

**Native Hawaiian Health Care Improvement Act
Funding Opportunity Announcement Technical Assistance Call**

**Moderator: Joanne Galindo
May 24, 2012
2:00 pm CT**

Coordinator: Good afternoon and thank you for standing by. All parties will be able to listen-only until the Q&A portion of today's conference.

If you'd like to ask a question during your Q&A portion you may press Star 1 on your phone. To withdraw the question you may press Star 2.

Today's call is being recorded. If anyone has any objections you may disconnect at this time.

I would now like to turn today's call over to Ms. Joanne Galindo. Ma'am you may begin.

Joanne Galindo: Thank you. Good morning everyone and thank you for joining us for the Technical Assistance call for the Native Hawaiian Healthcare and Improvement Act Funding Opportunity Announcement HRSA-12-174.

My name is Joanne Galindo and I'm a Public Health Analyst here in the Office of Policy and Program Development in the Bureau of Primary Health Care.

And before I get started I just want to address you to the Adobe Connect page if you're not already there.

To join the meeting you can go to <https://hrsa.connectsolutions.com/oshockey> and sign in as a guest.

The presentation slides are all posted on our Technical Assistance Web page and the forms as well and that is at <http://www.hrsa.gov/grants/apply/assistance/nhhcs>.

And I'd also like to let you know that an MP3 recording of the call will be posted on the Technical Assistance Web site approximately one week after this call - so sometime next week.

So first our agenda for the call, I'll give you a brief overview of the Funding Opportunity Announcement, in particular the changes that have been made since last year, a brief overview of the submission process.

We'll talk about the application components of the program narrative and the review criteria as well as required attachments.

And I'll give an overview of the requirements for the performance measures and the form. And then we'll have Candace Kugel and Ed Zuroweste give a more in-depth look at the clinical performance measures.

And we'll end with some important reminders, who to contact for technical assistance and leave some time for your questions and answers.

The purpose of the Native Hawaiian Healthcare Improvement Act Funding Opportunity is to improve the provision of comprehensive disease prevention, health promotion and primary care services to Native Hawaiians in Hawaii.

Approximately \$13 million is available for grants to the six current Native Hawaiians Health Care grantees.

The project period start date is August 1, 2012 and the project period is for one year.

The grants.gov due date is June 20, 2012 at 8:00 pm Eastern Time or 2 o'clock Hawaii time.

Some of the changes in this FOA they are outlined in the Executive Summary of the FOA. But I'd like to go over a few of them.

Through the Appropriations Bill this year the Congress has imposed a salary limitation for personnel funded by Federal grants. HRSA funds may not be used to pay the salary of an individual at a rate in excess of \$179,700. And there's more information on that in the funding opportunity announcement.

Medicare and Medicaid reimbursements may now be used as matching funds for this grant. The staffing plan has been revised to collect some specific position information. And an Income Analysis Form has been revised to collect specific income data.

The project narrative and review criteria have had a few updates to help them align and better reflect your projects.

The health care plan and business plan have been replaced by a comprehensive project work plan for Papa Ola Lokahi.

And one of the major changes is the health care plan and business plan have been replaced by the clinical and financial performance measures for the Native Hawaiian Healthcare Systems. And we'll talk a good deal about that later on in the call.

On our TA web site you'll find a link to [grants.gov](https://www.grants.gov) to access the application instructions and application package.

You can also go directly to [grants.gov](https://www.grants.gov) and search by the announcement number HRSA-12-174 and that will get you to the application instructions as well as the application process to begin your submission.

Applications for funding must consist of the following forms and documents. The SF424 which is the application for Federal Assistance Form, and within that form you'll upload your project abstract on line 15. The project narrative, the SF424A, which is the Budget Information Form, and the budget narrative, the SF424B, which are assurances for non-construction programs.

The Performance Site Location Form, your Grants.gov Lobbying Form. and the SF-LLL which is the disclosure of lobbying activities if that's applicable.

And then you'll also include your required attachments through the submission process.

The main section of the application is the program narrative. The program narrative section is a general request for information about the project.

And the review criteria is the section that's utilized by the reviewers to assess the application.

They're both aligned with each other so it's beneficial to look at both when you're developing your application.

There are seven sections which include need, project update, response, resources and capabilities, evaluative measures, impact, and requested support.

The attachments that are included are the clinical and financial performance measures which are required for the healthcare system. And for Papa Ola Lokahi it would be the project work plan as Attachment 1.

For Attachment 2, the Income Analysis Form, this is also a required form except for a POL.

Attachment 3 is a staffing plan which is also required.

Attachment 4 is the position descriptions for new key personnel.

Attachment 5, biographical sketches for new key personnel, which are both as applicable.

Attachment 6 is the letters of support. Attachment 7, summary of contracts and agreements, which are both also as applicable.

Attachment 8 is the board profile which is optional and Attachment 9 are other relevant documents as you feel necessary.

So for Attachment 1 which are the clinical performance measures I'll give a brief overview of the performance measures requirements and forms.

In a few minutes Candace and Ed will go over them a little bit more thoroughly.

The applicants must include at least four of the standard clinical performance measures which are defined by HRSA.

And these include measures on diabetes, cardiovascular disease, cancer, prenatal health, perinatal health, child health, weight assessment and counseling for children and adolescents, adult weight screening and follow-up, tobacco use assessments, tobacco cessation counseling and asthma pharmacological therapy.

Applicants can also add variable clinical performance measures for which the applicant determines the measurement elements.

And these can include behavioral health, oral health, hearing, traditional healing, health education and disease prevention, nutrition, and physical activity or other performance measures that would be necessary for your project.

