Opportunities and Strategies to Strengthen Primary Care Office and Primary Care Association Collaboration

Introduction
Primary care offices (PCOs) and primary care associations (PCAs) play important roles in ensuring access to care and creating a health workforce that meets their populations’ needs. Although PCOs’ and PCAs’ responsibilities are distinct, there are many opportunities for them to collaborate. PCO/PCA collaborations allow primary care stakeholders to learn about policy decisions and provide input, enable state public health to work with current provider and community information, and help PCOs target efforts based on community needs. By working together, PCOs and PCAs can more effectively manage and use their federal, state, and private resources to improve access to and quality of primary care, including behavioral and oral care.

PCOs are publicly-funded entities that support and enhance access to primary care in each of the 50 states and territories, connecting state government, public health, and the larger healthcare delivery system. PCAs represent health centers, which are accessible, affordable sources of care for many rural, underserved groups. Currently, there are over 1,400 health centers with more than 10,400 care delivery sites serving over 24 million patients yearly. PCAs serve as a vital conduit for information and initiatives developed by state agencies, as well as a source of feedback and direct response from the community back to state agencies. They provide critical support to the primary care network in the states and territories, supplying technical assistance and expertise to function within the intersecting sets of state and federal health policy.

This document describes several ways in which PCOs and PCAs can collaborate on issues of mutual interest and provides examples of successful collaborations. It aims to help states establish, improve, or sustain PCO/PCA relationships and lays out best and promising practices for helping states achieve those goals. It also presents concrete, actionable recommendations that can help establish a strong PCO/PCA partnership, including details of action steps that have worked in other states, such as communication structures and frequency of communication. The listed opportunities for PCO/PCA collaboration, state examples, and recommendations are not exhaustive. Instead, they represent a selection of methods and cases that demonstrate how work can succeed.

Role of Primary Care Offices
Fifty-four states and territories have PCOs, which are dedicated to creating and maintaining an effective primary care delivery system. All PCOs receive funding from HRSA through a cooperative agreement, but some PCOs also receive funding from their states or other sources, such as foundations. Under their cooperative funding agreement with HRSA, PCOs are responsible for coordinating shortage designations, creating statewide primary care needs assessments, supplying technical assistance, and fostering collaboration to expand access to primary care. Shortage designations are specific descriptions of areas,
populations, or facilities with healthcare provider shortages.iii The designation allows federal and state programs to identify and target areas where access to care may be lacking.

The PCO/HRSA cooperative agreement specifically requires PCOs to collaborate and coordinate with other entities as part of three core objectives, which are: (1) Conducting statewide primary care needs assessments, (2) coordinating shortage designations, and (3) providing technical assistance and fostering collaboration that seeks to expand primary care.iv PCOs’ partners include state offices of rural health and PCAs, both of which are also supported by HRSA. Examples of this joint work can include PCOs providing information to assist in developing and siting new health centers or making decisions to expand capacity at specific health center sites.

PCOs also help to administer the National Health Service Corps (NHSC) program, which supports qualified healthcare providers dedicated to working in areas with limited access to care.v Many of the NHSC providers work at health centers or in rural settings. Moreover, many programs and incentives overlap, such as those for health centers located in underserved rural areas. In these cases, PCOs have a central role to play in maximizing the effectiveness of the care their partners provide.

Role of Primary Care Associations
PCAs are nonprofit organizations that represent the interests of health centers at the state or regional levels, including look-alikes and other safety net providers, as well as provide training and technical assistance to safety net providers. All 50 states and the U.S. territories are represented by a PCA. PCAs receive funding through membership dues, cooperative agreements with HRSA, and other sources, such as grants.vi PCAs contribute to health centers’ capacity by providing them with resources and information, as well as establishing network connections on the state and national levels. In addition to connecting their members with PCOs, PCAs also connect their health centers with the state or territorial health official, Medicaid director, and health transformation leader, among others.

Common Areas of PCO/PCA Collaboration
PCOs rely on primary care providers to meet identified needs and shortage areas, while PCAs represent and assist those providers. This creates ample opportunities to collaborate and create joint initiatives. Some of these may be focused on meeting specific needs, but they may also provide ongoing support. The types of collaboration and state examples described in this brief demonstrate how PCOs and PCAs can increase primary care capacity by leveraging each other’s resources to advance shared goals. These examples are not exhaustive, but they do include some of the most common opportunities for collaboration, and may be easiest for PCOs and PCAs to implement in their first efforts to improve their working relationship.

