

JSI RESEARCH AND TRAINING INST

Moderator: Ann Loeffler
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Operator: This is conference # 83152678.

Operator: Good afternoon. My name is (Sherry) and I will be your conference operator today. At this time I would like to welcome everyone to the 2016 Forecast: Office of Population Affairs Town Hall Webinar. All lines have been placed on mute to prevent any background noise. If you should need assistance during the call please press the pound key and then zero and an operator will come back on the line to assist you. Today there will also be a Q&A session through the webinar chat. Thank you.

Ms. Loeffler, you may begin your conference.

Ann Loeffler: Hi, everyone. Thank you, (Sherry). Welcome to today's webinar. This is Ann Loeffler from the Title X training centers and our webinar will start with some brief remarks from Sue Moskosky, the Acting Director at the Office of Population Affairs (OPA). She'll be followed by updates from OPA Senior Staff, Dr. Lorrie Gavin and Christina Lachance, Nancy Mautone-Smith, Dr. Tasmeen Weik, and David Johnson.

To ask a question please type it into the chat box which – if it's not already activated you can activate it by clicking on the chat icon in the top right corner of your screen and send your questions to the host Paul Rohde. OPA will pause from time to time to answer your questions. They may reply directly to your chat if they need to make any clarification.

And in the interest of time they're going to be answering only those questions that are applicable to other participants so they may defer more specific questions to regional staff for response later. So if you have a specific question to your situation please direct those to your regional office staff. So we will include the question and answers with an archive of this webinar.

And with that I'll turn it over to Sue Moskosky.

Sue Moskosky: Thanks, Ann and thank you everybody for joining us this afternoon for updates from the Office of Population Affairs. So during the webinar this afternoon I'm going to provide you with an update on where we are with a number of our priorities and activities and give you an update. Many of you were at the National Grand Team Meeting that occurred back last summer and we'll give you an update on everything that you heard about there as well as some other issues going on here at OPA.

And one of the reasons that we're doing this Webinar is that we want to make sure that we keep communication lines open with grantees so that you all are hearing directly from OPA in terms of activities and priorities. So we'll be talking this afternoon about initiatives from OPA that address improving quality, expanding access and building sustainability, data systems and service delivery and then we've saved lots of time for questions from you all so again, please do chat your questions into the chat box and we'll be giving a lot of time devoted to your questions.

So this is what the OPA staff looks like at this point. If you see this slide six months from now hopefully there'll be a lot more names up here. But I'm still the Acting Director at OPA and you can see that we have our Admin and Budget section which is David Johnson and (Susan Denelle), Service Delivery Nancy Mautone-Smith and we'll have a new staff person joining us next Monday, Cenda Hall. Lorrie Gavin is, as you can see is a one-lady show here in the Performance and Quality Area and extremely busy and hopefully we'll be having some additional staff joining her very soon.

Health systems improvement is our team lead by Tasmeen Weik includes Emily Jones and Carolina Loyola and Health IT Christina Lachance, again

we're trying to staff up her team as well. She's very, very busy as you'll hear. Communications team is (Shena Merain) and Laura Gray and then Embryo Adoption which is Bob Scholle.

But just a little bit on program funding, you'll be hearing a little bit more about specifics later in the presentation but we feel fortunate that our FY-16 Appropriation was level funding that followed from FY-15 so that was all, you know, kind of up in the air up until the last minute but we do feel fortunate that we were level funded in FY-16.

As you all are probably very aware we have undergone, over the last couple of years re-alignment process so that all new grants now have an April 1st or a July 1st start date and we're announcing in the funding announcement – funding opportunity announcement we're announcing all competitive areas as the entire state. This is because we want to fund just one grant in every state. It's really not – doesn't have anything to do with that. We're still funding in many cases, you know, four and five grants in some states. But announcing as one state or one service area is actually an efficiency issue.

Also I want to make – spend a little bit of time talking about how important the OPA database is and the fact that it's going to become more important in the next few weeks. So it's really crucial that you all have your information in there and that the information is accurate a number of reasons. And one of the reasons is, that within the next few weeks we are going to be connecting with the 340B office of drug pricing program so that when somebody goes to register as a 340B eligible provider the folks in the Office of Pharmacy Affairs are going to be using the OPA database to validate that you're actually a Title X recipient.

So if the names and addresses of any of your service sites are not accurate you are not going to be eligible to participate in the 340B program until that gets corrected and as you all know there is a little bit of a waiting period. There are only certain times that you can register so it's crucially important for your 340B eligibility that your service sites are all located on OPA database.

Additionally, the database is used by CMS for the Central (Community) Provider List and so there's many, many reasons for you all to have that information to be accurate at all times and it's your responsibility to make sure that it is, at all times so please, please, please help us to help you because this could mean money for you all.

I'm going to spend a little bit of time talking about FPAR data and Data Quality and some concerns and some acts that we have of you. So first I just want to talk a little bit about the fact that we know that over the last few years there have been some declines in client volume across the Title X Network. The highest point in terms of number of users was in 2010 where we had well over 5 million users so 5.2 million was the number in 2010 and that volume has been dropping every year with the 2014 numbers being at 4.13 million so that's almost a 21 percent decrease between 2010 and 2014. And just between 2013 and 2014 alone we saw a 9 percent decrease in the number of clients served.

So there's – while there's many factors that we think may be legitimately contributing to this we also think that one of the issues might be how you're counting family planning clients. And so I'm going to spend a few minutes talking about who should be counted on FPAR as a family planning client and as I've gone through a number of meetings across the country I've actually become increasingly concerned. I know there's a lot of new people out in the field, a lot of folks that don't have, you know, long histories of Title X and that they may not completely understand who's eligible to be counted as an FPAR user.

So a family planning user or somebody that should be counted on FPAR is any individual who has had at least one family planning encounter at a Title X service site during the reporting period. So it really doesn't matter whether you billed Medicaid for that patient, whether you billed private insurance for that patient or that patient is a zero pay patient - all of those patients that are seen within your family planning project as defined in the competing grant application are counted as a family planning user for purposes of FPAR.

So it's not a matter of who's paying for that service. It's anybody that has a documented face-to-face contact between an individual and a family planning provider that takes place in a site that receives Title X fund and there has to be information or services related to preventing or avoiding pregnancy. So I just want to clarify that it's not – if you bill somebody for Medicaid that doesn't mean you don't count them on FPAR.

You count all of those clients on FPAR even if they're seen in a community health center if you're on FQHC setting and that client receives primary care services and you're collecting data to report them on UDS you also report for FPAR. It's not – you're not getting double paid, you're not getting double credit. It's actually to account for the services provided and I'll talk a little bit more as I go through some of these additional slides.

Also, not so good news we really have a lot of concern about the high numbers of unknown or not reported income information. And this is really important information for us to have so that we know whether we're serving the priority population. So as you all know priority for Title X Services is to individuals from low income families. We have some grantees where the unknown are not reported. On this table it's as high as 30 percent. So the bad news is that right now FPAR reports are coming in.

If we have reports that we receive from grantees where the number or percentage of unknown or not reported is higher than 5 percent those reports are going to be returned to you to actually provide the information to go about figuring out how to get that information to us so, just something to be aware of. We really want to cut down because we really can't tell the story of whether we're really serving the priority population when in some cases 30 percent of clients are being reported as unknown or not reported income.

