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2015 DPH Consolidated Contract Addendum

This contract addendum is specific to Dunn County Health Department Courthouse whose principal business address is 800 Wilson Avenue, Menomonie, WI 54751. The contact for the GRANTEE'S Contract Administrator is:

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Section 6.D Funding Controls

Funding controls are summarized below. The 2015 Consolidated Contract Overview contains current funding controls for all Profile IDs that are part of the consolidated contract.

Payments through June 30, 2015 are limited to 6/12th of the contract with the balance paid after July 1, 2015 based on reported costs up to the contract level. This applies only to the following Profile IDs:

Profile IDs Subject to 6/12th Funding Controls			
Profile ID	**Name**	**Profile ID**	**Name**
103010	Regional Radon Information Centers	159320	MCH
151734	Oral Health Supplement	159321	Reproductive Health
151735	Oral Health Mouth Rinse	159327	Family Planning
152002	Reproductive Health SLOH	181005	TPCP-WIS-WINS
152020	Family Health-Women's	181012	Tobacco Prevention & Control Program
157720	Childhood Lead		

Payments through September 30, 2015 are limited to 9/12th of the contract with the balance paid after October 1, 2015 based on reported costs up to the contract level. This applies only to Profile ID 154710.

Section 34.A Special Provisions

1. Contract Period

The contract period for Profile 157000 (Well Woman) is limited to January 1, 2015 through June 30, 2015. No expenses incurred after June 30, 2015 will be reimbursed. The 2015 Consolidated Contract Overview contains current funding periods for all Profile IDs that are part of the consolidated contract.

2. Final Report Dates

The due date of the final fiscal report for Profile 150327 (Radon Outreach) shall be sixty (60) days after the Grant Agreement Period ending date. Expenses incurred during the Grant Agreement period on Profile 150327, but reported later than sixty (60) days after the period ending date, will not be recognized, allowed or reimbursed under the terms of this Grant Agreement.

The 2015 Consolidated Contract Overview contains final report due dates for all Profile IDs that are part of the consolidated contract.

Contract Agreement Addendum: Exhibit I

Program Quality Criteria

Generally high program quality criteria for the delivery of quality and cost-effective administration of health care programs have been, and will continue to be, required in each public health program to be operated under the terms of this contract.

This Exhibit contains only applicable quality criteria for this contract.

Contract Agreement Addendum: Exhibit I

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015

Program: Immunization

Program Quality Criteria

1) Assessment and surveillance of public health to identify community needs and to support systematic, competent program planning and sound policy development with activities focused at both the individual and community levels.

    A) Contractees must assure reported vaccine preventable diseases (VPD) are investigated and controlled as detailed in the most current edition Wisconsin Disease Surveillance Manual (EPINET) and/or written disease-specific guidance from DPH (e.g. Pertussis Guidelines). Local Health Departments (LHDs) should maintain regular contact with local required reporters of VPDs to encourage and assure prompt reporting. Contractees should solicit the help of the Wisconsin Immunization Program when needed to help assure that an adequate system is in place to report and investigate VPD.

    B) Contractees must annually formally evaluate immunization delivery and the use of vaccine preventable disease surveillance systems and improve the use of those systems in their jurisdictions where needed (e.g., the Wisconsin Electronic Disease Surveillance System (WEDSS).

    C) Contractees must work in collaboration with the Wisconsin Immunization Program to increase the use of existing electronic data collection systems for vaccine record keeping and vaccine preventable disease data systems.

2) Delivery of public health services to citizens by qualified health professionals in a manner that is family centered, culturally competent, and consistent with the best practices; and delivery of public health programs for communities for the improvement of health status.

    A) Contractees must assure the delivery of immunization services in a safe, effective and efficient manner as detailed in the Wisconsin Immunization Program Policies and Procedures Manual and in section 252, HFS 145, Wis. Admin. Code. Contractees must assure the immunization of children is consistent with Healthy People 2020 goals.

3) Record keeping for individual focused services that assures documentation and tracking of client health care needs, response to known health care problems on a timely basis, and confidentiality of client information.

    A) Contractees must use the Wisconsin Immunization Registry (WIR) or an electronic immunization population-based data system that links with the WIR. The data system must have a tracking and recall function to identify children whose immunization records are behind schedule according to the ACIP recommendations. Tracking and recall shall be conducted at least every other month as required by the Wisconsin "Policies and Procedures Manual for Immunization Programs".

    B) Contractees immunization practice must assure the immunization of children, and share children's immunization records with parents or guardians, schools and day care centers and other healthcare providers as provided by the Wisconsin School Immunization Law HFS 144 (section 252).

4) Information, education, and outreach programs intended to address known health risks in the general and certain target populations to encourage appropriate decision making by those at risk and to affect policy and environmental changes at the community level.

    A) Contractees must engage in community partnerships to identify and address the needs of high-risk populations, reduce racial and ethnic health disparities, and to educate families and the community on the importance of immunizations.

5) Coordination with related programs to assure that identified public health needs are addressed in a comprehensive, cost-effective manner across programs and throughout the community.

    A) Contractees must coordinate immunization services with local child healthcare (service) providers: e.g., WIC projects, Medical Assistance programs, and other local public health programs to assess the immunization status of, refer, and provide immunization services to under-immunized children.

6) A referral network sufficient to assure the accessibility and timely provision of services to address identified public health care needs.

    A) Contractees must develop relationships among public and private healthcare providers to facilitate access by children and families to immunization services. Contractees should work with these providers to assure that current immunization guidelines are followed.

    B) The LHD should promote the medical home concept by referring vaccine recipients to their medical home provider for subsequent immunizations and coordinate with this medical provider to assure adherence to the recommended immunization schedule.

    C) LHDs should promote the exchange and sharing of immunization data using immunization registries.

    D) The LHD will assure adequate surveillance, prompt reporting and epidemiologic follow-up of vaccine preventable diseases. When prompt reporting of a vaccine preventable disease does not occur, the LPHD will formally address the issue with the reporting agency to assure that reports are made according to the latest EPINet Manual.

7) Provision of guidance to staff through program and policy manuals and other means sufficient to assure quality health care and cost-effective program administration.

    A) Contractees will ensure program staff is competent in current immunization program policy and processes, including that provided through the Centers for Disease Control and Prevention (CDC) distance learning course and CDC updates.

    B) The LHD will follow the Wisconsin "Policies and Procedures Manual for Immunizations" developed and distributed by the Wisconsin Immunization Program, unless otherwise agreed upon; as well as Immunization Policy Memos issues periodically issued from the Wisconsin Immunization Program. The LHD must have written policies on the proper handling and storage of state-supplied vaccine as required by the Vaccines for Children (VFC) Program. These policies must be reviewed with all immunization program related staff on at least an annual basis.

8) Financial management practices sufficient to assure accurate eligibility determination, appropriate use of state and federal funds, prompt and accurate billing and payment for services provided and purchased, accurate expenditure reporting, and, when required, pursuit of third-party insurance and Medical Assistance Program coverage of services provided.

    A) Billing for payment of childhood immunization services is not required under this section.

    B) LHDs must assure that parents of children who are on Medical Assistance will not be charged a vaccine administration fee or be requested to make a donation for vaccine or vaccine related services. Administration fees cannot be mandatory and clients must be informed that failure to pay the administration fee or make a donation does not preclude them from receiving state-supplied vaccine. This information must be added to immunization advertising materials used by the LHD for state supplied

vaccines. The message must be given to the client in a way and in a language the client understands.

C) Grantees must screen for insurance eligibility in accordance with current DPH guidelines for state supplied vaccines.

9) Data collection, analysis, and reporting to assure program outcome goals are met or to identify program management problems that need to be addressed.

A) Contractees must collect and analyze agency and available private provider immunization data for children 12-35 months of age, school immunization law reports and other available population-based information needed to identify strengths and weaknesses in local delivery systems and plan improvements. Only children who have moved out of the agency's jurisdiction may be removed from the cohort for analysis.

B) LHDs will utilize the WIR for immunization level data analysis.

C) LHDs and Tribes will assure staff competence with the WIR system. LHD and Tribal health staff must attend at least one Regional WIR User Group Meetings or Wisconsin VFC Workshops where WIR is included in the agenda. Attendance at these meetings is necessary for staff to maintain a thorough working knowledge of the functionality of the WIR.

Contract Agreement Addendum: Exhibit I

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015

Program: Wisconsin Well Woman
Program Quality Criteria

1) Assessment and surveillance of public health to identify community needs and to support systematic, competent program planning and sound policy development with activities focused at both the individual and community levels.

    A) There are no separate sub-criterion to this Quality Criteria Category.

2) Delivery of public health services to citizens by qualified health professionals in a manner that is family centered, culturally competent, and consistent with the best practices; and delivery of public health programs for communities for the improvement of health status.

    A) The following information applies only to breast cancer screening: 1) Each coordinating agency must ensure it focuses its breast cancer screening outreach efforts on women ages 50-64. Seventy-five percent of women receiving mammograms should be between the ages of 50 and 64. 2) Each coordinating agency must document attempts to contact annually 100% of the women enrolled in the program, where rescreening is clinically indicated, to arrange mammography rescreening examinations, and must assure that at least 50% of these women are rescreened for breast cancer. 3) Each coordinating agency must follow the program standards for median days between abnormal mammography results and final diagnosis for women enrolled in the program. The median days between an abnormal mammography result and final diagnosis shall be less than 60 days, with not more than 25% over 60 days. 4) Each coordinating agency must document attempts to follow-up 100% of the women reported to have abnormal or suspicious breast cancer screening findings to assure they understand the need for further evaluation and to assist and refer them for appropriate diagnosis and treatment.

    B) The following information applies only to cervical cancer screening: 1) Each

    coordinating agency must follow the program standards for median days between abnormal Pap smear results and final diagnosis for women enrolled in the program. The median days between an abnormal Pap smear result and final diagnosis shall be less than 60 days, with no more than 25% over 60 days. 2)Each coordinating agency must document attempts to follow-up 100% of the women reported to have abnormal or suspicious cervical cancer screening findings to assure they understand the need for further evaluation and to assist and refer them for appropriate diagnosis and treatment.

3) Record keeping for individual focused services that assures documentation and tracking of client health care needs, response to known health care problems on a timely basis, and confidentiality of client information.

    A) Each coordinating agency must maintain a paper system or a computerized tracking database of women from its county enrolled in the program. At a minimum, the database should include annual eligibility determination, results of screening services provided, documentation of follow-up in situations of abnormal screening results, and recommended rescreening dates.

4) Information, education, and outreach programs intended to address known health risks in the general and certain target populations to encourage appropriate decision making by those at risk and to affect policy and environmental changes at the community level.

    A) Each coordinating agency must document contacts made to recruit new WWWP clients with special emphasis on women 50-64 years of age. The agency must provide information and education about covered services and rescreening at appropriate intervals.

5) Coordination with related programs to assure that identified public health needs are addressed in a comprehensive, cost-effective manner across programs and throughout the community.

    A) There are no separate sub-criterion to this Quality Criteria Category.

6) A referral network sufficient to assure the accessibility and timely provision of services to address identified public health care needs.

    A) Each coordinating agency is responsible for recruiting new providers to the WWWP as needed.

    B) Women diagnosed with breast and/or cervical cancer will be referred to Well Woman Medicaid as appropriate.

