

DRAFT

Family Medicine Residency/HC Affiliation Workgroup Summary

May 22, 2007

8:30-4:00PM

Invited Workgroup Meeting held in conjunction with the Northwest Primary Care Association meeting at the Portland World Trade Center; Portland, OR

Organizers:

Lil Anderson and Kevin Murray, MD, Co-Facilitators

Carl Morris MD, Freddy Chen MD, Bruce Gray and Ardis Davis

Meeting Participants: Invited participants from Health Centers across Regions VIII and X and Family Medicine residency programs from the WWAMI region (Washington, Wyoming, Alaska, Montana, Idaho) and Colorado.¹

Abstract

Introduction: Health Centers and Family Medicine Residencies have struggled over the past 20 years to work together to provide community service and health workforce education.

Methods: As part of a workplan² to understand and improve Health Center-Family Medicine Residency (HC-FMR) collaboration, experts with experience in residency education in HCs were brought together for a daylong working group. The experts were charged with designing demonstration projects for HC-FMR affiliation that would support a shared mission of service and education.

Results: The components of demonstration projects for innovative HC-FMR affiliation were delineated.

Conclusion: Demonstration projects incorporating the recommendations of the working group would provide an opportunity to test innovative solutions for the health workforce crisis of safety net providers.

Introduction

The specialty of family medicine and the Health Center (HC) organizations have a long history of shared philosophy and values. HCs and the specialty of Family Medicine were created to provide comprehensive medical and preventive care to communities and populations. Both HCs and the FFM project share the vision of breaking down barriers to access so that every American has a patient-centered medical home that serves as the focal point through which all individuals -- regardless of age, gender, race or socioeconomic status -- receive acute, chronic and preventative medical services. In both systems, the patient is an active participant in their health and their health care and both emphasize people caring for people.

Unfortunately, in addition to their common values of service, both HCs and the specialty of Family Medicine share the burden of a health workforce crisis. As a result of a decreased interest in primary care, the recent expansion of HCs, and a chronic problem of recruitment and retention of health care providers to underserved areas, there is an anticipated significant increase in the demand for Family Physicians (FPs). A recent national survey of 890 HCs revealed significant shortages of staff and providers.¹ The most pronounced shortage was for FPs. Not accounting for the projected doubling in HC physician staffing needs, 20% of the annual production of family medicine residency graduates would have to choose employment in a HC to fill existing needs. The future of HCs and the specialty of Family Medicine are strong as long as a solid, well trained, and committed workforce is available. The current health workforce crisis, however, threatens this very productive safety net system and the vulnerable population it serves

The current Family Medicine training environment is unlikely to meet these increasing workforce demands. Data from the WWAMI Family Medicine Residency Network on recruitment and retention of graduates from HC-based residency training programs from 1986-2002 supports the need for further collaboration between HCs and Family Medicine Residencies (FMRs).² The environment of education matters. Approximately 80% of graduates from residency programs affiliated with HCs choose employment in underserved areas in the year following graduation and the largest effect is on recruitment to HCs. However, this cohort of family physicians represented only 9% of graduates during this time period. Further HC-FMR collaboration is needed to enhance the training of family physicians for work in underserved areas.

Following 2 years of work by the WWAMI Family Medicine Residency Network (FMRN) Directors and collaboration with the Northwest Regional Primary Care Association (NWRPCA) a workplan was created to: 1) provide an evaluation of HC-FMR affiliations; 2) suggest improvements in existing relationships and 3) create new model(s) for innovative HC-FMR training program(s). This paper reports on a part of the workplan that brought HC and FMR representatives from 8 Western States together in a daylong working group to design demonstration projects that would improve HC-FMR affiliation.

Methods

Attendees were selected to represent both HCs and FMRs from a ten-state region (Washington, Oregon, Montana, Idaho, Wyoming, Colorado, North Dakota, and South Dakota). Representatives included HC administrators, HC medical directors, FMR Directors, PCA administrators, and University representatives. Working group participants were chosen for their knowledge, experience, and/or interest with/in HC-FMR affiliations. Two-thirds of the participants had taken part in either the key informant qualitative analysis³ or one of 3 focus groups that had been conducted in the same region in the 3 months prior to convening the working group.

