Coordinator: Welcome and thank you for standing by. At this time all lines are in listen only mode for the duration of today’s call.

This conference is being recorded. If you have any objections, you may disconnect at this time.

Today’s conference will feature a question and answer session. If you would like to ask a question, please press star 1.

Now I’ll turn the call over to our first speaker today, Ms. Susan Moskosky. Ma’am, you may begin.

Susan Moskosky: Thank you (Jeremy). Thank you everybody for joining us this afternoon for us to talk with you again about our clinical performance measures for contraceptive care. And (unintelligible) okay.

So our objectives for the webinar this afternoon are to reintroduce you to the measures that we have submitted for endorsement to the NQF -- the National Quality Forum -- and to describe the National Quality Forum and their
endorsement process and where we are in the process, and why endorsement matters and also to talk at length about responsible use of the measures and what they’re intended to do.

You’ll also be hearing from some of the organizations and about some of the organizations that have supported the measures and helped us with submission of them. And then the opportunity for you to submit public comments.

So in terms of why we created contraceptive measures and why they’re important, as you all are very aware approximately half of all pregnancies in the United States are still unintended. I think that the unintended pregnancy level is going in the right direction -- it’s decreasing -- but I think that these measures really have the potential to actually continue that movement in a positive direction. And that we think that by integrating quality improvement processes into the delivery of clinical services, that we might be able to strengthen our efforts to prevent unintended pregnancy.

And most importantly, there are no endorsed contraceptive measures for contraceptive use so this is a huge gap area and there never have been any contraceptive performance measures.

So there are three contraceptive care measures that were submitted for NQF endorsement. You all are hopefully already aware of these.

The first measure, evaluate the percentage of women at risk of unintended pregnancy provided a most or moderately effective contraceptive method at their visit, which is an intermediate outcome measure because it represents a decision that is made at the end of the clinical encounter about the type of contraceptive method that a woman will use and because of the strong
association between the type of contraceptive method used and the risk of unintended pregnancy.

The second measure is a really different measure and it’s intended to be used in a very different way. So the second measure evaluates the percentage of women at risk of unintended pregnancy provided a long-acting, reversible method of contraception -- which is an access measure. It’s not intended to have a high bar. We’re not looking for people to set some sort of high bar for that measure, because it’s really intended to identify situations in which women to not have access to LARC. So we’re looking at it as an access measure -- not as an outcome measure but an access to care measure.

And the third measure evaluates the percentage of women who had a live birth and were provided with the most or moderately effective contraceptive method within three days and within 60 days of delivery.

So the 60-day period reflects (ACOG) recommendations that women should receive contraceptive care at the six-week post-partum visit. And the three-day period reflects CDC and ACOG recommendations that the immediate post-partum period at delivery or while the woman is still in the hospital is a safe time to provide contraception, which may offer great convenience to clients and avoid missed opportunities to provide contraceptive care.

So all three of these measures were submitted as separate measures in that NQF endorsement process.

Just as a review, I think that we all recognize that contraception is a highly effective, clinical preventive service that is intended to prevent teen and unintended pregnancy. And that the type of contraceptive method that a woman uses is strongly associated with her risk of unintended pregnancy.
So the most effective methods -- which are in that top tier there and include LARC and sterilization -- have failure rates less than 1% per year under typical use. So these are methods that once they’re inserted or implanted, the woman doesn’t have to do anything.

The moderately effectives -- which include the pill, patch, ring, shot, and diaphragm -- have a typical failure rate of between 6 and 12% per year. And the least effective methods -- which are in that third tier toward the bottom -- have a typical failure rate of between 18 and 28% per year.

But not using any method at all has a failure rate of 85%. So all women that are not using any method have about an 85 -- if they’re sexually active -- have an 85% chance of becoming pregnant within a year.

So the performance measures for contraceptive use are based on the fact that some methods are more effective than others at preventing unintended pregnancy and are designed to encourage use of the most and moderately effective methods. Again, I think that it gives a lot of choice if you look at those top two tiers of methods, it gives women a lot of choice for them to talk with their provider about what - and make decisions with regard to which method will work the best for them.

