B. Needs Assessment

Methodology

Virginia's needs assessment for Title X services employed primary and secondary data analysis to identify localities across the state with poor reproductive health indicators and to examine Title X services and characteristics of service recipients during the (four year) project period. Primary data collection efforts have been three fold; 1) Title X program data at the Virginia Department of Health (VDH), 2001 – 2005, to identify user and service trends, 2) Title X provider surveys to obtain information about clinic practices and 3) state-wide focus groups with low income women of childbearing age to learn more about their knowledge and attitudes towards family planning in general and specifically their perceptions of Title X services. Secondary data sources include the U.S. Census Bureau, Vital Records, Behavioral Risk Factor Surveillance Study, Alan Guttmacher and the Weldon Cooper Center for Public Service at the University of Virginia. Also, the Centers for Disease Control (CDC) report entitled, "Fertility, Family Planning, and Reproductive Health of U.S. Women: Data From the 2002 National Survey of Family Growth" provides a benchmark to assess Virginia's progress in reaching women most in need of publicly funded family planning services. Healthy People 2010 reproductive health objectives will serve as target performance measures for family planning services.

Geography

The Commonwealth of Virginia is a mid-Atlantic state, bordered by the District of Columbia, Maryland, West Virginia, Kentucky, Tennessee and North Carolina. Virginia encompasses 40,767 square miles, that have been divided into five distinct Health Planning Regions. The regions are: Region I: Northwest, Region II: Northern, Region III: Southwest, Region IV: Central, and Region V: Eastern. The VDH has further grouped Virginia's 135 localities in these

regions into 35 Health Districts, with Arlington and Fairfax (in Northern Virginia) operating independently under contractual relationships with the state's health system. (Please see Appendix A for map of Virginia Health Planning Regions). Virginia's Title X family planning program funds reproductive health services in 131 sites within the 35 health districts across the state. (Please see maps of Virginia Health Planning Regions, and Virginia Title X program sites in Appendix A)

Virginia Medically Underserved Areas: The Office of Health Policy and Planning at the Virginia Department of Health works with the federal Bureau of Health Professions – Shortage Designation Branch (SDB) to improve access to health care in geographic areas, or special populations and facilities in Virginia to address unmet health related needs across the state. Federal legislation defines the criteria for determining this type of need for assistance. In Virginia, a total of 43 localities have been designated Medically Underserved Areas by the federal government, which includes 36 counties and eight independent cities. The designation for a Medically Underserved Area is determined by using a number of indicators including poverty rates, infant mortality rates, and fertility rates. A map of Virginia's Medically Underserved Areas (VMUA) is located in Appendix A. The following is a brief description of Virginia's geography and VMUA designations, which indicate localities with barriers to accessing health care.

Region I: The Northwest Region of Virginia is comprised of five health districts; Lord Fairfax, Central Shenandoah, Thomas Jefferson, Rappahannock-Rapidan and Rappahannock. Five of the 24 counties in this region have MUA designations.

Region II: Northern Virginia is located just south of Washington, D.C. While northern Virginia is situated on only eight percent of Virginia's total landmass, it is the most densely

populated, with 33 percent of the state's total population.[1] Northern Virginia does not have any MUA designations. However, with over 150 languages spoken in the region, and limited translation services, communication can be problematic and interfere with access to health care.

Region III: Virginia's southwest region is known as the "Heart of Appalachia". Southwest Virginia has rugged terrain, and is home to Virginia's highest mountain peak, Mount Rogers (5,729 feet). The region has nine health districts, and half of the 30 localities in this region have a MUA designation.

Region IV: Central Virginia is home to state government in the capital city of Richmond. The region contains seven health districts, and has nine localities with MUA designation across twenty-two counties, located mostly in southern Virginia.

Region V: The Eastern Region of Virginia runs along the east coast of the main body of Virginia, and includes the Eastern Shore, a peninsula separated from the mainland by the Chesapeake Bay, as well as the area known as Tidewater or Hampton Roads. This region is comprised of eight health districts and varies in both population density and access to care. Tidewater is the second most populated area in Virginia, while the Eastern Shore is very sparsely populated, and has high poverty. All of the Eastern Shore and four counties in this health planning region are designated Medically Underserved Areas.

Health district provider survey results related to barriers to care: Twenty-seven health districts reported that transportation (to appointments) was somewhat or definitely a barrier to access care. Large numbers of survey respondents also reported language and cultural barriers are also somewhat or definitely factors in accessing family planning services. However, the most frequently sited factor as a definite barrier to care was insufficient funding.

Demographics

Population. Virginia is the 12th most populous state with an estimated 7,567,465 residents in 2005.[2] This number represents a net gain of 890,000 people or a 14.4 percent increase since 1990, slightly higher than the national growth average of 13.2 percent.[3] Virginia' population grew by 25 percent in northern Virginia alone, between 1990 and 2000, where 70 percent of Virginia's foreign born population lives.[4] Since 2000, Virginia has gained more people than all except six other states (California, Texas, Florida, Georgia, Arizona, and North Carolina). Overall, there are more persons per square mile (178.8) in Virginia compared to the U.S. with 79.6 persons per square mile.[5] However, there is also great diversity between Virginia's urban and rural areas.

Virginia's racial composition differs slightly from the overall U.S. population. Non-Hispanic whites comprise approximately 71.7 percent of the total population, less than the national average of 75 percent. Non-Hispanic black residents comprise 19.1 percent of Virginia's population, compared to the national figure of 12 percent, and persons of Hispanic origin make up six percent of Virginia's population, which is less than the national average of 14.5 percent.[6] Asian residents comprise just fewer than five percent of Virginia residents (4.7 percent), which is roughly the same as national statistics.

While the percent of Hispanic residents in Virginia is lower than the U.S. average, the growth in the population, 166 percent since 1990, is unprecedented and health districts most affected by the increase have struggled to be able to provide culturally competent services to address the needs of this population. In addition, the Hispanic population in Virginia is younger; 59 percent of Virginia Hispanics are under 30 years of age compared to only 40 percent of non-Hispanic residents.[7]

Virginia's most racially and ethnically diverse communities are in Northern Virginia and the Tidewater area. Foreign-born residents now comprise 18 percent of the total population in Northern Virginia.[8] In Tidewater, where the population is almost two-thirds white non-Hispanic and one-third black non-Hispanic, the Asian population grew by 25 percent in the last decade.[9]

Income/Poverty. While the Commonwealth of Virginia enjoys a higher median income than the nation ($50,028 compared to $43,318) as well as lower rates of poverty (9.9 percent compared to 12.5 percent), there are gross disparities between racial and ethnic groups and geographic regions.[10] Income estimates for 2005 show that the largest income category in Northern Virginia was $75,000 to $99,000 while in southwest and south central Virginia, the largest income category was $10,000 to $19,999. Other regions in the state showed two large income categories; $20,000 to $30,000 dollars and $60,000 to $74,000 annually. Large portions of southwest and south central Virginia are designated Virginia's Medically Underserved Areas.[11]

Virginia's overall poverty rate is lower than U.S. poverty, however, like income, there are tremendous differences among regions in the state. Several areas across the state have higher rates of poverty than the nation. In southwest Virginia, the poverty rate is the highest, at 15.8 percent, south central Virginia is next at 15 percent poverty and the Eastern Shore and southern Piedmont area, each have poverty rates of 13.3 percent. According to the 2006 Annual Social and Economic Supplement, Current Population Survey of the Census Bureau, race and ethnicities most affected by poverty are black non-Hispanics and Hispanics at 24.9 percent and 21.8 percent respectively.[12] Black non-Hispanic women and Hispanic women all experience greater poverty at 25.6 percent and 22.4 percent, respectively.

Education. Results from the National Survey of Family Growth (2005) suggests there is a relationship between education and pregnancy.[13] In this study, women aged 22-24 with a bachelor's degree or higher were more likely to have never been pregnant compared to women who had not completed high school. In Virginia, 67 percent of the total population has not completed a BA or higher educational attainment.[14] In fact, compared to the nation, Virginia ranks in the bottom half of states (29) with persons 25 and older who have completed high school.[15] Fully one-third of residents in Southwest and south Central Virginia have not completed high school. However, in Northern Virginia, 47 percent of residents have a BA or higher educational attainment, which contributes to Virginia's higher than U.S. educational attainment percentage computed by the Census Bureau. Without Northern Virginia's education statistics, Virginia looks very similar to the rest of the country, but with a smaller percentage of persons completing high school and college.[16]

Employment. In September 2005, Virginia's unemployment rate was 3.3 percent which was less than the U.S. average of 4.8 percent during that time.[17] However, like previous indicators, employment rates varied greatly between regions. South and northwest Virginia, Eastern Virginia and large portions of Central Virginia had high unemployment rates (4.4 percent to 5.1 percent). Retail, manufacturing and health care assistance were the top industry employers. Public administration, scientific and manufacturing jobs provided employment for more residents in Virginia compared to the national average.[18]

Non-marital births. The relationship between non-marital births, poverty and child well being is now well documented. Non-marital births, particularly those that occur while the mother is still in her teens, often result in poor birth outcomes as well as poor educational attainment and poverty for both the mother and child.[19] The rate of non-marital births in

Virginia is lower than the U.S. non-marital birth rate (31.0 per 1000 live births compared to 35 per 1000). However, 62.6 percent of births to black non-Hispanic mothers are non-marital and 83 percent of births to all teen mothers are non-marital.[20]

The Health Districts of Crater, Eastern Shore, Portsmouth, Richmond City, Roanoke City, and Southside all had non-marital birth rates above 50 percent. Loudon has the highest fertility rate in the state and the lowest non-marital birth rate (11 percent). Other health districts with non-marital birth rates lower than the state average are; Alexandria, Alleghany, Arlington, Chickahominy, Cumberland Plateau, Fairfax, Henrico, New River, Prince William, Rappahannock, Rappahannock / Rapidan, and Virginia Beach.

Insurance Status. More Virginians are insured than residents in other states. Fourteen percent of the Commonwealth does not have medical insurance compared to 16 percent nationally. However, 16 percent of women in Virginia are uninsured and 24% of children are not insured compared to 22 percent nationally.[21]

In 2004, Medicaid paid for 24 percent of all births in Virginia and another 5 percent of births were self pay. Medicaid paid for 42 percent of all black non-Hispanic births, 33% for Hispanic births and 17 percent of white non-Hispanic births. Hispanic women were four times more likely to self pay, 21 percent of all births in this group compared to 3 and 4 percent for white and black non-Hispanics respectively.

Reproductive Health Indicators (See Appendix A for reproductive health indicators by race and ethnicity). While Virginia compares favorably with national reproductive health indicators, Healthy People 2010 goals to reduce teen pregnancy, infant mortality, or low birth weight have not been met, and there are persistent disparities between groups with black non-Hispanic women disproportionately affected by poor reproductive health indicators. Unless otherwise

indicated, data sources are 2004, Vital Records, Center for Health Statistics, Virginia Department of Health.