    C) Each coordinating agency must document contacts with each of its WWWP providers as needed, but at least quarterly, to access program status, identify needs, and share information.

7) Provision of guidance to staff through program and policy manuals and other means sufficient to assure quality health care and cost-effective program administration.

    A) There are no separate sub-criterion to this Quality Criteria Category.

8) Financial management practices sufficient to assure accurate eligibility determination, appropriate use of state and federal funds, prompt and accurate billing and payment for services provided and purchased, accurate expenditure reporting, and, when required, pursuit of third-party insurance and Medical Assistance Program coverage of services provided.

    A) Each coordinating agency must ensure accurate eligibility determination whether completed by the local coordinating agency or the provider.

    B) Each coordinating agency must document attempts to ensure that billing problems between the providers and the fiscal agent are resolved.

    C) Each coordinating agency is responsible for educating clients on program-covered services and client responsibility for non-covered services.

    D) Each coordinating agency is responsible for educating providers on the WWWP and billing practices.

9) Data collection, analysis, and reporting to assure program outcome goals are met or to identify program management problems that need to be addressed.

    A) There are no separate sub-criterion to this Quality Criteria Category.

Contract Agreement Addendum: Exhibit II

Program Objectives

(A) Contract Funds, Program/Objective Values, and Other Contract Details

(B) Objective Details

Contract Agreement Addendum: Exhibit II(A)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015

Contract Source of Funds

Source	Program	Amount
Dunn County	Childhood Lead - Consolidated	$4,617
Dunn County	Family Planning - RH	$68,924
Dunn County	Immunization - Consolidated IAP	$12,429
Dunn County	Maternal Child Health - Consolidated	$24,030
Dunn County	Oral Health - Fluoride Supplement	$2,659
Dunn County	Radon Regional Information Centers	$9,164
Dunn County	WIC USDA	$197,470
Dunn County	Well Woman - WWWP GPR ss.255.06(2) LPHD	$7,331
	Contract Amount	**$326,624**

Contract Match Requirements

Program	Amount
Childhood Lead - Con	$0
Immunization	$0
MCH	$18,023
Oral Health	$0
Radon-RICs	$0
Reproductive	$0
WIC	$0
Well Woman	$0

Contract Agreement Addendum: Exhibit II(A)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015

Program Sub-Contracts

Program	Sub-Contractee	Sub-Contract Amount
Childhood Lead - Con	None Reported	$0
Immunization	None Reported	$0
MCH	None Reported	$0
Oral Health	None Reported	$0
Radon-RICs	None Reported	$0
Reproductive	None Reported	$0
WIC	None Reported	$0
Well Woman	None Reported	$0

Contract Agreement Addendum: Exhibit II(A)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015

Immunization **Program Total Value $12,429**

1	LHD Template Objective	$12,429

By February 15, 2016 81% children residing in Dunn County jurisdiction who turn 24 months of age during the contract year will complete 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella and 4 Pneumococcal Conjugate (PCV) vaccination by their second birthday.

MCH **Program Total Value $24,030**

1	Template Objective 1	$24,030

By December 31, 2015,implementation activities for the Wisconsin Healthiest Families Initiative will be undertaken by the Dunn County Health Department in collaboration with community partners focusing on safety/injury prevention.

Oral Health **Program Total Value $2,659**

1	Template Objective 1	$2,659

School-Based Fluoride Supplement/Mouthrinse Program: By December 31, 2015, 250 children ages 6 months through 16 years from non-fluoridated communities will participate in a dietary fluoride supplement program administered by the Dunn County Health Department and 725 children will participate in the school based fluoride mouthrinse program.

Radon-RICs **Program Total Value $0**

1	This is a multi-year objective, from 2015 through 2017. Throughout calendar years 2015, 2016, and 2017, residents of [INSERT REGIONAL AREA] Counties will be served by a regional Radon Information Center managed by the [INSERT AGENCY NAME].	$0

WIC **Program Total Value $197,470**

1	Template Objective 1	$197,470

During the contract budget period of January 1, 2015 through December 30, 2015, the Dunn County WIC Project will maintain an average monthly participation that is at least 97% of the assigned case load.

Well Woman **Program Total Value $7,331**

1	Template Objective 1:	$7,331

By June 30, 2015, 35 Dunn County County residents ages 35-64 years will be screened through the Wisconsin Well Woman Program.

Total of Contract Objective Values	$243,919
Total of Contract Statement Of Work Values	$0

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Immunization **Objective #:** 1 of 1 **Objective Value:** $12,429

Objective: Primary Details

Objective Statement

LHD Template Objective

By February 15, 2016 81% children residing in Dunn County jurisdiction who turn 24 months of age during the contract year will complete 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella and 4 Pneumococcal Conjugate (PCV) vaccination by their second birthday.

Deliverable Due Date: 10/31/2016

Contract Deliverable (Evidence)

A Wisconsin Immunization Registry (WIR) generated population based standard benchmark report documenting the number of children in (insert health department) jurisdiction who turned 24 months of age in 2015 contract year. Reports should be run with a 45 day buffer to ensure that all updated data has been received by the WIR. If the objective is not met, include a report of the accountability targets and the progress achieved including the activities and interventions conducted; include any barriers that may have been identified.

For your information the cohort of children for this objective is:

Date of Birth 01/01/2013- 12/31/2013

Criteria for the 2015 End of the Year Report:

The date of birth for End of Year Benchmark: 01/01/2013 - 12/31/2013

Evaluation date: 01/01/2016

Run date: 02/15/2016

Programs Providing Funds for this Objective

Immunization: $12,429

Agency Funds for this Objective:

Data Source for Measurement

Wisconsin Immunization Registry Records.

Baseline for Measurement

The 2013 end of year population based standard benchmark report will be used to determine the baseline for the 2015 population based objective.

For the baseline the following parameters will be used to run the benchmark report:

Birthdate Range: 01/01/2011 thru 12/31/2011

Evaluation Date: 01/01/2014

Run Date: After: 02/15/2014

Benchmark was 78%

Context

Children will be assessed using the standard benchmark report for having 4 DTaP, 3 Polio, 1 MMR, 3 Hib 3 Hepatitis B, 1 varicella and 4 Pneumococcal Conjugate (PCV) vaccination by 24 months of age. Progress towards reaching 90% will be measured using a WIR Benchmark report. Only children who have moved out of the agency's jurisdiction may be removed from the cohort for analysis. Unless you can prove that a child has moved out of your jurisdiction, you cannot remove them from your cohort.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Immunization **Objective #:** 1 of 1 **Objective Value:** $12,429

Guidelines for determining increase needed for progress towards 2015 goals:

2013 Calendar Year Baseline Required Increase:

50-59% - 5% Above Baseline;

60-69% - 4% Above Baseline;

70-79% - 3% Above Baseline;

80-85% - 2% Above Baseline;

86-89% - 1% Above Baseline;

> 90 - Maintain.

Agencies should consult with their Regional Immunization Program Advisor for assistance in determining activities and interventions that will help them achieve the required increase for their population assessment.

Context Continued

Input Activities

The Wisconsin Immunization Program recommends the following activities to help ensure success of this objective:

- Contacting parents of infants without immunization histories

- Tracking

- Coordination of immunization services with other LHD programs

- Sharing information with area physicians

- Requesting that information is entered into the WIR.

- Reminder/recall

The Wisconsin Immunization Program requires a minimum of 3 attempts to personally contact a responsible party.

Only children who have moved out of the agency's jurisdiction may be removed from the cohort for analysis. Unless you can prove that a child has moved out of your jurisdiction you cannot remove them from your cohort.

Reminder/recall activity is not listed in a particular order and we suggest you use the method that is the most successful for your community:

- Letter

- Phone call

- Home visit

- Email

- Text message

Additional interventions/activities are in an addendum to the Immunization Program Boundary Statement. These are suggested

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Immunization **Objective #:** 1 of 1 **Objective Value:** $12,429

interventions/activities that LHD's may want to consider in order to achieve this objective.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%

Corresponding Percentage Recoupment

Corresponding Potential Recoupment Amounts

Definition of Percent Accomplished

Conditions of Eligibility for an Incentive

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Maternal and Child Health Block Grant **Objective #:** 1 of 1 **Objective Value:** $24,030

Objective: Primary Details

Objective Statement

Template Objective 1

By December 31, 2015,implementation activities for the Wisconsin Healthiest Families Initiative will be undertaken by the Dunn County Health Department in collaboration with community partners focusing on safety/injury prevention.

Deliverable Due Date: 10/31/2016

Contract Deliverable (Evidence)

1. A completed baseline assessment of agency core competencies by 1-31-15, updated throughout the year and completed by marking Final for Contract Year by 1-31-16.

2. A completed Partnership Report for the Focus Area(s) that directly align with the objective.

3. Documentation of the number of life course trainings held, audience, and the number of participants in Sphere.

4. Completed evaluation surveys as requested by the MCH Program.

5. Documentation of agency participation in the MCH/KKA annual summit.

6. A completed Wisconsin Healthiest Families Report related to the step identified in the Objective Statement.

Reporting forms are available at: http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems.

Programs Providing Funds for this Objective

Maternal and Child Health Block Grant: $24,030

Agency Funds for this Objective:

Data Source for Measurement

1. SPHERE Report of the MCH Core Competencies

2. SPHERE Partnership Report to include data from the following tab/screen: Partnership Tool. Data entry on this screen includes partner Representation and Contribution of Partnership

3. SPHERE Community Report to include data from the following screens: Community Activity (all appropriate fields), Intervention: health Teaching; Subintervention: Life Course Framework

4. Evaluation and/or survey tools

5. MCH/KKA Summit attendee list

6. Reporting forms related to selected step(s) for Wisconsin Healthiest Families (available at: http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems)

Baseline for Measurement

Baseline information as identified in the 2015 Wisconsin Healthiest Families Supplement to GAC Objective.

Context

Note: This work will be accomplished over multiple years with progressive steps negotiated annually. The populations to be served are all infants and children, children and youth with special health care needs, and expectant and parenting families with young children with a special focus on those at risk for poor health outcomes.

All local health departments need to propose reasonable use of their allocated MCH dollars. Those agencies receiving greater allocations of MCH dollars will be expected to provide multiple steps, focus areas, input activities, and/or objectives.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Maternal and Child Health Block Grant **Objective #:** 1 of 1 **Objective Value:** $24,030

Goal: To assure that all families in Wisconsin have access to a coordinated, integrated and sustainable system of services and supports focused on health promotion and prevention. For more information go to: http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems.

Focus Areas: The focus areas for the Wisconsin Healthiest Families Initiative includes: family supports, child development, mental health, and safety and injury prevention. Go to http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems/WHFdefinitions.htm for definitions. Agencies need to identify separate objectives for each focus area selected.

Framework: Key concepts of the Life Course Framework link to the Wisconsin Healthiest Families Initiative. The focus is on early childhood because it is a critical, sensitive period with life-long impacts on health. The objective promotes a plan for a community system that supports early childhood health and development that can build on protective factors and reduce risk factors for young children and families. Collaborations with community partners are important because the broader community environment strongly affects the capacity to be healthy. The lead for this work may vary from one community to the next and from one focus area to the next. Strengths of community partners should be promoted and supported through strategies identified by the collaborating partners. It is expected that education and/or training and utilization of the Life Course Framework concepts will be provided and implemented on an ongoing basis with community partners.