So in terms of effectiveness it’s important to remember that women care about effectiveness, too. So in a 2016 study that was conducted by a number of people -- Andrea Jackson, Deborah Karasek, Christine Dehlendorf, and Diana Greene-Foster -- with 1,783 women in family planning and abortion clinics across the US that asked them what characteristics of contraceptive methods were extremely important to them.
And of 23 total items, effectiveness of the method at preventing pregnancy was the item that most -- in 89% -- of women said was extremely important. The next most important characteristics were that the method was easy to get, which 81% of women said, affordable which 81% of women said, and easy to use 80%. So I think that effectiveness really does I think illustrate that it really is an important aspect, that effectiveness is something that people do care a lot about.

I just want to say a few words about the National Quality Forum and why their endorsement is important to us. So the careful evaluation and endorsement of consensus standards is central to National Quality Forum’s ongoing mission to improve the quality of American healthcare. And consensus standards endorsed by NQF are used for measuring and publically reporting on the performance of a number of different aspects of the healthcare system. And they’re widely viewed as the gold standard for the measurement of healthcare quality.

They have a very rigorous consensus development process. And NQF fosters consensus among a wide variety of stakeholders around specific standards that can be used to measure and publically report on healthcare quality.

It’s important to note that perinatal and reproductive health measures only come up for review once every three years, which means that after this year it would be another three years before we could introduce contraceptive measures that could be considered. So it’s not like if they don’t make it through this year we can just resubmit it next year. It’s only every three years that they even send a call out for measures. So it’s really important that we take advantage of this opportunity.
So the following list is the criteria that NQF uses to evaluate the measures, which each of the proposed measures was evaluated. A number of us at OPA and some folks from Planned Parenthood and (ACOG) and other places were actually there the day that the measures were presented to NQF for their consideration. And the committee votes on each of these different criteria, these evaluation criteria. And a measure has to pass each one of them for it to actually even get to the point that our measures are right now.

So the first of these evaluation criteria is importance. And this includes evidence that the measure will influence outcomes based on a strong body of evidence, evidence that there is a significant opportunity for improvement, and that there’s a high priority for measuring and reporting.

The second criteria is scientific acceptability, including reliability and validity. And the third criteria is usability and use. And we actually know already that across the country that Title X and Medicaid and PPFA -- Planned Parenthood Federation -- are already using the measures with great success.

The fourth criteria is feasibility. And one of the things that we looked at and (Brittni Frederiksen), who’s now here at OPA but was with the Iowa Department of Health before coming up here, actually helped a lot with examining some of the claims data that we actually looked at in terms of was it feasible to measure using Medicaid claims data, which actually proves that nationally this data can be collected, not just from (FPAR) in Title X but from claims data across other kinds of programs and service providers.

And finally the fifth criteria is that they look at it in comparison to other measures to make sure that it’s not duplicating other measures. But since there
are no other measures to assess contraceptive care, there wasn’t anything else to compare it to, because there aren’t any.

So it was actually a really interesting process to observe and really pretty impressive -- a lot of work leading up to presentation of those measures at the NQF meeting. A lot of work had gone into it.

So I just want to say a few words about why the NQF endorsement is really important to us. So why it matters to us is that our efforts to prevent unintended pregnancy will be strengthened by integration of quality improvement processes into a wide variety of private and public providers and healthcare delivery systems. That NQF endorsement is the standard that many health plans and other payers require before adopting a measure. And we’ve already been have (unintelligible) them in terms of this being turned into an e-measure and also a HEDIS measure, which looks very positive if this is endorsed by NQF.

And also as I mentioned before, there are no current NQF endorsed measures for contraceptive care, which is a huge gap. And it’s a huge opportunity for us to hopefully fill that gap.

So how we think these measures will improve care is that more providers will be motivated to screen women about pregnancy intention and then offer contraceptive care to those who need that and want that. And more providers will offer women a wide range of methods in accordance with the quality family planning recommendations and hopefully it will also lead to women having greater access to the method that’s going to work best for them.

So that’s why we are moving forward with this and think it has a real opportunity to improve unintended pregnancy in the country at least as well as
access to contraception. So there’s substantial opportunity for improvement in the percentage of women who use a most or moderately effective contraceptive method in the United States.

So the National Survey of Family Growth -- which as you all know is a national survey. It’s not Title X but it’s national data that is collected by the National Center for Health Statistics at CDC. This NSFG analysis showed that only 43.5% of adolescents and 63% of adult women use the most or moderately effective contraceptive method the last time that they measured it.

And you can see from these next couple of slides that even within Title X, which is a program that’s dedicated as you know to providing family planning services, that there are Title X grantees with percentages of women ages 20 to 44 using a most or moderately effective method that are well below the median. So you can see all the way. This represents 93 grantees and you can see that there are a number of grantees that are way on the bottom end of that scale with, you know, 30% or 35%.

