

Vermont Title X Family Planning Needs Assessment

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Vermont Department of Health

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Executive Summary

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

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

Vermont Population

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

Insurance Status

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

Unintended Pregnancy & Teen Pregnancy

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

Births & Infant Mortality

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

Sexually Transmitted Infections & HIV

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

Title X in Vermont

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

- In 2013, Title X family planning services helped women in Vermont avoid 2,000 unintended pregnancies, 1000 unplanned births, and 700 abortions, including 400 pregnancies to teens, 200 births to teens, and 100 abortions to teens.
- In 2014, PPNNE's Title X health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont.
 - 47% had incomes at or below 100% of the FPL
 - 77% had incomes at or below 250% of the FPL
 - 24% were uninsured
 - 21% were teens under the age of 20, and
 - 11% were men.
- In 2014, 7714 female clients not pregnant or seeking pregnancy were using the following contraceptive methods:
 - 53% Moderately effective hormonal method – pill, patch, ring, Depo
 - 16% Long-acting reversible contraception (LARC) – IUD or implant
 - 3% Permanent sterilization
- In 2014, of the 776 male clients not seeking pregnancy, 65% were using the male condom, 1% vasectomy, 1% withdrawal, and 2% relied on a female method for contraception.

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

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

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

Summary & Considerations

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

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

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

- I. Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding.
- II. Promote awareness, implementation, and adherence to evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.
- III. Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling.
- IV. Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's health centers); support innovations and solutions to promote access and awareness of LARC.
- V. Facilitate linkages between primary care providers and Title X health centers in Vermont.

- VI. Increase provider and consumer knowledge of covered family planning and related preventive health services.
- VII. Explore potential opportunities to address family planning, reproductive and sexual health needs of adolescents within school-based health centers in Vermont.
- VIII. Explore opportunities for clinical-community linkages between Vermont Title X health centers and community based organizations to establish family planning—human service referral networks.

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

Introduction

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

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

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

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

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

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

Needs Assessment Process

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

¹ Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMR 2014; 63(No. 4).

² Office of Population Affairs. Program Requirements for Title X Funded Family Planning Projects. April 2014.

³ Gavin L, Moskosky S, Carter M, et. al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMR 2014; 63(No. 4).

