

Health Resources and Services Administration (HRSA)
Bureau of Primary Health Care (BPHC)
Cooperative Agreement Quarterly Call
September 4, 2014
1:30 PM – 2:30 PM ET

Coordinator: Welcome and thank you for standing by. I would like to remind all parties that your lines have been placed on listen-only until the question-and-answer portion of today's conference.

At that time if you're wishing to a question, please press star 1 on your touch-tone phone and please be sure your telephone is unmuted and clearly record your name at the prompt so that your question may be introduced.

Today's conference is being recorded. If you should have any objection, you may disconnect at this time. It is now my pleasure to introduce your first speaker today, Mr. Jim Macrae, Associate Administrator for the Bureau of Primary Health Care. Thank you sir, you may begin.

Jim Macrae: Thank you and good afternoon and good morning to those out on the West Coast. Thank you all for joining us. I was going to say in the summertime I guess it is still officially summer although I guess after Labor Day it sometimes feels like we're moving into the fall season.

I hope everybody had a great summer. I actually had the opportunity over the last several months to actually meet with many of you that are on the phone, had the opportunity to participate in the national migrants conference, the healthcare for the homeless conference.

Got to meet with all of the PCOs recently. Did not have the opportunity because I was taking my daughter to college to participate in the PCA meeting but did get the chance to meet with many of you at the National Association of Community Health Centers CHI in San Diego.

So I feel like I've been a little bit more on the road than I typically have been and to be honest it's been great to just hear all the wonderful things that are happening out there.

As well as to be honest, you know, some of the challenges that we all continue to face in terms of making sure that we're doing all that we can for the patients that we're trying to serve so just a big thank you for all that you've been doing.

As we've shared with a few people internally and externally, it's going to be a busy next couple of months in particular we have a number of different awards that we're going to be putting out there.

We also have of course the whole new enrollment season that's going to be beginning in November that we're all going to have to gear up for and then just, you know, continuing all the work that we're trying to do in terms of making the program the best that it can be.

In terms of just a couple of highlights and then I'm going to turn it over to some of the folks here to share some more specific highlights, we've had the opportunity recently because of a new secretary coming in to take a step back on what we've been able to accomplish in the Bureau of Primary Health Care.

In fact we've been asked to share really some of our highlights in terms of some of the work that we've been doing and we've had the opportunity to put that down on paper and actually tomorrow we're going to have the opportunity to share some of that directly with the secretary because she's actually coming to visit HRSA and meet with many of the staff here so we're very excited about that opportunity.

But when we've had the chance to share with her, it really is impressive what we've been able to do over the last five or so years in terms of our program and we basically we identified four key areas that we have really focused on in terms of trying to make the program the best that it can be.

And you all of course have been a huge part of that through the support and assistance that you provide and also just to be honest helping work with us as partners to make sure that all of this is successful.

So I just want to share a couple of those things and then a little bit about resources and money and some of the things coming and then we'll jump into more policy and special populations, updates and other activities that are going on here in the Bureau.

So in terms of those four areas, the first one is about increasing access to primary healthcare services for underserved populations. As you all are well aware, we've been doing a number of activities in this area, most specifically around supporting new access points. We've supported over 650 new access points in the last five years. Just think about that for a moment.

That's a lot and those things don't just happen in terms of either the applications or actually more importantly making sure that they actually function and operate. It takes a lot of work and we know many of you have been very involved in that whole activity so a big thanks in that area.

As a result of those investments and many others that we've made, we've actually increased the number of patients that are served at health centers by over 27% just in the last five years so we've increased by almost five million patients in those last five years.

And I think what's even more impressive is that we've actually been able to increase our capacity to provide not just primary care services but also oral health and behavioral health services for our patients. In fact when you look at the increase in the number of oral health patients, it's almost 45% increase since 2008 and for behavioral health it's almost a 60% increase.

Over a million more oral health patients and over a million more behavioral health patients have received services just in the last five years which is really impressive. Another big part we know about increasing access is to actually get people in the doors and so we've been making a huge concentrated effort around both outreach and enrollment.

And (Jen Joseph) from our policy shop will talk more about that and really gearing-up for the next round but we've been able to support and train almost 16,000 assisters out there and who have provided support to almost six million people.

That's really amazing and just for a point of comparison, there was a recent Kaiser study done that said that 26% of all of the assisters in the entire country are from health centers so you are a huge part of that impact that's been felt all across the country and as a result the expectations will be high going forward that you will be able to continue to do that work and do it as successfully if not more in terms of what's going on.

The next big area that we shared with the secretary and really have shared with you in terms of what we've been trying to do is to modernize our infrastructure so basically how do we modernize what we're doing with our health centers and I think the biggest representation of that has been all of our capital investments both through the Recovery Act and through the Affordable Care Act.

We've invested almost \$3 billion into the infrastructure all across the country. In fact we have either constructed or modernized more than 25% of all health center sites in the country. Just think about that for a moment. Twenty-five percent of the sites have been updated in the last four years.

It's remarkable, just really amazing and I think for me in particular to see the pictures, to see the stories, to hear about what the impact is both for your patients and for the providers is really remarkable and we know that doesn't happen just by accident.