We have some that are doing really well, but you know probably for a program like Title X, which is devoted to providing family planning services, you would expect to see that at about 80%. And that’s just kind of ballpark. We haven’t actually set the numbers that we would expect. But we would expect that, you know, 80-85% of women in a Title X agency would be receiving a most or moderately effective method when they leave the visit.

This next slide just shows the LARC measure and I just wanted to talk again about that and the way that we intend for this to be used and why it’s so important in terms of you all understanding and being able to translate this to other folks that are interested or are wondering about it.
So there are some Title X grantees -- you can see over in the far left hand side of this graph -- that there are a number of Title X grantees that the LARC is 0% and we have a number that are 0 or 1% and we want to identify for those that are really low like that if there are specific barriers that are preventing providers from offering LARC and providing the clients that choose that method since everybody should have the availability of a LARC method as an option. People should not be coerced or in any way persuaded to use those methods. But people should have access and should have access on the day that they want that method.

So we’re also interested in both ends of this graph. We’re interested in the end of the graph as well where you see that one where it’s almost as high as 35% to make sure that we accept what’s going on on the high end of the graph too to ensure that there’s no coercive practices that are happening where it’s really high like that.

So the primary goal of this measure is to monitor whether women have access to LARC methods.

So the LARC measure is used to assess access by identifying very low rates of LARC use -- and what we’re calling low rates would be 2% or less -- and then calculating the median or mean and then identifying those entities where the rates of LARC use are well below the median or mean.

So you can see that, you know, in most cases, you know, it’s not 0 or 1% but we’re really interested in looking at that across the country just to see if there are things that we can do to remove barriers to access where there are barriers to access.
I’ll talk a little bit later on about some of the efforts that we are embarking on to make sure that people that are going to adopt these measures hopefully will have a clear understanding of how they’re to be used.

There is no Title X LARC measure bar. We have not set a bar. We’ve heard some things from out in the field where people are talking about some Title X bar for LARC measure. There is no such thing. So I just want to reassure you that we are not establishing a specific target that everybody should be at for LARC. We’re sincerely only looking to identify where there are barriers to access.

So just a couple of words about a new, important use for the measure. So since submitting the measure for NQF endorsement, Zika kind of came on the horizon in terms of the importance of us addressing contraceptive access in the context of Zika. So we think that these contraceptive care measures will be especially important in monitoring contraceptive provision and contraceptive access in Zika response and that access to and use of most and moderately effective methods of contraception are really important in reducing unintended pregnancies that may be at risk for Zika exposure.

So in the response to Zika, we want to make sure that people have access to any method that they choose. And we want to make sure, as you all know, special training and financing is, you know, there’s a higher requirement in terms of being able to have LARC methods available on site. So that’s why we want to make sure that folks do have the training, that there are those methods on site when somebody accesses services so that that’s not a barrier for the women that choose that method. So it’s incredibly important.

So Healthy People and the World Health Organization recommend an interpregnancy interval of at least 18 months. Therefore, all postpartum
women can be considered at risk of unintended pregnancy for that period of time. So using PRAMS 2011 to 2012 postpartum contraception data, only 50% of women were using a most or moderately effective contraceptive method at two to six months postpartum, and 14% of women were using a LARC.

So the postpartum measure focuses on two time periods, as I mentioned before -- three days after delivery that reflects the CDC and ACOG recommendations that the immediate postpartum period is a safe time to provide contraception, and 60 days after delivery the reflects ACOG recommendations that women should receive contraceptive care at the six-week postpartum visit.

So again the LARC measure is used to assess access by identifying very low rates of LARC use, again as we defined as being, you know, at or below 2% of the total.

So as the measure steward, we want to assure you that OPA is committed to responsible use of the measures. And so in that vein OPA is going to be maintaining a web page dedicated to the measures and their appropriate use and interpretation such as that there should be no benchmark for LARC. So that will be clearly explained. The website will be accessible and we hope that people will refer to that for any questions having to do with the measure.

