16-18th Centuries

The Age of the Scientific Revolution began with experimentation. Math was more prevalent and average life span was shorter. Scientists shaped research and discoveries by publishing journals.
Just Prior to the Turn Of the Century

“The Bills Of Mortality Are More Affected By Drainage Than This Or That Of Medical Practice.”

--Oliver Wendell Holmes 1809-
MEN WALK ON MOON
ASTRONAUTS LAND ON PLAIN;
COLLECT ROCKS, PLANT FLAG

Later 20th Century
“The current battle follows a decade or two of dreams and delusions during which both parties... believed sincerely that a nation that defied the law of gravity to go to the moon could also defy the most fundamental laws of economics”

--Uwe Reinhardt, PhD
Princeton University
Post World War II Payers
The Government Buys

• 1960 Great Society-war on poverty-liberalism
• Access to care addressed for the poor and the elderly
• 1965/66 Medicare and Medicare-President Johnson
• Burgeoning Commercial Insurance
Cost Per Day In 1985 Dollars For Hospitals

![Chart showing the cost per day in 1985 dollars for hospitals from 1900 to 2005. The costs increase significantly from 1980 onwards.](chart.png)
Per Capita Cost Spending – U.S. has No Peer

Relative to the size of its wealth, the U.S. spends a disproportionate amount on health care.

Total health expenditures per capita/GDP per capita, U.S. dollars, PPP adjusted, 2016

The US value was obtained from the 2016 National Health Expenditure data.

U.S. health care spending per capita rising

# U.S. Life Expectancy Lowest in World Among Peers

Life expectancy at birth in years, 2015

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>83.9</td>
</tr>
<tr>
<td>Switzerland</td>
<td>83</td>
</tr>
<tr>
<td>Australia</td>
<td>82.5</td>
</tr>
<tr>
<td>France</td>
<td>82.4</td>
</tr>
<tr>
<td>Sweden</td>
<td>82.3</td>
</tr>
<tr>
<td>Comparable Country Average</td>
<td>82</td>
</tr>
<tr>
<td>Canada</td>
<td>81.7</td>
</tr>
<tr>
<td>Netherlands</td>
<td>81.6</td>
</tr>
<tr>
<td>Austria</td>
<td>81.3</td>
</tr>
<tr>
<td>Belgium</td>
<td>81.1</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>81</td>
</tr>
<tr>
<td>Germany</td>
<td>80.7</td>
</tr>
<tr>
<td>United States</td>
<td>78.8</td>
</tr>
</tbody>
</table>

Note: Data for Canada are for 2013

Source: Kaiser Family Foundation analysis of data from OECD (2017), Life expectancy at birth (indicator) (Accessed on November 13, 2017). • Get the data • PNG
Disease burden is higher in the U.S. than in comparable countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Age standardized disability adjusted life year (DALY) rate per 100,000 population, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>23,104</td>
</tr>
<tr>
<td>Belgium</td>
<td>19,747</td>
</tr>
<tr>
<td>Germany</td>
<td>19,399</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>19,321</td>
</tr>
<tr>
<td>Canada</td>
<td>19,119</td>
</tr>
<tr>
<td>Austria</td>
<td>18,961</td>
</tr>
<tr>
<td>Netherlands</td>
<td>18,795</td>
</tr>
<tr>
<td>Australia</td>
<td>18,758</td>
</tr>
<tr>
<td>France</td>
<td>18,746</td>
</tr>
<tr>
<td>Comparable Country Average</td>
<td>18,552</td>
</tr>
<tr>
<td>Sweden</td>
<td>17,749</td>
</tr>
<tr>
<td>Switzerland</td>
<td>17,468</td>
</tr>
<tr>
<td>Japan</td>
<td>16,012</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation analysis of data from Institute for Health Metrics and Evaluation. Global Burden of Disease Study 2015 (GBD 2015) Data Downloads • Get the data • PNG
The U.S. has lagged behind comparable countries in improving on a score of mortality amenable to health care.

Healthcare Quality and Access (HAQ) Index, 1990-2015

The Affordable Care Act (ACA)

Reform U.S. health care system that poorly performs on
• Cost and quality indicators
• Underperforming on health indicators and patient satisfaction measures
• Disorganized delivery system
• High cost
• Inaccessible care
• Unsustainable public spending
• Bankrupting families
• Lags behind most industrialized countries on cost and quality metrics
Strategy #1 - Uninsured, 1960-2014

Uninsured Rate, 1963-2014:Q2

Source: NHIS; Cohen et al. (2009); Klemm (2000); CMS (2009); CEA calculations (see appendix).
Note: Data for 2014 are quarterly. Data for earlier years are generally either annual or bi-annual.
National Health Care Strategy

• Address major deficiencies in health care system through a three-pronged approach known as the Three-Part Aim

  1. **Affordable Care**: Reduce the cost of quality health care for individuals, families, employers, and government.

  2. **Better Care & Patient Experience**: Improve the overall quality of care, by making health care more patient-centered, reliable, accessible, and safe.

  3. **Better Health**: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
The Maryland Context

• Maryland Primary Care Program
• Total Cost of Care Model
• Population Health Measures/ Credits
Maryland – a Test Case for System-Wide Transformation

• Maryland began working early on Access - Strategy #1
  • Early Medicaid Expansion state
  • State based Marketplace
  • Health Reform Workgroups established soon after the passage of ACA

• However, broader transformation necessary to control cost growth and improve health indicators
Strategy #2 – All Payer System to All Payer Model

- Hospitals in Maryland since 1970s have adhered to rate schedule to control cost per case
- Medicare waiver from national payment system (IPPS), extended five years at a time
- Worked effectively for 30+ years; controlled prices and cost-shifting
  - Positive – Inpatient utilization rates decreased below the national average.
  - Negative – Volume growth; Explosion of outpatient hospital services
- Unintended consequence = volumes rose, Medicare per capita hospital costs in Maryland exceeded national average
- Reinvent Hospital reimbursement – Maryland Medicare Waiver and All Payer Rate Setting System
  - 2012 – State began working with CMS on Innovation Model
  - 2014 – All Payer Model Agreement implemented
Focus Shifts to Patients – Transition to All Payer Model

- Maryland is taking a unique approach and making unprecedented efforts to:
  - Move from a volume-based system to a value-based system
  - Improve outcomes, health, and costs
  - Meet the Three-Part Aim

Maryland’s All Payer Model → • Improve Care & Patient Experience
                              • Improve Health
                              • Lower Total Cost of Care
Overview of All Payer Model

• Approved by Center for Medicare and Medicaid Innovation (CMMI) effective January 1, 2014 – December 31, 2018
• Modernizes Maryland’s Medicare waiver and unique all-payer hospital rate system

Key provisions of the new Model:
• Hospital per capita revenue growth ceiling of 3.58% per year, with savings of at least $330 million to Medicare over 5 years
• Patient and population centered-measures to promote care improvement
• Payment transformation away from fee-for-service for hospital services
• Proposal covering Total Cost of Care due at the end of 2016 for Phase 2 (2019 and beyond)
Moving Away from Volume

Former Hospital Payment Model: Volume Driven

- Units/Cases
- Rate Per Unit or Case
- Hospital Revenue

- Unknown at the beginning of year
- More units creates more revenue

New Hospital Payment Model: Population and Value Driven

- Revenue Base Year
- Updates for Trend, Population, Value
- Allowed Revenue for Target Year

- Known at the beginning of year
- More units does not create more revenue
## Performance in Years 1 – 3