Outcomes: See sample outcomes at: http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems/WHFdefinitions.htm.

Context Continued

Primary Activities: The Wisconsin Healthiest Families Initiative will be implemented in collaboration with community partners. Sequential steps will be implemented to complete: 1) assessment, 2) plan, 3) implementation, and 4) evaluation and sustainability. These steps will be completed over multiple years. Reporting documents for these steps are located at: http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems.

Step 1: Assessment - Complete a community, population focused assessment that identifies the community program needs or other resources related to family supports, child development, mental health, and/or safety and injury prevention within the agency¿s jurisdiction. Assessment of multiple focus areas can be reported on one Assessment Findings form.

Step 2: Plan ¿ In collaboration with community partners, develop a plan that addresses the strengths and gaps identified in the assessment completed in Step 1. The plan should promote integrated, multi-sector service systems to assure services are easily accessed by expectant families and families with infants and young children, with special focus on those at risk for poor health outcomes. Coalitions/collaboratives will identify strategies and specific activities that map out their process to complete the initiative. The plan will be reported as a Community Logic Model (with one logic model submitted for each focus area) and must reflect the activities of the agency and partners.

Step 3: Implementation; The agency and partners will implement strategies and activities identified in the plan completed in Step 2 to strengthen the system of early childhood services. Step 3 will be reported on the Implementation Report with one report submitted for each focus area addressed by the agency and partners.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Maternal and Child Health Block Grant **Objective #:** 1 of 1 **Objective Value:** $24,030

Step 4: Evaluation and Sustainability ¿ Evaluate the impact on the community of the strategies and activities implemented and identify how this system will be sustained long term.

Input Activities

Required activities to support assessment, planning, implementation, and evaluation/sustainability steps include the following:

- Complete an initial agency assessment of MCH Core Competencies and enter in SPHERE by January 31, 2015; review at mid-year; and update in SPHERE by contract reporting deadline.

- Participate in education to support the ongoing development of MCH Core Competencies.

- Identify existing and new community partners, their contributions, and level of collaboration via the Partnership Tool in SPHERE.

- Provide and implement education and/or training and utilization of the Life Course Framework on an ongoing basis with community partners and enter in SPHERE.

- Participate in MCH Program requests related to evaluation efforts throughout the contract year.

- Participate in the 2015 Wisconsin Healthiest Families and Keeping Kids Alive Summit.

- Engage in activities with community partners to accomplish assessment, planning, implementation and/or evaluation/sustainability, as identified in the 2015 Wisconsin Healthiest Families Supplement to GAC Objective.

- Request technical assistance from MCH contract administrator as needed.

- Promote the MCH Hotline.

- (Optional) Participate in a Learning Community.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%

Corresponding Percentage Recoupment

Corresponding Potential Recoupment Amounts

Definition of Percent Accomplished

Conditions of Eligibility for an Incentive

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Oral Health **Objective #:** 1 of 1 **Objective Value:** $2,659

Objective: Primary Details

Objective Statement

Template Objective 1

School-Based Fluoride Supplement/Mouthrinse Program: By December 31, 2015, 250 children ages 6 months through 16 years from non-fluoridated communities will participate in a dietary fluoride supplement program administered by the Dunn County Health Department and 725 children will participate in the school based fluoride mouthrinse program.

Deliverable Due Date: 01/31/2016

Contract Deliverable (Evidence)

A report to document, by age and community, the number of children who participated in a dietary fluoride supplement program administered by the Dunn County Health Department.

Programs Providing Funds for this Objective

Oral Health: $2,659

Agency Funds for this Objective:

Data Source for Measurement

1. Wisconsin Oral Health Program Annual Report will be provided and must be completed and submitted with documentation of the number of children, including age and community, who participated in the dietary fluoride supplement program.

2. SPHERE Community Report to include the data from the following screens: Community Activity (all appropriate fields) and Fluoride Supplement (no detail screen).

Baseline for Measurement

Context

This program is targeted to children in non-fluoridated communities or rural areas with low natural fluoride in the water. The target population for this program is children from age 6 months to 16 years. Water sources must be tested to determine the fluoride content prior to determining the dosage for dietary fluoride supplements. The dosage for dietary fluoride supplements is established by the American Dental Association (ADA). The ADA Dietary Fluoride Supplement Schedule must be adhered to when administering dietary fluoride supplements for this objective.

Context Continued

Input Activities

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%

Corresponding Percentage Recoupment

Corresponding Potential Recoupment Amounts

Definition of Percent Accomplished

Conditions of Eligibility for an Incentive

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Radon Indoor Radon RICs **Objective #:** 1 of 1 **Objective Value:** $0

Objective: Primary Details

Objective Statement

This is a multi-year objective, from 2015 through 2017. Throughout calendar years 2015, 2016, and 2017, residents of [INSERT REGIONAL AREA] Counties will be served by a regional Radon Information Center managed by the [INSERT AGENCY NAME].

Deliverable Due Date: 10/31/2016

Contract Deliverable (Evidence)

Six-month reports, emailed by 7/31/15 and 1/31/16 to the Division of Public Health, document the activities and progress toward the negotiated annual target quantities specified in the Context section of this contract. Each report should be emailed as a single file, with all documents, photographs, etc. incorporated in the file, as required for our reports to US EPA.

Programs Providing Funds for this Objective

Agency Funds for this Objective:

Data Source for Measurement

Agency records:

Report ot DHS bi-annually on the: number of media responses to news releases and other outreach with journal publications and broadcasts: journal and/or broadcast station names; the dates, lengths, and scanned images or the media's website versions of the stories. For Outreach to Professional, Trade and Other Groups needing to know about radon for their work: names of meetings and shows, venues, dates, attendance, and supporting information like announcements and agendas. For Response to Requests for Radon Information and Consulting: A tally of public requests from all channels: telephone, email, walk-in, etc. For Radon Proficiency Certification: Who at the agency is currently certified for radon measurement and mitigation proficiency. For Training and Stocking of Cooperating Local Agencies: A list of local public health agencies in the region and how they are trained and stocked with handouts, detectors and literature as appropriate, with brief information on what they have done. For Statewide and Regional Meetings: meetings RIC staff attended. For Database Development: Summary of measurement results added to the database. Field Site Visits: Number of sites visited. Quality Control Results: spreadsheet of duplicate and sample results.

Baseline for Measurement

Context

These activities shall be completed in 2015: 1) OUTREACH VIA MEDIA: Staff will have issued news releases and other public outreach, stimulating reports on radon risk, testing, and mitigation in major journal and broadcast media. Some of the outreach will have been done during January (National Radon Action Month), for synergy with outreach by other LPHAs, WI DPH and US EPA. Media interviewing the RIC will have been encouraged to also contact local businesses and residents for their radon stories; and to include the RIC telephone number and state website address, www.lowradon.org. 2) OUTREACH TO PROFESSIONAL AND TRADE GROUPS: Presentations will have been delivered by staff at meetings, shows, or conferences of groups that need to deal with radon as part of their work, such as realtors, home builders, code officials and health professionals. 3) RESPONSE TO REQUESTS FOR RADON INFORMATION: Respond to public requests for radon information and consulting. 4) RADON PROFICIENCY CERTIFICATION: National proficiency certification for radon measurement and mitigation will have been maintained by at least one staff working on radon, unless they have attended all recent annual RIC meetings, in which case after eight years of an individual being certified they may let their certification lapse. 5) TRAINING AND STOCKING OF COOPERATING LOCAL AGENCIES: Staff will traing cooperating local public health agencies in their region as interest arises and help with follow-up for elevated measurement results as needed. 6) MEETINGS: Staff will attend statewide conference calls and meetings of RICs and DPH. 7) DATABASE DEVELOPMENT: Staff will have add new results of radon measurements that they facilitated to a database. 8) FIELD SITE VISITS: Staff will visit sites to consult and become informed about challenging radon mitigations or measurements as funding and schedules permit. 9) QUALITY ASSURANCE: Staff will submit radon test kits on a routine basis for duplicate and blank samples, and maintain records of sample results on a spreadsheet. Submission of sample results will be included in 6 month reports to the Division of Public Health.

Context Continued

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Radon Indoor Radon RICs **Objective #:** 1 of 1 **Objective Value:** $0

Input Activities

See Context above.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%

Corresponding Percentage Recoupment

Corresponding Potential Recoupment Amounts

Definition of Percent Accomplished

Conditions of Eligibility for an Incentive

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Women Infants Children Supplemental Nutrition **Objective #:** 1 of 1 **Objective Value:** $197,470

Objective: Primary Details

Objective Statement

Template Objective 1

During the contract budget period of January 1, 2015 through December 30, 2015, the Dunn County WIC Project will maintain an average monthly participation that is at least 97% of the assigned case load.

Deliverable Due Date: 12/31/2015

Contract Deliverable (Evidence)

The State WIC Office will be responsible for providing this deliverable. Monthly participation, 3-month average participation, and/or 12-month average participation per the monthly participation report will be maintained and monitored by the State WIC

Office.

Programs Providing Funds for this Objective

Women, Infants, and Children (WIC) Supplemental Nutrition:

Agency Funds for this Objective:

Data Source for Measurement

WIC Participation Reports. Baseline for Measurement:

Current caseload is 819 participants.

Programs Providing Funds for this Objective

Women Infants Children Supplemental Nutrition: $197,470

Agency Funds for this Objective:

Data Source for Measurement

Baseline for Measurement

Context

WIC participation means the number of "total participating" on the monthly participation report maintained and monitored by the State WIC Program Office. It is defined as the number of WIC participants, who receive WIC food instruments for one calendar month,

including the number of exclusively breastfed infants.

Context Continued

Input Activities

Policies and procedures as outlined in the Wisconsin WIC Operations Manual.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015

Program: Women Infants Children Supplemental Nutrition **Objective #:** 1 of 1 **Objective Value:** $197,470

Corresponding Percentage Recoupment

Corresponding Potential Recoupment Amounts

Definition of Percent Accomplished

Conditions of Eligibility for an Incentive

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Wisconsin Well Woman **Objective #:** 1 of 1 **Objective Value:** $7,331

Objective: Primary Details

Objective Statement

Template Objective 1:

By June 30, 2015, 35 Dunn County County residents ages 35-64 years will be screened through the Wisconsin Well Woman Program.

Deliverable Due Date: 10/31/2016

Contract Deliverable (Evidence)

An agency generated report to document an unduplicated count of Dunn County residents ages 35-64 years who received screening services through the Wisconsin Well Woman Program.

Programs Providing Funds for this Objective

Wisconsin Well Woman: $7,331

Agency Funds for this Objective:

Data Source for Measurement

Agency records.

Baseline for Measurement

Context

Screening services supported by the Wisconsin Well Woman Program include breast cancer and cervical cancer. Refer to the program boundary statement and program updates for exceptions for women ages 35-44.

The Wisconsin Well Woman Program also provides staged assessment for Multiple Sclerosis for high risk women.

Context Continued

Input Activities

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%

Corresponding Percentage Recoupment

Corresponding Potential Recoupment Amounts

Definition of Percent Accomplished

Conditions of Eligibility for an Incentive

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Women's Health – Family Planning

Exhibit I
Division of Public Health (DPH)
Women's Health-Family Planning and Reproductive Health Program

Service Plan and Agreement
January 1, 2015 through December 31, 2015

A grant award was offered and accepted by the Agency identified in the attached 2015 DPH Women's Health-Family Planning and Reproductive Health Program Contract Agreement.