And OPA as the steward is responsible for monitoring use of the measures and convening an advisory group to reflect on the measure’s use and considering improvements over time. And we’re currently funding the development of a patient reported outcome measure for contraceptive care that we think will be a good complement to this measure to ensure also that there’s no coercive practices that are happening. And also we’re working on an
eMeasure that better identifies women at risk for unintended pregnancy. So we’re really committed to these measures not being the only measure. We’re going to continue moving forward and we are sincerely committed to making sure that these measures are used correctly and that there’s no coercive practices that people are embarking on as a result of or in spite of these measures or in spite of how we’ve explained that they’re supposed to be used.

So I just wanted to mention that there’s significant external support from a number of other federal agencies as well as organizations for these measures and they’re very much in support of our efforts to have NQF endorsed measures. So these are just some of them -- the US Centers for Disease Control and Prevention, the Centers for Medicaid and CHIP Services, and the measures have been used on a developmental basis by the Maternal and Infant Health Initiative across a number of states, Planned Parenthood Federation of America, the National Family Planning Reproductive Health Association, ACOG, and (AWHONN).

So I’m just going to read a few of the folks that have actually endorsed these measures or -- have supported the measures, I should say -- are not able to be with us on the call today but did submit written comment. So the first of these is from Barbara Levy at the American College of Obstetricians and Gynecologists. She actually was at the NQF meeting when the measures were presented and actually they had an opportunity for public comment and Barbara Levy was one of the individuals that did stand up at the microphone to express her support for the measures on behalf of ACOG.

So what she said was, “I just want to reiterate our support for these contraceptive measures. It’s critically important for access and for us to be able to measure that access. And it’s also critically important that we understand that 49% of pregnancies are unintended in this country and that we
have a large population of women with chronic disease, chronic conditions, and that we cannot impact perinatal morbidity and mortality if we can’t plan those pregnancies in advance and optimize their care. And we feel very strongly that these measures will help to support us in that work.”

Also we had a written statement from (Debra Bingham) who was at AWHONN and also expressed verbal support for the measures at the NQF meeting. And she stated that she also wanted to underscore AWHONN support of the contraceptive measures. So thank you for all of your hard work on those measures.

Next, Daryn Eikner has joined us on this call and is going to provide a few comments on behalf of the National Family Planning and Reproductive Health Association. And she is the Vice President of Health Care Delivery there. So Daryn?

Daryn Eikner: Thank you, Susan. Good afternoon everybody. You know, I’ve been working in the area of quality improvement, including the use of performance measures, for more years than I really care to discuss anymore. And I guess that one thing that I’ve learned when I’ve worked in the area of implementation of performance measures in a large Title X network is that the collection of this kind of data can really have a powerful impact on the quality of services provided.

And more importantly I think that staff working in these settings are truly interested in receiving this kind of data -- not only to identify areas for improved performance, but to reinforce things that were going well. And I think that’s an important thing to remember.
So these measures represent one more step in a continuous improvement process that’s really going to allow us to understand more about services and how they’re provided and where we need to make some improvements. And we can use the data from these measures to focus improvement efforts -- whether that be improved counseling to ensure that women are receiving the most effective contraceptive method that is right for them, or tackling systems or structural barriers that are preventing access to all methods of contraception.

NFPRHA has been a part of this workgroup that has helped to develop these measures. And we are thrilled that we have come so far in the development of national measures related to the provision of contraceptive services. And we look forward to continuing to be a part of this important effort moving forward. Thank you.

Susan Moskosky: Thanks, Daryn. Next we’ll hear from Dr. Carolyn Westhoff who is with Planned Parenthood Federation of America as well as Columbia University. So Carolyn?

Carolyn Westhoff: Yes, thank you Sue. I’ve been having a really interesting time involved with working with the measures for the last couple years. And as a medical director for a Title X clinic at Columbia University for about 20 years, we were, you know, very used to all of our reporting through FPAR. We were very used to looking at mainly things around number of visits, number of tests, and things like that. And we wanted to find a way to get to more clinical outcomes.

And when I came to Planned Parenthood four years ago, we have about 300 Title X clinics in the Planned Parenthood system and so a partnership with OPA was a really, you know, relevant and wonderful thing. And in the Planned Parenthood universe, the clinics are really quite independent and even
though we have core standards across Planned Parenthood, what’s happening individually is something you can only really assess if you’ve got a metric. And, you know, we all have doing our work a feel whether it’s by clinic or provider that some places things are going well and some places aren’t going so well.

But these measures are really a great opportunity for us to find our areas for action.

Now also it’s a way for us to I think, you know, advertise the great quality of what we do to individuals outside of our own direct clinic. And whether those are payers for the services, whether those are regulators or auditors, and whether those are patients having some numbers to describe what we do and to be able to make fair comparisons with other providers is something that can be useful not only for our own internal quality improvements but for marketing, really.