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Targets</th>
<th>2014 Results</th>
<th>2016 Results</th>
<th>2016 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Payer Hospital Revenue Growth</td>
<td>≤ 3.58% per capita annually</td>
<td>1.47% growth per capita</td>
<td>2.31% growth per capita</td>
<td>0.80% growth per capita¹</td>
</tr>
<tr>
<td>Medicare Savings in Hospital Expenditures</td>
<td>≥ $330m over 5 years (Lower than national average growth rate from 2013 base year)</td>
<td>$120m (2.21% below national average growth)</td>
<td>$275 cumulative (2.63% below national average growth since 2013)</td>
<td>$586m cumulative¹ (5.50% below national average growth since 2013)</td>
</tr>
<tr>
<td>Medicare Savings in Total Cost of Care</td>
<td>Lower than the national average growth rate for total cost of care from 2013 base year</td>
<td>$142m (1.62% below national average growth)</td>
<td>$263m cumulative (1.31% below national average growth since 2013)</td>
<td>$461m cumulative¹ (2.08% below national average growth since 2013)</td>
</tr>
<tr>
<td>All-Payer Quality Improvement Reductions in PPCs under MHAC Program</td>
<td>30% reduction over 5 years</td>
<td>25% reduction</td>
<td>34% reduction since 2013</td>
<td>44% reduction since 2013</td>
</tr>
<tr>
<td>Readmissions Reductions for Medicare</td>
<td>≤ National average over 5 years</td>
<td>19% reduction in gap above nation</td>
<td>58% reduction in gap above nation since 2013</td>
<td>79% reduction in gap above nation since 2013</td>
</tr>
<tr>
<td>Hospital Revenue to Global or Population-Based</td>
<td>≥ 80% by year 5</td>
<td>95%</td>
<td>96%</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹ Actual revenues were below the ceiling for CY 2016 and these numbers have been adjusted to reflect the hospital undercharge of approximately 1% that occurred in the second half of CY 2016.
Population Health Transition
Strategy #3 – Population Health in Maryland

- Definition: “Population Health” is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group”. It is an approach to health that aims to improve the health of an entire human population.
  - Source: Kindig D, Stoddart G.

- Population Health components:
  - Management efforts in full swing
  - Improvement slowly coming into focus
Transformation Progression

2014 – 2015

Hospital Global Budgets

2016 – 2018

Financial Alignment

2019 and Beyond

Total Cost of Care

ALL-PAYER MODEL

Submit designs of:
• Primary Care Model
• State Population Health Plan
• All Payer Model Progression Plan
• Duals ACO

Dec 31, 2016

POPULATION HEALTH

SHIP and LHICs

2017

• All Payer Model Amendment, Population Health Plan – Design
• Primary Care Model – infrastructure development

2018

• Primary Care Model – Year 1 Operation
• Additional Population Health Plan and VBP - Planning

MARYLAND Department of Health
Stakeholders in Population Health
Focus on Social Determinants
Focus on Health Equity

- Community Providers
- Hospitals
- Local Health Departments
- Nonprofits
- Community Based organizations
- Consumers and families
- CRISP
- Care Management organizations
- Others
Population Health Model – Where we need to focus...

- Health Outcomes
  - Length of Life (50%)
  - Quality of Life (50%)
- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity
- Clinical Care (20%)
  - Access to Care
  - Quality of Care
- Social & Economic Factors (40%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety
- Physical Environment (10%)
  - Air & Water Quality
  - Housing & Transit

MARYLAND Department of Health
Areas of Focus for Improving Population Health

• Chronic disease supports
• Long term and post-acute care integration and coordination
• Physical and behavioral health integration and coordination

• Primary care supports
• Case management and other supports for high needs and complex patients
• Episode improvements, including quality and efficiency improvements
• Clinical consolidation and modernization to improve quality and efficiency

• Integration of community resources relative to social determinants of health and activities of daily living
Strategy #3 – Enhanced Total Cost of Care Model

Population Health Focus
Maryland Primary Care Program (MDPCP)

Improving health, enhancing patient experience, and reducing per capita costs.

2017

HSCRC Models
- All Payer – 2014-18
- Total Cost of Care – 2019-29
- 2014 - 2029

Reduction in unnecessary lab tests

Increase communication between hospital and community providers

Increase complex care coordination for high and rising risk

Reduce unnecessary lab tests

2017 - TBD

HSCRC Care Redesign Programs

2019-2026

Increase care coordination

Increase community supports

Increase appropriate care outside of hospital

Reduce hospital-based infections

Reduce unnecessary readmissions/utilization

2029

Maryland Primary Care Program (MDPCP)

Increase preventive care to lower the Total Cost of Care

Decrease avoidable hospitalizations

Decrease unnecessary ED visits

Increase care coordination

Increase community supports

MARYLAND Department of Health
Maryland Primary Care Program (MDPCP)

• Strengthens and transforms Primary Care Delivery by moving from volume to value
  • Components include care managers, 24/7 access to advice, medication management, open-access scheduling, behavioral health integration, and social services

• Complements and supports existing delivery system innovation in State
  • Sustain the early gains of the All-Payer Model as targets become increasingly reliant on factors beyond the hospital
MDPCP Impact on TCOC

- Federal financial investment in building primary care infrastructure in Maryland.

- Impact on hospital global budgets
  - MDPCP expected to reduce avoidable hospitalizations and ED usage through advanced primary care access and prevention

- Reduction of disease prevalence crucial for long-term sustainability of the Model.
  - Recognition that reductions in prevalence are not immediately realized in hospital global budgets
  - Opportunity for Maryland to get credit for these long-term efforts
Care Delivery Requirements: Primary Care Functions

Track 1

1. Access and Continuity
   - 24/7 patient access
   - Assigned care teams

2. Care Management
   - Risk stratify patient population
   - Short-and long-term care management

3. Comprehensive
   - Identify high volume/cost specialists serving population
   - Follow-up on patient hospitalizations

4. Patient and Caregiver Engagement
   - Convene a Patient and Family Advisory Council

5. Planned Care and Population Health
   - Analysis of payer reports quarterly to inform improvement strategy

Track 2

1. Access and Continuity
   - E-visits
   - Expanded office hours

2. Care Management
   - 2-step risk stratification process
   - Care plans for high risk chronic disease patients

3. Comprehensive
   - Enact collaborative care agreements with two groups of specialists and with two public health organizations
   - Behavioral health integration
   - Psychosocial needs assessment and inventory resources and supports

4. Patient and Caregiver Engagement
   - Implement self-management support for at least three high risk conditions

5. Planned Care and Population Health
   - At least weekly care team review of population health data
Total Cost of Care Model – Population Health Commitment

• #1: Fulfill commitment to establish high-level population health goals and methodology in Total Cost of Care Model

• #2: Improve specific population health (entire state) measures and earn bonus toward Total Cost of Care savings
  • State is proposing credit concept for healthier and less costly enrollees entering Medicare, as well as keeping Medicare beneficiaries healthy.
  • Potential of offsetting CMS investments in TCOC model.
Methodological Concept

- All-payer, statewide population health measures
- Demonstrate improvement in population health
- Create value for State and federal government

<table>
<thead>
<tr>
<th>Examples</th>
<th>Effect on Disease Prevalence</th>
<th>Effect on TCOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>System helps manage people with diabetes so fewer have complications</td>
<td>None - patients already have diabetes</td>
<td>Short Term Reduced hospital utilization, incentive payments to PCP</td>
</tr>
<tr>
<td>People with pre-diabetes lose weight and they do not progress to diabetes</td>
<td>Lowers or restricts growth in prevalence</td>
<td>Longer Term Control</td>
</tr>
</tbody>
</table>
Total Cost of Care, Primary Care, and Population Health Improvement

• Success requires Statewide participation of clinical care and public health system, state health programs leadership, and stakeholder focus

• Opportunity for statewide alignment of the delivery system, community, and public health to focus on Population Health Goals

