Katie Quimby:

Good afternoon, everyone. Welcome. My name is Katie Quimby. Thank you so much for joining us for today's discussion about the 2021 Title 10 regulations, and most importantly, what's new and what you as family planning program staff should know. Just a couple of housekeeping items before we dive in here. We will have a number of places where we will pause today for your reflections and questions. Feel free to chat in your questions at any time, but we'll pause and address those questions and a number of points and again, be looking for your reflections at a number of points throughout the session. We are recording today's session. We will be posting our recording to our website NYSFPtraining.org in the next few days. And we will be looking for your feedback. So I am going to chat out an evaluation link now, encourage you just to open that evaluation link, fill it out as we're going, and before you leave, make sure to submit your evaluations since we really do rely on your feedback to make these sessions better and more relevant for you.

I am delighted today to be joined by my colleague, Lisa Shamus. Lisa is the Title 10 training and TA lead for the Reproductive Health National Training Center, my colleague at the RHNTC. We're also joined today by [inaudible 00:01:26] and Mary Furin from the New York State Department of Health. So we wanted to start today with a poll before we dive into the 2021 regulations. So Becky is going to launch the poll and we just want to know how familiar you feel with the 2021 Title 10 regulations. No wrong answer here. We're all here to talk about the 2021 regulations today. So we are not expecting you to be very familiar, but we are curious to know how you feel at the outset with about your familiarity. So we will give it just five more seconds and then close the poll and bring up the responses here so we can see where we're starting from.

So it looks like we got a range, which is great. That's what we expect. That's what we want to see. Looks like most of you are feeling like you're right in the middle, a three. Maybe thinking, "I feel like I've got a sense, but I'm not sure." I just want to make sure I'm not missing anything. That's great. That's what we're here today to talk about. For those who feel a little less familiar, that's great too. We hope we will draw your attention to some of the key provisions of the regulations that we think are really important for you to know. And if you feel like you're a little more familiar, you're on the fours and fives, at least the fours, feel free to jump in on the chat when there are questions.

We hope you will weigh in and share your thoughts and maybe there will be something new for you here as well. So the 2021 regulations went into effect on November 4th, 2021. These regulations repealed the Trump administration 2019 regulations, re-adopted the original of 2000 regulations. However, with a number of revisions that were made to reinforce the program's central tenets of quality, equity, and dignity for all individuals who seek Title 10 services. As you may recall, the New York State Department of Health rejoined the Title 10 network in 2022, which means that the New York State Family Planning Program sites must now again comply with Title 10 regulations.

Some of the key updates in the 2021 regulations were related to pregnancy options, counseling and referrals, separation of family planning and abortion services method access, telehealth, income verification, the information that education materials review process, as well as confidentiality. And these are the provisions that we're going to focus on today and spend some time going through in detail.

Lisa:

Great. So let's start off with what the 2021 regulations require regarding pregnancy options, counseling and referrals. The 2021 regulations require staff to provide non-directive pregnancy options counseling. And as you may recall, the 2019 regulations repeal this requirement. But importantly, the 2021 regulations have reinstated this fundamental component of the program. So staff working in top 10

funded settings like the family planning program sites in New York State are required to offer pregnant clients the opportunity to provided information and counseling regarding prenatal care and delivery, infant care, foster care or adoption and pregnancy termination. Staff must provide neutral factual information and non-directive counseling on each of these options and referral upon request, except with respect to any option about which the pregnant client indicates that they don't want the information in counseling. And by the way, you'll notice that on the bottom of each of these slides, we have a citation so that you can go to the code of federal regulations where the language comes from if you so desire.

All right, so staff must provide referral for abortion upon request. And we know that there can be a lot of questions about what this looks like. And here's the guidance from OPA on this question. So a Title 10 project may, upon the request from the client, provide a referral for abortion, which may include providing a patient with a name, address, telephone number, and other relevant factual information such as one of the provider accepts Medicaid, whether they charge or not, et cetera, about the abortion provider. However, the project may not take further affirmative action such as negotiating a fee reduction, making an appointment, or providing transportation to secure abortion services for the patient.

