
Human Trafficking – Upon Hire and annually	Yes	Yes
Cultural Competency Per agency's policy	Yes	Yes
Pregnancy Options Counseling and Education – At least once during employment	Yes	No
HIPAA and client confidentiality Upon Hire and at least once during each project period	Yes	Yes
Non-Discrimination – Upon Hire and annually	Yes	Yes
Emergency and disaster response and staffs' roles – Upon Hire	Yes	Yes

*Clinical Staff = MD, DO, NP, MSN, MSW, RN, LPN, CNA, MA, etc.
**Non-Clinical Staff = front desk staff, etc.

AFHP will provide a comprehensive training program for sub-recipient staff that includes an all-day Introduction to Family Planning training for all sub-recipient staff providing family planning education and counseling. Attendees of this training are staff new to family planning, any staff that would like to learn about the fundamentals of family planning, or staff needing a refresher. The cornerstone of this training is to inform decision-making and enhance client communication to support the optimal health of clients. Participants gain a deeper understanding of preconception care, reproductive life planning, positive family relationships, family participation, resisting coercion, family planning methods including abstinence (sexual risk

avoidance), natural family planning, and fertility awareness based methods, and STDs. AFHP consistently receives very positive reviews for this interactive and skill building training, therefore AFHP will continue providing this training in the coming years. During site visits (both formal and informal), AFHP staff observe client education and counseling sessions with sub-recipient staff to ensure proper knowledge and skills. AFHP staff may model and provide constructive feedback as a means of providing technical assistance.

AFHP is well positioned to provide training with two staff members that are particularly suited for such work. (b)(6) Program Manager, develops and conducts numerous trainings on topics such as customer service, clinic efficiency, sexual health and program compliance. (b)(6) Clinical Program Manager, provides IUD procedural trainings, serves as a clinical resource, and conducts a Title X Clinical training for clinicians new to the Title X network. Both Managers successfully completed training from Georgetown University and are certified in the Standard Days Method. Together, (b)(6) develop and deliver trainings on various topics including healthy relationships, family participation, resisting sexual coercion, mandatory reporting, pregnancy intentions and attitudes, life course perspectives, family planning methods including natural family planning and fertility awareness based methods, building skills for sexual risk avoidance and sexual risk reduction, and shared decision-making for optimal health outcomes. In 2017, AFHP delivered trainings to approximately 300 Title X staff through sub-recipient meetings, webinars and customized presentations based on specific needs.

AFHP maintains an annual training plan that includes specific training topics, target populations, target dates, and target number of trainings. AFHP is committed to sub-recipient training needs and ensuring that Title X training requirements are met. In an effort to reduce

barriers such as travel restrictions, clinic coverage, and lost revenue due to clinic closure, AFHP will continue to offer and deliver on-site training to sub-recipient staff. AFHP will evaluate and modify trainings as needed based on participant feedback, sub-recipient needs, changes in Title X program regulations and priorities, and clinical best practices and recommendations.

19. Evidence of ability to bill third party commercial insurance carriers and Medicaid and ability to facilitate enrollment of clients into Medicaid

AFHP understands that third party reimbursement is essential to financial stability. As described in Section 3, both sub-recipients have contracts in place to bill third party payers including commercial and Medicaid plans. Sub-recipients must bill third party payers without application of any discounts and without compromising client confidentiality. During 2017, (b)(4)% of (b)(4) (b)(4) combined visits had an expected pay source of public insurance and (b)(4)% of (b)(4) combined visits had an expected pay source of private insurance.

Another important aspect of sustainability is facilitating enrollment of clients into various health insurance programs. Both (b)(4) (b)(4) have on-site enrollment assisters for Medicaid and Marketplace plans.

20. Conclusion

As reflected in the Needs Assessment, Arizona and Utah are in great need of family planning services. The Navajo Nation has a high percentage of households living in poverty and women living in poverty are at an increased risk of unintended pregnancy and need for publicly funded family planning services. For the target population (women ages 13-44), 59% in Arizona and 58% in Utah are in need for family planning services. The Navajo Nation's physical geography with long stretches of undeveloped land, lack of sufficient funding, linguistic barriers, and issues surrounding cultural competency create challenges in the provision of health care

services. All of these challenges combined exemplify a need for an accomplished administrator of the Title X grant in the Navajo Nation, like AFHP.

Demonstrated throughout this application, AFHP is committed to the efficient and effective use of federal dollars to support communities across the Navajo Nation in need of family planning services. By leveraging Title X dollars, AFHP will devote substantial staff expertise and capacity to connect with the community, addressing their distinct needs, while simultaneously ensuring administrative processes and procedures integral to fiduciary responsibility are in place. AFHP provides positive and constructive feedback while listening to the needs of sub-recipients. In addition, AFHP delivers quality training and education necessary to implement the grant with fidelity to the program priorities and key issues, reaching those most in need.

Organizational intelligence cannot be created overnight; therefore, AFHP is the only agency in Arizona with the capacity, staff, and expertise to administer Title X funds with integrity and without a gap in services for the Navajo Nation. Upon receipt of the Notice of Award, AFHP's committed network of providers are well positioned to deliver services in a culturally competent manner. Collaboration between AFHP and an extensive network of community organizations, faith-based partners, and referral agencies enhances the client's ability to achieve optimal health outcomes. AFHP will provide comprehensive oversight of the Title X program, assuring that Title X statute and regulations are adhered to. The Title X cost per AFHP client is (b)(4) and the estimated administrative cost to manage this program is (b)(4)% which is well below the 20% non-profit industry standard. AFHP is innovative in its approach to improving service delivery using nationally recognized standards and processes for quality improvement. As the leading expert on family planning service delivery in Arizona and a trusted resource in the

community as well as throughout the Navajo Nation, AFHP is dedicated to a holistic approach to reproductive health, focusing on the overall well-being and optimal health of each individual.

Upload #4

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress
Document Title:	SF424_2_1-1236-Service Areas and Congressional Districts - current.pdf

Current Delegate	Clinic	County	Congressional District
	(b)(4)	Navajo	1
		Coconino	1
		Coconino	1
		San Juan	UT 3
		San Juan	UT 3
		San Juan	UT 3
		San Juan	UT 3

Upload #5

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress
Document Title:	BudgetNarrativeAttachments_1_2-Attachments-1234-AFHP Navajo Budget Narrative and Supporting Documents.pdf

Arizona Family Health Partnership Revised: * 5/21/2018

Title X Navajo Competitive 2018 - 2019 Budget

From: 9/1/2018 **To:** 8/31/2019

		Management and Administrative	Reproductive Healthcare Services and Support	Other	Total
Revenue and other Support					
Title X Arizona services grant - AFHP	$	(b)(4)			
ADHS (IPP contract)	$				
Development	$				
Interest Income	$				
AFHP contract work	$				
Sub-Total Revenue and Support	$				
Title X Services grant - Delegates	$				
Patient Collections	$				
Third party Payers	$				
Agency Contribution	$				
Total Revenue and other support	$				
Salary	$				
Fringe benefits	$				
Promotion/Outreach	$				
Audit	$				
Consulting	$				
Depreciation	$				
Fees	$				
Insurance	$				
Main Contracts	$				
Meeting Costs	$				
Memberships	$				
Office Supplies	$				
Postage	$				
Printing	$				
Program Supplies	$				
Program Awareness	$				
Registrations	$				
Rent	$				
Subscriptions	$				
Telephone	$				
Misc. Other	$				
Travel	$				
Sub-Total Expenses	$				
Title X Delegate Expenses	$				
Other related Delegate Expense	$				
Total Expenses	$				
Change in net assets	$				
Admin %					
Clients			(b)(4)		
Title X Cost per Client	$		(b)(4)		
Total Cost per Client	$				

Budget Narrative

1. **Federal Resources: Title X Grant Funding - $477,000**

Title X network currently consists of two sub-recipients, (b)(4) and (b)(4) providing family planning services through seven health center sites across the Navajo Nation. Arizona Family Health Partnership (AFHP) is requesting the full $477,000 allowable for the Navajo region service area with an average cost per Title X client of $(b)(4)

2. **Non-Federal Resources -** (b)(4)

Based upon 2017 FPAR data, 81% of clients served were under 100% of FPL, 24% were uninsured, and of the remaining clients served, 45% were publicly insured and 30% privately insured. AFHP's contract with the sub-recipients requires contracting with third party payers (Medicaid and private insurance) in order to maximize revenues made possible by the Title X grant. Any revenue shortfalls are covered by "agency contributions" which represent the financial support each agency will contribute in order to balance their budgets. The table below demonstrates the availability and commitment to the Title X program with the support of non-Federal resources within the communities served.

Projected Non-Federal revenues by source for the budget period.

Non-Federal Revenue		
Patient Collections	$	(b)(4)
Third Party Payors	$	
Agency Contribution	$	
Total	$	

3. **Total Revenue -** (b)(4)

For AFHP, the Title X grant represents (b)(4) of the total revenues and costs projected to support the Navajo region family planning project. For every $1 of Title X funding spent, an additional $(b)(4) is generated in program income, client donations and agency contributions. Effectively leveraging Title X funds allows AFHP's program to serve more clients, demonstrating AFHP's agency need and ability to meet client needs.

4. **Total Expenditures -** (b)(4)

a. Federal $477,000 & Non-Federal $(b)(4)

All specifically identifiable costs associated with a grant/project/activity are considered direct costs of that grant/project/activity and are allocated as such. AFHP does not have a federally approved indirect cost rate and does not charge an indirect cost as part of this proposal. However, for any and all shared costs undertaken by AFHP that are required to carry out the various grants/projects/activities, AFHP utilizes the simplified allocation method consistent with 45 CFR 75, Appendix IV based upon time and effort reporting.

b. Personnel - $(b)(4) *Fringe -* (b)(4)

Each AFHP staff member submits a biweekly time sheet for each pay period that identifies all hours worked by cost center. The Navajo region Title X planned activities during the 2018-2019 budget include (b)(4)% of staff time is allocated towards monitoring with the remaining (b)(4)% is allocated to administration. The table below summarizes AFHP positions, salaries, and estimated time spent on Title X activities by position.

Fringe Benefits consists of payroll and unemployment taxes; worker's compensation insurance; health, life insurance and matching retirement contributions equal to (b)(4)% of salary. The table above breaks down fringe by category of expenditure.

Arizona Family Health Partnership
Title X Navajo Competing Application
From: 9/1/2018 To: 8/31/2019

	Position Title		FTE	Annual Salary	No. Months	% Time	Title X Cost	Total Cost
	Ferreiro	Vice President of Finance and Administration	1.00	$				
(b)(4);(b)(6)		Program Manager	1.00	$				
(b)(4);(b)(6)		Program and Community Information Coordinator	1.00	$				
(b)(4);(b)(6)		Business Coordinator	1.00	$				
	Thomas	Chief Executive Officer - Principal Investigator	1.00	$				
(b)(4);(b)(6)		Communications and Administration Coordinator	1.00	$				
		Program Manager	1.00	$				
		Clinical Program Manager	1.00	$				
	Min	Vice President of Program and Evaluation	1.00	$				

(b)(4);(b)(6)

Total Salaries	$	(b)(4)
FICA	$	
Medicare	$	
State Comp Fund	$	
SUTA (up to $7000)	$	
Workers Comp	$	
Health Insurance	$	
AD&D	$	
Life Insurance	$	
Retirement	$	
Sub-total Fringe Benefits	$	
Total Salaries and Benefits	$	

The Chief Executive Officer is the Title X Project Director with responsibility for establishing the goals for the sub-recipients and holding the staff as well as network providers accountable for meeting performance measures and goals. The Chief Executive Officer establishes policy priorities, relationships with key partners, and leads AD HOC RFP committee to select sub-recipients and determine funding allocation for approval by the Board of Directors.

The Vice President of Finance and Administration (VPFA) is responsible for ensuring compliance with federal cost principles and federal and state financial reporting, as well as conducting quarterly actual to budget analysis. The VPFA monitors both AFHP's and sub-recipient's fiscal performance including, audited financial statements, and sub-recipient financial Corrective Action Plans (CAP). Additionally, the VPFA in coordination with the Vice President of Program and Evaluation works with outside legal counsel to update contracts, policies and procedures for any new state or federal regulations.

The Vice President of Program and Evaluation (VPPE) leads the Program team staffed by Program Managers, Clinical Program Manager and the Program and Community Information Coordinator and is primary responsible for administrative and clinical monitoring activities, performance monitoring, and tailoring training and education to support sub-recipient's success in meeting performance and quality improvement measures. Additionally, the VPPE is responsible for data grooming and analysis as well as database management to create dashboard performance reports and the annual Family Planning Annual Report (FPAR). The VPPE also develops an annual training plan for the sub-recipients.

Program Managers including the Clinical Program manager have four distinct activities: direct service delivery through contracts with sub-recipients, training and education, program awareness and information, and compliance activities. These compliance activities include

quality assurance, quality improvement, performance measurement, and monitoring activities. AFHP's goal is to maximize the federal dollars available for direct service delivery. As a result, payments to sub-recipient account for (b)(4), or $(b)(4) of total federal expenditures of $477,000. Of the remaining federal funds, (b)(4)% will be used for administrative activities and (b)(4)% will support performance monitoring, tailoring training and education to support sub-recipient's success in meeting performance and quality improvement measures and SRA training scholarships for sub-recipient staff.

Annually, AFHP hosts three mandatory sub-recipient meetings, two in person meetings and one webinar. The agendas will be designed to have a clinical track as well as a fiscal/administrative track as well as sessions that address mandated reporting, human trafficking, Title X requirements and billing coding sessions. Additionally, AFHP Program Managers often have monthly calls to follow on CAP issues, disseminate information to sub-recipients, and offers in person training at each sub-recipient health center site as necessary. AFHP's CEO, VPPE and VPFA and/or selected Clinical/Program Manager will attend the biennial Title X clinical conference. Activities will be planned to ensure access to a broad range of family planning methods and services including abstinence (SRA), natural family planning, and fertility awareness-based methods, to improve performance related to STD testing and treatment rates, and training.

In order to reach additional clients in the Title X clinics, AFHP is taking a leadership role in addressing program information and promotion this budget cycle. Ten percent (10%) of staff time will be dedicated to targeted program information and promotion. Activities include participating in outreach/tabling events, assisting sub-recipients with developing materials that promote the family planning services offered, and meeting with partners in the communities they

serve to enhance program awareness. Activities are designed to increase awareness of and access to Title X services.

Approximately 50% of staffs' time will be spent on compliance activities, which are designed to ensure programmatic and fiscal compliance, and include monitoring, quality improvement, quality assurance, training, and reporting. AFHP performs on-going monitoring that includes a quarterly review of finances, performance measurement as well as a monthly client encounter reporting. This monitoring drives program improvement as well as content for training and education. One of the sub-recipients will undergo (b)(4) formal site visit in the year one budget period and at least one in person training will be conducted at each of the sub-recipient sites. Due to the geographic distance of the sub-recipients and the service sites, travel can require up to eight hours and overnight stays are often necessary to reach the rural areas of the state.

The Program and Community Information Coordinator (PCIC) is primarily responsible for engaging community participation and education activities, disseminating Title X program materials, tabling at community events and conferences as well as other outreach activities. Additionally, the PCIC assists in the creation of publications and community awareness materials for use by AFHP staff and the network, as well as assists with the Information and Education (I and E) approval process.

c. *Total Travel $*(b)(4) *In-State Travel - $*(b)(4) *& Out of State Travel - $*(b)(4)

In-state travel costs will be used to facilitate training and education activities on Title X program statute and regulations, clinical updates, one formal site visit, as well as conducting onsite monitoring and training. Travel to (b)(4) in Page, AZ is budgeted using rental cars taking a minimum of six hours from Phoenix, thus contributing to multi-day trips with various overnight stays. Out of state travel includes visits to the (b)(4) attendance at NFPRHA meetings

as well as the Title X Clinical Conference and other relevant training/conferences. AFHP has determined that the most cost effective manner of travel to (b)(4) is via flights with multiple night stays.

d. Consulting - (b)(4)

AFHP will budget for the following contracts in the consulting line item: a Medical Director; an IT consultant for updates and maintenance of the website and the Computerized Data System (CDS) software used by sub-recipients for monthly reporting; a certified SRA trainer; a facilitator for sub-recipient meetings; a policy and education consultant; a public affairs consultant; and attorneys for legal services as required throughout the year for contract compliance and updates to policies and procedures; and other consultants for programmatic reviews and assistance. All of the costs are a percentage of the total budgeted costs as the remainder is budgeted in the Arizona Title X application.

e. Equipment - $0

No equipment purchases are planned for FY 2018-2019.

f. Office Supplies - (b)(4)

Reflects the cost of miscellaneous office supplies to support Title X activities. The annual cost is based on past expenditures with 98% of total cost allocated to Title X.

g. Program Supplies & Awareness - (b)(4)

The cost of Title X materials needed to support the implementation of Title X services is budgeted at (b)(4) The cost of the Program Awareness campaign is budgeted at $(b)(4) The annual cost is based on past expenditures with 100% of the costs allocated to the Title X grant.

h. Sub-Recipient Expenditures

AFHP proposes to provide Title X family planning services throughout the Navajo Nation specifically targeting Arizona and Utah. The sub-recipients are two FQHCs, with (b)(4) administrative offices in Page, Arizona and (b)(4) administrative office in Montezuma Creek, Utah. (b)(4) has three health centers with one on the Navajo reservation and (b)(4) has four health centers with three on the reservation.

AFHP does not utilize an indirect cost rate and thus does not include one in this application. AFHP will ensure that all procurement transactions will be conducted in a manner to provide open and free competition to the maximum extent practical, pursuant to 45 CFR 75.329. Projected federal Title X funding in the amount of $(b)(4) will be allocated to sub-recipients based upon a funding formula designed to distribute funds based upon performance. Additionally, the table below shows the sub-recipient expenses associated with the Title X program.

Sub Recipient Expenses	**Budget**
Personnel	$ (b)(4)
Fringe Benefits	$
Travel	$
Equipment	$
Supplies	$
Contractual	$
Occupancy	$
Other	$
Sub-Total	$
Indirect	$
Total	$

i. Other expenses

All specifically identifiable costs associated with a grant/project/activity are considered direct costs of that grant/project/activity and are assigned as such. AFHP utilizes the simplified

allocation method (45 CFR 75, Appendix IV) based upon time and effort reporting. The following are line item expenses.

i. *Facility rent $*(b)(4) Includes rental costs of AFHP's administrative office in Phoenix, Arizona and includes all utilities and the cost of parking for staff and guests throughout the year.

ii. *Legal* (b)(4) - AFHP will utilize the services of legal to review contracts and other legally binding documents for the agency. AFHP will also use an attorney to review and interpret issues that affect the delivery of Title X services and to review of policies and procedures in order to comply with state and federal regulations. At an hourly rate of $(b)(4) the budgeted amount purchases (b)(4) hours of legal services.

iii. *Audit* (b)(4) - Expense reflects the prorated annual cost for audited financial statements, the single audit, the preparation of the 990 tax return and discussion during the budget year as needed. The VPFA oversees all accounting functions.

iv. *Postage $*(b)(4) AFHP produces three publications each year. When possible, print jobs will be drop shipped or materials must be shipped. Projections are based upon historical cost.

v. *Printing $*(b)(4) - To ensure consistency in printed information distributed by sub-recipients, AFHP will publish material to be used by sub-recipients. All publications will refer to the standard language that the publications are made possible under this grant. Printing estimate was based upon prior year's expenses.

vi. *Phone* $(b)(4) Includes landlines, conferencing, long distance phone services, and a portion of the cellular phones costs for three staff. Conferencing, landlines and long distance charges incurred by a program will be charged directly to the appropriate program.

vii. *Insurance* $(b)(4) Consists of general business insurance, business liability, professional liability and Directors/Officers Liability insurance. Insurance costs will be allocated based upon time spent on Title X versus other cost centers. AFHP will obtain bids for its insurance policies every three years.

viii. *Membership* $(b)(4) Includes memberships in professional associations. AFHP will purchase a health center level membership for NFPRHA, which provides travel assistance for one AFHP staff member and one staff member from each sub-recipient to attend National Family Planning and Reproductive Health Association's annual and seasonal meetings free of charge. AFHP is also a member of the Arizona Alliance for Community Health Centers, The Family Planning Councils of America, PAFCO, and the Society for Human Resource Management (SHRM) and ONE.

ix. *Meeting costs* $(b)(4) Reflects the annual costs of the sub-recipient meetings hosted by AFHP, the onsite training meetings held at each health center, the costs related to meetings of the AFHP Board of Directors and committees that are necessary for the governance of the organization. AFHP Board of Directors are from the greater Phoenix and Tucson areas and meetings will be held from late afternoon into the evening. The board meetings will be conducted via

teleconference or web conference as necessary for members living in rural areas of the state.

5. Plan for Oversight of Federal Award Funds

Upon receiving a Notice of Award, AFHP's Audit and Finance committee will meet to reconcile the proposed budget with Board of Director's approved 2018 budget. Existing sub-recipient selection and funding will be proposed by the CEO and approved by AFHP's Board of Directors. Upon board approval, sub-recipients will be notified of their application's approval for funding and contracts are then issued. Sub-recipient will submit amended budgets when funding available is less than that requested in the sub-recipient's application.

AFHP's board-approved fiscal policies include, but are not limited to: policies that address internal controls; prohibition of using funds for prohibited activities, such as programs that include abortion as a method of family planning, or lobbying; annual audit requirements; and adherence to federal cost principles. AFHP maintains a separate account for the distribution of Title X funds and detailed accounting records, supported by invoices and journal entries to ensure separation of Title X and non-Title X activities. Similarly, AFHP requires its sub-recipient maintain Title X project activities and funds separate from non-Title X activities. AFHP adheres to 42 CFR 50 and 40 CFR 59. The separation of Title X and non-Title X activities is monitored at the sub-recipient's program review to ensure revenue, expenses are kept separate, and that program revenue is used to further the family planning project's objectives. On a monthly basis, all sub-recipient requests for reimbursement will be reviewed initially by the Program Manager and finally by the VPFA to ascertain that the sub-recipient is submitting the required client report and supporting documents associated with the invoice. On a quarterly basis

the revenue and expense reports will be reconciled to the invoices and reviewed for accuracy to confirm that contractual obligations are met.

AFHP's Audit and Finance Committee and Board of Directors will review the organization's financial statements at each Board meeting. Financial statements include balance sheet and income statements with budget to actual comparisons and the Title X Status report, which tracks the number of clients served against the contracted amount, and the approved expenditures versus the approved contract expenditures. The AFHP Audit and Finance Committee will meet in conjunction with full board meetings to approve transactions for fiscal governance.

AFHP will perform a budget analysis quarterly and material variances addressed with sub-recipient. Reconciled sub-recipient revenue and expenditure reports will be used to report program income and expenditures on the quarterly Federal Financial Report (FFR).

AFHP will draw down funds from the HHS Payment Management System (PMS) for approved sub-recipient disbursements and process ACH payments within five business days of receipt of federal funds. AFHP requires two staff members to process ACH transactions, one person to initiate the ACH and a second person to approve it. The CEO is required to approve all ACH or checks greater than $25,000. The VPFA and the VPPE can approve ACH transactions up to $25,000. The VPPE, one Program Manager and one Board member can act as a signatory in the event the CEO is not available to sign checks. The VPFA will reconcile all bank accounts on a monthly basis and thus cannot be a signatory for checks.

AFHP's VPFA will reconcile monthly cash receipts drawn from the HHS PMS against AFHP's financial statements. AFHP's reconciled financial statements along with the sub-

recipient's quarterly revenue and expenditure reports are the source documents used to file the quarterly FFR SF-425 and quarterly cash reporting to the HHS PMS.

An independent accounting firm will conduct AFHP's financial and compliance audit annually. AFHP's audits and opinion have consistently been unmodified and contained no findings; qualifying AFHP as a low-risk auditee. AFHP sub-recipient will be required to have an independent, annual audit performed in accordance with government auditing standards. AFHP's VPFA reviews all sub-recipient financial and compliance audits. A sub-recipient's corrective action plan will address any noted audit deficiencies and will be required to file a copy of the sub-recipient's corrective action plan with AFHP. Audit findings will also be considered when setting the monitoring schedule and planning monitoring fieldwork for interim and formal site visits.

a. Sliding Fee Schedule

Each sub-recipient is required to submit an annual update of their fee schedule and a schedule of discounts based on the most recently issued Federal poverty guidelines. The sub-recipients will be required to conduct a cost analysis once every three years and to compare their proposed fees with the prevailing rates in the community. Any changes to the fee schedule will be submitted to AFHP for review.

b. Monitoring of Patient Billing

All sub-recipients are contractually required to bill to third party payors in order to maximize the Title X program. The VPFA will review selected encounters during site visits to confirm the charges issued, compliance with the Explanation of Benefits (EOB), and ensure that patients are not charged more than what they would pay under the sliding fee schedule for services including deductibles. Program staff will review the selected encounters for poverty

status, collected patient fees, the billing codes and the progress notes, to ensure that the encounter conforms to a Title X visit.

Budget Narrative Year 2, 3, and 4

The only substantive change for years 2, 3, and 4 is a projected change to salaries, health insurance costs, and sub-recipient allocations. This includes a (b)(4) increase in Title X funding for years 2, 3, and 4, contingent upon availability of Federal funds. All budget changes will be approved by the Board of Directors at the meeting preceding the start of the program period as the fiscal decisions are dependent on confirmation of revenues for the future program period. Please refer to summary budgets from years 2, 3, and 4.

	2018 - 2019 Budget	Management and Administrative Navajo	Reproductive Healthcare Services and Supporty Navajo	Other Navajo	Total Navajo
Income					
	4000 · Other Support		(b)(4)		
	4041 · Patient Collections	$			
	4042 · Third Party Payors	$			
	4043 · Title V	$			
	Total Other Support	$			
	4200 · TitleX-AFHP				
	42008 · TitleX-Delegates Navajo	$			
	42005 · TitleX-AFHP - Navajo	$			
	Total 4200 · TitleX-AFHP	$			
Total Income		$			
		$			
Expense					
	6000 · Promotional/Outreach	$			
	6010 · Audit	$			
	6030 · Consulting				
	603009 · Monthly Web Hosting	$			
	603012 · Computer				
	603025 · CDS Updates	$			
	603012 · Computer - Other	$			
	Total 603012 · Computer	$			
	603020 · Policy & Education	$			
	603021 · AFHP Medical Director	$			
	603022 · Public Affairs	$			
	603024 · Website Updates	$			
	603027 · Data Tracking System	$			
	60304 · Facilitator	$			
	60305 · Legal Services	$			
	6030 · Consulting - Other	$			
	Total 6030 · Consulting	$			
	6050 · Depreciation Expense	$			
	6090 · Fees				
	60901 · Service Charges	$			
	60905 · Paypal/Auth.Net/Cybersource	$			
	6090 · Fees - Other	$			
	Total 6090 · Fees	$			
	6100 · Insurance				
	61001 · Business (Gen. Liab)	$			
	61002 · Professional Liability	$			
	61003 · D & O Insurance	$			
	Total 6100 · Insurance	$			
	6110 · Maint Contracts	$			
	6140 · Meeting Costs - Misc.				
	6140 · Meeting Costs - Misc. - Other	$			
	Total 6140 · Meeting Costs - Misc.	$			
	6150 · Membership	$			
	6160 · Miscellaneous	$			
	6170 · Office Supplies	$			
	6180 · Other Expenses	$			
	6190 · Payroll Expenses				
	6080 · ERE				
7.17%	60801 · Medical/LTD/Life	$			
0.62%	60802 · Medical Reimbursement	$			
4.53%	60803 · Retirement Contribution-ER	$			
	Total 6080 · ERE	$			
	61903 · Gross Wages	$			
	6200 · Payroll Taxes				
5.98%	62001 · FICA	$			
0.11%	62002 · FUTA	$			

			(b)(4)
1.40%	62003 · Medicare	$	
0.43%	62005 · State Fund	$	
0.26%	62006 · SUI - State Unemployment	$	
	Total 6200 · Payroll Taxes	$	
0.04%	6190 · Payroll Expenses - Other	$	
	Total 6190 · Payroll Expenses	$	
	6210 · Postage		
	62102 · Bulk	$	
	62103 · FedEx	$	
	62105 · Metered	$	
	62107 · Rental for Meter	$	
	6210 · Postage - Other	$	
	Total 6210 · Postage	$	
	6220 · Printing and Reproduction	$	
	6230 · Program Supplies	$	
	6235 · Program Awareness	$	
	6240 · Publications	$	
	6250 · Registrations (Conferences)	$	
	6270 · Rent		
	6271 · Central Parking Staff & Guests	$	
	6270 · Rent - Other	$	
	Total 6270 · Rent	$	
	6280 · Subscriptions	$	
	6300 · Telephone		
	63001 · Long Distance	$	
	630025 · Cell Phone/Internet	$	
	Total 63002 · Mobile Phone	$	
	6300 · Telephone - Other	$	
	Total 6300 · Telephone	$	
	6311 · Navajo Title X Grant - Delegates	$	
	6312 · Other Related Delegate Expenses	$	
	63201 · Airfare	$	
	63202 · Car Rental	$	
	63203 · Gasoline purchases	$	
	63204 · Hotel	$	
	63205 · Mileage	$	
	63206 · Parking/Taxi	$	
	63207 · Per Diem/ Meals	$	
	Total 6320 · Travel	$	
Total Expense		$	
Net Income		$	

Arizona Family Health Partnership
Title X Navajo Competing Application

From: 9/1/2018 **To:** 8/31/2019

	Position Title	FTE	Annual Salary	No. Months	% Time	Title X Cost	Total Cost
Ferreiro	Vice President of Finance and Administration	1.00	$	(b)(4);(b)(6)			
(b)(6)	Program Manager	1.00	$				
	Program Community and Information Coordinator	1.00	$				
	Busines Coordinator	1.00	$				
Thomas	Chief Executive Officer - Principal Investigator	1.00	$				
(b)(6)	Communications and Adminstration Coordinator	1.00	$				
	Program Manager	1.00	$				
	Program Manager	0.92	$				
	Clinical Program Manager	1.00	$				
Min	Vice President of Program and Evaluation	1.00	$				
			Total Salaries		$	(b)(4)	$ (b)(4)
			FICA		$		$
			Medicare		$		$
			State Comp Fund		$		$
			SUTA (up to $7000)		$		$
			Workers Comp		$		$
			Health Insurance		$		$
			AD&D		$		$
			Life Insurance		$		$
			Retirement		$		$
			Sub-total Fringe Benefits		$		$
			Total Salaries and Benefits		$		$

Arizona Family Health Partnership
Title X Navajo Competitive Application 2018 - 2019

From: 9/1/2018 **To:** 8/31/2018

	Purpose	**Purpose**	**Purpose**	**Purpose**		
Staff Traveling to Out of State Conferences or Meetings	CEO, Director of Finance and Administration, Director of Program Evaluation, Program Manager	Vice President of Program and Evaluation	Program Manager & Clinical Program Manager	CEO & Vice President of Finance and Administration		**Sub-Total**
Out of State	Out of State meetings - Annual Conference & NFPRHA meetings	Delegate site visit (b)(4) UTAH	(b)(4) Training Meetings in Utah	Site Visit (b)(4) Utah		
Airfare	$	(b)(4)				
Hotel	$					
Registration	$					
Per Diem	$					
Rental Car	$					
Gasoline	$					
Mileage	$					
Taxi	$					
Parking	$					
Sub-Total	$					

	Vice President of Program and Evaluation	Program Manager & Clinical Program Manager			
Staff In-State Travel	**Training Visit** (b)(4) **Navajo Nation AZ**	**Delegate Site Visits** (b)(4) **Navajo Nation AZ**	**Other**	Sub-Total	Total
Airfare	$	(b)(4)			
Hotel	$				
Registration	$				
Per Diem	$				
Rental Car	$				
Gasoline	$				
Mileage	$				
Taxi	$				
Parking	$				
Sub-total	$				

AFHP AGENCY ANNUAL REVENUE BUDGET REPORT

Agency Name: (b)(4)

Grant Name: NAVAJO GRANT

Name of Person filling out form: (b)(6)

Date: 05/16/2018

Revised Date: 04/26/2018

Reporting Period: Annual Budget (September 1, 2018 - August 31, 2019)

Annual Budget Form 2018-2019 : Revenue Summary

REVENUE	2017 Budget	2018 Title X Funds	2018 Non Title X Funds	2018 Total Program Budget
1) Federal Grants				
1. Title X - Base		(b)(4)		
2. Bureau of Primary Health Care (BPHC)				
3. Other Federal Grants (Specify)				
4. Other Federal Grants (Specify)				
5. Title X Additional Funds (Specify)				
Sub Total of Federal Grants				
2) Payment For Services				
1. Patient Collections/Fees				
3) Third Party Payers				
1. Medicaid (Title XIX)				
2. Medicare (Title XVIII)				
3. Other public health insurance				
4. Private health insurance				
Sub Total of Third Party Payers				
4) Other Sources				
1. Title V (MCH Block Grant)				
2. Local Government				
3. State Government				
4. Client Donations				
5. Agency In Kind				
6. Agency Contribution (Non-County agencies only)				
7. Other (Specify)				
Sub Total of Other Sources				
TOTAL REVENUE				

AFHP AGENCY ANNUAL EXPENSES BUDGET REPORT

Agency Name: (b)(4)

Grant Name: NAVAJO GRANT

Name of Person filling out form: (b)(6)

Date: 05/16/2018

Revised Date: 03/30/2018

Reporting Period: Annual Budget (September 1, 2018 to August 31, 2019)

Annual Budget Form 2018-2019 : Expenses Summary

EXPENSES	2017 Budget	2018 Title X Funds	2018 Non Title X Funds	2018 Total Program Budget
1. Personnel				
2. Fringe Benefits				
3. Travel				
4. Equipment				
5. Supplies				
6. Contractual				
7. Occupancy				
8. Other				
9. Indirect				
TOTAL EXPENSES				

(b)(4)

☒ I certify that information in this budget proposal is correct to the best of my knowledge.

Completed By : (b)(6)

AFHP AGENCY PERSONNEL EXPENSES REPORT

Agency Name : (b)(4)

Grant Name : NAVAJO GRANT

Revised Date : 04/26/2018

Date : 05/16/2018

Complete for all staff positions included in the 2018-2019 Budget Form under Personnel Expenses Line Item. List each position individually on a separate line.

Position	Annual Salary	FTE Allocated to Family Planning	Amount $ of Salary in Family Planning Budget	Title X Portion	Other Funding Sources Portion
Medical Receptionist	(b)(4)				
MA					
MA					
Office Support					
Office Support					
CEO					
NP					
Finance Contact					
Physician (MD)					
Physician (MD)					
MA					
IT Contact					
NP					
CFO					
NP					
Medical Director					
PA					
Billing					
Office Support					
MA					
MA					
PA					
Program Manager					
MA					
Medical Receptionist					

Accounting		(b)(4)				

Budget Justification for 2018-2019 – Navajo Grant

The Budget Justification must contain detailed information to explain and justify the expenses your agency has budgeted for the total family planning program. The justification should include information about who, what, where, when and why. All costs in the budget including those listed in "Other" must be described in detail.

Agency Name: (b)(4)

Budget Overview

Category	Detail		$
Personnel	Wages/Salaries		(b)(4)
Fringe Benefits	ERE		
Travel	Staff travel		
Equipment	Equipment		
Supplies	Office, Contraceptive, and Medical Supplies		
Contractual	Contracted Staff and Lab		
Occupancy	Rent, Utilities		
Other	Miscellaneous		
Indirect	Cannot exceed 15%		
		TOTAL	

Budgeted Expense Line Items

Personnel

Report the amount of costs for salaries associated with the family planning program and provide a brief summary of the family planning program staffing plan in the box below. For example, how many full time equivalent clinicians, medical assistants and support staff will be supported by the family planning budget.

Summary of Staffing Plan	Total Salary Amount

The total personnel costs are associated with the portions of salaries for the personnel who will be working on this program. These staff include (b)(FTE Program Manager, (b)(FTE Administrative Assistant, (b)(4) Educator, (b)(4 FTE Chief Medical Officer/Physician, (b FTE Medical Assistants, (b)(FTE Billing, .(FTE Clinicians, (b)(FTE Schedulers, (b)(FTE Accounting Staff, .(b)(FTE Medical Records, (b)(FTE IT, and (b)(4) FTE Chief Executive Officer.		(b)(4)
TOTAL PERSONNEL		

Fringe Benefits

Report costs associated with FICA, unemployment insurance, long and short term disability, pension plan contribution, workman's compensation, and health, dental and life insurance, etc. These costs are usually expressed as a percentage of personnel salaries and wages (i.e., (b)(4) ; personnel cost = (b)(4)).

Fringe Benefit	%	$
FICA (Social Security and Medicare)		(b)(4)
Unemployment & Compensation Insurance		
Health, Life & Disability Insurance		
Total (b)(4) %		
TOTAL FRINGE BENEFITS		(b)(4)

Travel

Report costs for client, volunteer and staff travel. List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in two (2) mandatory in-person delegate meetings and other proposed trainings or workshops.

Meeting Location	Staff Traveling	Purpose of Travel	# of Persons /Trips	Total Cost
Clinic Locations	Project Manager & Educator	Training and program oversight.	1 Person 6 Trips	(b)(4)
TBD	Project Manager & Support Staff	Delegate Meeting in Phx.	2 People 2 Trips	
TBD	Clinical Conference	Clinical training conference	2 People 1 Trip	
TOTAL TRAVEL				

Equipment

Report cost for any single item with a useful life of at least three (3) years and a minimum acquisition cost determined by you agency's policy (i.e., computers, autoclave, electronic records system, electronic exam tables for individuals with disabilities, etc.). The depreciation or use allowance of any equipment purchased with federal dollars, in the proposed budget period or prior budget periods, must not be reflected in any other line item.

Equipment	Purpose	$
None		0.00
	TOTAL EQUIPMENT	**0.00**

Supplies

Report costs for all consumable items with a useful life of less than three (3) years, or any single item with a unit cost determined by your agency's policy. Office and program supplies should be entered here including contraceptive methods, medical supplies, etc.

Supplies	Purpose	$
Contraceptive	Contraceptive devices and products at (b)(4) per client (b)(4) clients).	(b)(4)
Medical	$(b)(4) per visit based on historical cost (b)(4) visits).	
Office	$(b)(4) per visit based on historical cost (b)(4) visits).	
Other Specify:		
	TOTAL SUPPLIES	

Contractual

Report costs for all consulting expenses that are paid to technical experts hired on a contractual basis. These individuals are not members of the salaried staff. Report costs for any contractual expenses (subcontracts) that are performed by an organization in accordance with a documented contract or other written agreement (i.e., laboratory, medical professionals, etc.).

Service	Purpose	$
Lab	Contracted lab services at $(b)(4) per visit (1,496 visits annually)	(b)(4)
	TOTAL CONTRACTUAL	

Occupancy

Report costs for rent, minor repairs, janitorial services, extermination services, garbage removal, etc. Occupancy includes utilities such as electric, gas, telephone service, heat and water. The computation of depreciation (i.e., use allowance) shall be based on the acquisition cost of the assets involved. Computation details are provided in Circular A-122, A-21 and A-87.

Item	Purpose	$
Rent, Utilities, Janitorial, Repairs	Occupancy at 3 locations ($ (b)(4) per month)	(b)(4)
	TOTAL OCCUPANCY	

Other

Report costs that do not fit easily into any of the other budget categories. Examples include, but are not limited to: client incentives; staff recruitment; family planning outreach; payroll service fees; etc.

Item	Purpose	$
Marketing & Patient Education	Development of a marketing plan to reach out to individuals in need of family planning services. Produce digital stories that can be shared with potential clients that demonstrate the value and benefits of the program to the patient.	(b)(4)
	TOTAL OTHER EXPENSES	

Indirect

In order to charge indirect costs you must either submit your approved indirect cost rate application with supporting documents or submit an indirect rate application to AFHP for approval.

Indirect costs are those that have been incurred for common or joint objectives, and thus are not readily subject to treatment as direct costs. Examples include costs for advertising, computing, maintenance, security, supervision, etc. and are incurred in joint usage and are therefore difficult to assign to or identify with one specific cost object or cost center (department, function, program, etc.).

Indirect expenses are allowed up to a maximum of 15% of total program expenses and include items such as administrative overhead and support staff.

Item	Purpose	$
	NONE	
	TOTAL INDIRECT	**$**

AFHP AGENCY ANNUAL REVENUE BUDGET REPORT

Agency Name: (b)(4)

Grant Name: NAVAJO GRANT

Name of Person filling out form: (b)(6)

Date: 05/16/2018

Revised Date: 04/12/2018

Reporting Period: Annual Budget (September 1, 2018 to August 31, 2019)

Annual Budget Form 2018-2019 : Revenue Summary

REVENUE	2017 Budget	2018 Title X Funds	2018 Non Title X Funds	2018 Total Program Budget
1) Federal Grants				
1. Title X - Base				
2. Bureau of Primary Health Care (BPHC)				
3. Other Federal Grants (Specify)				
4. Other Federal Grants (Specify)				
5. Title X Additional Funds (Specify)				
Sub Total of Federal Grants				
2) Payment For Services				
1. Patient Collections/Fees				
3) Third Party Payers				
1. Medicaid (Title XIX)				
2. Medicare (Title XVIII)				
3. Other public health insurance				
4. Private health insurance				
Sub Total of Third Party Payers				
4) Other Sources				
1. Title V (MCH Block Grant)				
2. Local Government				
3. State Government				
4. Client Donations				
5. Agency In Kind				
6. Agency Contribution (Non-County agencies only)				
7. Other (Specify)				
Sub Total of Other Sources				
TOTAL REVENUE				

(b)(4)

AFHP AGENCY ANNUAL EXPENSES BUDGET REPORT

Agency Name: (b)(4)

Grant Name: NAVAJO GRANT

Name of Person filling out form: (b)(6)

Date: 05/16/2018

Revised Date: 04/12/2018

Reporting Period: Annual Budget (September 1, 2018 - August 31, 2019)

Annual Budget Form 2018-2019 : Expenses Summary

EXPENSES	2017 Budget	2018 Title X Funds	2018 Non Title X Funds	2018 Total Program Budget
1. Personnel		(b)(4)		
2. Fringe Benefits				
3. Travel				
4. Equipment				
5. Supplies				
6. Contractual				
7. Occupancy				
8. Other				
9. Indirect				
TOTAL EXPENSES				

☒ I certify that information in this budget proposal is correct to the best of my knowledge.

Completed By (b)(6)

AFHP AGENCY PERSONNEL EXPENSES REPORT

Agency Name : (b)(4)

Grant Name : NAVAJO GRANT

Revised Date : 04/12/2018

Date : 05/16/2018

Complete for all staff positions included in the 2018-2019 Budget Form under Personnel Expenses Line Item. List each position individually on a separate line.

Position	Annual Salary	FTE Allocated to Family Planning	Amount $ of Salary in Family Planning Budget	Title X Portion	Other Funding Sources Portion
MA	(b)(4)				
MA					
Physician (MD)					
Pharmacy Director					
MA					
Office Support					
Back Office Manager					
Medical Director					
MA					
Executive Director					
RN					
Medical Receptionist					
Physician (MD)					
MA					
Grant Contact					
Medical Receptionist					
PA					
LPN					
Medical Receptionist					
Information Systems Director					
Program Manager					
Finance Contact					

Budget Justification for 2018-2019 -- Navajo Grant

The Budget Justification must contain detailed information to explain and justify the expenses your agency has budgeted for the total family planning program. The justification should include information about who, what, where, when and why. All costs in the budget including those listed in "Other" must be described in detail.

Agency Name: (b)(4)

Category	Detail		$
Personnel	Wages/Salaries		(b)(4)
Fringe Benefits	ERE		
Travel	Staff travel		
Equipment	Equipment		
Supplies	Office, Contraceptive, and Medical Supplies		
Contractual	Contracted Staff and Lab		
Occupancy	Rent, Utilities		
Other	Miscellaneous		
Indirect	Cannot exceed 15%		
		TOTAL	

Budgeted Expense Line Items

Personnel

Report the amount of costs for salaries associated with the family planning program and provide a brief summary of the family planning program staffing plan in the box below. For example, how many full time equivalent clinicians, medical assistants and support staff will be supported by the family planning budget.

Summary of Staffing Plan	Total Salary Amount
17 Medical Providers at (b)(4) FTE each, support staff at (b)(4) FTE each, other clinical staff at (b)(4) FTE each, administrative support at (b)(4) FTE	(b)(4)
TOTAL PERSONNEL	

Fringe Benefits

Report costs associated with FICA, unemployment insurance, long and short term disability, pension plan contribution, workman's compensation, and health, dental and life insurance, etc. These costs are usually expressed as a percentage of personnel salaries and wages (i.e., (b)(4); personnel cost = $(b)(4)).

Fringe Benefit	%	$
FICA (Social Security and Medicare)		(b)(4)
Unemployment & Compensation Insurance		
Health, Life & Disability Insurance		
Retirement Plan		
Total %		(b)(4)
TOTAL FRINGE BENEFITS		

Travel

Report costs for client, volunteer and staff travel. List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in two (2) mandatory in-person delegate meetings and other proposed trainings or workshops.

Meeting Location	Staff Traveling	Purpose of Travel	# of Persons /Trips	Total Cost
Delegate meeting	Program Director/Medical Director	Mandatory in-person delegate meeting	2/2	(b)(4)
			TOTAL TRAVEL	

Equipment (greater than $5,000 or your agency's limit)

Report cost for any single item with a useful life of at least three (3) years and a minimum acquisition cost determined by your agency's policy (i.e., servers, autoclave, electronic records system, electronic exam tables for individuals with disabilities, etc.). The depreciation or use allowance of any equipment

purchased with federal dollars, in the proposed budget period or prior budget periods, must not be reflected in any line item.

Equipment	Purpose	$
	TOTAL EQUIPMENT	**$**

Supplies

Report costs for all consumable items with a useful life of less than three (3) years, or any single item with a unit cost less than $5,000 or your agency's limit, whichever is less. Office and program supplies should be entered here including contraceptive methods, medical supplies, etc. Also, include any LARC donated from the Arch Foundation or other agency.

Supplies	Purpose	$
Contraceptive		(b)(4)
Medical		
Office		
Other Specify:		
	TOTAL SUPPLIES	

Contractual

Report costs for all consulting expenses that are paid to technical experts hired on a contractual basis. These individuals are not members of the delegate agency. Report costs for any contractual expenses (subcontracts) that are performed by an organization in accordance with a documented contract or other written agreement (i.e., laboratory, medical professionals, etc.).

Service	Purpose	$
	TOTAL CONTRACTUAL	**$**

Occupancy

Report costs for rent, minor repairs, janitorial services, extermination services, garbage removal, etc. Occupancy includes utilities such as electric, gas, telephone service, heat and water. The computation of depreciation (i.e., use allowance) shall be based on the acquisition cost of the assets involved. Computation details are provided in the OMB Super Circular.

Item	Purpose	$
	TOTAL OCCUPANCY	**$**

Other

Report costs that do not fit easily into any of the other budget categories. Examples include, but are not limited to: client incentives; staff recruitment; family planning outreach; payroll service fees; etc.

Item	Purpose	$
	TOTAL OTHER EXPENSES	**$**

Indirect

In order to charge indirect costs, you must submit a letter indicating your federally approved indirect cost rate in order to charge up to 15% as indirect expenses. If your agency does not have a federally approved indirect rate, the maximum allowed indirect rate will be limited to the de minimis rate of 10%.

Indirect costs are not charged on contractual expenses. Indirect costs are those that have been incurred for common or joint objectives, and thus are not readily subject to treatment as direct costs. Examples include costs for advertising, computing, maintenance, security, supervision, etc. and are incurred in joint usage and are therefore difficult to assign to or identify with one specific cost object or cost center (department, function, program, etc.).

Item	Purpose	$

TOTAL INDIRECT	**$**

Arizona Family Health Partnership Year 2 Revised: * 5/21/2018

Title X Navajo Competitive 2019 - 2020 Budget

From: 9/1/2019 **To:** 8/31/2020

		Management and Administrative	Reproductive Healthcare Services and Support	Other	Total
Revenue and other Support					
Title X Arizona services grant - AFHP	$	(b)(4)			
ADHS (IPP contract)	$				
Development	$				
Interest Income	$				
AFHP contract work	$				
Sub-Total Revenue and Support	$				
Title X Services grant - Delegates	$				
Patient Collections	$				
Third party Payers	$				
Agency Contribution	$				
Total Revenue and other support	$				
Salary	$				
Fringe benefits	$				
Promotion/Outreach	$				
Audit	$				
Consulting	$				
Depreciation	$				
Fees	$				
Insurance	$				
Main Contracts	$				
Meeting Costs	$				
Memberships	$				
Office Supplies	$				
Postage	$				
Printing	$				
Program Supplies	$				
Program Awareness	$				
Registrations	$				
Rent	$				
Subscriptions	$				
Telephone	$				
Misc. Other	$				
Travel	$				
Sub-Total Expenses	$				
Title X Delegate Expenses	$				
Other related Delegate Expense	$				
Total Expenses	$				
Change in net assets	$				
Admin %					
Clients			(b)(4)		
Title X Cost per Client	$		(b)(4)		
Total Cost per Client	$				

Arizona Family Health Partnership **Year 3** Revised: * 5/21/2018

Title X Navajo Competitive 2020 - 2021 Budget

From: 9/1/2020 **To:** 8/31/2021

		Management and Administrative	Reproductive Healthcare Services and Support	Other	Total
Revenue and other Support					
Title X Arizona services grant - AFHP	$	(b)(4)			
ADHS (IPP contract)	$				
Development	$				
Interest Income	$				
AFHP contract work	$				
Sub-Total Revenue and Support	$				
Title X Services grant - Delegates	$				
Patient Collections	$				
Third party Payers	$				
Agency Contribution	$				
Total Revenue and other support	$				
Salary	$				
Fringe benefits	$				
Promotion/Outreach	$				
Audit	$				
Consulting	$				
Depreciation	$				
Fees	$				
Insurance	$				
Main Contracts	$				
Meeting Costs	$				
Memberships	$				
Office Supplies	$				
Postage	$				
Printing	$				
Program Supplies	$				
Program Awareness	$				
Registrations	$				
Rent	$				
Subscriptions	$				
Telephone	$				
Misc. Other	$				
Travel	$				
Sub-Total Expenses	$				
Title X Delegate Expenses	$				
Other related Delegate Expense	$				
Total Expenses	$				
Change in net assets	$				
Admin %		(b)(4)			
Clients				(b)(4)	
Title X Cost per Client	$			(b)(4)	
Total Cost per Client	$				

Arizona Family Health Partnership **Year 4** Revised: * 5/21/2018

Title X Navajo Competitive 2021 - 2022 Budget

From: 9/1/2021 **To:** 8/31/2022

		Management and Administrative	Reproductive Healthcare Services and Support	Other	Total
Revenue and other Support					
Title X Arizona services grant - AFHP	$	(b)(4)			
ADHS (IPP contract)	$				
Development	$				
Interest Income	$				
AFHP contract work	$				
Sub-Total Revenue and Support	$				
Title X Services grant - Delegates	$				
Patient Collections	$				
Third party Payers	$				
Agency Contribution	$				
Total Revenue and other support	$				
Salary	$				
Fringe benefits	$				
Promotion/Outreach	$				
Audit	$				
Consulting	$				
Depreciation	$				
Fees	$				
Insurance	$				
Main Contracts	$				
Meeting Costs	$				
Memberships	$				
Office Supplies	$				
Postage	$				
Printing	$				
Program Supplies	$				
Program Awareness	$				
Registrations	$				
Rent	$				
Subscriptions	$				
Telephone	$				
Misc. Other	$				
Travel	$				
Sub-Total Expenses	$				
Title X Delegate Expenses	$				
Other related Delegate Expense	$				
Total Expenses	$				
Change in net assets	$				
Admin %		(b)(4)			
Clients			(b)(4)		
Title X Cost per Client	$			(b)(4)	
Total Cost per Client	$				

Upload #6

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress
Document Title:	Form AttachmentForm_1_2-V1.2.pdf

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	1238-Navajo 2018 appendices c		Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment		
3) Please attach Attachment 3		Add Attachment		
4) Please attach Attachment 4		Add Attachment		
5) Please attach Attachment 5		Add Attachment		
6) Please attach Attachment 6		Add Attachment		
7) Please attach Attachment 7		Add Attachment		
8) Please attach Attachment 8		Add Attachment		
9) Please attach Attachment 9		Add Attachment		
10) Please attach Attachment 10		Add Attachment		
11) Please attach Attachment 11		Add Attachment		
12) Please attach Attachment 12		Add Attachment		
13) Please attach Attachment 13		Add Attachment		
14) Please attach Attachment 14		Add Attachment		
15) Please attach Attachment 15		Add Attachment		

Upload #7

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress
Document Title:	Form BudgetNarrativeAttachments_1_2-V1.2.pdf

Budget Narrative File(s)

* **Mandatory Budget Narrative Filename:** 1234 AFHP Navajo Budget Narrative and Supporting Do

	Delete Mandatory Budget Narrative	View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative		

Upload #8

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress
Document Title:	Form ProjectNarrativeAttachments_1_2-V1.2.pdf

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** 1235-AFHP Navajo Program Narrative 2018.pdf

Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File

Tracking Number:GRANT12628687 Funding Opportunity Number:PA-FPH-18-001 Received Date:May 21, 2018 08:59:14 PM EDT

Upload #9

Applicant:	Arizona Family Health Partnership
Application Number:	FPH2018008765
Project Title:	Arizona Family Health Partnership application for Title X service in the Navajo Region
Status:	Review in Progress
Document Title:	Form SFLLL_1_2-V1.2.pdf

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
4040-0013

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d loan
- [ ] e loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

*Name: Arizona Family Health Partnership

*Street 1: 3101 N Central Ave Street 2: Suite 1120

*City: Phoenix State: AZ: Arizona Zip: 85012

Congressional District, if known: AZ 9

6. * Federal Department/Agency:

Office of Assistant Secretary of Health

7. * Federal Program Name/Description:

Family Planning Services

CFDA Number, *if applicable:* 93.217

8. Federal Action Number, *if known:*

PA-FPH-18-001

9. Award Amount, *if known:*

$ 474,000.00

10. a. Name and Address of Lobbying Registrant:

Prefix: *First Name: none Middle Name: none

*Last Name: none Suffix:

*Street 1: na Street 2: na

*City: na State: AZ: Arizona Zip: 85012

b. Individual Performing Services (including address if different from No. 10a)

Prefix: *First Name: none Middle Name: none

*Last Name: none Suffix:

*Street 1: none Street 2:

*City: none State: AZ: Arizona Zip: 85012

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Manuel E Pereira

***Name:** Prefix: Mr. *First Name: Manuel Middle Name: Lyle

*Last Name: Pereira Suffix:

Title: Chief Executive Officer **Telephone No.:** 602[illegible] **Date:** 05/21/2018

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

Table Of Contents

Applicant:	Carson City
Application Number:	FPH2018008746
Project Title:	Carson City Health & Human Services Family Planning and Related Health Services.
Status:	Review in Progress

Online Forms

Program Narrative

Additional Information to be Submitted

Proof of Filing

1. SF-424 Application for Federal Assistance Version 2
   - (Upload #1): ProjectNarrativeAttachments_1_2-Attachments-1235-Final CCHHS Title X Project Narrative 2018 Application.pdf
   - (Upload #2): AttachmentForm_1_2-ATT1-1234-Title X 2018-2021 Attachments.pdf
   - (Upload #3): BudgetNarrativeAttachments_1_2-Attachments-1236-CCHHS Title X 2018-2021 Budget Narrative.pdf
   - (Upload #4): Form AttachmentForm_1_2-V1.2.pdf
   - (Upload #5): Form BudgetNarrativeAttachments_1_2-V1.2.pdf
   - (Upload #6): Form ProjectNarrativeAttachments_1_2-V1.2.pdf
   - (Upload #7): Form SFLLL_1_2-V1.2.pdf
2. SF-424A Budget Information - Non-Construction
3. SF-424B Assurances - Non-Construction
4. SF-LLL Disclosure of Lobbying Activities
5. Project Abstract Summary
6. Key Personnel
7. Budget Narrative
8. Program Narrative
9. Exhibits/Tables/Attachments
10. Negotiated Rate Agreement
11. Copy of By-Laws
12. Proof of Non-Profit Status

Note: Upload document(s) printed in order after online forms.

OMB Approval No. 4040-0006
Expiration Date: 01/31/2019

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Family Planning and Rela	CFDA 93.21			$430,485.00	(b)(4)	
2.						
3.						
4.						
5. Totals				$430,485.00		

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) Family Planning and Relat	(2)	(3)	(4)	(5)
a. Personnel	(b)(4)				(b)(4)
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual					
g. Construction					
h. Other					
i. Total Direct Charges *(sum of 6a-6h)*					
j. Indirect Charges					
k. TOTALS *(sum of 6i and 6j)*					
7. Program Income					$

Authorized for Local Reproduction

Standard Form 424A (Rev. 7-97)
Prescribed by OMB Circular A-102

Previous Edition Usable

SECTION C - NON-FEDERAL RESOURCES				
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8		(b)(4)		
9.				
10.				
11.				
12. TOTAL *(sum of lines 8-11)*				

SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$430,485.00	(b)(4)			
14. Non-Federal		(b)(4)			
15. TOTAL *(sum of lines 13 and 14)*					

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.	$430,485.00	(b)(4)		
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$ $430,485.00	$		

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges:	22. Indirect Charges:
23. Remarks:	

Authorized for Local Reproduction

OMB Number: 0980-0204
Expiration Date: 04/30/2015

Project Abstract Summary

Program Announcement (CFDA)
93.217

*** Program Announcement (Funding Opportunity Number)**
PA-FPH-18-001

*** Closing Date**
05/24/2018

*** Applicant Name**
Carson City

*** Length of Proposed Project** 36

Application Control No.

Federal Share Requested (for each year)

*** Federal Share 1st Year**
$ 430,485.00

*** Federal Share 2nd Year**
(b)(4)

*** Federal Share 3rd Year**

*** Federal Share 4th Year**
$ 0.00

*** Federal Share 5th Year**
$ 0.00

Non-Federal Share Requested (for each year)

*** Non-Federal Share 1st Year**
$ (b)(4)

*** Non-Federal Share 2nd Year**

*** Non-Federal Share 3rd Year**

*** Non-Federal Share 4th Year**
$ 0.00

*** Non-Federal Share 5th Year**
$ 0.00

*** Project Title**
Carson City Health & Human Services Family Planning and Related Health Services.

Project Abstract Summary

*** Project Summary**

CCHHS is seeking funding to provide Title X family planning and preventive health to 3200 unduplicated clients in Carson City and Douglas County, Nevada. Services will be provided in according to Title X program priorities, guidelines and legislative mandates. CCHHS actively assists clients towards understanding and navigating the health care environment. Utilizing science-based practice to prevent unintended pregnancy, CCHHS will provide family planning and preventive health services to include a broad range of family planning methods. CCHHS will also place a special emphasis on improving optimal health outcomes of childbearing aged men and women through the provision of reproductive life planning, basic infertility services, sexually transmitted disease testing and treatment pregnancy testing, counseling and education. This Title X Family Planning project will include counseling and education to include: family participation, healthy monogamous relationships, abuse reporting laws, healthy decision making and education and counseling that prioritizes optimal health, benefits of avoiding sexual risk, behavioral risk avoidance, and risk -reduction education. CCHHS will ensure clinical and cost effectiveness through optimal patient scheduling, inventory management and staff education. CCHHS will ensure the delivery of quality care monitoring progress through the annual FPAR, client surveys and ongoing quality improvement activities.

CCHHS is a respected presence in the community, and is experienced in administrative, clinical and fiscal oversight. CCHHS has pro-actively adopted an electronic health record and practice management system, actively assists clients towards health insurance enrollment, is contracted with the majority of third party payers and a has formal collaborative relationship with primary care. CCHHS is positioned to utilize administrative, fiscal and clinical oversight experience with a sub recipient in an adjoining county to assure the delivery of services in compliance with Title X statutory, regulatory and legislative requirement and program priorities.

*** Estimated number of people to be served as a result of the award of this grant.** 3200

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
____ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	____ a. bid/offer/application b. initial award c. post-award	____ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: 93.217
8. Federal Action Number, *if known*:	**9. Award Amount**, *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____
Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

Approved by OMB
0348-0046

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: _____ Page 2 of 2

OMB Approval No.: 4040-0007
Expiration Date: 06/30/2014

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681- 1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93- 205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

*** SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL**	*** TITLE**
Ana Jimenez	Director
*** APPLICATION ORGANIZATION**	*** DATE SUBMITTED**
Carson City	05/18/2018

Standard Form 424B (Rev. 7-97) Back

Key Personnel

Name	Position Title	Annual Salary	No.Months Budget	% Time	Fed Amount	Non-Fed Amount	Total Amount Requested

Application for Federal Assistance SF-424 Version 02

*1. Type of Submission:	*2. Type of Application:	*If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

*3. Date Received:	4. Applicant Identifier:
05/18/2018	

5a. Federal Entity Identifier:	*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name:	Carson City

*b. Employer/Taxpayer Identification Number (EIN/TIN):	*c. Organizational DUNS:
88-6000189	0737871520000

d. Address:

*Street1:	201 North Carson Street, Suite 3
Street2:	
*City:	Carson City
County:	
*State:	Nevada
Province:	
*Country:	UNITED STATES
*Zip / Postal Code:	89701-4264

e. Organizational Unit:

Department Name:	Division Name:
CC Health & Human Services	Clinical Services

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:		*First Name:	Veronica
Middle Name:			
*Last Name:	Galas		
Suffix:			

Title:	Clinical Services Manager
Organizational Affiliation:	
*Telephone Number:	775-283-7620
Fax Number:	
*Email:	vgalas@carson.org

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

City or Township Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (specify):

*** 10. Name of Federal Agency:**

Office of the Assistant Secretary for Health

11. Catalog of Federal Domestic Assistance Number:

93.217

CFDA Title:

Family Planning Services

*** 12. Funding Opportunity Number:**

PA-FPH-18-001

*Title:

FY 2018 Announcement of Anticipated Availability of Funds for Family Planning Services Grants

13. Competition Identification Number:

PA-FPH-18-001-061595

Title:

FY 2018 Announcement of Anticipated Availability of Funds for Family Planning Services Grants

14. Areas Affected by Project (Cities, Counties, States, etc.):

*** 15. Descriptive Title of Applicant's Project:**

Carson City Health & Human Services Family Planning and Related Health Services.

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

*a. Applicant: 002

*b. Program/Project: 002

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

*a. Start Date: 09/01/2018

*b. End Date: 08/31/2021

18. Estimated Funding ($):

*a. Federal	430458
*b. Applicant	(b)(4)
*c. State	
*d. Local	
*e. Other	
*f. Program Income	
*g. TOTAL	

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

☐ Yes ☒ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

**The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	
*First Name:	Nicki
Middle Name:	
*Last Name:	Aaker
Suffix:	
*Title:	Director
*Telephone Number:	775-887-2190
Fax Number:	
*Email:	naaker@carson.org
*Signature of Authorized Representative:	Ana Jimenez
*Date Signed:	05/18/2018

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

Application for Federal Assistance SF-424 Version 02

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

Upload #1

Applicant:	Carson City
Application Number:	FPH2018008746
Project Title:	Carson City Health & Human Services Family Planning and Related Health Services.
Status:	Review in Progress
Document Title:	ProjectNarrativeAttachments_1_2-Attachments-1235-Final CCHHS Title X Project Narrative 2018 Application.pdf

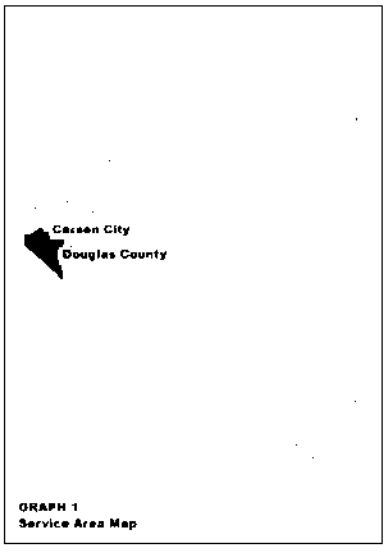
Carson City Health & Human Services Family Planning and Preventive Health Services Project

Funding Opportunity Announcement Number: PA-FPH-18-001; CFDA Number: 93.217

Project Narrative:

Carson City Health and Human Services (CCHHS) is applying for the *Announcement of Anticipated Availability of Funds for Family Planning Services Grant,* Funding Opportunity Number PA-FPH-18-00, CFDA number 93.217, for services to be conducted within the city municipality of Carson City and Douglas County in Nevada. The following assessment will outline the need for family planning services as evidenced by unintended pregnancy, adolescent pregnancy, sexually transmitted diseases (STD), low preventive health screening rates, poverty and poor access to health care. This proposal will also outline the experience and expertise of CCHHS in providing administrative, management, and clinical components of family planning and related preventive health services.

1. Description of Need for Services Provided and Geographic Area and Population:



GRAPH 1
Service Area Map

The proposed project service area spans 856 square miles in Nevada to include Carson City, a consolidated municipality that encompasses both city and county governments, and the adjoining Douglas County, located in the Northwestern part of the state bordering California. Both of these counties are directly south of Reno, Nevada and east of Lake Tahoe. Geographically, Carson City is the smallest Nevada County; however, it is the third largest by population, while Douglas County is the fourth largest county by population.[1] Total population of these two counties for 2017 is 104,139.[1] The proposed service area is comprised of slightly more female than males and is more homogenous in race

than Nevada overall. Carson City has a 21% Hispanic population and estimates of 19.4% of families who speak a language other than English at home, demonstrating a need for consistent and competent bilingual services.[2] Gender, age, race and ethnicity are outlined in Table I below.

Table 1: Population Estimate & Projection by Gender, Age, and Race/Ethnicity, 2017[2]							
		Carson City		Douglas County		Nevada	
		2017	% of Total Population	2017	% of Total Population	2017	% of Total Population
	Total Population	53,250	1.8	48,606	1.6	2,965,767	-
Gender	Female	28,062	52.7	23,897	49.2	1,480,327	49.9
	Male	25,188	47.3	24,709	50.8	1,485,441	50.1
Age Group	<5	2,761	5.2	1,865	3.8	184,055	6.2
	5-19	10,446	19.6	7,375	15.2	605,091	20.4
	20-49	18,059	33.9	14,825	30.5	1,200,320	40.5
	50-64	11,425	21.5	11,589	23.8	553,384	18.7
	64>	10,559	19.8	12,953	26.6	422,918	14.3
Race/ Ethnicity	White	39,304	73.8	39,519	81.3	1,534,050	51.7
	Black	305	0.6	286	0.6	253,408	8.5
	AI/AN	1,331	2.5	1,199	2.5	34,291	1.2
	Asian	1,111	2.1	1,364	2.8	281,620	9.5
	Hispanic	11,198	21.0	6,237	12.8	862,399	29.1
Density	2010 data	339.2		65.9		26.8	

Income, Employment and Poverty

Unemployment rates and poverty in general are higher in the proposed services area when compared with state and national averages. The number and percent of family households headed by a single female with children under 18 years of age is higher in Carson City, NV than statewide or nationally. United States Census Bureau estimates that 16.7% of Carson City's and 10.9% of Douglas County's total population live in poverty, versus the state and national average of 15%.[4] Special populations are the primary users of family planning and related health services and they face obstacles not always apparent in overall statistical averages. Need is particularly prominent when evaluating ethnicity and specific age groups within the service area. Analysis

reveals 23.8% of Hispanics/Latinos in Carson City and 21.8% in Douglas County live in poverty. Further, 18.2% of Carson City's and 17.7% of in Douglas County's residents aged 18-34 live below the federal poverty level (FPL) compared with 21.1% and 17.7% of Nevadans and 23.4% and 18.9% nationally.[4] The estimated annual income for those 18- 24 years of age decreases to $33,359 for Carson City and $30,250 for Douglas County. Finally, 28.2% of family households headed by a single female with children under 18 years of age in 28.2% in Carson City compared with 25.7% statewide and 24.5% nationally.

Table II: Socioeconomics: Service Area Compared with State and National Averages[3,4,5]				
Estimated Median Household Income[3]	Carson City	Douglas County	Statewide	National
total population	$50,108	$58,940	$52,205	$53,482
18 – 24 year olds	$33,359	$30,250	Not available	Not available
Unemployment Rate[3] (March 2018)	Carson City	Douglas County	Statewide	National
Total Population	5.9%	4.8%	4.9%	4.1%
Poverty[4] (2016)	Carson City	Douglas County	Statewide	National
# / % of population in poverty	8,744 /16.7%	5,148 / 10.9%	417,257 / 14.9%	47 million / 15.1
# / % of children <17 in poverty	2,960 /26.8%	1,405 /16.5%	144,947 / 22.2%	15.3 million/ 21.7
# / % 18-44 years old in poverty	3,336 /19.4%	2,136 / 17.5%	110,882 / 17.2%	13.3 million/ 18.9
# and % of Hispanics in poverty	2,914 /23.8%	1,233 / 21.8%	164,476 / 21.1%	12.5 million/ 23.4
Household Make-up[5]	Carson City	Douglas County	Statewide	National
# / % of FAMILY households headed by a single-Female with OWN children under 18	5298 / 28.2%	4163 / 21.5%	290523 / 25.7%	33567476 / 24.5%

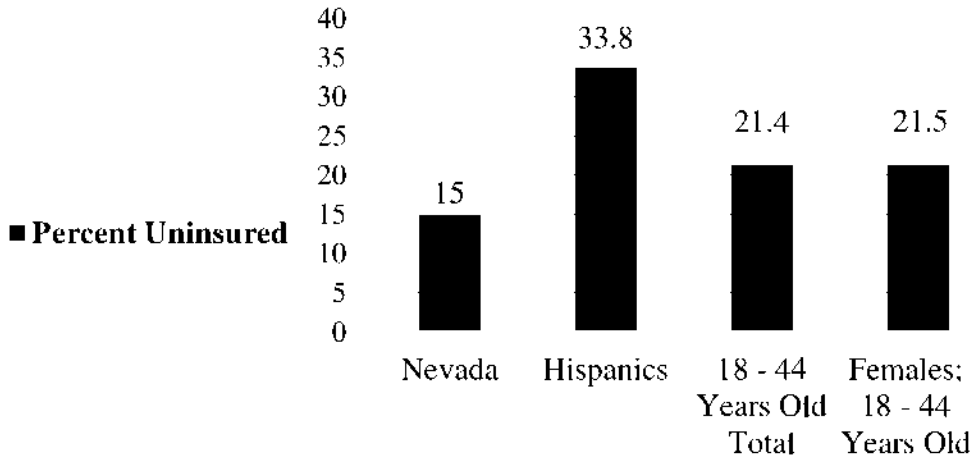
Residents are attracted to this area by employment opportunities within the hotel, gaming, manufacturing, and construction industries. Most employment categories in these industries are lower than prevailing wages. The 2015 average annual wage for a job classified in the Leisure and Hospitality category is only $23,286 and makes up as high as 28% of the total employment workforce.[6] The prevailing wage for this prominent service area industry is below

the median household income by 54 % - 60 % for the overall service area, state and nation. Workers in this industry are generally young adults with young families. Gaming, retail and construction industries in Nevada are seasonal. Layoffs are not uncommon during economic down turns or seasonal weather variations, which has contributed to Nevada's transient and mobile population. The Nevada Department of Employment, Training and Rehabilitation states, "wage growth has been relatively constrained to date and is perhaps the weakest aspect of the recovery."[6] Employment and wage growth lags behind national recovery efforts.

Uninsured Population

Nevada is eighth in the nation for uninsured residents; with 15% of individuals reporting they do not have any kind of healthcare coverage as found in Centers for Disease Control (CDC) Behavioral Risk Factor Survey (BRFSS) in 2016 .[7] Hispanics lack insurance at a higher rate of 33.8%, while 21% of individuals and females aged 18 44 years of age lack healthcare coverage.[7]

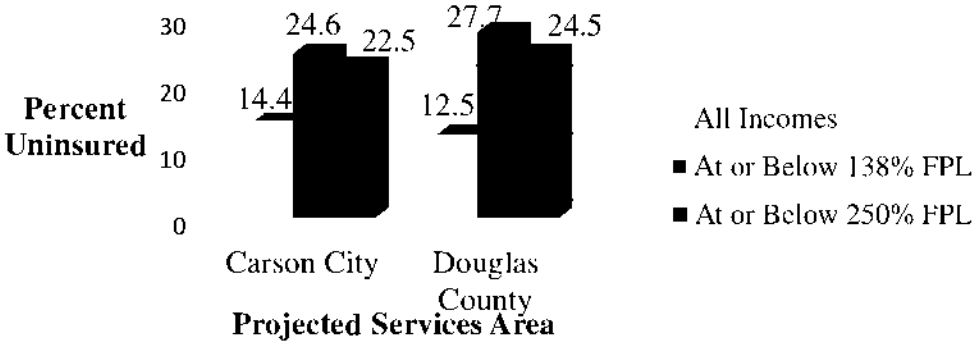
Graph 2: Percent of Uninsured in Nevada by State and Special Populations 2016[7]



When adjusting for the Federal Poverty Level (FPL) the percent of uninsured rises dramatically. Income < 250% FPL in the project service area dramatically increases the risk of being uninsured. And when incomes fall below 138% of the FPL, the uninsured rate is at its highest.

These points are illustrated in Graph 3 below;

Graph 3: Percent of Uninsured Population age 18 - 65 years old by Federal Poverty Level (FPL) in 2016[8]



In 2016, 22.5% of Carson City and 24.5% of Douglas County residents with incomes below 250% of poverty were without health insurance.[8] For 2016, 27.7% of Douglas County residents and 24.6% in Carson City whose income fell below138% of the FPL were uninsured.[8] CCHHS 2017 FPAR data reported 47.6% uninsured being served at the Title X Grantee service site. National attempts to improve the percent of the population that are uninsured have fallen short of the needs within local communities, impeding the access to care.

Access to Medical Services

Recruitment and retention of healthcare providers, as well as transportation to and from any medical services, can be a challenge for rural communities, and in particular for Douglas County.

Table III: Medical Providers 2016[3]				
Primary Care Medical Doctors	Carson City	Douglas County	Statewide	National
Number / number per 100,000 population	50 / 110.6	20 / 48.0	1,704 / 70.6	Data Unavailable
Obstetrics & Gynecology Medical Doctors	Carson City	Douglas County	Statewide	National
Number	13	1	296	Data Unavailable
Population in Number and Percent Residing in a Primary Care Health Professional Shortage Area (HPSA)	Carson City	Douglas County	Statewide	National
	50,857 92.2%	18,501 38.4%	985,416 33.4%	Data Unavailable

Carson City and Douglas County, Nevada are designated as Primary Medical Care Health Care Professional Shortage Areas (HPSA) with an HPSA score of >16. Table III highlights that 95.5 percent of Carson City residents and 38% of Douglas County residents live in a HPSA.

The local federally qualified health center (FQHC) faces frequent provider retention and shortage issues. At the time of writing this application (April 13, 2018), the local FQHC had a four month wait for new patients and a six week wait for established patient appointments. The wait time did not change whether or not the patient was having a problem or needed a routine visit. These is compared with CCHHS where there is a 1-3 day wait to see the RN for initiation and continuation of a method, a 4-6 day wait time for a problem visit and a 2 week wait time for a new or established annual preventive health visit. These wait times are the same whether or not the patient is new or established. This FQHC is 20 miles from the residents in the sub recipient jurisdiction (Douglas County). There is a FQHC-designee that serves the adjoining community. However, this site frequently refers both women's health and family planning patients to the sub recipient site in order that they might focus on the chronic health conditions of those they serve.

The 2016 CDC BRFSS reveals that 30.8% of Nevadans report "No" when asked if they have one person they think of as their healthcare provider.[7] As many as 30.9 % of Nevada reported they had not visited a doctor for a routine check-up in the past year while 18.7% of Nevadans report two or more years since they last visited a doctor for a check-up.[7] Finally, 16% reported times in the last 12 months that they needed to see a doctor but could not due to costs.[7]

Reproductive and Preventive Health Indicators

Youth Risk Behaviors and Protective Factors

Nevada fares slightly worse in 5 of the 13 categories related to teen behavioral risk in comparison with the national averages, as reported in the Youth Risk Behavior Surveillance

System (YRBS). For eight of the behavioral risks categories Nevada performs better than the National average. Students who reported no sexual contact had a decrease in risk behaviors below national and state averages. Current public health efforts in Nevada strive to engage youth in positive ways towards building skills towards better health.

Table IV. YRBS: 2015 Youth Risk Behavior Survey [2, 8]				
Behavioral Risk Questions	Proposed Service Area	State of NV	Nevada Youth Reporting No Sexual Contact	U.S.
Ever had sexual intercourse (SI)?	35.8%	39.1%	N/A	40.9%
Has had four or more sex partners?	8.4%	9.5%	N/A	11.2%
Sexually active in the past 3 months?	22.8%	26.1%	N/A	30.1%
Who were ever physically forced to have SI?	5.3%	6.6.%	3.3%	6.5%
Who experienced physical dating violence?	6.9%	7.8%	2.8%	8.3%
Who drank alcohol or used drugs during their last SI?	17.9%	17.1%	N/A	20%
Who used birth control pills, an IUD, Implant, shot, patch or birth control ring during last SI?	30.3%	25.1%	N/A	27.1%
No method used to prevent pregnancy during last SI?	10.5%	10.3%	N/A	12.4%
Who experienced sexual dating violence?	6.9%	10.0%	N/A	9.1%
Who felt sad / hopeless almost every day for 2 or more weeks in a row?	30.1%	28.8%	22%	26.4%
Made a plan about how they would attempt suicide?	16.2%	13.3%	9.9%	11.9%
Who currently used tobacco, smokeless tobacco, cigar	17.2%	26.1%	13.4%	18.5%
Who currently drank alcohol?	33.3%	30.7%	16.3%	32.1%
Took prescription drugs without a prescription?	20.2%	15.9%	6.0%	15.5%

Unintended Pregnancy and Birth Rates

Strides have been made nationally in assisting women and men to be at their healthiest when desiring to start or add to their family. However, per the CDC, "Unintended pregnancy is associated with an increased risk of problems for the mom and baby. If a pregnancy is not

planned before conception, a woman may not be in optimal health for childbearing."[10] "Births resulting from unintended or closely spaced pregnancies are associated with adverse maternal and child health outcomes, such as delayed prenatal care, premature birth, and negative physical and mental health effects for children."[10] Significant health disparities exist for special populations. National data shows that more than half of all unintended pregnancies occur in women in their twenties.[9] The rate of unintended pregnancies was highest among women aged 18–24, unmarried women (especially those living with a partner), low-income women, women who had not finished high school and minority women.[11] Per the CDC, protective factors for reducing unintended pregnancy include: marriage, increased education and increased income[10].

National data shows 45 unintended pregnancies per 1,000 women aged 15 44, with states ranging from 32 per 1,000 to 62 per 1,000.[11] In a 2014 Guttmacher Institute report, Nevada had the 7th highest pregnancy rate in the nation with 54 per 1,000 women aged 15-44.[10] Unintended pregnancies in Nevada cost the state and federal government 102.9 million dollars.[12]

In Carson City, the rate of unintended pregnancies was 43.9 per 1,000 and in Douglas County it was 27.5 per 1,000 for women aged 18-44.[8] Breaking down the age groups further reveals a concerning problem with teen pregnancy in those 18–19 years of age. The charts below show the pregnancy rate for those 15 – 19 years of age and even higher rates when looking specifically at those 18 19 years of age.

Table V	**Pregnancy and Birth Rates 2015 & 2016[2,13]**						
	Carson	**Douglas**	**Nevada**		**Carson**	**Douglas**	**Nevada**
2015 Pregnancy Rate				**2016 Pregnancy rate**			
15-17	18.9	14.2	14.8	**15-17**	13.9	13.0	12.5
18-19	117.8	24.3	58.2	**18-19**	63.4	15.0	51.9
15-19	52.6	18.3	31.9	**15-19**	37.6	13.8	28.0
2015 Birth Rate				**2016 Birth Rate**			
15-17	13.3	11.8	11.2	**15-17**	10.1	7.8	9.2
18-19	92.1	20.8	46.7	**18-19**	53.7	9.4	40.2
15-19	40.2	15.5	25.2	**15-19**	31.0	8.4	21.4

In 2015, the birth rate per 1,000 women aged 15-44 in the United States was 62.5 and 63.3 in Nevada.[13]. In the same year, the teen birth rate per 1,000 women aged 15-19 in the United States was 22.3, and 27.6 in Nevada.[13] Nationally, in 2015 Nevada ranks 18th in teen birth rates with 25.2 births per 1,000 for women aged 15–19.[13] When looking at ethnic differences in the same year, Hispanic teens gave birth at a rate of 35.4 per 1,000.[13] Data at a county level for 2016 reveals that Carson City has a higher teen birth rate at 31.0 per 1,000, while Douglas County is below national and state averages at 8.4per 1,000.[13]

Carson City and Douglas County have made strides in reducing teen pregnancy and teen births thus meeting Objective FP-8.1 of Healthy People 2020, which sets a goal of reducing teen pregnancy rates in 15–17 year olds to 36.2 per 1,000 and in 18-19 year olds to 105.9 per 1,000.[14] However, in order to continue to meet pregnancy prevention objectives access to confidential family planning services that include a broad range of family planning methods and reproductive life planning remains an essential need for teens in the proposed service area. As previously noted available appointment with community medical providers involves an extensive wait for appointments. The CCHHS Title X Family Planning Project is essential in order to increase optimal health and decrease social and economic disadvantages for both mothers and infants.

Sexually Transmitted Diseases (STD)

Chlamydia (Ct) is the most frequently reported STD in the U.S. and can result in pelvic inflammatory disease, ectopic pregnancy and infertility.[15] Rates of asymptomatic Ct can reach 90% in men and 70-95% in women.[15] In Carson City and Douglas County areas. Ct is the most prevalent STD, occurring at a rate of almost 89% of all STDs diagnosed[15] When evaluating specific age groups, young adults aged 20–24 experienced a greater than 50% increase in Ct

rates from 2011 to 2016 in Carson City and a 33% increase in Douglas County. Increased testing rates have aided in identifying/treating this STD. [16]

Graph 4: Carson City 2011 - 2016:
Chlamydia Rate per 100,000 and Total Age-Adjusted Rate[16]

	2011	2012	2013	2014	2015	2016
15 to 19 Years of Age	1935	1982	1686	1327	2018	2902
20 to 24 Years of Age	1951	2251	2311	3151	2581	4052
Age Adjusted Rate	344	334	401	462	519	684

Graph 5: Douglas County 2011 - 2016:
Chlamydia Rates per 100,000 and Total Age-Adjusted Rate[16]

	2011	2012	2013	2014	2015	2016
15 to 19 Years of Age	796	834	1010	1133	1393	854
20 to 24 Years of Age	1017	1137	1008	1428	1353	1353
Age Adjusted Rate	154	221	200	247	278	288

Eighty percent of all Ct cases diagnosed are in individuals <25 years of age.16 Public Health family planning clinics in Carson City and the three adjoining counties diagnosed 35% of all STDs for the same counties.16 Patients and local health care providers consider CCHHS and the sub recipient site their primary and trusted source for quality education and screening for STDs.

The CDC recommends and Nevada law allows for expedited partner therapy. Thus, in addition to treating the patient, policies and procedures are in place to ensure partner treatment in the instances that he/she cannot seek testing and treatment in person. The 2015 CDC STD Treatment Guidelines highlights that "The most reliable way to avoid transmission of STDs is to abstain from oral, vaginal, and anal sex or to be in a long term, mutually monogamous relationship with a partner known to be uninfected."[15] The primary prevention of STDs and the secondary prevention of STDs through screening and surveillance as a means of preventing infertility and other sequelae remains an instrumental role for Title X Family Planning clinics.

Low Birth Weight and Infant Mortality

Low birth weight is a major public health problem in the U.S., contributing substantially to adverse health outcomes and infant mortality. The principal determinants of low birth weight in the U.S. is premature delivery and fetal growth restrictions.[17] Premature delivery is the factor most responsible for the high infant mortality rate in the U.S.[18] The CDC reported in 2014, the United States ranks 26th when compared with other industrialized nations for infant mortality.[18].

Table VI. Percent of Low Birthweight Births by Race/Ethnicity, 2015 [2,13]				
	Carson City	Douglas County	NV	US
Non-Hispanic White	7.1%	6.4%	7.8%	6.9%
Non-Hispanic Black	5.3%	Suppressed for confidentiality	13.6%	13.3%
Hispanic	7.2%	12.1%	7.3%	7.2%
All Races	7.3%	7.8%	8.5%	8.1%

Table VII. Percent of Preterm Births by Race/Ethnicity, 2015[2,13]				
	Carson City	Douglas County	NV	US
Non-Hispanic White	7.0%	5.9%	13.3%	13.4%
Non-Hispanic Black	Suppressed for confidentiality	Suppressed for confidentiality	9.4%	8.9%
Hispanic	6.7%	14.0%	9.2%	9.1%
All Races	7.2%	7.0%	10.0%	9.6%

Those of Hispanic Race in Douglas County in particular face dramatic increases in low birth weight births and preterm births and evidenced by Table VI and Table VII above. Low birth weight babies are more likely to have health problems impacting the respiratory and cardiac systems, the gastrointestinal tract, and the brain, compared to infants born of normal weight. Causes of low birth weight and infant mortality include undiagnosed or poorly controlled maternal medical conditions, genetic disorders and/or high risk behaviors, including tobacco, alcohol or illicit drug use. In 2014 in Nevada, 15.2% of women of childbearing age reported binge drinking in the past month, 13% reported smoking and 24% were obese.[17] All of these are health indicators that could lead to prematurity, low birth weight, and birth defects.[17]

Reproductive life planning, preconception counseling and early prenatal care improve the health of the mother during pregnancy, leading to healthy birth outcomes. Uninsured pregnant women in Carson City and Douglas County must travel to Washoe County, an adjoining county north of Carson City to the only available prenatal care provider who will see them. From Carson City, this is a 32 mile one-way trip, and from Douglas County, it is a 47 miles one-way trip. Also, Douglas County does not have a hospital with obstetrics services, and the closest prenatal care providers that will see women with Medicaid are 16 miles away. Title X services provided through CCHHS and the sub recipient site play a vital role in providing preconception screening/counseling to ensure women are in optimal health from the start of a pregnancy.

Breast & Cervical Cancer

One in every eight women will be affected by breast cancer in the U.S[19] Breast cancer is the leading cause of death in U.S women ages 40–54 and is second to lung cancer in all cancer deaths among U.S. women.[18] Per the State of Nevada's 2015 Comprehensive Cancer Report, breast cancer has the highest incidence and is second to lung cancer in all cancer deaths among

Nevada women, as well as women in Carson City and Douglas County.[20] To further compound breast cancer mortality, over one third of all breast cancer in Nevada is diagnosed at late stages.[20] This percentage rises from 34% in Caucasian women to 42% in Asian and 45% in Black and Hispanic women in Nevada.[20] The overall percent of late stage breast cancer diagnosis in Carson City is 33% and 29% for Douglas County.[20]

Healthy People 2020 names two objectives relating to breast and cervical cancer screening. Objective C-15: Increase the proportion of women who receive cervical cancer screening based on the most recent guidelines to 93.0%.[14] Objective C-17: Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines to 81.1 %.[14] Progress towards the Healthy People 2020 objectives can be seen in Table VI below:

Table VIII: Pap Smear and Mammography Screening Figures 2016[2]

	Carson City	Douglas County	Statewide	National
Pap Smear *% of women 18-64 reported pap within last 3 years*	79.8%	62.4%	74.8%	79.7%
Cervical Cancer *Incidence Rate / 100,000 Women*	9.4*	7.4*	7.8	7.5
Mammography *% of women 40+ reported having within last 2 years*	61.7%	58%	66.8%	72.3%
Breast Cancer *Incidence Rate/ 100,000 Women*	136.0*	114.6*	106.6	123.9

*Data obtained from the Nevada Cancer Registry for Combined years 2010 - 2014

Nevada women are at risk for late detection of breast and cervical cancer as evidenced by the fact that 20.2 percent in Carson City and 37.6 percent in Douglas County had not had a pap smear in the prior three years. In addition, 38.3% of women over forty in Carson City and 42% in Douglas County had not had a mammogram in the past two years. Since early detection can save lives, it is essential to increase breast and cervical cancer education and screening services to the low-income women throughout Nevada.