By acceptance of the 2015 DPH WH-FP/RH Contract Agreement, the Agency understands and agrees to follow Program guidelines, policies, and requirements agreed to in the Agency's Wisconsin DPH WH-FP/RH Program 2011-2015 RFP application (#G1675) and Business Plan.

Exhibit I outlines the **framework and scope** of DPH WH-FP/RH Program "community-based" services, reviews **key grant contract requirements** (agreed to in the Agency's 2011-2015 RFP application), and summarizes **performance measurement and reporting requirements**.

Exhibit I is an integral part of the 2015 contract.

Exhibit I is organized into five (5) Sections:

	PAGE
I. Introduction and Overview	1
II. Framework and Scope of Services	2
III. Summary of Key Grant Service Requirements	5
IV. Performance Measurement and Reporting Requirements	9
V. Other	9

I. Introduction and Overview

The Division of Public Health-Family Planning and Reproductive (DPH WH-FP/RH) Program has the responsibility under Wisconsin statutes at s. 253.07 to develop and maintain a statewide system of community-based clinic services for quality, accessible, affordable, and confidential care.

Contraceptive, reproductive and sexual health, and early intervention care is available through this system of community-based clinics. These community-based clinics are available as a reproductive medical (health care) home for women (and couples) choosing to receive their family planning and related reproductive/sexual primary health care in a specialty care setting.

The DPH WH-FP/RH Program awards grants to enhance the quality, comprehensiveness, patient-responsiveness, and cost-effectiveness of FP/RH services in existing community-based clinics. Grant awards are made on the basis of competitive applications.

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Women's Health – Family Planning

DPH WH-FP/RH Program Grant Awards are intended only to **supplement** funding in existing community-based health organizations to provide FP/RH services *as part of* the statewide system of services. Grant awards are **not** intended to fully fund the provision of services. Grant funds assist in supporting infrastructure costs.

II. Framework and Scope of Services

A. DPH WH-FP/RH Program Mission

1. Maintain a statewide system of community-based specialty clinic services to provide community access to contraceptive, reproductive/sexual health, and early intervention care.

2. Implement (and promote) standards of practice and quality improvement practice management guidelines to ensure quality, evidence-based, confidential, affordable, cost-effective, timely, and patient-responsive care.

3. Assure a medical (health care) home environment at community-based clinics for persons choosing to receive contraceptive and related-reproductive/sexual care in a specialty primary health care setting.

4. Increase community access to contraceptive, reproductive/sexual health, and preconception/inter-conception information and services to support optimal reproductive health and pregnancy planning.

The Agency must implement and maintain policies and practices that support the DPH WH-FP/RH Program's mission.

B. DPH WH-FP/RH Program Overarching Priorities: 2011-2015

1. Increased knowledge and skills among women, men, couples, and families for optimal reproductive health and pregnancy planning. (A Wisconsin Maternal and Child Health Program Priority).

2. Normalization of reproductive/sexual health for recognition and inclusion of reproductive/sexual health as a core component of public health and primary health care services. (A Healthiest Wisconsin 2020 priority).

3. Ensuring reproductive justice*: that all people and communities have access to the information, resources and support they need to attain sexual and reproductive self-determination. (A HW2020 priority). * From Kansas University Law School Reproductive Justice Project description of reproductive justice.

The Agency must implement and maintain policies and practices that support these overarching DPH WH-FP/RH Program priorities.

C. DPH WH-FP/RH Program Goals

1. Reduce unintended pregnancy, particularly among population segments most vulnerable to the adverse consequences of mistimed, unplanned, or unprepared-for pregnancy.
2. Reduce the prevalence of STD within the patient population and community
3. Increase access to STD screening and assessment, testing and treatment services

4. Increase behaviors that reduce reproductive/sexual health risk exposure and promote optimal reproductive/sexual health
5. Increase early access to care to prevent unintended pregnancy, to obtain early and appropriate pregnancy-related care, to promote pregnancy planning, and to support healthy birth spacing.
6. Increase access to health care coverage and affordable contraceptive and related-reproductive/sexual health care
7. Increase access to Medical/Health Care Homes for contraceptive and related-reproductive/sexual health care
8. Increase access to health care Intervention and messages that promote planned and prepared-for pregnancy (for pregnancies that are intended and wanted at the time of conception) including Reproductive Life Planning and healthy birth spacing)

The Agency must implement and maintain policies and practices that support these overarching DPH WH-FP/RH Program goals.

D. DPH WH-FP/RH Program Objectives

1. Increase access to and availability of Emergency Contraception in advance of actual need (ECIA).
2. Increase STD screening and risk assessment, appropriate testing, and timely treatment
3. Increase STD Disease Intervention with partner treatment (partners of patients diagnosed with STD)
4. Increase access to and availability of condoms
5. Increase timeliness with initiation of contraception, particularly following negative pregnancy tests and after pregnancy (post-partum).
6. Increase access and timeliness with initiation of early intervention services.
7. Increase consistency with Reproductive Life Planning/Healthy Spacing messages, particularly coinciding with pregnancy test visits, and planning (as part of prenatal care) for post-partum contraception.
8. Increase correct and consistent condom use, particularly those at higher risk of STD and unintended pregnancy
9. Increase consistency with Dual Protection patient education and messaging
10. Increase FPW (and other Forward Health) enrollment among eligible patients
11. Establish medical (health care) home setting with continuity of care and linkages for other primary care needs
12. Increase post partum contraceptive practices and intervention

The Agency must implement and maintain policies and practices that support these DPH WH-FP/RH Program objectives.

E. DPH WH-FP/RH Program Core Services

1. **Contraceptive Services and Supplies**
2. **STD Detection and Treatment, and Prevention (Risk Reduction) Services**
3. **Reproductive/Sexual Health Screening and Assessment Services and Women's Preventive Health Services**
4. **Early Intervention (EI) Services*: Emergency Contraception; Pregnancy Tests; Postpartum Contraception; Preconception/Interception (Pregnancy Planning) Services**

5. **Health Care Coverage and Benefits Eligibility Screening and Enrollment/Re-enrollment) and Referral Services**
6. **Medical Home Screening and Referral Services**

*__Early Intervention__. Early intervention, particularly when the risk of unintended pregnancy is higher, is critical to develop care plans for timely and appropriate care. Early intervention includes:

1. Early emergency contraception intervention following a contraceptive failure or no contraception to prevent an unintended pregnancy.
2. Early pregnancy testing with intervention to achieve timely and appropriate continuity of care, including pregnancy services or contraceptive services depending on a patient's pregnancy status and plans.
3. Early (third trimester) postpartum pregnancy (reproductive life) planning and contraceptive plans, supplies, and arrangements to ensure timely and successful initiation of contraception following delivery.
4. Early pregnancy planning and preparation favorable to healthy pregnancy and birth, and to ensure that pregnancy is planned and wanted at the time of conception.

The Agency must provide these DPH WH-FP/RH Program core services.

F. DPH WH-FP/RH Program Core Interventions

1. **Contraceptive/Dual Protection evaluation and prescription management**
2. **Contraceptive/Dual Protection supplies (including primary and dual protection methods, and Emergency Contraception)**
3. **STD screening and risk assessment, appropriate testing, treatment, and follow-up care (including re-testing)**
4. **STD Disease Intervention for patients and partners diagnosed with STDs**
5. **Reproductive/sexual health screening and assessment to identify health risks and needs, and to promote to promote women's health.**
6. **Early Intervention Pregnancy-related intervention (including early Emergency Contraception intervention, early pregnancy testing with timely and appropriate continuity of care, post-partum contraception plans and care, and preconception care and reproductive life plans for healthy pregnancy and birth spacing.**
7. **FPW (and other Forward Health Program) eligibility screening and enrollment**
8. **Screening and referral to establish reproductive/sexual health care and primary care Medical Homes**

Intervention for identified needs and risks include includes patient information/messaging; motivation and support to reduce risks and adopt protective health behaviors; anticipatory guidance; treatment and/or referral; follow-up; and short-term care coordination.

The Agency must provide these DPH WH-FP/RH Program core interventions.

G. DPH WH-FP/RH Program Core Components

1. **Components of Care**: Maintain the capacity and competency of community-based clinics to provide the essential **components of care** for contraceptive and related-reproductive/sexual health care, including
   a. Screening and Assessment
   b. Diagnosis and Treatment
   c. Follow-up/Referral
   d. Short-Term Care Coordination
   e. Patient Education/Messaging and Anticipatory Guidance

2. **Community Engagement**: Establish and maintain a recognized role in the community with channels of communication to promote the mission, goals, and objectives of the program in the community. Maintain community engagement to increase awareness of reproductive health specialty care as an important part of health care, and marketing to segments of the population who may choose to obtain care through this system.

3. **Community Systems Development**: Establish and maintain partnerships with community health care providers: to promote the adoption of key standards of practices, to increase timely access to care, and to improve timely continuity of care.

The Agency must provide these DPH WH-FP/RH Program core components.

III. Summary of Key Grant Service Requirements

The Agency must provide services and comply with policies and priority practices established by the DPH-Women's Health-Family Planning and Reproductive Health Program as agreed to as part of the DPH WH-FP/RH Program 2011-2015 RFP application.

DPH WH-FP/RH Program Guidelines were updated and distributed at the September, 2013 WH-FP/RH Program Business Meeting. A complete and current set of Guidelines are available on the Health Care and Education and Training (HCET) website.

The following is a summary of key grant service requirements organized under the following areas:

A. **Quality of Care**
B. **Financial Sustainability**
C. **Patient Responsiveness**
D. **Quality Practices**
E. **Quality Assurance: Performance Measurement and Quality Improvement**

A. Quality of Care

1. The Agency must **comply with DPH WH-FP/RH Program Guidelines**, and must ensure that local program staff to understand all **patient care guidelines and standards of care**.

2. The Agency must only use laboratory services through the **Wisconsin State Laboratory of Hygiene** (WSLH).

3. The local program Medical Director must agree to and support the DPH WH-FP/RH Program Guidelines, including ACOG cytology and STD guidelines (such as no routine cytology screening under age 21), and re-testing (following positive Ct or GC test results).

4. *Staff Development*
   a. The local program must meet **personnel requirements** established by the DPH WH-FP/RH Program.

   b. The nursing supervisor and lead staff in each clinic within the Agency must complete the Family Planning **"Just The Basics" Orientation** and the post-review, **<u>or</u>** must review the "Just the Basic" series IF previously completed.

   c. New personnel assigned to the local program must register for and complete the **Family Planning 101" Program** developed by Health Care Education and Training, Inc. (HCET)**. (Contact HCET for information).**

   d. New personnel must complete the WH-FP/RH Program Guidelines orientation and testing modules to be developed by HCET, as part of new staff orientation. Existing staff must also document an annual review of the Guidelines.

   e. ***[Clinics without on-site clinicians <u>on</u> <u>staff</u> (or "tele-medicine" clinician availability), including clinics with contract clinicians providing part time services on site].***
      i. The agency must have at least one clinic staff at each site who has completed or currently enrolled in the Reproductive Health Nurse (RHN) program for the didactic coursework.

      ii. The RHN course is currently available through Northern Technical College. Contact HCET for information about scholarships.

   f. **Staff attendance at DPH-sponsored meetings, conferences, and symposiums** is required. (See 2011-2015 DPH WH-FP/RH Program Personnel Requirements).

   g. Local agency staff must participate in **training and technical assistance** identified by the DPH WH-FP/RH Program as high priority.

   h. The Agency is responsible for **acquiring information available through DPH WH-FP/RH Program trainings and updates and** provider forums and workgroups, and subsequently sharing information among staff within the local program.

   i. The Agency must **acquire information** presented at DPH WH-FP/RH Program trainings (through HCET) related to core services and interventions and priority practices, and subsequently share information with local program staff).

