

**Health Resources and Services Administration  
Bureau of Primary Health Care  
Navigating the Health Center Program: An Introduction  
for American Indian/Alaska Native Communities  
August 14, 2014, 1 p.m. – 2:30 p.m. ET**

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode.

During our question and answer session you can ask questions in one of two ways. You can ask a question online using the Q&A feature. Or to ask a question by phone you can press Star 1 and record your name when prompted.

Today's conference is being recorded. If you have any objections you may disconnect at this time. And now I'd like to turn today's meeting over to Ms. Tonya Bowers. You may begin.

Tonya Bowers: Thank you so much and good afternoon and good morning to everyone. I'd like to welcome you to today's presentation titled Navigating the Health Center Program, an Introduction for American Indian and Alaska Native Communities.

My name is Tonya Bowers. And I'm the Deputy Associate Administrator for Primary Care in HRSA. I think today's presentation will provide a really valuable opportunity for everyone to learn about the Health Center Program and the resources available to you.

As you know the Health Center Program has seen tremendous growth over the last couple of years thanks to the Affordable Care Act which has enabled us to provide support to many new dually funded health centers.

And those are health centers that receive funding from both HRSA under the Health Center Program as well as the Indian Health Service.

We are excited to share this opportunity with you today; for a few of our dually funded health centers to share how they were successful in meeting the Health Center Program requirements and their journey to becoming a program grantee.

We are also hopeful that today's presentation will provide an opportunity for Native American communities to learn from one another and to provide as I said valuable resources about the health Center program.

Today we have a great lineup of presenters. Our first presenter will be Mr. Alan Pruhs. He is the Executive Director of the Association for Utah Community Health in Salt Lake City.

Mr. Pruhs will talk about their assistance to tribal groups like the Paiute Indian tribe of Utah in applying for the Health Center Program funding.

After Mr. Pruhs you'll hear from Ms. Michele Lefebvre who is the Project Director of the Paiute Indian Tribe of Utah in Cedar City, Utah.

Following Ms. Lefebvre will be Maria Clark. Ms. Clark is a Project Director for the Pueblo of Jemez which is another one of our newest health centers. They are located in Jemez, New Mexico.

All three speakers will talk about the advantages and responsibilities of being a Health Center Program grantee.

Following those presenters Mr. William Davis of HRSA's Office of Federal Assistance Management will briefly share some tips and highlights of our grants application process and will also provide some valuable resources about the process.

Finally we will have a question and answer period following Mr. Davis' presentation.

By the end of today's session we are really hopeful that you will have gained an understanding of the responsibilities of being a Health Center Program grantee and also

understand the resources that our primary care associations can provide to those of you and many others out there who are seeking to become HRSA funded health centers and finally to make sure that you're familiar with the valuable resources that are available to assist you along the way.

I'd like to now turn the presentation over to Mr. Alan Pruhs with the Association for Utah Community Health in Salt Lake City. Alan?

Alan Pruhs: Thank you Tonya and thanks to the HRSA team for the opportunity to present today. Good morning everybody and good afternoon wherever you're located.

As mentioned my name is Alan Pruhs. I'm the Executive Director of the Association for Utah Community Health or affectionately referred to as UCH.

UCH has been the federally recognized primary care association in the state of Utah since 1985.

Primary care associations are located in every state across the country with many serving multiple states such as in the Dakotas.

And so for all of you seeking to connect with your primary care association for assistance just be aware that there are availability of PCAs across the country to assist you.

I think it's important to note that primary care associations like health center grantees are private nonprofit organizations.

We work cooperatively with the Bureau of Primary Healthcare under a grant or a cooperative agreement to provide training and technical assistance to community health centers and also to provide assistance for communities who are interested in learning more about the health center program or actually interested in seeking 330 grants, health center program grants.

I'll quickly give you a brief -- next slide please - a brief overview of the health centers in Utah. We're fortunate to have 13 Health Center organizations in the state of Utah and 11 of which are community health centers. One actually operates under a dual grant is a community center as well as migrant and seasonal farm worker grantee.

We have one homeless health center organization in the state of Utah. And we are also fortunate to have two tribal entities operating as health centers in Utah, one that's operating under a 638 self-determination self contract, the Utah Navajo Health Systems and then the Paiute Indian Tribe of Utah who just recently received a health center grant in the fall of 2013.

Together these health centers operate over 40 clinics across the state of Utah and provide a medical home to over 120,000 patients providing over 400,000 patient visits annually.

Our patient population is similar to the population of health centers across the state or across the country I should say with 98% of our patients living in households earning less than 200% of federal poverty level and 76% actually living in households earning less than 100% of federal poverty level.

Unique to Utah is the number of uninsured in our health centers. We're currently serving about 60% of the patients who are uninsured in the state. And so the health centers play an extremely vital role in providing access to patients who otherwise would go without care and not have access to affordable primary and preventive health care.

Next slide please. In the fall of 2013 Utah was extremely fortunate to receive six new access points awards. This was by far the largest, you know, number of awards we had received at any one time.

I've been with the Primary Care Association for almost ten years now and in ten years time we haven't had six new health centers opened up.

So this actually provided us with a great opportunity and a tremendous amount of excitement for myself and our staff as we worked with our members as well as new communities.

And three of the - I should say two of the health centers that received the grants were absolutely brand new grantees - Paiute Indian Tribe of Utah and Utah Partners for Health. And that provided us with a great opportunity.

In the past our expansion has been primarily with existing grantees who then branched out and opened new clinics.

This was an opportunity to work with two new communities in establishing health centers in their areas.

And as a primary care association as I mentioned it was refreshing and it was very exciting to work with these new communities.

Next slide please. As a primary care association as I mentioned we provide technical assistance in obtaining grants or learning about the health center program.

On some of the technical assistance that we provide really related quite, you know, really started I should say with a statewide expansion plan.

As a primary care association we typically on an annual basis take a look at the needs across the state of Utah and identify areas where there are populations who do not have access to affordable primary and preventive healthcare where other needs determine that those areas would be suitable for expansion.

And we provide those reports and information to the public through our Web site and through other forms including, you know, providing that information to communities who are interested.

I think one of the biggest issues or areas that we were helpful in working with the new grantees was really in the collaborations area.

Both of our new grantees last year were operating in areas that had been identified as within the service area of existing health centers.

However we knew that those existing health centers were not meeting the needs or unable to meet the high demand of needs or just simply weren't located in the geography even though it was in their service area.