For our financial performance measures, applicants must also include at least three of the standard financial performance measures.

These include the total cost per patient, the medical cost per medical visit, the change in net assets to expense ratio, the working capital to monthly expense ratio, the long term debt to equity ratio, or non-federal matching funds.

The ratio measurements are based on an organization's audited financial statement.

On this call we will not be discussing in-depth the financial performance measures but we will be scheduling a conference call to discuss the financial performance measures on June 5 at 10 o'clock Hawaii time.

The Performance Measures Forms include the following components seen on Slide 13. And I will switch to the forms now so you can see exactly what they look like.

So the components of the Performance Measures Forms include the focus area, in this case it is diabetes, the performance measure description, is this performance measure applicable to your organization. And if you're completing the particular performance measure you would mark yes.

There is a place to input your target goal for this measure. The numerator description, the denominator description, the baseline data which includes the baseline year, the measure type, for example a percent or a ratio, the numerator number, the denominator number, and there's an area to include your projected data which you will achieve by the end of the project period.

There is also an area to input your data source and methodology and your key factor type.

Applicants must specify at least one contributing and one restricting factor. There is a place for your key factor description and your major planned action description where you'll provide action steps of strategies to be used to achieve each performance measure.

At the bottom of the form there is a comments section which you can use as desired.

The instructions for completing the Performance Measures Forms are found in Appendix A in the Funding Opportunity Announcement.

And I'll now ask Candace and Ed to talk about each clinical performance measure.

Candice Kugel: Okay good morning. It's funny to say good morning at 3:30 in the afternoon.

Ed Zuroweste: Candace could you make that larger on the screen to take up the whole screen?

Candice Kugel: There how's that? Is that better?

Ed Zuroweste: Yes. That's better.

Candice Kugel: Okay can you hear me okay?

Ed Zuroweste: Yes I hear you fine.

Candice Kugel: Okay good. All right my name is Candace Kugel and my compadre here is Ed Zuroweste. And we are both the clinical consultants for the project officers at the Bureau of Primary Health Care.

And so we work a lot with these clinical measures and so we're happy to have the opportunity to try to explain them to you.

It may be that you've already had some experience with them or this may be completely new to you.

And I'll just say that there are several of them so we're going to be giving you kind of a basic overview of all the measures.

But I can guarantee that you're going to need to use some of the resources that are cited in the guidance in order to really be able to gather the data that you're going to need.

So let me try to start out with some of the first measures here and then Ed you can chime in at any point if you want to.

The format that we're showing you here is what you'll need to use as you fill in your grant application.

Okay so let's start with the diabetes measure. You can see at the top there it's says Focus Area: Diabetes. And each of these does have a focus area.

And then the performance measure itself is standardized so that's not something that you need to worry about the wording. It'll just be there.

So with this particular measure what we're looking at is the percentage of all of your diabetic patients whose hemoglobin A1C levels are less than 7%, less than 8%, and less than or equal to 9% or greater than 9%. So it's really looking at a few different ways of breaking down that information.

And since you're being asked to choose four of these clinical measures where it says is this performance measure applicable to your organization, so the four that you're selecting you would check yes. For the others you would check no.

The numerator description and the denominator description are standard also.

So this particular measure I'm going to start with the denominator because what you're looking at is how many adult diabetics you have who are between 18 and 75 years of age as of the end of the measurement year which is 2012 who have Type I or Type II diabetes and who have had a visit at least twice during the reporting year.

So if you've just seen them once you don't count them. And then the numerator is of all of those diabetics you want to look at their most recent hemoglobin A1C and calculate how many of those were less than 7%, less than 8%, less than or equal to 9% or greater than 9% so you'll have columns for each of those categories.

The next line is providing us with baseline data. So if you have never - if you choose this measure and you've never looked at it before then you would put for your baseline zero. And this would be your baseline year.

If you have looked at this measure in the past, put where you started, the baseline year and indicate, you know, so you started looking at this in 2010, put that.

The measure type is going to be either percent or ratio. I think with all the clinical measures it's a percentage so that's what you fill in there.

Numerator and denominator is the exact numbers. So if you have, you know, 2000 diabetics and then you would put that there.

If you have 200 who have a hemoglobin A1C less than seven you would put that there.

Projected data, the white box to the right of that is where you want to put the percentage. That's your goal for the year.

So let's say you're - you know that you're now at 55% and your goal by the end of the year is to get to 60% so you would put that in that box.

Joanne explained a little bit how about that key factors. And what's expected here is that you indicate at least one contributing and one restricting factor for each of these measures.

And so you check either contributing or restricting and you say what that key factor is.

And contributing factors are things that are going to help you to improve, things like we just hired a diabetes educator. That's a contributing factor. And that's what you would put under key factor description.

And then your major planned action description might be that diabetes educator is going to start giving group nutrition classes for diabetics. So that's just an example of a contributing factor.

Restricting factor might be that there is let's see - the local diet it is not supportive of improving the status of diabetes. And so that would be a restricting factor.

And so you would want to put what your planned action is surrounding that. And then you might see at the bottom there where it says comments I always encourage grantees to put something in there.

If you have a special situation that you're dealing with related to this measure fill it in there. It's your one chance to sort of personalize this application.

Okay I just wanted to go into a little bit of detail there on the form itself with that measure. But I'm going to probably have to kind of pickup our speed since there's so many of these.

The next measure is cardiovascular. And this one is related to blood pressure. And one thing I did not mention is under that where it says is this performance measure applicable to your organization yes or no, the next line is target goal description.

