

**State and Regional Primary Care Association (PCA)  
Data Clarification Technical Assistance Call**

**Moderator: Denise Nguyen  
April 5, 2012  
2:30 pm ET**

Coordinator: Welcome and thanks for standing by. At this time all participants are in a listen-only mode. During the question-and-answer session please press star-1 on your touchtone phone.

Today's conference is being recorded. If anyone has any objections you may disconnect at this time. Now I'd like to go ahead and turn today's call over to Tonya Bowers. Ma'am, you may begin.

Tonya Bowers: Thank you very much and thanks to everyone on the phone. I'm sending apologies from Jim Macrae who can't be here this afternoon. He's actually downtown with the Secretary at an event and so he apologizes for not being with you today.

I just wanted to reiterate that today's call is really focusing on clarifying data reports for the PCA FY 2012 PCA Competitive Grant. And we'll give you a lot of information about that shortly.

First, I just want to acknowledge and appreciate everyone's patience for us as we embark on a new competitive opportunity for our PCAs this year. We know there's been a lot of challenges thus far with this application guidance and working with in Grants.gov and EHB and there's been some data challenges. And we appreciate everyone's patience in working with us as we get all of these issues resolved.

What I can tell you is that we know there's been a lot of questions on where to find certain things in applications. For instance, where is the 424A form? Where do I upload my budget narrative, my project narrative?

We are working with our contractors, REI Systems, to resolve all of those issues and hopefully within the next 24 hours - 48 hours at the most you will see all of those - that information in your EHB application.

We will be providing you with new instructions through EHB in order to complete the application and hopefully resolve all of these system-based issues that you're experiencing right now. So again, we really appreciate your patience working with us.

And if you continue to have questions or concerns about what you're seeing in EHB, how to interact with the system, information to provide, please feel free to send any of your questions to [BPHCPCA@HRSA.gov](mailto:BPHCPCA@HRSA.gov) and we will get that information as quickly as possible.

Also note, we will be posting frequently asked questions on our website so we encourage you to check back at that website as often as possible, just so that you can get the most up to date information.

For today's call we will be focusing on clarifications on the data reports as I said earlier for the PCA competitive funding opportunity for 2012. And at this point I guess I will turn it over to Suma Nair who is the Director of the Office of Quality and Data here in the Bureau of Primary Health Care. Suma?

Suma Nair: Great, thank you, Tonya. I want to make sure that everyone had the opportunity to download the slides for today. If you haven't they're posted at the Technical Assistance webpage for this funding opportunity, encourage you to pull those down.

It is [www.hrsa.gov/grants/apply/assistance/pca/](http://www.hrsa.gov/grants/apply/assistance/pca/) and you should be able to find that information. If you perchance don't have those in front of you we'll talk about the three items that you might want to have in front of you that will help you track along as we provide clarification on the call today.

So thank you for joining us. And really thanks to your insightful questions about the performance profiles and the conditions report that we were able to send. We identified a couple of opportunities for clarification.

So what we'd like to do on the call today is during our time together, one, provide additional clarification on each one of the metrics including the related data sources and how we calculated the different percentages because they are a little different than how we've done things before, how you've seen some of this data represented before so that's an important point.

Two, talk about how to use the data for your planning purposes and our intention behind sharing this data for this new opportunity. And then finally, open the lines for any additional questions that you may have and we ask that you ask questions more generally about the data and the metrics.

If you have very nuance questions about my state has, you know, X grantees in the numerator here but I think I really have, you know, Y in my total portfolio, send those in to the email box Tonya just mentioned, the PCA -

[BPHCPA@HRSA.gov](mailto:BPHCPA@HRSA.gov) email address and we'll get back to you guys one on one and provide any clarifications or additional information so that you have the appropriate data.

So let's start with what information you should have in front of you or you should be looking at a minimum in preparation for your application and your planning for this application.

One, we hope that you've all received the health center condition report. Two, you should have received the state performance profile. And then finally, you should have received the metric definition document. We provided updates about a week or two after the P&I and so that was the second round of information that we provided that included the additional metric documentation.

But subsequently, again, because of your great questions we identified a data error with the audit metric and so we've provided updated information this morning so encourage you to pull that down and have that in front of you if you haven't accessed it from your email. They were sent this morning around 10 o'clock or so and so make sure that you have that in front of you.

Okay, so with that let's go ahead and start on our slides and let's start with the health center condition report and talk a little bit about the information in that. The metric definition document, it's essentially what I'm going to be describing as we go through all of the slides today.

So you can have it in front of you but you won't necessarily - if you don't have the slides it might be helpful to have that reference document in front of you.

Great, so Slide 3 is a snapshot of a health center condition report. So the health center condition report aligns with the health center program requirements goal in the application. It provides you with data on how many grantees the overall percentage in your state currently have a condition on their grants.

So let's talk about on the next slide a little bit about the definition of how we came up with this metric. For each one of the metric I'll talk about the universe of grantees that we considered, those that then qualified for the numerator, and how we came up with the actual percentage.

So for this particular measure, the universe was the total number of currently funded or active health center grantees as of March 28. We pulled this information from the electronic handbook.

For the numerator we looked at all grantees that have no conditions within the last 12 months. And you all are familiar, conditions can come on and come off and some are put on and they're quickly addressed and removed. Others come on and it takes a little bit more time for grantees to come into compliance and they move through the progressive action cycle.

So we've taken this yearlong, 12-month snapshot as a proxy for what are some of the key program requirement challenges that the health centers have experienced at large over the last year. So remember to keep that in mind.

An important note about this spreadsheet with the condition report, we all fall into the - whenever you see a bunch of numbers in various rows you

want to sum them at the bottom. I think that would be a misrepresentation here and so we have that note that we've highlighted. You can't add up the number of conditions and get to the total number of grantees.

So on the revision we've included a line, a row that says the total number of unique grantees with conditions. So here, for example, on the sample it's seven. And you'll notice that with all of the conditions that are listed you only see one, two or - you know, one or two next to them.

So of those seven grantees they can have more than one of these conditions on that particular grantee. So the note that we have there at the bottom that you can't add all these up, a grantee can have multiple conditions. And then finally we've drawn your attention to where you can access more information on the 19 key program requirements if you need that.