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

Vermont's Family Planning Safety-Net

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



Figure 1. PPNNE Vermont Health Center Sites, 2015

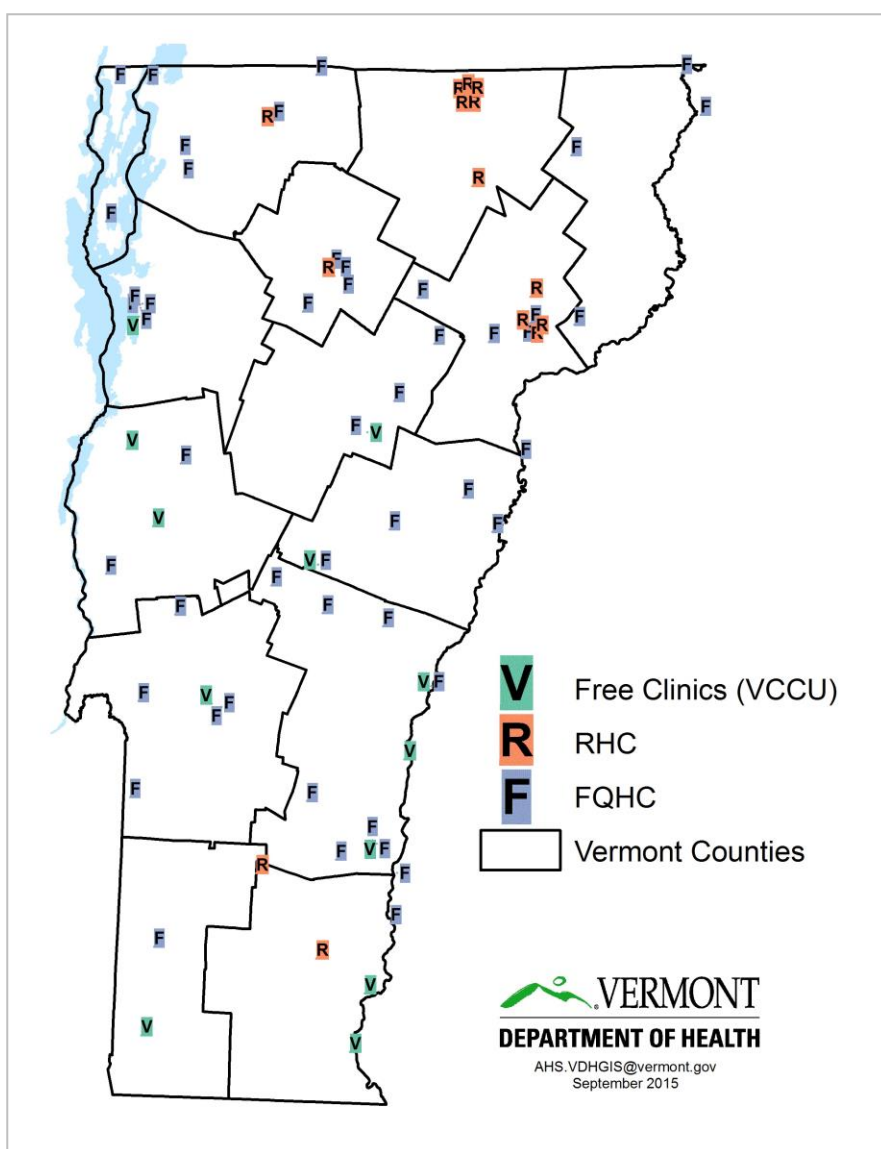
and White River Junction⁴ (Figure 1). At present, the PPNNE health centers in Burlington and Williston are not Title X sites. This network of health centers serves as a foundation for providing sexual and reproductive health, and related preventive health services to Vermont's low-income and vulnerable populations.

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

Other Safety-Net Providers.

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

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



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

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

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

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

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

Other Vermont Resources to Support Family Planning Needs

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

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

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

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

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

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

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

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

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

Vermont Geographic, Demographic & Socioeconomic Overview

Geography. Vermont is one of the most rural states in the U.S., and one of the smallest, with a population estimate of 626,630 in 2013.⁷ Vermont has only one true urban area (i.e. metropolitan statistical area) comprised of Chittenden, Franklin, and Grand Isle counties. Over 60% of Vermont's population resides in rural areas.⁸

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

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

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

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

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

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

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

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

⁷ Vermont Department of Health. Vermont Population Estimates 2013.

⁸ Census Bureau. Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports. March 26, 2012. https://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html Accessed June 26, 2015.

⁹ Vermont Department of Health. Vermont Population Estimates 2013.

¹⁰ Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.

¹¹ Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.

¹² Census Bureau. Quick Facts Vermont. Accessed August 11, 2015.

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

Income. In 2014, Vermont's average annual wage was \$43,011, with higher wages in Chittenden County at \$49,656 and the lowest wages in Grand Isle County at \$31,111.¹⁴ According to the 2014 federal poverty guidelines, an income of \$23,850 for a family of four is equal to the federal poverty level (FPL).¹⁵

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

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

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

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

¹³ Vermont Department of Labor. Local Area Unemployment Statistics. May 2015.

¹⁴ Vermont Department of Labor. Vermont Quarterly Census of Employment Wages. 2014.

¹⁵ U.S. Department of Health and Human Services. 2014 Federal Poverty Guidelines.

¹⁶ The U.S. Census Bureau's poverty threshold for a family with two adults and one child was \$18,751 in 2013.

¹⁷ The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org

¹⁸ Census Bureau. Quick Facts Vermont. Accessed June 26, 2015.

¹⁹ Vermont Behavioral Risk Factor Surveillance System. 2014 Data Summary.