B.Financial Sustainability

1. Policies and practices must be in place to **maximize third party reimbursement** for services.

2. **Fee Exempt and other sources of payment** through the Wisconsin State laboratory of Hygiene (WSLH) must be used as the payment sources of last resort.

3. The Agency must manage **Program Generated Revenue (PGR)** in the following manner:
   a. Retain all PGR (including third party reimbursements, and patient fees and donations) within the FP/RH program supported with grant funds under this contract;
   b. Only use PGR to support FP/RH services supported with grant funds under this contract;
   c. Account for PGR when earned and expended;
   d. Maintain a PGR operating capital fund balance;
   e. Maintain excess PGR in Fund Balance account; and
   f. Establish and maintain a 3-6 month PGR operating capital Fund Balance.

4. All PGR must be retained within the local FP/RH Program to support and maintain services.

5. The Agency must ensure maximum "managed enrollment" performance for the Badger Care Family Planning Only Service Program (BC-FPOS).

6. An annual Cost Analysis report, using the standardized Relative Value Unit methodology, must be prepared.

7. Fee Schedules (including fees and discounts) must be updated at least annually have been updated to reflect the latest cost and revenue requirements. Costs must be determined (or verified) using the standard methodology for family planning clinics.

8. A process must be in place to routinely provide receipts to patients and explain fees, discounts, and charges for each visit, and an explanation that donations are accepted to support the services provided by the local program.

9. A patient financial system must be in place to maintain individual patient accounts.

10. *Forward Health Business Capacity*
    a. **The Agency must have ACCESS Enrollment, Express Enrollment (for prenatal care), and Forward Health Community Access Partner (CAP)** capacity is in place.

    b. **The Agency must have Forward Health Portal and/or PES Billing capacity** is in place.

11. The Agency must develop capacity to fully participate as provisions under the Affordable Care Act evolve, including negotiations to participate as providers in private insurance plans and to obtain reimbursement.

C.Patient Responsiveness

1. The Agency must develop and maintain an on-going process to improve patient-centered care: to maintain patient satisfaction and to increase patient recruitment and retention.

D.Quality Assurance: Performance Measurement and Quality Improvement

1. The Agency must maintain a quality assurance/quality improvement program and include quality and performance indicators identified by the DPH WH-FP/RH Program.

2. NOTE: The Agency must conduct and document an ***annual*** internal privacy review, and clinic personnel must review all confidentiality and privacy requirements. **Privacy protections and safeguards must be in place within the agency.**

3. The Agency must follow the chart selection methodology established by the DPH WH-FP/RH Program to ensure that record audits are randomly selected and represent the patient population and practice, and use the Record Audit Templates established to reflect the Program Guidelines.

4. The Agency must calculate performance measurements using the Quality Indicators/Performance Measurement template provided as part of the 2015 contract.

5. The Agency must update **local protocols and practices** to meet revised DPH-FP/RH Guidelines released in September, 2013. (A list of new policies that will require change in protocols and practices were distributed at the September, 2013, Annual DPH WH-FP/RH Program Business Meeting).

6. The Agency accepts responsibility to identify technical assistance needs and to communicate those requests directly to the DPH WH-FP/RH Program (including HCET).

E.Quality Practices

1. The Agency must ensure that priority practices are in place, including the following **core priority practices:**
    a. ECIA supplies
    b. Dual Protection supplies
    c. BCFPOS enrollment (TE <u>and</u> Continuous Application information obtained at the *same* visit) and Express Enrollment
    d. Care coordination with completion of Continuous Enrollment, including submitting application on behalf of patient
    e. STD screening and assessment and testing <u>and</u> re-testing (on-site)
    f. Primary contraceptive methods initiated for new patients (first visit), including Depo
    g. Standing orders/protocols in place for contraceptive methods in advance of physical examination at initial visit. (Initial visit not delayed for physical examination or nurse practitioner encounter).

2. **The Agency must use standard messaging** developed by the DPH WH-FP/RH Program, including:
    a. Emergency contraception (progestin only)

b. Post-partum contraceptive recommendations. (Please contact HCET for "Factsheets" that provide the required messaging).

3. *Integration of Services with the Wisconsin Maternal and Child Health Program*.
A substantial part of the grant funds that support this contract are part of the Wisconsin Maternal and Child Health Program. Therefore, agencies have an obligation to participate in and improve community systems of care that support maternal and child health care.

The Agency must continue coordination and integration of contraceptive intervention and services with PNCC and WIC services [and other appropriate community partners, such as home visitation] (in each county served) in 2015.

a. **Under the 2015 DPH WH-FP/RH contract, and as part of responsibilities under Wisconsin Statutes s. 253.07, the Agency assumes increased accountability to increase PNCC participation (as part of its MCH "continuity of care" charge), to improve the content of PNCC intervention, to increase third trimester contraceptive intervention and supplies among PNCC and WIC clients), and to increase post partum primary contraceptive method intervention and supplies among PNCC and WIC clients.**

b. Contraceptive intervention includes (*at a minimum*) development of post partum contraceptive plan in third trimester, delivery of dual protection kit contraceptive kit in third trimester, information for initiating a primary method following delivery, and early (within three (3) weeks following delivery) follow-up to address post-partum primary contraceptive method needs.

c. The Agency is shares responsibility with other community partners to review PNCC Enrollment data. Agencies receiving grants under the DPH WH-FP/RH contracts must assess the need and feasibility of becoming PNCC certified and directly providing complete PNCC services based on community access and patient needs. In some instances, providing early or initial prenatal care intervention may be another service needed to meet patient needs.

d. Regardless of specific plans, the Agency will have increased accountability to increase and quality improve access to and participation in PNCC, and post-partum contraceptive intervention. The Agency is expected to participate in PNCC meetings as needed promote integration.

e. The Agency must summarize plans and implementation progress in the year-end narrative performance report.

For more information, contact Katie Gillespie at 608-266-1538, or Kate.Gillespie@dhs.wisconsin.gov

IV. Performance Measurement and Reporting Requirements

A. The Agency must maintain a quality assurance/quality improvement system, including performance measurements, patient record audits, and internal program reviews as required by the WH-FP/RH Program.

a. The Agency will maintain a process for "real-time" patient record review and quality control, including a **monthly review of 1-2 patient records** using patient record templates —to assure compliance with priority practices and guidelines and proper documentation. **(See Attachment B).**
b. The Agency will schedule **at least one conference call with WH-FP Program staff**, which will include a review of 1-2 patient records (as part of agency's monthly review).
c. The Agency will **organize and prepare for at least one program review/consultation visit** arranged by WH-FP/RH Program staff.

B. The Agency will use SPHERE screens developed for Family Planning and Reproductive Health Services, **or** an agency information system as the source for performance measurement and demographic reporting requirements.

C. The Agency must submit performance measurement, demographic, and performance narrative reports to the DPH WH-FP/RH Program by January 31, 2016. See Attachment A.

D. The Agency must conduct patient record audits in 2015, and submit report performance in relation to key quality indicators by August 31, 2015. See Attachment C.

E. The Agency must prepare a Cost Analysis Report in 2015 (based on 2014 cost and utilization reports) using the standardized Relative Value Unit methodology, and submit a report by August 31, 2015.

V. Other Grant Conditions

Any additional Agency-specific grant conditions and requirements are described in **Attachment D** *(if applicable)*. The Agency must comply with and implement grant conditions and requirements described in **Attachment D**.

Attachment A (to Exhibit I)

Division of Public Health (DPH)
Women's Health - Family Planning and Reproductive Health Program

Reporting Requirements
January 1, 2015 through December 31, 2015

I. Year-End Patient Services Report

1. The **total unduplicated number** of *female* patients *(with ICD-9 code of v25 in the current cycle of care).*
    a. The unduplicated number of *female* patients with **new** patient CPT coded Office Visits in the contract year, and
    b. The unduplicated number of all other *female* patients with **established** CPT-coded Office Visits.

2. The **total unduplicated number** of *male* patients

3. The **unduplicated number** of patients who received pregnancy tests.
    a. The unduplicated number of new patients who received a *negative* pregnancy test.

4. The unduplicated number of *female* patients enrolled in Badger Care Family Planning Only Services among (i.e., as a sub-set of) the total unduplicated number of patients reported under #1.

II. Year-End Demographic Reports

Title V required demographic data by type of individual

1. Type of individual includes:
    A. Pregnant (includes CSHCN pregnant)
    B. CSHCN patients < 22 years (non-pregnant)
    C. Patients < 22 years (non-CSHCN or pregnant)
    D. Other patients (non-pregnant 22 years or older)

2. Number of unduplicated patients (male and female) by race by type of individual served
   Race includes: Total, American Indian, Asian, Black, Hawaiian/Pacific Islander, White, Other, Unknown, or More than One Race Reported

3. Number of unduplicated patients (male and female) by ethnicity by type of individual served:
   Ethnicity includes: Total, Not Hispanic/Latino, Hispanic, Latino, Unknown

4. Number of unduplicated patients (male and female) with Primary Health Care Coverage by type of individual served:
   Primary Health Care Coverage includes: Total, None, Medicaid, Forward Health family Planning Only Services, BadgerCare, Private, Other

5. Number of unduplicated patients (male and female) with Dental Coverage by type of individual served: *Primary Health Care Coverage includes:* Total, None, Medicaid, Forward Health family Planning Only Services, BadgerCare, Private, Other

6. Number of unduplicated patients (male and female) with Primary Care Provider and Dentist/Oral Health Provider by type of individual served:
    a. Primary Care Provider includes: Total, Yes, No, Unknown
    b. Dental/Oral Health Provider includes: Total, Yes, No, Unknown

7. Total number of CYSHCN patients (male and female) served:
    a. Number of CYSHCN patients < 22 years
    b. Number of CYSCHN patients < 16 years on SSI (0 to 16)
    c. Number of CYSHCN patients with a Primary Care Provider

NOTE: SPHERE users will obtain data for Title V required demographic data reports listed above by entering data into SPHERE Screens. See SPHERE Instructions.

Definitions

1. Family Planning (FP): a patient with a CPT office visit code and an ICD-9 code of v25 (contraceptive management) as the primary or secondary diagnosis code within the current cycle of care.

