GME in CHC’s
Family Medicine Residency – Health Center Training
Creating Effective Administrative and Operational Structures
A case-based approach
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Game plan
- 20’: Introductions and preliminaries
- 75’ (25’ x 3): Case Presentations
- 25’: Q&A

The Cases
- Late contemplative:
  - Valley Wide Health System
    - Alamosa, CO
  - Southern Colorado Family Medicine Program
    - Pueblo, CO
- Early planning:
  - Health West
  - Idaho State University Family Medicine Residency
    - Pocatello, ID
- Advanced planning:
  - Sunrise Community Health
  - North Colorado Family Medicine
    - Greeley, CO
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Collaboration
- Five elements of successful collaborations
  - Outcomes-based advocacy
  - Vision-focus balance
  - Systems orientation
  - Infrastructure development
  - Community linkages
  - (Alexander, et al. Sustainability of Collaborative Capacity in Community Health Partnerships; Medical Care Research and Review, Vol. 60 No. 4, 1305-1605)

Outcomes-based advocacy
- Communicate the value ($ and non$) of the educational collaboration (internal & external)
  - Recruitment savings
  - Retention
  - New $$ to community healthcare
- Identify unique contributions
  - Academic atmosphere
- Leverage early successes
  - Increase credibility/legitimacy/enthusiasm
  - New resources
  - Expanded efforts
Vision-focus balance
- Partners share a compelling vision
- Oriented to action
  - Big picture perspective
- & avoiding distraction
  - Funding “opportunities”
  - Service “opportunities”
  - Educational “opportunities”

Even if you don’t know where you are going, be sure that you know who you are.

Systems orientation
- Partners assist one another to understand the broad determinants and multiple facets of health in the community
- Educational program is uniquely positioned to serve as a catalyst and broker collaborations

Infrastructure development
- Partners must appreciate the need to properly capitalize the collaboration
  - Breadth and depth of leadership
  - Dedicated staff
  - Sources of capital
- Employment, roles, responsibilities, and powers
Community linkages

- Integration into the local ecology of health and human services
- Institutional ownership
- Broad based participation in the community

Case #1

- Valley Wide Health System
- “Complete Affordable Health Care—Close to Home”
  - Alamosa, CO

- Southern Colorado Family Medicine Program
  - Pueblo, CO

Valley Wide Health System

- Serving southern Colorado for over 30 years
- Now with 14 sites & a large voucher program
- Approx. 40k users and 100k encounters
- GME focus: the San Luis Valley Region
  - 8 clinics: esp. Alamosa FMC
    - OB (300 deliveries), women’s health, Fam Med
  - Sierra Blanca Med Ctr
    - Large Family Medicine center, opened 3 y ago
VWHS cont’d

- Community
  - Pop. ~11000 (includes ~4000 students of Adams State College)
- Service area: ~150k (SLV region 50k)
  - 50 beds
  - Rural/Disproportionate share/Non-Profit
  - Major employer of specialty physicians

Southern Colorado Family Medicine Program (Pueblo)

- Over 30 years training FP’s to meet the needs of rural Colorado
- Accredited MD residency and DO internship

Envisioned Future

- New training initiative
- 2 residents per year
- First year: Pueblo
- Year 2 & 3: Alamosa (1:2 program)
- Start: 2010
SWOT Analysis

- Strengths
- Weaknesses
- Opportunities
- Threats

Strengths
- Both organization have a long history in the same region
- Both share a mission devoted to rural and underserved populations
- The organizations have a long history of collaboration in medical education
- Valley Wide has had significant success in recruitment related to existing student and resident participation

Strengths cont’d
- Historical relationship of VW and SCFM
- Good patient volumes and case mix
  - 300 deliveries/yr (of 600 in community)
- Strong interest amongst medical staff
  - And willingness of Hospital/Employer to have them participate
- VW is financially independent
- Teaching hospital is non-profit
Strengths cont’d

- Innovation
  - Possible housing for residents
  - Participation in PharmD program enhances FMR education

Weaknesses

- 1:2 model is a tough sell
- Distance and difficulty of travel from the satellite to the mother ship
- Rurality
- Resident isolation
- Participation in didactics
- Faculty recruitment – Pueblo & Alamosa

Weaknesses cont’d

- Hospital relationship
  - Trust and cooperation
  - Restricted service to VW patients (referrals & outpatient services)
  - Competition over issues such as hospitalist services
- Development of financial and administrative models
**Opportunities**

