EvidenceNOW
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FINDING SUSTAINABLE FUNDING FOR PRIMARY CARE EXTENSION PROGRAMS

Finding sustainable funding for primary care extension programs is a challenge. This resource shares information about potential opportunities for funding to provide guidance for existing programs that seek to become financially sustainable. We include examples and tips for funding from health extension programs, primarily from the Agency for Healthcare Research and Quality's (AHRQ's) IMPaCT and EvidenceNOW initiative grantees in Oklahoma, Oregon, and New Mexico.

Funding Strategies

Primary care extension programs are often funded, at least initially, through Federal or State grants.[1] Grant funding can be essential for establishing the coalition of partners throughout a State needed to carry out the work and develop needed statewide infrastructure. Some primary care extension programs have been successful at securing **sequential funding**, where previous grant experience is leveraged for new (and often larger) grants across agencies.

However, funding that is not project specific is needed to allow primary care extension programs to work with primary care practices more holistically, and based on their self-identified quality improvement (QI) needs, rather than being limited to funders' priorities. In addition, without ongoing funding for core infrastructure costs, inevitable gaps between grant funding periods occur. These gaps can lead to loss of trained

and specialized staff – and with them the collective knowledge, skills, and relationships built with primary care practices statewide that allow primary care extension programs to be efficient and effective.[1,2]

Most primary care extension programs have found they need funding from multiple sources to sustain their work over time. This often includes seeking a mix of both project-based grant funding and more ongoing non-project-based funding from various sources. Braiding or layering funding are approaches that use multiple funding streams to support a program.*

- In **braided funding,** the full costs of the program are shared across multiple funding sources, with each funding stream remaining separate so it can be individually tracked. In this strategy, cost-allocation methods are used to make sure program and administrative costs are appropriately shared across funding sources and to prevent any duplication in funding.[3-5]
- In **layered funding,** funding for the program's core services is supplemented with additional funding (from the same source or other sources) to allow for the provision of broader or more comprehensive services.[6] An advantage of this approach is that core services are not disrupted if supplemental funding ends.[4]

Sequential, braided, and layered funding approaches can all be used to help sustain primary care extension services over time.

Primary Care Extension Programs provide external support to primary care practices to help them implement the best evidence and increase their capacity for QI.

AHRQ's EvidenceNOW model for primary care extension includes:

- Practice facilitation or coaching
- Health information technology (IT) support
- Expert consultation or academic detailing
- Data feedback and benchmarking
- Shared learning among practices

* Another funding strategy known as "blending" refers to mixing funds from multiple sources together such that individual funding sources lose their program-specific identity and cannot be tracked separately.[3] We did not find any examples of blended funding to support primary care extension programs.

Potential Funding Sources

Below, we provide information about the various sources of potential funding for primary care extension programs. We include examples based on interviews we conducted with representatives from the following programs that provide health extension services: The Oregon Rural Practice-Based Research Network (ORPRN)[7], the Oklahoma Primary Healthcare Improvement Cooperative (OPHIC)[8], and the University of New Mexico Office for Community Health's Health Extension Regional Officers (HERO) Program.[9]

- **Legislative authorization from the State budget.** State legislatures can authorize funding for programs that are focused on primary care improvement.
  - For example, OPHIC receives a small amount of annual funding from their State to cover some infrastructure expenses (i.e., office space, administrative staff, etc.) and to develop and support interagency community coalitions called County Health Improvement Organizations.
- **University funding and non-financial support.** Often, primary care extension programs are coordinated through one or more universities – frequently the clinical and translational science center within a State university. This relationship with the university can benefit the primary care extension program through financial investment and infrastructure support, as well as through staff and faculty sharing arrangements. For example:
  - The University of New Mexico Health Sciences Center provides continuous, sustainable funding for administration of the HERO program and for partial funding of HEROs' positions.
  - ORPRN, which exists as a standalone unit within the School of Medicine at Oregon Health & Science University, gives all indirect funding from their grants to the University. In return they do not pay for any overhead costs (such as for office space, central finance and human resources staff costs, etc.). This arrangement provides stability for the program when it experiences gaps in funding between large grants.
  - OPHIC is organizationally situated within the University of Oklahoma's federally funded Clinical and Translational Science Institute, which serves as its dissemination and implementation arm.
- **Federal grants.** While it is not recommended that primary care extension programs rely solely on Federal grants, these grants often make up a sizeable portion of overall funding for State QI efforts.
  - There are several Federal agencies that have funded primary care extension services. This includes the agencies presented in the table below, along with the general focus of the funding they each provide. You can view available grants at Grants.gov and set up to receive alerts for current and projected funding opportunities. (The successful award of a Federal grant requires staff with grant writing skills and experience. Primary care extension programs that are not run through a university may want to partner with one for this type of support or hire professional grant writers for their team.)

