Introduction: State Primary Care Offices

State Primary Care Offices (PCOs) are Federally-funded programs located within all state health departments. PCOs have operated continuously under federal/state cooperative agreements for more than 20 years. They are a state-level focal point for primary care safety net activities, particularly with regard to the National Health Service Corps (NHSC) and Health Center Program. PCOs conduct their work in collaboration with key partners, including:

- State Primary Care Associations (PCAs);
- State Offices of Rural Health;
- Health Resources and Services Administration (HRSA) Regional Offices; and
- Area Health Education Centers.

The Patient Protection and Affordable Care Act (ACA) contains provisions for a major expansion of the Health Center program. With the rapid expansion of this program, there is a need for expanded activities by PCOs. This case study will explore the efforts of two state PCOs to support accelerated community health center development.

Background: Health Center Expansion under ACA

Under Section 10503 of the Patient Protection and Affordable Care Act (ACA) a new federal special fund was established - the **Community Health Centers and the National Health Service Corps Fund**. Over $9 billion was appropriated to this fund to provide enhanced funding for health centers over a five year period. Assuming maintenance of base funding levels, this additional appropriation could lead to a doubling or tripling of the capacity of the health center sector nationwide.

The provisions of the ACA would provide health insurance coverage to many of the more than 40 million uninsured in the United States by 2014. Expansion of the community health center sector prior to 2014 will provide a primary care medical home to some of these uninsured individuals in advance of 2014, and will help assure that the capacity of the health care system is adequate to meet the needs of the underserved. An extension of the PCO role in this area is likely, and will assure that states are actively involved in this important public health function. The programs profiled in this case study will provide ideas for what other states can do under new PCO program expectations.
The Role of States and PCOs in Health Center Expansion

Under their HRSA Cooperative Agreements, state PCOs have a defined role in the development of expanded health center capacity in their states. HRSA program expectations call for PCOs to provide data support to health centers that are eligible for or are receiving grants under section 330 of the Public Health Service Act and Primary Care Associations to be used in the planning of expanded health center capacity. Program expectations also call for PCOs to coordinate and oversee the HPSA and MUA/P designation process within the State to ensure consistent and accurate assessment of underservice.

Many PCOs go above and beyond the minimum requirements of the Cooperative Agreement in their support of health center development. They use a significant commitment of state resources to conduct these activities, consistent with the core assurance function of public health. Under this core function, state public health agencies are called upon to:

- Link people to needed personal health services and assure the provision of health care when otherwise unavailable, and
- Assure a competent public health and personal health care workforce.

In the more than 20 year history of HRSA funding for PCOs, the program expectations for support of health center growth have expanded and contracted. At one time PCOs were asked to conduct primary care access planning – the development of strategic plans for new health center capacity in the state, based upon comprehensive assessments of underserved populations. At other times PCOs were provided with supplemental funds to conduct community development efforts within their states – providing technical and organizational assistance to local groups wishing to establish a new community health center. As seen in the case study presented below, several state PCOs have demonstrated that expanded efforts similar to what was done in the past can have a major impact on the success of community health center development.

Overview: Support of Health Center Development

Several things can be done by state agencies and organizations to support the development of community health centers:

- **Provide data support for individual applications**: provide community specific data required in the needs assessment section of the new access point application. In the funding guidance substantial weight is given to applications which demonstrate substantial need on a broad range of different health indicators. Applicants must choose appropriate health indicators from a potential list of more than forty different alternatives. It is a major effort to compile this data and choose those indicators which give an application the highest possible score.

- **Assess unmet needs for primary care**: conduct a comprehensive assessment of communities to determine their unmet needs for primary care services. This assessment can help identify which communities have the most pressing need for a new health center. To assure that communities
with needs can participate in the health center program, there is also a need to secure federal designation of these communities.

- **Promote community collaboration:** identify those in the local community with an interest in community health center development and facilitate their cooperation in the development of a new health center. A successful application must demonstrate this type of collaboration. There is a potential for competition within a community for available funds, with competing applications being submitted by different groups. Competing applications seldom score well in proposal review. Trusted outside facilitators can help resolve potential conflicts at the community level.

- **Provide technical assistance for health center planning and proposal development:** provide planning assistance to potential applicants in the implementation and operation of a health center as well as assistance in the development of a responsive health center proposal. A successful funding application must address the many program requirements for health centers. These requirements are not limited to what is needed for a proprietary primary care practice, but address issues of governance and service to the indigent. Support from experts in these requirements is essential to the development of a good application.