It really does take a lot of efforts and we know a lot of primary care associations natural cooperative agreements have been really instrumental in terms of helping with all of that around our capital. In addition we've been making a huge push to make sure that all of our health centers can report their data electronically.

So a lot of our network investments have been really geared towards making sure that all health centers adopt EHRs and we're up to 96%. In fact 88% of all health center providers at all sites, 80% of our health centers have all of their providers and all of their sites hooked-up to an EHR and then of course money's important.

We estimate that almost 76% of all health centers have received meaningful-use payments and that again doesn't just happen. It really has taken some real dedication and work in particular from our networks but also from many of our other national and state and regional partners.

And then finally the last big piece about modernizing our infrastructure has been the whole effort around patient-centered medical home. As you know we went from about zero in 2010 to now we're I think over 55% of health centers have been recognized and that is making a difference.

We've done some quick analysis of those health centers that have gone through PCMH as compared to those that have not and while it's not a direct causation there is clearly some correlation between being PCMH recognized and your performance on clinical measures.

If you have PCMH you are four times more likely to have done weight screenings so basically you've screened people for BMI. You're 3-1/2 times more likely to have provided asthma medication to your patients.

You're four times more likely to have done cervical cancer screening or to have a higher rate of entry into prenatal care and you're three times more likely to have screened for tobacco or to have provided tobacco cessation counseling if you are PCMH recognized.

So it does show that at a minimum it has some impact in terms of either recognizing those that have already done it and are doing things clinically or it actually may help improve some of those actual outcome measures.

And I will share with you that those health centers that are at the bottom in terms of our clinical performance, I've had to look at it twice and I've looked at it for the past two years, none of them - not a single one - has gone through the PCMH process so they haven't even attempted it.

And to me that says something that PCMH while not the end-all be-all or even the end result that we all want to see clearly has some impact or some again correlation with clinical

performance and so I think all of our efforts and really this has been across the board have been impactful in terms of making a difference in terms of quality of care.

Speaking of quality of care, we continue to try to push in terms of those measures. We just put out the 2013 data. I won't go over all of that. We did that on our all-programs call just recently but I would just encourage you to continue to look at that data because it really is important in terms of what it is that we're trying to accomplish and again we really are doing very well in terms of many of these measures.

We actually are in many cases exceeding Healthy People 2020 goals or at least exceeding national averages but again there's always room for improvement. I think the most impressive thing that our staff have most recently assessed is looking at health disparities in terms of some of our measures and being able to see what the impact is of our program on those.

In fact in our most recent patient survey that we did, it was actually found that we had no disparities in terms of people having access to care or even their satisfaction with their care based on race or ethnicity.

Similarly we're able to do screenings that are basically equitable across the board. We're still struggling a little bit in terms of some of the health outcomes but in terms of making sure that people have access and making sure that people get the services that they need, we have been able to eliminate health disparities for our patients which is remarkable and really a huge accomplishment.

We still have to figure out how to do a better job in terms of actual health outcomes but we've made a big difference and then finally the last piece for us which is something that we've done internally but we're going to work to do more with you externally is really to work on promoting a more performance-driven and innovative organizational culture.

We had the opportunity several months ago to do a time-out basically we called a BPHC 2.0 and we introduced the concept of PDSA as well as rapid cycle quality improvement in terms of trying to really test the different models of doing our work here internally.

The idea is that, you know, we've gotten to a point where we've gotten so big that sometimes we've gotten stuck with how we do things and really what we wanted to do was open up our organization and to be honest in some cases free our staff to try things differently to see if we could improve how we do the work here.

And do it in ways that we didn't have to move the entire I call it aircraft carrier sometimes that is this program but that we could actually pockets of pilots to try to improve what it is that we're doing.

And so we've done a couple of different things recently. We did some pilots with site visit reports and we've actually been able to improve I think both the quality as well as the timeliness of some of those reports.

We've reduced the amount of time that it's taken to do those reports by I think it's almost half in terms of what we've been able to do. We also as you know recently in the last year did something around the budget period progress report where we reduced the amount of information that we required from you all by almost 75% in terms of what we're trying to do.

But we're looking at a number of different areas and so we're going to be testing-out some different pilots about how to do our work going forward. We've definitely heard feedback that we could improve upon some of our processes internally. Changing scope is definitely something we've heard about and so we're trying a couple of different pilots there.

We've heard different things about getting information out so the idea that we're playing around with is the idea of creating some frequently-asked questions, not just for our funding opportunities but also for just in general work that we do and then the big thing that we're actually going to take a look at is even the whole role of the project officer.

Could we do some pilots in terms of different ways to approach the project officer role? You know, I think we're sometimes asking ourselves is it realistic to have one person be able to know everything for all grantees and is that realistic or should we like we're asking in some cases health centers to do, look at more of a team-based approach.

You know, is a patient-centered medical home approach around the PO role actually something that we may want to explore? Could we actually explore even centralizing where information and inquiries come in to achieve, you know, greater consistency, greater quality of timeliness of responses and things like that.

So the bottom line is we're in a testing phase right now and so we're going to be doing a lot of different things both internally and may have some impact on you externally and we just wanted to give you the heads-up that we're going to do that.