Also, I want to just talk a little bit about chlamydia screening and I think this table and the fact that the trend in terms of the percentage of female users that are below the age of 25 being screened for chlamydia may not be reported accurately so you can see that the number right now is below 60 percent. The highest that we've had is at 60 percent which was in 2013, 2014 it was at 58 percent. But I had heard some things sometimes when I've been out in the

field about, well the chlamydia test wasn't paid for by Title X so didn't count it. This is not an account of who paid for the services. It's whether people were provided services at the appropriate time. So we want to know that folks are actually getting screened at the appropriate time. It doesn't matter who's paying for the actual chlamydia test. So again, please help us with collecting this information and reporting it accurately.

Also, FPAR update on PAP testing trends, you can see that the percentage of female users tested is actually going down. We hope that this is a good sign. We hope that it reflects that you all are adhering to the most recent guidelines but to the extent that it's maybe a factor of not reporting if it's not paid for by Title X again, please report it accurately. It's just a measure of did people receive the service at the appropriate time.

Again, this is the Insurance Status table and the number of users with unknown and not reported insurance status is decreasing but it's still unacceptably high. So again, this is the table where if the percentage that is unknown or not reported of insurance status is – if it's above 5 percent when you have provided that data to OPA or to your regional office if it's above 5 percent we're going to be following up with you to gather that information. So all of this information is crucially important for us in terms of actually being able to tell the story of the services provided and, you know, who's getting services and what types of services they're getting so we really need for the – data to be as accurate as possible so again please help us.

I'm going to finish up by just talking a little bit about the really robust partnerships that we have and how important these partnerships are to the work that we're doing. So we have active, legitimate, collaborative, every day on the phone with our partners that you see illustrated up here on this slide and many others that aren't reflected here. So we – I'm sure have left off many key partners but in my time at OPA which has – many of you that know me know that I've been here for a very long time.

This current time at OPA we have more robust partnerships than we've ever had before that are really helping us to do our work and actually reducing cost for providers, working out strategies with CMS, working side by side with

CDC on guidelines and responding to things, working with ASPE, the Office of the National Coordinate for Health IT and our HRSA partners as well as a number of different groups like the Association for State and Territorial Health Officials, NFPRHA of course and the National Association of Community Health Centers so it's really a very exciting time here at OPA and we really value the partnerships that we've built.

So over the next few minutes you're going to be hearing from other OPA staff on a number of OPA priorities service delivery, improving care quality, ensuring access to services and investing in health information technology.

So I'm going to turn it over now to Nancy Mautone-Smith who's going to spend some time talking with you about service delivery. Nancy?

Nancy Mautone-Smith: Thank you, Sue. I'm delighted to be here today with you to give you an update on where things stand with the program review tool. Our technical assistance contractor Atlas research conducted a training webinar for program review consultants back in November of this year. This training provided an orientation to the revised title fund guidelines and the revised program review tool in order to ensure a shared understanding of how the program review process should be completed in the most fair, equitable and uniform way possible.

Any consultant who wishes to be considered conducting program reviews must take this training prior to commencing any work on program reviews. The training is available in an online format for those who do not have the opportunity to attend the live webinar. Final revisions of the tool are underway and we hope to release the tool within the next couple of weeks. Soon after the release of the revised tool OPA will conduct a webinar for grantees to orient them to the tool and provide ample opportunity for questions and answers.

Then during the next several months Atlas research will begin the transition process to bring the paper format of the program review tool to an online format. That's my update and now I'd like to pass things on to Dr. Lorrie Gavin.

Lorrie Gavin: Good afternoon. I'm going to give a brief update on steps that OPA is taken to support the delivery of quality family planning services. We're doing the best we can to keep you current with most recent scientific findings and clinical recommendations. On a periodic basis, approximately every year we'll release what we're calling an occasional update to QFP. For the most part this will simply provide updated references to the other Federal guidelines such as CDC and (USPFTS) recommendations as well as professional medical association guidelines that are cited in QFP.

The first occasional update has been formally cleared at CDC and will be published as an MMWR weekly article with an expected publication date for the week of March 11. We're also in the midst of a larger update of QFP which will occur every four to five years. We've dubbed it QFP 2.0 expect to have it published in late 2018. This is also being done in cooperation with CDC and we're convening our first full expert recruit meeting later this week. Two new topics for systematic review and possible new recommendations will be considered. Serving LGBT clients will be one of those two topics and the second topic is not yet determined.

We've been working hard on efforts to support implementation of the QFP recommendations in both the Title X network as well as non- Title X settings. A baseline survey of the extent to which QFP recommendations were implemented and publicly funded clinics has been analyzed and the results will be published soon. Overall the results show that Title X providers do better than non-Title X providers in almost all aspects of QFP implementations. So, kudos to all of you. However, there's still room for improvement in many aspects of care. So stay tuned for the release of these findings.

Our efforts to support QFP implementation are focused in three areas: payments, quality improvement and the provision of training and technical assistance. I'll cover each of these points separately. Oh, how do I go back? OK. Thank you. In terms of payment we're working very closely with Medicaid to identify ways to remove payment barriers to the delivery of concept of services. Several strategies have been identified as you can see on the slide and we hope that many state Medicaid programs will agree to adopt

them. Over the coming year we'll be working with you and others to increase awareness of these strategies and help identify ways to implement them.

Quality improvement is an evidence-based strategy for supporting health systems change and we're really excited about efforts to strengthen quality improvement for concept of services. Some of the activities that we're engaged in is first of all, (QA-QI/E), the NTC is supporting 12 grantees in a learning collaborative focused on improving contraceptive abuse and there'll be many lessons learned from this experience to share with other grantees over the coming year.

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OPA has also submitted an application to the National Quality Forum for endorsement of the first ever contraceptive use clinical performance measures. We expect to hear about endorsement and follow up 2016. CMTS has already funded 13 states to report on these contraceptive use measures over the next four years – four-year period so it's ample opportunity to work with these states on improving performance. And finally, we're working with the National Association of Community Health Centers to pilot use of the contraceptive use performance measures in the community health center setting.

Finally, we've released a new funding opportunity announcement to support the training and technical assistance needs of the Title X program. We intend to fund a single FPNTC focused on service delivery improvement. It'll build on a very strong foundation of training materials that's been laid by the existing NTC network. We'll have an increased emphasis however on identifying ways to help support grantees in their role and we'll be continuously informed by an expert worker for grantees that will convene for this purpose. We've worked with experts on implementation science and health systems from the University of North Carolina to learn about evidence-based approaches to training of technical assistance. So expect a new FPNTC to have an emphasis on this as well.

With that, I'm going to hand it off to my colleague Dr. Weik.

Tasmeen Weik: Hi, everyone. Thank you for sticking with us. I know it's been a lot of information already and it might a little bit like your speed dating with OPA. Well, we're all – more than halfway done with the OPA portion of the presentation and we're really looking forward to taking your questions in the chat box so once again please chat your questions to us.