And I’m, you know, very happy that we’re so close now to having a nationally recognized endorsed measure that we can stand behind. That said, I think these are, you know, really in the category of starting somewhere because these are measures that are based on administrative data and as Sue said, they’re going to be eMeasures as the next step, which actually take advantage of our electronic records.

But, you know, these take advantage of the routine records that generate bills and charges and it is limited in some ways what we can do to define who’s sexually active that way, to define what method they’re getting that way. The measures are imperfect but they’re so far ahead of having no measures at all.
And in the Planned Parenthood universe, very have extremely large amounts of variability on how affiliates and individual health centers perform on this. And this gives us an opportunity to look at places where like the numbers are too low and start a conversation about where that might be coming from and start the conversation on how to improve it.

And it specifically allows us to identify clinics that are doing really great and use them as our experts to help the clinics who are, you know, having trouble hitting the mark. And so being able to have these quantitative assessments of what’s going on are a really useful tool for us to do quality improvement. And I’m looking forward to working with everybody, with OPA and with all of the other groups who have been partners in this in figuring out, you know, new and better measures for us to use.

Susan Moskosky: Thank you so much, Carolyn and Daryn. We really appreciate your comments and support. So where are we right now? So I want to talk a little bit about where we are right now and how you all can be involved.

So we want to make sure that you’re aware of the opportunity that you have to provide public input on the measures. So as I mentioned we did participate in the NQF meeting about a month and a half ago. And all three of the measures that I described were provisionally endorsed by the Perinatal and Reproductive Health Review Committee that was convened by NQF. So 80% approval for the most to moderately effective measure and the LARC measure and 90% approval for the postpartum measures. So they were already provisionally voted on.

And then the next step is the public comment period. So the public comments are welcome from June 7 to July 6 so we’re right now within the public comment period. And you can access the public comment forum at the
website that’s listed on the slide there. And the public comments will be taken into consideration when the committee will make its final determination regarding NQF endorsement of these measures later this summer.

Let me just say a couple of words. Like Carolyn mentioned, we’re aware that the measures are not perfect and that we will have opportunities in the future to improve them and we do intend to do that, but for right now the vote is being taken on the measures as they currently are worded right now. But we do recognize so if you do provide comments, you know, you’re welcome to submit comments with regard to whether you think these measures are useful to providers and whether you think they should be endorsed as they were submitted.

But any recommendations in terms of considerations for how they should be changed would be for the future. It wouldn’t be for these measures. So what they are voting on right now is whether these specific measures will be endorsed or not. As I said before, any of them that are not endorsed it would be another three years before we could reintroduce other measures or before we could actually make changes.

So it’s not the only opportunity to, you know, make changes. We can make changes later on. It’s just for right now the endorsement process is for these specific measures that have been introduced and have been studied and data has been submitted on.

So we want to encourage you to submit comments -- both positive comments as well as if you have other comments about the measures. And if you have any kinds of constructive suggestions in terms of how you think they could be improved in the future, we think that that would be helpful too.
So what NQF wants to know in terms of your comments are, you know, are they useful? Are these measures, do you think that they’re useful to providers? And should they be endorsed as they were submitted? And then any caveats or considerations for the future.

So we really want to encourage you like I said to submit comments. I know that there’s a lot of interest in these and we hope that you all will again, even if you think that they’re great please submit a comment reflecting that. If you think that there are other things that we need to know in terms of any kind of comments in terms of how they should be changed in the future, we want you to submit that too.

It’s important I think in summary to be aware that, you know, we really believe it’s important to have measures around contraceptive care because we really think it’s key to improving the quality of care and to really improving unintended pregnancy rates as well as reproductive health outcomes. But we need to ensure that the measures are being used responsibly. That’s what we’re intending to do.

One of the reasons that we thought it was so important to have this call today was to once again explain to you, you know, how we view these measures, how they are supposed to be used, and to get you all’s support and cooperation in helping to relay those messages. So we really need you all’s help in terms of being able to communicate how all of the measures are to be used.

So in closing, just want to encourage you to submit comments to the National Quality Forum. And then we will take some questions if folks have any of them. So (Jeremy) I’m going to turn it back over to you to get us started with the question and answer period.
Coordinator: Thank you. If you would like to ask a question today, please press star 1 and record your name clearly at the prompt. Your name is required to introduce your question. To withdraw your question, you may press star 2. Once again if you would like to ask a question today please press star 1 and record your name clearly at the prompt. One moment while we wait for the incoming questions.