Because we think that really is important for us to be able to move forward but that means we may not necessarily do everything exactly the same either because we're going to test in pilot before we do it so we will definitely give you warnings when we're doing that.

But I would say just stay tuned for us to try things differently here in the Bureau because to be honest just looking at what the future is, we can't sustain the way we're doing things now. It's just not going to happen.

I mean, if anything close to what the Senate just approved in terms of the program happens, there's no way that we can sustain what it is that we're doing and be as successful if we keep doing things the way we're currently doing it.

So we would just ask you to partner with us around all of that moving forward so that leads to my last piece which is around funding so we've made a lot of awards, we've made a lot of awards. Just last week we awarded about \$35 million for 147 patient-centered medical home capital awards.

I believe the week or a couple of weeks before that we had done \$55 million for behavioral health. We have a long list of approved unfundeds on those which is great and so should money become available in the future that would be something we would definitely look at. I know a lot of people have asked that question.

We also put out money for base awards which was very exciting and included in that we recognized people that actually had gone through patient-centered medical home. If you received a base award and you were PCMH recognized, you received \$25,000 and then \$5000 for every site that was recognized.

And then finally the two last but not least for this year, we are going to be announcing about \$300 million for expanded service. It will be out soon shortly. No, it will not be on this call or this week but hopefully soon or shortly.

And then finally we are doing another sort of pilot out there around providing services to people that have HIV or AIDS and in particular what we're looking at is trying to increase the capacity of non-Ryan White health centers to provide HIV services in a health center setting basically recognizing that the disease has become much more of a chronic disease.

And while we will never become necessarily experts across the board in all of our programs around HIV and AIDS care, there are some things in a primary care setting that we can absolutely do and should be doing more of than what we're currently doing.

So we're going to be testing some pilots out there in I think it's in four states - Maryland, Florida, New York and Massachusetts - and we hope to get those awards out by the end of the year.

With respect to 2015, we like you are waiting to see what happens in terms of what the money will look like. There are a couple of different scenarios out there. With respect to the President's budget, the bulk of the money would go towards capital activities and so we are working on a variety of different capital guidances related to that.

But as I mentioned the Senate also has a different version which is much more focused on services. In fact they allocate - I'll just say this once again - \$1 billion for new access points and expanded service.

That's a lot of money no matter how you slice it and then they have another \$210 million for capital or quality improvement activities, basically one-time activities and then \$140 million

for base adjustments so we of course are planning for all different types of scenarios in terms of all of that but please stay tuned.

We will get more information on all of that as things become clearer here so with that I will stop and turn it over to (Jen) to give you a little bit more on the outreach enrollment and then I think we'll open it up for some questions and then we'll go to the rest of our agenda. (Jen)?

(Jen Joseph): Sure. Good afternoon and good morning, everyone. I'm pleased to be with you. For those of you I say both to meet in person, it's so exciting for me to have the opportunity to talk to you in these rooms but also to be able to connect faces with names.

So it's an exciting time to be in the Bureau of Primary Health Care and specifically around the issue of outreach and enrollment, I wanted to just talk for a minute about reflecting back a little bit about what we've accomplished and we've talked about these numbers of 16,000 folks trained to do assistance, six million people assisted.

But all of that was accomplished in a pretty challenging environment, you know, when I reflect back to a little over a year ago when we were trying to figure out this was all going to work, we did some disaster scenarios in our team to sort of think through what were some of the worst-case things that could happen.

And a few of those actually came to fruition so despite the bumpy ride I think it's been amazing what health centers have been able to do and the assistance you've provided them in those accomplishments. It's been really essential and also the assistance you've provided to us.

So with all of those accomplishments, there is a bright light shining on health centers that's a really positive thing because they really are shining and our leaders in their ability to get this work done and the list that they did for the country basically but that also means that there are high expectations going into this new open enrollment period.

And I think we're getting to the place and thank you for any assistance you've provided in this and helping to bring clarity to everyone that our recent enrollment funds that were

initially provided in Fiscal Year 2013 have been rolled into health center-based awards and likewise PCAs are continuing to be supported to help health centers with their outreach and enrollment work.

With that support, continued support comes those continued expectations so from our perspective we're really looking for health centers to be engaged at a similar level of effort as they were with their initial funding and the rest of the world is looking to health centers I think in a different way than they were before because of their past successes.

And so we've talked about this being an ongoing through-the-year effort I'm a runner and I've begun to think of this as sort of the Medicaid marathon and the marketplace 10K so we got to keep doing the Medicaid work and really be ramping-up to be able to get through the open enrollment period that's beginning in November 15th.

And you know, that next open enrollment period will hopefully have fewer of the same challenges as last year but certainly will bring its own new challenges so it will be a shorter period of time. There will be a reenrollment list in terms of helping people - the actual process for reenrollment - is quite simple for both people's situations.

The people who are probably going to be in the most challenging situations for reenrollment are going to be health center patients who have enrolled through these marketplace plans and I anticipate that health centers will have a pretty heavy lift in helping people to understand the communications that are being sent to them and what to do with those communications.

And it's something that they know how to do but it will be added to the mix of all the rest of the activity that will be involved in getting people who are interested in new enrollment assistance that they need, in particular that's the explanation about how to keep people enrolled is potentially a challenging one particularly for health center patients who might not have access to specialty care or hospitalization or other things that being newly-insured would provide them access to.