- Recruitment and retention
- U. Colorado program for early ID of rural primary care interest
- UNM/Albuquerque strong rural programs
- New osteopathic school (Rocky Vista) grads in 2012
- Other med school expansions and primary care initiatives

**Opportunities cont’d**

- Recruitment
  - VW has had remarkable recent success in FM recruitment – promise of future teaching program
- Hospital relationship
  - Working toward a common good
  - New money to community
  - Improved patient service and quality

**Threats**

- SCFM needs more FP faculty
  - Difficult recruiting
- Changes to GME funding mechanism
- Student interest
  - Family Medicine
  - Rural
- Hospital financial picture
  - Support to employed providers
  - Conflict with VW re: unfunded patient needs
Next Steps

- Financial pro formas for hospital GME
  - Requires projected curriculum development
- Hospital collaboration & buy in
- Define operational & admin structure
  - Authorities & reporting relationship for PD
- Define timeline
  - Communicate & adhere

Case #2
Health West & Idaho State Family Medicine Residency
Pocatello, ID

Health West
- Federally-funded CHC
- Established in 1975
- Mission: “dedicated to providing high quality health care for all, regardless of a patient's ability to pay.”
- 6 primary care sites, many community outreach programs
- ~20,000 patients
Idaho State University Family Medicine Residency

- Community-based, university-affiliated, 6-6-6 program
- Established in 1992
- Residency clinic at Portneuf Medical Center
- ~18,000 patients cared for by faculty and residents

Idaho State University Family Medicine Residency

Mission: “...to provide a collegial learning environment in which residents become mature, competent and compassionate family physicians...The Residency will provide comprehensive training in a broad range of practice settings with an emphasis on the care of under-served populations in Idaho and the Intermountain West. The Residency is committed to clinical excellence through residency training, research, and patient services.”

Other Stakeholders

- Current Residents
- Patients
- Residency Clinic Staff
- Portneuf Medical Center
- Legacy (for-profit hospital management company in merger negotiations with Portneuf Medical Center)
Current collaborative efforts

- Two Health West sites serve as OB training sites for Idaho FM residents
- Health West physicians share call with residency faculty
- Residents take after hours phone calls for Health West patients
- Residents cover many Health West patients in the hospital

The Proposal

- The current residency clinic will become a site of Health West
- Sponsorship of the residency will remain through Idaho State University Dept. of Family Medicine
- Financial support for residency training will flow in proportion to the time residents spend in clinic
- Start: 2010?

Individual and joint goals for an affiliation – what is each party hoping to accomplish?

Health West:
- Access to IT and quality expertise of Pocatello Family Medicine
- Enhanced recruitment and retention of providers
- Economies of scale
- Aligned with mission

Pocatello Family Medicine:
- Mitigate operating loss of residency clinic
- Expanded educational opportunities for residents
- "Better model for access in South East Idaho"
- Alternative to future under new, for-profit hospital management
Current Status

- CHC and Residency leadership, Idaho St. University, Hospital Administration broadly in agreement that affiliation will be beneficial
- Questions/issues not yet resolved (Selected)
  - Whether to seek a “change of scope” under current federal funding or to seek new site funding for Health West
  - Numerous issues related to transition of hospital employees to CHC employees
  - Financial issues in early stages of discussion

Questions/issues not yet resolved – cont’d

- This creates two Pocatello Sites. Whether and when to merge to single site to be decided
- Naming - What will the new clinical site be called?

Analysis

- Positive forces
- Challenges/negative forces
- Are the goals realistic?
- Who benefits the most? Who stands the most to lose?
Analysis - Positive forces

- Similar Missions
- Leaders of the CHC and the Residency have respect for each other and shared goals and vision
- History of positive, collaborative work together
- Some opportunity to save money

Analysis - Positive forces

- Possibly better reimbursement rates as a CHC compared to a hospital-based clinic
- Other benefits of CHC’s
  - Access to 340B pharmacy program
  - Support for free-care via federal 330 expansion grant
- The Chairman of the Health West Board of Directors is a prior faculty member of the ISU residency

Analysis - challenges/negative forces

- Merging cultures never easy
- Fear of change
- Significant resistance/resentment possible among current residency clinic staff
- The Residency Health West site will be significantly different compared to other Health West sites.
Analysis - challenges/negative forces

- Joint Venture between for-profit Legacy and Portneuf Health Care Foundation not complete and somewhat of a wildcard
- Finances are complicated
- Financial gains/losses not entirely clear

Are the goals realistic?