²⁰ Medicaid.gov. Vermont Profile. Accessed September 9, 2015.

²¹ Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.

²² Vermont Department of Financial Regulation, Insurance Division. 2014 Vermont Household Health Insurance Survey Research Findings.

Vermont Family Planning & Reproductive Health Overview

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

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

Births. In 2013, 5,951 babies were born to Vermont residents, representing a birth rate of 51.2 births per 1000 women 15-44 years of age (i.e., fertility rate), a slight decrease from 51.5 in 2012 and 51.6 in 2011. The teen birth rate in Vermont in 2013 was 14.5 births per 1000 women 15-19 years of age, compared to the U.S. rate of 26.5; 317 infants were born to Vermont mothers ages 15-19 in 2013.²⁵

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

Pregnancy & Unintended Pregnancy. In 2013, the pregnancy rate in Vermont was 61.2 pregnancies per 1,000 women age 15 to 44, a decrease from 61.7 in 2012 and 62.4 in 2011. The 2013 teen pregnancy rate was 21.9 pregnancies per 1,000 women age 15 to 19 years, a decrease from 23.1 in 2012 and 25.2 in 2011. In general the teen pregnancy rate has been decreasing since 1991.²⁷

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

²³ Vermont Department of Health. Vermont Population Estimates 2013.

²⁴ Vermont Behavioral Risk Factor Surveillance Survey. 2013 Data Summary.

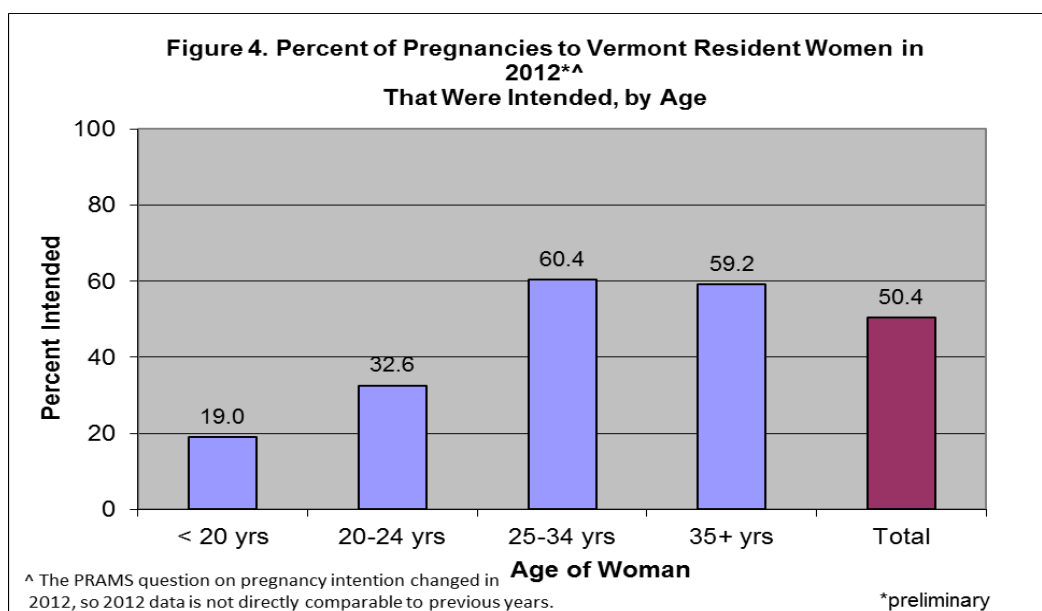
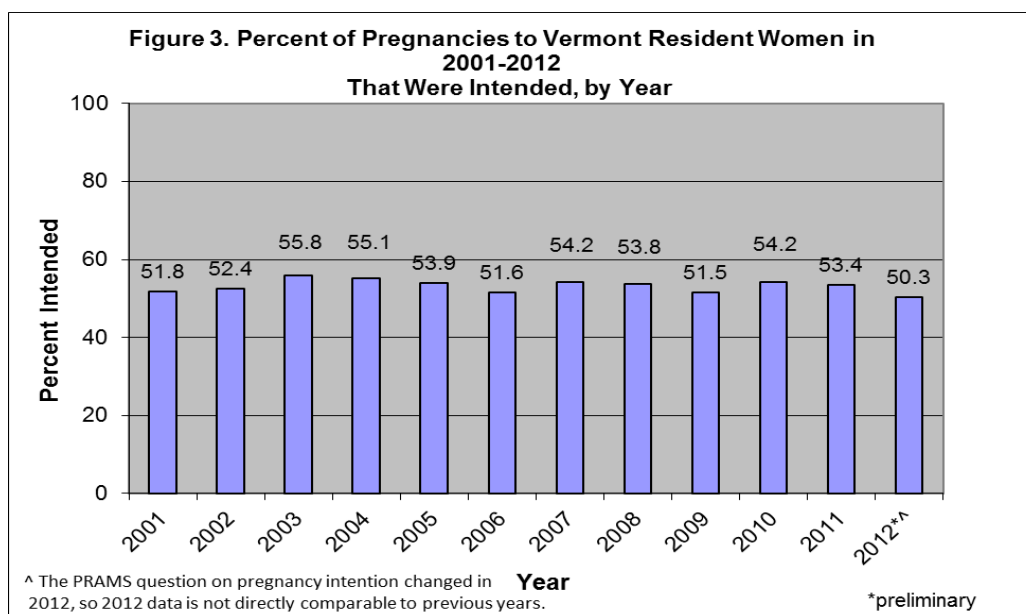
²⁵ Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.