Table 1

	2000	2001	2002	2003	2004
Crude Birth Rate / 1000 live births	13.91	13.69	13.61	13.61	13.92
General Fertility Rate / 1000	62.17	61.60	61.65	62.91	64.93
General Pregnancy Rate / 1000	83.82	81.32	81.68	84.22	85.77
Abortion Rate / 1000 15-44	17.1	15.0	15.1	16.4	16.2
Teen Pregnancy Rate / 1000	62.17	58.56	55.27	54.68	52.30
Infant Mortality Rate / 1000	6.84	7.41	7.31	7.62	7.40
Low Birth Weight (percent)	7.87	7.81	7.83	8.08	8.22

Data Source: Vital Records, Center for Health Statistics, Virginia Department of Health

Birth rate. Virginia's overall birth rate is slightly lower than the U.S. birth rate however, there are differences between race and ethnicity. Between 2000 and 2004, white non-Hispanic women had birth rates lower than the national average (between 11.93 and 12.51), black non-Hispanic women had higher rates (between 14.61 and 15.64). Hispanic women, had the highest rates of birth, which have steadily increased since 2000. Birth rates for Hispanic women were a low of 23.8 in 2000 to a high of 27.36 in 2004.

General fertility rate. Much like the rest of the country, Virginia's general fertility rate has gone up every year since 2001. However, fertility in Virginia is still under the national rate of 66.3. As with all other indicators for Virginia, there are differences between groups. White non-Hispanic women have the lowest fertility rates (57.14 – 59.50). Rates for black non-Hispanic women appeared to decline 2001 – 2003, but rose again slightly in 2004. Since 2000, fertility rates for black non-Hispanic women ranged from 61.54 – 63.95. Fertility rates for Hispanic women have increased steadily since 2000, from 89.93 to 112.43 in 2004.

Virginia's health district with the highest fertility in 2004 was Prince William at 81.9 (compared to 60.9 state average). Loudoun health district was a close second at 81.79. The health districts of Portsmouth, Norfolk and Alexandria all had fertility rates above 77. Prince

William and Loudoun are two of the fastest growing areas in the state, and both have high percentages of Hispanic residents. The health district with the lowest fertility was New River (42.1).

General pregnancy rate. As with the previous indicators, black non-Hispanic women have slightly higher rates of pregnancy than white non-Hispanic women (91.61 in 2004 compared to 69.71). Hispanic women have the highest rates of pregnancy, increasing steadily since 2000 from 113.53 to 134.44 in 2004).

Abortion rate. Virginia abortion rates have mirrored national abortion trends, steadily declining during the 1980's and 1990's. Since 2000, Virginia's abortion rate has leveled off ranging from 17.1 per 1000 women age 15-44 years old in 2000 to a low of 15.1 per 1000 in 2002. Central and Eastern Virginia have the highest rates of abortion. Northwest and southwest have the lowest rates, both under 10 per 1000 since 2001. (See Table 1)

Black non-Hispanic women have the highest rates of abortion, averaging 20.98 per 1000 pregnancies since 2000. In Central Virginia, abortions rates for black non-Hispanic women have increased from 29.9 per 1000 in 2000 to 35.7 in 2004. Since 2000, abortion rates for Hispanic women average 17.98 per 1000, and the five year average for white women was below the national rate at 7.24 per 1000. It is important to note that the number of abortion providers in the state has also declined.[22]

Teen pregnancy rate. Teen pregnancy in Virginia is following the national trend of decline, going from 62 per 1000 teens in 2000 to 52 per 1000 teens in 2004. The greatest rate of decline has been among black non-Hispanic teens, however, the pregnancy rate for this group continues to be twice that of white non-Hispanic teens (34.12 compared to 76.87). (See Table 1) Hispanic teens have the highest rate of teen pregnancy at 99.13 in 2004.

The percent of abortions is a correlate for unintended pregnancy. Several localities had high percentages of teen abortions, with Richmond City the highest at 47 percent, Norfolk City was next at 40 percent, Alexandria at 29 percent, Roanoke City at 28, and in Hampton and Crater Health Districts, approximately 27 percent of teen pregnancies were terminated.

Infant mortality rate. Virginia has not met the Healthy People 2010 infant mortality goal of 4.5 infant deaths per 1000 live births and there are great disparities in perinatal outcome indicators such as infant death and low birth weight. Virginia's infant death rate in 2004 for all races was 7.4 per 1000 live births. Infant deaths to white non-Hispanic infants are below the national average at 5.71 in 2004. Hispanic infant death rates are similar, at 5.66 in 2004. Black non-Hispanic infant deaths occur much more often however, at a rate of 14.11 in 2004.

Low birth weight. There has been a slight increase in the percent of low birth weight infants born in Virginia, occurring in 8.22 percent of all births in 2004. Low birth weight is the leading cause of infant death in Virginia, which disproportionately affects black non-Hispanic women. The percent of white non-Hispanic low birth weight infants has also increased slightly in the last four years, up to 7.40 percent in 2004. Hispanic infants experienced the least percent of low birth weight at birth (6.34 percent). Black non-Hispanic infants were most affected, with 12.57 percent of infants born with low birth weight in 2004.

Health districts most affected by low birth weight are Piedmont, Portsmouth, Richmond City, Mount Rogers, Crater, Southside, Portsmouth, Richmond City, Cumberland Plateau, Norfolk City, and Pittslyvania Danville. All of these districts had low birth weight percents, well above the state average. Health districts with the lowest percent of low birth weight are Arlington, Prince William, and Alexandria, each with less than seven percent low birth weight.

Sexually transmitted infections (STI). Racial disparities also exist in STI statistics. Black non-Hispanics are over represented in the rate of persons with AIDS, Chlamydia, Gonorrhea, HIV infection and Early Syphilis.

Table 2. Number of Reported Cases of Selected Diseases and Rate per 100,000 by Race, VA 2005

	Total	Black NH		White NH		Other		Unknown	
		N	Rate	N	Rate	N	Rate	N	Rate
AIDS	**630**	**384**	**26.1**	**169**	**3.1**	**71**	**1.5**	**3**	
Chlamydia	**22,633**	**12,979**	**875.2**	**5,244**	**95.3**	**1,691**	**35.6**	**2,719**	
Gonorrhea	**8,345**	**8,345**	**6,367**	**1,090**	**19.8**	**238**	**5.0**	**650**	
HIV infection	**834**	**508**	**34.3**	**232**	**4.2**	**90**	**1.9**	**4**	
Syphilis, early	**290**	**181**	**12.2**	**86**	**1.6**	**21**	**0.4**	**2**	

Data Source: Virginia Reportable Diseases Surveillance Data, Virginia Department of Health, Division of Epidemiology

In 2005, there were fewer reported cases of AIDS and HIV infection than previous years. However, the number of persons with chlamydia in Virginia was a record high of 22,633 cases reported to the Virginia Department of Health, which has nearly doubled since 1996. The number of syphilis cases reported has increased quite significantly from 165 cases per 100,000 in 2002 to 290 cases per 100,000 in 2005.

Females had more chlamydia infections than males (443.0 per 100,000 compared to 158.3 per 100,000) and slightly more gonorrhea infections (116.0 per 100,000 compared to 107.4 per 100,000) in 2005. However, HIV and AIDS affected males more often than females in 2005 (12.3 per 100,000 compared to 4.7 per 100,000 and 16.3 per 100,000 compared to 6.3 per 100,000). Males also had higher rates of early syphilis (6.3 per 100,000 compared to 1.6 per 100,000).

In 2005, the 20 – 29 year old age group was most affected by all types of sexually transmitted infections with the exception of AIDS, which affected the 30 – 39 year old population the most. Chlamydia affected age groups from <1 year up to 50+ years old, with 10 – 19 years and 20 – 29 year olds most represented in reported cases in 2005.

Cervical and breast cancer. Breast and cervical cancers are serious illnesses with high mortality and morbidity. Early detection and treatment are critical to reduce the burden of these silent killers. Virginia's family planning clinics have documented the need to help low income women pay for diagnostic and treatment for breast and cervical disease. In 2006, the Virginia General Assembly earmarked additional funding to expand screening and diagnostic services for women in Virginia, which will help an additional 1,000 women receive treatment, many identified through Title X family planning clinics.

Women In Need. (Data used to describe women in need (WIN) are estimates based on the National Summary and Survey Detail from the Alan Guttmacher Institute, 2004).

The total number of women of childbearing age during 2004 in Virginia was 1,703,560[23]. Of these women, 851,890 were women in need (WIN) of contraceptive services and supplies. Women in need are defined as sexually active, not pregnant, or trying to get pregnant, perceive themselves and their partners to be fertile and are between the ages of 13 and 44 years of age. Women in need of publicly funded contraceptive services and supplies have incomes that are below 250 percent of the Federal Poverty Level. Based on population and poverty estimates of the United States Census Bureau, Guttmacher estimates that between 2000 and 2004, the number of WIN of publicly funded contraception and supplies in Virginia increased by 5.8 percent to 386,980. [24]

Of Virginia's WIN, 66 percent are white non-Hispanic, 21 percent are black non-Hispanic and 6 percent are Hispanic.[25] Approximately 15 percent (125,050) of WIN in Virginia are less than 20 years old, which is the same as the national average. Ten percent of WIN, 20-44 years of age have incomes <100 FPL, 20 percent of WIN live between 100 and 249 percent FPL and the remaining 55 percent are 250 percent above poverty.

Of all women needing contraceptive services and supplies in Virginia, 45 percent are in need of *publicly funded* contraceptive services and supplies. Nearly half of all Hispanic WIN (47 percent), over half of all black non-Hispanic women (58 percent) and 39 percent of white non-Hispanic WIN meet the criteria for publicly funded contraceptive services and supplies. The following description is of women in need of publicly funded contraceptives and supplies only.

(Please refer to Appendix A for map of the Number of Women In Need of Publicly Funded Contraceptive Services and Supplies by Family Planning Site and Health District/County for the following section of the narrative.)

The number of WIN varies a great deal between Virginia's health districts. The greatest number of WIN are in Fairfax (34,800) which is located in Northern Virginia. Fairfax is home to almost 10 percent of all WIN and approximately 32 percent of all Hispanic WIN live in Fairfax. Hampton, Virginia Beach, Norfolk, and Portsmouth are contiguous cities that have a combined total of 72,080 WIN. The Peninsula and Chesapeake Health Districts, adjacent to these areas in the eastern region of the state, adds an additional 30,090 WIN. Richmond City is approximately 100 miles from the City of Norfolk, on the north side of the Peninsula Health District and has approximately 16,130 WIN of publicly funded contraceptive services and supplies. Chesterfield Health District has an additional 13,040 WIN. Crater Health District has 8,830 WIN, which is located just south of Richmond and borders Chesterfield. These nine health districts comprise over 38 percent of all WIN in Virginia and 51 percent of all black non-Hispanic WIN in Virginia.