The other piece here is just in case you're wondering what the R12, R12.2, etc., that's just data that we've pulled from our system, that's how we code them in the electronic system. That actually has no impact on you and you don't need to pay any attention to that; no special significance associated with those.

So for more information on the key program requirements and what each of these conditions stem from you can, of course, go to our website. In addition - the website lists all of the requirements. In addition to the website - where you find the key program requirements on the website, there's also a link to the health center site visit guide.

And I think that's a nice opportunity to work closely with looking at the requirements that gives you a sense of what we look for in terms of evidence

of compliance with these program requirements and might be helpful as you're considering training and technical assistance around some of these domains.

So let's then move on to the next metric, Slide 5. Now, we're shifting from program compliance to clinical performance improvement and that next section in the application around clinical performance improvement goal.

So here's where we're going to start - we're going to start with the overall metric around clinical performance and Healthy People 2020 and then I'll walk you through each of the six subsequent measures that really hone in on a particular clinical measure.

And again, it's important that I'll go through each of them because each of them have a slight nuance around their numerator and denominator that's important to keep in mind as you're looking at this.

So in terms of overall, the data here that you'll see is for each state. So I know the measures read state/region but the way we've developed the state profiles they are state. For those of you who are regional primary care associations, you'll get all of the states that are connected with your region. And just keep in mind that the profile data is based on state numbers.

So the metric here is the number of grantees who have met or exceeded Healthy People 2020 goals on at least one clinical measure out of the six clinical measures that we have here.

The universe is all grantees who have reported on the 2010 UDS, that's an important point of differentiation from the previous metric that we talked

about that's just the entire universe of currently funded health center grantees.

So for example, on the condition metric, our universe was about 1,126. When we look at UDS overall it's actually 1,124 so that's where I think some of the questions stem from understanding the universe of grantees.

So an important note as we get into the subsequent clinical measures is if we - we have different universes for each one of the clinical measures and I think you'll - particularly start to see this when we get to low birth weight and prenatal patients where if a grantee wasn't providing these services directly then they would not be included in the UDS. So if we had zero or grantee didn't report on that metric they're not included in our calculation.

So again, an important note because this is a little bit of a different representation than how we usually talk about clinical measures.

We're really focused on meeting or exceeding the Health People 2020 goal in this set of measures that we're talking about here, which is a little different than how you see it portrayed in the national UDS report, the data averages where we actually talk about performance on a particular measure, not performance against Healthy People 2020. So that's an important part of clarification and I'll highlight that again.

So the goal with these measures at large is that we want to know that - we want all of our health centers to meet or exceed Healthy People 2020 on all of the measures. However, we know that given each health center's unique target populations and environments that it may not be feasible for every measure.

So we're looking at least one as a proxy for - and insuring that we are providing high quality, evidenced based, culturally competent care and that it's ultimately improving patient outcomes. So that's really what we're looking towards when we talk about the Healthy People measures.

For more information on these metrics in addition to the data that we've presented, we encourage you to look at the Healthy People 2020 website to understand how they came up with their benchmarks and goals and their numerators and denominators. That will be helpful, as well as - since all of these metrics are rooted in - or come from the UDS, the UDS manual would be a very helpful resource for you as you're kind of thinking about these and making plans connected with these metrics.

So let's move on now to each specific one and we'll start with childhood immunizations first. So on Slide 6, childhood immunizations, our Healthy People 2020 goal at large is 80%.

So Healthy People 2020 is looking for 80% of children or pediatric patients to have - made sure that they have gotten all of the immunization and the series of immunization by year - by age 2. So what we're looking at here is our universe for this measure is all grantees who reported on the childhood immunization measure in their 2010 UDS.

And then the numerator is we looked at all of our grantees and those who had an 80% or higher performance rate on this measure, they were included in the numerator. And that's how we came up with our performance data around this.

Again, an important note here, this is different than the national and state averages that you've seen. For example, if you go on the UDS website and you pull down the rollup reports, if you look at childhood immunization you're going to notice that the rate there is 74%. So 74% of our pediatric patients across the entire health center program are getting the full series of their vaccines by age 2.

This is different than this metric, which is looking at performance against the Healthy People 2020 goal. So nationally with our performance against Healthy People 2020, 35% of health centers are meeting or exceeding our Healthy People 2020 goal. So that's an important point of clarification that we need to look at.

For more information, again, the Healthy People 2020 website and the UDS website is going to be helpful. And as you look and you're wondering where these calculations and data come from, you have access to your state rollups as well as the national rollups.

Table 6B and Table 7 in the UDS, the quality of care indicators and the health outcomes and disparities indicators are where you want to go for more information and to look at the actual state performance on each of these metrics.

So again, if you have questions about the definitions or calculations we encourage you to make sure that you look at the 2010 UDS manual. If you go to the UDS website you'll see the 11 but also on the right-hand side in a box you'll see the 2010, 2009, and 2008 manuals.

Make sure that you're pulling the 2010 manual and you'll get details around which vaccine, what were the exclusion criteria, what were the inclusion criteria, all important information as you're digging into this data and developing your application.

We'll move on to now Slide 7 and look at the next measure around diabetic patients with hemoglobin A1cs less than or equal to 9%. So again, similar issues as I mentioned before with the childhood immunization. The universe here is all of the grantees that reported on this particular measure that they're providing diabetic care and measuring hemoglobin A1c.

And the numerator is all grantees who's performance met or exceeded the goal of 85.4% of the patients having their hemoglobin A1c under or equal 9%. So again, our national performance, how we're doing with our patients, about 71% of our patients are under control, you know, less than or equal to 9.

However, when we look at the Healthy People 2020 goals we see that 11.5% of our health centers are meeting or exceeding those goals. Again, tough national goals that are set for 2020 but that's the difference in those numbers.

If we move on then to Slide 8 we can look at the PAP test. The universe, again, here are those who have reported on this particular clinical measure and the numerator are all of those grantees who have reported that more than 93% of their female patients that are in the criteria for this measure have received their PAP test.