FEDERAL AGENCY	FOCUS OF FUNDING
Agency for Healthcare Research and Quality (AHRQ)	Research and demonstration grants (e.g., IMPaCT and EvidenceNOW)
Centers for Disease Control and Prevention (CDC)	Public health (e.g., state program grants)
Centers for Medicare and Medicaid Services (CMS)	Payment models for Medicare and Medicaid beneficiaries (e.g., Comprehensive Primary Care-CPC, CPC+, Primary Care First, and Accountable Care Organizations-ACOs)
Health Resources and Services Administration (HRSA)	Safety net patients (e.g., Health Center Quality Improvement Awards, Small Health Care Provider Quality Improvement Program)
Office of the National Coordinator for Health Information Technology (ONC)	Health information technology, including electronic health records and health information exchanges (e.g., Beacon Community Program)

- **State contracts and funding.**
  - **State Departments of Health** (including Public Health or Mental Health) and **Medicaid programs** often contract with primary care extension programs to support implementation of a QI initiative to improve health outcomes. For example:
    - The Public Health Division of the Oregon Health Authority has supported several ORPRN initiatives. This work is generally related to working with primary care clinics to improve prevention activities, such as screening for heart disease or diabetes and referral to self-management programs. In addition, ORPRN has had a number of contracts with the State of Oregon (State Medicaid and the vaccine program) to support primary care practices with COVID vaccine storage and handling.
    - OPHIC has had several subcontracts with Oklahoma's Departments of Health and Mental Health to gather data to support chronic disease management and to design and implement systems to screen for alcohol and substance use disorders.

- In an example of States partnering with Federal agencies (and payers) for funding, the Maryland Department of Health partnered with the Center for Medicare and Medicaid Innovation (CMMI) at CMS to develop the Maryland Primary Care Program (MDPCP). MDPCP "aims to make strategic investments in primary care practices and build a resilient statewide infrastructure to prevent and manage chronic disease. Specific objectives include: 1) Strengthening primary care infrastructure 2) Broad care transformation 3) Meeting goals in clinical quality and utilization performance."[10] BlueCross BlueShield CareFirst has since joined MDPCP as a partner with aligned support and payment for practices.

- Some States have funds designated to be spent on health promotion, such as **cigarette tax revenues** or **tobacco settlement money** (and eventually opioid settlement money), that are a possible source of funding for primary care QI efforts. For example:

  - The State provided ORPRN with start-up funding from tobacco settlement funds.

  - The California Department of Public Health spent $126.7 million of its tobacco tax revenue on the California Tobacco Control Program which included "efforts to improve awareness, access, and availability of cessation support offered by the health care system, health care plans, and employers."[11]

  - Oklahoma has the Oklahoma Tobacco Settlement Endowment Trust, which funds "prevention, research and emerging opportunities to improve the health of every Oklahoman."[12]

- **Contracts with payers and other entities for technical assistance, training, or other services.**

  - Payers often prefer to hire their own QI staff to work directly with practices. However, payers (including **private health insurance plans** and **Medicaid** or **Medicare managed care plans**), provider associations, health systems, primary care practices, or other entities will sometimes contract with primary care extension programs. Services include providing technical assistance or staff training for QI activities, practice facilitation, health information technology support, multi-disciplinary case management infrastructure, etc. For example:

    - Medicaid Coordinated Care Organizations (CCOs) in Oregon contract with ORPRN to provide technical assistance and education to primary care practices and other health system partners on improving quality measures such as depression screening. Technical assistance includes training practice staff in QI methods to build practices' quality improvement capacity (e.g., conducting rapid tests of change). ORPRN also helps CCOs in Oregon develop and implement tools and strategies to analyze community needs to inform community health improvement plans.

    - The State's Medicaid funding of its Managed Care Organizations has been a significant, long-term funder of the University of New Mexico's community health worker programs[13] including funding the role of some HEROs who train them.

- **Fees or membership dues.** Payers, health systems, primary care practices, or other entities sometimes pay primary care extension programs fees or membership dues for services. For example:

- ORPRN runs its Extension for Community Healthcare Outcomes (ECHO) program using a membership model. ECHO provides remote education from clinical specialty experts to help primary care providers manage patients with health conditions that would otherwise have to be referred to specialty care. Currently most payers in Oregon, including the State Medicaid program, pay to be members so their clinical teams can participate.