Yes!

(Depending)

Analysis - Who benefits the most?

- The Medical Center rids itself of a $350,000 loss
- CHC
  - expands operations and achieves economies of scale
  - enhances reputation locally,
  - Gains IS expertise, enhanced recruitment and retention
Analysis - Who benefits the most?

- Community:
  - Strengthened Community Health Center
  - expanded (or at least protected) access to care for underserved
- ISU:
  - residency clinic run by known partner
    (compared to unknown Legacy)

Analysis - Who stands to lose the most?

- Current non-faculty and non-resident staff members of the Residency Clinic
  - Will change employers (different salary structure, benefits, expectations, culture)
  - Some positions may be lost or consolidated
- Residents and faculty:
  - may also perceive a loss of control and loss of educational focus

Recommendations

- Continue current collaborative meetings and communication
- Continue to discuss and reinforce how this benefits each organization. Be explicit about it.
- Involve everyone – early and often
- Be clear about how success will be defined and how it will be measured.
- Identify and educate everyone involved about the practical and cultural differences between CHC’s and residency programs.
Recommendations

- Be clear about the money issues –
  - realistic resident productivity
  - The precise formula for how much money flows between Hospital, the Dept of Family Medicine and Health West
  - How future changes in GME funding will be dealt with
  - time needed by faculty to do things other than see patients and supervise residents seeing patients
  - resident scheduling issues, overhead, etc
- Avoid the “opportunity cost trap”

Recommendations

- Have a clear agreement/understanding about resident recruitment, ranking, and what to do if the program doesn’t fill in a particular year.
- Look for synergy. Avoid the “Service versus education” trap.
- Assuming initial success, never forget to “dance with the one who brung you”

Case #3
North Colorado
Family Medicine & Sunrise Community Health
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Collaboration Themes
- Leadership
- History
- Ownership and control
- Organizations’ missions
- Communication – official and unofficial
- Change
- Outcome focus vs process focus - timeline
- Outside view?

Collaboration Themes
- Just Do It
  - Identify Key Leadership
  - Identify constituents
  - Communicate desired outcome
  - Seek input from constituents
  - Set timeline
  - Communicate clearly, consistently and often
  - Teams to evaluate and direct processes
  - Involve everyone
  - Celebrate process and progress

The Collaborators in Greeley, CO
- Sunrise Community Health (Sunrise)
- North Colorado Family Medicine Residency (NCFM)
- Banner Health / North Colorado Medical Center (Banner)
NCFM established in 1974
- Full scope family medicine
- Successful rural and underserved mission
- Strong procedure training
- Community Health and Rural tracks since 1992
- 30k sq foot office building in 1997
- 42k visits; 24 residents; 10 MD faculty; 3 NP faculty; 2 Behavioral Health faculty; 40 employees
- Sponsoring hospital promoting residency scope meet local community needs
- > 50% patients served are safety net patients

Sunrise established in 1973
- 7 sites; 110k visits; 25k patients; 200 employees
- New 60k square foot clinic – 40k for patient care with 20k undeveloped
- History of growth in service for large underserved community
- Integrated Behavioral Health, Dental, Public and Primary Care Services and Electronic Health Record
- Desire to expand scope of services to meet patients needs
- History of affiliation with NCFM since 1992
- Workforce development strategy

Banner acquired management contract for NCMC in 2000
- National hospital system -- specialty hospital service model
- Envisions primary care as outpatient feeder to hospital specialty service lines
- Wants NCFM scope to match Banner mission and the local community needs
- New competition in region
- Working with local hospital Board
- $2m contribution to safety net in 2007
Where the Venn Diagram Converges

- Growing patient population has many needs and limited resources
- NCFM desires to maintain scope of practice and training
- Sunrise desires to meet needs of underserved population and to expand scope of services, has space to grow, has workforce development strategy
- Banner values robust safety net capacity
- Community vision of health care excellence

Challenges

- Matching missions
- Responsive leadership with vision
- Complex decision making
- Administrative changes at hospital and residency
- Communication across multiple agencies
- Financial limitations
- Fear of change and the unknown

Tools

- Business plans
- Research
- New leadership
- Consultant
- Implementation Team
- Project Plan: governance, finance, education, operations, human resources, IT, communications
- Local patient data: GIS origin mapping, community needs assessments
- Blogging
- Decision deadline
Creating an Educational Health Center to meet our community's needs.