SHAPING THE TITLE X FUTURE: CONVERATIONS WITH OPA

Moderator: Ann Loeffler
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3:00 p.m. ET

Operator: Good day ladies and gentlemen and welcome to the Shaping the Title X Future: Conversations with OPA conference call.

At this time all participants are in the listen only mode. If anyone should require operator assistance please press star then zero on your touchtone telephone. As a reminder this call is being recorded. I would now like to introduce your host for today’s conference Ann Loeffler. Ma’am, please begin.

Ann Loeffler: Thank you, (Malory) and thank you to all 600 plus of you who registered to join today’s webinar. This is Ann Loeffler and I am with the Family Planning National Training Centers. And today we are trying something new. Those of you with the bandwidth will be able to see our first speaker Sue Moskosky, the Acting Director of the Office of Population Affairs also referred to as OPA.

We encourage your participation during our 90 minute session today. OPA wanted to take this opportunity to share what’s going on in some of the key areas that they are working on and they also really wanted to take your questions. And in order to does that please submit your questions or comments in the chat box, which is in the lower right hand corner of your screen. You can chat them at any time during the presentation. And please direct your chat questions to the user named chat to OPA. And we’ll be stopping at certain point throughout the webinar to answer questions.

So again we are going to begin with Sue Moskosky and then she will be followed by her team at OPA, Lorrie Gavin, Tasmeen Weik, Christina Lachance, Johanna Goderre, Nancy Mautone-Smith, and David Johnson. These presentation materials and the transcript will be posted about a week
after this webinar today on the National Training Center Web site. And after this webinar you are going to receive an e-mail with a link to an online evaluation. We really want to get your feedback. So please take a few minutes to complete that evaluation by December 17th.

So now I am going to turn it over to you Sue to begin.

Sue Moskosky: Good afternoon. Thanks, Ann and thanks everyone for joining us this afternoon for this important webinar. As Ann described this is something new for OPA, but we hope to be able to do this more frequently maybe every six months or so to give you all an update on what’s going on with OPA and what’s important to us.

So as Ann described you are going to hear from a number of the OPA staff today and I’ll start this off with an overview a more strategic initiatives. And then Lorrie will give you an update on activities related to the recommendations for quality family planning services. After that Tasmeen will talk about some data and resources from our ACA related work. Christina will give you an update on our HealthIT and FPAR 2.0 activity. And then Nancy and David will go into some service delivery and grants management announcements. So we’ll be stopping after each presenter to take some questions from you all through the chat box.

And you can chat your question to questions to (Paul Rohde) or to OPA and we’ll take as many questions as we have time for. So I wanted to talk a little bit about the staff here at OPA. You can see here this is the entire staff of the Office of Population Affairs, so we are small, but mighty. There are 14 staff here at OPA and you can see all of their names up here. Most staff work on multiple projects such as generally let me go through that Nancy Mautone-Smith and David Johnson work directly on a number of service delivery issues. Nancy deals with the liaison – being the liaison with our regional office staff as well as being the contracting officer representative of our core on our FPAR activities.

She also helps with our HIV grants, which we are actually managing through headquarters. David is our person who deals with performance and budget
related issue and manages grants management and budget, so he is our liaison with the Office of Grants Management and Budget and admin activity. The health reform team is lead by Tasmeen and she has two (ORISE fellows) Emily and Carolina, who are helping her with those.

Christina leads our HealthIT team and does that very ably with the help of Johanna Goderre and Lauren Corboy. Bob works on embryo adoption issues and then we have a new staff person here at OPA that most of you haven’t met yet named Laura Gray. She will be helping with communications issues, but she is also going to be helping with the HIV grantees along with Nancy. (Sima) is actually going to be leaving OPA next week, so Laura will be stepping in and they are transitioning a number of the communications activities right now.

(Shanae) is actually on maternity leave right now, but she will be returning next week and she has worked on our Web site and also on our TA contract and will be stepping back in in that role. (Susan Dennell) is our administrative person who works to keep our office running smoothly. And we just are lucky enough to have hired Lorrie Gavin who had been with the CDC as you all know. And she’ll be leading our efforts with regard to program implementation, quality and performance measures as well as a number of research and evaluation activities.

So that’s who the staff are here at OPA. Little bit of data fresh off the presses from FPAR 2013, we just got a box with the FPARs from 2013 yesterday, actually. So the FPAR 2013 is in the process of being made 508 Compliant and then it will be posted to the OPA Web site that you can see here from the slide where in the past our client volume had been about five million clients every year that we are down slightly over 4.5 million.

So we have decreased by about 13 percent in the number of our users. So we have actually decreased users by 13 percent. And I hope that’s a reflection of the fact that you all are investing in HealthIT systems and quality improvements, which is appropriate and that that’s the reason for the loss new just, but we will be seeking to do some analysis to determine exactly what’s going on.
So I was talking about our FPAR numbers in the fact that they had gone down and that we are hoping that that’s as a result of you all. Using some funds to purchase HealthIT and build your infrastructure, but nevertheless we are still seeing the priority population, which is the end people and folks who are low income, so that’s a good thing. So hopefully this will continue to be me. OK, so these are some of the key funding years for Title X. And as you are very aware this week shown a dramatic decline, particularly between 2010 and 2013, when the actual money that was available to Title X providers decreased by about 12.3 percent. For FY15 we are currently under continued resolution that goes through December the 11th, which is this Thursday. We are expecting something to be passed that will not put us into shut down mode. But even if that should happen for a few days we doubt that would not have any impact on you all as grantees, you should just continue to function as you always do. So we will of course, you know, keep up with the news, but you know, should not have any direct impact on grantees anyway in any event. So we will continue moving forward. So right now this is projective. We are hoping that our continued resolution level is about at that level right now, which is not great news, but at least it’s level funding, which is what we hope to have available to us. So some general items for you all to be aware of. The FY15 services funding announcements has some new updates since some new areas of emphasis in particular for emphasizing the need for you all to have practices that are sustainable. And that is through being investing in HealthIT through enrolling clients into health insurance, contacting with their party payers and partnering with primary care.

So in your competing application you need to clearly articulate how you are going to do that and how that will help to preserve the sustainability within the service delivery program that you are actually or the service area that you are proposing to serve. Also just to let you all know we’ve been working with AHIP, which is the America’s Health Insurance Plans to identify ways in which you can communicate to help plans about the Title X policy on copay and the sliding fee scale. We had a very, very nice phone call with them a couple of weeks ago. As you know we covered this on many of the pervious webinars. You may not charge patients that have family incomes that are
below a 100 percent of the Federal poverty level, a copay; you can’t collect a copay or deductible from those clients.