²⁶ The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org

²⁷ Vermont Department of Health. Vital Statistics. Internal Communication.

²⁸ Vermont Department of Health. Pregnancy Risk Assessment Monitoring System. Internal Communication.

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



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

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

Vermont has a relatively low teen pregnancy rate of 22 pregnancies per 1000 women 15-19 years of age, a decrease from 23.1 in 2012 and 25.2 in 2011. In 2013, there were 478 pregnancies to Vermont teens aged 15-19; 317 or 66% resulted in a live birth. Based on this data, the 2013 teen birth rate is 14.5 per 1,000 women 15-19 years of age, a decrease from a rate of 16.3 in 2012 and 16.8 in 2011.³¹

STIs & HIV.

*Syphilis*³²

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

*Chlamydia & Gonorrhea*³³

In 2012, Vermont:

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

HIV

- In 2011, an estimated 12 adults and adolescents were diagnosed with HIV in Vermont. Vermont ranked 50th among the 50 states in the number of HIV diagnoses in 2011.³⁴
- In 2014, 3 in 10 (31%) of Vermont adults reported every being tested for HIV, with more than half indicating their last HIV test was at a private doctor's office. Adults 25-44 were significantly more likely to have ever been tested for HIV (52%) than other age groups. Six percent of Vermont adults reported HIV testing in the past year.³⁵

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

³⁰ Vermont Youth Risk Behavior Survey. 2013.

³¹ Vermont Department of Health. Vital Statistics. Internal Communication and 2011 Vital Statistics Report.

³² CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.

³³ CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.

³⁴ CDC. Vermont—2013 State Health Profile. http://www.cdc.gov/nchhstp/stateprofiles/pdf/Vermont_profile.pdf Accessed July 9, 2015.

³⁵ Vermont Behavioral Risk Factor Surveillance System. 201.

³⁶ Vermont Pregnancy Risk Assessment Monitoring System. 2011.

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

Vermont 2011 PRAMS data indicate the following regarding preconception health:

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

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

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

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

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

³⁷ Vermont Pregnancy Risk Assessment Monitoring System. 2011.

³⁸ Vermont Pregnancy Risk Assessment Monitoring System. 2011.

³⁹ Vermont Pregnancy Risk Assessment Monitoring System. 2011.