And that is something you do need to fill in. You need to say we plan to go from 48% of our hypertensives who are under control to 55% by the end of the year.

That's what you put as your target goal description. You state where you are and where you want to end up at the end of the year.

All these other things that you see here are going to be filled in. So for hypertension we're looking at all of our patients who are 18 to 85 years of age during the measurement year and who have a diagnosis of hypertension and who have been seen at least twice during the reporting year and have a diagnosis of hypertension before the middle of the year. So that's who you're looking at for this measure.

Within that group you want to look at how many of them have blood pressure less than 140 over 90. And both numbers have to be below 140 and below 90.

And the rest of these boxes are the same for each measure. The next measure is cervical cancer screening or Pap testing.

And this one is the percentage of women who are 21 to 64 years of age who received one or more tests to screen for cervical cancer.

And so the reason it's 21 to 64 is that the new guidelines for Pap testing recommends beginning screening for most women at 21.

So when you look at the denominator description it says the number of female patients 24 to 64. It doesn't say 21. It says 24 who have - who were seen for at least one visit before their 65th birthday.

So you're taking all those women and then you look at how many of them had one or more Pap tests during the measurement year or during two years before. So did they have a Pap test this year in 2012, 2011, or 2010?

So that's why you're only looking at women from 24 because you're actually looking back over a three year period. So that's always a source of confusion on this particular measure.

The next measure is now there are two measures related to prenatal care or pregnancy care. And this one is a percentage of pregnant women beginning prenatal care in the first trimester.

Now with the federally funded community health centers they are expected to report on all of these measures but we don't require them to report on this measure if they're not doing prenatal care direct services on-site. So I would say the same for you all too.

If you're not taking care of pregnant women or doing comprehensive prenatal care this would probably be a difficult one for year to get data on.

If you are it's a great measure to see how well your - how successful you're being in terms of being accessible for prenatal care.

So what you're looking at here is the number of your patients who received prenatal care during the measurement year either at your own service

delivery location or with another provider which means they might have come to you in their second trimester but they started prenatal care somewhere else before they came to you.

And that means, initiation of care means the first visit with a clinical provider who does prenatal care.

That means the distinction there is that you might have a system where you have them see a nurse on the first visit who does their medical history and some education. That is not considered a prenatal visit.

So it has to be with the physician nurse practitioner or nurse midwife or does prenatal care. And an exam is actually done. So that's where you would start counting for determining when care begins.

And then of those women how many of them started that care in their first trimester? And first trimester is considered to be the first three months of pregnancy.

For this measure it actually is, I think it goes up to 15 weeks is what they allow you to include.

All right I think I skipped one there. The next - this next one is another perinatal measure. And this is the percentage of births. And it's not just the births it's the babies that are the result of that birth who weigh less than 2500 grams.

And so again - this is a measure that's most appropriate for people who are doing comprehensive prenatal care and attending births and/or following-up

with women after they give birth. Because you need to retrieve that information about what the baby weighed when it was born.

So you're looking at all the births for all women who were seen for prenatal care regardless of who did the delivery.

So what that means is a lot of places will do prenatal care. They have a, you know, a nurse practitioner or somebody on staff who sees women during pregnancy.

And then when they go into labor they're referred to a local OB/GYN practice. So in that case the grantee is responsible for tracking down that birth weight information.

So for all of those births you look at how many of the babies weighed less than 2500 grams at birth because 2500 grams for those of you who are metrically challenged is about 5-1/2 pounds. So those are low birth weight babies.

And then so that ends up being a percentage. And this is one if you do choose this measure, this is a measure that you want to be low on this one.

So if you say we're at 7% and we want to go to 10% that's not going to make us too happy because that's the wrong direction in this particular measure.

And the only reason I mentioned that is because I've seen it many times. People often do that because all the other measures we want to increase, we want to do better by getting higher numbers so that one we want to get the lower number.

So next measure is immunization, and this one may be one that would be relevant for you is to look at all of your 2-year-olds and figure out how many of them are up to date on their vaccinations.

So again your denominator is any child with at least two medical visits during the measurement year who had their second birthday during the measurement year. So this is all kids who turned 2 during this calendar year.

And you take that whole group of kids and you look at how many of them have had, if you look at the numerator it's a long list of vaccinations. And it is a long list of vaccinations. If they have missed one then you can count them.

It's - this is one that's difficult to do well on. And sometimes we've had issues with vaccine shortages or those kinds of things where an organization may be doing really as well as they can possibly do considering the circumstances.

So if that's a limitation that's just one of those things that you put in the comments box. You know, we had a vaccine shortage in our area. We're not able to maintain our stock. So don't be intimidated even if that's a situation that you come up against.

Let's see where are we? We're into the BMI. So this is where I'm going to hand off to Ed and he's going to take on some of the new ones for you.

Ed Zuroweste: Okay thank you Candace. Can you hear me all right there?

Candice Kugel: Yes. You sound good.

Ed Zuroweste: Okay. I'm - we're going to start out with answering one of the questions or at least addressing one of the questions I see in the Chat box from (Hardy) who asked about many of the problems around diabetes and cardiovascular are detectable in use before age 18. How can the systems address youth diabetes and obesity in youth affecting cardiovascular?

So this measure (Hardy) you may want to look at because what this one is the measure - the performance measure is percentage of patients aged 2 to 17 who had a visit during the current year and who had a body mass index percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

So the denominator here is the number of children and adolescents in your practice ages 3 to 17 because you're going to look back a year so going to catch those 2-year-olds as of December 31 of the measurement year who have been seen in the clinic at least once during the year. So that's the criteria to put them in the pool.