And then have just continued to be health center patients and their experience in terms of the care that they receive hasn't significantly changed and so why should I continue paying this premium?

So we know the health centers have been educating consumers about how to use their new insurance and this is just going to add another layer of communicating why you need to continue your insurance and as I'm sure you all know, there is also a requirement that all assisters be recertified and those in federal-facilitated marketplaces all have to complete new training.

So there are a lot of things to get in line in order to be prepared for November 15th so we are at the ready and are excited to be working with health centers to support them and are really going to lean on you again this year to do what you can to support them as well.

I think as we look back at all of the different lessons learned and best practices, really what comes to the surface when I think about it is the thing that made things work were really partnerships. It was the health center partnership with PCAs, with NCAs, with others in their communities, our partnership with CMS and our partnership with you.

And so we're really looking at this next open enrollment period and our preparation for it in that same vein and are going to be relying on you for really if I could categorize them into two things, it's really to make sure that you're paying attention to the information that we're pushing out.

So making sure that you're reading the updates that we're putting in the digest, participating on Webinars which we will be having monthly this year starting on September 10th where we will provide federal updates, do a portion of that Webinar that will speak to best practices or tools and resources that health centers can use to improve their (urgent) enrollment efforts.

And then provide us an opportunity for questions and answers and depending on what's going on in the world and what we hear from you, we will bring other partners - CMS or others - into those conversations and they have been available for questions and answers or updates as well.

And then the other piece of this is that we're really leaning on you four as to share those messages or reinforce those messages with health centers to be paying attention to those things and then also to be helping us to know what's going on as we sit in windowless rooms and think about what we need to be doing to better support these efforts.

Please don't assume that we know what's going on and please do share what you know with us because it's really it's so important for us not only to understand what the challenges are but also to hear the stories of success, those anecdotes as you know from all the work that you do, you know, the stories can - is worth a thousand words - the anecdotes are really helpful to us.

And then just generally how we can just be doing a better job with whatever we're doing, if we're sending out confusing messages or you're sensing there's confusion and we need to speak to that, we really would like to hear from you and then I guess the last piece on outreach and enrollment that I know some health centers are curious about is the quarterly progress report.

So those are continuing at least into the near future. We're going to reset at zero in October and on our call on September 10th we'll provide everybody with a mock-up of what the reporting form will look like that folks will use after the 1st Quarter so for the data that ends December 31st so that everybody will be clear about what they're supposed to document and collect for that 1st Quarter reporting.

We're not significantly changing what we're asking for. We're just trying to clarify and based on feedback we've gotten, what needs to go in which boxes and (lie in) what to count and not so that's a quick update on outreach and enrollment and I guess Jim has covered most of the other things that I was planning to speak to.

I guess I would also just quickly touch on the sliding fee 10, coming soon, coming soon, imminently soon. The program requirements manual, work is underway. Folks are really digging-in and trying to tease-out as clearly as possible what the musts are and where there

are flexibilities so that we all can be clearer about what our expectations are and where there's room to move.

And we have plans in place to translate that into site visits and other ways that we're affecting compliance so that we're all on the same page and as I'm sure you've heard before that will go out for public comments and we'll be able to get your feedback on that.

And then just a plug for any part that you've played in encouraging health centers with (scope align) the validations. We had a fantastic response to that and folks are also working hard through all of the issues that were identified that we needed to resolve in order to get that picture clean and clear.

Jim Macrae: All right, thanks (Jen). At this point why don't we operator open it up for questions and then we'll turn it over to (Jacqueline) to give us an update us an update on national assistance in special populations and then we'll do a quick quality and data update too but since we've gone through a lot of material, a lot of density why don't we open it up for questions?

Coordinator: Thank you, sir. At this time anyone wishing to ask a question or make a comment, please press star 1 on your touch-tone phone. Please be sure your telephone is unmuted and clearly record your name at the prompt so that your question may be introduced.

Once again anyone wishing to ask a question or make a comment, please press star 1 at this time. One moment, please, for the first question and once again if we have anyone wishing to ask a question or make a comment, it is star 1 and I'm showing no questions at this time.

Jim Macrae: All right, well we'll let people keep thinking about what their questions might be. I'm sure you guys have some questions. You can't be just so overwhelmed with all of this stuff although I'm sure you probably are but with that why don't we turn it over to (Jacqueline) to give us an update on national assistance in special populations?

(Jacqueline): Okay, good afternoon. We funded 16 national training and technical assistance cooperative agreements and I would like to welcome my three newly-funded NCAs, the Association for Clinicians for the Underserved. Craig Kennedy is our Executive Director.

The Corporation for Supportive Housing, Sandy Jamet is the Principal Investigator and our National Center for Medical and Legal Partnership at Georgetown and Ellen Lawton is the Principal Investigator.

Our NCAs and PCAs have developed an overarching and unified strategy for providing training and technical assistance across both the NCAs and the PCAs and our work in closely with the special populations points of contact.

We have identified a number of broad-level TA activities that are consistent with our short-term as well as our long-term needs of health centers serving special and vulnerable populations. The NCAs and the PCAs have identified a number of collaborative projects that they will be working on again this year.