Lorrie talked about how we are promoting quality family planning services. I'm going to discuss ensuring access to quality family planning services. First, we have a funding opportunity out that you can use to make infrastructure improvement to ensure the long term sustainability of your Title X program. You can apply for funds to improve health IT, enroll clients into health insurance, partner with primary care, optimize your revenue cycle management or outreach to new clients.

Note that to submit an application you have to be the grantee that's funded directly from OPA. So if you're a separate recipient or a service site that receives your funding from an entity other than OPA, work with the OPA grantee to submit an application. Letters of intent are due Monday to Emily Jones and applications are due March 31st.

So, now for the exciting part. Those of you who attended the grantee meeting may remember that I discussed the sustainability assessment that we had submitted to OMB for approval. We have now received approval to collect data from all of you. This assessment will evaluate where sites stand with their efforts around health IT, revenue cycle management, enrolling clients into health insurance and clinical quality. The purpose of this data collection is for us OPA to gauge where our clinic network is in terms of responding to the various health system changes that have happened as a result of the ACA.

The idea is that we provide you with better technical assistance and better resources. We anticipate this being an annual data collection and we really hope that it's going to benefit you in the long term. So there are two different instruments, one for grantees that's again the direct OPA grantee to complete and one that we would ask each service site or each clinic to complete. This is a new and big effort so I'm sure you're going to have a lot of questions.

Sometime this week you're going to get a PDF of the online survey from your original project officer.

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OPA's primarily going to communicate with the grantees that we directly fund but then those grantees will communicate with the subs in sites that they fund. We're going to be hosting webinars for both grantees and service sites to not only explain the process but to also go over the tool with you so that you can have all of your questions answered before you have to submit the survey.

So this is what the timeline looks like. Again, you'll get an e-mail shortly from your regional project officer which you'll have a PDF of the survey so you have time to review it before our first webinar which will be on March 7th. This webinar will be just for the OPA grantees so we can talk to you about the process and how to communicate with your subs in sites. Then on March 21st we will have a second webinar for sub-recipients and sites and anyone else and again we will go over not just the process but the specific data collection tool and really spend a lot of time answering your questions.

And then after that some time in March and April you'll be getting e-mail reminders from OPA about the data and then the data will be due April 30th and again it's an online collection form. After the data has been submitted OPA headquarters may contact you to follow up and ask about missing information or to clarify your answers. We will have staff available to answer your questions even after the two March webinars. We know that there will be some growing pains in this first year we're rolling out this brand new data collection so we're open to both your questions and your feedback. So please mark these dates on your calendar. We will talk specifically about these tools and will spend a lot more time on these then.

Lastly, I want to let you know that we have some resources available and coming your way. First, the National Training Center for Management and Systems Improvement has put together this wonderful online mapping tool where – that allow you to see where there are populations in need of reproductive health services relative to the location of Title X centers. So you can see if there are gaps in your service areas. It's a really great visual tool

and it's available in the sustainability community of process on the (fpntc.org) website.

Secondly, many of you may have heard about the great technical assistance that many of the grantees from MSI last year. I'm excited to announce that MSI will be providing technical assistance that will be available to all grantees through learning collaboratives and some one-on-one technical assistance. More information about that will be coming in the next several weeks from MSI as well as from your regional project officers.

And with that I am going to turn it to my colleague Christina Lachance.

Christina Lachance: Thank you, Tasmeen. Good afternoon or good morning wherever you are. This is Christina Lachance. I'm here to give you a quick update on our health IT initiatives. So a brief review first I wanted to re-state this. It's something that I announced at the telethon grand team meeting in August but I think not everyone heard me because I was having mic problems. So I just wanted to let everybody know that the implementation timeline for FPAR 2.0 we've pushed it back to 2019. We hope initially to begin in 2017 but that's not going to be possible so 2019 we're anticipating will be the first calendar year for data collection for FPAR 2.0.

From the past two years our teams had a lot of successes, you know, publishing of a planning profile, testing that connect us on putting up that data element survey and demoing at hands and for you all. We've had to slow the pace of work in recent months due to some staffing challenges but as Sue mentioned we're hoping to hire up – staff up shortly and be able to ramp up the work again.

So one of the pillars of our FPAR 2.0 strategy is the continuous assessment of the readiness of the network for the future of health care and operability that we can plan for and provide as much assistance as possible in preparation for deployment of the new system. Some response that data element survey that many of you filled out about a year ago it only showed that about 30 percent of the respondents who took part were using systems that met the meaningful use to criteria that are so vital for the (FPMs) sending profile. Some responses

you make sure that the new insuring access (FOA) offered Title X grantees and their networks, the ability to request funds in order to make wise investments and modern health information technology.

Your applications are due in about a month and we're hoping that everyone will take advantage of it to (treat these) dedicated funds. And we did make some suggestions for areas for you to propose in but really, you know, it's pretty wide open for you to ask to whatever your network needs at this point in time. So I encourage everyone to apply.

We do have some new assessments coming up and one of them (Jasmin) has already mentioned which is sustainability assessment. There is a health IT section on that – assessment that's going to allow us to keep an eye on how the network's progressing in terms of (the HR) and health IT usage.

And then we have another instrument that's we've been working on for a few months now so it's a quick instrument to assess service sites privacy and security practices. We know that HIPAA compliance is a key concern for all health providers but we know very little about the current state of practice within the Title X network in regards the essential privacy and security safeguards that may or may not already be in place. So this again, is so we can provide training and try to adapt the FPAR 2.0 privacy and security work flows to fit as much as possible within your current practices.

I'm currently waiting (on own) the approval for this instrument so I don't have a launch date to announce yet. But when we do get approval we will only need about 100 service sites to participate in this assessment and we already got a good snapshot of what's going on in the ground so this one shouldn't be too burdensome.

So the major works that we've been participating in for about a year has been the (DI) Identification Guidance and we've been working with another committee within integrating health care enterprise or IAG that's helping us decide how to best mask the future data set so that we – what you all submit to OPA for FPAR reporting is less identifiable than the data that you collect in the clinical record. So we've gone element by element through the FPAR 2.0

data inventory to examine every element and figure out what the best algorithm is to use.

And it really has been a little bit of a tug-of-war between two sides that you see represented here on this slide. And on the one side is the family planning expert which is most folks here on the phone today. And for us, you know, we like our data. We want to keep as many data elements as possible as close to the original value as possible in order to fulfill a reporting requirement and performance – and calculate performance metrics. And that has been kind of an opposition to the privacy and security experts on the IT committee and their orientation is to try to apply the most restricted algorithm possible to limit the data and the detail in it so that the overall data set is discarded as much as possible.

So as everyone knows the current data that we collect for FPAR is sensitive. But it's also largely anonymized due to the tables and age groups that you're using for current reporting. But these same data and the new data elements that will be collected for 2.0 as being counter level become a lot more identifying. So we want to implement a best practice in the privacy world known as the minimization principle. And this basically states, you know, what is the minimum amount of information necessary for OPA to receive in order for us to be able to achieve our goals for using the data for modern range surveillance and performance measurements and how to achieve this, you know, less identifiable set of data as the work of a committee has been engaged in.

So the committees produce two documents out of our discussion that we required public comments on over the past two months and in case you didn't see them the first is a supplement is this is kind of just the quick and dirty of what is the element and what am I supposed to do to it to mask the identifying features of the data. And on the white paper was on much longer more complex document and it described the rationale for each of the recommendation and the larger context to why they are being made.