And then also clients that fall on the sliding fee schedule meaning clients who had family income between a 101 and 250 percent of the Federal poverty level cannot pay more and copays or deductibles that would pay on that sliding fee schedule. So we’ve heard your concerns that you are having trouble contracting with insurance carriers because of these Title X requirement that you – and that you know, your contracts stipulates that you may have already signed that you must collect the copay as part of your insurance contracts. And so that’s why we are working with AHIP. They represent all of the major insurance plans nationwide and they’ve asked us how many clients this really will affect and what kind of services that are provided in the family planning clinic wouldn’t be covered. So we are actually needing your help with that. We need to actually gather some information that we would share with them about how many clients are projected that this would be impacting how much money is actually being lost.

And also what are some of the services that are not being covered with no copays or no deductibles because when we start to thinking about what are the services that for which you might need to be charging clients for which you could charge a copay or deductible what would those services include. So we are asking that you provide that information through your regional office. So we are asking for two things. A an estimate based on data how many clients do you have that are addable or 100 percent the Federal poverty levels who have copay or deductibles. So we need that information as well as information on what are some of those services that are not covered under the no copay, no deductible under the women’s preventive health service exclusions. So we need examples of those that we can continue to have those conversations with the folks at AHIP.

Also one last point on this slide and that is that we continue because of the Federal budget as well as lots of scrutiny to have a lot of emphasis on and a lot of scrutiny on travel. So you’ll continue to see Federal staff having not being able to travel to the extent that they had in the past both headquarters and regional office staff. So we ask that you be patient with us it does mean
that we are having to conduct more of our business electronically just like the webinar today. And that meeting in person is, even though we know that those are in many cases more effective, won’t be able to occur as often. So next I am going to highlight some key initiatives and I am going to talk about them very briefly and these are the ones that you’ll be hearing more from the staff that are leading these efforts.

So the first one I just want to talk about briefly is the Quality Family Recommendations, as you know this is an initiative we have been working over the four years. We were very grateful when it actually was released in April as an MMWR. So hopefully you are familiar with this image and it provides a visual image of how QFP is related to other guidelines that actually compliment QFP. So QFP actually compliments these existing guidelines in two different ways. One it integrates other guidelines such as the STD guidelines or the MEC and SPR, so that we are not repeating other guidelines. We just incorporate them and say that folks should be using those to guide their contraceptive practice. And that it also fills gaps where there are not guidelines for instance they detail in how you would serve out lessons or how you might provide contraceptive counseling.

In addition I just wanted to let you know that we hope that we’ll be supporting QFP not just with training efforts, but training is very important, but also with performance measures, which Lorrie will be talking about that also with the surveillance summary that will document where we are with the provision of quality family planning services and also with research to fill the evidence gaps. We won’t talk much about the surveillance summary, but we did want you to know that it exists and that we are – there are a number of different efforts that support our quality family planning efforts. You’ll next be hearing from Christina Lachance, who’ll talk about our efforts with regard to transforming FPAR into a new system that will have two main characteristics that the current system lags.

The first is a true performance orientation meaning that it will enable timely and accurate monitoring better demonstrate Title X’s impact and ideally provide performance feedback to the network. So information coming back to you. And the second is that it will be 21st century ready meaning that a smart
or interim operable tool that ultimately decreased its burden of data collection and reporting increases the quality of the data submitted and interfaces well with other HealthIT systems as needed. Next you’ll be hearing from Tasmeen and you’ve already heard me say in the past that the ACA will impact Title X grantee regardless of what state you are in and it’s we are already seeing this as you know. We expect and we are already seeing more clients that are qualifying for health insurance and Title X providers should help them to find out for that insurance.

As I mentioned we expect that more clients will qualify for health insurance and that Title X provider should help them sign up for that insurance. And clients will have greater access to preventative services and expect more from their Title X sites. So in order to retain those clients you are going to be able – you are going to need to be able to expand your services and provide primary either yourself or by having close linkages with and formal linkages meaning written formal agreements with primary care providers that are accessible and in your community. And also an important thing to remember and Tasmeen will talk about this is that clients who have insurance who want to see in network providers, and so that means you are need to have contracts with qualified health plans.

And in order to do that you are going to need to be able to report on quality data, which means that you have to have inoperable electronic health record systems and other kinds of claims administration. And finally you need to be able to provide good patient experience, so that your clients who want to come back to see you. So Tasmeen will talk more about all of that when she has the – when she is speaking to you. Finally I want to highlight the important partnerships and collaborations that OPA has both with other Federal agencies as well as with other non-Federal organizations. And OPA uses it expertise and partnerships with these agencies to leverage support with many agencies. As you can see the ones that are in the larger dark blue circles are agencies for with which OPA directly shares missions and goals. And the lighter and smaller circles are agencies in which OPA and the agencies provide support to and for each other.
And then the purple ones are agencies, which are ongoing collaborations in the family planning reproductive health field and we exchange technical support with those other agencies. So we have a lot of partnerships this is really something that is great for OPA. We haven’t – we right now have many more partnerships than we’ve ever had before and so that’s something that we think is a very positive and we are very well respected by all of this organizations that we are working in partnership with. So I am going to stop now and take some questions before we move along to hearing from Lorrie Gavin. So if you have questions, please go ahead and chat them.

Nancy Mautone-Smith: Yes, we have a couple of questions that have come in for Sue. First question is we provide contraceptive for clients but we do have some have some difficulty getting reimbursement for Medicaid and looks like this is in Pennsylvania. Can you offer some suggestions on how to bill and be it reimbursed for contraceptive supplies by Medicaid and also private insurer? We are able to get to supply 340B.

Sue Moskosky: What I can suggest to you all is not so much of a different practice, but for you all to let us know specifically when these types of difficulties are happening. We’re – this is the first time that we are hearing of that or hearing of difficulties particularly with being able to be reimbursed. Now we have, we are going to be gathering information and Tasmeen will talk a little bit about some of the activities that we are engaged in collecting information via ACA collaborative that we funded. But that actually will at the difference between what is built for and what the reimbursement levels are that when you all are having difficulties of this sort please do let us know because we are in close communication with the folks at CMS and you know, if you let your regional office either let your regional office know or call us directly here at OPA, I know that that’s not a frequent thing that we ask. But as you are having difficulties like that we need to know about it so that we can communicate those difficulties at the line and be able to help troubleshoot for you.