Participants were sent invitations by email and/or phone and asked to participate in the working groups. Participation was voluntary and remuneration was limited to

reimbursement for travel and lodging. Funding for the working group was provided by a combination of donations of money, time, or space from the Northwest Regional Primary care Association, the University of Washington Dept. of Family Medicine, the TJ Phillips Professorship, and the WWAMI Family Medicine Residency Network.

Participants were sent a pre-working group packet of information which included a summary of the HC-FMR collaboration work plan and a summary of background studies conducted by Drs Morris and Chen that included a key informant study³, a retrospective analysis of WWAMI HC-FMR training⁴, and a summary of the focus group findings.⁵ Each participant was assigned one of three topic areas (governance, finance, or administration) and instructed to review the pre-working packet pertinent to these areas.

The participants represented a spectrum of leadership and included 22 representatives from FMR or HCs with the following distribution of titles: 1) HC administrators (12); 2) FMR Directors (5); 3) Family Medicine Department Chairs/Vice chairs (2); 4) Consultants (2); and 5) State or Federal Government official (1)

The working group was co-moderated by Kevin Murray, MD, Residency Director of Tacoma Family Medicine and President of the UW network of residency programs across the five-state WWAMI region and Lil Anderson, Executive Director of Deering CHC and President-elect of the National Association of Community Health Centers (NACHC) Executive Board.

An agenda⁵ focused on the development of demonstration projects that would facilitate improvements in HC-FMR affiliations and a shared mission of service and education was followed throughout the day. Participants were charged with the creation of blended models of service/education for creation of demonstration projects that create well-trained family physicians for the underserved. It was reviewed that there is unlikely to be one model that incorporates the needs and interests of the spectrum of FMR and HC environments, but that the day's goals were to create a framework that defines the changes that will facilitate innovative solutions for HC-FMR training and service.

The background work done prior to the meeting had identified the difficulty of forming and maintaining a HC-FMR affiliation in which the primary outpatient training environment was located in the HC. The barriers to the affiliation had been identified in the key informant study and validated in the focus groups. The focus groups had also identified the thematic description of this relationship which was based on a shared mission of service and education. The themes of governance, financing, and administration were identified as central to this relationship and the source of barriers to successful affiliation.

Results

The day started with opening remarks, a brief background review, an introduction to demonstration projects and time for general questions and comments. The agenda and the goals for the working group were reviewed with the participants. They were

instructed to work together to create solutions that could be implemented in demonstration projects that would facilitate a shared mission of service and education.

The working group was split into three smaller working groups: 1) Governance; 2) Financing; and 3) Administration. Participants were chosen for each group based on their experience with a focus on equalizing the balance of participants by HC vs FMR background and demographics. Following the breakout sessions, each group reported back to the larger group with the following recommendations:

Governance: 4 recommendations were made

- 1) One board, consisting of member representation and committee structure that is tasked with an equally shared mission of ensuring service and education, should govern the functions of the HC and FMR. This would include tasking them with the responsibilities of meeting the residency requirements of the RRC and ACGME, the HC requirements of the BPHC, and those of Medicare/JACCHO.
- 2) The board should be a 51% user board. This is consistent with the HS 330 bylaws in which the majority of the board must be comprised of individuals who receive their medical care in the clinic. It was discussed that a clearly stated mission and bylaws would facilitate both excellence in service and education.
- 3) The governance structure must be centralized to facilitate the integration of the education and service functions and eliminate siloing of personnel into either HC or FMR functions. This requires the CEO to be directly responsible to the board and responsible for overseeing both the residency education and clinic service functions. The responsibility of the Director of Medical Education to meet the training requirements outlined by RRC and ACGME must be accommodated.
- 4) The residency sponsoring institution would optimally be the joint HC-FMR entity. The traditional sponsoring agency has been the community or university hospital that is responsible for meeting Medicare requirements for GME reimbursement and directing IME and DME dollars back to the residency. The complexity of this relationship and the discordance between funding ambulatory care training through inpatient education accounting methods creates both significant barriers to governance and inadequate accounting for the indirect costs of residency training that occur primarily in the outpatient setting.