• Key points:
  • No additional upfront investment for population health goals from CMS (doesn’t preclude other investments)
  • All-payer, population-wide measures
Guiding Framework for Population Health

State Pop Health Goals
- Behavioral Health
- Chronic Condition Prevention
- Senior Health and Quality of Life

Outcome Measures
- Avoidable Admissions
- Disease status
- Fall Injury rate
- Smoking Cessation
- Substance Use ED visits

Process Measures
- Screening
- Counseling and Care Planning
- Treatment

Drivers
Coordination between public health, clinical care, access to care, process improvement, data/information sharing at the point of care, provider coordination, focus on prevention and health, addressing social determinates of health, violence, and health disparities
Figure 2

Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td></td>
<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td></td>
<td>Discrimination</td>
<td>Quality of care</td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Social Vulnerability Index 2014
Worcester County, Maryland

Overall Social Vulnerability

Social vulnerability refers to a community’s capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters, such as tornadoes or disease outbreaks, to human-caused threats, such as toxic chemical spills. The Social Vulnerability Index (SVI 2014) County Map depicts the social vulnerability of communities at the census tract level within a specified county. SVI 2014 groups fifteen census-derived factors into four themes that summarize the extent to which the area is socially vulnerable to disaster. The data regarding education, family characteristics, housing, language ability, ethnicity, and vehicle access. Overall Social Vulnerability combines all the variables to provide a comprehensive understanding.
Healthy Beginnings

Healthy Living

Healthy Communities

- Child maltreatment rate
- Suicide rate
- Domestic Violence
- Children with elevated blood lead levels
- Fall-related death rate
- Pedestrian injury rate on public roads
- Affordable Housing

Access to Health Care

Quality Preventive Care
Additional PCO/ORH Collaboration and Overlapping Areas

• Share and review your grant application and grant activities
• Federal and State Loan Repayment Program (including J1 visa waivers)
• Strategic Planning (Access to care issues)
• Web page coordination (Shortage areas, Incentive programs)
• Recruitment and Retention (3RNet, Retention Collaborative, ...)
• Various councils or committee (Public Health, Commissions, NOSORH)

Thomas Rauner, Primary Care Office Director, DHHS - Nebraska Office of Rural Health
thomas.rauner@nebraska.gov, 402-471-0148
• **The current practice environment in rural Nebraska**

  • Medicare Certified Rural Health Clinics (RHC) and Critical Access Hospitals (CAH)
  • RHCs require physician assistant and/or nurse practitioner
  • CAHs have referral and patient care coordination with larger hospitals
  • Communities generally recruit in a very informal basis and word of mouth

• **Nebraska Office of Rural Health**

  • supports integrated practices for sustainability and long term retention
  • provides limited recruitment assistance through [www.3RNet.org](http://www.3RNet.org)
  • provides loan repayment assistance to practitioners with local matching funds
  • maintains information on state and federal shortage areas
  • Website: [http://www.dhhs.ne.gov/orh](http://www.dhhs.ne.gov/orh)
  • Resource: Health Professions Tracking Service: [https://www.unmc.edu/publichealth/hpts/directory/index.html](https://www.unmc.edu/publichealth/hpts/directory/index.html)
Obligated NE Loan Repayment and Student Loan Incentive Program Participants

79 Total As of Oct 01, 2017
There are 1,151 total nurse practitioners listed by community and primary practice location. 102 of 1,151 (9%) of nurse practitioners work at safety net sites.
Physician Assistants as of April 2017 by Safety Net Sites
Federally funded Community Health Centers, Indian Health Service/Tribal Clinics, and Medicare certified Rural Health Clinics

137 of 905 (15%) of physician assistants work at safety net sites.

There are 905 total physician assistants listed by community and primary practice location.

Source: Health Professions Tracking Service, Office of Community and Rural Health
Last Updated: April 2017
Location: K:\Rural Health Intern\HPTS Data

Cartography: Maggie Harthoorn, Community and Regional Planning Intern
For: Thomas Rauner, DHHS Primary Care Office Director
thomas.rauner@nebraska.gov, 402-471-0148
Physician, Physician Assistant, Nurse Practitioner with a specialty of Family Medicine - 2017

Primary Practice Location

Physicians (713) and Physician Assistants and Nurse Practitioners (612) for a total of 1325 with a specialty of Family Medicine. This is the most predominant primary care specialty serving in Nebraska.

Source: Health Professions Tracking Service, Office of Community and Rural Health
Last Updated: March 2017
Location: K:\Rural Health Intern\HPTS Data

Cartography: Thomas Rauner, DHHS Primary Care Office Director
thomas.rauner@nebraska.gov, 402-471-0148
Psychiatric | MD, PA, APRN | Location | Nebraska 2015

Primary Specialty & Total

- **MD**: 147
- **PA**: 15
- **APRN**: 95

Source: Health Professions Tracking Service
DHHS - Office of Rural Health
Last Updated: April 2015

Cartography: Clark Sintek | Community & Regional Planning Intern | DHHS
For: Thomas Rauner | Primary Care Office Director
thomas.rauner@nebraska.gov | 402-471-0148
New Hampshire Primary Care Office Community Engagement

Alisa Druzba, PCO Director
April 18, 2018
PCO Guidance Overarching Goals

1. Statewide Primary Care Needs Assessment
2. Shortage Designation Coordination
3. Technical Assistance and Collaboration that Seeks to Expand Access to Primary Care
Community Engagement

...the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices.

Community Engagement Strategies

Advisory Boards and Committees
Charrettes
Community Inventory
Community Theatre and Arts
Cultural Complementarity
Cultural Competency Training
Decision-Making
Dialogue
Diversity Forums
Focus Groups
Health Impact Assessments
Informal Open Houses/Exhibits
Listening Circles
Media Strategies
Public Meetings and Forums
Public Opinion Polling
Storytelling
Study Circles
Surveys and Field Canvassing
Visioning

http://www.health.state.mn.us/communityeng/needs/strategies.html
Statewide Primary Care Needs Assessment

• Conduct an overall statewide primary care needs assessment that identifies the communities with the greatest unmet health care needs, disparities, and health workforce shortages, and also identifies the key barriers to access health care for these communities.
• In addition, provide a discussion of past and/or future plans to coordinate the collection of provider data with all licensing boards for health professionals in the state or other appropriate organizations.
Shortage Designation Coordination

• Provide technical assistance to organizations or communities about the designation process;
• Update existing and apply for new HPSA and MUA/P designations as needed;
• Ensure that designation applications are supported with the most up-to-date and appropriate data; and
• Proactively seek designations for areas and populations with access to care barriers as demonstrated by primary care, dental, or mental health provider shortages or other high need indicators as detailed in the HPSA regulations.
2a. Coordination of NHSC Program and Provider Recruitment and Retention:
Support outreach and education that encourages participation in BCRS programs, which will help sites recruit providers to work in underserved areas of the State. Efforts may include, but not be limited to, distributing program information by BCRS, speaking about the BCRS programs at schools in state, and distributing program materials at public events.
• Offer technical assistance to potential and current NHSC sites in the pre-application phase of submitting an NHSC Site Application.
• Coordinate and collaborate with other state agencies and state recruitment efforts to incorporate resources including NHSC Scholars, Loan Repayors, and State Loan Repayors, and/or other scholar and loan repayment programs) into the state’s strategy to increase the number of health professionals serving in HPSAs and MUA/Ps.
Technical Assistance and Collaboration that Seeks to Expand Access to Primary Care, 2b

2b. Collaboration in Health Center Planning and Development:

- Collaborate with the state PCA and other interested entities by providing information to assist in the development of new and expansion of existing health centers in the State.
- Serve as the point of contact to the PCA and other entities for access to and use of relevant statewide and sub-county data to support applications for new and expanded capacity of health centers.
- Facilitate the ability of PCAs and other entities to work with various divisions of the State Health Department to obtain data needed to educate leaders about unmet needs and the role of health centers and the safety net in addressing these needs, as well as the sustainability needs of health centers.
- Work with PCA, State Offices of Rural Health (SORH), Area Health Education Centers, and other entities to seek ways through which partnerships can be maintained and strengthened to assist with the growth and support of health centers and to encourage the provision of quality care.
- Work with PCA, SORH, and other entities to develop reciprocal mechanisms of communication, information dissemination, follow-up, and referral to organizations seeking 330 and other funding opportunities.
Technical Assistance and Collaboration that Seeks to Expand Access to Primary Care, 2c

2c. Collaboration with Other HRSA Partners and Organizations to Support Access to Primary Care Services

- Collaborate with other HRSA-supported entities, (e.g., the state PCA, the SORH, and other appropriate entities) to provide technical assistance to communities and organizations interested in expanding access to care and to maximize the effectiveness and impact of activities through formal linkages with diverse entities working to strengthen the safety net in the state/region.