Nancy Mautone-Smith: Thank you. We have one more question at this point. The question is we provide family planning services to uninsured and under insured.
our ability to continue these services would be greatly impacted by our loss in Title X funding. Will financial resources continue to be available?

Sue Moskosky: So the answer to that is that we fully expect financial resources to continue being available through Title X. There is a lot of work going on right now just looking at you know, what the impact is the ACA or the needs for Title X funding at the level it is and what we would use Title X funding for. But there is a general and good awareness within department that there will be a continuing need for Title X funds and Title X services. So we fully expect that they will continue to be Title X funds and we don’t foresee cuts in the near future.

Nancy Mautone-Smith: Thank you, Sue. That’s all the time we have right now for questions. We need to turn things over next to Lorrie Gavin.

Lorrie Gavin: Great. Thank you, Nancy. And I am just want to say how excited I am about joining both OPA and giving you an update today on recent activities and soon to be released activities and products related to quality, providing quality family planning services. So in the few minutes I have today I am going to try do three things. I am going to give you a brief update on QFP related training and occasional update that we are preparing for QFP and again an update on the clinical (proven methods for contraceptive views). I am going to start with an update on QFP related training. As I trust you all know the National Training Centers have a joint webpage at www.fpntc.org, which serves as repository for wide range of training materials and other resources for the Title X program.

There are already a number of QFP related resources available on the webpage such as factsheets, links to webinars and videos describing the recommendation, continuing education, training opportunity, job aids three community to practice and e-learning course of the coding an improving patient experience toolkits. There are a large number of products that will be added in the coming year. The next few slide show examples or highlights the products that are currently under development. As you can see on contraceptive services very soon we’ll have instructional and job aid. There is some idea assertion training plans and then a series of webinars real specific
to contraceptive services. With the clinical services training products that’ll be both a (phone App and a virtual clinic) that are currently under development, which will give you more online and easy web based access to QFP as well as a series of virtual coffee breaks.

In 2015 the National Training Centers are launching a webinar series called putting the QFP into practice. The first webinar on determining client need for services is scheduled for January 2015. Also please mark your calendars because on May 8, 2015 we are launching what we call QFP day, which will also live and virtual presentations on the QFP guidelines as part of the 2015 Women's Health Care Symposium in Overland Park, Kansas. This slide shows some of the products that are – the training products that have been developed on quality improvement and business practices that are available on quality improvement for family planning will be available in mid January. And the billing and coding job aid ties into the currently available e-learning course and coding.

In addition a new community of practice on electronic health records will begin in January. Ultimately National Training Centers’ resources will address each area of the QFP. For example, contraceptive counseling, infertility and preconception care, pregnancy testing and counseling. This will include adjusting, so, again ultimately the NTCs are planning to develop flexible (tetra packages) of training resources using multiple mortality for each of the Content areas covered in QFP. These packages may would include fact sheet webinars e-learning courses, implementation tools, videos, mobile apps or and or assessment tools.

The packages will help you to build staff awareness to build staff skill, support implementations and facilitate monitoring evaluation and continue its improvement. All the products would be made available fpntc Web site, so keep monitoring it for updates and new releases. I am going to switch now and talk about an update for QFP. We plan to conduct a major kind of complete overhaul of QFP every three to five years after which we’ll issue a new version of the recommendations.
However the Federal and professional medical associations that are sighted in QFP will be updating their clinical recommendations during that three to five year period. We think it’s important that provide us access of current version of the recommendations, so we are talking steps to make them available to you by publishing what we are calling occasional updates. The first occasional update will be released in early 2015 and provide the most current version of existing come for recommendations that were cited in the original version of QFP.

Any major implications for practice will be highlighted. As of now we do not anticipate any major changes in practice to occur as a result of the occasional updates.

I also wanted to give you a quick update on our work related to clinical performance measure. That we’ve explained – that we’ve explained before there are no NQF or HEDIS measures for contraceptive services, we are trying to fill that gap. We are validating and we’ll seek NQF endorsements for the following two measures of contraceptive services. The first, which we consider the primary measure, is the percentage implement of reproductive age for a risk of unintended pregnancy and who adopt or continue use of the most effective or moderately effective FDA approved methods for contraception. This we consider an intermediate outcome measure because it reflects what happens at the end of the clinical visit. And we are not setting a benchmark, but we do have expectations that the performance should be quite high and that the vast majority of women will be using a most to moderately effective methods.

The second measure is the same denominator, but the numerator is the women who adopt or continue use of a long acting reversible method of contraception or a LARC. This is treated varied and interpreted very differently from the primary measure. This is an access measure and what we’ll be asking people to the way we want people to use it is to look at the mean or the median across providers or service sites. And then look at those entities that are well below the mean. So the goal is to find providers or service sites, which are having trouble and you are facing large barriers to getting access to contents to (LARC) and then helping them find ways to remove those barriers. This
would not for example be an appropriate measure for pay per performance or similar approach because it concerns about the potential coercion.

In the mean time while we are getting these measures validated and hopefully soon into our signed QF, CMCS, the Center for Medicaid and Chip Services has decided to use some measure on a developmental basis as part of a new national initiative they’ve launched, called the maternal and infant health initiative. So we expect 10 to 20 state Medicaid program to start reporting on these measure using claims data by the end of this month.

Over the coming year we have to submit the measures to NQF for endorsement and within that application we’ll be using data from Title X or partner with Planned Parenthood and Medicaid on putting together that application. We have the data from (FPAR) to use their performance measures within the Title X program already. And although next year we are going to explore rates to engage with grantees on using the data to help find – help them find ways to improve the quality of care.

Nancy Mautone-Smith: Thank you, Lorrie. We have a few moments for questions for Lorrie. Please remember to go ahead and chat those questions in. And while we are waiting for your questions for Lorrie, we do have one question that came in for Sue. And the question is you mentioned continued travel restrictions, is it expected that the Title X grantee meeting in August will be cancelled?