So initially in being contacted with the Paiute Indian Tribe we set up relationships with the existing health centers and sort of paved the way for them to move forward in collaborating with those health centers in trying to meet the needs of an area that were not being met currently.

We also provide assistance with needs assessments. If any of you are currently looking at the new access point award you'll notice that there are two forms that will help you identify the communities you serve, Form 4 for the community characteristics as well as Form 9 the needs for assistance.

And we provide assistance with those forms for our members and for the communities that are interested.

We also update our healthcare marketplace assessments to give a better understanding of the healthcare marketplace within the state of Utah for example whether or not we have chosen to expand Medicaid and others that would be important.

We also provide lots of sample documents, sliding fee schedules, policies and procedures, job descriptions, grant requirements.

And then we're of course through the process of obtaining a new access point award or applying for one we work with them on the requirements of that process as well as helping to navigate through the EHB when uploading all of your information.

Sometimes that can be a little daunting when we provide assistance as does HRSA, tremendous assistance to the looking for that. Next slide please.

The next slide gives you a little bit of information about the other areas of technical assistance that we continue to provide both to our members and to as I mentioned any community who's interested in seeking 330 or health center program grants.

And they vary as I mentioned. I'm getting into some of the details here. Many of these help when writing the grants and help write a strong grant and hopefully lead to the awarding of such a grant.

Next slide please. You know, in working with the tribal entities it's been our experience that they are well-suited to become successful applicants.

Many of the areas that we noted that contribute to their success is the - essentially that they're already targeting a high need service area.

Many cases in Utah they are located in what we would call frontier locations or very sparsely populated regions.

The tribal entities had very realistic patient projections. They knew their areas well and they knew the needs of their areas and so that - we felt that that helped contribute to their success.

There was a familiarity with the health centers program. Many have had involvement with Indian Health Services and have had some involvement with HRSA and had an understanding of the health center program.

I think that the next bullet point really identifies what we thought was one of the better, you know, strengths. And this was an awareness of and sensitivity to the healthcare needs of the communities.

Who knows that better than the actual tribal entities who are working within those communities? And so we worked closely with them as we went through the community characteristics and the needs for assistance worksheets and found that to be extremely helpful.

And then of course I believe that, you know, our thought was what the tribal organizations had a strong leadership in their governance set up as was right now.

And there was some transitions that needed to be made. But by having that tribal leadership and integrating that into the health center governance that we believe proved to be another successful computing factor.

So we have two other speakers that will provide information to you and overviews. Michele Lefebvre is the Health Director of the Paiute Indian Tribe of Utah.

And Michele will be followed by Maria Clark who is the Director of Health and Human Services for the Pueblo of Jemez in New Mexico.

Michele and I have worked closely together now for the past year and a half. And we found them to be an extremely great tribe to work with. And we're so happy to have them in the health center family. So Michele I'm going to turn the time over you.

Tracy Pace: Sorry Ms. Lefebvre if you could unmute your phone. We can't hear you.

Michele Lefebvre: Oh I'm sorry.

Tracy Pace: Yes. So you want to take it from the top.

Michele Lefebvre: Okay. Good morning or good afternoon. My name is Michele Lefebvre. I'm Tribal Health Director as mentioned. I'm also the Project Director for our health center.

I'd like to just take a quick moment to thank the Bureau of Primary Healthcare for the opportunity to present on this Webinar.

Just a little bit of background on myself, I'm relatively new to Utah. I actually became the Tribal Health Director towards the end of 2011.

And then prior to that I worked as the Assistant Health Director for the Aleutian Pueblo of Islands Association in Alaska for about 20 years.

So actually I came down to Utah to defrost for a while and had been really enjoying serving the Paiute people. But I also really do miss Alaska as well.

Next slide please. So the tribe as mentioned a newly funded CAC in our first year of operation. We applied for a New Access Point in April 2013.

And we were elated to receive notification in September that we were funded. So that's just a couple of pictures of our community health center.

We are still in the process of getting our signage changed. And in fact our (Kashurum) community health centers our signage is going up today changing them from a clinic to community health center.

Our health centers are pretty small. They're about 1200 square feet with about two exam rooms originally built about six years ago with Indian community development block grant funds.

Next slide please. So the tribe has been funded by Indian Health Services since 1982 and currently operates under a Title I contract under public law 638.

However we have been exploring the possibilities of moving to a Title V self-governed compact, compacted tribe.

We also have - what are - we have community health centers located in Miller, Severe, Iron and Washington Counties.

Of the four health centers we have two are HRSA 330 CHCs and the other two are operated look-alikes.

So what happened was our tribal council recently decided to change the name of every - all of our clinics to health centers because it projects a wider range of services.

And we're trying to get the communities kind of used to the change and the name at this point, especially our tribal members we've also - always seen it as a clinic.

Our central office is located in Cedar City which is about 120 miles north of Las Vegas. And about 110 to 15 - 115 miles from (Arkanosh) and Richfield which Richfield is actually where the (Kashuram) Community Health Center is located which is north of our central office.

We have about 900 federal - federally enrolled tribal members who mostly reside off reservation. So really the closest Indian Health Services Hospital is either Fort Duchenne which is in Utah but it's 245 miles north of our (Kanash) and (Kashuram) community health centers.

And the other option is for them to go to the Phoenix Indian Medical Center but that is about 550 miles away.

Next slide please. So staffing-wise we have five PAs, three nurses, four CNAs, a nutritionist and three contracted physicians.

And our contractor physicians actually go to our health centers monthly to provide direct patient care. We have a contracted dentist, contracted psychologist. And we use our internal behavioral health counselors and substance abuse counselors for referrals.

And our service area includes the following Fillmore, Holden and (Kanash) which is part of Millar County, Richfield and Joseph which is part of Sevier County.

Our numbers show that our total service population is 13,469 with a target population being 4026 which is about 30% of our entire service area population.

The next bullet just talks about the number of homeless uninsured and individuals living in poverty. And our area really does have a high level of poverty.

And it doesn't seem according to what I've read that statistically that the economy is growing quickly so, you know, that still continues to be a problem which of course social economic status has an impact on individuals ability to access care which then can increase health disparities and undesirable health outcomes which is why health centers are so important to help knock down those barriers as we see everybody regardless of their ability to pay.

And that's at all of our health centers regardless of whether or not we receive HRSA funding for them.