So a common question that we get on this topic is do you have a sample policy template that we can adopt? And yes, we do. The RHNTC's non-directive counseling and referral sample policy template can be adapted by Title 10 subrecipients to demonstrate compliance with these counseling and referral requirements. We just chatted the link out to some of the resources that we've mentioned including this one. And we're also going to provide a list of all the reference resources at the end of the slides as well. So a natural follow up question from our discussion on options counseling referrals is what about separation of family planning and abortion services? The 2021 Title 10 regulations eliminates, and this is the sorting is directly from OPA, it eliminates the burdensome requirement established under the 2019 Title 10 rule for providers to maintain strict physical and financial separation of abortion services.

So Title 10 recipients are required to ensure that non-Title 10 abortion activities are separate and distinct from Title 10 project activities. And stick with me here because this is going to be a lot of words and we can talk about it later, but where recipients conduct abortion activities that aren't part of the Title 10 project that would not be permissible, the recipient must ensure that the Title 10 supported project is separate and distinguishable from those other activities. So what must be looked at is whether the abortion element is so large and so intimately related to all aspects of the program estimate it difficult or impossible to separate out the Title 10 eligible from the non-eligible Title 10 costs.

The Title 10 project is the set of activities that the recipient agreed to perform in the relevant [inaudible 00:08:30] grant documents as a condition of receiving the Title 10 funds. So in other words, what New York State said they would do when they applied to the office population affairs. So the grant application may include both project and non-project activities in its grant application. And so long as these are properly distinguished from each other and prohibited activities are not reflected in the amount of the total approved budget, there's no problem created. So this needs naturally to the question of how does one sufficiently properly distinguish between Title 10 program activities and abortion related activities.

So this guidance again comes directly from OPA, and separation of Title 10 from abortion activities does not require separate recipients or even a separate health facility. But separate bookkeeping entries alone will not satisfy the spirit of the law. So again, here there's going to be a lot of words, so bear with me again. [inaudible 00:09:34] technical allocation of funds attributing federal dollars to non-abortion activities is not legally supportable avoidance of section 1008. Certain kinds of shared facilities are permissible so long as it is possible to distinguish between the Title 10 supported activities and then

non-title 10 abortion related activities. So I know this can be confusing, so let's break it down a little bit. We have some examples, here are specific examples that OPA provided on this question. So a common waiting room is permissible as long as the costs are properly prorated. Common staff is permissible so long as the salaries are properly allocated and all abortion related activities, the staff members are performed in a program, let me back up.

Common staff is permissible so long as the salaries are properly allocated and all abortion related activities of the staff members are performed in a program which is entirely separate from the Title 10 project. A hospital offering abortions for family planning purposes and also housing a Title 10 project is permissible as long as the abortion activities are sufficiently separated from the Title 10 project. And maintenance of a single filing system for abortion and family planning patients is permissible as long as the costs are properly allocated. And just on another note, OPA sees no issue with providing post-abortion contraception under Title 10 provided that the visits are separate. So we're just going to take a pause here and reflect on what we've presented so far. What has resonated with you or surprised you about these provisions?

Katie Quimby:

We'll give it a minute here, just a pause because I know it can be helpful to take some time to reflect as we're sharing a lot of words. If there's something that's resonated with or surprise you, just chat it in and we encourage you to chat it to everyone so that we can have a discussion about this. Well, as you're thinking about what's resonating to you, I also want to just have an opportunity here to ask questions. So if there's something surprising or questioning to you, questioning of you, if you have questions about what we've just talked about, feel free to jump in. Yeah, the clarification and samples. Sherry says the clarification and samples being very helpful. I find that very helpful. The specific examples that provides there and allowing the full range of services as in the past. Yes.

Lisa:

And I thought it was really helpful that they clarified, which I feel like was the first time that they can share the same chart. And so that was really, I think, that could have a big impact for folks.