Sue Moskosky: So along with all of the travel restrictions that I mentioned we have a quite, started the use of – the term that I probably should use that it’s a fairly restrictive practice that we have to submit for approvals any meetings that we are holding for apartment – departmental approval and depending on the cost – total cost of the meeting the level of official within the department who approves it actually goes up the chain. So we are in the process of seeking approval for the national grantee meeting to be held, which we anticipate will be approved, but until it’s approved we can’t actually get anything on the calendar. So what we are anticipating and how we have actually submitted approval to this department for that meeting.
And if we have that meeting we would hope that all of our regional office staff or at least one person from each region would be able to join us for that meeting at least for the foreseeable future we are holding most of our meetings here in the D.C. area so that it enables at least this OPA staff to be able to fully participate as well as other people from throughout the department because everybody’s travel costs are considered as part of it whether we are traveling ourselves or whether other folks are traveling. And if you all remember when we had the meeting, the last national grantee meeting, which was held in Seattle we had a limited contingent of the OPA headquarter staff that we are able to be at that meeting. So we do plan to the extent that we can plan to have a national grantee meeting this next summer that will be face to face unless we get – unless we don’t get approval to hold that meeting.

So we are looking to do it later summer or early fall. So we once we have approval then we’ll be able to start seeking space to hold the meeting and we’ll be back in touch with you. But we fully intend to if we are approved to hold that meeting.

Nancy Mautone-Smith: Thank you, Sue. Now it’s time for us to turn Tasmeen Weik, who will continue the presentation.

Tasmeen Weik: Great. Hello everyone. This is Tasmeen Weik and I am going to talk about our ACA related activities. So the question we get asked most often is will there be a continued need for Title X after the ACA is fully implemented? OPA and CDC published a paper in MMWR showing that client volume in Massachusetts did not decrease appreciably after they instituted health reform in 2005.

In fact Massachusetts grantees are 90 percent of the client volume that they were seeing in 2005 and the clients who remained uninsured were between 101 and 250 percent of the Federal poverty level. So the very clients who qualified for affordable health insurance program through expansions, waivers or market place subsidies. We’ve also done some internal analysis at headquarters and found that declines in client volumes of Massachusetts were
not that significant when you compared it to national trends where there was
also a small decline in client volume over those same years.

So we really do expect that you are going to continue seeing your current Title
X clients even after years after the ACA is fully implemented. The health
system has already changed as a result of the ACA, you heard Sue say that. A
greater number of clients, insured clients can mean increased revenues for you,
but only if you are an in network provider, which means contracting this
private health plans. Although we know this has been challenging for some of
you many grantees report that health plans are eager to work with them
because Title X providers are essential community providers automatically.
Let’s talk about Medicaid expansion. Twenty-eight states including D.C. are
expanding Medicaid, but even if your state hasn’t expanded there are only
eight states that don’t have a SPA or 1115 waiver to provide coverage for
family planning. And then all of the states there are market place subsidies
that are available.

Enrollment on site is one opportunity that you have to let your clients know
that they should come back to you particularly if you are in a state with a
managed care program for Medicaid. This is your chance to tell your clients,
that they can see any family planning provider that they want. And lastly your
clients now have access to a number of essential health benefits without cost
sharing.

Fifty five million Americans live in areas where there is an inadequate supply
of primary care physicians. The Title X program is already a usual source
care for many family planning clients. So this is the time to think about
expanding your services or partnering with primary care providers. (MSI) has
produced this poster that gives you some sustainability indicators that you
should be thinking about now. It’s organized around the tenants of healthcare
improvement better care, better health and at lower cost.

If you read these indicators from the bottom up the practices of the bottom are
what we considered to be unsustainable. And working your way to the top is
how you are going to make sure that your site remains financially viable. For
example if your current revenue sources are primarily from the Federal Title
X grant and Medicaid that’s not sustainable. You need to diversify your revenue sources to include commercial insurance.

Take some time to assess your own site and your own network and be honest with yourself about where you are and work towards making your way up to the top of the chart. We have this poster available on the fpntc Web site for you to take a closer look. We recognize that we are asking a lot from you. All of you are doing more and more with less and less. So I want to go over some resources that we do have for you and these are not comprehensive and I am always willing to listen to any suggestions you have for what else we can provide you other than more funding that’s something we don’t control, it does take an act of congress.

So related to contracting we suggest that you identify peers in your area and reach out to them. Again the NTCs have created several resources first is the document to help you discuss the value proposition of Title X to a payer or a primary care clinic (Value proposition for Title X - http://fpntc.org/training-and-resources/value-proposition-document-for-title-x-essential-community-providers). This is a document that you can customize with your clinics information. We have webinars on contracting (NTC webinar on Contracting - http://fpntc.org/training-and-resources/webinar-recording-answers-about-health-plan-contracting) and revenue cycle management (Revenue Cycle Management Webinar Series - http://fpntc.org/training-and-resources/webinar-recording-revenue-cycle-management-before-and-during-the-client-visit http://fpntc.org/training-and-resources/webinar-recording-revenue-cycle-management-after-the-client-visit http://fpntc.org/training-and-resources/webinar-recording-revenue-cycle-management-contracting-with-payers) and a job aid for how to get providers credentialed for those all important health insurance contracts (NTC credentialing job aid - http://fpntc.org/training-and-resources/how-to-credential-family-planning-providers-with-health-plans). We’ve also partnered with NFPRHA to provide all the Title X grantees with the NFPRHA life after 40 case studies (NFPRHA Case Study on building relationships with third party payers - http://fpntc.org/training-and-resources/nfprha-case-study-building-blocks-for-effective-relationships-with-third) regardless of whether NFPRHA member. And you can access those through fpntc Web site. We

MSI will be chatting out these links to you on this webinar, but you can also search for them on www.fpntc.org website. So relate to enrolment some of grantees have already began to see dramatic shifts in revenue sources as a result of enrollment efforts. Enrollment is not just the right thing to do, but may really help you increase your revenue. Just as we heard from the Nevada division of public health and behavioral health in Carson City that while revenue stream from other Federal grant programs have been decreasing from them. Revenue from Medicaid has increased so much over the past year that they’ve been able to fill the funding gaps and retain staff at their clinics. The grantees has been identified an existing clients who may be eligible for Medicaid and found that many clients who regularly visit their clinics have actually been eligible for years. And getting these clients enrolled has helped them increase their revenues to the point that they are already at 60 percent of their fiscal target even though they are only half way through their fiscal year.