- Collect, maintain, and report on the number of J-1 visa waiver clinicians and other similar programs practicing in the state.

- Support and enhance access to comprehensive, culturally competent, quality primary health care services for underserved and vulnerable populations.
NH PCO Strategies

• Committees
• Dialogue
• Forums
• Storytelling
• Open Houses/Exhibits
PCO PIMS

Performance Measure 3a:
Percent increase in the number of clients provided technical assistance (TA) by the State Primary Care Office detailed by type of requestor and topic requested in support of the development or expansion of health care services to vulnerable and underserved communities.

• Documents the extent of PCO contribution towards facilitating community health improvement efforts for vulnerable and underserved populations;
• Documents the level of PCO involvement in promoting effective health care services, and access to and the appropriate use of health care information; and
• Demonstrates partnerships which are maintained and strengthened through adequate information exchange.
NH PCO Contact Info

Alisa Druzba
alisa.druzba@dhhs.nh.gov
603-271-5934
https://www.dhhs.nh.gov/dphs/bchs/rhpc/index.htm
The Center for Population Health Strategies

Association of State and Territorial Health Officials
Public Health vs. Population Health
What is Population Health?

- **Population health** envisions “a strong, healthful, and productive society which cultivates human capital and equal opportunity.”

- **Population health outcomes** are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors.

- **Population health strategies** improve health outcomes but ALSO drive effective use and alignment of funds.

## Three Pillars of Population Health Improvement

<table>
<thead>
<tr>
<th>Supporting</th>
<th>Supporting “clinical to community” connections – linking public health interventions and healthcare delivery systems to enhance efficacy and improve health outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressing</td>
<td>Addressing the social determinants of health and advancing ASTHO’s Triple Aim of Health Equity.</td>
</tr>
<tr>
<td>Advancing</td>
<td>Advancing data analytics and public health informatics to monitor health status, evaluate population health improvements, and address pressing population health issues.</td>
</tr>
</tbody>
</table>
Integrated and informative data and technology solutions

Strategic alliances of public health with healthcare payers and providers

Optimal Health for All by addressing SDOH with a health equity lens

Clinical to Community Connections

Data Analytics and Public Health Informatics

Health Equity and Social Determinants of Health
Who do we work with in the state/territorial health agency?

• State/territorial health officials and senior deputies
• Offices of Minority Health/Offices of Health Equity
• Informatics directors
• Chronic disease staff (engaged with prevention, CHWs, telehealth)
• Offices of Population Health
Clinical to Community Connections: Objectives, priorities, and projects

Alliances between public health, healthcare, and payers:

• Ensure public health can “speak the language” of Medicaid.
  • Examples: Cross-Agency Leaders Roundtable, Medicaid Innovations Group, Accountable Health Communities initiative

• Support payment and delivery innovations.
  • Examples: Telehealth, Community Health Worker, and Primary Care Intensive learning communities, and the 6|18 Initiative
Clinical to Community Connections in Action

**Georgia Telehealth Program**
- Georgia Department of Public Health has created telehealth programs in each county health department, and in collaboration with healthcare providers and Medicaid, to improve health access, address workforce shortages, and reduce health disparities.

*Website:* [https://dph.georgia.gov/office-telehealth-telemedicine](https://dph.georgia.gov/office-telehealth-telemedicine)

**Oregon Coordinated Care Organizations (CCOs)**
- Oregon Public Health leveraged State Innovation Model funds to build connections between CCOs and local public health authorities to provide a better overall understanding of health issues across the state and within the Medicaid population.

*Website:* [http://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx](http://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx)
Data Analytics and Public Health Informatics: Objectives, priorities, and projects

*Integrated and informative data and technology solutions:*

- Enhance state and local capacity for using health data and informatics to effectively improve health outcomes and allocate resources.
  - *Examples:* Electronic case reporting learning community, Cancer data linkages, Biosense

- Build a strong informatics workforce.
  - *Example:* Informatics Directors Peer Network
Data Analytics and Public Health Informatics in Action

Massachusetts Chapter 55 Report

- MA Department of Public Health analyzed ten data sets from across five state agencies to deeply investigate opioid-related deaths and drive policy solutions. MA has been able to use this information to engage new partners in criminal justice and clinical settings.

Website: [http://www.mass.gov/chapter55/](http://www.mass.gov/chapter55/)
Health Equity & Social Determinants of Health: Objectives, priorities, and projects

**Optimal Health for All by addressing social determinants of health through a health equity lens:**

- Position public health to be the leader in engaging multiple sectors to address the social determinants of health.
  
  Example: Guidance on successful examples of multi-sector collaborations

- Build public health capacity to address health equity:
  
  Examples: Guidance on including health equity language in funding announcements, Public health leaders roundtable on communication strategies to address health equity, informational interviews with S/THOs
Health Equity & Social Determinants of Health in Action

**Virginia Health Opportunity Index**
- Online mapping tool showing the social, economic, educational, demographic, and environmental factors in each county that influence a community’s wellbeing.


**Rhode Island Health Equity Zones**
- Place-based approach that brings communities together to define collective priorities and build the infrastructure for healthy communities (e.g., access to healthy foods, education, transportation).

  Website: [www.health.ri.gov/hez](http://www.health.ri.gov/hez)
Stay Tuned......

Twitter chat on Population Health Strategies (April 24)

Podcast on how S/THOs can become Chief Health Strategists (week of April 23)

SHO video interview on health equity and cross-sector partnerships

Population Health Summit (April 25-26)

my.ASTHO discussion on the Center for Population Health Strategies page (ongoing)
HPSA Designation
April 18, 2018

Dr. Janelle Anderson
Management Analyst
Division of Policy and Shortage Designation (DPSD)
Bureau of Health Workforce (BHW)
Health Resources and Services Administration (HRSA)
Focus On:
1. Define Health Professional Shortage Areas (HPSA)s;
2. Identify the geographic and demographic data used to establish HPSAs; and,
3. Provide websites where the public can find more information about HPSAs
HRSA uses designation criteria established in statute and regulation to determine whether or not a geographic area, population group or facility is a Health Professional Shortage Area or if an area or population is a Medically Underserved Area or Population.
## Shortage Designations
### Federal Programs Using HPSAs and MUA/Ps

<table>
<thead>
<tr>
<th>Shortage Designation Type</th>
<th>National Health Service Corps (NHSC)</th>
<th>NURSE Corps</th>
<th>Health Center Program</th>
<th>CMS Medicare Incentive Payment</th>
<th>CMS Rural Health Clinic Program</th>
<th>J-1 Visa Waiver Program</th>
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<tbody>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<tr>
<td>Facility HPSA</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dental Care</td>
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<td>Facility HPSA</td>
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<td></td>
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<tr>
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<td>Geographic HPSA</td>
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<td>X</td>
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<td>Facility HPSA</td>
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<td>Exceptional MUP</td>
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<td>Medically Underserved Area</td>
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<td>X</td>
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<tr>
<td>Medically Underserved Population</td>
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<tr>
<td>State Governor's Certified Shortage Area</td>
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</table>
Definitions 101

