

## V. Summary of Focus Group Analysis

### HC-FMR Focus Group Summary

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Carl Morris, MD

Freddy Chen, MD

Bruce Gray

A series of three focus were convened on from February-April, 2007 to discuss the key themes of HC-FMR affiliations. This document is a summary of the findings from these focus groups.

**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). HRSA predicted that there would be an increase in demand for more than 11,000 additional clinicians by 2006. A recent national survey of 890 HCs revealed significant shortages of staff and providers.<sup>1</sup> 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).<sup>2</sup> 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.

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 enhanced efforts 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.

As part of a workplan<sup>3</sup> to better understand HC-FMR collaboration, experts with experience in residency education in HCs were brought together in a series of focus groups across the ten-state areas of Regions VIII and X to discuss ways to improve the existing relationship between FMRs and HCs. The focus group participants were asked to: 1) validate the thematic description of the HC-FMR affiliation<sup>4</sup>; and 2) suggest changes to enhance this affiliation. The following document is a summary of the findings from these focus groups.

**Methods:** Attendees were selected to represent both HCs and FMRs a ten-state region (Alaska, Washington, Oregon, Montana, Idaho, Wyoming, Utah, Colorado, North Dakota, and South Dakota). Representatives included HC administrators, HC medical directors, FMR Directors, HC Board members, PCA administrators, and University representatives. Focus group participants were chosen for their knowledge, experience, and/or interest with/in HC-FMR affiliations.

The focus groups were 2 ½ hrs in length and were facilitated by the PCA CEOs of the appropriate region (Julie Hulstein, CEO CHAMPS Region VIII PCA or Bruce Gray, CEO Northwest Regional Primary Care Association Region X) and a University of Washington faculty member (Carl Morris, MD or Freddy Chen, MD MPH). A record/note keeper was also present to organize and document the discussion. Each focus group was conducted following a standard outline (see attachment). All focus groups were audio taped.

Summaries of the individual focus groups were created reviewing the audiotapes and combining the notes of the facilitator, the faculty person and the record/note keeper. This summary document is a distillation of the common themes from the focus group summary documents. It is intended as a document that can be used to facilitate the Working Group Meeting on 5/22/07 where representatives from Regions VIII and X who, primarily, participated in the original focus groups will meet for a daylong development and planning session.

The attendees at the three focus groups included 25 representatives from FMR or HCs with the following distribution of titles:

1. HC administrators (10)
2. HC medical directors (5)
3. FMR Directors (7)
4. HC Board members (1)
5. PCA administrators (4)
6. University faculty (1)
7. Consultant (1)
8. State Government official (1)

Each focus group was charged with:

- I. Validation and discussion of the themes describing the HC-FMR affiliation.
- II. Discussion of the major issues and potential improvements to address the problems of each of five major themes:
  - a. Mission
  - b. Money
  - c. Administrative complexity/structure
  - d. Governance
  - e. Leadership

**Results:**

- I. Validation and discussion of the themes describing the HC-FMR affiliation.  
 The attendees of each of the three focus groups validated that the major and minor themes, as outlined in the qualitative assessment provided by Drs Morris and Chen, described the HC-FMR relationship and provided a framework for further discussion. Leadership was found to be centrally important in this relationship and was recommended to be elevated to a major theme and specifically addressed in discussion of improvements and innovations. The diagrammatic representation of the themes (see index I) was validated as a useful tool for understanding this relationship. The array of themes is shown by a diagram demonstrating the foundational importance of leadership, mission, and money balanced by the interplay between the categorization of themes into: 1) Barriers to affiliation; and 2) Advantages of affiliation.

The barriers to affiliation included: 1) Administrative complexity/structure; 2) Governance; 3) Mission conflicts; 4) Economic barriers; and 5) Leadership failure

The advantages of affiliation included: 1) Recruitment enhancement (HC providers, faculty, residents, clinic staff); 2) Quality improvement (HC and FMR clinical quality); 3) Enhanced teaching environment; 4) Integration of the safety net; 5) Enhanced community affiliations; 6) Shared resources and vision for health care; 7) Enhanced community relationship.

- II. Discussion of the major issues and potential improvements to address the problems of each of five major themes:

Discussion of the themes was divided into discussion and recommendations and conclusions.