Populations to be Served

Through review of the needs assessment and current available family planning program data, CCHHS has identified five target areas/populations to be addressed in the two-county region.

a. Low-Income and Uninsured Residents

Unemployment rates are 4.8% in Douglas County and 5.9% in Carson City, the proposed service area.[2] Available employment lags behind national and local recovery efforts. Poverty is experienced by 19.4% of women 18 – 44 years of age and 23.8 % of Hispanics/Latinos in Carson City. Poverty is experienced by 17.5% of women 18 44 years of age and 21.8 % of Hispanics/Latinos in Douglas County. Poverty undermines the ability of women and men to put in place holistic activities to achieve optimal health. Family Planning Annual Report (FPAR) data for CCHHS' 2017 FPAR data reported 62% of unduplicated clients were below 100% of the FPL, 80% were below 150% of FPL and 48% uninsured are being served at the Title X Family Planning service site. This data provides evidence that CCHHS prioritizes men and women of low income and uninsured populations as required in 42 CFR 59.5. Considerable efforts have been made to assist clients towards Medicaid and health insurance enrollment. Using a sliding fee scale for clients whose income falls below 250% of the FPL and regardless of a client's ability to pay allows clients to voluntarily choose family planning services: obtain pregnancy testing and prenatal care referrals; STD testing and treatment; reproductive life planning, and preventive health services, including cervical and breast cancer screening.

b. Women of Child Bearing Age

Over one half of all pregnancies nationwide and in Nevada are unintended. Preventing unintended pregnancy has far-reaching implications for the improvement of maternal and child health outcomes, as well as social and economic benefits. Addressing health disparities within

special populations will be instrumental in reaching this goal. CCHHS seeks to aid in the prevention of unintended pregnancies as a way of also addressing public health and social challenges facing clients within the service areas. CCHHS is committed to patients through appointments available within 2-3 weeks for annual preventive services and 3-5 days for problem visits. To accommodate patients, CCHHS offers walk-in visits and Saturday hours; a patient portal for patient use in making appointments and viewing lab results; and bilingual staff.

c. Adolescents

Historically, teen pregnancy has been an obstacle in Nevada to teens reaching their optimal potential. Nevada has the 7th highest pregnancy rate among states and the 16th highest birth rate for teens aged 15-19 .[10] Students who reported no sexual contact had a decrease in risk behaviors below national and state averages. In addition to providing voluntary, non-coercive family planning and related health services to adolescents, Title X family planning staff are in place to facilitate conversations between teens and their parents, help teens avoid the negative consequences of sex, including pregnancy and STDs, while being available to encourage long term goals for education and healthy monogamous relationships. In both Carson City and Douglas County, CCHHS has cultivated interactive relationships with local community partners, parents, coalitions and the community high schools. Public health nurses are included in presenting education on the negative results of STDs during high school health classes. STD presentations by family planning staff complement the abstinence-based "Promoting Health Among Teens" (PHAT) that is provided to local high schools, youth detention centers and onsite at CCHHS by the Adolescent Health program within CCHHS' Chronic Disease Division.

d. Men and Women of Reproductive Health Age in Need of Preventive Health Services

Low birth weight and infant mortality are the result of many factors, including the health of

the mother, prenatal care, quality of health services delivered, and child and infant care. Chlamydia is especially a concern, as it may lead preventable and costly health outcomes, such as pelvic inflammatory disease, ectopic pregnancy and infertility. Low birth weight and infant mortality may be prevented by addressing health issues, such as obesity, tobacco/ illicit drug use, and undiagnosed or poorly controlled maternal medical conditions. Chlamydia can be detected and treated with routine, age-based screening per national standards. Providing reproductive life planning, recommended health screenings and health education for men and women of child-bearing age is imperative in order to improve reproductive health outcomes in Nevada.

e. *Women Without Access to Breast and Cervical Screening*

Breast cancer is second only to lung cancer in cancer deaths among Nevada women. Over one-third of all breast cancer in Nevada is diagnosed at a late stage, compounding efforts for treatment and cure.[19] Early detection lags, as evidenced by the fact that 25% of Nevada women had not had a pap smear in the prior three years and 33% of women over age forty years had not had a mammogram in the past two years.[2] For the service site area, cervical cancer screening rates ranged from 62-80% of women over age forty report they have not had a mammogram in the past two years. As early detection saves lives, it is essential to increase breast and cervical cancer education and screening services to low-income women throughout Nevada.

2. Proposed Projects Addresses the Family Planning Needs of Population to be Covered

The proposed project area is Carson City and Douglas County, Nevada. Services would be available to those living in the area and those from outlying counties who work, do business or seek resources in our communities. Per the needs assessment, there are 5,472 individuals 18 – 49 years of age living in the service area whose income falls below the FPL. This project proposes to reach those in this age group who due to being uninsured or having Medicaid are unable to get

appointments in a timely manner with the limited availability of providers in our community. This project does not seek to reach those that may already have established medical care in our communities. (Appendix A: Service Area Map)

3. Experience in the Particular Service Area and the Particular Community to be Served

Experience in Particular Service Area

CCHHS has a 12-year history in providing quality Title X family planning services. CCHHS has provided clinical, educational, social, and referral services relating to Title X family planning in Carson City, Nevada, since 2005. Initially, CCHHS was a sub-grantee of the State of Nevada for the service area specific to Carson City, Nevada. In 2010, CCHHS became a direct grantee for the Title X project. In 2009, Nevada State Health Division delegated to CCHHS extended authority to conduct public health preparedness activities and perform disease surveillance and investigation for Douglas County. Recognizing the success of this public health cross-jurisdictional sharing relationship, Carson City and Douglas County partner to provide services to its residents. Since January 2012, CCHHS has been providing and/or overseeing family planning and preventive health services in this second county: first as a sub recipient of the state, then as a direct grantee and now including these services in a sub grantee relationship. (Appendix B: Douglas County Letter of Commitment)

Experience with Particular Community to be Served.

CCHHS is located within the census tract with the densest population, the lowest median household income, and the most ethnically diverse in the City. The sub recipient site is centrally and conveniently located in a brand new county-operated community center within 10 minutes of the most densely populated family community. In the two county areas in 2017, just over 5,000 high-quality family planning and other preventive health visits were provided to thousands of

low income and/or uninsured individuals. Per the 2017 FPAR, 87% of the people we serve are women and 13% are men. Thirty-nine percent self-reported a Hispanic ethnicity. Sixty-two percent have incomes below 100% of the Federal Poverty Level (FPL), while 80% report incomes at or below 150% of FPL. Forty-eight percent are uninsured and28% have public insurance. Since, access to a healthcare provider is not readily available to all residents in our community; CCHHS is designated by CMS as an Essential Community Provider. Services at our Title X Funded sites are provided at a lower cost than physician-based clinics, as our Title X clinics are staffed with nurse practitioners and registered nurses.

Per 42 CFR 59.5(4), services are provided without regard to religion, race, color, national origin, handicapping condition, age, sex, number or pregnancies or marital status. Both family planning sites are located in buildings accessible per the Americans with Disabilities Act. CCHHS is conveniently located just outside of the downtown within 0.5 miles of several community agency resources, including Partnership Carson City (Hispanic and Youth services) and Ron Wood Family Resource Center. Carson City operates Jump Around Carson (JAC), a public transit system, which stops at the side of the CCHHS building. Douglas County operates Douglas Area Rapid Transit (DART), a public transit system that is run out of the community center where the sub recipient clinical site is located for easy access.

Bilingual Services

Staffing at both clinical sites is representative of the target population and sensitive to Title X Program Requirements 8.5.2. The management assistants who act as front-line medical receptionists represent the ethnicity of the population served and are available for translation and interpretation services. Each service site also employs a registered nurse bilingual in English-Spanish and one site has an Asian nurse bi-lingual in English-Bisaya. All essential paperwork,

including demographic and consent forms, authorization for release of information, the Notice of Business Practices, complaint forms, and educational materials, are available in both English and Spanish. The program has a Limited English Proficiency (LEP) policy that is reviewed by staff upon hire and annually thereafter. Access to a language line allows for the ability to serve populations that speak other languages. Policies and training include attention to cross cultural interactions, provision of nondiscriminatory services and culturally sensitive written materials.

4. Organizational Capacity and Qualifications/Experience Providing Family Planning and Related Preventive Health Clinical Services

Organizational Overview

Carson City became a consolidated municipality in 1969 in accordance with Chapter 439 of the Nevada Revised Statutes (N.R.S.). In 2003, the Carson City Board of Supervisors approved the creation of a local health department and a County Board of Health. The Board of Health has jurisdiction over all public health matters in the City and consists of 5 elected officials (4 Board of Supervisors and the Mayor), the elected Sheriff, and the County Health Officer. CCHHS is a department within the city municipality. (Appendix C: Carson City Board of Health)

CCHHS structure includes six divisions: Fiscal, Clinical Services, Disease Prevention & Control, Environmental Health, Human Services, and Public Health Preparedness. Each division is headed by a manager that reports to the CCHHS Department Director. The Title X family planning program is administered within the Clinical Services Division of CCHHS. The Clinical Services Manager is responsible for managing day-to-day operations, ensuring all program components meet Title X statutory and regulatory guidelines, facilitating staff training and development, and consulting with contractual service providers regarding any program issues, problems, needs or concerns that arise. (Appendix D: Organizational Chart)

Public Health Accreditation

CCHHS became an accredited health department through the Public Health Accreditation Board in May 2016. Engaging the broader community (hospitals, educational institutions, service organizations, businesses, civic organizations, faith-based groups, housing organizations and criminal justice organizations) in a Community Health Needs Assessment and a Community Health Improvement Plan has contributed to a coordinated service and referral network in our community. CCHHS stands ready to mobilize partners towards successful public health – preventive health initiatives and leverage available community resources.

Federal Title X Site Review Results

Strong evidence of CCHHS' administrative, clinical and fiscal qualification, capacity, and expertise is evidenced by the December 2016 Federal Title X Program Review. There were no findings identified during the program review. CCHHS received a score of highly developed for providing a framework for planning and evaluation. CCHHS scored as fully developed in the areas of client-centered counseling; cultural competency and client dignity; clinical protocol compliance; pregnancy testing and counseling; and communication and education.

Additional Onsite Services Available to Title X Patients

CCHHS has a robust internal network of services for clients onsite within our organization. Human Services is available onsite to assist with housing, workforce readiness, employment and Women, Infants and Children (WIC) Services. CCHHS has partnered with the Division of Welfare and Supportive Services (DWSS) to offer onsite enrollment and education for public health insurance; and education and referrals for private health insurance. CCHHS' Health Educators conduct a science-based Abstinence program "Promoting Health Among Teens" (PHAT) in our schools as well as onsite at our facility. CCHHS is a smoke-free workplace and

promotes the prevention/cessation of tobacco products. A tobacco prevention program has been successful in working with multi-unit housing complexes to become tobacco free; is assisting the community college to become a tobacco free institution and provides resources for Title X staff and patients about the "5 As" model of tobacco cessation. (Appendix E: DWSS Letter of Commitment and Appendix F: CCHHS Human Services Letter of Commitment)

Infrastructure Development and Maximizing Use of Non-Federal Funds

Carson City and Douglas County, NV represented approximately 4% of Nevada's population in 2016 and notable is the fact that CCHHS' Title X Family Planning Program saw 25% of the total of all family planning users reported on the 2016 FPAR for Nevada.

CCHHS has been in the forefront of using an electronic health record (EHR) and billing for public health services in Nevada. CCHHS converted to an EHR / Practice Management System, eClinicalWorks (eCW), in 2006. The sub recipient site has been utilizing eCW since 2012. A laboratory interface allows for the electronic submission and receipt of laboratory tests. eCW also has encounter level FPAR reporting capabilities that CCHHS has utilized exclusively since 2014 for FPAR reporting. eCW is designed with tiered security assigned when an employee is granted access to the system. Programming features restrict employee access to the areas of eCW deemed unnecessary for job performance. CCHHS also has an electronic interface with the Nevada Immunization Registry WebIZ and is enrolled in a health information exchange HealthHIE Nevada for a seamless exchange and retrieval of patient medical record data.

Medical records and patient information are handled in a confidential manner. Annual training and review policies occur on Confidentiality, HIPAA and security of electronic information. Staff is required to review and sign a "Confidential Information User Agreement" when assigned email and eCW access. HIPAA Business Associate agreements are active.

CCHHS has established and maintains contracts with all major private and public insurance carriers in our area. (Appendix G: Contracted Insurance List) CCHHS and the adjoining community have committed local general funds to support the project. Our local health department has invested in building the infrastructure that supports quality care for our residents. We are a responsible steward of federal dollars. CCHHS utilizes multiple revenues streams in order to minimize the need for and use of federal funding while sustaining our safety net public health, family planning and reproductive health program. Federal funds are requested and utilized only when non-federal funds fall short of operational needs.

Personnel and Oversight

Per 42 CFR 59.5 (b)(6) and Program Guideline 8.5.2, CCHHS' Title X Family Planning Program is overseen by a physician who is board certified in Obstetrics and Gynecology. The Clinical Services Manager has 17 year's experience in family planning and preventive health services; 8 of those years managing the Title X program. Personnel at CCHHS include a full-time Advanced Practice Registered Nurse (APRN) with 27 years of experience in women's healthcare as well as training and certification in colposcopy and cryotherapy; a part-time APRN with 27 years of experience in women's healthcare; and three registered nurses (RN) with a range of 8-10 years of women's health experience. Nursing staff also has 5-year backgrounds in urgent care and internal/adult medicine. Nursing staff are licensed by the Nevada State Board of Nursing and required to practice under the Nurse Practice Act, NRS Chapter 632. The local school of nursing utilizes CCHHS as a clinical training site for of undergraduate nurses, registered nurses seeking a bachelor's degree, and APRN's. Other personnel at both sites include and management assistants. (Appendix H: Curriculum Vitae Key Personnel)

Staffing at the selected sub recipient site consists of a full-time and a per diem APRN, both of

whom have more than 15 years of women's health experience and certification in colposcopy (per diem APRN) and cryotherapy (per diem APRN) with multiple years working with Title X family planning sites. In addition, the team at the sub recipient site has two full-time Registered Nurses (RN) who each have more than 6 years of Title X Program experience, and each more than 10 years of women's health experience. Clinical staff is trained in and complies with the regulations governing grants for family planning services (42 CFR part 59, subpart A) and follows all requirements regarding the regulations, statutes, and provision of family planning services under Title X of Public Health Service Act, 42 U.S.C. 300 et seq.

(Appendix I: Curriculum Vitae Key Personnel – Sub Recipient Site)

Policies and Procedures

Per Title X Program Guidelines 8.5.1 and 9.6, both clinical sites operate under clinical and administrative policies and procedures. Policies and procedures are updated annually by the Clinical Services Manager, along with clinical staff, based on current practice recommendations. Updated policies and procedures are reviewed and approved by the Medical Director. Clinical staff also review and sign off on the policies. Region IX Title X Regional Office staff has requested the use of CCHHS' policies and procedures as a template for other Title X providers.

Family Planning Methods Offered

Nevada is unique in legislating public health nurses' ability to safely dispense medication, such as those needed for family planning, under the direction of the State Board of Health, N.R.S. 454.215. Having the ability to dispense medications onsite decreases barriers and costs and while increases patient accessibility to affordable care. Per 42 CFR 59.5(a)(1) and Program Guidelines 9.8 and Program Priority 1 this project ensures that a broad range of family planning methods to include: education and support related to abstinence, fertility awareness based

methods (FABM) and the lactation amenorrhea method (LAM); condoms, diaphragm fit provision; combined-oral contraceptive pills; progestin-only contraceptive pills; 3-month hormonal injection; vaginal ring; and long-acting methods which include intrauterine and implantable devices. All services are available, to adolescents as well, with emphasis on counseling that communicates the risks with pregnancy and STDs, the benefits of abstinence, delaying sex, or returning to a sexually risk-free status and encourages family participation in the adolescents' healthcare decisions. (APPENDIX J: List of Services, Tests and FP Methods)

Pharmacy and Laboratory Services

Per 42 CFR 59.5 (b) (1) the applicant and sub recipient site have made provision for prescription and laboratory examination. Per N.R.S., public health registered nurses administer and dispense medications from an approved formulary. CCHHS and the sub recipient site contract with Clinical Pharmacy Services; a pharmacist that is available onsite weekly at CCHHS and monthly at the sub recipient site to oversee and monitor pharmacy activities. Pharmacy services provided conform to Nevada State Laws, Nevada Administrative Code (NAC), and State Board of Pharmacy (NSBP) Policies and Procedures. CCHHS is inspected annually by the NSBF to monitor compliance. The Pharmacy Law is covered under NRS Chapter 454 – Poisons, Dangerous Drugs and Hypodermics; Chapter 585 – Food, Drugs and Cosmetics: Adulteration, Labels, Brands; and Chapter 639 Pharmacists and Pharmacy. NAC also governs practices in Chapter 453 – Controlled Substances; Chapter 454 – Poisons, Dangerous Drugs and Devices; and Chapter 639 Pharmacists and Pharmacy. Pharmacy policies and procedures describe regulations and controls to ensure proper storage and distribution.

Both clinical sites are registered under the 340B Cooperative Purchasing Program and participate in the prime vendor program. This program allows CCHHS and the sub recipient site

to obtain optimal pricing for family planning methods. The sub recipient site was selected in 2015 for a Federal 340B compliance audit. This federal audit recorded no findings and noted program integrity and compliance in all areas of the 340B Program.

CCHHS and the sub recipient site operate an on-site laboratory certified by the Nevada State Health Division of Public and Behavioral Health's Bureau of Health Care Quality and Compliance (BHQC). The Laboratory Director and Clinical Services Manager are responsible for providing staff training, monitoring proficiency testing, quality control and reviewing/updating the laboratory manual. Onsite CLIA waived testing includes urine pregnancy testing, blood glucose monitoring, anemia screening, rapid HIV testing, urine analysis. APRN's may also perform additional microscopy to include vaginal wet prep. No deficiencies were noted in laboratory documentation or practice during a May 2015 site monitor by the State of Nevada BHQC. Specimens may also be collected and sent to outside laboratories for analysis. These tests may include cervical cancer screening, HPV testing, Hepatitis B and C, Chlamydia and other sexually transmitted diseases, lipid panel, and HIV confirmatory testing.

Emergencies

Staff is trained to handle clinical emergencies. Policies and procedures address vasovagal reactions, anaphylaxis, syncope, cardiac arrest, hemorrhage and respiratory difficulties, all of which enable staff to contend with a wide range of potential emergencies. Both sites have an automated defibrillation unit and oxygen available. Clients are referred to the local urgent care or emergency department, when necessary and for after-hours emergencies.

5. Evidence of Familiarity With and Ability to Provide Services

The environment in which we live, work, learn, and play can have an enormous impact on health outcomes. Thus, addressing people's physical, social and economic environment can

encourage healthy behaviors and improve health. Providing a wide-range of related preventive health services supports families in making healthy choices.

Family Planning and Related Health Issues

CCHHS and the sub recipient site prioritize family planning and related preventive services in accordance with Title X Program Guidelines and Program Priorities. Per Priority #1 and Program Requirement 9.1, 42 CFR 59(a)(6) services in this project are prioritized towards low-income adolescents, individuals, and families. 2017 FPAR for the CCHHS family planning project shows 62% of clients were below 100% of the FPL and 80% were below 150% of the FPL. Family planning and related preventive health services provided in this project proposal include non-hormonal contraceptive services, hormonal family planning services, pregnancy testing, basic infertility services, STD services and preconception health. Other related preventive health services include breast and cervical cancer screening and colposcopy. Service provision at both sites is based on nationally recognized standards of care that include CDC, the U.S. Preventive Task Force, and the American College of Obstetrics and Gynecologists (ACOG). Sourced policies and procedures outline practice in order to establish consistency and accuracy across service sites. Per 42 CFR 59.5(a)(2), Title X Program Requirement 8.1, 9.9 and Program Priority #3, all services are provided to clients on a voluntary, client-centered and non-coercive manner without any eligibility prerequisite requirements. Staff acknowledges in writing annual education that they are aware that all services must be voluntary and free of coercion.

Sexual Health Assessment

Assessment of clients' sexual health history follows guidance in the US Department of Health and Human Services CDC, "A Guide to Taking a Sexual History". The assessment is incorporated into an initial visit, annual preventive health exams and whenever a client presents

with symptoms consistent with a potential sexually transmitted disease. Five areas are addressed that include: partners, practices, protection from STDs, past history of STDs and prevention of pregnancy. The ultimate goal of a sexual risk assessment is to lead to client-centered discussions that promote positive family relationships, family participation and healthy decision making as well as education and counseling that prioritize optimal health as outlined in program priority #2.

Family Planning Services

As part of a family planning visit, staff establishes rapport, collects and assesses clinical and social information that includes a client medical history, reproductive life planning assessment, and sexual health assessment. Standards of medical eligibility for family planning are evaluated by staff based on a client's medical history. Clinical staff then facilitates an interactive session of client experiences and preferences. Staff assesses and educates clients related to STD, HIV, intimate and sexual partner violence, and substance use behaviors. Physical assessment and laboratory testing are recommended and performed based on nationally recognized standards. Per 42 CFR 59.5(a)(1) and Program Guidelines 9.8 and Program Priority #1, this project ensures that a broad range of family planning methods to include: education related to the abstinence, FABM and LAM, condoms, diaphragm fitting and provisions, cervical cap, combined-oral contraceptive pill, progestin-only contraceptive pills, 3-month hormonal injection, vaginal ring, and long-acting methods which include intrauterine and implantable devices. During counseling a client will: (a) be informed of method risk, side-effects and on how to discontinue the method selected, if needed, and (b) discuss and plan a return schedule. Clinical staff confirms client understanding of education. Services are provided while ensuring a client confidentiality throughout all areas of the patient visit from check-in through service billing. Per 42 CFR (5), abortion is not provided as a method of birth control. Neither CCHHS nor the sub recipient site

performs abortions. (Previously Noted - APPENDIX J: List of Services, Tests and FP Methods)

CCHHS has (b)(4) resource in the area of fertility awareness-based methods. They are included in our grant application budget for the provision of staff training and technical assistance for outreach efforts. (Appendix K: Letter of Commitment - (b)(4)

Pregnancy Testing and Counseling

Per Title X Program Requirement 9.9, service sites in this project provide pregnancy diagnosis and counseling services. During a pregnancy assessment, staff establishes rapport, assesses clinical and social information that includes a client medical and sexual health history, & reproductive life planning. Staff assesses and educates clients related to STDs, HIV, intimate and sexual partner violence, and substance use behaviors. Health screening is offered and based on nationally recognized standards. At this time counseling is based 42 CFR 59.5(a)(5)(i)-(ii) and Program Guideline 9.11. Information and discussion is provided in a neutrally factual manner without coercion into a specific course of action or decision. Education encourages optimal health and includes gestational age, prenatal care and social services referrals, folic acid / prenatal vitamins, substance use, medication contraindications and dietary and exercise recommendations. Community referrals are provided as indicated by patient identified need. Per Key Issue #3, a local faith-based agency is included on the referral list to support those who are pregnant. (b)(4) to respond to the needs of a mother-to be through mentorship, emotional support and resource access. In women whose pregnancy testing is negative, reproductive life planning and family planning education is offered.

Basic Infertility Services

CCHHS utilizes the Family Planning National Training Centers Check List in implementing

basic infertility services. Women and men seeking pregnancy are provided a medical history, sexual health assessment, and reproductive life planning and counseling. For women, physical examination may include height, weight, blood pressure, clinical breast and pelvic exam including a pap, a review of signs for androgen excess, and a thyroid examination. For men, physical examination may include height, weight, blood pressure and genital exam.

Personal Family Planning, Fertility and Reproductive Life Plan

Incorporating Title X Program Priority #1, reproductive life planning is initiated with male and female patients of child-bearing age. Reproductive life planning assessment and health addresses an individual's physical, emotional and social health needs while providing resources to reach optimal health outcomes. A medical and social history guides testing, and education recommendations and provision. Providers screen, educate and refer related to height, weight, body mass index, blood pressure, intimate partner violence, substance use and abuse, immunizations, depression and diabetes. Clinical staff is trained and use a nationally recognized brief intervention for tobacco cessation. Referrals are made to Nevada's Tobacco QuitLine, as needed. CCHHS has a Public Health Nurse that coordinates the area's Tobacco Prevention and Control Program so Title X staff receives training and can consult with her as needed. Our facilities provide a comprehensive immunization program across the lifespan that utilizes vaccines through the Federal Vaccines for Children's Program and Section 317 of the Public Health Services Act for uninsured and underinsured adults, as well as private purchased vaccines for the insured. Following the Advisory Committee on Immunization Practices (ACIP), any recommended immunizations are provided with emphasis on the human papilloma virus (HPV); influenza; measles, mumps, rubella (MMR); and tetanus, diphtheria, and pertussis (Tdap).

Health Screenings - Sexually Transmitted Disease Services

Utilizing the 2015 CDC Sexually Transmitted Disease guidelines, clinical staff assesses, screens, treats, and provides behavioral counseling for chlamydia, gonorrhea, syphilis, HIV, and Hepatitis C. CCHHS and sub receipt utilize 4th generation Rapid HIV testing with confirmatory testing for any positive result. Clinical staff receives training on HIV counseling and testing, and HIV pre and post-test education and counseling. Clinical staff receives thorough training on STD sample collection. RNs and APRNs provide counseling and treatment. Per CDC and U.S Preventive Services Task Force, clients <25 are screened for Ct. Clients of other ages are offered testing based on risk. Attempts to reach clients with positive results are made on the day the lab results are received and reviewed to arrange for immediate treatment. Staff at both sites work closely with CCHHS's onsite Disease Investigator to perform contact investigations for treatment and recommended follow-up. As required by state statute, physicians, laboratories and hospitals are required to report positive STDs from a quad county area to the CCHHS Disease Investigator. Clients may use the patient portal to access test results and his/her convenience.

Health Screenings - Related Preventive Health Services

In addition to reproductive health services, related preventive health services may be offered based on currently recommended national standards for reproductive health of our family planning clientele. These services include: cervical exams with follow-up procedures for abnormal Pap smears and clinical breast exams with a referral program for screening mammography, as well as diagnostic screening of a palpable breast mass. APRN's utilize protocols adopted from the American Society for Colposcopy and Cervical Pathology (ASCCP) for follow-up of abnormal pap smears. Additionally, CCHHS provides colposcopy diagnostic services per sliding fee scale at our Caron City site. The sub recipient refers to CCHHS as

needed. Adolescent males genital examinations may be provided for purposes of documenting normal growth and development, signs of STDs, and other abnormal or normal findings.

Adolescents

Adolescents are often faced with uncertainty, ambivalence, and anxiety about making sexual health decisions. Staff is objective and sensitive to clients' individual differences and strives to create an environment in which they are comfortable discussing very personal information. Per 42 CFR 59.5(a)(2), individuals are not coerced to accept services or to employ or not employ any particular method of family planning. Staff provides non-coercive counseling so teens can reach a voluntary informed decision that reflects their individual needs. Communication is encouraged and facilitation offered related to parental, familial and/or legal guardian involvement in decisions related to family planning services as outlined in Program Priority #6. Per program priority #5, staff reviews with each adolescent state law related to abuse reporting, human trafficking, child molestation, intimate partner violence, incest and sexual statutory seduction. Per Program Priority # 5, staff assists teens in identifying and learning skills for resisting coercive tactics for engaging in sexual activity. Adolescent clinical services are consistent with medical practice standards and include annual preventive health check-ups, STD testing and treatment, depression screening, counseling regarding substance use effects on impaired decision making, avoiding sexual risk, the risk of pregnancy and STDs and returning to a sexual risk-free state. Charting in the EHR captures all pertinent and required documentation.

Adherence to State laws regarding Child Abuse Reporting

Per Program Priority # 5, staff receives annual education and follows Nevada's laws, listed below, related to mandatory abuse reporting.

- Mandatory Child and Neglect Abuse (NRS 432B.220): Mandates reporting to appropriate

authorities any contact that causes a reasonable person to believe that there is abuse or neglect of a minor occurring.

- Definitions of Abuse (NRS 432B.090, 432B070, 432B.140, 432B.100, 432B.110): Outlines what constitutes physical abuse, mental injury, child neglect or maltreatment, sexual abuse, sexual exploitation.
- Mandatory Lewdness with a Minor of or under the age of 14 (NRS 201.230): Mandates the reporting to appropriate authorities any contact that causes a reasonable person to believe there is any kind of lewd acts occurring with a minor of or under the age of 14.
- Mandatory Statutory Sexual Seduction: (NRS 200.364 and 200.368). This law mandates reporting to appropriate authorities about the discovery of a person who is 18 years of age having sexual relations with anyone who is 14 or 15 years of age and who is at least 4 years younger than the perpetrator.

CCHHS and the sub recipient site have policies regarding Child Abuse and Neglect Policy, Statutory Sexual Seduction Protocol & Human Trafficking. These policies address the laws and reporting requirements for child abuse, neglect, child molestation, sexual abuse, and rape and incest, as well as human trafficking. During orientation, and annually thereafter, new clinic staff is required to receive training that reviews these protocols, and policies and procedures. CCHHS has enlisted, Awaken, a local not-for-profit, faith-based organization whose mission is to provide education related to commercial sexual exploitation to provide annual Human Trafficking training to staff. (Appendix L: Awaken Letter of Commitment, Faith-Based Partnership)

Counseling Techniques for Teens - Family Participation and Resistance Skills

CCHHS' Health Educators in our Chronic Disease Division conducts a science-based Abstinence program "Promoting Health Among Teens" (PHAT) in our schools, local detention

centers as well as onsite at our facility. As part of the core curriculum, PHAT addresses areas such as "*Getting to Know You and the Steps to Making Your Dreams Come True, Making Abstinence Work for Me, Consequences of Sex: HIV/STD Infections, and Pregnancy, Improving Sexual Choices and Negotiation, Role plays: Refusal and Negotiation Skills.* CCHHS will utilize Abstinence Program staff to provide education and resourcing to family planning staff.

Per Program Priority #2 and #6 and Key issue # 5and #6, CCHHS will engage staff at the primary and sub recipient family planning sites in education regarding teen developmental issues and current trends to recognize why an adolescent might resist engaging parental/familial support and what might be the learning needs or barriers to teens avoiding sexual risk or maintaining and/or returning to a sexually risk-free state. Staff will use open-ended questions with teen clients to assess family dynamics and relationships as well as perceptions the teen may have regarding barriers of seeking parental involvement. Staff will utilize open-ended questions to explore resistance to delaying sex or returning to a sexually risk-free state. As clinical time allows, staff will incorporate experiential activities such as role play to model an interpersonal relating skills building exercises. Then staff and teens can debrief the exercises and identify how the teen anticipates trialing a conversation at home and within their current sexual relationship. Staff will facilitate a conversation with the teen to identify a trusted adult family member that they can discuss health matters with and ask the teen to have a conversation with this adult as a "practice" for how he/she might approach a parent/guardian. Together, the staff and teen identify one goal and/or action the teen would enlist between clinical visits. Staff will inform the client that staff is available to facilitate any conversation the teen may need assistance in undertaking.

Counseling Techniques for All Clients that Encourage Family Participation

Per Program Priority#2 and working off of the model expressed in in the previous

paragraphs, staff will use open-ended questions with all clients to understand family dynamics and relationships as well as perceptions regarding barriers to seeking familial participation in sexual health and general health matters. Using techniques such as the "Empty Chair Technique": a partner may express his or her feelings to a sexual partner/spouse/family member (empty chair), then play the role of the spouse and carry on a dialogue. This technique facilitates communication skills. Together, the staff and client can identify one goal and/or action that the client feels will lead to his or her optimal health between clinical visits. Project staff will inform the client that staff is available to facilitate conversations with families or partners as needed.

6. Proposed Schedule of Discounts

Sliding Fee Schedule and Client Intake

This project operates under a schedule of discounts that complies with 42 CFR 59.5 (a)(7) – (9) and Title X Program Guidelines 8.4 Charges, Billing and Collections. A financial screening process occurs at check-in. Clients are asked questions regarding third party payers, household size and household income during the check-in process and annually thereafter. Proof of income is requested through earnings statements or annual IRS tax return documents. Household income and size are then verbally verified by management assistant staff poverty level is determined.

Clients are assessed to see if they have a third party payer, such as Medicaid or private insurance. Each client is then ascribed a tiered schedule of discounts in accordance with FPL. The methodology used to calculate the fee schedule is based on a cost analysis study that is updated every 3 years. Both CCHHS and the sub recipient site utilize the cost analysis that can be found at the Family Planning National Training Center's website www.fpntc.org.

A tiered system establishing fees for those whose income falls above 251% of the FPL decrements in the following categories 250%–201%, 200–151%, 150–101% and <100%. Each

tier discounts charges by [(b)(4)] from the top tier schedule until reaching a zero charge category for those below [(b)(4)] of the FPL. The sliding fee schedule is maintained according to the FPL and is used to determine the client's financial category. Minors seeking confidential services are assigned a schedule of discounts based on a household size of one and the minor's separate income. (Appendix M: CCHHS Policy and Procedure A11: Title X Sliding Fee Assessments)

If a client does have a third party payer, charges are calculated at full fee and reimbursement is sought through the third party payer. When copays, deductibles or additional fees come into play, a client is not charged more than they otherwise would be charged based on his/her tiered discount. Clients are informed of the total cost of services, the ascribed discount based on tier, and then the total amount that is due at the end of each visit. Clients without a third party payer and with a stated income below [(b)(4)] of the FPL are placed in a zero pay category and thus have a zero charge for services following the discount. If uninsured self-pay clients with incomes above [(b)(4)] FPL have a tiered balance and are unable to pay at the time of service, a statement is issued for future payment. Family planning and related preventive health services are provided without condition and never denied to any client for inability to pay regardless of income level.

Client confidentiality is maintained when billing and collecting outstanding balances. All charges that have been outstanding for more than [(b)(4)] months are written off. Each billing statement is addressed to the client only, and can be mailed to an alternate address of the client's choice. The client may also elect to have no written correspondence. Payments received by phone, via mail, or by the third party medical billing company are recorded in the patient EMR.

7. Proposed Services in Accordance with Title X Statute, Program Regulations Legislative Mandates, Program Guidelines and Program Policy Notices

Clients accessing services within this project are ensured they can do so on a voluntary basis

without prerequisite while being treated with the utmost respect regardless of religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies or marital status as outlined in 45 CFR 59.5(a)(3)(4) and Program Guidelines 8.1, 9.2 and 9.3. Previously outlined in this application are programmatic requirements 45 CFR 59.5(a)(1)(2)(3)(4)(5)(6)(7)(8)(9): 1) the provision of a broad range of acceptable family planning methods; 2) services on a voluntary basis without coercion; 3) protection of the dignity of the individual; 4) nondiscrimination and culturally competent staff representative of the community served; 5) service sites do not provide or coerce abortions; 5a) pregnancy information and counseling services; 6) prioritization of services to low-income individuals; 7) a schedule of discounts; and no charge to qualifying low income; 8) third party billing persons policies and procedures sourced to national standards of care; 9) familiarity with abuse reporting laws; 10) adolescent counseling that incorporates family participation; 11) education and skills for resisting sexual coercion and abuse reporting; 12) confidentiality safeguards; and 13) programmatic supervision by a physician trained and experienced in family planning. CCHHS has also outlined per 42 CFR 59.5 (b)(1), the applicant and sub recipient site has made provision for prescription and laboratory testing. Each of these items specifically addressed in the application establish evidence that statutes, guidelines, and legislative mandates will be adhered to within this project.

The following programmatic components support further evidence of the operationalization of statutes, guidelines, and legislative mandates within the proposed service provision and will also be found outlined in the project work plan. Per 42 CFR 59.5 (b)(3), CCHHS has an information and education advisory committee that is representative of age, race, and sex of clients served in both Carson City and Douglas County. This committee approves all educational materials utilized under this project, after it is determined that it is factually correct, meets the

educational and cultural make-up of those who will be using the material, and is appropriate for the population served. In addition, per 42 CFR 59.5(b)(10), CCHHS has an established advisory board that broadly represents the population served and participates in the development, implementation and evaluation of the family planning project. The committee reviews the Title X work plan and provides feedback on new ideas, items specific to the needs of their particular community and ways of facilitating community awareness of the project.

Finally, per CCHHS's and the sub recipient policy and procedure this project is aware of and follows 42 CFR 59.5 requirements for voluntary informed consent for sterilization in competent individuals who are at least twenty-one years of age. This project makes referrals but does not perform or arrange for sterilization. Annually, staff receives education and signs off that they are aware of the requirement for voluntary informed consent for sterilization.

8. Evidence Funds Will Not be Utilized for Abortions

Neither CCHHS nor the sub recipient provide abortion services and neither organization will utilize Title X Grant Funds to provide or facilitate abortion services. CCHHS and sub recipient staff shall not engage in activities which promote, encourage or directly facilitate abortion as a family planning method. Examples of activities forbidden to staff include transportation, negotiating reduced fees, arranging appointments or obtaining informed consent. Staff review and sign off on policies and acknowledge that they are aware per Section 205 of Pub L 94-63 that coercing a person to undergo an abortion or sterilization shall result in fine or imprisonment.

9. Separation of Title X Project Activities and Finances

CCHHS and the sub recipient site are required to adhere to Internal Control Procedures set in place by each Finance Department. These procedures provide reasonable assurance regarding the safeguarding of assets against loss from unauthorized use or dispositions and the reliability of

financial records for preparing financial reports that demonstrate compliance with applicable laws and regulations. The annual budget, which includes individual grant budgets, serves as the financial plan for the department's programs and activities. The budgets are reviewed and approved by the City Board of Supervisors or the sub recipient's Board of Commissioners. The budget is then integrated into the financial system for monitoring and control. Each individual grant is assigned a separate cost center identification number. Each individual revenue source has a series of accounts that separate personnel, operating, travel, training, contractual, equipment, professional services. Program revenue is also separated into differing cost centers and identified at the time of receipt according to the program that generated the revenue. In-house spreadsheets organized by cost centers are used to separate operational expenses and are retained as supporting documents. Grant expenses, approved for payment, are validated as meeting Title 2 CFR 200 for cost eligibility. In addition, no costs are charged to a grant that are not approved as meeting the individual grant parameters, as specified in the applicable Notice of Grant Award.

Policies outline the specific procedures used to access the City's accounting system to secure recorded grant expenditures. Per 42 CFR 59.5 (b)(7), all services purchased for project participants are authorized by the Title X Manager or her designee. Purchases made by the sub recipient site are authorized by the program supervisor following budget approval by CCHHS. A separation in duties exists for purchasing, receiving and accounts payable

Financial Audit

NRS 354.624 requires Carson City to issue an annual report on its financial position and operations for the fiscal year. The Comprehensive Annual Financial Report (CAFR) is prepared annually in accordance with the auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in Government Auditing Standards, issued

by the Comptroller General of the United States. The financial statements are the responsibility of and are compiled by Carson City's Finance Department.

The most recent audit conducted for the fiscal year ending June 30, 2017 was performed between September and November 2017 by Eide Bailly LLP and accepted by the Carson City Board of Supervisors. The results of the audit disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

10. Community Information and Education Plan

42 CFR 599b)(3) this project "provides for informational and educational programs designed to— (i) Achieve community understanding of the objectives of the program; (ii) Inform the community of the availability of services; and (*iii*) Promote continued participation in the project by persons to whom family planning services may be beneficial." CCHHS utilizes the local newspaper and social media to educate the public regarding pertinent health issues and to inform the public about available services. CCHHS has an annual marketing plan that utilizes national health observance days and months to guide content. This plan is outlined for the content of 52 weekly educational newspaper articles and 260 week–day social media posts. The marketing plan is updated every year and previous plans document topic areas and platforms utilized. All specific community education content is archived in a shared computer drive. The sub recipient site utilizes social media to inform and educate the community regarding available services.

CCHHS and sub recipient staff participate with local community-based coalitions that include: (b)(4) (b)(4) in Douglas County, and the (b)(4) (b)(4) These coalitions aid in reaching low-income, Hispanic, African American, and Asian populations in our communities. Meeting minutes document and archive activities.

11. Information and Education Advisory Committee

Per CFR 59.6 "the project shall provide for the review and approval of informational and educational materials developed or made available under the project by an Advisory Committee prior to their distribution, to assure that the materials are suitable for the population or community to which they are to be made available and the purposes of title X of the Act." CCHHS has an established Information and Education Committee (I & E) that has evaluated all educational materials in use to date. This committee is made up of participants that utilize the family planning preventive health services at CCHHS and sub recipient site. CCHHS will continue to facilitate a bi-annual client-based Information and Education Committee in July and December of each project period and evaluate 100% of new family planning educational materials or any materials that have not been re-evaluated within 3 years of original approval. A three-part review will consist of staff review for reading level and culturally sensitive content, medical provider review for factual accuracy, followed by the I & E Committee review. The ultimate selection of materials deemed medically accurate by staff is completed by the I & E Committee members. Revision of policy and processed will occur as needed.

12. Evidence that Title X Priorities and Key Issues are Addressed in Project Plan and 15. Goals and Outcome Objectives (Appendix N: Work Plan)

Goals, objectives, activities, and evaluation will occur at both clinical site locations. Any use of CCHHS in this work plan is intended to include both CCHHS and the sub recipient site.

Goal 1: To provide client-centered, voluntary and non-coercive, quality family planning and related preventive health services in accordance with 42 CFR 59.5 and nationally recognized standards of medical care, with an emphasis on low-income and other vulnerable populations of Carson City, Douglas County and surrounding rural communities in Nevada to reduce unplanned pregnancy, prevent reproductive complications, and promote optimal health and wellness.

Objective 1.1: From Sept. 1, 2018 – Aug. 31, 2019 this project will provide client-centered, voluntary and non-coercive, schedule of discounted core family planning services to 3,200 low-income clients (2,200 CCHHS, 1,000 sub recipient) with a 5% increase annually through 2021 as supported by adequate funding. At least 70% of participants will have an income < 100% of FPL

Activities in Action Plan: Services will be available to 2200 clients at CCHHS & 1000 at the sub recipient site in project year 1, (Total 3200); 2310 by CCHHS & 1050 by sub recipient in the 2nd project year (Total – 3360), and 2425 by CCHHS and 1102 by sub recipient (Total - 3527) in the 3rd project year:

- Walk-in or same-day appointments available for all clients including adolescent clients.
- Saturday Hours at CCHHS two days per month.
- A broad range of family planning methods, including abstinence, barrier methods, fertility awareness-based methods, lactation amenorrhea method, EC, intrauterine devices, implants, pills, Excludes abortion services.
- Quick start of any applicable family planning method per best practice standards.
- Provision of Basic Infertility Services
- Public/private insurance billing to maximize federal resources - cost centers to identify and separate finances.

Time Frame / Result / Evaluation: Client totals based on age, race and income; will be retrieved from activity reports available via the EHR and reported for the mid-year progress report, annual progress report and FPAR. Annual progress reports will be submitted within 90 days of the close of the project period on August 31, 2019 and annually thereafter. Initial FPAR report completion for calendar year 2018 will occur by February 15, 2019, and annually thereafter.

Responsible Entity: Clinic APRN, Clinic RN, Clinical Services Manager

Objective 1.2: From Sept. 1, 2018 – Aug. 31, 2019 CCHHS will offer client-centered, voluntary and non-coercive, schedule of discounted preventive health services to 3,200 low-income clients (2,200 CCHHS, 1,000 sub recipient site). Per the CDC's 2015 STD Treatment Guidelines, CCHHS and the sub recipient site will screen 90% of women <25 years of age for Chlamydia and 90% of individuals for HIV. Per Healthy People 2020 Objective C-15 and C-17 the proportion of women receiving cervical cancer screening will reach 93.0% and the proportion of women receiving breast cancer screening will reach 81.1% per medical standards.

Activities in Action Plan:

Services will be available to 2200 clients at CCHHS and 1000 at the sub recipient site, in project year 1, (Total 3200); 2310 by CCHHS and 1050 by sub recipient in the 2nd project year (Total 3260), and 2425 by CCHHS and 1102 by sub recipient (Total - 3527) in the 3rd project year:

- Client counseling and education regarding risk of STD and HIV, Annual Ct testing to women < 25 years old, and HIV Prevention education, counseling, testing & referral per the2015 CDC STD Treatment Guidelines
- Breast and cervical cancer screening per the U.S Preventive Task Force & ACOG
- Public and private insurance billing, Utilization of Women's Health Connection, Mammovan and Soroptimist to maximize federal resources
- Active referral, appointment scheduling and follow up for clients with identified health issues utilizing primary care MOU & process

Time Frame/Result/Evaluation: Client totals based on age, race and income; will be retrieved via the EHR and reported for FPAR, the mid-year, annual and final progress report. Progress reports will be submitted within 90 days of the project period end on August 31, 2019 and annually thereafter. 2018 calendar year FPAR will occur by February 15, 2019, and annually thereafter.

Responsible Entity: Clinic APRN(s), Clinical Services Manager

Objective 1.3: CCHHS will optimize quality services for all clients. CCHHS and sub recipient site will conduct ongoing quality assurance and improvement to include 5 monthly chart audits, quarterly Meaningful Use (MU) /FPAR audits and an annual client satisfaction survey. Audits will reflect 90% of women <25 years for Chlamydia and 90% of individuals for HIV testing per 2015 CDC Guidelines. Satisfaction surveys will show satisfaction rate of at least 90% annually.

Activities in Action Plan:

Implementation of Quality assurance/quality improvement

- Perform 5 chart audits monthly per clinical site,
- Perform quarterly MU/FPAR audits and annual satisfaction survey
- Bi annual evaluation of clinic services based on chart audits, MU/FPAR data and satisfaction survey recommendations and findings by the CCHHS and sub recipient site Quality Improvement Committees.
- Initiate Improvement Team as needed upon evaluation

Time Frame / Result / Evaluation: A minimum of 5 chart audits will be completed monthly beginning October 2018 through August 2019. MU Dashboard and Clinical Quality Measure Reports will be reviewed quarterly in and December 2018, and 2019 in March, June, and September and continue each project year through September 2021. Patient satisfaction surveys will be conducted annually beginning January 2019 and annually through 2021. Tabulation of satisfaction survey data will be completed by March 2019 and annually through 2021, Survey data will be evaluated during the April 2019 QI committee meeting and annually through 2021. This evaluation will include strategies to improve deficit areas and assign a lead staff member and improvement team for implementation once improvement strategies have been developed.

Responsible Entity: APRN, QI Committee Members and Clinical Services Manager

2018 Program Priority (PP) #1, #3, #4, #7 and #8: Key Issues #1, # 2, #3, #4, #7, and #8:

Assuring the delivery of quality family planning, infertility and related preventive health services to improve overall health with priority for services to low-income families. Project offers a broad range family planning methods and related preventive health services tailored to the individual. Ensure voluntary, client-centered and non-coercive services. Promoting the provision of primary care. Title X activities clear and distinct, ensuring abortion is not a family planning method. Use of OPA performance metrics, regular performance of quality assurance and quality improvement activities. Efficiency and effectiveness in management and operations. Management & accountability for outcomes. Cooperation with community-based organizations. Meaningful collaboration with sub recipient. Emphasis on voluntary nature of family planning services. Data collection for use in monitoring and improving services.

GOAL 2: To provide voluntary, client centered, non-coercive education and counseling to women and men of child bearing age, including adolescents applicable to family participation, healthy monogamous relationships, healthy decision making-relationship skills and education and counseling that prioritizes optimal health and the benefits of avoiding sexual risk to all clients while assuring patient confidentiality and compliance with abuse reporting laws.

GOAL 2.1: To provide adolescent-sensitive services and teen pregnancy prevention interventions with activities that do not normalizing sexual risk behavior, with an emphasis on benefits of delaying sex to avoid sexual risk or returning to a sexually risk-free status, encouraging family participation and resisting coercion.

Objective 2.1: 90% of women/men of childbearing age seen at CCHHS and the sub recipient site will receive screening, education and counseling related to family participation, healthy

monogamous relationships and decision making, healthy relationships and education and counseling that prioritizes optimal health and the benefits of avoiding sexual risk behavioral and risk -reduction education.

Activities in Action Plan:

- Annual Staff education related to abuse reporting laws: child abuse & molestation, sexual abuse, rape, incest, intimate partner violence and human trafficking (Awaken).
- Monitor staff compliance with reporting laws through chart audits identified in Goal 1.3
- Implement the National Resource Center for Healthy Marriages and Families integration strategies for Level 1: Basic engagement through brochures to clients and handouts in waiting room (Project year 1); Level 2: Engaging community members and stakeholders that teach healthy relationships (Project Year 2 and 3).
  https://www.healthymarriageandfamilies.org/program-development

With 90% of all clients' staff to engage:

- Annual Sexual Health Assessment
- Open-ended questions to understand family dynamics and relationships and to ascertain perceptions regarding barriers to seeking familial participation in sexual health and general health matters
- Use of skills-based communication techniques (Empty Chair Technique) to identify one goal/action client feels can assist to optimal health.
- Facilitation of familial conversations as requested by client

Time Frame / Result / Evaluation: Structured data field created in electronic health record by Sept 30, 2018. Structured data fields will be monitored and reported out per the Title X mid-year,

annual and final progress report requirements beginning Sept. 1, 2018 - August 31, 2019, with a (b)(4) increase for each project year through August 31, 2021.

Responsible Entity: APRN, RNs and Clinical Services Manager

Objective 2.2: CCHHS and the sub recipient service sites will implement nationally recognized teen pregnancy prevention strategies to reduce unplanned pregnancy and improve family planning services to include health screenings, labs, and other related health services. Counseling and education will assess and address participation of the family, parent or legal guardian in the decision to seek family planning services, abuse reporting laws, counseling and skills building to resist attempts coercing sexual activity, a review of the benefits of delaying sex to avoid sexual risk or returning to a sexually risk-free status on adolescent clients at least once annually and more often as needed based on the intake and repeat visit assessment.

Activities in Action Plan:

- Staff education regarding teen development issues, current trends and resistances to familial involvement and resisting coercive sexual activities

With 90% of all adolescents' staff to engage:

- Implement science-based education and counseling techniques on the benefits of delaying sex to avoid sexual risk and/or returning to a sex-free status.
- Implement science-based education/counseling related to familial participation in health and decision making and negotiation skills for resisting coercive sex.
- Facilitation of familial conversations as requested by clients.

Time Frame / Result / Evaluation: Structured data field created in electronic health record by Sept 30, 2018. Structured data fields will be monitored and reported out per the Title X mid-year, annual and final progress report requirements beginning Sept. 1, 2018 - August 31, 2019, with a

5% increase for each project year through August 31, 2021.

Responsible Entity: APRN, RNs and Clinical Services Manager

2018 Program Priority #2, #5, and #6; Key Issues: #5 and #6: Assuring activities that promote positive family participation, healthy decision making; education and counseling that prioritizes optimal health. Assure compliance with state laws regarding child abuse & molestation, sexual abuse, rape, incest, intimate partner violence and human trafficking. Participation of families, parents, legal guardian in decision of minors to seek family planning and counseling to minors on how to resist coerce to engage in sexual activities. Meaningful emphasis on education and counseling related to healthy relationships, to committed, safe, stable, healthy marriages, and benefits of avoiding sexual risk or returning to a sexually risk free state. Adolescent activities that do not normalize sexual risk behaviors and communicates benefits of sexually risk-free state.

GOAL 3: Improve birth outcomes through the introduction of reproductive life planning.

Objective 3.1: 90% of women and men of childbearing age seen at CCHHS and the sub recipient site will be introduced to tools for a personal family planning, fertility, and reproductive life plan to reproductive life planning and engaged in screening and behavioral risk reduction education and actively linked to primary care as needed to improve pregnancy outcomes and optimize overall health during each year of the project period.

Activities in Action Plan:

- Staff training will on reproductive life plan and preconception policy and procedures.
- Assessment of the client's reproductive health plan and readiness for pregnancy.
- Screen for undiagnosed or known chronic health conditions or high risk behaviors.
- Active referral, appointment scheduling and follow up for clients with identified health issues utilizing primary care MOU & process.

- Assess for history of or current intimate partner violence, depression and other mental health concerns.
- Facilitate social services and mental health referrals as outlined in Project Narrative.
- Provide physical exam, pap, STD/HIV screening per clinical guidelines.
- Provision of immunizations utilizing a separate (Non-Title X Family Planning) program and fee structure. Cost centers will delineate separate expenses and revenue. This service will follow internal Immunization program policies, procedures and fee schedules along with federal VFC and 317 Guidelines.
- Provide prenatal vitamins to any woman considering pregnancy.
- Provide family planning per patient request.
- Client-centered education-pregnancy spacing, breastfeeding and risk-reduction behaviors.

Time Frame / Result / Evaluation: Client totals for reproductive life planning will be retrieved via the EHR and reported for the mid-year, annual and final progress reports. Annual progress reports will be submitted within 90 days of project year end date August 31, 2019 as required by grant guidelines, and annually thereafter through 2021

Responsible Entity: APRN, Clinical Services Manager

Objective 3.2: CCHHS and the sub recipient site will assess 90% of all clients for tobacco use and provide 90% of all tobacco users brief intervention cessation counseling and Nevada tobacco QuitLine referral in order to decrease by (b)(4) annually those reporting tobacco usage.

Activities in Action Plan:

- Assess individual client's use of tobacco products and readiness to quit.
- Provide tobacco prevention and cessation brief intervention and referral activities.
- Annual training and evaluation of tobacco cessation efforts lead by Chronic Disease

Prevention Tobacco Program Specialist.

Time Frame / Result / Evaluation: Client totals for tobacco assessment and cessation activities will be retrieved via the EHR and reported for the mid-year, annual and final progress reports. Annual progress reports will be submitted within 90 days of project year end date August 31, 2019 as required by grant guidelines, and annually thereafter through 2021

Responsible Entity: Tobacco Program Specialist, APRN, and RNs

2018 Program Priority #1, #2, #4, #7 and Key Issue #4: Assuring innovative high quality family planning and related health services that will improve the overall health of individuals, couples and families, with priority for services to those of low-income families, offering, at a minimum, core family planning services enumerated earlier in this Funding Announcement. Assuring that projects offer a broad range of family planning and related health services that are tailored to the unique needs of the individual, that include natural family planning methods (also known as fertility awareness based methods) which ensure breadth and variety among family planning methods offered, infertility services, and services for adolescents; breast and cervical cancer screening and prevention of STDs as well as HIV prevention education, counseling, testing, and referrals. Assuring activities that promote positive family relationships for the purpose of increasing family participation in family planning and healthy decision-making; education and counseling that prioritize optimal health and life outcomes for every individual and couple; and other related health services, contextualizing Title X services within a model that promotes optimal health outcomes for the client. Promoting provision of comprehensive primary health care services to make it easier for individuals to receive both primary health care and family planning services preferably in the same location, or through nearby referral providers, and increase incentive for those individuals in need of care choosing a Title X provider.

Demonstrating that Title X activities are separate and clearly distinct from non-Title X activities, ensuring that abortion is not a method of family planning for this grant. Meaningful collaboration with sub recipients/ documented partners in order to demonstrate a seamless continuum of care;

GOAL 4: To address comprehensive family planning and preventive health needs among families (including adolescents) and vulnerable populations by engaging community stakeholders in educational material review and community-wide outreach efforts.

Objective 4.1: CCHHS will facilitate a bi-annual client-based Information and Education Committee in December and July of each project period and evaluate 100% of family planning educational materials. Approved Educational materials will be re-reviewed every 3 years. Committee will meet guidelines as set forth in 42 CFR 59.

Activities in Action Plan:

- Ongoing education material evaluation for reading level and culturally sensitive content.
- Complete three-part review—client, staff and medical —for new educational material.
- Update review of materials that were reviewed prior to 3 years.
- Revision of policy as needed.

Time Frame / Result / Evaluation: Bi-annual client Information and Education Committee in December and July in each project period beginning in 2019 and continuing through 2021. Meeting documentation and Educational material review tracking spreadsheet citing recommendations with annual recommendations provided to the Division Manager.

Responsible Entity: Information and Education coordinating RNs

Objective 4.2. CCHHS will create an annual marketing plan that address written and social media forms of reaching the public to educate regarding Family planning and related preventive health. CCHHS will engage four community stakeholders through our community health

improvement plan and strategic planning process as well as a Title X Family Planning Advisory Board each project period to seek input on improving access to family planning and related preventive health services and implement these methods within 6 months of identification. This objective will follow guidelines as set forth in 42 CFR 59

Activities in Action Plan:

- Annual written and social media marketing plan as outlined in project narrative
- Convene Title X Advisory Board
- Implement recommended interventions

Time Frame / Result / Evaluation: CCHHS will document Marketing Plan development by January 2019 and annually thereafter through 2021. Title X Advisory Board will be convened annually in November or December beginning 2018, continuing annually through 2021. Data will be reported for the mid-year, annual and final progress report. Annual progress reports will be submitted within 90 days of project year end date August 31, 2019 and annually to 2021.

Responsible Entity: Clinical Services Manager

Key Issue #4 and 42 CFR 59: Meaningful collaboration with sub recipients/documented partners in order to demonstrate a seamless continuum of care. Provide for informational and educational programs designed to (i) Achieve community understanding of the objectives of the program; (ii) Inform the community of the availability of services; and (iii) Promote continued participation in the project by persons to whom family planning services may be beneficial.

13. Service Site Selection Process and Criteria

CCHHS issued a Request for Application (RFA) for the adjoining county, Douglas County, Nevada. The RFA was posted on the CCHHS website, distributed via email to community coalitions and posted at areas prescribed by open meeting law processes in that county (Library

Administrative offices, courthouse). Eligible entities included public and private not-for-profit entities including primary care providers, hospitals, healthcare coalition, women's health centers, and community or faith-based entities. Final selection was made by a Review and Selection Committee based on 1) Capabilities as addressed in Project Narrative and Work Plan, 2) Project Experience, 3) Personnel, and 4) Fiscal Evidence of capability to carry out the project.

14. Staffing Plan

Personnel Policies

Per 42 CFR 59.5(b)(4), orientation and in-service education is provided to staff at CCHHS and the sub recipient site. Department orientation covers phone and computer systems, incident policies, evacuation plan, overview of CCHHS and the 10 Essential Public Health Services. New staff members participate in a clinic-specific orientation. A skills – based competency checklist T includes laboratory skills training and competency review, policy and procedure review, blood borne pathogens training, introduction to Title X Statutes and guidelines via webinar, HIPAA, abuse reporting and human trafficking laws, family planning, immunizations, and STDs.

Position Descriptions

Director, Carson City Health and Human Services (MPH, MSN, RN) is responsible for strategic planning, business operations, personnel management; and the oversight of all activities of CCHHS. The Director is vested with: a) final review and approval of the Title X grant program application, b) oversees Clinical Services Manager with regard to the professional and clerical staff and Title X grant administration, c) approves contracts with outside service providers, and d) reviews program and training travel requests.

Clinical Services Manager (RN) is responsible for the development and initial review of the Title X grant application, development and execution of grant monitoring processes, Family

Planning fee regulations, coordinating and monitoring clinic protocol activities, supervising assigned professional and paraprofessional staff, providing staff training in proper work methods and techniques, employee performance evaluations, participating in resource allocation decisions for clinic services deliverables, and sub recipient monitoring

Medical Oversight - (b)(6) is the Family Planning Medical Director and Collaborating Physician at CCHHS. Dr. (b)(6), reviews policies and procedures, participates in Quality Improvement meetings, reviews medical records, provides consultation to the APRNs for specific client issues, takes referrals for clients when emergent gynecological needs are identified and or for clients whose gynecological needs surpass the scope of this project or, and is available by phone or e-mail when not onsite. (Appendix O – Medical Director Letter of Commitment)

Advance Practice Registered Nurse (APRN) Project has one full-time and one part-time APRN. The APRN is the primary provider in family planning clinical aspects, including: conducting the initial and annual physical exams, performing screening tests such as Pap smears, counseling of clients on various birth control methods, and prescribing and dispensing birth control medications and devices. The APRN is responsible for the diagnosis and treatment of sexually transmitted diseases and other gynecological conditions.

Public Health Nurse (RN) provides professional family planning services, including initiations and refills. The RN initiates medical records, obtains comprehensive medical and social histories, collects and processes laboratory specimens, and educates and counsels clients on family planning issues and preventive health measures. The RN also provides tracking of clients with abnormal health findings to ensure necessary testing and treatment.

Office Specialist supports clinic reception duties to include: answering phones, patient intake/checkout, scheduling, and daily receipt reconciliation. The Office Specialist operates a variety of office equipment, including computer terminal, inputs and retrieves a variety of data and text, and maintains computerized records, including electronic medical records, monthly reports and statistics, and the state immunization registry. This position performs general secretarial and clerical work such as filing, faxing, and ordering and maintaining office supplies. This position is primarily responsible for payment collection and insurance billing coordination. Bilingual staff provide translation and interpretation services.

Billing Specialist – Establishes and renews third party contracts. Processes client and third party payments. Responsible for back-end revenue cycle management and processes.

Fiscal Grants Analyst is the primary fiscal agent who is responsible for internal controls to include developing, reviewing and monitoring the grant program budget requests; participating in resource allocation decisions and reconciling grant fiscal activities while tracking grant expenditures. (Previously Noted Appendix H & I: Curriculum Vitae Key Personnel)

15. See Item # 12 as #15 is included in that section.

16. Referral Agencies and Access Plan

Comprehensive Primary Care

Per Program Priority # 4, CCHHS has an active linkage with Nevada Health Centers, a federally qualified health center that provides comprehensive primary care services throughout Nevada. CCHHS entered into a Memorandum of Understanding (MOU) with the local federally qualified health center in 2015 and the MOU is effective through 2020. In addition to the MOU formalizing the primary care partnership, an electronic system is utilized to communicate bi-directional referrals. Clients may contact either of our agencies directly and both agencies also

contact the referred client to schedule an appointment. Once a client is given an appointment, the appointment information is communicated back to the referring agency for documentation and follow up purposes. The sub recipient site is exploring expanding their services to include primary care. In the meantime, they have engaged in formal conversations with the local rural health center to ensure primary care is available to any client in need. (Appendix P: Primary Care MOU; Appendix Q: Sub Recipient Primary Care Documentation)

Obstetrics and Gynecology

A local OB/GYN Office associated with our Title X Medical Director provides emergent care to our clients on a referral basis. CCHHS and the sub recipient site are able speak with the office manager and arrange for necessary appointments. (Appendix R: OB/GYN Care)

Other Needed Health, Mental Health and Social Services

Carson City Human Services is co-located in the same building as CCHHS' family planning services. A second social services agency, Ron Wood Family Resource Center, is located within walking distance of CCHHS. Douglas County Social Services (DCSS) is located within a few miles of the sub recipient site along the bus route. DCSS is managed by the same individual supervising the sub recipient family planning site, leading to integrated services. These agencies assist clients with social services and are equipped to handle other ancillary needs of clients, including shelter, food, energy assistance, job readiness and employment. W.I.C. is co-located in the same building of both clinical sites and is managed by the CCHHS Human Services Division Manager. CCHHS and the Douglas County sub recipient site have partnered with the Division of Welfare and Supportive Services for onsite enrollment for public health insurance and education and referrals for private health insurance. By addressing social, cultural, and basic survival

needs, these agencies provide a complete assistance package. (Previously Noted - Appendix F: Social Services Letter of Commitment; and Appendix E: DWSS Letter of Commitment)

For women under 40 with a palpable breast mass without a payer source, screening and diagnostic services funding is available through S(b)(4), a local philanthropic group focused on assisting low-income/uninsured women w/ diagnostic screening.

Clients testing positive for HIV will be referred to(b)(4) federally qualified health center in Reno, NV specializing in HIV care. These clients will also be referred to the CCHHS' Ryan White HIV program's treatment adherence case manager. This case manager is onsite at CCHHS for immediate intervention.

CCHHS staff works collaboratively with mental health providers as well as substance abuse treatment centers. There is an inpatient substance abuse treatment center co-located in the same complex as CCHHS. CCHHS clinical staff provides tuberculosis testing and immunizations at this substance abuse treatment centers= through a Substance Abuse Treatment grant (SAPT). This formal relationship has enhanced provider referral relationships between public health and mental health providers in Carson City. In Douglas County, a coalition is addressing mental health on a community level. Sub recipient staff participates on this coalition that includes mental health professionals, social services, faith-based agencies and medical providers.

CCHHS' County Health Officer leads a Sexual Assault Response Team (SART), and the Clinical Services Manager is a member of this team. This team also includes a county elected official, sexual assault nurse examiners, the district attorney's office, the Sheriff Office's detectives and a not-for-profit assistance agency, (b)(4) These relationships allow for addressing barriers to seamless access to any patient identified with service needs related to domestic or sexual violence. CCHHS collaborates with the local hospital

and [(b)(4)] to provide a sexual assault program in Carson City.

Clinical Services professionals within the family planning project utilize and refer to the local Mobile Outreach Safety Teams (MOST) teams in both communities. These teams are available to residents during immediate and ongoing mental health crisis.

17. Collection and Reporting of Required FPAR Program Data

CCHHS has been submitting an FPAR report since first receiving Title X funds in 2005. Initially, as a sub grantee, we submitted reports to the State of Nevada. Since 2009, we have submitted the FPAR data directly via the internet processes established by the Title X Program. eCW has encounter-level FPAR reporting capabilities. Specific FPAR structured data fields were developed and staff was trained in optimal charting to capture needed data. Quarterly quality improvement monitoring at our primary and sub recipient sites ensures accurate reporting. CCHHS has exclusively utilized this electronic data from our EHR for the FPAR since calendar year 2014. The sub recipient site also uses eCW and has the same FPAR reporting capabilities.

18. Evidence for Ensuring Quality Family Planning Services

Federal Site Review Results

Strong evidence of CCHHS' administrative, clinical and fiscal qualification, capacity, and expertise is evidenced by the December 2016 Federal Title X Program Review. There were no findings identified during the program review. CCHHS received a score of highly developed for providing a framework for planning and evaluation. CCHHS scored as fully developed in the areas of client-centered counseling; cultural competency and client dignity; clinical protocol compliance; pregnancy testing and counseling; and communication and education.

Program Requirement Compliance Process

CCHHS' Clinical Services Manager is tasked with monitoring, evaluating and ensuring

compliance with Title X Program Requirements. The Clinical Services Manager has utilized the Office of Population Affairs Title X Program Guidelines: Program Review Tool to regularly monitor program compliance. The sub recipient's Title X Program Policies set the framework for sub recipient compliance and the Clinical Services Manager utilizes the Office of Population Affairs Title X Program Guidelines: Program Review Tool, chart audits and data monitoring to assess the quality of services provided throughout the defined project. Fiscal, Administrative and Clinical monitoring of the clinical site will occur annually and more frequently as needed utilizing the Federal Title X site review tool. Monitoring will be conducted by CCHHS Fiscal Analyst and Clinical Services Manager

Defined Performance Measures and Assessment Process

CCHHS has a comprehensive Quality Assurance/Improvement Plan in place to assure high-quality care is provided to all clients and that all federal, state and local requirements are met, including OSHA and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). This plan has been adopted by CCHHS and the sub recipient site with clinic-specific additions.

CCHHS utilizes program performance measures to track the following areas: client satisfaction, service utilization, Chlamydia testing rates, low income and minority population participation, outreach methods, Title X grant activities and deliverables.

The following sources are used for data collection for monitoring and evaluating quality of care:

- Audits on infection control, laboratory and clinical procedures,
- Chart reviews by the medical director, supervisor or peers,
- Discussion of Quality Improvement in monthly team meetings,
- Incident reports review and evaluation by management,
- Program review using the Title X Program Review Tool.

- Review of personnel files for required licensure, certification and training,
- Bi-annual review of program performance measures with action plans for unmet goals
- Annual staff performance evaluations

Specific examples of performance monitoring include: Laboratory audits are performed annually at a minimum to ensure standards are met. A medical records audit tool was developed in collaboration with Title X Regional Staff. Approximately fifteen charts per quarter are reviewed, and more if found to be necessary. An internal auditing tool is used; discrepancies and a time frame for correction are discussed with the practitioners individually and through presentation at monthly quality improvement committee meetings.

19. Third Party Billing and Facilitation of Medicaid Enrollment

CCHHS has actively pursued infrastructure development to ensure sustainability. CCHHS is contracted with Medicaid as well as 11 commercial insurance plans with a total of 20–25 networks within these plans. The sub recipient site is contracted with Medicaid and the majority of private payers in our area. (Previously Sited Appendix F: Insurance Plans List)

Both service sites also enroll women in the Breast and Cervical Cancer Early Detection Program, through W(b)(4) This program is designed for women ages 40 and older that meet low-income guidelines. The program funds clinical breast exams and pap smears for clients aged 40 49. Clients aged 50 and older also benefit from screening mammograms in addition to the clinical breast exam and pap testing.

As previously mentioned, CCHHS has partnered with the Division of Welfare and Supportive Services to offer onsite enrollment and education for public health insurance, and education and referrals for private insurance enrollment.

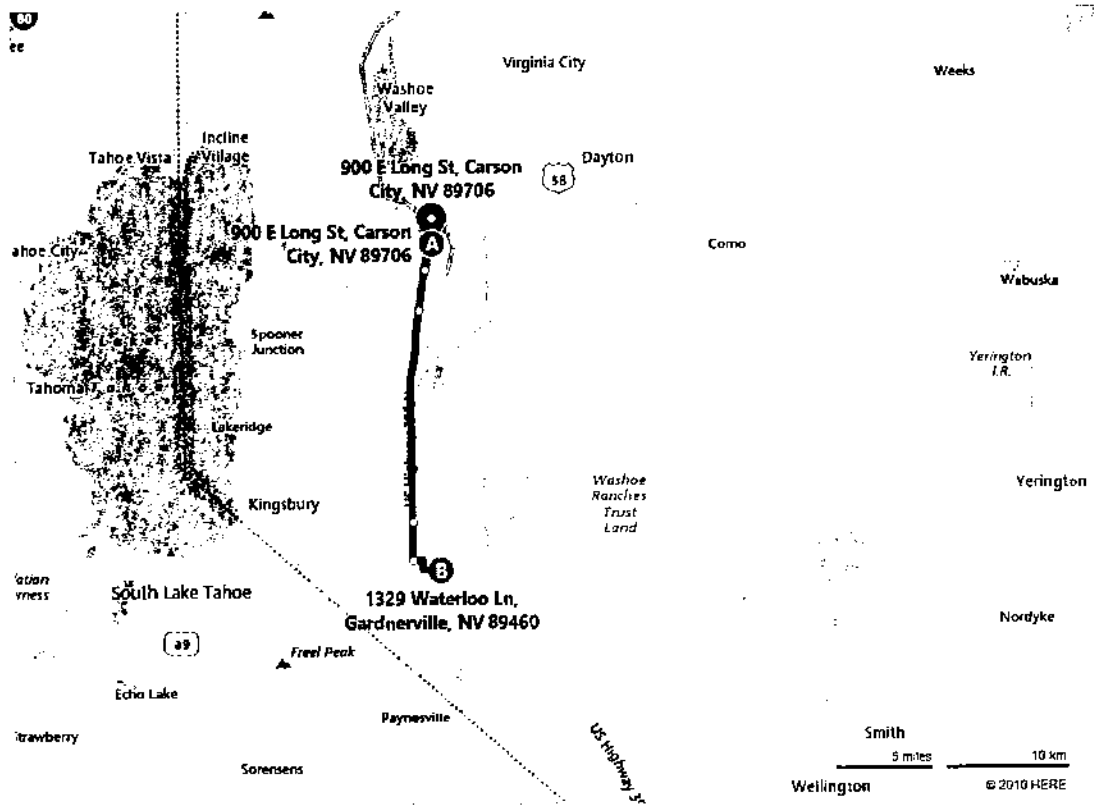
(APPENDIX S: Sources of Data)

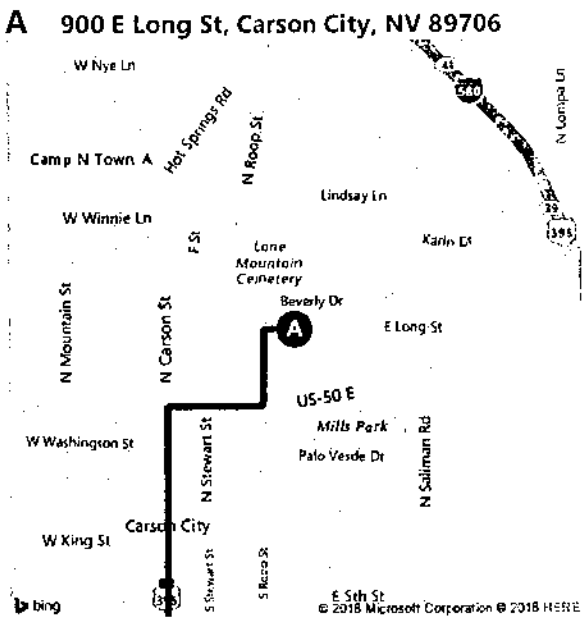
Upload #2

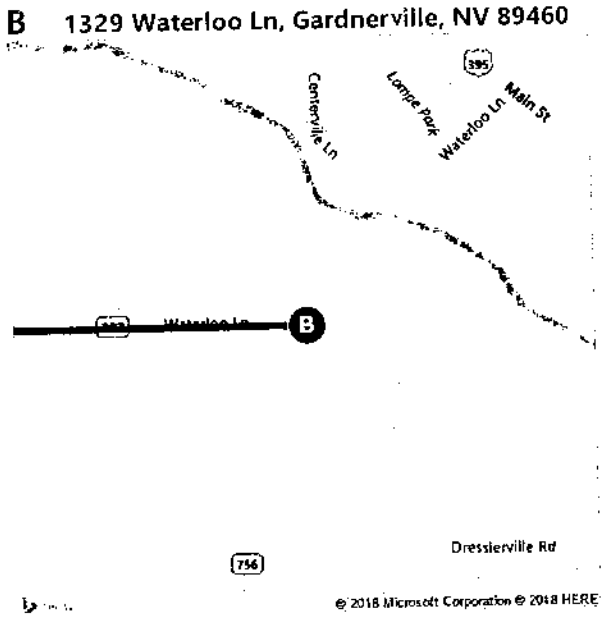
Applicant:	Carson City
Application Number:	FPH2018008746
Project Title:	Carson City Health & Human Services Family Planning and Related Health Services.
Status:	Review in Progress
Document Title:	AttachmentForm_1_2-ATT1-1234-Title X 2018-2021 Attachments.pdf

APPENDIX A

Carson City Health & Human Services Family Planning and Preventive Health Services Project
Funding Opportunity Announcement Number: PA-FPH-18-001; CFDA Number: 93.217
Service Area Map







DOUGLAS COUNTY

Community Health

1329 Waterloo Lane, Gardnerville, NV 89410
Mailing address: P.O. Box 218; Minden, NV 89423
(775) 782-9038 * Fax (775) 782-9875

May 4, 2018

Department of Health and Human Services
Office of Assistant Secretary for Health
Office of Population Affairs and Office of Grants Management

RE: CFDA Number 93.217, Family Planning Services

To Whom It May Concern:

On behalf of Douglas County Community Services, Community Health Clinic, please accept this statement as our commitment to Carson City Health and Human Services' (CCHHS) application for Federal Title X Grant – CFDA Number 93.217 for continuation of Family Planning service in Douglas County. We have worked with CCHHS since January, 2012 for the provision of Family Planning services through our Community Health Clinic in Douglas County and surrounding areas.

In January, 2017 we became our own stand-alone clinic, changing the partnership we have with CCHHS but remaining as a subgrantee under their Title X funding. We have increased our office hours and our marketing and branding efforts in the community and are enjoying a growing patient base. This growth is based on our strong foundation of family planning services to patients across the age range and income status.

While we enjoy strong relationships with our local health providers and hospital, we are the only clinic that specializes in Family Planning services. With help from the State Family Planning grant created by AB397, we have the unique ability as well to dispense our patients' chosen method of birth control during their office visit, thus capitalizing on every opportunity to assist is implementing the chosen approach to family planning.

Our clinic staff is dedicated to continuous learning of best practices in the field. Our Health Officer, Dr. John Holman, attends regular Quality Assurance/Quality Improvement engagement and annual skills recertification days. The quality of our staff and their commitment to the patients and providing the best care possible is what will keep this clinic viable well into the future. We appreciate the opportunity to work under the guidance and support of Title X funding in meeting this mission.

The clinic enjoys a close relationship with Social Services in that it is primarily supported through Social Services and indigent funds from the county. Dffice staff are crosstrained to work in both units. This connection also allows seamless referrals between the clinic and the Social Services office for those in need of financial support and/or connection to Medicaid. We host a DWSS intake worker in Douglas five days a

week in various locations to make access to those benefits easy for clients throughout the county. The relationship between Douglas County Social Services, Douglas Community Health, Carson City Health and Human Services, and the state Welfare office provide a broad network of opportunities for family planning patients in our community to access the services they need and receive any financial supports for which they are eligible. We believe this removes many barriers to their receiving care.

Sincerely,

Karen Beckerbauer, M.S.
Manager

APPENDIX C

CARSON CITY BOARD OF HEALTH MEMBERS
ORGANIZATIONAL STRUCTURE

Bob Crowell
Mayor, Carson City Board of Supervisors

Ken Furlong
Carson City Sheriff. elected

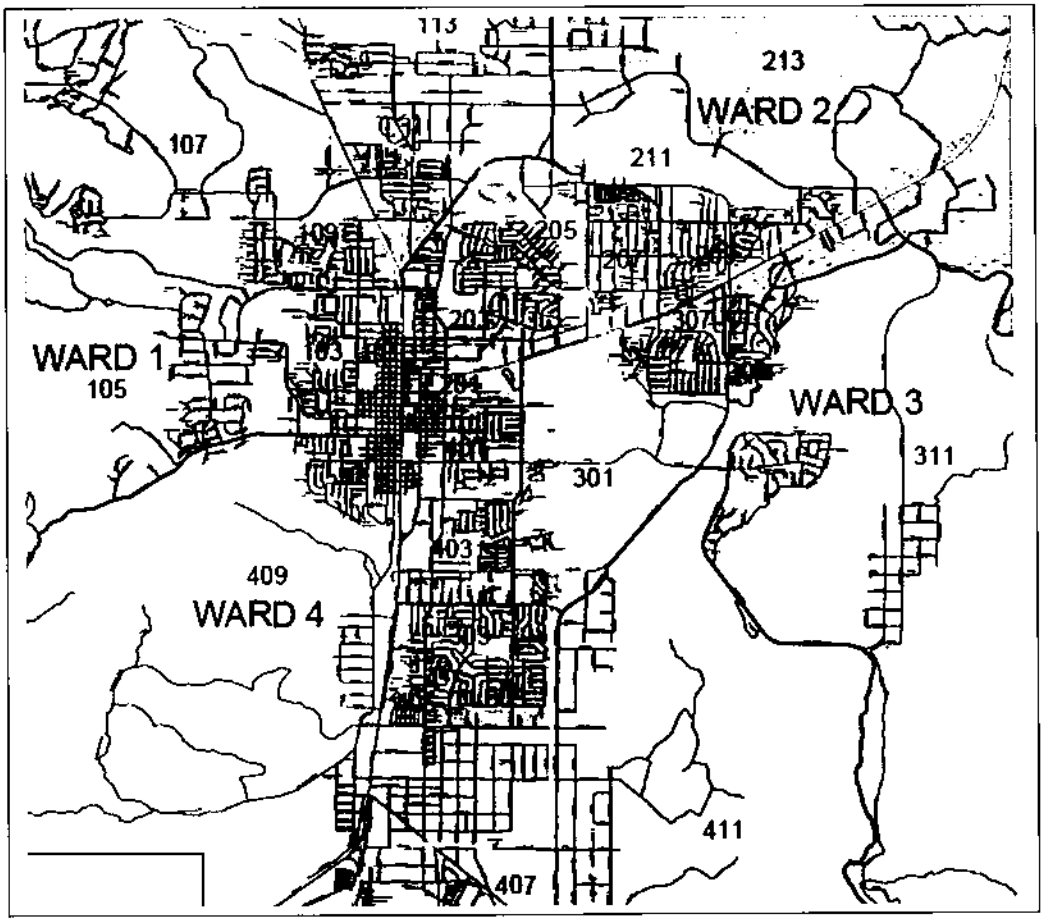
Susan Pintar, M.D.
Carson City Health Officer, appointed

Karen Abowd
Ward 1, Carson City Board of Supervisors

Brad Bonkowski
Ward 2, Carson City Board of Supervisors

Lori Bagwell
Ward 3, Carson City Board of Supervisors

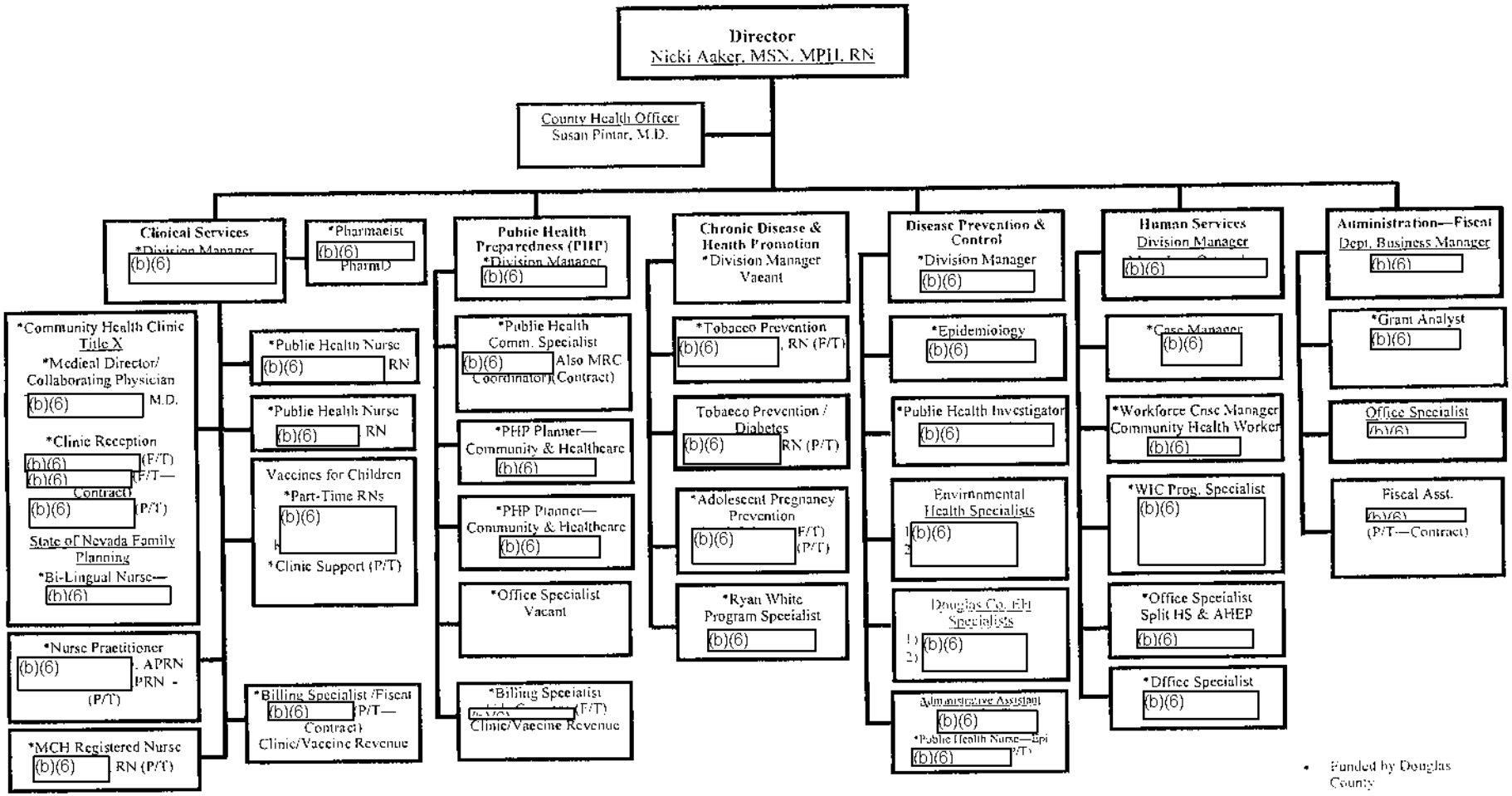
John Barrete
Ward 4, Carson City Board of Supervisors



Appendix B: Board Of Health

APPENDIX D

Carson City Health & Human Services



• Funded by Douglas County

*ongoing grant funded

"To protect and improve the quality of life for our community through disease prevention, education and support services."

Revised 4/5/2018

APPENDIX E

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

STEVE H. FISHER
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISIDN OF WELFARE AND SUPPORTIVE SERVICES
1470 College Parkway
Carson City, NV, 89706
Telephone (775) 684-0500 • Fax (775) 684-0614
http://dwss.nv.gov

May 11, 2018

Ms. Valerie Huber
Senior Policy Advisor
DASPA
U.S. Department of Health and Human Services
Office of the Assistant Secretary of Health
1101 Wooten Parkway, Suite 700
Rockville, Maryland 20852

RE: Announcement of Anticipated Availability of Funds for Family Planning Services Grant: PA-FPH-18-001

Dear Ms. Huber:

This letter should serve as the Division of Welfare and Supportive Services' (DWSS) commitment to support and partner with Carson City Health and Human Services (CCHHS) and Douglas County Community Health (DCCH) for the Announcement of Anticipated Availability of Funds for Family Planning Services Grant Application.

The Nevada DWSS will commit to its role as a partner by providing a DWSS eligibility worker, either full or part-time, as volume dictates, at both the CCHHS clinic and the DCCH clinic.

The DWSS eligibility worker will accept referrals from clinic staff to evaluate applications for assistance such as Medicaid, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance Needy Families (TANF) in an accurate and timely manner.

This letter also attests that CCHHS and DCCH will cooperate with DWSS in implementing the partnership to improve access to DWSS services at their respective locations in Carson City and Gardnerville, Nevada.

The DWSS is dedicated to engaging clients, staff and the community to provide public assistance benefits to all who qualify and reasonable support for children with absentee parents to help Nevadans achieve successful, stable and healthy lives. The DWSS' mission clearly supports the goal of this CCHHS and DCCH initiative to improve access and services for our mutual clients.

I appreciate your consideration of this important matter.

Sincerely,

Steve H. Fisher
Administrator

CARSON CITY, NEVADA

CONSOLIDATED MUNICIPALITY AND STATE CAPITAL

May 14, 2018

To Whom It May Concern:

Carson City Human Services is a community action agency providing a variety of services to the Carson City Community. The Human Services Division is responsible for ensuring that Carson City meets its health, welfare, and community responsibilities as set forth in the Nevada Revised Statutes and city ordinances. The primary mandates are to provide services to the City's indigent residents and as a community action agency assist them in becoming self-sufficient.

We are committed to partnering with the Clinical Services Division of Carson City Health and Human Services to bring the services we offer to assist Title X Family Planning patients towards improved and stable livelihoods with the eventual goal of assisting patients along the roads to be self-supporting. The Human Services Division considers Title X Family Planning an important component in planning for the needs of Title X clients and applicants.

We commit the following services in their availability to Title X Family Planning patients. To enhance the basic needs services, the Human Services Division manages grant programs for housing, case managements services, job readiness training, financial literacy as well as provide Women, Infants, and Children (WIC) services. The Human Services Division partners with other agencies to provide services on site such as Northern Nevada Center for Independent Living, Aging Disability Resource Center, and Financial Guidance Center. The Human Services Division is part of the department of Carson City Health and Human Services which provide the public an array of services in one place.

In addition, as we are assisting households in stabilizing we include goals for preventative healthcare. Having Title X services on site, our case managers can directly assist in making the appointments in person and with a warm hand-off. This also happens in reverse, a patient being seen that may need additional guidance can be brought to the Human Services Division in person. This is a tremendous asset as many do not follow up with referrals once they leave the building.