Shortage Designation

Identification of an area, population, or facility experiencing a shortage of health services. There are two types of shortage designations, each linked to a HRSA activity or function.
Types of Shortage Designations

**HPSA**
(Health Professional Shortage Area)

**MUA/P**
(Medically Underserved Area/Population)

<table>
<thead>
<tr>
<th>A shortage of:</th>
<th>Limited access to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Dental Health</td>
</tr>
<tr>
<td>Population Group</td>
<td>Facility</td>
</tr>
<tr>
<td>Geographic Area</td>
<td>Geographic Area</td>
</tr>
<tr>
<td>Population Group</td>
<td>Population Group</td>
</tr>
</tbody>
</table>

providers in a:
services in a:
Health Professional Shortage Areas

HPSAs
Types of HPSAs

A shortage of:

- Primary Care
- Mental Health
- Dental Health

providers in a:

- Geographic Area
- Population Group
- Facility
HPSA Designation Criteria

In order to achieve a designation, the area under consideration must:

1. Be a **rational area** for the delivery of services;

2. Have a **certain ratio of population to providers** serving the area that has been determined to qualify as a shortage; and

3. Demonstrate that health professionals in contiguous areas are **excessively distant, over-utilized, or inaccessible** to the population under consideration.
Designation Criteria Overview

While each type of designation has its own distinct rules, there are several cross-cutting factors that go into any designation application:

**Rational Service Area (RSA)**
A PCO-identified geographic area within which most area residents could or do seek and obtain most of their health care services.

**Contiguous Area (CA)**
All whole counties, multiple counties, or sub-counties that border the RSA under consideration for designation.

**Population to Provider Ratio**
The count of full-time equivalent providers that are seeing patients of the area or population group in relation to the population of the area or group.

**Nearest Source of Care (NSC)**
The nearest qualified provider to the RSA, identified by determining the shortest travelable path.
Rational Service Area (RSA)

A PCO-identified geographic area within which most area residents could or do seek and obtain most of their health care services.

RSAs can be:
1) A whole county;
2) Multiple counties;
3) Sub-counties;
4) Statewide Rational Service Areas (SRSA); or
5) Catchment areas (for mental health only).

Rules of RSA Determination
1) RSAs cannot overlap.
2) RSAs cannot be smaller than a census tract.
3) RSAs cannot exceed travel time guidelines between population centers.
4) RSAs cannot carve out interior portions.
5) RSAs must have only one area or population designation.
## Ratio of Population to Providers

### Which Providers Count?

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Mental Health</th>
<th>Dental Health</th>
</tr>
</thead>
</table>
| Includes Doctors of Medicine (MD) and Doctors of Osteopathy (DO) who provide services in the following specialties: | Includes:  
- Only Psychiatrists  
- Psychiatrists AND all:  
  - Clinical Social Psychologists  
  - Clinical Social Workers  
  - Psychiatric Nurse Specialists  
  - Marriage & Family Therapists | Includes:  
- Dentists and  
- Dental Auxiliaries  
Dental auxiliaries are defined as any non-dentist staff employed by the dentist to assist in the operation of the practice. |
|  
- Family Practice  
- Internal Medicine  
- Obstetrics and Gynecology  
- Pediatrics |  |

**Note:** Providers solely engaged in administration, research or training are excluded.
Each HPSA category has a unique **ratio of population to providers**, which has been identified as the threshold ratio at which a geographic area, population, or facility qualifies for designation.

<table>
<thead>
<tr>
<th>Category</th>
<th>Primary Care</th>
<th>Mental Health</th>
<th>Dental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic</td>
<td>3,500:1</td>
<td>6,000:1 &amp; 20,000:1 CMH and Psychiatrists OR 9,000:1 CMH only</td>
<td>5,000:1</td>
</tr>
<tr>
<td>Population</td>
<td>3,000:1</td>
<td>4,500:1 &amp; 15,000:1 CMH and Psychiatrists OR 6,000:1 CMH only</td>
<td>4,000:1</td>
</tr>
<tr>
<td>Facility</td>
<td>1,000:1</td>
<td>2,000:1</td>
<td>1,500:1</td>
</tr>
</tbody>
</table>

*Excludes high-needs and special population designations, which have distinct ratios*
Review of Contiguous Area Resources

Contiguous Area (CA)
All whole counties, multiple counties, or sub-counties that border the RSA under consideration for designation

When selecting an RSA in the Shortage Designation Management System, the user will be required to identify all contiguous areas for the selected RSA.

HRSA Questions:
• Is the contiguous area (CA) inaccessible?
• Is there a demographic disparity?
• Are the CA providers excessively distant?
• Are providers in the CA over-utilized?
• Does the CA have economic barriers?*
When determining whether an area’s “neighbors” are accessible for health care services, HRSA asks:

- Is the contiguous area (CA) inaccessible?
- Is there a demographic disparity?
- Are the CA providers excessively distant?
- Are providers in the CA overutilized?
- Does the CA have economic barriers?*
The Nearest Source of Care is used to determine the time and distance the population of the RSA must travel to seek care outside of the RSA.
Nearest Source of Care Identification

SDMS identifies a qualifying provider with the **shortest path originating from the centroid/population center of the RSA to the geographic coordinates of the provider.**

**NSC Checks**

- Is it in a Geo or Pop HSPA or OFAC?
- Does it have a socio-economic or physical barrier?
- Is it over-utilized?
- **✓** Is it excessively distant?

NSC falls within the Travel Polygon, therefore is NOT excessively distant. It may still be in another HPSA, have barriers, or be over-utilized.
HPSA Scoring Criteria

HPSA scores are based on a variety of factors and range from 0 to 25 in the case of Primary Care and Mental Health, and 0 to 26 in the case of Dental Health.
## HPSA Scoring Calculations

<table>
<thead>
<tr>
<th>Factor</th>
<th>Max Pts Awarded</th>
<th>Multiplier</th>
<th>Total Points Possible</th>
<th>Max Pts Awarded</th>
<th>Multiplier</th>
<th>Total Points Possible</th>
<th>Max Pts Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population: Provider Ratio</td>
<td>5</td>
<td>x 2</td>
<td>10</td>
<td>5</td>
<td>x 2</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>% of Population below FPL</td>
<td>5</td>
<td>x 1</td>
<td>5</td>
<td>5</td>
<td>x 2</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Travel distance/time to NSC</td>
<td>5</td>
<td>x 1</td>
<td>5</td>
<td>5</td>
<td>x 1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Infant Mortality Rate or Low Birth Weight</td>
<td>5</td>
<td>x 1</td>
<td>5</td>
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<td></td>
<td></td>
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<tr>
<td>Water Fluoridation</td>
<td></td>
<td></td>
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<td>1</td>
<td>x 1</td>
<td>1</td>
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<tr>
<td>Ratio of children under 18 to adults 18-64</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
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<tr>
<td>Ratio of adults 65 and older to adults 18-64</td>
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<td>3</td>
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<tr>
<td>Substance prevalence</td>
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<td>1</td>
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<tr>
<td>Alcohol abuse prevalence</td>
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<tr>
<td><strong>Max Score:</strong></td>
<td><strong>= 25</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Once an area qualifies for a designation or is automatically designated under the statute or regulations, the system uses criteria to provide a *score*.