Again we have some enrollment resources for you as well. First we have a community of practice (Enrollment CoP - http://fpntc.org/cop/enrollment-assistance) on the fpntc Web site where we post the latest and greatest as it comes out. We have a print ready flyer (NTC Print ready flyer - http://fpntc.org/training-and-resources/fpntc-take-charge-of-your-health-%E2%80%93-a-print-ready-flyer); you see the fun picture on my slide. We have an enrollment job aid (Enrollment Job Aid - http://fpntc.org/training-and-resources/enrollment-job-aid-for-front-desk-staff-0) and a podcast or audio cast for clinicians where they can listen to a provider talking to a client about health insurance (Podcasts for Clinicians - http://fpntc.org/training-and-resources/fpntc-outreach-and-enrollment-providerclient-interaction-podcast).
http://fpntc.org/training-and-resources/fpntc-outreach-and-enrollment-enrollment-enrolling-the-young-demographic). So they have a ready script that they can use. OPA also funded 22 enrollment grants in September these were limited to existing Title X grantees. And you see on the map where all the grantees and service sites are located. In April we asked all of you to submit data to us on your enrollment efforts. We want to share back with you the analysis of this data.

First we looked at what impact we had on uninsured Title X clients. We know from FPAR data that many uninsured clients are seen in Title X centers, so we took that and compared it with the number that each state reported in terms of numbers enrolled from October 2013 to April 2014. Note that we aggregated the data by state. This standardized map shows you the ratio of the Title X clients enrolled by the number of Title X clients in the state where we had uninsured or unknown insurance from the FPAR data.

So what this shows you is the number who enrolled by those who were technically eligible for enrollment or at least to be assisted. Here is a national number is an impressive 25 percent. Now you know that we ask grantees to submit data for all enrollment activities regardless of whether they were paid for by Title X. So we do know that these numbers may be an overestimate. And the white states by the way are those states in which we were unable to verify the data with the grantees. So rather than use those numbers we decided to just leave them blank for this first go around.

So just looking at how well we did Title X clients isn’t enough. Many of you did considerable outreach and our sites counted all individuals they assisted. So we looked at the number of low income reproductive age uninsured women living in the state and standardize our map by that. So this tells us the reach we have not just current Title X clients, but potential clients, title X clients. And we found that naturally an average of nine percent of low income reproductive uninsured women may have been enrolled by Title X center.

The data really is quite impressive and helps us demonstrate the HHS that Title X can make an impact. And here is the overall nationwide numbers. Most significant is that very last bar Title X enrolled 6.2 percent of all new
Medicaid and marketplace enrollees. Again we know this data isn’t perfect, but it still provides us with the picture and it’s quite an impressive picture.

We are going to continue collecting data this year and we did a whole separate webinar just on this ongoing data collection, which we do have archived, so I won’t talk too much about it here. For primary care partnerships we have a sample memorandum of understanding on the NTC Web site. This is a new resource that you can use and we also have a video showing you a real-life conversation between a Title X director and a (FQHC) director to help you prepare for these conversations.

And again we have some general webinars on the primary care partnerships (http://fpntc.org/training-and-resources/webinar-recording-partnering-with-primary-care-sustaining-your-clinic-while) and again (MSI) will chat these links out to you. Lastly I want to talk about the ACA collaborative. I know we are asking you to do a lot, so we’ve also taken it on ourselves at OPA to study the impact of the ACA on Title X and provide you with tools and resources to help implement good practices and sustainability.

This summer we funded four grants to three organizations. The National Family Planning and Reproductive Health Association or NFPRHA. The Guttmacher Institute and Altarum Institute in partnership with Urban. We call them the ACA collaborative and this is a really important initiative to help Title X. Specifically the grantees will be looking at evaluating and understanding financial viability and sustainability in Title X center in doing a qualitative analysis looking at the impact from trying to bill for services that have to be provided confidentially.

An analysis of current (inaudible) has been provided by family planning centers nationally and how they are changing. To do their work the collaborative grantees will need your help in completing surveys. And we appreciate you participating in these requests. Last week NFPRHA sent out a survey on how confidential services are billed.

In February Guttmacher will be sending out a field survey on family – on how family planning clinics provide services. I also want to assure you that
grantees won’t share your individual responses with OPA. So only share aggregate data. So it’s important that you give them honest answers because that will help them develop tools that you can use in future years. I thank you in advance for completing these. I know it’s yet another thing we are asking you to do, but hopefully from this one you’ll get something back in return in terms of tools and promising practices. So I’ll end here and take questions. Again please chat your questions in. And we also have a general e-mail box. If you think of questions afterwards where you can send your questions. You can also post the question in the community of practice on the fpntc Web site.

Nancy Mautone-Smith: Thank you, Tasmeen. We do have one question that’s come in from someone in New York State. And the question is. We’ve recently been notified by an insurance company that provides family planning coverage for fidelity plans on our state exchange that they will longer be covering Mirena, Skyla and Nexelon. The only LARC that they are covering is Paragard. Have you heard of its happening in other states and or with other insurers?

Tasmeen Weik: So we have heard of not this exact situation, but similar situations. The way that the Affordable Care Act was written in subsequent FAQs put out from CMS does allow insurance companies to do some reasonable medical management. And how each company is dealing with that varies considerably across states. So there are many advocacy organizations that are tracking women’s experiences with actually being able to use their coverage.

There are I think other efforts underfoot to look at what health insurance plans are covering. From your perspective, from a provider perspective there is not a lot you can do about this. It is helpful for us at OPA to know when these things happen. So I appreciate you telling us and please feel free to continue sharing these stories so that we can bring them up when we have department meetings on these types of issues.

But again know that this is not an uncommon situation as a provider what it means for you is that you have to verify benefits for every single client when they come in for a visit because you don’t know what their particular plan covers or doesn’t cover.
Nancy Mautone-Smith: Thank you, Tasmeen. Next we’ll move on to Christina Lachance’s update on the HealthIT activity and FPAR 2.0.

Christina Lachance: Thanks, Nancy. Hi, everybody its Christina Lachance. I am here with Johanna and Lauren from OPAs HealthIT team. And we are really excited to give you a brief update on all things family planning HealthIT. So we realize you’ve been listening to this webinar for almost 50 minutes at this point, so stand up stretch out your arms and pretend that we are standing right there in front of you getting ready to give you a big high five because we are rocking at Title X and all thanks to you.

More in that a few minutes first off we are going to let you know two important things. Number one is that in case you don’t already know our team has a blog we post updates about all the works we are engaged in. So if you want to stay up to date on the latest it’s really easy to subscribe and follow the blog.