2. Pregnant: a female from the time pregnancy is confirmed to 60 days after the birth, delivery, or expulsion of fetus. (MCH Block Grant definition for demographic data)

3. Children and Youth with Special Health Care Needs (CSHCN): a child birth through 21 years of age with long term, chronic physical, developmental, behavioral, emotional illness or condition. The illness or condition meets the following criteria: severe enough to restrict growth, development, or ability to engage in usual activities; has been or is likely to be present or persist for 12 months to lifelong; and is of sufficient complexity to require specialized health care, psychological, or educational services of a type or amount beyond that required generally by children.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2015
Program: Women's Health – Family Planning

Review Criteria

FINANCIAL INFORMATION:		
At end of visit, did patient have a pay source (e.g. BadgerCare/FPOS or Private Insurance)?	Y	N
Prior to the visit, did the patient have (i.e., come to visit with) a pay source (BadgerCare, FPOS or Private Ins.)?	Y	N
IF NO: (IF Patient had NO pay source)		
Was the patient screened for eligibility for FPOS?	Y	N
Was the patient elibible for FPOS?	Y	N
Was the patient temporarily enrolled?	Y	N
Did you submit Continious Enrollment application for the patient?	Y	N
Did you submit documentation for the patient?	Y	N
Did the patient obtain Continious Enrollment?	Y	N
IF YES: IF FPOS or BC expired in next 3 months, was the patient advised?	Y	N
HISTORY:		
Was patient a new patient?	Y	N
Is there documentation indicating the pregnancy test was needed?	Y	N
Was pregnancy desired?	Y	N
Is the pregnancy test result documented?	Y	N
LABORATORY ASSESSMENT/TESTING:		
Was the patient assessed using the chlamydia/gonorrhea selective screening criteria?	Y	N
Did the patient meet one or more SSC for hlamydia?	Y	N
Was the patient tested at the visit for Chlamydia	Y	N
EDUCATION AND ANTICIPATORY GUIDANCE:		
Did the patient receive education/anticipatory guidance on the following?		
Test validity?	Y	N
Preconceptional Planning?	Y	N
CONTRACEPTION:		
Was the patient currently using a method of birth control at the time of the pregnancy test?	Y	N
Did the patient receive a prescription method at the time of the pregnancy test?	Y	N
Was Quick Start used?	Y	N
PLAN:		
A prescription/order in the chart for emergency contraception?	Y	N
A prescription/order in the chart for male condoms?	Y	N
A prescription/order in the chart for female condoms?	Y	N
A prescription/order for patient's method of birth control?	Y	N
SUPPLIES:		
Was Patient a NEW patient?	Y	N
Did the new patient receive the standard dual protecton kit? (Skip to Line 53 IF patient is "Established")	Y	N
NOTE: A standard Dual Protection Kit contains 2 EC, 3 dozen male condoms, and 2-3 female condoms.		
NOTE: A self-pay patient can receive an EC prescription rather than supply.		
Was Patient and ESTABLISHED Patient?	Y	N
Was the patient's need for the following supplies assessed?		
Emergency Contraception?	Y	N
Male condoms?	Y	N
Female condoms?	Y	N
DOCUMENTATION:		
The **Dispensing Log** documents that supplies were given?	Y	N
The **Dispensing Log** includes prescription numbers as required?	Y	N
Are the results of laboratory test(s) in the chart?	Y	N

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Is the face-to-face time and education/counseling time documented?	Y	N
Are all entries signed and dated by staff?	Y	N
BILLING:		
Does the billing sheet reflect the services/supplies documented in the patient chart?	Y	N
Does the chart documentation support the charges for the office visit?	Y	N
Did the patient receive an explanation of their charges?	Y	N
Did the patient receive a copy/receipt of their charges?	Y	N
Is the pay source documented on the billing sheet?	Y	N
Is documentation for the health professional shortage area (AQ modifier) on the billing sheet?	Y	N

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Contract #: 27435 **Agency:** Dunn County Health Department **Contract Year:** 2014
Program: Women's Health – Family Planning

Attachment C to 2015 Contract Exhibit I

Wisconsin Women's Health-Family Planning/Reproductive Health Program
Quality Assurance Performance Measurement

Audit Period: ____/____/____ to ____/____/____

Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
Pregnancy Testing **Number of Charts Selected for Chart Audit:**					
[1]: *New* patients receiving prescription contraceptive services and supplies at the same visit following a negative pregnancy test. **Negative Pregnancy Test Audit** **Numerator:** Row 39 = **"Y"** **Denominator:** Negative Test Result, ***and*** **New Patient (Row 15 = "Y"), *and*** **Pregnancy Not Desired (Row 17 = "N"), *and*** **Prescription method not used at time of pregnancy test (Row 37 = "N")**	New patient; Pregnancy test; Negative test result; No current Rx method prior to pregnancy test visit; Pregnancy not desired	Percent: **[numerator]** # of patients who received a prescription method (at same visit as pregnancy test) ÷ **[denominator]** # of new patients with negative pregnancy test result (*and pregnancy not desired*)	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	95%	All new pregnancy test patients with negative pregnancy tests results (not desiring pregnancy) will receive a primary (prescription) method at the same visit. Quick start is recommended for method effectiveness.
[2]: *New* patients receiving a *standard* Dual Protection Kit following a pregnancy test.* **Negative Pregnancy Test Audit** **Numerator:** Row 50 = **"Y"** ***Denominator:*** *Pregnancy Test,* ***and*** **New Patient (Row 15 = "Y"), *and*** **Payment Source (Row 4 = "Y")** **[AND]** **Positive Pregnancy Test Audit** **Numerator:** Row 44 = **"Y"** ***Denominator:*** *Pregnancy Test,* ***and*** **New Patient (Row 43 = "Y"), *and*** **Payment Source (Row 63 = "Y")**	New patient; Pregnancy test; Patient with payment source;	Percent: **[numerator]** # of patients (*with payment source** for visit) who received a standard Dual Protection Kit ÷ **[denominator]** # of new patients (*with payment source for visit*). *payment source means a "third party" source such as Badger Care or private insurance.	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	95%	All new patients receiving a pregnancy test will receive a standard Dual Protection Kit.* Supplies provided to patients with health care coverage (payment source). A prescription is provided for emergency contraception if patient is private pay (no payment source) and unwilling to purchase supplies. Use of regular OHCs for emergency contraception (with instructions) is acceptable for private pay patients without health care coverage.
[3]: Patients (new or established) with	New patient;				All pregnancy test patients with positive test results and

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
positive pregnancy test result and assessed as likely to proceed with pregnancy. **Receiving the following intervention:**	Established patient; Pregnancy test; Positive test result; Likely to proceed or uncertain				likely to proceed with pregnancy will receive intervention and formal (actively assisted and managed) referrals to facilitate timely continuity of care into pregnancy services. Patients should have health care coverage with broadest benefits to support pregnancy related care. Continuity of care is a core standard of practice within the WH-FP/RH Program. All family planning patients receive intervention to facilitate timely and appropriate continuity of care, including intervention that supports early entry into prenatal care and pregnancy support services, including PNCC.
See Quality Indicators Below: 3.1 – 3.8					
[3.1]: Receiving Badger Care Express Enrollment (*at the clinic visit)* for Forward Health prenatal care benefits **Positive Pregnancy Test Audit** **Numerator:** Rows 61 = **"Y"** ***Denominator:*** Positive test result, ***and*** **No payment source for pregnancy prior to visit (Row 59 = "N")**, and **Eligible for BC-EE (Row 60 = "Y")**, and **Likely to proceed with pregnancy or uncertain (Row 12 = "Y")**	New patient; Established patient; Pregnancy test; Positive test result; No payment source for pregnancy prior to visit; Eligible for BC-EE; Likely to proceed or uncertain	Percent: **[numerator]** # of patients who received Express Enrollment at the clinic visit ÷ **[denominator]** # of patients meeting the selection criteria.	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	95%	Pregnant patients are screened for Forward Health eligibility and provided the opportunity to complete (with assistance) Express Enrollment. Patients receive anticipatory guidance and assistance to complete the enrollment process. Patients will be assessed for health care coverage eligibility with broadest benefits to support pregnancy related care.
[3.2]: Receiving a formal referral (including written consent for PNCC follow-up)** ***Referral within or outside agency* **Positive Pregnancy Test Audit** **Numerator:** Row 36 = **"Y"** ***Denominator:*** Positive test result, ***and*** **Eligible for BC-EE (Row 60 = "Y")**, and **Likely to proceed with pregnancy (Row 12 = "Y")**	New patient; Established patient; Pregnancy test; Positive test result; Eligible for BC-EE; Likely to proceed with pregnancy	**Percent: [numerator]** # of patients who received a formal referral for PNCC ÷ **[denominator]** # of patients meeting the selection criteria.	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	To Be Determined	Coordination of services between family planning and pregnancy-related services, including PNCC and WIC, is critical for the Continuity of Care standard. Patients will be screened for PNCC eligibility. A "managed referral" to facilitate connection with PNCC is the standard of care: more than only patient information and recommendations and health teaching. A "formal" (or "managed") referral has the following components: the provider is actively involved in facilitating the connection with the referral source, provides anticipatory guidance and logistical assistance, and provides follow-up to determine if the referral connection was made.
[3.3]: Receiving a PNCC Pregnancy	New patient;	Percent: **[numerator]** #	Number of Charts that Met	To Be	Family planning providers are strongly encouraged to

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
Assessment* by the clinic at same or subsequent visit **(PNCC Pregnancy Questionnaire)* **Positive Pregnancy Test Audit** **Numerator:** Row 34 = **"Y"** ***Denominator:*** Positive test result, ***and*** **Eligible for BC-EE (Row 60 = "Y")**, and **Likely to proceed with pregnancy (Row 12 = "Y")**	Established patient; Pregnancy test; Positive test result; Eligible for BC-EE; Likely to proceed with pregnancy	of patients who received PNCC Pregnancy Assessment by clinic ÷ **[denominator]** # of patients meeting the selection criteria.	the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	Determined	directly provide all or partial PNCC services to ensure patient access, convenience, and responsiveness. The pregnancy assessment is an important intervention for short-term care coordination into pregnancy related care.
[3.4]: Receiving follow-up to determine status of Forward Health enrollment and PNCC connection **Positive Pregnancy Test Audit** **Numerator:** Row 73 = **"Y"** ***Denominator:*** Formal Referral for PNCC (Row 36 = **"Y"**)	Patients receiving a PNCC referral	Percent: **[numerator]** # of patients who received follow-up feedback to verify PNCC referral connection ÷ **[denominator]** # of patients eligible for PNCC.	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	To Be Determined	Continuity of care requires actively managed referral and follow-up to support and motivate successful connections with pregnancy-related services. This is particularly important for patients eligible for PNCC and therefore considered at higher pregnancy risk. The WH-FP/RH Program is part of the Wisconsin Maternal and Child Health Program. Continuity of care throughout the life cycle of reproduction, growth and development is a key principle of practice.
[3.5]: PNCC patients receiving third trimester family planning intervention through the clinic (including post-partum contraceptive plans and supplies) **Positive Pregnancy Test Audit** **Numerator:** Row 75 = **"Y"** ***Denominator:*** *F*ormal Referral for PNCC (Row 36 = **"Y"**)	Patient referred for PNCC;	Percent: **[numerator]** # of PNCC patients who received third trimester family planning services ÷ **[denominator]** # of patients who received formal referral for PNCC	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	To Be Determined	Pregnant patients, eligible for PNCC, will receive actively managed referral and follow-up to support and motivate connections with a PNCC provider. anticipating pregnancy will
[3.6]: Patients returning to the clinic for contraceptive services and supplies post	Patients with positive test	Percent: **[numerator]** # of patients who returned	Number of Charts that Met the **Quality Indicator**:	?%	Health birth spacing is a key maternal and child health/reproductive health practice. Continuity of care