Workforce Recruitment and Retention

PCOs and PCAs work together in many states to make healthcare workforce recruitment and retention programs more effective. Because PCOs manage state programs to attract and retain providers, while PCAs represent some of the most common practice sites for these providers, PCOs and PCAs have natural synergy in this area. PCOs and PCAs can coordinate and share policy objectives related to shortage designations, recruitment and retention incentive programs, site capacity, marketing and publicity efforts, and candidate selection. Through collaboration, PCOs and PCAs can create a more comprehensive understand of workforce incentive programs among current and future health professionals, yet do so with fewer resources. The end result of these partnerships is a larger pool of potential participants to improve access to primary care in states and territories.

A coordinated approach can increase the impact of both PCO and PCA efforts. The Pennsylvania Department of Health’s PCO and the state PCA, the Pennsylvania Association of Community Health Centers, work together to maintain the Pennsylvania Primary Care Career Center, which centralizes job postings and information for openings in shortage areas and specialties. This allows the PCO to list information about state and federal incentive programs, such as loan repayments, alongside information about primary care position openings. It also allows the PCO’s information to reach a broader audience through the association’s network of health centers. The association’s involvement allows sites to connect these programs to actual positions and market them to prospective providers.

Colorado’s loan repayment program, the Colorado Health Service Corps, offers another example of strong PCO/PCA collaboration on recruitment and retention. Modeled on NHSC, the program uses state funds to attract providers to primary care and rural health positions. The Health Access Branch of the Colorado Department of Public Health and Environment, which is the state’s PCO, works closely with the PCA, the Colorado Community Health Network, and other partners to administer the program, including involving the PCA in conversations about the program’s policies and strategic direction. This is a natural partnership because more than half of the participating sites are health centers. Although the Health Access Branch manages the program, it also reaches out to a broad group of stakeholders to help evaluate program applicants, including the PCA. The PCA also helps promote the program and shares information with its members. To align work outside of the program, the PCA reaches out to the Health Access Branch when developing new workforce planning programs and resources for its members.

**Primary Care Site Development**

PCOs and PCAs are attuned to communities’ health provider needs. PCOs maintain and analyze a wealth of data on provider shortages and access issues that allow them to identify and address areas of need. PCAs are linked to the community through their members and have a solid awareness of their members’ capacity and opportunities to expand their networks. PCAs can provide PCOs with the provider data necessary to make appropriate shortage designations. PCAs can also work with health centers and target existing members to expand into a shortage designation area, or work with an existing provider within the shortage area to gain designation or health center status. This collaboration is particularly

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ix Author’s interviews with Colorado PCO and PCA, April 3 and May 1, 2017.
powerful because it allows PCOs and PCAs to efficiently connect communities with state and federal resources that can incentivize providers to expand into underserved areas.

In North Carolina, the PCO, which is based in the North Carolina Department of Health and Human Services, and the PCA, the North Carolina Community Health Center Association, coordinate around new opportunities to use federal, state, and philanthropic resources to increase the number of safety net access points. They work with other safety net provider associations, such as the state’s hospital association, North Carolina Academy of Family Physicians, and North Carolina Pediatric Society, to ensure that the right type of facility is matched to the right funding opportunity and resources. Each year, the state’s PCO and PCA work together to hold a joint primary care conference, which helps increase the visibility of primary care issues and drive shared projects forward.

About 20 years ago, the Missouri PCO, which is located in the state Department of Health and Senior Services, and PCA, the Missouri Primary Care Association, began working together to spur the development of new health centers to improve access. This served as the basis for a lasting partnership. The PCO and PCA currently collaborate on recruitment and retention work, as well as a number of structured projects, including several contracts and collaborating to meet each organization’s targets and goals, especially related to workforce development and sustainability. Today, their focus still includes community development, but they devote much of their joint work to expanding services in primary care and safety net access points.

Policy Development Collaboration
PCOs and PCAs can be effective partners in the policy development process. PCAs can provide PCOs with information from providers about their capacity, priorities, and challenges, which can help inform the PCO’s policies and programs. When PCOs implement policies, they can collaborate with PCAs to learn about and communicate the impact of changes to the field. They can also work together to provide technical assistance to primary care providers around policy changes. For example, Vermont’s PCO, the Vermont Department of Health’s Office of Rural Health and Primary Care, and the state’s PCA, the Bi-State Primary Care Association (which serves both Vermont and New Hampshire), collaborated to inform the state’s care transformation initiative policies and explain the changes in the primary care and safety net workforce.