In northeast Virginia, Prince William, Rappahannock and Rappanhannock/Rapidan Health Districts have an additional 34,370 WIN of publicly funded contraceptive services and supplies. Sixteen percent of the total number of Hispanic WIN live in these three health districts. In

Prince William the number of Hispanic WIN exceeds the number of black non-Hispanic WIN. Prince William is part of Northern Virginia, and Rappahannock and Rappahannock/Rapidan are quickly becoming bedroom communities for Northern Virginia because of their close proximity. Nearly half of all Hispanic WIN live in Fairfax and these contiguous health districts.

Loudon, Arlington and Alexandria Health Districts are part of Northern Virginia and have comparatively fewer WIN, compared to the population in these areas. This is most likely due to higher incomes in this area. However, the combined total of WIN in these areas is 28,150.

In the western part of the state, the largest numbers of WIN are located in Central Shenandoah (17,090) and Thomas Jefferson with 13,700 WIN of publicly funded services. Most WIN here are white non-Hispanic, but Harrisonburg, in Central Shenandoah has more Hispanic WIN than other localities in this district. However, white non-Hispanic women are the overwhelming majority of WIN in these two districts.

The Central Virginia Health District is south and west of Central Shenandoah and Thomas Jefferson, and has a large number of WIN (13,510), mostly white non-Hispanic. Combined these three health districts comprise 12 percent of the total WIN in Virginia.

New River Health District has the greatest number of WIN in the western part of the state (14,840). Montgomery County has much larger numbers of WIN, perhaps because Virginia Tech is located there.

Most of the remaining districts with WIN are located along the west and southern border of Virginia, where the population is less dense. The Eastern Shore has the fewest WIN (3,040), Southside and Chickahominy are next with just over 4,000 each and both are very different in terms of population and poverty. Southside is very poor and sparsely populated, while Chickahominy has become a moderately wealthy suburb for Richmond City.

Mount Rogers, Lenowisco, the Cumberland Plateau, and Alleghany Health Districts have a combined number of 28,560 WIN. This number represents all of the western part of the state, approximately 8 percent of all WIN in Virginia.

Western Piedmont, Western Tidewater and Pittsylvania/Danville are located on the southern border of the state. In these districts there are 19,740 WIN of publicly funded contraceptive services and supplies, about 5 percent of Virginia's total WIN.

***WIN summary*.** Approximately 70 percent of WIN of publicly funded services live in northern Virginia, the east coast and a few parts of central Virginia. Additionally, large portions of black non-Hispanic and Hispanic WIN live in these areas. According to the National Survey of Family Growth, minority women are at great risk of unintended pregnancy. These geographic areas offer greatest opportunities to improve Virginia's reproductive health indicators for women at risk of unintended pregnancy. Although Alexandria, Roanoke, Southside, Cumberland Plateau and Pittsylvania / Danville do not have high numbers of WIN, these localities tend to have poor birth outcomes which position them as critical areas of concern. Also the extreme poverty and isolation in Virginia's outlying counties, also places these WIN at great risk of unintended pregnancy.

High Priority Areas

Virginia's family planning goals related to Healthy People 2010 are to decrease the proportion of pregnancies that are unintended. Virginia policy experts conclude that "…family planning remains a keystone in attaining a national goal aimed at achieving planned, wanted pregnancies and preventing unintended pregnancies."[26] Virginia's Family Planning Program, will utilize Title X funds to reach populations at highest risk to reduce unintended pregnancy.

High-risk populations are described in "Fertility, Family Planning, and Reproductive Health of U.S. Women: Data From the 2002 National Survey of Family Growth". This survey showed women with low educational attainment, particularly minority women, and women who initiated sex early have a higher risk of unintended pregnancy. In Virginia, minority women have higher fertility, pregnancy, abortion and birth rates. They have less education, lower incomes and more likely not to have health insurance. Additionally, linguistic and cultural challenges are present for the growing number of young Hispanic women. Sexually active teens are also at great risk because they have all of the above risk factors and little experience with navigating the health care system by themselves. These groups are Virginia's high priority populations for family planning services.

Women who are overweight and obese are of great concern in Virginia. More than half of Virginia adults are at an unhealthy weight with 36 percent overweight and 25 percent obese.[27] When gender, race and ethnicity are considered, disparities emerge. Black non-Hispanic women are more likely than women of other races or ethnicities to have weight problems; 41 percent of black non-Hispanic women were obese in 2005, compared to 24 percent Hispanic women and 13 percent white non-Hispanic women. [28]

Existing Resources

Virginia has modest resources for family planning services. In fact, the Alan Guttmacher Institute ranked Virginia 41st among states for availability of family planning services.[29] In 2004, Title X dollars supported 134 of the total 178 publicly funded family planning clinic sites in Virginia that helped to avert 17,700 unintended pregnancies.[30] Partners such as Planned Parenthood and a few other privately funded family planning clinic sites are included in the total number of sites supported by Title X (134). In addition to Title X family planning sites, all (21)

of Virginia's Federally Qualified Community Health Centers provide family planning services. Free Clinics located in Arlington, Chesterfield, the Peninsula and Richmond City also provide family planning services. (Please see the matrix of family planning service providers in Appendix A.).

In Virginia there are 952 licensed or board certified OB/GYN medical providers. Of these, 589 participate in the Virginia Medicaid program. Of providers who participate in the Medicaid program, 488 are accepting new patients; therefore slightly more than half (51.3 percent) of all OG/GYN providers in the state are accepting new Medicaid patients.

Virginia has three major medical schools that have obstetrics and gynecology departments as well as clinical care at the University of Virginia in Region I (Northwest), Eastern Virginia Medical School (Region V, Eastern Virginia) and Virginia Commonwealth University Health Systems in Central Virginia (Region IV). Reproductive health care and contraceptive services are also provided through student health at the state's larger colleges and universities. Title X funds clinics in one college and two high schools, located in the far southwestern part of the state, Roanoke and Alexandria. Family planning is also offered at a Job Corp Center in far southwest Virginia.

Statewide and Community Resources

Improving women's health across the lifespan is a new goal of Virginia's Title X program. Title X program managers have collaborated with the VDH women's health coordinator to identify health education topics and strategies for the preconceptional and interconceptional periods that address 1) preventive care (such as screening) 2) risk factors (such as intimate partner violence) 3) access to care (such as appropriate referrals) and 4) mortality (such as diabetes and weight control). Key VDH partners to improve women's health across the lifespan

are: Every Woman's Life; Breast and cervical cancer screening, the Division of HIV/STD, Division of Injury and Violence Prevention, Division of Chronic Disease Prevention and Nutrition, Partners In Prevention, Resource Mothers, Virginia Healthy Start Initiative, Teen Pregnancy Prevention Initiative, Virginia Sickle Cell Program, Virginia Regional Perinatal Councils, and the Office of Minority Health. These intra-agency partners are expert sources to provide training and education to Title X staff statewide in addition to the essential function of advocacy and referral source and safety net provider.

Inter-agency collaborations include working with the Department of Medical Assistance Services (DMAS) in an advisory capacity for Virginia's Family Planning Waiver; the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), also in an advisory capacity for substance abuse and fetal alcohol syndrome; and the Department of Social Service (DSS) for Training 3 (pregnancy prevention targeting older teens in foster care). Family planning management is also very involved in the Collaborative HIV/STD, Abstinence, Teen Pregnancy , Sexual Health Team (CHATS). The goal of this inter-agency collaborative is to prevent pregnancy among middle school students. CHATS is funded by the Centers for Disease Control with the Department of Education as the lead agency.

State and local family planning staff make extensive use of community resources. Key community partners described in the 2006 Health District Provider Survey are Planned Parenthood, Elizabeth Project (serves pregnant teens), adoption centers, local Departments of Social Service, local hospitals, homeless shelters, Susan Koman funding for mammograms, Sexual Assault Centers, HIV/AIDS testing centers, private physicians (in-kind colposcopy, ultrasounds, cervical biopsy, GYN consults, etc.). On the local level, community partners are

more likely to be referral sources or provide in-kind or low cost services to family planning patients in need.

Summary Of Unmet Family Planning Needs

According to the Guttmacher Institute, of Virginia's total number of women in need of publicly funded contraceptive services and supplies, 97,150 women were served in 2001, leaving an unmet need for an estimated 274,490 women. [31] Also, data from the National Survey of Family Growth suggests that 49 percent of all pregnancies are unintended. In Virginia, there were 137,157 pregnancies in 2004 with perhaps as many as 67,207 unintended[32]. Of these unintended pregnancies, 49 percent, or 29,571 resulted in a live birth[33]. These figures illustrate that unmet family planning needs persist. In addition to data gathered from provider surveys and secondary data, focus groups have taken place in two health districts with high indicators for unmet need. Preliminary data from these focus groups suggest there are problems with the public's perception of health department services overall. Participants in these focus groups suggested there is no distinction between services offered in local health departments, and that the general perception is that a visit to the health department indicates a sexually transmitted infection. One respondent said that a "…trip to the health department was never a good thing", suggesting a person going to the health department had somehow done something wrong. Some focus group respondents shared their personal experiences while using clinics, and questioned why they were asked all the personal questions about number of partners, etc. The view of many participants was that they were being judged harshly. This suggests there is room to improve the way staff communicates with clients. Respondents also shared that it was difficult to bring their children into the health department because of the environment. They suggested more family friendly environments would allow mothers with children in tow to access services. Primary

messages from these early focus groups suggest there are problems with the health department's image overall in communities. None of the focus group participants were aware of the array of family planning services provided. All focus group participants strongly supported "getting the word out" about family planning services, but also said the services had to be offered in family friendly environments, with flexible hours, and a more comprehensive and sensitive approach that matched the users life style.

A complete report of the Title X focus groups will be completed in January 2007. The family planning staff will share this information with others VDH health administrators, as early results show there are systemic problems with accessing care at local health departments and require systemic strategies to reduce barriers to care. Information obtained through implementing the Pregnancy Risk Assessment Monitoring System (PRAMS) will further help state program planners identify areas with highest rates of unintended pregnancy to target future efforts.

C. Organization and Management

Organizational structure. The Virginia Department of Health (VDH) has provided Family Planning Services funded by state and local cooperative budgets and Title V Maternal Child Health Block Grant funds since the 1960's. Since 1972, VDH has received Title X funds to supplement state and local funds to provide expanded services. Patient level services are provided in 131 city/county health departments in 34 health districts. A physician health director heads each health district. (See Appendix X -Health District Map) The statewide Family Planning Program is located in the Division of Women's and Infants' Health (DWIH), in the Office of Family Health Services (OFHS) at the VDH Central office in Richmond. (See Appendix Y -Organizational Charts). As can be seen by the organization charts, the Family Planning Program does not have direct supervision or administrative responsibility for the health

districts; however does have strong collaboration and communication across organizational levels. The Program provides direct consultation, technical assistance, monitoring of Title X grant activities and fiscal management.

The Board of Health, whose members are appointed by the governor, provides planning and policy development for the Commonwealth and the Virginia Department of Health to promote and protect the health of Virginia's citizens. (See Appendix_Z_, Board of Health).