And then of those children and adolescents what number have had a body mass index percentile?

Now this is different - you have to not only have a body mass index, the weight in the height of the child. So you get a weight and height of a child and then you go to a table and that'll give you a body mass index. Then you have to put the age of the child and look at a percentile to come up with a body mass index percentile.

And then you have to have counseled the parents and the child on both nutrition and physical activity (irregardless) of whether they're obese or underweight.

So this is to try to instill in all practitioners that childhood obesity is such a huge issue in our country that we want to address it at any point in time where we have contact with children.

So the bureau and the country as a whole really are looking at this obesity issue and talking to parents.

We want to talk to the parents of that 3-year-old before they become obese to make sure we're talking about nutrition and exercise. So this is the whole pool of kids so that means that you have to height and weight all children which you should be doing anyway. And once you height and weight them then you go to the body mass index table. And that'll give you a body mass index number. And then you go match that to the age of the child and that'll give you a percentile for that child. Okay we can go to the next one.

And the next one is the adult one. And this one's a little bit different. And this is the performance measure the percentage of adult patients 18 and older. So it goes up to 100 or higher.

All your adults who have had their body mass index calculated at the last visit or within the last six months and if they are overweight or underweight had a follow-up plan documented.

So on this one the denominator is the number of adult patients you have 18 years and older of the measurement year who's been seen in the clinic at least once during that measurement year.

So you're going to look at all your adults. And then of those adults over 18 who had their body mass index calculated at their last visit or within the last six months and if they are overweight or underweight have had a follow-up plan documented along with including - among those patients who are included in the denominator.

And just for your knowledge it doesn't say so here, but a BMI of 25 or over in patients under 65 is considered overweight or a BMI of 30 or over for patients over 65. And for underweight anyone who is less than 18.5. And that's listed in your guidance. But those are the BMIs. It's either over 25 if you're under 65; or over 30 if you're over 65; or anybody under 18.5 would fall into this category.

And then anybody that falls into that category should have also had then counseling on - no for this one it's just to calculate the BMI.

Candice Kugel: Well and a follow-up plan.

Ed Zuroweste: Right and, excuse me, and a follow-up plan. You're going to document how you're going to address that. Thank you Candace.

These are the kind of new ones and they're a little tough. But I think these are ones that you folks may very well have the ability to do and I think in your patient population you may be able to document the most impact with outcomes.

The next one is on tobacco use and counseling. And the performance measure is percentage of patients 18 and older who were queried, who were asked, about tobacco use one or more times during 24 months. So you have two years for this one. You can go back two years. So the denominator is the number of patients age 18 and older who had at least one medical visit - again you only have to have seen them once - and who have had at least two office visits ever. So they have to have been seen in your place at least twice historically but only once during the measurement year.

And then the numerator is the number of those 18 and older who were asked about whether they smoke or use tobacco. They were asked that once or more during their most recent visit or within 24 months. So you can go back two years to see if anybody ever asked them if they use tobacco use. Okay so this one is just asking.

You know, they've shown, good study showing just asking people if they use tobacco is important for eventual smoking cessation.

Okay, then I think we can go to the next one. So this was just asking. And then the next one is also related to tobacco because once you ask what are you going to do about it, right?

So this performance measure is the percentage of patients 18 and older who are users of tobacco - so you obviously have had to ask them - and who have received and you've charted that you've given them advice to quit smoking or quit any tobacco use if they're doing chew or whatever else - snuff, et cetera.

So the denominator is those number of patients 18 and older who are users of tobacco. And their most recent visit was identified during their most recent visit or any time in the 24 months during before the reporting period and who had at least one medical visit during the current year and who've been seen at least twice overall historically.

And then of those individuals the number of 18 year olds and older who are users of tobacco and who have received and you've charted, you've got a document this, have given advice to quit smoking or tobacco use during their most recent visit or within 24 months of their most recent visit.

And again this is another - studies have shown that if any provider of healthcare to an individual if they bring up smoking and they counsel them on smoking cessation there's a significant number of people who will attempt smoking cessation just from that advice alone.

All right next one...

Candice Kugel: Ed, just want to mention that since we have this enlarged we aren't seeing questions. So if there are any either go ahead and address them or let us know.

Ed Zuroweste: Well there are - they're coming in.

Candice Kugel: They're coming in?

Ed Zuroweste: Yes.

Joanne Galindo: Well most of them we can just wait for the end.

Ed Zuroweste: Okay.

Joanne Galindo: We'll make sure that we address everything that's - whether it's voiced or typed.

Ed Zuroweste: Yes there's a lot of typed ones. They're very active. We have an active group out there.

Candice Kugel: You mean they're paying attention?

Ed Zuroweste: I think they are.

Candice Kugel: Okay good.

Ed Zuroweste: All right. So the next one is related to asthma and that is, the performance measure is the percentage of patients aged 5 to 40 - so 5 to 40, this is a different age group - with a diagnosis of persistent asthma. So they have to have that diagnosis.

It can be either mild, moderate or severe, but it has to be persistent, not intermittent but persistent asthma, who are prescribed either the preferred long-term control medications or an acceptable alternative pharmaceutical therapy during their current year.

So the denominator here are the number of patients 5 to 40 with a diagnosis of persistent asthma, again either mild, moderate or severe, who've had at least one medical visit during the current year and have been seen at least

twice ever. So they've had to be in your institution at least twice, but seen within the measurement year, the last year.

And of those, the number again from 5 to 50, with a diagnosis of persistent asthma who have been prescribed either a preferred long-term control medication, which would include an inhaled corticosteroid or an acceptable alternative like leukotriene modifiers, Cromolyn Sodium, Nedocromil Sodium or sustained release Methylxanthines, any of these - and you can look these up, they are described better in the guidance.