And so this is just to give you a quick taste of what I mean by algorithm. It sounds really intimidating but it's not that complicated when you break it

down. So instead of sending OPA the visit date for a patient visit let's say it was, you know, December 27th 2014 the algorithm that committee is recommending is for us to use is to generalize that visit date to the week of the year. So in this instance it would be week 52 that would come to OPA.

And instead of the patient's data first, the algorithm they're recommending to apply is to calculate the patient's age and send that through instead. And this – the first recommendation was, you know, to do this for everybody except for those people who are under 18 because they're adolescents and we want to protect them the most and for people who are over 50 because they're the smallest pool of users within Title X.

And then if you go down the chart you'll see there's two dashes next to pregnancy intention and sexual activity and there are that – indicates that no algorithm as necessary because the data themselves were not that identifying so the response to pregnancy intention would be a no and sexual activity was true or false and that data would be passed through unchanged. You don't need an algorithm there.

And so at the end of the day after applying all the algorithms the data that OPA would receive would look something like this. And as you can see it's highly coated and mapped and therefore much less identifying, you know, in the event of a breach or hacking attack that this data were intercepted. Very few people would, you know, be able to do anything with it that would hurt an individual and, you know, served by Title X. So the committee's recommendation that was outlined in the white paper was to try a have a single entity that would perform this de-identification to every single record that would be submitted to OPA.

So I'm going to talk a little bit about the themes from the public comment period which we just, you know, looked at last week when there was an IT meeting in Portugal. The public comment period closed on February 5th and at that point IT received over 100 comments. So they really want to thank everybody and this community who took the time to send in comments. I know that these documents were not easy to read or understandable to some people and I really appreciate you taking the effort to do so.

There were about four themes that came out of the comments that we, you know, took initial stab at reviewing last week. The first one is that people seem to prefer having longitudinal consistency and data accuracy over the ability – over the flexibility for grantees to do the de-identification themselves. It didn't seem like many grantees said that they could support this functionality at this point in time.

There was also almost unanimous push to maintain the current age groups as (power reporting) instead of class inside under 18 category. Folks felt strongly that we should maintain, you know, the under 15, 15 to 17, to 18 to 19 poor performance metrics. And then other folks also pointed that since we are collapsing the visit date down two weeks of the year it would be important for us to know the sequence of encounters during a given week if a patient has more than one visit to a clinic during a week. So the committee came up with the convention so that we could note the sequence of a visit.

But overall the comments that we've reviewed so far have really confirmed a lot of the committee's assumptions about clinical level experiences and the concerns that we were trying to mitigate through the data de-identification.

And so now we have to get to the work of resolving all those comments. And as usual all IT work is completely public and transparent. The entire (clientele) community is welcome to participate. The goal of the call is to reconcile the de-identification concerns and to document any concerns about the daily planning profile because we're still planning to submit a profile – a change proposal later in the year. These calls are not really to talk about Title X programmatic concerns except where it influences the de-identification work.

So the calls will begin on Wednesday March 9th, they're going to be every other week from 12:30 to 2 PM Eastern. And if you'd like to join to be invited please send an e-mail to our co-chair and that's her e-mail address on the screen (gila@cogna.ca). And the timeline that we're hoping to abide by is to resolve all of comments by late spring and then publish, update a document on the usual IT cycle in August.

And I just wanted to close with a reminder of the health IT resources that we have for everyone. We have our [blog](#) which I'm trying my best to keep up-to-date. It's more of a challenge but I'm trying. And then you can always reach out to me at [FPAR 2.0 inbox](#). I love hearing from folks. People send some really good queries in the past week and I always respond as soon as I can.

We do have a health IT community practice upon the [NTC website](#) so you can reach out to folks there. And then if you want to learn more about standards or to, you know, check out the family planning profile or the (DID) work it lives at ([www.iet.net](#)).

So thanks so much for listening and I'm going to turn it over to David Johnson.

David Johnson: Thank you, [Christina](#). Good afternoon. Today I'll be providing an update on the Title X re-alignment process as well as give some reminders about the grant's administrative processes. Beginning with – excuse me, the Title X re-alignment process is set out with the goal of standardizing the Title X services grant award in administrative process. [Oops](#). Thank you. This is accomplished in two ways, either by extending project periods or by shortening the first budget period.

So looking here by the numbers it will take us about three years to completely accomplish this process of which we're actually in the third and final year of this. 36 grantees were directly impacted and 21 states and 4 territories as well. We had four major considerations when we embarked on this process. They were to reduce the disruption in project periods as much as possible, reduce risk on grantees, reduce grantees burden as well as minimize the cost with re-alignment.

We've been able to achieve our goal as well as improve efficiency in the award-making process. So we reduced 12 different start dates down to two, April 1st and July 1st. We were able to reduce the administrative time and costs related to this as well as supply these savings back to the (brokers). We also standardized the funding opportunity announcement and the subsequent review process. We clarified the service competition areas by competing as

the entire state of jurisdiction and the purpose of this was really to better ensure access and not with the intent of limiting competition or reducing the number of grantees.

The new award start dates also sync with the beginning of the Federal fiscal year quarters and therefore eased the Federal financial reporting process, the FFR. Finally, the re-alignment reduced the likelihood of partial funding which occurred when an award is made or was made without having a Federal budget most likely those that started in September. As a result this ideally reduced the – this will ideally reduce the grantee uncertainty and related risks by enabling more long term planning.

The re-alignment process also provided an opportunity to create and establish a more transparent expectation and scheduling of program views. Program reviews are planned to occur now between the end of the first budget period and the beginning of the second. This will give the grantees and the program an opportunity to work together to better monitor the project, track on-going performance and correct any deficiencies that may be identified during the review process.

Finally, a quick review on the grant's administration, non-competing applications are due 90 days prior to the end of the grant period. These applications will always include a program narrative which has a progress report, has a work plan and it also includes a budget and – excuse me, a budget and a budget narrative. The full package is in your grant solutions account as well as guidance can always be found on the OPA link which is down below.

(Part of) approval items, there are several approval items that need to be addressed at the office of grant's management with a copy to your project officer. These need to be submitted for approval at least 30 days prior to the change. And these are, change in scope, change in principal investigator or project director or budget revisions that are in excess of 10 percent of the approved budget. For budget revisions that are less than 10 percent the revised budget must be uploaded into grant solutions with an e-mail to the

office of grant's management and a cc to the project officer. As always the project officer is your first point of contact for all programmatic related issues.

And now I'm going to turn it back to (Jasmin Weisz).

Tasmeen Weik: Great, thank you (David). So I understand that we are having some technological challenges and may not be able to have captured all of your questions in the chat box so we are going to adapt and I'll turn it back over to MSI to give you instructions on how to ask via phone.

Ann Loeffler: Thank you, Tasmeen. This is Ann Loeffler with MSI and we just opened up a Q&A panel on your screen. In the top right corner there's an icon that says Q&A and so if you would still like to chat your question please do so via that Q&A panel. And then we're also going to be taking questions, as Tasmeen mentioned via this conference call line and (Sherry) our operator will instruct you on doing that.