So last of all is the last bullet just talks about the top three health issues that we have -- diabetes, cardiovascular disease and cancer which mainly are breast and colon.

I was really - it was really interesting to see that one of the barriers is limited access to fruits and vegetables because when I thought about Utah I thought of it as a really funny state and there's, you know, no problem growing anything.

And when I researched that further in our area I found out that the reason people don't grow their own fruits and vegetables is because of the insect infestation.

Specifically have something called Mormon crickets. I don't know why it's called Mormon crickets but it is. And so they mainly kind of demolish all the crops.

And in fact if you go to our health center in about April or May you'll drive down the road and it looks like the road is swaying because there's such a thick layer of crickets on them which, you know, can make driving a little bit challenging.

So that's all I really had for my presentation today. And I'd like to just turn it over right now to Maria Clark who's a project director for the Pueblo of Jemez Health Center. And I thank you for your time.

Maria Clark: Thank you Michele. This is Maria Clark and I'm the Director of Jemez Health and Human Services Department.

A little bit about myself. I've been with Indian health care for a little over 26 years, 24 of that with Indian health care.

Our Indian health service itself is in the Albuquerque area and a little over two years now with the Pueblo of Jemez.

So the picture you here see is the Pueblo of Jemez is one of 19 pueblos in New Mexico. And this is just a picture of New Mexico four going up through the corridor to some large canyons.

And we're about 50 to 55 miles north of Albuquerque, New Mexico. Next slide please. And here's some more pictures of surrounding area. We're surrounded by a lot of red rock.

Next slide please. And this is just the more of the beautiful scenery.

Next slide please. So the Pueblo of Jemez its history so far has been we've been under Title V for public law 93638 of the Indian Health Service or Indian Self-determination Act since 1992 with taking public health nursing first.

So the first program function of service and activities that they did take was public health nursing. And then they really started in 2000 to take nearly 100% of its tribal shares and the PFSA's from Indian Health Service.

In 2010 the Pueblo of Jemez completed its journey and became a self governance tribe under Title V of Public Law 93638 which allows greater independence and flexibility in the delivery of healthcare, i.e., we have greater flexibility in our programs, functions service and activities.

Under the ACA and the reauthorization of the Indian Healthcare Improvement Act the Pueblo of Jemez Tribal Council passed two tribal resolutions to expand its federal mission to serve non Indians.

Next slide please. So with this journey the Jemez Department of Health and Human Services department as I mentioned earlier is located about 50 to 55 miles northwest of Albuquerque, New Mexico.

It's governance includes the Office of the Governor. And those are three governors. We have the governor, a first lieutenant and a second lieutenant governor, tribal council and the health board.

JHHS employs approximately 140 people in 17 different programs. Right now we have currently 3-1/2 medical providers, one licensed medical health counselor, a contract nutritionist, an on-site x-ray and ultrasound.

We have two dentists, two hygienists and three dental assistants. And we have three pharmacists. We're waiting for the third pharmacist to come on in the next few weeks but we do have three pharmacists now and four pharmacy technicians.

For behavioral health we have one contract psychiatrist, four licensed therapists, a family support worker, some peer support specialists and an adolescent counselor.

Next slide please. So right now the Pueblo of Jemez there are 3073 enrolled Jemez tribal members of which 2126 live on the Pueblo or the reservation.

And 1092 live off the Jemez or Pueblo reservation and this is due to housing. There's not a lot of housing on the Pueblo right now so a lot of them are going into town Lake Rio Rancho and Albuquerque and find housing there.

In 2013 there were 31,300 ambulatory visits and 2801 patients served.

Our target population under the new, our New Access Point is low income population of a service area which includes 11,000 individuals of which 9700 individuals are unserved.

This population and the larger population of Sandoval County face significant barriers in primary health access and persistent health disparities that exceed national severe benchmarks.

Next slide, and that's my presentation right now and I'll just turn it over to Alan Pruhs.

Alan Pruhs: Great. Thank you Marie and thanks Michele for those great overviews of your organizations. I have a number of questions that I'd like to throw out to the two of you that I think will help the attendees understand some of the process that you went through.

And the first question I'll start with you Maria is can you give us an example of what steps you took to prepare as an organization in applying for the New Access Point funding or the 330 grant and then actually after that becoming compliant with the HRSA program requirements?

Maria Clark: Well it was rather - we didn't look at HRSA right away when we were going - when we were trying to get accredited by AAA HC.

AAA HC is the Accreditation Association for Ambulatory Care Health - for Ambulatory Healthcare and for which I'm a surveyor as well.

So when I came on with the Pueblo of Jemez they were just getting ready to become AAA HC accredited. They were waiting for the surveyors to come in May. So that happened within the month of being here.

And so much of the AAA HC requirements mirror or parallel with the HRSA requirements so that was our first major goal was to become accredited.

And then afterwards we're also certified as a patient medical home along that accreditation survey process. So we had a lot of positives on our side. And it was really almost an afterthought to become eligible for or to apply for the HRSA New Access Point grant.

So many things were in place and so it really made it quite easy.

Alan Pruhs: Michele?

Michele Lefebvre: Yes. So I - when it came out in 2011 coming from the Alaska Tribal Health system I was really surprised that there were no - there was only one tribal community CHC within Utah.

And spoke with the CEO, Donna Singer extensively to kind of think about that and got a lot of encouragement from her.

So what we started to do before we applied for the HRSA was to just start implementing some of the policies, you know, the infrastructure that I was familiar with within our clinics.

And a lot of it they were already seeing non-tribal as well and they had already implemented a sliding fee scale. And so this kind of all came together that way. It wasn't a big - it wasn't such a big jump for them.

It still is a lot of learning but then it wasn't like something that was totally new. We just talked about it for over a year by the time we had applied.

And then to become compliant with the program requirements it was just, you know, just to learn as we go along and to get feedback from others who are already within the HRSA system.

Alan Pruhs: So Michele you mention some interaction with one of the existing tribal grantees in Utah. And this question is for both Maria and Michele.

Did you have any other involvement with the existing health centers or the primary care associations from your state prior to taking 330 grant funds?

Woman: (Unintelligible).

Maria Clark: For the Pueblo of Jemez we did not initially engage with the New Mexico Primary Care Association. So we didn't have - really have - I'm not blaming them - too much help from them because we didn't engage them.

Michele Lefebvre: So for me and I'm not just saying this because you're online Alan but I definitely got a lot of help from the AUCH from Alan's office from it's just been great. I don't know what else to say, just encouragement along the way advice on how to do things.