So our national average on performance - national average performance here is about 58%. 57.8% of our women have met this metric. When we compare it to the standard in Healthy People 2020, which is a pretty high threshold, their goal is to have 93% of women screened, we find that we're only at 1.8%. So this is one of those opportunities that we have to understand why the data is how it is. And so that's the information that we have on the PAP test.

Moving then ahead to Slide 9. Looking at hypertension, again, the universe for this is all of the health centers who have reported 2010 UDS on this clinical measure. The numerator is those who have met or exceeded the Healthy People 2020 goal of 61.2% of patients had their blood pressure less than 140/90. Nationally about 62.3% of our patients report having this clinical outcome. However, when we look at the Healthy People - the benchmark against the Healthy People 2020 goal we see that 56.4% of our health centers are meeting or exceeding the Healthy People 2020 goal.

I'll now move forward to Slide 10 and talk about low birth weight and entering into prenatal care. And this is where I mentioned earlier where there's a little opportunity for some changes - significant changes in the denominators here or the universe that we're looking at.

So with low birth weight and early entry into prenatal care you'll notice the difference in the universe that's reported out on these measures. So if you generally have 17 grantees in your state, for example, and the universe is 17 for most of your clinical measures, you may see that only 13, for example, are reporting on these clinical indicators that are related to the provision of prenatal care and birth outcomes. So this is to be expected. If some health

centers don't provide prenatal care and/or labor and delivery services directly, they don't report on these measures.

So here are the numerator and the universe for the low birth weight metric. The universe is all grantees who have reported on this measure in the 2010 UDS. The numerator is all grantees who have reported they've met or exceed the goal set in Healthy People 2020, which is 7.8% of live births being low birth weight, less than 2,500 grams.

So for our national average, we're actually doing pretty well, 7.4% of our live births are less than 2,500 grams. And for Healthy People 2020 the goal is have 58% of our health centers have met or exceeded that goal.

So again, similarly on Slide 11, when we move towards looking at entry into prenatal care we have that similar issue. So the universe, again, is all of those health centers who have reported on this metric in the UDS for 2010. And the numerator is looking at those who have had 77.9% of their prenatal patients receiving care in the first trimester.

Nationally our performance on this measure is about 69% of our pregnant women are getting care in the first trimester. Then our performance against Healthy People 2020 is 34.9% of our health centers are meeting or exceeding this goal of getting 77.9% of their women into care in the first trimester.

So now we're moving away from the key clinical measures in the UDS and we're going to look at patient centered medical home. So again, a bit of a different universe with our grantees.

So here, we're looking at patient centered medical home and the universe is the number of grantees who reported in 2010 UDS. So we've used that numerator and that - excuse me, that universe or denominator and here the number's about 1,124 grantees.

The numerator now is - and I'll parse this out but it's a couple of pieces here. It's the number of health centers with at least one site that has been recognized as a patient centered medical home in the last 3 years. So that would include folks who are recognized through NCQA, The Joint Commission, or AAAHC.

We do understand that there have more recently in the last year or so been some states that have been developing their own recognition process that is not included in here. The data source behind this is the information we've received from these three recognition bodies and that we have as a part of our patient centered medical home initiative. So that's where that's coming from.

We would entertain as we've said before in other venues, including health centers that are recognized by state or another national level recognition body as long as they have published standards that are equivalent to NCQA or some of the other PCMH recognition standards.

Please send that information to us and then we'll make sure to include that. It's also information that you can include in your application. But this data is only reflective of the information that we had from the vendors and our own initiative as of March 12. And this is a bit of an evolving process. Grantees are always putting in NOIs and going through the recognition process so we - there may be a bit of flux either way on this measure.

And if you have additional information we encourage you, one, to get that information and let us know so that we can make sure that it's captured. And then two, of course, you would use this with additional landscape information that you have as you develop your training and technical assistance plan and your application further.

And the important point about this also is, one, it's site level because some recognition standards are not site level. They're health center level and others are site level. So we're saying if you have at least one site that it would be included in this metric.

Okay, now we're going to depart from the clinical realm and move on to our financial performance measures. So if you would move to Slide 13 we'll look at the percentage of health center program grantees with a cost increase less than the national average.

So you'll have to track with me here - this is a bit of a complicated measure and we'll walk you through the logic behind this. So on this measure the universe here is, again, all of our grantees that reported the 2010 UDS. You may be wondering why we're looking at UDS on this particular measure. Well, this data for cost per patient comes - total cost per patient actually comes from the UDS table.

So let's start with the metric of total cost for patient, understand where we, how we got that from the UDS, and then we'll back into the measure at large. So if you go back and look at Table 8A, Line 17, Column C you'll see the information around total accrued cost after allocation of facilities and administrative costs.

So we took that number for total cost, again, Table 8A, Line 17, Column C, and we divided it by the total number of patients that you reported in your UDS for that year. The total number of patients is taken from Table 3A, Line 39, the sum of Column A and B on Line 39.

So we divided the total cost per the total patient and we came up with your total cost per patient.

So then when we looked at - as the measure defined percent increase, we took the information provided in each grantee's 2009 UDS and we subtracted it from your cost increase reported in - your cost per patient reported in 2010. And then we divided by the data from 2009 to get the percent increase.

Once we had the percent increase we compared it. Our comparison point was CMS National Health Expenditure Data. And if you go back to the website that's been shared before and that's in the slide you'll see that the CMS National Health Expenditure rate for 2010 was 3.94. So we compared it.

So the universe is all of our grantees who reported 2010 UDS and then how we defined the numerator was if your cost increase using the calculation I just mentioned looking at 2010 costs minus 2009 costs per patient.

If that cost increase was less than 3.94% then you are included in the numerator for this metric that was looking at the percentage of our health centers that had a cost increase less than the national average, the CMS National Health Expenditure Rate.

It's a complicated measure but that's how we calculated this measure. For more information you want to check out the CMS website to learn a little bit more about the National Health Expenditure Data, and again, for the definitions of how we calculated cost per patient and how we did this metric, go ahead and look at the UDS manual, Table 8A and Table 3A for that information.

Okay, and we've heard feedback that this may not be the most ideal measure ever but cost is actually a critically important area and I think most - many of you know that and understand that very, very well. And so it's an important area for us to keep focus on, which is one of the reasons that we've looked at this.