PCOs and PCAs can also help inform statewide policymaking. For example, PCOs’ data can help inform legislative proposals. Thanks to their data and role as independent organizations, PCAs can reinforce key impacts as part of the policy conversation. Collaboration on policy issues is an impactful area for PCO and PCA collaboration because it is an effective way for a state’s primary care sector to collectively and cohesively support evidence-based laws and regulations that can help improve access to care.

Best Practices for PCO/PCA Collaboration
Focusing on specific areas and projects where PCOs and PCAs can have a greater impact by aligning their work is a natural foundation for a strong relationship. In addition to recommendations on areas in which to work, many PCOs and PCAs have shared their insights into how to work well together. These best or

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x Author’s interview with North Carolina PCO and PCA, April 25, 2017.
xi Author’s interview with Missouri PCO and PCA, April 13, 2017.
xi Author’s interview with Vermont PCO and PCA, April 4, 2017.
promising practices include recommendations for structuring and maintaining interactions. By keeping some of these practices in mind, PCOs and PCAs can begin or further the process of working together to advance their states’ primary care capacity and their residents’ ability to access it.

**Maintain Regular Channels of Communication**

PCOs and PCAs should have frequent interactions, not just on an as-needed basis. Regularly scheduled communication is a common feature of all successful PCO and PCA relationships. At the leadership level, it is important for PCOs and PCAs to have standing times to speak freely and develop ways to work together without the pressure of the current issue or crisis. Many PCOs and PCAs find that quarterly calls or meetings are sufficient for regular check-ins, but they also supplement them with as-needed communication as well. In several states, PCOs and PCAs reported that regular touch points for regular interaction and collaboration in a variety of areas can help create a foundation of mutual respect that allows for differences in viewpoints to constructively fit within a productive working relationship. Regular communication also allows PCOs and PCAs to continuously outline and manage roles and expectations as part of their collaborative work, as well as ensure that both organizations are on the same page about their respective roles.

PCOs and PCAs also need to have face-to-face meetings because in-person dialogue can improve working relationships. PCOs and PCAs should try to meet face-to-face at least twice a year. For example, the Missouri PCO and PCA recognize the importance of standing face-to-face meetings because they have found that the in-person dialogues have been an especially productive, efficient use of time. In some states, the PCA’s annual or regular board meetings provide such opportunities. Colorado’s PCA has board meetings three times a year that the PCO attends. In North Carolina, the PCO attends all PCA board meetings.

PCAs can specifically facilitate direct face-to-face contact between PCOs and senior health center leadership that can be highly useful in fostering workforce collaboration. This gives PCOs an opportunity to update the leaders in PCA networks about policy priorities and upcoming issues and changes, and gives PCA leaders an opportunity to provide input into the PCO’s processes and policies. PCOs can also invite PCAs to meetings when relevant, both to share information and provide an opportunity for follow-up dialogue. Adding onto other regularly-scheduled meetings can also reduce the time burden and disruption of in-person meetings.

**Assess Strengths and Gaps in Work and Communication**

When establishing or strengthening communication channels, one key focus of PCOs’ and PCAs’ conversations should be a rigorous, structured review of each organization’s role, goals, stakeholders, strengths, and successes, as well as current projects and programs. PCOs and PCAs should also evaluate issues or areas in which they are not currently working, but would like to. This can reveal true gaps, gaps that the other organization is filling, and shared priorities for next steps. For example, PCOs’ strengths include shortage designation and provider recruitment program management, while PCAs are respected providers of technical assistance and offer a single portal to reach a network of primary care sites.

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xii Author’s interview with Missouri PCO and PCA, April 13, 2017.
xiv Author’s interviews with Colorado PCO and PCA, April 3 and May 1, 2017.
xv Author’s interview with North Carolina PCO June 15, 2017.
In Nebraska, the state’s PCO, the Nebraska Office of Rural Health, and the Health Center Association of Nebraska, the state’s PCA, work closely on how to meet the state’s primary care needs. The PCO’s data and tools, such as the UDS Mapper and other shortage designation information, help point to areas of need.\textsuperscript{xvi} PCAs work with the provider sites that can help fill these gaps, and can leverage their networks to assess a health center’s ability to expand to meet the need or whether a new health center needs to be created either from scratch or by re-designating an existing provider of another type.