Especially the forms that were required as part of the application, you know, the Form 9 and 4 for the needs assessment were just invaluable in at a time when you're trying to multitask and get the applications together. So I just can't say enough about how wonderful it's been to work with this - the UCH.

Alan Pruhs: And Maria I know that we've spoken and that you since becoming a grantee have been involved with your PCA in your state. And this again will go out to both of you.

But could you provide some, you know, a little bit of information about the type of resources and support that you've received either prior to or since becoming a 330 health center program grantee to talk about, a little bit about what the types of resources that you now receiving and what type of help they were in your transition?

Maria Clark: Okay. We had - we did hire a grant writer who was very familiar with the HRSA application process and the HRSA program requirements. So that was a very valuable service that we were able to connect with.

Our medical director did work in a former - well they weren't former but he was a medical director for a community health center in North Carolina.

So he had his network of individuals. And that's where we reached out and contracted with a grant writer and who really assisted and was incredibly valuable in our application process.

Now afterwards, you know, it was a surprise getting and being notified of the grant award. We didn't make the 2013 cut if you will and were surprised about the 2014.

And almost immediately upon our Notice of Grant Award the wealth of the resources and the emails and the conferences and the New Mexico Primary Care Association the outreach was incredible.

I was really impressed with the amount of people that just kind of circled you wanting to make sure that you are going to be successful in becoming a New Access Point grantee.

Michele Lefebvre: Yes I'm sorry - go ahead.

Alan Pruhs: No go ahead Michele.

Michele Lefebvre: Yes so for me it was having a great grant writing team. I was fortunate that in on my team was a person who had - was the first in Alaska to become a tribal CHC. So he was pretty knowledgeable about CHC operations and requirements.

Also of course a key factor I mentioned was the UCH. And then last is pretty much like my staff and my tribal leadership were very motivated and excited about the grant opportunity. And they were very willing to help wherever was needed with the grant application collecting letters of support and so forth.

Alan Pruhs: Great. I think and we're all in agreement that, you know, as a New Access Point grantee it's quite a transition at times even if you've been operating health services and providing health services. There are some changes but there's a lot of support from primary care associations, from the bureau itself, from our national association. And I believe that we've all been a number of those trainings together working side by side and so that's great.

So since you've become a health center what do you think has been most helpful in meeting and maintaining compliance with the program requirements?

For example, you know, your involvement with your project officer, trainings, communications received, conferences?

If you can we'll start with you Michele and give us an idea about specifics about was that helpful now that you're a grantee and maintaining compliance?

Michele Lefebvre: Sure. One of the key things was attending the new grantee orientation. I think I brought my governing board because they were - they really didn't know what they - what we would be involved in.

So having governance involved from the very beginning is very important. They need to be knowledgeable with their responsibilities because this is really overwhelming.

And once they have that understanding they can move - they'll move things forward and work with you I think more because they understand like reviewing and approving policies for instance.

So that would be one thing. And the other thing I have to say is I really have a great project officer who is very easy to work with -- supportive, understanding and understands the nuances of being duly funded. So that's been a big benefit as well.

And last I would say again, you know, having resources here locally like through Alan, having roundtable meetings that we can attend and that allows for networking with other community health centers.

Alan Pruhs: Maria?

Maria Clark: Exactly. I think our project officer is absolutely wonderful. I know some of the National Association for Community Health Center and their conferences and being able to attend the orientation our health board members are really excited and we're able to attend the orientation as well.

We're also were able to attend the Policy Conference in Washington DC. That was exciting.

But just the sessions are one in these conferences are so valuable and just an eye-opener for even just our health board members and for those that are not familiar with community health centers.

So I can't say enough about the bureau, about HRSA, about the National Association of Community Health Centers and New Mexico Private Care Association because they also hosted quite a few trainings which we were in attendance for free.

So everything's at our fingertips and that's what we really are pleasantly surprised with.

Alan Pruhs: Fantastic. So now both of you were existing tribal healthcare providers and with that I believe comes some advantages.

Maria would you speak to what you believe are or were the advantages of already being an existing healthcare provider in this transition?

Maria Clark: Well absolutely. And you had mentioned that tribal facilities or health facilities are well suited to become a HRSA CHC.

And the infrastructures alone, you know, that the tribes have some are gaming some are non-gaming. You know, they have an HR, you know, human resources department. They have an accounting department, a contracting grants department. Those are key elements. And even IT is real important.

And so with along with Indian Health Service, you know, and taking over the PSSA in the contracting or compacting process we adopted much of those infrastructures. So it was real important I think moving forward in our success in gaining the HRSA funding.

The - there's a lot of things that the tribes and Indian Health Service - while tribes mostly because Indian Health Service can't become HRSA. But the OMB rate for Medicaid and Medicare those are, you know, those are advantages that we still maintain as a tribal entity.

We also have 340B pricing. We were an FQHC look-alike. So we had a lot of things in place prior to that made it - the transition very easy.

I often wonder how truly New Access Point grants get started within the 120 days. But because we - we were in existence for 20 some years, you know, with Indian Health Service at - well even longer than 20 some years but, you know, as a compact tribe going on 15 years having that experience under our belt if you will and just made everything so much easier.

And of course the health board, you have to have governance. We had the health - we still have our health board. We had our health board in place and that's real important.

Alan Pruhs: Michele?

Michele Lefebvre: Yes. From my perspective as you mentioned in your presentation Alan we knew who our patients were and so we had developed a provide a patient relationship already.

We understood what the realistic goals would be to set for our service population. And as Maria just mentioned we had infrastructure in place to open our doors. Our clinics were already operating.

And then there are also resources available through Indian Health Services as well so those were some of my thoughts.

Alan Pruhs: So Michele just playing off of that question I'll ask the other side of that. Have you seen any disadvantages or challenges in that role?

Michele Lefebvre: Yes. For our tribal members it's - there has been a fear that now that they're seeing more nontribal come in what is that going to do to services for them? They're wondering if it's going to decrease their impact services for them.

And it's just a matter of communicating and letting them know that there will be no, you know, impact to them and if they do see it to make sure to let me know as a health director.

Also it's just a whole new lingo and language. So especially with governing, our governing board is to familiarize them with the whole different world of program requirements.

And then the other part of it is the challenge of educating our tribal community overall on the benefits of why CHC is important to help us over as a tribe, you know, to sustain our programs.