And it was helpful for us to have a national comparison point, which is why we selected to look at the CMS National Health Expenditure Data. And it is something that the health center program at large is being measured against, if you will. So it's important for us to continue to look at that and think about that.

So then getting to our last measure on Slide 14, let's look at the percent of health center program grantees without a going concern issue. So this is the second of our two financial measures that we have. And with this measure we're really looking at extreme cases.

As a going concern issue on an audit it's typically indicative of serious issues at a health center and concern with the near term financial variability and solvency of that organization.

So we really want to look at that as a proxy for if the trend starts to move in a bad direction. If we get further away from 100% there are some issues that we need to look at.

So the numerator and universe here. The universe was all of the grantees who had submitted their 2010 audit report to HRSA and that we had had an opportunity to review that. So the number here we're thinking it's about 1,070 grantees out of our 1,100. And again, this variability is connected to the differences in each of our health center's fiscal year end date.

So as you know, health centers have about 9 months after their fiscal year end date to submit their final audit to us. At that time we receive it and we review it. And one of the issues that you can note on their audit is whether or not the auditor identified this grantee as having a going concern. If they did then they would not be included in the numerator of this metric. So again, all of those grantees who we have received their 2010 audit and reviewed it by March 28 were included in the universe. So it may not be all of your grantees.

And then in terms of the numerator, it was all of those grantees that did not have a going concern that were added to numerator as we calculated this metric.

We could have also looked at it - some of you had asked about most recent audit. We started to slice some of that data. We really did focus on the 2010 fiscal year because we had the most data and it was the best representation of the health center program at large and each one of - what's happening in each one of your states. So we did end up with 2010.

If we had looked at the most recent audit we would have probably had maybe one additional, you know, change. So it was not any significant variance. So we feel comfortable with the fact that the 2010 data is representative of what's currently happening in terms of going concerns with our grantees.

So with that, that brings us to the end of discussing each of these metrics in large. And before I hand it back over to Denise and open it for questions I would like to spend a moment just talking about the use of this data and why we've shared it connected to this new PCA application.

You know, this is data that we currently have available here in the health center program in the Bureau and that we're focused on. You know, as I mentioned at the beginning, this is truly a minimum dataset for you to consider - consult as you develop your training and technical assistance plan in your application.

Most of you have far more granular data and environmental surveillance insight and information as to what's happening in your state or your region. And this is simply meant to complement that insight.

We've always said that it's so important not to look at the numbers in isolation and that that would be really dangerous in terms of program planning or training and technical assistance planning.

So we encourage you to look at this information as proxy data and combine it with the additional granular information that you have through data that you have from your health centers and your own experience with health centers over these years.

And build that up to tell the story behind the data and then identify from that story and that analysis, what are the strategies that would truly have the most impact in terms of facilitating improvement and advancing the health center program at large.

So with that I ask you to keep that in mind as you look at the data and are pulling that together and forming your application. I'll turn it back over to Denise.

Denise Nguyen: So now we'll open the floor up for any questions that you may have.

Coordinator: Thank you. We will now begin the question-and-answer session. If you'd like to ask a question over the phone please press star-1. Please unmute your phone and record your name clearly when prompted. Your name is required to introduce your question.

Again, if you would like to ask a question over the phone please press star-1. To withdraw your question press star-2. One moment please for the first question over the phone.

The first question comes from (Kathy Davis). Your line is open.

(Kathy Davis): Hi, question on the financial performance goal, on both of them actually. Percentage of health center program grantees with cost increase less than national average. Was any consideration given for those centers that have added big sites. Like a lot of these capital projects finally came online in the last couple of years.

As an example, we have one health center that converted an entire Sears building into a health center. His costs, of course, went up.

So was any - was there any look at that at all?

Suma Nair: Great, thank you. Great question, (Kathy). So as we mentioned, the administrative and facility costs were not included in this cost. It was a total accrued cost minus those allocated for facilities and administrative divided by the total number of patients. So hopefully that won't play into this as so much of an issue.

And again, it's really looking at your baseline and defining that baseline and looking towards making sure there's not any significant increases in the cost per patient. And that generally speaking we try to stay below the national average there because that is something that we're being looked at.

We know there might be exceptions and there's stories to explain some of this but it's something that we want to keep track of at a high level.

(Kathy Davis): Okay, and then - thank you. My second question was a number of health center program grantees without a going concern. I mean we did pretty good on this one but there are a couple where it's been listed as a going concern.

Now in terms of the audit, at least in my state, we don't typically get the health center audit. So it that something that you all would be sharing with us in terms of who those centers are? Because that's a more targeted approach than doing a training for 18 centers that didn't have a going concern versus the two that did.

Suma Nair: So we can't share grantee level information at this point. I think there's probably information that you have through your ongoing work with health centers that may give you some ideas about who those grantees may be.

But in terms of - for this opportunity we really want to be focused on state level data. And so with respect to that, again, if there's one out of your state, the general auspice of this opportunity is really looking at what would be most impactful statewide. So you want to look at what are those training and technical assistance opportunities for your larger pool of health center grantees in your state.

And as I mentioned, you know, again, if you're one of those states who have 100%, none of your grantees at this point had a going concern, so there may not be an issue that is so critical. We talked about this really extremely when a grantee has a going concern.

However, there's a fair amount of preventative training and technical assistance that you may want to do. You may want to look more deeply in talking and working with your grantees to understand some of the financial areas that they may have an audit finding on or areas that have been flagged for health centers to focus on, especially in lieu of kind of emerging health landscape, the financial situation where you are.

Those are all things that we want to make sure that we're thinking about and develop training and technical assistance to prevent any more grantees having going concerns in the future.

So with the idea that you're looking at more broadly - broad technical assistance rather than honing in on one or two grantees with this

cooperative agreement opportunity. You should be looking more toward prevention.

(Kathy Davis): Okay. I still have a concern about that but I'll let it go for now. Thank you so much.

Coordinator: The next question comes from (Nancy Houck). Your line is open.

(Nancy Houck): Hi. Were these state reports emailed to us or are we supposed to go somewhere and get them because I don't have them.