Katie Quimby:

Yes. Yeah. Laura says being clear and specific about what constitutes, I forget exactly the wording, but promotion or support for abortion and what kind of sources, what activities are allowable, what is not allowable, what is not allowable, including making an appointment for abortion. Yeah, details on referrals and staff duties. Great. All right. We're going to move on to some of the other regulations or other provisions in the regulations, but these are great reflections and similar things that have resonated to me and Lisa, and we encourage you to keep dropping those in. We'll have a couple other places where we're looking for what's surprising and also and what questions this has raised for you.

Okay, so a couple other provisions. Some of these I think are going to be newer or more different than others. Some of these will probably feel like maybe they weren't all that new, but these are what OPA has really called out as things they believe are new and different and want to draw attention to. So first, the 2021 Reg stipulate that sites that do not offer a broad range of methods on site must provide a prescription to the client for their method of choice or a referral as requested. And this is under their method access provision. Telehealth services, we've been talking a lot about telehealth the last couple years and the 2021 regulations codify that the allowability of telehealth for Title 10 Family Planning services. The regulations state that Title 10 providers must provide for medical services related to family planning, including consultation by a clinical services provider, examination, prescription and continuing

supervision, laboratory examination, contraceptive supplies, in person or via telehealth and necessary referral to other medical facilities but medically indicated. So adding this specific call out for telehealth.

2021 regulations added a statement that income verification must not impede access. Title 10 providers are required to take reasonable measures to verify client income without burdening clients from low income families. Recipients that have lawful access to other valid means of income verification because of the client's participation in another program may use those data rather than re-verify income or rely solely on the client's self report. And if a client's income cannot be verified after reasonable attempt to do so, charges are to be based on the client's self-reported income. So this being one of the places where OPA really trying to drive home the core principle of access and building an access to the Title 10 program.

A common question we get on income verification is what income should be included to determine family income? So this answer that I'm sharing here comes directly from an OPA approved income verification job aid that the Reproductive Health National Training Center created. There is no standard definition of income to determine eligibility for all federally funded programs when considering IRS form 10 40 guidance regarding what constitutes income, the following inclusions and exclusions are recommended to calculate family income for the title 10 visits. And this comes from charges, billing collections, job aid from the RHNTC, which I'm going to chat out right now for you. Family is defined as a social unit composed of one person or to shoot two or more people living together as a household. And as a reminder of something, I know all of core to this is clients must not be denied services or be subjected to any variation in services or in quality of services because of an inability to pay.

Lisa:

Great. So the 2021 regulations provide some new language and guidance around the information and education materials review process. One update is that the regulations now make me clear that the electronic educational materials are subject to material review process. Having said that, we do get a frequent question about this update. And that is, do social media posts on platforms such as Facebook and Twitter and Instagram need to go through the in INE materials review process? And the answer to this is no. So while INE materials shared on social media ... So INE materials that are shared on social media must undergo an INE advisory committee approval process. Social media posts themselves do not require INE advisory committee approval and are instead subject to the Title 10 agency's social media policy.

And Katie is, I think chatting out a link to the frequently asked questions document that that comes from. So the 2021 regulations also updated the committee requirements. Many of you will be happy to hear that there's no longer an upper limit to the number of members on the committee. This updated regulation states that the committee shall consist of no fewer than five members and up to as many members the recipient determines, except that this provision may still be waged by the secretary for a good cost show. In terms of function, when reviewing the materials, the advisory committee shall consider the educational, cultural and risk backgrounds of individuals to whom the materials are addressed, consider the standards of the population are community to be served with respect to such materials and review the content of the material to assure that the information is actually correct, medically accurate, culturally and linguistically appropriate, inclusive and trauma informed.

And by the way, the reference to trauma informed review is new and the RHNTC has created a job made to help Title 10 agencies integrate a trauma informed review into their INE process. And that is also being chatted out in the link or in the chat box, the link is. So when reviewing the materials, the advisory committee shall also determine whether the material is suitable for the population or community to which it is to be made available and establish a written record of its determinations. And the RHNTC has

an INE materials review toolkit with resources to facilitate the INE materials review process from start to finish and we'll also be providing that link at the end at presentation.