If the person has - the asthmatic been prescribed one of these known modifiers of their asthma, known treatments, during the current year, then they would be included in your numerator. Okay?

And the next one if there is - is that - was that the last one? Yes, that was the last one of the 11. So of these you have to pick four out of the ones that (Candice) and I have just gone over. And I think hopefully you folks will be able to find four of those that speak to you and speak to the population that you're trying serve, and you want to improve the outcomes of those particular measures.

Candice Kugel: The page that you see now says, "Behavioral Health," and there's no standardized measure in there. And Joanne mentioned earlier that there are some additional measures that are really optional. I don't believe any are required, right?

Joanne Galindo: No, they're not required but we have given you some options for additional measures that might apply to your project. So we have just blank forms for behavioral health, oral health, hearing and otitis media, traditional healing,

health education, nutrition and physical activity. And you know, so that's just if you want to add a performance measure on one of these other indicators, you can do so.

Candice Kugel: And there are some widely accepted measures in some of these areas like in behavioral health and oral health. But if you are involved in a particular project area that has been a focus of a lot of effort, that this just gives you the opportunity to kind of show what you've been doing.

So these, like I say, are optional. And if you need some guidance on what - how to choose a measure in these categories, then that's something that we could probably offer some help on.

Ed Zuroweste: You know, there's a question that came up, I think might be a good time to answer it now, if we've got a minute. And it's - the question is to clarify; client must have been seen in a "clinic" does not include clients receiving BMI within health education.

Candice Kugel: Right, it says, "Medical Visit," right?

Ed Zuroweste: Right, so I guess if the client is being seen within health education but had a visit and got referred over for health education where the BMI was measured and counseling was done at that time, I think that would count, to answer that question.

Candice Kugel: So the question is, "Does that BMI count, if it was done in the context of an education visit?"

Ed Zuroweste: Right, so I think as long as they had a medical clinic visit...

Candice Kugel: Right.

Ed Zuroweste: ...and then were sent over for education and the BMI was actually done...

Candice Kugel: Yes.

Ed Zuroweste: ...there in counseling, I think that would - that certainly would be very acceptable.

Candice Kugel: I agree, yes.

Ed Zuroweste: Okay.

Joanne Galindo: Were there more questions related to performance measures that were on the list that you wanted to do now (Ed)?

Ed Zuroweste: Well the one I addressed, the question was, "Many of the problems around diabetes and cardiovascular occur in youth," so I think looking at the BMI in children would be a way to address that since we don't have any true cardiovascular for children.

And then another one, and maybe you folks can help with this question, is "Given all these indicators, how are you going to determine whether or not the health of Native Hawaiians is being impacted? Numerators and denominators need to reference Native Hawaiians." So that's the question. You folks - are you able to answer that? I'm a little confused about that.

Joanne Galindo: Well maybe we should, when we open it up for questions and answers we can go over...

Ed Zuroweste: See if we can get - yes, see if...

Joanne Galindo: ...because then we have a little bit of back and forth and have a little bit (unintelligible)...

Ed Zuroweste: Exactly, see if they can clarify that one.

Joanne Galindo: Right, so...

Ed Zuroweste: But those are the only ones I see on the screen right now.

Joanne Galindo: Okay, so let's just finish up just a little bit. Oops, sorry I did not mean to do that.

Okay, so before we go to the question and answer session I'd just like to give you a few important reminders.

The grants.gov deadline is June 20, 2012 by 8:00 pm Eastern Time, and of course that's 2 o'clock Hawaii Time. Applications may not exceed 80 pages or 10 megabytes. And this is pretty important because now the pages are counted like within the system, by the system automatically, so there's not a person counting these. So if it goes over the page limit it might not get through the system for - to get to us for review. So just be aware that the page limit for these applications are 80 pages.

And we'd like you to use an easily readable font, 12 point, you know, we're not going to be very strict on that, but just so that we can - our reviewers are able to read it easily. And again, to access those forms, these templates, these slides and some samples, you can go to our TA Web page which is at www.hrsa.gov/grants/apply/assistance/NHHCS.

For technical assistance you can contact me, Joanne Galindo, for program related questions, and the email address is bphcnh@hrsa.gov, or you can call me at 301-594-4300.

For budget related questions and in particular if you have questions about the salary limitation change you can contact (Christie Walker) in the Division of Grants Management Operations, and she's at cwalker@hrsa.gov, or 301-443-7742.

For grants.gov related questions, especially if you're having any kind of technical difficulties when you're submitting, please contact support@grants.gov or 800-518-4726.

And again I will always refer you to our Technical Assistance Web page where you will - in about a week or so, there'll be an mp3 recording of this call. And if we have a lot of questions that need to be addressed, I will try and make available some of those questions on the web site so that you can have access to those answers for the people - especially for the people who aren't on the call.

So now let's go to the question and answer session, (Crystal) the operator, can you open it up for everyone to ask questions?

Coordinator: Thank you. As a reminder, if you would like to ask a question please press star 1 at this time. To withdraw your question you may press star 2. Once again, any questions please press star 1. One moment for the first question.

Our first question comes from (Tina Watson), your line is open.

(Tina Watson): Hi. My question is, "When I'm looking at the performance measures and the table, is there a minimum goal that you guys are asking for when it comes to the numerator and denominator?"

Candice Kugel: That's a very good question and the answer is, "No." So really what we want to know is where you are. So there are not any particular benchmarks or any overall goals that everybody's expected to meet.