Finance: Three models emerged

- 1) Extend cost-based financing to residency clinics. This would include enhanced Medicaid and Medicare reimbursement and cost-based reimbursement per HS 330 requirements. Requirements would include 51% user board, and existing compliance and monitoring. This would extend only to the residency clinic and would not necessarily require partnering with a FQHC.
- 2) HC-FMR shared model. FMR would move their clinic operations into a FQHC and form a new type of FQHC that would have unique funding sources and shared profit and loss. New funding streams would include: 1) creation of funding to allow educational costs to be put into the cost report for FQHC reimbursement; 2) increase the cost per visit cap; 3) FTCA malpractice coverage would be extended to all residents and faculty regardless of their training location; 4) GME

- could either funnel through the sponsoring hospital or possibly through the HC-FMR joint entity. There would be shared administrative performance and quality improvement standards that would incentivize both education and service.
- 3) Workforce incentives. Residents and providers in either model should be incented to train and work in this setting. Opportunities include NHSC, loan repayment, and enhanced resident salary for commitments to work in HCs. This could help address the fact that residency training programs are often not in HPSAs due to the necessity of providing a broad spectrum of inpatient exposure usually found in urban areas.
 - 4) Other considerations. It was felt that the current models create an economic wedge between FMRs and HCs secondary to their funding mechanisms and that problem needs to be addressed in whatever funding model is proposed. The separation occurs with the HC's productivity incentives and the lower productivity of resident physicians. It was suggested that a waiver on current UDS reporting requirements would be necessary. It was also mentioned that GME reimbursement changes could be facilitated by taking residents out of university settings in which the number of residents exceeds the GME cap and applying funding solutions to this cohort of residents. This might avoid the resistance of sponsoring hospitals.

Administration: One joint HC-FMR model was proposed with specific recommendations regarding its hierarchy and structure.

- 1) Administrative tree. The group proposed a community-based management tree with shared administrative responsibilities, a single budget, a single 51% user board, and one administrative structure in which the shared mission of service to the underserved and education were clearly defined at all levels of the administration and personnel. The requirements of community-based service development, underserved service commitment, and educational requirements would not be changed. They would be combined into one strategic plan that would include the goals of meeting benchmarks defined to meet community needs for access, population health, evidence-based quality medical care, and best practices for resident education.
- 2) One director of the joint HC-FMR model. The executive director/CEO is responsible for education and clinical operations.
- 3) One defined administrative structure that co-administers service and education, addresses community needs, fulfills service and educational requirements (such as JCAHO, BPHC, RRC, ACGME), answers to the CEO in an integrated fashion, and integrates the shared mission into the recruitment of personnel at all levels of the organization.
- 4) Integration of the shared mission throughout all levels of the organization. All employees must be responsible for ensuring the success of service and education.

Combining the Recommendations

- **Areas of agreement**

Consensus was obtained on the following recommendations:

- 1) The governance, administration, and financing structures need to support the shared mission of education and service to ensure continued success in community service and health workforce training. Without changes in the current structure it is unlikely that there will be increased numbers of successful HC-FMR affiliations.
- 2) A joint HC-FMR entity with new funding streams would facilitate the adoption of the necessary changes to the HC-FMR affiliation.
- 3) The preferred organizational structure is a joint HC-FMR entity with one governance tree structured to equally support the missions of service and education.
- 4) The joint HC-FMR entity should be governed by one board of directors.
- 5) The governing board should be a 51% user board consistent with the HS 330 bylaws.
- 6) One CEO, responsible to the board, should oversee all operations and be responsible for the education and service missions.
- 7) The current scope of practice of a residency program and the scope of CHC service provision must be met and continued.
- 8) The HC-FMR entity must be eligible for FTCA coverage that extends to residents at training sites away from the HC-FMR entity.
- 9) Funding streams for a joint HC-FMR entity should not compete with existing funding streams for either FMRs or HCs.
- 10) Cost-based reimbursement mechanisms for educational expenses for the HC-FMR entity should be developed.
- 11) Changes to the current GME reimbursement mechanism for family medicine residency training in the HC-FMR entity would stimulate further affiliations and support their longevity.
- 12) Workforce incentives that apply to residents and providers in HC-FMR entities to address loan repayment and recruit and retention of health workforce should be developed.