Please contact me if you have any questions

Regards,

Mary Jane Ostrander, Human Svcs. Division Manager
Carson City Health and Human Services
mostrander@carson.org; (775) 283-7234

Page 695 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 696 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 697 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 698 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 699 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 700 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 701 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 702 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

APPENDIX J:

	FAMILY PLANNING METHODS PROVIDED WITHIN THE TITLE X PROJECT							
Agency	Abstinence Education	Cervical Cap /Diaphragm	Contraceptive Sponge	Female Condom	Female Sterilization	Fertility Awareness Method	Hormonal Patch	Hormonal Implant
Carson City Health & Human Services	1	1	2	2	2	1	1	1
Douglas County Community Health	1	1	2	2	2	1	1	1

Agency	Hormone Injection	IUD/IUS	Male Condom	Oral Contraception	Spermicidal Methods or Products	Vaginal Ring	Vasectomy
Carson City Health & Human Services	1	1	1	1	2	1	2
Douglas County Community Health	1	1	1	1	2	1	2

Legend

1= Provided on-site
2=Screened and Referred to Outside Resource
3=Referred to Outside Source
4=Not Provided

Agency	SERVICES PROVIDED WITHIN THE TITLE X PROJECT								
	Informed Consent	History	Physical Exam	C.L.I.A Labs – Blood sugar, hemoglobin, Urinalysis	Pap Testing	Client Education Counseling	Pregnancy Diagnosis /Counseling	STD Testing	STD Treatment
Carson City Health & Human Services	1	1	1	1	1	1	1	1	1
Douglas County Community Health	1	1	1	1	1	1	1	1	1

Agency	Male Services	HIV Testing, Counseling and Referral	Identify Estrogen Exposed Offspring	Level I Infertility Services	Minor GYN Problems	Health Promotion /Disease Prevention	Special GYN Procedures	Emergency Contraception
Carson City Health & Human Services	1	1	2	1	1	1	1	1
Douglas County Community Health	1	1	2	1	1	1	1	1

Legend

1= Provided on-site
2=Screened and Referred to Outside Resource
3=Not Screened, Referred to Outside Resource
4=Not Provided

Page 705 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 706 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 707 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

SLIDING FEE ASSESSMENTS

Purpose

(b)(4)

Policy

(b)(4)

Procedure

(b)(4)

Appendix M: Process and Schedule of Discounts

(b)(4)

Appendix M: Process and Schedule of DIscounts

FEDERAL POVERTY SCALES

From Federal Register retrieved on 1/31/18 from https://aspe.hhs.gov/poverty-guidelines

Annual - Income Guidelines	Tier 1 251% & above Federal Poverty	Tier 2 201-250% Federal Poverty	Tier 3 151-200% Federal Poverty	Tier 4 101-150% Federal Poverty	Tier 5-no pay 100% & below Federal Poverty
1	(b)(4)				
2					
3					
4					
5					
6					
7					
8					

Monthly Income Guidelines	Tier 1 251% & above Federal Poverty	Tier 2 201-250% Federal Poverty	Tier 3 151-200% Federal Poverty	Tier 4 101-150% Federal Poverty	Tier 5-no pay 100% & below Federal Poverty
1	(b)(4)				
2					
3					
4					
5					
6					
7					
8					

Appendix M: Process and Schedule of Discounts

Weekly Income Guidelines	Tier 1 251% & above Federal Poverty	Tier 2 201-250% Federal Poverty	Tier 3 151-200% Federal Poverty	Tier 4 101-150% Federal Poverty	Tier 5-no pay 100% & below Federal Poverty
1	(b)(4)				
2					
3					
4					
5					
6					
7					
8					

APPENDIX N: Work Plan; Sept 1, 2018 – August 31, 2021
Carson City Health & Human Services (CCHHS) Family Planning and Preventive Health Services Project
Funding Opportunity Announcement Number: PA-FPH-18-001; CFDA Number: 93.217
CCHHS 900 East Long Street Mon-Wed and Fridays 8:30-5:00, 2 Saturdays each month 8:30-5:00
Douglas County Community Health 1329 Waterloo Lane, Garnerville, NV, Mon- Friday: 8:30-5:00 pm

NEED 1: In Nevada,17.2 % of individual 18-44 years of age, 21.1% of Hispanics/Latinos live in poverty, 5.0% are unemployed and 21% of individuals and females 18-44 are unisured.[2,6] In Carson City, 19.4 % of individual 18-44 years of age, 23.8% of Hispanics/Latinos live in poverty, 5.9% are unemployed and 24.6% whose income fell under 138% of the FPL were uninsured.[1,7] In Douglas County, 17.5 % of individual 18-44 years of age, 21.8% of Hispanics/Latinos live in poverty, 54.8% are unemployed and 27.7% whose income fell under 138% of the FPL were uninsured.[1,7] These barriers impede vulnerable populations in seeking family planning/related health services, and can lead to unplanned pregnancies, undiagnosed health conditions, infertility, and even death.
GOAL 1: To provide client-centered, voluntary and non-coercive, quality family planning and related preventive health services in accordance with 42 CFR 59.5 and nationally recognized standards of medical care, with an emphasis on low-income and other vulnerable populations of Carson City, Douglas County and surrounding rural communities in Nevada in an effort to reduce unplanned pregnancy, prevent reproductive complications, and promote optimal health and wellness.
Objective 1.1: From Sept. 1, 2018 – Aug. 31, 2019 this project will provide client-centered, voluntary and non-coercive, schedule of discounted core family planning services to 3,200 low-income clients (2,200 CCHHS, 1,000 sub recipient site) with a 10% increase annually through 2021 as supported by adequate funding. At least 70% of participants will have an income < 100% of FPL.
Objective 1.2: From Sept. 1, 2018 – Aug. 31, 2019 CCHHS will offer client-centered, voluntary and non-coercive, schedule of discounted preventive health services to 3,200 low-income clients (2,200 CCHHS, 1,000 sub recipient site). Per the CDC's 2015 STD Treatment Guidelines, CCHHS and the sub recipient site will screen 90% of women <25 years of age for Chlamydia and 90% of individuals for HIV. Per Healthy People 2020 Objective C-15 and C-17 the proportion of women receiving cervical cancer screening will reach 93.0% and the proportion of women receiving breast cancer screening will reach 81.1% per medical standards.
Objective 1.3: CCHHS will optimize quality services for all clients. CCHHS (and sub recipient site) will conduct ongoing quality assurance and improvement to include 5 monthly chart audits, quarterly Meaningful Use (MU) /Family Planning Annual Report (FPAR) audits and an annual client satisfaction survey. Audits will reflect 90% of women <25 years for Chlamydia and 90% of individuals for HIV testing per 2015 CDC Guidelines. Satisfaction surveys will show satisfaction rate of at least 90% annually.

TIMELINE	ACTIVITIES/ACTION STEPS	RESPONSIBLE	EVALUATION
Sept. 1, 2018 - August 31, 2019, with a 5% increase for each project year through August 31, 2021	Services will be available to 2200 clients at CCHHS & 1000 at the sub recipient site in project year 1, (Total 3200); 2310 by CCHHS & 1050 by sub recipient in tear 2 (Total – 3260), and 2425 by CCHHS and 1102 by sub recipient (Total - 3527) in year 3: • A broad range of family planning methods, including abstinence, barrier methods, fertility awareness-based methods, lactation amenorrhea method, EC, intrauterine devices, implants, pills. Excludes abortion services. • Quick start of family planning method per practice standards. • Walk-in or same-day appointments available for all clients including adolescent clients. • Saturday Hours at CCHHS two days per month • Provision of Basic Infertility Services • Public/private insurance billing to maximize federal resources - cost centers to identify and separate finances	APRN; Clinical Services Manager; Sub recipient Supervisor	Client totals by age, race and income retrieved from activity reports via EHR, and reported via FPAR. Project year 1, (Total 3200); 2nd project year (Total – 3260); 3rd project year: (Total - 3527)
Sept. 1, 2018 - August 31, 2019, with a 5% increase for each project year through August 31, 2021	Services will be available to 2200 clients at CCHHS and 1000 at the sub recipient site, in project year 1, (Total 3200); 2310 by CCHHS and 1050 by sub recipient in the 2nd project year (Total – 3260), and 2425 by CCHHS and 1102 by sub recipient (Total - 3527) in the 3rd project year: • Breast and cervical cancer screening per the U.S Preventive Task Force & American College of Ob/GYNs • Client counseling and education regarding risk of STDs; the expedited partner therapy; HIV Prevention education, counseling, testing & referral; and Annual Ct testing to women < 25 years old per the 2015 CDC STD Treatment Guidelines	APRN; Clinical Services Manager; Sub recipient Supervisor	Annual FPAR data and evaluation of STD, HIV, breast/cervical cancer screening activities

	• Public and private insurance billing. Utilization of Women's Health Connection, mobile Mammovan and Soroptimist to maximize federal resources • Active referral, appointment scheduling and follow up for clients with identified health issues utilizing primary care MOU & process		
Chart Audits Monthly Sept. 2018 – Aug. 2019; and each project year to 2021 MU/FPAR – Dec., March, June, Sept, 2018 -2019 and each project year to 2021 Satisfaction Surveys Jan 2019 & and each project year to 2021 Evaluation –Biannual Jan 19 and July 19 & each project year 2021	Implementation of Quality assurance/quality improvement • Perform 5 chart audits monthly, per clinical site • Perform quarterly MU/FPAR audits and annual satisfaction survey • Bi annual evaluation of clinic services based on chart audits, MU/FPAR data and satisfaction survey recommendations and findings by the CCHHS and sub recipient site Quality Improvement Committees. • Initiate Improvement Team as needed upon evaluation	Clinical Services Manager; Sub recipient Supervisor; CCHHS and sub recipient site QI Committee	Documentation of chart audit results, satisfaction survey results. Quality Improvement (QI) Meeting minute documenting evaluation and action taken related to QI activities
2018 Program Priority (PP) #1, #3, #4, #7 and #8: Key Issues #1, # 2, #3, #4, #7, and #8: Assuring the delivery of quality family planning, infertility and related preventive health services to improve overall health with priority for services to low-income families. Project offers a broad range family planning methods and related preventive health services tailored to the individual. Ensure voluntary, client-centered and non-coercive services. Promoting provision of primary care. Title X activities clear and distinct, ensuring abortion is not a family planning method. Use of OPA performance metrics, regular performance of quality assurance and quality improvement activities. Efficiency and effectiveness in management and operations. Management & accountability for outcomes. Cooperation with community-based organizations. Meaningful collaboration with sub recipient. Emphasis on voluntary nature of family planning services. Data collection for use in monitoring and improving services.			

NEED 2: In a 2014 Guttmacher Institute report, Nevada had the 7th highest pregnancy rate overall and the 16th highest birth rate for teens 15-19 years of age in the nation.[10] In 2016 Carson City unintended pregnancies was 43. 9/1,000 and for teens 15-17 yrs old aged 13.0 /1000 pregnancy rate, while those aged 18-19 remains at 63.4/1000.[2,12] In 2016 Douglas County unintended pregnancies was 27.5/1,000 overall and for teens 15-17 years old aged 13 /1000 pregnancy rate, while those aged 18-19 is at 15/1000.[2,12]

GOAL 2: To provide voluntary, client centered, non-coercive education and counseling to women and men of child bearing age, including adolescents applicable to family participation, healthy monogamous relationships, healthy decision making and education and counseling that prioritizes optimal health and the benefits of avoiding sexual risk to all clients while assuring patient confidentiality and compliance with abuse reporting laws.

GOAL 2.1: To provide adolescent-sensitive services and teen pregnancy prevention interventions with activities that do not normalizing sexual risk behavior, with an emphasis on benefits of delaying sex to avoid sexual risk or returning to a sexually risk-free status, encouraging family participation and resisting coercion.

Objective 2.1: Ninety percent of women and men of childbearing age seen at CCHHS and the sub recipient site will receive screening, education and counseling related to family participation, healthy monogamous relationships, abuse reporting laws, healthy decision making and education and counseling that prioritizes optimal health and the benefits of avoiding sexual risk behavioral risk avoidance, and risk -reduction education

Objective 2.2: CCHHS and the sub recipient service sites will implement nationally recognized teen pregnancy prevention strategies to reduce unplanned pregnancy and improve family planning services to include health screenings, labs, and other related health services. Counseling and education will assess and address participation of the family, parent or legal guardian in the decision to seek family planning services, abuse reporting laws, counseling and skills building to resist attempts coercing sexual activity, a review of the benefits of delaying sex to avoid sexual risk or returning to a sexually risk-free status on adolescent clients at least once annually and more often as needed based on the intake and repeat visit assessment.

TIMELINE	ACTIVITIES/ACTION STEPS	RESPONSIBLE	EVALUATION
Structured data field created in electronic health record by Sept 30, 2018 Sept. 1, 2018 - August 31, 2019, with a 5% increase for each project year	• Annual Staff education related to abuse reporting laws: child abuse & molestation, sexual abuse, rape, incest, intimate partner violence & human trafficking (Awaken). • Monitoring staff compliance with reporting laws through chart audits identified in Goal 1.3	APRN RN Clinical Services Manager; Sub recipient Supervisor	Sign in sheets and documentation training content Chart Review

through August 31, 2021 National Resource Center for Healthy Marriages and Families Level 1: Basic engagement(Project year 1); Level 2: Engaging community members and stakeholders that teach healthy relationships (Project Year 2 and 3).	• Implement the National Resource Center for Healthy Marriages and Families integration strategies for Level 1: Basic engagement through client brochures and handouts in waiting room Level 2: Engaging community members and stakeholders that teach healthy relationships. https://www.healthymarriageandfamilies.org/program-development With 90% of all clients staff to engage: • Annual Sexual Health Assessment • Open-ended questions to understand family dynamics and relationships and to ascertain perceptions regarding barriers to seeking familial participation in sexual health and general health matters • Use of skills-based communication techniques (Empty Chair Technique) to identify one goal / action client feels can assist to optimal health. • Facilitation of familial conversations ((client requested)		EMR reports from Structured data fields
Sept. 1, 2018 - August 31, 2019, with a 5% increase for each project year to August 31, 2021	• Staff education regarding teen development issues, current trends and resistances to familial involvement and resisting coercive sexual activities With 90% of all adolescents staff to engage: • Implement science-based education and counseling techniques on the benefits of delaying sex to avoid sexual risk and/or returning to a sex-free status.	APRN RN Sub recipient supervisor	1.Sign in sheets &documentation training content 2.Chart Review 3.EMR reports from Structured data fields

	• Implement science-based education/counseling related to familial participation in health and decision making and negotiation skills for resisting coercive sex. • Facilitation of familial conversations (client requested)		4. Evaluate teen utilization of services with the annual FPAR.

2018 Program Priority #2, #5, and #6; Key Issues: #5 and #6: Assuring activities that promote positive family participation, healthy decision making; education and counseling that prioritizes optimal health. Assuring compliance with state laws regarding child abuse child molestation, sexual abuse, rape, incest, intimate partner violence and human trafficking. Participation of families, parents, legal guardian in decision on minors to seek family planning and counseling to minors on how to resist attempts to coerce into engaging in sexual activities. Meaningful emphasis on education and counseling related to healthy relationships, to committed, safe, stable, healthy marriages, and benefits of avoiding sexual risk or returning to a sexually risk free state. Adolescent activities that do not normalize sexual risk behaviors and communicates research informed benefits of delaying sex, sexually risk-free state.

NEED 3: In Nevada 8.5% of infants are born with low birth weight. In Carson City 7.3% of infants are born with low birth weight and in Douglas County the rate is 7.8%.[2,13] In 2014 in Nevada, 15.2% of women of childbearing age reported binge drinking in the past month, 13% reported smoking and 24% were obese.17 These are risk factors could lead to prematurity, low birth weight, and birth defects.[17] Addressing preconception health issues prior to pregnancy is imperative in order to improve birth.

GOAL 3: Improve birth outcomes through the introduction of reproductive life planning.

Objective 3.1: 90% of women and men of childbearing age seen at CCHHS and the sub recipient site will be introduced to tools for a personal family planning, fertility, and reproductive life plan to reproductive life planning and engaged in screening and behavioral risk reduction education and actively linked to primary care as needed to improve pregnancy outcomes and optimize overall health during each year of the project period.

Objective 3.2: CCHHS and the sub recipient site will assess 90% of all clients for tobacco use and provide 90% of all tobacco users brief intervention cessation counseling and Nevada tobacco QuitLine referral in order to decrease by 3% annually those reporting tobacco usage.

TIMELINE	ACTIVITIES/ACTION STEPS	RESPONSIBLE	EVALUATION
Sept. 1, 2018 - August 31, 2019 and for each project year through August 31, 2021	• Staff training regarding reproductive life plan and preconception policy and procedures. • Assessment of the client's reproductive health plan and readiness for pregnancy.	APRN Clinic Manager Sub recipient supervisor	Documentation of staff training regarding evidence based counseling

Quarterly report review of EMR structured data: Oct., Jan., April, July of each project reporting year Sept. 1, 2018 - August 31, 2019 and for each project year through August 31, 2021	• Screen for undiagnosed or known chronic health conditions or high risk behaviors. • Active referral, appointment scheduling and follow up for clients with identified health issues utilizing primary care MOU & process. • Assess for history of or current intimate partner violence, depression and other mental health concerns • Facilitate social services and mental health referrals as outlined in Project Narrative. • Provide physical exam, pap, STD/HIV screening childbearing women per clinical guidelines. • Provision of immunizations utilizing a separate (Non-Title X Family Planning) program and fee structure. Cost centers will delineate separate expenses and revenue. This service will follow internal Immunization program policies, procedures and fee schedules along with federal VFC and 317 Guidelines. • Provide prenatal vitamins to any woman considering pregnancy. • Provide family planning per patient request. • Provide client-centered education regarding pregnancy spacing, breastfeeding and risk-reduction behaviors.		techniques. EMR reports from Structured data fields EMR reports from Structured data fields
Sept. 1, 2018 - August 31, 2019 and for each project year through August 31, 2021	• Assess client's use of tobacco products / quit readiness. • Provide tobacco prevention and cessation brief intervention and referral activities. • Annual training and evaluation of tobacco cessation efforts lead by Chronic Disease Prevention Tobacco Program Specialist.	APRN RN Chronic Disease Prevention Tobacco Program Specialist.	EMR reports from Structured data fields

2018 Program Priority #1, #2, #4, #7 and Key Issue #4: Assuring innovative high quality family planning and related health services that will improve the overall health of individuals, couples and families, with priority for services to those of low-income families, offering, at a minimum, core family planning services enumerated earlier in this Funding Announcement. Assuring that projects offer a broad range of family planning and related health services that are tailored to the unique needs of the individual, that include natural family planning methods (also known as fertility awareness based methods) which ensure breadth and variety among family planning methods offered, infertility services, and services for adolescents; breast and cervical cancer screening and prevention of STDs as well as HIV prevention education, counseling, testing, and referrals. Assuring activities that promote positive family relationships for the purpose of increasing family participation in family planning and healthy decision-making; education and counseling that prioritize optimal health and life outcomes for every individual and couple; and other related health services, contextualizing Title X services within a model that promotes optimal health outcomes for the client. Promoting provision of comprehensive primary health care services to make it easier for individuals to receive both primary health care and family planning services preferably in the same location, or through nearby referral providers, and increase incentive for those individuals in need of care choosing a Title X provider. 7. Demonstrating that Title X activities are separate and clearly distinct from non-Title X activities, ensuring that abortion is not a method of family planning for this grant. Meaningful collaboration with sub recipients and documented partners in order to demonstrate a seamless continuum of care for clients;

NEED 4: Engaging community members who access family planning services into the service delivery of family planning and related health services can build a shared understanding of the barriers that exist for our vulnerable populations. A community may often perform redundant services in which greater inefficiencies begin to occur. In building shared understanding with our community partners we will accomplish three things: 1) a method to determine what services are needed within the community; 2) a consistent approach in information dissemination; and 3) increase our abilities to reach vulnerable populations.
GOAL 4: To address comprehensive family planning and preventive health needs among families (including adolescents) and vulnerable populations by engaging community stakeholders in educational material review and community-wide outreach efforts.
Objective 4.1: CCHHS will facilitate a bi-annual client-based Information and Education Committee in December and July of each project period and evaluate 100% of family planning educational materials. Approved Educational materials will be re-reviewed every 3 years. Committee will meet guidelines as set forth in 42 CFR 59

Objective 4.2. CCHHS will create an annual marketing plan that address written and social media forms of reaching the public to educate regarding Family planning and related preventive health. CCHHS will engage four community stakeholders through our community health improvement plan and strategic planning process as well as a Title X Family Planning Advisory Board each project period to seek input on improving access to family planning and related preventive health services and implement these methods within 6 months of identification. This objective will follow guidelines as set forth in 42 CFR 59

TIMELINE	ACTIVITIES/ACTION STEPS	RESPONSIBILITY	EVALUATION
December 2018 and July 2019 and annually thereafter through 2021	• Ongoing education material evaluation for reading level and culturally sensitive content. • Complete three-part review—client review, staff review and medical review—for newly introduced educational material. • Update review of materials that were reviewed prior to 3 years. • Revision of policy as needed.	Clinic Manager (RN) I and E Committee members	Educational material review Tracking spreadsheet siting annual recommendations Policy revision
Marketing Plan by January 2019 and annually to 2021;Title X Advisory Board annually in Nov/Dec. 2018, to 2021	• Creation of annual written and social media marketing plan as outlined in project narrative • Convening Title X Advisory Board • Implement recommended interventions		

Key Issue #4 and 42 CFR 59: Meaningful collaboration with sub recipients and documented partners in order to demonstrate a seamless continuum of care for clients. Provide for informational and educational programs designed to— (i) Achieve community understanding of the objectives of the program; (ii) Inform the community of the availability of services; and (iii) Promote continued participation in the project by persons to whom family planning services may be beneficial.

Page 721 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 722 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 723 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 724 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 725 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 726 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 727 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 728 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 729 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 731 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 732 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 733 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 734 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 735 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

APPENDIX S: Sources of Information and Data Check

1. State of Nevada Department of Taxation, Population and Statistics Reports, *Population of Nevada Counties and Incorp Cities 2017 Governor's Certified Series.* Web. 5 April 2018. https://tax.nv.gov/Publications/Population_Statistics_and_Reports/
2. Source: Nevada Division of Public and Behavioral Health, Nevada State Demographer, 2017 Population Demographics, via email
3. University of Nevada, Reno School of Medicine, *Statewide Initiatives.* https://med.unr.edu/statewide/instant-atlas/county-data-map. Web. 5 April 2018
4. US Census Bureau. American Fact Finder. Web. 5 April 2018. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_S1701&prodType=table
5. American Community Survey, 2016, Estimates from Table S1101 Households / Families.
6. Nevada Department of Employment, Training and Rehabilitation. Nevada Workforce Informer. Web 5 April 2018. http://nevadaworkforce.com/Home/PAGEID/67/SUBID/117
7. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data. Web 5 April 2018 https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=CLASS07&islTopic=TOPIC29&islYear=2016&islLocation=
8. United States Census Bureau. Small Areas Health Insurance Estimates (SAHIE) Program. Web 5 April 2018. https://www.census.gov/data-tools/demo/sahie/sahie.html
9. Centers for Disease Control and Prevention. MMWR Vol (65), No (9) Sexual Identity,

Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9-12 – United States and Selected States, 2015. Web 5 April 2018. https://www.cdc.gov/mmwr/volumes/65/ss/pdfs/ss6509.pdf

10. Centers for Disease Control and Prevention. Unintended Pregnancy Prevention. Web 5 April 2018. https://www.cdc.gov/reproductivehealth/unintendedpregnancy/index.htm
11. US Teenage Pregnancies, Birth and Abortions, 2010: National and State Trends by Age, Race and Ethnicity. www.guttmacher.org. Web 5 April 2018.
12. Sonfield A and Kost K, Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010, New York: Guttmacher Institute, 2015. Web 5 April 2018
13. The Centers for Disease Control and Prevention (CDC), National Vital Statistics Reports (NVSR), Vol. 66, No. 1: Births: Final Data for 2015, January 5, 2017K.Retrieved at Henry J Kaiser Family Foundation State Health Facts. Web 5 April 2018. https://www.kff.org/statedata/?state=NV
14. Office of Disease Prevention and Health Promotion. Healthy People 2020. Web 5 April 2018. http://www.healthypeople.gov/2020/topics-objectives
15. Center for Disease Control. Morbidity and Mortality Weekly Report. 2015 Sexually Transmitted Disease Treatment Guidelines – Recommendations and Reports/Vol64/No.3, June 5, 2015. Web 4 Nov 15. http://www.cdc.gov/std/tg2015/default.htm
16. Boothe, Dustin. (2015) Nevada Sexual Transmitted Disease (STD) 2009-2014 STD MIS Database. Carson City Health & Human Services. Carson City, Nevada.
17. March of Dimes. (October 2015) Web 4 Nov. 2015. http://www.marchofdimes.org/Peristats/ViewSummary.aspx?reg=32&stop=60

18. National Vital Statistics Reports – Volume 63, Number 5 September 2014 International Comparisons of Infant Mortality and Related Factors: United States and Europe 2010.

19. Susan G Komen Northern Nevada Quantitative Data Report 2015-2019. Web. 20 April 2018. http://komennorthnv.org/grants/how-to-apply-for-community-grants/

20. Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, Department of Health and Human Services. Comprehensive Cancer Report, September 2015, Edition 1.0

Upload #3

Applicant:	Carson City
Application Number:	FPH2018008746
Project Title:	Carson City Health & Human Services Family Planning and Related Health Services.
Status:	Review in Progress
Document Title:	BudgetNarrativeAttachments_1_2-Attachments-1236-CCHHS Title X 2018-2021 Budget Narrative.pdf

BUDGET NARRATIVE
Carson City Health & Human Services – Family Planning Services: CDFDA 93.217

This descriptive Budget Narrative corresponds to the specific line item budget included in an Excel spreadsheet. Included is a specific budget for each year of the proposed 3-year project. A table at the end of each project year outlines the costs of the Total Family Planning Project per year as well as the requested Federal Title X Family Planning dollars by these categories: Personnel Salary, Personnel Fringe, Travel & Training, Equipment, Operating, Contractual and Other. The Excel Spreadsheet also denotes how to distinguish funds attributed to CCCHHS and costs related to the sub recipient. Also highlighted is the amount and percent requested in Federal Funds, the Government of other in-kind funds, Program Income and cost per unduplicated User.

TOTAL COST - Budget Year 1			(b)(4)
	FP Project Costs	Title X Grant	Title X Grant Requested amount
Personnel Salary/Wages	(b)(4)		
Personnel Fringe Benefits			
Travel &Training			
Equipment Total - N/A			
Operating Supplies Total			Program Income - client receipts, third party payers
Contractual Total			
Other Total			Unduplicated Patient Cost/Year - 3200 Users
TOTALS			

DCCH - Sub recipient	(b)(4)	Title X Federal Share
CCHHS - Grantee		Title X Federal Share

1. PERSONNEL/FRINGE

CCHHS Title X Medical Director: Responsible for oversight and leadership for the Title X Program and nurse practitioner in the family planning clinic. Reviews APRN protocols, provides random chart reviews, and participates in quality improvement processes.

Clinical Services Manager: Supervises the professional nursing staff and paraprofessional employees who provide family planning services. Coordinates scheduling and clinic activities. The Clinic Manger is responsible for the planning, developing, managing and implementing the CCHHS family planning grant goals and objectives. 66% of this position manages Title X deliverables and clinic operations at our primary clinical site and monitors the sub-grantee site. 46% is funded through local government funding and 20% is funded through the Title X grant.

CCHHS Advanced Practice Nurse (APRN): Under the direction of the collaborating physician and reporting to the Clinical Services Manager, provides direct health care for a specified patient population. Performs tasks involved in the reproductive care of adult and adolescent clients; prescribes and administers medical treatment; orders and evaluates laboratory and diagnostic

testing; counsels and educates patients; maintains accurate electronic medical record, administers prescriptions; reviews, reports, records, and general progress of patients; instructs and educates trainees and/or staff. This position is funded 100% with Title X funds.

CCHHS Advanced Practice Nurse (APRN) (Part-Time): Under the direction of the collaborating physician and reporting to the Clinical Services Manager, provides direct health care for a specified patient population. Performs tasks involved in the reproductive care of adult and adolescent clients; prescribes and administers medical treatment; orders and evaluates laboratory and diagnostic testing; counsels and educates patients; maintains accurate electronic medical record, administers prescriptions; reviews, reports, records, and general progress of patients; instructs trainees. This part-time APRN works 336 hours of her time on Title X covering Saturday hours and vacations. This position 100% funded with Title X Grant Funds

CCHHS Public Health Nurse (RN): Under general supervision, provides professional family planning services, including method initiations and refills. The RN obtains comprehensive medical/social/sexual histories, processes laboratory specimens, and educates clients on family planning issues and preventive health measures. The RN follows up w/patients regarding abnormal test results. This RN is funded 66% with Title X grant funds and 15% with in –kind.

CCHHS Public Health Nurse (RN): Under general supervision, provides professional family planning services, including method initiations and refills. The RN obtains comprehensive medical/ social / sexual histories, collects and processes laboratory specimens, and educates and counsels clients on family planning issues and preventive health measures. This position is funded 45% through local government and in-kind funds to work within the Title X Project.

CCHHS Public Health Nurse (RN) (Part-time) (Bi-lingual - Spanish): Under general supervision, provides professional family planning services, including method initiations and refills. The RN obtains comprehensive medical/ social / sexual histories, collects and processes laboratory specimens, and educates/counsels clients on family planning issues and preventive health measures. This position is funded 100 through in-kind funds for the Title X Project

CCHHS Office Specialist (Bi-lingual - Spanish): This position is responsible for processing all incoming patients. The receptionist assists clients with in-take forms, making appointments, and reviewing and monitoring of the client's Title X billing. The receptionist is bi-lingual and assists not only ESL clients who need help with required forms but also with ESL patients when this skill is needed by an RN during the exam. This position is 80% funded with Title X grant funds.

CCHHS Fiscal Analyst: Under general supervision, provides grant oversight, administration and procurement of services for funding. Conduct principles and practices of budget preparation, fiscal analysis, and statistical data analysis. This position is pad .05 FTE from Title X funds and 05 FTE from in kind revenue to work within the Title X project.

CCHHS Billing Specialist: Establishes and renews third party contracts. This position processes client and third party payments. This position is Responsible for back-end revenue cycle management and processes. 60% of this position's time is spend on Title X Family Planning, 30 Title X Funded and 30% Program Income

Fringe Benefits: Employer paid plan – (b)(4) Employer/Employee paid plan 1 (b)(4)

Fringe Benefits for the Public Employee's Retirement System are currently calculated by the percentages above. These percentages can change annually, biannually, or during other periods depending on State Legislation changes and/or other organization factors.

Insurance benefits depend on the employee's level of coverage. Benefits range from (b)(4) o $ (b)(4)

Medicare is calculated at (b)(4) and Workers Compensation Insurance is a flat rate of (b)(4) per fiscal year.

2. TRAINING/TRAVEL EXPENSES: Training expenses for the staff associated with the eCW annual National Conference and including attendance at the bi-annual Title X Administrators related to family planning.

3. SUPPLIES/ OPERATING

Medical Supplies: These funds will be used to purchase auxiliary medical and laboratory supplies necessary to operate a community clinic. Items such as onsite laboratory testing devices, control solutions, thermometer probes, gloves, table paper, client covers, and speculums are among the necessary items.

Laboratory Services: CCHHS contracts with LabCorp to process all required outside lab test including: Pap tests, blood work, biopsies and STIs, etc.

Pharmaceuticals: Pharmaceuticals include birth control - oral contraceptives, Depo-Provera, intrauterine devices, diaphragms, implants, condoms, contraceptive patch, contraceptive ring, and emergency contraceptive and prenatal vitamins. Medications utilized to treat sexually transmitted, bacterial, viral, and urinary tract infections. These medications include antibiotics, antivirals, and antifungals in oral, injectable, or cream preparations.

Social Media – Facebook promotion of family planning services and education for family planning and related health services health topics.

4. CONTRACTUAL

CCHHS Professional Services Contract: Physician Select Management will provide Internet-based software application and components hosting and delivery services related to integrated business software and clinical systems, including the application eClinicalWorks®;

CCHHS eClinicalWorks: Funds will be used to secure ongoing maintenance of our Electronic Medical Records (EMR) System including the following quarterly costs: recurring maintenance - Support, Business Optimizer, e-prescribe.

Sub recipient Advanced Practice Nurse (APRN): Under the direction of the collaborating physician and reporting to the Clinical Services Manager, provides direct health care for a specified patient population. Performs tasks involved in the reproductive care of adult and adolescent clients; prescribes and administers medical treatment; orders and evaluates laboratory and diagnostic testing; counsels and educates patients; maintains accurate electronic medical record, administers prescriptions; reviews, reports, records, and general progress of patients; instructs and educates trainees and/or staff. This position is funded 50% with Title X funds.

Sub recipient Public Health Nurse (RN): Under general supervision, provides professional family planning services, including birth control method initiations and refills. The RN initiates medical records, obtains comprehensive medical/social histories, collects and processes laboratory specimens, and educates and counsels clients on family planning issues and preventive health measures. The public health nurse provides tracking of clients with abnormal test results to ensure necessary testing and treatment. This position is 75% funded by the local government to work within the Title X Family Planning Project.

Sub recipient Public Health Nurse (RN): Under general supervision, provides professional family planning services, including birth control method initiations and refills. The RN initiates medical records, obtains comprehensive medical/ social histories, collects and processes laboratory specimens, and educates and counsels clients on family planning issues and preventive health measures. The public health nurse provides tracking of clients with abnormal test results to ensure necessary testing and treatment. This position is 50% funded by the local government to work within the Title X Family Planning Project.

Sub recipient Management Assistant: This position is responsible for processing all incoming patients. The receptionist assists clients with the in-take forms, making appointments, and reviewing and monitoring of the client's Title X billing. The receptionist is bi-lingual and assists not only ESL clients who need help with required forms but also with ESL patients when this skill is needed by an RN during the exam This position is 50% funded by the local government to work within the Title X Family Planning Project.

Sub recipient Medical Supplies: These funds will be used to purchase auxiliary medical and laboratory supplies necessary to operate a community clinic. Items such as onsite laboratory testing devices, control solutions, thermometer probes, gloves, table paper, client covers, and speculums are among the necessary items.

Sub recipient Laboratory Services: CCHHS contracts with LabCorp to process all required outside lab test including: Pap tests, blood work, biopsies and STIs, etc.

Sub recipient Pharmaceuticals: Pharmaceuticals include birth control - oral contraceptives, Depo-Provera, intrauterine devices, diaphragms, implants, condoms, contraceptive patch, contraceptive ring, and emergency contraceptive and prenatal vitamins. Medications utilized to treat sexually transmitted, bacterial, viral, and urinary tract infections. These medications include antibiotics, antivirals, and antifungals in oral, injectable, or cream preparations.

Sub recipient Title X Medical Director: Responsible for oversight and leadership for the Title X Program and nurse practitioner in the family planning clinic. Reviews APRN protocols, provides random chart reviews, and participates in quality improvement processes.

Sub recipient Professional Services Contract: Physician Select Management will provide Internet-based software application and components hosting and delivery services related to integrated business software and clinical systems, including the application eClinicalWorks®;

Sub recipient eClinicalWorks: Funds will be used to secure ongoing maintenance of our Electronic Medical Records (EMR) System including the following quarterly costs: recurring maintenance - Support, Business Optimizer, e-prescribe.

Page 745 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 746 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 747 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 748 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 749 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 750 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 751 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 752 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 753 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 754 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 755 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 756 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 757 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 758 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 759 of 957

Withheld pursuant to exemption

(b)(4):(b)(6)

of the Freedom of Information and Privacy Act

Page 760 of 957

Withheld pursuant to exemption

(b)(4):(b)(6)

of the Freedom of Information and Privacy Act

Page 761 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 762 of 957

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Upload #4

Applicant:	Carson City
Application Number:	FPH2018008746
Project Title:	Carson City Health & Human Services Family Planning and Related Health Services.
Status:	Review in Progress
Document Title:	Form AttachmentForm_1_2-V1.2.pdf

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	1234-Title X 2018-2021 Attach		Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment		
3) Please attach Attachment 3		Add Attachment		
4) Please attach Attachment 4		Add Attachment		
5) Please attach Attachment 5		Add Attachment		
6) Please attach Attachment 6		Add Attachment		
7) Please attach Attachment 7		Add Attachment		
8) Please attach Attachment 8		Add Attachment		
9) Please attach Attachment 9		Add Attachment		
10) Please attach Attachment 10		Add Attachment		
11) Please attach Attachment 11		Add Attachment		
12) Please attach Attachment 12		Add Attachment		
13) Please attach Attachment 13		Add Attachment		
14) Please attach Attachment 14		Add Attachment		
15) Please attach Attachment 15		Add Attachment		

Tracking Number:GRANT12628105 Funding Opportunity Number:PA-FPH-18-001 Received Date:May 18, 2018 06:38:07 PM EDT

Upload #5

Applicant:	Carson City
Application Number:	FPH2018008746
Project Title:	Carson City Health & Human Services Family Planning and Related Health Services.
Status:	Review in Progress
Document Title:	Form BudgetNarrativeAttachments_1_2-V1.2.pdf

Budget Narrative File(s)

* **Mandatory Budget Narrative Filename:** 1236 CCHHS Title X 2018 2021 Budget Narrative.pdf

Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative

Upload #6

Applicant:	Carson City
Application Number:	FPH2018008746
Project Title:	Carson City Health & Human Services Family Planning and Related Health Services.
Status:	Review in Progress
Document Title:	Form ProjectNarrativeAttachments_1_2-V1.2.pdf

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** 1235-Final CCHHS Title X Project Narrative 2018 Applic

Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File

Tracking Number:GRANT12628105 Funding Opportunity Number:PA-FPH-18-001 Received Date:May 18, 2018 06:38:07 PM EDT

Upload #7

Applicant:	Carson City
Application Number:	FPH2018008746
Project Title:	Carson City Health & Human Services Family Planning and Related Health Services.
Status:	Review in Progress
Document Title:	Form SFLLL_1_2-V1.2.pdf

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
4040-0013

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name:* Carson City

** Street 1:* 201 North Carson Street, Suite 3 *Street 2:*

** City:* Carson City *State:* NV: Nevada *Zip:* 89701

Congressional District, if known: 002

6. * Federal Department/Agency:

Office of Population Affairs

7. * Federal Program Name/Description:

Family Planning Services

CFDA Number, *if applicable:* 93.217

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: ** First Name:* Not Applicable *Middle Name:*

** Last Name:* Not Applicable *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

b. Individual Performing Services (including address if different from No. 10a)

Prefix: ** First Name:* Not Applicable *Middle Name:*

** Last Name:* Not Applicable *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Nicki Jimenez

***Name:** *Prefix:* ** First Name:* Nicki *Middle Name:*

** Last Name:* Baker *Suffix:*

Title: Director **Telephone No.:** 775 887 2190 **Date:** 05/18/2018

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

Table Of Contents

Applicant:	Colorado Department of Public Health and Environment
Application Number:	FPH2018008758
Project Title:	Colorado Family Planning Program
Status:	Review in Progress

Online Forms

Program Narrative

Additional Information to be Submitted

Proof of Filing

1. SF-424 Application for Federal Assistance Version 2
   - (Upload #1): SF424_2_1-1237-family_planning_clinics_October2017.jpg
   - (Upload #2): BudgetNarrativeAttachments_1_2-Attachments-1235-Combined Budget Narrative and Tables_Final May 17.pdf
   - (Upload #3): AttachmentForm_1_2-ATT1-1236-Combined Appendices 2018.pdf
   - (Upload #4): ProjectNarrativeAttachments_1_2-Attachments-1234-Project Narrative_Title X App_FINAL.pdf
   - (Upload #5): Form AttachmentForm_1_2-V1.2.pdf
   - (Upload #6): Form BudgetNarrativeAttachments_1_2-V1.2.pdf
   - (Upload #7): Form ProjectNarrativeAttachments_1_2-V1.2.pdf
   - (Upload #8): Form SFLLL_1_2-V1.2.pdf
2. SF-424A Budget Information - Non-Construction
3. SF-424B Assurances - Non-Construction
4. SF-LLL Disclosure of Lobbying Activities
5. Project Abstract Summary
6. Key Personnel
7. Budget Narrative
8. Program Narrative
9. Exhibits/Tables/Attachments
10. Negotiated Rate Agreement
11. Copy of By-Laws
12. Proof of Non-Profit Status

Note: Upload document(s) printed in order after online forms.

OMB Approval No. 4040-0006
Expiration Date: 01/31/2019

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. CDPHE Family Planning	93.217			$3,728,000.00		(b)(4)
2.						
3.						
4.						
5. Totals				$3,728,000.00		

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) CDPHE Family Planning $	(2)	(3)	(4)	Total (5)
a. Personnel		(b)(4)			
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual					
g. Construction					
h. Other					
i. Total Direct Charges *(sum of 6a-6h)*					
j. Indirect Charges					
k. TOTALS *(sum of 6i and 6j)*	$3,728,000.00				$3,728,000.00
7. Program Income					$ (b)(4)

Authorized for Local Reproduction

Standard Form 424A (Rev. 7-97)
Prescribed by OMB Circular A-102

Previous Edition Usable

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8		(b)(4)		(b)(4)
9.				
10.				
11.				
12. TOTAL *(sum of lines 8-11)*				

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$3,728,000.00		(b)(4)		
14. Non-Federal					
15. TOTAL *(sum of lines 13 and 14)*	$3,728,000.00				

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.	$3,728,000.00		(b)(4)	
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$ $3,728,000.00	$		

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:
Provisional: Basc: (b)(4) Indirect: (b)(4)

23. Remarks: Indirect costs are based on provisional rates: Subawards (b)(4) , Onsite: 2 (b)(4)

Authorized for Local Reproduction

OMB Number: 0980-0204
Expiration Date: 04/30/2015

Project Abstract Summary

Program Announcement (CFDA)
93.217

*** Program Announcement (Funding Opportunity Number)**
PA-FPH-18-001

*** Closing Date**
05/24/2018

*** Applicant Name**
Colorado Department of Public Health and Environment

*** Length of Proposed Project** 48

Application Control No.

Federal Share Requested (for each year)

* Federal Share 1st Year	* Federal Share 2nd Year	* Federal Share 3rd Year
$ 3,728,000.00	(b)(4)	
*** Federal Share 4th Year**	*** Federal Share 5th Year**	
(b)(4)	$ 0.00	

Non-Federal Share Requested (for each year)

* Non-Federal Share 1st Year	* Non-Federal Share 2nd Year	* Non-Federal Share 3rd Year
$ 0.00	$ 0.00	$ 0.00
*** Non-Federal Share 4th Year**	*** Non-Federal Share 5th Year**	
$ 0.00	$ 0.00	

*** Project Title**
Colorado Family Planning Program

Project Abstract Summary

*** Project Summary**

For the past 48 years, the Colorado Department of Public Health and Environment (CDPHE) has successfully managed the Title X grant in order to meet the family planning needs of low-income Coloradans. Looking to the future, CDPHE will build on this legacy of success by furthering its partnership with 30 delegate agencies to serve 45,000-50,000 Coloradans annually.

CDPHE's 2018-2022 proposed work plan will continue to meet the family planning needs of the state's diverse population through a variety of clinical and administrative activities that ensure Title X guidelines, priorities, and legislative mandates (42 CFR part 59, subpart A) are met. CDPHE has the knowledge of existing Title X best practices, and experience in forecasting innovative solutions for future family planning health systems. CDPHE is considered a national leader in the expanded use of long-acting reversible contraceptives, has a long track record of implementing quality and innovative programming and is consistently asked to assist other state Title X State agencies with their program work. Combined with a skilled fiscal and contracting branch that is prepared to respond to federal funding requirements, CDPHE and its partner agencies are well-positioned to efficiently utilize federal assistance in identify and meet the family planning needs of low-income Coloradans within a changing healthcare environment.

*** Estimated number of people to be served as a result of the award of this grant.** 50000

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
____ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	____ a. bid/offer/application b. initial award c. post-award	____ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: 93.217
8. Federal Action Number, *if known*:	**9. Award Amount**, *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____
Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

Approved by OMB
0348-0046

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: _____ Page 2 of 2

OMB Approval No.: 4040-0007
Expiration Date: 06/30/2014

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681- 1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93- 205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

*** SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL**	*** TITLE**
John Chase	Interim Chief Financial Officer
*** APPLICATION ORGANIZATION**	*** DATE SUBMITTED**
Colorado Department of Public Health and Environment	05/21/2018

Standard Form 424B (Rev. 7-97) Back

Key Personnel

Name	Position Title	Annual Salary	No.Months Budget	% Time	Fed Amount	Non-Fed Amount	Total Amount Requested

OMB Number: 4040-0004

Expiration Date: 08/31/2016

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission:	*2. Type of Application:	*If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

*3. Date Received:	4. Applicant Identifier:
05/21/2018	

5a. Federal Entity Identifier:	*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name:	Colorado Department of Public Health and Environment

*b. Employer/Taxpayer Identification Number (EIN/TIN):	*c. Organizational DUNS:
840644739	8782088260000

d. Address:

*Street1:	4300 Cherry Creek Drive South
Street2:	
*City:	Denver
County:	
*State:	Colorado
Province:	
*Country:	UNITED STATES
*Zip / Postal Code:	80246-1523

e. Organizational Unit:

Department Name:	Division Name:
Colorado Department of Public	Prevention Services Divsion

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:		*First Name:	Jody
Middle Name:			
*Last Name:	Camp		
Suffix:			

Title:	Colorado Title X Director
Organizational Affiliation:	CDPHE
*Telephone Number:	303.692.2301
Fax Number:	
*Email:	jody.camp@state.co.us

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (specify):

*** 10. Name of Federal Agency:**

Office of the Assistant Secretary for Health

11. Catalog of Federal Domestic Assistance Number:

93.217

CFDA Title:

Family Planning Services

*** 12. Funding Opportunity Number:**

PA-FPH-18-001

*Title:

FY 2018 Announcement of Anticipated Availability of Funds for Family Planning Services Grants

13. Competition Identification Number:

PA-FPH-18-001-061595

Title:

FY 2018 Announcement of Anticipated Availability of Funds for Family Planning Services Grants

14. Areas Affected by Project (Cities, Counties, States, etc.):

See attached file: 1237-family_planning_clinics_October2017.jpg; Mime Type: image/jpeg; Location: 696910.SF424_2_1_P2.optionalFile1;

*** 15. Descriptive Title of Applicant's Project:**

Colorado Family Planning Program

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant CO-01 *b. Program/Project CO-all

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

*a. Start Date: 09/01/2018 *b. End Date: 08/31/2022

18. Estimated Funding ($):

*a. Federal	3728000
*b. Applicant	(b)(4)
*c. State	0
*d. Local	0
*e. Other	0
*f. Program Income	(b)(4)
*g. TOTAL	

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

☐ Yes ☒ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

**The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	*First Name: John
Middle Name:	
*Last Name:	Chase
Suffix:	
*Title:	Interim Chief Financial Officer
*Telephone Number:	303-692-2023 Fax Number:
*Email:	john.chase@state.co.us
*Signature of Authorized Representative:	John Chase *Date Signed: 05/21/2018

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

Application for Federal Assistance SF-424 Version 02

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

Upload #1

Applicant:	Colorado Department of Public Health and Environment
Application Number:	FPH2018008758
Project Title:	Colorado Family Planning Program
Status:	Review in Progress
Document Title:	SF424_2_1-1237-family_planning_clinics_October2017.jpg


(b)(4)

Upload #2

Applicant:	Colorado Department of Public Health and Environment
Application Number:	FPH2018008758
Project Title:	Colorado Family Planning Program
Status:	Review in Progress
Document Title:	BudgetNarrativeAttachments_1_2-Attachments-1235-Combined Budget Narrative and Tables_Final May 17.pdf

Colorado Department of Public Health and Environment - Health Services and Connections Branch

FY 18-19 FAMILY PLANNING BUDGET--Title X

	FUNDING SDURCE				
		Indirect	STATE	Projected	TOTAL
EXPENSES	TITLE X	(b)(4) / (b)(4)%	GEN.FUND	Program Income	COSTS
PERSDNNEL					
OPERATING					
Travel					
Equipment					
Educational Supplies					
Office and Data Supplies					
Subtatal Operating					
CDNTRACTS					
(b)(4)					
Subtatal Cantracts					
OTHER					
Training, Dues, Subscriptions, Conference					
DIRECT CHARGES - TDTALS					
CDPHE INDIRECT CHARGES					
GRAND TOTALS - DIRECT PLUS INDIRECT	**$3,728,000**		(b)(4)		
	$3,728,000		*10 % cost sharing*		

(b)(4)

Federal Title X 2018-2019 Budget				2018-2022 Projected Budget
Description	**Cost**	**Description**	**Leverage support through state and grant funds**	**Multi Year Budget Narrative September 2018 to September 2022**
Personnel and Fringe Benefits: Division Costs	(b)(4)	The Division Administrative Cost Pool includes the resources needed to perform the critical functions, programs, and initiatives required by the Prevention Services Division (PSD) to effectively meet our mission, remain competitive as a grant recipient, and assure that our Division's financial and contracting activities comply with state and federal laws. The funds are distributed to the following functions: The Fiscal, Contracts, Compliance, and Operations Branch is a team of fiscal, contracting, and purchasing officers who provide fiscal services and support for PSD grants. The officers are responsible for ensuring federal and state fiscal rule compliance, tracking the collection and expenditures of all funds, processing of contracts and purchase orders, budget tracking, reconciliation and monthly projections. In addition, the branch maintains a compliance monitoring unit for grant sub-recipient fiscal monitoring. The branch also provides administrative support for HR processes, centralized supply room, and other common services throughout the division. The Communications Unit plans and manages marketing campaigns to support policy and environmental change and positive health behaviors, uses media relations to increase visibility of key public health messages and information, provides quality improvement for written communications products, manages the Division's website and builds technology and communications capacity among Division staff. The Policy, Systems and Analytics Group works on developing effective public health policies with the legislature on issues impacting the PSD, including issues of funding. Work performed is complex, involving different levels of government, numerous stakeholders with diverse needs and interests, and the need to manage scientific uncertainty. The Group promotes an understanding of public health policy, ultimately helping PSD work with policy- and decision-makers effectively to accomplish our goals for public health. Costs related to these services were previously charged as a percentage of total direct costs. Based on a comprehensive analysis of the use by each program of Administrative Services, each program within PSD has been asked to fund a proportional portion of the total costs. This equates to an increase in this budget category for some programs and a decrease for others.	$0.00	Roughly the same amount for the four year project period.
Personnel and Fringe Benefits: Evaluation	$0.00	The **Health Surveys and Evaluation Branch** is responsible for planning, evaluation and data analysis for the PSD. A program evaluator and an epidemiologist will be assigned to the Family Planning Unit to address the program's various surveillance and evaluation needs, including the Women Without Insurance assessment for the state and individual counties and the annual Title X funding formula. EPE will devise a framework to evaluate the impact of the Family Planning Program, using existing data from the Behavior Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS). The budget estimate is based upon projected staff time allocation for the Family Planning Unit.	(b)(4)	Roughly the same amount for the four year project period.
Personnel and Fringe Benefits: Informatics	$0.00	The **Public Health Informatics (Informatics) Unit** works alongside public health practitioners to strategically and effectively apply and manage information systems. Informatics is responsible for maintaining usability, supporting test environments, designing reports, and resolving data issues as well as implementing design modifications for the electronic data system resulting from changes in program data requirements.		Roughly the same amount for the four year project period.

Personnel and Fringe Benefits: Statistics	$0.00	The **Health Statistics Section** promotes understanding and utilization of health status information through the collection, analysis, and dissemination of vital event and health survey data. The section is comprised of the Vital Statistics Unit, Maternal and Child Health Surveillance Unit, Survey Research Unit and Public Health Informatics Unit. (b)(4) a question x 3 questions on the BRFSS.	(b)(4)	Roughly the same amount for the four year project period.
Personnel and Fringe Benefits: Family Planning Staff	(b)(4)	Personnel costs reflect salaries for **CDPHE Family Planning Unit staff**. This includes a portion of the Branch Director's salary (Yharra), Unit Manager (Camp), a Nurse Consultant (Fellers-LeMire), a Family Planning Coordinator (Franklin) and a quarter-time program assistant position. Ad-hoc contractors are included in this line item, as well. Salaries are based on last year's salaries allow with a 3% increase included for salary increases. Fringe benefits include Public Employees Retirement Association health, dental and life insurance (as chosen by the employee); short term disability insurance and Medicare Amounts.	(b)(4)	Roughly the same amount for the four year project period.
Travel	(b)(4)	Travel cost estimate	$0.00	Roughly the same amount for the four year project period.
Equipment	$0.00	No planned Equipment costs	$0.00	We don't anticipate equipment to be purchased with Federal funds.
Educational Supplies	(b)(4)	Title X funds will be used to purchase books for clinicians, CDs, videos, and English and Spanish pamphlets that provide a comprehensive overview of birth control methods, emphasizing LARC, as part of the training, technical assistance and outreach materials for delegate agencies.	$0.00	Roughly the same amount for the four year project period.
Office and Data Supplies		Cost estimates include in general office supplies, including computer equipment, and meeting and conference supplies. This includes the shared, PSD supply room costs of (b)(4)	(b)(4)	Roughly the same amount for the four
Contractual		Title X funding will retain a board-certified obstetrician-gynecologist physician for consultation regarding state family planning policies and procedures. Title X funding will be used to hire trainers for such topics as adolescent issues, sexual risk avoidance, clinic efficiency, CPT coding, preconception counseling, reproductive life plans, Human Trafficking and/or contraceptive updates. Title X funding may be used to hire a temporary contractor to assist on time-limited projects such as quality assurance reviews and Male training. This budget also includes funds for Department of Corrections contraceptive access project.		Roughly the same amount for the four year project period.
Other		Title X funding will support subscriptions, memberships (NFPRHA $5,000), periodicals from professional organizations, and training registration fees and continuing education for Family Planning staff members specific to program responsibilities. This also includes staff training costs for leadership programs such as The Regional Institute for Health and Environmental Leadership (RIHEL). The majority of this line item will be used to support the Title X. Family Planning Conference.	$0.00	Roughly the same amount for the four year project period.
Contracts		Sub-recipient / Vendor contracts for Title X work. In 2018-2019, we will contract with 30 delegate agencies to provide Title X clinical, educational and counseling services to approximately 42,000 women and men in Colorado.	(b)(4)	Dependent of Federal Title X funding. Requesting 5% increase annually for next three years.

Indirect	(b)(4)	Using CDPHE's federally 2017-2018 negotiated indirect cost rate. (b)(4) % in indirect costs have been assessed on on-site direct costs. An off-site rate of 1.1% has been applied to the subcontract total.	$0.00	This is variable each year and dependent on approval by the Federal Government for the IDC
Leverage		Projected Income (from delegates) used for purpose of Title X such as Medicaid and insurance reimbursement, gifts, grants and donations. client fees and county contributions.	(b)(4)	Roughly the same amount for the four year project period.
TOTAL	**$3,728,000.00**	**Budget for 2018-2019**	**$3,372,800.00**	10% cost sharing plus sub recipient program income from contracts.

2018-2019 Itemized Travel Budget / Justification

FY18-19 (July 2018 - June 2019)	Location	Mileage	Hotel	PerDiem	Misc parking, taxi	
Administrative Site Visits						
(b)(4)						
Clinical Site Visits					$ 10.00	
(b)(4)						
		(b)(4)				
	Subtotal mileage x (b)(4) cents					

		Flights				
NFPRHA in Atlanta in September						
(b)(6)		$	(b)(4)			
		$				
		$				
NFPRHA in DC in March						
(b)(6)		$				
		$				
		$				
Title X in Kansas City in July						
(b)(6)		$				
Contraceptive Technology San Francisco						
(b)(6)		$				
Work Related Conference						
(b)(6)		$				
		$				
		$				
Clinical Trainings		$				
Misc Mileage		$				
Misc Hotel						
	Subtotal	$				
	TOTAL	$			$	(b)(4)

Detailed Budget & Budget Narrative for CDPHE FPP Sub-Recipients

2018-2019

	Name of Sub-Recipient	Total Project Award for 2018-2019	Federal Award for 2018-2019	State Award for 2018-2019
1	(b)(4)			
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				

23	(b)(4)
24	
25	
26	
27	
28	
29	

Detailed budgets not available at this time. The nature of the work to be delegated is as follows:

In addition to providing high-quality, client-centered contraceptive counseling, delegate agencies are required to provide a broad range of medically approved family planning methods including, at a minimum, all CDPHE Title X providers must provide (onsite or by referral):

- At least three types of combined oral contraceptives;
- A progestin only oral contraceptive;
- The 3-month progestin only injection;
- One type of hormonal long-acting, reversible contraceptive method;
- One type of non-hormonal long-acting, reversible contraceptive method;
- One non-pill hormonal method such as the patch or vaginal ring;
- One barrier method;
- Condoms and spermicidal products;
- Fertility awareness-based methods (natural family planning), including, but not limited to, Standard Days Method®, sympto-thermal method, Marquette method, and Billings Ovulation method (cervical mucous method).

- Pregnancy testing and counseling is a core family planning service offered onsite at all.

Many delegate agencies choose to offer a much broader range of methods and services beyond those included on this list. CDPHE Title X agencies.

- Abortion is not considered a method of family planning and is not part of Title X services.

Delegates must offer all family planning and related preventive health services to ensure optimal care for clients, with referral to primary and specialist care, as needed. The 2011 American College of Obstetricians and Gynecologists and HRSA-supported Women's Preventive Service Guidelines list the following services that women should be included in all family planning visits:

- Well-woman visits;
- contraceptive counseling and follow-up care;
- STI and HIV counseling and screening;
- cervical cancer screening;
- breast cancer screening;
- interpersonal and domestic violence screening.

CDPHE FPP delegate agencies utilize the QFP clinical pathway of family planning services to assess client's need for services. This pathway includes 1) Reason for visit 2) Does the client have another source of primary care 3) What is the client's reproductive life plan, and 4) Does the client need preconception health services, STD services or other related preventive health services. Of the services listed above, the following are CDPHE FPP's required elements of each service:

- **STI and HIV:** All clients complete an assessment and history of STI risk as part of the initial, annual, and/or interim FPP visit. STI risk reduction is discussed as indicated. All clients under 25 years of age are offered Chlamydia and gonorrhea testing.
- **Cervical cancer:** Cervical cancer screening is required of all FPP delegate agencies.

Delegate agencies follow nationally recognized cervical cancer screening guidelines. Starting at age 21 years, women are screened with a Pap test every three years and women 30 years and older have the option of a Pap test with HPV screening every 5 years. A pelvic exam may also be provided following shared decision-making between client and provider.

- **Breast cancer:** Delegate agencies follow nationally recognized breast cancer screening guidelines for the early detection of breast cancer (i.e. ACOG, ACS, USPSTF, and ACR). Clinical breast exams may be provided every one to three years, starting at age 20, for asymptomatic women at low risk for breast cancer.
- **Preconception health:** Preconception health is a routine part of family planning visits, and focuses on establishing a reproductive life plan. An initial assessment of a client's plan for pregnancy is elicited through asking the One Key Question®.
- **Other, recommended, but optional services:** Other preventive health services may also be available onsite or by referral, including, but are not limited to lipid disorders management, skin cancer screening, colorectal cancer screening, osteoporosis evaluation and management, mental health assessments, and non-sexual health risk behavior screenings.

The process for Selecting delegate agencies if featured in the response to question # 13 of the Program Narrative.

Plan for Oversight of Federal Award Funds

How your organization will provide oversight of federal funds and how award activities and partner(s) will adhere to applicable federal award and programmatic regulations. And organizational controls that will ensure timely and accurate submission of Federal Financial Reports to the OASH Office of Grants Management and Payment Management Services as well as timely and appropriate withdrawal of cash from the Payment Management System.

The CDPHE Fiscal, Contracts, Compliance and Operations unit oversees the preparation of contracts and purchase orders following state fiscal rules and procurement processes, monitors compliance with federal and state financial regulations by delegate agencies, and provides technical assistance for delegate agencies regarding financial issues. Staff implements budgets, approves expenditures, prepares financial reports, and monitors spending. In addition, the FPP has built a strong quality assurance system that includes a team of fiscal experts that perform onsite and desk audits of all contractors fiscal practices, physical site visits, medical record audits, periodic data report reviews through the iCare database, sliding fee scale and cost-analysis annual verification, mandatory delegate trainings, review of annual client satisfaction surveys, and a series of other checks.

The organizational systems that demonstrate effective control over and accountability for federal funds and program income, compare outlays with budget amounts, and provide accounting records supported by source documentation.

CDPHE FPP financial policies and procedures are determined by the Colorado Department of Personnel and Administration, State Controller's Office, Division of Finance and Procurement, Fiscal Rules, State of Colorado Procurement Code, Title X Administrative Manual, Accounting Section, and the CDPHE Accounts Payable Manual. The Family Planning Unit Manager, branch fiscal officers, and CDPHE Accounting, Purchasing, Contracts, and Budget Sections staff are responsible for appropriately dispersing and accounting for Title X funds, and ensuring there is an extraordinary separation of duties and internal controls. Title X federal requirements are incorporated at every level of policy and procedures. FPP staff work closely with FCCO unit to analyze, track and monitor the separation of Title X from non-Title X funds using the following reporting tools:

- **Monthly Invoice:** CDPHE works on a cost reimbursement model. Invoices from delegates are submitted monthly and reviewed to ensure that agencies request reimbursement and are paid for approved and appropriate costs only.
- **Site Visits:** During administrative site visits, staff verifies that family planning income, including client fees and donations, are only used for program purposes by reviewing delegate policies on donations, review charts, patient master bills, receipts and clients billing spreadsheets.
- **Financial Risk Monitoring System (FRMS):** Title X delegates are subject to CDPHE's Financial Risk Monitoring System (FRMS). FRMS is a standardized process to assess a contractor's risk of noncompliance with contractual fiscal requirements. Additionally, the system improves fiscal monitoring throughout the department by establishing standardized practices at the department and program level and utilizes a standardized invoice form. Delegates are monitored through random samplings of paid invoices and supporting documentation. Monitoring is conducted by FRMS expert staff based on risk level. Delegates rated as "high risk" are monitored more frequently than "low risk".
- **Annual Time and Effort:** The U.S. Office of Management and Budget (OMB) has established standards and principles for determining cost for federal awards through grants, cost reimbursement contracts and other agreements. Delegate agencies are required to comply with time and effort reporting, using these OMB guidelines.

For any program incentives proposed, the specific internal controls that will be used to ensure only qualified participants will receive them and how they will be tracked.

Not applicable.

Upload #3

Applicant:	Colorado Department of Public Health and Environment
Application Number:	FPH2018008758
Project Title:	Colorado Family Planning Program
Status:	Review in Progress
Document Title:	AttachmentForm_1_2-ATT1-1236-Combined Appendices 2018.pdf

Title X Work Plan 2018-2022
September 2018 to September 2022

Year 1 of 4-Year Grant

GOAL 1: Assure the CDPHE Family Planning Program is following the CDC's Quality Family Planning document and training its statewide network of delegates on family planning best practices.

Objective 1: Decrease the rate of unintended pregnancy for women 15-44 in Colorado from 28.5 in 2017 to 26.0 in 2022

	Specific Activities	Measurement	Timeline	Responsibility
1.1	Provide quality family planning services to 50,000 clients annually.	The number of clients served reported in iCare data and the Family Planning Annual Report (FPAR).	September 2018 to September 2022	Informatics
1.2	Ensure Title X delegate agencies are clinically prepared to serve Title X clients by providing at least two trainings or clinical training opportunities based on Title X program requirements.	Summary of trainings offered each year. Agency representation for required trainings.	September 2018 to September 2022	Nurse Consultant
1.3	Provide Title X orientation trainings, as needed, but no less than one, for Title X Coordinators and staff.	A list of orientations by type each year.	September 2018 to September 2022	Unit Manager and Nurse Consultant

	Specific Activities	Measurement	Timeline	Responsibility
1.4	Provide unintended pregnancy rate expressed as the number of unintended pregnancies per 1,000 women 15-44. Unintended includes births desired later or not at all or where the mother responded she was not sure, plus reported induced terminations of pregnancy.	(Number of unintended births based on PRAMS data plus number of induced terminations of pregnancy from CDPHE vital statistics, ages 15-44) / Number of women 15-44; percent calculated each year.	September 2018 to September 2022	Health Surveys and Evaluation Branch, CDPHE

Objective 2: Each year through September 30, 2022, 95 percent of Title X agencies will provide the following to clients under the age of 18 seeking family planning services: 1) Counseling that encourages family involvement in decisions regarding sexuality and contraception, 2) information about sexual coercion, and 3) services provided in compliance with mandatory reporting laws.

	Specific Activities	Measurement	Timeline	Responsibility
2.1	Provide technical assistance and resources to delegate agencies in the three stated areas through meetings, Nursing and Administrative site visits and orientations.	List of agencies, site visit dates, orientations and topics covered each year. Percentage of agencies providing counseling, sexual coercion and services to clients under age 18 each year. Summary of technical assistance and resources provided through meetings.	September 2018 to September 2022	Nurse Consultant

	Specific Activities	Measurement	Timeline	Responsibility
2.2	Provide information regarding training opportunities and resources related to adolescent counseling and adolescent health care such as 1) Counseling that encourages family involvement in decisions regarding sexuality and contraception, and 2) information about sexual coercion.	Description of training and resources information provided each year.	September 2018 to September 2022	Nurse Consultant
2.3	Ensure all delegate agencies are up-to-date with Colorado mandatory reporting laws during each project period through the clinical site visit activity and training opportunities.	Percent of agencies that received a clinical site visit and confirmation that their mandatory reporting training of staff is up-to-date. Summary of technical assistance and resources provided through meetings.	September 2018 to September 2022	Nurse Consultant

Objective 3: Ensure that 85 percent of total clients will be at or below 150 percent of the Federal Poverty Level (FPL) and/or age 19 or less.

	Specific Activities	Measurement	Timeline	Responsibility
3.1	Encourage delegate agencies to recruit, serve and retain clients who are at or below 150 percent of FPL and/or 19 years or younger.	Percentage of clients at or below 150 percent FPL. Percentage of clients age 19 or under in the iCare data base.	September 2018 to September	Informatics

	Specific Activities	Measurement	Timeline	Responsibility
			2022	
3.2	Provide teen friendly training materials to delegate agencies to ensure their clinics systems are inclusive of younger clients.	Summary of content and resource provided.	September 2018-2019	Nurse Consultant

Objective 4: Over the course of the project period (2018-2022), 95 percent of delegate agencies will attend training that incorporates The Office of Population Affairs (OPA) Title X program priorities and key issues.

	Specific Activities	Measurement	Timeline	Responsibility
4.1	Provide training information and resources for providers and clinic staff on OPA priorities and key issues such as natural family planning methods, updates on OPA performance metrics, and sexual risk avoidance education and counseling to adolescents These trainings will change annually, based on stated interests of OPA. In 2018-2019, CDPHE FPP will provide training information and resources on OPA Priority #1, Natural Family Planning methods and counseling, OPA Priority #6, Family Involvement in	List of delegate agencies, with trainings and content each year. Percentage of agencies attending trainings. Summary of trainings, content and resources provided.	September 2018 to September 2022	Nurse Consultant

	Specific Activities	Measurement	Timeline	Responsibility
	Decision Making and OPA Key Issue # 5, Sexual Risk Avoidance.			

Goal 2: Improve the reproductive health of individuals and communities by partnering with community-based, faith-based and other service providers working with vulnerable or at risk populations.

Objective 5: Each year through September 30, 2022, 95 percent of delegate agencies will connect with one new group, throughout the state, to increase the visibility of their family planning programs.

	Specific Activities	Measurement	Timeline	Responsibility
5.1	Title X delegate agencies will engage with at least one community group to share Title X information. Delegates will be encouraged to strengthen existing linkages and/or create new networks and raise visibility.	List of delegate agencies and associated community groups. Percentage of agencies that connected with at least one community group.	September 2018 to September 2022	Unit Manager and delegates
5.2	Delegates will provide information or training on birth control basics, family planning Medicaid coverage or other reproductive health topics to at least one	A summary of trainings provided to community groups.	September 2018 to September	Unit Manager

	Specific Activities	Measurement	Timeline	Responsibility
	community partner.		2022	
5.3	Collaborate with the Colorado Department of Corrections (DOC) to explore partnerships in the areas of inmate education and counseling in family planning, breast and cervical cancer screenings and heart health.	Summary of DOC activities during the program year.	September 2018-2019	Program Coordinator

Goal 3: Monitor delegate quality of services and enhance clinical and administrative management of the Title X program in Colorado

Objective 6: Each year through September 30, 2022, 95 percent of delegate agencies will receive training and resources regarding quality care and healthcare business practices.

	Specific Activities	Measurement	Timeline	Responsibility
6.1	Require an updated cost setting activity and updated sliding fee scale every three years. Provide training, coaching and technical assistance, if requested.	Description of training sessions.	September 2018 to September 2022	Unit Manager
6.2	Conduct administrative, medical and chart audit visits to delegate agencies as a quality assurance activity. Provide technical assistance to sites in need of	Number and description of quality assurance activities, such as site visits and chart audits,	September 2018 to September	Unit Manager, Nurse Consultant

	Specific Activities	Measurement	Timeline	Responsibility
	corrective measures.	completed each year.	2022	
6.3	Delegates to administer a client satisfaction survey one time during the project period, using results to improve or refine business practices when applicable.	Percentage of agencies with surveys administered.	September 2018 to September 2022	Unit Manager
6.4	The FPP staff will attend at least one conference related to Title X best practices and share information learned with delegate agencies.	List of staff and number of trainings/conferences attended each year. Percentage of staff attending at least one conference.	September 2018 to September 2022	CDPHE staff

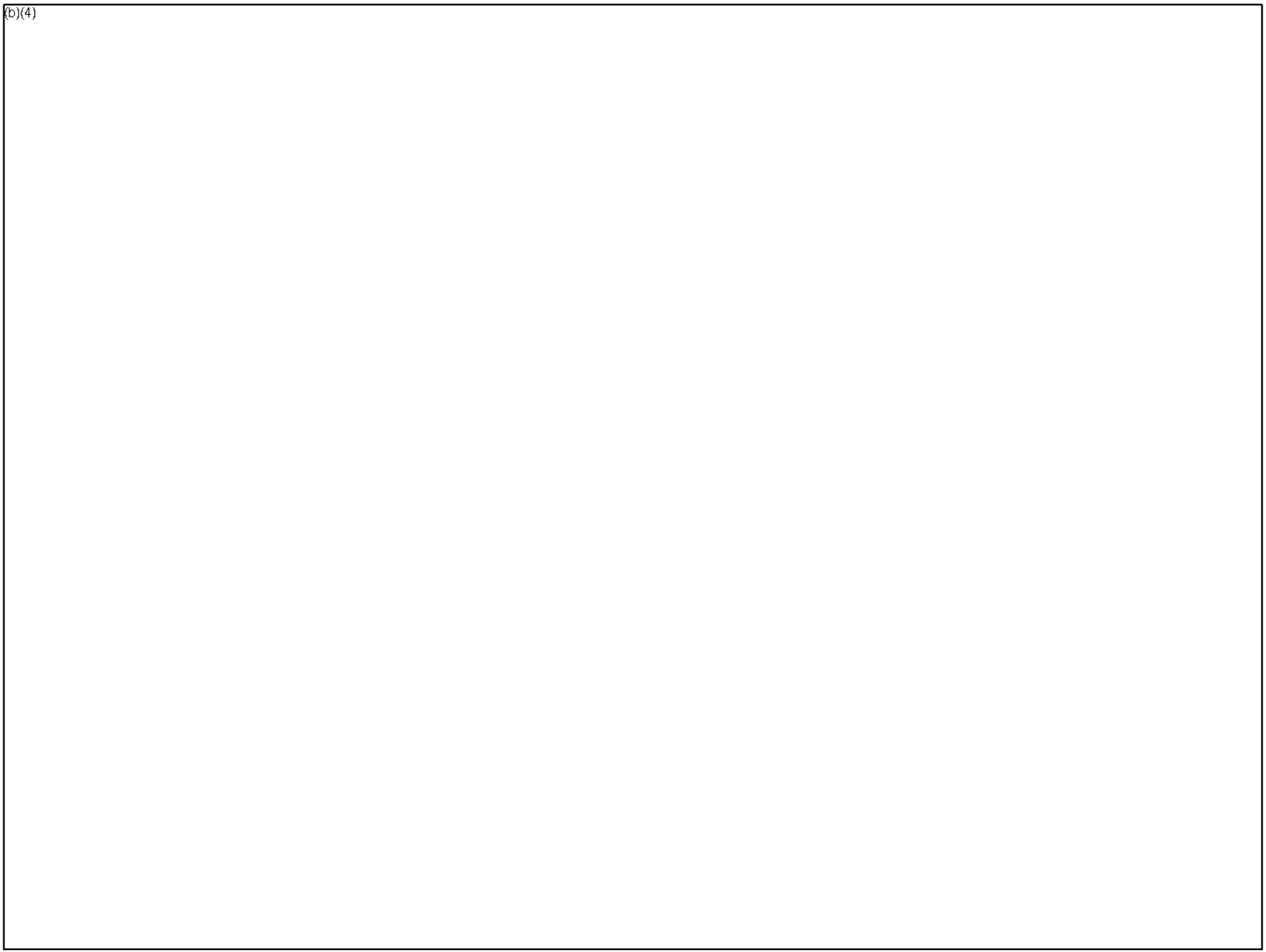
Goal 4: Family planning delegate agencies adapt to the changing health care environment and improve clinic business practices.

Objective 7: Each year through June 30, 2022, Title X agencies will increase total clinic revenue from Medicaid and 3rd party payors by one percentage point.

	Specific Activities	Measurement	Timeline	Responsibility
7.1	Provide delegate fiscal trainings, clinic assessments and coaching to improve reimbursement.	Use of Annual Expense/Revenue Report to determine percentage	September 2018 to	Unit Manager

	Specific Activities	Measurement	Timeline	Responsibility
		point increase each year.	September 2022	
7.2	Host an annual Title X delegate conference where new and innovative Title X related information is presented and discussed. Trainings to include current and effective business practices for health clinics.	Description of activities, date and content of conference.	September 2018 to September 2022	Unit Manager
7.3	Assure collaboration between the family planning unit and the Colorado Department of Health Care Policy and Financing (HCPF) to improve access to reproductive health services among the Medicaid-covered population.	Description of contacts made between FPP and HCPF.	September 2018 to September 2022	Unit Manager

(b)(4)



Page 239 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 240 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 241 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 242 of 957

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Section 1: Family Planning Health Care Services

Comprehensive Sexual Health History and Requirements

Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. (World Health Organization, 2002)

Musts: comprehensive history all clients; wt., ht., BMI ; BP; staff must stress the importance of and provide for health maintenance screening, including breast exam if appropriate; cervical cancer screening if appropriate; CT/GC screening for women 24 and younger, one screening test annually; high quality comprehensive counseling and education regarding the chosen contraceptive method

A. Introduction

1. Health care service policies are based on Providing Quality Family Planning Services, Recommendations of the CDC and the US Office of Population Affairs (QFP), Male Training Center for Family Planning and Reproductive Health, Preventive Male Sexual and Reproductive Health Care: Recommendations for Clinical Practice, and the Program Requirements for Title X Funded Family Planning Projects. National guidelines and recommendations do not replace clinical judgment based on individual circumstances of the client.

   http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/qfp.htm

   http://www.hhs.gov/opa/program-guidelines/program-requirements/

   https://www.hhs.gov/opa/title-x-family-planning/preventive-services

   https://www.fpntc.org/

   http://www.maletrainingcenter.org/wp-content/uploads/2014/09/MTC_White_Paper_2014_V2.pdf QFP Mobile App

   http://fpntc.org/training-and-resources/quality-family-planning-services-mobile-app

   Refer to the family planning and related preventive health services checklists for men and women regarding service recommendations.

   http://fpntc.org/resources

2. Family planning services include contraceptive services, pregnancy testing and counseling, achieving pregnancy, basic infertility services, preconception health, sexually transmitted infection services. Breast and cervical cancer screening are related preventive services and are required services. These service delivery topics are covered in separate sections of the clinical manual.

3. Other preventive health services for men and women such as screening for lipid disorders, colorectal cancer or osteoporosis are not covered in the QFP or CDPHE clinical manual. These other preventive health services may be offered on site or by referral.

4. Service sites must develop and implement plans to address the related social service and medical needs of clients as well as ancillary services needed to facilitate clinic attendance.

5. Title X family planning services were established to assist individuals in determining the number and spacing of their children through the provision of affordable voluntary family planning services (Program Requirements pg. 5). Clients may not be coerced to use contraception or to use any particular method of contraception. Service sites may not coerce anyone to undergo an abortion or sterilization procedure and staff may be subject to prosecution if they coerce or try to coerce any person to undergo an abortion or sterilization procedure. A client's acceptance of family planning services must not be a prerequisite to eligibility for or receipt of any other services, assistance from, or participation in any other program that is offered by the grantee or sub-recipient. Clinical protocols should include a written statement to this effect.

6. Services must be provided without imposing any durational residence requirements or a requirement that the client be referred by a physician for services.

7. Services must be provided without regard to religion, race, color, national origin, disability, age, sex, number of pregnancies or marital status.

8. Current (i.e. updated within the past 12 months) clinic protocols state that the following services will be offered to female, male and adolescent clients: high quality contraceptive counseling and education and contraception, pregnancy testing and counseling, services to assist with achieving pregnancy, basic infertility services, STD services, and preconception health services. Further, that breast and cervical cancer screening will be offered to female clients, and services will be offered to male clients in accordance with QFP.
9. The QFP encourages using a client centered approach to providing services. A client centered approach includes respecting the client's primary purpose for their visit; providing confidential services; offering a broad range of contraceptive methods; and delivering services in a culturally competent manner to meet the need of all clients including adolescents, those with limited English proficiency, racial and ethnic minorities, those with disabilities and those who are lesbian, gay, bisexual, transgender, or questioning their sexual identity (LGBTQ).
10. Clinical pathway of family planning services: Assess client's need for services (QFP pg. 5)
    a. Reason for visit
    b. Does the client have another source of primary health care
    c. What is the client's reproductive life plan
    d. Does the client need preconception health services, STD services or other related preventive health services
11. A medical history must be taken to ensure that the methods of contraception being considered by a client are safe for the client to use. In addition to contraceptive safety, the following comprehensive history for men and women includes health

conditions to assess for preconception care services, infertility services, sexual health, and related family planning services.

12. The delivery of preconception, STI, and related health services should not become a barrier to a client's ability to receive contraceptive services. Receiving contraceptive or achieving pregnancy services is a priority. If other family planning services cannot be delivered at the initial visit, then follow-up visits should be scheduled. (QFP pg. 7)
13. Services should include development and integration of male-focused family planning and reproductive health services. Research shows that young men recognize unintended pregnancy, STDs and HIV/AIDS as serious concerns and acknowledge that prevention is a joint responsibility with their partner(s). It is important to include questions about their reproductive life plan during their visit.
14. The medical director or physician responsible for the service site(s) must sign the CDPHE clinical manual.

B. A comprehensive history must be obtained for all clients

1. Assess <u>all</u> clients for their reproductive life plan. Use the One Key Question®, "Would you like to become pregnant in the next year?" or "Are you planning a pregnancy in the next year?" to make an initial assessment of a client's plans for pregnancy and contraceptive needs. You may also consider asking the question, "Do you have a sense of what is important to you about your method?" This question explicitly focuses on client contraception preferences in the shared decision making process.
2. To ensure obtaining a comprehensive sexual health history and sexual health assessment, including behavioral practices, use A Guide to Taking A Sexual History (HHS and CDC), the 5 "P"s of Sexual Health, and OPA's "Conducting a Sexual Health Assessment".
3. Relevant family history to include breast or uterine cancer, history of myocardial infarct, stroke, or thromboembolitic disorder before age 50, diabetes or other chronic or serious disorder, such as hypertension.
4. Gynecologic history, including age of menarche, date of last normal menstrual period, history of dysmenorrhea, hypermenorrhea, oligomenorrhea, polymenorrhea, intermenstrual bleeding, post-coital bleeding, dyspareunia, previous history of pelvic infection, sexually transmitted infections, or vaginal discharge, date of last Pap test and any abnormal Pap tests and follow up, infertility or difficulty conceiving, or prolonged time from discontinuing birth control to conceiving a pregnancy. For men: urological conditions, infertility or difficulty conceiving.
5. Obstetric history covering gravidity, parity, pregnancy outcome, i.e., number of abortions (spontaneous or induced), ectopic pregnancies, premature deaths, living children, breastfeeding status, and intervals between pregnancies. Specific complications of pregnancies should be recorded. For partners: pregnancy and parenthood status.

   Medical and surgical history - special emphasis on systemic review:

   a. Cardiovascular history, including peripartum cardiomyopathy
   b. Thromboembolic disease
   c. Hypertension (essential or malignant)
   d. Vascular or migraine headaches with pertinent neurological aura
   e. Rheumatic disease such as systemic lupus erythematosus (SLE)

f. Neurologic/visual disturbances

g. Metabolic history

1) Diabetes, prediabetes, or gestational diabetes

2) Hepatic disease

3) Hyperlipidemia

4) Thyroid disorders

5) Gall bladder disease

6) Bariatric surgery

7) Inflammatory bowel disease

h. Cancer (potential or confirmed) history

1) Diagnosed or suspected breast cancer

2) Diagnosed or suspected reproductive tract cancer

i. Neurologic history

1) Psychiatric disorders such as depression, anxiety, bipolar disorder, etc.

2) Epilepsy

j. Hematologic history

1) Hemoglobinopathies (e.g., Sickle cell trait or disease, thalassemia)

2) Blood dyscrasias

k. Genito-urinary history

1) Renal disease

2) UTI

l. Previous contraceptive use and any problems with method.

m. Client's plans for any future pregnancies and when.

n. Sexual history- Use the five "P"s of sexual health (partners, practices, protection from STDs, past history of STDs, and prevention of pregnancy) to guide the discussion.

1) Review of recent sexual activity

2) Time since last sexual encounter

3) Number of partners and any new partners in the last 60 days

4) Vaginal, rectal or pharyngeal exposure

5) Gender of sexual partners

6) Current STI symptoms and history of STI

7) Illness or evidence of STIs in recent partners

o. History of or risk for sexually transmitted infections, including Hepatitis B and HIV, including client or partner history of IV drug use, multiple partners, bisexuality

p. History of intimate partner violence (IPV)

q. History of substance misuse or abuse, including opioids

r. History of smoking/tobacco use and marijuana use

s. Immunization for mumps, measles, rubella (MMR), tetanus, pertussis, varicella, hepatitis B, Human Papilloma Virus, and annual flu vaccine.

t. Nutritional history.

u. Allergies.

v. Current medications, prescription, non-prescription or herbal.

C. Periodic health assessment for women and female to male transgender individuals

Most individuals will need no or few examinations or laboratory tests before starting a method of contraception. Unnecessary medical procedures and tests might create a barrier to contraceptive access for some women, especially adolescents. Exams and tests not routinely needed to safely start a healthy client on a contraceptive method are: pelvic exams, unless inserting an IUC or fitting a diaphragm; breast and cervical cancer screening; HIV screening; lipid, glucose, liver enzymes, and hemoglobin tests (QFP pg. 11). These exams and tests may be needed to address other health concerns though.

The following are guidelines for the periodic health examination. Guidelines should never be a substitute for sound clinical judgment. References used in preparing these guidelines include:

American College of Obstetrics and Gynecology (ACOG) Well-Woman Visit, Committee Opinion No. 534, August 2012, Reaffirmed 2014

STI services, including HIV testing, are one of six core family planning services which also include contraceptive services, pregnancy testing and counseling, achieving pregnancy, basic infertility services, and preconception health. (Providing Quality Family Planning Services Recommendations of the CDC and the US Office of Population Affairs (QFP). http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf Pages 17-20). Providers should consult the Centers for Disease Control and Prevention (CDC). Sexually Transmitted Diseases Treatment Guidelines, 2015 (CDC STD Guidelines 2015). MMWR 2015; 64 (No. 3). http://www.cdc.gov/std/tg2015/default.htm and updates to the Guidelines for STI diagnosis and treatment information.

A treatment app provides easy access to updated treatment and alternative treatment regimens: http://www.cdc.gov/std/tg2015/default.htm

Other resources:

- Denver PTC https://www.denverptc.org/
- CDPHE https://www.colorado.gov/pacific/cdphe/dceed
- HIV/AIDS Treatment, Prevention and Research http://aidsinfo.nih.gov/
- Information and resources http://www.aids.gov/ , http://www.cdc.gov/hiv/ , http://aidsvu.org/ , http://www.cdc.gov/hiv/basics/prep.html
- National HIV/AIDS Strategy Updated to 2020 https://www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/index.html
- CDC STD web site includes client handouts http://www.cdc.gov/std/
- Mountain and Plains AIDS Education Center, HIV education and resources for healthcare professionals
- UCSF Clinician Consultation Center http://nccc.ucsf.edu/

A. STI Prevention includes
   1. Risk reduction counseling.
   2. Abstinence (sexual risk-avoidance) and reduction of number of sex partners.
   3. Pre-exposure vaccination: HPV, Hepatitis A and B.
   4. Barrier methods: male and female condoms.
   5. Note: Spermicides containing N-9 may disrupt genital or rectal epithelium and have been associated with an increased risk of HIV infection. Condoms with N-9 are no more effective than condoms without N-9. Therefore, N-9 alone or in a condom should not be recommended for STD or HIV prevention. (2015 CDC STD Treatment Guidelines, pg. 5)
   6. Retest after STI treatment to check for re-infection (e.g. 3 months after treatment for Chlamydia or gonorrhea).

B. For each STI, the CDC Treatment Guidelines generally include the following information:
   1. Diagnostic considerations
   2. Treatment, recommended and alternative regimens
   3. Management of sex partners
   4. Follow up
   5. Special considerations such as pregnancy or HIV infection

C. Please consult the CDC Treatment Guidelines directly regarding STI screening and treatment. The following is general information regarding providing STI services and topics specific to family planning. The CDC recommends the Five Ps for assessing clients: Partners, Prevention of Pregnancy, Protection from STDs, Practices, and Past History of STDs.

1. History as indicated
    a. Signs and symptoms such as unusual discharge, presence of lesions, lower abdominal, scrotal or pelvic pain, fever/chills, dysuria, dyspareunia, spotting between periods or with intercourse and duration of symptoms
    b. Number of partners, any new partners in the last 60 days, partners are men, women or both
    c. Known recent exposure to STI
    d. Positive STI test in the past year
    e. Vaginal, oral, or anal intercourse
    f. LMP, any unprotected intercourse since LMP, contraceptive method using, pregnancy signs and symptoms
    g. Breastfeeding
    h. Medication allergies
2. Examination
    a. BP, heart rate and temperature, if indicated
    b. Throat exam if history includes oral intercourse
    c. Abdominal tenderness or masses
    d. Regional or generalized lymphadenopathy
    e. Visual inspection external genitalia for discharge or lesions
    f. Visual inspection vagina and cervix for discharge or lesions, cervical friability
    g. Uterus/ovaries or scrotal contents - palpation for uterine and adnexal tenderness, cervical motion tenderness
    h. Anal exam if history includes anal intercourse
3. Labs may include
    a. Chlamydia -gonorrhea Nucleic Acid Amplification Test (NAAT). Specimen sources: urine, urethra, cervix, vagina. Contact your lab regarding obtaining pharyngeal and anal specimens. Labs must validate CT/GC tests for pharyngeal and rectal sites. Specimens of choice: urine for men, self-collected vaginal for women.

Provide CT/GC test annually for women 24 and younger, as well as any woman that is symptomatic (mucopurulent cervicitis and urethritis). Recommendation for women with hysterectomy - urine specimen. Clients with a positive GC test result should be tested for HIV and Syphilis. Best practices determined to increase CT/GC screening percentages in Family Planning clinics include:

- Screening at all qualifying family planning visit types, which include annual visits, express visits, emergency contraception visits and pregnancy test visits
- Change clinic flow for routine collection of specimens
- Using opt-out language with clients
- Provider EHR reminders to screen clients or use of a tracking or tickler system

Additional articles on best practices to increase CT/GC screening percentages:
https://www.cdc.gov/std/program/interventions.htm
http://journals.lww.com/stdjournal/Fulltext/2016/02001/Interventions_to_Improve_Sexually_Transmitted.6.aspx

b. Wet prep, if indicated

c. Pregnancy test, if indicated

d. Syphilis test, if indicated. The CDC currently recommends screening with a non-treponemal test (RPR or VDRL) and confirm with a treponemal test (TPPA or FTA-ABS). Many laboratories are switching to screening tests based on detection of treponemal antibody: enzyme immunoassay (EIA) or chemiluminescent immunoassay (CIA). Check with your lab regarding the test used and interpretation.

e. HIV

f. Hepatitis C

CDC Recommendations for the Identification of Chronic Hepatitis C Virus Infection among Persons Born During 1945-1965:

1) In addition to testing adults of all ages at risk for HCV infection, CDC recommends:
2) Adults born during 1945-1965 should receive one-time testing for HCV without prior ascertainment of HCV risk (Strong Recommendation, Moderate Quality of Evidence)
3) Testing should be initiated with anti-HCV. A reactive result should be followed by nucleic acid test (NAT) for HCV RNA.
4) All persons identified with HCV infection should receive a brief alcohol screening and intervention as clinically indicated, followed by referral to appropriate care and treatment services for HCV infection and related conditions.