Number two is that because I tend to talk fast and this IT stuff tends to be a little complex we circulated a handout of today’s presentations, so you should have received it this morning by e-mail. If you didn’t get it you can download it from the blog after the webinar. The handout just summarizes the main points I am going to make here, so you can really just sit back and relax and listen right now and not worry too much about taking notes. OK, so let’s get down to business. So in the past we’ve shown you fancy strategies of pillars describing the coordinated approach we are taking to better integrate family planning concept into HealthIT system. So today we really want to focus on three things to update you on the work we are currently doing to (prepare for FPAR 2.0).

Number one is the work we are doing to make sure the network will converge on the FPAR 2.0 data elements and formats. Number two is some activities that we designed – we are designing to ensure the FPAR 2.0 to have a safe take off. And lastly support our longer term goal; get you back your data in the form of clinically relevant performance measures. OK, so first our converging. The biggest thing we are doing to converge to FPAR 2.0 is creating the family planning profile and a public domain that sets the standard
restructuring these data elements in the EHR. As most of you have now experienced end users like yourself are extremely important (stakeholders) in these efforts. This is why you have to pestered you so much, please, please comment on our profile and please, please get your vendors to partner with us. So now we want to thank you. There we go.

So we thank you for your amazing well all those participation you brought for us. The 600 plus comments you submitted on our profile broke (IAT’s) 16 year record. You can see here in the purple graph almost three quarters of the comments came from folks of the clinic level and 12 percent from technical partners including the EHR vendors. This is tremendous. Anyone who pays attention to this role in the universe now knows what family planning is and what we can get done when we work together.

Most importantly your comments will directly influence the final guidance that we will issue for FPAR 2.0. We’ll work with our partners in the coming year to make some executive decisions on the more complex common domain, so we can resubmit to (IAT) a version of the profile in August, a revised version of the profile next August 2015. So if you didn’t submit comments it’s not too late to have a voice.

Please contact us so we can discuss your ideas and incorporate them into the revised version. But first we are going to Connectathon. After talking about it for the past year, it’s actually happening next month. This is a big testing event where the EHR vendors will construct the family planning profile within their systems and exchange (fake) family planning data with our testing platform. Connectathon help us find out what works and what doesn’t work about the way the profile is currently written.

We had an insanely busy month this past October getting all the partners you see here on board. Thank you again for all the calls and e-mails you made (asking them to test with us). We heard from so many of them that they could not just ignore this because their clients were demanding it. At Connectathon we are sponsoring three EHR teams. Who are competing to be the most successful vendor to pass (the test showing) they can exchange to this data. But even better news is that in addition there are three sponsor teams for other
systems who also signed up to test our profile. And one of them is (even the state) health department.

We also have a whole other cadre of systems who have agreed to work with us in our longer term FPAR 2.0 standard collaborative. The three teams were sponsoring at connect-a-thon are competing to be the most successful vendor using a scoring system our contractor has established. And then as we get to the highest score will win a free ride to go with us to show off their system at the HIMSS Interoperability Showcase, next April.

The Interoperability Showcase is the demonstration where you show off to the larger vendor community the success you achieve while testing at connect-a-thon. Connectathon and interoperability showcase are really important because of what we will learn from the vendors that they’ve prepared for these events. We are already learning what might be missing from the systems, what they are capable of, what’s critical for successful during data transmission. How do I address some of the workflow concern? Would they really support and improve in their systems and what they want for FPAR 2.0 moving forward.

It is helping us build our relationship with the vendors, so we can figure out together the best ways to support your work in the clinic. We will take all of these lessons and incorporate them to improve the profile for next August. Beyond converging we are also engaging in activities that help us prepare for a safe takeoff when it comes trying to build the real FPAR 2.0. As with any long flight we certainly expect turbulence along the way, but our goal is to be prepared for the bumps, so that everyone can eventually get to stable cruising altitude together.

The first activity I am going to highlight really quickly is the JSI Feasibility Study. What you’re seeing now is the screenshot of one of the summary documents they are preparing for their final report. Nine sites participated in the case study this past summer. Five of them are health departments; two were (FQHC), one Planned Parenthood and one nonprofit. And I wanted to really thank all of these sites were incredible they worked with JSI during the study.
The study reflects how well the proposed 2.0 data elements matched with currently in some Title X system. The takeaway message from this table is good news. All those green (cells) represent data elements that folks are already capturing electronically that exactly match proposed FPAR 2.0 formats. Well the sample is definitely remitted these results indicate that some grantee networks are already collecting the data according to the way that it’s written in the family planning profile.

JSI is planning to conduct a survey this coming March that will afford you another opportunity to provide feedback on the 2.0 get elements, definitions and formats. Second takeoff activity is new work that the team began in response to the concern we received during the public comments here regarding about – regarding protecting the privacy and security of the FPAR 2.0 data. The team was working with experts to create the privacy and security roadmap you see here.

The team is also working with the committee who is going to help OPA write guidance outlining how the FPAR 2.0 data should be identified to compile the best practices and state and Federal regulations such as HIPAA. Ultimately we here at the Federal level wants to give Title X grantees control and ownership over the data you submit to us. So ideally it will be de-identified before it ever hit the 2.0 repository. This guidance will tell you how to go about doing that.

The roadmap leaves out the tasks that we need to complete to have a healthy, privacy, and security risk mitigation plan in place for FPAR 2.0. It’s just one of the couple documents that are in draft form right now that (work for) you know, further development in the coming month. The big ask that we have at this activity is that we need a little more information about your current privacy and security practices that we can best develop the guidance.

So putting together brief survey that we submit for OMB approval and hope to administer sometime in May that will help us determine your current privacy and security practices to manage and transmit (encounter) level data. OK, so finally updates on our activities on the output side.
And the output, I mean, the data that’s going to come out of the 2.0 repository. So these are the things we are doing to prepare to give you back clinically relevant family planning performance metrics. We are showing an example of what that performance data can look like on the screen here. This is what we (borrowed) from Million Hearts Campaign.

The main benefit of (encounter level) data is that it gives the entire network access to the own data and performance measures to use to improve services to clients compare trends overtime, identify opportunities for incentive programs or apply for additional funding. We want to free the FPAR data, so you can use it for whatever you need it for.