- Some primary care extension programs have received fees for providing technical assistance to consult with other States on establishing statewide QI infrastructure.

- **Funding from foundations, private trusts, or individual donors.** Some health extension programs have had success getting supplemental funding through foundations or individual donors. For example:

  - New Mexico's Health Extension Program receives substantial funding from local foundations and private donors. W.K. Kellogg Foundation of New Mexico and the local J.F. Maddox Foundation fund health extension work in rural and urban underserved areas. OPHIC receives modest funding for their primary care extension program through individual donors.

  - Endowments can offer long term, stable funding for health extension. In New Mexico, a substantial component of the support for health extension work in research and in partnership with community-based organizations comes from the federal Centers for Disease Control and Prevention and from private donors, identified by the University through its Development Office.

  - Health conversion foundations (also known as health legacy foundations), could potentially provide funding for primary care extension programs. These foundations, which are formed when a hospital, health system, or health plan is converted from non-profit status to for-profit status, fund efforts that improve the health of the community served by the original institution.[14,15]

Other Funding Strategies and Tips

In addition to seeking funding from across multiple sources to support the work, health extension programs have found other strategies to find sustainable funding for their work.

- **Consider different funding sources for different components of the work.** It may be more effective to pitch parts of your primary care extension program to certain funders, rather than pitching the full program. As described by Dr. Kaufman and colleagues, "…outcomes meaningful to Medicaid-managed care insurers may differ from outcomes of interest to the local, nonprofit community."[1] For example:
  - Some funders (e.g., local foundations) may be more interested in funding practice facilitators than funding the primary care extension program more broadly.
    - AHRQ developed a How-To Guide for developing a primary care practice facilitation program, which includes ideas for finding funding to support these positions.
  - **Community health workers (CHWs)** are sometimes included in a primary care extension program. Because CHWs provide a direct service to patients, it is easier to show a short-term return on investment based on their work (e.g., a reduction in hospitalizations) compared to practice facilitators – whose impacts are more indirect and long-term. Because of this, a hospital or health system may be more willing to help cover the salaries of community health workers and, as in the case of New Mexico, support the role of health extension agents in training community health workers.
- **Pitch relationships with practices to funders.** Primary care extension programs can pitch their strong and trusting relationships with primary care practices and knowledge of community needs and organizations throughout the State or region to potential funders. As Anne King from ORPRN explained, "It helped that we had staff embedded in communities because Oregon is a really huge State, and we

had staff in communities where there wasn't anybody else." She went on to explain that they were able to bring on funders, including payers, by showing them "we have relationships with primary care practices, that we understand how they operate, we know how to get in and help facilitate change."[7] OPHIC also maintains the most complete and accurate database on primary care practices within the state, which is a valuable resource to various state agencies and offices.

- **Invite potential funders to serve on your Advisory Board or Board of Directors**. One way to build relationships with potential funders is to invite them to participate in your program early on, such as on an Advisory Board or Board of Directors. Jim Mold, the founder of OPHIC, described how they did this during an earlier iteration of the program in Oklahoma: "We established a Board of Directors that included representatives from many of these groups, including Medicaid and the health department – anybody we thought might be interested and have some money. [By doing this] we got to know the folks and how their funding systems work."[8]

- **Make use of intra-governmental transfers**. State-based public entities can often share funding with other State entities without a contract, using an intra-governmental transfer (and in poorer States, this can be increased with Federal dollars). For example, a State-based hospital, the Medicaid program, or a State's department of health could fund a primary care extension program housed in a State university for services that benefit patients in the State, without entering into a contract or grant. This type of arrangement is appealing to the State because it is easier and more flexible than a contract, and for primary care extension programs run by State entities it can mean easier access to significant amounts of funding. As an example, the University of New Mexico's Office for Community Health and the University of New Mexico Hospital negotiated an Intergovernmental transfer of funding with the State's Human Services Department that runs state Medicaid to support work of the Office's HERO and community health worker programs in the service of Medicaid patients.

- Another strategy some organizations use is to **house health extension programs in an organization that has a broader overall mission**, which allows them to use funds that may not be available for primary care extension service to support infrastructure. For example, the health extension program in New Mexico is not limited to primary care or even clinical settings, but rather provides broad services to improve the health of people throughout the State.

Other Resources

- ReThink Health has developed a Typology of Potential Financing Structures for Population Health, which is part of a larger Financing Workbook for multi-sector partnerships. These materials may be useful to primary care extension programs to identify additional funding sources and approaches.

- New Mexico developed an online Health Extension Toolkit so others can learn more about the model they have developed with other states, including different ways health extension work is funded.[16]

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