But before I turn it over to (Sherry) please note to ask questions that are applicable to other participants.

And so, with that I'll turn it to (Sherry), our operator to give you instructions on how to submit – how to queue up for the conference call line questions. (Sherry)?

OK to ask your question please press star one and while you're doing that we'll be collecting your questions through the chat as well. And Tasmeen do we have any questions at this point?

Tasmeen Weik: Yes we do. So looks like the chat box is working. That sounds great so again, you have the option to ask a question via phone or that Q&A panel that should have popped up electronically.

So the first question that I have is for Dr. Gavin. What states have been funded by Medicaid to report on the new contraception measures?

Lorrie Gavin: 12 states and 1 territory. So the states are Alabama, California, Colorado, Delaware, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, Missouri, New York, Washington State and the Northern Mariana Islands.

Tasmeen Weik: Great, thank you. OK. Our next question is probably for Nancy. Nancy, when an entire state is available for competition, can my organization apply for a smaller service area? Or actually maybe Sue can answer that.

Sue Moskosky: Yes and the Title X regulations and statutes are very clear that any public or private regional or local entity can apply directly to the secretary for a grant so the answer to that is emphatically yes that any small entity that meets the requirements of being a public or private not for profit agency can apply directly for our grants. You don't have to compete for a whole state or a whole service area.

Tasmeen Weik: OK, great. The next question I think is for me which is: Will grantees in service (IT) expected to submit information at outreach and enrollment activities this year or will outreach and enrollment be part of the sustainability survey? Thank you to whoever asked that question. It's a great question. So the enrollment and outreach information is the same as what you submitted in previous years and it is part of the sustainability assessment. We combined the two so that you would not have two different data collection efforts in addition to what you already submit for FPAR 1.0. So, excellent question and yes the two of them will be combined.

OK the next question is: Many of our insured clients do not want to disclose their income. How should be approach asking about income for these clients?

Sue Moskosky: So the – one of the things that I would say is that there are a number of different tools on the family planning national trainings website about getting family income and size to be able to assess where someone falls in the sliding fee scale. So what I would say is that there needs to be some attempt in a sensitive way to gather that information and the number of patients that should refuse – if you have a lot of patients that are refusing to provide that information then probably as an agency you need to assess, you know, how the questions are being asked.

And maybe getting some training or going to the (FPNTC) website to see what resources are up there to assist with that because without knowing where client falls on the sliding fee scale they could very well be – being charged either more or less than they should be being charged. So it's absolutely a Title X requirement and not assessing client's income and family size is actually with – have a grantee not be in compliance with Title X requirements and it would be a reason for us as a Federal government to have to take some sort of enforcement action so we have had that issue asked of us before and it's actually not acceptable to try to gather that information even if clients – if when clients have insurance.

Tasmeen Weik: Great. Thank you, Sue. Seeing the next question is for Christina, what EHR vendors were involved in the testing process?

Christina Lachance: So we've had some relationships with a number of (EHR) vendors and the ones that we were able to recruit for the 2015 Connectathon were Netsmart Technologies, Patagonia Health and Mitchell & McCormick and then we – at Connectathon we're able to recruit GE and a smaller company known as ITH icoserve. We also partnered with the Utah Department of Health although they weren't really acting as an (EHR) vendor. And then outside of the Connectathon process we're also working hard to build relationships with NextGen, E-Clinical Works, Ahlers and most recently Athena Health so those are all the vendors that I can think of in the recent history who should have knowledge of this work and either participated as a testing partner or have been sent the specifications for FPAR 2.0.

Tasmeen Weik: Great. The next question I think is again for Dr. Gavin, what is OPA doing about Zika?

Lorrie Gavin: Well, I'm going to defer that to Sue. I think we've been talking to CDC trying to get updates but I'm going to hand that off to Sue actually.

Sue Moskosky: Right so we are, you know, extremely concerned and trying to keep up with the news and what the latest information is that's coming from CDC on Zika. A lot of attention being given to it right now and one of the things that we are planning to do is to ask CDC to partner with us to present a webinar for the

Title X community on what is known at this point, what they're advising, what kind of counseling implications there may be.

But what we are asking of you all is to please e-mail us specific questions that you would like to be addressed as part of that webinar because we'll be asking them to help us with it within the next month. So please send questions to us that you would like for us to address on that webinar. We do realize that there's a lot of concern about that right now and we want to be responsive to that.

Tasmeen Weik: OK the next question I have – I have a couple of questions asking about the April 30th deadline for the sustainability data collection so I'll take that. So we purposely picked a somewhat shorter timeline because in our past experience when we have provided two or more months for folks to submit data they tend to forget about it. And so we timed sort of the implementation and roll out of that data collection to have our webinars and then give you at least five if not more weeks to get the data completed.

If you run into any problems or if you have concerns you will always be welcome to contact us and we can help you work through those. But really we wanted to make sure that you had adequate time but not so much time that folks would forget about it and again we're basing this on the experience from the last two years of collecting the outreach and enrollment data and as you all recall the last year we collected it at the service site level.

And what we overwhelmingly found is that many of the service sites had forgotten to submit the data or just kind of put it out of mind because there was so much time. So that's the reason why it's an April 30th deadline and why we're having the roll out in March so that information is fresh in your mind and that shortly after the webinars you'll be able to go out and get the information collected and submitted to us. But again we will be available to you if you have specific concerns about your site to talk through that with you.

OK I think the next question is going to be for Sue. We are sub grantee and all of our clients are pediatric patients. Are we correct in asking those patients

for their income and not gathering information about their family income?  
Many of the patients are using our services confidentially.

Sue Moskosky: OK so the – I think that last part of that question is really key. I think the first thing even for adolescent clients that are coming in for services what we're finding is that many of those clients that are coming in for services they're coming in with their parents or their parents know that they're coming for services. But in the case that adolescent or other clients are coming in and they're requesting that their services be confidential for insurance or for billing purposes and they don't want their family to know that they're receiving services then they – the charges for their services should be based on their own income and that means income that's available to them.

So it's not income – what's acceptable to gather in terms of their own income would be things like allowance or if they have a part-time job. It's not acceptable to actually assess them at being at a certain level based on room and board for raising an adolescent and then adding income on top of that. It really should be income that is available to them that they have at their – that they can access. So, you know, again it's, you know, just because they're coming in and they're an adolescent you still need to be asking whether they're there and – their services whether their parents or other folks that are responsible for them know that they're coming for services before determining whether family income can be taken into consideration.

Let me just – there's another question about private insurance and co-pays, I just want to refer people to the program requirements document that it's very clear. Again, you have to assess clients' income and family size to assess where they fall in the sliding fee scale regardless of whether they have insurance and they cannot pay more on co-pays or deductibles than what they would pay on the sliding fee scale. It's really clear. We've had numerous discussions with the attorneys that advise the program and this may be different from other Federal funding sources but it is the Title X requirement and they're firm on that. So I know that that's been a sticking point for a lot of folks but just wanted to reiterate that that is the requirement.

Tasmeen Weik: OK thank you, Sue. I think there are a lot of questions for Sue today which is great. That's the purpose of this webinar so please keep them coming. So for grantees that have a higher percentage of unknown income and unknown insurance status and already collect the data at the encounter level, what do we do when our sub recipients just didn't collect this information during the encounter?