Katie Quimby:

Confidentiality. So the 2021 regulations reaffirm the title time program's commitment to confidentiality, that information about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as maybe necessary to provide services to the patient or as required by law with appropriate safeguards for confidentiality. The regulations clarify that reasonable efforts must be made to collect charges without jeopardizing client confidentiality and the regulations added a new requirement that clients must be informed of any potential for disclosure of their confidential health information. The regulations also reaffirmed that it's allowable to require consent of parents or guardians in order to provide services to minors or to notify parents or guardians before or after minors request or receive services.

The 2021 regulations also enable a broader range of clinical services providers to direct Title 10 services and provide consultation for medical services. So Title 10 providers must provide that family planning medical services will be performed under the direction of a clinical services provider with services offered within their scope of practice and allowable under state law and with special training or experience in family planning. They also provide for medical services related to family planning, including consultation by a clinical services provider. And what's important or interesting or exciting is the 2021 regs expand the definition such that the direction of Title 10 services can now be done by staff such as physician assistants, nurse practitioners, certified nurse midwives and registered nurses with an expanded scope of practice who are trained and permitted by state specific regulations. So let's pause there. What, if anything, resonated with you or surprised you about some of these provisions that cover a array of different categories of provisions here that we've just talked about? What was new? What, if anything, surprised you?

Lisa:

Katie, while people are chatting in, I think that we had some questions come in after we opened up the questions last time. So one of them being a question around, what do you mean we can't make an appointment for an abortion? If I have a woman who walked in for a free pregnancy test and the result is ... I have to scroll to get the rest of it. Positive, and obviously reviewed all the options and she's decided to terminate, can I walk her to the appointment desk so she can make her appointment?

Katie Quimby:

Do you want to take that one?

Lisa:

I would err on the side of caution and let her know where she can go to make the appointment, but I probably would not personally walk her to the desk.

Katie Quimby:

And I was going to try to go back to that slide and just pull that language again. And I'll just recap that language again. So Title 10 projects may, upon request from a client provider or referral, which can include providing a patient with a name, address, phone number, and other factual information about the abortion provider, but may not take further affirmative action such as making an appointment,

providing transportation, [inaudible 00:24:09] reduction. So I think to Lisa's point on erring the side of caution, further affirmative action to me would feel like walking someone to a desk to make an appointment.

Lisa:

And then we had another question asking if a patient can self attest for income household size at each visit and receive a discount now. Documentation is not needed after the first visit? And I would say that I'm going to defer that one to Katie because I'm not as familiar with the New York State requirements. And each grantee on a national level can have more restrictive policies than the policies that we're stating here, which are from the Office of Population of Harris.

Katie Quimby:

I know we have a couple DOH folks on who, if that's something you want to jump in with, great. Otherwise, we can go back to New York State and get clarification on that. It's not something I know off the top of my head. I'm seeing if, and we are recording, we're keeping track of the questions that are coming in here and who has asked them so we can follow up with you if we're not able to get you a realtime response. I see a couple other, looks like something that has resonated is around telehealth and increasing the number of advisory members and expanding the scope of providers. These are all very exciting revisions.

Lisa:

And I would love to take the next one on-

Katie Quimby:

I was going to give it to you.

Lisa:

This really resonates with me. When I was the project director at the Arizona Family Health Partnership, we actually had a finding from our federal reviewer because we had 10 people on our INE committee. And so it resonated very much with me because, well, it is usually really challenging for people to get to that minimal limit. We know that that can be a challenge. We also had that challenge of having a finding on our federal program review for going above the upper limit.

Katie Quimby:

Lisa, to Sema's question, we have hard time finding people to fill the spots. Obviously that's not addressed, that's not obviously called out in the Title 10 regs that we're focused on here. But any thing to say about that?

Lisa:

Yeah, I think that the INE toolkit has been approved by the Office of Population Affairs, provides some maybe new and creative ways that you can fulfill that requirement of having a committee. And I think that OPA is really cognizant of the fact that it's really challenging for folks to get a committee that's a standing committee together and that that's not maybe always the best approach, right? Because you want to make sure that the folks that are reviewing the materials are representative of the population that that material is meant for.