4. Treatment according to current CDC STD Treatment Guidelines

a. If client is presumptively treated for CT with azithromycin and the GC test later comes back as positive, treat GC with ceftriaxone and azithromycin (again) - ceftriaxone and azithromycin is a dual treatment to treat GC.

b. Providers should have a low threshold for treating PID

5. Management of sex partners

a. All sex partners of clients who have a positive STI test should be evaluated and treated if their last sexual contact with the client was within 60 days before onset of symptoms or diagnosis of infection in the index client. If a client's last sexual intercourse was > 60 days before onset of symptoms or diagnosis, the client's last partner should be treated.

b. For clients with a lab confirmed positive CT or GC whose partner's treatment cannot be ensured or is unlikely, consideration should be given to the use of expedited partner therapy (EPT) (CDC STD Treatment Guidelines 2010, pg. 52)., except in cases of men who have sex with men (MSM). EPT is not routinely recommended for MSM clients due to the high risk of coexisting/undiagnosed infections (i.e. HIV and Syphilis) among their partners, and limited data in the effectiveness of EPT in reducing persistent or recurrent CT among MSM. For additional information visit: https://www.cdc.gov/std/ept/gc-guidance.htm

c. .

6. Education

a. Provide the client information about the STI and the medication prescribed for treatment.

b. Inform the client of complications of untreated STIs, including PID, hospitalization, and infertility for women and epididymitis and prostatitis for men, increased risk of HIV transmission, disseminated GC, reactive arthritis.

c. Clients should be instructed to abstain from sexual intercourse until therapy is completed and they and their partners no longer have symptoms. If one day treatments have been used, advise refraining from intercourse for 7 days following treatment. In cases where compliance is doubtful, recommend condom use and provide a supply of condoms.

7. Follow up
    a. Clients with uncomplicated CT or GC who have been treated with any of the recommended regimens need not return for a test of cure. However, advise the client to be retested in 3 months after treatment. If client does not seek retesting in 3 months, encourage retesting if client presents to the clinic within the next year.
    b. Clients who have symptoms that persist after treatment should be further evaluated.
    c. Appropriate resuscitation equipment must be available in the clinic and clinic personnel must be up to date in its use if parenteral medications are used.
8. Reporting procedures
    a. State law requires that positive STI tests be reported by the provider to the Colorado Department of Public Health and Environment (CDPHE) Registry. Clinic staff members are responsible for completing the state reporting form, including treatment information and faxing it to the STD Registry. See form for instructions.
    b. Clinic sites using a lab other than the state lab must report both positive and negative CT and GC test results to the CDPHE STI-HIV Section for prevalence monitoring.

D. CT/GC Screening

1. The USPSTF recommends screening for Chlamydia and gonorrhea in sexually active women aged 24 years or younger and in older women who are at increased risk for infection. Grade: B Recommendation.
2. The CDC recommends annual screening for Chlamydia and gonorrhea for all sexually active women aged less than 25 years old and screening of older women at increased risk for infection.
3. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for Chlamydia and Gonorrhea in men. Grade: I statement. http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/chlamydia-and-gonorrhea-screening?ds=1&s= (September 2014)
4. According to the USPSTF, risk factors for [CT/GC] infection include having a new sex partner, more than 1 sex partner, a sex partner with concurrent partners, or a sex partner who has an STI; inconsistent condom use among persons who are not in mutually monogamous relationships; previous or coexisting STI; and exchanging sex for money or drugs. Prevalence is also higher among incarcerated populations, military recruits, and patients

   receiving care at public STI clinics. There are also racial and ethnic differences in STI prevalence. In 2012, black and Hispanic persons had higher rates of infection than white persons. Clinicians should consider the communities they serve and may want to consult local public health authorities for guidance on identifying groups that are at increased risk. Gonococcal infection, in particular, is concentrated in specific geographic locations and communities."
5. Gonorrhea screening for men is no longer on the list of services for which evidence does not support screening, as was noted in Appendix F of the QFP. However, because QFP recommends following CDC's STD Treatment Guidelines from 2015, which recommends GC screening of males at risk, no change in practice is recommended.
6. 2014 USPSTF CT/GC screening recommendations: http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening
7. All female clients 24 years old and younger must have a screening CT/GC test annually. If the test is not done at the discretion of the provider or client, there must be documentation as to the reason. Annual screening is to be charged on a sliding scale fee schedule that slides to zero. Clients who present for revisits should be tested as indicated. All screening at revisits may be charged as non-required services. Clinics are advised to waive the fee if it is a barrier to testing.
8. In December 2017, a Call to Action was released due to a 97% increase in gonorrhea rates in Colorado

from 2012-2016. This Call to Action included ensuring national screening and treatment guidelines are being met for both patients and partners, screening all patients at increased risk for gonorrhea, screening all women under 25 years, and referring to Denver Public Health's STD Clinic as needed. DenverSTDClinic@dhha.org/303-602-3540.

E. Incorporation of ACOG's Primary and Preventive Care: Periodic Assessment Guidelines in to STI screening and treatment care

1. Colorado Family Planning Program clinic providers have incorporated ACOG annual woman's health care and well woman recommendations (http://www.acog.org/wellwoman) in to practice. A pelvic examination (including visualization and inspection of external genitalia, vagina, and cervix, and bimanual exam) is not recommended for women until age 21, unless indicated by medical history. Female clients also are seen in the clinic for express visits in which the women are provided contraceptive counseling and a method of contraception without the provision of an exam. Asymptomatic male clients are also provided an opportunity for an express visit for contraceptive counseling and STI screening. Clients are asked to return to the clinic at a later date for a comprehensive history and an exam as indicated by the client's age or health history. Clinics have the capability of providing genital Chlamydia and gonorrhea screening for asymptomatic clients without the necessity of performing an exam with the use of urine based or vaginal self-collected swabs for women and urine based testing for men.
2. Providing Chlamydia and Gonorrhea screening to asymptomatic clients without requiring an exam helps reduce barriers to screening. Colorado Family Planning clinic sites have adopted the practice of treating asymptomatic clients who have had screening Chlamydia or gonorrhea testing without an exam and a positive test without performing an exam prior to treatment.
3. Clients who have received Chlamydia and gonorrhea test screening without the performance of an exam and who have a positive Chlamydia or gonorrhea test must be questioned regarding complaints or reports of STI symptoms and the possibility of pregnancy before treatment is provided. A physical exam should be provided to clients who report STI symptoms. An exam is particularly important to rule out complications of Chlamydia and gonorrhea infections such as pelvic inflammatory disease (PID). Symptoms may include recent pelvic pain, pain with intercourse, or unusual discharge or bleeding.
4. Clients who have a positive Chlamydia or gonorrhea tests, who received a screening Chlamydia or gonorrhea test without an exam being performed and continue to be asymptomatic for STIs may be provided treatment without an exam being performed prior to treatment. Follow the CDPHE STI Testing and Treatment protocol.
5. Clients' partners should be treated as outlined in the CDPHE STI Testing and Treatment protocol.
6. Clients should be counseled regarding STI prevention.
7. Clients should be counseled regarding the signs and symptoms of STIs and told to return to the clinic if any develop.
8. A repeat Chlamydia or gonorrhea test should be offered 3 months after treatment to rule out re-infection. (2015 CDC STD Treatment Guidelines)

F. Expedited Partner Therapy

1. The use of EPT in Colorado is done with the approval of both the Board of Pharmacy (Policy 40-4, July 19, 2007) and the Board of Medical Examiners (Policy 40-10, May 1, 2001, revised 7-1-2010; 8/20/2015).
2. Client selection: client has a lab confirmed positive CT and/or GC and partners of client. EPT is contraindicated for CT or GC infections in men who have sex with men (MSM).
3. Client should be counseled to encourage her/his partner to present to clinic or private provider for testing and treatment; however, if partner(s) is not willing or able to be evaluated, then client should be encouraged to use EPT. If the client selects EPT, then the client should be counseled to tell the partner(s) to read all the information in the partner pack before taking the medication

4. EPT is carried out with the use of "partner packs." A client may be offered up to 3 (three) partner packs. Partner packs contain the appropriate treatment drug for either Chlamydia, gonorrhea, or both, information about the infection, and information about the medication(s) and how to take it.
5. Any medication dispensed as EPT must be properly labeled and logged out in the clinics pharmacy log. If possible, collect the partner name, date of birth, and phone number. If unable to collect this partner information, use "Partner #1," "Partner #2," or "Partner #3" for the log book and the label. Assign an Rx number as per usual, as well as provider name, lot #, expiration date, and instructions for use. Label is placed on the medication container.
6. Documentation in the client record must include whether EPT was offered, whether it was accepted, and how many and what type of EPT were given. If an agency chooses to use such a checklist, then documentation in the client record should also indicate that this checklist was completed and signed.

G. The Denver Prevention Training Center provides a STD Clinical Consultation Network, providing STD Clinical Consultation services within 1-3 business days, depending on urgency, to healthcare providers in the states of Colorado, Montana, New Mexico, North Dakota, South Dakota, Texas, Utah and Wyoming. The Clinical Consultation "Warm Line" can be reached at 1-855-4-STD-CCN (1-855-478-3226) or online at: https://www.denverptc.org/Consultation.html . The phone line is staffed from Monday to Friday, 7 AM - 5 PM Mountain Time and 8 AM - 6 PN Central Time.

H. National HIV Recommendations

1. Title X program priorities include HIV prevention education, testing, and referral in accordance with Title X program requirements and nationally recognized standards. The incorporation of CDC's "Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings" (CDC Revised Recommendations for HIV Testing), published in 2006, into family planning clinical services is a key issue for the federal Title X program. (Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings. MMWR 2006;55 (No. rr-14 [1-17]) See the following link for the full report: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm
2. The CDC Revised Recommendations for HIV Testing include the following:
    a. Routine screening for HIV infection for all clients aged 13-64 years unless the prevalence of undiagnosed HIV infection is documented to be less than 0.1 %.
    b. In the absence of existing data for HIV prevalence, health care providers should initiate voluntary HIV screening until they establish that the diagnostic yield is less than 1 per 1,000 clients screened, at which point such screening is no longer warranted. Subsequently, health care providers should test clients who are at high risk for HIV at least annually.
    c. All pregnant women in the US should be tested for HIV infection as early during pregnancy as possible (CDC STD Treatment Guidelines 2010 and CDC Revised Recommendations for HIV Testing).
3. In April 2013, the US Preventive Services Task Force (USPSTF) published updated HIV screening recommendations, which also recommend expanded screening for HIV infection. See the following link for the full report: http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm

    The USPSTF recommends that:

    a. Clinicians screen for HIV infection in adolescents and adults ages 15-65 years. Younger adolescents and older adults who are at increased risk should also be screened.
    b. Clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
    c. An approach to screening intervals, since there is not sufficient evidence to determine optimum testing intervals, is one-time screening of adolescents and adults to identify clients who are HIV positive, then provide repeat screening for clients at risk for HIV infection. Individuals at very high risk for HIV infection should be screened at least annually.
4. It is imperative that the clinic staff be educated about HIV/AIDS prior to instituting any counseling,

education, or referral. This is to avoid any misinformation, as well as to ensure sensitivity and confidentiality.

a. The Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS), is transmitted by blood and body fluids.

b. The HIV antibody test is a test for the presence of HIV antibody, not a test for AIDS.

c. The body will produce HIV antibodies three weeks to six months after infection with HIV.

d. Due to this time frame, it is important to consider the client's risk when interpreting HIV antibody test results.

e. The type of exposure, the length of time since last exposure, and previous test history are all important factors.

f. Return visits for HIV testing are recommended at 1 month and 3 months post exposure.

5. HIV infection leads to immune dysfunction and deficiency. In untreated individuals, the time between HIV infection and the development of AIDS varies from a few months to many years, with an estimated median time of approximately 11 years. (2015 CDC STD Treatment Guidelines)

6. Early diagnosis of HIV infection, prompt referral, and ensuring linkage to care and support services can help improve the health of the individual tested, and reduce the risk of HIV transmission to others.

7. The family planning and prenatal settings provide a climate conducive to HIV risk reduction counseling and HIV/AIDS prevention messages.

I. Recommendations for Testing

1. Each new family planning client must be offered HIV education, including information about pre-exposure prophylaxis (PEP) and post-exposure prophylaxis (PrEP) for HIV prevention, and HIV testing information. Family planning clinic staff should provide community resources for the provision of PrEP and PEP for clients in need of these services. PrEP providers and resources can be found at this website: https://proudtobeprepped.com/

2. All family planning clients should receive an educational handout on HIV and HIV testing.

a. All family planning clients should be offered a one-time screening HIV test. Repeat screening should be based on client risk for HIV infection.

b. The client may be tested at the family planning clinic site, or referral may be made to an HIV testing site or medical provider, with staff experienced in HIV testing.

3. Testing resources

a. Denver Public Health's website provides testing services and locations: http://denverpublichealth.org/home/clinics-and-services/hiv-care-and-prevention/hiv-testing- CDC National HIV and STD Testing Resources https://gettested.cdc.gov/

http://www.cdc.gov/hiv/testing/laboratorytests.html. Many labs are moving to a 4th generation HIV test. Discuss the specifics of testing with the lab the clinic uses.

4. Point of Care (POC) testing using FDA-approved rapid HIV tests is recommended so that clients receive their test results on the day of their clinic visit.

5. The CDC Revised HIV Testing Recommendations contain the following provisions:

a. Voluntary HIV screening is recommended for clients in all health care settings after the client is notified that testing will be performed unless the client declines (opt-out screening).

b. Oral or written information should include an explanation of HIV infection and the meaning of positive and negative results. The client should be offered an opportunity to ask questions and to decline testing.

c. Persons at high risk for HIV infection should be screened for HIV at least annually.

d. Repeat screening of persons not likely to be at high risk for HIV should be performed based on clinical judgment.

e. Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass HIV testing.

f. Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health care settings.

g. Easily understood informational materials should be available in the clinic.

h. If a client declines an HIV test, this decision should be documented in the medical record.

i. HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.

6. The USPSTF concurs with the CDC's recommendations that:

   a. HIV screening should be voluntary and done only with the client's knowledge and understanding;

   b. Clients should be informed orally or in writing that HIV testing will be performed unless the client declines;

   c. Clients should receive an explanation of HIV infection and the meaning of positive and negative results.

7. The following procedure should be used with clients who are pregnant or considering pregnancy and are assessed to be at high risk for HIV infection:

   a. Encourage HIV counseling and testing prior to pregnancy or as soon as possible if already pregnant.

   b. The American College of Obstetrics and Gynecology, the American Academy of Pediatrics, and the CDC recommend the opt-out approach, meaning that women should be informed that an HIV test will be conducted as a routine part of prenatal care unless they opt to decline the test.

   c. If the client is living with HIV and currently pregnant, refer for expert counseling and care. Inform client of the benefits of antiretroviral therapy in pregnancy.

   d. The risk for perinatal HIV transmission can be reduced to <2% if antiretroviral regimens and obstetrical interventions (elective Cesarean section at 38 weeks gestation) are used, and by avoiding breastfeeding. (See CDC Sexually Transmitted Diseases Treatment Guidelines, 2015 and American College of Obstetrics and Gynecology [ACOG] Committee Opinion Number 635, June 2015).

   e. If individual living with HIV and considering pregnancy, family planning providers must refer the client for expert counseling and care with a provider experienced in conception related services for individuals living with HIV (see linkage to care information below). Discuss delaying pregnancy until client receives expert counseling and information. Provide birth control information and contraceptives if the client wishes to start a contraceptive method.

   f. The following is provided as resources for staff. Providers should be aware that there are safe(r) conception opportunities for individuals living with HIV, including treatment of the index individual and PrEP for the uninfected person.

      Resources for staff:

      Prevention with Persons with HIV
      http://www.cdc.gov/hiv/prevention/programs/pwp/rpc.html
      Preconception Counseling and Care Women of Childbearing Age. Reproductive Dptions for HIV-Concordant and Serodiscordant Couples
      https://aidsinfo.nih.gov/guidelines/html/3/perinatal-guidelines/153/reproductive-options-for-%20hiv-concordant-and-serodiscordant-couples

g. Provide appropriate (internal or external) referral for further counseling and testing to at-risk clients or upon request.

J. Assessing Client Risk

1. The CDC recommendations indicate that prevention counseling should not be required as a part of HIV screening programs in health care settings. Prevention counseling, though, is strongly encouraged for persons at high risk for HIV in settings in which risk behaviors are assessed routinely, but should not be linked to HIV testing.

2. Risk assessment questions should be asked, in a non-judgmental manner, about the following behaviors:

3. Also see the Clinical Guideline for HIV Screening in Colorado which includes the Denver HIV Risk Score tool. Obtain copies of the guidelines from the Denver Prevention Training Center.

4. Responses to questions should be explored with the client. Any information the client can provide about the context of the potential exposure should be used to help the client determine her/his level of risk. A risk reduction plan tailored to the client's skills and motivation should be documented, if appropriate, and followed-up on subsequent visits.

K. Education

Education of health care personnel regarding all facets of AIDS and HIV antibody testing, including the legal, ethical, and psychological ramifications is critical.

1. According to the CDC, client risk reduction behaviors include (see http://www.cdc.gov/hiv/basics/index.html and https://www.cdc.gov/hivrisk/est imator.html):
    a. Know your HIV status;
    b. Abstain from sexual activity or be in a long term mutually monogamous relationship with an uninfected partner;
    c. Limit the number of sex partners;
    d. Correct and consistent condom use;
    e. Get tested and treated for STIs and insist that your partners do, too;
    f. Male circumcision has also been shown to reduce the risk of HIV transmission from women to men;
    g. Don't use IV drugs; If you are using IV drugs don't share needles, syringes or other injection equipment;
    h. Obtain medical treatment immediately if you think you were exposed to HIV. Sometimes HIV medications can prevent infection if they are started quickly - within 72 hours of a possible exposure. This is called post exposure prophylaxis, or PEP. PEP is the use of antiretroviral drugs after a single high-risk event to stop HIV from making copies of itself and spreading through your body. http://www.cdc.gov/hiv/basics/pep.html
    i. Pre-exposure prophylaxis, or PrEP, is a prevention option for people who are at high risk of getting HIV. It is meant to be used consistently, as a pill taken every day, and to be used with other prevention options such as condoms. http://www.cdc.gov/hiv/basics/prep.html
2. Provide information about harm reduction programs in the community for individuals using IV drugs, such as needle exchange programs. There are many needle exchanges in Colorado: https://www.colorado.gove/pacific/cdphe/reducing-infections-injection-drug-use
3. Documentation in the client's chart of the HIV/AIDS educational component will indicate that this protocol was used to inform the client about HIV screening and testing availability at the clinic or by referral.

L. Linkage to care for individuals who are HIV positive (Including case management and counseling)

1. Treatment as prevention - treating persons living with HV improves their health, reduces viral load in blood and genital fluids and reduces the risk of transmission to others http://www.cdc.gov/hiv/prevention/research/tap/
2. Linkage to Care is a free and confidential service offered by the Colorado Department of Public Health and Environment that links people with HIV into care. The service is available to Colorado residents who are newly diagnosed or have been out of care. The HIV Linkage to Care Coordinator works with individuals to provide assistance and ensure connection to a provider based on area of residence, insurance status and personal preference. For more information please contact the Linkage to Care Coordinator, phone: 303-692-2734 or maria.chaidez@state.co.us. Spanish language help also available.
3. Denver Metro Area
    a. HIV Resources Planning Council, http://dhrpc.org/default/index.cfm
    b. Denver Metro Area Counties, DenverHealth.org/LinkagetoCare 303-602-3652
    c. Denver Colorado AIDS Project, http://www.denvercap.org/
4. Other resources outside the Denver Metro Area
    a. Boulder County AIDS Project (BCAP) (Boulder, Broomfield, Clear Creek, and Gilpin Counties) http://bcap.org/
    b. Northern Colorado AIDS Project (NCAP) (Larimer, Logan, Morgan, Philips, Sedgwick, Washington, Weld, and Yuma Counties) http://www.ncaids.org/
    c. Western Colorado AIDS Project (West-CAP) (Archuleta, Delta, Eagle, Dolores, Garfield, Grand, Gunnison, Hinsdale, Jackson, Lake, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, and Summit Counties) http://www.westcap.info/
    d. Southern Colorado AIDS Project (S-CAP) (Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, El Paso, Elbert, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Mineral, Otero, Park, Powers, Pueblo, Rio Grande, Saguache and Teller) http://www.s-cap.org/
5. CDPHE Services for individuals living with HIV web page: https://www.colorado.gov/pacific/cdphe/sti-hiv Information about case management services, drug assistance, health insurance assistance, navigating care
6. Post test results counseling (negative and positive results) http://www.aids.gov/hiv-aids-basics/prevention/hiv-testing/post-test-results/
7. Just Diagnosed: Next Steps After Testing Positive for HIV http://aidsinfo.nih.gov/education-materials/fact-sheets/21/65/just-diagnosed--next-steps-after-testing-positive-for-hiv

Section 14: Preconception and Interconception Health Services

Resources:

- National Preconception Curriculum and Resource Guide for Clinicians
  http://beforeandbeyond.org/
- Health Team Works Preconception Care Guidelines
  http://www.healthteamworks.org/guidelines/preconception.html
- CDC Preconception Health and Healthcare
  http://www.cdc.gov/preconception/index.html
- One Key Question®
  http://www.onekeyquestion.org/
- Providing Quality Family Planning Services, Recommendations of the CDC and the US Office of Population Affairs (QFP)
  http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
- BeforePlay
  http://www.beforeplay.org/

A. Preconception and Interconception Counseling

Emphasize the importance to family planning clients on establishing a reproductive life plan. Discuss a reproductive life plan with all clients receiving contraceptive, pregnancy testing, and counseling, and basic infertility, sexually transmitted infection and preconception health services. (QRP pg. 7).

Use the One Key Question®, "Would you like to become pregnant in the next year?" to make an initial assessment of a client's plans for pregnancy and contraceptive needs.

Further questioning may include asking if the client has children now, does the client want to have children (or more children) in the future, and how many children the client would like to have and when.

Provide preconception counseling as a part of family planning services, as appropriate. Couples or individuals planning a pregnancy, seeking infertility services, or at high risk for an unplanned pregnancy should be offered preconception counseling. Clients contemplating pregnancy within the next year should be given the opportunity for special counseling prior to discontinuing their method, with the objective of improving the outcome of a planned pregnancy.

1. Female screening and history. Also see
   http://www.cdc.gov/preconception/careforwomen/index.html
   a. Medical history, including heart disease, hypertension, anemias or blood disorders, liver disease, diabetes, epilepsy, asthma, renal disease, SLE and

Rheumatoid arthritis, thyroid disease.

b. Reproductive history including previous pregnancy problems, preterm delivery, stillbirth, recurrent pregnancy loss.

c. STI history including genital herpes, HIV, Hepatitis B, Chlamydia, gonorrhea, syphilis.

d. Medication history

e. Occupational and environmental exposures history

f. Tobacco, alcohol, or drug use. There is no known time or amount of alcohol that is safe during pregnancy.

Alcohol and substance abuse guidelines are available for download from Health Team Works http://www.healthteamworks.org/guidelines/sbirt.html) and from SBIRT Colorado http://improvinghealthcolorado.org/

Guidelines include:

1) Alcohol and Substance Use Screening, Brief Intervention and Referral to Treatment (SBIRT) Guideline (September 2011)
2) Guidance on Marijuana Supplement (February 2014)
3) Prescription Drug Abuse Prevention Supplement (September 2011)
4) Fetal Alcohol Spectrum Disorder Supplement (August 2010)
5) CRAFT Toolkit for screening youth for substance use (June 2010)

The Substance Abuse and Mental Health Services Administration (SAMHSA) also provides resources for health care providers. http://www.samhsa.gov/ and http://www.integration.samhsa.gov/clinical-practice/sbirt

CDPHE Marijuana resources for health care providers
https://colorado.gov/cdphe/marijuana-clinical-guidelines

It is recommended that clients be screened for tobacco use at every visit and for alcohol and drugs at least yearly. Offer tobacco cessation counseling and referral to the Colorado QuitLine https://www.coquitline.org/. Providers are encouraged to screen for tobacco use status using the "5 A's" intervention: Ask, Advise, Assess, Assist, and Arrange. Dependent upon client need, provider capacity, and clinic preference, the "Ask, Advise, Refer" (AAR) intervention model may also be used to assess for tobacco use.

Clinics should have substance use and abuse community referral resources available for clients in need of services.

g. Social history including intimate partner violence (IPV).

Clinicians should screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services.

IPV resources for staff and clients

http://www.thehotline.org/help/ National Domestic Violence Hotline

http://ccadv.org/ Colorado Coalition Against domestic Violence

http://www.futureswithoutviolence.org/ Futures Without Violence

http://www.ccasa.org/ Colorado Coalition Against Sexual Assault

http://www.loveisrespect.org/ Resource for youth regarding dating and relationships

http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services HHS Family Violence Prevention & Services

h. Nutritional history

i. Family history, including anemias or blood disorders, diabetes, genetic conditions or birth defects.

j. Screen for immunization status including Rubella immune status and for age appropriate vaccinations such as influenza, Tdap, MMR, varicella, pneumococcal and meningococcal, Hepatitis B

k. USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation) (USPSTF Screening for Depression Adults 2016). "Screening should be implemented with adequate systems in place. "Adequate systems in place" refers to having systems and clinical staff to ensure that patients are screened and, if they screen positive, are appropriately diagnosed and treated with evident based care or referred to a setting that can provide the necessary care" (JAMA Volume 315, Number 4, January 26, 2016). See the following link for more information: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1 . Consider using the Patient Health Questionaire-2 (PHQ-2), not as a diagnosis tool, but as a first step to assess the need for more in-depth screening and referral for care.

In the last 2 weeks:

1) Have you had little interest or pleasure in doing things?
2) Have you felt down, depressed or hopeless?

A "yes" answer to either question is considered a positive screen. The Health Team Works web site provides more in-depth screening tools such as the Patient Health Questionnaire-9 (PHQ-9) or for women who are pregnant or have recently had a baby, the Edinburgh Postnatal Depression Scale.

See Health Team Works Adult Depression Guidelines and Guidelines for Adolescent Depression in Primary Care
http://www.healthteamworks.org/guidelines/depression.html

USPSTF Depression in Children and Adolescents: Screening 2016
http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-children-and-adolescents-screening1

Pregnancy Related Depressive Symptoms Guidance
http://www.healthteamworks.org/guidelines/prd.html

Clinics must have mental health community referral resources available for clients in need of services.

2. Male screening and history. Also see

http://www.cdc.gov/preconception/careformen/index.html

a. Past medical and surgical history that may impair reproductive health such as genetic conditions, history of reproductive failures, conditions that impair sperm quality such as obesity, diabetes mellitus, and varicocele.

b. Environmental exposures, hazards and toxins.

c. Tobacco, alcohol and drug use, including opioid misuse and abuse.

d. Screen for immunization status and for age appropriate vaccinations such as influenza, Tdap, MMR,

varicella, pneumococcal and meningococcal, Hepatitis B.

e. STI history including genital herpes, HIV, Hepatitis B, Chlamydia, gonorrhea, syphilis.

f. Screen for depression when staff assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and follow up. (QRP pg. 17)

A mental health resource for men: http://mantherapy.org/

3. Physical exam may include
   a. Height, weight, and body mass index
   b. Blood pressure
4. Lab tests as indicated
5. General education
   a. The need for early and continuing care during pregnancy, with referral to prenatal care providers, if requested.
   b. The importance of good nutrition, including the addition of 400-800 µg of folic acid supplemented per day to decrease the risks of neural tube defects. The importance of being a healthy weight before and during pregnancy. January 2017, the USPSTF released a final summary for "Folic Acid for the Prevention of Neural Tube Defects: Preventive Medicine" and assigned the recommendation a Grade "A". This recommendation concludes that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg of folic acid.
   c. Warnings regarding the use of tobacco, alcohol, and drugs during the preconception period as well as during pregnancy.
   d. Counseling regarding HIV testing. The standard is for all pregnant women to be tested, regardless of risk status (Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant women in Health Care Settings, MMWR September 22, 2006/55 (RR14); 1-17). There are benefits to women and men of knowing their HIV status before a pregnancy.
   e. The importance of being up to date on immunizations prior to pregnancy.
   f. The importance of spacing pregnancies.
   g. Explanation regarding referrals for care as indicated.
6. Recommendations for Stopping Birth Control Methods

a. Oral contraceptive/contraceptive patch/contraceptive vaginal ring

1) There is no evidence to recommend that a period of time elapse between the cessation of hormonal contraceptive use and initiation of a planned pregnancy.

2) Client may be advised to return for evaluation if menstrual periods do not resume six to eight weeks after cessation of these hormonal contraceptives.

b. IUD

No special recommendations

c. Depo-Provera

Since ovulation may take as long as 9-12 months to return, it is advisable to have the client plan to stop the injections up to a year before she wishes to become pregnant, and to use another method of birth control until conception is desired.

d. Contraceptive implant

No special recommendations

Section 24: Mandatory Reporting & Human Trafficking

A. Mandatory Reporting

Agencies must be compliant with all applicable state laws regarding the mandatory reporting of child abuse, child molestation, sexual abuse, rape, incest, or domestic violence. Agencies must have written procedures in place demonstrating compliance.

Family Planning Coordinators must assure that all staff members are trained and familiar with Colorado law regarding mandatory reporting / human trafficking (summarized below).

Family Planning agencies must develop written internal procedures for staff on how to address mandatory reporting incidents. It is expected that the Family Planning Coordinator will solicit input from local agencies involved in the issue before writing up a local procedure. Local agencies include law enforcement, child protective services, etc. Your clinic's procedure must detail how you will respond to any reportable or potentially reportable situation as outlined in this policy. All Family Planning Program staff must be familiar with the policy and procedures outlined in this section.

The Colorado Department of Human Services (CDHS) provides the Child Welfare On-line Training System at http://www.coloradocwts.com/community-training. This is a valuable resource for introducing staff members to mandatory reporting requirements.

References are made to various Colorado statutes in the information below. Statutes are noted for use as reference. This is not legal advice, consult legal counsel for legal advice. Staff should consult the Colorado Revised Statutes for the most current and complete wording of the child abuse and neglect reporting laws. http://www.lexisnexis.com/hottopics/colorado/

1. Who are mandatory reporters?

   Colorado law specifies the persons or professions that are required to report child abuse or neglect. Colorado mandatory reporters are listed in Colorado Revised Statute. (CRS 19-3-304).Failure of a mandatory reporter to report suspected child abuse or neglect or to knowingly make a false report is a class 3 misdemeanor and punishable under Colorado law.

2. How is a report made?

   Reporting procedures are detailed in CRS 19-3-307, 25-1-122 (4) (d) and 25-4-1404 (1) (d).

   A report is made immediately to the county child protective service, local law enforcement agency, or through the child abuse reporting hotline followed by a written report prepared by the mandatory reporter.

   Child protective services (CPS) personnel are required to assess reports of child abuse and/or neglect. CPS works with community professionals, who are mandated reporters, to prevent, identify, and respond to child abuse and/or neglect.

3. To whom should a mandatory report be made?

   Generally, interfamilial abuse (includes abuse that occurs within a family context by a child's parent, stepparent, guardian, legal custodian, relative, spousal equivalent or any other person who resides in the child's home) is reported to the child protective services in the county where the victim lives. Third party abuse (includes abuse by any person who is not a parent, stepparent, guardian, legal custodian, spousal equivalent) is reported to law enforcement where the crime occurred. Local child protective services can provide guidance regarding to whom a report should be made. (Definitions from CRS 19-1-103)

4. Are there concerns about violating HIPAA privacy regulations when reporting child abuse or neglect?

   HIPAA regulations permit covered entities to disclose certain types of personal health information, without an individual's authorization or giving an individual the opportunity to object or agree to the disclosure, if the law requires the disclosure. Reporting suspected child abuse or neglect by

designated mandatory reporters is required by Colorado law and thus permitted by HIPAA regulations. The report of suspected child abuse or neglect must be made to the government authorities authorized by Colorado law to receive reports, child protection services or law enforcement agencies. (45 C.F.R. 164.512)

5. What information should be included in a mandatory report?

   Reports of known or suspected child abuse or neglect, when possible, should include the following information (CRS 19-3-307 in part)

   a. The child's name, age, address, gender and race,

   b. The name and address of the person(s) responsible for the suspected abuse and/or neglect,

   c. The nature and extent of the child's injuries, including any evidence of previous cases of known or suspected abuse or neglect of the child or the child's siblings,

   d. The family composition,

   e. The source of the report and the name, address, and occupation of the person making the report.

   f. Any action taken by the reporting source.

   Please note that CRS 25-1-122 (4) (d) (concerning epidemic and communicable diseases, morbidity and mortality, cancer in connection with the statewide cancer registry, environmental and chronic diseases, sexually transmitted infections, tuberculosis, and rabies and mammal bites) limits the information an officer or employee of the state department of public health and environment may provide when making a report. CRS 25-4-1404 (1) (d) (concerning HIV infection) limits the information an officer or employee of the county, district, or municipal public health agency or state department of public health and environment may provide when making a report.

6. Assistance for mandatory reporters:

   Staff should follow the reporting policies established by their local agency. A suspicion of abuse or neglect is adequate for reporting to child protective services. Staff should not attempt to further investigate or probe suspected child abuse or neglect. Staff making a report may find speaking with a fellow staff member or supervisor helpful but the mandatory reporter is ultimately responsible for complying with reporting laws. If staff are unsure about whether a report should be made, they should contact their local child protective services for guidance.

7. What happens when a report is made?

   When a report of suspected child abuse and/or neglect is made, child protective services collects relevant information from the reporting party and screens the call to determine if a report will be accepted for assessment. Child protective services will prioritize accepted reports and assign them for assessment or for referral to other agencies, community services or another jurisdiction.

   After a report is made, the county is required to notify the person who made the report within 30 days regarding whether or not the referral was assigned for assessment. A call may also be made to the county to follow-up to see if the report was assigned. If the referral was assigned, the person making the report may be contacted for additional information.

8. Applicable Colorado Revised Statutes include but are not limited to:

   a. Child abuse and neglect and sexual abuse
      CRS §19-1-103. Definitions - repeal (in part)

   As used in this title or in the specified portion of this title, unless the context otherwise requires:

   (1) (a) "Abuse" or "child abuse or neglect", as used in part 3 of article 3 of this title, means an act or omission in one of the following categories that threatens the health or welfare of a child:

   (I) Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to

thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition or death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death; or the circumstances indicate that such condition may not be the product of an accidental occurrence;

(II) Any case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102 (9), C.R.S.;

(III) Any case in which a child is a child in need of services because the child's parents, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take. The requirements of this subparagraph (III) shall be subject to the provisions of section 19-3-103.

(IV) Any case in which a child is subjected to emotional abuse. As used in this subparagraph (IV), "emotional abuse" means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development or a substantial risk of impairment of the child's intellectual or psychological functioning or development.

(V) Any act or omission described in section 19-3-102 (1) (a), (1) (b), or (1) (c);

CRS §18-3-402. Sexual assault. (In part)
(a) The actor causes submission of the victim by means of sufficient consequence reasonably calculated to cause submission against the victim's will; or

(b) The actor knows that the victim is incapable of appraising the nature of the victim's conduct; or

(c) The actor knows that the victim submits erroneously, believing the actor to be the victim's spouse; or

(d) At the time of the commission of the act, the victim is less than fifteen years of age and the actor is at least four years older than the victim and is not the spouse of the victim; or

(e) At the time of the commission of the act, the victim is at least fifteen years of age but less than seventeen years of age and the actor is at least ten years older than the victim and is not the spouse of the victim...

Additional clarification, the Colorado Age of Consent is 17 years old. This is the minimum age at which an individual is considered legally old enough to consent to participation in sexual activity. Although the age of consent is 17, child prostitution laws extend to those 18 or under. Individuals aged 16 or younger in Colorado are not legally able to consent to sexual activity, and such activity may result in prosecution for statutory rape. Colorado statutory rape law is violated when an individual has sexual intercourse with an individual under age 17. Close in age exemptions exist allowing 16 and 17 year olds to engage in sexual intercourse with partners who are less than 10 years older, and minors younger than 15 to engage in sexual intercourse with those less than 4 years older. This is based on the Colorado Age of Consent Law, C.R.S. 18-3-402(1)

(Mandatory reporting laws also apply for minor victims of human trafficking. Child abuse or neglect includes unlawful sexual behavior as defined in CRS 16-22-102 (9) and includes sexual assault, trafficking in children, sexual exploitation of children, procurement of a child, procurement of a child for sexual exploitation, and inducement of child prostitution.)

CRS §19-3-304 Persons required to report child abuse or neglect. (in part)

(a) Except as otherwise provided by section 19-3-307 and sections 25-1-122 (4) (d) and 25-4-1404 (1) (d), C.R.S., and paragraph (b) of this subsection (1), any person specified in subsection (2) of this section who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect shall immediately upon receiving such information report or cause a report to be made of such fact to the county department or local law enforcement agency.

(b) The reporting requirement described in paragraph (a) of this subsection (1) shall not apply if the person who is otherwise required to report does not:

(I) Learn of the suspected abuse or neglect until after the alleged victim of the suspected abuse or neglect is eighteen years of age or older; and

(II) Have reasonable cause to know or suspect that the perpetrator of the suspected abuse or neglect:

Has subjected any other child currently under eighteen years of age to abuse or neglect or to circumstances or conditions that would likely result in abuse or neglect; or is currently in a position of trust, as defined in section 18-3-401 (3.5), C.R.S., with regard to any child under eighteen years of age.

b. Intimate Partner Violence

Licensees have a duty to report injuries resulting from domestic violence/intimate partner violence.

CRS §12-36-135. Injuries to be reported - penalty for failure to report - immunity from liability.

(1)(a) (I) Every licensee who attends or treats any of the following injuries shall report the injury at once to the police of the city, town, or city and county or the sheriff of the county in which the licensee is located:

(A) A bullet wound, a gunshot wound, a powder burn, or any other injury arising from the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument that the licensee believes to have been intentionally inflicted upon a person;

(B) An injury arising from a dog bite that the licensee believes was inflicted upon a person by a dangerous dog, as defined in section 18-9-204.5 (2) (b), C.R.S., or

(C) Any other injury that the licensee has reason to believe involves a criminal act; Except that a licensee is not required to report an injury that he or she has reason to believe resulted from domestic violence unless he or she is required to report the injury pursuant to subsection (1)(a)(I)(A) or (1)(a)(I)(B) of this section or the injury is a serious bodily injury, as defined in section 18-1-901(3)(p).

(II) Any licensee who fails to make a report as required by this section commits a class 2 petty offense, as defined by section 18-1.3-503, C.R.S., and upon conviction thereof, shall be punished by a fine of not more than three hundred dollars, or by imprisonment in the county jail for not more than ninety days, or by both such fine and imprisonment.

(III) Except as described in subsection(1)(a)(I)(C) of this section, a licensee may, but is not required to, report an injury that he or she has reason to believe occurred as a result of domestic violence if:

(A)The victim of the injury is at least eighteen years of age and indicates his or her preference that the injury not be reported; and

(B) The injury is not an injury that the licensee is required to report pursuant to subsection(1)(a)(I)(A) or (1)(a)(I)(B) of this section

(IV) If the licensee does not report an injury pursuant to a victim's request, as described in subsection (1)(a)(III) of this section, the licensee shall document the victim's request in the victim's medical record.

(V) Before a licensee reports an injury that he or she has reason to believe results from domestic violence, as described in subsection (1)(a)(III) of this section, the licensee shall make a good-faith effort, confidentially, to advise the victim of the licensee's intent to do so.

(VI) If the licensee has reason to believe that the injury resulted from domestic violence, the, regardless of whether the licensee reports the injury to law enforcement, the licensee shall either refer the victim to a victim's advocate, as defined in section 13-90-107 (1)(k)(II), or provide the victim with information concerning services available to victims of abuse.

(b) (I) When a licensee or nurse performs a forensic medical examination that includes the collection of evidence at the request of a victim of sexual assault, the licensee's or nurse's employing medical facility shall, with the consent of the victim of the sexual assault, make one of the following reports to law enforcement:

(A) A law enforcement report if a victim wishes to obtain a medical forensic examination with evidence collection and at the time of the medical forensic examination chooses to participate in the criminal justice system;

(B) A medical report if a victim wishes to obtain a medical forensic examination with evidence collection but at the time of the medical forensic examination chooses not to participate in the criminal justice system. The licensee or nurse shall collect such evidence and victim identifying information, and the employing medical facility shall release the evidence and information to law enforcement for testing in accordance with section 24-33-113 (1) (b) (III), C.R.S., and storage in accordance with section 18-3-407.5 (3) (c), C.R.S

(C) An anonymous report if a victim wishes to obtain a medical forensic examination with evidence collection but at the time of the medical forensic examination chooses not to have personal identifying information provided to law enforcement or to participate in the criminal justice system. The licensee or nurse shall collect such evidence, and the employing medical facility shall release it to law enforcement for storage in accordance with section 18-3-407.5 (3) (c), C.R.S. Law enforcement shall receive no identifying information for the victim. Law enforcement shall assign a unique identifying number to the evidence, and the licensee or nurse shall record the identifying number in the medical record and notify the victim that the identifying number is recorded. Additionally, the licensee or nurse shall provide the identifying number to the victim.

(II) Nothing in this section:
(A) Prohibits a victim from anonymously speaking to law enforcement about the victim's rights or options prior to determining whether to consent to a report described in this paragraph (b); or

(B) Requires a licensee, nurse, or medical facility to make a report to law enforcement concerning an alleged sexual assault if medical forensic evidence is not collected.

(III) If the licensee's employing medical facility knows where the alleged sexual assault occurred, the facility shall make the report with the law enforcement agency in whose jurisdiction the crime occurred regarding preservation of the evidence. If the medical facility does not know where the alleged sexual assault occurred, the facility shall make the report with its local law enforcement agency regarding preservation of the evidence.

(IV) In addition to the report required by subparagraph (I) of this paragraph (b) to be filed by the employing medical facility, a licensee who attends or treats any of the injuries described in sub-subparagraph (A) of subparagraph (I) of paragraph (a) of this subsection (1) of a victim of a sexual assault shall also report the injury to the police or sheriff as required by paragraph (a) of this subsection (1).

(1.5) As used in subsection (1) of this section, unless the context otherwise requires:

(a) "Domestic violence" means an act of violence upon a person with whom the actor is or has been involved in an intimate relationship. Domestic violence also includes any other crime against a person or any municipal ordinance violation against a person when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

(b) "Intimate relationship" means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time.

(2)(a) Any licensee who, in good faith, makes a report pursuant to subsection (1) of this section or does not make a report as described in subsection (1)(a)(III) of this section is immune from any liability, civil or criminal, that might otherwise be incurred or imposed with respect to the making of such report, and has the same immunity with respect to participation in any judicial proceeding resulting from such report.

(2)(b) A licensee who, in good faith, refers a victim to a victim's advocate or provides a victim with information concerning services available to victims of abuse, as described in subsection (1)(a)(VI) of this section, is not civilly liable for any act of omission of the victim's advocate or of any agency that provides such services to the victim.

(3) Any licensee who makes a report pursuant to subsection (1) of this section shall not be subject to the physician-patient relationship described in section 13-90-107 (1) (d), C.R.S., as to the medical examination and diagnosis. Such licensee may be examined as a witness, but not as to any statements made by the patient that are the subject matter of section 13-90-107 (1) (d), C.R.S.

In summary, HB 17-1322 states that a healthcare professional is not required to report an injury that they have reason to believe involves an act of domestic violence it:

- The victim of the injury is at least 18 years of age and indicates their preference that the injury not be reported;
- The injury is not an injury that the healthcare professional is otherwise required to report; and
- The injury is not a serious bodily injury.

When a healthcare provider declines to report an injury that they have reason to believe resulted from domestic violence due to client preference, the provider must document the client's request in the medical record. The new law creates a safe and confidential option for domestic violence victims to confide in their healthcare provider, closes the intimate partner sexual assault reporting exemption gap (requiring all sexual assault survivors have a choice in reporting options), and removes the mandate on domestic violence reporting. Healthcare providers can use discretion on how to care for victims of domestic violence. Mandatory reporting requirements for children and elders did not change under this new law.

The Colorado Coalition Against Domestic Violence's webinar explains this new law:
http://ccadv.org/medical-reporting-options/

c. Sexting
    a. Guidance on HB17-1302 Juvenile Sexting Crime legislation can be found here: https://www.colorado.gov/pacific/publicsafety/news/guidance-new-legislation-regarding-sexting
    b. Prior to the enactment of this law, prosecutors' only option for charging teen sexual behavior (even among consenting friends) was felony exploitation of a child. HB17-1302 went into effect January 1, 2018, and uses a tiered approach that separates abusive forms of sexting (such as malicious distribution) from consensual electronic exchange of explicit images.
    c. A brief video is available through the Colorado School Safety Resource Center (CSSRC) to assist staff in understanding the new law: https://www.youtube.com/watch?v=DOhi56LndVo&feature=youtu.be

Resources:

- Futures Without Violence http://www.futureswithoutviolence.org/ Provides resources such as small safety cards (Did you Know Your Relationship Affects Your Health?) in English and Spanish and Guidelines for Clinical Assessment and Intervention as a free download.
- Colorado Coalition Against Domestic Violence http://ccadv.org/
- Colorado Coalition Against Sexual Assault http://www.ccasa.org/
- Resource for youth regarding dating and relationships http://www.loveisrespect.org/
- HHS Family Violence Prevention & Services Program http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services
- CDHS Child Welfare On-line Training System http://www.coloradocwts.com/community-training
- CDHS - call 1-844-CO-4-Kids to report child abuse and neglect https://sites.google.com/a/state.co.us/cdhs-dcw/reportchildabuse

- Family Planning National Training Center http://fpntc.org/
- Mandated Child Abuse Reporting Law: Developing and Implementing Polices and Training http://www.fpntc.org/event/mandated-child-abuse-reporting-law-developing-and-implementing-policies-and-training
- National Domestic Violence Hotline http://www.thehotline.org/he

Human Trafficking

1. Family Planning Coordinators must assure that all staff members are familiar with Federal and Colorado human trafficking law. Family Planning agencies must develop written internal procedures for staff on how to address human trafficking incidents. It is expected that the Family Planning Coordinator will solicit input from various agencies and entities before writing a procedure regarding support and resources for victims of human trafficking.
2. Federal anti-trafficking laws include Victims of Trafficking and Violence Protection Act of 2000 and Trafficking Victims Protection Reauthorization Acts of 2003, 2005, 2008, and 2013.
3. Human trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery; or sex trafficking in which a commercial sex act is induced by force, fraud, coercion, or in which the person induced to perform such act has not attained 18 years of age.
4. Sex trafficking is defined as the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age.
5. Labor trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery.
6. Colorado Revised Statues also contain criminal statutes related to human trafficking. Please consult the Colorado Revised Statutes for the most current language.

Resources for staff and victims of human trafficking:

a. Colorado Resources:

- Colorado Organization for Victim Assistance (COVA) manages the Office for Victims of Crime (OVC) federal human trafficking grant for the Denver Metro Area and the Northern Front Range in Colorado. Through this grant, COVA provides case management support for domestic and international human trafficking victims, documented or undocumented. COVA works with adults and minors; male, female, and LGBTQ community. COVA's human trafficking program has available multi-lingual staff (Spanish, German, Japanese, and Portuguese) to serve a diverse clientele.
  Phone numbers: 303-996-8087 and 303-996-8084
  http://www.coloradocrimevictims.org/index.html

- Colorado Network to End Human Trafficking (CoNEHT)
  CoNEHT represents a statewide network of service providers who work with human trafficking victims, foreign and domestic, and collectively provide an array of case management, interpreting/translation services, food, clothing, shelter, medical/dental services, legal advocacy, immigration
  services, mental health treatment, and transportation. CoNEHT will also provide information regarding training for clinic staff related to human trafficking
  CoNEHT Hotline at 1-866-455-5075 (toll-free, 24 hours/day, 7 days/week).

- Laboratory to Combat Human Trafficking
  Provides training and educational sessions on the issue of human trafficking for law enforcement personnel, service providers, community members, and other potential first responders across Colorado. LCHT also conducts research around the

state and provides technical assistance to community-based task forces; for more information about LCHT's research, visit http://lcht.hotpressplatform.com/about/theproject

Email: info@combathumantrafficking.org Phone number: 303-295-0451

Hotline: 1-866-455-5075

- Lutheran Family Services Rocky Mountains (LFS)

  http://www.lfsrm.org/

  LFS provides services to international adult and minor human trafficking victims who have received their Office of Refugee Resettlement (ORR) Certification Letter if an adult, or an Eligibility Letter if a minor. Victims of Human Trafficking (VOTs) can receive services up to 5 years after the date of their certification/eligibility letter. Depending on need and eligibility, services provided to clients may include: case management, employment placement services, health case management, pre-employment training, cash assistance, basic needs, and ESL, public assistance, physical and mental health and other referrals as needed. Services for adults are managed through the Refugee and Asylee Programs and services for minors are managed through the Unaccompanied Refugee Minor program. LFS also is a subcontractor to the National Human Trafficking Victim Assistance Program through the U.S. Committee for Refugees and Immigrants (USCRI) and can provide supplemental assistance to VOTs though this program as needed. LFS sits on the steering committee for CoNEHT. For more information please call (303) 217-5181.

- Prax(us) http://www.praxus.org/ 720-317-7009

  Serves victims of domestic trafficking, particularly homeless youth.

b. National Resources:

- National Human Trafficking Resource Center

  http://www.polarisproject.org/what-we-do/national-human-trafficking-hotline/the-nhtrc/overview

  24 hour Hot Line 1-888-373-7888 or text BeFree (233733)

  Email: nhtrc@polarisproject.org

  The National Human Trafficking Resource Center (NHTRC) is a national, toll-free hotline, available to answer calls and texts from anywhere in the country, 24 hours a day, 7 days a week, every day of the year. The NHTRC is operated by Polaris, a non-profit, non-governmental organization working exclusively on the issue of human trafficking. NHTRC is not a government entity, law enforcement or an immigration authority.

- Polaris Project http://www.polarisproject.org/

  The Polaris Project provides human trafficking victim assessment tools for health care providers entitled "Identifying Victims of Human Trafficking - What to Look for During a Medical Exam/Consultation" and "Medical Assessment Tool" at http://www.traffickingresourcecenter.org/audience/service-providers

  The Polaris Project also provides a range of social services to survivors of human trafficking including emergency services, comprehensive case management, group therapy, transitional housing, and victim outreach.

  Email: info@polarisproject.org Telephone: (202) 745-1001

- US Department of Health and Human Services, Office of Refugee Resettlement

  http://www.acf.hhs.gov/programs/orr/programs/anti-trafficking

  The Anti-Trafficking in Persons Program (ATIP) identifies and serves victims of human trafficking, assisting foreign trafficking victims in the United States to become eligible for public benefits and services to the same extent as refugees. The program also raises awareness of human trafficking through the HHS Rescue & Restore Victims of Human Trafficking campaign.

  Email: Trafficking@acf.hhs.gov Telephone: (202) 401-551

2018 Table of Contents for the CDPHE Family Planning Administrative Manual

Table of Contents

		Page
➢	Federal and Colorado Title X Overview	5
➢	Voluntary Participation	9
➢	Prohibition of Abortion	10
➢	Client Bill of Rights	11
➢	Structure and Management	12
➢	Charges, Billing and Collections	15
➢	Family Planning Services Required to Slide	22
➢	Sliding Fee Scale Examples	24
➢	Cost Setting / Cost Analysis	*25*
[redacted]		[redacted]
➢	Planning and Evaluation	30
➢	Family Planning Annual Report and iCare Data	31
➢	Opening and Closing a Title X Clinic	32
➢	Project Services and Clients	34

➢ Community Participation, Education & Project Promotion	39
➢ Legislation and Statutes	47
➢ Forms and Templates	47

2018 Table of Contents for the CDPHE Family Planning Clinical Manual

Section 1:	Family Planning Health Care Services	5-16
Section 2:	Contraception Services	17-19
Section 3:	Intrauterine Contraception	20-26
Section 4:	Contraceptive Implants	27-30
Section 5:	DMPA	31-32
Section 6:	Combined Hormonal Contraception	33-40
Section 7:	Progestin Oral Contraception	41-43
Section 8:	Barrier Methods	44-49
Section 9:	Fertility Awareness-Based Methods (FABM)	50-51
Section 10:	Emergency Contraception	52-55
Section 11:	Sterilization	56-62
Section 12:	Pregnancy Testing and Counseling	63-68
Section 13:	Achieving Pregnancy and Basic Infertility Services	69-70
Section 14:	Preconception Health Services	71-74
Section 15:	Sexually Transmitted Infection and HIV Services	75-85
Section 16:	Breast Cancer Screening	86-88
Section 17:	Cervical Cancer Screening	89-91
Section 18:	Adolescent Services	92-94

Section 19:	Menopause	95-102
Section 20:	Client Consent	103-107
Section 21:	Medical Emergencies	108-109
Section 22:	Pharmaceuticals	110-112
Section 23:	Referral and Follow up	113-116
Section 24:	Mandatory Reporting-Human Trafficking	117-126
Section 25:	Medical Records/Personal Health Information/Confidentiality	127-130
Section 26:	Personnel	131-140
Section 27:	Risk Management/Quality Assurance and Evidence-Based Quality Improvement	141-146
Section 28:	Laboratory	147-149

Section 25: Medical Records/Personal Health Information/Confidentiality

Agencies must maintain complete medical records for every client, in accordance with accepted professional standards. The medical records must be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. Each entry must be signed.

A record must be maintained of every client encounter with the staff. All staff, including non-medical workers, should record every encounter (including telephone calls), reason for encounter, and any action taken.

A. Custody of Records

1. The agency is the legal custodian of client records. It is responsible for the provision of a safe place for storage of client records to prevent disclosure to unauthorized persons.
2. Client records should be kept in locked files when not in use and must not be left where individuals other than authorized persons have access to them. EMRs must be password protected and should have an automatic time out when not in use. Users should lock the EMR when not in use to ensure against unauthorized access. Also, consider that portable laptops should not be left in a room with a client. An additional layer of security can be provided with the use of biometrics.

B. Confidentiality and HIPAA

1. Agencies must be compliant with HIPAA regulations. HIPAA covered entities are expected to have adequate administrative, technical and physical safeguards in place to protect personal health information under its control.
2. A summary of the HIPAA privacy rule is available at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html
3. A summary of the HIPAA security rule is available at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html
4. In January 2013, HHS announced a final rule that implements a number of provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act to strengthen the privacy and security protections for health information established under HIPAA. See http://www.hhs.gov/ocr/privacy/hipaa/administrative/omnibus/index.html for the press release and a link to the final rule.
5. Clients must be informed of agency privacy practices and a signed acknowledgment of receipt of the notice must be part of the medical record. Model notices of privacy practices that reflect 2013 regulatory changes are available at http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html
6. The Colorado Department of Public Health and Environment (CDPHE) is not a Covered Entity under HIPAA, as it does not meet the definition of a health plan, a healthcare provider billing electronically, a clearinghouse or a Medicare Drug Plan. However, the CDPHE Title X program does receive Personal Health Information (PHI) from its

delegates. CDPHE has a privacy and security program designed to meet industry standards for safeguarding information under its control, and assuring that adequate physical, administrative and technical safeguards are in place. Inform clients about the statewide iCare database using the Family Planning Program Consent wording.

C. Colorado's Open Records Law (See CRS §24-72-200.1 et al)

D. See CRS § 25-1-1202 Index of statutory sections regarding medical record confidentiality and health information

E. Other Considerations in Maintaining Confidentiality

1. All staff must be oriented to the importance of safeguarding the confidential nature of the record and any other client information.
2. Privacy and confidentiality in gathering client information by interview or any other means is essential.
3. Office and clinic facilities should be such that client information is not inadvertently revealed to persons in the waiting room or any place else.
4. Use discretion in engaging a client in discussion in his home or on the street while neighbors, relatives, or other persons are present.
5. Electronic email exchanges with clients should be encrypted.

F. Documentation

1. Each entry must be signed by the person providing the information or service. If the full name of the signer is not used in the medical record, a signature sheet with full name, title, and signature of each individual making entries in the chart must be maintained.

   For the purpose of quality assurance, a physician should also co-sign a percentage (10% is recommended) of the entries of an appropriately trained person for whom the physician is responsible (examples - an RN providing services under physician signed standing orders or APRN without prescriptive authority).

2. It is also recommended that the agency have an internal policy in place regarding the percentage of charts that are to be cosigned by the physician.

   See the Colorado Medical Board Rules and Regulations for Licensure of and Practice by Physician Assistants (Rule 400 - Revised 8/19/10; Effective 10/15/10) for instruction regarding review and signature of a Physician Assistant's (PA) charts by the PA's supervisory Physician. The rule provides for a graduated plan depending on the PA's experience and length of time at a particular practice.

3. All laboratory, X-ray, and referral follow-up reports should be reviewed, initialed, and dated by; (1) the provider (preferable); or (2) the clinic nurse/coordinator before filing in the chart. The provider(s) must be notified as soon as possible of any abnormal lab results for appropriate treatment, referral, or follow-up. This information must be documented in the medical record.
4. Document in the medical record when information is presented to the client either by means of translation or reading the information aloud to the client. Drug and food allergies alerts should be prominently noted in the medical record to inform the provider.

G. Accessibility of medical records

1. The records must be systematically organized to facilitate retrieval and compiling of information.
2. Funding agencies, such as the U.S. Department of Health and Human Services, have the right to review charts of those individuals whose care is supported by their funds.
3. The original medical record is the property of the clinic. However, the client or her/his attorney, upon presentation of appropriate documentation, is entitled to copies of the record.

H. Retention of records

1. Each agency should have an established written policy regarding the length of time for retention of records and the method of disposing of client records. This is usually done by obtaining a ruling from the agency or county attorney.
2. It is recommended that all client records be retained for a minimum of 7 years plus current year after discharge; or, in the case of a minor, 7 years after their 18th birthday. Resource: Colorado Medical Board Policy # 40-07 Guidelines Pertaining to Release and Retention of Medical Records (8/20/2015).

I. Destruction of records

1. When materials no longer need to be retained, in order to ensure the confidentiality of records, they should be destroyed. Agencies that use EMRs should establish a business plan that addresses how and when records will be deleted or moved to a secure network drive.

J. Content of client record

1. The medical record must contain sufficient information to identify the client, justify the diagnosis or clinical impression, and warrant the treatment and end results.
2. The record should contain the following:
    a. Personal Data
        1) Client identification.
        2) Name, address, and telephone number.
        3) Name of someone who may be contacted to reach client.
        4) Name, address, telephone number, and relationship to client of a person who may be contacted in the event of a medical emergency. For the client under 18, the parent or guardian should be listed.
        5) Dates of visits.
        6) Identification of other sources of medical care.
    b. Clinical data
        1) Medical history, which must be updated at least annually or more often as indicated.
        2) Documentation of physical examination.
        3) Documentation of laboratory tests ordered, results, and follow-up.
    c. Diagnostic and therapeutic orders, observations, clinical findings, and action taken

1) Indication of treatments and/or medications given, observations, and action taken.

2) Progress notes.

3) Special instructions.

4) Follow-up contact when applicable.

5) Any telephone calls to or from a client regarding medical problems.

6) Referral forms.

7) Follow-up of referrals.

8) Whenever possible, a summary of relevant health-related encounters in other health facilities should be included in the client's family planning medical record.

K. Record audit

a. Internal record audits should be performed at least monthly, to determine completeness of records, e.g., blanks filled in, releases and consent signed appropriately, physician and staff signatures, etc.

b. A full Clinical Chart Audit under the direction of Colorado Department of Public Health and Environment will be performed every third year by an independent auditor. (See Section 28 - Risk Management/Quality Assurance of the Clinical Manual).

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

FAMILY PLANNING PROGRAM

CLINICAL SITE VISIT EVALUATION

Agency	
Address	
Program Coordinator/Clinic Manager	
Clinic Services Provider	
Consultant Physician	
Evaluator	
Date of Evaluation	
Date of Report	

Revised 9/2016

Based on Title X Statutes and Regulations, Program Requirements for Title X Funded Family Planning Projects and Providing Quality Family Planning Services April 2014 and the Title X Program Review Tool

Required

Requirements/Recommendations with Source	Yes	No	Comments
Facilities and Accessibility			
Services are provided in a manner which protects the dignity of the individual (42 CFR 59.5 (a)(3) Title X Requirements 9.2) The design of the program's facilities ensures privacy, confidentiality, and regard for self-respect and dignity of the served individual during personal interviews, consultations, medical examinations, and treatment. (observe facilities)			
Service site is physically accessible to persons living with disabilities.			
Interpreters/interpretation services are available as needed.			
Translated written material are available			
Service site has English and Spanish after hours phone messages			
Same day or next day appointments are available			
Evening and weekend hours available			
Health Care Services (See QFP)			
Service site provides 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 (Title X Requirement 9.7)			
Service sites 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). (42 CFR 59.5(a)(1) Title X Requirement 9.8)			
Client Services - History			
Complete medical history is documented for all clients and updated at subsequent visits.			
History includes contraceptive risk factors			
Health history documented in EMR is consistent and standardized among providers.			
Client Services-Assessment			

Physical assessment is consistent with national standards for care (ACOG, ACS,ASCCP,USPSTF, CDC)			
Female assessment: BP; Ht/Wt/BMI; breast exam, if appropriate; cervical cancer screening, if appropriate; STI and HIV screening, as indicated			
Male assessment: STI and HIV screening, as indicated, BP, Ht/Wt/BMI			
Contraceptive Services			
Providers follow U.S. Medical Eligibility Criteria (US MEC) for Contraceptive Use and U.S. Selected Practice Recommendations (US SPR) for Contraceptive Use			
Staff and Providers are signed up to receive US MEC and US SPR updates and use related apps and eBook http://www.cdc.gov/reproductivehealth/unintendedpregnancy/contraception_guidance.htm http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usspr.htm http://www.cdc.gov/reproductivehealth/unintendedpregnancy/qfp.htm			
Staff and providers are signed up to receive updates from the Family Planning National Training Centers http://fpntc.org/home http://fpntc.org/training-and-resources/quality-family-planning-services-mobile-app			
There is documentation that clinic staff have received training on QFP			
Clinic offers a broad range of FDA approved contraceptive methods either on-site or by referral (Section 9.8 and 42 CFR 59.5(a)(1))			
• Barrier methods			
• Consistent and correct use of condoms is encouraged, as appropriate			
• IUCs			
• Hormonal contraceptives			
• Fertility awareness methods including natural family planning			
• Emergency contraception			
This program does not provide abortion as a method of family planning (Title X sec 1008, 300 a-b)			
In determining the appropriate method of contraception, the personal preference of the client receives prime consideration unless the method selected has medical contraindications. Contraindications are explained to the clients (review client medical records)			
Agency offers same day LARCs when appropriate			
A 3 month revisit is provided, if indicated, for clients new to a method (OC, Ortho Evra, Nuva Ring, Depo Provera, Nexplanon) (See US SPR)			
During return visits an interim history is taken (especially for estrogen containing methods), including but not limited to			
• Satisfaction with method			
• Side effects or other problems			
• Change in health status or medications that would change the appropriateness of method			
• Does client wish to change method?			
Blood pressure if indicated			
Laboratory procedures are performed as indicated			
IUC clients are scheduled to return no later than 3 months following insertion, if indicated			
IUC recheck exams includes visualization of the cervix and bimanual exam (See US SPR)			
• Satisfaction with method			
• Side effects or other problems			

• Change in health status or medications that would change the appropriateness of method			
• Does client wish to change method?			
• Lab procedures performed as indicated			
Permanent Sterilization			
Federal sterilization regulations are complied with when sterilization is performed or arranged for by the family planning program. [42 CFR Part 50, Subpart B]			
Counseling and consent process for sterilization assures that the client's decision is completely voluntary			
Agency uses Federal Sterilization Consent. Consents are completed correctly. Required signatures: individual sterilized, interpreter, person obtaining consent, and physician performing the sterilization.			
Contraceptive Method Education/Counseling:			
Information on all contraceptive methods, benefits, risks, effectiveness and potential side effects provided to clients.			
Clients provided CDPHE family planning booklet			
Client centered counseling is provided, including written material (QFP Appendix C). 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, and 5) confirm client understanding.			
Tiered approach to method counseling used, starting with most effective method first			
For clients chosen method there is a process in place for ensuring and documenting client understanding of: • Instructions in correct use of method • Method benefits and risks • Effectiveness of method • Potential side effects and how to manage • Possible complications and danger signs and symptoms of method • How to seek emergency care if needed • How to discontinue method • Except for condoms, method does not protect against STIs (See QFP)			
Counsel client regarding quick start of contraceptive method, when indicated (See QFP)			
Pregnancy Testing and Counseling Services (See QFP)			
Service site must provide pregnancy diagnosis and counseling to all clients in need of this service (42 CFR 59.5(a)(5) Title X Requirement 9.10)			
Pregnancy testing is provided on site			
Service site 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) Title X Requirement 9.11).			
A list of referral sites for all options is available for clients with a positive pregnancy test.			
Clients with a positive pregnancy test who wish to continue their pregnancy are offered initial prenatal counseling and assessment regarding social support			

Clients with a negative pregnancy test who do not wish to be pregnant are offered contraception			
Achieving Pregnancy and Basic Infertility Services (See QFP)			
Provides basic infertility services. Includes initial infertility interview, education, physical exam, counseling and referral. (Section 9.8 and 42 CFR 59.5(a)(1)) (See QFP)			
Preconception Health Services (See QFP)			
One Key Question/reproductive life plan counseling is provided			
Preconception counseling and services are provided regarding future pregnancies, as indicated. (See QFP)			
• Counseling is provided regarding the benefits of folic acid supplementation			
STI and HIV Services (See QFP)			
Providers follow current CDC STD Treatment Guidelines for STI screening and treatment			
Staff and providers are signed up to receive email updates to the CDC STD Treatment Guidelines and have related App http://www.cdc.gov/std/default.htm			
Chlamydia and gonorrhea tests are done on all clients requesting IUC insertions, all clients with PID, other clients as indicated by current screening guidelines including woman 24 y.o. and younger annually.			
Provides STI/HIV risk reduction counseling,			
Offers education about HIV infection and risks, information about PEP and PrEP and community resources for PEP and PrEP			
Knowledgeable regarding linkage to care for individuals living with HIV			
Offers information about and a strong recommendation for the HPV vaccine, as indicated			
If not using the CDPHE lab or MetroPath, site is reporting CT/GC data to CDPHE STI-HIV Section			
Site reports STI positives and treatments to the CDPHE STI Registry			
Additional laboratory services are available as indicated when required by the specific contraceptive method (FDA or prescribing recommendations) or according to screening recommendations as stipulated in QFP or requested			
• Serology for Syphilis			
• Hepatitis B and C screening			
• HIV testing			
Adolescent Services (See QFP)			
Provides adolescent services (Section 9.8 and 42 CFR 59.5(a)(1))			
Complies with HHS legislative mandates:			
• Encourages family participation in the decision of minors to seek family planning services			
• Provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities			
Adolescents are counseled about all methods including LARCs and abstinence			
Adolescents are counseled regarding safe sex practices			
Adolescents are counseled/assured regarding confidentiality of their visits			
Services are youth friendly			
Breast and Cervical Cancer Screening (related preventative health services) (See QFP)			
Provides cervical cancer screening according to ASCCP guidelines			
Sign up for email updates and app at http://www.asccp.org/			
Provides breast cancer screening according to current national guidelines			

Requirements/Recommendations with Source	Yes	No	Comments
Client Services-Consents			
Written program and procedure specific informed consents are signed by the client before receiving medical services/methods are (8.1 Voluntary Participation):			
• Written in a language easily understood by the client			
• Available in other than English if applicable			
• Contain interpreter information, if indicated.			
• General consent form informs clients that services are provided on a voluntary basis			
• General consent form informs clients that acceptance of family planning services is not a prerequisite to receiving other services offered by the agency.			
Medical Emergencies			
Service site provides 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 (Title X Requirement 9.7)			
In order to provide services for emergencies that arise outside of clinic hours, the program has medical back-up through liaison with a hospital, clinic or physician or arrangements for emergency care after clinic hours are (Section 9.7).			
Clients are provided instructions on how to access afterhours emergency care.			
Service site staff document how client wishes to be contacted (e.g. for positive STI test result)			
Service site collects emergency contact information for each client			
Site has written internal plans for the management of on-site medical emergencies to include vaso-vagal reactions, anaphylaxis, syncope, cardiac arrest, shock, hemorrhage, and respiratory difficulties. (Section 9.7 and 42 CFR 59.5(b)(1))			
Training for emergencies is available for staff			
CPR training available to staff			
Pharmaceuticals			
A pharmacy protocol is utilized. The inventory, supply, and provision of pharmaceuticals must be conducted in accordance with state pharmacy laws and professional practice regulations.			
• Protocol is reviewed and signed annually by a Registered Pharmacist			
• Inventory control and reconciliation being performed in a timely manner.			
• Expiration dates are checked regularly and out of date supplies are removed from the shelves in the presence of the pharmacist. Written expired medication disposal policy.			
• All clinic locations are individually licensed.			
• Agency has or is in the process of developing a 340B Policy and Procedure manual based on Apexus sample P&P			
Agency staff are signed up to receive Apexus 340B and HRSA 340B email updates http://www.hrsa.gov/opa/ https://www.340bpvp.com/controller.html			
Referral and abnormal lab follow-up			
Provides 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) Title X Requirements 9.5)			

Provides 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)Title X Requirement 9.4).			
Abnormal lab follow up			
All clients in this program are treated or referred for continuing care when their laboratory tests show abnormal findings			
Clients are notified of abnormal lab test results and notification procedure maintains client confidentiality			
All abnormal labs, i.e. Pap tests, Chlamydia, gonorrhea, lipid screens, etc. are followed through a tracking system.			
Referrals			
Referral recommendations are explained to client			
Program has referral tracking system i.e. log or tickler file as a reminder to staff regarding contacting client and documenting if client has received follow up for referrals and abnormal lab work (if the client was referred for abnormal lab work)			
The program has, by prior arrangement or **written agreement** (where necessary), a group of agencies to whom clients may be referred, because of problems noted at the time of the history and physical exam or laboratory testing, or because of problems arising as a result of the contraceptive method, or because the clients requested an additional evaluation.			
Program has list of referral sites, which includes name, specialty, address, and telephone number of site. Referral list includes health care providers, local health departments, hospitals, voluntary agencies, health services projects, and other federal programs. List is dated.			
Program provides follow up, either directly or by referral, for the following conditions (Section 9.7 and 42 CFR 59.5 (b)(1)):			
• Medical problems beyond the scope of the facility including chronic care management			
• Emergency care			
• Diabetes screening			
• HIV/AIDS care and treatment agencies			
• Positive STI			
• Abnormal cervical cytology			
• Pregnancy related services when appropriate			
• Future planned pregnancies/preconception counseling			
• Infertility work up and/or therapy of an extensive nature			
• Clients or partners of clients requesting information about and/or procedure for sterilization if that service is not available on site			
• Genetic issues			
• Mental health issues			
• Intimate partner violence			
• Sexual abuse/sexual violence			
• Substance use/abuse drug/alcohol/tobacco			
• Nutrition services			
• Health promotion/disease prevention			
• Referral regarding Medicaid eligibility and enrollment			
Mandatory Reporting/Human Trafficking			
Service site complies with state statute regarding mandatory reporting of child abuse, child molestation, sexual abuse, rape, or incest abuse and intimate partner violence (Section 9.12)			
Program has internal written mandatory reporting policy and human trafficking resources for clients and staff.			

Medical Records			
Service site must have safeguards to ensure client confidentiality. Information obtained by the clinic 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 Title X Requirements 10)			
The program maintains complete medical records for every client in accordance with accepted professional standards. The medical records are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling of information, signed by clinician (check client medical records)			
Records are safeguarded against loss or use by unauthorized persons.			
Clients sign a **Notice of Privacy Practices** (review this notice -available in other languages)			
All client contacts, including phone calls, are documented in the medical record			
Personnel			
Nurses are licensed to practice in the state with current nursing license (review license number and expiration date)			
Physicians providing supervision of personnel are currently licensed to practice in the state (review license number and expiration date)			
Family planning clinical services are performed under the direction of a physician with special training or experience in family planning (42 CFR 59.5 (b)(6) Title X Requirements 8.5.4)			
Services provided operate within written clinical protocols that are in accordance with nationally recognized standards of care and are signed by the physician responsible for the service site. (Title X Requirements 9.6)			
There is a written agreement or job description with the physician describing family planning program responsibilities and functions			
Policy is in place re the percentage of charts cosigned by the medical consultant			
Medical policies, procedures, and protocols are in written form			
Medical policies, procedures, and protocols are reviewed and signed by nursing staff and mid-level providers			
Medical services are provided by mid-level providers (NP, CNM, PA)			
• Collaboration according to appropriate act			
• Mid-level providers have prescriptive authority			
• Contract mid-level providers have liability insurance			
Advanced Practice Nurses and Physician Assistants dispense medications following protocols or according to prescriptive authority.			
Registered nurses dispense medication per chart order or physician standing orders.			
Training provided for clinic support staff (e.g. Medical Assistants) regarding Nursing/Medical delegated tasks.			
Quality Assurance			
Agency has written policy/procedure for infection control that includes cleaning of rooms, instruments, and other equipment.			
Agency follows blood borne pathogens (BBP) protocols and conducts periodic staff training (procedure for work site injuries)			
Documentation of periodic maintenance of clinic equipment such as autoclave, hemocue, scale			
Procedures for ensuring effective sterilization of instruments e.g. spore testing			
Client satisfaction surveys obtained in the last 12 months			
Documentation of internal quality assurance and quality improvement activities			

Laboratory			
Facility has CLIA license appropriate for the testing it conducts			
• Laboratory manuals are up to date with CLIA standards, including a wet prep procedure			
• Proficiency testing is done as indicated by type of CLIA license			
• Site uses most current CLIA waived test instructions when performing the tests. The instructions are readily available to staff.			
• Staff run controls for the CLIA waived tests performed according to package insert instructions and document the results			
Lab log is maintained for tracking all labs performed and sent to outside lab.			
• Lab log reflects receipt of results			
• All results are dated and initialed upon receipt			
• There is a system for tracking labs in EMR			

Describe observed clinic flow:

COLORADO
Department of Public Health & Environment
Dedicated to protecting and improving the health and environment of the people of Colorado

FAMILY PLANNING PROGRAM
ADMINISTRATIVE SITE VISIT TOOL

Subrecipient Agency:

CDPHE Staff:

Subrecipient Staff in Attendance:

Date of Visit:

Client Rights and Services			
Requirement	**Met**	**Not Met**	**Remarks**
1. Administrative policies used by programs include a written statement that clients may not be coerced to use contraception, or to use any particular method of contraception or service [42 CFR 59.5 (a) (2)].			
2. The receipt of family planning services is not a prerequisite to receipt of any other services offered by the program [Section 1007, PHS Act; 42 CFR 59.5 (a) (2)].			
3. General consent forms at programs inform clients that services are provided on a voluntary basis and that receipt of family planning services is not a prerequisite to receipt of any other services offered by the program. Please demonstrate that clients have signed a general consent form and have received written or other assurance that services are voluntary.			
4. Documentation (e.g., staff circulars, training curriculum) indicates staff has been informed at least once during their period of employment that services must be provided on a voluntary basis and that a client's receipt of family planning services may not be used as a prerequisite to receipt of any other services offered by the program.			
5. Subrecipient has a written policy stating that programs must provide services without the imposition of any durational residence requirement or a requirement that the client be referred by a physician [42 CFR 59.5(b) (5)].			
6. Documentation demonstrates that staff has been informed at least once during employment that 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)].			
7. Agency personnel have been 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 CFR 59.5(a) (2)].			
8. Documentation demonstrates that staff has been informed at least once during period of employment about policies related to preserving client confidentiality and privacy [42 CFR 59.11].			
9. General consent forms for services state that services will be provided in a confidential manner, and notes any limitations that may apply [42 CFR 59.11].			

10. Client education materials (e.g., posters, videos, flyers) noting the client's right to confidential services are freely available to clients [42 CFR 59.11].			
11. Subrecipient policies and procedures ensure access to services for individuals with disabilities at their sites and maintains documentation of any accommodations made for disabled individuals. [45 CFR 84].			
12. Subrecipient policies assure language translation services are readily provided when needed and staff are aware of these polices and processes [HHS Grants Policy Statement 007, II-23].			
13. Educational materials are tailored to literacy, age, and language preference of client populations. Materials are clear and easy to understand (e.g. 4-6th grade reading level).			
14. Walk us through how your organization's sliding fee scale prices are calculated. What are the common challenges with the SFS?			
Personnel			
Requirement	**Met**	**Not Met**	**Remarks**
1. Subrecipient has written policies and procedures in place that provide evidence that there is no discrimination in personnel administration at its organization. These policies should include, but are not to be limited to, staff recruitment, selection, performance evaluation, promotion, termination, compensation, benefits, and grievance procedures [Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act			
2. Documentation at programs includes records of cultural competence training, in-services, client satisfaction surveys [42 CFR 59.5(b) (10)].			
3. There is an established procedure for orientation and in-service training for all staff that include family planning and Title X specific training [42 CFR 59.5(b)(4)].			
4. Subrecipient maintains written records of orientation, in-service and other training attendance by project personnel.			
5. Orientation includes and staff routinely attends training on Federal and state requirements for reporting or notification of child abuse, child molestation, sexual abuse, rape or incest, as well as on human trafficking.			
6. Orientation includes and staff routinely attends and documents training on involving family member 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.			
7. Subrecipient disaster plans have been developed and are available to staff [29 CFR 191D, subpart E].			
8. Staff has completed training and understands their role in an emergency or natural disaster. Staff can identify emergency evacuation routes.			
9. Subrecipient has established 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 the desire for private financial gain for themselves or others [HHS Grants Policy Statement 2007, II-7].			
Facility			

Requirement	Met	Not Met	Remarks
1. Programs are open at times that are convenient to clients including evenings and/or weekends [42 CFR 59.5 (a) (4)]. Program provides care to walk-in clients.			
2. Clinic environment demonstrates that it is welcoming (i.e., privacy, cleanliness of exam rooms, ease of access to service, fair and equitable charges for services including waiver of fees for "good cause", language assistance.			
3. The physical layout of the facility ensures that client services are provided in a manner that allows for confidentiality and privacy [42 CFR 59.11].			
4. Project sites are free from obvious structural or other barriers that would prevent disabled individuals from accessing services. Exits are recognizable and free from barriers.			
Project Services and Referrals			
Requirement	**Met**	**Not Met**	**Remarks**
1. Subrecipient has developed and implemented plans to address the related social service and medical needs of clients as well as ancillary services needed to facilitate clinic attendance.			
2. Current (i.e., signed within the past 12 months) written collaborative agreements with relevant referral agencies exist, for example: child care agencies, transport providers, WIC programs.			
3. Subrecipient has plans to coordinate with and refer clients to 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)].			
4. Resource and Referral: CDPHE contractors shall offer clients printed resource and referral materials that direct them to the nearest community Medicaid and Connect for Health Colorado enrollment location(s), including online enrollment options. Printed resource and referral materials for Medicaid and Connect for Health Colorado enrollment shall be available for clients with Limited English Proficiency (LEP). Contractors that routinely offer enrollment services on-site are exempt from this requirement because the services provided go beyond this minimum requirement.			
5. Sub-Contracting Title X Services • Do you sub-contract any Title X required services? Y /N • If yes, please present your annual monitoring and evaluation plans and tools. • Is yes, please present the signed MDU / Contract. • If yes, please show us documentation that an in-depth, onsite site visit was performed within the past 24 months, which included review of the administrative, clinical and financial requirements of Title X.			
Community Outreach			
Requirement	**Met**	**Not Met**	**Remarks**

1. The subrecipient has written policy and procedures in place for ensuring that there is an opportunity for community participation in developing, implementing, and evaluating the project plan. Participants should include individuals who are broadly representative of the population to be served, and who are knowledgeable about the community's needs for family planning services [42 CFR 59.5(b) (10)].			
2. The community engagement plan: (a) engages diverse community members including adolescents and current clients, and (b) specifies ways that community members will be involved in efforts to develop, assess, and/or evaluate the program.			
3. Documentation demonstrates that the subrecipient conducts periodic assessment of the needs of the community with regard to their awareness of and need for access to family planning services [42 CFR 59.5(b) (10)].			
4. Subrecipient has a written community education and service promotion plan that has been implemented (e.g., media spots/materials developed, event photos, participant logs, and monitoring reports). The plan: (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, and (d) includes an evaluation strategy [42 CFR 59.5 (b) (3)].			
5. Documentation that the plan has been implemented, evaluation has been conducted, and that program activities have been modified in response (e.g. reports, meeting minutes, etc.).			
Information and Education Materials Approval			
Requirement	**Met**	**Not Met**	**Remarks**
1. Subrecipient has policies and procedures that ensure materials are reviewed prior to being made available to the clients that receive services within the project. [Section 1006 (d)(2), PHS Act; 42 CFR 59.6(a)].			
2. Subrecipient maintains a list of approved materials, approved for use in the service sites by the I&E committee.			
3. Committee meeting minutes demonstrate the process used to review and approve materials.			
4. Subrecipient has established a project advisory board that is comprised of members who are broadly representative of the population served [42 CFR 59.6 (b)(2)].			
5. Subrecipient has documentation (meeting minutes, lists of board members, etc.) that demonstrates the advisory board requirement has been met.			
6. Subrecipient has policies and procedures addressing the required size of an Advisory Committee - five to nine members [42 CFR 59.6 (b)(1)]. The Advisory Committee must review and approve all I&E materials prior to distribution [Section 1006 (d)(1), PHS Act; 42 CFR 59.6(a)].			
7. Subrecipient maintains and updates lists/rosters of Advisory Committee members, and meeting minutes - indicating that the committee is active.			

8. Subrecipient policies and procedures that document the Information and Educational Advisory Committee's role to [Section 1006(d), PHS Act; 42 CFR 59.6(b)]: • 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			
9. Meeting minutes and/or review forms document that all required components are addressed for the I&E Committee.			
Administration			
Requirement	**Met**	**Not Met**	**Remarks**
1. Subrecipient should notify CDPHE in writing of any research projects that involve Title X clients [HHS Grants Policy Statement 2007, II-9].			
2. Data from client experience surveys document that clients perceive providers and other clinic staff offer services in a non-discriminatory manner (e.g., provider communicates well, spends enough time, is helpful and courteous, etc.).			
3. Website Review: Please show us the family planning / Title X section to your organization's website. Is the nondiscrimination statement included? Up -to-date hours of operation, costs and services available? Tell us about your quality control of the data on the website and ensuring accuracy.			
4. iCare Data: Please walk us through how your organization ensures iCare data is inputted correctly from the client chart into the CDPHE iCare system. Tell us about your quality control of data and ensuring accuracy.			

iCare: The organization should pull 5 recent client charts. CDPHE staff will review what services were received, confirm the income code and then ensure the sliding fee scale was correctly applied to the visit (either by hand or in an electronic health record).

	Chart # (iCare#)	Income code recorded? Current?	Client assigned correct income code?	Charges for services complete and accurate?	Comments
1					
2					
3					
4					
5					

<table>
<tr><th>Title X Program Requirement</th><th>Implementation Strategy</th><th>Assessment</th></tr>
<tr>
<td>8.4 Charges, Billing, and Collections

8.4. 1 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)).

Although not required to do so, grantees that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on the client's self-report.</td>
<td>Evidence that this requirement has been met includes:

1. (F) Grantee has 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.

There is evidence of the grantee's oversight of sub-recipients/service sites including:

2. (F) Financial documentation at the service site indicates clients whose documented income is at or below 100% FPL are not charged for services.
3. (F) Financial documentation at the service site indicates that if a third party is authorized or legally obligated to pay for services, the project has billed accordingly.
4. (F) Service sites follow a written policy and procedure for verifying client income that is aligned with Title X requirements.
5. (F) Service site policy and procedures for verifying client income does not present a barrier to receipt of services.</td>
<td>Grantee Policies
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table>Financial Documentation- charges
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table>Financial Documentation- Third Party Billing
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table>Sub-Recipient Policies for Verifying Income
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr></table></td>
</tr>
</table>

		Comments: Sub-Recipient Policy and Procedures Met ☐ Not Met ☐ N/A ☐ Comments:
8.4.2 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: 1. (F) Grantee has policies and procedures requiring that a schedule of discounts be developed for services provided in the project and updated periodically to be in line with the FPL. There is evidence of the grantee's oversight of sub-recipients/service sites including: 2. (F) Service site documentation indicates client income is assessed and discounts are appropriately applied to the cost of services.	Grantee Policies and Procedures Met ☐ Not Met ☐ N/A ☐ Comments: Documentation at Service Site Met ☐ Not Met ☐ N/A ☐ Comments:
8.4.3 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: 1. (F) Grantee has policies and procedures that require sub-recipients to have a process to refer clients (or financial records) to the service site director for review and consideration of waiver of charges.	Grantee Policies and Procedures Met ☐ Not Met ☐ N/A ☐

	2. (F) Documentation at the service site demonstrates a determination is made by the service site director, is documented and the client is informed of the determination.	Comments: Documentation at Service Site Met ☐ Not Met ☐ N/A ☐ Comments:
8.4.4. 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: 1. (F) Grantee has documented policies and procedures requiring sub-recipients and service sites to have a sound rationale and process for determining the cost of services. There is evidence of the grantee's oversight of sub-recipients/service sites including: 2. (F) Financial records indicate client income is assessed and that charges are applied appropriately to recover the cost of services.	Grantee Policies and Procedures Met ☐ Not Met ☐ N/A ☐ Comments: Documentation at Service Site Met ☐ Not Met ☐ N/A ☐ Comments:
8.4.5 Eligibility for discounts for unemancipated 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: 1. (F) Grantee policies and require service sites to have a process for determining whether a minor is seeking confidential services and stipulates that	Grantee Policies-Minor Confidentiality Met Not Met N/A

	charges to adolescents seeking confidential services will be based solely on the adolescent's income. There is evidence of the grantee's oversight of sub-recipients/service sites including: 2. (F) Client records indicate appropriate implementation of policy.	☐ ☐ ☐ Comments: Grantee Oversight- Met / Not Met / N/A ☐ ☐ ☐ Comments:
8.4.6 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: 1. (F) Grantee policies and procedures require that all project sites bill insurance in accordance with Title X regulations. There is evidence of the grantee's oversight of sub-recipients/service sites including: 2. (F) The grantee can demonstrate that it (and/or its sub-recipients) has contracts with insurance providers, including public and private sources. 3. (F) Financial records indicate that clients with family incomes between 101%-250% FPL do not pay more in copayments or additional fees than they would otherwise pay when the schedule of discounts is applied.	Grantee Policies and Procedures Met / Not Met / N/A ☐ ☐ ☐ Comments: Contracts with 3rd Parties Met / Not Met / N/A ☐ ☐ ☐ Comments: Charges and Collection Records at 5ervice Site Met / Not Met / N/A

		☐ ☐ ☐ Comments:

8.4.7 Where reimbursement is available from Title XIX or Title XX of the 5ocial 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: 1. (F) Grantee maintains written agreements and ensures they are kept current, as appropriate. There is evidence of the grantee's oversight of sub-recipients/service sites including: 2. (F) Documentation indicates that the grantee maintains oversight of its sub-recipients' agreements with Title XIX and/or Title XX.	Grantee Policies and Agreements Met / Not Met / N/A ☐ ☐ ☐ Comments: Grantee Oversight Met / Not Met / N/A ☐ ☐ ☐ Comments:
8.4.8 Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.	Evidence that this requirement has been met includes: 1. (F) Grantee has policies addressing collection by service sites that include safeguards that protect client confidentiality, particularly in cases where sending an explanation of benefits could breach client confidentiality. There is evidence of the grantee's oversight of sub-recipients/service sites including:	Grantee Policies Met / Not Met / N/A ☐ ☐ ☐ Comments:

	2. (F) Documentation demonstrates that clients' services remain confidential when billing and collecting payments.	Documentation at Service Site Met ☐ Not Met ☐ N/A ☐ Comments:
8.4.9 <u>Voluntary</u> 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: 1. (F) Grantee policies and procedures indicate if the project service sites may request and/or accept donations. There is evidence of the grantee's oversight of sub-recipients/service sites including: 2. (F) Onsite documentation and observation demonstrates that clients are not pressured to make donations and that donations are not a prerequisite to the provision of services or supplies. Observation may include signage, financial counseling scripts, or other evidence.	Grantee Policies and Procedures Met ☐ Not Met ☐ N/A ☐ Comments: Documentation at Service Site Met ☐ Not Met ☐ N/A ☐ Comments:

<table>
<tr>
<td>8.3.3 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)).</td>
<td>Evidence that this requirement has been met includes:

1. (F) Policies clearly indicate the approval process for any services that are purchased for participants.
2. (F) Documentation of purchases demonstrates that the grantee's established policies and procedures are followed.</td>
<td>Grantee Policies
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table>Review of Purchases
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table></td>
</tr>
<tr>
<td>8.3.4 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)).</td>
<td>Evidence that this requirement has been met includes:

1. (F) Grantee contracts clearly indicate the schedule of rates and payment procedures for services.
2. (F) The grantee can substantiate that the rates are reasonable and necessary. This includes demonstrating the process and/or rationale used to determine payments, examples of financial records, applicable internal controls.</td>
<td>Grantee Sub-contracts
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table>Process for determining rates
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table></td>
</tr>
</table>

<table>
<tr>
<td>8.3.6 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).</td>
<td>Evidence that this requirement has been met includes:

1. (F) Grantee financial policies and procedures can be referenced back to federal regulations as applicable.
2. (F) Grantee financial records and oversight documentation demonstrates that the financial management practices within all project sites are aligned with Title X and other applicable regulations and grants requirements.</td>
<td>Grantee Policies
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table>
2Documentation-Oversight
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table></td>
</tr>
<tr>
<td>8.5.5 Appropriate salary limits will apply as required by law.</td>
<td>Evidence that this requirement has been met includes:

1. (F) Documentation such as budgets and payroll records that indicate that the grantee is complying with required salary limits as documented in the most current family planning services Funding Opportunity Announcement (FOA).</td>
<td>Documentation
<table><tr><th>Met</th><th>Not Met</th><th>N/A</th></tr><tr><td>☐</td><td>☐</td><td>☐</td></tr><tr><td colspan="3">Comments:</td></tr></table></td>
</tr>
</table>

COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

May 7, 2018

To Whom This May Concern:

The Colorado Department of Public Health and Environment's Family Planning Program certifies that, if funded, the Title X Family Planning Services Project will encourage family participation in the decision of minors to seek family planning services, and that it will provide counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

Jody Camp

Jody L Camp

CDPHE Family Planning Section Manager

Attachment P: Letter of Committment from Sub-Recipient Agencies

Letter of Commitment
Colorado Family Planning Program

May 2018

This document serves as a letter of commitment to partner as a Title X subrecipient with the Colorado Department of Public Health and Environment's Family Planning Program. The agencies listed below have reviewed the requirements, roles, and responsibilities of participation in the project and attest to their expertise, experience and access to Title X target population.