And as a reminder if you would like to ask a question, please press star 1 and record your name at the prompt. Thank you. And I’m currently showing no questions in queue at this time.

Susan Moskosky: Okay let’s just wait another few more minutes just in case people are being shy. And then if there are no questions then we’ll go ahead and end the call. Also if folks have concerns, even if it’s not a question. If you have concerns that you’d like us to know about, that would be fine too if anybody would like to share those.

Coordinator: We do have our first participant in queue. One moment for the name, please. And the first question is from (Marie McLane). Your line is now open.

(Marie McLane): Hi Sue. How are you? (Marie McLane) from Access Matters.

Susan Moskosky: Hi Marie.

(Marie McLane): So I’m going to ask the question that I bet a lot of people are sitting out there thinking about, and it’s collection of the postpartum data. So if it’s not - like what are your thoughts, you know, collecting three-day data, you know, currently potentially some grantees may not have questions around who is a postpartum patient and I’m wondering what your thoughts are on that
particular - it’s a great measure. I’m just wondering about the practicality of collecting that data.

Susan Moskosky: So (Marie) and other folks out there, I think you know one of the things to keep in mind is that these measures are intended to be considered for use by a wide range of audiences. So it may not be appropriate, you know, in a Title X agency to collect the postpartum measure because you’re not seeing a lot of postpartum clients.

So I think when we were thinking about the postpartum measure, for instance, it might be a measure that a hospital would adopt and decide to use. Or it could be within an agency that does prenatal care and postpartum care. So the measures are not - not every family planning setting would even adopt and use all of these measures necessarily. They can pick and choose which one they think is appropriate for their setting. So hopefully that helps.

(Marie McLane): Excellent. That’s absolutely wonderful clarity. And I think, you know, the Title X network can act as a proxy for a long time for lots of different data points. And it would be really nice to see hospitals and other sites report on some of this data. So then I say kudos, well done.

Susan Moskosky: Great. I mean, I think back about 100 years ago when I was in family planning and prenatal clinics, because we actually were the service provider that provided prenatal and postpartum care for clients that delivered at Parkland Hospital in Dallas. So in a setting like that, even though we were a Title X setting, we also did prenatal and postpartum care. So in a setting like that, you know, it’s a measure that, you know, we would’ve adopted and I think could’ve, you know, that would’ve been helpful for us.
But probably most Title X settings probably aren’t seeing a large number of postpartum clients.

And again I mean one of the things to say is we have within Title X we have FPAR data that Title X grantees and service providers are already collecting. So we’re able to compute the measures quite easily, at least for the most and moderately effective method and for the LARC measures as I illustrated by virtue of those graphs on the slides.

But in other places I think these measures will be available to anybody to use and I think, you know, if they do in the future become HEDIS measures, for instance, you know a lot of other big hospital systems -- Kaiser or other folks -- might decide to adopt them within their system. So the purpose of them is not for Title X specifically.

It’s actually I think we’ve illustrated they can be used in the Title X setting but also within a Medicaid population where clients are being seen by private providers or within the FQHC 330 programs, you know, they’ve shown a lot of interest in these measures as well. And there’s actually a couple of different sites that are actually collecting the data right now to see how easy it would be to collect them in a primary care setting.

So I think they’re not intended exclusively for Title X; they’re intended for anybody that is seeing individuals of reproductive age that should be assessing pregnancy intention and looking potentially at collecting data on this measure to see how they’re doing.

Are there questions or comments?
Coordinator: And as a reminder if you would like to ask a question please press star 1. One moment while we wait for the next question. And there are currently no other questions in queue at this time.

Susan Moskosky: If there’s no other questions in the queue, then I think we can go ahead and finish the call. And I just want to thank everybody for participating in the call this afternoon. And hopefully this information has been helpful for you. Please know that if you have additional questions or concerns, you can always reach us here at the Office of Population Affairs and we’re happy to entertain any additional questions that people have after the webinar.

So - and the webinar will be posted on the OPA website within a couple of weeks, so for folks that weren’t able to join if any of your colleagues you think might be interested please share that information with them.

Thank you (Jeremy).

Coordinator: Thank you. And this does conclude today’s conference. All parties may disconnect.

END