Now we’ll talk about the really cool work we’ve been doing to see if we can get performance metrics like these actually show up inside your EHR systems. So Johanna has been pioneering these clinical quality measure activities and partnership with the Office of the National Health Coordinator for HealthIT otherwise known as ONC. This work is both super exciting and super technical, so I am not going to dive deep here.

So bottom line for today is that we’ve been working to create a precise (flow that will live in the entire database) available to all EHR vendors, the copying use and they are trying to implement (CQM) meaningful use. And they just have a lot of trouble with this work and they really want (clinical) review of these things before they implement. This is a big pain point that we can leave it in. The cool thing about this code is that it standardizes things up to a certain point; it then allows each vendor to tailor to the client’s needs. So with the client and the vendor maintain choice and control.

The first quality measure we tackle was chlamydia screening. Since this is already (HEDIS) and optional meaningful use measure it was low hanging fruit pilot testing in EHR systems. We are submitting the final report that fully describes this pilot project to ONC next month. We’ll also be posting some features on our blog about this work and the partners who are engaging with us.
So stay tuned for more details and definitely reaches out to us if you want to get involved. So that’s just a major content updates. This slide is just to remind that we really do love hearing from you. This is all the way you can reach us including our Twitter handle, please tweet at us if you are on Twitter. And here is the schedule of things that we will ask of you or opportunities to further engage with us in the coming months. I want to be clear about one of these opportunity are going to happen, so you can prepare for them because we know it takes time and energy to provide us the feedback.

And the only one I didn’t really talk about, but Lorrie mentioned quickly is the HealthIT community practice it’s going to be run by the National Training Centers. They are currently building this site, and we’ll have that ready in the coming weeks. We are really hoping that you’ll join the (COP) as a new forum to engage around HealthIT issues and to even see if you can it as forum to (crowd source) any solutions that you are having for particular challenges with HealthIT system.

So that was a lot of information given very quickly, so if you remember nothing else from today just remember three things. Subscribe to the blog, continue to engage because we really cannot do this without you and our (foundational work) is paying off. It’s positioning us for safe takeoff and readying us to give back relevant metrics. I’ll be happy to take questions. If you don’t get your questions today, please feel free to e-mail us at the FPAR inbox.

Christina Lachance: Johanna is going to help me answer some of the questions like there is a bunch of questions in (queue).

Johanna Goderre: Hi, everyone this is Johanna. So one of the first questions that came in was should I contact (IAT) to determine the status of interoperability of my current (EMR) vendor? And that’s a great question and I love the way that you are thinking, whoever asked that question, you are right on track. And it’s a little bit the other way around though.

So (IAT) doesn’t actually keep records on what (EMR) vendors adopt in terms of standards. However it’s really important to know about the standards and
then talk to the (EMR) vendors and ask them what kinds of standards they have adopted. Interestingly enough there is actually a result database that we can point you to that shows you all of the different standards and whether or not a vendor has actually passed those standards and has passed certification on those standards, so we can definitely talk (details). So you know, please call us or please let us know over e-mail what you are interested in and what kind of conversations you would like to be really informed about to have with those vendors.

One of the other questions was how do FPAR 2.0 and QFP relate to one another? And so the main thing to keep in mind is that the QFP informs the kinds of performance measures that OPA wants to select for FPAR 2.0. So to support this performance measure we then walk back to make sure that all the data elements necessary to calculate those performance measures are, is in the (IAT) profile. So I hope that makes sense.

Another question was about a specific vendor and if they engage all and so we highlighted the vendors that did actually successfully engage with us. That doesn’t mean that we are not so working our contact trees and constantly renewing our efforts to talk with people. So if you didn’t see a vendor that you are interested in on that one slide and I just want to backup to that slide, Christina. Then they are not unfortunately participating in this round. But if you have a contact that your vendor that you like us to speak to please let us know. And we’ll also – you know, we are continuing to work on all the major vendors that are very active in Title X.

Nancy Mautone-Smith: Is that it? We’ll move on.

Female: Yes. Are there are more? I don’t think so.

Nancy Mautone-Smith: Yes, let’s take – I do believe that we have one question actually.

Nancy Mautone-Smith: Yes, I think we have time for one more questions. And I believe this maybe for perhaps for Christina, no I think possibly for Sue. How do we find a copy of the sample MOU for primary care clinic?

Sue Moskosky: Great question...
Tasmeen Weik: That is a great question that is fresh off the printers. I believe it is posted on the fpntc.org Web site and you can either search for it using the search function on the top right hand corner Web site, so you’ll see if during the rest of this webinar we can also chat a link out to you (http://fpntc.org/training-and-resources/primary-care-partnership-video).

Nancy Mautone-Smith: Thank you.

Ann Loeffler: Ann Loeffler at (MSI) I thank Tasmeen for mentioning primary care resources and those will actually be posted by the end of this week on the fpntc.org web site. But for people who are on this webinar, people who register we will be sending you the direct link, so it’ll come right to your inbox.

Nancy Mautone-Smith: Thank you, Ann. Next we move on to the service delivery update. This is Nancy Mautone-Smith and David Johnson and I will be providing a brief update on service delivery issues. The first thing I’ll talk about is the status of the crosswalk. I know that many people have questions about the status of the crosswalk and just as a reminder the crosswalk is a document that outlines the program requirements, links them to QFP and provide some implementation strategies.

We received hundreds and hundreds of pages of comments regarding the draft document that was sent out over the summer. We are currently working on the next version and its progress and we still do expect to have that next draft completed in January of 2015. So imminently hopefully going to have another iteration of that. And we do have to ultimately this tool will be used as the new program review tool. But in the mean time the interim program review tool that most of you are familiar with now should still continue to be used.

In addition a new technical assistance and meeting support contract was awarded in October to Atlas Research. Currently Atlas is updating the consultant database and also planning for training of existing and new consultant in early 2015. And this includes training on consultants that would potentially be used for program review. As Sue mentioned the 2013 FPAR
has been completed and finalized. Will be posted up to the OPA Web site probably within the next week. And along with that the 2014 FPAR cycle is beginning to rev up. And as you all know the 2014 reports are going to be due on February 15th of 2015. I’ll pass things on to David to continue the update.

David Johnson: Thank you, Nancy. So I am going to talk about two things that relate to new competitions in project periods. OPA has been in the process of—process of better align service grants. This process has two major components. One is identifying and awarding on two standard states as well as synchronizing awards within states territories and other independent jurisdictions. This process official began this past summer and it’s likely to continue through Federal fiscal year 2017.