Designated agents who have signed this document commit to fully participate in the following activities of the project from September 2018 to September 2022. The designated agents affirm to provide the following as part of the project commitment:

a. Contraceptive services;
b. Preventative health counseling and education services;
c. Reproductive health related testing;
d. Preconception health services and discussion with clients regarding reproductive life plans;
e. Screening and Referrals;
f. Other services and activities, as required by Title X and Colorado State regulations.

The designated agents who have signed this document affirm that the agency shall:

a. Adhere to Title X program requirements, including the prohibition of funds being used for abortion;
b. Prioritize and care for low income clients, that are at 100% of the federal poverty level and below;

c. Provide all services on a sliding fee scale for clients with incomes that are at or below 250% of the federal poverty level;

d. Prioritize and care for adolescent clients, that are 19 years of age or younger;

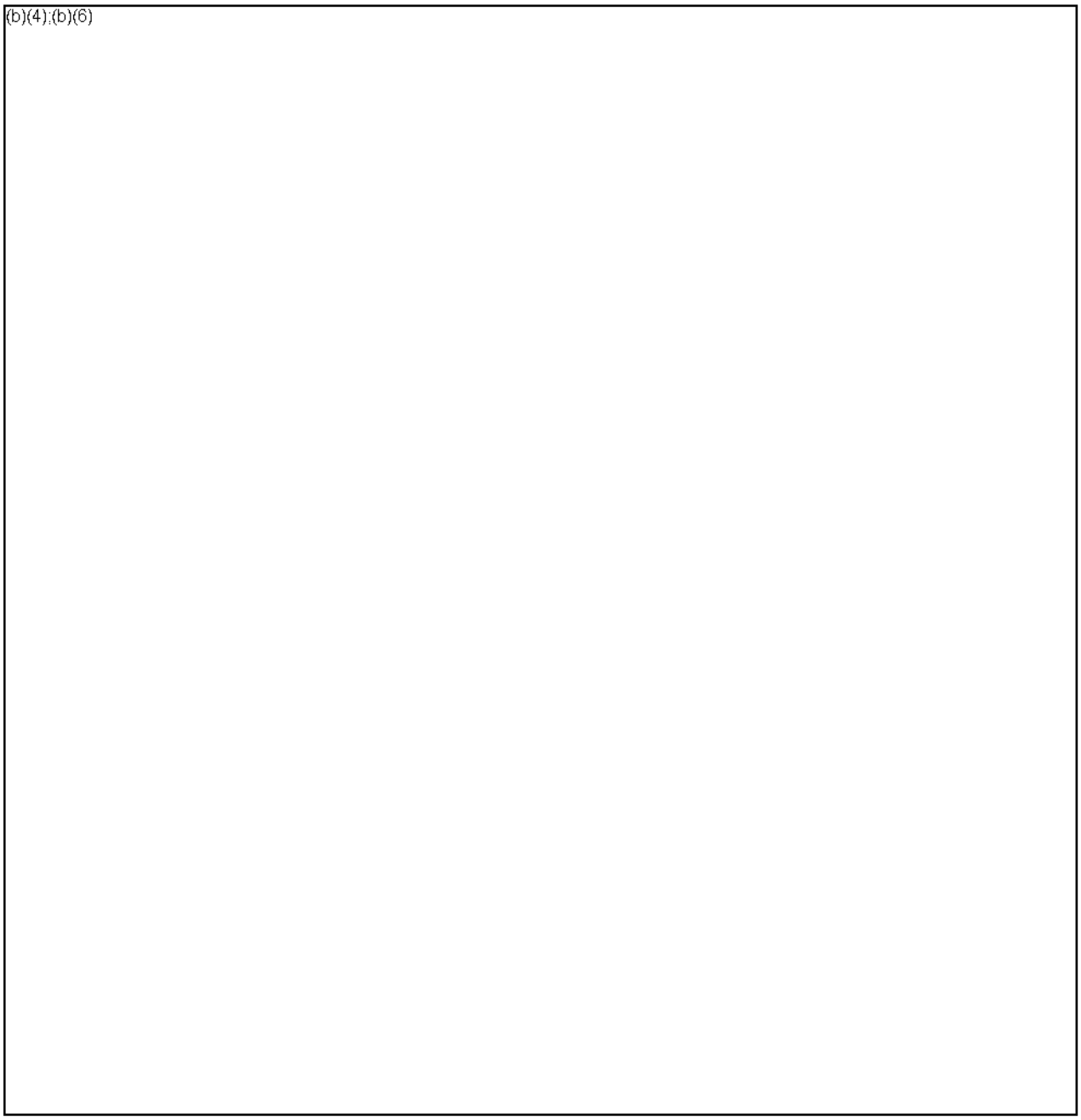
e. Compile appropriate data regarding family planning visits;

f. The agency is currently providing family planning services in their clinics, have appropriate personnel to run the Title X program and have evidence to the agencies experience and expertise in the family planning services provided.

g. Invest time and effort in the annual Title X priorities and key priorities, as featured in on the Office of Population Affairs website: https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/program-priorities/index.html

The signing authority for each agency listed below has given approval via email to electronically sign their name to this letter of commitment. Documentation of this approval is available upon request. Agency signatures affirm that the delegate agency understands and is committed to the proposed Title X project, and that they will be fully engaged in activities and plans. Agencies will follow through on these commitments, regardless of changes in agency leadership, budget modifications, or other foreseeable events.

Delegate Agency	Service Area – Counties	Signing Authority Approval
(b)(4);(b)(6)		


(b)(4);(b)(6)

Services Required to Slide on the Sliding Fee Scale
Colorado Family Planning Program

May 2018

Laboratory Services	
Services	When Required to Slide
Blood Draw/Venipuncture	With a lab for a BC method
Collection of Capillary Blood Specimen	With a lab for a BC method
Hematocrit or Hemoglobin	Pre-IUD or for BC method
Chlamydia	Pre-IUD; females <25 years; one screening test annually.
Gonorrhea	Pre-IUD; females <25years; one screening test annually
Pap Test/ HPV 88141/87621	With an initial or annual exam
Urine pregnancy - 81025	Always
Serum pregnancy	If urine not offered or if used for BC method
Medical Procedures	
Services	When Required to Slide
New Patient - Focused (99201)	When includes FP-related service(s)
New Patient - Expanded (99202)	When includes FP-related service(s)
New Patient - Detailed (99203)	When includes FP-related service(s)
New Patient - Comprehensive (99204)	When includes FP-related service(s)
Established Patient - Minimal (99211)	When includes FP-related service(s)
Established Patient - Focused (99212)	When includes FP-related service(s)
Established Patient - Expanded (99213)	When includes FP-related service(s)
Established patient - Detailed (99214)	When includes FP-related service(s)
New Patient Prev. - 12-17 years (99384)	When includes FP-related service(s)
New Patient Prev. - 18-39 years (99385)	When includes FP-related service(s)
New Patient Prev. - 40-64 years (99386)	When includes FP-related service(s)
Est. Patient Prev. - 12-17 years (99394)	When includes FP-related service(s)
Est. Patient Prev. - 18-39 years (99395)	When includes FP-related service(s)
Est. Patient Prev. - 40-64 years (99396)	When includes FP-related service(s)
Individual Counseling, 15 minutes (99401)	When includes FP-related service(s)
Individual Counseling, 30 minutes (99402)	When includes FP-related service(s)
Individual Counseling, 45 minutes (99403)	When includes FP-related service(s)
Diaphragm Fitting (57170)	Always
Nexplanon Insertion (11981)	Always
Implant Removal (11976 or 11982)	Always

Medical Procedures Continued	
Services	When Required to Slide
Implant Removal with Reinsertion (11983)	Always
IUD Insertion (58300 with -51 or -59)	Always
IUD Removal (58301)	Always
Supplies	
Services	When Required to Slide
Condoms *	Always
Cycle Beads *	Always
Depo Provera	Always
Diaphragm	Always
Diaphragm Jelly *	Always
EC (Plan B) *	Always
Ortho Evra Patch	Always
FemCap *	Always
Nexplanon	Always
IUD, Non-Hormonal	Always
IUD, Hormonal	Always
NuvaRing	Always
Oral Contraceptives	Always
Spermicide *	Always
Azithromycin	< 25 and/or pre-IUD (+ CT result)
Ceftriaxone	Pre-IUD (+ GC)/related to birth control method
Doxycycline	< 25 and/or pre-IUD (+ CT)

** If offered onsite, must slide on sliding fee scale.*

COLORADO
Department of Public
Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

April 2018

CDPHE Schedule of Discounts

The CDPHE FPP does not set a sliding fee scale for all delegate agencies. Rather, they create their own fee schedule that is appropriate for their community, patients and organization.

Schedule of Discounts (Sliding Fee Scale): In March of 2018, the FPP hired [(b)(6)] and Associates to oversee the training and review of CDPHE's 30 delegate agency with their cost-setting activities and sliding fee scales. [(b)(6)] and Associates are experts in cost-setting, and ACA readiness and implementation, especially within the local public health model of health care delivery. In March, [(b)(6)] hosted three training webinars on cost-setting, formulas and philosophies. CDPHE encourages delegates to set their fees according to their true costs and ensure payment of services, as appropriate for the patient. Because the 30 agencies vary in their business models, no one cost analysis model fits all. In May, [(b)(6)] will review several different methods of cost-setting for accuracy, fairness and incremental cost structure steps between 101 and 250 percent of federal poverty level, and will give technical assistance and follow-up with delegate agency questions. By June 2018, all 30 cost-setting activities and subsequent sliding fee scales will be validated by [(b)(6)] and approved by CDPHE staff. During both the 2015 and 2017 OPA Federal Review, [(b)(6)] met with [(b)(6)] staff and praised and approved this effort of training and review.

In Colorado, cost-setting activities must be done every three years or at any time there is a drastic change in costs or business models. As required by Title X guidelines, no client is ever denied services due to an inability to pay, and clients with incomes at or below 100 percent of the federal poverty level are not charged for required Title X services.

Examples of Sliding Fee Scale Models for Colorado are as follows:

- 5 Code Model

Income as % of Poverty Guidelines	CPT Code	0-100% Code 1	101-150% Code 2	151-200% Code 3	201-250% Code 4	250-350% Code 5	350% + UCR
% Pay Status	**Cost**	(b)(4)					
Supply Pick Up (No appointment)							
New Patient-Focused (Visit & supply pick up / Pregnancy Test)	**99201**						
New Patient-Expanded (Minimal Visit)	**99202**						
New Patient-Detailed (Moderate Visit)	**99203**						
New Patient-Comprehensive	**99204**						

- 6 Code Model

Poverty Level	Code	% of Full charge
<100%	1	0%
101-150%	2	20%
151-185%	3	40%
186-220%	4	60%
221-250%	5	80%
>250%	6	100%

Upload #4

Applicant:	Colorado Department of Public Health and Environment
Application Number:	FPH2018008758
Project Title:	Colorado Family Planning Program
Status:	Review in Progress
Document Title:	ProjectNarrativeAttachments_1_2-Attachments-1234-Project Narrative_Title X App_FINAL.pdf

2018-2019 Title X Project Narrative

Q1: A clear description of the need for the services provided and a detailed description of the geographic area and population to be served

Q1 Response: The target population in Colorado for this application has a clear need for services. There are still thousands of people without insurance coverage in need of safety net reproductive health care. The Colorado Department of Public Health and Environment Health Statistics and Evaluation Branch calculated the 2017 number of Colorado women without coverage for family planning services using data from the 2017 Colorado Health Access Survey. This calculation begins with the total Colorado female population in 2017 and determines the percent in need of family planning services (defined as sexually active women who are able to bear children, who are not pregnant and who do not desire a pregnancy). The number covered by Medicaid, private insurance and those who remain uninsured are also estimated. A conservative estimate is also made of the number of women with insurance who do not use their insurance because they fear a breach of confidentiality. Table 1 below shows the calculations.

Table 1: Colorado Women Without Coverage for Family Planning, 2017

Population				**Insured**			**Women Without Coverage**		
Age and Poverty Groups	Total Female Population, 2017	Percentage in Need of Family Planning*	Number in Need of Family Planning	Total Covered by Insurance	Covered by Medicaid	Covered by Non-Medicaid Insurance	Uninsured	Estimated Number Covered But Not Using Insurance**	**Total Uninsured plus Women Covered But Not Using Insurance**
Ages 13-19	261,632	29%	75,900	73,200	13,000	60,200	2,700	3,800	6,500
Ages 20-44	950,301	68%	646,200	591,000	118,100	472,900	55,300	30,800	86,100
Below 139% FPL	226,228	65%	147,000	134,000	65,300	68,700	13,100	7,000	20,100
139% to 250% FPL	148,246	61%	90,400	76,700	21,000	55,700	13,700	4,000	17,700
Above 250% FPL	575,827	71%	408,800	380,300	31,800	348,500	28,500	19,800	48,300
Total Ages 13-44	1,211,933	60%	722,100	664,200	131,100	533,100	58,000	34,600	**92,600**

*Guttmacher 2012 estimates. Sexually active women who are able to bear children who are not pregnant and who do not desire a pregnancy.

**An estimated 5.2% of women fall in this category. The percentage is based on a provider survey done in June 2015 by the Colorado Department of Public Health and Environment. The primary reason for not using insurance is concern for breach of confidentiality.

This calculation arrived at 92,600 females without family planning coverage in Colorado. Considering CDPHE's Title X program served 41,684 women in 2016, the need for subsidized (Title X) family planning services is evident as fewer than half of all women without coverage are being served by the program.

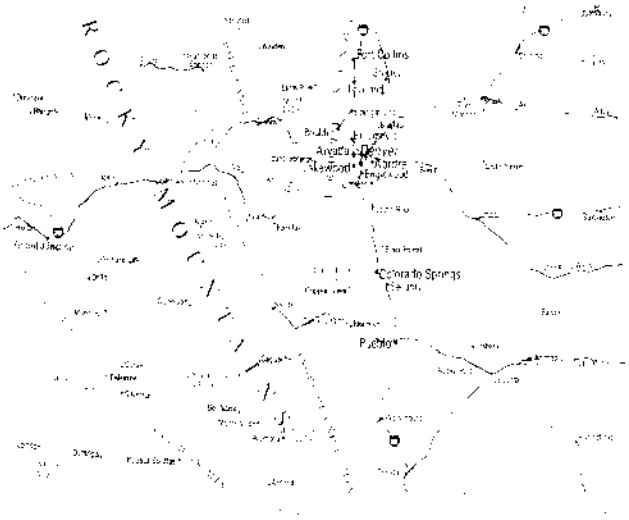
Males: In 2017, 2,853 of the 7,474 men served through CDPHE Family Planning Program (FPP) were 24-years or younger demonstrating that younger men, oftentimes still school-aged, are in need and seeking sliding fee scale family planning services. Moreover, 2016 Small Area Health Insurance Estimates (SAHIE) show that 16.6 percent of male, ages 16-64 years and <200 percent of Federal Poverty Level are uninsured in Colorado, indicating the need for safety-net health services for men.

While the Colorado economy is strong, there are still lower-income families who continue to struggle, facing food insecurity, inadequate housing and other challenges as described below:

- Nearly 1 in 7 Coloradans struggle with hunger, facing times when there is not enough money to buy food. (*Household Food Security in the United States in 2014, 9/2015)*
- Nearly 1 in 8 Coloradans live in poverty, including more than 1 in 6 children. *(U.S. Census Bureau, American Community Survey 2015 data)*
- Among all Colorado children, those under the age of six are most likely to be in poverty. They also are most at risk of living in homes without enough food. *(Colorado Children's Campaign, 2014 KIDS COUNT Colorado!)*
- Compared to other state participation rates, Colorado ranks 20th in school breakfast participation and 46th in SNAP/food stamps participation. *(Food Research and Action Center, School Breakfast Scorecard, February 2015)*

- Colorado ranks 30th in affordable housing. *(National Low Income Housing Center, Housing Spotlight 4 (1) (2014))*

This data, along with the Table 1 calculation, serve as compelling evidence that there is a need among families and individuals for safety net family planning services in Colorado.



Geography: The state of Colorado is bisected from north to south by the Rocky Mountains, dividing it into Eastern and Western Slopes. Eighty-six percent of the state's population lives in 16 metropolitan counties along the Front Range of the Eastern Slope and Mesa County on the Western Slope. The other 14 percent of the population is scattered throughout Colorado's 48 rural and frontier counties. Confirming the rural vastness of the state, 21 of Colorado's 64 counties are considered frontier, defined as having a population density of fewer than six persons per square mile. While beautiful and diverse, this geography creates a striking barrier in access to health care for Coloradans. Nearly all Colorado counties have some part of the county designated as a Health Professional Shortage or Medically Underserved Area (HPSA). The HPSA designation describes a community's need by the number of providers available to the population or a subset of the population. In addition, 51 of the 64 counties have some part of the county federally designated as a Medically Underserved Area. Despite previous increases in funding for community health center expansions, many of the Denver metropolitan area community health centers are at or over-capacity with extended waiting

periods for appointments and Colorado's rural areas are struggling to find qualified providers who will relocate to rural areas.

Population: Colorado's 2017 population was an estimated 5,655,405 and is expected to grow to 6,141,100 by 2022. The 2017 number of women of reproductive age (15-44 years) was estimated to be 1,136,800 and is anticipated to reach 1,247,700 by 2022. The vast majority (81percent) of the state's residents are white, non-Hispanic. The population includes 4 percent black/African Americans, 3 percent Asians, and 1 percent American Indians. Seven percent of the population identifies itself as some other race and 3 percent is classified as two or more races. When ethnicity is considered, fully 21 percent of the population identifies itself as Hispanic. Colorado residents are slightly younger than the rest of the nation, with a median age of 36.1 years compared to 37.2 years nationally.

Fertility: In 2016, there were 66,611 births in the state of Colorado. With births peaking at their highest in 2009 in the past two decades, the state experienced a decline in births beginning in 2010. Although the numbers recovered slightly in 2014 and 2015, the total is still some 2,000 births below the 2009 high of 68,605. Table 2 below shows the numbers of births in 2009 and 2016 by race/ethnicity. Births to white, non-Hispanic women currently comprise about six in ten births; births to white Hispanic women make up about two in ten. The largest numerical decline between 2009 and 2016 was in Hispanic births, which dropped by more than 3,200 (18 percent). The largest numerical increase was among Asian births, which increased by 742 (30 percent).

Table 2: Colorado Births by Race/Ethnicity 2009 and 2016	**2009**	**2016**
Total	68,605	66,611
White Non-Hispanic	40,975	40,185
White Hispanic	17,814	14,597
Black	3,304	3,836

Asian	2,486	3,228
American Indian	701	756
Other/Unknown	3,325	4,009

Table 3 below contains data on the number of births and the age-specific fertility rates for Colorado in 2009 and 2016. The numbers and rates fell between these time periods for every group below age 30, and only slight increases occurred for those over age 30. The drop in the fertility rate for teens showed the most substantial decline, falling 54 percent over seven years, from 37.5 to 17.1, an unprecedented change. A large decline of 30 percent is noted for women 20 to 24 as is the decline of 16 percent for women 25 to 29. The fertility rate for the age group 25 to 29 was the highest rate in 2009; by 2016 the highest rate shifted to ages 30 to 34.

Table 3: Colorado Births and Fertility Rates by Age, 2009 and 2016				
	Number		**Rate**	
Ages	**2009**	**2016**	**2009**	**2016**
10-14	71	35	0.4	0.2
15-19	6,201	3,053	37.5	17.1
20-24	15,256	11,818	91.9	64.7
25-29	19,105	18,704	111.4	93.9
30-34	17,130	20,404	96.1	96.3
35-39	8,885	10,365	51.3	55.3
40-44	1,898	2,064	11.2	11.9
45-49	133	132	0.7	0.7
*Births per 1,000 women in the age group				

Beginning in 2009, the CDPHE Colorado Family Planning Initiative (CFPI) provided substantial funding to increase patient load and to promote long-acting reversible contraception among Title X clients who wanted them. The availability of no- or low-cost intrauterine devices (IUDs) and implants contributed to the declines that occurred statewide. The 2016 Colorado Behavioral Risk Factor Surveillance System Behavior (BRFSS) survey data show that one out of every four women in Colorado using contraception is using an IUD or an implant, and the proportion using the same methods among Title X clients was one in three in 2016. Prior to the CFPI program, just one in 12

Colorado women using contraception was using an IUD or implant (2006 data) as was just one in 12 Title X patients (2008 data).

Unintended Pregnancy: Reductions in birth rates reflect reductions in unintended pregnancy, as abortion rates fell at the same time as birth rates fell. In 2009, for example, teens ages 15-19, had an abortion rate of 10.3 induced terminations per 1,000 women, but by 2016 the rate had fallen sharply to 3.8. Estimates of unintended pregnancy rates combine data on unintended births from the Pregnancy Risk Assessment Monitoring System with abortion data. Among teens in 2009, an estimated 35 pregnancies per 1,000 were unintended. By 2016, this number dropped to 17, a greater than 50 percent decline. ***Among young women ages 20-24, the 2009 rate of 75 unintended pregnancies per thousand fell to 49 in 2016, a drop of 35 percent. Among all women ages 15-44, the unintended pregnancy rate fell from 37 to 29 per thousand, a decline of 22 percent.*** While the drops in unintended pregnancies are notable, especially among young women, it is important to point out that the rates remain high. The 2016 rate of 17 unintended pregnancies for every 1,000 teens is based on the more than 3,000 unintended pregnancies that occurred, and the rate of 49 unintended pregnancies for women 20 to 24 is based on more than 9,100. In fact, for all women in 2016 the number of unintended pregnancies amounted to 33,130, a number that forcefully underscores the continuing need for safety net, family planning services in Colorado.

Q2: Evidence that proposed projects will address the family planning needs of the full population in the service area to be covered;

Q2 Response: CDPHE's proposed project covers all of Colorado's 64 counties and meets the family planning needs of patients, statewide. Through a vast network of delegate agencies (sub-recipients), CDPHE's FPP has successfully managed the Title X grant and built on lessons learned to meet the family planning needs of low-income Coloradans for the past 48 years. The activities below, along with FPP's 2018-2022 work plan (see Appendix A: 2018-2022 work plan)

demonstrate that the proposed project will meet the family planning needs of the state's diverse population.

- After decades of cultivating partners in the field, CDPHE FPP currently has a statewide network of 30 delegate agencies, serving patients in over 75 clinics statewide. Partners include Federally Qualified Health Centers, large hospitals, public health clinics and nonprofit agencies. This variety of clinical settings allows Title X patients access to the full spectrum of health care, including primary, dental and mental health services at some sites. (see Appendix B: 2018 Service Site Map)
- Delegate agencies are skilled at addressing family planning and other health needs of individuals, families, and communities through outreach to hard-to-reach populations and by partnering with primary care providers, other community-based health and social service providers, school based health centers and faith-based organizations. The FPP and its delegate agencies have served low-income people over the past four decades and understand the outreach strategies needed to be successful. In recent years, the FPP served an average of 50,000 individuals each year, 89 percent of whom are at or below 150 percent of the federal poverty level (2017 Family Planning Annual Reports data).
- In some communities, delegate agencies partner with school based health centers to provide health education, counseling and contraceptives to school-aged youth.
- The FPP is considered a government champion and innovator of women's health and family planning, and has the full support of CDPHE leadership, Colorado Medicaid leadership and the Colorado Department of Corrections (DOC) and the Governor's Office. In addition, since 2011, CDPHE selected Reducing Unintended Pregnancy as one of Colorado's 10 Winnable Battles: https://www.colorado.gov/pacific/cdphe/colorados10winnablebattles

- The FPP has in-house fiscal and contracting expertise to ensure the highest stewardship and due diligence of Title X funds. The FPP also receives support from the Colorado General Fund (state funds). In recent years, fourteen local foundations and an anonymous CFPI donor helped to leverage the Title X budget and expand the Family Planning Program statewide.

Q3: Evidence of experience in the particular service area and with the particular community to be served;

Q3 Response: CDPHE FPP's cadre of delegate agencies have the experience needed in their communities to meet the needs of Title X clients. The following are just a sample of the vast experience our agencies possess:

- Delegate agencies possess the capacity and capability to serve the family planning needs of Colorado's linguistically diverse residents with staff trained on the Limited English Proficiency (LEP) Executive Order. This allows delegates to provide clients from all linguistic backgrounds with meaningful access to federally funded and operated programs and activities, thereby reducing LEP as a barrier to reproductive health equity.
- All delegates are trained on The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards).
- Agencies participated in multiple trainings focused on cultural competency as well as expanding male services, parental involvement, teen-friendly clinics, and human trafficking.
- The CDPHE FPP recruited unique and innovative partners specializing in particular areas or particular communities. For example, The Colorado Coalition for the Homeless, an FQHC delegate agency, not only focuses on the family planning needs of homeless people that come into their clinics, they also hire outreach workers to meet the needs of patients where they "live." CDPHE recently acquired a Federally Qualified Health Center partner, High Plains Medical

Center, which serves people in the southeast corner of Colorado. High Plains created a network of four, smaller extension clinics to better serve the rural communities of the region. Another delegate agency provides outreach to the LGBTQ and transgender community to provide critically needed health services, including family planning, that are culturally competent and inclusive of all community members.

- The CDPHE FPP is currently collaborating with the Colorado Department of Corrections (DOC) and other CDPHE programs to better serve their incarcerated female population. In 2018-2019, a subset of CDPHE FPP contractors will provide health education sessions in the Denver and Pueblo women's prisons. Training topics will include family planning, breast and cervical cancer screenings, sexually transmitted infection prevention, and heart health. In addition, CDPHE FPP will train the DOC clinical providers in LARC insertion and removal, and counseling techniques across all family planning methods. Roughly 2,000 female inmates continuously cycle through both prison systems, and roughly 50 women are in pre-release programs every month. During the pre-release period, CDPHE FPP will provide contraceptive counseling across the broad range of acceptable and effective family planning methods to inmates while DOC will provide contraceptives for women who choose them. Both DOC and CDPHE FPP are committed to the success of this collaboration and to better serve incarcerated women, particularly as they re-enter the community. The collaborative goals include addition of long-acting, reversible contraceptive methods to the DOC formulary and for CDPHE FPP to continue to provide family planning training to their clinical staff.
- The majority of FPP's delegate agencies have been contractors for several decades and have local support and commitment of the community to ensure they are meeting the needs of the men and women that live there.

Q 4: Evidence that proposed projects have experience in providing clinical health services, are qualified to deliver family planning services, and have the capacity to undertake family planning and related health services required in statute and regulation, including a broad range of acceptable and effective family planning methods, natural family planning methods, infertility services and services for adolescents. A complete list of the family planning methods offered as part of the project should be included. Projects may consist of a single provider or a group of partnering providers who deliver coordinated and comprehensive family planning services. Each project should offer core family planning services as described earlier in this Funding Announcement. Each project must provide the full array of required services under this grant.

Q4 Response: CDPHE's FPP has forty-eight years of experience successfully implementing the Title X grant, and maintains the capacity and support to continue managing program and clinical services. The FPP, located in the Family Planning Unit, is one of four units in the Health Services and Connections Branch. To ensure that all Title X clinical, fiscal, contracting, and data meet all requirements, FPP works collaboratively with the Fiscal, Contracts, Compliance and Operations (FCCO), Health Informatics Branch, and the Health Surveys and Evaluation Branch at CDPHE. The FPP and its delegate agencies are specially trained and qualified, and have the capacity to deliver high quality, culturally competent family planning services throughout the state across the broad range of acceptable and effective family planning methods. Experience and qualifications of FPP staff include the following:

- **Contracted Medical Consultant**, (b)(6) MD, is a board-certified obstetrician/gynecologist contracted to provide medical consultation in the form of medical policy and protocol review and approval. She also consults with the FPP on medical questions or individual client management issues. Dr. (b)(6) has served as FPP's medical consultant for the past seven years.
- **Nurse Consultant**, (b)(6) RN, MS, provides ongoing clinical consultation regarding client management issues and implementation of clinical guidelines to local delegate agency and state agency staff. (b)(6) directs quality assurance and improvement activities,

conducts clinical site visits, and reviews agency medical records to evaluate appropriateness of medical care and adequacy of clinical documentation. This position develops clinical policies and protocols for the CDPHE FPP Clinical Manual to meet Title X requirements and services as described in the Quality Family Planning to assure compliance with federal regulations for the Title X Program. See Appendix C for Angela Fellers LeMire Curriculum Vitae

- **Health Services and Connections Branch Chief,** (b)(6) directs daily operations of the branch, supervising the (b)(6) and School-Based Health Centers Units. As Director, she has overall responsibility for planning, development, management, administration, and evaluation of these programs. She formulates policies, procedures, goals, objectives, and authorizes contracts, program activities, budgets, and expenditures. She helps write grant applications, federal and state performance reports, legislative reports and decision items.

- **Unit Manager,** Jody Camp, provides program direction and supervision of staff for the FPP. She monitors grant objectives, programmatic activities, prepares program budgets, grant writing, performance reports, legislative reports, and decision items. She oversees the determination of program strategic directions, processes, methods of operation, guidelines and tools (forms, technical assistance, and training). She advises the Health Services and Connections Branch Chief on changes in program policy as appropriate at the state and local levels, and provides technical assistance at both the state and local levels. See Appendix D for Jody Camp's Curriculum Vitae.

- **Family Planning Coordinator**, Grace Franklin, monitors and tracks all administrative program requirements and regulations. She manages the master calendar for delegate agencies and directs activities related to family planning conferences, trainings and special events. See Appendix E for Grace Franklin's Curriculum Vitae.

- **Program Assistant,** Jean McMains, develops databases, spreadsheets, forms, reports, websites, maps, directories, training registrations, newsletters; designs effective work processes; and oversees daily office management.
- **Fiscal, Contracts, Compliance and Operations unit** oversees the preparation of contracts and purchase orders following state fiscal rules and procurement processes, monitors compliance with federal and state financial regulations by delegate agencies, and provides technical assistance for delegate agencies regarding financial issues. Staff implements budgets, approves expenditures, prepares financial reports, and monitors spending.
- **Health Informatics Branch** staff work to maintain and enhance the iCare data system through the creation of application databases, screens, queries, and reports. This branch oversees and develops operational procedures for Title X data collection and the ongoing improvement and updates to the system, and provides training and technical assistance to delegate agencies. Recently, the Health Informatics Branch implemented [(b)(4)] software to create more interactive visualization and analysis of FPP quality improvement measures in iCare.
- **Health Statistics and Evaluation Branch** ensures that surveillance data informs program targets and planning, and interventions are rigorously evaluated and revised according to research findings and outcomes. Evaluation team members coach FPP staff and ensures work is defined by objectives that are specific, measurable, achievable, realistic and time-framed.
- **Delegate Agencies:** The FPP has long-standing relationships with trusted Title X delegates throughout the state who are trained, experienced and committed family planning providers. In some cases, these relationships span four decades. For the past four years, delegates have been identifying specific strategies to address the advent of health care reform, adapting delivery of family planning and reproductive health services to a changing healthcare environment, and

assisting clients with navigating the changing healthcare system under health care reform, including Medicaid expansion. Most are billing Medicaid and third-party payers, which adds a source of revenue contributing to Title X sustainability. All current Title X delegate agencies provide the six, Core Family Planning and related preventive health services as outlined in the 2018 FOA and QFP.

- **Staff Expertise:** During the 2015 and 2017 Title X Federal Reviews, CDPHE FPP was given few findings and received ample praise for its management of the Title X program at the state level and through its delegate agencies. CDPHE FPP staff have been asked to serve as Title X "trainers" for other states on many oversight activities like conducting a family planning site visit, clinical policy and procedures, the design and implementation of the administrative and clinical delegate manuals and Chlamydia screening Quality Improvement projects.

Q4 continued: **A complete list of the family planning methods offered as part of the project can be found in the response to Q4 c (Core Services). Projects may consist of a single provider or a group of partnering providers who deliver coordinated and comprehensive family planning services. Each project should offer core family planning services as described earlier in this Funding Announcement. Each project must provide the full array of required services under this grant.**

The six Core Family Planning Services (A-F) featured in the 2018 FOA include:

Core Family Planning Service A). A sexual health assessment which ascertains current risk in light of sexual history and current behavioral practices. A sample is available at the CDC website. https://npin.cdc.gov/publication/guide-taking-sexual-history

Q4.a. Response: Delegate agencies use A Guide to Taking A Sexual History (HHS and CDC), the 5 "P"s of Sexual Health, and OPA's "Conducting a Sexual Health Assessment" to ensure comprehensive sexual health assessment and history components, including key dialogue

elements. A sexual health history must be included in each client's comprehensive history and includes a reproductive life plan, relevant family history, obstetric, gynecologic, medical/surgical, and sexual history. Previous contraceptive use, any problems with the method, current sexual risks, behavioral practices, and client's plan for current and/or future pregnancies are also included in a sexual health history. Please see Appendix F for comprehensive sexual history requirement from the CDPHE Clinical Manual. Delegate agencies received training on assessing a client's sexual health, including taking a gender-appropriate sexual health history. Delegate agencies also completed motivational interviewing training for collecting a sexual health assessment and taking a sexual history. During the 2018-2022 contract term, delegate agencies will receive training on adult and adolescent sexual risk avoidance and reduction strategies, including the strategy of empowering individuals to build a healthy life, healthy relationships, and setting goals for a healthy future. These services will be provided alongside a broad range of acceptable and effective family planning methods, natural family planning methods, infertility services and services for adolescents

Core Family Planning Service B). Introduction and access to tools for a personal family planning, fertility, and reproductive life plan, which informs decision-making and is important to client-provider communication. A reproductive life plan outlines personal goals about becoming pregnant: https://www.cdc.gov/preconception/planning.html.

Q4.b. Response: Colorado's Title X providers use Quality Family Planning (QFP) and Title X recommended client-centered counseling components to assess Reproductive Life Plans (RLP) of clients. The purpose of reproductive life planning is to assist the client in determining the primary purpose for visiting the clinic, and clarifying for themselves what is important to them so they can obtain necessary information, make choices, and fulfill their goals. All categories of contraceptive methods are presented to assist clients in making informed decisions on contraceptive use, including withdrawal, fertility awareness-based methods (FABM) or natural family planning, and

abstinence. Colorado Title X providers are encouraged to use One Key Question®, "Would you like to become pregnant in the next year" or a similar question such as, "How important is it to you to prevent pregnancy during this next year?" as a preliminary question. These questions begin the reproductive life planning conversation between client and provider. Family planning counseling is non-coercive and includes a tiered-counseling approach as a place to start the contraceptive conversation.

For men and women wanting to return to sexual risk-free status, FPP providers counsel on topics like avoiding sexual activities that put an individual at risk for unwanted pregnancy, sexually transmitted infections or other associated risks. Other topics may include limiting the number of sexual partners or waiting until an older age to engage in sexual activities. CDPHE FPP Title X providers present all information in a clear and transparent manner, share the risks that may be associated with sexual activities and introduce risk-free alternatives. All providers offer a range of family planning and sexual health options that are consistent with the client's expressed need

It is important to note that Colorado Title X providers use comprehensive, client-centered contraceptive counseling to avoid coercion. In addition, LARC devices are completely reversible and no FPP client is ever denied a LARC removal. The client ultimately makes the final decision determined in part by their personal goals about becoming pregnant. Delegate agency providers received reproductive life planning training, which includes acknowledging the complexity of RLP within a client-centered family planning encounter.

The control over one's own reproduction, is a concept supported in reproductive life planning. In some cases, the reproductive life plan is not clearly defined nor is contraceptive effectiveness the client's main concern. Client preferences should be the main emphasis during the family planning visit. Ultimately, assisting clients to clarify what they want and help them get it is most important.

A reproductive life plan may also include self-assessment of life priorities and goals (i.e. education, work, family, relationships). Providers assist, guide, empower, and support as needed. Reproductive life planning also includes preconception care. "Would you like to discuss ways to prepare for a healthy pregnancy?" is an example of one question providers utilize to begin this discussion. This is also a good way to begin counseling on FABMs and standard prenatal counseling (i.e. folic acid, exercise, risk reduction, etc.). In 2017, delegate agency staff received training on comprehensive and inclusive reproductive life planning and will continue to receive resources and training information throughout the duration of the grant.

Core Family Planning Service C). Family planning services which offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods- also called fertility awareness), and which includes pregnancy testing and counseling, as indicated. The broad range of services does not include abortion as a method of family planning.

Q4.c. Response: Currently, the FPP contracts with 30 agencies to provide family planning services at 75 clinic sites. In addition to providing high-quality, client-centered contraceptive counseling, delegate agencies are required to provide a broad range of medically approved family planning methods including, **at a minimum, all CDPHE Title X providers must provide (onsite or by referral):** At least three types of combined oral contraceptives; A progestin only oral contraceptive; The 3-month progestin only injection; One type of hormonal long-acting, reversible contraceptive method; One type of non-hormonal long-acting, reversible contraceptive method; One non-pill hormonal method such as the patch or vaginal ring; One barrier method; Condoms and spermicidal products; Fertility awareness-based methods (natural family planning), including, but not limited to, Standard Days Method®, sympto-thermal method, Marquette method, and Billings Ovulation method (cervical mucous method). Pregnancy testing and counseling is a core family planning service offered onsite at all.

Many delegate agencies choose to offer a much broader range of methods and services beyond

those included on this list. CDPHE Title X agencies. Pregnancy testing and counseling includes: Reproductive life planning; Pregnancy testing; Nondirective pregnancy counseling; Nondirective and client-centered options counseling and referral, if pregnancy test is positive and client desires; Achieving pregnancy education; Basic infertility services and counseling; Preconception health education and counseling; and pregnancy test is negative, contraceptive counseling and contraception may be provided. Abortion is not considered a method of family planning and is not part of Title X services.

d). Health screenings which are preventive and/or diagnostic in nature and which help clients achieve preconception health; offering at least STD screening and treatment and cervical and breast cancer screenings; and may also include other services including, but not limited to preventive health, mental health assessments, and risk behavior screenings.

Q4.d. Response: Delegates must offer all family planning and related preventive health services to ensure optimal care for clients, with referral to primary and specialist care, as needed. The 2011 American College of Obstetricians and Gynecologists and HRSA-supported Women's Preventive Service Guidelines list the following services that women should be included in all family planning visits: Well-woman visits; contraceptive counseling and follow-up care; STI and HIV counseling and screening; cervical cancer screening; breast cancer screening, and interpersonal and domestic violence screening.

CDPHE FPP delegate agencies utilize the QFP clinical pathway of family planning services to assess client's need for services. This pathway includes 1) Reason for visit 2) Does the client have another source of primary care 3) What is the client's reproductive life plan, and 4) Does the client need preconception health services, STD services or other related preventive health services. Of the services listed above, the following are CDPHE FPP's required elements of each service:

- **STI and HIV:** All clients complete an assessment and history of STI risk as part of the initial, annual, and/or interim FPP visit. STI risk reduction is discussed as indicated. All clients

under 25 years of age are offered Chlamydia and gonorrhea testing. The CDC's Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings, September 2006, is referenced in the CDPHE FPP Clinical Manual. The FPP Clinical Manual also has information on the importance of early detection and linkage to care, and treatment to improve the health of individuals living with HIV and decrease transmission risk. Agency staff members are directed to assess each client's HIV risk, including sexual and intravenous drug use history, client's knowledge of HIV transmission and prevention, and provide risk reduction counseling. Providers routinely offer HIV screening, which may be offered on site, including point–of-care HIV testing, or by referral. Delegate agency staff are directed to provide community resources for HIV pre- and post-exposure prophylaxis for clients in need of these services. Most Colorado Title X agencies completed training on PrEP program implementation within their agency and are dispensing PrEP or referring to same-day PrEP services. Annual STI/HIV and PEP/PrEP training are offered to providers. See Appendix G Clinical Manual: Sexually Transmitted Infection and HIV Services Section.

- **Cervical cancer:** Cervical cancer screening is required of all FPP delegate agencies.

Delegate agencies follow nationally recognized cervical cancer screening guidelines. Starting at age 21 years, women are screened with a Pap test every three years and women 30 years and older have the option of a Pap test with HPV screening every 5 years. A pelvic exam may also be provided following shared decision-making between client and provider. Clients with abnormal cervical cancer screening tests are provided follow-up medical care and/or a referral according to American Society for Colposcopy and Cervical Pathology guidelines. Provider recommendation regarding HPV vaccine is strongly associated with acceptance of HPV vaccination. Family planning providers include STI prevention and risk reduction counseling and education, including

HPV vaccine, in their counseling with clients. Parental consent is required for vaccination of minors. Minors are given information about HPV and the HPV vaccine to discuss with their parents. Clients 18 and older are given information about HPV and the HPV vaccine, including a recommendation for the vaccine if they have not received all recommended doses. VCF vaccine is available for clients under 18 years. Clients 19-26 years old may choose to receive the HPV vaccine and utilize private insurance or Medicaid for reimbursement. Several delegate agencies and the CDPHE family planning nurse consultant participate in a statewide HPV taskforce that brings together various stakeholders to focus on HPV-related cancer prevention and screening. FPP initiated purchase of the statewide license for the documentary, "Someone You Love: The HPV Epidemic", and is one of several programs bringing the documentary to communities across the state. The powerful documentary follows the lives of five women affected by HPV.

- **Breast cancer:** Delegate agencies follow nationally recognized breast cancer screening guidelines for the early detection of breast cancer (i.e. ACOG, ACS, USPSTF, and ACR). Clinical breast exams may be provided every one to three years, starting at age 20, for asymptomatic women at low risk for breast cancer. National guidelines begin screening mammography at either 40 or 45 years in asymptomatic, low risk women, depending on a woman's individual risk and preference. Emphasis is placed on shared decision-making between client and provider in determining when to initiate breast cancer screening and appropriate screening intervals in asymptomatic women. This client-centered approach empowers women to consider all available options and make an informed decision. Women considered at a higher risk for breast cancer may start mammography at an earlier age and/or are screened more frequently according to guidelines. Mammography recommendations also depend on physical exam findings and provider (including radiologist) recommendation. All women presenting as symptomatic are referred for a diagnostic

evaluation. Annual training is offered on breast cancer screening guidelines.

- **Preconception health:** Preconception health is a routine part of family planning visits, and focuses on establishing a reproductive life plan. An initial assessment of a client's plan for pregnancy is elicited through asking the One Key Question®. Other questions include asking if the client has children now and how many children, if any, the clients would like in the future. Clients planning a pregnancy, seeking infertility services, or at high risk for unintended pregnancy are offered preconception health counseling. Clients contemplating pregnancy within the next year should be given the opportunity to discontinue their method, with the objective of improving the outcome of a planned pregnancy. Additional screening and counseling elements for providing preconception health care (i.e. medications, drug use, intimate partner violence, nutrition, and depression) are included in Appendix H: Clinical Manual, Preconception and Interconception Health Services. Delegates are trained in providing preconception and interconception health services using CDC's Preconception Health and Health Care, Colorado's Guidelines for Preconception and Interconception Care, and Preventive Male Sexual and Reproductive Health Care: Recommendations for Clinical Practice.
- **Other, recommended, but optional services:** Other preventive health services may also be available onsite or by referral, including, but are not limited to lipid disorders management, skin cancer screening, colorectal cancer screening, osteoporosis evaluation and management, mental health assessments, and non-sexual health risk behavior screenings.

e). Health information, education, and counseling with an optimal health outcome as the desired goal for the client. Optimal health refers to the best possible outcomes for an individual's physical, emotional, and social health.

Q4.e. Response: CDPHE delegate agencies must provide health information, education, and counseling with optimal health outcomes as the desired goal for the client. The World Health Organization states that "Health is a state of complete physical, mental, and social wellbeing, not

merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition." There are interrelated factors connected to achieving holistic and optimal health, which include physical, emotional, social, spiritual, and intellectual health. Providing information, education, and counseling on these factors for clients to achieve their goals for optimal health and wellbeing are included in all CDPHE FPP visits. This allows for the development of optimal health throughout the lifespan, ensures a balance of the five areas of health, and encourages movement towards a client's best possible health outcomes, while keeping in mind that optimal health is defined differently by each client. During the course of this grant period, delegates will receive training resources on the concept of optimal health, including each of the five interrelated factors to achieving optimal health, and CDC's Health-Related Quality of Life (HRQOL) tool.

f). Referral services available to clients from a network of formalized linkages among community partners, as indicated.

Q4.f. Response: All 30 delegate agencies must refer Title X clients to comprehensive primary care services (i.e. Federally Qualified Health Centers, local clinics, hospital and nonprofit health centers). Of the 30 delegates, nine provide comprehensive primary care services directly as they are located in a Federally Qualified Health Center or hospital setting. Many delegate agencies have formalized linkages with community partners that specialize in HIV care and treatment, STI treatment, mental health, prenatal care, infertility, abnormal breast screening, abnormal cervical screening (i.e. colposcopy and LEEP), local social services, WIC services, nutrition services, intimate partner violence, human trafficking, emergency care, and drug and alcohol treatment providers. Referral lists must be updated annually, at a minimum. CDPHE FPP requires that all delegate agencies have referral resources for the following:

1. Medical problems beyond the scope of the treatment facility. Delegate agencies provide referrals to appropriate provider or hospital.
2. Problems noted at the time of the history taking, physical exam, or laboratory testing.
3. Problems arising because of contraceptive method.
4. Other preventive health services.
5. STI treatment.
6. Cervicitis, vaginitis, and minor gynecologic problems.
7. Positive or suspicious cervical cytology.
8. Hemoglobinopathies (e.g., sickle cell).
9. Positive tuberculin tests.
10. Pregnancy related services, when appropriate, including testing and counseling.
11. Sexual dysfunction and human sexuality counseling.
12. Infertility work-up and/or therapy of an extensive nature.
13. Clients or partners of clients requesting information about, and/or procedure for sterilization, if that service is not available on site.
14. Clients request additional referrals to other providers.
15. Social services and social casework not appropriately handled by project personnel.
16. Linkage to care for individuals living with HIV.
17. PrEP and PEP community providers.
18. Nutrition counseling and WIC services, the Colorado Department of Health Care Policy and

Financing https://www.colorado.gov/hcpf, the Colorado Program Eligibility and Application Kit: https://coloradopeak.secure.force.com/ and Colorado Connect for Health http://connectforhealthco.com/

Q 5. Evidence of familiarity with, and ability to provide services that include the following: a). family planning and related health issues; b). services that are consistent with standards of care related to family planning, adolescent health, and general preventive health measures for HIV, STDs, etc.; c). compliance with State laws applicable in the proposed service area requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, intimate partner violence, human trafficking, or incest; d). counseling techniques that encourage family participation in the decision of minors to seek family planning services, and incorporate resistance skills for minors to resist/avoid exploitation and/or sexual coercion; and e). counseling techniques that encourage family participation for all clients, including the involvement of parents, spouses, or family where practicable, mindful of the health, safety, and best interest of the client.

CDPHE FPP has the familiarity with, and the ability to provide services which include:

Q5.a Response: Family planning and related health issues: CDPHE follows the Office of Population Affairs, 2014 Program Requirements for Title X Funded Family Planning Projects and Providing Quality Family Planning Services, Recommendations of the CDC and the U.S. Office of Population Affairs (QFP), including the 2017 updates. Title X Program Requirements and the QFP are included in the FPP Administrative and Clinical Manuals developed for delegate agencies. Core family planning services are provided, including contraceptive services, adolescent health counseling and services, including a return to sexual risk-free status, pregnancy testing and counseling, achieving pregnancy and basic infertility services, preconception health services, sexually transmitted infection services, HIV, breast and cervical cancer screening, and other preventive services. While the services provided to family planning clients, and the sequence in which they are provided, depends on the type of visit, nature of the service requested, and clients' desires for the visit, the following components are offered and documented in the medical record:

- Informed consent; Reproductive life plan; Relevant and evidence-based educational materials;

Non-directive, client-centered counseling for all clients, including adolescents;

Comprehensive health history, including sexual health assessment and history; Physical assessment; Annual and return visits; Laboratory testing and Referrals and follow-up.

Q5.b Response: Services that are consistent with standards of care related to family planning, adolescent health, and general preventive health measures for HIV, STDs, etc.: Services provided by delegate agencies are consistent with current national standards of care and are outlined in the FPP Clinical Manual. The FPP Clinical Manual is reviewed and revised with assistance from a group of mid-level delegate providers and local reproductive health experts. Any changes or additions made to the Clinical Manual must be approved by Stephanie Teal, M.D., FPP Medical Consultant, then annually circulated to all delegate agencies to become the updated family planning clinical standard. Delegate agency medical directors, mid-level providers, coordinators, registered nurses, and other clinic staff are required to review and sign the Clinical Manual annually and with any interim changes.

FPP clinical policies and protocols, including the provision of family planning health care services, contraception services (counseling and methods), pregnancy testing and counseling, achieving pregnancy and basic infertility services, adolescent health services, preconception health services, STI/HIV services, and breast and cervical cancer screening and follow-up are based on the most recently published nationally recognized guidelines for sexual, reproductive and preventive health care are as follows: American College of Obstetrics and Gynecologists (ACOG), Center for Disease Control and Prevention (CDC) US Medical Eligibility Criteria for Contraceptive Use (US MEC), CDC US Selected Practice Recommendations (US SPR), CDC Sexually Transmitted Disease Treatment Guidelines, CDC Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings, CDC Division of Adolescent and School Health (DASH), U.S. Department of Health & Human Services Office of Adolescent

Health (OAH), Society for Adolescent Health and Medicine (SAHM), United States Preventive Services Task Force (USPSTF) Screening Guidelines, CDC Preconception Health and Health Care, Colorado's Guidelines for Preconception and Interconception Care, American Society for Colposcopy and Cervical Pathology (ASCCP) Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors, American Cancer Society (ACS), American Heart Association, American Society for Clinical Pathology (ASCP) Screening Guidelines for the Prevention and Early Detection of Cervical Cancer, American Society for Reproductive Medicine, American Urological Association, American College of Physicians (ACP). American Academy of Family Physicians (AAFP), Male Training Center for Family Planning and Reproductive Health, Preventive Male Sexual and Reproductive Health Care: Recommendations for Clinical Practice, Family Planning National Training Center, The Center of Excellence for Transgender Health and the GLMA Health Professionals Advancing LGBT Equality.

Q 5.c Response: Compliance with State laws applicable in the proposed service area requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, intimate partner violence, human trafficking, or incest: Policies and procedures regarding adherence to state laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, intimate partner violence, human trafficking, and incest are contained in both the Administrative Manual and the FPP Clinical Manual. Title X delegate staff members are required to read the policies and procedures, and provide signatures acknowledging understanding of, and adherence to, these laws. CDPHE FPP verifies that the manuals are signed by staff during clinical site visits. At a minimum, delegate agencies are required to have written internal mandatory reporting and human trafficking procedures that are reviewed during the clinical site

visit. The CDPHE nurse consultant also discusses mandatory reporting requirements, through the use of clinical examples, with delegate staff to assess their understanding of and adherence to both existing and new state laws. Delegates receive training on mandatory reporting laws in Colorado, including information on reporting child abuse and molestation, incest, sexual abuse, sexual assault, intimate partner violence, human trafficking, sexting, how to access Colorado Department of Human Services Child Welfare On-Line Training System, and how to report: https://www.coloradocwts.com/). See Appendix I: Clinical Manual: Mandatory Reporting & Human Trafficking.

Q 5.d Response: Counseling techniques that encourage family participation in the decision of minors to seek family planning services, and incorporate resistance skills for minors to resist/avoid exploitation and/or sexual coercion: The Adolescent Services section of the Clinical Manual describes family involvement that includes, but is not limited to, parental awareness of an adolescent's decision to seek family planning services, discussion of family planning options, and encouragement of responsible health care decision-making, including reproductive and sexual health and a return to sexual risk-free status, if the patient desires. The following are included in discussions with an adolescent client:

- An explanation of the confidentiality policy, including examples of information to be shared (e.g., certain STIs and situations covered under the mandatory reporting laws).
- A statement that it is the clinic policy to talk to all adolescents about family involvement.
- Adolescent motivational interviewing (MI) to determine if the adolescent client has talked to a parent, family member, or trusted adult about healthy relationships, sex, birth control, or STIs, and if not, what are the barriers. MI is a client-centered, directive counseling technique. MI strategies for brief clinic visits that encourage family participation are shared with delegates

regularly in the family planning newsletter (i.e. ask permission, ask-tell-ask, reflection, responding to resistance, and change talk). Adolescents that receive accurate information about healthy relationships, sexuality, reproduction, and sexual risk behaviors from trusted adults experiment less and at later ages compared to adolescents that do not receive such information.

- Resisting/avoiding sexual exploitation and sexual coercion are addressed in the Clinical Manual. Counseling content on this topic may include:
  - An explanation of the distinction between sexual exploitation, trafficking, sexual coercion (rape), and sexual abuse.
  - Review of risks that make sexual exploitation, trafficking, and sexual coercion more likely (i.e. poverty, power, sex and gender, societal tolerance, family conflict, disruption, or dysfunction, and history of abuse).
  - Review of skills that can be used for prevention of sexual exploitation, trafficking, coercion, and abuse (i.e. increase awareness and knowledge, avoid unsafe situations, risk reduction techniques).
  - The definition of sexual consent and the right to set limits and refuse sex at any time without negative consequences.
  - An awareness of the different kinds of peer pressure that might lead to sexual exploitation or coercion and how the influence of drugs and alcohol can affect behavior and decision making.
  - The importance of self-esteem and self-respect in avoiding exploitation and coercive relationships. Empowering and building client confidence may increase the likelihood that they will act against abuse.
  - A list of available community resources is readily available.

During the 2018-2022 project period, delegate agencies will continue to receive online resources and training opportunities related to family participation, sexual exploitation, sexual coercion, trafficking, and sexual abuse, including The National Family Planning Training Center website: https://www.fpntc.org/resources/encouraging-family-participation-adolescent-decision-making-training-guide

Q 5.e Response: Counseling techniques that encourage family participation for all clients, including the involvement of parents, spouses, or family where practicable, mindful of the health, safety, and best interest of the client: The Adolescent Services section of the Clinical Manual describes the importance of family participation and family engagement when this type of participation is in the best interest of the client. Family, guardian, or "askable" adult involvement/communication must be meaningful, on-going, two-way, and include mutual respect. Delegates will continue to receive online resources and training opportunities for increased family participation. Examples include:

- The CDC's "Parent Engagement: Strategies for Involving Parents in School Health"
- Colorado Personal Responsibility Education Program (PREP) "Becoming an Askable Adult" Training.
- CDPHE has a long history of supporting family planning education in public health, including a CDPHE unit dedicated to the prevention sexual violence. This unit has many resources for family participation on their website, and its resources will continue to be shared with delegate agencies: https://www.colorado.gov/pacific/cdphe/svp

Q 6. For the proposed schedule of discounts provided in the Appendices, a description of how the schedule of discounts was developed; or for applicants with multiple subrecipients, a policy that is applicable to sub-recipients which meets the criteria set out in the Title X regulations at 42 CFR §59.5(a)(7)-(9). (Title X regulations require that the schedule of discounts be applied to all services provided to individuals with family income between 101-250% of the Federal Poverty Level (directly by the grantee and/or through the subrecipient)

as part of the proposed projects as described in the application).

Q6 Response: Schedule of Discounts (Sliding Fee Scale): In March of 2018, the FPP hired RT Welter and Associates to oversee the training and review of CDPHE's 30 delegate agency with their cost-setting activities and sliding fee scales. RT Welter and Associates are experts in cost-setting, and ACA readiness and implementation, especially within the local public health model of health care delivery. In March, RT Welter hosted three training webinars on cost-setting, formulas and philosophies. CDPHE encourages delegates to set their fees according to their true costs and ensure payment of services, as appropriate for the patient. Because the 30 agencies vary in their business models, no one cost analysis model fits all. In May, RT Welter will review several different methods of cost-setting for accuracy, fairness and incremental cost structure steps between 101 and 250 percent of federal poverty level, and will give technical assistance and follow-up with delegate questions. By June 2018, all 30 cost-setting activities and subsequent sliding fee scales will be validated by RT Welter and approved by CDPHE staff. During both the 2015 and 2017 OPA Federal Review, Jerry Christie met with RT Welter staff and praised and approved this effort of training and review. Cost-setting activities must be done every three years or at any time there is a drastic change in costs or business models. As required by Title X guidelines, no client is ever denied services due to an inability to pay, and clients with incomes at or below 100 percent of the federal poverty level are not charged for required Title X services.

Q7. Evidence that the proposed services are consistent with the Title X statute, as well as the program regulations, and regulations regarding sterilization of persons in federally assisted family planning services projects, and legislative mandates, as applicable;

Q7 Response: The FPP has Administrative and Clinical Manuals that include policies, protocols, procedures and information about Title X regulations and Colorado state law. The manuals include links to the Title X statute, federal sterilization regulations, legislative mandates and program requirements. The Clinical Manual specifically addresses sterilization and the federal

regulations regarding sterilization of persons in federally assisted family planning services projects. Delegate agency staff are required to read the Administrative and Clinical Manuals and must sign a signature sheet verifying that they understand and will comply with the manuals. Delegate agencies have the option of utilizing their own medical policies and protocols, and these are reviewed during clinical site visits to assure congruence with the Title X regulations, and FPP policies and protocols. Title X Statute and Regulations include, but are not limited to regulations regarding the provision of family planning services under Title X can be found in the statute (Title X of the Public Health Service Act, 42 300 et seq.) and guidance for grants for family planning services (42 CFR part 59,subpart A), as applicable. In addition, sterilization of clients as part of the Title X program must be consistent with 42 CFR part 50, subpart B ("Sterilization of Persons in Federally Assisted Family Planning Projects"). Please see Appendix J for the table of contents for the Clinical and Administrative Manuals that are provided to delegates. The table of contents from these manuals demonstrates the depth, consistency and expectations of each delegate in relation to the Title X Program, including program regulations, Title X requirements, legislative mandates and the quality guidelines. These manuals serve as "musts" and "should" for all Title X activities and serve as the road map for any family planning program. Delegate agencies are expected to read, share, and embed manual sections and protocols into their day-to-day work. Compliance with this expectation is reviewed at the administrative and clinical site visits. A full electronic copy of both of these manuals can be found at https://www.colorado.gov/cdphe/titlex-familyplanning.

In addition to the manual guidance, the FPP has built a strong quality assurance system that includes a team of fiscal experts that perform onsite and desk audits of all contractors fiscal practices, physical site visits, medical record audits, periodic data report reviews through the iCare

database, sliding fee scale and cost-analysis annual verification, mandatory delegate trainings, review of annual client satisfaction surveys, and a series of other checks and balances to ensure that delegate agencies are in compliance with Title X and state regulations.

During administrative site visits, staff verifies that delegate agencies have a plan for policies and procedures that address all applicable HIPAA regulations. The Clinical Manual has a policy on medical records that details the confidential nature of personal health information (see Appendix K: HIPAA Policy). During the clinical site visits, clinic areas are observed for compliance with confidentiality standards.

Q8. Evidence that Title X funds will not be used in programs where abortion is a method of family planning;

Q 8 Response: Title X Regulations and Federal and State Laws contains information on complying with Title X federal requirements prohibiting abortion services (Section 1008 of the Public Health Service Act). Along with this requirement stated in each delegate agencies' contract, delegate staff must sign that they have reviewed the manual annually, indicating their agreement to comply. One of the items addressed on the clinical site visit is the provision that no Title X funds may go to a program that uses abortion as a method of family planning. In addition, delegate agencies that perform abortions (without Title X funds) as part of their work are subject to annual CDPHE separation audits by CDPHE's fiscal compliance staff to ensure Title X funds are accounted for separately from funds used to support abortion activities.

Q9. Evidence that Title X activities are separate and distinct from non-Title X activities;

Q9 Response: CDPHE FPP tracks Title X activities to ensure they are separate and distinct from non-Title X services. Currently, financial support for the FPP is received from Title X, Colorado State General Funds and local delegate agencies. Financial policies and procedures are determined by the Colorado Department of Personnel and Administration, State Controller's Office, Division

of Finance and Procurement, Fiscal Rules, State of Colorado Procurement Code, Title X Administrative Manual, Accounting Section, and the CDPHE Accounts Payable Manual. The Family Planning Unit Manager, branch fiscal officers, and CDPHE Accounting, Purchasing, Contracts, and Budget Sections staff are responsible for appropriately dispersing and accounting for Title X funds, and ensuring there is an extraordinary separation of duties and internal controls. Title X federal requirements are incorporated at every level of policy and procedures. FPP staff work closely with FCCO unit to analyze, track and monitor the separation of Title X from non-Title X funds using the following reporting tools:

- **Monthly Invoice:** CDPHE works on a cost reimbursement model. Invoices from delegates are submitted monthly and reviewed to ensure that agencies request reimbursement and are paid for approved and appropriate costs only.
- **Site Visits:** During administrative site visits, staff verifies that family planning income, including client fees and donations, are only used for program purposes by reviewing delegate policies on donations, review charts, patient master bills, receipts and clients billing spreadsheets.
- **Financial Risk Monitoring System (FRMS):** Title X delegates are subject to CDPHE's Financial Risk Monitoring System (FRMS). FRMS is a standardized process to assess a contractor's risk of noncompliance with contractual fiscal requirements. Additionally, the system improves fiscal monitoring throughout the department by establishing standardized practices at the department and program level and utilizes a standardized invoice form. Delegates are monitored through random samplings of paid invoices and supporting documentation. Monitoring is conducted by FRMS expert staff based on risk level. Delegates rated as "high risk" are monitored more frequently than "low risk" delegates.

- **Annual Orientation and Contract Kick-off:** The FPP is required to host a contract orientation and kick-off session where invoicing, contracting and fiscal processes are presented and discussed with delegate staff.
- **Annual Time and Effort:** The U.S. Office of Management and Budget (OMB) has established standards and principles for determining cost for federal awards through grants, cost reimbursement contracts and other agreements. Delegate agencies are required to comply with time and effort reporting, using these OMB guidelines.

Q10. A plan for providing community information and education programs which promote understanding about the availability of services. The plan should include a strategy for maintaining records of information and education activities;

Q10 Response: Information and Education Committee: The FPP delegated the Information and Education (I&E) Committee requirement to its 30 Title X delegates as they are most familiar with the needs of their communities. I&E committee members are representative of the community served, knowledgeable about the population, and cognizant of the community's need for services and health education. To help meet this important element to the program, delegate agencies are provided with instructions, a sample recruitment letter, a sample materials evaluation form, and a sample materials approval summary table in the Administrative Manual. I&E Committees approve all information and education materials to ensure that they are current, factual, and medically accurate. Materials are reviewed for literacy level, cultural competence, length, readability, and appropriateness for the target population. The FPP monitors compliance with this policy during administrative site visits and delegate agencies are required to retain documentation of I&E Committee determinations for as long as each material is in use by the family planning program.

Q11. A plan for an information and education advisory committee that is consistent with the Title X statute and regulations and that ensures that all information and education materials are current, factual, and medically accurate, as well as suitable for the population or community to which they will be made available;

Q11 Response: Advisory Committee: In addition to the required I&E Committee, the FPP delegated the education advisory committee requirement to all 30 Title X delegates. They must maintain an advisory committee that allows community members to participate in the program's mission, including assisting with the development, implementation and evaluation of the delegate family planning program. The FPP monitors compliance with this policy during administrative site visits and assures that the committee is broadly representative of the population served. Some delegate agencies utilize the same group of community members for the I&E Committee and the advisory committee, while others have two separate committees.

Q12.Evidence that the Title X program priorities and key issues outlined above in this announcement are addressed in the project plan;

Program Priorities 2018-2019
Priority 1: Assuring innovative high quality family planning and related health services that will improve the overall health of individuals, couples and families, with priority for services to those of low-income families, offering, at a minimum, core family planning services enumerated earlier in this Funding Announcement. Assuring that projects offer a broad range of family planning and related health services that are tailored to the unique needs of the individual, that include natural family planning methods (also known as fertility awareness based methods) which ensure breadth and variety among family planning methods offered, infertility services, and services for adolescents; breast and cervical cancer screening and prevention of STDs as well as HIV prevention education, counseling, testing, and referrals;
CDPHE Practice related to Priority 1: All core services featured in the 2018 funding announcement are offered in all CDPHE Title X clinics. CDPHE FPP requires a broad range of family planning clinical services (see answer to Q4c, page 16 for a list of required procedures, testing and pharmacy) and related health services. CDPHE Title X clinics offer Fertility Awareness-Based Methods (FABM), also known as natural family planning methods for patients that request them. According to recent Family Planning Annual Reports, 676 women and 71 men requested FABM or lactional amenorrhea method support between 2013 and 2017. All FPP staff

were trained and certified in the Georgetown University, Standard Days Method online training and certification program in December 2017 and participated in several refresher FABM trainings, including the April 9, 2018 National Clinical Training Center for Family Planning's one-hour webinar, "Understanding and Counseling Potential Users of Fertility Awareness-Based Methods for Pregnancy Prevention". CDPHE FPP will share information with delegate agencies through formal trainings and, newsletter updates and central email communications. . Resources include the U.S. MEC for Contraceptive Use (2016), NFPRHA FABM resources, and Family Planning: A Global Handbook for Providers. In addition, in 2018-2019, CDPHE FPP will host a minimum of one clinical training on FABMs (natural family planning methods), including, but not limited to Standard Days Method®, sympto-thermal method, Marquette method, and/or Billings Ovulation method. This training will include multiple categories and types of FABM, how to determine a client's fertile window, and observable fertility signs. If a client desires pregnancy prevention, this training will also include the importance of using a barrier method or other contraceptive method, or avoiding vaginal intercourse (periodic abstinence) during their fertile window.

Priority 2: Assuring activities that promote positive family relationships for the purpose of increasing family participation in family planning and healthy decision-making; education and counseling that prioritize optimal health and life outcomes for every individual and couple; and other related health services, contextualizing Title X services within a model that promotes optimal health outcomes for the client.

CDPHE Practice related to Priority 2: The Adolescent Services section of the Clinical Manual describes family involvement as, but is not limited to, parental awareness of an adolescent's decision to seek family planning services, discussion of family planning options, and encouragement of responsible health care decision-making, including reproductive and sexual health. The following are included in discussions with an adolescent client:

- An explanation of the confidentiality policy, including examples of information to be shared (e.g., certain STIs and situations covered under the mandatory reporting laws).
- A statement that it is the clinic policy to talk to all adolescents about family involvement.
- Adolescent motivational interviewing (MI) to determine if the adolescent client has talked to a parent, family member, or trusted adult about healthy relationships, sex, birth control, or STIs, and if not, what are the barriers. MI is a client-centered, directive counseling technique. MI strategies for brief clinic visits that encourage family participation will be shared with delegates regularly in the biweekly family planning newsletter (i.e. ask permission, ask-tell-ask, reflection, responding to resistance, and change talk). Adolescents that receive accurate information about sexual risk free and sexual risk avoidance counseling, healthy relationships, sexuality, reproduction, and sexual risk behaviors from trusted adults experiment less and at later ages compared to adolescents that don't receive such information.

In support of the "optimal health" concept, the World Health Organization states, "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." There are interrelated factors connected to achieving holistic and optimal health, including physical, emotional, social, spiritual, and intellectual health. Counseling and education on these interrelated factors allows for the development of optimal health throughout the lifespan, ensures a balance of the five areas of health, and encourages movement towards a client's best possible health outcomes, while keeping in mind that optimal health is defined by each client differently. During the course of this grant period, delegates will receive information about online training opportunities and resources on the concept of optimal health, including each of the five

interrelated factors to achieving optimal health, and CDC's Health-Related Quality of Life (HRQOL) tool.

Priority 3: Ensuring that all clients are provided services in a voluntary, client-centered and non-coercive manner in accordance with Title X regulation.

CDPHE Practice related to Priority 3: CPDHE FPP promotes patient-centered counseling in all of its patient sessions. In recent years, multiple trainings have been held in Motivational Interviewing and client-centered counseling for our family planning providers. The FPP program ensures non-coercive practices by having the patient lead the informational and education sessions, signing Title X consent forms, and IUD and implant consents including information on side effects and removal. All family planning required services are on the same sliding fee scale. The Family Planning Bill of Rights is given to every patient specifying the voluntary nature of all Title X services. Lastly, during all site visits, CDPHE FPP staff confirm that all delegate agency staff abide by these regulations and have reviewed and annually signed the Family Planning manuals inclusive of these regulations.

Priority 4: Promoting provision of comprehensive primary health care services to make it easier for individuals to receive both primary health care and family planning services preferably in the same location, or through nearby referral providers, and increase incentive for those individuals in need of care choosing a Title X provider.

CDPHE Practice related to Priority 4: The CDPHE FPP has a vast network of FQHC delegate agencies that offer Title X services and comprehensive primary health care services. The following are our current FQHC Title X delegate agencies and the regions they serve:

1. ***Denver Health and Hospital Authority FQHC***: A network of 18 Title X clinics that serve the Greater Denver area.
2. ***Metro Community Provider Network FQHC:*** A network of three Title X clinics that serve the Greater Denver area with Jefferson County.

3. ***Summit Community Cares FQHC:*** A network of two Title X clinics that serve Central Mountain and resort communities.
4. ***Northwest Colorado Health FQHC***: A network of two Title X clinics serving Northern and rural Colorado.
5. ***Mountain Family Health Centers FQHC (New Contractor)***: A new delegate agency that will onboard in July 2018. This FQHC has a network of five clinics that serve the Mountain corridor and some of western Colorado.
6. ***Colorado Coalition for the Homeless FQHC:*** A Title X clinic, Stout Street Health Center, serving the Greater Denver area. This FQHC has a network of six clinics that include a mobile medical unit and Southeastern rural Colorado.
7. ***High Plains FQHC:*** A network of five Title X clinics serving the Southeastern Plains region of Colorado.

All other (non FQHC) delegate agencies must refer Title X clients to comprehensive primary care services, including Federally Qualified Health Centers, local clinics, hospitals and nonprofit health centers. Many delegate agencies also have formalized linkages with community partners that specialize in HIV care and treatment, STI treatment, mental health, prenatal care, infertility, abnormal breast screening, abnormal cervical screening (i.e. colposcopy and LEEP), local social services, WIC services, nutrition services, intimate partner violence, human trafficking, emergency care, and drug and alcohol treatment providers. Referral lists must be updated annually, at a minimum. See required referral services in answer Q4f, page 21.

Priority 5: Assuring compliance with State laws requiring notification or the reporting of child abuse, child \molestation, sexual abuse, rape, incest, intimate partner violence, and human trafficking.

CDPHE Practice related to Priority 5: CPDHE FPP consistently trains to ensure compliance with Colorado mandatory reporting laws for child abuse, child molestation, child neglect, sexual abuse, sexual exploitation, sexual coercion, rape, incest, intimate partner violence, and human trafficking. CDPHE recently held a mandatory webinar for delegates on mandated reporters to the child welfare system, updates to current law, when and how to report, and community resources. Two additional training sessions were held at the CDPHE Annual Women's Conference in 2018. One training focused on Colorado mandatory reporting and human trafficking laws with a family planning lens, and the other was titled "Sexting: From Scandal to Opportunity." Colorado Possession of Child Pornography (Sexual Exploitation) laws recently changed dramatically, and these laws directly affected how delegates counsel on sexting and sexual exploitation.

Priority 6: Encouraging participation of families, parents, and/or legal guardians in the decision of minors to seek family planning services; and providing counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities;

CDPHE Practice related to Priority 6, family participation: CDPHE FPP consistently shares resources with delegate agencies, encouraging participation of families seeking family planning services and information on sexual violence prevention, as evidenced by its web resource library: https://www.colorado.gov/pacific/cdphe/svp. During the grant period, CDPHE will partner with a contractor to offer an "Askable Adult" training to its delegate agencies. This training helps adults build the skills and obtain the tools needed to talk to adolescents about sex and sexuality. From the intake form to the face-to-face counseling session to the clinical visit, providing counseling to minors on coercion is core to CDPHE FPP's work. At every appointment, counselors ask about the types of partners patients have, whether there are drugs, alcohol or anyone being forced into sexual activities. All providers have been trained in mandatory reporting laws and have the resources they

need to report, if necessary. While coercion counseling is especially important with minors, it crosses all age groups and is discussed with all patients, male or female, young or old.

Priority 7: Demonstrating that Title X activities are separate and clearly distinct from non-Title X activities, ensuring that abortion is not a method of family planning for this grant.

CDPHE Practice related to Priority 7: Title X Regulations and Federal and State Laws contains information on complying with Title X federal requirements prohibiting abortion services (Section 1008 of the Public Health Service Act). Delegate staff must review and sign the FPP manuals annually, which state that no Title X funds may go to a program that uses abortion as a family planning method. In addition, delegate agencies that perform abortions (without Title X funds) as part of their work are subject to a CDPHE separation audit that ensures Title X funds are accounted for separately from funds used to support abortion activities. Separation audits are conducted on an annual basis by CDPHE's Fiscal Compliance Unit.

Priority 8: Use of OPA performance metrics to regularly perform quality assurance and quality improvement activities.

CDPHE response to Priority 8: CDPHE FPP understands that the data it submits annually for the Family Planning Annual Report (FPAR) are used to calculate OPA performance measures. CDPHE FPP uses FPAR data in quality assurance and quality improvement activities, research, data fact sheets and storytelling as evidenced below:

- **Quality Improvement:** From 2015-2017, CDPHE FPP invested in a three-year, chlamydia screening QI project and uses FPAR data on a quarterly basis to track progress, monitor delegate agency compliance and inform analysis. The CDPHE Informatics team used FPAR data to create delegate agency dashboards to visually track progress and easily uncover challenges in the QI project delivery.
- **Research**: Using data to help inform the analysis, CDPHE used FPAR population and sex (Table 1), Race and Ethnicity (Tables 2&3), Income Level (Table 4) and Contraceptive

Methods by sex (Tables 7&8) to create "Game Change: Widespread use of Long Acting Reversible Contraceptives" in 2014 to share the early data returns and impacts of family planning on teen birth rates. In addition, CDPHE FPP used 10 years of FPAR data to help inform a 2017 cost avoidance analysis called, "Taking the Unintended Out of Pregnancy". This analysis featured the decrease in teen birth rates and detailed the fiscal impacts to Medicaid, Temporary Assistance to Needy Families, the food assistance program and the WIC program in Colorado.

- **Data Fact Sheets**: CDPHE FPP is regularly asked for data and facts regarding its Title X program, and FPAR data is used to inform this work. FPAR Revenue Report (Table 14 in FPAR) is used to demonstrate success in Medicaid and Insurance increased reimbursement through Title X clinics (see below).

	Medicaid Reimbursement	Private Health Insurance Reimbursement
2011	$464,699	$52,832
2012	$1,031,994	$138,394
2013	$1,137,395	$273,005
2014	$2,333,932	$547,387
2015	$3,187,623	$884,157
2016	$3,969,743	$1,191,984
2017	$3,534,950	$1,351,523

- **Storytelling:** Since 2015, CDPHE FPP was featured in over 300 media articles in print and online. FPAR data is consistently used to show impact and help tell the story of family planning. See examples below:
  - 2016 New York Times: https://www.nytimes.com/2016/07/19/opinion/winning-the-campaign-to-curb-teen-pregnancy.html
  - 2016 National Public Radio: https://www.npr.org/sections/health-

shots/2016/10/06/496393340/long-term-reversible-contraception-gains-traction-with-carolina-teens

- 2018 US News and World Report: https://www.usnews.com/news/best-states/articles/2018-03-13/rural-teen-pregnancy-rates-drop-in-colorado

2018-2019 Key Issues

Key Issue 1: Efficiency and effectiveness in program management and operations;

Key Issue 1 Response: CDPHE FPP has directed the Title X grant activities in Colorado for 48 years. It has the systems and skills needed to perform all due diligence on the grant in an efficient and effective manner. In fact, many of Colorado's monitoring tools have been shared in national family planning meetings and used as examples of good policy, clear procedure and best practices in the Title X field and among other CDPHE programs. In 2014, the CDPHE FPP went through a Lean event resulting in a mostly paperless system of management and combined several, separate reporting tools into a single, quarterly reporting system for delegate agencies. CDPHE FPP has an in-house FPAR data collection system that allows for efficient data collection and reporting.

Key Issue 2: Management and decision-making and accountability for outcomes;

Key Issue 2 Response: CDPHE FPP has been through several OPA Federal reviews and all resulted with little to no findings regarding the management and accountability for the Title X program. After 48 years, CDPHE FPP has proven its deep understanding of the work and has the staff, tools and data needed to demonstrate accountability. See staffing and management overview in the response to Q 4 on page 10.

Key Issue 3: Cooperation with community-based and faith-based organizations;

Key Issue 3 Response: CDPHE FPP relies on the cooperation of community-based and faith-based partners to implement the Title X work plan. Annually, CDPHE FPP requires that delegate agencies

connect with one new group (community and/or faith-based), throughout the state, to increase the visibility of their family planning programs, strengthen existing linkages and/or create new networks (see Appendix A for work plan which features this deliverable). Examples of partnerships include local health education session at community colleges, 1:1 counseling at domestic violence shelters, mental health referrals, healthy nutrition and cooking classes at the family planning clinic, participation on health advisory committees, and Information and Education work groups.
Key Issue 4: Meaningful collaboration with subrecipients and documented partners in order to demonstrate a seamless continuum of care for clients;
Key Issue 4 Response: CDPHE FPP considers its subrecipient partners as the backbone to the entire family planning program. Without their hard work, motivation and dedication to public health, Colorado could not claim the great success we enjoy today. The CDPHE FPP collaborate with subrecipients through face-to-face site visits, quarterly Med Pac meetings where subrecipient advise and manage the meeting content, the CDPHE Annual Women's Health Conference where subrecipient agencies advise on conference content. Annual, staff from multiple delegate agencies serve as CDPHE FPP thought partners and contribute to its work and through ad-hoc committees and quality improvement groups. This collaboration translates to seamless continuum of care for clients because the subrecipients are informing the training, funding and advisement ultimately to serve more clients and improve the quality of care.
Key Issue 5: A meaningful emphasis on education and counseling that communicates the social science research and practical application of topics related to healthy relationships, to committed, safe, stable, healthy marriages, and the benefits of avoiding sexual risk or returning to a sexually risk-free status, especially (but not only) when communicating with adolescents;
Key Issue 5 Response: The CDPHE FPP will put meaningful effort into educating FPP Contractors on topics related to healthy relationships; committed, safe, stable, healthy marriages; and the benefits of avoiding sexual risk or returning to a sexually risk-free status, especially (but not only) when communicating with adolescents by sponsoring no less than two delegate agency

trainings on these topic in the 2018-2019 project year. The FPP has many government counterparts that are committed to partner on this work.

Colorado PREP Program: In preparation for this FOA, CDPHE FPP discussed possible strategy and training opportunities with its sister agency, Colorado Department of Human Services (CDHS), Personal Responsibility Education Program (PREP) program which is an abstinence and contraceptive grantee for the state. CDHS received federal PREP funding in 2010 to develop a sexual health education program and awarded funding to three communities: City and County of Denver Department of Human Services, Garfield County Department of Human Services and Huerfano County Department of Social Services. In two of the three communities, CDPHE and CDHS already have a strong, referral relationship between FPP and PREP. Coordinators in each of these counties work to bring comprehensive sexual health programming to young people in Colorado along with trainings for trusted adults who would like to increase their skills in answering questions about sensitive topics. Comprehensive sexual health education is important because research has shown that it helps youth:

- Delay the initiation of sex (abstain);
- Reduce the frequency of sex;
- Reduce the number of new partners;
- Reduce the incidence of unprotected sex.

Colorado PREP supports various curriculum that complement the FPP program such as:

1. *Love Notes:* Love Notes builds skills and knowledge for healthy and successful relationships with partners, family, friends, and co-workers. It is designed to help young people (16- 24 years of age) make wise relationship and sexual choices.
2. *Be Proud, Be Responsible*: Be Proud! Be Responsible! An Evidence-Based Intervention to

Empower Youth to Reduce Their Risk of HIV is a multi-media, 6-module curriculum that provides adolescents with the knowledge, motivation and skills to change their behaviors in ways that will reduce their risk of contracting HIV.

3. *Street Smart:* Street Smart is for runaway and homeless youth ages 11-18. This skills-building intervention uses short group sessions and individual counseling sessions to help prevent HIV/STIs and other harm.
4. *Draw the Line, Respect the Line*: is a 3-year evidence-based curriculum that promotes abstinence by providing students in grades 6, 7 and 8 with the knowledge and skills to prevent HIV, other STD and pregnancy. Using an interactive approach, the program shows students how to set personal limits and meet challenges to those limits. Lessons also include the importance of respecting others' personal limits.

These four programs were vetted though CDHS and are well received in the communities they serves. CDPHE FPP will rely on partners like PREP to help us achieve our training goals in sexual risk avoidance and a return to sexual risk free status.

Colorado Title V, Abstinence Education Program: CDPHE FPP discussed possible strategy and training opportunities with its partner, the Colorado Department of Education's (CDE) Title V, Abstinence Education Program. The purpose of CDEs funding is to address the rates of teen pregnancy among groups who are most likely to bear children out of wedlock. For that reason, CDE funds sexual risk avoidance programs, including mentoring, counseling, and adult supervision as a means of promoting healthy relationships. CDE's current grantees include an afterschool club in the San Luis Valley, a coaching and mentoring program to help adolescents build healthy relationships from elementary through high school, a company that addresses relationship-building and healthy relationships between couples and workplace colleagues, and a peer mentoring

programs that provide teens with strong role models that enable them to make positive life choices like refraining from high-risk behaviors (e.g.alcohol, tobacco, and drug use; early sexual activity; and violence). A sample of sexual risk avoidance curriculum supported through these partners are as follows:

1. **Nu-CULTURE** helps students understand the risk associated with early sexual activity and develops skills necessary to make healthy decisions and avoid risky behaviors. The program emphasizes increasing skills and self-efficacy in communication and refusal skills using through age appropriate, medically accurate information about teen pregnancy prevention, sexually transmitted infections, and other sexual health topics. Nu-Culture includes daily parent connection forms designed to engage parents in the topics covered and encourage open parent-teen communication.
2. The ***Promoting Health Among Teens! Comprehensive*** curriculum helps students learn about puberty, sexually transmitted diseases (STDs), including HIV, and pregnancy prevention through a lively, interactive and student-centric curriculum, that includes talking circles, brainstorming, role plays, DVDs, exercises and games that make learning enjoyable. This curriculum includes information about condom use as well as abstinence.

The CDE, Title V Grant is part of a comprehensive approach to adolescent well-being that seeks to support Colorado youth in developing and navigating healthy relationships and in making decisions that result in reduced teen pregnancy and sexually transmitted infections. Annually, the CDE Title V Program hosts a Sexual Risk Avoidance Specialist (SRAS) Training, through Ascend Organization, that is open to the public and to those seeking program certification CDPHE FPP seeks to invite FPP providers and health educators to attend the SRAS training. Another opportunity might be for FPP providers to refer their family planning patients to sexual risk

avoidance community trainings being held by CDE Title V partners in the community.

In researching sexual risk avoidance programs in Colorado, CDPHE FPP was referred to Dr. Lisa Rue with University of Northern Colorado and Preventative Technology Solutions (PTS). PTS is a clinical waiting room application which allows patients to access iPad technology to screen for sexual health risk, mental health risk and substance abuse risk. Real time results from the risk assessment are electronically uploaded into the clinic EMR, printed out or emailed to a provider to delete after reviewing. If any flags arise from the three risk factors, the provider is alerted for counseling and warm hand-off referral. Of interest to the OPA Key Issue of sexual risk avoidance is the PTS sexual health risk screening component which bundles patients screening results into the following categories:

1. Primary—encouraging sexually inactive adolescents to refrain from sexual activity and encouraging risk reduction guidance if necessary.
2. Secondary—teaching social and emotional skills to encourage sexually active adolescents to reestablish sexual boundaries if they desire.
3. Tertiary—encouraging sexually active adolescents to engage in risk reduction practice.

This waiting room screening tool could be a piloted in Title X clinics to help providers rapidly reveal if patients are engaged in healthy relationships and/or committed, safe, stable, healthy marriages.

If awarded the Title X grant, CDPHE FPP will partner with CDE, CDHS, PTS and similar organizations to help secure training in sexual risk avoidance and a return to sexual risk-free status.

Key Issue 6: Activities for adolescents that do not normalize sexual risk behaviors, but instead clearly communicate the research informed benefits of delaying sex or returning to a sexually risk-free status.

Key Issue 6 Response: CDPHE FPP will put a meaningful effort into advancing FPP Contractors

knowledge on topics related to activities for adolescents that do not normalize sexual risk behaviors, but instead clearly communicate the research informed benefits of delaying sex or returning to a sexually risk-free status. CDPHE FPP commits to sponsoring no less than two delegate agency trainings on these topics in the 2018-2019 project year. While training partners have not been identified at this time, we have many government counterparts that will partner with us on this work. See response to Key Issue 5.

Key Issue 7: Emphasis on the voluntary nature of family planning services;

Key Issue 7 Response: CDPHE FPP promotes equitable and voluntary family planning services to ensure the client's right to attain the highest standards of sexual and reproductive health, free from coercion. Voluntary family planning services ensure individuals the basic rights and autonomy to choose their family size, access to high-quality family planning and preventive services, and a sense of empowerment in their decision-making. A signed informed consent for services is obtained from all family planning clients, including voluntary acceptance of services and receipt of family planning services is not a prerequisite to receipt of any other services offered. CDPHE FPP LARC contraceptive counseling training includes both consent and coercion relative to insertion and removal of LARC methods.

Key Issue 8: Data collection, such as the Family Planning Annual Report (FPAR), for use in monitoring performance and improving family planning services.

Key Issue 8 Response: CDPHE has an in-house data repository called iCare that is managed by the CDPHE Informatics Unit. iCare is an acronym for integrity, community, accountability, respect, and excellence and was named by a vote among delegate agencies. Delegate agencies are required to enter client profiles into the iCare data system for FPAR data collection and reporting. The FPP staff and delegates use iCare reports to monitor, evaluate, and assess the program's progress and utilization of family planning services throughout the state.

Q13. To the extent that the applicant will not provide all services directly, a description of the process and selection criteria used or to be used to select service sites and providers, including a description of eligible entities for funding as subrecipients.