So in other words, if you have materials that are adolescent facing and all of the people that are on your IMV committee are in their late twenties or early thirties, those might not be the right people to be reviewing that piece of material. And so the INE materials toolkit talks about some ways that you might either get input from folks in clinical settings at health fairs through virtual means instead of having to have everyone come in person via electronic means. And the INE toolkit talks about some of the advantages and disadvantages of all of these different approaches.

Katie Quimby:

Thanks, Lisa.

Brittany:

Hi, Katie. It's Brittany from Department of Health. Sorry. I started answering and I was on mute. I can answer the question about the financial attestations and verifying that discount and everything.

Katie Quimby:

That would be wonderful, Brittany. Thank you.

Brittany:

Yeah, no problem. So Department of Health, we, like as New York State, don't require documentation for income. We're fine with just a patient's self attesting to that. It's really the policy level of each organization. So it's up to your individual organization how far you want to take that, what documentation you need. But we're okay with patient attesting and receiving a discount that day for sure, if that's going to get them the services.

Katie Quimby:

That's great, Brittany. And I think part of the question too was whether that attestation would be needed to be done at every visit. And if I'm understanding your comment there, I'm guessing that would, again, be subject to the agency's policy.

Brittany:

Correct.

Katie Quimby:

Great. Okay. I see a question to get the INE toolkit link again, so I will chat that out. Becky beat me to it. Thank you, Becky. There was a question about going back to the social media, the INE FAQ around social media posts. Lisa, do you want to take that again? I can also try to bring up the FAQ here so that we've got them.

Lisa:

That would be great. I think that this is incredibly confusing for folks about what is actually an informational and material that's designed to either for clients or for potential clients versus social media posts. And I think that the key to the answer is that your social media policy might define that for you so that you have clarity about when does something flip to being an INE material that's client facing. Some of the social media posts are very, it's very obvious that it's a social media post that's sort of targeted towards your sister agencies or social service agencies or other professionals. But I think that if

you define that in your social media policy, that would be the route I would go. And Katie, what are your thoughts?

Katie Quimby:

Yeah, I mean, I would just add putting in the policy kind of defining kind of goals of certain types of social media posts. If the post is educational in nature, that would be subject to a different type of review than talking about your hours or how to make an appointment or events that you're hosting or things like that that are not designed for educational purposes. And that might be a useful delineate or in your definition. Lisa, question here, do we have a sample of a written consent that we could share with the parent ... a patient's written consent to share confidentiality with parent or another person as the request? I'm thinking I might need a clarification on what exactly you're looking for, whether that's ... Are you looking for an example of something that can be given to a patient for them to sign to share information with a parent or someone else? Or at least say you might have a sense of what the question is asking or we may need clarification.

Lisa:

I think clarification would be good.

Katie Quimby:

Okay. If you're there and can clarify your question, we will try to get you an answer. I think that's it. So it seems like things that jumped out were definitely around the INE. As we expect, there's always some good questions about that. The clinical services provider in telehealth being a particular interest. To share information with a parent or a person of choice. Okay. I don't know that we have an example of something that a patient sign to share information. I think maybe others on the call have something I've seen those mostly as kind of HIPAA compliance type sign documents that patients sign. We don't have one of those necessarily. Lisa, do you have a thought on that?

Lisa:

I was thinking along the same lines as you.

Katie Quimby:

So we might need to get back to you, Vita. Thanks for clarifying your question and if others on the call have an example that they have that can be shared, please feel free to share it here. All right, let's jump into our last section and then we'll I think still have time for questions, more questions as they come in at the end here.

Lisa:

Excellent. So the 2021 regulations included new section on definitions and terms and also revised language throughout the regulations to be more inclusive. So health equity is defined in those Title 10 regulations as, "When all persons have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances." And the Title 10 regulations reinforce that Title 10 services should be equitable. Family Planning Services is defined in the regulations in a way that aligns with the QFP recommendations and that is that family planning services include a broad range of medically approved services, which includes FDA approved contraceptive products and natural family planning methods for clients who

want to prevent pregnancy and [inaudible 00:34:26] pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, STI services, and other preconception health services.