The NCAs have also developed new and innovative models for a TA that will achieve maximum impact and effectiveness and the NCAs are also looking at how to integrate behavioral health and other special initiatives such as the Million Hearts initiative, the National HIV/AIDS Strategy and cultural competency to improve health outcomes.

We've also developed two new learning teams, one for the NCAs and then one for the small rural health center CEOs and these learning teams will provide a form for peer-to-peer exchange that's evidence-based practices as well as promising and emerging practices and also facilitate a more coordinated approach for TA services and we're planning to have face-to-face meetings this year with our NCAs.

And the next thing that we're working on is really trying to increase the visibility of our TA resources and spotlight innovative and best practices at health centers and through that we're looking at grantee enrichment Webinar series. We've already started our special populations enrichment series and our next ones are scheduled for school days health centers in October.

And then in November our healthcare for the homeless program will conduct their Webinar. We're looking at spotlighting the grantees as well as some of the best practices used by our

NCAAs and PCAs and we're also encouraging our NCAAs and PCAs to update the technical assistance calendar.

And we also have ongoing coordination and collaboration within the offices and divisions in BPHC and the last update is our national advisory council on migrant health committee will be held in October in Pittsburgh, Pennsylvania and more information will be coming forward. Thank you. Any questions?

Jim Macrae: Why don't I do the quality update? I think I've got the short straw and somehow got the quality and data piece so I'll do that brief update. I shared a lot of the data and then we'll open it up for questions on anything else that people want to talk about but just a couple of quick highlights from quality and data in terms of activities that are going to be forthcoming.

Besides the release of the data which was great, the folks in quality and data are working on the 2015 patient survey so they are planning to conduct that survey within the next several months and this is really an opportunity to get a cross-sectional view of the patient experience at health centers across the country.

And in particular this year we are going to be oversampling migrancies and farm workers as well as homeless patients to make sure that we get that further perspective in terms of the work and the impact of the care that we provide on those specific populations so we're very excited about that.

Another big activity that we're going to be undertaking in the next year or so and probably in the next several months it will start to kick-off is a whole relook at the uniform data system.

The UDS I think has been absolutely instrumental in terms of the success of the program, I would say both nationally in terms of being able to present the impacts but I hope also for you all individually.

But we also know it hasn't been updated in a while and so we're taking this time to look at are there different elements that maybe we aren't collecting that we should be collecting?

Are there different pieces that maybe we could collect it a little bit differently and basically we're going to get a group of folks together, folks from NCAs, PCAs, networks to basically as well as health centers and outside researchers and others to look at, you know, what is it that we're collecting?

What else could we be collecting? How do we balance that with the potential for reporting burden on health centers and others in terms of what it is we're asking but basically take a look at are we collecting the right things? Should we be still collecting the same things or are there any new or things that we should stop collecting in terms of our data?

So to me that's going to be a very exciting opportunity to really look at it. I think in particular a lot of the emphasis behind this is really to be able to better assess the impact of the ACA both on our patients as well as on our organizations out there, the health centers and having some data to be able to do that but maybe not as much as we currently want.

In addition the Office of Quality and Data is going to do this with the UDS to get data to be able to better assess the impact of the health centers on access, quality and cost because that's always the questions that we get asked and they have been doing a number of different studies with both our UDS data as well as some datasets from CMS to really look at what health centers are able to bring to the table.

And right now they're having several publications that are going through peer review to look at the impact of health centers on overall cost of care which just as a preview is very favorable in terms of what it is that they're able to do but really teases it out between the cost of primary care as compared to other settings, the cost of specialty care as well as the cost of hospitalization.

In addition they look at some of the services that we provide and their impact both on health outcomes as well as on costs and other variables so they have been working I think very diligently to build-up our capacity to be able to do further program evaluations and really better assess the impact of the program which is the name of the game that we're in right now.

And if that wasn't already well-known, our secretary who has come in is very much focused on performance metrics, being able to document what the impact is not just on programs but ultimately on the people, the ultimate end users of all of our programs to make sure that we can share at the end of the day that we've made an impact so that's definitely something that we're going to be doing more of.

The last item I just wanted to mention because it came out in the digest yesterday and I just wanted to make sure everybody saw it, we did share that we are making some internal changes in terms of some of how we approach different aspects of our work related to patient service levels as well as financial recovery plans.

Basically with respect to financial recovery plans, we are going to be moving out of the business of specifically requiring or monitoring financial recovery plans. This is really an outgrowth of what happened with respect to the total budget (10) where we got a lot of feedback about what our role was and was not in terms of what responsibilities we have versus what other real responsibilities of the health center.

And basically we came to the conclusion that our responsibilities are to make sure that health centers have the right financial systems in place that they are following standard accounting procedures, basically all of the financial management and systems pieces that they need to have as well as having an annual audit.

But the actual financial health of the organization is ultimately the responsibility of the board and the center itself and it's better for the centers to be able to make those decisions about what they need to do when they potentially run into financial difficulties.

It's not appropriate for us to be telling health centers to reduce their staff or to reduce this site or eliminate that service. It really is up to the board based on their own circumstances about what they can and can't do. Now that doesn't mean that we don't care about the ultimate financial impact and the health of these organizations.