- **Areas of disagreement**

The following areas were not agreed upon and are sources for further discussion and investigation.

- 1) The largest area of controversy was regarding the role of the hospital in this relationship. The majority of residencies have a sponsoring hospital that provides a conduit for GME funding and facilities for inpatient resident training. The group did not agree on the optimal role of the hospital in this relationship. In regards to the optimal structure for governance, administration, and finance it would be beneficial to avoid GME pass-through financing and the legal responsibility of ACGME accreditation that hospitals currently have by having the HC-FMR entity as the GME sponsoring organization. However, there were concerns regarding the political feasibility of such a change, the cost to the HC-FMR entity to obtain ACGME accreditation, and problems with obtaining inpatient training sites for family medicine residents. This discussion resulted in the design of two different

demonstration projects: One with a continued hospital sponsorship and another with the HC-FMR as the sponsoring institution.

- 2) The second largest area of disagreement was in the definition of education in the mission. There was discussion about whether the mission statement should be specific to family medicine residency education or remain broadly defined as health workforce education. There was concern voiced on both sides of the discussion regarding resistance to the idea if it was too narrowly defined and a lack of commitment and sustainability if it was not narrowly defined.

Demonstration project components

The components of a demonstration project can be separated into the parts of the structural relationship in governance and administration that demonstration projects would incorporate into their test sites and the “asks” or changes in funding and bylaws that would need to be secured in the formation of the demonstration project granting. Below is a list of these two areas taken from the areas of agreement.

- Successful applicants must have the following governance and administrative components:
 - 1) The governance, administration, and financing structures need to support the shared mission of education and service to ensure continued success in community service and health workforce training.
 - 2) The HC-FMR entity must have one governance tree structured to equally support the missions of service and education.
 - 3) The HC-FMR entity must be governed by one board of directors.
 - 4) The board of directors must be a 51% user board consistent with the HS 330 bylaws.
 - 5) One CEO, responsible to the board, must oversee all operations and be responsible for the education and service missions.
 - 6) The requirements of community-based service development, underserved service commitment, and educational requirements cannot be changed.
 - 7) A strategic plan must be developed and include the goals of meeting benchmarks defined to meet community needs for access, population health, evidence-based quality medical care, and best practices for resident education.
 - 8) The current scope of practice of a residency program and the scope of CHC service provision must be met and continued.
- Funding and Bylaws Changes. These are a list of the potential changes that could be incorporated in to the language of a demonstration project.
 - 1) The HC-FMR entity must be eligible for FTCA coverage that extends to residents at training sites away from the HC-FMR entity.
 - 2) Cost-based reimbursement mechanisms for educational expenses for the HC-FMR entity should be developed.
 - 3) The HC-FMR entity must qualify for enhanced Medicaid and Medicare reimbursement.
 - 4) GME reimbursement must be enhanced for organizations HC-FMR entities that obtain ACGME accreditation.

- 5) Funding must be available for the startup costs of HC-FMR entities that want to obtain ACGME accreditation.
- 6) Workforce incentives that apply to residents and providers in HC-FMR entities to address loan repayment and recruit and retention of health workforce should be developed.
- 7) One funding mechanism is to provide a block grant for the project and then a cost accounting during the project.

Areas for further work

- 1) Further definition of service and education. The current wording is not specific enough. What does service and education specifically mean. Are we talking only about family medicine residency education or education of the health workforce
- 2) Definition of the scope of service of HC-FMR entities. Outpatient vs inpatient vs both. It was suggested that the focus should be on health care in whatever realm is needed. Can or should we look into a model for bringing in specialty care.
- 3) Role of leadership development.
- 4) We must define how we measure success.
- 5) An economic analysis of the cost of affiliation needs to be done. This would include startup costs, changes in productivity and staffing, and indirect costs of administration and education. It was estimated that the overhead costs are ~\$100,000 to 200,000 per resident/per year.
- 6) Identify proponents and opponents to the suggested innovations. We need to identify champions at the HC, FMR and governmental levels. We need to engage the bureaucrats and the hospitals in this dialogue.
- 7) The funding for procedure-based care is not adequately addressed in current HC funding models. Residencies must provide a broader scope of services that includes more procedures to meet training requirements. Funding mechanisms to account or fund this broader scope may need to be investigated.
- 8) We need to investigate whether sponsoring hospitals would continue to sponsor a HC-FMR entity with a 51% user board. Anecdotally, this has been reported as a line in the sand for hospitals, however, if the entity had solid funding such that the outpatient costs were no longer a loss-leader for hospitals they might not have the same level of resistance.