The PCO also works with PCA members to ensure that federally qualified health centers and other entities eligible for an automatic health professional shortage area designation request scores or rescores. The PCO has significant expertise to offer on this process. Assisting sites with data to support an updated score helps maintain a strong primary care safety net.\textsuperscript{xvii} By outlining these strengths and each organization’s needs, PCOs and PCAs can better leverage each other’s resources and expertise.

Create Joint Projects and Action Steps in Structured Work
Many PCOs and PCAs have ongoing structured projects, such as loan repayment programs, technical assistance offerings, or roles in broader primary care collaboratives. PCOs and PCAs should consider how each can contribute to these efforts. For example, in many states, PCOs contract with PCAs for certain services. This structured way of working together can create clear parameters and expectations that facilitate future collaboration.

For both entities, there may be opportunities to collaborate on presentations, conferences, and events, such as a career fair, that occurs on a regular schedule. In New Hampshire, the state’s PCO, the Rural Health and Primary Care section in the New Hampshire Division of Public Health Services, and the state’s PCA, the Bi-State Primary Care Association (which serves both New Hampshire and Vermont), jointly fund recruitment work, and staff work together on joint projects, allowing each organization to directly leverage the other’s expertise in a single project.\textsuperscript{xviii} In Vermont, the PCO visits NHSC sites and must conduct site visits with critical access hospitals. Because of the overlap in these sites’ and PCA members’ goals and service areas, the PCO often collaborates with the PCA to include it and its members in the PCO’s regular site visits and regional meetings.\textsuperscript{xix}

Communicate, if not Collaborate, on Funding Opportunities
PCOs and PCAs should also think about how to incorporate one another into their workplans for funding opportunities. In some cases, this may be via a subcontract or jointly planning learning events for other primary care stakeholders. PCOs and PCAs should be sure not to duplicate existing or already planned work in each of their workplans. Consequently, it is critical that PCOs and PCAs communicate about upcoming funding opportunities.

While HRSA provides a substantial portion of most PCOs’ and PCAs’ funding, a number of grants and other opportunities can support each organization’s work, depending on the circumstances in each state. In many cases, funding opportunities may be tailored to one organization or the other, with PCAs often having more flexibility as independent 501(c)3 entities. However, early engagement can ensure

\textsuperscript{xvi} Author’s interview with Nebraska PCO and PCA, April 27, 2017.
\textsuperscript{xvii} Author’s interview with Nebraska PCO and PCA, April 27, 2017.
\textsuperscript{xviii} Author’s interview with New Hampshire PCO and PCA, April 12, 2017.
\textsuperscript{xix} Author’s interview with Vermont PCO and PCA, April 4, 2017.
that the best-suited entity can have the strongest application, or, if appropriate, both organizations can apply with a coordinated workplan. PCOs and PCAs should make it a practice of touching base before responding to funding opportunities. If PCOs and PCAs already have positive working relationships, they can also collaborate on responses to meet needs and fill gaps in current work and other funding mechanisms. For example, throughout the longstanding partnership in New Hampshire discussed above, the PCO and PCA found that communication, if not collaboration, when more funding was available made it easier to think creatively about how to maximize their impact through partnerships and shared funding when fiscal conditions tightened.

**Conclusion**

PCOs and PCAs are natural partners in efforts to improve access to care, broaden the primary care workforce, and ensure that preventive and primary care are central parts of healthcare and public health innovation. Both entities share common goals and visions for the health systems in their states and how existing primary and preventive healthcare needs should be met. Because PCOs and PCAs are “on the same team” in terms of goals for the state primary care system, there are many opportunities to align work to reduce duplication and maximize each organization’s strengths and connections.

As they strive to build strong working relationships, it is crucial for PCOs and PCAs to assess their strengths and current efforts to identify specific programmatic areas in which to improve collaboration. Mutual respect stemming from shared priorities and recognition of expertise and capacity is also critical to any collaboration. PCOs and PCAs can build this mutual respect and understanding through regular communication. From there, PCOs and PCAs can integrate each other into their workplans, using each other’s resources to address gaps in their own plans. Maintaining their relationship by serving as points of continuity during turnover in either office can help build joint PCO and PCA work. Entities can also work together by communicating regarding responses to funding opportunity and engaging joint planning regarding funded projects. Many other opportunities and recommendations for collaboration exist, but a basic framework of communication and functional alignment can substantially improve not just the individual PCOs and PCAs, but their entire state’s efforts to ensure all residents have timely and appropriate access to care.

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**xx** Author’s interview with New Hampshire PCO and PCA, April 12, 2017.