In fact we're going to lean more heavily on our national cooperative agreement partners as well as our PCAs to help provide assistance but we really feel the responsibility lies with the organization and it's better there than with us in terms of what actually happens.

And ultimately, you know, if we get into situations where we run into difficulties, we're ultimately going to have to make decisions about whether we continue to invest in organizations that aren't ultimately financially stable or viable in terms of what we ultimately do with our resources.

But I think what it does is it basically clarifies that yes, we are still going to stay very focused on having the systems, the accounting procedures in place and doing those annual audits but the real financial viability and responsibility lies with the board and the organization.

And we're here to provide assistance and support but we're not here to make those decisions for the organizations themselves. Similarly with respect to patient levels, we have as you know awarded a lot of resources in the last several years and there is a lot of scrutiny with respect to what organizations are doing with those resources.

We've had the GAO, the IG, many different people ask questions about what health centers are doing and one of the key areas that we have leaned on and are going to continue to lean on is being able to demonstrate that health centers have been able to serve more patients whether that's overall or in a particular area like behavioral health or oral health or other areas.

And so you saw that in our BPR that we asked for your feedback on how you were doing with respect to your performance not just on clinical measures but also with respect to your patients.

And we believe that continues to be a critical focus for us but we had taken a step to make it more of a compliance issue that if you weren't hitting certain targets, you could ultimately be disapproved or defunded as a result of not meeting certain targets.

And we felt like that was not appropriate in terms of sort of taking that dramatic step but what we did feel was appropriate was potentially to relook at funding levels based on ultimately your ability to reach certain patient targets or outcomes or measures of number of patients that you served.

And so hopefully most of you saw it in the 2015 service area competition. We basically gave people the opportunity to actually say that they weren't going to be able to serve the number that originally was projected but there would be a proportionate reduction in terms of the amount of funding that we provide.

And we also stated that in the out years if people didn't meet targets we would potentially adjust target funding levels to more accurately reflect what it is that people were actually able to accomplish.

And we felt like that was much more appropriate than sort of taking the more Draconian we're not going to fund you anymore but really to better adjust your funding levels based on your experience in terms of serving patients and we think it's in alignment with where we want to go.

It's definitely in alignment with what a lot of people are asking us to look at in terms of assessing the impact of all these investments and we just felt like again it was a more appropriate role for us to play more in terms of making our funding decisions as opposed to compliance and ultimately disapprovals or things like that.

So please, if you haven't had a chance look at the digest it's also just a general plug for the digest in general. There is a lot of information in there. There is a lot of information in the digest. There is a lot of information in the digest.

Please look at the digest. It is really important and we really try to pack a lot in to that weekly and it's only weekly so it's only once a week you have to look at it but there's a lot in there and this week in particular was a barnburner in terms of a lot of information.

So that's my plug, my commercial interruption for the digest so with that we will open it up and see if there are any questions on any of the topics that any of us have talked about or any other things that you all want to talk about, we're open and available for questions operator.

Coordinator: Thank you and once again if we have anyone wishing to ask a question or make a comment, please press star 1 on your touch-tone phone. Again it is star 1 to ask a question. One moment, sir. And again it is star 1 if you wish to ask a question. One moment, please, and sir our first question comes from Ms. (Woodard).

(Lathran Woodard): Okay, hello guys, this is (Lathran). I have -- if I can -- maybe two, maybe three -- just kind of throw out there.

Jim Macrae: Sure.

(Lathran Woodard): One is the UDS workgroup that was talked about. In terms of the timeframe for that, talk a little more about that and I know you get a wide number of kind of entities you want to participate on it but how do you plan to select the workgroup and if there's an interest, how can we get our input in?

Jim Macrae: Sure.

(Lathran Woodard): And you want me to just list all the questions first?

Jim Macrae: Well, let me take that one first. It's a great question so they're just in the process, they've awarded a contract that I don't remember the organization that received it. I believe it was Mathematica but I can't guarantee that that's going to help with the overall assessment and looking at all of this and helping to bring together different experts.

With respect to the PCAs the PCA steering committee has already been informed that we are going to be looking for volunteers so if you want to go to the PCA steering committee but for anybody or even PCAs if you want to come directly to Suma Nair, you can send an e-mail into Suma expressing your interest and we'll see how many folks we can actually take.

We want it to be a representative group but we can't have it be so big that we can't get things done but we definitely are looking for, you know, folks that bring different perspectives to the table because we think that's really important so I think it will kick-off in the next couple of months (Lathran) in terms of I think they were looking at the fall like in October or November for the first set of meetings.

(Lathran Woodard): Okay, and I'm sure we can give our comments just kind of throw this out. We just ran into a major issue with any state who has that family planning waiver on a Medicaid and have these patients that when they come to us for family planning, we've shown them as Medicaid recipients but if they're getting services outside of that package of family planning, they're really uninsured.

Jim Macrae: Yes.

(Lathran Woodard): We were having problems with oh my God, our state is referring all these people to the FQHCs and how are we going to be listing them as uninsured versus, you know, you will get a false figure of what uninsured is so I will Suma sounds like the contact person for the Bureau so I would deal with Suma on some of those in case I'm not selected.