- **Engage potential applicants for health center funds:** provide information on the Health Center Program to potential applicants, helping them to assess whether a community health center is an appropriate model for improving primary care services in their area. Many potential applicants rush to participate in the program when funds are made available without understanding the guidelines for health center operation. This can lead to unsuccessful applications when applicants fail to address governance, sliding fee scale and other requirements.

PCOs do not have sufficient resources to conduct all these activities. Different states have chosen to conduct different selections of these potential activities to maximize their effectiveness in the development of new health centers. The most successful states have developed broad multi-agency partnerships with the state primary care association and other key agencies to address all these areas.

**Wisconsin and Arizona: A Comparison of Different PCO Approaches**

In this case study the health center development efforts of two states, Arizona Wisconsin, will be profiled. The approaches of the two states provide an interesting contrast in how this safety net development function can be implemented under the auspices of the state PCO.

In Arizona, the PCO conducted a comprehensive primary care needs assessment for the state. The results of this assessment were used to identify communities with the greatest need for expanded primary care services and to provide individual communities with the information they needed to
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compete successfully in the application process. The PCO played the role of **objective needs assessment source** for the state.

In Wisconsin, the PCO was the focal point for a massive statewide collaborative effort, bringing together state level and community level partners in health center development. The key role of the PCO was that of **facilitator** – both at state and local levels.

They provide a model of how state health agencies can assure the provision of essential health services in their states.

**Arizona: Providing Comprehensive Planning Data Support**

**Approach:**

**Overview:** Historically, the Arizona Primary Care Office (AZ PCO) has provided data support to health centers in the preparation of their proposals, including continuation proposals, expansion proposals and new access point proposals. The PCO anticipated providing data to New Access Point (NAP) applicants in a manner similar to previous funding opportunities, but expanded and modified its efforts in response to significant changes in the application guidance. The PCO’s responses to the new requirements defined its unique response to the needs of applicants.

**Response to New NAP Requirements:** The 2010 Health Center NAP funding guidance included a new Need for Assistance (NFA) Worksheet that underlay the Needs Assessment component of the application. In previous funding cycles applicants had a relatively wide choice of needs indicators, and could show that a target population had needs when compared to locally defined benchmarks. In the latest NAP funding guidance the NFA specified more than 40 possible data indicators to be used in establishing the need of a target community. Applicants were required to select 12 indicators from among the different categories. The needs assessment portion of the application represented 30% of the overall score, and was critically important to an applicant’s funding chances.

Many of the health indicators identified in the NFA worksheet were not previously included in guidance for previous funding opportunities. In addition, the indicators in the latest guidance were much more prescribed, requiring specific health measures and identifying national benchmarks against which local measures would be compared. For many of the indicators there were separate benchmarks established for partial and maximum point scores. To make matters even more complex, much of the data was not routinely compiled by health data agencies.

In response to the issuance of the NAP guidance the AZ PCO mobilized a massive effort to compile, comprehensively, datasets geared to the NFA worksheet. In addition, the AZ PCO geared up to handle requests from individual applicants. This was a major effort, mounted starting in September 2010 for an application deadline of mid-November 2011. The PCO conducted extensive research to bring together data on as many of the NFA specified health measures as could be compiled. This required querying of new databases, including the establishment queries of a new Hospital Discharge Database. To create these queries, PCO staff had to learn International Classification of Diseases, 9th Revision (ICD-9) ICD9 diagnostic codes associated NFA measures and conduct data mining of the database.
The PCO compiled data from multiple state and federal databases, largely at the zip code level, and, where necessary converted the data into census tract equivalents. Where rates and percentages were required, PCO staff computed these indicators from the raw data. The PCO spent significant effort assuring the quality of the data and calculations produced from the database inquiries.

**Comprehensive Dataset Compilation and Dissemination:** Previously, the PCO had divided the state into 120 primary care service areas (PCSAs), built largely from aggregations of census tracts. The PCO prepared datasets geared to the NFA worksheet for all of these PCSAs. The datasets included as many of the guidance-specified health indicators as could be found.

The PCO generated NFA worksheets in response to specific inquiries from applicants, some of whom were proposing service areas somewhat different from the pre-defined PCSAs. In these efforts the PCO worked with applicants to identify the set of data indicators which would yield the highest application score. More than 40 application-specific NFA worksheets were prepared in response to inquiries. The PCO made presentations to the PCA and its members to orient them to the available data. In addition, the PCO made presentations to community groups on data availability. The PCO worked with the PCA to use the data for identification of areas with the highest needs. This information was used to help target the development of new health centers.