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

Impact of Services Provided by Title X

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

Vermont's Title X Population

In 2014, PPNNE's Title X network of health centers served 7,796 women and 923 men, for a total of 8,719 residents of Vermont,⁴³ compared to a total of 8,872 served in 2013.⁴⁴ Of the 8,719 clients served in 2014:

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

The following tables further describe the 8,719 Vermont residents served by Title X in 2014.⁴⁵

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

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

⁴⁰ Vermont Behavioral Risk Factor Surveillance System. 2014.

⁴¹ Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.

⁴² Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2013 Update, New York: Guttmacher Institute, 2015.

⁴³ Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

⁴⁴ Vermont Title X Family Planning Annual Report. 2013.

⁴⁵ Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

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

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

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

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

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

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

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

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

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

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

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

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

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

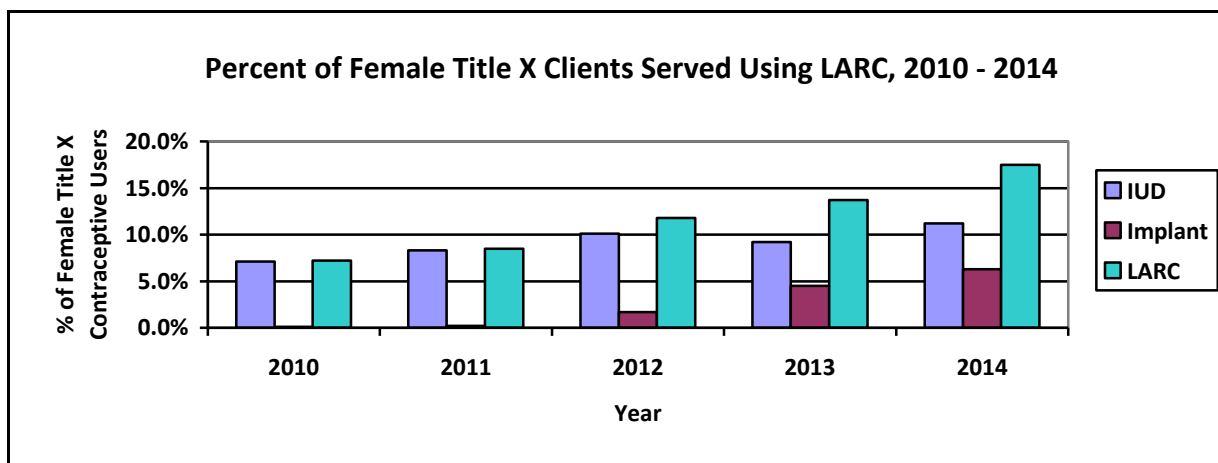


Figure 5. Percent of Title X Female Family Planning Users Reporting use of LARC, 2010 –2014.

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

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

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

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

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

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

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

- 1030 HSV tests
- 1544 rapid HIV tests

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

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

Findings from the Field

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

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

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

⁴⁹ Vermont Title X Family Planning Annual Report. Preliminary Data 2014.

⁵⁰ The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org

⁵¹ The Henry J. Kaiser Family Foundation. State Health Facts, Vermont. www.statehealthfacts.org