Family planning is just one clinical service in a constellation of clinical services offered by health departments throughout the state. VDH basic services are family planning, prenatal, well child, STD, communicable disease and school health. Additionally, larger health departments offer general medical, refugee health and sick-child care and are providers for Virginia's Medicaid managed care system. The Title X supported VDH family planning staff is small in number in comparison to total employees in the health districts. The family planning clinics operate under the Title X Guidelines, and are funded by state and local cooperative budgets and MCH Title V Block Grant.

The Division of Women's and Infants' Health is under the direction of Joan Corder-Mabe, R.N.C., W.H.N.P. The Family Planning Program is managed by Barbara E. Parker, R.N., M.P.H., Nurse Consultant. The program has two other staff, Elizabeth Elam, R.N., M.P.H., who provides professional support to the Family Planning Program. Ms. Elam also administers the Sterilization Program, the Cervical Cancer Screening Program, Family Planning Medical Advisory Committee, coordinates staff training and shares some of the responsibility for providing consultation and technical assistance to the health districts including conducting health district site visits. A second staff person in the program is Ms. Ardriene Stuart, Administrative and Program Support Specialist III, provides daily fiscal monitoring and general administrative

support for the Sterilization Program and serves as the VDH liaison to the health districts. (See Appendix Y, DWIH Organization Chart)

The OFHS is one of the largest offices in the VDH and is directed by David Suttle, M.D. One-third of the total VDH budget goes to OFHS, and great numbers of Virginians are impacted by OFHS policies and services. The Office is composed of five divisions: Women's and Infants' Health, Child and Adolescent Health, Dental Health, Chronic Disease Prevention and Control, WIC and Community Nutrition Services, and the Division of Injury and Violence Prevention. The Family Planning Program collaborates and coordinates across divisions and programs. (See Appendix Y, OFHS Organization Chart)

The OFHS provides a central support structure for the divisions through the Business and Policy and Assessment Units. Each division has an assigned accountant. The Policy and Assessment unit provides consultation, technical assistance and analysis for maternal and child health policy, public relations coordination, epidemiology, data and health prevention. This support has enabled program staff to work more closely with programs for improved monitoring, guidance and developing and implementing new programs affecting the populations served by OFHS.

The Office of Community Health Services provides centralized planning, oversight and management of the programs and operations of the 35 health districts. The director of Public Health Nursing is also located in this Office. (See Appendix Y Deputy of Community Health Services organizational chart) The family planning program staff collaborates and coordinates with the director of public health nursing on many activities. The nursing director uses the Nursing Council, made up of various levels of nursing staff from across the state, to function in

an advisory capacity to the Nurse Director. The Family Planning Program manager is also a member of the Nursing Council.

The Office of Health Policy and Planning whose mission is to improve access to quality health care for all Virginia residents, recognizes that Virginia has been impacted by changes in demographics. The increases in emigrant, refugee and undocumented populations have and are impacting the provision of health care in Virginia. In an effort to help health care providers, the office has created an online resource guide called CLAS Act-Culturally and Linguistically Appropriate Health Care at www.CLASActVirginia.vdh.Virginia.gov. Its website contains VDH translated materials for local staff use.

The Office of Information Management (OIM) manages the VDH centralized data systems that include health statistics, vital statistics, data warehouse and WebVISION. WebVISION is the web based billing and eligibility system that automatically bills Medicaid and private insurance for services provided. It is also the system from which data for the Family Planning Annual Report data is obtained. OIM maintains a Data Warehouse that stores data from multiple sources and is available to many VDH programs. The DWIH data manager has access to the data warehouse from which data is retrieved for reports, grants, and program monitoring. OIM maintains the e-mail system, which allows all VDH employees in the state to communicate at all levels. E-mail is the official communication system between and among program staff in the central office and staff in the local health departments. Documents are exchanged regularly between staff including work plans, budgets, and progress reports.

The OFHS uses DocuShare, a system that allows programs to electronically store information that is accessible to multiple staff including work plans, service site information, budgets, progress reports and site visit reports in DocuShare. The Business Unit provides templates for

contract preparation etc. that is available for all staff in OFHS. Confidential information is password protected and only accessible to authorized staff.

Program structure. The Division of Women's and Infants' Health is composed of programs that focus on maternal health and infant health. Programs include Resource Mothers, Sickle Cell Screening Awareness, Breast and Cervical Cancer Early Detection Program, Healthy Start and Partners in Prevention, an out-of-wedlock birth prevention initiative. Within these program areas are many specific activities designed for assurance, assessment and development of policy to improve the health status of women and infants. The location of these programs in a central division strengthens all of them. Many of the programs often serve the same populations. The programs often collaborate providing consultation, technical assistance and work cooperatively on joint projects. A data manager position has been recently added to the division. This addition has already benefited the division's programs, including Family Planning.

The Women's Health Nurse Consultant, who is the Family Planning Program Manager, is responsible for the administration of the statewide Family Planning Program by assuring that Title X and state requirements are met for the provision of these services. This is accomplished by the development of the Memorandum of Agreement (MOA) with the health districts and the DWIH; distribution of program funds to the districts and monitoring the expenditures of these funds; issuing specific policies and guidance; provision of consultation and technical assistance and regular site visits to districts to assure that services are in compliance with program requirements. The Nurse Consultant supervises the Women's Health Coordinator who manages the Partners In Prevention (PIP) Program and the Nurse Senior. The Nurse Senior supervises the Administrative and Program Support Specialist III.

The Program collaborates with other divisions in OFHS such as programs in the Division of Child and Adolescent Health-Adolescent Sexual Health, the Division of Injury & Violence Prevention and the Division of Chronic Disease by providing and obtaining consultation, technical assistance, training and participating in projects. The Program participates in the CDC Infertility Prevention Project as a collaborative partner with the Division of Disease Prevention and the State Consolidated Laboratory Systems and is a member of the Region III Infertility Prevention Project Advisory committee. In addition, the nurse consultant is a member of the Virginia Folic Acid Council, whose mission is to improve the numbers of child-bearing age women taking folic acid, a member of the internal work group for PRAMS and the Virginia Fetal Alcohol Spectrum Disorders Task Force.

The distribution process of family planning funds to the local health districts is through a Memorandum of Agreement. Prior to the fiscal year, the family planning program staff provides guidance to each of the local health district instructions to prepare work plans, budgets and service site information. (See Appendix C, MOA Instructions) The Family Planning Program requirements include the development of individualized; community-based strategies for the accomplishment of work plan program objectives. Twice a year, local health districts submit a progress report describing accomplishments to date related to their work plan activities.

The local districts submit MOA with proposed budget, work plans and services site information. The MOA between the local health districts and DWIH is executed after family planning staff review and approve the submission.

The Family Planning Program uses a formula to determine each year's allocation of Title X funds to the districts. The funding formula includes these three elements - 50% base (maintenance of effort), 40% caseload and 10% need based on the Guttmacher Institute, Women

In Need data. All health districts use the Title X funds to support staff salaries, limited travel, and to purchase contraceptive methods. Limited state funds are also added for Pap smear testing.

The Family Planning Program augments the resources of the local health department family planning programs by administering funds appropriated by the General Assembly. These special appropriations support the Sterilization Program, and gap funding for the high cost of Depo-Provera to the districts.

The Family Planning Program administrative budget is supported by Title X funds. Other expenses incurred by local health department family planning programs are borne by the local health districts. This includes the cost of contraceptives except Depo-Provera, laboratory expenses, travel, office supplies, clinic supplies, staff training and overhead. All personnel who work in local health departments are hired and supervised by district management staff according to state personnel policies. They assure that staff has appropriate professional credentials and proper orientation. All staff at both the local and state level is required to develop a yearly performance and development plan and is evaluated on the plan according to proscribed state personnel guidelines.

Monitoring. The Family Planning Program staff is responsible for assuring the health districts are in compliance with the Title X and state rules and regulations through the established MOA process. Receipt of Family Planning Program funds by health districts through the MOA process is a commitment that the districts accept the Title X requirements for operation and delivery of family planning services. A component of the MOA process is the Program review of all district budgets to assure that planned expenditures are within Title X and program guidelines.

The Program staff assures the Title X requirements are adhered to by regular site visit visits to local health districts on a rotating basis at least every 3 years. The site visit reviews include a visit to all or a majority of the local city/county health departments in a district.

Family planning staff at each site include clerical, nursing, clinician, fiscal, administrative and social worker or outreach worker. Patients are interviewed regarding availability and accessibility of services, staff issues or problems, and quality of services. If possible, a selection of patients are shadowed as they receive services from intake to exit, observing patient/staff interaction, eligibility process, education and counseling provided, adherence to protocols and guidelines, pharmacy and lab procedures. A site visit review tool is used to assure all aspects of the program are reviewed. This tool used is very similar to the federal family planning audit tool and includes a cultural competency element. Records are randomly selected for audit to assess for required services, appropriate follow-up for identified health problems, documentation of patient services according to Documentation by Exception record system guidelines, laboratory request forms accurately completed and results available in the record, and signed patient consents for services and methods. Additionally, client eligibility for services must be current.

The site visit provides an opportunity for district staff to receive consultation services from central office staff, to learn about district issues and concerns and to assist in resolving problems, concerns or answering questions. The site review visit is an excellent opportunity to learn about new strategies that can be shared with other health districts. The site visit reviews facilitate improved communications between district staff and the Program. At the end of the site visit, an exit conference is held with key health district staff, to include the district director, nurse manager, supervisors and service staff. At the exit conference feedback is provided on site visit findings, which include positive recognition and recommendations. A final written report is sent

to the district and shared with the division director and placed in the family planning DocuShare file. (See Appendix AA, Exp. Program Site Visit Report) Any significant issues identified are shared with the director of the OFHS and the Deputy Commissioner of Community Health Services, especially if any administrative action is indicated.

The family planning program manager monitors the expenditures of funds allocated to the health districts through Title X. The division accountant provides monthly expenditure reports to assure that funds are being expended appropriately and that budgets are not over spent. If any issues or questions are identified, the program manager contacts the district business manager. If the district overspends their budget, all funds over allocation must be returned to the program. This is the routine end of the year fiscal reconciliation review progress. Mid-year and year-end progress reports are submitted for review by family planning program staff.

Training and education. Training 3, Region III's training grantee, continues to provide much of the family planning training to local health department family planning staff. Training 3 provides from four to six continuing education workshops for the Family Planning Program each year, and options for online or audio continuing education courses. At the conclusion of these workshops, Training 3 provides family planning staff with a list of attendees and evaluations of the workshops. Periodic needs assessments are conducted to assure that the continuing education presentations provided by Training 3 meet the needs of Virginia's family planning staff and the Program and to plan for future training. Virginia family planning staff also attend Training 3 workshops held in neighboring states

Additionally, family planning staff request health district nurse managers to provide yearly input on training needs. Training needs are also identified during family planning program site visits. Training utilizing audio, video-conferencing and on-line opportunities is increasing as

staff finds it more difficult to leave their health departments to attend trainings some distance from their locations.