Suma Nair: They were sent out this morning around 10 o'clock or so. I believe they were sent to the CEOs of all of our primary care associations, as well as if there's anyone who is not currently a primary care association that is working on an application. You can again connect - contact Denise at the email address [bphcpca@hrsa.gov](mailto:bphcpca@hrsa.gov) and request the information for the states that you're interested in.

(Nancy Houck): Okay, thanks.

Coordinator: The next question comes from Susan Wilson. Your line is open.

Susan Wilson: Good afternoon and thanks for the very thorough explanation. I hope this is an easy question. We would like to use the PowerPoint slides for training for our health centers. And I noticed that on the formula definitions it says, "Healthy People 2010 goals," instead of 2020. Is there any chance of getting a revised slide set?

Tonya Bowers: Yes we will make that change. We noted some as we kind of cut and paste some of these formulas. We've had clinical measure where it probably should have been financial measures. But we'll make those corrections and post this up in the next day or so.

Susan Wilson: Thank you very much.

Coordinator: The next question comes from Keith Maxwell. Your line is open.

Keith Maxwell: Hi. It's a follow up to (Kathy)'s question in the sense that the last measure, the going concerns status measure. You know my understanding is that there's a strict read of something that would show up in the text of the letter.

But I guess my question is, the review that was done on the audits available, how was that scripted? Do you - were you asking folks to go through, you know, the audit standard related to this and look for anything that's noted there which is some ways broad -- negative trends or our level of debt, et cetera, et cetera?

Suma Nair: Sure, great question. Thank you, Keith. No, it was a strict read against the letter that said to use the term, "Going concern."

Tonya Bowers: The management letter.

Suma Nair: Yeah the management letter is the audit. So it was not further analysis by anyone here in the Bureau on additional findings and us making our own determination. It was that strict read of what was written in the management letter around that there's a going concern.

Keith Maxwell: Okay that's a good clarification for me. And just a process question. If we did have specifics on our report that we didn't - well in our case I don't - I still don't think we have credit so to speak for three PCMH centers that have NCQA status, and given the last stance you all have to go back and look at some of the audits and the audit letters.

But is it important for us to resolve any differences in how we see the data than the way you presented it, in order to use this as a baseline in our applications?

Suma Nair: Sure I think that's helpful. You know, as I mentioned you guys have a much better understanding of the day-to-day really what's happening on the ground and so we encourage you. This as I mentioned is just a minimum data set of what we have available to us today and, you know, at the point in time those data points were collected and shared back with you.

So our expectation is that you have a lot more insight and data around this, so we would expect to see some of that in your explanation of how you set your benchmark and baseline and how you set your goal for each year in the entire project period.

So we would - I think we would present what we have here but if we see additional data or, you know, slightly increased or lower data on some of these points, if you have an explanation to back it up I think that's perfectly legitimate.

Keith Maxwell: Okay thank you.

Suma Nair: And another important note I think I didn't - I failed to mention earlier. But as we have these questions is, and perhaps in some of these domains, as you're developing your training and technical assistance plan, you feel like these are helpful high level proxy measures.

But you may have a sense of, "Boy we've been working on X or Y in the state and this is a measure that we have gotten all of our health centers to collect or this is data that we have that we feel would be, you know, a little bit more representational of our efforts around X training strategy or Y training strategy." You can feel free to include additional metrics and data in your work plan, in your narrative.

At a minimum the work that you do and the plan that you develop has to address all of these, as was mentioned in the application. But you should feel free if you have additional data and metrics you want to include in developing your application to include those.

Keith Maxwell: Thanks.

Coordinator: The next question comes from (Carol Reid). Your line is open.

(Carole Reid): Yes. On the percent of health center program grantees with the patients that are medical home recognition, is that just Level 3 or is that any level?

Suma Nair: Great question. It's - and that's a good point that I didn't mention on here. It is any level of recognition because some of the recognition organizations don't have that differentiation between levels. For example The Joint Commission and AAAHC, you get recognition or not, and NCQA the one to our knowledge at this point that has that tiered structure. So we would

include any level of recognition for at least one health center site to allow you to be included in the numerator.

(Carole Reid): Okay thank you.

Coordinator: The next question comes from (Karen Northup). Your line is open.

(Karen Northup): Thank you and thanks for doing the call. This has been tremendously helpful. My question - well anyway here goes. The list of program conditions is obviously very helpful in terms of planning statewide training opportunities.

But if for example we have one grantee who should call and say, "Our Board is really struggling with strategic planning. Perhaps we attended the workshop and that was covered and we really still need some help, could you come and facilitate? Can you come and talk to our Board? Can you send us resources?" Is that kind of a technical assistance something that we may include in our applications?

Marquita Cullom-Stott: I think that with regard to helping a larger group versus an individual group, I mean our expectation only is to help the larger group. However, you know, if there are organizations that need specific help of course we would expect for some level of TA to be provided to them.

(Karen Northup): That's very helpful, thank you.

Coordinator: The next question comes from (Jody Samuel). Your line is open.

(Jody Samuel): Hi thank you. Yes, I was actually wondering, in terms of the fact that we have this baseline information but this is the first time that we really are being

asked to, you know, use this as a baseline and then provide and set our own goal for what I understand to be the end of the 5-year cooperative agreement, which is extremely hard to predict of course.

And it's not as though we can go back and see for example or have office for the previous 3 years or 5 years specifically see each year how we've been doing so far.

So I'm just curious to know if there is some additional insider guidance that can be provided in terms of how ambitious we should be in setting those 5-year goals. I mean ideally of course we want everything to be 100% perfect but we all know that's not going to happen.

Suma Nair: Right. And I think - you know, that's really where it presents the opportunity to look at what's happening in your particular landscape. I think looking at - on some of these really more emerging areas like patients in the medical home, there's a lot of work and initiatives around that to understanding where your health centers are.

There's data that we're sharing with you. I mean I think there's a fair amount of data out in the, you know, eco about patients in the medical home and the safety net and health centers that are connected with that and we know there's a lot of faith based initiatives happening.

So that level of on the ground information would probably be very supportive and you figuring out what the 5-year goal would be and what the benchmarks are in your annual targets are as well.