The 2021 regulations include definitions for client centered services, culturally and linguistically appropriate inclusive and trauma informed services and the regulations require provision of services in a manner that is client centered, culturally and linguistically appropriate, inclusive and trauma informed. Protects the dignity of the individual and ensures equitable and quality service delivery consistent with nationally recognized standards of care. So client centered care is respectful of and responsive to individual client preferences, needs and values and client values guide all clinical decisions. Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse patients.

Inclusive is when all people are fully included and can actively participate in and benefit from families planning, including but not limited to individuals who belong to underserved communities such as Black, Latino and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color, members of religious minorities, lesbian, gay, bisexual, transgender and queer or LGBTQ+ persons, persons with disabilities, persons who live in rural areas and persons otherwise adversely affected by persistent poverty and inequality.

And trauma informed means a program, organization or system that is trauma informed, realizes the widespread impact of trauma and understands potential path for recovery, recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system and responds by fully integrating knowledge about trauma into practices, procedures, and policies and seeks to actively resist retraumatization. The last definition we want to call out is adolescent friendly health services, which is defined as services that are accessible, acceptable, equitable, appropriate, and effective for adolescent. All right. So do we have any final surprises or reflections on what you've heard?

Katie Quimby:

Lisa, for me at least, I find the definitions just really helpful grounding from OPA and just making sure we're all kind of saying the same thing when we talk about being trauma informed and inclusive and adolescent friendly, all terms I think we use very often. And so having the shared definitions I find really helpful. I'm curious how others feel about the definitions or any of the other provisions that we've talked about. While we're thinking about that, there is an active discussion going in the chat around INE and INE material. So question, our health educator is using QR codes to cut down on the need for paper brochures. And because you prefer to receive information that way, information that is linked to through those QR codes, would that need to be reviewed by an INE committee? General consensus by our colleagues here is yes. What would you like to say about that?

Lisa:

Yes. Yeah.

Katie Quimby:

If the QR codes are taking them to information, educational information then yes. And I think this is probably at the core of what OPA was trying to get at when they clarified print or electronic materials that we are doing of disseminating information in ways like this because it is patient friendly and youth friendly if that's how they want to receive information. And so wanting to make sure we're including that in the denominator of materials that should be reviewed from this perspective.

Lisa:

And I would also include that when you're putting it through the INE committee to include that piece of the QR code and just to make sure that that is kind of ... I'm sure that you've already talked to your clients about making sure that that's the way they want to receive information. I would also encourage you to maybe have those available outside of the QR code as well for folks that may would not be as savvy with using a phone or may not have a phone. Just make sure that the materials are available to everybody.

Katie Quimby:

What other questions? We have a few minutes and we can take as much or as little time as you all want on questions that have come up for you on the 2021 rigs. And we've called out again what OPA has said is new and different and important to call attention to, all of which we agree and have also found helpful to focus on and think about. But we are welcome. Any other questions that you have?

Christy:

Hi, this is Christy from Hudson. We're trying to wrap our head around the non-directive counseling and we can't make an appointment. I'm reading this document and it talks about referral to another provider, but we provide both services, which would be a referral to us, which doesn't also feel like it makes sense to me, but staff not taking affirmative action such as making an appointment. I'm just trying to wrap my head around. Are we supposed to say to the patient call back and make the appointment? It just seems very strange.

Lisa:

Yeah, it does not seem very client friendly and this actually is not, even though they're calling it out as something new. I think if you look back in previous guidance, this is actually not a new provision, but I think that in the times that we are in, it's being highlighted more and being called out more and so I think it is a challenge. It is not client centered and it is the regulation.

Katie Quimby:

And I know again, DOH folks might be on and have some thoughts here and welcome you all to jump in on this too, but Christy, it seemed to me, and Lisa, feel free to jump in or clarify, but that this would get at what needs to be in your agency's policy around separation of services and the RHNTC is currently working on revising all of our policy templates. Actually, the sample policy that I chatted out around nondirective options counseling does include pieces around this.