In addition, family planning staff has access to distance learning opportunities provided by other programs regarding STD/HIV, maternal/perinatal health, nutrition, violence prevention and immunization. These same programs provide ongoing training at different geographic locations in the state to ensure access by local health department staff. Family planning staff attends local continuing education opportunities provided either in-house or in their districts by other organizations. This is assessed at the family planning program site review visits. Each year health district clinicians, including the nurse supervisor from the Family Planning Program, attend the Contraceptive Technology Update conducted by Contemporary Forums in Washington, D.C. Due to bioterrorism funds, all health districts have video teleconferencing capabilities and are now able to obtain multiple satellite down linkages for training on many topics including family planning. The Program also uses video conferencing technology as a media to link with health districts staff presenting topical program information, guidance, recommendations, conducting training and discussing current issues.

The Program purchases a copy of the most current edition of *Contraceptive Technology* for every local health department, provides a copy of *Managing Contraception* for each family planning clinician, and purchases the monthly newsletter “Contraceptive Technology Update” for each health district.

Personnel policies. The Virginia Department of Health has a centralized personnel office called the Office of Quality Improvement and Human Resources that is responsible for staff recruitment, selection, evaluation, promotions, terminations, compensation, benefits, and grievance procedures. This office provides guidance, policy and technical assistance to all the

entities of the VDH to assure that all state personnel policies are followed. Each organizational unit has a state personnel manual and each employee is provided an Employee Handbook when hired. The state Department of Personnel and Training (DPT) provides expertise on best practices of human resources policy and training to all state agencies. DPT is Virginia's central source for statewide information regarding the Commonwealth's employee work force and employment opportunities. Each work unit is responsible for developing an individualized employee orientation plan. The VDH Office of Quality Improvement and Human Resources provides new central office employees a half-day orientation, which is conducted monthly. Local health department staff is provided orientation by their supervisory staff. The program content, such as family planning, is provided by guidance developed by the health district nurse managers and the Director of Public Health Nursing, with input by the specific central office programs.

EXHIBIT D: VIRGINIA FAMILY PLANNING PROGRAM WORK PLAN FY 2008 –2011

Type of Objective: Administrative

GOAL: By FY 3/31, improve the efficiency, effectiveness and performance of the Family Planning Program.

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
A. By 3/31/2011 conduct site visits to at least one third of the health districts each year.	1. Negotiate with 10 health districts that are scheduled for site visits. (See Appendix__, District Site Visit Schedule) 2. Negotiate month and dates for visits. 3. Review site visit tool in Family Planning Manual with nurse managers prior to visits. 4. Within two weeks following the site visit, complete the written site visit report; send to district staff and DWIH director. (See Appendix __, Exp. Site Visit Report) 5. Provide TA and/or consultation at the time of the visit or return for a follow-up visit as necessary.	Nurse Consultant Nurse Senior	4/01/07 - 3/31/2011	1. Ten site visits made for each of the 4 fiscal years. 2. Reports are written for all the site visits made. 3. Consultation and TA provided for any problems identified at the time of the visit. 4. Site visit reports are provided within two weeks to district staff and DWIH director. 5. If necessary, a return follow-up visit was made.
B. By 3/2011, Monitor quarterly WebVISION program data to access service utilization to identify changes that may occur.	1. Obtain quarterly FPAR program data from division data analyst by district and state. 2. Review data to identify district(s), which have changes or drop in caseload and provide TA/consultation. 3.Provide districts data semi-annually that includes previous two years for comparison. 4. Update FP services codes when available to reflect current CPT/ICD9 codes changes and provide to the districts.	Nurse Senior Nurse Consultant	**1/07-12/2010**	1. Data is received quarterly (April, July, October, and January). 2. Districts with changes are identified, contacted and provided TA/consultation. 3. Districts are provided semi-annual data by e-mail. 4. Current codes are on FP service code list and provided to districts.

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
B. Continued	**5.** Assess correct use of standardized service encounter codes by districts by requiring districts to submit at least yearly copies of their FP patient encounter forms to assure that codes are current and are being used correctly. 6. Verify accuracy of data reported by reviewing quarterly. 7. Work in collaboration with VDH Web Users Group to improve the collection of FP data i.e. system calculates FPAR income categories and age categories for Community Events module.			5. Consultation with WebVSION manager to assess and assure districts are using standardized encounter codes and can retrieve FP data from WebVISION as needed. 6. FP patient encounter forms were submitted by the districts and reviewed for accuracy. 7. Business managers for those districts that do not have current codes and/or are not using correctly were contacted and advised to correct encounter forms. 8. Program staff met with Web Users group. All WebVISION system changes are completed.
C. By January 15, 2007, 2008, 2009, 2010, initiate yearly Memorandum Of Agreement (MOA) processes between the health districts and the Program in order to provide seamless continuation of services.	1.Send the guidance to the health districts to prepare the family planning services work plan (based on Title X grant submission), and a Service Site Form each fiscal year by January 15. 2. Send districts their Title X allocations and request budget preparation by 3/15 (after receipt of Title X NGA). 3. The Program staff will review districts' work plans and budgets. 4. The Program staff will notify districts of any identified issues or concerns and negotiate resolutions. 5. The Program staff will notify the business office of all approved district work plans so the MOA process can be initiated.	Nurse Consultant Nurse Senior Business Manager Health Districts Administrative managers District Nurse Managers	1/07-3/2011	1. Guidance sent to health districts by the Program. 2. Allocations are sent to the districts and budgets reviewed and approved. 3. Work plans and Service Site Forms received and reviewed by Program staff. 4. All issues and concerns are resolved. 5. Approved MOAs sent to districts for signatures and returned.

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
D. By 3/11, Partner with community based organizations (CBOs) that work with vulnerable or at-risk populations to increase client referrals to local health department family planning clinics and offer consultation, TA and training.	1. Require districts to identify CBOs etc. to work in partnership to provide services and/or resources, TA, consultation in their Work Plans. 2. Encourage districts to collaborate with CBOs and if possible identify resources available. 3. Require districts to describe in their Work Plan activities and/or resources to be provided to CBOs. 4. The Program will contact the Rural Health Assoc., Primary Care Assoc., and Free Clinics Assoc. leadership to schedule meetings to offer TA and consultation regarding referral of their populations to FP services, provide training on assessing all women ages 15-44 for family planning needs, new methods, cervical cancer screening and follow-up guidelines and staff training on provision of FP services. 5. Advise Training 3 to include in their training announcements, FQHCs, Free Clinics, and other family planning service providers. 6. Program staff will provide Training 3 with mailing address of above entities.	Nurse Supervisor Nurse Consultant District Administrative staff Program staff	4/05-3/2007	1. The 2007 Work Plan submissions identify CBOs the districts will offer resources if available, but at a minimum TA and/or consultation. 2. Health districts will identify CBOs in Work Plans and progress reports and what resources provided. 3.Program staff will assess district partnerships with CBOs at site visits. 4. Program staff collaborated with the 3 CBOs and TA/consultation provided. 5. Yearly, review Training 3's Virginia mailing list for correct addresses and current FP service providers, FQHCs etc. 6. Mailing addresses were provided.

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
E. By 6/2011, Monitor the Sterilization Program to assure maximum utilization of resources for service provision within the prescribed program time frames.	1. Provide on going guidance to local staff regarding the processes and procedures of the program. 2. Update the Medicaid reimbursement costs annually. 3. Determine each year the average cost per patient on which to base the following year's encumbrances. 4. Monitor accuracy of bills and timeliness of submission. 5. Assess areas with high cancellation rates for possible technical assistance. 6. Monitor provider contract status to assure contracts are valid/current. 7. Provide cumulative and specific health district data reports annually. 8.Update Sterilization Manual yearly & place on the Nursing website. 9. Provide yearly report to the Sterilization Program coordinators and nurse managers.	Nurse Senior Administrative and Program Support Specialist Local Health District staff	7/07-7/2010 (state funds provided on state fiscal year)	1. 98% of Sterilization Program funds are spent each year. 2. Training and consultation are provided on site to local staff as needed. 3. All sterilization procedures and services are performed by providers/facilities under current VDH contract. 4. Local coordinators notify Sterilization Program staff within 24 hours of patient cancellations. 5.Areas with high cancellation rates are identified and were provided assistance. 6. Provider Contracts are current and renewal notifications were sent. 7. Program Administrator and districts are provided annual data reports. 8. Revised Sterilization manual on web by July 1 each year. 9. Yearly Sterilization Report provided by 9/30.
F. By 3/31/2011, maintain the OFHS Family Planning Program web site for current and timely information.	1. Continuously add new information and links as they become available for use by field staff and the public. 2. Add updates regarding the Family Planning Manual, Sterilization Manual, patient education materials, order form for patient educational materials including the Program and Nursing web sites and links to other pertinent websites and other posted materials as necessary.	Nurse Consultant Nurse Senior Administrative and Program Support Specialist OIM web specialist	4/07-3/2011	1. The OFHS Family Planning web site is updated with current information and links.

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
	1. Provide the RPCs with Program/district Work Plans for review and feedback by 1/30 each year. 2. Use the RPC review recommendations in the preparation of the next cycle Work Plan. 3. Provide I & E committee with any newly created patient education materials for review quarterly i.e. Obesity brochure.	Nurse Consultant Nurse Senior	4/07 – 3/2011	1.RPCs reviewed the plans and provided input to the Program. 2. Committee reviewed all newly printed patient ed. materials.
	1. Explore and identify an evaluated performance measurement system. 2. Engage VDH management i.e. nursing director, DWIH director, and nursing council to start the process. 3. Establish performance measures work group to be composed of nursing staff of different levels. 4. Request TA for development, implementation and evaluation. 5. Develop a FP Program performance measures process. 6. Pilot-test the process in 2 districts. 7. Train district staff on use of the process. 8. Evaluate the use of the process in all the districts.	Nurse Consultant Nurse Senior Nursing Director Nursing Council DWIH Director	4/08-3/2011	1. Potential Performance Measures process is identified. 2. VDH management supports the concept. 3. The committee is established. 4. TA is approved and used. 5. The committee determines which Performance Measure process to use. 6. Several districts successfully pilot the process. 7. All district staff involved in implementing the process is trained. 8. Evaluation of the use of the process in the districts is successfully completed.

Type of Objective: Clinical

GOAL: By 2011, improve staff knowledge and skills to increase clinical efficiency, service availability and accessibility, while promoting holistic women's health across the life span.