So we would say to be aggressive and have good goals but also be realistic and grounded in what your health center experience is now, as well as what you see the, you know, immediate couple of years bringing for your health centers in terms of, you know, funding other state initiatives, transformation in the landscape. All of those issues that you consider and that should inform how you make, you know, how you set some of your goals.

And again with other opportunities that we've provided there is some opportunity once you've set your bench baseline and your 5-year goal, from year-to-year as you work with your grantees there may be a little bit of flexibility. For example right now you've set your 5 year goals and your annual targets.

As you start to have real experience around this and say we're in year two or three, there may be opportunities to make some modifications. Of course those would have to be explained and backed up around some of your measures.

But we really are focused on improving from where you are today and where your health centers are today to meet some of these goals and - but understanding and taking into consideration the context within which your health centers are operating.

(Jody Samuel): Okay thank you. And then just a second question about the Healthy People 2020 measures and the clinical performance goal - improvement goals in those areas. Just to clarify, because there are going to be differences in the services provided at the different health centers that we support, is it the intent that we indicate by sort of subcategory which doctors we're looking at?

My understanding was that we are really looking at the overall goal and then could look at the individual items as well in terms of like again sort of the landscape analysis of where our clinics are and where we can target some of our TA.

But that because there are differences and services provided, that in terms of what we actually set as our 5-year goal that we're looking at that overall larger total goal and performing better on one or more of the sub measures.

Suma Nair: Exactly. And that's why though the one in the application is that larger overall goal of all health centers meeting or exceeding on at least one clinical measure. So I think that sounds great.

(Jody Samuel): Okay thank you.

Coordinator: The next question comes from Brenda Thompson. Your line is open.

Brenda Thompson: Thank you and thank you so much for this clarification. It's very helpful. I've two quick and easy questions. The reports that you said were sent out this morning, was that an updated state performance profile if we have one from March 12 or is that the same one that would have gone out this morning?

Suma Nair: So there was two pieces of updates. You know, I mentioned three documents that we have been sharing. This morning what we shared was a revised state performance profile and a revised metric definition for the profile. There were no changes in the condition reports. And again those were sent to the email addresses that we have on file for each of your CEOs at the PCAs.

Brenda Thompson: Okay. So if we didn't receive those I'll be emailing Denise.

Suma Nair: Correct.

Brenda Thompson: And the second question I have is in regard to the denominator. Your explanation was really helpful. Would we know if we our denominator is ever not 100% of our grantees?

Suma Nair: I think you can work backwards because, you know, you have the sense of how many grantees you have as of today, right? And using - because we've provided the number -- the numerator and the percentage -- you could work backwards to figure out your denominator and that will give you a sense of if it's everyone in your - you know, if it's your whole pool of currently funded grantees or not.

Brenda Thompson: Okay thank you.

Suma Nair: Sure.

Coordinator: The next question comes from (Robert Shirakawa). Your line is open.

(Robert Shirakawa): Yes I think - well actually was sort of - well the question was sort of answered but I want to ask it again. In terms of the baseline measures, we're given 2010 data. Are we able to use more current data if we have it for baseline?

Suma Nair: Yeah that would be wonderful. We're - we used to say that all of the grantees have submitted their 2011 UDS. And so they all have their - you know, the

actual data submission. Once they submitted it into EHB to the Bureau, they also can access the report of what they submitted.

So if you have that data and they've shared it with you, you should by all means use that data. And again as I mentioned earlier it's one of the questions. We're presenting what we have at a point in time and it's the best data that we have here in the Bureau, full well knowing that you have a fair amount of additional data and information that you should bring into developing your planning, and so if you want by all means use that data.

(Robert Shirakawa): Thank you.

Coordinator: The next question comes from (Andrea Arthur). Your line is open.

(Andrea Arthur): Thank you. I just wanted to be sure of how we're defining what is training and what is technical assistance. I thought I had heard kind of two different answers to individual TA versus overall state training. So can you just define what do you mean by training and what do you mean by technical assistance?

And then also in terms of the updates for the FAQs -- frequently asked questions -- I'm not sure if they're being updated and when and how? If when they do those updates, if they can put a last updated by so we can be sure we have the most recent information.

There was some things that happened and questions that were asked then at first TA call that was going - they said were going to be addressed in the FAQs that I'm not seeing the answers for, so thank you.

Suma Nair: Sure great questions. We will - that was great advice. We will make sure that we add the updated as of date on the FAQs, and we haven't put a new set of FAQs because we wanted to have the call and we knew that you guys would come up with additional great question, so we wanted to hold and include these questions and then put them all out. So in the next few days you should see a revised FAQ list that we'll include the questions from the first set - from the first conference call, as well as some of the great questions you've asked around data clarification.

(Andrea Arthur): Thank you.

Marquita Cullom-Stott: And then to the first point of your question with regard to defining training and technical assistance. I think we kind of used it interchangeably and I think that...

(Andrea Arthur): Okay.

Marquita Cullom-Stott: ...without really knowing what - you know, what types of training and technical assistance you're going to propose, but it's really to your discretion to determine which one do you think is more appropriate to you? I mean right now it's kind of interchangeable.

(Andrea Arthur): Okay thank you.

Coordinator: And right now I'm showing no further questions. As a reminder, if you'd like to ask a question on the phone please press star 1. One moment please to see if we have any other questions.

Suma Nair: Are there any further questions?

Coordinator: I do have another question over the phone.

Suma Nair: Great.

Coordinator: And Stefanie Lindeman, your line is open.

Stefanie Lindeman: Hi, thanks for taking my question and thanks so much for the call. The clarification on setting our target was very helpful and I appreciate knowing we can bring in other measures.

But I'm also wondering, to what extent we might be able in some of these areas where we might not have been looking at things quite the way you're asking us to now, where we can consider the first 12 months of our cooperative agreement to sort of a ramp up year that's going to allow us to assess the landscape as it were and sort of understand how we should be addressing the particular measures. I'm thinking specifically about the finance and operations measures.

Suma Nair: So I think that you have some awareness of this information and still opportunity to get additional information and insight. I think it will be important as we look at this competitive application opportunity for you to have an application that's grounded in some data and that substantiates then the strategies of the technical assistance plans that you have in place.