And I would put really explicitly in that, "Here's how we are understanding affirmative action and here's what we are doing that is we are not understanding to be affirmative action." Where if they're in your organization, we're telling them to make another appointment to come back or sending them to another room if they're doing it that day. And here's how we are understanding affirmative action that we are not taking, e.g. like the same staff person walking them in and being with them the whole time or how you want to explain it. But that's something I would just try to be really explicit in your policy about what to show that you are trying to be very clear to what affirmative action is and is not being taken.

Lisa:

Okay. There was a quest to put that slide back up about reference to [inaudible 00:43:13].

Katie Quimby:

Here we go. Sorry I got to flip all the way back to the beginning. This one maybe is the most helpful. Okay.

Fran:

Hi, Katie, it's Fran. I just want to try to address slightly, if I can, the question from Hudson peon. I think in the past, the way this was handled when we were part of Title 10 previously was that someone might enter the clinic as a family planning patient with the intent that you're going to provide contraception or whatever services that that person's looking for and then through doing a pregnancy test finding out that this person's pregnant now was seeking termination that that is fine, that that person is still served by the same staff, they're still provided with whatever services they're looking for. It's just now not a family planning visit that's reportable to us under the grant. And assuming that you've already taken steps in your family planning budget to, as was mentioned earlier in the presentation to allocate staffing percentages, it's completely fine that you have staff that are going to be delivering services, delivering abortion related services.

And as long as that is out, their staff time is allocated, the same thing. It's noted here on this slide about common waiting rooms and all of that. So I don't know if that helps and I don't know if there are other organizations on this webinar that could speak to that, but from our perspective, we just would not want that patient reported as a family planning visit if you did in fact move forward with them in that same day visit with any abortion related services. Does that make sense? And I don't know if others from Planned Parenthoods or other abortion providers are on that could speak to that.

Christy:

I think that that makes sense. But I think the part that we could be struggling with is we have a patient who comes in for pregnancy and counseling, receives all of the counseling on the different forms that they have listed here. But then the idea that if the patient opts for a termination, that we can then not help them make that appointment. I mean, we're not referring them out because they're going to see us but they're just going to see us under the non-Title 10, non-family planning service side.

Katie Quimby:

Well, and my sense would be, and [inaudible 00:45:59], tell me if I'm wrong, if what you're saying is if in that situation, you absolutely can make that referral and take the affirmative action that you're describing, Christie, but then it would not be counted for the family planning visit reportable to New York State Department of Health because the termination happened as part of the same visit but-

Fran:

Yeah, yeah. That's what I'm trying to say.

Christy:

I love that suggestion.

Katie Quimby:

Christy, does that close the loop or still remaining?

Christy:

What if the patient doesn't want it that same day though? So they come in for their pregnancy testing options counseling, at the end of the visit they say, "I'd like to come back next week for an ICP service." Are we allowed to book that appointment or not book that appointment?

Fran:

My sense would be that you're providing them the information about how to book the appointment, whatever that means, whether that means you can go back up to the front desk and talk to them or you can call back once you're home and you've looked at your schedule and figured out when you are able to come back in for this. But as long as that is where it ends, they can still be counted as a family planning visit. Then obviously they come back for whatever abortion services are needed and then that's not reported under the Title 10 project.

I'm sure procedurally, it's just different depending on what your processes there are in your clinic. So I like the earlier suggestion about trying to clarify those processes internally and then if needed, discussing them with us, but just taking those steps to show how you are not taking the affirmative action in that same visit. I mean we're really walking a line here where we want to be as patient centered as possible, but we do have to keep some separation from the non-Title 10 activities.

Christy:

Okay, thank you.