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Considerations

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

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

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

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

- I. **Assess the financial, service delivery, and access implications due to exclusion of the PPNNE Burlington and Williston health center sites from Title X funding.** Interviewees indicated limited understanding as to why the Burlington and Williston sites, which serve the largest number of clients in the state relative to other sites, are not included as Title X sites. There is also uncertainty on whether this exclusion impacts access to services among low-income and other vulnerable populations being served by these sites.
- II. **Promote awareness, implementation, and adherence to the QFP's evidence-based family planning practice guidelines among providers, family planning programs, and health care organizations in Vermont.**
 - Disseminate QFP guidelines and related resources (e.g., job aids, webinars, e-learning courses) to providers, programs and organizations. Refer to OPA's National Family Planning Training Centers for existing resources. Explore dissemination mechanisms such as developing a resource hub for providers to access information, announcements, and tools.
 - Identify, coordinate, and support opportunities for provider education and training on QFP guidelines, with a focus on contraceptive effectiveness counseling and informed choice.
- III. **Explore implementing a quality improvement initiative within hospital systems and/or health care organizations (e.g., FQHCs) throughout the state to promote access to high-quality family planning services with emphasis on the provider's role in family planning and contraceptive counseling.** Providers should offer contraceptive services for women and men who want to prevent pregnancy and space births, including contraceptive counseling services. For individuals who might want to get pregnant in the future and prefer a reversible method of contraception, providers should use a tiered approach to presenting a broad range of contraceptive methods, presenting the most effective methods before less effective methods.⁵³
 - Explore the use of family planning quality measures among health care organizations to monitor on an ongoing basis (e.g., percentage of patients using moderately or highly effective contraceptive methods; or percentage of patients using LARC methods). Refer to

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

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

- IV. Continue to explore how to increase access to LARC in a broader way (e.g., beyond PPNNE's health centers); support innovations and solutions to promote access and awareness of LARC.**
- Work with Medicaid to establish reimbursement for post-partum provision of IUD
 - Coordinate with ACOs to include LARC use as a payment measure
 - Assess access and provision of LARC via other safety net providers such as FQHCs and RHCs
 - Explore use of quality improvement initiatives with safety net providers (e.g., FQHCs, RHCs) and primary care providers to promote a broad range of contraceptive method availability, and guideline-based contraceptive counseling and education
 - Establish collaborative agreements and referrals systems with PPNNE and other safety net providers well-equipped to provide LARC (e.g., Community Health Centers of Burlington)
- V. Facilitate linkages between primary care providers and Title X health centers in Vermont.** Vermont's network of Title X health centers provides access to comprehensive guideline-based family planning services throughout the state. Coordinate with primary care providers and practices, such as community health centers, to better understand: (1) their capacity for providing guideline-based contraceptive services and other family planning services; (2) existing referral systems; and (3) opportunities to support or strengthen referral systems with Title X health centers to ensure access to comprehensive high-quality family planning services and continuity of care.
- VI. Increase provider and consumer knowledge of covered family planning and related preventive health services.** The Affordable Care Act has expanded health payer coverage of contraception and a wide range of preventive services, including well-woman visits (Pap tests, cancer screenings, etc.). To promote high utilization of expanded health care benefits, disseminate information on covered family planning and related preventive health services to providers and consumers throughout Vermont. Explore dissemination and repackaging of existing information and education resources as well as developing resources specific to Vermont's health payer member benefits.
- VII. Explore potential opportunities to address family planning, reproductive, and sexual health needs of adolescents within SBHCs in Vermont.**
- Establish understanding of existing SBHCs in Vermont, including location, model of care, scope of services, and community linkages
 - Coordinate with SBHCs to identify prominent family planning, reproductive health, and sexual health needs within communities and related services that could be feasibly integrated into SBHCs scope of services
 - Assess other state models of SBHCs and scope of family planning services offered

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

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

Appendix I: Key Informant Interview Participants & Guides

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

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

Title V Strengths and Needs Assessment

Key Informant Interview Guide

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

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

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

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

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

3. Thinking about [population domain] and the corresponding national priority areas identified by the federal Bureau of Maternal of Child Health....
 - a. What have been some gains in this area for Vermont?
 - b. What have been the challenges?
 - c. What do you see as key strategies for addressing this issue?
 - d. What would be some challenges encountered?
 - e. What are the leverage points/opportunities that exist to address this issue (e.g., existing initiatives, coalitions, etc.)?

4. The sixth population domain is Cross-cutting or Life Course and refers to public health issues that impact multiple MCH population groups such as smoking or oral health. What do you see as significant cross-cutting issues for Vermont's MCH populations? Why?
 - a. Cross-cutting or Life Course can also include social determinants of health—how where we live, learn, work and play impacts our overall health and well-being. How do you see social determinants of health playing into the health and well-being of Vermont's women, mothers, children and families?
 - i. Which of those that you listed has the greatest impact for [population domain]?