Sue Moskosky: Well, this webinar is a heads up that, you know, even though this year there may be some flexibility in how we accept the data moving forward there will not be. So, you know, give your sub recipients a heads up that the 2016 we will not accept the data 2016 and moving forward with high percentages of unknown and not reported. We know that this is the first time many of you are hearing this but it's really become more and more of an issue for us. So while this year we'll still be going back to you and asking about the data I think, you know, this year we may have to exercise more flexibility but you all as a grantee need to let your sub recipients and service sites to know that this is an expectation and that you won't accept the data from them without those fields being filled out.

So it's just not acceptable and we don't – if we're not providing complete data and really don't even know because we have such high percentages of unknown and not reported it's really – we're not able to even determine whether we're seeing the priority population for Title X or be able to tell the story's just an incomplete picture. So thanks for that question. I know we're being kind of hard lined on that but it's really important.

Tasmeen Weik: Great. And it looks like that sparks a number of FPAR related questions which is great. So how does a male client qualify as a Title X client?

Sue Moskosky: So if a male client comes in and they receive services related – any services related to preventing or achieving pregnancy or have a conversation with them related to their pregnancy intentions or creating a pregnancy or having a family then they would qualify as a family planning client for purposes of FPAR and you could count them. If all they receive when they come in is an STD test and there is no counseling about preventing or achieving pregnancy then they would not count as a Title X client.

So again, going back to the definition of user it's any client that receives information or services related to preventing or achieving pregnancy in a face-to-face encounter where there's a permanent record of that visit.

Nancy Mautone-Smith: This is Nancy Mautone Smith just add on and strengthen what Sue had said and when in doubt I always refer questions because I get a lot of questions about what is a user, what is an encounter, how does somebody qualify to be counted on the FPAR. I encourage you to take a second look or third look or a fourth look at the FPAR forms and instructions which are available on the OPA website and there you can see several examples of different scenarios for which you can help determine whether or not in that particular circumstance including the question of the male client that was brought up and there was also I believe another question about STD only services that there are some Q&As within that form and instruction that can help you determine for those very specific situations whether or not it's appropriate to count that user on the FPAR.

Lorrie Gavin: Tasmeen, I just wanted – this is Lorrie, I want to add one other perspective on that question which comes from the quality family planning recommendation QFP is really designed to help people not miss opportunities to provide services related to preventing or achieving pregnancy. So even if someone came in for an STD test or some other purpose QFP recommendations are to screen them for pregnancy intention, offer services as needed if they're willing to receive them.

So it's not just a matter of necessarily waiting for them to come in. You are at a position to be offering services to them whether they ask for them or not and again, to remind that was a QFP recommendation.

Tasmeen Weik : Great. OK so let's take a little change of gear from FPAR data. So I think this question is for David, is there an official list or some guidance on the process of what is considered a change's scope and direction on what changes need approval or pre-approval?

David Johnson: Sure, thanks. On the OPA website and if you follow the link that was on one of the slides that I presented there is actually a list and some guidance

documents that you can follow both a template for the worksheet – I'm sorry, excuse me, template for the formal request as well as a worksheet to follow that is the guidance related to the change – making a change in scope or something related to that. So a change in scope essentially in definition is anything that significantly alters the pre-approved work plan that you were originally funded to do. That's probably about as precise as we can get at the moment for that. But the two documents are up on the website and if you have trouble finding them your private officer also has this electronically and they can send them out as well.

Tasmeen Weik : Great. OK. So, next few questions are around FPAR again and specifically the unknown or unreported insurance status. So, Sue what would you consider to be sort of a high percent of unknown or not reported?

Sue Moskosky: Well the – at least what – the bar that we have set is anything more than 5 percent would be considered unacceptable. So I don't know that we're saying that that's a high but that's the bar that we've accepted. So anything more than 5 percent is going to go back to the grantee for some explanation of why it's so high.

But after this year as I've mentioned we're not going to be accepting it so you need to actually, both for insurance status as well as for income, you know, we're not going to accept it if it's above 5 percent. So I think with any of the tables too there's going to be a lot – probably of additional questions in terms of any of the data that have high percentages, of data that are unknown or not reported. So it wouldn't just be these two tables that I mentioned but those two tables are particularly important.

Also we're going to be looking at, you know, I know that when we've looked at some of the FPARs that, you know, some of the grantees are saying – or actually setting their objectives in terms of even why chlamydia screening way too low for acceptable I mean chlamydia screening of individuals sexually active females in particular under the age of 25 is a (hideous) measure in addition to being a Title X performance measure.

And, you know, when grantees are saying that their goal is to do – to have annual screening of 40 percent in clients that's just not acceptable. So we're going to be going back probably to grantees too that have low percentages of chlamydia screening. So there's just going to be a lot more questions being asked so we really ask you to pay attention to your FPAR data. It's just a matter of collecting the data and reporting it. It's actually paying attention to it and using it to improve the quality of services provided.

Tasmeen Weik : Great, thanks. So I'm going to fill the next question to Nancy. When will OPA start using the new program review tool?

Nancy Mautone-Smith: Great, thank you for that question. As I've mentioned in my brief presentation we do plan to release that tool to the network within the next couple of weeks. And we've planned on using that tool over the spring and summer months for our folks that have program review scheduled at that time. And now we just want to assure you that the – while the tool may have a different format and look a little bit different from the tool that you may be used to seeing the requirements have not changed and in many cases you'll have more flexibility to demonstrate how you meet those requirements than you may have had in previous version. So we recognize there will be a learning curve for folks and that there may be bumps along the road but we're very excited about beginning to start to use that tool when it's finalized over the next six months or so.

Tasmeen Weik: Great. Thank you, Nancy.

Nancy Mautone-Smith: Thank you.

Tasmeen Weik: So couple of more for our questions, first is a clarifying question, if a conversation – when a conversation about preventing or achieving pregnancy can it change to an STD testing visit into a Title X visit?

Lorrie Gavin: Yes. it depends – so what QFP, the Quality Family Planning recommendation say again, in the interest of not missing opportunities to provide types of services related to preventing or achieving pregnancy is whenever you see a client – and so this is not only STD, if someone comes in for another preventive service or for an acute illness episode you are encouraged to ask

them about their pregnancy intention and if they indicate that they're interested in engaging in a conversation about that then you can screen them for pregnancy intention and then offer those services. That then can turn your visit into a family planning visit.

Sue Moskosky: It's not so much that it changes the visit. It's that you capture the information on FPAR that they are actually counted as a Title X family planning user. So it's not so much that whether they're a family planning patient or an STD patient. It's that you capture the information on FPAR and count them as a family planning user for purposes of FPAR. So, just to clarify. So – OK  
Tasmeen Weik. OK.

Tasmeen Weik: So let me – I'll take the next question and then we'll turn it back to Sue. So we have a question on whether we – the data we're collecting from the sustainability assessment is the same data we've collected and turned in, in January.