**Why does score matter?**
How are HPSA Scores Used?

1. Priority in Awards
2. Award Levels
3. Scholar Placement

1. Funding Preference
2. Scholar Placement
Shortage Designation Management System (SDMS)

... is an online application tool used by State PCOs and HRSA to manage designations

... uses standard data sets to calculate designations

... is based on regulations
Submit

Receive

Communicate

Process

Score
SDMS Data Sources

- **Standardized data are sourced from:**
  - The Centers for Medicare and Medicaid Services (CMS) for provider data
  - The Centers for Disease Control and Prevention (CDC) for infant health data
  - The Census Bureau for population data
  - The Environment Systems Research Institute (ESRI) for travel and spatial mapping data
Welcome to Shortage Designation Management System!
The Shortage Designation Management System is a tool for Bureau of Health Workforce staff to manage shortage designation processing, data used for designations, and communicate with Primary Care Officers (PCOs) regarding their state’s designations. The tool can be used to view designation information, review designations, correspond with stakeholders via inquiry functionality and access reports.

In the June 2016 Release, PCOs are now able to create new facility designations as well as update existing facility designations. Functionality to support automatic import of NPI updates made to provider records is also available. Additionally, improved stability, reliability and performance improvements were released.

Please look out for training sessions. You should be receiving invitations by email.
## Receive

### Designations Search

<table>
<thead>
<tr>
<th>Case ID</th>
<th>Public ID</th>
<th>Discipline</th>
<th>Type</th>
<th>Status</th>
<th>Submission Year</th>
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<td>Geographic Population</td>
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<td>Primary Care</td>
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**State:** AL
## 5430 Blanco County - General Information

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<td>Discipline</td>
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<td>Created by PCO</td>
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**- Comments**

**Add Comment**

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**HRSA Health Workforce**

---
# Data Points for Scoring

## 27951 User Guide Test - Supporting Details

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<th>RSA Details</th>
<th>CA Analysis</th>
<th>NND Provider</th>
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<td></td>
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<td>User Selected Population Center</td>
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<td>RSA Providers</td>
<td>RSA Provider Report</td>
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### RSA Data - test

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<td>African American Population</td>
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<td>Age 18 and under population</td>
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<td>Age 65 and over population</td>
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<td>Asian %</td>
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<td>Asian Population</td>
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<td>Caucasian %</td>
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<td>Does have alcohol abuse</td>
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<td>Does have substance abuse</td>
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<td>Elderly Ratio</td>
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<td>Hispanic %</td>
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<td>Hispanic Population</td>
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### RSA Details

<table>
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#### RSA Data - test

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<tbody>
<tr>
<td>African American %</td>
<td>0.4200</td>
</tr>
<tr>
<td>African American Population</td>
<td>22,000</td>
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<tr>
<td>Age 18 and under population</td>
<td>1342.0000</td>
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<td>Age 65 and over population</td>
<td>707.0000</td>
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<td>Asian %</td>
<td>0.1500</td>
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<td>Asian Population</td>
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<tr>
<td>Caucasian %</td>
<td>99.0000</td>
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<td>Caucasian Population</td>
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<td>Core Mental Health PTE</td>
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<tr>
<td>Does have alcohol abuse</td>
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<td>Does have substance abuse</td>
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<tr>
<td>Elderly Ratio</td>
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<td>Hispanic %</td>
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<td>Hispanic Population</td>
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## Rational Service Area Details - II

<table>
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<tr>
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<tr>
<td>Number Population at 100% FPL</td>
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<tr>
<td>Number Population at 200% FPL</td>
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<td>Pacific Islander %</td>
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<td>Pacific Islander Population</td>
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<tr>
<td>Percent Population at 100% FPL</td>
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<tr>
<td>Population Age 18-64</td>
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<tr>
<td>Psych Provider FTE</td>
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<td>Relevant Population Total</td>
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<tr>
<td>Total Resident Civilian Population</td>
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<td>Youth Ratio</td>
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### Insufficient Capacity Data

#### 21217920100 56667

<table>
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<tbody>
<tr>
<td>State FIPS:</td>
<td>21</td>
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<tr>
<td>County FIPS:</td>
<td>217</td>
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<tr>
<td>Name of Component:</td>
<td>CensusTract</td>
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<tr>
<td>Total Resident Civilian Population:</td>
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<tr>
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<tr>
<td>Percent Population Below 200% FPL:</td>
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#### 21045950200 56667

### Comments

Add Comment

[Save]
# Contiguous Area Details

## 30134 User Guide Test - Supporting Details

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<th>General Information</th>
<th>RSA Details</th>
<th>CA Analysis</th>
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<tr>
<td>Scoring Criteria</td>
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<td>CA Providers</td>
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<td>Review Support</td>
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</tr>
<tr>
<td>Inquiries</td>
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### CA Group 1 Name

- **Validity**: Passed By System Analysis
- **Analysis**: Demographic Disparity

<table>
<thead>
<tr>
<th>ID</th>
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<th>State FIPS</th>
<th>County FIPS</th>
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Nearest Source of Care - I

30133 User Guide Test - Supporting Details

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</tr>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>NPI:</td>
</tr>
<tr>
<td>Address: 367 COUNTY ROAD 412</td>
</tr>
<tr>
<td>City: YOAKUM</td>
</tr>
<tr>
<td>State: TX</td>
</tr>
<tr>
<td>ZIP: 77985-6672</td>
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<tr>
<td>Sliding Fee Scale: N/A</td>
</tr>
<tr>
<td>Serves Medicaid?:  N/A</td>
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<tr>
<td>Distance (Default): 41.7359 Miles</td>
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<tr>
<td>Distance (User):    N/A</td>
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<tr>
<td>Travel Time (Default): 87.09 Minutes</td>
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Nearest Source of Care - II

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<td><strong>ZIP:</strong></td>
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<td><strong>Sliding Fee Scale:</strong></td>
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<tr>
<td><strong>Serves Medicaid?</strong></td>
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<td><strong>Distance (Default):</strong></td>
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<tr>
<td><strong>Travel Time (Default):</strong></td>
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**Comments**

Add Comment

[Save Button]
### Scoring Criteria

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<td>% Population Below 100% Poverty</td>
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<td>Physician Shortage</td>
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<td>Degree of Shortage</td>
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</table>

**Comments**

Add Comment

[Save]
Contact Information

Dr. Janelle Anderson
Management Analyst
Division of Policy and Shortage Designation (DPSD)
Bureau of Health Workforce (BHW)
Health Resources and Services Administration (HRSA)
Email: janderson@hrsa.gov
Web: bhw.hrsa.gov
Twitter: twitter.com/HRSAgov
Facebook: facebook.com/HHS.HRSA
Recruitment and Retention Activities

Thomas Rauner, Nebraska Primary Care Office Director
402-471-0148
Thomas.Rauner@Nebraska.gov
http://dhhs.ne.gov/publichealth/RuralHealth/Pages/RuralHome.aspx
PCO Overview of Recruitment and Retention

Who are the players in your state? Join the team, it’s a big challenge

- Area Health Education Center (AHEC)
  - Rural Health Opportunities Program
  - Rural Health Education Network
  - Rural Healthcare Workforce Report 2018
    - Pipeline programs should be supported and enhanced

- Statewide Advisory Board

- Behavioral Health Education Center of Nebraska
  - BHECN 2017 Legislative Report on BH Workforce
    - [https://unmc.edu/bhecn/_documents/FY16-17-legislative-report.pdf](https://unmc.edu/bhecn/_documents/FY16-17-legislative-report.pdf)

- Advisory Council
Site Approvals and Loan Repayment

- The Division of Regional Operations and Primary Care Office portal communication
  - Communication on site approvals
  - Communication on site visits – can be used to coordinate visits
  - Review of retention survey responses and NHSC site visit evaluations