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
A. Increase the family planning caseload through 3/31/2011.	1. Health districts develop strategies to increase caseloads in the annual work plan submitted each year. 2. Program staff will provide consultation and technical assistance to improve services, efficiency, availability and outreach. 3. Require districts to perform PFA at least yearly at each site. 4. Districts using results of PFA, will develop strategies and plans to improve clinic efficiency.	Health district staff Nurse Consultant Nurse Senior	4/08-3/2011	1. Work Plans are submitted each year and document activities to increase caseloads. 2. Program staff site visits. PFA process and results reviewed. 3. WebVISION District caseload data reviewed quarterly. 4. Mid-year and end-of-year progress reports will note PFA results, improvement strategies and documented improvements.
B. By 3/31/2011, increase the numbers of Women in Need served.	1. Provide district profiles listing health stats, WIN, caseload etc. (See Appendix__, Health District Profile) 2. Those districts with highest WIN (VA Beach, Norfolk, Richmond City, Pr William and Newport News, plan a meeting to discuss the stats and request they bring community stakeholders together to develop strategies to target high-risk populations. 3. Require health districts to develop strategies in work plans each year to target specific populations (incarcerated,	**Health district staff** Nurse Consultant **Nurse Senior**	**4/07-3/2010**	1. District profiles were provided. 2. 5 Districts identified, meetings held and district have begun the process to target high-risk populations. 3District work plans reviewed with the required strategies provided. 4. Program site visits were made. 5. Mid-year and end-of-year progress reports submitted in outcome based format in 2008. 2009, 2010 and 2011. 6.CDC evaluation completed. 7. The focus groups report was provided and the districts in their

Clinical Continued

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
	teens, group homes, shelters etc). Require inclusion of Community outreach strategies. 4. At district site visits, Program will assess activities to reach WIN and provide consultation/TA as needed. >			work plans developed strategies to address the barriers to care.
B. By 3/31/2011, increase the numbers of Women in Need served. C. By 3/31/2011, increase the numbers of FP patients who know their HIV status, by referral for testing and provide HIV/STD risk reduction education/ counseling using the ABC" message.	5. Districts will document accomplishments in mid-year and end of year progress reports. 6.Collaborate with Training 3 for a 3 yr. CDC funded project with VA Dept of Social Services to implement an evidence based curriculum pilot project in Richmond area group homes/foster care settings aimed at prevention of teen pregnancies. 7. Provide districts report of the focus group findings. Require districts to include in work plans, strategies to begin to eliminate identified barriers to care. 1. Require health districts to include strategies in work plan each year on how they will encourage women to assess HIV status yearly. 2. Program staff assess at site visits, FP staff providing both written and verbal information about importance of knowing HIV status, providing HIV/STD risk	Nurse Senior Nurse Consultant Health district staff Division of HIV/STD and Pharmacy Services	4/1/08-3/11	1. District work plans and progress reports are submitted each year to Program staff for review and approval. 2. Program site visits made and staff assessed for provision of required written and verbal information. 3. Mid-year and end-of-year progress reports document staff are providing assessment tool. 4. Family Planning HIV/STD self - risk tool assessment is being used at family planning visits as assessed at site visits. > 5 HIV supplemental funds are received. 6. Training 3 training or resource provided yearly.

Clinical Continued

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
C. Continued	reduction education/counseling using the "ABC" message, and encouraging referral for testing. 3. Require staff to provide HIV/STD self-risk assessment tool to each client at initial and annual visit. 4. Program will collaborate with STD Program to apply for HIV Supplemental funds at the next funding cycle to implement HIV rapid testing in areas with high HIV/AIDS prevalence. 5. Request Training 3 to provide at least yearly, one training or training resources regarding pertinent HIV/AIDS/STD topics. 6.Require districts to return the STD program treatment documentation within 14 to 30 days that all patients testing positive were treated.			7. STD program provided the Program with documentation that reports on all patients were treated with in the time frame and reports were received.
C. By 3/2011, family planning clients with a known history of Gestational Diabetes Mellitus (GDM) will be made aware of their future risk of developing Type 2 diabetes and be informed of life style risk reduction behaviors.	1.In collaboration with the Women's Health Consultant, statewide staff will be trained via video conferencing on the association of GDM with Type 2 diabetes development and risk reduction behaviors 2.A section for GDM will be added to the patient health history form. 3.Staff will assess all FP clients for a history of GDM.	Nurse Consultant Nurse Senior Women's Health Coordinator	1/07-3/2011	1. Video conference presentation was provided live and taped for VDH FP staff future use. 2. Documentation by Exception Record committee accepted recommended change to record. 3. At the site visit, staff was observed assessing patients for GDM. **4. At the site visit, staff was observed providing the required**

Clinical Continued

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
	4.Staff will provide all women with a known history of GDM with risk reduction counseling and educational materials about future risk of Type 2 diabetes and subsequent GDM with future pregnancies. 5. Staff will assess Type 2 diabetes screening status for women with known history GDM and encourage women to be screened according to Diabetes Expert Panel or ACOG recommendations. 6. At least 3 health districts will be targeted and offered funding to provide blood glucose screening on women with a past history of GDM through Title V or PHHS funding.			counseling and education to at risk patients. 5. At the site visit, staff was observed advising patients to obtain follow-up screening according to recommendations with a referral given for a provider if the patient does not have a PCP. 6. 3 health districts provided funding to provide glucose screening to women with a history of GDM.
E. By 3/31/11, assure family Planning staff has the opportunity to train by a variety of modes such as telephone, video conference and face to face on various subjects such as, new contraceptive methods, encouraging parental involvement, sexual coercion/domestic violence and	1. Request Training 3 to provide at least one course on "New Contraceptive Methods" and clinical update as appropriate during each grant year using videoconference. 2. Collaborate with VDH DIVP to train FP staff on counseling teens about sexual coercion, sexual assault and domestic violence. 3. Require the districts to meet yearly with DSS/CPS and law enforcement to discuss changes in the laws on reporting child abuse, neglect etc. 4. Provide 2-3 statewide Program staff meetings via video-conferencing re "best	Nurse Senior Nurse Consultant Training 3 Health District staff	4/07-3/2011	1. Training 3 presented one training each project year. 2. Review regional training attendee list of VDH DIVP sexual coercion trainings, sexual assault and domestic violence trainings. 3. Districts document in progress reports that staff meets with DSS/ CPS and law enforcement. Community Education logs list DSS/CPS trainings 4. 1-2 Video-conferences were provided to statewide staff. 5. Districts clinicians are trained to insert IUDs and preceptors

Clinical Continued

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
improving clinic efficiency.	practices" and Program updates. 5. Collaborate with Training 3 to provide IUD clinical training and establish a preceptor program. 6. Partner with CDC Every Woman's Life Program to offer required web-based CEU training on cervical cancer screening and Pap smear follow-up to staff. 7. Women's Health Coordinator provide training using video-conference to district FP staff on the link of HPV to cervical cancer, the recommendations for HPV vaccination, use of the CDC Fact Sheet on HPV and the recommendations of the Cervical Cancer Task force.			identified to assist. 6. Training completed, evaluations and post-tests received. 7. Training provided
F. By 3/31/11, all women attending VDH family planning clinics will be informed of their BMI, and provided counseling regarding health risks and life style behavior changes.	1. The Program will consult with central office WIC staff to explore using local WIC staff for referral of over weight new parenting FP clients for counseling 2. Program staff will collaborate with the statewide Champion Project to reduce obesity. 3. The Program will contact VA Tech Extension Services to explore using them as a referral source for over weight clients in districts. 4. The Women's Health Coordinator will.	Nurse Consultant Nurse Senior Health District staff Training 3 Women's Health Coordinator	4/08-3/2011	1. The Program advised districts about the use of local WIC staff and provided contact information on locations of Extension Services staff for client referral. 2. Program staff collaborated with the Champion Project. 3. Training is provided to staff. 4. At the time of the site visit, staff was observed giving appropriate patients, if wanted, the brochure. 5. The FP Program established a link to the Training 3 website. 6. Program staff participated on the Obesity work group until the

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
	provide videoconference training to statewide staff on relationship of reproductive health and healthy weight, BMI measurement, and available resources. 5. Staff will provide patients needing weight management information with the Region 3 developed brochure "*A Healthy You-Understanding Weight Management and Reproductive Health.*" 6. The Program will establish a link on the Program website to the Training 3 website for Healthy Weight staff and patient resources. 7. Program staff will continue to participate on Region 3 Obesity work group.			work was completed.
G. Offer the new implantable contraceptive-Implanon to patients who desire this type of method by 9/07.	1. The Program will review the patient materials from the vendor regarding its use for VDH patients. 2. Determine if and what the public sector cost will be. Investigate and evaluate how Implanon can be integrated into existing services. 3. Develop an approved protocol by the Family Planning Medical Advisory Committee on use of Implanon. 4. Facilitate clinician training in collaboration with Organon. 5. Notify the districts of the availability of this method when appropriate. 6. Explore the use of state Contraceptive	Nurse Consultant Nurse Senior Health District Staff	6/07-12/2007	1. Information from the vendor is received, reviewed and determined if it is feasible to offer to VDH patients. 2. Cost information is obtained. 3. Protocol is developed, approved and distributed. 4. Training of clinicians is planned and coordinated with Organon if it is determined that it is cost beneficial to provide. 5. Districts provided information on the method, cost and how to order. 6. The Program provides funding

Clinical Continued

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
	funds to help districts purchase Implanon.			to assist the district to purchase Implanon.
H. By 3/2011, all patients attending family planning clinics will be assessed for depression especially postpartum depression	1. Promote use of the VDH web based, provider training on perinatal depression. 2. Request the division policy analyst to assist the Program in identifying a depression assessment tool that would be appropriate for use by family planning clients not postpartum. 3. Local health department staff must identify community patient referral resources. 4.Update Family Planning Manual guidance regarding assessing patients for depression. 5. Include this objective in the districts' work plan.	Nurse Consultant Nurse Senior Policy Analyst	04/07 – 03/31/2011	1. Reported at site visits & reports. 2. Tool is identified and provided. 3. Districts identify referral sources as reported in their progress reports. 4. Family Planning Manual has been updated to include assessment tool. 5. District work plans show activities regarding implementing assessment of patients for depression and progress reports document accomplishment. 6. At site visit, staff observed giving the tool for patient complete, providing counseling and referral as appropriate.
I. By 3/2011, each patient at the time of initial/annual visit will be assessed for domestic violence (DV).	1. Require Family Planning Staff to assure that all patients have answered DV related questions on patient completed history form and appropriate counseling is provided and recorded. 2. Require that all districts place DV posters/pamphlets with the hotline number in patient changing areas and bathrooms. 3. Collaborate with the VDH Division of Injury and Violence Prevention, domestic violence coordinator to facilitate districts obtaining DV	Nurse Consultant Nurse Senior Health Department Staff DIVP	4/08-3/2011	1. At the Program site visit, staff observations and record reviews show documentation that patients were provided DV information as indicated. 2. Program staff at the time of the site visit will observe if information available to patients in dressing areas and bathrooms. 3. Collaboration will have occurred and materials provided to local staff or information

Cinical Continued

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
	information for patients/staff, to include up to date listing of DV resources and centers in the localities. 4. Require districts to have an annual staff meeting with local DV staff for training. 5. Request DIVP to provide videoconference training based on the results from the provider survey.	Women's Health Coordinator Nurse Consultant Nurse Senior District staff	4/07-3/2011	provided regarding where they can be obtained. This will be documented in progress reports. 4. At site visit, Program staff will review staff in service records. Progress reports will document that the meeting with local DV staff has occurred. 5.Videoconference training was provided by DVIP staff.
J. By 3/2011, all patients will be provided information regarding the periodicity for women's health screenings as well as heart disease risk in women to include signs and symptoms of a heart attack.	1.Clinic staff will provide all clients the "*General Screenings and Immunizations Guideline for Women"* brochure developed by the Office of Women's Health and the "Heart Truth Campaign" fact sheets developed by NIH. 2. All districts will include in their work plan, activities that support National Women's Health Week Wear Red Day. > 3. The DWIH Women' Health Coordinator will provide each district with an initial supply of the screening periodicity brochure and how to obtain subsequent copies. 4.The DWIH Women's Health Coordinator will provide the districts with promotional materials for National Women's Health Week Wear Red Day.	Nurse Consultant Nurse Senior Training 3	4/07-3/2011	1.Districts provided the brochure/fact sheets to clients as reported work plan progress reports. 2. District work plans show activities supporting National Women's Health Week Wear Red Day. > 3. The Women's Health Coordinator provided the districts with initial supplies of the screening periodicity brochure and the information on where to obtain additional supplies. 4. The Women's Health Coordinator provided the districts with promotional materials for National Women's Health Week Wear Red Day.