Alan Pruhs: Maria any disadvantages or challenges that you've experienced?

Maria Clark: I would say most of them really mirror what Michele just said, you know, is convincing the community that it's okay, you know, we're being progressive.

And both populations, you know, both the non-natives and the Native American population are apprehensive in seeing each other in a tribally operated facility, you know?

I imagined the non-natives are just as nervous as we are. And but it is historic for the Pueblo of Jemez as it was for Paiute I'm sure.

And ironic on many levels as you have that our tribal counselors made the decision to expand its federal mission.

They are progressive in that outlook - in that's their outlook. They wanted to expand the federal mission to provide health care services to non-Indians.

We not only provide health services to non-Indians but we also provide police, fire and ambulance services to our non-Indian neighbors.

And given the fact that we have a New Mexico history and a US history regarding Native Americans that is ironic and it is historic.

But I believe the Pueblo of Jemez is very proud and in its desired to be able to do this for its non-Indian neighbors.

Alan Pruhs: Maria can you speak a little bit to the challenges of serving both tribal beneficiaries and non-beneficiaries? So for example there are certain services that each of the programs require?

Can you talk a little bit more about working with both tribal members and nontribal members?

Maria Clark: I think the transition is very easy because we've been, you know, we provide the services to the individual patient like we would anyone else.

You know, as we have in the past we've served our Native American population and we provide that same high quality care to the non-native population.

I think where we struggled with is being able to collect money up front. We - that was kind of strange for us to be able to bill a non-Indian patient because we weren't used to collecting payments. You know, we're prohibited from billing and collecting any kind of money from an Indian patient.

So developing that discount fee schedule and understanding it was really a challenge for us but we got through it.

We were serving non-native employees as well so but that was a really small scale. And so it kind of helped us transition into addressing the larger non-native population.

But like I said, you know, we provide high quality care already so that was, you know, providing the care itself directly is easy but it's the more it's the concept that's sometimes hard to grasp.

Alan Pruhs: Michele anything to add?

Michele Lefebvre: Yes. I would say you know when I came aboard they were already serving nontribal so I didn't really see and maybe because I'm a new grantee I don't see it yet but I haven't really seen any big challenges.

I think one of the challenges is that because we are on a reservation that the public perceives a nontribal perceives that our services are for tribal members only.

We've been trying really hard to outreach and to let them know through health fairs that that's not the case. But somehow it keeps going back to that perception.

Alan Pruhs: Yes I can speak to a little bit of our experience in working with the Utah Navajo Health Systems who's been a health center grantee since 2000.

You know, I can tell you that originally and initially they were serving almost 100% of their, you know, Navajo population, their patient mix.

And since that time they've actually expanded into other areas across it -- a very, you know, rural area in Utah, southeast corner one of the most beautiful places in the world.

But currently now they are now serving, 25% of the patients are now as they refer to Anglo. And so we've watch them grow and expand in the community, embrace then.

They're also one of the largest employers in San Juan County in Utah. And so we've watched some tremendous benefits as the basic maturity has grown and I'm sure both of you will experience those.

We are almost out of time but I'd like to ask each of you one last question. And that would be what advice would you give or offer to other tribal entities American Indian, Alaska Native organizations hoping to become a 330 grantee, a health center program grantee? Michele why don't you take this one to start?

Michele Lefebvre: Sure. So if asked the feedback I would provide is although the application process is really difficult because it's a lot of forms and stuff that you're not familiar with its really important to look for other sources of funds because historically Indian Health Services has been not funded at 100%. It's funded at 55% of need.

A good example is sequestration that happened. And that was - that had a devastating impact on Indian country so I really would provide the feedback that tribes need to look for other sources of funds.

I attended this year's self-governance conference. And tribes continue to provide testimonials to Dr. Roubideaux and others about the shortage of funds across Indian country and how their health services are being impacted.

So it's really important to brainstorm ways to create revenue streams to help to secure and sustain our program.

Alan Pruhs: Maria?

Maria Clark: Exactly I agree entirely with Michele. As far as HRSA they do provide grant funding to entities, you know, that serve the uninsured and underinsured.

So the Native American population meets the definition so why not pursue these grant funds especially in light of the fact that IHS is chronically underfunded?

And HRSA funds are a valuable funding source to address the issues with access and the health disparities that we struggle with.

And again too with the government shutdown and sequestration that was really a hard slap in the face to some of the tribes who weren't able to provide the services or even Indian Health Service to provide the services that they - it's so desperate out there in Indian country.

So my advice to tribal entities, you know, interested in HRSA is you have a lot of things in place. It's not scary, it's just daunting in terms of the work that goes into the application process and getting all the - all your Is dotted, Ts crossed and everything together but it is well worth the effort.

Alan Pruhs: Great. And, you know, I would add to that -- and this may sound self-serving in a way as a primary care association -- but I would encourage any organization that's interested in

seeking or obtaining 330 grant dollars and awards to reach out to their primary care association.

And I say this with all sincerity it's been a pleasure actually working with the Paiute Indian tribe and with our nontribal brand-new community in seeking these funds.

So the primary care associations are well-suited to assist you. Oftentimes we don't know who's applying unless they reach out to us.

Again I would encourage everybody who's interested to reach out to your primary care association. They'll be able to provide you with a wealth of information and support as you seek these funds.

So I'd like to just thank Michele and Maria for those terrific overviews and for answering these questions with really good information for our listeners.

And at this point I'm going to turn over the presentation to Will Davis who is with the Office of Federal Assistance and Management.

Will is going to share technical assistance and helpful tips when applying for a grant. Will?

Will Davis:

Thank you Alan. My name is Will Davis and as Alan said I'm a Grants Management Specialist at the Department of Health and Human Services for the Office of Federal Assistance Management where we administer review, monitor all grant awards for our health center grantees.

Next slide please. Most important thing for you to do is to get registered when you're seeking to apply for HRSA funding.

There are three different systems that an organization must register with prior to applying for a grant.

If your organization does not have a DUNS number you will need to obtain one from Dun & Bradstreet. This can be completed online. After you complete all of the Web form information the DUNS number will be emailed to you.

Once you have received your organization's DUNS number you can register with the System for Award Management or SAM.

The applicant organization and any sub recipient of HRSA award funds is required to register annually with the federal government system for award management.

In order to do electronic business with the federal government there's no cost to register, SAM registration must be updated annually which can take up to five days.