Jim Macrae: Yes, absolutely, and you can definitely provide it through their different representatives too because that's going to be part of the expectation.

(Lathran Woodard): Okay, the pilots that we talked about for HIV and AIDS for non-Ryan White entities, what (length) is that pilot and what are you really trying to get from that? I think it's great because I think that we have a lot of centers who aren't getting Ryan White dollars but are seeing HIV/AIDS patients but kind of what timeline and what is the outcome of the pilot that you - the next steps - if you will?

Jim Macrae: So basically it's a three-year demonstration project and it's targeting states that were not part of the CAPUS program that was an earlier initiative from the CDC and HRSA as well as the Department.

This is sort of the next phase in that and really what sort of encouraged this to occur was the recognition that there are a lot of people out there that are either unaware of their HIV status or have HIV that are not able to access care.

And the Ryan White programs are in a lot of places in the country but they're not everywhere and the pilot is to really see what can non-Ryan White providers do in terms of doing everything from testing to care and treatment, in terms of providing services.

And the expectation is not that the health centers will become Ryan White programs or that they will become HIV specialty care clinics but it's what can be done in a primary care setting for these patients and then how do you develop appropriate referral arrangements with other specialty care providers or Ryan White programs to make sure that when the case gets too complicated or there's issues with the medications that you can provide adequate support for the patients and make sure that they get referred to the right place.

So this is really an attempt to see if we can do this. I think the other part of it honestly is to see how much it will cost in terms of both staff resources and time as well as just monetarily in terms of the impact so we're really excited about this because this is something that we've been encouraging all health centers to get more involved in.

But this is really an opportunity to sort of dig in deeply, figure out what can happen and we have resources that are not just from HRSA but also includes state health departments through the CDC as well as even through the office of the secretary and the national HIV office at the White House.

So there's real interest in this and I think the idea is how can we do more in maybe non-traditional places of providing that care and can we actually do it in ways that make sense? The challenge of course is you don't want to at least I don't want to create any kind of false competition between health centers and Ryan White programs.

That's not the intent. It's really there's more than enough need. How do we do this in the best and most smart way and hopefully this pilot will help us do some of that.

(Lathran Woodard): And I hope it's also going to be looking at just what the reality is, how many patients we already seen that have not been diagnosed?

Jim Macrae: Well, that's a big part of it is around the whole testing piece. In fact there was some health center that was in the paper just a couple of months ago and they started to do the full-blown CDC guidelines and they were to be honest somewhat surprised by the level of HIV-positive patients that then came out from doing this more intensive effort around testing.

And we anticipate that that will be part of what comes out too in terms of the program and then how do you as an organization approach that or address that because, you know, if you screen or if you test and then they are found to be positive, you've got to figure out a way to provide care and treatment for them and how do you do that in a primary care setting?

(Lathran Woodard): Exactly, okay, my last one shortly cannot be the answer, soon cannot be the answer. I would like to have a month at least a year the sliding fee (pen).

Jim Macrae: We think it will be either September or October.

(Lathran Woodard): Oh, that is great Jim. First time I've gotten that answer.

Jim Macrae: Yes.

(Lathran Woodard): Okay, those are my questions. Thank you.

Jim Macrae: You're welcome.

Coordinator: Our next question comes from (Lori Anne Russo). Your line is open.

(Lori Anne Russo): Hi, thank you, my question was answered.

Coordinator: Thank you. Our next question comes from (John McDonald).

(John McDonald): Hi. (Lathran), thanks for asking your questions because they were a couple of mine but I do Jim have a question on the patient-centered medical home.

Jim Macrae: Yes.

(John McDonald): Really appreciate the \$35 million that was funded for that and the 147 sites that were funded but we had several sites in Arizona that we're hoping to get funded and I've been to ask what is the probability that this cycle of funding will happen again and what's the impact on the application they've already submitted?

Jim Macrae: So the applications that folks submitted if they scored in the approval range will be good for up to a year. It really depends on whether we have additional resources to be able to fund any more organizations.

Right now we basically are down to almost zero in terms of our capital dollars because we've done I think a great job in terms of getting those resources out but part of the reason why we even had the \$35 million is that many health centers were able to come in under budget and complete their project.

So we still have some projects that are out there and we anticipate that there may be some more resources that come back in. We're not sure how much will come back in but should they come back in within the next year, we could potentially go down the list. That's one option.

Or if something close to the President's budget or even what happened in the Senate occurs, that's another option for us in terms of having resources to be able to go down that list but it really honestly (John) depends on whether we have money available or not but the applications themselves are good for up to a year.

Their are summary statements should be coming out soon, shortly, probably within the next 20 days or so that they'll receive their summary statements with their scores as well as their strengths and weaknesses.

(John McDonald): All right, thanks Jim.

Jim Macrae: Yes.

Coordinator: Thank you and our next question comes from (Stephanie Harrison).

(Stephanie Harrison): Hi Jim, this is (Stephanie). I had a question about the patient levels as it relates to the (nap app) opportunity. By my read on this it's going to be more critical for the new opportunities especially the (nap) opportunities for the health centers to be really specific about the patient targets they're planning to hit.