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
pregnancy test **Positive Pregnancy Test Audit** **Numerator**: Row 76 = **"Y"** ***Denominator:*** Patients with positive pregnancy test results	results	to clinic for services and supplies ÷ **[denominator]** # of patients who received pregnancy test and positive test result at clinic	___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%		into and through prenatal care and delivery and into inter-conceptional care is essential for optimal reproductive health. Timely initiation of a primary contraceptive method following delivery requires coordination of care for post partum contraceptive plans and supplies (or service if method is provider initiated, such as depo). Patients will have the opportunity to develop a post partum contraceptive plan (initiated by a health care provider) in the third trimester, and have dual protection and patient initiated supplies on hand prior to delivery. Patients will receive Now and Beyond intervention and patient education. Patients will receive intervention following delivery to address initiation of a primary method.
[3.7]: Patients receiving a STD (SSC) risk assessment for Chlamydia *at same visit* as pregnancy test. **Negative Pregnancy Test Audit** **Numerator:** Row 27 = **"Y"** ***Denominator: Negative*** *Pregnancy Test* **[AND]** **Positive Pregnancy Test Audit** **Numerator:** Row 15 = **"Y"** ***Denominator: Positive*** *Pregnancy Test*	New or Established Patient; Pregnancy test	Percent: **[numerator]** # of patients who received a STD risk assessment (SSC for Chlamydia) ÷ **[denominator]** # of patients receiving a pregnancy test.	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	95%	All pregnancy test patients will receive risk assessment for Chlamydia and testing as indicated. The need for a pregnancy test is a critical reproductive health event and opportunity for intervention to protect fertility and reproductive health. The need or request for a pregnancy test probably indicates sexual activity without a condom. The circumstances surrounding the need for a pregnancy test often involve a behavior placing patient at increased risk of STD exposure. A pregnancy test service in the WH-FP/RH Program is more than a laboratory procedure.
[3.8]: Patients receiving a Chlamydia test (based on the Chlamydia SSC risk assessment) *at same visit* as pregnancy	New or Established Patient;	Percent: : **[numerator]** # of patients who received a Chlamydia test (based	Number of Charts that Met the **Quality Indicator**: ___ [Numerator]	90%-95%	All patients meeting one of more of the established Selective Screening Criteria (SSC) for Chlamydia will be tested. Urine-based tests for Chlamydia at the time

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
test. **Negative Pregnancy Test Audit** **Numerator:** Row 30 = **"Y"** ***Denominator:*** **Patients meeting 1 or more Chlamydia SSC (Row 28 = "Y")** **AND** **Positive Pregnancy Test Audit** **Numerator:** Row 18 = **"Y"** ***Denominator:*** **Patients meeting 1 or more Chlamydia SSC (Row 16 = "Y")**	Pregnancy test; Meets 1 or more SSC	on SSC for Chlamydia) **÷ [denominator]** # of patients receiving a Chlamydia SSC risk assessment and test recommended.	Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%		of pregnancy can be conveniently performed.
Number of Charts Selected for Chart Audit:					
Contraceptive Services and Supplies					
[4]: New female patients receiving a standard Dual Protection Kit. **New Patient Audit** **Numerator:** Rows 60, 61, and 62= **"Y"** ***Denominator:*** New Patients, and **Payment Source for visit** (Row 5 = **"Y"**)	New patient; With payment source for visit;	Percent: **[numerator]** # of patients (with payment source) who received a standard Dual Protection Kit **÷** **[denominator]** # of new patients (*with payment source for visit*).	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	95%	Dual protection is a core standard of care. All new female patients will receive a standard Dual Protection kit and standard messaging on importance of dual protection, backup contraception, and benefits of female condoms. Supplies provided to patients with health care coverage (payment source) or prescription for emergency contraception if private pay and unwilling to purchase supplies. The use of regular OHC for emergency contraceptive use is an option for private pay patients for whom the cost of even discounted Plan B is not affordable. Use of regular OHCs for emergency contraception (with instructions) is acceptable for private pay patients without health care coverage. All family planning patients are offered and strongly encouraged to have condoms on hand, for back-up or "dual protection," as recommended by the DPH WH-FP/RH Program and ACOG. New patients received the standard dual protection kit.
[5]: Established female patients assessed for dual protection supplies on hand at last office visit or supply visit.	Established patient; With payment source for visit;	Percent: **[numerator]** # of patients with documentation of assessment of dual	Number of Charts that Met the **Quality Indicator**: ___ [Numerator]	100%	All family planning patients are offered and strongly encouraged to have condoms on hand, for back-up or "dual protection," as recommended by the DPH WH-FP/RH Program and ACOG.

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
Returning Patient Audit **Numerator:** Rows 55, 56, and 57 = **"Y", AND** Rows 61, 62, and 63 = **"Y"** ***Denominator:*** *Returning patients*	Without payment source for visit	protection supplies on hand at last office (M/E) or supply visit ÷ **[denominator]** # of returning patients	Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%		All established female patients will be assessed for supplies on hand and the need to replenish supplies. Supplies are provided as needed, unless refused. New prescription provided for emergency contraception if private pay and unwilling to purchase supplies.
[6]: Initiating new prescription contraceptive methods using Quick Start **New Patient Audit** **Numerator**: Row 64 = **"Y"** ***Denominator:*** **New prescription Method** (**Row 63** = **"Y"**)	New patient; New prescription method	Percent: **[numerator]** number of new patients initiating* prescription contraceptive methods at the clinic (Quick Start) ÷ **[denominator]** number of new patients receiving prescription methods of contraception **initiating a new method*	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	95**%**	WH-FP/RH providers will be responsive to patient contraceptive preferences (for initiating contraceptive methods). Quick start is an evidence-based approach of method management, is safe and effective, has demonstrated increased initial success with contraception. WH-FP/RH providers will provide patients the opportunity to initiate prescription methods using quick start.
[7]: New patients with no current method, initiating a new prescription method of contraception at first visit. **New Patient Audit** **Numerator:** Row 63 = **"Y"** ***Denominator:*** **New patients, AND** Row 53 = **"N"**	New patient; First visit; New prescription method	Percent: **[numerator]** number of new patients initiating new prescription methods at first visit ÷ **[denominator]** number of new patients	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	95**%**	WH FP/RH providers will not routinely require an examination prior to initiating a new primary method of contraception, i.e., will not routinely postpone or defer initiating a new primary method of contraception until an examination is completed. A physical examination will not routinely be a prerequisite for initiating a new method per WH-FP/RH Clinical Guidelines. Providing patients timely and convenient care and access to services is an important element of community-based services. When examinations are indicated but not immediately available, examinations will be deferred to accommodate the initiation of a contraceptive method. The intent of this standard is to enable the maximum percent of new patients to leave first visit with their chosen prescription method.
STD Screening, Testing, and Treatment					
[8]: New female patients receiving a risk assessment for Chlamydia using SSC	New patients; First visit	Percent: **[numerator]** # of new patients with	Number of Charts that Met the **Quality Indicator**:		Sexually transmitted disease (STD) services (including patient education, screening, testing, treatment, and re-

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
New Patient Audit **Numerator:** Row 34 = **"Y"** ***Denominator:*** New patients and first visit		documented Chlamydia risk assessment using SSC at first visit ÷ **[denominator]** # of new patients (at first visit)	___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%		testing) are essential components of community-based family planning/reproductive care accompanying contraceptive services. Epidemiologic-based screening criteria are used to identify patients at a higher relative risk of infection and a priority for testing. Throughout each STD service component, the goals are to: 1) Increase patient awareness of personal STD exposure risk, and 2) Motivate and support patients to adopt behaviors to reduce the risk of STD exposure. Dual Protection is a primary prevention goal toward maintaining reproductive health and protecting fertility.
[9]: Established female patients receiving a risk assessment using Chlamydia SSC within the most recent 12 month cycle of care. Note: NOT including a returning visit in the year in which patient became a New patient, i.e., NOT including the first 12 month cycle of care that included the initial visit. **Returning Patient Audit** **Numerator:** Row 28 = **"Y"** ***Denominator:*** **Established patients, at least 12 months since new patient first visit (Row 15 = "Y")**	Established patients; Returning visit. NOTE: Returning visit in the latest 12 month cycle of care as an established patient.	Percent: **[numerator]** # of established patients with documented Chlamydia risk assessment using SSC ÷ **[denominator]** # of established patients with returning visit (*excluding the 12 month cycle of care in which patient had initial visit)** **established patients beyond the first 12 month cycle of care in which they had their New patient initial visit.*	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%		Patients are assessed at least annually for potential risk of STD (Chlamydia) exposure. Patient are routinely asked at office visits if they have had any changes with "sex partners" that might have increased their risk of STD exposure.
[10]: Female patients meeting one or more Chlamydia SSC receiving a test at the same visit **New Patient Audit** **Numerator**: Row 36 = **"Y"** **Denominator: Patients meeting one or more SSC (Row 35 = "Y")** **Returning Patient Audit**	All patients (new or established); Patients meeting one or more SSC	Percent: **[numerator]** number of patients tested ÷ **[denominator]** number of patients screened and meeting one or more Chlamydia SSC.	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	95%	

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
Numerator: Row 30 = **"Y"** **Denominator: Patients meeting one or more SSC (Row 29 = "Y")**					
[11]: Female patients testing positive for Chlamydia receiving treatment (medications or prescription) through the clinic. ***Numerator:*** Female patients receiving treatment through the clinic ***Denominator:*** Female patients with a positive test through the clinic **Note: Performance data not from chart sample but actual universal performance during the audit period.**	All female patients (new or established); Positive test result through the clinic	Percent: **[numerator]** number of female patients* treated ÷ **[denominator]** number of female patients with positive test results* **who received a positive Chlamydia test result through the clinic*	Number of Patients who Met the **Quality Indicator**: ___ [Numerator] Number of Patients who Met **Selection Criteria**: ___ [Denominator] Performance: _____%	90%	
[12]: Female patients treated through the clinic receiving subsequent re-tests for Chlamydia ***Numerator:*** Female patients re-tested* following treatment ***Denominator:*** Female patients who received treatment through clinic **re-tested 30-120 days following treatment* **Note: Performance data not from chart sample but actual universal performance during the audit period.**	All female patients (new or established); Received treatment through the clinic;	Percent: **[numerator]** number of female patients re-tested following treatment at the clinic* ÷ **[denominator]** number of female patients treated at treated at the clinic **re-tested 30-120 days following treatment*	Number of Patients who Met the **Quality Indicator**: ___ [Numerator] Number of Patients who Met **Selection Criteria**: ___ [Denominator] Performance: _____%	80%-90%	Treated patients are re-screened. Reference: Region V Infertility Guidelines.
Health Care Coverage					
[13]: Verifying BC-FPOS status prior to *or* at each patient visit or service. **New Patient Audit** **Numerator:** Row 6 = **EITHER "Y" OR "N"** **Denominator: All patient charts selected for audit** **[AND]** **Returning Patient Audit** **Numerator:** Row 5 = **EITHER "Y" OR "N"** **Denominator: All patient charts selected for**	All patients (new and established); All office visits; All supply visits; Re-supply by mail	Percent: **[numerator]** number of patients whose BC-FPOS eligibility and/or status was verified at last visit or supply ÷ **[denominator]** number of patients with office visits, supply visits, or re-supply by mail.*	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	100%	Health Care Coverage and Benefits Eligibility Screening and Enrollment/Re-enrollment and Referral is a core WH-FP/RH service. Eligibility screening for Badger Care-Family Planning Only Services (and other sources of payment) is routinely performed and enrollment is initiated if patients are eligible. Patients are actively assisted with BC-FPOS