While in SAM you will be asked to designate an e-business point of contact. We'll call this person the eBiz POC. Individuals designated to submit applications are called authorized organization representatives.

The eBiz POC approval of the people in these roles protects your organization by preventing fraud and insurance that only authorized individuals can submit on behalf of your organization.

Grants.gov is where all funding opportunity announcements are posted and where organizations download and submit their application packages.

To begin registration with grants.gov the authorized organization representative creates a username and password and completes their profile on grants.gov.

An AOR username and password serves as an electronic signature when submitting a grants.gov application. The eBiz point of contact must approve the authorized organization representatives to submit on behalf of the organization.

And I can't stress enough how important it is to make sure that you are registered in advance. There are deadlines associated and sometimes folks get caught in the unfortunate situation where they have registered and are trying to submit. But we want to make sure that you guys get your applications in on time.

There are also some tips that we have when applying for a grant. You want to register to get email notifications when opportunities are available at the Web site listed on the PowerPoint.

Read through and pay close attention to all of the instructions on the Funding Opportunity Announcement. Be sure to address each section of the FOA.

Beginning in fiscal year 2014 budget instructions require a slightly greater level of detail with regard to the use of federal funds for health center grantees.

Be detailed yet concise. Remember the reviewer may not be as familiar with your area and needs so be sure to explain your circumstance.

And most importantly become an expert on the grant program you want to apply for researching the program and the work that the current grantees do.

HRSA has developed also a Grant Technical Assistance Web page. This is a one-stop shop for potential applicants on how to apply for HRSA federal assistance.

Applicants will find valuable information on how to apply for HRSA grants including Web casts, videos and other technical assistance guidance and a wealth of other relevant and useful information and links tailored to HRSA's specific process and requirements.

For who to call Section 7 of the FOA list the grants management contact as well as the program contact. They are there as a resource for any questions that you may have concerning the application and the announcement.

To reach grants.gov you can use the number on your screen or the email. And HRSA's Electronic Handbooks or what we call EHB's helpdesk number is listed as well.

There is also an opportunity to become an objective reviewer. As you know these are individuals designated to review applications for HRSA funding.

This is a great way to get familiar with the application process and what HRSA looks for and expects from applicants. This type of knowledge and experience could strengthen your organization's future applications.

The HRSA Grant Reviewer's form is available as a downloadable document to the left of your screen in the section titled Presentation Materials.

And at this time I will turn the presentation back over to Ms. Tonya Bowers.

Tonya Bowers: Thank you Will and certainly to all of our other speakers for such great presentations today and for the really valuable discussion on your experiences in seeking and operating a health center under this program.

We know it's complex. We know that it can seem daunting at times when you see as you said and you heard earlier in the call. When you see what the application looks like but I really hope that you've also heard what great opportunities it can present to your communities in seeking this grant.

What we're showing you here is the contact information for the presenters on the call today as well as for our own internal the Bureau of Primary Healthcare's American Indian Alaska native workgroup who are really - were instrumental in bringing you this Webinar today.

And also as well the link to our Bureau of Primary Healthcare Technical Assistance Web site where there are a whole host of resources that you can take advantage of and a little bit

more in getting a better understanding of the health center program itself as well as resources to help you in terms of what's expected in submitting grant applications.

I just also I want to make sure that you understand that the contact information is provided you today in case you have questions that we're not able to answer today or you'd like to reach a specifically to these individuals with questions.

Certainly feel free to do that both with the presenters today as well as with our staff here in the Bureau of Primary Healthcare. We would be more than happy to assist you in your journey in seeking health center program grant.

Before I turn it over to (Jeffrey) our operator for today's call I want to make sure that I remind you that if we don't get a chance to answer all of your questions today that you can certainly send us an email at the website you see I mean at the email address you see there for our workgroup [bphcaian@hrsa.gov](mailto:bphcaian@hrsa.gov).

We really value all of your feedback about the call today. But if you have questions we want to make sure that we don't leave any question unanswered. We would be happy to do that and also point you to additional resources.

And finally I really would encourage all of you it's so helpful to us if you could fill out the evaluation questions that appear on your Adobe screen.

That kind of feedback is really important to us as we continue to make technical assistance resources available to you. So please do take that - take the time to fill out those questions.

So I think now we have some time to be able to answer your questions. And I know that we have a lot of people here from HRSA and the Bureau of Primary Health care as well as the Indian Health Service that are available to answer your questions and I want to thank them for their participation this afternoon.

And with that I will ask (Jeffrey) to please open the lines for the Q&A.

Coordinator: Thank you. At this time we will begin our question and answer session. You can ask a question in one of two ways.

First you can ask a question using the Q&A feature available to you online or to ask a question by phone press Star 1 and record your name when prompted.

To withdraw your question from the phone queue press Star 2. Once again to ask a question you can either ask it by using the Q&A feature available to you online or by phone, press Star 1 and record your name when prompted.

Would you have a question from the phone but if you'd like you can check to see if there are any questions online.

Tasha Akitobe: Let's take some of the questions online. We had a question come in and I think this was the most appropriate for Michele to answer regarding the population that her health center serves.

So the question is what population focus did you use when applying? Was it the homeless population or an alternate population Michele?

Michele Lefebvre: It was actually off of the UDS Mapper. So it was not homeless. It was just overall service population available in the communities that are listed on the PowerPoint.

Did I answer that right, the question?

Tasha Akitobe: Yes you did.

Michele Lefebvre: Okay.

Tasha Akitobe: Another question I think this is related to the recent announcement for our NAP opportunity. I think Joanne is in the room? Are you there in the room Joanne?

Joanne Galindo: I am. So this is Joanne Galindo. And I'm actually the Program Lead in the Office of Policy and Program Development for the New Access Point Funding Opportunity Announcement.

And just to get it out there since it wasn't on the slides but if you have specific questions about the New Access Point applications you can always send me an email.

We have a team of people feverishly answering emails questions that come in around the New Access Point application.

And that email address is bphcnap@hrsa.gov. And it's also on the front of the Funding Opportunity Announcement.

So I see the question was can...

Tasha Akitobe: The...

((Crosstalk))

Joanne Galindo: ...could you describe the documentation that must be submitted by August 20 and then by October 7?

So the New Access Point application is a two tier, a two-step process. First you must submit in grants.gov. And that is - there's not a lot that you have to submit in grants.gov.