The new start dates are April 1st and July 1st. These dates are—these dates, excuse me, aligned with the beginning of the third and fourth Federal fiscal year quarter. Part of this is that it helps align with your Federal financial reports that you are required to submit and those will now be in line with those dates.

In addition there how to reduce actually the likelihood of grantees receiving partial grant awards in the absence of an improved Federal budget. Currently right now in the absence of one those that have start dates in December for example would only receive a partial award based on the continued resolution amount that we have. Finally it will also increase the available time for grant applicants prepare their applications for consideration. Well not all grantee will actually be affected by these date changes.

There will be some of you that will. And for those that will be directly affected and those are the ones that are currently grant that expire prior to either April 1st or prior to July 1st. They’ll be receiving several months prior to the end of your budget—your project period. You’ll be receiving and being contacted by OPA headquarters in order to, with an explanation about available options that will be (for you to), excuse me, (for you to) continue your grant—your project period.
The second component will align project period start dates and will insure that grants in state territories and other independent jurisdictions with multiple grantees share the same start dates as well as the project period length. You will see this change most specifically in the funding opportunity announcement. And each of the competitive service areas will only be advertised as one state one territory or the entire independent jurisdictions indicated.

We started to do this in this current funding opportunity and now, excuse me, Federal fiscal year 15. However not all – not all states actually indicate that there are being advertised as one state. We will do our best. Again, this will also be continued through Federal fiscal 17. And by that time all states, all territories and all independent jurisdictions will only be advertised as the whole area.

As we only ever, excuse me, as with the start date standardization the purpose of both of these components is to streamline the funding award process. Help insure consistent family planning services to clients and also reduce potential interruptions in services due to not having Federal budgets. We want to be clear that none of this is actually to be interpreted as trying to reduce competition.

As you see in the last bullet applicants may still submit applications for an entire state territory or independent jurisdictions. They can also submit multiple applications, which could also include applications for a specific area which include that maybe a city, a county or region or combined. So submit one application for entire state another one for a specific county or even another one for multiple areas. Thank you for this and let us know if you have any questions.

Nancy Mautone-Smith: All right. Thank you, David. It looks like one question came in regarding the FAQ document. And the question is do you know when the FAQs on the QFP and program requirements will be released?

I can answer that. This is Nancy. We are currently working on the next draft version of that. We did send the first draft that we had up for a review. And
hopefully around the same time that we complete the next version of the crosswalk that is January 2015. We should have a completed version of the FAQs available and posted on the OPA Web site that’s our intent at this point.

All right and not seeing any other questions we’ll turn things – we’ll open up for sort of general Q&A for some of our remaining time. And we’ll pause a few minutes while you have an opportunity to chat your questions in. All right we have received one question that relates to funding. And the question is, if applying for only a portion of a state how will we know how much funds are available? David, would you like to take that?

David Johnson: So your application should – it’s a very good question. Your application should represent really the amount of funding that you feel is sufficient to be able to provide the services that you are applying for. So if you are to be able to – if you are applying for a specific area of the state specific portion of the state, your request really should align with what you’ve in your application is appropriate based on the services, the population and really the scope of the project that you are presenting.

Nancy Mautone-Smith: OK, thank you. And again we’ll pause if there are any further questions from the participants. Thank you. I don’t believe we have any more questions coming in. So with that we’d like to turn things back over to our – Sue Moskosky.

Sue Moskosky: We are on to the final slide. And I just want to first of all thank you all for your participation this afternoon and hopefully you’ve learned what is going on here at OPA and why we are very, very busy as well as getting some updates on you know, many of the requests that will coming down the line to you all that you’ll definitely ask me to help with because we can’t do this work without you, obviously.

So I just want to review some of the things that, you know, where we are now or where we’ve been and where we are moving to and what the vision is for the future. So right now I think we’ve been very focused on just program compliance and those of you that have heard many of our presentations on the quality family planning recommendations can recognize that we are moving
from not – more of a (cookie cutter kind of) approach in terms of you know, a list of things you have provide actually focusing on what is actually recommended for providing quality services. And having to make some judgments about that.

And actually moving from rather than must related to clinical services expectations that everybody is seeking to provide the best quality services that they possibly can. We are also focusing much more on performance measurement leading to quality improvement. So really a sincere focus on improving the quality in documenting the high quality of services that are actually being provided in Title X, and knowing that this is really what’s needed to ensure continued access to reproductive health services that are of high quality. And even recognizing that there are challenges we know that there are challenges with funding. We know that there is challenges with you all addressing the changes that are needed within your state to be able to contract with insurance carriers and lots of challenges out there. But we can’t lose sight of the ball that really what we are about is providing the best quality services that we can for the people that need your services out there.

And making sure that you have sustainable practices in place so that you are there to provide the services, which folks come to you and depend on. We are moving from a static FPAR system that counts just kind of an aggregate a little bit about what the Title X system does to a very different dynamic and counter level data system that measures national performance measurement that gives you back information on the services that you are providing that enables you to be able to use those data in real time to be able to improve your services and document the high quality of services you are providing.

Also we’ve gone from just making people aware of what the new requirements are under the Affordable Care Act and helping people to be aware and to start building some of those systems that are needed to be able to be sustainable in a new environment, a new healthcare environment to continuing that work, but making sure that we can ensure that individuals will continue to have access to the best quality family planning services possible.
And also you know, we are focusing on collaborating with other agencies and in effort to actually harmonize to decrease the siloing of healthcare across systems so that clients can come to us for services and that we have the ability to link them with other services that are needed that we have the ability to talk with other Federal agencies and to work with them to make sure that the services that we provide together are the best possible that they can be for the clients that we all serve.

So again I want to thank you all for your participation this afternoon. You know where to find us. We are here to support you. Sincerely we want to work with you as we move forward into this new dynamic healthcare environment. We think that Title X right now is making a big difference we are finally getting recognition for many of the positives that have been provided over the years. But I think the fact that we are moving forward we are actually doing some things that are really cutting edge has really gotten a lot of positive attention.

So it’s not a time to sit back and worry about what’s happening. It’s time to kind of seize that opportunity and move forward doing what you all do best out there. So thank you so much and we will be in touch with you. I hope that everybody has happy holidays and we’ll be back in touch on more frequent basis to update you on the exciting activities happening at OPA. Thank you.

Operator: Ladies and gentlemen thank you for participating in today’s conference. This conclude today’s program. You may all disconnect. Everyone have a great day.