Type of Objective: Community Education and Outreach

GOAL: By 3/2011, provide community education and outreach to state and local entities to reach populations in need of family planning services and education.

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
	1. The Program will identify sources for family planning health education materials in languages needed by the districts. 2.The Program will collaborate with Training 3 to provide training to staff about working with special growing populations such as Hispanics, in the regions of the state that are impacted. 3. Collaborate with the VDH Health Policy office in locating resources for staff and use of the VDH website for translated materials. 4. Collaborate with the Northern Virginia AHEC who has expertise in working with diverse population to assist in training staff and for language resources. 1. Districts will identify community partners. 2. Require districts in their work plans to develop marketing strategies. 3.Require districts to provide education and training about reproductive health to appropriate community organizations i.e. PTAs, correction facilities, group homes etc. 4. All districts with Partners In Prevention (PIP) Programs (Non-Marital Birth prevention project) will be required to	Nurse Senior Nurse Consultant Health district staff	4/08-3/2011	1. Sources for Health Education materials in languages needed by the districts were provided. 2. Training 3 provided trainings to staff in working with identified specific populations. 3. The Program used the available resources from the Policy Office. 4. NOVA AHEC assisted the Program in providing training and language resources to health districts. 1. Partners are Identified in the districts' progress reports. 2. Marketing strategies are listed in the activities section of the work plan. 3. Community education and training provided as listed in the districts progress reports and WebVISION data reports for community events. 4. Districts report their collaboration activities with the PIP programs in their progress

Type of Objective: Family Involvement

GOAL: By 2011, assure that all teens are encouraged to discuss their family planning needs with parents.

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
	collaborate with them to provide programs to their participants about family planning, birth control methods and where services are available. Districts will be required to report their activities in their program reports.	Nurse Consultant Nurse Senior Health District staff Training 3	4/07-3/2011	report.
	1. Require districts to develop strategies in work plans. 2. Require family planning staff to counsel teens to include their family in reproductive health decisions and it is documented in the record. 3. At Program site visits, FP Program staff will observe district staff skills in counseling and encouraging teens to involve parents in reproductive health decisions. 4. Records will be audited for documentation.	Nurse Senior	4/07-3/2011	1. Program staff review and approval of district work plans. 2. On site visits, Program staff observes staff counseling teens and that is documentation in patient's record. 3. Program staff will interview teens to assess if counseling offered. 4.Record audits show documentation that all teens received counseling.
	1. The Program will meet regularly with CHATS (Collaborative HIV/STD, Abstinence, Teen Pregnancy and Sexual Health) team, composed of representative from VDH--DCAH, DWIH, DVIP, DDP, Departments of Social Services, Education and Mental Health.			1. Program staff is an active member of the committee. 2. The Program implements as appropriate targeted activities developed by the team.

Type of Objective: Financial Management

GOAL: By 3/31/2011, assure that the Family Planning Program's financial management meets all state and Title X financial standards and funds are spent appropriately.

OBJECTIVE	ACTIVITY	PERSON (S) RESPONSIBLE	BEGIN/END DATES	EVALUATION
A. By 3/31/2011, explore adding new sterilization providers in under served areas and maintain current providers.	1. Collaborate with district staff to identify potential providers and make personal contacts to encourage program participation. 2. District staff makes personal contact with those providers who do not renew their contracts emphasizing the importance of their continued participation in the program.	Administrative and Program Support Specialist Nurse Senior District Sterilization Program Coordinators Information Systems Technical Support	4/08-3/2011	1. Staff identified providers not under contract willing to provide sterilization procedures at VDH reimbursement rates. 2.Staff made personal contacts with providers that have not renewed contracts and were able to convince most of them to renew.
B. By 3/2009, determine a cost methodology to determine the actual cost of providing services by district.	1. Using the recommendations of the Region 3 Cost Methodology work group to begin the process in VDH. 2. Obtain TA to assist in developing and applying a cost methodology. 3. Convene a cost methodology advisory committee made up of district business managers, nurse managers, district director, and OFHS business manager. 4. Once a costing methodology is developed, apply the methodology to determine the actual costs of providing family planning services in the districts. 5. Evaluate the results and provide them to Community Health Services deputy commissioner and fiscal office.	Nurse Consultant Nurse Senior OFHS Business Manager	4/08-3/2011	1. Recommendations from the Region 3 Costing work group are obtained. 2. Requested TA obtained from Region 3. 3. Costing committee formed and using the TA consultant, a methodology identified. 4. The costing process using the identified methodology is completed. 5. The information obtained is evaluated and recommendations provided to VDH fiscal office and Community Health Services commissioner.

E. Clinical Management

The mission of the Family Planning Program is to provide reproductive health care to low-income women and men of Virginia in a caring atmosphere in the most effective and efficient manner possible. Eligibility for family planning services is based on the VDH Eligibility Guidelines. Family Planning staff collaborate on the Family Planning sections of the guidance to ensure they meet Title X guidelines. The Board of Health sets all charges and services on a sliding fee scale based on the Federal Poverty Level. Those at 100 percent of Federal Poverty Level are provided free services. Patients presenting themselves for family planning services are required to sign consent for the provision of the requested services. They also must sign a method specific consent form each year.

Family planning services in local health departments are uniform throughout the state. This uniformity is assured through the Family Planning Manual which is developed, maintained and distributed to every local health department by the Family Planning Program and contains the guidance for required services, including the Title X Guidelines (See Appendix __, Family Planning Manual-Table of Contents). The Title X Program has been essentially institutionalized in the Virginia Department of Health. Guidance and protocols for Sexually Transmitted Disease screening and treatment and Immunization services in statewide family planning clinics are provided by these programs through their manuals and by their staff, both at the state and local levels.

Direct care providers. Medical services are provided at all local health department family planning locations by either a nurse practitioner or a physician. Physicians are licensed by the Virginia Board of Health Professions, Board of Medicine and must be licensed in Virginia to practice. The Board of Nursing and the Board of Medicine, jointly license Nurse Practitioners,

who are family, women's, family planning or certified nurse midwives. They are required to obtain a specific number of continuing education credits every three years to maintain certification. Nurse practitioners must practice under the supervision of a physician. Each nurse practitioner working in a health district must have the review and approval of her practice protocols every year by the supervising physician who is usually the district director or another physician practicing in the district. Nurse Practitioners are licensed to prescribe drugs and authorized to dispense specific drugs according to Board of Pharmacy regulations.

Facilities. Each city and county in Virginia has a family planning clinic site or satellite site accessible to low-income citizens, with most located within a thirty-minute drive. Public transportation is available in the more urban and suburban areas. Clients living in rural areas must provide their own transportation or rely on family and friends. Some localities have formed transportation initiatives to obtain funds to develop a transportation system to assist low-income citizens in accessing health care. Clinical facilities are usually located in a health department building owned by the local jurisdiction. Many health departments are co-sited with social services and/or located in a governmental office complex.

Service plans and protocols. The basis for protocols is contained in the Family Planning Manual and other program manuals such as STD and immunization. The Family Planning Program with the approval by the Family Planning Medical Advisory committee developed Depo-Provera and Pap smear protocols as minimal standards for practice statewide.

The Family Planning Medical Advisory Committee is composed of two physicians; the chairman an OB/GYN and a district director, the other is an OB/GYN physician provider from a health district; and five health district nurse practitioners. The chairman is consulted whenever necessary to provide advice regarding medical issues. This committee advises and assists in the

development of medical policies and protocols for the statewide Family Planning Program. The committee invites reproductive health experts in the state to provide consultation and guidance as needed to assist the committee. Policies adopted by the committee are issued to local health department staff for inclusion in the Family Planning Manual. At the time of the site review visit, assessment regarding the adherence to statewide medical policies and protocols is determined. Statewide protocols are periodically reviewed and revised as needed by Program staff.

Services. All family planning services are provided directly on site, however some localities may refer for IUD services and abnormal Pap follow-up. Staff routinely review and counsels patients on how to handle a method-related emergency. Family planning patients must rely on their private physicians or local emergency departments for acute gynecological emergencies when health departments are closed. Patients are encouraged to call during working hours for problems and are scheduled for a problem visit at the first opportunity. Many health departments have integrated clinics and are able to see patients the same day they call for assistance. Teens remain a priority for appointment availability.

All health districts must have procedures in place to assure clinical tracking for follow-up and referral of abnormal findings. Districts must follow protocol in the Family Planning Manuel. The program manager observes the follow-up system and local health department staff are also asked to describe the system at the time of the site review visit. For abnormal high grade Pap smears, health districts are required to initially complete part of a CA406A-Follow-Up of Abnormal Pap Smear form and send it to the Family Planning Program. It documents the date of the follow-up appointment. Once follow-up and treatment are completed the form is returned to the Program with the results. The CA406A form is multi-copy with one copy retained by the

Program, another is sent to the Cytology Laboratory, one copy is retained in the patient's record and another for the referral/treatment provider. The Program receives a monthly listing of abnormal Pap smears from the cytology laboratory, which is used as a follow-up surveillance system by field staff. If the program does not receive a CA406A within 8 weeks of the identified abnormal Pap, central office staff contact the health district to determine if follow-up has occurred.

Laboratory Services. The Division of Consolidated Laboratory Systems (DCLS), which is the state public health laboratory with two satellite labs and 11 regional laboratories, provides the laboratory services for gonorrhea, syphilis, HIV and chlamydia unless the patient has Medicaid or private insurance and these tests are sent to a private laboratory. The HIV/STD Program picks up the costs for all STD screening tests for non Medicaid patients. The DCLS, which is a reference laboratory, and the regional laboratories are located in the Virginia Department of General Services (DGS). This department assures that these labs have proper credentials, are accredited and provide quality assurance.

Cytology laboratory services for local health departments are obtained through the Department of Mental Health, Mental Retardation and Substances Abuse Services (DMHMRSAS) contract. The DMHMRSAS, DGS and a Cytology Service Review committee develop the competitive Request for Services (RFS), review submitted RFS and recommend the laboratory for contract award. The Family Planning Program staff is a member of this committee and provides expert advice regarding the development of the scope of services contained in the RFS. The Family Planning Program works directly with the cytology laboratory regarding issues and problems reported by the health districts, in addition to informing the DMHMRSAS cytology contract manager about identified problems.