The idea of doing this is so that you can see how well you - what kind of impact your services are having, and to set goals so that you can improve your impact. So it's really - there's no penalty if you don't reach a certain level or no rewards either.

Ed Zuroweste: Only to your patients.

Candice Kugel: That's right.

Ed Zuroweste: Only to the clients that you serve.

(Tina Watson): Thank you.

Ed Zuroweste: And I think the idea is what we're trying to do is, you can't compare a Hawaiian - Native Hawaiian setup with inner-city New York City with a 99%

African American population or a 80% Hispanic population, when you're looking at diabetes or obesity or any of these measures.

So it really is, "Where are you," and then, "What are you going to do to move that ball up the hill?" if you're at you know, 40% of the hypertensive patients who you are working with are their hypertension is controlled, that's obviously not where you want to be.

What can you do to move that from 40% up to 50, 60, 70% over the next several years? What sort of interventions can you do to help your clients improve their blood pressure control? And so that's the idea, find out where you're starting and then over the next year, over the next two years, over the next ten years, how are you going to improve the outcomes for those individuals?

Coordinator: Our next question comes from (Mylee).

(Mylee): Aloha, it's (Mylee). Is this - am I live?

Ed Zuroweste: Yes.

(Mylee): Okay, hi. The question that I have, one I'd like to first maybe try to clarify the question that was asked that folks weren't sure of what the question was. And I think the question that was being asked was specifically about Native Hawaiians as - how are all these measures that are being asked of the Native Hawaiian Health Care Systems, how are those measures actually - how are they indicating the health of Native Hawaiians being improved?

And I think one of the questions might have been to the - leading to the issue of that we are - I'm assuming it's under the assumption that Native Hawaiians are going to be - who are the assessment population. Are you asking the clinics to measure their entire population because that's how resources are being spent and there can be clarification on who is included as part of the population?

And then my second question is, "Is there any room for negotiation or conversation about measures and performance measures from the Native Hawaiian Health Care Systems that go beyond the sort of clinical measures, given the fact that our Native Hawaiian population is coming to the table with, as far as health needs, may not necessarily start at clinical measures, but have other support system needs that are not being assessed through these clinical measures?"

"Is there a way that we can come up with additional metrics to help assess the performance and the success of the Native Hawaiian Health Care Systems beyond clinical measures?"

Joanne Galindo: Yes. And that's one of the reasons why we wanted to make sure that there's the optional ones, or the - that we give you some way to report additional performance measures that are the most applicable for your organization. And in so doing, hoping that we can get some really rich and valuable data and information about the quality work that you're doing and be able to, you know, provide the evidence of that in the larger health care arena.

And the first part of the question was around separating out the Native Hawaiians from the - for lack of a better word, the general population? And right now I don't think that's something that we can easily track. I think since

this is the first time we're using the performance measures for the Native Hawaiian grantees, that I think we need to continue the conversation around how we're using them and what makes the most sense.

So we do want to hear from you about how it's working and what makes the most sense to focus on for this group of grantees.

Candice Kugel: You know I would add, this is (Candice), that might be something that you could do as an - one of those additional measures. If you're interested in focusing on your Native Hawaiian population for a particular health behavior or health condition, then I would encourage you to look at that.

I mean we've had the same issue with community health centers that take care of other special populations like migrants or homeless, we don't separate out those populations from the universal population that's being served. And that is a bit of a frustration to organizations that provide specialized services for those populations. So I would encourage you to look at that.

Joanne Galindo: And I also think if it's - if you're able for the standard performance measures to break it up like that, you could put in the comment section, you know, specifically about just the Native Hawaiians that you serve.

Candice Kugel: Yes.

Joanne Galindo: You know, give some additional specific information, I think that would be fabulous.

Candice Kugel: Yes.

Coordinator: Our next question comes from (Michelle).

(Michelle): Yes, hi everyone can you hear me?

(Michelle): Okay. So my question, I'm sorry to keep parking on the clinic issue, but as far as like collecting BMI and that type of information, does that referral have to come from our own internal clinic or can it come, like say from one of our community health centers that referred to our educational services and we collect BMI within our services?

Candice Kugel: I would say yes.

Ed Zuroweste: Yes I would agree. I mean the bottom line is we want to make sure that wherever the point of contact is if BMI is being measured and there's counseling being done for nutrition and exercise, that's great and you should get credit for doing that so.

Candice Kugel: Yes, and it's probably going to have - well I mean my guess is that it's going to have more impact than what happens in a medical visit where you just say, "You need to lose weight."

Ed Zuroweste: Yes, I think this is a great example of how you can justify your, you know, your funding. That, you know, "We get referrals and here's what we see." And over time, hopefully you're going to be able to improve, or with this one, you don't even have to show that the BMI gets better.

It's been shown that as long as you tell somebody, "You know, your BMI is higher than it should be and so you're at higher risk for heart disease and

diabetes and those sort of things, and so here's some ways both through nutrition and exercise, where we can bring your weight under control." So just that counseling alone, just the identification and counseling has been shown to have a good outcome.

(Michelle): Perfect, thank you.

Candice Kugel: And just one additional comment that kind of relates to these last few questions, I think I mentioned earlier that the community health centers are expected to report on all of these measures, but in recognizing the care model that you are involved in, that's why we are asking you to report on only four of them.

We felt like there were enough measures here that are health education related or behavior - health behavior related, that they - you'll not have trouble finding four of them that are relevant to you.

Coordinator: Our next question comes from (Hardy Spoehr), your line is open.

(Hardy Spoehr): Hi folks. I'm going to just reiterate the comments I've made on screen. But I am a little discouraged that I heard the response in terms of Native Hawaiian.