That deadline is August 20. And on Pages 12, 13, 14 of the FOA it tells you what you need to submit in grants.gov.

It's basically just the SF424 which is the face page for the Application for Federal Assistance, the project abstract and a couple other forms the SF424B and your performance site locations and the grants.gov lobbying form.

So there's not a lot of information that you have to submit in grants.gov. Once you submit in grants.gov you will get a tracking number to access your application in the Electronic Hand Books. And that's where you submit everything else -- the project narrative, all your attachments, all the programs specific forms.

But first you have to make the grants.gov deadline. If you don't meet the grants.gov deadline you will not be able to submit your application in EHB.

So getting those that small amount of form submitted in grants.gov by August 20 is important.

Tasha Akitobe: And a related question maybe Will can answer this. If an agency is not registered with grants.gov is there sufficient time to register to meet the August 20 deadline?

Woman: There yes. It only takes a few days for you to get registered so I would go ahead and start that process now, but yes.

Joanne Galindo: Yes start it as soon as possible because every once in a while they - you do run into trouble and so that's why we say to do it as soon as possible but if everything goes well like Will said it just takes like a few days.

Tasha Akitobe: Another question online and maybe Alan at our health center participants can help answer this. Can you describe alternate data sources that would be considered reliable when extrapolating AI and data to support the need for assistance worksheet?

Joanne Galindo: You can see that information in the Data Resource Guide which is posted on our New Access Point Technical Assistance page.

Basically it's that is publicly available data and it meets those requirements that it's the same data parameters that we're looking for in the indicator.

So take a look at the Data Resource Guide and if you have additional questions around that you can send me an email and I will answer your specific questions.

Tasha Akitobe: And I think that's it so far for the questions online. Operator do we have any questions in queue over the phone?

Coordinator: Yes we do. Our first question comes from (Frederick Renlit). Your line is open and please check to make sure that your phone is un-muted.

(Frederick Renlit): Hello. Can you hear me?

Tonya Bowers: Yes we can.

Woman: Yes.

(Frederick Renlit): Okay. I have actually two or three questions. The first question that nobody has really addressed we're trying to make an assessment. And we're by the way we're a Title 5 Indian health tribally owned program with eight friendly recognize tribes that we serve.

We're trying to make the decision as to whether we should do that, pursue an FQHC or stay as a Title V tribe that has in MOA agreement with the state of California wherein we received a, you know, a high rate of reimbursement.

So I'm just for the people that have submitted before did they do that analysis to say is this really financially something that we want to do?

And I wonder if somebody could comment on that and how you did that analysis in what your findings were? That's the first question. I'll guess I'll wait on my second question after somebody addresses that.

Tasha Akitobe: Michele did you want to go first?

Michele Lefebvre: Yes actually we didn't even take that into account because we don't have that type of arrangement in our state. So for us it was a no-brainer.

We're a Title I so maybe Maria can speak better to that as a Title 6.

(Frederick Renlit): Do you have Medicaid in your state?

Michele Lefebvre: I'm sorry?

(Frederick Renlit): Do you have Medicaid in your state?

Michele Lefebvre: Yes we do so we actually are a Title I plus an FQHC. So we're both.

(Frederick Renlit): Your both okay so I'll let the other person...

Michele Lefebvre: Okay.

(Frederick Renlit): ...respond.

Maria Clark: This is Maria from Jemez. And we became an FQHC look-alike first so we were able to build a Part A, you know, Medicare Part A.

And then when we - and we're a look-alike because we weren't receiving HRSA funding. Once we received HRSA funding the look-alike dropped. Now we're an FQHC.

In terms of the Medicaid reimbursement and the state we don't necessarily have an agreement. It's already, you know, a federal law if you will, that IT - Indian health service and tribes are entitled to the OMB rate.

(Frederick Renlit): Right.

Maria Clark: So we maintain that status as an entity. And we did not need to make any changes with our New Mexico state Medicaid. We didn't need to redo everything, you know, when we became a HRSA site. We're a tribe first and a Title 5 entity first.

(Frederick Renlit): So we have been led to believe that you cannot be a FQHC and also get the MOA rate of reimbursement. So is that not true?

Maria Clark: That's not true.

(Frederick Renlit): So that's a...

Maria Clark: Yes FQHC, you know, that's a different rate anyway. That's not technically an OMB rate. That just allows you to bill Medicare Part A because you're not tied to a hospital. But as a tribal entity for Medicaid and Medicare we are still entitled to get reimbursed at OMB rate or MOA - that's an old terminology but yes MOA OMB rate.

(Frederick Renlit): Well that's something that respectfully you may want to communicate with the HHS area directors because we were told by in Region 9 that the state of California says you can be - you can only be one of the other. You can't bill for both.

So if that's something that we can bill for both that changes I think the direction that we're going to be heading.

The second question that I have is I'm aware of FQHCs that have had reviews where the federal government has come in where the reviewer is saying your physicians need to see more patients per hour whether it's, you know, four per hour or what have you.

So do you have those kind of requirements, the program? Because if you do in the state of California we have the Corporate Practice of Medicine Act that says no entity can tell a doctor how long he can see a patient for.

Maria Clark: Well there are some, you know, there's some standards but as far as length no, as long as you meet those standards. But we don't have anybody coming in saying that one we're a tribal entity.

So we do file our reports, you know, our Medicare cost reports as usual. We have an accounting department that - or not department but an accounting firm that we contract with to do that but as far as how long to see a patient, no.

(Frederick Renlit): Okay. And the last thing is you mention the different primary care associations in the state that can be helpful in this process. Do these primary care associations need to give their blessing on an application that we're submitting?

Alan Pruhs: No. This is Alan from the Utah Primary Care Association. It's not a requirement. I would just recommended it just as an additional resource for you.

(Frederick Renlit): Right.

Alan Pruhs: I can put you in touch with others but it is not a requirement for your grant application.

(Frederick Renlit): Right. So in regards to the Affordability Care Act now that essentially like everybody in California we have our own program is going to be having some form of insurance.

How does that affect the reimbursement that we would get as an FQHC from the federal government for those that we serve?

Alan Pruhs: Well nothing has actually changed as far as the rate of reimbursement for your Medicaid, you know, patient population your Medicaid or Medicare you're still receiving and respective payments as a health center and/or acknowledging the rate that you have right now is a tribal entity.

There are some concerns in each state. It's really different with the marketplace and how that might work with contracting.