- Monitoring of NHSC placements and NHSC SLRP
  - Transfers are something usually handled via phone or email
  - University of Nebraska Medical Center - Health Professions Tracking Service
  - Program impacts and retention

- Recruitment and working with providers and communities
  - On line application process initiated recently
  - Coordination between programs and staff
  - Evaluation of best program for applicants and sites
Impact Analysis and Retention Collaborative

• UNMC – Health Professions Tracking Service
  • Established in 1995 at the University of Nebraska Medical Center
  • Monitoring of all actively practicing providers including clinics
  • Ability to review ongoing updates and map provider locations
  • Initiating impact analysis of various loan repayment programs

• Retention Collaborative and Data Management System
  • Currently 20 states are engaged in this effort started in 2013
  • NHSC – PCO- FHLI-Sheps Research Center
  • NHSC provides quarterly updates of providers
  • FHLI assists with updating providers in the Data Management System
  • Reports can be self generated with analysis support from Sheps Center
Review your Options

• Determine who performs recruitment and retention activities
• Determine which activities your office will be able to perform
• Coordination with other recruitment and retention partners
• Recruitment and Retention are long-term process activities
Primary Care Office Training Academy

Association of State and Territorial HealthOfficials (ASTHO)

April 17, 2018

Matthew Salaga
Management Analyst,
Shortage Designation Branch
PCO Roles and Responsibilities with the Shortage Designation Branch (SDB)

• PCOs work with HRSA to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs.
  • This is accomplished through the U68 Cooperative Agreement with HRSA.

• What is a Cooperative Agreement and how does it differ from a grant?
  • A Cooperative Agreement is similar to a grant except that “it provides for substantial involvement between the Federal awarding agency or pass-through entity and the non-Federal entity in carrying out the activity contemplated by the Federal award.”

• 5-year project period (the 5th year of the cooperative agreement began April 1, 2018) include three parts:
  • PCOs developed statewide Needs Assessment plans
  • PCOs identify potential Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas or Populations (MUA/Ps)
  • PCOs engage in recruitment and retention activities

• Over $11 million is awarded annually to 54 states and territories

• HRSA expects to release a Notice of Funding Opportunity for the PCO cooperative agreement for 2019-2023 in the latter half of 2018.
PCO Major Responsibilities

- Attend the annual Reverse Site Visit
- Participate in the PCO Monthly Call
- Engage in quarterly calls with Project Officers
  - All deliverables completed and submitted through the Electronic Handbooks System (EHB)
- Ask for technical assistance when needed
- Keep your Project Officer advised of any unusual issues or problem areas
PCO Major Responsibilities – Reverse Site Visit

- Scheduled for July 24-27, 2018

- A forum where PCOs can all meet, hear about programmatic updates and best practices from their state and federal partners, and share information.

- Also a chance for other stakeholder groups to meet with and present to PCOs (e.g. CMS, ASTHO, etc.)
PCO Major Responsibilities – Monthly Call

• Takes place on the third Thursday of every month

• This call is for PCOs to receive updates from SDB and its partners in activities related to the U68 Cooperative Agreement. It also provides a forum for PCOs to ask any questions they may have about these programs.

• Participants generally include staff from the Shortage Designation Branch (SDB), Division of Regional Operations (DRO), National Health Service Corps (NHSC), and NURSE Corps.
PCO Major Responsibilities – Quarterly Calls

- Occur every January, April, July, and October

- These calls serve as an opportunity for PCOs to have 1x1 interaction with their Project Officer (PO) and Division of Regional Operations (DRO) representative

- PO provides updates on any issues surrounding shortage designation and the U68 Cooperative Agreement including deliverables

- DRO representative provides updates on the recruitment and retention portion of the Cooperative Agreement
  - Includes National Health Service Corps (NHSC), NURSE Corps, State Loan Repayment (SLRP), etc.

- Provides PCOs a forum to raise any questions, concerns, or challenges they are facing with the administration of the cooperative agreement.
Primary Care Needs Assessment
• Needs Assessments are completed once during the entire grant period

• What is the Needs Assessment?
  • A mechanism to identify areas for PCOs to prioritize their efforts in order to promote access to care, especially for the underserved, while performing the goals detailed in the cooperative agreement awarded to the PCO by HRSA

• Another Needs Assessment will be required during the 2019-2023 grant period

- Due July 31 of each grant year and submitted by your state budget office

- Report on how the year’s federal funds were spent by PCOs
  - Once your office has submitted the FFR, carryover requests are due no later than 30 days after submission
Annual Performance Report (also referred to as Performance Measures)

- Due November 30 of each year – reporting on time period of October 1 of the prior year to September 30 of the current year (ex.: October 1, 2017 – September 30, 2018)

- Three measures to report on in this report
  - **PCO-1**: Number of NHSC Site Application and Recertification recommendation forms submitted by the State Primary Care Office to the NHSC
    - PCO staff work with their assigned DRO representative to obtain these numbers
  - **PCO-2**: The effect of obligated health providers (OHPs) on HPSAs that are already in your state and how they are contributing to the shortage of medical professionals.
    - Federal OHPs are captured by HRSA in the Field Strength Reports that are available after September 30th of each year.
    - PCOs are responsible for reporting on the state OHPs working in HPSAs in your states.
PCO Major Responsibilities – U68 Cooperative Agreement Reporting Deliverables

• **PCO-3a: Instances where PCOs provided Technical Assistance (TA) on certain activities associated with the U68 Cooperative Agreement to clients**
  
  • Activities include NHSC, expansion of health services in their state, Data Sharing, Designations, Needs Assessments and other types of TA such as NURSE Corps and J1 Visa Waivers.
  
  • Types of clients include Communities, Providers, potential J1 Visa Waiver recipients, Community Health Centers, Health Departments, State Agencies, HRSA Office of Regional Operations, Medicaid Offices, Primary Care Associations (PCA), SLRP recipients, Rural Health Clinics, NHSC recipients and other clients.

• **PCO-3b: Groups receiving technical assistance for activities related to the U68 Cooperative Agreement**
  
  • This measure differs from 3a in that while 3a measures clients asking PCO staff for technical assistance on topics, 3b measures the outreach that PCOs do to groups about the benefits associated with the U68 Cooperative Agreement such as NHSC, Nurse Corps, J1 Visa Waivers, etc.
PCO Major Responsibilities – U68 Cooperative Agreement Reporting Deliverables

U68 Progress Reports

• Due in December – once guidance is received from the Office of Financial Management (OFAM)
  • Once guidance is received from OFAM, the Progress Report may be submitted by the PCO in EHB

• This deliverable serves as a mid-year review on progress PCOs have made towards achieving the goals stated in their work plan when the grant was originally awarded.
  • Includes a performance narrative of work completed, biographies on staff involved in the work, a project abstract for the upcoming year, and any unobligated balances anticipated.
PCO Roles and Responsibilities - Questions
Contact information

Matthew Salaga (MSalaga@hrsa.gov)
Management Analyst, Shortage Designation Branch (11W13B)
Division of Policy and Shortage Designation
Bureau of Health Workforce
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane, 11SWH03
Rockville, Maryland 20857
Office phone-301.945.0194
Primary Care Office/State Office of Rural Health Collaboration

April 18, 2018

Rachel Moscato, MPH
Public Health Analyst
Federal Office of Rural Health Policy (FORHP)
Health Resources and Services Administration (HRSA)
Today’s Presentation

• Background on the Federal Office of Rural Health Policy (FORHP)
• Divisions within FORHP
• Overview of the State Offices of Rural Health (SORH) Program
HHS, HRSA & FORHP
Mission
FORHP collaborates with rural communities and partners to support programs and shape policy that will improve health in rural America.