As we mentioned, you can set the 5-year goal. And if there's need then as you go through and start to do some of this work and you find, "Oh what was an issue a year ago is now no longer an issue and we have another set of issues," you know, there's some opportunities to tweak around the edges.

But we do encourage you to do your best with this and, you know, you will have the opportunity to do a yearly goal.

So if you have a sense of what's happening in the landscape now but you're not 100% confident that that's going to be still the case in 5 years from now, you've - as we've said you have the opportunity to do annual goals as well.

And so you can do your best with figuring out with this opportunity to training and technical goal assistance that you proposed where you will be in a year from now and then, you know, that will then inform what your next goal would be in kind of your next set of activities. Because this work plan speaks highly to 5 years but the specific activities are for 1 year.

Denise Nguyen: Yeah so the project work plan is supposed to be for a 12-month period. So the only difference is the goals are established for 5 years but the rest of the work plan in terms of your activities is supposed to be set for 1 year.

And then if funded on an annual basis, you'll have an opportunity to do a noncompeting continuation, and at that point is when you have an opportunity to provide an update on the quantitative percentage and that's when, you know, you can provide just the qualitative and the quantitative updates on your progress towards that 5-year goal.

Stefanie Lindeman: Okay thank you.

Coordinator: The next question comes from Keith Maxwell. Your line is open.

Keith Maxwell: Hi, I'm wondering Suma and Tonya, for the snapshot we have just gotten, will you be tweaking and finalizing the format further and should we expect to -- I

don't know -- see if the clinical measures as soon as the review - the final review of this year's UDS is done by you folks?

Or see if for the financial measures and some other schedules based on when the CMS national health stuff is updated? Will you be institutionalizing these reports in a particular way that will relate to how we evaluate our progress?

Suma Nair: Sure. So our hope is that the data is in a good place and frozen. And I say I'm knocking on wood and with like a four leaf clover or something, we think we're static for now and you can use this information that you have, this final revised set of information we provided today in your planning, in your application development.

We are exploring then the opportunity to make a snapshot like this available to the PCAs and every year, so that you get a sense of how things are moving forward. In addition to the data and metrics that you're going to be keeping yourself as a part of this work, we would share this information annually and that's what we're thinking about. So we're trying to still figure out what the best format is but...

And remember, in many cases you have some of this information through the state and national roll up, the UDS data that you get is a part of cooperative agreement, the conditions reports you received before is part of your work in the cooperative agreement. So I think you have most of this data, but the way it's calculated here is a little bit nuanced and different, so we're looking at how do we get you that - you know, those updates every year.

Keith Maxwell: Okay thank you.

Coordinator: The next question comes from (Karen Northup). Your line is open.

(Karen Northup): Thank you. Tonya, this is (Karen Northup) from Virginia. And I wanted to clarify an issue that we briefly tested on earlier and that is that I think we've clearly got the message from HRSA that our work to be statewide additional training to reach large groups of our grantees or potential grantees and that we're - our work is to be preventive in nature and to keep folks from getting into trouble or being out of compliance and not being per requirement.

But I did want to follow up and that is that frequently a lot of our work is done with individual grantees who struggle with one particular area. For example around strategic planning or evaluating their executive director or, you know, struggling to get a particular policy or procedure in place.

And I wanted to make sure that it would be acceptable because those are preventative in nature for the individual health centers as they are doing statewide training.

I just wanted to make sure that it's okay in our work plan to include work around doing individualized stuff, technical assistance when it's not appropriate to do it in a statewide sort of training setting.

Tonya Bowers: Well (Karen) thanks for the clarification or the request for clarification. Absolutely, I mean the intent overall is to really look statewide and to move all grantees forward, to look at where there's larger areas for technical assistance and to really focus on those.

But there's an absolute understanding that there are some cases, some opportunities or where you're going to need to do a more intensive work with a particular grantee because of an individual struggle.

But the overall intent of the cooperative agreement, really the larger focus for you and for all of the PCAs that are applying here is really to look at the statewide level to really assess what you can do and where to invest your resources at a statewide level to move all grantees forward.

As it's been said before we have our national cooperative agreements that are really looking from a national perspective how to provide technical assistance and training to move all grantees, all health centers forward. And then we also as a Bureau have a technical assistance contract that provides us the opportunity to do that intensive individualized technical assistance with the grantees.

And so we're really looking for the state and regional PCAs to be that statewide, that place between what we can do and what our national cooperative agreements are doing to provide that statewide or regional technical assistance activities.

But there is again as I said an understanding that on occasion you may need to do a more individualized technical assistance activity and that's certainly appropriate, but we really do want those - the focus to be on the larger statewide or regional aspect of the cooperative agreements.

(Karen Northup): Thank you. And the reason I asked that question again and I don't mean to be asking the same questions again, Tonya, is somehow we're under the

impression - and I don't think we're the only PCAs that were absolutely not to do any individual TA technical assistance and so that's very, very helpful.

Because, you know, we do of course work very closely with the project officers, with individual grantees that are struggling and sometimes they do the TA and sometimes we do, but thank you so much. That certainly was quite helpful.

Tonya Bowers: And I would encourage you actually to continue that collaboration and that discussion with the project officers, because that's a really great opportunity to determine whether it's something you should be doing or something that we can take on from where we are and be able to support that technical assistance and that whatever is necessary for that individual grantee or health center. So I do encourage and really would hope that that collaboration, that communication would continue.

(Karen Northup): Absolutely. Absolutely. It's a great resource. It's the best way to work for the grantees, so thanks again.

Tonya Bowers: Sure.

Coordinator: The next question comes from (Lorie Real). Your line is open.

(Lorie Real): Hi thank you. This is (Lorie Real) from Bi-State Primary Care Association. I have three questions if I may. One is, when you're looking at the increasing cost per patient, do I understand that that includes the percent increase in medical, behavior, dental, clinical care as well as administrative cost?

Suma Nair: So it includes everything that you mentioned except it does not include facilities and administrative cost. So let me find my notes on that so I can make sure that I can give you that information clearly as possible.

It is - so the calculation again for total cost for patient comes from Table 8A in the UDS -- again the 2010 UDS, Line 17 Column C. And we're looking at the total accrued cost after allocation of facilities and administrative cost. And then we divide that by the total of patient number which is Line 39, Column A and B added together from Table 3A.