Several data inquiries came from potential applicants who did not fully understand the nature of the health center program. The potential applicants wanted the PCO to analyze the datasets and help them identify ‘where the clinic should go’. The PCO declined to make this type of recommendation, but used the opportunity to educate the requestor about the nature and appropriateness of the health center model for the requestor’s needs.

The datasets compiled during this effort were shared widely, and will be posted on the Arizona Department of Health Service’s website. The PCO is working with Geographic Information System (GIS) specialists and would like to mount an interactive Internet based mapping site using the data. Given sufficient resources, the PCO would like to update the datasets annually, as new data permits.

**Technical Support:** In addition to the dataset effort, the PCO provided limited technical information and technical assistance to potential applicants. The PCO responded to numerous requestors who were seeking general information on the community health center program. Many inquiries were from local groups and agencies who did not fully understand the requirements of the health center program. The PCO helped counsel the requestors on the specifics of the program, particularly with regard to governance, sliding fee discount schedule and other important requirements. Requestors were referred to the PCA for additional assistance.

**Resources**

The data compilation and analysis work of the PCO was an enormous effort – probably the largest of its type in the nation. The PCO brought together many different resources to support the effort. Existing PCO staff resources were shifted to work on the effort, with four different staff working approximately half-time on the effort. The assigned staff held weekly meetings to coordinate their assignments. The staff was supported by multiple sources of funds, including PCO Cooperative Agreement funding, state
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funding and American Recovery and Reinvestment Act (ARRA) stimulus bill funding. The state absorbed additional costs, including the significant costs of the special data runs needed to produce the NFA worksheet datasets.

Impact

The data compilation and analysis efforts of the AZ PCO stimulated and supported widespread consideration of health center expansion. More than 40 communities and agencies utilized the data in planning for new health centers. Many different types of groups utilized the data in their planning, including community health centers, behavioral health agencies and tribal health agencies. From this preliminary planning a total of 20 different NAP applications were submitted to HRSA. There were a wide variety of different applicant types, with a good mix of rural and urban areas targeted. The majority of NAP applications were for service points in new service areas, as opposed to expansion sites in existing service areas.

The datasets will have additional use in the near future. The NFA worksheets are being circulated as planning support for the Community Transformation grant program, authorized under the ACA. The Arizona Department of Health Services is applying for funding under this program on behalf of rural communities in the state, and is using the datasets for the needs assessment required in those applications. The data is also being shared with local community groups preparing applications for this program.

Wisconsin: Promoting Collaborative Planning of Health Centers

Approach:

Overview: The Wisconsin Primary Care Office (WI PCO) chose to collaborate with the state PCA in the provision of information about the Health Center Program and the promotion of collaboration within communities. It took this approach in cooperation with other partners, who took on complementary support roles for community applicants. The WI PCO’s approach was unique in that it was a statewide effort to promote collaborative community planning of health centers.

The WI PCO took a leadership role in developing a coordinated statewide approach to health center development. It convened a multiagency group to bring together partners for a unified effort to develop new health centers. Key partners included the Department of Health Services (Secretary, State Health Officer, Primary Care Office), the Wisconsin Primary Health Care Association (WI PCA), HRSA Chicago Regional Office, the Wisconsin Office of Rural Health and the Wisconsin Hospital Association. The group worked together to plan a community health center stakeholder meeting, where local community groups and programs could explore prospects for developing new health center sites.

The WI PCO has a long history of collaboration with both state and local programs. It supports Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) in efforts to secure NHSC and J-1 Visa Waiver Program personnel. In addition, it provides assistance to the system of more than 75 free clinics in the state, in part through the state tort claims program for such clinics. This history of collaboration makes the WI PCO a trusted partner in efforts to expand health safety net capacity.
**Statewide Stakeholder Meeting:** The community health center stakeholder meeting was the highlight of the coordinated development effort. It was a full day collaboration planning meeting that included 150 participants both in a central location (Madison) and at four regional locations around the state (Eau Claire, Rhinelander, Green Bay, and Milwaukee). All meeting sites were connected through videoconferencing, and had individual meeting facilitators to assure a coordinated group process.

The meeting provided participants with an overview of health centers and the potential for new centers as authorized under the ACA. The presentations explored the benefits and limitations of the Section 330 health center model, and indicated why community collaboration is important to successful health center applications. Speakers from HRSA provided information on the Health Center Program. A speaker from the National Association of Community Health Centers provided technical information on strategic planning for health center development and on proposal development steps. WI PCA and PCO staff compiled and presented information on the health service environment in the state.