Q 13 Response: CDPHE does not directly provide clinical family planning services. Currently, 30 delegate agencies are contracted to provide family planning services. Selection of delegate agencies is accomplished through an open and competitive process to identify new, potential delegates and retain strong, existing delegates. CDPHE uses a competitive Request for Applications (RFA) process for Title X funding every 3 to 5 years, when needed due to resignation of an existing Title X agency, or pursuant to a new Title X FOA. Selection criteria include, but are not limited, to:

- The technical aspects of applications are assessed based on the soundness of the applicant's approach and the applicant's understanding of the requirement. Past experience/qualifications are assessed by considering the extent to which the qualifications, experience, and past performance are likely to foster successful, on-time performance. Technical and past experience assessments may include a judgment concerning the potential risk of unsuccessful or untimely performance, and the anticipated amount of State resources necessary to insure timely, successful performance. The criteria for scoring are in direct correlation to the required application components and ask questions like:
    - Does the applicant have the capacity to provide services?
    - Does the applicant have required commitment of personnel, including reasonableness to accomplish objectives?
    - Does the implementation plan match the deliverables in the scope of work?
    - Was the response submitted on the requested templates and required supporting documents and attachments, etc.?

- Does the applicant demonstrate the ability to complete this project and knowledge and experience providing the services proposed?
- Does the response demonstrate sufficient understanding of the project?
- Does the organization have a diverse clinic budget that can help to sustain a family planning program?
- The extent to which the applicant agrees to Colorado's basic contract terms and required Special Provisions without seeking exceptions.

Applications are scored (100 point scale) needing a minimum score of 80 to be considered for funding. A review committee made up of state agency staff score all complete applications and then meet to make funding decisions.

In 2015, 2017 and 2018 the FPP used either the Request for Application (RFA) or the state bids system to solicit new delegate agencies. CDPHE FPP gained Metro Community Partners Network in 2015, High Plains Community Network in 2017, and will gain Mountain Family Health Centers in 2018 all as FQHC delegate agencies. To ensure continuity of care, Mountain Family Health Centers will replace a longtime partner that resigned from the program. **Description of eligible entities for funding as sub-recipients:** Eligible sub-recipients, referred to as delegate agencies, currently include local public health agencies, FQHCs, FQHC look-alike clinics, community health centers, school-based health clinics, hospital clinics, and nonprofit clinics. Current and new delegates must implement a comprehensive family planning program in compliance with Section 1001 of the federal act and all applicable federal regulations, as amended, in Title X, 42 C.F.R., subpart A, Part 59 as well as all applicable state regulations and the Colorado Constitution, including mandatory reporting laws. Delegate agencies must offer the following family planning services to women and men of reproductive age:

- Program promotion efforts designed to recruit clients for family planning services and make services known to the target population.
- Direct clinical services to include a comprehensive health and social history, physical examination, and laboratory services following all applicable clinical policies and procedures that have been, or may be, established in the Title X program requirements and regulations and CDPHE Heath Services and Connections Branch.
- Provision of contraception services to include a broad range of contraceptive methods (including FABMs/natural family planning methods), pregnancy testing and counseling, services to help clients achieve pregnancy, basic infertility services, STI/HIV services, preconception health services and breast and cervical cancer screening.
- Provision of education and counseling regarding family planning, STIs and HIV, nutrition, adolescent parental involvement, avoiding sexual coercion, and other related health issues.
- Follow-up and/or referral services, as appropriate.
- Collection and monthly submission of family planning data utilizing CDPHE web-based data submission system.
- Participation in the development, implementation, and evaluation of the project by persons broadly representative of the population served and by persons in the community who are knowledgeable about the community's needs for family planning services.
- Community education programs, based on a community needs assessment, that enhance the community's understanding of family planning and reproductive health.

Delegate funding and budget guidelines: Title X delegate agencies must have a diverse mix of funds available to carry-out their family planning activities and demonstrate that that the FPP is not the sole funder of their family planning program. Other delegate-related funds are generated

from local/agency support, patient fees, donations, Medicaid, and other third-party payment sources. Typically, CPDHE FPP Title X program funding covers 30-40 percent of the overall budget for delegate agencies.

Budget Guidelines: In accordance with Title X guidelines, delegate agencies may not charge for any Title X-required family planning services provided to patients with incomes at or below 100 percent of the federal poverty level. Service charges to patients with incomes at 101 to 250 percent of the federal poverty level must be set on a sliding fee scale model and based on the delegate's actual costs in providing family planning services. Delegate agencies are also required to utilize program income generated from client fee collections and donations for family planning purposes only. The delegate may not deny services based on the patient's inability to pay any of the agencies' sliding fees.

Q14. A staffing plan which is reasonable and adheres to the Title X regulatory requirement that family planning medical services be performed under the direction of a physician with special training or experience in family planning. Evidence that staff providing clinical services (e.g., physicians, State-recognized advanced practice nurses, physician assistants) will be licensed and function within the applicable professional practice acts for the State in which they practice.

Q 14 Response: Clinical staff members are licensed and expected to follow their respective Colorado State board rules and regulations for practice. The following is a summary of applicable professional staff legislation, rules and regulations.

- **Physician (M.D. or D.O):** Physicians providing oversight at both CDPHE and at delegate level practice under the Colorado Medical Practice Act must be licensed to practice medicine in Colorado, follow Colorado Medical Board rules and regulations, and must possess expertise in the area of family planning.
- **Registered Nurse:** Professional nurse licensure requirements from the Colorado Board of Nursing include that the applicant has completed a professional nursing educational program and

has a certificate of graduation or a certificate of completion from an approved program. The applicant must pass a written examination approved or prepared by the Board.

- **Advanced Practice Registered Nurse:** Advanced Practice Registered Nurses (APRN), including nurse practitioners (NP) and certified nurse midwives (CNM), practice under the scope of the Colorado Nurse Practice Act. The training and education received by the APRN within a particular specialty area defines the APRN's scope of practice per Colorado Revised Statutes. To be included in the APRN registry, a professional nurse must successfully complete an appropriate graduate degree as determined by the Colorado Board of Nursing; and obtain national certification from a recognized accrediting agency, as defined by the Colorado Board of Nursing, in the appropriate role and population focus. CDPHE recommends that a physician review and co-sign a sample of 10 percent of delegate agency medical records for the purpose of quality assurance and risk management. The APRN collaborates with a physician when indicated, and follows protocols developed by the Medical Policy Advisory Committee and signed by the consulting physician.

All family planning clinic sites have onsite pharmaceuticals, which allow APRNs without prescriptive authority to select and dispense pharmaceuticals according to protocols. APRNs with prescriptive authority are expected to follow Colorado Board of Nursing rules and regulations regarding prescriptive authority.

- **Mid-Level Providers Other Than Nurses (Child Health Associates and Physician Assistants):** Physician assistants are licensed by the Colorado Medical Board and practice under the supervision of a licensed physician. The requirements to be licensed as a physician assistant include successful completion of an education program that complies with standards approved by the Colorado Medical Board, and successful completion of a physician assistant national certifying examination or examination approved by the Colorado Medical Board.

- **Professional Credentials and Licensure:** Delegate agencies are required to have a policy in place to verify that health care professionals are properly licensed in the state of Colorado. Compliance is verified during the clinical site visit.

Q15. Goal statement(s) and related outcome objectives that are specific, measurable, achievable, realistic and time-framed (S.-M.-A-.R.-T);

Q 15 Response: CDPHE FPP created a 4-year budget period, September 2018-September 2022. The full report with all details is featured in Appendix A. The Title X Work Plan 2018-2022 high level goals and objectives areas follows.

GOAL 1: Assure the CDPHE Family Planning Program is following the CDC's Quality Family Planning document and training its statewide network of delegates on family planning best practices.

- *Objective 1*: Decrease the rate of unintended pregnancy for women 15-44 in Colorado from 35 in 2018 to 32 in 2022.
- *Objective 2*: Each year through September 30, 2022, 95 percent of Title X agencies will provide the following to clients under the age of 18 seeking family planning services: 1) Counseling that encourages family involvement in decisions regarding sexuality and contraception, 2) information about sexual coercion, and 3) services provided in compliance with mandatory reporting laws.
- *Objective 3*: Annually, ensure that 85 percent of total clients will be at or below 150 percent of the Federal Poverty Level (FPL) and/or age 19 or less.
- *Objective 4:* Over the course of the project period (2018-2022), 95 percent of delegate agencies will attend training that incorporates The Office of Population Affairs (OPA) Title X program priorities and key issues.

Goal 2: Improve the reproductive health of individuals and communities by partnering with

community-based, faith-based and other service providers working with vulnerable or at risk populations.

- *Objective 5*: Each year through September 30, 2022, 95 percent of delegate agencies will connect with one new group, throughout the state, to increase the visibility of their family planning programs.

Goal 3: Monitor delegate quality of services and enhance clinical and administrative management of the Title X program in Colorado

- *Objective 6:* Each year through September 30, 2022, 95 percent of delegate agencies will receive training and resources regarding quality care and healthcare business practices.

Goal 4: Family planning delegate agencies adapt to the changing health care environment and improve clinic business practices.

- *Objective 7:* Each year through June 30, 2022, Title X agencies will increase total clinic revenue from Medicaid and 3rd party payors by one percentage point. Please see full work plan (Appendix A: SMART work plan) for more detailed information on goals, objectives, activities and measurements.

Q16. Evidence, including signed referral agreements with relevant referral agencies, that the applicant has a plan to facilitate access to the following: all required clinical services, provided according to a schedule of rates that are reasonable and necessary as required by 42 CFR 59.5; comprehensive primary care services, if not provided by the project, and other needed health and social services for clients served in the Title X funded family planning projects, such as HIV care and treatment services.

Q 16 Response: All delegate agencies provide family planning services, as required by Title X, on-site, or by referral for specialized services such as LARC insertion or pelvic exams. With only five agencies referring some clinical services, the majority of CDPHE FPP delegate agencies perform all required clinical services in-house. The five agencies that sub-contract specialize services must adhere to the sub-contracting policy. The policy requires all delegates to notify

CDPHE FPP about all subcontracted Title X services and provide an Attestation of Memorandum of Understanding (MOU) signed by both the delegate agency and subcontractor. The Attestation of MOU outlines the work performed by the subcontractor, how the delegate agency is monitoring and evaluating plans of the subcontractor, and ensure that the MOU includes Title X program requirements, including the prohibition of funds used for abortion. The FPP monitors compliance with this policy during administrative site visits with delegate agencies.

Required services:

1. Contraceptive services;
2. STI and HIV screening and prevention services;
3. Breast and cervical cancer screening services;
4. Adolescent services;
5. Preconception health services and discussion with patients regarding reproductive life plans;
6. Basic infertility services and counseling;
7. Pregnancy testing and counseling.

Typical subcontracted services include:

1. Insertion or removal of long-acting, reversible contraceptive (LARC) insertions;
2. Breast and cervical cancer screening related services, such as a pap test;
3. Sexually transmitted infection services.

Q17. Evidence of the capability to collect and report the required program data for the Title X annual data collection system, the Family Planning Annual Report (FPAR)

Q 17 Response: CDPHE has an in-house data repository called, iCare that is managed by the CDPHE Informatics Unit. Delegate agencies are required to enter client profiles into the iCare data system for FPAR data collection and reporting. Delegate staff assigned to iCare data entry must abide by the terms of the Data Security, Use and Confidentiality Agreement in order to be granted

access to the data system. An alternate data submission method is submission of an electronic file of data records. To ensure the data in iCare is accurate throughout the year, reports are periodically generated and reviewed to identify data inaccuracies and correct errors. In addition, a lot of time is spent training, building capacity and coaching delegate staff on data entry. In December of each year, complementary FPAR surveys gather additional data, such as full-time equivalent staff, abnormal Pap test results, and expense and revenue reports. The iCare data system is an important tool for reporting annual Title X data. In addition, the FPP staff and delegates use iCare reports to conduct QI projects, and to monitor, evaluate, and assess the program's progress and utilization of family planning services throughout the state.

Q18. Evidence of a system for ensuring quality family planning services, including: a process for ensuring compliance with program requirements; defined performance measures, including an agreement to measure those provided to successful grantees upon notification of award, and a process for systematically assessing the quality of services provided throughout the defined projects; and a methodology for ensuring the healthcare practitioners have the knowledge, skills, and attitudes necessary to provide effective, quality family planning and related preventive health services that are consistent with current, evidence-based national standards of care and which include core family planning services, as enumerated early in this Funding Announcement. This will include training of select healthcare practitioners by OPA, and may utilize other clinical training opportunities available through OPA.

Q 18 Response: A process for ensuring compliance with program requirements: The FPP evaluates compliance with program requirements through the following, rigorous quality assurance and reporting system:

- **Medical Record Audit:** Each delegate agency participates in a medical record audit every three years conducted by either a contracted advanced practice nurse with women's health care and family planning expertise or the FPP nurse consultant. Agencies must score at least 90 percent on criteria in the medical chart audit tool. Delegates scoring below 90 percent must provide a corrective plan with technical assistance provided by the CDPHE nurse consultant.

- **Clinical Site Visit:** Each delegate agency participates in a clinical site visit every three years.

The FPP nurse consultant observes clinic flow, and the content and quality of care provided. The site visit tool is a checklist for monitoring compliance with all Title X clinical services requirements. An onsite review of medical records is conducted for completeness of documentation of care. At the close of the visit, recommendations for improvement are discussed. After the site visit, delegates receive a written site visit report, highlighting pertinent Title X compliance issues. Delegates are required to respond with correction and improvement plans that must be implemented within three months. If concerns are not resolved within the three-month time frame, the nurse consultant coaches the delegate and negotiates a new plan that may include a follow-up site visit. See Appendix L for the Clinical Site Visit tool.

- **Administrative Site Visit**: Each delegate agency participates in an administrative site visit

every three years on an alternating basis with medical chart audits and medical site visits. The purpose of the site visit is to determine whether delegate agencies are managed effectively and comply with Title X, federal and state requirements. The site visit includes a review of charts, program income documentation, service charges and collections, donations, and a comparison of chart information to iCare reported data. The administrative site visit tool is a checklist for monitoring compliance with the Title X administrative requirements. At the close of the visit, recommendations for improvement are discussed and delegates later receive a written site visit report highlighting Title X compliance issues. Delegates are required to respond with correction and improvement plans that must be implemented within three months. If concerns are not resolved within the three-month time frame, FPP staff coaches the delegate, negotiates a new plan that my include follow-up site visit, and monitors monthly. See Appendix M for the Administrative Site Visit Tool.

- **Fiscal Desk Review/Site Visit:** The fiscal site visit takes all questions on the Federal Review

Tool and applies them to every delegate agency. The FCCO Unit manages this process by requesting materials and documentation from delegate agencies and performing a desk review of their fiscal practices. A report is sent to the delegate agency detailing any findings and citing any recommendations. The fiscal site visit is performed by a trained compliance officer who is skilled in the monitoring and evaluation practices needed to manage Title X and state family planning funds. See Appendix N for the Fiscal Site Visit Tool.

- **Laboratory Results**: Pap tests and other lab work results are tracked via the delegates' electronic health record (EHR) or in lab logs listing the client's name, clinic or identification number, type of test, testing date and results. This provides a mechanism for identifying labs for which no results are returned, as well as for tracking abnormal lab results that need follow-up. Laboratory compliance and best practices are reviewed during the clinical site visit.
- **Cervical Cancer Screening Compliance**: CDPHE provides consultation, training, written policies and procedures for cervical cancer screening and follow up. Tracking systems exist to ensure that lab results are received by the agency and that abnormal tests receive prompt follow up. The CDPHE nurse consultant monitors the tracking and follow-up of abnormal lab results as a quality assurance activity through the review of reports and procedures during site visits.
- **Referral Follow-Up**: All service referrals beyond the scope of the family planning clinic are given in writing and tracked for appropriate follow up. Referrals are categorized as emergent, urgent, essential, or discretionary with time frames based on the level of concern. Clinics must have a referral follow up procedure to avoid losing clients in the event of abnormal findings. The clinics' system for recording, tracking, and following up on referrals is evaluated during the clinical site visit. The systems used for tracking and follow up of labs and referrals vary in nature from paper logs to more sophisticated electronic tickler systems.

- **Client Satisfaction:** Every family planning clinic conducts annual client satisfaction surveys. CDPHE provides a template for agencies to use or agencies may use their own survey. Delegates use the results of their client satisfaction surveys to understand where strengths and challenges lie in service delivery and to adjust their clinic practices.
- **Sliding Fee Scales and Cost Analysis:** Each delegate agency is required to do a cost analysis or cost-setting activity every three years or sooner if significant changes have occurred affecting costs.

Defined performance measures, including an agreement to measure those provided to successful grantees upon notification of award; and a process for systematically assessing the quality of services provided throughout the defined projects: iCare reports, including statewide, aggregate and agency-specific data elements, are downloaded into an Excel spreadsheet used to evaluate statewide and individual delegate agency performance. The iCare data elements evaluated include chlamydia and gonorrhea screening rates for women under 25 years and women 25 years and older; percentage of female clients who use the most, moderately and least effective contraceptive methods; client demographics such as gender, age, race, and ethnicity; and percentages of client insurance types (private, public, and uninsured). The reports are used to develop benchmarks for quality improvement targets and measures, compare sites with each other and the state as a whole, and evaluate gaps in data collection. Each agency receives its individual report and the statewide report for comparison. In 2015, the FPP convened a committee of delegate agency coordinators and providers to develop a clinical quality improvement (QI) plan. Preliminary goals, standards, measures and targets developed by the FPP QI committee include chlamydia and gonorrhea screening rates in females under 25 years old, percentage of females using LARC methods, and percentage of females using the most, moderately and least effective

contraceptive methods.

A methodology for ensuring the healthcare practitioners have the knowledge, skills, and attitudes necessary to provide effective, quality family planning and related preventive health services that are consistent with current, evidence-based national standards of care and which include core family planning services: Training and networking are important elements to Colorado's Title X program. Financial and human resources are allocated to this work from staff training to engaging delegate agencies in family planning best practices and cutting edge technology. This objective is met through a variety of efforts, including:

- **Title X Training Meeting:** Three times a year, CDPHE holds a two-hour Title X training meeting. During these meetings, CDPHE clinical staff book expert speakers to discuss innovative strategies in contraceptive technology, data collection pitfalls and best practices, and the latest family planning trends and Title X guidelines. In addition, these meetings are a forum to discuss the Office of Population Affairs priorities, including human trafficking education and training.
- **NFPRHA membership and website:** CDPHE's National Family and Reproductive Health Association (NFPRHA) membership includes a family planning training module for delegates and an opportunity for free or discounted registration for NFPRHA conferences and meetings.
- **National Training Centers:** CDPHE consistently refers to the OPA-funded National Family Planning Training Centers for resources, training, updates and innovation.
- **Newsletter Correspondence:** CDPHE emails a biweekly FPP newsletter to all delegates. Title X coordinators and clinic staff are provided information regarding upcoming local and national conferences and trainings related to contraceptive and preventive health services. The e-newsletter is also used to share updated national guidelines, such as the CDC US Medical Eligibility Criteria for Contraceptive Use and STD Treatment Guidelines, adult and adolescent immunization

recommendations and schedules, cervical cancer screening guidelines, nutritional and physical activity counseling information, and drug and alcohol resources.

- **CDPHE family planning website:** The FPP maintains a web site with Title X family planning program information for the public, such as service site information. The complete Clinical and Administrative Manuals, clinical and administrative forms, and resources and training information for delegate staff. https://www.colorado.gov/cdphe/family-planning
- **Family Planning Orientation:** FPP staff members provide various orientations for delegate staff ranging from larger sessions where all interested delegate staff are invited, via phone or in-person at CDPHE, to an individualized, agency-level orientation for new delegate family planning coordinators and interested staff.
- **Contraception information resources:** CDPHE has traditionally purchased and distributed updated editions of Contraceptive Technology to delegate agency clinic staff.
- **CDPHE Annual Family Planning Conference and Noteworthy Speakers:** For seven years, the FPP has hosted an annual conference that brings together delegates to network, learn, and train together. In years past, CDPHE brought in national speakers on contraceptive technology (Dr. Michael Policar), the future of family planning in the United States (Rachel Gold) and several billing and coding experts. This conference is done in conjunction with CDPHE's Women's Wellness Connection and the WISEWOMAN program to expand topics to breast and cervical cancer screening, and heart health. These other programs bring to the conference a wider provider network and more peer learning opportunities.

This will include training of select healthcare practitioners by OPA, and may utilize other clinical training opportunities available through OPA.

CDPHE FPP relies on the training and expertise of OPA funded training centers to covers topics

like financial operations, best practices in chlamydia screening and 340b trainings. Both the clinical and administrative National Family Planning Training Centers are invaluable resources for CDPHE FPP staff and delegate agencies.

Q19. Evidence that the applicant has ability to bill third party commercial insurance carriers and Medicaid in accordance with Title X requirements; and the ability to facilitate enrollment of clients into Medicaid.

Q 19 Response: *Billing:* All CDPHE Title X delegate agencies are billing Colorado Medicaid and actively receive reimbursements from the Colorado Department of Health Care Policy and Finance. Most delegate agencies have contracts with insurance companies and are receiving reimbursements. In some Colorado communities, for-profit insurance companies will not contract with Title X providers, citing "adequate network coverage" as the reason. In addition, Kaiser Permanente was the most widely chosen insurance company on Colorado's health insurance exchange and Kaiser is a closed system that does not contract outside of its own network. Below is evidence of billing success:

	Medicaid Reimbursement	Private Health Insurance Reimbursement
2011	$464,699	S52,832
2012	$1,031,994	S138,394
2013	$1,137,395	S273,005
2014	$2,333,932	S547,387
2015	$3,187,623	S884,157
2016	$3,969,743	S1,191,984
2017	$3,534,950	S1,351,523

Enrollment: Several of CDPHE's FPP delegate agencies have an onsite insurance and Medicaid enrollment specialist to assist patients with eligibility and enrollment. For those agencies that do not have in-office enrollment, they are required to refer patients to Medicaid and the insurance marketplace. Most other delegate agencies have enrollment counselors "down the hall" or on a different floor in the building. All delegate agencies are required to share information with clients as to where they can enroll in both Medicaid and for-profit insurance.

Upload #5

Applicant:	Colorado Department of Public Health and Environment
Application Number:	FPH2018008758
Project Title:	Colorado Family Planning Program
Status:	Review in Progress
Document Title:	Form AttachmentForm_1_2-V1.2.pdf

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	1236-Combined Appendices 201		Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment		
3) Please attach Attachment 3		Add Attachment		
4) Please attach Attachment 4		Add Attachment		
5) Please attach Attachment 5		Add Attachment		
6) Please attach Attachment 6		Add Attachment		
7) Please attach Attachment 7		Add Attachment		
8) Please attach Attachment 8		Add Attachment		
9) Please attach Attachment 9		Add Attachment		
10) Please attach Attachment 10		Add Attachment		
11) Please attach Attachment 11		Add Attachment		
12) Please attach Attachment 12		Add Attachment		
13) Please attach Attachment 13		Add Attachment		
14) Please attach Attachment 14		Add Attachment		
15) Please attach Attachment 15		Add Attachment		

Upload #6

Applicant:	Colorado Department of Public Health and Environment
Application Number:	FPH2018008758
Project Title:	Colorado Family Planning Program
Status:	Review in Progress
Document Title:	Form BudgetNarrativeAttachments_1_2-V1.2.pdf

Budget Narrative File(s)

* **Mandatory Budget Narrative Filename:** 1235 Corbined Budget Narrative and Tables_Final May

	Delete Mandatory Budget Narrative	View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative		

Upload #7

Applicant:	Colorado Department of Public Health and Environment
Application Number:	FPH2018008758
Project Title:	Colorado Family Planning Program
Status:	Review in Progress
Document Title:	Form ProjectNarrativeAttachments_1_2-V1.2.pdf

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** 1234-Project Narrative_Title X App_FINAL.pdf

Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File

Tracking Number:GRANT12628613 Funding Opportunity Number:PA-FPH-18-001 Received Date:May 21, 2018 06:08:13 PM EDT

Upload #8

Applicant:	Colorado Department of Public Health and Environment
Application Number:	FPH2018008758
Project Title:	Colorado Family Planning Program
Status:	Review in Progress
Document Title:	Form SFLLL_1_2-V1.2.pdf

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
4040-0013

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

*Name: Colorado Department of Public Health and Environment

*Street 1: 4300 Cherry Creek Drive South Street 2:

*City: Denver State: CO: Colorado Zip: 80246

Congressional District, if known:

6. * Federal Department/Agency:

Health and Human Services, OPA

7. * Federal Program Name/Description:

Family Planning Services

CFDA Number, *if applicable:* 93.217

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: *First Name: n/a Middle Name:

*Last Name: n/a Suffix:

*Street 1: n/a Street 2:

*City: n/a State: Zip:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: *First Name: n/a Middle Name:

*Last Name: n/a Suffix:

*Street 1: n/a Street 2:

*City: n/a State: Zip: 80246

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** John Chase

***Name:** Prefix: *First Name: John Middle Name:

*Last Name: Chase Suffix:

Title: Interim Chief Financial Officer **Telephone No.:** 303.692.2043 **Date:** 05/21/2018

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

Table Of Contents

Applicant:	Family Planning Council of Iowa
Application Number:	FPH2018008738
Project Title:	Title X Family Planning Services
Status:	Awarded

Online Forms

Program Narrative

Additional Information to be Submitted

Proof of Filing

1. SF-424 Application for Federal Assistance Version 2
   - (Upload #1): SF424_2_1-1235-FPCI COUNTIES.pdf
   - (Upload #2): ProjectNarrativeAttachments_1_2-Attachments-1236-FPCI PROJECT NARRATIVE.pdf
   - (Upload #3): AttachmentForm_1_2-ATT1-1237-APPENDICES.pdf
   - (Upload #4): BudgetNarrativeAttachments_1_2-Attachments-1234-FPCI BUDGET NARRATIVE.pdf
   - (Upload #5): Form AttachmentForm_1_2-V1.2.pdf
   - (Upload #6): Form BudgetNarrativeAttachments_1_2-V1.2.pdf
   - (Upload #7): Form ProjectNarrativeAttachments_1_2-V1.2.pdf
   - (Upload #8): Form SFLLL_1_2-V1.2.pdf
2. SF-424A Budget Information - Non-Construction
3. SF-424B Assurances - Non-Construction
4. SF-LLL Disclosure of Lobbying Activities
5. Project Abstract Summary
6. Key Personnel
7. Budget Narrative
8. Program Narrative
9. Exhibits/Tables/Attachments
10. Negotiated Rate Agreement
11. Copy of By-Laws
12. Proof of Non-Profit Status

Note: Upload document(s) printed in order after online forms.

OMB Approval No. 4040-0006
Expiration Date: 01/31/2019

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Family Planning Services	93.217			$2,828,000.00	(b)(4)	
2.						
3.						
4.						
5. Totals				$2,828,000.00		

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) Family Planning Services	(2)	(3)	(4)	(5)
a. Personnel	(b)(4)				(b)(4)
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual					
g. Construction					
h. Other					
i. Total Direct Charges *(sum of 6a-6h)*					
j. Indirect Charges					
k. TOTALS *(sum of 6i and 6j)*					
7. Program Income					$ (b)(4)

Authorized for Local Reproduction

Standard Form 424A (Rev. 7-97)
Prescribed by OMB Circular A-102

Previous Edition Usable

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8			(b)(4)	
9.				
10.				
11.				
12. TOTAL *(sum of lines 8-11)*				

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$2,828,000.00	(b)(4)			
14. Non-Federal		(b)(4)			
15. TOTAL *(sum of lines 13 and 14)*					

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.	(b)(4)			
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$			

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:	22. Indirect Charges:
23. Remarks:	

Authorized for Local Reproduction

OMB Number: 0980-0204
Expiration Date: 04/30/2015

Project Abstract Summary

Program Announcement (CFDA)
93.217

*** Program Announcement (Funding Opportunity Number)**
PA-FPH-18-001

*** Closing Date**
05/24/2018

*** Applicant Name**
Family Planning Council of Iowa

*** Length of Proposed Project** 48

Application Control No.

Federal Share Requested (for each year)

* Federal Share 1st Year	* Federal Share 2nd Year	* Federal Share 3rd Year
$ 2,828,000.00	(b)(4)	
*** Federal Share 4th Year**	*** Federal Share 5th Year**	
$ (b)(4)	$ 0.00	

Non-Federal Share Requested (for each year)

* Non-Federal Share 1st Year	* Non-Federal Share 2nd Year	* Non-Federal Share 3rd Year
$ (b)(4)		
*** Non-Federal Share 4th Year**	*** Non-Federal Share 5th Year**	
$ (b)(4)	$ 0.00	

*** Project Title**
Title X Family Planning Services

Project Abstract Summary

*** Project Summary**

FAMILY PLANNING COUNCIL OF IOWA

PROJECT ABSTRACT 2018-2022

The Family Planning Council of Iowa (FPCI) plans to provide Title X Family Planning Services in 55 of Iowa's 99 counties. FPCI plans to provide services to (b)(4) individuals of whom (b)(4) will have incomes at or below 100% FPL in 2018-2019; with a total of (b)(4) individuals of whom 56,000 will have incomes at or below 100% FPL served over the four year period. For this, FPCI is seeking $2,828,000.00 in Title X Family Planning funds for Year 1 (2018-2019.) The funds will be used for direct services and administration of the Project.

The core of FPCI's Title X Project is assuring availability of clinical family planning services to priority populations of low-income and vulnerable populations. It addresses the provision of community education and outreach programs and the promotion of family planning services within the health care delivery system. Ensuring high quality of care and safety through staff training, monitoring and oversight are also objectives of the Project. FPCI assures that all Title X administrative, clinical and fiscal requirements are met at the grantee and subrecipient level. FPCI will work to ensure that its family planning network is positioned to participate in the changing health care systems and utilize health information technology.

The administration of the Project will be provided by the FPCI Board of Directors and key project staff at the corporate headquarters at 108 3rd Street, Suite 220, Des Moines, IA. FPCI will subcontract with (b)(4) subrecipient agencies to provide Title X family planning services at (b)(4) clinic sites, offering the full range of family planning services as required by Title X. The sub-recipients and FPCI will provide community education and outreach programs.

Key partners include statewide organizations such as the IA Primary Care Association, IA Community Action Association and IA Public Health Association; state agencies such as IA Dept. of Public Health and IA Dept. of Human Services. Services are provided in accordance with all applicable Federal and State requirements; in agreement with the standards prescribed by the American College of Obstetrics and Gynecology.

*** Estimated number of people to be served as a result of the award of this grant.** 23441

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
____ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	____ a. bid/offer/application b. initial award c. post-award	____ a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____, *if known*: **Congressional District**, *if known*:	 **Congressional District**, *if known*:
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: 93.217
8. Federal Action Number, *if known*:	**9. Award Amount**, *if known*: $
10. a. Name and Address of Lobbying Registrant (*if individual, last name, first name, MI*):	**b. Individuals Performing Services** (*including address if different from No. 10a*) (*last name, first name, MI*):
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____
Federal Use Only:	Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

Approved by OMB
0348-0046

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: _____ Page 2 of 2

OMB Approval No.: 4040-0007
Expiration Date: 06/30/2014

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681- 1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93- 205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

*** SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL**	*** TITLE**
Jodi Tomlonovic	Executive Director
*** APPLICATION ORGANIZATION**	*** DATE SUBMITTED**
Family Planning Council of Iowa	05/17/2018

Standard Form 424B (Rev. 7-97) Back

Key Personnel

Name	Position Title	Annual Salary	No.Months Budget	% Time	Fed Amount	Non-Fed Amount	Total Amount Requested

OMB Number: 4040-0004

Expiration Date: 08/31/2016

Application for Federal Assistance SF-424

Version 02

*1. Type of Submission:	*2. Type of Application:	*If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	*Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

*3. Date Received:	4. Applicant Identifier:
05/17/2018	

5a. Federal Entity Identifier:	*5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

*a. Legal Name:	Family Planning Council of Iowa

*b. Employer/Taxpayer Identification Number (EIN/TIN):	*c. Organizational DUNS:
42-1145646	1809579790000

d. Address:

*Street1:	108 Third Street Suite 220
Street2:	
*City:	Des Moines
County:	
*State:	Iowa
Province:	
*Country:	UNITED STATES
*Zip / Postal Code:	50309-4758

e. Organizational Unit:

Department Name:	Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:		*First Name:	Jodi
Middle Name:			
*Last Name:	Tomlonovic		
Suffix:			

Title:	Executive Director
Organizational Affiliation:	
*Telephone Number:	5152889028
Fax Number:	5152884048
*Email:	jtomlonovic@fpcouncil.com

Application for Federal Assistance SF-424 Version 02

9. Type of Applicant 1: Select Applicant Type:

Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education)

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

*Other (specify):

*** 10. Name of Federal Agency:**

Office of the Assistant Secretary for Health

11. Catalog of Federal Domestic Assistance Number:

93.217

CFDA Title:

Family Planning Services

*** 12. Funding Opportunity Number:**

PA-FPH-18-001

*Title:

FY 2018 Announcement of Anticipated Availability of Funds for Family Planning Services Grants

13. Competition Identification Number:

PA-FPH-18-001-061595

Title:

FY 2018 Announcement of Anticipated Availability of Funds for Family Planning Services Grants

14. Areas Affected by Project (Cities, Counties, States, etc.):

See attached file: 1235-FPCI COUNTIES.pdf; Mime Type: application/pdf; Location: 950629.SF424_2_1_P2.optionalFile1;

*** 15. Descriptive Title of Applicant's Project:**

Title X Family Planning Services

Attach supporting documents as specified in agency instructions.

Application for Federal Assistance SF-424 Version 02

16. Congressional Districts Of:

*a. Applicant IA-003 *b. Program/Project IA-All

Attach an additional list of Program/Project Congressional Districts if needed.

17. Proposed Project:

*a. Start Date: 09/01/2018 *b. End Date: 08/31/2022

18. Estimated Funding ($):

*a. Federal	2828000
*b. Applicant	0
*c. State	0
*d. Local	0
*e. Other	(b)(4)
*f. Program Income	
*g. TOTAL	

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☒ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

☐ Yes ☒ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

**The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	
*First Name:	Jodi
Middle Name:	
*Last Name:	Tomlonovic
Suffix:	
*Title:	Executive Director
*Telephone Number:	5152889028
Fax Number:	5152884048
*Email:	jtomlonovic@fpcouncil.com
*Signature of Authorized Representative:	Jodi Tomlonovic
*Date Signed:	05/17/2018

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

Application for Federal Assistance SF-424 Version 02

*** Applicant Federal Debt Delinquency Explanation**

The following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

Upload #1

Applicant:	Family Planning Council of Iowa
Application Number:	FPH2018008738
Project Title:	Title X Family Planning Services
Status:	Awarded
Document Title:	SF424_2_1-1235-FPCI COUNTIES.pdf

FAMILY PLANNING COUNCIL OF IOWA
TITLE X SERVICE DELIVERY AREA
COUNTIES SERVED

Adair	Emmet	Lyon	Poweshiek
Adams	Fremont	Madison	Ringgold
Boone	Grundy	Marion	Scott
Buena Vista	Hamilton	Marshall	Sioux
Cedar	Hardin	Mills	Story
Cherokee	Henry	Montgomery	Tama
Clarke	Humboldt	Muscatine	Taylor
Clay	Ida	O'Brien	Union
Clinton	Iowa	Osceola	Warren
Decatur	Jackson	Page	Washington
Delaware	Jasper	Palo Alto	Webster
Des Moines	Johnson	Plymouth	Woodbury
Dickinson	Lee	Polk	Wright
Dubuque	Louisa	Pottawattamie	

Upload #2

Applicant:	Family Planning Council of Iowa
Application Number:	FPH2018008738
Project Title:	Title X Family Planning Services
Status:	Awarded
Document Title:	ProjectNarrativeAttachments_1_2-Attachments-1236-FPCI PROJECT NARRATIVE.pdf

FAMILY PLANNING COUNCIL OF IOWA

TITLE X FAMILY PLANNING SERVICES FOA PA-FPH-18-001

September 1, 2018 – August 31, 2022

The Family Planning Council of Iowa (FPCI) is a private, 501(c)(3), non-profit organization incorporated in June of 1980. FPCI's mission is to assure access to quality reproductive health care and family planning services for all people in Iowa who desire such services. The function of FPCI is the planning, developing, financing, and administering of voluntary, confidential family planning and related services.

FPCI has long been recognized as a leader in the family planning field at the state, regional and national level. Using a diverse network of providers, FPCI has increased access to family planning services in Iowa through its provision of clinical services, community education and program promotion activities, and advocacy for family planning services and providers in the changing health care environment. FPCI utilizes a provider network of (b)(4) subrecipients (SRs) providing family planning services at (b)(4) clinic sites located throughout its (b)(4) county Service Delivery Area (SDA) to implement its Title X Project. FPCI and its SRs have established a Title X program that strives to ensure their clients have optimal health outcomes.

From showing need, identifying services provided, displaying required administration, and exhibiting sustainability this application will demonstrate FPCI's capacity and ability to continue and to enhance the provision of Title X services in Iowa. FPCI will utilize these strengths to meet its priorities of serving low-income individuals, minorities, teens, and males.

Throughout this application, FPCI demonstrates its organizational capability to effectively and efficiently implement and maintain a sustainable Title X project. The application shows that FPCI can make rapid use of the Title X funds, translating them into actions that address the

identified family planning needs and implements program priorities and key issues. And, while FPCI will not be able to meet all the family planning needs identified, it will continue to provide services to as many people as possible with the funding provided. This application proposes to serve (b)(4) individuals of whom (b)(4) have incomes ≤ 100% of the Federal Poverty Level (FPL) for the project period of September 1, 2018 through August 31, 2022. For the 2018-2019 period, FPCI proposes to serve (b)(4) individuals of whom (b)(4) have incomes ≤ 100% FPL.

1. A clear description of the need for services, and a detailed description of the geographic area and population to be served:

The statement of need will cover the following areas: **A) Need for Family Planning Services:** 1) Women in Need (WIN); 2) Poverty 3) Health Insurance 4) Health Professional Shortage Areas 5) Medically Underserved Areas 6) Sexual and Reproductive Health Indicators 7) Preconception Health Services and Reproductive Life Planning. **B) Description of the Geographic Area C) Population to be Served and D) Summary.** Data sources referenced in the needs statement are included as an attachment *(See Appendix A: End Notes).*

A. Need for family planning services: For many people, particularly low income women, family planning service sites serve as the point of entry into the healthcare system. Family planning services are widely considered a key component of the healthcare safety net for low income women and men. Yet, numerous studies show several obstacles that can undermine a woman, man, or a family's ability to access affordable family planning services. That access contributes to optimal health.

Considerations such as "women in need" of publicly funded family planning services, health professional shortages for primary care physicians, medically underserved areas, poverty, birth

outcomes, health disparities, and health insurance coverage can impact the ability of individuals to access affordable family planning services.

1) Women in Need (WIN): FPCI's assessment of the need for publicly funded family planning services includes the most recent WIN data available, the Guttmacher Institute's *Women in Need of Contraceptive Services 2014 Report*. The WIN report utilizes the following definitions as part of its analysis. Women are defined as *"in need of contraceptive services and supplies"* during a given year if they are ages 13-44 and were 1) sexually active 2) able to conceive and 3) neither intentionally pregnant nor trying to become pregnant at any time during the past year. Women were defined as *"in need of publicly funded contraceptive services and supplies"* if they met the above criteria and have a family income below 250% of the federal poverty level. Both men and women receive family planning services, however, the majority of services are provided to women. Therefore, it is important to address the total number of women of childbearing age as well as those ages traditionally identified as in need of publicly subsidized family planning services. While the traditional age range for studying family planning services is 13-44, there are a significant number of older women who become pregnant; they are often the ones for whom a pregnancy is unintended. Thus, we have included them when looking at the number of women in the FPCI SDA.

According to the 2014 Guttmacher WIN Report, the number of women in need of publicly subsidized family planning services in IA was 190,270.[1] **[See Table 1]** This is an increase of 4% from 2010, which were 182,930 women. Of the total number of IA women in need of publicly subsidized family planning services, (b)(4) reside within the FPCI SDA.[1]

Table 1. Iowa & FPCI SDA Gender/Age Analysis of Ages 15-54 & WIN Ages 13-44

	Women 15-54	WIN 13-44	Men 15-54
Iowa	708,755	190,270	730,254
FPCI SDA	(b)(4)	(b)(4)	(b)(4)

*Sources: *US Census (2016 Iowa Data Center, 2016 American Community Survey), Alan Guttmacher Institute: Contraceptive Needs and Services, 2014 –Women in Need (WIN) of Publicly Supported Contraceptive Services*

While there are no figures on men that correspond to the WIN study of publicly subsidized family planning services, FPCI recognizes and addresses the family planning and preventive health needs of men, therefore, we have included those demographics within our population figures. There are (b)(4) men ages 15-54 in the FPCI SDA [**See Table 1**]. In CY2017, the FPCI Title X program provided family planning and reproductive health care services to (b)(4) men.[2]

2) Poverty: In 2016, the percentage of people living in poverty in the U. S. was 12.7%. [3] This is down from 13.5% in 2015. Nationally, this represents a 2.1% decrease since 2014. In 2016, the percentage of Iowans living in poverty was 11.8%.[4] While the poverty rate has declined in recent years, the need to address the impact of poverty on the health of Iowans remains high. When we take a closer look at poverty in Des Moines, the state's most populous city located in Polk County, households living below the poverty line were highly concentrated in zip codes 50032 (53.1%), 50314 (37.7%) and 50309 (29.3%).[5] These targeted pockets of poverty in economically underserved areas exist throughout the state and provide a more clear indication of the depth of poverty experienced by many Iowans. In addition to geographic considerations, poverty experienced by racial and ethnic minorities in IA compared to their white counterparts is substantial. In 2016, the poverty rate for Whites was 10.2%. Comparatively, the poverty rate for African Americans was 35.7%, American Indians 25.8%, Latinos 23.1%, and 13.9% for Asian/Pacific Islanders.[6] In 2017, racial and ethnic minorities comprised (b)(4) of

FPCI's family planning clients.[2] (b)(4) [redacted] (b)(4) [redacted] Ensuring the provision of family planning services to IA's low-income and underserved populations remains a high priority.

Federal guidelines determine poverty levels. However, costs associated with basic living expenses are also determining factors of need and are more reflective of today's actual cost of living. Child care, omitted entirely from the federal guidelines, is a far greater expense for families with children under 18 in 2016, particularly for single parent households. In 2016, the median family income for single parents with children under 18 was $30,235 for female head of household with no husband present, compared to $45,462 for single parent male head of households.[6] The Iowa Policy Project (IPP), a non-partisan organization, identifies "basic needs" as expenses that working families must provide, such as rent, utilities, health care, health insurance premiums, child care, transportation, clothing, and household necessities. Like many families and communities, Iowans are working harder than ever, yet struggling to earn a wage that allows them to provide even the most basic household necessities.

The *2016 IPP Cost of Living in Iowa Report* states that 1 in 5 households are living below self-sufficiency or minimum basic needs. At 61.9%, **[See Table 2]** single parent households are particularly challenged to have incomes that effectively support a basic standard of living. While the percentage for married couples without children show the lowest percentage at 7.1%, earnings for this group still falls short of meeting the minimum of basic household needs.

Table 2. Proportion of Iowa Working Families with Incomes below Self-sufficiency

Demographic	Proportion Below
Single persons	27.5%
Married w/o children	7.1%
Married w/children under 18	11.8%
Single parents	61.9%
All households	18.8%

Source: Iowa Policy Project: Cost of Living in Iowa Report – 2016

When looking at rural and urban communities, the 2016 IPP Cost of Living Report indicates that 17% of Iowans living in urban areas and 22% of rural areas do not earn enough to meet their basic needs.[8]

In 2016, the median hourly wage in IA was $16.72.[8] For nearly 1.5 million Iowa workers, half earned more and half earned less. According to an analysis by the IPP, when adjusted for inflation, Iowa's median hourly wage has changed little since 1979 when it was $15.91 per hour. That means an average person working 40 hours per week for a full year would have seen a real increase of only $270.40 over a thirty-seven year span.[9]

3) Health insurance: The overall percentage of Iowans without health insurance coverage has decreased due to the Affordable Care Act having taken effect. In 2016, 6.5% of all adult Iowans reported they had no health insurance. However, when we look closer at adults within the ages of 18-64 the number of those who do not have health insurance coverage increases to 7.8%.[10]

The *Behavior Risk Factor Surveillance Survey (BRFSS),* a surveillance study developed by the CDC, analyzes health conditions, risks, behaviors and other factors that impact health status, such as health insurance coverage. The 2016 BRFSS showed populations most likely to report lack of health care coverage were those with less than a high school diploma, young adults, and low-income, unemployed, and racial and ethnic minorities. With 27% of all people with less than

a high school education reporting no health insurance, this group accounted for the highest percentage of individuals without coverage. [10] Of young adults ages 18-24, 11% reported having no health insurance. [10] Of adults ages 25-34, 9.7% reported having no health insurance coverage.[10] In 2016, Iowans with incomes less than $15,000 per year, 17.7% had no health care coverage.[10] For those with incomes between $15,000 - 24,999, and $25,000 - $34,999, 17.4% and 12.5% respectively, reported they had no health insurance coverage. [10] In CY2017, (b)(4) of FPCI's family planning clients did not have health insurance.[2]

As we continue to assess the economic challenges facing Iowans, the *2016 IPP Cost of Living in Iowa Report* goes on to analyze the impact on family budgets for those with employer sponsored health insurance and families without. *(See Appendix B: Table 3 Basic Family Budgets for Single Parent & Two Working Parent Households in Iowa.)* There are considerable cost differences with health care plans. The share of lower and moderate income families without employer-sponsored health insurance is large and increasing. With the uncertainty of the Affordable Care Act, Iowa Medicaid Program's fragmented transition to a privatized managed care system, and the impact on family budgets, the need for additional public support for family planning and preventive health services is critical.

Data in *Appendix B* shows that a single parent with two children and without health insurance from their employer would need an income that exceeds $54,000. A single parent with one child would need an hourly wage of $21.52. Most jobs in IA pay considerably less than that wage. Child care costs account for $565 per month for a single-parent with one child. That figure increases to $711 if she/he has two children. It's important to note that those are conservative estimates for the cost of child care. The analysis shows that single parents could save a significant amount if they had a job with employer provided health insurance. A single parent

with two children could take a job that paid 13% less if it included employer provided family health insurance. For two working parents with one child, each would need to earn $14.37 per hour to make ends meet. For two children that figure is $16.89 per hour. With employer provided health insurance, health care costs for two working parents with children, drops from 20% to 10% of the budget.

(b)(4)

4) Health professional shortage areas: Another challenge for Iowans seeking medical services, particularly those in rural communities, is the lack of available primary care providers and specialty care providers such as OB/GYNS. The U.S. Health Resources and Services Administration (HRSA) determines the Health Professional Shortage Areas (HPSA), and Medically Underserved Areas and Populations (MUA/MUP) based on criteria such as geographic areas, populations, and facilities.

As of January 2018, IA reported 132 HPSA designations for primary health care in IA's 99 counties. [11] Of these, 35 were due to geographic concerns, 31 due to low-income status, and 66 due to facility, which refers to patient population served by the facility.[11] The population within all of Iowa's designated HPSAs is 726,989. [11] (b)(4) of these designations are located within the FPCI SDA.[11] The 2018 HRSA report shows only 62% of the primary care physician "need" in IA is being met. Ninety-four (94) additional primary care practitioners are needed to remove the current health professional shortage designations.[11]

The lack of available primary care physicians in rural communities can delay medical care and ultimately lead to poor health outcomes for patients. It also means fewer providers available for much needed family planning services. A 2014 American College of Obstetricians and Gynecologists (ACOG) workforce report determined that 66 of Iowa's 99 counties did not have any OB-GYNS. The ACOG report also noted that there were 1.91 OB-GYNS per 10,000 women and 4.13 per 10,000 women ages 15-45. Family planning providers, particularly in rural areas, often help fill the gap for women seeking much needed reproductive health and related services.

The Robert Wood Johnson Foundation conducted a *"2018 County Health Rankings"* study to analyze access to health care as it relates to the availability of primary care physicians. The *2018 County Health Rankings* analyze health care access through two measures. The first measure reports the percentage of the population under age 65 without health insurance. In IA, that percentage was 6% compared to 11% nationally.[12] The second measure reports the ratio of population in a county to primary care physicians in a county (the number of people per primary care physician). In the 2018 report, it shows IA's ratio of population to primary care physicians was 1,360:1.[12] The report shows that in some of Iowa's rural counties, that gap is more dismal with ratios as high as 11,190:1.[12] This is consistent with data from the *2018 HRSA HPSA Report*, which shows IA as having a shortage of 38% of primary care services needed.[11]

The lack of primary physicians, particularly in rural areas, worsens the impact on family planning service sites and the services they provide. Family planning service sites are often regarded as the go-to provider for many women seeking contraceptive care as well as primary health care services. More than six in ten women who obtained care at a publicly funded family planning clinic that provides contraceptive services considered it as their **primary** source of

medical care.[13] Four (4) in 10 women obtaining care at family planning clinics that specialize in the provision of contraceptive care, reported that clinic as their **only** source of health care.[14]

5) Medically underserved areas and populations MUAs/MUPs: HRSA designates Medically Underserved Areas and Populations based on indicators such as too few primary health care providers, high infant mortality, low-income or Medicaid-eligible populations or populations with a cultural and/or linguistic access barrier to primary medical care services. As of January 2018, there were 94 total designations in IA's 99 counties.[15] (b)(4) of those designations are located within the FPCI SDA. Of the 94 designations, 87 were identified as medically underserved areas, and one (1) designation was identified as a medically underserved population due to low-income status. [15] This designation is located in Story County (b)(4) The remaining six were identified as the Governor's designation. [15] Studies have shown that disparities in access to health care services can lead to poor health outcomes and further delays in treatment, which can result in hospitalization for preventable conditions. As family planning service sites are often seen as the primary source of health care for many low-income women, the need to continue provision of preventive health services in medically underserved areas is vital.

6) Sexual and Reproductive Health Indicators: a) Birth Rates: According to the National Center for Health Statistics, in 2015 the U.S. birth was 12.5 births per 1,000 women.[16] IA, like most states has experienced a downward trend in birth rates. Iowa's birth rate declined from 12.8 in 2014, to 12.5 in 2016. [16] There were 39,223 live births recorded in IA in 2016.[17]

In 2016, IA's teen birth rate was 17.0 per 1,000 (ages 15-19) teen girls. This is down from 19.8 in 2014.[17] When looking at births to teen mothers as a percent of live births **[See Table 4]** this downward trend continues from 5.9% in 2013 to 4.6% in 2016.[17] Despite the downward

trend in births among teens, a sustained multi-level engagement strategy is essential in our effort to facilitate sexual risk avoidance and risk reduction behaviors among adolescents.

Table 4. Births to Teen Mothers as a Percent of Live Births (2013-2016)

Age Group	2013	2014	2015	2016
19 & Under	5.9%	5.2%	4.1%	4.6%

(Source: IDPH Center of Vital Statistics 2016)

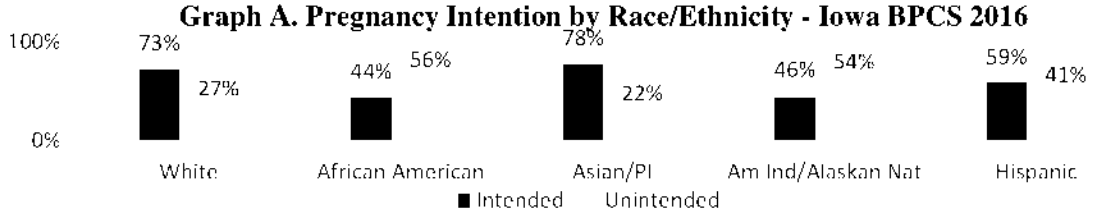
When analyzing Iowa's births to single women, teens comprised 11.8% of births to single women in 2016.[17] Women ages 20-24 accounted for the largest percentage of births to single women at 38.0%.[17] For women ages 25-29 the percentage was 28.5%; ages 30-34 was 14.6% and ages 35-39 was 5.8%.[17] The data indicates that women of all ages have a clear need for publicly subsidized family planning services. This reflects national trends of older women who are not married and bearing children.

b) Intendedness of pregnancy: Another measure of family planning need is the intendedness of a pregnancy. IA has an evaluation mechanism to capture a sense of the unintendedness of a pregnancy that ended in a live birth. It is the "*Barriers to Prenatal Care Survey*" *(BPCS)*. The BPCS is a survey of women who have delivered babies in IA hospitals. The BPCS measures pregnancy intention by asking women key questions centered on their desire to become pregnant at the time of pregnancy and plans for having a child at some point in the future. The BPCS is distributed to all hospitals in IA and all birth mothers are requested to complete the questionnaire prior to dismissal from the hospital.

Graphs A-C comprise the BPCS results for intention by race and ethnicity, age, and household income. Twenty-nine percent (29%) of women completing the survey reported that their pregnancy was unintended.[19] This percent includes women of all income levels, ages, and races.

In looking at unintendedness across racial and ethnic populations **[See Graph A]** minority women reported their pregnancy was unintended at a significantly higher percentage than white women. Fifty-six percent (56%) of African American, 22% of Asian women, 54% of American Indian, and 41% of Hispanic women reported their pregnancy was unintended compared to 27% of white women. [19]

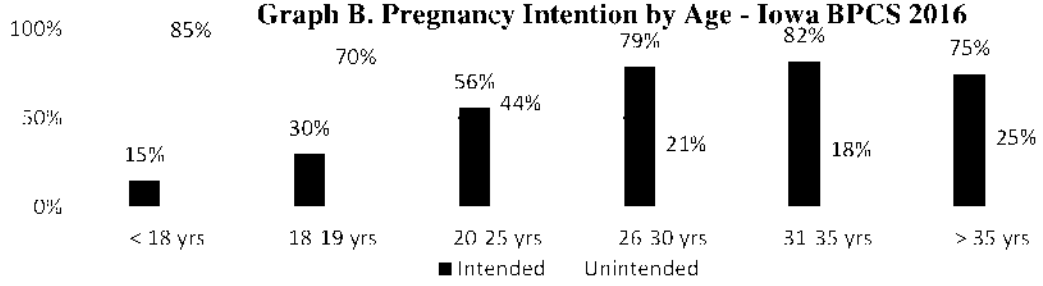
Graph A. Pregnancy Intention by Race/Ethnicity - Iowa BPCS 2016



Pregnancy intention was significantly impacted by age **[See Graph B]**. In 2016, of those women under the age of 18, 85% did not desire to be pregnant at that time. Of women ages 18-19, 68% did not desire pregnancy. For women ages 20-25, 44% did not desire to be pregnant at that time. While the incidence of unintendedness of pregnancy decreased for women ages 26-30, there was a slight increase for women ages 36 and older.[19] (b)(4)

(b)(4)

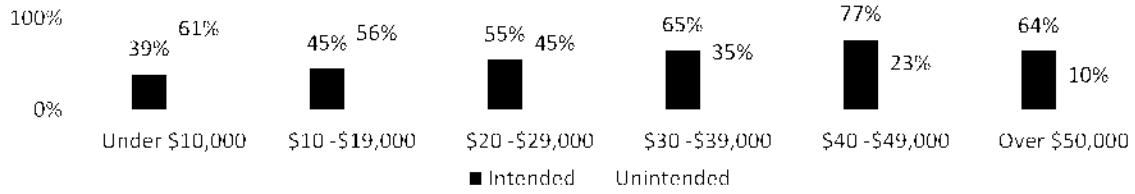
Graph B. Pregnancy Intention by Age - Iowa BPCS 2016



When looking at pregnancy intention by income **[See Graph C]** the study showed that women with lower family incomes were much less likely to desire to become pregnant. Sixty-

one percent (61%) of those with family incomes of less than $10,000 and 56% of women with family incomes between $10,000 and $19,000 did not intend to become pregnant at that time. [19]

Graph C. Pregnancy Intention by Household Income - Iowa BPCS 2016



This data shows intendedness of pregnancy and the continued need for family planning services in IA among Title X priority populations. In 2017, FPCI's Title X Program prevented (b)(4) unintended pregnancies within its SDA.[2, 18] The rate of unintended pregnancies among these groups would be significantly higher without publicly supported family planning services.

c) Birth outcomes: Another measure for assessing the need for family planning services is birth outcomes. Two such indicators are low birth weight and infant mortality. Studies show that poor pregnancy outcomes such as low birth weight and increased infant mortality can result from unplanned pregnancies, lack of preconception care, cigarette smoking, substance and alcohol use, chronic diseases, as well as the health condition of the mother.

In 2016, the percentage of women who delivered low-birth weight infants statewide was 6.8%.[17] African-Americans had the highest level at 11.7%, with Asian/Pacific Islanders second highest at 7.6%.[17] The percentage of low-birth weight infants among white women was 6.3%.[17] In 2016, the infant mortality rate in IA was (b)(4) and (b)(4) in the FPCI SDA.[17]

A strong publicly supported family planning program can help to reduce the incidence of low birth weight births and high infant mortality levels. In 2016, FPCI's Title X Program prevented (b)(4) unplanned pre-term and low-birth weight births, and (b)(4) miscarriages following unintended pregnancies.[2, 18] Additionally, the investment of publicly funded family planning

services resulted in a gross cost savings of (b)(4) for IA taxpayers for miscarriage and ectopic pregnancies in 2017. [2, 18]

A key emerging issue for health care providers, which can negatively impact birth outcomes, is opioid use disorders. In the U.S. from 1999 to 2015, the rate of prescription opioid overdose among women increased by 417% compared to 218% for men.[22] In Iowa, the number of *opioid related* deaths increased from 59 in 2005 to 146 in 2016.[23] *Opioid overdose* deaths increased from 28 to 67 for the same time period. Iowa Department of Public Health (IDPH) Bureau of Substance Abuse reports that treatment admissions related to opioid use in Iowa has also tripled since 2005. In 2016, the number of admissions was 2,274, up from 608 in 2005.[23]

Negative birth outcomes such as neonatal abstinence syndrome (NAS) due to opioid use disorders are increasing. Although NAS is associated with other substance use disorders, it most commonly occurs in infants after in utero exposure to opioids. Opioid exposure during pregnancy might result from pain-associated prescription use of opioids, misuse of prescription, medication-assisted treatment (MAT) or illicit use.[24] Two recent legislative initiatives *(Protecting Our Infants Act of 2015, The Comprehensive Addiction and Recovery Act of 2016)* call for providers to address maternal opioid use and NAS. The percentage of Medicaid-enrolled women who filled at least one opioid prescription during pregnancy increased from 18.5% to 22.8% from 2000-2010. [24] Reflective of the increasing use of opioids in the U.S., the incidence of NAS increased 400% from 2000-2012.[24] One of the key strategies to address NAS for those groups heavily impacted is quality family planning services.[24]

FPCI will collaborate with key stakeholders, such as substance use treatment facilities, to train, educate and coordinate referral options for treatment and enhance preconception health

care. All SRs will be better equipped to not only inform clients about the serious implications of opioid abuse, but how to address them safely and effectively.

d) Sexually transmitted diseases (STDs): STDs continue to be a major challenge for IA's public health system. IA has seen a significant increase in STDs. The IA Department of Public Health (IDPH) receives funding for chlamydia and gonorrhea screening for the IA Community-Based Screening Services Program from the Centers for Disease Control and Prevention (CDC), which is coordinated at the FPCI Administrative Office located in Des Moines, IA. Screening takes place at family planning service sites, community health centers, and other identified health care facilities.

STD rates, **[See Table 5]** specifically syphilis and chlamydia, continue to increase. In 2016, there were 276 reported cases of syphilis and 12,983 reported cases of chlamydia.[20] This represents increases of 14% and 12 % respectively, of reported cases since 2014. [20] There were also 2,600 reported cases of gonorrhea in 2016. [20] This represents a 2% increase in reported cases of gonorrhea since 2014. [20]

Table 5. Trends in STDs in Iowa (2014-2016)

STD	2014	2016	% Change
Chlamydia	11,632	12,983	+12%
Gonorrhea	1,626	2,600	+2%
Syphilis	243	276	+14%

(Source: IDPH Bureau of HIV/STD/Hepatitis 2016 STD Surveillance Data Report)

The rate of HIV/AIDs [**See Table 6**] is another means of assessing need for publicly supported family planning services and health education provided within the FPCI family planning provider network. In 2016 there were a total of 139 reported cases of HIV to the IDPH. The HIV diagnosis rate per 100,000 was 4.4.[21]

Table 6. Iowa HIV Diagnosis Rate per 100,000 (2014-2016)

	2014	2015	2016
HIV Diagnosis Rate – Statewide	3.2	4.0	4.4

(Source: IDPH Bureau of HIV/STD/Hepatitis 2016 STD Surveillance Data Report)

As of December 31, 2016, 2,647 individuals were living with HIV disease in Iowa.[21] Of the 2,510 individuals that were diagnosed with HIV on or before December 31, 2015, and living in IA as of December 31, 2016, 2,115 (84%) were retained in HIV care and 1,965 were virally suppressed.[21] (b)(4)

(b)(4)

7) Preconception Health Services: (b)(4)

(b)(4)

The need for preconception health services is evidenced by data presented in the *2016 BPCS,* which showed that for 29% of women in IA who became pregnant, it was unintended.[19] Therefore, our focus is on addressing preconception health services for women who seek family planning services and also in educating and screening women of reproductive age to help identify any potential maternal and fetal risks or potential hazards to pregnancy both before and between pregnancies. This is important in that data also presented through the 2016 BPCS

reported that 31% of women did not see a health professional in the 12 months prior to becoming pregnant. [19]

Behaviors such as alcohol and substance use are particularly harmful to the health of infants. According to the 2016 BPCS, 40% of women surveyed smoked 1-10 cigarettes per day in the last three months of their pregnancy. [18] FPCI's emphasis on preconception health services with a focus on diet, lifestyle, medical and family history, medications, and any past pregnancies can help reduce adverse pregnancy-related outcomes, such as low birth weight, premature birth, and infant mortality.

While the evidence centered on recommendations for improving the preconception health of men is less than that for women, FPCI's Clinical Protocols include specific recommendations for men. This includes services that address men as partners in family planning, their direct contributions to infant health, and their role in reducing transmission of STDs to women. The consequences of an STD can be significantly more serious, even life threatening, for a woman and her unborn baby if the woman becomes infected with an STD while pregnant.

B) Description of the geographic area: IA is located in the central part of the country between the Mississippi and Missouri River on the east and west, with Minnesota to the north and Missouri to the south. Extending 205 miles from north to south and 310 miles east to west, the state covers 55,857 miles. IA is known for its harsh winter weather which can make travel difficult. Rural communities often experience challenges which can negatively impact the ability of family planning service site staff to reach their facilities in order to provide services as well as the ability of clients to keep their scheduled appointments. Most IA communities have no public transportation, and in those that do, it is extremely limited.

Iowa is comprised of many small towns with several larger cities. IA's largest city and state capitol is Des Moines. The state is comprised of 99 counties. (b)(4)

(b)(4)

(b)(4) of Iowa's rural designations are located in the FPCI SDA. [25] Thirty-six percent (36%) of Iowa's total population density is rural and 64% is urban, with 54.5 people per square mile. [26] This has a considerable impact on the availability of health care services. Health care providers are less likely to locate in rural areas. Those who do work in rural areas often find themselves overworked with little or no backup or relief assistance. As documented in the *2018 County Health Rankings Report*, the overall ratio of IA primary care physicians to population is 1,360:1. Yet in many rural IA counties, the ratio is significantly higher at 11,190:1.[12]

Polk County, IA is currently served by two Title X grantees, FPCI and IDPH, to provide family planning services. Polk County is the most populous county in the state, as well as the most diverse in terms of race and ethnicity, income levels and available resources. During preparation of this funding application the Executive Director of FPCI and leadership at IDPH had conversations about the service delivery areas in the application. If both applicants are funded, FPCI and IDPH request that both grantees be funded to continue providing Title X Services in Polk County. The grantees will continue their long collaboration in the county. Each

grantee brings a different perspective and strength to this collaboration and the provider mix for Polk County, ensuring access to different service sites in different locations within the county.

C) Description of population(s) to be served: FPCI has consistently ensured access and availability of high quality family planning services to Title X priority populations. (b)(4)

(b)(4)

(b)(4) The analytical data presented demonstrates the continued need for family planning services among Title X priority populations such as low income, medically underserved, and those groups impacted by health professional shortages and health disparities.

In 2017, the total population in the FPCI SDA was 2,104,847.[26] This represents 67% of IA's total population of 3,145,711.[26] IA is expected to experience a 10% increase in population from 2017 to 2050.[27] **[See Table 7]**

Table 7. Population Projections for Iowa 2050

Year	2017	2030	2050
Total Population	3,145,711	3,328,308	3,474,647

(Source: 2017 Iowa Data Center; 2015 Woods & Poole Economics Projections)

FPCI identifies people with family incomes at or below 100% (≤ 100%) of the federal poverty guidelines as a priority population consistent with the federal reporting system used in the Family Planning Annual Report. Data presented from the *2016 BRFSS* and *2016 BPCS* support the basis for listing the population with family incomes of less than $25,000 as a priority population. Even with the implementation of the Affordable Care Act, Iowans with incomes less than $15,000, 17.7% still had no health insurance coverage.[10] For those with incomes between $15,000-24,999 and $25,000-$34,999, 17.4% and 12.5% respectively, reported they had no health insurance coverage.[10] When comparing unintendedness of pregnancy among family

incomes, data presented in the *2016 BPCS* showed that for those whose family incomes were under $10,000 per year, 61% were unintended, and for those with incomes between $10,000-$19,000, that figure was 56%.[19] Family incomes of $20,000 translate to between 151-200% of the poverty guidelines for a family of one and 100-150% for a family of two.

FPCI's Title X Project will focus on low-income women and men. Data supports the inclusion of targeting low-income women and men as identified in the *IPP Cost of Living in Iowa Report.* The study showed the difficulty facing many Iowans to meet the minimum threshold of their ability to provide basic household needs. An unintended pregnancy can derail an already fragile infrastructure for a low-income family, whether a single parent or two parent household. *The IPP Cost of Living in Iowa Report* showed that a single-parent's expenses for child care costs per month were $565 for one child and $711 for two children.[9] Affordable family planning services allows women and couples to effectively determine the number of children they want, and the spacing of time between the births of those children.

(b)(4)

(b)(4) In 2016, IA's racial and ethnic minority population consisted of 14.4% of the total population.[28] The racial demographic profile in FPCI's SDA [**See Table 8**] is (b)(4) white, (b)(4) Black (b)(4) Asian, (b)(4) Am. Indian, 0.1% Nat. Hawaiian or Pacific Islander, and (b)(4) are Multi-Racial.[27] The ethnic (Latino) demographic profile of FPCI's SDA is (b)(4). The Latino percentage includes all races. In 2017, FPCI served (b)(4) racial/ethnic minorities.

Table 8. Iowa & FPCI Area Population by Race & Ethnicity (2016)*

	Total	White	Afr. Am.	Am/Ind. /A. Native	Asian	Nat. Haw. /PI	Multi-Racial	Hisp./ Latino
Iowa	3,134,693	2,864,884	114,874	15,924	78,735	3,592	56,684	182,606
(b)(4)								

(Source: 2016 U.S. Census-American Community Survey, Iowa Data Center 2016
**Most recent county level data)*

The 2016 BRFSS also found that racial and ethnic minority populations were among those groups most likely to report lack of health care coverage. Data from the various need indicators show significant health disparities among racial and ethnic groups as it relates to sexual and reproductive health and access, desirability of pregnancy and lack of consistent birth control usage, provides evidence that FPCI should continue its focus (b)(4)

(b)(4)

(b)(4)

(b)(4)

2) Evidence that proposed projects will address the family planning needs of the full population in the service area to be covered: (Priorities 1, 4; Key Issues 2, 4)

FPCI has established a strong service delivery mechanism that is responsive to the family planning needs of clients within its SDA. The FPCI SDA covers (b)(4) counties in IA. FPCI will utilize its existing provider network consisting of (b)(4) SRs to provide direct family planning services in (b)(4) service sites located in (b)(4) of the (b)(4) counties within its SDA. FPCI's SRs are (b)(4) (b)(4) *(See Appendix D for information about each SR). All SRs have signed Letters of Commitment. (See Appendix E: Letters of Commitment)*

FPCI establishes annual contracts with SRs to provide family planning services at the (b)(4) service sites, which are located in rural and urban communities within its SDA. SRs are required to provide a broad range of safe, acceptable and effective family planning methods as required

by Title X. Title X services include clinical family planning services, client education, community participation, education and project promotion. SRs are required to have referral agreements for clients who need additional services for primary care, mental health, substance use, as well as other identified support services. (*See Appendix F: Coalitions and Workgroups*)

The demographic profile of FPCI's 2017 client base shows the diversity in age, income, and race and ethnicity that exist among clients receiving family planning services. In CY2017, (b)(4) women and (b)(4) men) received family planning services though the FPCI provider network.[2] Of that total, (b)(4) were 19 years of age and younger, (b)(4) were ages 20-34, and (b)(4) were ages 35-44, and (b)(4) were over the age of 40. [2] Data presented in the needs assessment shows that (b)(4) of FPCI's clients served in 2017 were racial and ethnic minorities.[2] In CY2017, (b)(4) FPCI's clients were at or below 100% of federal poverty guidelines. Of those, (b)(4) had no health insurance coverage.[2]

A mechanism that demonstrates FPCI's effectiveness in addressing family planning needs and related health services is shown by using the Guttmacher Institute's Tool, "Health Benefits and Cost Savings of Publicly Funded Family Planning." Data analysis showed that in 2017, through its provider network, FPCI's Title X program prevented (b)(4) unintended pregnancies, prevented (b)(4) unplanned births, prevented (b)(4) abortions, and prevented (b)(4) chlamydia infections. These figures show the valuable impact of FPCI's Title X program.

FPCI has established an impressive collaborative network throughout the state to ensure that changes within Iowa's health care delivery system do not have a negative impact on the delivery of family planning services. As of December 2017, FPCI established 21 statewide partnerships and its SRs have 442 partnerships. These partnerships consist of 153 social service organizations, 48 public health entities, 19 domestic violence/sexual assault centers, 104 middle/high schools,

40 colleges/universities, 29 substance abuse and mental health organizations, 25 adult correctional/juvenile detention facilities, and 9 faith-based groups. FPCI staff and its SRs are actively involved through state and local committees/boards, facilitating referrals arrangements, providing education sessions, family planning services, and participating in project promotion activities.

Through partnerships and the coordination of its Title X program with other programs that fund family planning services and related health services, FPCI has the ability to leverage its existing resources to better serve clients. FPCI partners with the Iowa Medicaid Program to ensure that the Medicaid and Title X program complement and support each other. All FPCI subrecipients are approved and enrolled Medicaid providers

FPCI has a long history of partnering with IDPH. FPCI partners with the IDPH family planning program to ensure coordinated family planning services through training and education. The IDPH STD program subcontracts with FPCI to coordinate the Community-Based Screening Services. In this role, FPCI is able to ensure that STD services are available to family planning clients. It also enables FPCI to provide input into decisions regarding STD programming and services. Some SRs have contracts with IDPH to provide maternal and child health (MCH) programs. This onsite collaboration allows a continuum of care for the clients who need clinical family planning services with minimal wait times. SRs that do not have maternal and child health contracts have established referral systems with the maternal and child health program in their area. FPCI works with IDPH's Breast & Cervical Cancer Program and the Vaccine for Children Program.

FPCI has a formal MOU agreement with the IA Primary Care Association (IPCA) which is the association for the Federally Qualified Health Centers to share information and resources.

Iowa had a Medicaid Family Planning Waiver that was discontinued June 30, 2017. It was replaced by a state funded family planning program (SFPP). The new program retained client benefits and eligibility of the Waiver program but excluded certain provider entities. Preliminary data on the first six months of the new program show a significant decrease in enrolled clients and claims reimbursements from the State for services. The decreased use of this program places increased need on the Title X program.

FPCI will continue efforts to enhance its partnerships to ensure that the family planning needs within its service area and throughout IA are met. FPCI recognizes the importance of addressing the healthcare needs of clients across the lifespan. Having worked extensively with vulnerable and low income populations, FPCI has become keenly aware of the harsh reality of the impact that unforeseen health issues and limited financial resources can have on a client's family, relationships, and their livelihood. Working to limit barriers to care remains FPCI's priority.

As evidenced throughout this application, FPCI demonstrates its organizational capability to effectively and efficiently implement a strong Title X project. FPCI will make rapid use of Title X funding by implementing a comprehensive four-year work plan that addresses the identified family planning needs. FPCI reviews SR program performance through a variety of reporting and monitoring systems to ensure a consistent focus not only on meeting organizational goals and objectives, but more importantly the needs of family planning clients.

3. Evidence of experience: (Key Issues 3, 4)

The Family Planning Council of Iowa (FPCI) has a long and solid history of providing access to family planning services within a framework of holistic health care to assure optimal health for its clients. This framework is FPCI's partnership with a variety of health systems such as IA

Primary Care Association, IA Cancer Consortium, IA Dept. of Public Health, and IA Medicaid program, and its partnership with social service entities such as the IA Community Action Association (*See Appendix P*), and FPCI's provider network with their extensive partnerships.

FPCI has worked with a variety of providers within its (b)(4) county SDA for over 30 years to deliver family planning services. The composition of its subrecipient network has been changed to reflect changes in health care providers, delivery systems and community needs. This composition results in a varied network of providers including Federally Qualified Health Centers (FQHC), faith-based organizations, county health departments, a planned parenthood, hospital affiliated clinics and free standing family planning clinics. Over the past five years, 16 of FPCI's family planning service sites have closed due to financial difficulties. When a service site is closed, FPCI strives to find a replacement subrecipient site, and have found nine replacement sites. Finding replacement sites is difficult especially in rural areas.

The SRs are entities that are established in the communities they serve and have long experience in working with the Title X targeted populations. These are community-based and faith-based organizations that are connected with other community-based organizations and faith-based organizations in their communities. These connections furnish the SRs with the ability to make linkages and referrals that benefit their clients.

Because connections made at the local service delivery level are best for ensuring timely and appropriate referral, it's required that the SRs develop partnerships with a variety of entities in their communities. The SRs provide an annual report on those partnerships to FPCI. These reports detail a large and wide range of partnerships and connections with community and faith-based organizations. A clearer identification of connections and collaborations with faith-based organizations will be included in future reports from the SRs.

FPCI itself has partnerships with entities that have statewide connections. While FPCI stresses collaborations at the SR level, it recognizes the need to maintain and expand connections at the grantee level. In the coming years, FPCI will identify additional state level community-based and faith-based groups to partner with on programming, training and education.

Combined sections: 4. Evidence that proposed projects have experience in providing clinical health; and 5. Evidence of familiarity with and ability to provide services that include family planning: (Priorities 1, 2, 3, 4, 5, 6, 7; Key Issues 4, 5, 6, 7)

Experience: FPCI's capability to provide clinical health and family planning services in its Service Delivery Area (SDA) and communities served is demonstrated by its experience as detailed below. The key components of FPCI's Title X project are to ensure provision of clinical services, health information, education, and counseling to the women and men who need such services in the (b)(4) Iowa counties identified as its SDA. Clinical services include health screenings for routine preventive visits, examinations for diagnosis and treatment, providing a broad range of family planning methods (including natural family planning) and services, helping clients achieve pregnancy, performing STD screening and treatment, providing pregnancy testing and counseling, cancer screenings, preconception counseling and assessing clients' reproductive life plan. These services will be discussed in detail below.

FPCI utilizes (b)(4) family planning service providers as subrecipients (SRs) in the SDA to provide clinical care, client education, and community participation and education. The SRs are responsible for specified counties as their SDA. An SR is not required to have a service site in every county of its SDA. However, it is required to have at least one clinical service site in its SDA and provide community participation, education and project promotion (CPEPP) in all of its SDA counties. SRs submit annual workplans for the clinical services and CPEPP in each of

their counties. All SRs have a Medical Director (MD), either on staff or under contract, who oversees the clinical services of their Title X project and must have special training or experience in family planning. Clinical services are provided by clinicians, defined as physicians, Advanced Registered Nurse Practitioners (ARNPs, which include Certified Nurse Midwives), and Physician Assistants (PAs) with training in family planning.

The majority of FPCI's SRs have long standing experience in providing family planning and related services, even before becoming a subrecipient of FPCI. Expectations of the SRs to provide high quality, client centered comprehensive family planning and preventive healthcare services as detailed by the Program Requirements are clearly and consistently communicated by FPCI. All SRs provide the core Title X services onsite and do not refer clients for any required Title X services. FPCI's SRs strive to encourage clients to be healthy overall. This holistic view of health is not just the absence of disease; instead, it is the combined wellness of a client's physical, emotional, social, mental and spiritual health. To assist clients to achieve the best total health, SRs have established relationships with other healthcare and social service providers in their communities.

Voluntary Services and Confidentiality: FPCI recognizes one of the essential tenants of Title X is to provide family planning services on a voluntary basis. Prior to receiving any clinical services, all clients must sign an informed consent for services. All consent forms must state that services are voluntary. Clients have the opportunity to ask questions about anything they do not understand. Clients may decline any medical treatment or procedure at any time, but are instructed that refusing a medical treatment or procedure may impact their health outcome. Services must be provided in accordance with Title X statute: clients cannot be coerced to accept services or any particular method of family planning; services must be solely on a

voluntary basis and not a prerequisite to eligibility for any other services; and services are provided without any requirement of durational residency or referral by a physician. FPCI routinely reviews SR consent forms for compliance.

All SRs comply with the Health Information Portability and Accountability Act (HIPAA) laws; privacy forms are provided to clients and signed as required. SRs are required to provide safeguards for individuals against the invasion of personal privacy, as required by Title X and HIPAA. Confidentiality and its legal limits (State required reporting) are discussed with all clients. No information obtained by SR staff about individuals receiving services may be disclosed without the individual's written consent, except as required by law or as necessary to provide services to the individual. Information may otherwise be disclosed only in summary, statistical, or other formats that do not identify the individual.

Core Family Planning Services and National Standards of Care: As with all medical clinic settings, a medical record is established for each client who receives services at SR facilities. The medical record includes informed consents, all required demographic data, all medical services provided, a plan of care, education provided, follow-up needed, referrals, and all telephone communications. All SRs use electronic medical records with authorized users. The medical records on electronic systems are highly controlled through security codes. Those who have paper charts stored, have them securely locked and safeguarded to protect all client information. SRs are in compliance with HIPAA regulations regarding protection of client information.

Clinical Protocols establish a framework of practice guidelines for providing medical care for clients. FPCI has Clinical Protocols which reflect Title X Requirements, federal and state regulations and are based on national standards of care: the American College of Obstetrics and Gynecologists (ACOG) and the Centers for Disease Control and Prevention (CDC). FPCI's

protocols were developed by and are reviewed annually by the FPCI Medical Committee which is comprised of FPCI's Medical Director (MD) and Clinical Coordinator (CC) and a clinical staff representative from each of FPCI's SRs. As changes are identified with Title X, ACOG guidelines for care and treatment, and the CDC, protocols are revised by the Medical Committee and approved by FPCI's MD. These protocols are disseminated to the SRs. Each SR develops their own protocols based on FPCI's and these must be approved by the SR Medical Director and accepted by FPCI.

Core family planning services are provided to men and women to help them plan their families and space their children. These services include preventing pregnancy by providing a broad range of family planning methods, including natural family planning/FAM; helping clients to achieve a pregnancy; basic infertility services; pregnancy testing and counseling; adolescent services; and STD services. SRs offer a broad range of acceptable and effective Food and Drug Administration (FDA) approved family planning methods. These methods include intrauterine devices (IUDs); subdermal implants; hormonal methods including pills, patch, ring and injection; male and female condoms or other barrier methods; natural family planning/fertility awareness methods; and emergency contraception. Clients are provided unbiased, nondirective and medically accurate education and counseling regarding the proper use, possible side effects, risks, benefits, and warning signs of their chosen method. Fertility awareness aids and handouts are provided to help clients use the NFP method most effectively. Clients are encouraged to use condoms correctly and consistently along with their regular method of contraception in order to minimize the risks of pregnancy and STDs/HIV. All SRs provide onsite distribution of family planning methods and condoms. Family planning services do not include abortion as a method of family planning. (*See Appendix G: Services Provided*)

FPCI's network of SRs currently provides natural family planning methods (NFP), and FPCI will strengthen this provision by increasing focus and training for clinical staff members. FPCI is working with the Institute for Reproductive Health (IRH) at Georgetown University to provide several webinars on NFP methods to increase the clinical staff's ability to offer and teach a variety of NFP methods to clients. IRH will also assist our SRs to develop strategies for outreach and communication in their community, enabling SRs to market NFP methods that are offered.

Related Family Planning Services: Related family planning services include general preventive health services which include screening for breast and cervical cancer, testicular cancer, intimate partner violence, diabetes, hypertension, lipid disorders, anemia, opioid misuse, and other general health screenings, as deemed necessary. FPCI's FQHC SRs are actively involved in trying to combat the opioid crisis, by regularly performing SBIRT (Screening, Brief Intervention, and Referral to Treatment) with all their primary care and family planning clients. FPCI's non-FQHC SRs assess for alcohol and drug use, and FPCI will have additional training to increase their ability to identify and refer clients for opioid misuse. All clients are universally educated and screened for domestic violence and intimate partner violence: reproductive coercion, forced sex, birth control sabotage, pregnancy pressure and condom manipulation, since these situations can increase unintended pregnancies, the number of sexual partners, and shortened interval repeat pregnancies.

The goal of counseling and education in the family planning setting is a process for mutual sharing of information in order for clients to make informed healthy decisions about their reproductive health. Client centered education is medically accurate, unbiased and non-directive regarding their family planning choices. Clients are encouraged to include family and partner participation in their reproductive health decisions. These relationships are important in creating

thoughtful discussions about their decision to seek family planning services. A thorough assessment of behavioral, sexual and social risks are performed and clients are encouraged to reduce or avoid risky behaviors and to make healthy choices in their daily lives in order to have the best health outcomes for themselves as well as their families. Verbal and written educational materials provided are client centered, and based on clients' needs and existing knowledge of relevant information. All education and counseling, as well as the client's understanding of the education provided, must be documented in their medical record.

Pre-pregnancy Related Service: Encouraging a healthy lifestyle is essential to helping clients achieve overall well-being. Preconception health services are offered to female and male clients, to identify and modify risks to their health and improve pregnancy outcomes through prevention and management. Preconception describes any time a woman of reproductive potential is not pregnant, but is at risk of becoming pregnant, or any man who is at risk for impregnating his female partner. It promotes the health of women of reproductive age before conception and thereby helps to reduce pregnancy related adverse outcomes, such as low birth weight, premature birth, and infant mortality. Preconception health services address men as partners in family planning, their direct contributions to infant health (genetics), and their role in improving the health of women (reduced STD transmission). Clients are encouraged to be healthy in preparation for a planned or unplanned pregnancy. Reproductive life planning (RLP) helps determine a client's desire to prevent or achieve pregnancy, and the timing and spacing of their children. All clients are asked about their RLP to help guide clinical services offered and education provided. These counseling and education topics are documented in a client's medical record.

Because of FPCI's relationship with IRH as described previously, basic infertility services provided by all SRs will be strengthened since fertility awareness methods (FAM) are also used to assist clients in achieving pregnancy, if they are unable to achieve pregnancy on their own. These clients are counseled how to maximize their fertility: to assess their menstrual cycles, predict ovulation, and time the frequency of coitus. Clients' reproductive, medical, and sexual histories, as well as social habits are assessed and a physical examination, basic STD screening, education and counseling, and referral, when appropriate, is performed.

Pregnancy testing, diagnosis and counseling are provided at all SR clinic service sites. A positive result initiates a discussion with the client regarding her pregnancy intention and her options. Appropriate counseling is provided in a neutral, factual and nondirective manner for each of the options of interest as required in statute and regulation (42 CFR 59.5(a)(5)). Information about available community resources for their pregnancy options are provided to clients. Clients who have a negative pregnancy test result are asked about their pregnancy intention. Information about contraception or infertility services are provided, whichever is appropriate. Sexual risk avoidance and the benefits of returning to a sexually risk-free status will be communicated and encouraged, especially with adolescent clients.

Infection Assessment and Treatment: Chlamydia and gonorrhea infections are the two most commonly reported STDs in the United States and can cause serious sequelae, because they are often asymptomatic and undetected. These complications can include pelvic inflammatory disease, ectopic pregnancy, and infertility in women. An integral part of FPCI's program requires all SRs to perform STD screening, testing, and counseling services, which include chlamydia and gonorrhea (CT/GC), syphilis, Hepatitis, and HIV. FPCI works closely with IDPH's STD project, the Community-Based Screening Services (CBSS) program, following the CDC's

recommendation of routine annual CT/GC screening for sexually active females ages 24 and under. Women age 25 and older are tested when risk factors or symptoms are present. When a positive STD result is identified, the treatment of STDs for clients and their partner(s) is accomplished in a timely manner to prevent complications, re-infection and further spread of the infection. Teens will be screened for victimization when they present for STD or pregnancy testing. Expedited partner therapy for CT/GC is permissible by Iowa state laws. If a partner refuses to come to the clinic, medication is provided to the client to give to their partner(s) to prevent reinfection. All clients with positive results are encouraged to return for retesting in three months. All SRs provide HIV testing onsite and have referral mechanisms for linkage to care for clients with positive test results. SRs also assess each client's sexual risk (adopted from the CDC's sexual health assessment) by performing a detailed sexual history, inquiring about current and past partners, sexual practices, use of STD protection, and past history of STDs. Counseling is then client centered to encourage clients to avoid sexual risks.

The provision of pharmaceuticals must be done by a physician, ARNP, PA, or physician designee under written orders. Both ARNPs and PAs have prescriptive authority under Iowa law. By Iowa law, family planning clinics may provide birth control supplies without having a pharmacist onsite. FPCI requires each SR to maintain a drug formulary that includes a broad range of contraceptive supplies and gynecological-related drugs as part of the Title X project. All SRs are enrolled in the Office of Pharmacy Affairs 340B program to provide access to low cost family planning methods and other supplies. All SRs are also enrolled in the 340B Prime Vendor program to receive even better prices. Medications are available through a schedule of discounts for self-pay clients between 101-250% of federal poverty level and at no cost for clients ≤100% of poverty.

Basic onsite laboratory (lab) services are an essential component to providing comprehensive family planning services. These include performing pregnancy tests and the diagnosis of vaginal and urinary infections in the clinic and collecting specimens for other lab tests that are sent to an outside lab for processing. All SRs provide basic laboratory services onsite and contract with offsite laboratories for their other lab services. For onsite laboratory services, FPCI requires each clinic to have a current Clinical Laboratory Improvement Amendments (CLIA) certificate appropriate for the type of testing conducted at the clinic. SRs' medical policy and procedure manual must specifically direct the provision of all onsite laboratory services and include a list of tests performed. When offsite laboratories are used, the laboratory must be CLIA certified for the performed tests and include liability coverage.

Referrals: In order to assist clients achieve and maintain optimal health, they are assessed for other health related or social service needs. SRs must provide referrals and have written policies regarding counseling and referrals to and from other social and medical service agencies in their communities. Each SR must have a list of available referral agencies in their area with established linkages to these agencies. A system must be in place to track clients who have been referred or are in need of follow-up or continued care for abnormal results.

FPCI recognizes the importance of having primary care services readily available to provide needed healthcare and social support to maintain a client's wellbeing or to return them to ideal health. Primary healthcare services are provided either onsite or through partnerships and written agreements with primary care organizations in their local communities. Of FPCI's (b)(4) SRs, (b)(4) are Federally Qualified Health Centers and (b)(4) are associated with a large integrated health system enabling them to have timely access to a primary healthcare provider. SRs which do not provide primary care onsite or within their network must have formalized

linkages for referrals to a primary care provider. Family planning clients are routinely asked if they have a primary care provider or if they need help to obtain one. FPCI will ensure all SRs document this information in clients' medical records.

Services that are consistent with standards of care related to family planning: As described previously, FPCI has Clinical Protocols which reflect Title X Requirements, federal and state regulations, and national standards of care. FPCI and its Medical Committee adopted American College of Obstetrics and Gynecology (ACOG) as their expert national standard of care in 2009, using their Practice Bulletins and Committee Opinions to guide the revision and annual updating of FPCI's Clinical Protocols. If ACOG does not have guidance on a specific topic, then the CDC or the United States Preventive Services Task Force (USPSTF) recommendations are used for guidance. All SRs must follow the FPCI policies and clinical protocols in the course of providing family planning, reproductive health, and general health services.

FPCI's Medical Committee meets quarterly and fulfills several functions. It establishes clinical protocols, conducts an annual FPCI wide Quality Assurance/Quality Information (QA/QI) project, and is a forum for clinicians to share information, discuss client treatment questions and best practices. The Medical Director (MD) and Clinical Coordinator (CC) distribute updated evidence-based practice information, national guidelines and standards of care to the committee. Medical committee members are expected to share this information as well as education opportunities with their staff. The MD and CC compose and distribute a quarterly newsletter to SR medical directors, informing them of Title X activities and updates, and medical committee meeting minutes.