Pharmacy services. The Virginia Department of Health operates a central pharmacy that provides drugs and biologics to 12 health district pharmacies and local health departments. The VDH Pharmacy Services is headed by a licensed pharmacist, as are the 12 health district pharmacies.

VDH follows all the federal and state laws and regulations regarding the handling and storage of pharmaceuticals as outlined in the *Code of Virginia* and regulated by the Board of Pharmacy. Licensed physicians dispense pharmaceuticals and nurse practitioners are licensed to prescribe and authorized to dispense by the Board of Pharmacy.

The inventory, supply and provision of pharmaceuticals are the responsibility of the health district physician director, who may delegate to another physician or nurse practitioner according to state laws. Each local health department maintains a supply of drugs and devices according to utilization and patient needs. In addition to contraceptives, local health departments maintain supplies of drugs to meet the routine needs of patients for other related medical problems. All drugs in local health departments are stored in secure, locked rooms or cabinets accessible to only medical staff. All health departments maintain emergency resuscitative drugs, supplies, and equipment. During district site reviews, pharmaceutical security, drug/method availability and adequacy of contraceptive drugs and devices are assessed.

HIV services. All family planning patients receive education and counseling on their risks for HIV/AIDS prevention. Each patient is provided on each visit an STD/HIV self-assessment tool to help determine risks for STDs/HIV and determine need for HIV testing. All patients are provided written information on HIV/AIDS infection initially and annually. The Program provides all the health departments with a brochure entitled "AIDS, Women get it, too" for distribution to all family planning patients.

All women in family planning clinics are referred for HIV/AIDS testing. Many attend the local STD clinic or are able to obtain testing at the time of their visit. The HIV/STD Program is responsible for VDH staff training. Patients are encouraged to use condoms. The Program offers free condoms to all clients in addition to their contraceptive method of choice.

Medical records. VDH has in place policy and procedures for the maintenance and safekeeping of patient records located in the Department Administrative Management Manual. All records must be located in secure files that can be locked or placed in a locked room only accessible to authorized health department staff. Records can only be released at the request and with written permission of the patient. VDH has a standardized patient record release form that allows for this process. The current recommended record system is Documentation By Exception (DBE). The purpose of this record system is to improve the patients record system by reducing the amount of time spent in documentation to promote cost-effective, legally defensible patient care.

The DBE system is based on standards that define acceptable practice; minimum program requirements, which for the family program is Title X; and normal parameters for assessment, examination, intervention, expected patient responses and outcomes. The baseline of services is defined for every patient served in any health department in Virginia. Providers meeting that baseline level of service can use flow sheets to note assessment, examination, intervention and expected patient responses in the areas indicated by using a checkmark. An asterisk indicates that the patient response was not normal or the provider omitted something that is required by the standard. In most cases, the asterisk indicates the reader should look somewhere else for clarification. Retention of records is set at 10 years after last treatment. For a minor, records are

retained 5 years after age of majority (age 23) or 10 years after last date of treatment, whichever is later.

The Family Planning Program manager was a member of the Electronic Health Records Strategic Planning Group organized by the Deputy Commissioner for Public Health programs to discuss issues, concerns, advantages, disadvantages, project steps, preliminary design steps, business and cultural changes, training etc before proceeding with an RFP. The VDH has issued a Request for Proposals for the establishment of an electronic medical record.

Client education and counseling. All patients are required to receive individualized education and counseling about the availability of all FDA-approved contraceptive methods; how to use their method of choice, risk and benefits; understand the procedures and testing provided at the visit; basic male and female anatomy and physiology as necessary; prevention of sexually transmitted diseases, the benefits of abstinence as a choice; resisting sexual coercion and family involvement for teens, breast self-exam, preconceptional health, and how to access staff for problems. The requirements for education and counseling are contained in the Family Planning Manual and the Title X Guidelines. Documentation of counseling and education is proscribed by the DBE Record Guidelines. During the site review visits, staff is observed and assessed for the provision of quality patient education and counseling.

The Family Planning Program has historically provided the health districts, schools, health care providers, agencies and organizations with basic family planning brochures and pamphlets. Where ever possible the program provides Spanish versions of the information. The program produces and prints *Practice Birth Control/Plan Your* Pregnancy *Carefully* and *Dir*ectory *of Local Health Department Clinics and Virginia Genetic Disease programs Locations.* State statute requires that these two pieces of information also be provided to all state circuit courts to

be distributed to persons obtaining marriage licenses. See Appendix__, Family Planning Order Form.

Clients receiving sterilization services funded by VDH must be 21 years of age, mentally competent, receive counseling, sign a consent, wait 30 days before receiving the surgery. All patients must review and sign a Sterilization Information Check Sheet to assure the decision is voluntary, they must understand the risks and the procedure, and can understand they can withdraw consent at any time and reapply, and that all their questions are answered. The Program does not serve clients that have court ordered procedures.

VDH requires that patients sign a Patient Application for Health Care to give permission or general consent to authorize clinicians to examine and treat, agreement to pay for services based on income, to release records for payment by third-party payer and deemed consent for HIV, Hepatitis B or C. Patients selecting Depo-Provera, IUD, Oral Contraceptive or other prescription methods must sign an Informed Consent for Special Health Services that requires that the risks and benefits must be explained and documented in the patient record.

Patients who are found to be pregnant in a family planning clinic are provided requested information and non-directive counseling regarding the management of their pregnancy and referral on request to include prenatal care and delivery; infant care, foster care and adoption; and pregnancy termination. The process is assessed during site visit reviews.

Community education / outreach. The Family Planning Program Information and Review Committee is regularly sent new brochures or other patient information for review. At the time of the site review visit, districts are asked to provide their community education plan and discuss what promotional efforts they have participated in their communities. All districts provide education and promotional efforts in a variety of settings such as housing projects, churches,

schools, jails, detention centers, etc. Approved Family Planning patient education brochures are available on the VDH internal website Community Health Services-Nursing. Community Education is provided by health district staff. The Program assures this is done from twice a year district progress reports listing specific community education and outreach activities.

Evaluation and quality assurance assessment. The Family Planning Program is responsible for evaluation and monitoring of the quality of care provided to patients who receive family planning services at local health department clinics. The most effective and efficient method to evaluate and assure that quality and required services are being provided locally is through the family planning site review visit conducted by the Family Planning Program staff. All aspects of patient care are evaluated through observations of staff providing services to patients, patient and staff interviews, review of records, review of local protocols, procedures and policies. The Virginia Family Planning Program has been providing Title X-based services for thirty-two years and staff is very knowledgeable about the requirements. Health districts conduct peer review audits to assure that appropriate and required care is documented. Verification is provided during the site visit.

Health districts are required to assess patient satisfaction with their services by conducting patient satisfaction surveys at least yearly; most conduct them more often. The districts report the results of patient satisfaction surveys in their progress reports to the Program. The program manager at the time of the site review visit also interviews patients regarding their satisfaction with their health department services. Usually without fail, most report they are pleased with their services, they are treated with respect, their questions and concerns are answered and they can usually reach a staff person if they have a need. The only consistent complaint voiced by patients is that in some locations they may have a long wait to receive clinic services on the day

they are in clinic. Consultation is provided regarding conducting Patient Flow Analysis, and evaluating the appointment system as basic approaches to eliminating wait times for services.

Financial management. It is the responsibility of the VDH to ensure that sound fiscal systems, policies and procedures are in place for accountability of all funds, property and other assets. The Agency's Fiscal Office and the Office of Family Health Services (OFHS) assist program managers in this endeavor.

The Agency's Accounting Office provides accounting direction, which includes coordination with the Agency's grants accountant and the assigned budget analyst to OFHS. Statewide direction is received from the State of Virginia's Department of Accounts. Monthly financial reports and special financial reports are provided as needed. All such reports are based on Virginia's Commonwealth Accounting and Reporting System (CARS), which is the official reporting system for all State agencies. The reports are made available to the Agency from the State Comptroller's Office.

OFHS has an established Business Unit responsible for budgeting, accounting, procurement, contracting, human resource management, grants administration and general administration. These functions are centralized into one unit to ensure programs are managed in compliance with policy and regulations. The Business Unit has a close working relationship with the Agency's administrative offices and divisions including the Accounting Office, Budget Office, Auditing Office, Purchasing Office and Human Resource Office. OFHS Business Unit and the Agency's Accounting Office work collaboratively to account for all funds and to monitor, track, reconcile expenditures and ensure compliance with policy and regulations.

The division accountant provides the program manager a monthly budget report detailing expenditures for the administrative budget and district funds, which have been allocated by the Program. Mid-year budget reviews are conducted with the program manager, division director and business manager to determine if budgets are in compliance. Documentation must be provided for any identified problems. In addition, there are centralized contract and procurement units to provide consultative and technical assistance to program staff to assure that all state policies/guidelines are followed.

The Virginia Department of Health links service eligibility, patient charges, billing and collections in its statewide web based WebVISION system. Patients entering the VDH health system receive an initial eligibility screening by providing their income either with actual proof or self-declaration before receiving services. This is updated yearly. The system calculates the income level and intake staff informs the patient what portion of their services for which they will be responsible unless they are 100% of poverty or below or are over 250% of poverty. (See Appendix__, Chart 1 – Health Department Income Levels) At the conclusion of their services, the patient returns to the intake staff where codes for services provided are entered into WebVISION. The system calculates the patient charges and generates a statement, which is presented to the patient. Patients are expected to pay their bill at the time services are provided or they can be placed on a payment plan. The health district fiscal staff monitors bill payments and age accounts.

The VDH schedule of discounts is based on the Federal Poverty Guidelines and is updated yearly. The costs for services are based on Medicaid reimbursement rates. The WebVISION system is updated when Medicaid reimbursements change. VDH has contracts with all Medicaid HMOs for reimbursement and also accepts private insurance reimbursements. The

funds the districts collect such as patient pay, insurance and Medicaid reimbursement is revenue and is used to supplement state, local and grant funds such as Title V and Title X funds for specific expenditures such as purchase of birth control methods. There are specific regulations for eligibility and charges for medical services. They are contained in a document that was recently revised. (See Appendix__, Virginia Department of Health Guidance Document for Virginia Administrative Code Chapter 200, "REGULATIONS GOVERNING ELIGIBILITY STANDARDS AND CHARGES FOR MEDICAL CARE SERVICES TO INDIVIDUALS", October 1, 2006)

The Department of Medical Services (DMAS-Medicaid) was approved for a Family Planning waiver in 1992. Women become eligible after a Medicaid reimbursed pregnancy for 22 months 60 days after the end of the pregnancy. They must remain Medicaid eligible at 133% of poverty. The waiver reimburses for an annual GYN exam, all FDA approved contraceptive methods, STD screening, Pap smear screening, and family planning office visits. DMAS is currently in the process of writing a new waiver proposal to extend the waiver to all men and women at 133% of Federal Poverty level.

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