The meeting emphasized the importance of local collaborations in support of health center development. It included time at each meeting site for participants to explore the possibilities for collaboration. Trained facilitators were present at each site to promote discussion of potential collaborations.

Attendees at the meeting represented a broad range of community stakeholders. Participants included representatives of RHCs, FQHCs, free clinics, Critical Access Hospitals, Tribal Health Centers and local health departments. Organizations were limited to a maximum of 2 representatives to permit a larger number of groups to attend. Targeted outreach was conducted to key community groups, including outreach through the free clinic network, the community action coalition, the tribal consultation network and the local public health agency system. The State acted as neutral convener of the meeting. This was an intentional choice of the planning group to minimize the potential for special interest or bias.

**Reference Materials and Technical Assistance:** A comprehensive package of reference materials was made available to participants at the meeting. The package included:

- Health planning resources and web links,
- Health Center reference materials, including overviews of the program and program requirements,
- References on community health needs assessment, and
- Documents describing collaborations and affiliations.

This material was posted on both the PCO and PCA web sites.

Subsequent to the meeting, the WI PCA took the lead in providing direct technical assistance to potential applicants. The WI PCA received funding to plan an FQHC incubator project, and used some of these resources to provide technical assistance to applicants for new access points. The PCA prepared a county-level needs assessment data tool for the state, compiling the data needed to be included in new access point applications with assistance from the PCO. The tool identified which indicator measures would yield the highest potential score for each county.
The WI PCO developed a map showing the currently designated MUA/Ps and current health safety net sites, and helped the PCA develop a map which showed the low income populations not currently served by FQHCs. These maps highlighted those areas with high need and a low penetration of safety net services. The PCA held several subsequent webinars addressing specific issues, including needs assessment procedures and collaboration techniques.

The division of responsibilities between WI PCA and WI PCO worked very well. The division of responsibilities was different than that in Arizona, which also was very effective. It demonstrates how states can take contrasting approaches with equally good results.

**Resources**

The Secretary of the Wisconsin Department of Health Services provided major support to the new health center development process. The Secretary committed the use of the Department’s regional meeting spaces, the Department’s IT and telecommunications capacity and dedicated a half-time staff person to help coordinate the effort. This staff person was a trained facilitator who organized and documented all the planning calls and coordinated the use of the Department’s facilities for the meeting. The Secretary also arranged for a recorded message from the Governor to be presented at the beginning of the statewide collaboration meeting. This underscored the importance of the effort to the state.

The WI PCO provided major staffing for the overall effort. The WI PCO Director spent 40% time on related activities from the release of the funding opportunity announcement until the final deadline for new health center access point applications. PCO staff provided supplemental needs assessment data to applicants, directing them to available data sources and to maps developed by the Department for safety net providers and local health department needs assessments.

This development effort was conducted with the support of many additional collaborators. WI PCA staff did online registration for the event, arranged for speakers and prepared all handouts for the session. The State Office of Rural Health covered the travel costs of speakers. The state hospital association covered the cost of breaks for the session, and the HRSA Regional Office supported the cost of box lunches during the lunch break for regional networking.

**Impact**

As measured by attendance and participation, the planning initiative was a huge success. More than 150 people attended — filling the available meeting capacity to its maximum at both the central and regional sites. Participants at all locations stayed for the entire session and engaged actively in discussions and planning.

The effort had a significant impact in a very short period of time. Eight new access point applications were submitted from across the state. These included applications for a tribal health center, a new center to be operated by an organization new to primary care, and expansion sites for currently operating community health centers. In addition, multiple planning grant applications were developed stemming from the coordinated new health center initiative. These applications were submitted by a
free clinic, critical access hospitals and a tribal health center. Given the rapid turnaround time for the funding opportunity, this is a remarkable outcome.

Conclusion

PCOs have a unique role in state government. They are at the nexus of federal and state programs designed to assure the provision of primary care to underserved populations. Over the years many PCOs have established reputations as reliable sources of information and assistance for community groups and agencies. They are perceived as objective in their approaches to health system development. These things make PCOs the best qualified state agency to support the expansion of health centers authorized by the ACA.

PCO success in supporting health center development is dependent upon the creation of a well-defined partnership with other agencies. As is evidenced by the efforts in Arizona and Wisconsin, the precise manner of collaboration – who should do what – can vary significantly. What is important is that a partnership provides the full range of support that is needed by local communities.

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