Katie Quimby:

Thanks, Fran. Okay, I'm just scrolling back up to see what other questions have come in. Pascal, I know you're asking for a chart with Alyssa the regs. I'm not sure exactly which chart you're referring to. If you have any more detail about what that chart is, please let me know and we can see if there is a chart and/or who might have created that in the past and we can try to see if we know there is an updated version of that. If that may have come from New York State Department of Health, then let us know. That might help us. Clarification on the requirement for an annual external medical record review. Should this review be done by a certified reviewer? If so, how are certified defined and what needs to be audited? Fran, not to put you back on the spot again, but I think this is related to the IPRO audits that folks are planning for. And I know that it is supposed to be a certified reviewer, but do we have any guidance around what is defined as certified?

Fran:

I believe we do. I'd have to get back to the person who asked the question on that. And so if we can just kind of, you said you'd provide this back to us, right, Katie?

Katie Quimby:

Yeah.

Fran:

So we can follow up, yeah.

Katie Quimby:

We're recording your names and questions. So yes, so we will follow up with you, Amy, about that clarification. Amy, yes. Okay. Okay. So Janet says we do not, or sorry, a program does refer out for

abortion. When we refer to any external service, we attempt to schedule the appointment for our patients. Unfortunately, we will schedule referral appointments for all other care, but one service we can only provide information. Yeah, it is. It is unfortunate.

Do you want to jump in on that, Lisa? I know we talked about it. Yeah. I think I've addressed all the questions that we've received. Are there any other questions? If so, now is your time as you were thinking about final questions. Thank you, Pascal. We'll take a look at that and get back to you. Okay. This is the program review tool? Yes. So Pascal, the OPA is actively, actively working on the program review tool, which does help translate the regulations into implementation strategies. Our understanding is that [inaudible 00:51:23] review tool will be released imminently and we, as a training center, we will send an alert or let you make sure you know, especially Pascal, when that is up. But it should be up very soon and is a very helpful tool. I know New York State then has a version of their audit tool that's based on the program review tool. And so I know as soon as the Title 10 one is set, that will set other things into motion but it's close.

Okay. Just a couple things as we wrap up here. We are going to make sure to send around the slides to you because I know you can't click on these links and I'm not going to track them all out. But I want to just call your attention to this references page. This does link to the source documents for where we pulled all of the texts and the citations from today. In particular, I think things that might be new or that you may not have seen, these last two there, the FAQ that was just released on the Dobbs decision that pulled that had some good specific guidance as well as their provision of abortion related services document back from 2000. That's where we pulled the specific language around separation of abortion and family planning services. So if you're interested in and going back to the source documents, that's where you can find them here. We did try to pull the source language directly so that we're not trying to interpret it too much for you, although give a place to reflect and process it. It's a really hard line to navigate sometimes. But here is the link, the links, and again, we'll send this around to those of you who are here today.

Similarly, at the last slide you'll find just the links to some of the resources that we shared. Just so they're all in one place. So that if you didn't have a chance to grab them from the chat, you will be able to click on the link from here in the resource list. I don't see other questions coming in, so this will be my chance to plug one more time the evaluation. We are rely on your feedback for making these sessions better, as you know. So if you can take two minutes and just tell us what you thought and if you have a question that we didn't get to or that you didn't want to put in the chat for any reason, feel free to drop it in the evaluation.

If you do do that, you just know you'll have to tell us your name so we can follow up with you. So if you want us to follow up with you on a question, drop it in the evaluation, but give us your name so we can make sure to get a response for you. But otherwise, we hope you'll just share your thoughts, so that we can make sure our next session of this is better. And very explicitly or specifically we are planning to do this presentation a couple other times for some other audiences. So we're especially looking for your thoughts to know how to make this better for other audiences. I think with that and not seeing any other questions come in, I will see if Lisa has any final things she would like to say.

Lisa:

I just want to say that it's great to see some familiar faces again. It's been a long time, names on the Zoom participant list. It's been a little while and I'm really glad to see you all back.

Katie Quimby:

Well, we are happy to have you back, Lisa, briefly. Hopefully everyone will join me in thanking Lisa for joining me today and going through these regs, which can be complicated, but hopefully this was a chance to dig in on some of the provisions that may or may not have been new to you. Thank you all so much and hope you have a great rest of your day. We'll talk soon.

Lisa:

Bye.