At the same time I know that they're really wanting to make it as compelling as they possibly can so I was wondering I know in the past for (nap) grants, I mean, guessing this is four or five years ago, there was kind of a thumbnail version where it was a certain number you kind of could do some short math and kind of get like \$150 per communities or \$250 per homeless.

Is that still a fair way to sort of measure or give advice to especially new start organizations as they're thinking about setting patient targets?

Jim Macrae: Yes, I mean, I think they can even go further in terms of looking even on the Website. They can look at health centers in their particular states because in certain states as we all know, you know, Medicaid programs are expanding or not so it may have an impact on the grant and their ability to see more patients but that is sort of a general rule of thumb is that people can look at it.

You can also look at the national numbers, you know, nationally it's right around \$125 a patient per grant just if you look at it roughly but if you go actually on the Website you can actually do the quick math in terms of looking at the grant expenditures and then look at the different types of patients so people can use that as a general rule of thumb.

We don't have a target per se because, you know, it is honestly different by state but does it give them a general ballpark? Yes, it does and I think your point about people being more

realistic really is important because what has happened to some extent is that people have promised certain things and then they haven't delivered.

And we all know overpromising and underdelivering is not the way to be in terms of what you do because again the accountability part is much higher in terms of what people are expecting so pushing people to give more realistic projections really is the intent and we will say that to the reviewers themselves too in terms of what they're looking at, in terms of what's being projected.

Because we think that's as important as the reviewers so seeing that somebody's going to serve 20,000 patients versus somebody that's going to serve 4 or 5000, you know, of course you'd pick the 20,000 but is that realistic?

And providing real feedback to the reviewers when they're doing this I think is also important from where we sit and so we'll do that from where we sit but if you can get that message out that realistic projections is what we're looking for.

(Stephanie Harrison): Great, that's very helpful, thanks so much.

Coordinator: Thank you and once again if we have anyone wishing to ask a question or make a comment, please press star 1 at this time. One moment, please, and at this time I'm showing no further questions.

Jim Macrae: All right, does anybody else around the table have anything to say, anyone, going once, going twice, anyone here? All right, well thanks everybody.

Coordinator: Sir, we do have an additional question that just came up. One moment, please.

Jim Macrae: Okay dokey.

Coordinator: And sir the question is from Ms. (Woodard). Your line is open.

Jim Macrae: The answer is no.

(Lathran Woodard): Okay, I will take that.

Jim Macrae: Go ahead (Lathran).

(Lathran Woodard): Just real quickly Jim, you mentioned something about when you were talking about pilots, I know at the CHI you mentioned something about a pilot around project officers. Did I not write that correctly?

Jim Macrae: No, you did. You heard it so, I mean, the idea is can we look at different models of doing the project officer role? You know, right now it's very much a one-to-one type of relationship. Could we look at, you know, different approaches where you might have a team of people that are providing support to a set of grantees or could you have a primary point of contact but then have experts in different areas that could help support that primary point of contact?

Could you have even like a central number that people called into for, you know, if we did it like as a pilot for a state, you have all the inquiries come into one central place and the team divvies it up or they, you know, maybe have some people that are the customer service agents and then maybe they have other people that are the people that go out and do site visits and other people go out and do this.

But just different models of how we might approach this work because, you know, the criticisms that we've heard and we've heard them is that, you know, sometimes it depends on, you know, whether you get a response back, whether it's timely or not, whether the project officer knows the answer or not, there's questions about, you know, somebody asked a question.

The project officer gives an answer but nobody else benefits from that question or from that answer so how do we do a better job of sharing that more broadly and then how do you better support in terms of getting, you know, greater consistency and accountability in terms of what it is that we're doing?

You know, when we have a great project officer or grantee relationship, it is phenomenal, I mean, it is like the best thing that can happen and so we don't want to throw that out because we think that's critically important.

But we can't require project officers to always stay here or to always be with the same grantees because that's the criticism we get is oh my God, I have a great project officer. Please don't ever take them away but that's not realistic for the staff.

It's not necessarily realistic for the grantee so how do we build that capacity across the board in ways that make sense and provide that good level of service but don't have it be so dependent on just one individual because to be honest they have lives themselves and they need to be able to balance all of that in terms of the work that they're doing.

So we're just going to try a couple of different things. You know, we'll do some with the current model and see how that works. We'll do some with a different model, see how that works and just see, you know, what might make sense. We don't know the answer and I don't think there is a perfect answer about how to do this.

I think that's part of the reason why we want to test and experiment is to see what could work but, you know, we've heard enough that we know we need to try something to just see if there are different ways to approach this that might make more sense, okay?

(Lathran Woodard): No, I followed it this time. Thank you.

Coordinator: And at this time I'm showing no further questions.

Jim Macrae: All right, well thanks everybody for joining us. Have a great fall and we'll talk again soon and like I said, there will be a lot of activity over the next couple of months so get ready and please help us in any way that you can around outreach and enrollment. It is as (Jen) said going to be a heavy lift. It's going to be an exciting time.

We have several new partners joining us which is great on the national cooperative agreement stage which I think will really help us but again I think the expectations and the

potential for this program to grow exponentially are right there and we're going to need you to help us be successful and ultimately to make an impact across the country so thanks everybody.

Coordinator: This does conclude today's conference. Thank you so much for joining. You may disconnect at this time.

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