Compliance with State laws ...requiring notification or the reporting of child abuse, molestation: FPCI is committed to protecting children and dependent adults from being

trafficked or situations of possible abuse, neglect, rape, or incest. Iowa law defines who is a mandatory reporter for child and dependent adult abuse and the training requirements for those reporters. Iowa law does not require the reporting of sexual assault, rape, or intimate partner violence; however, all SRs work with the domestic violence/sexual assault programs and law enforcement agencies in their communities to make referrals as needed. FPCI requires its SRs to have written policies and procedures that fully implement the requirements of IA law; these policies and procedures are reviewed by FPCI during site visits. While the State law requires formal training every five years for mandatory reporters, FPCI will require its SRs to provide annual staff training on policy and protocols, how policies will be implemented and monitored, and ensure that staff have a clear understanding of the reporting process. The State of Iowa requires that any curriculum used for training mandatory reporters of child/dependent adult abuse must be approved by the Iowa Abuse Education Review Panel (IAERP). FPCI received approval from IAERP for family planning providers to use a training module on Mandatory Reporting of Child and Dependent Adult Abuse developed by the University of Iowa. FPCI provided all SRs with the training materials from this approved curriculum. Each agency is responsible for providing a certificate of completion to all mandatory reporting staff and documenting in personnel files that they have received the required training. Program reviews assure that these requirements are met and that all staff are in compliance with State requirements for mandatory reporting. Iowa does not have laws governing the reporting of or training on human trafficking. FPCI SRs participate in local coalitions that address human trafficking issues in their area. FPCI requires SRs to comply with Federal anti-trafficking laws, including the Trafficking Victims Protection Act of 2000, as amended, and 18 U.S.C. 1591 and provides training every two years on Human Trafficking for Grantee and SR staff.

Counseling techniques that encourage family participation in the decision of minors:

Adolescent client counseling includes encouraging family participation in the decision of a minor seeking family planning services, abstinence, and ways to resist sexual coercion as required by legislative mandates. All adolescent clients are asked if their parents or guardians are aware of their desire to seek family planning services. If an adolescent comes to the clinic alone, they are counseled on ways to talk to their parents or guardians. There is strong evidence showing increased communication between a parent/guardian and their child leads to a delay of sexual activity among teens and healthier decision making. Adolescents will be encouraged to delay sexual activity or return to a sexually risk-free status by counseling them on the health and social benefits of postponing sex. Adolescent sexual activity is not identified as acceptable normal behavior. Instead, adolescents will be encouraged to delay sexual activity, since sex can change the dynamics of a relationship, increase their risks for STDs and pregnancy, and increase their vulnerability for other life altering events. Adolescents are informed that avoiding sex is the most effective way to prevent pregnancy and STDs and maintain overall ideal health. This approach empowers adolescents to make informed and healthy decisions. FPCI's Medical Committee will develop sample scripts and documentation templates for clinic staff to use when counseling adolescents, to assure consistency and comprehensive messaging. These sample scripts are especially important when encouraging adolescents to involve a family member and how to resist coercion. As recommended by the World Health Organization, services for adolescents are provided in a "youth-friendly" manner: being accessible, appropriate, comprehensive, effective and efficient for youth. Teens will be screened for victimization at clinic visits, especially when they have a pregnancy or STD test. In Iowa, the general age of consent to engage in sex is 16. However, they may consent to sex at age 14 as long as their partner is no more than 5 years

older. FPCI directly observes client interaction, counseling and education, and clinical services provided at SRs during full program reviews.

Counseling techniques that encourage family participation for all clients: Client centered counseling skills are characterized by establishing and maintaining a rapport, developing mutual respect, in a culturally responsive and nonjudgmental attitude with compassion. Effective techniques include open-ended questions and understandable language with clients. Discussions with all clients will encourage partner involvement in their family planning decisions: whether to achieve or prevent pregnancy, the spacing of their children, the method of family planning chosen and their general health decisions. Clients are encouraged to have a strong family or social support system, where they feel safe to discuss important life decisions, which may enhance a client's confidence about their family planning method and reproductive health choices. Domestic violence and intimate partner violence are always a discussion and consideration with clients when helping them to choose a method of family planning, keeping their health and safety at the forefront.

6. Proposed Schedule of Discounts: (Key Issue 1)

As mandated by the Title X statute, FPCI requires each of its subrecipients to have a schedule of discounts (SOD). FPCI does not mandate one schedule that is used by all SRs. Rather, each agency prepares its own schedule of discounts based on that agency's situation. The SOD must not charge clients with incomes $\leq$100% of FPL and must provide discounts to those with incomes between 101-250% of poverty. Third party payers must be billed full costs. SRs must use a cost analysis as a basis to establish the SOD. FPCI provides training on the development of a cost analysis. (*See Appendix H: FPCI requirements for SR SOD*)

7. Evidence that the proposed services are consistent with the Title X statute:

(Key Issues 1, 2)

FPCI ensures that the services are consistent with Title X statute, program regulations, legislative mandates, Program Guidelines and Program Policy Notices through a variety of mechanisms. The FPCI contract with SRs has the following documents as an integrated component of the contract: "2 CFR Part 200 and 45 CFR Part 75; Code of Federal Regulation 42, Part 59, Grants for Family Planning Services DHHS General Administration Code of Federal Regulations 45 Part 75. Title X – Population Research and Voluntary Family Planning Programs of the Public Health Services Act; Title X Program Guidelines for Project Grants for Family Planning Services (Program Requirements for Title X Funded Family Planning Projects, OPA Policy Notices and the Providing Quality Family Planning Services – Recommendations of CDC and the U.S. Office of Population Affairs (QFP)); all applicable Department of Health and Human Services (HHS) Grant Policy Statements, and requirements imposed by program statutes and regulations and HHS grant administration regulations, as applicable; as well as any requirements or limitations in any applicable appropriations acts." FPCI and its SRs utilize Title X Requirements and Statutes as one guide for workplan activities in order to ensure compliance.

FPCI has established the FPCI Administrative Policies Manual and the FPCI Clinical Protocols (*See Appendix I: Tables of Contents*). These documents are based on the Program Guidelines, Program Policy Notices, the Title X statute, program regulations, legislative mandates, and evidence-based nationally recognized standards of care. FPCI reviews these documents on a regular basis for adherence to Title X and other requirements. The Administrative Policies Manual addresses the required components of the Title X program. FPCI SRs are required to have Title X administrative policies and clinical protocols which follow the

FPCI Administrative Policies Manual, FPCI Clinical Protocols and Title X Guidelines. In addition SRs sign the same Legislative Mandate Certification and Title X Assurance of Compliance that FPCI signs. (*See Appendix J: Legislative Mandate*)

Program reviews are conducted to evaluate the SRs' compliance with Title X, federal, state and local laws and requirements, and FPCI policies. See **Section 18** for a more detailed description of the program review process.

FPCI does not fund sterilization as part of its Title X project. However, SRs are required to have systems in place for assisting clients who request such service. In addition, SRs' staff members are informed annually and acknowledge that they may be subject to prosecution if they coerce or try to coerce any person to undergo a sterilization procedure.

SRs may participate in research studies which meet Human Subjects Research requirements. A copy of the Institutional Review Board (IRB) approval must be filed with FPCI. FPCI notifies its Regional Office of all Human Subjects Research Projects.

8. Title X funds not used for abortion: (Priority 7)

FPCI does not allow Title X funds to be used in programs where abortion is a method of family planning. The FPCI contract with the SRs contains the following specific language regarding this requirement. FPCI SR Contract states: ARTICLE III: GRANT CONDITIONS: *The Contractor acknowledges that it will not utilize Title X funds or grant related income:*

1) to provide abortion as a method of family planning, or

2) for abortion related activities as defined in the July 3, 2000, Federal Register Notice titled, Provision of Abortion-Related Services in Family Planning Services Projects (65 Fed. Reg. 41281) and the Final Rule entitled Standards of Compliance for Abortion-Related Services in Family Planning Services Projects

(65, Fed. Reg. 41270), establishing Program Policies regarding the Section 1008 Abortion Prohibition of the Title X Statutes.

Section 8.2 of the FPCI Administrative Policies Manual upholds the requirement and contract language. SRs must have written policies on not using Title X funds to provide abortions as a method of family planning. FPCI and SRs staff sign annual statements that they understand the Title X requirements on Title X and abortion. Compliance is ensured through the SR program review. SRs annually sign the same Title X Certificate of Compliance and Legislative Mandate Certification forms as FPCI. (*See Appendix J: Legislative Mandate*)

9. Title X funds separate and distinct and financial management:

(Priority 7; Key Issue 1, 2)

Separation of Title X funds: FPCI is responsible for compliance with grantee financial management administration as identified in Title X Program Guidelines, HHS Federal Regulations, PHS Grants Policy Statement, Single Audit Act and other related federal government requirements. FPCI maintains a financial management system that meets program requirements in safeguarding the use of Title X project funds; establishes appropriate policies and procedures for funds to be used for allowable costs; and uses an accounting system that assures financial information is reported accurately and timely. FPCI keeps detailed records to separate its Title X and non-Title X activities and expenses for its general accounting and financial procedures. FPCI uses double entry full accrual basis bookkeeping with generally accepted accounting principles. FPCI has a Chart of Accounts which lists the title of all accounts used in the journals and ledgers, describes the type of item (revenues, expenses, etc.) to be recorded in each account, designates a numerical code for identification of each account and identifies whether revenue or expenses are Title X or non-Title X. FPCI uses a system of

procedures for reporting income and expenses by function that conforms with the content and Uniform Grant Guidance. Federal Title X funds are maintained separate from other operating funds by identification in a specified account.

FPCI requires its SRs to keep Title X project activities and funds separate from non-Title X projects. SRs must have policies and procedures for the separation of Title X and non-Title X project activities, revenues and expenditures. SRs must have distinct revenue and expenditure codes to manage and separate Title X project activities from non-Title X activities. The separation of Title X and non-Title X activities is monitored and tested for compliance at the annual fiscal management review of each SR and at the SRs full program review.

Financial Management: The financial management of FPCI's Title X Family Planning Program and its SRs conforms to Title X, federal, and state regulations. Financial management is conducted by the Fiscal Officer and the Staff Accountant. As stated previously, there are strict requirements regarding separation of Title X and non-Title X expenses. SRs submit annual budgets identifying Title X project expenses which are approved by FPCI. Title X project expenditures and revenue are reported monthly by the SRs and reviewed by FPCI. SRs submit quarterly expenditure to budget comparison reports. FPCI reviews the quarterly reports and follows up on any identified issues. An annual interim financial review is conducted on all SRs. Each SR receives a full financial management program review every three years. FPCI's Plan for Oversight of Federal Award is detailed in the budget narrative. Key points of the plan include approval of SR budgets, review of SR expenditures, audit requirements, federal financial report submissions.

10. A plan for providing community information and education programs: (Priorities 2, 6; Key Issues 3, 5, 6)

FPCI believes that a community education and engagement plan is essential to increase understanding of family planning services. FPCI requires each of its SRs to develop a community education and engagement plan that promotes the use of family planning services among those in their respective communities with unmet need. SRs concentrate their community information and education programs on audiences identified in the needs assessment of their Service Delivery Area. The programs focus on promoting the availability of family planning services to potential clients and ensuring that community members understand how they may benefit by these services. SR community education and outreach staff do not encourage activities that normalize adolescent sexual risk behavior. Rather, when working with adolescents, staff stress the impact of sexually risky behavior and emphasize that abstinence is the only 100% way to avoid negative consequences.

Community education programs funded through the Title X project will use curricula that clearly empower teens and young adults to make healthy decisions about relationships and strongly emphasize the health benefits of delaying sexual activity in order to avoid all sexual risk. To make certain that health educators have the knowledge and skills necessary to teach such curricula, FPCI will sponsor select SR and Grantee staff to attend Sexual Risk Avoidance Specialist training.

FPCI collaborates with the IDPH team that administers the Personal Responsibility Education Program and the Abstinence Education Grant Program. FPCI recognizes the value of these teen outreach programs and supports its SRs who contract with these programs to provide the required educational programming.

FPCI expects SRs to use a range of methods to reach their target audiences. SRs are to review their plan for delivering community education (CE) annually to make certain they are still meeting the needs of their respective communities. FPCI reviews SR CE plan during full program reviews. SRs submit an annual workplan describing their community education and outreach activities, and submit semi-annual progress reports. SRs are required to maintain records of the programs they conduct by tracking audience, topic, curriculum, and evaluations, and must submit this data to FPCI quarterly. The Training Coordinator (TC) reviews the submitted data to ensure that activities are consistent with the submitted workplans.

FPCI established the Iowa Community Health Educators Network (ICHEN) which continues to provide support to SRs in their education and outreach endeavors. This group is comprised of health educators from each of FPCIs SRs and meets twice annually. Members of ICHEN conduct education and outreach activities and maintain partnerships with community and faith-based organizations in their communities. FPCI's work with this group ensures that SRs are complying with the Title X vision for providing community information and education promoting the understanding of available family planning services. The ICHEN will develop innovative ways of providing education and information that meet TX statutory requirements and address OPA Program Priorities and Key Issues.

Using a Request for Application (RFA) process within its provider network, the FPCI Board makes small, competitive grants available for SRs to develop innovative programs for the purpose of increasing family participation in family planning and promoting healthy decision making for adolescents. In 2018/2019 this grant will focus on programs that promote cooperation with community and faith-based organizations or promote and strengthen family involvement in a minor's decision to seek family planning services.

The FPCI Board has designated funds for FPCI to develop its own original community education project which focuses on parent/child communication because parental involvement has been associated with delayed sex among teens. Parental involvement in the lives of teens is associated with success in education, optimal health outcomes, risk avoidance, and healthy relationships. FPCI developed "Movie Talk", a booklet that summarizes popular movies and provides questions about these movies to initiate conversation between parents and their children on a variety of topics related to growing up including but not limited to decision making, dealing with peer pressure, and making healthy choices. The purpose of this booklet is to help strengthen family communication and provide parents a non-threatening opportunity to share their values with their children and help their children avoid negative risk behaviors.

11. A plan for an information and education advisory committee: (Key Issue 1)

FPCI is dedicated to ensuring that all material developed or acquired through Title X undergo a review and approval process before it is made available to the clients that receive services within its Title X project. In fulfillment of Title X requirements, FPCI and its (b)(4) SRs each have and maintain an Information & Education Materials Review Advisory Committee (I & E) that follows the Title X statute and requirements. FPCI and its SRs have written policies and procedures which state that the committee must ensure that all material to be distributed meets the required Title X components. FPCI developed an assessment tool which lists the Title X components and which is used by all of its SRs' I & E Committees for reviewing material before it is distributed in the community or given to clients. FPCI monitors its SRs for compliance by requiring each of its SRs to annually submit a list of their I & E committee members indicating how they are demographically representative of their service delivery area. Along with

membership lists. FPCI also requires SRs to submit I & E meeting minutes in order to ensure that material reviews occur and all elements required by Title X are documented.

12. Program Priorities and Key Issues

Title X program priorities and key issues are prominent in developing FPCI's Title X program and its goals and objectives for all the components of our project. All priorities and key issues are addressed and incorporated into FPCI's overall plan to provide Title X services. Priorities and key issues are addressed throughout the program narrative. Each section identifies the priorities and key issues addressed in that section. In FPCI's workplan (*Appendix G*), each goal for Administrative, Clinical, Community Participation, Education, and Project Promotion, and Financial Management identifies the Title X Program Priority and Key Issue it addresses. Goals were developed with this focus in order for FPCI and its SRs to address these priority objectives. *Appendix K* cross references Program Priorities and Key Issues listing where FPCI's workplan addresses each item.

13. Subrecipient Selection process: (Priority 1)

FPCI does not provide Title X services directly; rather, it uses a network of SR entities to provide the services. FPCI uses a competitive Request for Application (RFA) process for the selection of its subrecipient entities. The RFA packet is developed using the federal Title X Funding Opportunity Announcement as a basis. Under this process, an announcement is made that Title X funding is available within the FPCI service delivery area. The announcement is distributed as widely as possible through a variety of mechanisms such as posting on the FPCI Website, the IA Public Health Association Website, the IA Primary Care Association, the IA Community Action Association, and any other groups and means FPCI can identify.

FPCI staff conducts a technical review of the submitted applications. An Objective Review Committee that does not include FPCI staff reads, scores, and makes recommendations for funding or not funding each application. The FPCI Board of Directors makes the final decision on which applications to fund. The most recent RFA was issued in the fall of 2017.

FPCI has a long history of funding diverse types of entities as SRs. Public and non-profit entities eligible to apply include but are not limited to: county and local health departments, federally qualified health centers, family planning agencies; planned parenthoods; hospital affiliated clinics; and faith-based entities. There are no restrictions on the type of entity that is eligible. Any entity public or private non-profit that can meet the Title X requirements for services, data collection, financial management and administration and provide community participation, education and program promotion is eligible.

Over the past few years, FPCI has issued several RFAs. Based on those RFAs, FPCI has seen a significant change in the makeup of its provider network. An important change has been the addition of a number of FQHCs as SRs. FPCI will continue to explore opportunities to find new providers in areas of need.

Title X funding for each subrecipient is based on a funding formula which is detailed in the budget narrative.

14. Staffing plan: (Key Issues 1, 2)

As a private 501 (c)(3) non-profit entity (*See Appendix L: Proof of Non-Profit Status*) FPCI is governed by an 18 member volunteer Board of Directors who present a geographic representation from across IA. Board members are chosen to represent a broad range of interests in IA. It is an active body of volunteers who, because of their interest in and support for family

planning, are willing to provide leadership in the provision of family planning services in IA. (*See Appendix M: Board of Directors*).

The FPCI Board of Directors is the policy making and governing body for the organization. Implementation and administration of the policies and directives of the Board are implemented by an administrative and program staff that reports to the Board. FPCI's own staffing plan (*See Appendix N: FPCI's Table of Organization*) is developed to meet the needs of administering the Title X project. It strives to fulfill its Title X responsibilities in an efficient, cost-effective manner. The Title X project is FPCI's major program.

Key responsibilities of the FPCI staff include implementation of the Title X grant and its requirements; submission of required reports; preparation of the Title X grant; interaction with the Regional Office, Grants Management and OPA as needed, accountability for the expenditure of Title X funds; maintenance and reporting of project data; oversight and monitoring of SRs; coordination of training and technical assistance for SRs and staff; program planning and development; dissemination of information to the public about family planning and health care; collaboration with other health care programs and systems; liaison and networking with human services programs and other involved groups and organizations. The Executive Director and all program staff work to ensure that the family planning program is developed within a holistic framework of health care by serving on a number of committees and task forces at the local, state and national level.

Collectively, the FPCI staff has over 137 years of working in the family planning/health care field. (*See Appendix O: CV/Biographical Sketches/Key Personnel*) The Executive Director (ED) is the Chief Executive Officer of FPCI. Reporting to the FPCI Board, the ED provides leadership in developing the program, organizational and financial plans with the Board and staff, and

carries out policies and plans authorized by the Board. The ED is responsible for the overall administration and implementation of all of FPCI's programs including its Title X project. In this roll, she is responsible for assuring compliance with all Title X, federal and state requirements. She is responsible for the supervision of staff, budget preparation, program planning, and contract compliance. The ED collaborates with other health care programs to assure a holistic approach for family planning clients. The ED conducts program reviews, data analysis, monitoring and other program activities.

The Outreach Coordinator (OC) manages communication and program promotion efforts for FPCI. This includes managing FPCI's website, preparing quarterly newsletters, and reports. She conducts analysis and develops impact statements and other documents identifying the value of FPCI and its Title X project. The position includes partnering with state and local organizations. The OC oversees special initiatives targeting Title X priority populations.

The Training Coordinator (TC) manages the FPCI training program and community education program. This includes staffing the Training Advisory Committee (TAC); identifying training needs; developing the training plan; preparing and conducting training events; and evaluating training events. The TC provides Title X Orientation training to SR staff. She is responsible for monitoring required TX training at FPCI and at the SRs. She arranges technical assistance services for FPCI and its SRs. The TC administers FPCI's community education programs; tracking and monitoring the SR community education programs as well as FPCI's own community education programs. The TC conducts the training, community participation, community education and outreach sections of SR program reviews.

The FPCI Staff Accountant (SA) is responsible for the day-to-day operation of the fiscal portion of the program. This includes recording and maintaining accounting records; issuing

payments; payroll, tracking revenue; issuing invoices; and reviewing SR monthly revenue/expenditure reports.

The FPCI Administrative Assistant (AA) provides overall support to the FPCI Board and staff. The AA maintains the OPA database and the 340B database. The AA assists with various FPCI data reports such as the FPAR and Quarterly Data Reports. She is responsible for overall office administration.

While the FPCI Community-Based Screening Services Coordinator (CBSSC) mainly works on another project; she does work with the Title X project on issues around Health Information Technology and data.

FPCI contracts for its Fiscal Officer (FO). The FO is a CPA who is responsible for overseeing the fiscal policies of FPCI. She prepares and files all the required Title X, PMS and FFR reports, federal and state reports; oversees FPCI's annual independent Fiscal Audit and reviews all SR's annual independent Fiscal Audits. The FO is responsible for assuring compliance by FPCI and its SRs with all applicable Title X, federal and state regulations. The FO conducts the financial management and fiscal systems reviews of SRs. The FO reviews all SR cost analyses and schedules of discounts. The FO is responsible for assuring separation of Title X and non-Title X activities.

The Clinical Coordinator (CC) manages the clinical component of the FPCI program. This includes assuring compliance with Title X, federal and state requirements by conducting SR program reviews and monitoring activities; overseeing FPCI's clinical Quality Assurance/ Quality Improvement Program throughout the FPCI network; ensuring appropriate clinical policies and procedures throughout the delivery system; staffing the FPCI Medical Committee; ensuring the provision of quality patient care, ensuring linkages to primary care and other

services; and serving as a clinical resource. The CC collaborates with other health care programs to coordinate and share information about services.

FPCI's Medical Director (MD) services are provided through a contract with University of IA (U of I) Hospital & Clinics, Dept. of Obstetrics and Gynecology (OB/GYN). The MD, Dr. Noelle Bowdler, is a faculty member of the U of I School of Medicine as well as a practicing OB/GYN physician. The MD provides direction concerning medical aspects of the FPCI family planning service delivery; chairs the FPCI Medical Committee; works with the FPCI Medical Committee to review and revise FPCI Clinical Protocols which she approves. She provides consulting services and technical assistance to FPCI staff and the SRs as needed.

As the Title X Grantee, FPCI does not employ clinical staff directly. FPCI establishes requirements with its SRs regarding the staff who are providing the clinical services. Each SR must have a Medical Director who is either a direct employee or on a contractual basis. The MD must be a physician with training or experience in family planning, who is responsible for overseeing the clinical care component; reviews clinical practices and services provided by their clinicians; ensures care is consistent with nationally recognized standards; works with the SR clinical staff to develop clinical protocols and provide consultation for clinic staff. All staff providing clinician care must be licensed in IA as a physician, ARNP, or PA and practice within their allowable scope of practice. IA law establishes licensure requirements for ARNPs and PAs. Under IA law, ARNPs can practice independently, whereas PAs must have a supervising physician. In IA both ARNPs and PAs have prescriptive authority. The SRs are required to verify licensure prior to hiring. SRs annually submit the license numbers of their clinical staff. FPCI reviews those license numbers to ensure they are valid in IA.

SRs submit organization charts and staffing plans for their Title X project annually to FPCI for review. Each SR is required to maintain copies of licensures, board certification, and documentation of mandatory training and continuing education hours for each employee. FPCI monitors compliance with these requirements during program reviews.

15. Goal Statements and related outcome objectives…

FPCI's workplan, *Appendix G,* establishes goals and objectives, addressing Title X Program Priorities and Key Issues. The Workplan contains goals, measurable and time framed objectives, descriptive activities to achieve the objectives, people responsible for the activities and the evaluation process to monitor successful completion of the stated activity. The Workplan contains the Services Site Table and Services Provided Table.

Administration: Goal 1: By 8/31/2022, ensure that the FPCI Title X project is administered effectively and efficiently through policies, monitoring, data collection and oversight. Outcome: An effective Title X program that assures optimal health outcomes across the Service Delivery Area. Goal 2: By 8/31/2022, ensure quality of care through ongoing staff training and professional development. Outcome: Family planning staff will have the knowledge, skills, and attitudes necessary to provide effective, quality family planning and related preventive health services. Goal 3: By 8/31/2022, utilize data to increase management, sustainability and performance. Outcome: Better health outcomes for clients through the use of program data.

Clinical: Goal 1: By 8/31/2022, quality holistic family planning and related health services are provided to targeted populations. Outcome: Optimal physical, emotional and social health is achieved for medically underserved groups. Goal 2: By 8/31/2022, 100% of SRs provide quality services consistent with nationally recognized standards of care. Outcome: Quality family planning and related services are provided to medically underserved groups. Goal 3: By

8/31/2022, 100% of SRs have active quality assurance/quality improvement programs. Outcome: Active quality assurance/improvement programs enhance and improve services provided by SRs. *Community Participation, Education and Project Promotion*: Goal 1: By 8/31/2022, strengthen understanding of family planning services by providing programs using approved methods that promote understanding about the availability of services to those for whom family planning is needed. Outcome: A stronger community with increased understanding of family planning services. Goal 2: By 8/31/2022, increase knowledge of and access to family planning services through targeted promotional and engagement efforts. Outcome: Low income and medically underserved populations will have increased access to family planning services. Goal 3: By 8/31/2022, develop and implement special initiatives targeting Title X priority populations. Outcome: A stronger, better connected healthcare collaborative that is prepared to provide and support the health care needs of Title X priority population. *Financial Management*: Goal 1: By 8/31/2022, maintain and improve a Project-wide financial system that is in compliance with Title X, federal regulations and follows generally accepted accounting principles. Outcome: Federal funds are used in accordance with the requirements of Title X and the federal government. Goal 2: By 8/31/2022, ensure that FPCI subrecipient network maximizes third party payer support for clients. Outcome: Effective and sustainable network in place, assuring access to family planning services.

16. Evidence of plan to facilitate access: (Priorities 1, 4; Key Issue 3)

Throughout this narrative and workplan, FPCI identifies its plan to facilitate access to clinical care, primary care and health and social services. Access to required clinical services is through a network of subrecipient agencies. FPCI has a formal contract with each of its subrecipients. The contracts require the SRs to comply with all Title X requirements including providing services

on a schedule of discounts which are based on cost analyses. FPCI is unable to have a service site in each of its (b)(4) counties for several reasons. It is extremely difficult to find health care providers in rural areas. The low rural population severely impacts cost effectiveness as the cost per client becomes very high. There is limited access to non-federal resources. The lack of significant Title X funds makes it very difficult to develop and maintain service sites in these areas. FPCI continues to explore means to expand services in those areas.

Access to comprehensive primary care is through SRs that provide primary care within the same location or within its health care system or through SRs that have signed referral agreements with primary care providers. FPCI has signed a Memorandum of Understanding with the Iowa Primary Care Association to assist in access to primary care. (*See Appendix P: Memorandums of Understanding*)

Access to other needed health and social services is accomplished through agreements and referral arrangements that the SRs have with entities in their communities. Some of the SRs receive Ryan White funding for HIV care and treatment. Those SRs that do not have this funding have linkages for continued HIV care.

17. Collect required program data: (Key Issues 1, 2, 8)

FPCI annually reported its Title X program data on the Family Planning Annual Report (FPAR). At this time, FPCI does not have a centralized data system which receives line-listed data from its subrecipients. Rather, each SR provides the information needed for each FPAR table by clinic level data. FPCI reviews and analyzes the submitted data and clarifies questions and issues. The agency level data is then combined into a FPCI project wide FPAR which is submitted to the Office of Population Affairs.

While the FPAR is the main source of data for the FPCI Title X program, another major data source is the Quarterly Data Report (QDR). The QDR is submitted by the SRs at the end of each calendar quarter. Data from the QDR is reviewed and a report sent back to each SR on that review. Items identified on the QDR include income levels, STD screening, and family planning methods.

The data from the FPAR and the QDR are used to monitor the SRs performance on various issues. FPCI staff analyze the QDRs and prepare a written report for the SRs on the data from the QDR. The report identifies issues and positive actions. The report may require the submission of an explanation or corrective action plan for an identified issue. Data from the FPAR and from the QDR are used to identify both individual SR performance issues and for possible project wide issues. If the same issue/problem appears across several SRs reports, it is identified as a system issue and training is conducted to correct the issue.

FPCI recognizes the value of a centralized data system (CDS) for data collection, performance metrics and oversight. However, establishing such a system can be an expensive endeavor for both FPCI and its SRs. To this end, FPCI received outside funds to assist in determining the costs to FPCI and to each SR to create a CDS. The goal is to use that information to identify further outside funding to cover the costs of establishing such a system.

18. Evidence of a system for ensuring quality family planning services: (Priority 8, Key Issues 1, 2, 4, 8)

Process for ensuring compliance with program requirements: FPCI uses a variety of mechanisms to ensure that SRs comply with Title X Program Guidelines. These methods include onsite visits; monthly, quarterly and annual reports; semi-annual and annual review of workplans; annual fiscal evaluations; periodic medical records review; an annual QA/QI project;

and annual review of Clinical Protocols. FPCI monitors SRs for compliance with Title X program guidelines and all local and state laws by performing full program reviews every three years for each SR, which evaluates Administrative, Community Participation, Education and Project Promotion, Clinical Services and Financial Management. Full program reviews are accomplished by going onsite, reviewing SR facilities, policies and protocols, forms, consents, performing chart audits, interviewing staff members, and observing client intake and clinic staff providing healthcare services, administrative procedures, income determination, billing, accounting, and other processes. FPCI uses a Program Review Tool when performing SR full program reviews. This tool corresponds with the Federal Program Review Tool released in 2017. The SR receives a program evaluation report within 45 days of their review, requiring a response and corrective action for any "findings" with a specified timeframe identified.

Annual interim reviews are performed for SRs not receiving a full program review, which focus on a different topic or area each year. The reviewer evaluates a particular topic in an onsite visit, such as consents, QA/QI programs, education programs, community participation and promotion, data verification, or fiscal. Throughout the year other reviews may be offsite and may include medical record reviews performed by the CC using a direct secure message system. Annually each SR receives a fiscal management review performed by the FO.

Regular ongoing communication and clinical service updates occur throughout the year through mechanisms such as regular mail, email, webinars, conference calls, and phone conversations with SRs. Quarterly meetings of FPCI's Advisory Committee (made up of SR directors) and Medical Committee are other ways of sharing information.

Program compliance is also demonstrated by FPCI establishing Clinical Protocols which reflect Title X Program Guidelines, federal and state regulations and guidelines consistent with

national standards of care and ACOG guidelines. Clinical Protocols give instructions on consents, confidentiality, contraceptive methods, examinations, GYN conditions, STDs, other infections, reproductive life planning, adolescent services and pregnancy related issues. FPCI's CC distributes new information to all members of the Medical Committee, such as any new published research and new or revised guidelines released by ACOG and the CDC.

Defined performance measures: Performance measures are evaluated using an assortment of methods. The FPAR is one tool FPCI uses to evaluate each SR. FPCI assesses the services reported by each SR, as well as FPCI's data as a whole. When assessing FPAR tables, FPCI first evaluates data for integrity. If there is a question about the data, FPCI asks for clarification and verification of correct data from that particular SR. Once the data is validated, FPCI assesses the number of clients served and the types of services provided. FPCI may question why national standards of care are not being followed (for example, performing too many cervical cytology tests or too few chlamydia screens for recommended age groups). The data can identify an individual SR issue or it can highlight positive trends in SR services, which would be used to develop best practices. The data can also identify a project wide problem which would lead to a quality improvement change.

Data from the FPAR tables assessing female and male family planning users by primary methods and age groups, and family planning users tested for chlamydia (Tables 7, 8, and 11) are presented to the Medical Committee each year, with comparisons to previous years. Data elements emphasized for discussion are family planning methods used, methods reported as "unknown" and "no method, other reason" and chlamydia testing performed by age.

Another tool to evaluate performance is the Quarterly Data Reports that FPCI requires its SRs to submit. This reports the number of new and established preventive visits, family planning

methods used, STD tests performed, poverty levels and county of residence. FPCI analyzes the data, evaluates the integrity of the data, provides feedback and requests responses if questions arise. By submitting these quarterly and annual reports, FPCI can regularly monitor its SRs for Title X provided services, and compliance of performance measures within the Title X project. This data is also used to identify quality improvement needs.

SRs must perform self-assessments on a regular basis as an important aspect of providing quality healthcare. FPCI requires SRs to have an active Quality Assurance/Quality Improvement (QA/QI) Committee in order to maintain high quality family planning and related preventive health services. In addition, an effective and active QA/QI committee ensures compliance with state laws, Title X and ACOG guidelines. A QA/QI committee is made up of a variety of staff members, which could include the clinic manager, a clinician, a nurse or assistant, a biller, or an administrator. The SR QA/QI committee meets at least quarterly and provides ongoing evaluation of project personnel, services, and processes. The established set of standards, such as FPCI and SR Policies and Clinical Protocols, are used as the benchmark by which conformity is measured. Regularly planned activities include auditing medical records for compliance and tracking the systems used to identify a need for follow up. Data collection findings are analyzed and shared with staff in order to reinforce or improve performance. When a weakness is identified, changes are made, and the process is re-evaluated. Documentation of all meetings, audits, evaluations, surveys and quality assurance/improvement activities are maintained by the SR and evaluated by FPCI during full program reviews. FPCI's CC is available to assist and guide SRs with QA/QI projects and technical assistance.

SRs are required to elicit client feedback on a regular basis. This data is reviewed and used for program improvement. Client satisfaction surveys were widely used in the past, but many SRs are changing to client experience surveys to improve their customer service.

Each year a FPCI project wide QA/QI project is performed by the Medical Committee. The committee determines the topic to evaluate (such as Reproductive Life Planning, pregnancy test services, and possible causes of client no shows), data is collected by each SR, by clinic site, through chart reviews, and sent to the Clinic Coordinator (CC). The CC tallies, analyzes and reports the findings to the Medical Committee at the April meeting each year. The committee discusses if corrective actions, changes of protocol, or SR staff training needs to occur.

FPCI established a performance measure for its SRs, using the Family Planning National Training Center calculation tool for chlamydia screening per CDC guidelines: Chlamydia screening is routinely being performed for 60% of the females age 24 and under. Using FPAR data, FPCI's CC records its SR's data into the calculation tool in order to evaluate each SR individually and FPCI's project as a whole. This data is analyzed and presented to the Medical Committee each April. After notification of award, FPCI agrees to incorporate defined OPA performance measures into its Title X project once they are established.

Staff Training: FPCI believes that the training of staff in its Title X family planning project is integral to developing and supporting the skills, knowledge, and attitudes necessary to provide effective family planning and related preventive health services. FPCI has a long established Training Advisory Committee (TAC) in partnership with the Iowa Department of Public Health (IDPH) Title X program. TAC has representatives from all of its and IDPH's SRs, including directors, clinicians, counselors, and health educators. TAC develops and administers a training plan based on needs identified through an annual needs assessment, OPA Program Priorities and

Key Issues, Title X Requirements and family planning core services. Training is provided to all Title X staff statewide using a variety of modalities including webinars, teleconference, and classroom sessions.

In collaboration with IDPH and the TAC, FPCI administers an annual Family Planning Update, which is the largest training event sponsored by the two Grantees. It is attended by over 100 Title X staff from throughout Iowa. The conference brings local, regional, and nationally recognized speakers to address topics that provide staff with the most current skills and knowledge to deliver quality family planning services.

FPCI and SRs also utilize the Family Planning National Training Center and the National Clinical Training Center for Family Planning training modules and certificates of completion are maintained in personnel files. FPCI provides support for at least one clinical staff member from each SR to attend the National Reproductive Health Title X Conference.

FPCI staff developed an Orientation to Title X and presents it to all new Grantee and SR staff upon employment. This orientation covers all the key components of a Title X project and includes information on Section 1008 as well as all other Title X requirements. It is reviewed/revised annually or whenever there are program changes. FPCI and its SRs also ensure that all staff within the Title X project are informed annually on the following Title X requirements: voluntary participation; no pre-requisite for eligibility; staff may be subject to prosecution for coercing or attempting to coerce persons to undergo abortion or sterilization; abortion is prohibited as a method of contraception; services must be provided without discrimination; cannot impose durational residency; minors must be counseled on parental involvement and ways to resist coercion; and that client confidentiality must be safeguarded.

Staff must sign forms that state they have been informed on these requirements and FPCI reviews these forms for compliance.

Other required training for all Title X staff includes mandatory reporting of child and dependent adult abuse, human trafficking, counseling adolescents on family participation and ways to resist coercion, and the QFP. SRs are required to document in the personnel file that staff received this training.

In addition to the required orientation for all staff, FPCI has developed and conducts specialized training for select staff. The CC presents a program discussing the specific Title X clinical components in more detail. This training is for clinicians, medical directors, and other identified clinical staff. Clinic staff must also view the FPNTC archived series of six QFP trainings. FPCI's CC also meets with all new clinician and clinical staff members prior to a new SR providing Title X services, to ensure understanding and compliance of the Title X requirements. The FPCI fiscal staff present a training developed to address financial requirements of a Title X program. Key SR fiscal staff are required to participate in this training.

FPCI staff will develop a training webinar on Information & Education Committees, and the Community Participation, Education and Project Promotion components of Title X.

19. Ability to bill third parties and facilitate enrollment into Medicaid: (Key Issue 1)

The Title X federal funds are a vital component of implementing the Title X program. However, the federal funds are not enough to implement an effective program and provide services. Thus it is necessary to ensure that other resources are available and used to help stretch the federal funds. To meet this need, FPCI requires that all SRs have contracts with Medicaid and third party commercial insurance carriers. FPCI works with various commercial carriers to ensure that carriers are contracting with the family planning agencies. All FPCI SRs have a

contract with IA's largest commercial insurance carrier, Wellmark – Blue Cross/Blue Shield. IA's Medicaid program is administered through two private Medicaid Managed Care Organizations (MCOs). FPCI works closely with the IA Medicaid program and the MCOs to ensure that the SRs are part of the system and able to bill for services provided to Medicaid clients. All SRs have contracts with each Medicaid MCO. Iowa's transition to Medicaid Managed Care has been extremely rocky for all provider types. All Medicaid provider types, including family planning, have had immense difficulty receiving payments from the MCOs. FPCI works with the MCOs and Medicaid on resolving the SR payment issues.

FPCI has worked to ensure that its SRs can bill third party commercial insurance and Medicaid using electronic billing. All FPCI SRs have electronic billing capabilities. FPCI strives to ensure billing/coding staff have the needed knowledge to maximize claims payments. To this end, FPCI has partnered with the IDPH program to establish a Biller/Coder Workgroup. This group is composed of billing/coding staff from each of the Title X agencies. The Workgroup holds quarterly conference calls to identify billing issues, receive information and share approaches and solutions. FPCI has sponsored regular billing/coding training sessions that include billing staff and clinical staff.

Non-federal Resources: SRs are required to identify and pursue available non-federal resources to support their Title X program. All revenue received through third party payers of services to Title X clients and payment from clients is identified as program income and required to be put back in to the program. SRs must report all program income received and expended to FPCI. While some areas of the SDA may have access to more non-federal resources, all SRs are required to provide some level of non-federal resources for their program. Even with access to third party payers and Title X funding, FPCI SRs provide an agency subsidy beyond the program

income generated. This creates a challenge for the SRs to provide services. The FPCI budget identifies those non-federal resources.

While FPCI and its SRs do all they can to maximize non-federal resources there continues to be a significant need for the Title X funds (b)(4) of the clients seen have no insurance coverage; thus the Title X funds are needed to pay for the costs of providing services to those clients. The budget information shows that the Title X funds are needed for (b)(4) of the cost of the project. As reported previously, IA's Managed Care Medicaid program continues to delay and deny payments to Medicaid providers resulting in severe cash flow problems for providers. Agencies have had to wait months for payments. The Title X funds stabilize the SRs allowing them to continue to provide services, particularly the smaller more rural entities.

Accessing primary care is not only a matter of identifying a primary care provider for a client; helping the client to find a third party payer for those services is also important. To aid clients in this endeavor, FPCI SRs have processes in place for facilitating the enrollment of clients into Medicaid. All FPCI intake staff are required to assess whether a client might be eligible for Medicaid. If clients are identified as potentially eligible for Medicaid, the SR uses its enrollment referral system to assist them. Some FPCI SRs are navigators and can enroll clients directly into Medicaid.

FPCI, its provider network, and partners have established a strong Title X program that will assist the people of Iowa in achieving their best health outcomes. FPCI stands ready to provide the Title X services and connecting our clients with needed medical and social services.

Upload #3

Applicant:	Family Planning Council of Iowa
Application Number:	FPH2018008738
Project Title:	Title X Family Planning Services
Status:	Awarded
Document Title:	AttachmentForm_1_2-ATT1-1237-APPENDICES.pdf

FAMILY PLANNING COUNCIL OF IOWA

APPENDICES

End Notes	Appendix A
Table 3: Basic Family Budgets	Appendix B
Map of FPCI Service Delivery Area	Appendix C
Subrecipient information list	Appendix D
Letters of Commitment	Appendix E
Coalitions and Workgroups	Appendix F
Workplan	Appendix G
- Service Site Information/Client Numbers	
- Services Provided	
- FPCI Title X Program Organization Chart	
Schedule of Discounts	Appendix H
FPCI Policies:	
- Administrative Policies Manual Table of Contents	Appendix I
- Clinical Protocols Table of Contents	Appendix I
Legislative Mandate	Appendix J
Cross Reference Goals with Program Priorities and Key Issues	Appendix K
Proof of Non-Profit Status	Appendix L
FPCI Board of Directors	Appendix M
FPCI Table of Organization	Appendix N
Curriculum Vitae/Biographical Sketches	Appendix O

Memorandums of Understanding:

- (b)(4) Appendix P
- Appendix P

2018 – 2022 GRANT APPLICATION END NOTES

[1] Guttmacher Institute: *Contraceptive Needs and Services 2014 Update*

[2] CY2017 FPCI Family Planning Annual Report

[3] U. S. Census Bureau: *Income and Poverty in the United States 2016 Population Report*

[4] State of IA Data Center, 2016 Table - Estimated Number of People Living in Poverty

[5] US Census Bureau ZCTA American Community Survey 5-Year Estimates. Percent of Population Below 100% Poverty Level by ZIP code in Polk County 2011-2015.

[6] U. S. Census Bureau: American Community Survey, 2016 Poverty by Race

[7] American Congress of Obstetricians and Gynecologists (ACOG) 2014 Iowa Workforce Fact Sheet

[8] U. S. Bureau of Labor Statistics, 2016 & 2017 – Median Hourly Wage

[9] IA Policy Project: *Cost of Living in IA 2016 Report*

[10] Iowa Behavioral Risk Factor Surveillance Survey, 2016 Report – Health Insurance

[11] U.S. Dept. of Human Services: Health Resources and Services Administration (HRSA) Data Warehouse - Health Professional Shortage Areas Report (HPSA) – 1/2018

[12] Robert W Johnson Foundation & Univ. of Wisconsin Population Health Institute: *2018 County Health Rankings & Roadmaps Project Report*

[13] Frost JJ, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use*, 1995–2010, New York: Guttmacher Institute, 2013

[14] 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.

[15] U.S. Dept. of Human Services: Health Resources and Services Administration (HRSA) Data Warehouse - Medically Underserved Areas (MUA) and Populations Report-1/2018

[16] CDC U. S. DHHS National Center for Health Statistics 2015 – Birth Rates

[17] IDPH Bureau of Vital Statistics, 2016 Report

[18] Guttmacher Institute Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the U.S. Publicly Funded Family Planning Tool

[19] Barriers to Prenatal Care Survey, 2016

[20] IDPH Bureau of HIV/STD/Hepatitis 2016 STD Surveillance Data Report

[21] IDPH Bureau of HIV/STD/Hepatitis 2016 State of Iowa HIV Disease End-of-Year Surveillance Report

[22] *U.S. Dept. of Health & Human Services Office of Women's Health Final Report: Opioid Use, Misuse and Overdose in Women July 1, 2017*; Reference Notation - Centers for Disease Control and Prevention. Analysis of the National Vital Statistics System Multiple Cause of Death data, Wide-ranging OnLine Data for Epidemiologic Research (WONDER) 2017.

[23] IDPH 2016 Opioid Report

[24] Ko JY, Wolicki S, Barfield WD, et al. CDC Grand Rounds: Public Health Strategies to Prevent Neonatal Abstinence Syndrome. MMWR Morb Mortal Wkly Rep 2017;66:242–245. DOI: http://dx.doi.org/10.15585/mmwr.mm6609a2.

[25] U.S. Consumer Financial Protection Bureau 2018 FIPS U.S. List of Rural Counties & USDA Classifications

[26] 2016 U.S. Census Population Estimate – American Community Survey - IA Total Population

[27] IA Data Center; Woods & Poole Economics, Inc. Projections for Iowa 2020- 2050

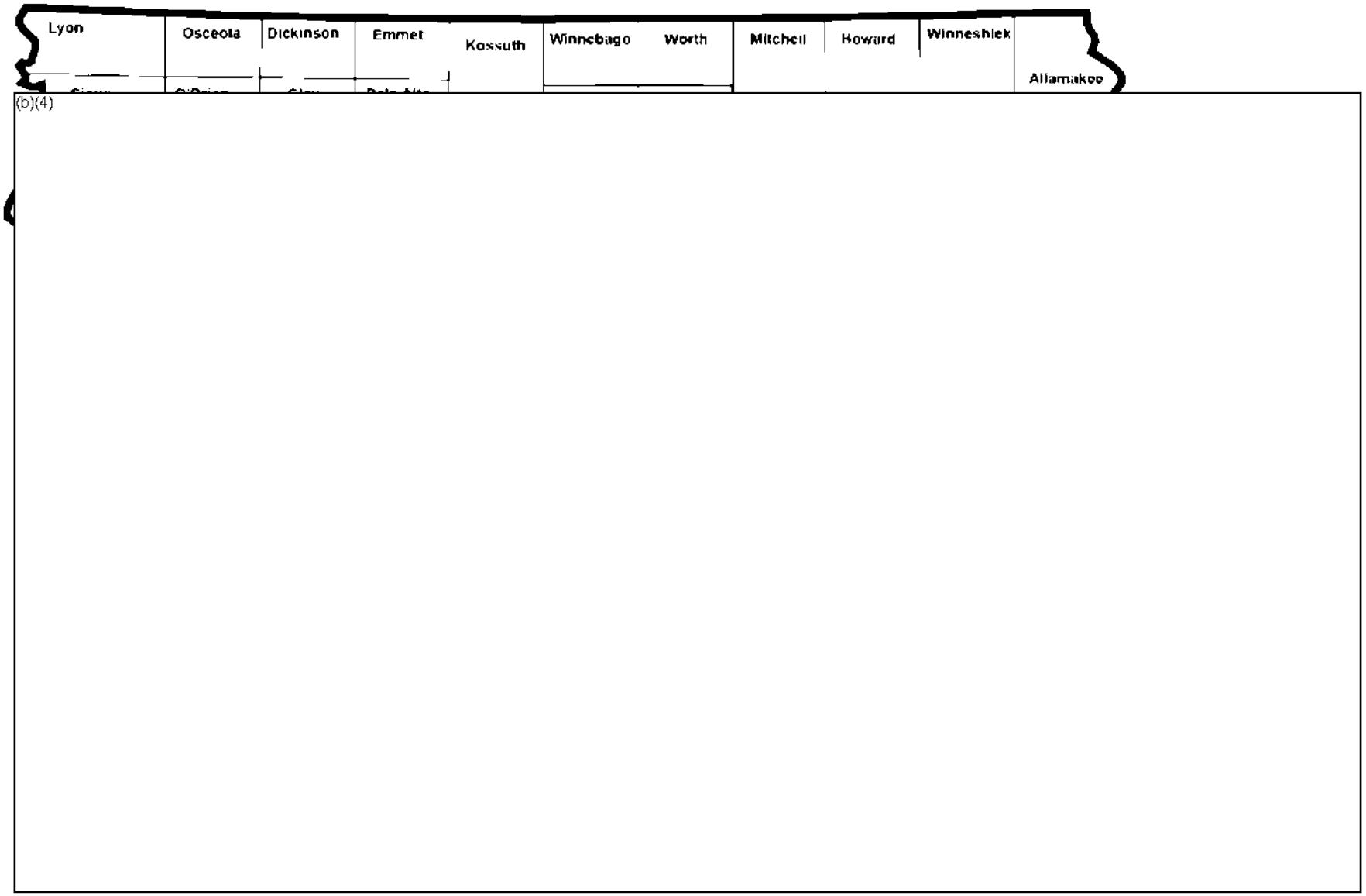
[28] Iowa State Data Center 2016 - IA Population by State/County Population - (Race, Ethnicity, Sex and Age)

Table 3. Basic Family Budgets for Single-Parent and Two Working Parent Households in IA
COSTS FOR FAMILIES WITH AND W/O EMPLOYER HEALTH INSURANCE COVERAGE

	SINGLE PARENT		TWO WORKING PARENTS	
FAMILIES WITHOUT HEALTH INSURANCE FROM EMPLOYER	**One Child**	**Two Children**	**One Child**	**Two Children**
Monthly Expenses	(b)(4)			
Child Care				
Clothing & Household expenses				
Food				
Health care				
Rent & Utilities				
Transportation				
Total Monthly Expenses				
Total Annual Basic Expenses				
Income and Taxes				
Before-tax earnings needed				
Less: Income & Payroll Taxes				
Plus: EITC & other credits				
Net after-tax income				
Family supporting wage per/hr.				
FAMILIES WITH HEALTH INSURANCE FROM EMPLOYER	**One Child**	**Two Children**	**One Child**	**Two Children**
Monthly health care savings	(b)(4)			
Total Annual Total Basic Expenses				
Before-tax earnings needed				
Family supporting wage per/hr.				

+Source: Iowa Policy Project: Cost of Living in Iowa Report –2016

FAMILY PLANNING COUNCIL OF IOWA
TITLE X SERVICE SITES



FAMILY PLANNING COUNCIL OF IOWA – TITLE X CLINIC SITES

1	(b)(4)	11	(b)(4)
2		12	
3		13	
4		14	
5		15	
6		16	
7		17	
8		18	
9		19	
10		20	

Appendix D

FAMILY PLANNING COUNCIL OF IOWA

LIST OF SUBRECIPIENT FAMILY PLANNING AGENCIES

(b)(4)

Page 091 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Appendix E

FAMILY PLANNING COUNCIL OF IOWA

SUBRECIPIENT LETTERS OF COMMITMENT

The Family Planning Council of Iowa has received a letter of commitment from each of its subrecipient agencies. Those letters are included in this Appendix.

The letters are from:

1. (b)(4)
2.
3.
4.
5.
6.
7.
8.
9.
10

Page 093 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 094 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 095 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 096 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 097 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 098 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 099 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 100 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 101 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Page 102 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

FAMILY PLANNING COUNCIL OF IOWA
2018 COALITIONS AND WORKGROUPS

ORGANIZATION	FPCI LIAISON
1. **National Family Planning and Reproductive Health Association:** A national organization working to assure access of voluntary, comprehensive and culturally sensitive family planning and reproductive health care services.	Executive Director
2. **Family Planning Councils of America:** A national membership organization, which provides a forum for Title X grantees to share information, resources and projects.	Executive Director
3. **IA Collaborative Safety Net Provider:** A network created by the IA General Assembly in 2005. Through creation of this network, community health centers, free clinics and rural health clinics work together to gather information, identify and address challenges in providing care to the underserved and uninsured.	Executive Director
4. **IA Rural Health Association:** A statewide membership organization working to preserve and enhance the health of citizens in rural IA.	Executive Director, Outreach Coordinator
5. **IA Dept. of Public Health Maternal and Child Health Advisory Committee:** This statewide committee advises the IA Dept. of Public Health Maternal and Child Health Program.	Clinical Coordinator
6. **IA Cancer Consortium:** This statewide membership organization is public/private partnership of researchers, legislators, health care providers, public health providers, faith based organizations, caregivers, cancer survivors, and volunteers responsible for the development and implementation states' cancer plan.	Outreach Coordinator, Clinical Coordinator
7. **IA Coalition Against Sexual Assault:** A statewide membership organization of 24 sexual assault centers in IA. It provides training, support and technical assistance for all statewide programs.	Training Coordinator, Clinical Coordinator
8. **IA Asian Alliance:** A statewide membership organization of the Asian communities in IA.	Outreach Coordinator
9. **IA Coalition Against Domestic Violence:** A statewide membership of 28 domestic violence organizations, working to engage all people in a movement to change the social and political systems that perpetuate violence against women through education, advocacy and quality services.	Training Coordinator, Clinical Coordinator
10. **IA Dept. of Public Health HIV/Hepatitis Community Planning Group:** A statewide committee works to develop the comprehensive HIV and Hepatitis prevention and care plans for the state of IA.	CBSS Coordinator
11. **Medical Assistance Advisory Council:** A council that advises the IA Medicaid Program.	Executive Director

12. **IA Public Health Association:** A statewide membership association that represents and advocates on behalf of public health interests in IA.	CBSS Coordinator
13. **IA Dept. of Justice – Office of the Attorney General, Crime Victim Assistance Division:** ***(Sexual Assault and Domestic Violence Programs)*** provides services and assistance to victims of violent crimes. The division administers programs that directly benefit victims of crime	Outreach Coordinator
14. **St. Louis STD/HIV Prevention Training Center:** A training center serving Iowa, Illinois, Kansas, Minnesota, Missouri, Nebraska, and Wisconsin. It is part of the National Network of Prevention Training Centers, which provides clinical training in the areas of STD and HIV for public and private health care providers.	CBSS Coordinator, Training Coordinator
15. **IA Dept. of Public Health Personal Responsibility Education Program:** An advisory council established to educate adolescents on abstinence and contraception to prevent pregnancies and STDs through use of evidence-based curricula.	Training Coordinator
16. **IA Network against Human Trafficking:** An Iowa-based organization focused on ending sex and labor trafficking.	Outreach Coordinator
17. **IA Department of Public Health's *Care For Yourself*:** Iowa's program is part of a national program that helps reduce risks from breast, cervical, and cardiovascular health issues by providing screenings for women who qualify.	Clinical Coordinator
18. **Iowa Coalition for Collective Change:** Provides specialized domestic violence and sexual assault training and services for LGBTQ, Persons with Disabilities, Deaf Iowans, and Communities of Color.	Outreach Coordinator
19. **Iowa Primary Care Association:** A non-profit membership association comprised of Iowa community health centers whose mission is to provide leadership and ensure availability of quality health care for underserved populations in Iowa.	Executive Director
20. **Iowa Community Action Association:** A statewide association that works to enhance opportunities and ensure economic stability for low-income Iowans.	Executive Director

FAMILY PLANNING COUNCIL OF IOWA
SEPTEMBER 1, 2018 – AUGUST 31, 2022 WORKPLAN

(b)(4)

(b)(4)

(b)(4)

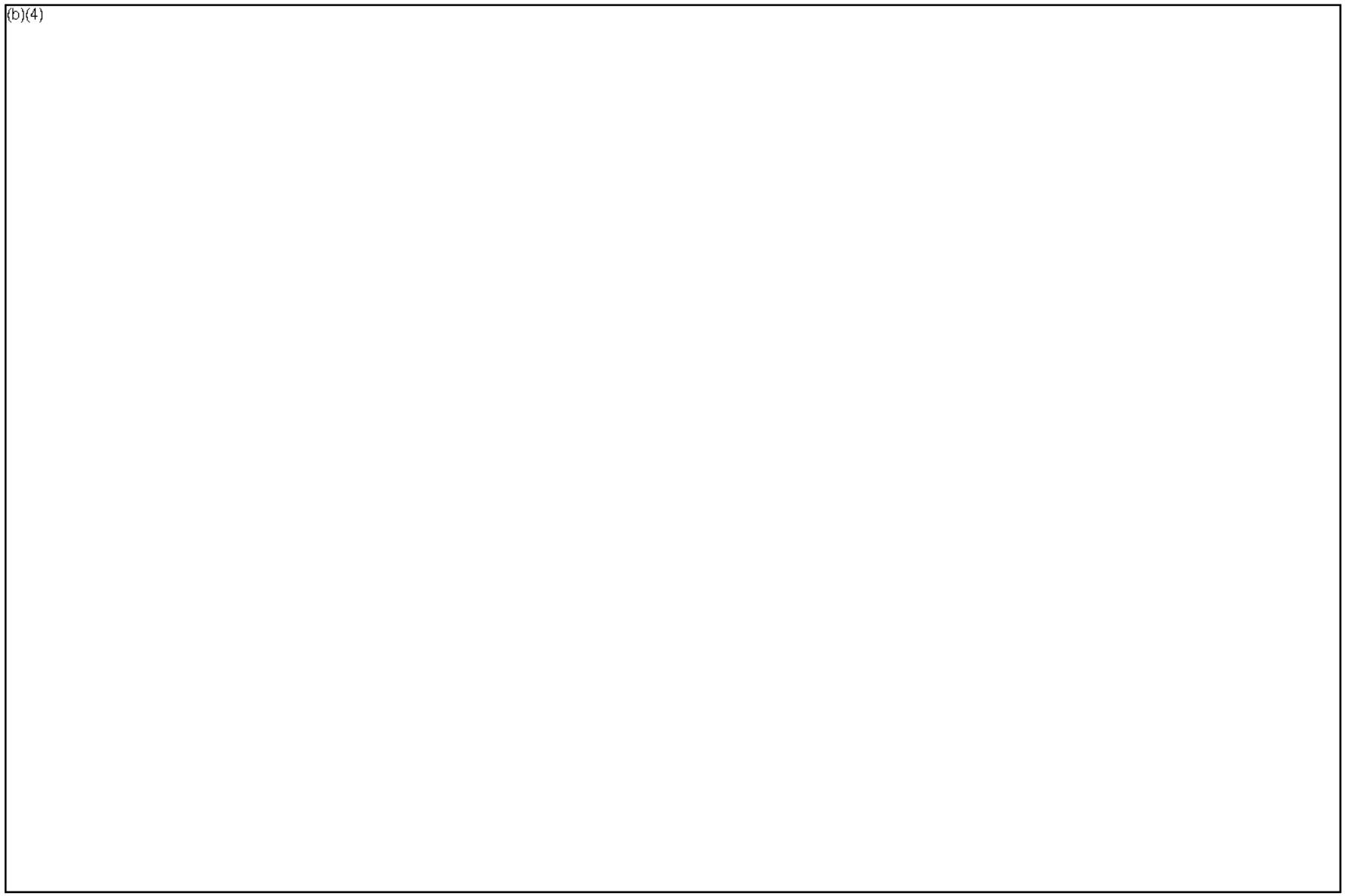

(b)(4)


(b)(4)

(b)(4)

(b)(4)

(b)(4)


(b)(4)

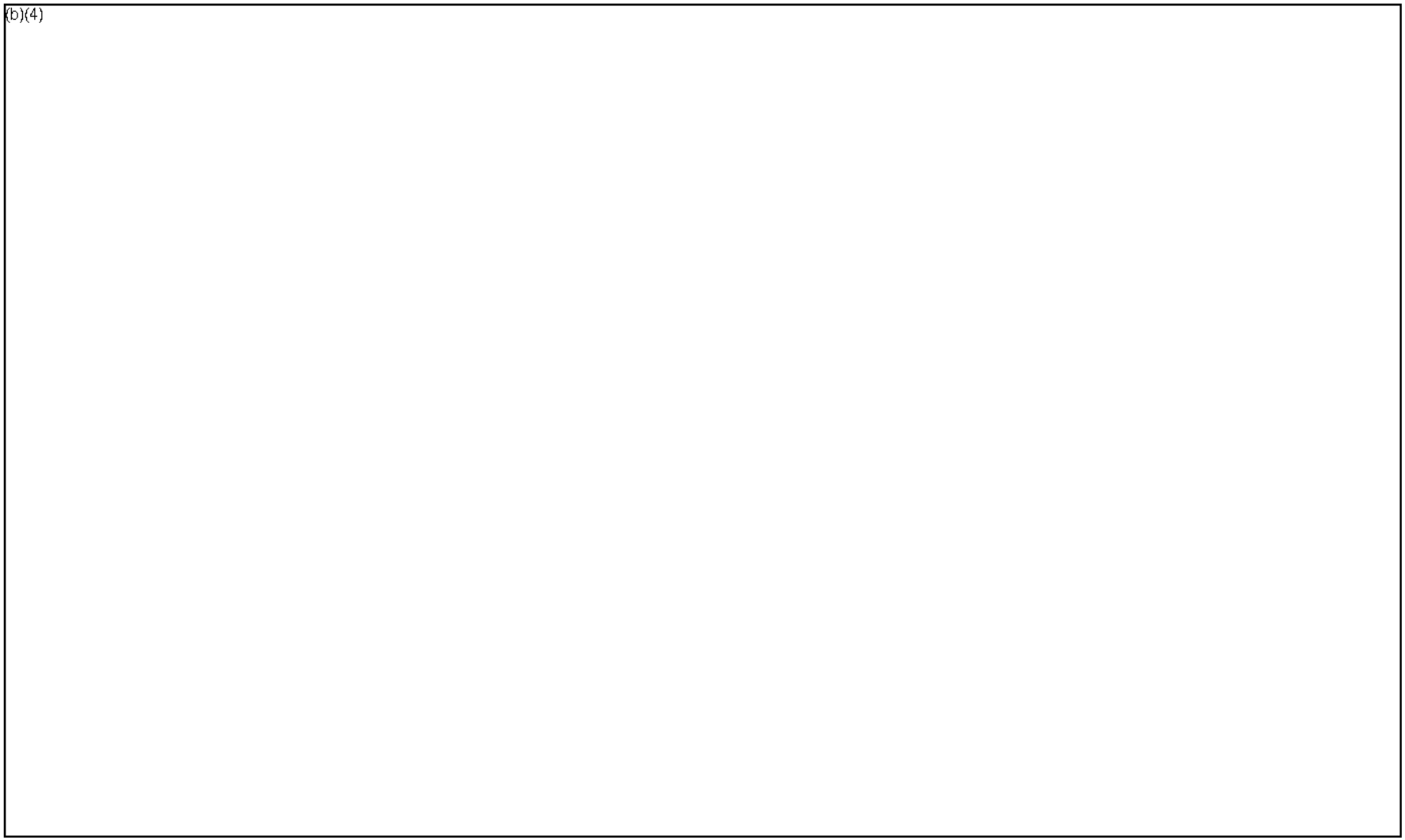
(b)(4)

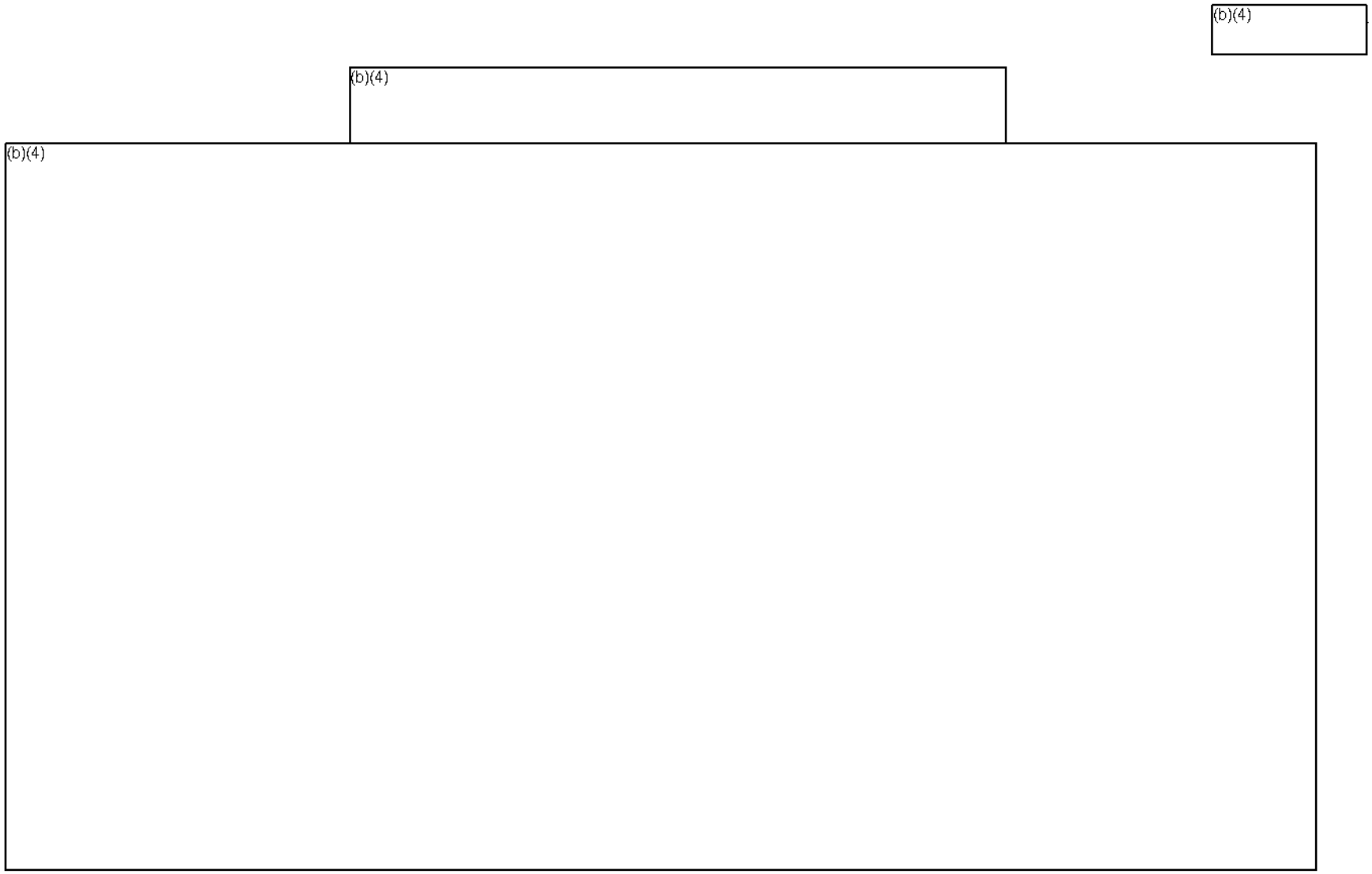

(b)(4)


(b)(4)

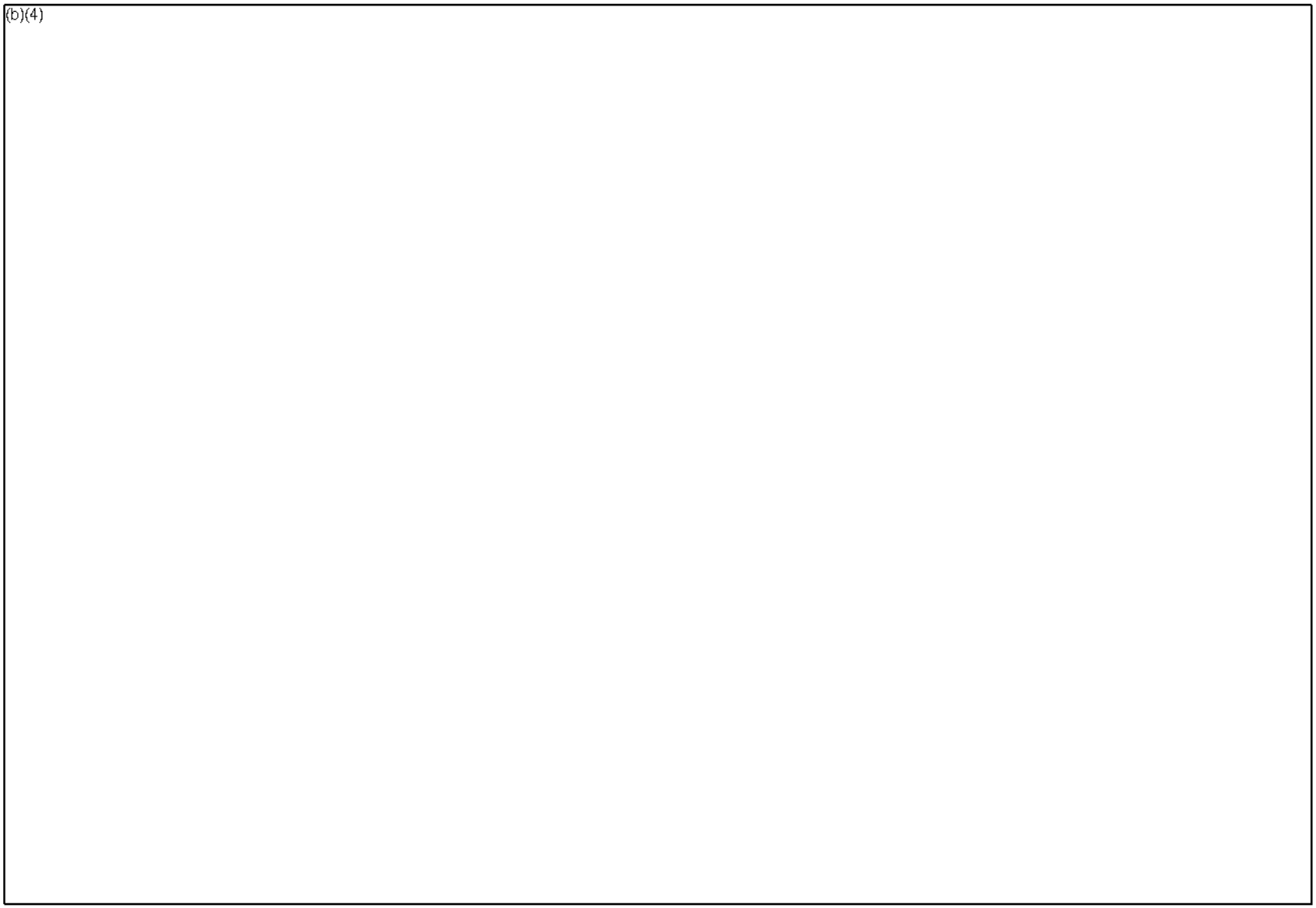

(b)(4)

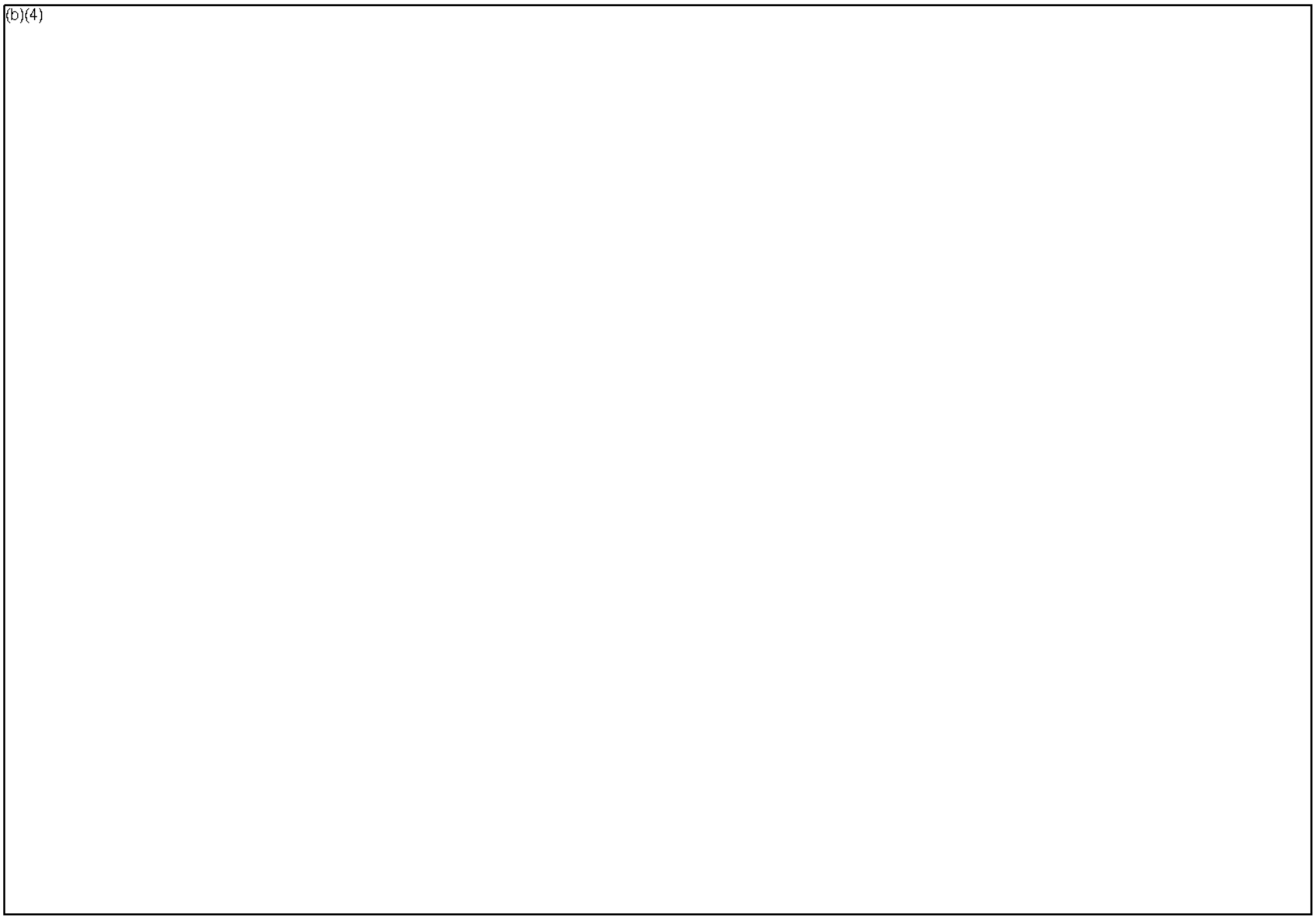

(b)(4)


(b)(4)


(b)(4)
(b)(4)
(b)(4)


(b)(4)


(b)(4)


(b)(4)

(b)(4)

FAMILY PLANNING COUNCIL OF IOWA
SERVICES PROVIDED WITHIN THE TITLE X PROJECT

SERVICES PROVIDED within the FPCI Title X Project (page 1 of 3)

Sub-Recipient	Voluntary Services and Informed Consent	History	Physical Assessment	Lab Testing	Cancer Screening	Client Education/ Counseling	Pregnancy Diagnosis/ Counseling	STD Testing	STD Treatment
(b)(4)	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1

Legend

1=Provided on-site	3=Referral outside clinic, but paid for by Title X
2=Reserved for Grantee Use Only	4=Not provided at clinic site

SERVICES PROVIDED within the FPCI Title X Project (page 2 of 3)

Sub-Recipient	Male Services	Adolescent Counseling: Family Participation	Adolescent Counseling: Resisting Coercion	Adolescent Counseling: Abstinence Education	Adolescent Counseling: Limits of Confidentiality	HIV: Education	HIV: Testing	HIV: Linkage to Care
(b)(4)	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1

SERVICES PROVIDED within the FPCI Title X Project

Sub-Recipient	Reproductive Life Planning	Preconception Health	Basic Infertility Services	Intimate Partner Violence Assessment/ Education	Health Promotion/ Disease Prevention
(b)(4)	1	1	1	1	1
	1	1	1	1	1
	1	1	1	1	1
	1	1	1	1	1
	1	1	1	1	1
	1	1	1	1	1
	1	1	1	1	1
	1	1	1	1	1
	1	1	1	1	1
	1	1	1	1	1

Legend

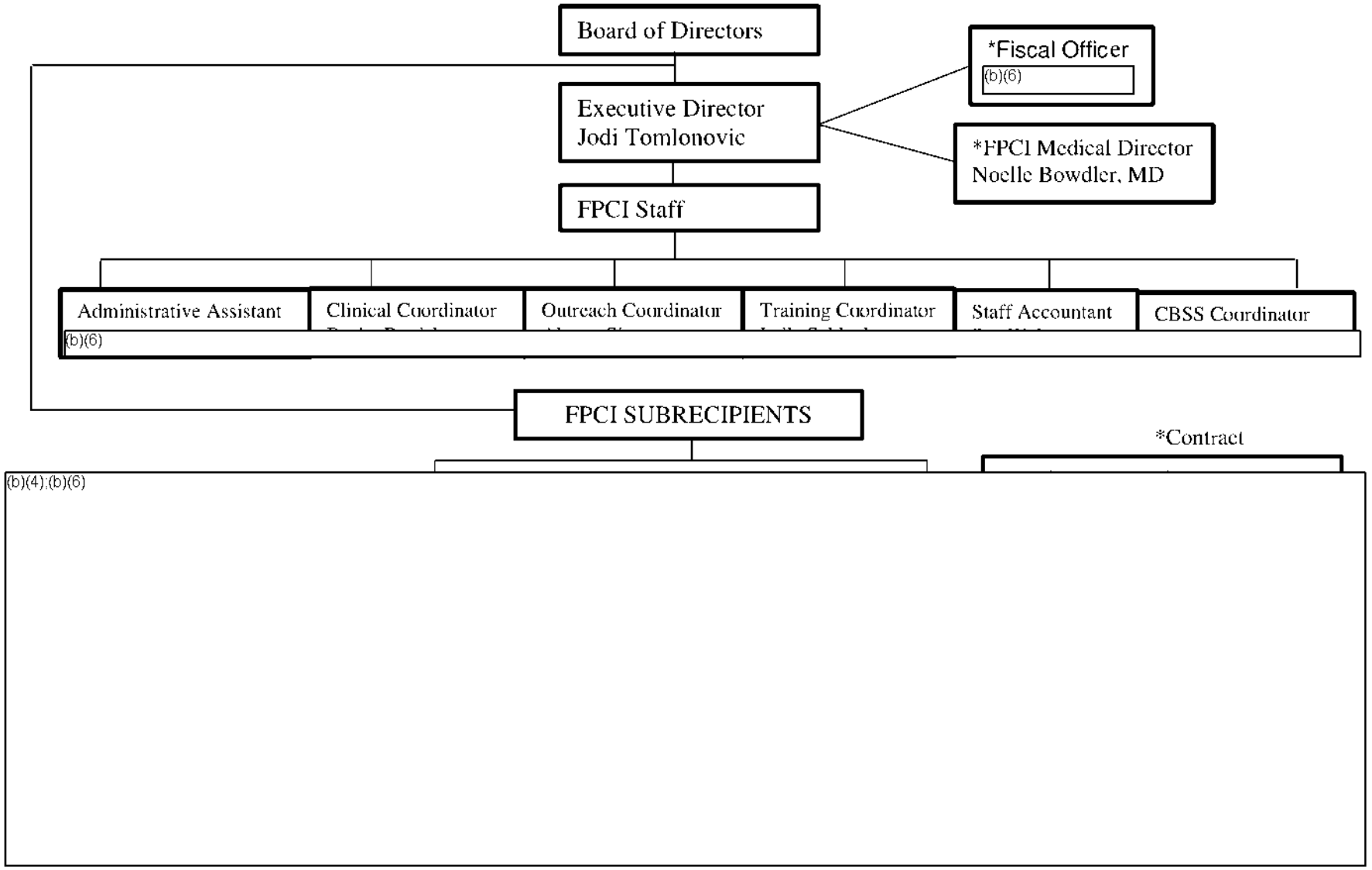
1=Provided on-site	3=Referral outside clinic, but paid for by Title X
2=Reserved for Grantee Use Only	4=Not provided at clinic site

SERVICES PROVIDED within the FPCI Title X Project (page 3 of 3)							
	FAMILY PLANNING METHODS OFFERED						
Sub-Recipient	IUD/IUS	Hormonal Implant	3 Month Hormonal Injection	Oral Contraceptives	Contraceptive Patch	Vaginal Ring	Cervical Cap/ Diaphragm
(b)(4)	]	]	]	]	]	]	]
	]	]	]	]	]	]	]
	]	]	]	]	4	]	4
	]	]	]	]	4	]	]
	]	]	]	]	]	]	]
	]	]	]	]	]	]	]
	]	]	]	]	]	]	]
	]	]	]	]	]	]	]
	]	]	]	]	]	]	]
	]	]	]	]	]	]	4

SERVICES PROVIDED within the FPCI Title X Project							
	FAMILY PLANNING METHODS OFFERED						
Sub-Recipient	Natural Family Planning (FAM)	Abstinence	Female Condom	Male Condom	Emergency Contraception (EC)	Spermicidal Methods or Products	Contraceptive Sponge
(b)(4)	]	]	]	]	]	4	4
	]	]	]	]	]	]	]
	]	]	4	]	]	4	4
	]	]	]	]	]	]	4
	]	]	]	]	]	]	]
	]	]	]	]	]	]	]
	]	]	]	]	]	]	4
	]	]	]	]	]	]	]
	]	]	]	]	]	4	4
	]	]	4	]	]	4	4

Legend	
1=Provided on-site	3=Referral outside clinic, but paid for by Title X
2=Reserved for Grantee Use Only	4=Not provided at clinic site

FAMILY PLANNING COUNCIL OF IOWA
TITLE X PROGRAM ORGANIZATION CHART



FAMILY PLANNING COUNCIL OF IOWA

SCHEDULE OF DISCOUNTS DEVELOPMENT

The Family Planning Council of Iowa (FPCI) requires its ten subrecipients to apply a Schedule of Discounts (SOD) to all services and supplies within the project provided to individuals with incomes between 101-250% of the Federal Poverty Level (FPL). FPCI does not require that its 10 subrecipients use the same schedule of discounts; however FPCI reviews and approves each agency's schedule of discounts. Each year FPCI provides an updated Poverty Level Chart to be used in developing the SOD.

The following parameters are to be followed by the subrecipients when developing their SOD:

1) The SOD must be based on an analysis of the costs to provide services;

2) The SOD is revised and reviewed annually using the most current FPL guidelines;

3) There must be a zero pay category for clients with incomes at or below 100% of poverty;

4) The SOD must have discounts between 101-250% of FPL;

5) Eligibility for discounts must be documented in the client record;

6) SRs must have a system for waiving fees of individuals with family incomes above 101% of FPL who, as determined by the service site project director, are unable for good cause to pay for family planning services and;

7) Third party payers must be charged for the full cost of the service or supplies.

FPCI's Fiscal Officer reviews each SR's SOD annually, and conducts an annual fiscal management review of each SR to ensure clients' incomes were properly determined; the client was placed on the proper discount level; and the appropriate amount was charged to the client based on the SOD. SRs are required to conduct a Title X cost analysis at least every three years.

Factors to be considered for the development of fees for services include: wages, overhead, supply costs, time to provide the services, follow-up activities and administrative costs.

Appendix I

FAMILY PLANNING COUNCIL OF IOWA

ADMINISTRATIVE POLICIES MANUAL and CLINICAL PROTOCOLS

In order to provide an overview of the Family Planning Council of Iowa's Title X Administrative Policies and its Clinical Protocols, this appendix contains the Table of Contents for:

1) Family Planning Council of Iowa: Administrative Policies Manual

2) Family Planning Council of Iowa: Clinical Protocols

FAMILY PLANNING COUNCIL OF IOWA

ADMINISTRATIVE POLICIES MANUAL

TABLE OF CONTENTS

1. PURPOSE 1

2. BASIS 1

3. MAINTENANCE OF THE MANUAL 1

4. DEFINITIONS 1

5. CRITERIA FOR FUNDING 1

6. CONTRACTS 2

7. USE OF GRANT FUNDS 2

8. PROJECT MANAGEMENT AND ADMINISTRATION 2
   - 8.1 Voluntary Participation 3
   - 8.2 Prohibition of Abortion 3
   - 8.3 Structure and Management 4
   - 8.3.1 Written Agreement 4
   - 8.3.2 Sub-recipient Sub-contracts 4
   - 8.3.3 Services Purchased 5
   - 8.3.4 Fee Schedule 5
   - 8.3.5 Sub-recipient Participation 5
   - 8.3.6 Financial Management System 6
   - 8.4 Charges, Billings and Collections 7
   - 8.4.1 Client Income 7
   - 8.4.2 Schedule of Discounts (Sliding Fee Scale) 7
   - 8.4.3 Waived Fees 8
   - 8.4.4 Charges for Families whose Income Exceeds 250% of FPL 8
   - 8.4.5 Discounts for Minors 8
   - 8.4.6 Third Party Payment 9
   - 8.4.7 Medicaid 9
   - 8.4.8 Collections 9
   - 8.4.9 Donations 10
   - 8.5 Project Personnel 10
   - 8.5.1 Personnel Policies 10
   - 8.5.2 Project Staff 10
   - 8.5.3 Project Director 11

8.5.4 Medical Director 11
8.5.5 Salary Limits 11
8.6 Staff Orientation and Training Requirements 11
8.6.1a Orientation 11
8.6.1b Training/Continuing Education 12
8.6.2 Federal/State Training Plan Requirements 12
8.6.2a Mandatory Reporting 12
8.6.2b Human Trafficking 13
8.6.3 Family Involvement and Counseling Minors 13
8.7 Planning and Evaluation 13

9. PROJECT SERVICES AND CLIENTS 14
9.1 Services to Low-Income Families 14
9.2 Services with Dignity 14
9.3 Non-Discrimination 14
9.4 Referrals (Social Services) 15
9.5 Referrals (Other Health Care Providers) 15
9.6 Clinical Services 16
9.7-8 Related Reproductive Health Services and Family Planning Methods
(Provision of Family Planning Services) 17
(Broad Range of Family Planning Methods and Services) 17
9.9 Durational Residency 18
9.10-11 Pregnancy Diagnosis and Counseling 18
9.12 Adolescent Services 19
9.13 Laboratory Services 20
9.14 Medical Protocols 20
9.15 Quality Assurance and Improvement 20
9.16 Permanent Contraception 21

10. CONFIDENTIALITY 21

11. COMMUNITY PARTICIPATION, EDUCATION AND PROJECT PROMOTION 22
11.1 Community Participation 22
11.2 Project Promotion 23
11.3 Community Education 23

12. INFORMATION AND EDUCATION MATERIALS APPROVAL 24

13. ADDITIONAL ADMINISTRATIVE REQUIREMENTS 25
13.1 Facilities and Accessibility of Services 25
13.2 Emergency Management 25
13.3 Change in Sub-recipient Clinic Sites 26
13.4 Standards of Conduct 26
13.5 Human Subjects Research 26

13.6 Financial Reporting Requirements 27
13.6a Financial Audits (Independent) 27
13.6b Financial Audits (Internal) 27
13.7 Financial Reports 28
13.8 Liability Coverage 28
13.9 Reporting Requirements 28
13.9a Family Planning Annual Report (FPAR) 28
13.9b FPCI Reports 29

14. MONITORING AND OVERSIGHT 29

ATTACHMENTS 30

ATTACHMENT A:
Separation of Non-Title X Expenses From the Title X Project Policy

ATTACHMENT B:
B-1: FPCI Billings and Collections Policy
B-2: FPCI Income Determination Policy
B-3: FPCI Schedule of Discounts Policy
B-4: FPCI Donation Policy
B-5: Use of 340B Medications
B-5A: IME 340B Informational Letter #1404

ATTACHMENT C:
C-1: Guidance on Community Participation
C-2: Information and Education Committee Policy

ATTACHMENT D:
D-1: FPCI Change in Clinic Site Policy
D-2: Procedures for Sub-recipient Withdrawal from the Title X Program

ATTACHMENT E:
Procedures for Conducting Program Reviews

ATTACHMENT F:
FPCI Publications and Copyright Policy

ATTACHMENT G:
Title X Program Guidelines
1. Program Requirements
2. Quality Family Planning Services

ATTACHMENT H:
Office of Population Affairs Program Policy Notices

FAMILY PLANNING COUNCIL OF IOWA

CLINICAL PROTOCOLS TABLE OF CONTENTS

SECTION 1: ADMINISTRATIVE 1

Clinician Guidelines for Providing Family Planning Services 2
Consents 4
Mandatory Reporting 6
Preconception Health Services 7
Family Planning Council of Iowa Title X Requirements 10

SECTION 2: CONTRACEPTION 1

A. Introduction
Initiating Methods 2
Changing Methods 10
Standing Orders 13
B. Long Acting Reversible Contraceptives
Implantable 17
Cu-IUD 21
LNG-IUD 25
C. Hormonal Contraceptives
Combined Oral 29
Injectable 34
Progestin Only Pills 39
Transdermal Patch 42
Vaginal Ring 47
D. Barrier Methods
Diaphragm 52
Female Condom 56
Male Condom 59
E. Other
Emergency Contraception 62
Spermicide 67
Abstinence 70
Natural Family Planning/Fertility Awareness 72

SECTION 3: PREVENTIVE CARE 1

Well Woman Visits, Age 13-20 2
Well Woman Visits, Age 21 and above 6
Well Man Visits 11

SECTION 4: GYN CONDITIONS 1

Abnormal Cervical Cytology Management 2
Abnormal Uterine Bleeding 8

Amenorrhea and Oligomenorrhea 12
Dysmenorrhea 16
Estrogen Exposed Offspring 19
Basic Infertility Services 22
Polycystic Ovarian Syndrome 26
Sexual Assault 30

SECTION 5: INFECTIONS 1
Chlamydia 2
Condyloma Acuminata 5
Gonorrhea 7
Herpes Simplex Virus 10
Human Immunodeficiency Virus 13
Pediculosis Pubis 18
Pelvic Inflammatory Disease 20
Syphilis 23
Urinary Tract Infection 26
Vaginal Discharge 28

SECTION 6: PREGNANCY RELATED VISITS 1
Early Pregnancy Loss 2
Ectopic Pregnancy 4
Pregnancy Testing & Options Counseling 6

SECTION 7: APPENDICES
Algorithms: Updated Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors
CDC, MMWR, Providing Quality Family Planning Services, 2014
CDC, MMWR, Sexually Transmitted Diseases Treatment Guidelines, 2015
CDC, MMWR, U.S. Medical Eligibility Criteria for Contraceptive Use, 2010
CDC, MMWR, Update to CDC's U.S. Medical Eligibility Criteria For Contraceptive Use, 2010: Revised Recommendations for the Use of Contraceptive Methods During the Postpartum Period, 2011
CDC, MMWR, Update to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: Revised Recommendations for the Use of Hormonal Contraception Among Women at High Risk for HIV Infection or Infected with HIV, 2011.
CDC, MMWR, U.S. Selected Practice Recommendations for Contraceptive Use, 2013
CDC, Effectiveness of Contraceptive Methods
CDC, Management of Women with Bleeding Using Contraception and Management of the IUD When User is Found to Have PID
CDC, Recommended Actions After Late or Delayed Contraception
CDC, When to Start Using Contraceptive Methods
Office Of Population Affairs. Program Requirements for Title X Funded Family Planning Projects, April 2014
Reproductive Health Access Project, How to Switch Birth Control Methods

TITLE X CERTIFICATE OF COMPLIANCE
and
LEGISLATIVE MANDATE CERTIFICATION

Family Planning Council of Iowa assures that it will:

1. Provide services without subjecting individuals to any coercion to accept services or coercion to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of services.