(Lorie Real): Okay. So I understand the location at which you're finding the information but I wanted to be sure that I understood the intent, which I believe is to look at the total cost increase in patient's clinical care.

Suma Nair: Yes.

(Lorie Real): Is that correct?

Suma Nair: Yes.

(Lorie Real): Okay. And so, can you give me any examples of what you would like to see for training and technical assistance in this area?

Suma Nair: I can't think of anything off the top of my head but I'm sure that, you know, in conferring with the CEO and, you know, the folks that you work with, you might get some good ideas about what are kind of the most appropriate issues, what are some of the concerns for your grantees and how some of this can be, you know, kind of really looked at.

And some of the things that one might think about generally in terms of opportunities to reduce or hold steady on total cost per patient, here are some of the things that we've talked about in terms of the efficiencies realized through the adoption of health information technology.

Once you have the information in EHR, thinking about transforming the way we deliver care so patients in the medical home looking at patient wait times, workflow redesign, I think all of the elements that are part of doing that work should help us realize some cost efficiencies and efficiencies in care. You know, developing care teams, all of those types of things could contribute toward holding steady on cost or even decreasing and preventing an increase.

So those are opportunities to look at in terms of training and technical assistance around some of these financial arenas, as well I'm sure there's many important state and regional nuances that come to bear that, you know, I don't dare speak of.

(Lorie Real): Okay thank you. My final question is, can you tell me what your plans are for communicating the PCA new expectations to the federally qualified health center grantees?

Tonya Bowers: Well certainly - they have actually been included - all of the health center program grantees have been included in all of the notifications on the funding opportunity. So just in the first place they've seen everything that we've been sending out.

Secondly we will continue to provide that information to our grantees through a variety of communications. But - and so that they understand the

expectations that we are placing on the cooperative agreement, so they recognize how to best utilize your resources as well.

(Lorie Real): Thank you.

Coordinator: The next question comes from (Bob Marsalli). Your line is open.

(Bob Marsalli): Hi thanks. (Bob) here from Montana PCA. A question about the CMS national health expenditure rate. I'm not familiar with that and I was wondering if you could just sort of talk a little bit about what that is and why you think that is a meaningful benchmark for community health centers.

The reason I'm asking is because I'm particularly interested in the comparison of cost of care and care quality, and I'm just curious what that CMS national health expenditure rate will do in comparing the efficacy of care and the cost of care in community health centers with standard health care delivery systems like hospital outpatient clinics, private practice clinics and things of that sort?

Suma Nair: Great that's a great question, (Bob). And so I think what we have today and kind of the best proxy I think as people looked at what can we say about health center cost and expenditure was and how we compare it to some national benchmark, was the CMS data.

I think we fully recognize that there may be better opportunities to provide a picture of health center performance and efficacy around some of this work, so we're really excited to see what you all propose.

You know, in addition to looking at this and kind of telling the story that we have to explain our performance connected to this, looking forward to hearing what you guys are proposing in terms of additional measures that you feel would be better representation and hearing how you arrived at those metrics, how you've identified the data sources and, you know, really looking at some of the data that you've been able to collect and what that says.

And I think that's going to really be helpful in terms of them looking across all the different PCAs and what you've been able to do in this domain to inform, you know, national program policy that would provide us then an opportunity to revisit this metric and see what else is out there that might be more appropriate.

(Bob Marsalli): Thank you.

Coordinator: The next question comes from (Robert Shirakawa). Your line is open.

(Robert Shirakawa): Yes I have a question about the UDS reports and the annual progress reports that we have to provide to you, and I guess my question is that those two things are going to be out of sync with each other.

So when the UDS report, when we get the UDS data it's going to be in March or April I guess. Well we're going to be providing you with the progress reports in December I'm assuming? So how do we reconcile that?

Suma Nair: So yeah we'll always be in that position where we're not technically a year behind but, you know, less than ideal. You won't have real time points and time data unless you do.

So one of the things we know many health primary care associations have worked with health center control networks and others and many of you are involved in data warehousing, at which point you will have perhaps more real time data.

So and again as a minimum data set you'll have the 11 UDS as you're thinking about your next progress report for this opportunity. But perhaps many of you will have more robust and more real time data given some of the efforts that you're doing around data collection, data warehousing that you could again by all means use in, you know, developing your annual progress reports.

(Robert Shirakawa): Thank you.

Coordinator: The next question comes from (Lorie Real). Your line is open.

(Lorie Real): Hi. I'd like to go back to the conversation about the increasing cost per patient. What we are trying to work towards is impacting the total cost of the delivery up here for patients on a per member per month basis of which the measure that you have given us is a component because that's the primary care component of the medical cost.

And I wonder if you would be open to health centers and primary care association to have access to the information, redefining this to the entire total cost of patient care rather than primary care, which in often times we're trying to actually increase the expenditure on in order to hold down the hospital emergency department and admissions and readmissions cost.

Suma Nair: See that's great and I think we'd love to see that data and that's something that you all should definitely be collecting, and we should have a sense of how that works for the larger dialogue around some of this cost. I think unfortunately because we have to have, you know, a standard set across, we can't replace one with the other but we should have both.

So I encourage you as you're developing your application to include both, and so respond to what you see here because again this is a competitive opportunity. I want everyone to be at the same playing field. And then what you have in addition to that or better representations from your perspective that would be really helpful I think and enhance your application perhaps. So we'd love to see that.

(Lorie Real): Thank you.

Suma Nair: Sure. At this time we're going to have to - because we're at time and we realize you perhaps have other commitments as do we. We're going to thank you all for joining. Hopefully we provided some clarifications to some of your first set of questions.

We realize as you go back and you start to get into the data and look at it, you may have additional questions. We encourage you to go ahead and contact us if you have additional questions at the [bphcpca@hrsa.gov](mailto:bphcpca@hrsa.gov).

In addition, look out for a revised set of slide as well as a revised set of FAQs on the technical assistance website where you found the information today, and good luck in developing your applications. We look forward to reading them. Thank you all.

Coordinator: Thank you so much for participating in today's conference call. You may disconnect your lines at this time. Thank you and have a great day.

END