So again, I'm not sure if you are a service site, you may have had to submit some data to your grantee. The particular data that we are collecting on April 30th has not been collected by OPA before and I do want to note that that April 30th is sort of an OPA-wide data collection. Many of you may have additional data or request from the entity that funds you so if you are a sub recipient or service site you have a grantee that provides you with money that they get from OPA and they may have additional request of you that either relates something OPA has requested or it's just data that they need as part of their grant project. So I do want to clarify that and again, I encourage you to attend the webinar we will have in March so you can more fully understand the sustainability assessment specifically.

OK so the next question that we have is probably for Sue, must everything offered during a Title X visit slide to free?

Sue Moskosky: So let me just confuse you all slightly, so I think the person asking the question is a Title X sub recipient agency. So how we determine what services have to be included, any service that is defined in the grantee's competitive grant application as services that they're going to provide within

their Title X project are services that would be expected to be placed on a sliding fee scale.

So for instance if the grantee comes in with a competing grant application and lists a whole set of services that they're planning to provide as part of their Title X project, let's say that they include Colposcopy services if it's included as a service that they're providing as part of their Title X project then that service would need to be provided on the sliding fee scale.

There are some grantees that have Title X funds but also have other sets of funds where they provide other sets of services that are completely separate from their Title X project and as long as those services are completely separate from their Title X project meaning physically separate as well as being able to account for all the services separately then no, they wouldn't be bound by the sliding fee schedule.

But by and large anything that is in a grant application or that your grantee has said it's considered as Title X service would have to slide to zero and if you're taking things off at the slide there has to be completely – like contraceptive services cannot be taken off the sliding fee scale. They have to be provided based on the sliding fee schedule which means they would slide to zero for clients at or below 100 percent of poverty.

Tasmeen Weik: OK.

Sue Moskosky: I think there was another question too, that might be good for Lorrie to answer and that was a question that was on up about services - family planning services for LGBT clients and so we wanted to spend a little bit of time talking about that. So – and why it's important and why we're actually dedicating one of the systematic reviews to reproductive health services, family planning services for LGBT population. So Lorrie, do you want to...

Lorrie Gavin: Yes, as we mentioned this will be a new focal area for the new Quality Family Planning recommendations and we'll be looking at the evidence on this. I mean just because you're an LGBT individual it does not mean that you're interested in one, achieving pregnancy which is an important part of the Title

X services. There are maybe concerns about fertility, achieving pregnancy and in some populations at certain point rates of unintended pregnancy among LGBT especially adolescents have been shown to be very high.

So, we definitely consider that an important – very important population for us that are desperately in need of a family planning services. Again, I want to remind you the definition of family planning in the Quality Family Planning recommendation is more than contraception. It's that full set of services you need to help individuals and couples achieve their desired number and spacing of health children. So it's contraception, it's pregnancy testing and counseling, it's achieving pregnancy, it's basic and fertility services, it's STD services and it's other pre-conception health services. So family planning is not assuming them for contraception.

Tasmeen Weik: Great, thank you. So the next question is, should we expect a response from – and I think the person means (OGM) office of grant management to a change of scope letter.

David Johnson: That's correct. So all changes in scope either acceptance or denials will be coming directly from the office of grant management. It will be a letter 99 percent of the time via e-mail.

Tasmeen Weik: Great, thank you. Next question, is primary care or non Title X services are offered during a Title X visit, monthly sliding fee or is a separate visit required?

Sue Moskosky: OK so let me – I know that there has – I've heard that there are some places where there has been some confusion, if you are a site set – is a primary care site meaning you're a Federally qualified health center or a community health center there is no reason to do a separate visit. There is no reason – if the client comes in and has for instance symptoms of a UTI and you have, you know, screened them for a urinary tract infection but they also need services related to preventing pregnancy for instance you don't want that client to have to come back. You want to provide those services in the same visit.

If you are a site that is a 330 program or an FOHC in addition to receiving Title X funds and clients are getting any primary care service that's part of that

visit the FQHC regulations are different from the Title X regulations and the FQHC the primary care providers are allowed by HRSA to charge a nominal fee or a nominal charge for the visit. So the client gets any primary care visit as part – or primary care service as part of that visit that nominal fee can be charged.

The other thing we'll be sending some guidance out pretty soon. We're in – we're working with HRSA making sure that they're comfortable with it. We'll be sending out a primary – a program policy notice within the next hopefully month or so that will clarify some of the issues that I think make it difficult for primary care and Title X providers to work together.

But let me just clarify one thing if you're a primary care provider and a Title X provider and clients are getting a combination of primary care services and family planning visits that's part of that visit then the slide can end at 200 percent of the Federal poverty level which is what the CHC regulations require. So you will – at 200 percent of Federal poverty level, above 200 percent they charge full fee and you're allowed to do that if people are getting both a primary care service as well as a family planning service during that visit.

If on the other hand the only service they're receiving when they come in to a primary care provider if the only service that they're getting is a family planning service then yes, we could not charge the nominal fee nor – and you would have to have the sliding fee scale go 250 percent of the Federal poverty level before full fee is charged. So I hope that that's (reasonably) clear but we'll be sending out the – a (PPN) like I said within the next month or so that hopefully will clarify that issue and make it a little bit easier for those of you that are working together but please don't have people come back for separate visits. There is no reason for that and, you know, we don't want to put people at risk for an intended pregnancy by having them come back for another visit.

Tasmeen Weik: Right. And I will – to just add to that there was an earlier question about whether there were any resources available around sliding fee scales for Federally qualified health center and Title X centers and as Sue mentioned we will have some guidance coming out of OPA hopefully soon. But in the

meantime on the [fpntc.org](http://fpntc.org) website if you search by primary care there is a current resource that is available that was developed by [MSI](#) so in the meantime you can access those resources. I know they also have a wonderful video available talking about how to partner with primary care services, sample ([MOUs](#)), there's a number of really great resources so please do go check that out on the [FP NTC](#) website.

So Sue, I think it's – this has been very popular for you because we have yet another question for you. Can we require a family planning patient to provide us proof of income so we can verify where to place them on the sliding scale?

Sue Moskosky: So I would again, refer you back to the Title X program requirements document but the answer to that is yes, you can require them to provide proof of income but you have to do it in a way that doesn't prevent a barrier to services. So what that means is that if a client – let's say that a client comes in and they say they have zero income and you need to have some way to make allowances for clients that cannot prove that they have zero income.

So I've heard of some grantees or some providers having for instance a self-attestation form whereby a client that says they have a certain, you know, self declaration that they're saying, "I have zero income." They actually have them sign basically an affidavit that says, I'm, you know, certifying that I have no income and if it's found that this is not accurate that I could be liable for all the charges for the visit that day. I actually like an approach like that. Some grantees are still accepting or some providers still accepting self, you know, oral or verbal declaration of income as a proof of income so you do not have to have proof of income.

But all I would say is that if you're requiring clients to provide verification of income or proof of income but you need to do so in a way that it's not going to present a barrier to care for clients that have – that are low income in particular. And some of the practices that I've heard do, in my opinion, provide a barrier to care. For instance I've heard of grantees that say that if a client doesn't produce proof of income within – that they make them pay upfront and then if a client can't bring in proof of income within 30 days that

they have to pay the full fee if they can't provide proof of income and I think that's unacceptable particularly for the low income clients.