And so in some cases their contracting with all FQHCs. In some cases they're just meeting their essential community provider ECP requirements in their contracting.

And the rates of contract I think I can speak from my state in Utah vary. But there is nothing in the state that the marketplace or the exchange products have to pay you a certain right. That's something you can negotiate.

There are some other very, you know, nuances of the bill that we can provide information on to you, a little bit more detail about how that's working in the marketplace in commercial insurance.

(Frederick Renlit): So prior to the Affordability Care Act would we had certain tribal members they came in with no insurance that may have been - I mean non-native they came to our clinics there was like a sliding fee scale. Does that kind of all go away now that everybody is going to have insurance?

Alan Pruhs: No. The sliding fee scale will still stay in place. We're in a state unfortunately that has not chosen to expand Medicaid. And we're still seeing, you know, upwards of close to 60% of our patients uninsured because of the gap being below 100% and not having a Medicaid option for jobless adults in our state.

And so the sliding fee scale services will still remain in place regardless of that insurance. And folks obviously will transition at times, you know, of being insured and not having insurance.

And then as a health center of course we provide services to individuals in our community regardless of residency status.

So anybody who is an undocumented citizen who seek services and is not able to gain insurance if they meet the eligibility requirements from a household income below 200% they'll still qualify for sliding fee scale services. So that's - that will remain in place.

(Frederick Renlit): So in the state of California for example where we do have cover California insurance we would bill the insurance first and then is there a wraparound that we then bill the FQHC rate to get the difference or how does that work?

Alan Pruhs: Yes it's really dependent on the state. And so...

(Frederick Renlit): Okay.

Alan Pruhs: ...that's one of the areas where I would recommend talking to your state primary care association because they'll be able to give you the details for the state itself.

(Frederick Renlit): Right. So again the last thing is if you can may be cite the person that we can talk to that can tell the state of California that we can bill for both because they are adamant in saying you got to make a decision go one way or the other. You can't do both. And I just need that from some authority that we can straighten their heads out a little bit?

Alan Pruhs: (Unintelligible).

Maria Clark: Yes counseling is a little different but I think the Indian Healthcare Improvement Act and you have the Indian Self-determination Act that among other things there's a lot of Indian law out there that will support your position as being a tribal entity. You're not subject to some of the things of the state is saying.

(Frederick Renlit): I know. So I guess I just need some name of a person. If you can send that to us that would be great.

Colleen Meiman: Hi. My name is Colleen Meiman. I'm with the HRSA Policy Office and I've actually - I'm happy to follow up with you after words because I'd actually like a little more information on the situation.

(Frederick Renlit): So Colleen what's your phone number?

Colleen Meiman: Three o one...

(Frederick Renlit): Yes.

Colleen Meiman: ...594...

(Frederick Renlit): Right.

Colleen Meiman: ...4486.

(Frederick Renlit): And your last name?

Colleen Meiman: Meiman, and M as in Mary E-I M as in Mary A N as in Nancy.

(Frederick Renlit): Right. Thanks so much for answering my questions and thanks for this. It was a good presentation. Appreciate it.

Coordinator: We do have an additional question for Mr. (Rick Vegal). Your line is open.

Mr. (Vegal) could you check to see if your phone is un-muted?

(Rick Vegal): Good afternoon.

Tasha Akitobe: Good...

(Rick Vegal): Hello?

Coordinator: You're loud and clear.

Woman: (Unintelligible) quick question.

(Rick Vegal): Well I would just like to say I appreciate having to participate. And I know Maria we've been working together and looking at that same type of infrastructure here in Pueblo.

And, you know, the information was rather valuable. And I know, you know, we've been working with the Indian Health Service also.

The city of Pueblo is located 10 miles north of Santa Fe. And I know today's information was something, a preliminary approach as a tribal leader to bring resources for our community.

And is there anyone that I can coordinate with or contact from the Indian Health Service with maybe in the Albuquerque area to again continue to explore this opportunity?

Maria Clark: (Rick) this is Maria.

(Rick Vegal): Yes?

Maria Clark: We can talk off-line about that. We can - and even talk with the Albuquerque area Indian Health Service leadership there too.

(Rick Vegal): Okay. Because eventually I know there's some timelines in place but for us I think we need to prepare ourselves...

Maria Clark: Right.

(Rick Vegal): ...before we move forward into the future because this would be an exciting opportunity because we also want to be self-reliant. You know, and right now we are pretty much under 638 programming for many of our health programs that we have.

And we're a very small community but again we want to be self-reliant.

So I appreciate the information and, you know, there's a lot of wonderful things that Indian people are doing in the Indian country to be self-reliant in the arena of healthcare. So I would like to say thank you.

Maria Clark: Thank you Governor.

Coordinator: And I show no further questions in the phone queue.

Tasha Akitobe: And it looks like we don't have any more questions in the Chat Box so with that I will hand it back on over to Tonya.

Tonya Bowers: Wonderful, thank you so much. And I want to thank all of our presenters and our guest speakers today for taking the time to share some really great advice and insights based on their experience.

As you can hear from them there's a lot of information, there's a lot of knowledge that you need as part of this program.

We really encourage everyone to take advantage of the opportunity we have with technical assistance.

I know that seeking a health center program grant can be a huge undertaking. We've heard that both from the speakers today and we've heard that from other organizations across the country.

But I also want to make sure that everyone understands that it can be exceptionally rewarding and a great opportunity for communities to really expand access to primary care services for all of the people that you serve and all of the communities that you serve.

And so I encourage you not to look at it as an uphill climb but really a journey for you and for your organization that you are undertaking this effort to help your community get the care that they need and deserve.

I also encourage all of you to take advantage of the resources that we've made available today to see all of the Web site and contact information.

All of our speakers as you've heard are very available to you to answer your questions following the call.

And I also very much want to encourage everyone to take advantage of the resources that we have available on our Web site as well as with all of the great staff here in HRSA that are available to answer your questions.

And finally please, please, please again I encourage you to take the time to complete that evaluation. It is - does provide us some really valuable feedback.

And I finally want to just thank again all of my colleagues here in the Bureau of Primary Health Care especially our American Indian Alaska Native American workgroup and of course our Office of National Assistance and Special Populations for their great work in putting together today's Webinar and for providing you with all this great information today.

And with that I thank you very much for your - for all of your participation today and have a wonderful day. Thank you.

Coordinator: Leader and speakers please stay on the line for your post conference. That concludes today's conference. All participants may now disconnect.

END