Title X

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

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

Recommendations/Closing Observations

7. As we come to the close of our interview, what are the top recommendations you have for ensuring an accessible high-quality system of support and services for Vermont's women, mothers, children and families?
8. Are there any closing observations or thoughts you would like to share regarding _____ [population domain] and how Vermont can strive to ensure the overall health and well-being of _____ [population domain]?

Table 1: National Priority Areas by Population Domain

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

Vermont Title X Needs Assessment

Key Informant Interview Guide

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

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

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

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

1. Let's begin by setting the context for the interview. Can you briefly describe your organization and its involvement in the family planning system in Vermont?
 - a. Describe specific programs
 - b. Reach/ population focus
2. Thinking about Title X and the family planning service delivery system in Vermont, what are the strengths of Vermont's Title X service delivery system and/or existing family planning services?
 - a. What have been some of the gains for Vermont in recent years?
 - b. To what do you attribute these gains?
 - c. What partners are important to expanding or enhancing the Title X service delivery system?

- d. Which of these partners do you collaborate/partner with, and how, to meet family planning needs in the state?
- 3. Similarly, what are some of the barriers or challenges of Vermont's Title X service delivery system and/or existing family planning services?
 - a. What are potential strategies to address barriers or challenges of the system?

Access & Quality

- 4. Describe the populations most in need of family planning services in Vermont?
 - a. What are we currently doing on outreach and access to best meet the need(s) of these populations?
 - b. What more could providers and/or the system be doing?
- 5. Is the system adequately reaching the needs of vulnerable populations (e.g., teens, LGBT, racial and ethnic minorities, recent immigrants and refugees)?
 - a. Is the system effectively reaching and engaging vulnerable populations?
 - i. What are the barriers or challenges to doing so?
 - ii. What more could Title X/PPNNE centers and other providers do to engage vulnerable populations?
 - b. What are their most pressing family planning needs?
- 6. Is the system effectively reaching and engaging men?
 - a. What are the barriers or challenges to doing so?
 - b. What types of services are most commonly delivered to the men served in your program/organization?
 - c. What more could Title X/PPNNE centers do to engage men?
- 7. Now let's turn to thinking about the quality of the family planning service delivery system in Vermont. Components of a quality system include *accessible, equitable, timely, coordinated, client-centered, and culturally competent* care.
 - a. What components of quality are well-addressed within Vermont's current system of family planning and reproductive health care?
 - b. What components of quality could be better addressed within Vermont's current system of family planning and reproductive health care?

Long-Acting Reversible Contraceptives (LARCs)

- 8. To what extent do you feel family planning patients have access to a broad range of contraceptive options, including long acting reversible contraceptives (LARCs)?
 - a. What are the primary barriers to promoting use of LARCs to prevent unintended pregnancy?
 - i. Provider training and skills to counsel and provide LARCS

- ii. Adolescents' knowledge, attitudes, beliefs, and use of LARCs

Preconception Health & Related Preventive Health Services

9. Promoting preconception health and reproductive health planning are important components of family planning, as they influence birth outcomes and men and women's health in general. How does Vermont's family planning service delivery system fair in regard to providing recommended preconception health services (i.e., per USPSTF recommendations)?
 - a. What are some of the challenges or barriers to doing so?
10. The family planning service delivery system is often a point of access into the health care system for many women and men, and therefore presents an important opportunity to provide or refer for other related preventive health care services (e.g., cervical cancer screening, breast cancer screening). Similar to the previous question, how does Vermont's family planning service delivery system fair in regard to providing or referring clients for other preventive health services?
 - a. What are some of the challenges or barriers to doing so?
11. To wrap up our discussion, what are the top recommendations you have for ensuring an accessible high-quality system of family planning and reproductive health in Vermont?