There's, you know, I think that it's going to be difficult to prove that you don't have any income in many cases. So I think, you know, having somebody be at risk for an unintended pregnancy that's going to be a lot more expensive long term versus taking somebody's word for it and even though I know that there may be some abuses to the system that on balance I think, you know, we need to exercise and remember that the clients that we're, you know, our priority population are the clients that need the services the most.

And making them feel bad when they can't produce the documents or paying when they really are having to choose between buying food for their families or paying for, you know, \$100 for a visit, you know, I think we have to remember when we're in this field and exercise tolerance and flexibility where we can. And I know I'm not trying to put anybody out of business but I think that that's, you know, really why we've all gone into this line of work.

Tasmeen Weik: So Sue, I think you clarified this already but given the number of comments we're getting in the Q&A box I think it might be worth reiterating, so someone just said, I'm sorry if I missed it but I didn't think you could require proof of income under Title X and what if clients who have third-party care don't want to provide income? So I know you've sort of answered but I – given the questions I think it might be good to reiterate what you've said.

Sue Moskosky: Right and what I've said is – and again there are, you know, in Title X you can require that clients produce proof of income. We had issued a program – back when we were doing program instructions – a program instruction series which now has enfolded in to the program requirements document. We issued a program instruction that actually talked about collecting information that grantees should have some sort of policy for how they actually collect client income and that you have you – if you have access to other sources of data for instance, if clients have to produce proof of income from Medicaid or for other programs you can use that as well or (WIC) programs.

Title X is not considered as the same kind of program where you have to provide proof of income but again grantees do have the flexibility to establish policies for how they verify client income and it can mean that they do – they don't necessarily have to have their policy be that it's just first – based on self-declaration. So I think that's probably – I don't know if I answered the whole question or not but the bottom line is that regardless of whether clients have insurance or not we do have to assess family income and family size because even if they have insurance you need to determine where they fall in the sliding fee scale so that you can assure they're not paying more in co-pays or deductibles than what they would pay on a sliding fee scale. So to not collect that information is in violation of Title X requirements.

Tasmeen Weik: OK Sue, I think we'll give you...

Sue Moskosky: A break?

Tasmeen Weik: A few seconds of break and go to Christina. I didn't have time to participate in the public comment period for de-identification. Are you still accepting comments?

Christina Lachance: So the official public comment period has closed as far as (IAT) is concerned but we here at OPA always love to hear from grantees so if you were not able to submit comments during the two months that the public comment period was open you can still e-mail me at ([fpar2.0@hhs.gov](mailto:fpar2.0@hhs.gov)) with any comments, concerns or just thoughts that you might have about the documentation and I can always raise that in committees if you can't join those calls or we can just have it here for, you know, food for thought at OPA. We'd love to hear anyone's thoughts at all times. Thank you.

Tasmeen Weik: Great. And Christina we have another de-identification question, please clarify what point is the data reporting process, the de-identification process will occur.

Christina Lachance: So this is a little bit TBD because they don't have the whole architecture for the future system laid out yet but at this point in time we're thinking that, you know, OPA will hire one third-party contractor to do de-identification for the whole country, for all 7 million records that are submitted. So you

grantees and service sites, you know, you wouldn't have to do anything at your level. The data would only be de-identified when you submit it to that contractor once – one time. But again this is very early and we don't have an architecture yet so things could change in the future. We would love to hear comments from folks if they have, you know, strong feelings about that proposed plan. It is what's outlined in the white paper.

Sue Moskosky: OK I need to backtrack on – let me just clarify something too, in terms of – there was a question that said they didn't think that they could require proof of income under Title X I'm not sure whether that is – that question's coming from a grantee or whether it's coming from a sub recipient. But if you're a sub recipient your grantee should have policies that actually speak to this. So a grantee can actually set their policy for their sub recipient or for their entire Title X project that says that they will not allow you to require proof of income.

What I'm saying is, OPA talking to grantees which is our communication. We communicate with grantees so we set those requirements. As long – a grantee can't require less than what OPA does. But a grantee can impose additional requirements as long as they're not out of compliance with Title X. So I just want to say depending on who it was that asked that question if your grantee has stated that you have to accept self-declaration of income then that's who you have to listen to. So it just kind of depends whether you're a grantee or whether that was a grantee question or whether it was question coming from an agency that receives funds underneath a Title X grantee. So I just wanted to clarify that.

Tasmeen Weik: OK. So believe it or not our time is winding down. So I'm going to take the last question and then turn it back over to MSI. They will give you instructions on where this webinar will be archived as well as some final thoughts. The last question is...

Operator: Excuse me?

Tasmeen Weik: Yes?

Operator: This is the operator. I just wanted to let you know we do have a couple of questions on line if you want to take those today also.

Tasmeen Weik: I'm so sorry for those who are on line but because we are almost out of time with all of the chat questions we won't be able to get to you but please chat your questions in now and what we will do is have an FAQ available as part of the webinar recording and for the few questions that we did not get to in the chat box we will attempt to answer them as a follow up in the FAQs. And also those are the questions kind of help us understand what questions we're getting from the field so we can provide with more guidance as necessary.

So the last question is around, what data will be due April 30th and this particular person had already submitted some data. So it sounds like FPAR 1.0 data so I do want to clarify that this is a separate data collection and again encourage you to come to the March webinars where we will have a lot more time to go over the tool and explain exactly what data you will be collecting. But it is definitely different data than what you may have submitted in January.

So again, I know we are running out of time but please chat your questions and we will produce an FAQ for all of the questions that we did not get to in the chat box. I'll let Sue close this out and then we're going to turn back – turn it back over to MSI to give you final instructions and instructions on how to download the slides.

Sue Moskosky: So I hope that you all have found this webinar helpful. I hope that the questions haven't serve to confuse you even further. I know that, you know, a lot of times when things are said they don't come out or people interpret them a little bit differently so we will attempt to clarify anything that may not have – may have been interpreted incorrectly.

So again, we appreciate all of the questions. We appreciate everybody staying on here. And we know that there's a lot of interest. And we really do want to hear from you all and this is our opportunity to talk to you directly so we thank all of you for hanging in there, for sending us questions and we will be, as Tasmeen said, you know, attempting to answer as many of the additional

questions as we can in the form of some FAQs that we'll be posting really soon. Again, we just want to put in a plug for the (FP NTC) website and there's lots of resources up there that hopefully many of you have taken advantage of – hopefully all of you have. But just want to put in an additional plug for them and we wish you well and we will be doing this periodically.

And I'm going to turn it back over to the folks at MSI. So thank you very much.

Ann Loeffler: Thank you, Sue. Great updates and great questions, everyone. Thank you to each of you for joining today's webinar and for your hard work to support family planning. As Tasmeen mentioned if you were waiting to answer – ask your question on the phone please go ahead and type your question into the Q&A box and we will include answers to those questions in the archive which will post at the National Training Center website (fpntc.org).

We'll also include links to the resources mentioned by OPA staff on today's call such as the primary care resource document and the communities of practice which includes the mapping tool and also online discussions with your peers. And we will e-mail you the link to those items once they get posted. So thank you again for joining us and the operator will now conclude our webinar for today.

Operator: Thank you for attending today's conference call. You may now disconnect.

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