2. Not provide abortions as a method of family planning.

3. Provide that priority in the provision of services will be given to persons from low income families.

Further: Family Planning Council of Iowa certifies that it will:

1. Encourage family participation in the decision of minors seeking family planning services.

2. Provide counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

3. Require that no provider of services under Title X of the Public Health Services Act shall be exempt from any State Law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape or incest.

Jodi Tinnemeyer
Name

Executive Director
Title

5/14/18
Date

FAMILY PLANNING COUNCIL OF IOWA

Cross Reference: 2018 Program Priorities/Key Issues

PROGRAM PRIORITIES	WHERE ADDRESSED
1. Assuring innovative high quality family planning and related health services that will improve the overall health of individuals, couples and families, with priority for services to those of low-income families, offering, at a minimum, core family planning services enumerated earlier in this Funding Announcement. Assuring that projects offer a broad range of family planning and related health services that are tailored to the unique needs of the individual, that include natural family planning methods (also known as fertility awareness based methods) which ensure breadth and variety among family planning methods offered, infertility services, and services for adolescents; breast and cervical cancer screening and prevention of STDs as well as HIV prevention education, counseling, testing, and referrals	Narrative Sections: 2, 4, 5, 13, 16 Workplan: ADM Goals 1 and 2 CL Goals 1 and 2
2. Assuring activities that promote positive family relationships for the purpose of increasing family participation in family planning and healthy decision-making; education and counseling that prioritize optimal health and life outcomes for every individual and couple; and other related health services, contextualizing Title X services within a model that promotes optimal health outcomes for the client.	Narrative Sections: 4, 5, 10, Workplan: CL Goal 1 CPEPP Goals 1 and 3
3. Ensuring that all clients are provided services in a voluntary, client-centered and non-coercive manner in accordance with Title X regulations.	Narrative Sections: 4, 5 Workplan: CL Goal 1
4. Promoting provision of comprehensive primary health care services to make it easier for individuals to receive both primary health care and family planning services preferably in the same location, or through nearby referral providers, and increase incentive for those individuals in need of care choosing a Title X provider.	Narrative Sections: 2, 4, 5, 16 Workplan: CL Goal 2
5. Assuring compliance with State laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, and human trafficking	Narrative Sections: 4, 5 Workplan: ADM Goal 2; CL Goal 1; CPEPP Goal 3
6. Encouraging participation of families, parents, and/or legal guardians in the decision of minors to seek family planning services; and providing counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities;	Narrative Sections: 4, 5, 10 Workplan: CL Goal 1; CPEPP Goal 1
7. Demonstrating that Title X activities are separate and clearly distinct from non-Title X	Narrative Sections: 4, 5, 8, 9

activities, ensuring that abortion is not a method of family planning for this grant.	Workplan: ADM Goal 1; FM Goal 1
8. Use of OPA performance metrics to regularly perform quality assurance and quality improvement activities.	Narrative Sections: 18 Workplan: ADM Goal 3; CL Goal 3
KEY ISSUE	**WORKPLAN GOAL**
1. Efficiency and effectiveness in program management and operations.	Narrative Sections: 6, 7, 9, 11, 14, 17, 18, 19 Workplan: ADM Goals 1 and 2; CPEPP Goal 1; FM Goals 1 and 2
2. Management and decision-making and accountability for outcomes.	Narrative Sections: 2, 7, 9, 14, 17, 18 Workplan: ADM Goals 1, 2 and 3; CL Goal 3; FM Goals 1 and 2
3. Cooperation with community-based and faith-based organizations.	Narrative Sections: 3, 10, 16 Workplan: CPEPP Goals 1, 2, 3
4. Meaningful collaboration with subrecipients and documented partners in order to demonstrate a seamless continuum of care for clients.	Narrative Sections: 2, 3, 4, 5, 18 Workplan: ADM Goals 1 and 2; CL Goals 1 and 2; CPEPP Goal 2
5. A meaningful emphasis on education and counseling that communicates the social science research and practical application of topics related to healthy relationships, to committed, safe, stable, healthy marriages, and the benefits of avoiding sexual risk or returning to a sexually risk-free status, especially (but not only) when communicating with adolescents.	Narrative Sections: 4, 5, 10 Workplan: CL Goal 1; CPEPP Goal 1
6. Activities for adolescents that do not normalize sexual risk behaviors, but instead clearly communicate the research informed benefits of delaying sex or returning to a sexually risk-free status.	Narrative Sections: 4, 5, 10 Workplan: CL Goal 1; CPEPP Goals 1 and 3
7. Emphasis on the voluntary nature of family planning services.	Narrative Sections: 4, 5 Workplan: CL Goal 1
8. Data collection (such as the Family Planning Annual Report (FPAR)) for use in monitoring performance and improving family planning services.	Narrative Sections: 17, 18 Workplan: ADM Goal 3; CL Goal 3

Internal Revenue Service

Department of the Treasury Appendix L

P. O. Box 2508
Cincinnati, OH 45201

Date: January 18, 2000

Person to Contact:
(b)(6)
Customer Service Representative
Telephone Number:
877-829-5500
Fax Number:
513-263-3756
Federal Identification Number:
42-1145646

Family Planning Council of Iowa
1101 Walnut St. Suite 200
Des Moines, IA 50309-3425

Dear Sir or Madam:

This letter is in response to your telephone request January 18, 2000, for a copy of your organization's determination letter. This letter will take the place of the copy you requested.

Our records indicate that a determination letter issued in January 1981 granted your organization exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. That letter is still in effect.

Based on information subsequently submitted, we classified your organization as one that is not a private foundation within the meaning of section 509(a) of the Code because it is an organization described in ection 509(a)(1) and 170(b)(1)(A)(vi).

This classification was based on the assumption that your organization's operations would continue as stated in the application. If your organization's sources of support, or its character, method of operations, or purposes have changed, please let us know so we can consider the effect of the change on the exempt status and foundation status of your organization.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, only if its gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of $20 a day, up to a maximum of $10,000, when a return is filed late, unless there is reasonable cause for the delay.

All exempt organizations (unless specifically excluded) are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more paid to each employee during a calendar year. Your organization is not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, these organizations are not automatically exempt from other federal excise taxes.

Donors may deduct contributions to your organization as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to your organization or for its use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

JAN 24 2000

Family Planning Council of Iowa
42-1145646

Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Code. If your organization is subject to this tax, it must file an income tax return on the Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your organization's present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

The law requires you to make your organization's annual return available for public inspection without charge for three years after the due date of the return. You are also required to make available for public inspection a copy of your organization's exemption application, any supporting documents and the exemption letter to any individual who requests such documents in person or in writing. You can charge only a reasonable fee for reproduction and actual postage costs for the copied materials. The law does not require you to provide copies of public inspection documents that are widely available, such as by posting them on the Internet (World Wide Web). You may be liable for a penalty of $20 a day for each day you do not make these documents available for public inspection (up to a maximum of $10,000 in the case of an annual return).

Because this letter could help resolve any questions about your organization's exempt status and foundation status, you should keep it with the organization's permanent records.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

This letter affirms your organization's exempt status.

Sincerely,

Robert C. Padilla
Manager, Customer Service

FAMILY PLANNING COUNCIL OF IOWA
BOARD OF DIRECTORS
PROJECT PERIOD 2018 - 2019

Julie Mellecker
Coralville, Iowa

Adam Stark
Des Moines, Iowa

Eric Nemmers
Des Moines, Iowa

Steve Harms
West Des Moines, Iowa

Chloe Butler
Ankeny, Iowa

Carrie Coyle
Davenport, Iowa

Lisa Dahlhauser
West Des Moines, Iowa

Hannah Ellis Ackerman
Davenport, Iowa

Elisabeth Giles
Sioux City, Iowa

Ann Fields
Knoxville, Iowa

Kimberly Hope
Ames, Iowa

Dierdre Large
West Des Moines, Iowa

Karen Ligas
Des Moines, Iowa

Amber Rajcevich
Davenport, Iowa

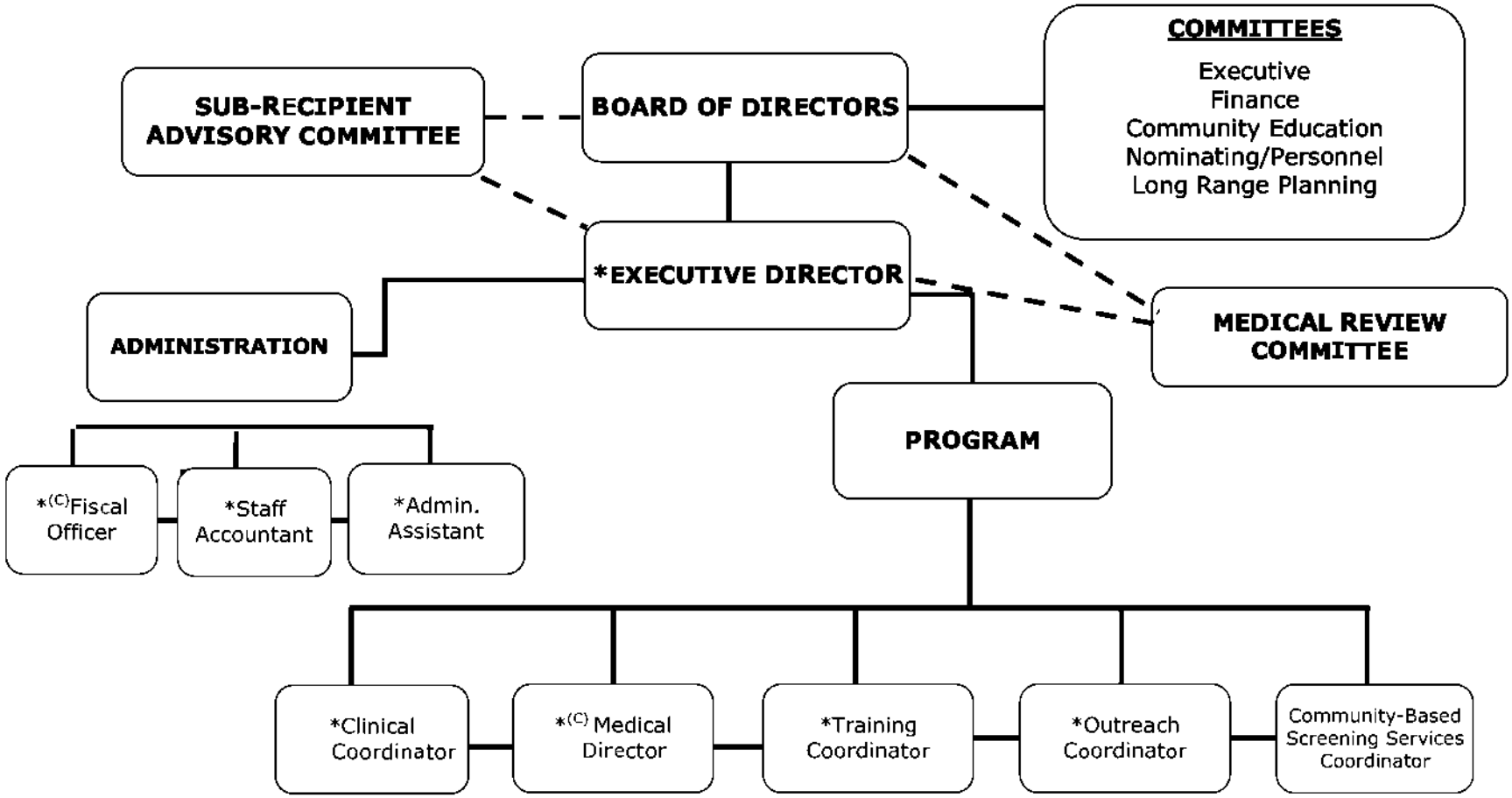
Mary Salazar
Urbandale, Iowa

Rev. Milo VanVeldhuizen
West Burlington, Iowa

Mary Warren
Waukee, Iowa

Scott Warren
Urbandale, Iowa

FAMILY PLANNING COUNCIL OF IOWA
ORGANIZATIONAL CHART



(C) Contractual *Title X Project

Page 144 of 232

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

FAMILY PLANNING COUNCIL OF IOWA
BIOGRAPHICAL SKETCHES

(b)(6)

Page 146 of 232

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 147 of 232

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

Page 148 of 232

Withheld pursuant to exemption

(b)(6)

of the Freedom of Information and Privacy Act

FAMILY PLANNING COUNCIL OF IOWA
KEY PERSONNEL -- TITLE X PROJECT

Project Director: Family Planning Council of Iowa
Jodi Tomlonovic
Executive Director

MEMORANDUM OF UNDERSTANDING

(b)(4)

Page 151 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

MEMORANDUM OF UNDERSTANDING

(b)(4)

Page 153 of 232

Withheld pursuant to exemption

(b)(4)

of the Freedom of Information and Privacy Act

Upload #4

Applicant:	Family Planning Council of Iowa
Application Number:	FPH2018008738
Project Title:	Title X Family Planning Services
Status:	Awarded
Document Title:	BudgetNarrativeAttachments_1_2-Attachments-1234-FPCI BUDGET NARRATIVE.pdf

FAMILY PLANNING COUNCIL OF IOWA

TITLE X – FAMILY PLANNING SERVICES

SEPTEMBER 1, 2018 - AUGUST 31, 2019 BUDGET NARRATIVE

Summary:

The Family Planning Council of Iowa (FPCI) proposes to implement a Title X project which provides family planning services to (b)(4) individuals at a total cost of $(b)(4) per client and a Title X cost of $(b)(4) per client. The proposed budget covers the costs of implementing the project over a (b)(4) county area subcontracting with (b)(4) subrecipient entities. The budget covers the FPCI administrative costs, training costs, monitoring, oversight, program promotion, and contracts with subrecipients for services.

As the cost of providing health care rises across the country, it also rises in Iowa. Clinician shortages increase costs as salaries must be competitive. Even with the use of the 340B drugs contraceptive costs increase, and the basic costs of overhead and other fixed costs continue to increase. The FPCI does not use an indirect cost rate. All project allowable costs are budgeted and expensed as direct costs.

FPCI's overall cost per client reflects the FPCI administrative costs and the subrecipient entities' cost of implementing the Title X program and providing Title X services. FPCI's subrecipient network ranges from a small rural county health department to large FQHCs. The costs of providing care vary among the 10 subrecipients reflecting regional variations in costs and expenses. The amount of non-federal resources available by subrecipient reflects the availability of those resources within that subrecipient' s community and target population.

Cost effectiveness can be identified through several means. One is by the leveraging of non-federal resources resulting in the ability to expand services and reach a larger number of clients than we would have been able to with only Title X funds. This budget shows FPCI's ability to use that leverage.

Another is through using discount purchasing agreements. All FPCI subrecipients are required to participate in the 340B Drug Purchasing Program in order to reduce contraceptive costs. To further reduce the costs all FPCI subrecipients are enrolled in the 340B Prime Vendor Program which can provide even lower costs. A more encompassing measure of cost effectiveness looks at the savings produced by the Title X program. In 2017, FPCI's Title X program showed a net saving of (b)(4) in averted costs related to maternal and birth related costs, STI testing, cancer screening in Iowa (*Source: #18 in Appendix A).* We anticipate that this budget's project would provide similar cost savings. By these measures, FPCI's Title X project is a very cost effective program.

FPCI's Plan for Oversight of Federal Funds follows this budget narrative.

BUDGET DETAIL:

Personnel (b)(4)

The personnel category contains the cost of FPCI employees to achieve the goals and objectives of the work plan and all necessary functions for the Title X project. It also includes the cost of providing administration and oversight of the Title X project, monitoring of subrecipients, submission of required reports, collaboration with other entities and programs, and all other tasks necessary to implement the Title X project. The budget provides for (b)(4) FTE for the Title X project. (The costs of consultants who are used to help achieve the goals and objectives are shown in the "Other" category.) (*Please see the more detailed Personnel Cost Form at the end of this narrative.)*

Fringe Benefits (b)(4)

The benefit expenses included in this category are employer FICA (Social Security and Medicare), a monthly stipend, health insurance, a pension plan, Iowa Unemployment, and Workers Compensation. FICA expense is expected to remain a (b)(4) percent of salaries. The monthly stipend provides (b)(4) monthly for each full time employee and is prorated according to estimated percentage of Title X time.

Pension expense is [redacted]% of salary for permanent employees who have completed at least one year of service. There is no pension expense for temporary employees. FPCI's Unemployment Rate is estimated to be [redacted] on the first [redacted] of each salary. Workers Compensation in Iowa is set at [redacted] cents per [redacted] of salary plus a minimum fee and a compulsory terrorism surcharge, which we estimated to be [redacted] for Title X employees during the fiscal year. Also, since FPCI personnel policies allow employees to carry over unused vacation from one year to the next, we add an estimate of [redacted] days per employee to their fringe benefit expenses.

The actual expected fringe benefit expense was figured for each individual position and the individual expenses were added together to find the total fringe benefit expense for the agency. The total fringe benefit expense divided by total salary expense is the fringe benefit rate.

Travel:

Travel expense is based on both past experience and projected rates and travel needs for the 2018-2019 project. *(Please see travel breakout attached Travel Sheet)*

In-State Travel [redacted]

In-state travel includes expenses for the Executive Director, Fiscal Officer, Training Coordinator and the Clinical Policy Coordinator who will conduct full program site reviews of selected sub-recipient agencies in order to fulfill our monitoring responsibilities. FPCI staff will be traveling to the other sub-recipient agencies for interim site reviews or to provide technical assistance. Most of the FPCI sub-recipients are located several hundred miles from the FPCI office. The Executive Director, Clinical Policy Coordinator, and Training Coordinator will attend training committee meetings, conferences and events around the state. This also includes travel for the Outreach Coordinator to travel to sub-recipient sites to work with the agencies on expansion and outreach efforts. The Clinical

Policy Coordinator will be traveling to clinic sites to monitor and provide technical assistance. This is based on reimbursement at the rate of (b)(4) per mile.

Out-of-State Travel (b)(4)

Out-of-state travel includes expenses for the staff to attend any national Title X meetings, national Title X training events, meetings of the National Family Planning and Reproductive Health Association, and meetings of the Family Planning Councils of America. It includes funds for each professional staff member to attend one out -of- state conference/training.

Board Travel (b)(4)

FPCI's 18 member Board of Directors are from across the state. The distance for some members to travel is 100-400 miles round trip. FPCI reimburses members of the Board of Directors for mileage and travel expenses incurred when traveling to quarterly board meetings, committee meetings, and meetings with FPCI staff. This is based on reimbursement at the rate of (b)(4) per mile.

Equipment **$0**

There are no anticipated equipment expenses.

Supplies (b)(4)

Since FPCI does not operate a clinic, our budget does not include medical supplies. FPCI does not do bulk purchasing for the subcontractors who provide our medical services. Therefore, this category includes supplies needed for office operation. These are items such as paper, copier & printer inks, software programs such as Sage Accounting, server back-up programs, etc. and their updates. It includes furniture as needed.

Contractual

Services Subcontracts (b)(4)

FPCI has identified (b)(4) entities to contract with to provide family planning services in its 55 county Service Delivery Area. FPCI has retained some funding to be utilized for funding new subrecipients as needed/identified.

Entity	Title X Funds	Non-Federal Resources		Total
		Program Income	Other	
(b)(4)				

Description of methodology used to allocate funds: FPCI established a county based funding formula. That formula is based on six criteria: 1(b)(4)

(b)(4)

Available funds are allocated to each county based on this formula. Sub-recipients receive the funds allocated for each of the counties in the sub-recipient's service delivery area.

FPCI has set aside $(b)(4) to be used for identifying and contracting with new providers. One target area for new providers is southwestern Iowa.

Construction **$ 0.00**

There are no construction costs.

Other

Audit Fees (b)(4)

These expenses reflect the cost for FPCI's annual Independent audit. This will be a Single Audit.

Legal Fees (b)(4)

The budgeted amount is based on past experience and our best estimate of legal work, which will be needed for 2018-2019. The FPCI attorney reviews contracts, legal agreements and policies. He advises the agency on legal issues with contractors, subrecipient agencies, employment and other issues. FPCI's attorney is a Health Law expert so he also provides legal advice on various issues regarding the provision of health care in Iowa.

Fiscal Management (b)(4)

The Family Planning Council of Iowa contracts with an independent CPA who serves as the Fiscal Officer and is responsible for the fiscal oversight of FPCI and its sub-recipient agencies. Each year the Fiscal Officer performs on-site reviews of selected sub-recipient agencies. This person also provides other types of sub-recipient monitoring, such as performing desk audits and reviewing the annual audit reports received from each agency. In addition, the Fiscal Officer prepares and submits the FFR in PMS and FFR in GrantSolutions, forms 990 and 5500 for the IRS. This position provides another layer of fiscal oversight by reviewing the monthly general ledger activity and preparing the monthly bank

reconciliation. The Fiscal Officer also advises on audit and accounting issues and works with the Finance Committee of our Board of Directors. This is the proportion of the Fiscal Officer's cost that is charged to the Title X family planning project.

Medical Director (b)(4)

FPCI contracts with the (b)(4) for a Medical Director. The Medical Director chairs the FPCI Medical Committee, oversees the development of the FPCI Clinical Policies and serves as a resource for medical questions, issues, etc.

Other Consultants (b)(4)

Other consultants are contracted to provide assistance with special projects as identified. FPCI uses consultants for objective reviews, technical assistance, board trainings and planning sessions.

Rent and Utilities (b)(4)

This covers the proportion of the cost of rent and basic utilities charged to this project. The costs are calculated based on space allocated to the Title X project and staff time allocated to the Title X project.

Insurance (b)(4)

This covers our premiums for: Directors and Officers Liability; Bonding Coverage; and Business Owners insurance. The costs are calculated based on space allocated to the Title X project and staff time allocated to the Title X project.

Telephone (b)(4)

This is the proportion of the costs of basic local service, DSL line, and the fax line charged to the Title X family planning services project and the related long distance calls. It also includes the funds for the use of our conference calling system. FPCI uses conference calling for its Board, Committees, and various Title X Advisory Groups activities. The costs are calculated based on space allocated to the Title X project and staff time allocated to the Title X project.

Postage (b)(4)

This item includes the costs of mailing educational materials as well as the normal office mailing costs for letters, reports, contracts, etc.

Subscriptions, Professional References and Dues (b)(4)

This line item includes subscriptions to a number of professional publications such as Contraceptive Technology Update and Harvard Health Letter. Also included are memberships in professional organizations: the National Family Planning and Reproductive Health Association (this membership covers FPCI and all of its subrecipients for a total of 11memberships); the Family Planning Councils of America; Iowa Public Health Association; the Iowa Rural Health Association; the American Public Health Association; the Association of Reproductive Health Professional and several small local associations. This breaks out to (b)(4) for dues and $(b)(4) for subscriptions. Several of the memberships include subscriptions to professional publications.

Printing (b)(4)

The costs of printing manuals, protocols, etc., are included here. Also included are costs of printing brochures for education and outreach.

Advertising/Recruitment (b)(4)

This line item includes advertising costs for recruiting employees to fill vacant staff positions and other announcements.

Training (b)(4)

General Training: (b)(4)

This contains FPCI staff training and staff development expenses such as registration fees and tuition costs for training events and workshops. This line item includes mileage reimbursement for sub-

recipient staff to attend FPCI Training Advisory Committee meetings and FPCI Medical Committee meetings.

Update/Training (b)(4)

This line item includes training events produced by FPCI such as the annual Family Planning Update, in person training and webinars. Expenses for training events include such items as consultant costs (honorarium and travel), room rental and equipment rental. We anticipate (b)(4) training events to reach (b)(4) participants. The line item includes the annual fee for GoToWebinar and the annual fee for SurveyMonkey which is used for training event evaluations. The line item includes educational materials that are used for reference materials by the FPCI staff and are shared with the sub-recipient agencies, including the approved video training for mandatory reporting.

Community Education

Sub-recipient Special Community Education Projects (b)(4)

FPCI Community Education Project

This line item contains funding for the special community education projects conducted by sub-recipient agencies and approved by the FPCI Board Education Committee as reported in the project narrative. This line item also contains funding for FPCI's community education project on family involvement through parent/child communication which is described in the project narrative.

Subrecipient Staff Training: (b)(4)

This is funding to for pay staff of the FPCI subrecipients to participate in national trainings such as that delivered by the Title X National Clinical Training Center. In 2018-2019, FPCI plans to provide funding for (b)(4) subrecipient staff to participate in Sexual Risk Avoidance training.

Meeting Accommodations (b)(4)

Funds are budgeted to cover the expenses of meetings for the FPCI Advisory Committee, the Board of Directors, and other FPCI Committee meetings as well as meetings of various coalitions and partnerships hosted by the Council.

Equipment Service (b)(4)

This line item includes service contracts for the phone system and printers, leases for copier and postage meter, and repair costs for computers and other office machines. The line item also includes the hosting and maintenance costs for the FPCI website and email services.

Miscellaneous (b)(4)

These funds are used for bank service charges.

Special Initiative Projects (b)(4)

This line item continues funding for a health education project at Iowa's two women's correctional facilities in Iowa.

FPCI Special Projects (b)(4)

These funds allow FPCI to provide (b)(4) f support for special projects such as funding for the (b)(4) with The IA Dept. of Corrections, a project with IA (b)(4) It contains (b)(4) to pay the annual fees for FPCI and its sub-recipients to participate in Iowa's Health Information Exchange Direct Secure Message System.

FPCI Outreach/Marketing (b)(4)

These funds will be used by FPCI for any outreach/marketing activities that occur during the year.

This also covers the cost of exhibiting at various conferences for outreach efforts.

TOTAL EXPENSES (b)(4)

Federal Title X Funds: (b)(4)

Program Income Total:

Medicaid: (b)(4) Patient Fees: (b)(4)

Other 3rd Party Payers: Other:

Other Funds: $ (b)(4)

Agency Subsidies: (b)(4) Local Funds: $ (b)(4)

Donations: Misc: $

The Title X cost participation of $(b)(4) was more than met with the Program Income total above.

FAMILY PLANNING COUNCIL OF IOWA

PERSONNEL COSTS—TITLE X SERVICES
2018-2019

Title and Name	Annual Salary (1)	# Mon. Budget (2)	% of Time (3)	Total Title X Required Cost (4)
Executive Direct	(b)(6)	12		
Admin Assistant		12		
Training Coord.,		12		
Staff Accountant		12		
Outreach Coord.,		12		
Clinical Policy Coor.	(b)(6)	12		
CBSS Coord.	(b)(6)	12		
Subtotal				(b)(4)

Temporary Help Salary & Fringe Pool	(b)(4)

Fringe Benefits-(Itemize without Federally approved rate):

Type	Rate	Total Title X Cost
FICA	(b)(4)	(b)(4)
Vacation Expense		
Group Health Insurance		
Monthly Stipend		
Retirement Plan		
Workers Comp Insurance		
SUTA		
Subtotal--Fringe Benefits		
Total Personnel Costs		

FPCI TRAVEL –
TITLE X BASIC SERVICES: 2018-2019

Location	Title	Purpose	No of Trips	Total Cost
In-State Travel	Ex. Director, Fiscal Officer, Clinical Coordinator Coordinator, Outreach Coordinator, Training Coordinator	Site visits for monitoring of the Subrecipients for Title X Program (b)(4) On-site Technical Assistance for SR ((b)(4) Travel to meetings outside Des Moines (b)(4) (dates to be determined)	(b)(4)	(b)(4)
In-State Travel	Director, Staff	Travel to local meetings, travel to purchase supplies, printing orders or signing of checks and vouchers(dates to be determined)		
Out-of-State Travel	Director, Staff	National Title X Clinical Conference for FPCI Staff, FPCA and NFPRHA meetings For staff and a Board member, and/or workgroup meetings, Regional Meetings & TX required meetings and national training conferences (dates to be determined)		
In-State and Out-of-State	Board Members (18)	Reimbursement for travel to Quarterly Board meetings and various Board committee meetings (Oct 2018, Jan 2019, April 2019, July 2019)		

FAMILY PLANNING COUNCIL OF IOWA

Plan for Oversight of Federal Award

FPCI is experienced at overseeing the use of federal funds both at the grantee and subrecipient level. The FPCI contracts with subrecipients require adherence to the Federal Code of Regulations 2 CFR Part 200, CFR 45 Part 75, and the OMB Uniform Grant Guidance.

FPCI establishes an annual budget which identifies expenses to be charged to the federal funds. FPCI prepares a monthly line item revenue and expenditure to budget report. A Quarterly Revenue/Expenditure Report by budget category of federal funds is presented to the FPCI Board of Directors each quarter.

FPCI subrecipients submit budgets which identify the expenses to be charged to federal funds and program income. FPCI reviews the submitted budgets and if acceptable, approves the budgets. FPCI subrecipients submit monthly revenue and expenditure reports which identify expenditures charged to the federal funds and to program income by budget category. Those reports are reviewed by FPCI fiscal staff. Subrecipients submit Quarterly Operating Budget Analyses which compare actual revenue and expenditures to the approved budget. The Quarterly Analyses are reviewed by FPCI and any questions or concerns are identified and followed up on. FPCI requires that all subrecipients maintain source documentation for all expenditures for a minimum of three years.

FPCI conducts an annual interim fiscal management review which examines expenses charged to the Title X project on each subrecipient. Every three years, a

subrecipient receives an on-site full program review which includes a fiscal component that follows the federal program review tool.

FPCI and subrecipients' financial reports and statements are reviewed to ensure that Title X activities and expenses are separate and distinct from non-Title X activities.

Each year, FPCI receives a Single Audit from an independent auditor. FPCI subrecipients are required to have annual independent audits. If a subrecipient meets the Single Audit requirements, the subrecipient must have a Single Audit. Those audits are submitted to FPCI and reviewed by the FPCI Fiscal Officer who follows up on any identified issues.

The FPCI Fiscal Officer is responsible for the submission of Federal Financial Reports (FFR) to OASH Office of Grants Management and Payment Management System. The FFR information is based on the FPCI General Ledger. The FPCI Executive Director receives notification of the submission. The withdrawal of cash from the Payment Management System (PMS) occurs one day prior to the issuance of checks or payments. A report on each PMS request is downloaded from the PMS system at the time of the request and maintained with the documentation of expenditures paid with the funds.

FAMILY PLANNING COUNCIL OF IOWA

SUBRECIPIENT AGENCIES' BUDGETS

Following are the 2018-2019 Budgets for the Family Planning Council of Iowa's subrecipient agencies.

(b)(4)

(b)(4)

2018-2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
Personnel	(b)(4)			
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

(b)(4)

Personnel

Salaries will support the cost of (b)(4) Nurse Practitioners (b)(4) FTE) to administer exams and prescribe any medication if necessary, (b)(4) registered nurses (b)(4) FTE) to assist patients, two medical assistants (b)(4) FTE), and (b)(4) front desk personnel (b)(4) FTE) to check patients in and verify insurance and/or income. The billing manager (b)(4) FTE) and billing coder (b)(4) FTE) will perform the billing and coding for Title X patients. (b)(4) medical assistant (b)(4) FTE) will perform in-house labs for patients. A Program Coordinator (b)(4) FTE) will provide administrative

oversight of the Title X Project and the Operations Manager ([b)(4)] FTE) will handle reporting obligations.

Fringe Benefits [b)(4)]

Fringe benefits includes the costs associated with benefits provided to the Title X personnel such as FICA, workers compensation, employer paid health claims (self- insured) including dental and vision, and retirement contributions. The table below breaks down fringe benefits by category of expenditure.

Social Security	[b)(4)]	[b)(4)]
Medicare		
Unemployment	[b)(4)] % on the first [b)(4)]	
Worker's Compensation Insurance		
Retirement Contribution 5% match		
Life insurance	[b)(4)]	
Health Insurance	[b)(4)] based off historical)	
Dental Insurance	[b)(4)] (based off historical)	
Total Fringe Benefits	[b)(4)]	$

Supplies

Contraceptives [b)(4)]

This is the cost of the range of contraceptives that we offer for the family planning program including birth control pills, Nuva Ring, Depo shot, Nexplanons, and IUDs.

Pills: [b)(4)] 12-month supply, est. [b)(4)] pts = [b)(4)]
Depo shot/Nuva Ring/patch: [b)(4)] month supply x 4, est. [b)(4)] pts = [b)(4)]
Nexplanon: [b)(4)] 4 avg.cost/device, est [b)(4)] pts - [b)(4)]
IUDs (Mirena, ParaGard): [b)(4)] avg. cost/device, est. [b)(4)] pts - [b)(4)]

Clinic/Lab Supplies [b)(4)]

This includes the costs associated with all the supplies used in each family planning program encounter, excluding contraceptives.

Average cost [b)(4)] encounter, est. [b)(4)] encounters = [b)(4)]

It also includes the costs of any in-house lab tests needed for Title X patients including pregnancy and HIV testing.

(b)(4) average lab test, est. (b)(4) tests = (b)(4)

Office Supplies (b)(4)

This includes pens, paper, labels, ink and toner and other office supplies used in the Title X program.

Other

Lab Fees $(b)(4)

This is the cost of any lab tests needed for Title X patients including STI testing and Cytology sent to an outside lab.

(b)(4) average lab test, est (b)(4) tests = (b)(4)

Malpractice Insurance (b)(4)

Malpractice insurance is budgeted at $(b)(4) based on historical costs.

Physician Contracts (b)(4)

Physician contracts includes contracts we have with physicians to support Title X functions.

Laundry (b)(4)

Laundry includes the costs of laundering patient gowns and provider lab coats.

Rent and Utilities (b)(4)

This covers the cost of rent for the space related to the Title X project. There are no utilities budgeted as the rental agreement covers heat, water, and sewage.

Telephone (b)(4)

Telephone expenses are budgeted based on historical costs.

Building and Contents Insurance (b)(4)

Insurance expense for property is based on historical information.

Housekeeping (b)(4)

Housekeeping is budgeted for the cost of cleaning patient exam rooms, waiting rooms, and for cleaning supplies.

Staff Training (b)(4)

Staff Training includes the costs associated with the training of personnel involved in Title X. Training includes webinars/meetings to discuss workflow processes, the utilization of education material for patients, and proper documentation of encounters.

(b)(4) staff attend a one day conference = (b)(4)

NP Training (b)(4)

NP Training includes CEU expenses for (b)(4) Nurse Practitioners. CHC allows (b)(4) per each provider towards continuing education.

Printing (b)(4)

Printing is budgeted based on historical costs for printing claims, forms, etc.

Equipment Maintenance (b)(4)

This includes the costs of repairing medical and IT equipment as well as contracts for providing routine maintenance.

Miscellaneous (b)(4)

This category includes (b)(4) budgeted for medical waste disposal from Stericycle, (b)(4) for internet service, (b)(4) for garbage removal, and (b)(4) for paper shredding.

TOTAL (b)(4)

(b)(4)

2018-2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
Personnel	(b)(4)			
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

Personnel (b)(4)

Salaries will support the cost of a Clinic Manager (b)(4) FTE) who will provide operational support of the clinic as well as assist with client services and be responsible for Title X grant reporting. (b)(4) Nurse Practitioner (b)(4) FTE) will administer exams, provide client education and prescribe any medication or contraceptives. A Medical Assistant/Registration staff person (b)(4) FTE) will provide counseling and education for clients, income verification and State Family Planning Program enrollment. A Community Educator (b)(4) FTE) will be hired in approximately February

2019 to provide Community Education and Outreach throughout the grant counties of Des Moines, Lee and Henry.

Fringe Benefits (b)(4)

Social Security (b)(4)
Medicare (b)(4)
FUTA (b)(4) on first (b)(4)
SUTA on first

Other covered benefits include Health Insurance (choice of plans), Dental Insurance (choice of plans), and Life Insurance (choice of enrollment). Employees have an option to enroll in the retirement plan when hired and a match begins after one year of service.

Total Fringe Benefits (b)(4)

Travel (b)(4)

In-State Travel

This includes trips to Des Moines for Advisory Council meetings and travel within southeast Iowa for program promotion and outreach in Lee and Henry counties at $ (b)(4) per mile.

(b)(4)
trips to FPCI Advisory meetings – (b)(4) miles = (b)(4)
trips to Keokuk – (b)(4) miles = (b)(4)
trips to Fort Madison – (b)(4) miles = (b)(4)
trips to Mt Pleasant – (b)(4) miles = $

Supplies

Contraceptives (b)(4)

This includes the cost of providing contraceptives to family planning patients including birth control pills, Depo, Nexplanon, IUDs, condoms and some non-prescription methods plus shipping.

Pills (b)(4) cycles x (b)(4)

Depo [redacted] vials x [redacted]
Nexplanon [redacted] x [redacted]
Liletta [redacted] x [redacted]
Kyleena [redacted] x [redacted]
Contraceptive foam [redacted]
Contraceptive film [redacted] [redacted]
Condoms will be supplied by IA Dept. of Public Health and Des Moines Co. Health Dept.

Other Pharmacy [redacted]

This is the cost of other medications associated with family planning visits.

Clinic/Lab Supplies [redacted]

This is the cost of disposable clinic supplies and in-house lab testing supplies.

[redacted] Pregnancy tests x [redacted]
[redacted] HIV tests 25/box x [redacted]
Controls [redacted] x [redacted] = [redacted]
Urine multistick 10/ 100 tube [redacted]
Disposable supplies = approximately [redacted]

Office Supplies [redacted]

This includes the cost of office supplies to maintain patient and insurance records.

Other

Lab Fees [redacted]

This is the cost of lab tests needed for Title X patients including Cytology sent to an outside lab.

Pap smear [redacted] patients x [redacted]
HPV tests [redacted] patients x [redacted] = [redacted]

Malpractice Insurance [redacted]

This is the cost of malpractice insurance to cover [redacted] Nurse Practitioner, the cost allocated to [redacted] provider in the GRHS network

Software Expense [redacted]

This is the cost of Cerner licensing for [redacted] provider, [redacted] /month.

Laundry [redacted]

This includes the cost of laundering clinic gowns for Title X patients.

Rent (b)(4)

This is the cost of rent for the Title X clinic located on Roosevelt Avenue at $(b)(4) per month.

12 x (b)(4)

Utilities (b)(4)

This is the cost of utilities including electricity and heat for the Roosevelt Avenue family planning clinic.

Telephone (b)(4)

This includes the cost of telephone and internet service for the Roosevelt Avenue family planning clinic.

Data (b)(4) month x 12 = (b)(4)
Fax line (b)(4) per month x 12 = (b)(4)
Long distance – (b)(4) minutes/month x (b)(4) per month = (b)(4)

Housekeeping (b)(4)

This includes the costs for trash, biohazard disposal ad, and pest control for the Roosevelt Avenue family planning clinic.

NP Training (b)(4)

This is the employee allocation for the Family Planning Nurse Practitioner for CEUs, conference registration, etc.

Education Materials (b)(4)

This is the cost of patient education pamphlets and brochures.

Support Services (b)(4)

This includes the costs of (b)(4) VoIP phones, workers comp, postage, clinic oversite.

Marketing (b)(4)

The is the cost of website domain and social media marketing.

Sterilizing

The is the cost of sterilizing supplies for family planning patients.

TOTAL

(b)(4)

(b)(4)

2018-2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
Personnel	(b)(4)			
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

Personnel (b)(4)

Salaries will support the cost of (b)(4) nurses (b)(4) FTE) to provide the counseling, education and care of the Title X patients, (b)(4) Nurse Practitioners (b)(4) FTE) to administer exams and prescribe any medication if necessary. A clinic manager (b)(4) FTE) will provide administrative oversight of the Title X Project, (b)(4) Funding Coordinator, to provide client orientation in regards to their health insurance and other funding related tasks, (b)(4) FTE) (b)(4) Patient Services Assistant (b)(4) FTE) to check clients in and out, to pick up the phone and other administrative duties directed to patient care and one (b)(4) FTE) bookkeeper to process billing.

Fringe Benefits

(b)(4)

Fringe benefits includes the costs associated with benefits provided to the Title X personnel such as FICA, workers compensation, employer paid health insurance (including dental and vision), and retirement contributions. We use actual benefit regarding health and dental expenses.

Social Security	(b)(4)	(b)(4)
Medicare	(b)(4)	
Work Comp/unempl		
Pension		
Health insurance		
Dental insurance		
Total Fringe Benefits	(b)(4)	

Travel

In-State Travel

(b)(4)

Travel includes costs associated with attending quarterly Advisory Committee meetings in Des Moines, Medical Committee Meetings in Iowa City, Training Committee in Des Moines and conducting outreach events.

Out-of-State Travel

(b)(4)

Out-of-state travel will include costs associated with NFPRHA (National Family Planning and Reproductive Health Association) meetings for the clinic manager, to improve quality of services provided to Title X clients.

Supplies

Contraceptives

(b)(4)

The cost of the range of contraceptives that we offer for the family planning program including birth control pills, Nuva Ring, Depo shot, Nexplanon, and IUDs. These numbers do not include oral contraceptives clients with third-party payer drug coverage who choose to receive oral contraceptives at an outside pharmacy.

Estimated Cost for Pills in a 12 mon Period: (b)(4) X 12 mon X (b)(4) clients (b)(4)
Estimated Cost for IUS/IUD in a 12 mon Period: (b)(4) X (b)(4) clients
Estimated Cost for Nexplanon in a 12 mon Period (b)(4) clients
Estimated Cost for Nuvaring in a 12 mon Period: (b)(4) 3 mo x 4 x (b)(4) clients
Estimated Cost for Depo Provera in a 12 Mon Period: (b)(4) x 4 x (b)(4) clients

Clinic/Lab Supplies (b)(4)

The costs associated with all the supplies used in each family planning program encounter, excluding contraceptives. That includes but it is not limited to: Alcohol Pads, PVP pads, gauze, gloves, syringes, needles, pregnancy tests and others.

The costs of any in-house lab tests needed for Title X patients including pregnancy and Wet Mount.

Misc. expenses (pads, gloves, syringes, needles etc.) (b)(4)
Average cost $(b)(4) /encounter, est (b)(4) encounters
(b)(4) /average preg test, est (b)(4) tests
/average wet mount, est. (b)(4) tests

Office Supplies (b)(4)

Office supplies includes, but is not limited to: paper for printing, pens, pencils, clip boards, stick notes, paper charts, paper tags, printer ink and others.

Other

Lab Fees (b)(4)

The costs of any lab tests needed for Title X patients including STI testing and Cytology sent to an outside lab.

(b)(4) /average lab test, est. (b)(4) tests = (b)(4)

Malpractice Insurance (b)(4)

Malpractice insurance includes insurance to protect Title X Professionals of liability associated with wrongful practices resulting in any type of damage to the patient.

Physician Contracts (b)(4)

Physicians Contract includes all contracts we have with physicians to support Title X functions, including but not limited to admitting privileges in local hospitals for image tests related to Title X and Medical Director Fees.

Laundry (b)(4)

Laundry includes the costs of laundering clinic gowns for Title X patients.

Rent (b)(4)

This covers the costs of rent on the building where Title X services are provided. The building where the clinic is located is used by multiple programs; the cost is allocated based on space allocated for the Title X project.

Utilities (b)(4)

This covers the costs of basic utilities such as power, water, heat, and air conditioning when being used for Title X project.

Telephone (b)(4)

This includes the costs of telephone/internet lines associated with services provided to Title X clients.

Building/Content Ins. (b)(4)

This includes insurance protecting Title X assets such as the building itself and its content.

Housekeeping (b)(4)

This includes the costs associated with cleaning products for spaces utilized by Title X patients.

Staff Training (b)(4)

This includes costs associated with webinars or in person trainings that are related to Title X and will provide knowledge for staff to better perform their jobs.

NP Training (b)(4)

This includes costs associated with webinars or in person trainings that are related to Title X and will provide knowledge for staff to better perform their jobs.

Printing (b)(4)

This includes costs associated with any printing materials for the Title X project, i.e., receipts, reports, brochures, other Title X marketing materials.

Education Materials (b)(4)

This includes all educational materials in regards to the Title X Program to be handed out to clients or displayed in the clinic with the objective to inform and educate our clients.

Computer Supply (b)(4)

This includes (b)(4) which is used by the healthcare providers to insert progress notes in the Electronic Medical Records.

Equipment Maintenance (b)(4)

This includes cost associated with maintenance of clinic equipment that includes, but is not limited to: microscope, auto-clave, sphygmomanometers and others, that are used to provide care to our Title X patients.

Legal (b)(4)

This includes legal fees that might be charged to Title X if the legal service is utilized in relation to Title X clients or clinic staff.

Audit (b)(4)

This includes partial costs for audits that are conducted for the Title X Program.

Miscellaneous (b)(4)

This includes bank card fees, bad debt collection expense, and staff wellness program.

Organization Dues (b)(4)

This includes the Title X program's allocation for Joint Commission fees.

Data Communications (b)(4)

This includes internet service and the cable TV services for the client waiting area.

Software Fees (b)(4)

This includes fees for Electronic Medical Records.

Indirect Charges

General and Admin Fees (b)(4)

This includes expense for our federally approved indirect rate of .(b)(4) (see approval letter attached).

TOTAL (b)(4)

(b)(4)

2018-2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
Personnel	(b)(4)			
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

Personnel (b)(4)

These are the personnel costs for the administration of the Title X project and the provision of Title X services at (b)(4) service sites. There is a total of (b)(4) FTEs in this budget. The FTEs breakout as: Chief Financial Officer (b)(4) FTE); (b)(4) accountants (b)(4) FTE); Director of Health Services (b)(4) FTE); Senior Director of Clinical Services (b)(4) FTE); Medical Director (b)(4) FTE); (b)(4) Patient Services Office Support (b)(4) FTE); (b)(4) Clinicians (b)(4) FTE); (b)(4) Clinic Assistants (b)(4) FTE); (b)(4) Certified Medical Assistants (b)(4) FTE); (b)(4) Registered Nurses (b)(4) FTE); (b)(4) Regional Directors (b)(4) FTE); (b)(4) Center Managers (b)(4) FTE); (b)(4) Assistant Center Managers (b)(4) FTE); (b)(4)

Medical Office Specialists (b)(4) FTE); Director of Education (.(b)(4)); (b)(4) Educators (b)(4) FTE); (b)(4)

Education Manager (b)(4) FTE).

Fringe Benefits (b)(4)

Fringe Benefits (b)(4) of total personnel cost.

FICA: (b)(4)
Health/Dental Insurance: (b)(4)
Life/Disability: (b)(4)
Workers Compensation/Unemployment: (b)(4)
*Employee administration fees and miscellaneous benefits (b)(4)

(b)(4)

**Employee administration fees and benefits includes the costs of administration of employee pension plans, third party administration fees for health, life and dental and administration fees for flexible spending accounts (medical and dependent care benefits). This also includes the cost of providing an Employee Assistance Program.*

Travel (b)(4)

In-State Travel

(b)(4) has gone to a more cost effective means of travel through the use of fleet cars and rental vehicles. Fleet cars will be utilized for education staff when available in lieu of staff vehicles and/or rental cars. (b)(4) utilizes a per mile rate of (b)(4) per mile for costs associated with leasing of the vehicles plus fuel charges. Education staff will utilize their own vehicles for shorter trips and (b)(4) travel policy requires employees to rent a car when the total trip is more than 160 miles roundtrip on the same day.

Fleet car and mileage for attending quarterly Advisory Committee meetings

in Des Moines, travel for clinicians and other health center staff to provide family planning services at satellite clinics, and conducting education and outreach events in the community.

(Fleet Car (b)(4) miles x (b)(4) /mile= (b)(4) Fleet Fuel (b)(4) tanks x (b)(4) mileage for staff cars (b)(4) miles/week x 52 weeks x (b)(4) /mile = $(b)(4) Total = (b)(4))

Supplies

Contraceptives (b)(4)

This is the cost of the range of contraceptives that we offer for the family planning program including birth control pills, Nuva Ring, Depo shot, Nexplanons, and IUDs.

Pills: (b)(4) (average)/month supply x (b)(4) = (b)(4)
Depo shot: $(b)(4) /3-month supply x (b)(4) = (b)(4)
Nuva Ring (b)(4) month supply x (b)(4) = [redacted]
Nexplanon/IUD: (b)(4) avg.cost/device x (b)(4) = (b)(4)

Clinic/Lab Supplies (b)(4)

This is the costs associated with all the supplies used in each family planning program encounter, excluding contraceptives. (b)(4) x (b)(4) encounters = (b)(4)

Office Supplies (b)(4)

This includes pen, paper, labels, ink and toner and other consumable supplies for health centers.

(b)(4) /month x 12 months (b)(4)

Other

Lab Fees (b)(4)

This is the costs of lab tests needed for Title X patients including STI testing and Cytology sent to CDD lab (non-state testing) and those covered by commercial insurance. $(b)(4) Average test x (b)(4) tests.

Malpractice Insurance (b)(4)

This includes the costs of insurance for clinical staff.

Rent (b)(4)

This covers the proportion of the costs of rent charged to the Title X project. These costs are allocated based on space allocated for the Title X project.

Utilities (b)(4)

This covers the proportion of the costs of basic utilities such as water, heat and air conditioning charged to the Title X project. These costs are allocated based on space allocated for the Title X project and staff time charged to the Title X project.

Telephone (b)(4)

This covers the proportion of the costs of telephones (health centers and cell phones) charged to the Title X project. These costs are allocated based on staff time charged to the Title X project.

Building/Content Insurance (b)(4)

This includes property and associated insurance for health centers. These costs are allocated based on space allocated for the Title X project.

Housekeeping (b)(4)

This includes janitorial and cleaning for health centers. These costs are allocated based on space allocated for the Title X project.

NP Training (b)(4)

These expenses include conferences and trainings, including registration fees, travel and hotel.

(b)(4) per clinician x (b)(4) clinicians.

Education Materials (b)(4)

This includes the costs of purchasing program specific pamphlets, brochures and posters that are used for the education of Title X patients and the community about the services that are provided through Title X.

TOTAL (b)(4)

(b)(4)

2018-2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
Personnel	(b)(4)			
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

Personnel (b)(4)

This includes personnel costs for provider staff and support staff: Program Coordinator (b)(4) FTE) Nurse Practitioners (b)(4) FTE (b)(4) Nurse (b)(4) FTE), Interpreter (b)(4) FTE), COS (b)(4) FTE) and HBS (b)(4) FTE): Total (b)(4) FTE

Fringe Benefits (b)(4)

Fringe benefits are (b)(4) % of wages and salaries paid. This is comprised of FICA Tax (b)(4) % (b)(4); Unemployment (b)(4); Life and Disability Ins (b)(4); Retirement

(b)(4) Tuition reimbursement (b)(4) Health Insurance (b)(4); and

Dental Ins (b)(4) ($(b)(4)

Travel (b)(4)

Local staff travel: $(b)(4)

Out of state travel: (b)(4)

Supplies

Contraceptives (b)(4)

This is the projected annual cost of contraceptives for the Title X Program (using 340B Pharmacy pricing) at an average of $(b)(4) per month.

Clinic Supplies (b)(4)

This is the projected annual cost of clinic supplies for the Title X Program at a cost per visit of (b)(4) for (b)(4) visits.

Office Supplies $(b)(4)

This the cost of office supplies for the Title X project: (b)(4) per month

Other

Lab Fees (b)(4)

This is the projected cost of lab tests sent to an outside lab for Title X clients for the year at (b)(4) per month average.

Staff training (b)(4)

(b)(4) staff to attend Washington D.C. training: (b)(4)

Local trainings and educational materials: $(b)(4)

Printing (b)(4)

This includes the costs of brochures and outreach educational flyers for Title X.

Educational Materials and Outreach Supplies (b)(4)

This is the cost to prepare and produce outreach educational supplies in service delivery area.

GE Centricity Software (b)(4)

This includes the EHR costs allocated to Title X program at $(b)(4).00 per month.

Interpreter Fees (b)(4)

This is the cost of outside services and tele-interpretation needs.

Marketing and Public Relations (b)(4)

Development of marketing materials for Title X services in target area.

Admin Costs (b)(4)

Equating to approximately (b)(4)% of total expenses, under the allowable De Minimis cost allowable not to exceed (b)(4)% of total program costs.

TOTAL (b)(4)

(b)(4)

2018-2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
	(b)(4)			
Personnel				
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

Personnel (b)(4)

These are the personnel costs for the Title X project. Family planning services are provided by (b)(4) clinicians ((b)(4) FTE); (b)(4) clinic nurse ((b)(4) FTE); (b)(4) medical assistant/interpreter (b)(4) FTE); (b)(4) medical assistant (b)(4) FTE). The clinic manager ((b)(4) FTE) oversees clinical services. Other staff are: Quality & compliance staff ((b)(4) FTE); Chief Financial Officer (b)(4) FTE); Community Educator ((b)(4) FTE) and Outreach Coordinator ((b)(4) FTE).

Fringe Benefits (b)(4)

FICA Taxes ((b)(4)%) (b)(4)

Health Insurance
Dental Insurance
Life Insurance
Retirement Contribution (3% match)

(b)(4)

Travel

(b)(4)

Travel is needed for the project staff to attend local meetings, conduct project activities, attend community events and meetings, and attend workshops and trainings. The training and local meetings will promote implementation and sustainability for the project. In addition, travel costs include sending (b)(4) individuals to training within the state of Iowa for family planning services. The local travel rate is based on Promise CHC policies and procedures for privately owned vehicle reimbursement of $(b)(4) per mile. Travel was estimated as: (b)(4) miles total for the year at $(b)(4) per miles the cost is $(b)(4) With lodging and meals (per diem rates utilized) estimating $(b)(4)

Supplies

Contraceptives

(b)(4)

This is the costs of purchased contraceptives used for the family planning program. Purchased contraceptives include, but are not limited to, Nexplanon, Depo Provera, IUD, NuvaRing, patch, oral contraceptives, condoms, etc.

Nexplanon: $(b)(4) avg. cost/device, est. (b)(4) patients = $(b)(4)
Dep shot: $(b)(4) avg. cost/device, est. (b)(4) patients = $(b)(4)
IUD: (b)(4) avg. cost/device, est. patients (b)(4) = (b)(4)
NuvaRing: $(b)(4) avg. cost/device, est. patients (b)(4) = $(b)(4)
Patch: (b)(4) avg. cost/device, est. patients (b)(4) = $(b)(4)
Oral Contraceptives: (b)(4)/year, est. patients (b)(4) = (b)(4)

Clinic Supplies

(b)(4)

This is the costs of all supplies used in the clinical provision of care for family planning services.

Office Supplies (b)(4)

This includes the costs to support project staff and on-going consumables for copies, notepads, file folders, postage, and other items needed for general operation and implementation of project activities. This was calculated at approximately $(b)(4) per month for consumables and on-going office needs.

Other

Lab Fees (b)(4)

This includes the costs for the use of outside lab services (Quest Diagnostics and State Hygienic Lab) related to family planning services.

Utilities (b)(4)

This is the costs of utilities, allocated based on square footage of the facility and family planning services project FTEs compared to total family practice FTEs.

Telephone (b)(4)

This is includes the costs of local and long distance service, allocated based on square footage of the facility and family planning services project FTEs compared to total family practice FTEs.

Building/Content Insurance (b)(4)

This is the costs of building and content insurance, allocated based on square footage of the facility and family planning services project FTEs compared to total family practice FTEs.

Housekeeping (b)(4)

Costs of janitorial and cleaning services, allocated based on square footage of the facility and family planning services project FTEs compared to total family practice FTEs.

Training (b)(4)

(b)(4) is allocated to support training and technical assistance on topics such as fundamentals of HIV, hepatitis and STD prevention and counseling, human trafficking, counseling minors on how to resist being coerced into engaging in sexual activity and involving family members in the minor's decision to seek family planning services and other training topics as identified. Training monies also include the annual family planning conference.

Staff Training
NP Training (b)(4)

Printing (b)(4)

This is the costs associated with project staff printing needs for general operation and implementation of project activities. This was calculated at approximately (b)(4) per month for printing related to family planning services.

Education Materials (b)(4)

This is the costs for educational materials to support network activities allocated at (b)(4). This includes items such as informational brochures and pamphlets, books and teaching DVDs for patient education, and other materials to support outreach and education.

Accounting (b)(4)

This is the costs for accounting expenditures to support grant oversight by management, including third-party billing services received from Success EHS and software/licensure to support electronic health recordkeeping system.

Audit (b)(4)

This includes the fee for completion of the annual audit as required by family planning services grant and federal requirements.

Subscriptions & Dues (b)(4)

This includes the costs for provider licensure and certifications in providing family planning services and other periodicals/publications.

Outreach (b)(4)

Outreach expenditures include costs related to assisting patients with navigating the health care system, securing resources and assistance that increases access to information, and coordinating care with other community based agencies.

Information Technology (b)(4)

This includes costs associated with services for server and ongoing maintenance along with electronic health record database. Access to up-to-date technology is essential for data collection, communication with community service providers, contracting agencies, and families, as well as, to support the project objectives and activities to explore and expand the use of emerging technology to promote project activities.

Occupancy Cost (b)(4)

Occupancy cost for the family planning program is allocated based on square footage of the facility and family planning services project FTEs compared to total family practice FTEs.

TOTAL (b)(4)

(b)(4)

2018-2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
Personnel	(b)(4)			
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

Personnel

(b)(4)

Salaries will support the cost of (b)(4) Reproductive Health Assistants (b)(4) FTEs), to provide the counseling and education of the Title X patients, (b)(4) Nurse Practitioners (b)(4) FTE), to administer exams and prescribe any medication if necessary, along with their nurses (b)(4) FTE). (b)(4) Program Coordinator (b)(4) FTE) will provide administrative oversight of the Title X Project and the Accounting Supervisor (b)(4) FTE) will be handling any fiscal obligations. The rest of the clinic staff will have minimal time with Title X (b)(4) FTE), that time includes the checking in of patients, financial counseling, and the billing out of charges.

Fringe Benefits

(b)(4)

Fringe benefits includes the costs associated with benefits provided to the Title X personnel such as FICA, Employer paid insurance (including dental and vision), and Retirement contributions (401K). We use a standard rate of 25% of the annual salary.

Social Security (b)(4)%
Medicare (b)(4)%
Retirement Contributions (5%match)
Health Insurance

(b)(4)

Travel

(b)(4)

Travel includes costs associated with attending quarterly Advisory Committee meetings in Des Moines and conducting (b)(4) outreach events. Also, any conferences that are attended out-of-state including hotel and airfare.

Supplies

Contraceptives

(b)(4)

This is the cost of the range of contraceptives that we offer for the family planning program including birth control pills, Nuvaring, Depo shot, Nexplanons, and IUDs.

Pills: $(b)(4) 12-month supply, est. (b)(4) pts = $(b)(4)
Depo shot/Nuva Ring: (b)(4) 3-month supply, est. (b)(4) pts = $(b)(4)
Nexplanon: $(b)(4) avg.cost/device, est. (b)(4) pts - $(b)(4)
IUD (Mirena): $(b)(4) avg. cost/device, est. (b)(4) pts - (b)(4)
IUD (ParaGard): $(b)(4) avg. cost/device, est. (b)(4) pts -

Other Pharmacy

(b)(4)

This is the cost of any other medications needed to service Title X patient needs, excluding contraceptives.

Average cost $(b)(4) /encounter, est (b)(4) pts

Clinic/Lab Supplies (b)(4)

The costs associated with all the supplies used in each family planning program encounter, excluding contraceptives.

Average cost $(b)(4) /encounter, est. (b)(4) encounters

Other

Lab Fees (b)(4)

This is the costs of any lab tests needed for Title X patients including STI testing and Cytology sent to an outside lab.

$(b)(4) average lab test, est. (b)(4) tests

Staff Training (b)(4)

Staff Training includes the costs associated with the training of personnel involved in Title X. Training includes webinars/meetings to discuss workflow processes, the utilization of education material for patients, and proper documentation of encounters.

NP Training (b)(4)

NP Training includes expenses for a Nurse Practitioner to attend the Women's Health Symposium in Kansas City, Missouri, such as conference fees and any other annual meetings.

Printing (b)(4)

Printing includes the costs to have Title X information printed in the form of brochures and handouts to distribute to patients and the community.

(b)(4) brochures/handouts x $(b)(4)

Education Materials (b)(4)

This includes the costs of purchasing program specific pamphlets, brochures and posters that are used for the education of Title X patients and the community about the services that are provided through Title X.

TOTAL (b)(4)

(b)(4)

2018-2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
Personnel	(b)(4)			
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

Personnel $(b)(4)

These are the personnel costs for the administration of the Title X project and the provision of Title X services. There is a total of (b)(4) FTEs in this budget. The FTEs breakout as: Director (b)(4) FTE); Fiscal Manager (b)(4) FTE); Program Manager (b)(4) FTE); Nurse Practitioner (b)(4) FTE); (b)(4) Registered Nurses (b)(4) FTE); Billing Specialist (b)(4) FTE) (b)(4) Patient Service Reps/Interpreters (b)(4) FTE).

Fringe Benefits $(b)(4)

Fringe benefits includes FICA, Medicare, state unemployment (at standard rates) – for the employees within a given department, and with an allocation of our health insurance

costs. UnityPoint Health is self-insured. Each region has a specific cost allocated back from our parent system. That amount is allocated to departments, based on the number of FTEs. It is not expensed to the individual departments as a direct expense, but rather as an allocation.

Travel

In-State Travel $[redacted]

UnityPoint reimburses employees at $0.[redacted]/mile. UnityPoint reviews travel required and utilizes a rental car if the mileage reimbursement for the trip would exceed a daily rental cost of [redacted] to $[redacted] per day dependent on vehicle size needed. This would equate to any travel over 75 miles round trip or 150 miles per day.

Rental vehicle at estimated $[redacted] per trip x minimum of [redacted] Advisory meetings = $[redacted] + gas charges of approximately $4[redacted] x 4 = $[redacted] is a total of approximately $[redacted]
NP attends [redacted] Medical Committee Meetings in person per year in Iowa City, IA [redacted] miles round trip x [redacted] x [redacted] [redacted]
Additional outreach activities supporting Title X such as health fairs and community events from Program Manager, Director, NP, RNs at $[redacted]/mile x [redacted] = $[redacted]

Supplies

Contraceptives $[redacted]

This includes specified offered options for Title X patients such as birth control pills, implants, IUDs, Nuvarings, Depo injection, patches, condoms

Pills [redacted] mo supply, est [redacted] patients = $[redacted]
Depo [redacted] per, est [redacted] patients = [redacted]
IUD $[redacted] per, est [redacted] patients = [redacted]
Patch [redacted] per pack, est [redacted] patients = $[redacted]
Ring [redacted] per, est [redacted] = $[redacted]
Implant $[redacted] per, est [redacted] patients = $[redacted]
Plan B [redacted] per pack, est [redacted] patients = $[redacted]
Condoms $[redacted] per pack, est [redacted] patients = $[redacted]
Non latex condoms [redacted] per pack, est [redacted] patients = $[redacted]

Clinic/Lab Supplies $(b)(4)

This includes supplies required to provide the services for Title X patients (not including contraceptives),i.e., glass slides for microscope, table paper, pillow cases, lubricants, scalpels, needles, marker pens, bags, gauze, specimen cups, thermometers, gloves, bandages, iodine, lubrication, drapes for patient covers, saniwipes, etc.

Average cost of such supplies $(b)(4) x (b)(4) patients = $(b)(4)
Title X pregnancy Testing each (b)(6) x (b)(4) tests = $(b)(4)

Office Supplies $(b)(4)

This includes any supplies needed to support Title X patients and program, i.e., paper, tissues, lamination supplies, notebooks, writing utensils, supplies to create and maintain patient charts, postage specific to Title X, etc.

Other

Lab Fees $(b)(4)

This includes external lab fees associated with processing Title X patient results including STI & PAP related testing.

Estimated (b)(4) patients at avg appox fees of $(b)(4) = $ (b)(4)

Malpractice Insurance $(b)(4)

This is the cost of insurance for clinical staff.

Rent $(b)(4)

This is the amount charged for rent and utilities specific to Title X project areas utilized for Title X services and Title X staff.

NP Training $(b)(4)

This includes the costs associated with training provided to the Nurse Practitioner to attend Women's Health Symposium in Kansas City, Mo including conference fees, travel, hotel.

Telephone $(b)(4)

This includes any fees charged from the contracted telephone company for monthly fees, phone replacement, service calls, or troubleshooting by the vendor contracted with Unitypoint related to Title X clinic or providers for Title X.

Printing & Educational Materials $(b)(4)

This is the costs associated with printing materials used for Title X including brochures and handouts for patients and community.

Equipment Maintenance $(b)(4)

This includes any fees set forth by Unitypoint contracts for assistance from facilities to maintain equipment related to Title X patients

Miscellaneous $(b)(4)

This includes other fees that are related to grant activities, small items/small equipment replacement and maintenance (i.e., shelving, Joint Commission requirements), other facility costs, water for patients in need, etc.

TOTAL $(b)(4)

(b)(4)

2018-2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
Personnel		(b)(4)		
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

Personnel $(b)(4)

Salaries will support the cost of (b)(4) ARNP (b)(4) FTE) to administer exams and prescribe any medications if necessary, (b)(4) nurses/program coordinators (b)(4) at (b)(4) FTE and (b)(4) at (b)(4) FTE) to provide administrative oversight of the Title X Project and assist the ARNP, (b)(4) interpreter to help translate for clients when necessary (b)(4) FTE), (b)(4) accounting supervisor (b)(4) FTE) and (b)(4) biller to bill services to 3rd party payers, Medicaid, private fees, etc (b)(4) FTE).

Fringe Benefits $(b)(4)

Fringe benefits includes the costs associated with benefits provided to the Title X personnel such as FICA, IPERS (retirement contributions), workers compensation and employer paid health insurance. We use a standard rate of [redacted]% of the annual salary.

Social Security [redacted]% $[redacted]
Medicare [redacted]% $[redacted]
Retirement Contribution – IPERS [redacted]% $[redacted]
Health Insurance $[redacted]

Travel $[redacted]

In-State travel includes costs associated with attending quarterly Advisory Committee meetings in Des Moines, costs associated with providing family planning services at satellite clinics, and conducting outreach events.

[redacted]

Supplies

Contraceptives $[redacted]

This is the cost of the range of contraceptives offered by the family planning program including birth control pills, Nexplanons, IUDs and Depo Shots.

Pills: [redacted] avg cost/12mth supply est. [redacted] patients = $[redacted]
Depo Shot: $[redacted] avg cost/3 mth supply, est [redacted] patients = $[redacted]
Nexplanon: $[redacted] avg cost/device, est [redacted] patients = $[redacted]
IUDs: $[redacted] avg cost/devise, est [redacted] patients = $[redacted]

Clinic/Lab Supplies $[redacted]

This includes the costs associated with all the supplies used in each family planning program user, excluding contraceptives.

Average cost is $(b)(6) per user, est (b)(4) users= $(b)(6)

Office Supplies: $(b)(6)

This includes the costs of all supplies not used for clinical services.

Other

Lab Fees $(b)(4)

This is the costs of any lab tests needed for the Title X patients including STI testing and Cytology sent to an outside lab.

Approx. (b)(4) tests x $(b)(4) /test = $(b)(4)

Malpractice Insurance $(b)(4)

This is the cost of our malpractice insurance for Family Planning.

Rent $(b)(4)

This includes rent costs for the main clinic in Fort Dodge. $(b)(4) x 12mths = $(b)(4)

This also includes rent costs for satellite clinics. (b)(4) satellites clinics x (b)(4) x 12mths= $(b)(4)

Utilities $(b)(4)

It costs $(b)(4) for MidAmerican Energy and Walters Sanitary monthly. $(b)(4) x 12mths= $(b)(4)

Telephone $(b)(4)

This is the telephone costs for the clinic. Approx. $(b) x 12mths = $(b)(4)

Staff Training $(b)(4)

Staff training includes the costs associated with the training of personnel involved in Title X. Training includes webinars/meetings to discuss workflow processes, the utilization of education material for patients and proper documentation of encounters.

(b)(4) staff to attend one training @ $(b)(4) /staff person= $(b)(4)

NP Training $(b)(4)

NP training includes expenses for ARNP to attend (b)(4) conference annually.

Printing $(b)(4)

Printing includes the costs to have Title X information printed in the form of brochures and handouts to distribute to patients and the community.

(b)(4) brochures/handouts x $(b)(4) each= $(b)(4)

Education Materials $(b)(4)

This includes the costs of purchasing program specific pamphlets, brochures and posters that are used for the education of Title X patients and the community about the services that are provided through Title X.

Accounting $(b)(4)

This is the cost of accounting and claims processing services for the Family Planning Program provided by the County Auditor's office.

Audit $(b)(4)

This is the cost of our annual audit for Family Planning.

Total $(b)(4)

(b)(4)

2018- 2019 TITLE X FAMILY PLANNING BUDGET

Object Class	Federal Funds	Non-federal Resources: Program Income	Non-federal Resources: Agency Contrib	Total Budget
Personnel	(b)(4)			
Fringe Benefits				
Travel				
Equipment				
Supplies				
Contractual				
Construction				
Other				
Total Direct Charges				
Indirect Charges				
Totals				

Anticipated Unduplicated Users	Title X Cost Per User	Total Cost Per User	Title X Cost %
(b)(4)			

NARRATIVE

Personnel $(b)(4)

Salaries will support the cost of (b)(4) Nurse Practitioners (b)(4) FTE) to administer exams and prescribe any medication if necessary for the Title X patients as well as (b)(4) RN (b)(4) FTE) and (b)(4) Certified Medical Assistant (b)(4) FTE) to support the NP staff by rooming patients, collecting patient histories, taking vitals, obtaining and processing labs, and providing counseling and education. The CEO (b)(4) FTE) will provide administrative, operational, outreach, and fiscal oversight of the Title X Project and the Accountant (b)(4) FTE) will be handling all fiscal obligations. An Office Administrator (b)(4) FTE) will provide daily clinic administrative functions

in support of the Title X Project. A Health Educator ([redacted] FTE) will perform community outreach and education for the Title X Project.

Fringe Benefits $[redacted]

Fringe benefits includes the costs associated with benefits provided to the Title X personnel such as FICA, state unemployment insurance, workers compensation, retirement contributions, and employer paid insurance (life, health, and dental). The list below shows each item.

Fringe Benefit Category:	**Amount**
Social Security ([redacted]%)	[redacted]
Medicare ([redacted]%)	
IA Unemployment ([redacted]%)	
Fed Unemployment	
Workers Compensation Ins	
Life Insurance	
Health Insurance	
Dental Insurance	
Total Fringe Benefits	

Travel

In-State Travel $[redacted]

Travel includes costs associated with attending quarterly Advisory Committee meetings in Des Moines and other Title X meetings, costs associated with providing family planning services at satellite clinics, and conducting outreach events.

Advisory Meetings: Des Moines [redacted] staff, [redacted] x $[redacted] + $[redacted] parking [redacted] /year = [redacted]
Medical Committee Meetings: IA City [redacted] staff, [redacted] x $[redacted] [redacted] /year = $[redacted]
Training Advisory Committee Meetings: Des Moines [redacted] x/year [redacted] staff, [redacted] mi x [redacted] + [redacted] parking = $[redacted]

Satellite Clinic costs: Maquoketa travel for [redacted] staff multiple times/month, mileage varies
Outreach (county fairs, women's health fair, community college events, schools)
Collaborative & outreach meetings (Board of Health, domestic violence, CPPC, ASAC, Council of Agencies, United Way, etc.) [redacted] staff, mileage varies, trips throughout each month

Out-of-State Travel $[redacted]

Travel includes costs associated with attending national and regional Title X trainings /conferences for staff. Anticipated (b)(4) staff traveling to NFPRHA conference for training March 2019 in Washington, DC: hotel $(b)(4), meals $(b)(4) transportation $(b)(4), misc $(b)(4)
Planned (b)(4) staff attends (b)(4) regional NFPRHA trainings dates and locations TBD costs each trip: hotel $(b)(4), meals $(b)(4) transportation $(b)(4), misc $(b)(4)

Supplies

Contraceptives (b)(4)

This is the cost of the range of contraceptives we offer for the family planning program including birth control pills, Nuva Ring, Depo shot, Nexplanon, and IUDs. These numbers do not include oral contraceptives clients with third-party payer drug coverage who choose to receive oral contraceptives at an outside pharmacy.

Pills: (b)(4) /year (b)(4) pts = $(b)(4)
Depo Shot: $ (b)(4) per 3 month supply, est. (b)(4) pts = $(b)(4) annual
Nuva Ring: $(b)(4) per year (b)(4)
Nexplanon: $(b)(4) ost/device, est. (b)(4) pts = (b)(4) annual
IUDs: ParaGard $(b)(4) average cost/device, est. (b)(4) pts = $(b)(4); Liletta $(b)(4) average cost/device, est. (b)(4) pts = $(b)(4)

Other Pharmacy (b)(4)

This includes the cost of non-contraceptive drugs used for Title X patients.

Clinic/Lab Supplies (b)(4)

This is the costs associated with all the supplies used in each family planning program encounter, excluding contraceptives and any in-house lab tests needed for Title X patients including pregnancy and HIV testing.

Average cost $(b)(4) /encounter, est. (b)(4) encounters = $(b)(4)

Office Supplies (b)(4)

This is the cost of general office supplies to support the Title X Project.

Other

Lab Fees (b)(4)

This is the cost of any lab tests needed for Title X patients including STI testing and Cytology sent to an outside lab.

Malpractice Insurance (b)(4)

This includes the proportion of costs of professional liability/malpractice insurance for providing services to Title X patients.

Rent (b)(4)

This covers the proportion of the costs of rent for our main clinic and satellite clinic operations.

Utilities (b)(4)

This covers the proportion of the Title X costs for our main clinic and satellite clinic operations for utilities and data processing.

Telephone (b)(4)

This includes costs associated with operating phones at the main clinic and satellite clinic.

Building/Content Insurance (b)(4)

This covers the proportion of Title X costs to provide insurance on building and contents for clinic sites.

Housekeeping (b)(4)

Housekeeping includes the costs for contracted housekeeping services and related cleaning supplies.

Staff Training (b)(4)

Staff training includes the costs associated with the training of personnel involved in Title X. Training includes webinars/meetings to discuss workflow processes, the utilization of education

material for patients, and proper documentation of encounters. It also includes the costs for the health educator to attend trainings on reproductive health, teen outreach, and various adolescent health topics.

NP Training (b)(4)

NP training includes the costs associated with the training of NP staff involved in Title X. Training includes webinars/meetings to discuss clinical protocols, workflows and processes, the utilization of education material for patients, and proper documentation of encounters.

Equipment Maintenance (b)(4)

This covers the proportion of the costs for upkeep of facility equipment charged to the Title X Project.

Accounting (b)(4)

This includes costs for an outside accounting firm to assist with financial statements and annual tax filings and support financial needs of the Title X Project.

Audit (b)(4)

This is the costs associated with annually auditing the Title X Project.

Miscellaneous (b)(4)

Support Services/Claims (b)(4)

This includes the proportion of costs for an outside agency to manage claims billing, processing, and collecting receivables for the Title X Project.

Postage (b)(4)

This includes the postage costs of mailing annual reminder cards, State Family Planning Notice of Decision letters, and other communications to patients and vendors related to the Title X Project.

Bank fees (b)(4)

This includes costs for bank accounts and credit card processing for the Title X Project.

Outreach (b)(4)

Outreach includes any marketing, such as newspaper and media ads for the Family Planning Title X Project, other marketing expenses, and attendance at health fairs that have a participation fee.

Subscriptions/dues (b)(4)

This includes costs for marketing annually with local chambers, newspaper dues, and subscriptions to vendors for processing and ordering for Title X Project.

TOTAL (b)(4)

FAMILY PLANNING COUNCIL OF IOWA

TITLE X –FAMILY PLANNING SERVICES

2019-2020 BUDGET NARRATIVE

Summary:

In the 2019-2020 budget period, The Family Planning Council of Iowa (FPCI) proposes to implement a Title X project which provides family planning services to (b)(4) individuals at a total cost of $(b)(4) per client and a Title X cost of $(b)(4) per client. The proposed budget covers the costs of implementing the project over a (b)(4) county area subcontracting with (b)(4) subrecipient entities. The budget covers the FPCI administrative costs, training costs, monitoring, oversight, program promotion, and contracts with subrecipients for services. FPCI does not anticipate any significant changes in its Title X project and therefore does not anticipate categories that vary significantly from the previous budget year.

BUDGET

RESOURCES			
Federal Title X Funds:	**$2,884,560**		
Non-Federal Resources:	(b)(4)		(b)(4)
Program Income:			
Medicaid		Patient Fees	
Other 3rd Party Payers		Other	
Other Funds:			
Agency Subsidies		Local Funds	
Donations		Misc	
TOTAL NON-FEDERAL			
TOTAL RESOURCES			

EXPENSES:

Line Items	TX	Non Federal Resources	Total
Personnel:			
Salaries	(b)(4)	$0	(b)(4)
Temp		$0	
Sal/Fringe Pool		$0	
Fringes		$0	
Subtotal		**$0**	
Travel:			
In-State		$0	
Out-of-State		$0	
Board		$0	
Subtotal		**$0**	
Equipment:			
Misc Equipment	$0	$0	$0
Subtotal	**$0**	**$0**	**$0**
Supplies:	(b)(4)		(b)(4)
Office Supplies		$0	
Subtotal		**$0**	
Contractual:			
Sub-Recipients		(b)(4)	
Subtotal			
Construction:			
Construction	$0	**$0**	$0
Subtotal	**$0**	**$0**	**$0**
Other:			
Audit	(b)(4)	$0	(b)(4)

Line Items	TX	Non Federal Resources	Total
Attorney	(b)(4)	$0	(b)(4)
Fiscal Mgt		$0	
Medical Director		$0	
Consultants		$0	
Rent (inc util)		$0	
Insurance		$0	
Telephone		$0	
Postage		$0	
Prof References		$0	
Dues		$0	
Printing		$0	
Advertis/Recruit		$0	
General Training-FPCI		$0	
Update/Trainings		$0	
Sub-Recip Comm Educ		$0	
FPCI Comm Educ		$0	
Sub-Recip Staff Training		$0	
Meeting Accom		$0	
Equip Service		$0	
Misc		$0	
Special Init Projects		$0	
FPCI Special Projects		$0	
FPCI Outreach/Mktg		$0	
Subtotal		**$0**	
Grand Total	**$**	(b)(4)	

FAMILY PLANNING COUNCIL OF IOWA

TITLE X –FAMILY PLANNING SERVICES

2020-2021 BUDGET NARRATIVE

Summary:

In the 2020-2021 budget period, The Family Planning Council of Iowa (FPCI) proposes to implement a Title X project which provides family planning services to (b)(4) individuals at a total cost of $(b)(4) per client and a Title X cost of $(b)(4) per client. The proposed budget covers the costs of implementing the project over a (b)(4) county area subcontracting with (b)(4) subrecipient entities. The budget covers the FPCI administrative costs, training costs, monitoring, oversight, program promotion, and contracts with subrecipients for services. FPCI does not anticipate any significant changes in its Title X project and therefore does not anticipate categories that vary significantly from the previous budget year.

BUDGET

RESOURCES:			
Federal Title X Funds:	(b)(4)		
Non-Federal Resources			
Program Income:	(b)(4)		
Medicaid		Patient Fees	(b)(4)
Other 3rd Party Pay		Other	
Other Funds:			
Agency Subsidies		Local Funds	
Donations		Misc	
TOTAL NON-FEDERAL			
TOTAL RESOURCES			

EXPENSES:

Line Items	TX	Non Federal Resources	Total
Personnel:			
Salaries	(b)(4)	$0	(b)(4)
Temp		$0	
Sal/Fringe Pool		$0	
Fringes		$0	
Subtotal		**$0**	
Travel:			
In-State		$0	
Out-of-State		$0	
Board		$0	
Subtotal		**$0**	
Equipment:			
Misc Equipment	$0	$0	$0
Subtotal	**$0**	**$0**	**$0**
Supplies:			
Office Supplies	(b)(4)	$0	(b)(4)
Subtotal		**$0**	
Contractual:			
Sub-Recipients		(b)(4)	(b)(4)
Subtotal			
Construction:			
Construction	$0	**$0**	$0
Subtotal	**$0**	**$0**	**$0**
Other:			
Audit	(b)(4)	$0	(b)(4)

Line Items	TX	Non Federal Resources	Total
	(b)(4)		(b)(4)
Attorney		$0	
Fiscal Mgt		$0	
Medical Director		$0	
Consultants		$0	
Rent (inc util)		$0	
Insurance		$0	
Telephone		$0	
Postage		$0	
Prof References		$0	
Dues		$0	
Printing		$0	
Advertis/Recruit		$0	
General Training-FPCI		$0	
Update/Trainings		$0	
Sub-Recip Comm Educ		$0	
FPCI Comm Educ		$0	
Sub-Recip Staff Training		$0	
Meeting Accom		$0	
Equip Service		$0	
Misc		$0	
Special Init Projects		$0	
FPCI Special Projects		$0	
FPCI Outreach/Mktg		$0	
Subtotal		**$0**	
Grand Total	$	$(b)(4)	$

FAMILY PLANNING COUNCIL OF IOWA

TITLE X –FAMILY PLANNING SERVICES

2021-2022 BUDGET NARRATIVE

Summary:

In the 2021-2022 budget period, The Family Planning Council of Iowa (FPCI) proposes to implement a Title X project which provides family planning services to (b)(4) individuals at a total cost of $(b)(4) per client and a Title X cost of $(b)(4) per client. The proposed budget covers the costs of implementing the project over a (b)(4) county area subcontracting with (b)(4) subrecipient entities. The budget covers the FPCI administrative costs, training costs, monitoring, oversight, program promotion, and contracts with subrecipients for services. FPCI does not anticipate any significant changes in its Title X project and therefore does not anticipate categories that vary significantly from the previous budget year.

BUDGET

RESOURCES:			
Federal Title X Funds:	(b)(4)		
Non-Federal Resources:			
Program Income:	(b)(4)		(b)(4)
Medicaid		Patient Fees	
Other 3rd Party Payers		Other	
Other Funds:			
Agency Subsidies		Local Funds	
Donations		Misc	
TOTAL NON-FEDERAL			
TOTAL RESOURCES			

EXPENSES:

Line Items	TX	Non Federal Resources	Total
Personnel:	(b)(4)		(b)(4)
Salaries		$0	
Temp		$0	
Sal/Fringe Pool		$0	
Fringes		$0	
Subtotal		**$0**	
Travel:			
In-State		$0	
Out-of-State		$0	
Board		$0	
Subtotal		**$0**	
Equipment:			
Misc Equipment	$0	$0	$0
Subtotal	**$0**	**$0**	**$0**
Supplies:			
Office Supplies	(b)(4)	$0	(b)(4)
Subtotal		**$0**	
Contractual:			
Sub-Recipients		(b)(4)	(b)(4)
Subtotal			
Construction:			
Construction	$0	**$0**	$0
Subtotal	**$0**	**$0**	**$0**
Other:			
Audit	(b)(4)	$0	(b)(4)

Line Items	TX	Non Federal Resources	Total
	(b)(4)		(b)(4)
Attorney		$0	
Fiscal Mgt		$0	
Medical Director		$0	
Consultants		$0	
Rent (inc util)		$0	
Insurance		$0	
Telephone		$0	
Postage		$0	
Prof References		$0	
Dues		$0	
Printing		$0	
Advertis/Recruit		$0	
General Training-FPCI		$0	
Update/Trainings		$0	
Sub-Recip Comm Educ		$0	
FPCI Comm Educ		$0	
Sub-Recip Staff Training		$0	
Meeting Accom		$0	
Equip Service		$0	
Misc		$0	
Special Init Projects		$0	
FPCI Special Projects		$0	
FPCI Outreach/Mktg		$0	
		----------	---
Subtotal		**$0**	
Grand Total		$ (b)(4)	

Upload #5

Applicant:	Family Planning Council of Iowa
Application Number:	FPH2018008738
Project Title:	Title X Family Planning Services
Status:	Awarded
Document Title:	Form AttachmentForm_1_2-V1.2.pdf

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	1237-APPEND1CSS.pdf		Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment		
3) Please attach Attachment 3		Add Attachment		
4) Please attach Attachment 4		Add Attachment		
5) Please attach Attachment 5		Add Attachment		
6) Please attach Attachment 6		Add Attachment		
7) Please attach Attachment 7		Add Attachment		
8) Please attach Attachment 8		Add Attachment		
9) Please attach Attachment 9		Add Attachment		
10) Please attach Attachment 10		Add Attachment		
11) Please attach Attachment 11		Add Attachment		
12) Please attach Attachment 12		Add Attachment		
13) Please attach Attachment 13		Add Attachment		
14) Please attach Attachment 14		Add Attachment		
15) Please attach Attachment 15		Add Attachment		

Upload #6

Applicant:	Family Planning Council of Iowa
Application Number:	FPH2018008738
Project Title:	Title X Family Planning Services
Status:	Awarded
Document Title:	Form BudgetNarrativeAttachments_1_2-V1.2.pdf

Budget Narrative File(s)

* **Mandatory Budget Narrative Filename:** 1234 FPCI BUDGET NARRATIVE.pdf

	Delete Mandatory Budget Narrative	View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative		

Upload #7

Applicant:	Family Planning Council of Iowa
Application Number:	FPH2018008738
Project Title:	Title X Family Planning Services
Status:	Awarded
Document Title:	Form ProjectNarrativeAttachments_1_2-V1.2.pdf

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** 1236-FPCT PROJECT NARRATIVE.pdf

Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File

Tracking Number:GRANT12627215 Funding Opportunity Number:PA-FPH-18-001 Received Date:May 17, 2018 02:39:34 PM EDT

Upload #8

Applicant:	Family Planning Council of Iowa
Application Number:	FPH2018008738
Project Title:	Title X Family Planning Services
Status:	Awarded
Document Title:	Form SFLLL_1_2-V1.2.pdf

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
4040-0013

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

*Name: Not Applicable

*Street 1: Not Applicable Street 2:

*City: Not Applicable State: Zip:

Congressional District, if known:

6. * Federal Department/Agency:

Not Applicable

7. * Federal Program Name/Description:

Family Planning Services

CFDA Number, *if applicable:* 93.217

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: *First Name: Not Applicable Middle Name:

*Last Name: Not Applicable Suffix:

*Street 1: Not Applicable Street 2:

*City: Not Applicable State: Zip:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: *First Name: Not Applicable Middle Name:

*Last Name: Not Applicable Suffix:

*Street 1: Not Applicable Street 2:

*City: Not Applicable State: Zip:

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Jodi Torkelson

***Name:** Prefix: *First Name: Not Applicable Middle Name:

*Last Name: Not Applicable Suffix:

Title: **Telephone No.:** **Date:** 05/17/2018

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)