I think it's really critical, particularly that the bureau and HRSA realize that the whole justification for this act is the Native Hawaiian health, and the Native Hawaiian Health Care Improvement Act. So the focus and the requirement needs to be on improving in the health of Native Hawaiians.

Now the general public, sure they're welcome to attend and come into our systems, and we certainly welcome them, but the whole focus of the entire

program, like that of American Indians and Alaska Natives. And you cannot confuse migrant and communities of color with indigenous populations.

And I know this sounds like a broken record but it will become particularly important to realize that there is statute of authority and a requirement to report, actually to the president from the secretary, on the ability of this program to improve the health of Native Hawaiians. So it's critical in the data gathering piece that that is not lost.

And I know we probably need to talk more about that, but Native Hawaiians as a group should not be confused with Asians, African Americans, and Latinos. The community health centers cannot distinguish between who they serve. This act enables that to occur just as the Indian Health Care Improvement Act enables health care services for Indians - American Indians and Alaska Natives.

So I think that's a critical piece in the data collection if we can't gather the Native Hawaiian component to justify how the act is impacting positively, the health of Native Hawaiians. Thank you.

Joanne Galindo: (Hardy) I agree, this is Joanne. And I think at this point in time since we're just introducing these performance measures to some of the organizations, that we didn't want to make that a mandatory thing right now.

But recognizing that the - that is the reason for these funds and for these grants, that the whole project as a whole, we're looking at as benefiting Native Hawaiians. So I'm hoping that we can get closer to being true to that goal through the performance measures, not move away from it.

(Hardy Spore): But we should then be talking about how we capture that.

Ed Zuroweste: Yes, and this is (Ed). My question would be, "In your situations, is there some identification that is retrievable that identifies Native Hawaiians from the other population that you might serve?" And if that's a very distinct separation and you could pull the data separately, then I would encourage you to report the data specifically on the Native Hawaiian population and then on the other populations.

Candice Kugel: Yes, I agree and that's...

Ed Zuroweste: Because you can split it out. That's terrific.

Candice Kugel: Yes, that's what I was saying earlier was just, you know, to fulfill the expectation I mean I think the bureau does want to know how you're performing for your total population, but if you are able through identifying information to separate out the Native Hawaiian, then that could be reported under the additional measures, or it could be something you do internally.

I mean I would certainly encourage that also, so that you know. But like you say, reporting it - you have that option with these numerous additional measures that you're able to include.

(Hardy Spore): Yes I believe we already do. In fact, we've done a diabetes survey already. And (Mylee) can talk to you more about that. But if we aren't able to focus on that Native Hawaiian piece then we might as well close up shop because our whole focus is predicated on the Native Hawaiian Health Care Improvement Act...

Candice Kugel: Right.

(Hardy Spore): ...which is improving the health of Native Hawaiians.

Joanne Galindo: Right, I guess I didn't see it as separate from what - you know, what you do. I didn't see it as separate. That's - I see that as the goal of the funding of the grantees.

(Hardy Spore): Yes it's - well the program is not like an Indian Health Service where the eligibility requirements are strictly that you need to be of native ancestry, whatever the definition.

But if you'll look at the act it does define Native Hawaiian, and we do keep track I believe, of all the Hawaiian - well through the UDS requirements, we have to keep track of the various people who come in, and we do keep track of the Native Hawaiian piece.

Joanne Galindo: Well I think that's something to talk about a little bit more and whether or not we need to collect the data a little bit differently to reflect that.

(Hardy Spore): Okay, that's something we can have an ongoing discussion about. And (Mylee) is working - she's going to start fairly soon with all the systems on data collection so.

Joanne Galindo: Great.

Coordinator: Our next question comes from (Hau'oli Komoso). Your line is open.

(Hau'oli Komoso): Hi, aloha (unintelligible), this is (Hau'oli) and those two questions by Dr. (Towalee) and (Hardy) are good segues into my question.

We are - well I want to preface the question by saying that we are with the other systems, you know, using the UDS and tweaking and working our tables, especially Table 2A regarding additional kinds of clinical measures now that we know are now resident to this grant.

And so as we work that I know that we're going to be taking all of our Ps and Qs from those tables and from those measures, especially the audit that Dr. (Towalee) helped us as the system. So are we on the right track here in terms of we're already collecting things through the traditional UDS and we're adding things to that, and we're being proactive to add to that what we now know are to be these clinical measures. So are we on the right track there?

And number 2, I think all the systems are able to bifurcate and separate out information already as to the Native Hawaiians and the "non-Native Hawaiians" we serve. So I think we're already doing that, so we're on that right track too already. Those are my questions. Mahalo.

Joanne Galindo: I do believe, yes. I mean that's - it sounds like you are on the right track and maybe that's something we need to, you know, more formally add into this reporting process. So...

(Hau'oli Komoso): I caught you, that's good.

Joanne Galindo: I'll continue the conversation and discussions so - and make sure that you're aware of it on this end.

(Hau'oli Komoso): Yes because I think that's important. Because at least for the Hui No Ke Ola Pono the UDS has been our only tool that we've been reporting for years on, and we're working it you know?

But we need to - I don't want to reinvent the wheel and say that what we've been collecting are - is no longer good. I think they are very good and we want to segue and we want to immigrate now into these clinical measures that formalize things the way I was doing it through the UDS. So I really appreciate that, Mahalo.

Joanne Galindo: And all these proposed measures are aligned with everything in the UDS, this is what's in the UDS.

Woman: Right.

(Hau'oli Komoso): Mahalo.