Discussion

This report summarizes the findings of a HC-FMR Working Group. Leaders from the HC and FMR community have come together to create innovative ways to improve access to care for underserved populations through HC-FMR partnerships. The products from this work include the components of demonstration projects for new HC-FMR affiliation.

This document provides a framework from which demonstration projects can be designed. There are specific requirements for the governance and administrative structure that will guide innovative HC-FMR affiliations to succeed in a joint mission of service and education. There are also a list of potential funding and bylaws changes that provide a range of options to financially and structurally support these affiliations.

The most important aspects of demonstration projects for HC-FMR affiliation were unanimously agreed upon by the conference attendees. The administrative structure and rules of governance that support a shared mission of service and education will ensure the success of these affiliations if the funding mechanisms are similarly and adequately focused. The success at attaining changes in bylaws and funding mechanisms will depend on the political support and environment these demonstration projects receive. The mixture of funding and bylaws changes in combination with the diversity and creativity of eventual demonstration project fundees will determine the “models” for HC-FMR affiliations.

The successes engendered when family physicians are trained in the culture of service and care in the HC model paired with HCs long and respected history of providing care for all is a perfect match. Together, the commitment to community and patient-oriented care for the underserved through demonstration projects in workforce education can transform the health care system by guaranteeing entry of a steady stream of family physicians into the HC workforce while providing high quality and broad scope primary care to the underserved that is indistinguishable from that available to people of means.

Appendices

I. Participant List: **=In attendance on May 22*

David Goldberg (ED, Oregon Healthcare workforce Institute)*
Mike Maples MD (CEO Central Washington Family Medicine Clinic)*
Scott Graf (CEO Community Healthcare Association of the Dakotas (CHAD))*
Rebecca Landau (consultant with OPCA, Strategies For Healthier Communities)*
Stephen Weeg ED, Health West HC, Pocatello, ID)*
Anita Monoian (CEO/President of Yakima neighborhood Health Services)*
John Saultz MD(Chair OHSU Fam Med)*
Mark Wallace MD(interim RD NCFM)*
Patrick Monahan (ED WY Primary Care Association)*
Rich Kovar (ED of country doctor CHC)*
Bill Gillanders MD(RD Milwaukee FMR)*
Roger Rosenblatt MD(Vice Chair UW Dept. Family Medicine)*
Jo Gallegos (Vice President of Operations Western Region VI-X)*
Mark Norby (CIO CHCCW)*
Alan Strange (ED Montana Primary Care Association)*
Karen Wildman MD(Residency Dir Casper FMR)*
Vickie Ibara (YVFWC Director, Planning and Development)*
Erwin(Ern) Teuber (ED Terry reilly HC, Nampa, ID)*
Nicholas Gideonse MD(med dir. Richmond Clinic and asst Residency Dir OHSU)*
Roxanne Fahrenwald MD (Residency Dir. MT FMR)*
Mitzi Moran (Pres.CEO Sunrise CHCO, Greeley, CO)*
Don Weaver MD(HRSA Deputy Assoc. Administrator for Primary Care)*

Julie Hulstein (Ed CHAMPS, Region VIII)
Joel Young (Manager of health Systems Planning at the Oregon Health Division)
Harold Johnston MD(RD Alaska Family Practice Residency)
Carolina Lucero (VP Operations, Sea Mar CHC)
Colleen Conry MD(Vice Chair Dept. of Family Medicine, University of Colorado
Medical School)
Tony Pedroza MD(RD Valley Family Medicine Residency)
Gary Newkirk MD(RD Spokane FM Res.)
Carlos Olivares (ED Yakima Valley Farmworkers Clinic)
Pat Gemperline MD(RD Sea Mar CHC)
David Ruiz MD(RD SW Washington FM Residency)
Christopher Snyder MD(Medical Director CHCCW)
Ann O'Connell (ED OHSU Family Medicine Clinic-Richmond)