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
audit		**among charts selected for audit*			enrollment. Temporary enrollment is performed at the same visit. Continuous Enrollment information is obtained and the application is submitted on behalf of patients as needed to complete their enrollment. Patients are assisted in submitting verification documents as needed.
[14]: Screening patients for BC-FPOS eligibility. **New Patient Audit** **Numerator: Row 7 = "Y"** ***Denominator:* New patients, and** **Not enrolled in BC-FPOS prior to initial visit: (Row 6 = "N")**	New patients; Not enrolled prior to initial visit;	Percent: **[numerator]** number of patients screened for BC-FPOS eligibility ÷ **[denominator]** number of new patients	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	100%	
[15]: Completing BC-FPOS Temporary Enrollment for eligible patients **New Patient Audit** **Numerator: Row 9 = "Y"** ***Denominator:* New patients, and** **Not enrolled in BC-FPOS prior to initial visit: (Row 6 = "N"), and** **Eligible for BC-FPOS (Row 8 = "Y")**	New patients; Not enrolled in BC-FPOS prior to initial visit; Eligible for BC-FPOS	Percent: **[numerator]** number of patients temporarily enrolled in BC-FPOS ÷ **[denominator]** number of new patients eligible for BC-FPOS	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	100%	
[16]: Obtaining BC-FPOS Continuous Enrollment information (when patient is Temporarily Enrolled) and submitting application on behalf of patient **New Patient Audit** **Numerator: Row 10 = "Y"** ***Denominator:* New patients, and** **Temporarily enrolled in BC-FPOS (Row 9 = "Y")**	New patients; Temporarily enrolled in BC-FPOS at clinic	Percent: **[numerator]** number of patients for whom BC-FPOS Continuous Enrollment application was submitted ÷ **[denominator]** number of patients Temporarily Enrolled at clinic	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%		
[17]: Submitting BC-FPOS Continuous Enrollment Verification Documents on behalf of patients	New patients; Temporarily enrolled in BC-	Percent: **[numerator]** number of patients for whom BC-FPOS	Number of Charts that Met the **Quality Indicator**: ___ [Numerator]		

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
New Patient Audit **Numerator**: Row 11 = **"Y"** ***Denominator:*** New patients, and Temporarily enrolled in BC-FPOS (Row 9 = **"Y"**)	FPOS at clinic	Verification Documents were submitted ÷ **[denominator]** number of patients Temporarily Enrolled at clinic	Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%		
[18]: Patient receiving Continuous Enrollment approval **New Patient Audit** **Numerator: Row 12** = **"Y"** ***Denominator:*** **New patients**, **and** **Eligible for BC-FPOS** (**Row 8** = **"Y"**)	New patients; Eligible for in BC-FPOS	Percent: **[numerator]** number of patients who obtained BC-FPOS Continuous Enrollment approval ÷ **[denominator]** number of patients BC-FPOS eligible	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%		
Other Health Care Services					
[19]: Sexual assault/abuse screening and assessment as part of the sexual history for minors. **New Patient Audit** **Numerator:** First visit and Row 77 = **"Y"** ***Denominator:*** **Female patients, under age 18 at initial new patient visit** (**Row 75** = **"Y"**)	New female; adolescent patient under age 18	Percent: **[numerator]** New female patients (*under age 18*) assessed for specific reportable conditions ÷ **[denominator]** new female patients	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	100%	All adolescents receiving family planning/reproductive health care services must be assessed for conditions of sexual abuse reportable under Wisconsin law. Family planning providers have an ethical and legal responsibility to assess for sexual assault. This is a specific standard of practice related to reportable sexual assault/abuse among minors. Family planning/reproductive health providers have specific responsibilities under the sexual abuse reporting statutes at s. 48.981 (2m), for care services to minors, and do *NOT* automatically report sexual abuse based *solely* on the minor's age and sexual activity so that minors can "obtain confidential health care services". Sexual abuse reports are to be based on specific facts and circumstances defined in law, and an assessment by the health care provider of these circumstances. Knowledge and skills to implement these responsibilities is essential.
Cytology					
[20]: Cytology screening initiated no earlier than age 21 **New Patient Audit** **Numerator**: **Row 40** = **"N"** ***Denominator:*** **Female patients, under age 21**	New patients; Established patients	Percent: **[numerator]** number of patients under age 21 not receiving pap test ÷ **[denominator]** number	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**:	100%	ASCCP/ACOG Guidelines for cytology screening, management, and follow-up are followed by WH-FP/RH providers.

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Quality Indicators	Selection Criteria	Measurement	Performance	Benchmark	Standard of Practice
(**Row 76** = **"Y"**) **[AND]** **Returning Patient Audit** Numerator: Row **35** = **"Y"** ***Denominator:*** **Female patients, under age 21** (**Row 70** = **"Y"**)		of patients under age 21	___ [Denominator] Performance: _____%		
Patient Privacy and Confidentiality					
[21]: "No-contact" patients records clearly and conspicuously flagged* according to agency policy to prevent unauthorized contact. **New Patient Audit** **Numerator:** **"No contact" patients. Patients not to be contacted at home address: Row 78 = "Y"** **Denominator: All patient charts selected for audit** *Prominent affirmative indication in patient chart whether or not patient can be contacted at home address	All patients	Percent: **[numerator]** number of no-contact patients with clear records flags ÷ **[denominator]** number of no-contact patients	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	100%	**A health care provider *shall not* release, deliberately or inadvertently, *any* information** that reveals (directly *or* indirectly) the identity of *any* individual (including a minor patient) who has received family planning/reproductive health care services, to any third party *without prior written consent* of the patient who received the FP/RH/SH services. ***Exceptions* to the release of family planning/reproductive health care related information**, otherwise *only allowed with prior written consent of the patient receiving services*, are limited to circumstances explicitly identified in statute, or a lawful order from a court of record. All family planning patient information, whether or not in the form of a patient record, is protected from disclosure or release to third parties without prior written consent and release by the patient receiving services. Safeguards must be maintained.
Health Assessment Visit					
[22]: Established patients receiving periodic health assessment (wellness) visits **Numerator:** **Assessment Visit** (Row 25 = **"Y"**) **Denominator:** **Established Patient in last 12 month cycle of care** (Row 15 = **"Y"**)	Established female patients; Active patients; Patients beyond first 12 month cycle of care	Percent: **[numerator]** # of patients who received a health assessment visit ÷ **[denominator]** number of patients meeting selection criteria	Number of Charts that Met the **Quality Indicator**: ___ [Numerator] Number of Charts that Met **Selection Criteria**: ___ [Denominator] Performance: _____%	Baseline	An **annual health assessment visit**, with or without and exam, is a WH- FP/RH Program Standard of Care. This is a prime opportunity to address a patient's reproductive life plan and health promotion behaviors. It is an appropriate time to discuss reduction of chronic disease risk(s).

9.20.13

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NOTES

Patient Visits
Patient Status during audit period is based on the CPT definition of "new" and "established" patient:
- New patient during the audit period. **Patient's First Visit** is audited unless selection criteria specifies otherwise.

- Established patient prior to the audit period. **Patient's care within the last 12 months (excluding the first 12 months of services** unless selection criteria specifies otherwise.

Selection Criteria
Patients are assumed to be receiving contraceptive services unless otherwise noted by the selection criteria.

Patients are female unless otherwise specifically noted.

Measurement
Measurement is based on documentation of the intervention (quality or performance indicator) *for visit to be audited*.

Core Services
- Contraceptive Services and Supplies
- STD Screening, Testing, and Treatment
- Cytology
- Pregnancy testing
  - Pregnancy-related services
  - Post-partum services
- Health Care Coverage
- Other Health Related Services

Standard Dual Protection Kit
a. Emergency Contraception in advance of actual need is provided (2 cycles)
b. Condoms (3 dozen male and 2 female condoms) are provided
c. Basic information is provided: use of EC; use of condoms; re-supply instructions

OTHER
This document outlines performance measurement against quality and other performance indicators.

Other reports will address other capacity and performance issues, such as:
- New patients as percent of total unduplicated patients
- Established patients (established prior to audit period) as percent of unduplicated patients

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Exhibit II

Division of Public Health (DPH)
Women's Health-Family Planning and Reproductive Health Program

Service Plan and Projections
January 1, 2015 through December 31, 2015

Name of Agency: Dunn County Health Department

Agency agrees to:

Maintain for all required core services, intervention, and components agreed to in its Wisconsin DPH WH-FP/RH Program 2011-2015 RFP application and Business Plan.

Deliver services and provide care according to the standards of care, standards of practice, and other requirements in the Wisconsin DPH WH-FP/RH Program Guidelines.

Meet all requirements and grant conditions as required by Wisconsin DPH WH-FP/RH Program and specified in the 2015 Contract Exhibit I.

Failure to comply with the above requirements is basis for non-continuation (non-renewal) of the DPH WH-FP/RH Program grant contract.

2015 Projections

By December 31, 2015, **570** *women* of reproductive age (*total unduplicated number*) are projected to receive contraceptive, reproductive health, and/or early intervention care through the agency's family planning and reproductive health clinic services in **Dunn County (Counties)**.

Agency's Patient Projections for 2015:

1. **the *total* unduplicated number of female patients: *500***
   (NOTE: List number for each clinic *if* a multi county agency)

2. **the total unduplicated number of pregnancy test patients: *75***
   (NOTE: List number for each clinic *if* a multi county agency)

3. **the *total* unduplicated number of male patients: *60***
   (NOTE: List number for each clinic *if* a multi county agency)

Agency's Total Operating Budget Projections for women's health-family planning services for 2015:
$ *295,000* **[NOTE: Include Grant + Program Generated Revenue (PGR) BUT NOT In-Kind].**

Agency's Grant Award is projected to be *22%* % of the total operating budget above.
[NOTE: Divide the Grant award by the total projected operating budget above].

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Amount of Program Generated Revenue Projected to be on-hand (after program expenses) at the end of 2015: $*10,000*.

2014 Baseline Performance

2014 YTD Performance through 6/30/2014

Number of total unduplicated female patients receiving services through 6/30/2014: *571*
(NOTE: List number for each clinic *if* a multi county agency)

Number of total unduplicated pregnancy test patients through 6/30/2014: *102*
(NOTE: List number for each clinic *if* a multi county agency)

Number of total unduplicated male patients through 6/30/2014: *57*
(NOTE: List number for each clinic *if* a multi county agency)

2014 Performance Measurement:
Quality Indicator 18: Patients Receiving Continuous BC-FPOS

NOTE Percent: [numerator] number of patients who received BC-FPOS Continuous Enrollment determination ÷ [denominator] number of patients BC-FPOS eligible) 75%

Total Program Generated Revenue Received through 6/30/2014

Total (Gross) Third Party and Patient Fee Revenue received through 6/30/2014: $88,614

Assurances

All WH-FP/RH Program Staff have reviewed Exhibit I. Yes

All WH-FP/RH program staff have been informed of the expectations and due dates for all required performance measurements and reports, identified in Exhibit I, Section IV. Yes

A privacy review has been completed and documented: Exhibit I, Section III.D.2: Yes
NOTE: A presentation relevant to the Internal Privacy review is scheduled at the September, 2014, Business meeting in Wausau that will review patient privacy rights and provider responsibilities.