Coordinator: Our next question comes from (Mary Tom). Your line is open.

(Mary Tom): Hello everyone. It turns out I wanted to make comment on some of the comments that had been made previously. Indeed the Native Hawaiian Health Care Improvement Act does want to attend to the assessment of improving the quality of health for Native Hawaiian people.

That is why for each of the islands we are looking for island specific data that assesses, you know, what is the needs assessment the - what are the chronic diseases within that particular island so that in fact the roadmap of direction of what clinical performance measures are being selected are relevant to the needs of each specific island.

And certainly I can appreciate (Hardy)'s comment as well is about the Native Hawaiians universally, even on the continental U.S. You know, our systems right now can attend to only the needs of Molokai and Kauai and Oahu and the Big Island and Maui.

So their direction is, "How am I improving, within my community on my island, what am I doing in improving the quality of health for the residents of my island, that you know, and preferably those who have Native Hawaiian heritage background."

And on the UDS data the Table 3D, when Congress calls me and asks me, "How many Native Hawaiians are being serviced by the Native Hawaiian health care systems?", it may not be a true representation because indeed there are other non-Native Hawaiian people that are being served. But for the purposes of the statute we report only that line item on Table 3D that talks about the Native Hawaiian ethnicity.

So that - it's a - this model, (Ed) and (Candice) and Joanne, as we've had conversations before, unlike our community health centers where not all of our systems have little mini-clinics that are providing primary health care delivery. A good many of them like (Billy) on the island of Molokai, they have a very nice model of providing case management and providing enabling services and the disease prevention health education model.

And then working in tandem with the Molokai health center, as is (Hau'oli) working on the island of Maui with the - you know, with the Clinic of Maui there and the (Hana) Health Center, wonderful partnerships and collaborations that we really do support, as is (Michelle) that's working on

the big island in Hilo, that she's working with, you know, the West Hawaii Health Center and with, you know, with other adjoining health centers.

So this truly is a different model of care, which is very complimentary. And I think (Ed), you and I spoke about the value of the preventative health care that the systems are providing to that health care delivery.

So (Ed) you know, if you could comment on that, because it turns out - I think - I want to make sure that in fact the Native Hawaiian Health Care Systems realize the important value that they add in the improvement of health because the case managers are doing wonderful work. "Today Sister, Auntie, Uncle, please understand this issue of hypertension or diabetes," or you know whatever the case might be, it turns out it's very instrumental in terms of being agents of change.

You know, the garden plots, "Grow your vegetables, eat them," you know, and you know it's all of these very unique and wonderful programs that are contributing. You know, the gyms and the swimming pools and the things that are adding value to the lives of the Native Hawaiian people.

So (Ed) or (Candice), you know, could you add some emphasis that you know, there is much value in this complimentary type of health care support that's being provided by the systems.

Ed Zuroweste: Yes, there's no question (Mary). You spoke of it very well. I think that, you know, this is - you're not giving a medical model, you're giving a health model, a healthy model. And it's been shown over and over again, you know we've said it for generations, you know, a pound - you know, an ounce of prevention's worth a pound of cure.

And all the preventive things, especially on these measures we're talking about, obesity, tobacco cessation, all of these things, even hypertension and diabetes, much of the control of those diseases or prevention of those diseases can be done very much outside of the medical model so that you don't have to come in to the medical model if you can prevent it or if you can improve it with the behavioral adjustments that you folks are going to do much better than I would at a clinic on one of the islands.

So I think this is a great opportunity for you folks to really demonstrate and quantify how much impact you're having with your population. And so I encourage you to embrace these sort of things. And as one of the speakers said before, "you know, you're already kind of proactive with the UDS."

And I would be very proactive with these measures because I think these measures are having - these disease processes are having a huge impact on the Native Hawaiian population with diabetes and hypertension and obesity especially, so that if you can demonstrate that through your counseling and your support and your education that you're improving the outcomes, then that's terrific. And you are doing wonderful and creative things. And there's no question that outcomes using those methods are just as good, if not better, than a pill.

Candice Kugel: Yes, I completely agree. And I also am kind of excited about the opportunity to have you working in a more preventive, traditional healing kind of model, using these same measures to - and giving you the opportunity to demonstrate the impact of your work.

So there's no question that - it would not surprise me if your measures are higher than what we're seeing in a lot of the community health centers.

(Mary Tom): Yes and I think (Jim Macrae) says it time and time again, "Tell us the story behind the numbers," but you've got to give us the numbers too.

Woman: Yes.

(Mary Tom): But you've got to set those benchmarks and you've got to say, "All right, you know, you've got the Simply Healthy Café, is there some way that you can measure exactly if they're eating at the café and they're eating healthy foods and making healthy food choices nutritionally and you know, doing physical exercise and what not?

The garden plots, if you can do a benchmark and say that you know, there's been improvement in their BMIs and their diabetes hemoglobin counts and their hypertension, all of that is valued. But it has to be recorded and data driven. And (Mylee) I think that you fully understand that.

(Mylee) was the EPI director for (Papa Ola Lokahi) and so she is a master in data collection.

Woman: Oh great.

Coordinator: At this time there are no further questions.

Joanne Galindo: Well thank you very much for being with us on the call. And as I said, we will have a call to discuss the financial measures and that will be on June 5. And you'll get an email about that so that you'll know where and when to call.

And look for the replay of the call on the technical assistance web site. Thank you so much for joining us. Thank you (Ed) and (Candice) and (Mary) and all of the grantees in Hawaii. Mahalo.

Coordinator: Thank you for joining today's conference call. All parties may disconnect at this time.

END