Values
Accountable  Knowledgeable
Collaborative  Respectful
Innovative  Responsive
Active Physicians per 100,000 population by Physician Specialty and Urbanization Level: United States, 2010

Monitoring Workforce Data

Rural Health Research Gateway

Workforce

Projects on this Topic
The Centers have 9 research projects currently underway to explore this issue. In the past, 58 research projects have been completed on this topic.

Research Findings
View publications, including policy briefs, working papers, and final reports, on this topic:

- Research Products - (97)
- Journal Articles - (19)

Literature Review

- Informing Rural Primary Care Workforce Policy: What Does the Evidence

Related Topics
- Allied health professionals
- International Medical Graduates (IMGs)
- Nurses
- Physician assistants
- Physicians

https://www.ruralhealthresearch.org
Rural Considerations
Hospital Closures

Figure 2. Closed rural hospitals, 2010 - 2017

Legend
- 78 rural hospitals closed since 1/1/2010
  - CAH (26)
  - Rural PPS (52)
  - FORHP Rural Health Areas
  - Non-Rural Health Areas

Alaska and Hawaii not shown because they have no closed rural hospitals in this time period.
State Offices of Rural Health (SORH) Grant Program
SORH Grant Background

- Authorized by Public Health Service Act (42 U.S.C. 254r) as amended, 1990
- Reauthorized by Congress 1998
- Funds appropriated by Congress since FY 1991
- Primary goal - to assist States in strengthening rural health care delivery systems by creating a focal point for rural health in each State
1. Establish and maintain clearinghouse for collection and disseminating information on:
   - rural healthcare issues
   - research findings related to rural healthcare
   - innovative approaches to the delivery of care in rural areas

2. Coordinate activities within state to avoid duplication.

3. Identifying Federal and state programs regarding rural health, and providing technical assistance regarding application and participation.

SORHS may also: conduct activities pertaining to the recruitment and retention of health care professionals to serve in rural areas; and provide sub-awards and contracts to public and non-profit organizations to carry out SORH activities.
Contact Information

Rachel Moscato, MPH
Public Health Analyst
Federal Office of Rural Health Policy (FORHP)
Health Resources and Services Administration (HRSA)
Email: rmoscato@hrsa.gov
Phone: 301-443-2724
Web: hrsa.gov/ruralhealth/
Twitter: twitter.com/HRSAGov
Facebook: facebook.com/HHS.HRSA
To learn more about our agency, visit

www.HRSA.gov

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twitter  
linkedin  
youtube
Primary Care Office/State Office of Rural Health Collaboration

Chris Salyers, MA
Education and Services Director

National Organization of State Offices of Rural Health
Who is NOSORH?

- **Mission:** NOSORH promotes the capacity of state offices of rural health to improve health care in rural America through leadership development, advocacy, education, & partnerships.

- Webinars
- Fact Sheets
- Learning Communities
- Institutes
- Toolkits
- Meetings
- Legislative Activities
Co-located SORH-PCO
How can we collaborate?

• Recruitment and Retention
• Shortage Designations
• Reporting
• Other Opportunities
Recruitment and Retention

• Majority of SORH are also the 3RNet member
• Assist with recruiting sites for loan repayment programs
• Assist with linkage of community facilities to J-1 and other PCO programs
Shortage Designations

- Site visits
- Population insights
- Direct linkages

NOTE: HPSA score can impact: loan repayment, reimbursement rates, etc.
Reporting

- PCO can be that link between urban underserved and rural
- State Rural Health Plans
- Grant Applications
- Policy/Issue Briefs on Rural Needs
- Strategic Planning
- Joint Health Professions Workforce Plan (DOL Initiative)
Other Opportunities

• Public Health Accreditation

• Consider HHS Priorities:
  • Opioid Use
  • Childhood obesity
  • Reducing cost of prescription drugs
  • Reducing regulatory burdens
NOSORH Services

Available to PCO for capacity building
TruServe

• Web-based performance tracking tool
• Customizable reports and inputs
• Currently used by 3 PCO offices (not including joint offices)

Contact:
Matt Strycker
(888) 391-7258 x103
stryckerm@nosorh.org
NOSORH Institutes

Grant Writing Institute
• 9 session over 18 weeks
• Complete grant writing process
• Final project – project narrative

Data Institute
• 8 sessions over 16 weeks
• Data use process
• Final project – data-driven fact sheet
Contact Information

Chris Salyers
Education and Services Director
National Organization of State Offices of Rural Health (NOSORH)
Email: chris.salyers@nosorh.org
Phone: (888) 391-7258 x106
Web: www.nosorh.org
Facebook: www.facebook.com/NOSORH
Twitter:@NOSORH
State/Regional Primary Care Associations 101

ASTHO Primary Care Meeting

April 18, 2018

Jennifer Nolty, Director
PCA & Network Relations
jnolty@nachc.com
Your Health Center Support Network

Alliance of Chicago
Community Health Services, L3C

California Primary Care Association

CHCANYS - Community Health Care Association of New York State

OPCA - Oregon Primary Care Association

OSIS
Your Health Center Support System

**PCAs**: State focused trainings based upon the unique health care delivery systems – mainly Medicaid

- Research-based advocacy
- Education about the mission and value of health centers.
- T/TA to health center staff and boards.
- Develop alliances to increase access to primary care

~~~~~~~~~~~~

**HCCNs**: ~ 80 across the country. Services vary from group purchasing, IT support, EMR hosting and data warehouses

~~~~~~~~~~~~

PCAs and HCCNs now focused on building Clinical Integrated Networks such as Independent Practice Associations (IPAs), Accountable Care Organizations (ACOs) and/or Managed Services Organizations (MSOs) to increase quality at HCs
2017-20 S/R PCA Funding

PCA funding will support training and technical assistance (T/TA) for existing and potential health centers to:

- Increase access to health care services
- Achieve operational excellence
- Enhance health outcomes and health equity
Focus Area 1: Access to Care
Goal 1: Increase patients receiving care in health centers, including special and vulnerable populations
Goal 2: Increase the number of health centers providing comprehensive services, including medical, oral health, behavioral health, vision, and enabling services

Focus Area 2: Operational Excellence
Goal 1: Increase PCMH recognition and/or optimization of the PCMH model
Goal 2: Increase the percentage of health centers with a cost increase less than the national average

Focus Area 3: Health Outcomes and Health Equity
Goal 1: Improve diabetes care health outcomes and disparities
Goal 2: Improve health outcomes and disparities for one of the following: hypertension control, colorectal cancer screening, or cervical cancer screening
The Roles of PCAs

HRSA Cooperative Agreement
- Strict Use of Federal Funds
- Approved *Cooperative Work Plan*
- Must provide Training/TA to all grantees and those seeking to become HCs or LAs

Trade Association
- Membership Services
- Advocacy and Policy
- May have other lines of related businesses
PCA + HCCN = Clinical Integration

# of PCA led IPAs: 16
# of PCA led ACOs: 17
Main concerns cited by PCAs (beyond overall uncertainty in current environment):

1. Changes to Medicaid (Block grants/capitation)
2. State budget deficit causing cuts to primary care
3. PPS rate endangerment/Waiver concerns
4. Opioid Challenge/ Behavioral Health
5. Health Center Program Expansion concerns
6. Workforce

– 52 PCAs Surveyed
Primary Care Funding Cliff

Health Center Funding: FY 2011 - FY 2018

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</table>

Billions

Fiscal Year
PCA/PCO Collaborations/Suggestions

• Aligned!
  – Same team and same goals!

• Joint work on HPSA and MUA/MUP Designations
  – Some PCAs have contracts with PCOs

• Quarterly Meetings
  – More meetings = more understanding

• Recognize each others strengths
  – Inside vs Outside push
Questions