**a. Mission**

**i. Discussion**

**All three focus groups unanimously agreed on the importance of the development of a shared mission of service and education.**

Each group concluded that:

- The mission was centrally important to the affiliation
- Historically, the mission served both to draw the HC and FMR together and pull it apart
- The future mission needs to provide the framework that avoids “siloing” HCs and FMRs into different sides
- The mission should be a shared vision of service and education

Both HCs and FMRs shared a mission for service to the underserved and their communities. However, the mission of service was primary to HCs and secondary to the primary mission of education of the FMRs. It was noted that when there were problems related to the barriers of money, governance, administrative structure, and leadership the lack of shared missions exacerbated the differences.

It was noted that HCs have not historically identified health education/training as a priority of their mission statement. There are governance issues that prohibit funding from being spent on education. However, the lack of emphasis and support for the role of education in HCs was noted to be improving. This was motivated by an increasing exacerbation of the health workforce crisis and, specifically, the problems of recruitment and retention of family physicians. It was also driven by the number of HCs that provide medical training, but receive little support, financial or otherwise, for it.

**ii. Recommendations and Conclusions**

- The HC-FMR affiliation must have a blended vision of service and education
- The vision should have a mission of service and workforce supply for underserved populations.
- The shared mission must be communicated throughout the entire organization

- The mission needs to be fundamentally connected with the funding source. Reimbursement should motivate, facilitate and incentivize the shared mission.
- The mission should contain the long-range vision of health workforce supply and quality of care.
- The success of the model will depend on a paradigm shift from thinking of the model from the perspective of one of the two organizations (FMR or HC), to seeing the model as one organization that shares an equal mission of service and education.

## b. Money

### i. Discussion

**All three focus groups unanimously agreed that new streams of funding are needed.**

- It was unanimously validated that the issues of money is a central theme in the HC-FMR affiliation. Reimbursement models served as a motivating factor and a barrier to affiliation. The current funding models are insufficient

Economic factors that motivated affiliation included:

- Enhanced cost-based reimbursement for Medicaid and Medicare (primarily the former)
- Liability coverage through the HC
- Very rarely GME dollars transferred through the hospital were a benefit to the affiliation, but not seen as a benefit for HC function.

Economic factors that served as barriers or challenges included:

- HC and FMR have been chronically under funded. As a result they are very protective of their respective funding streams and are limited in their ability to absorb costs associated with functions that are not their primary mission.
- When economic viability is challenged, each institution returns to their primary mission of service or education;
- Complexity and costs of resident training. The increased administrative requirements of residency training increase direct and indirect clinical costs and decreases productivity.
- The indirect costs of providing residency training are not accounted for adequately in the current reimbursement model.
- The HC representatives noted that HCs do not have a mechanism for accounting for the costs providing training and note the shortsightedness of not investing in health workforce training.

## ii. Recommendations and Conclusions

- All three focus groups unanimously agreed that new streams of funding are needed. The current funding models are insufficient.
- Funding should be based on the success of the shared mission of service and education.
- The funding mechanism needs to be fundamentally connected with the mission. Reimbursement should motivate, facilitate and incentivize the shared mission.
- Reimbursement should not be calculated based on comparison with other entities that are not providing both clinical care and residency education.
- Funding should not challenge the HS 330 or GME funding streams. Both of these issues were considered “lines in the sand.” HCs not involved in training and FMRs not affiliated with HCs would not accept funding that took money from the HS 330 or GME reimbursement streams respectively.
- Reimbursement needs to account for and reimburse for outpatient training.
- An assessment of the cost to run a training program is needed. This must include the costs of administration, clinic function, resident recruitment and productivity.
- New payment models should be linked to the resident, not the time spent in the hospital.
- Suggestions not unanimously offered:
  - GME dollars should flow directly through the training program.
  - Create a new type of Health Center with a line of funding separate from GME or HS 330.
  - Simply improve FMR reimbursement for training.
  - Uncouple GME payment from the hospital and make into an all payer system, not just for Medicaid and Medicare.
  - Identify federal funding sources (CMS, BPHC, Bureau of Clinician Recruitment and Service) and bring them to the discussions.
  - Extend cost-based reimbursement to FMRs independent of HS 330 funding.
  - Form a FQHC look-a-like model.
  - Remove caps on reimbursement to HCs
  - Create State funding that would be promoted as a model for access to care for vulnerable populations.
  - Individual HCs directly funding training programs.
  - Create a hybrid reimbursement model that comes from both GME and HC funding.

- The administrative role of recruiting new residents needs to be accounted for in the cost structure.
- The administrative requirements of credentialing, obtaining privileges, maintaining oversight, conducting orientations, interviewing new residents, introducing new providers into the practice occurs on a rotating basis with new residents and is a cost that needs to be accounted for.

**c. Administrative complexity/structure**

**All three groups unanimously agreed that the complexity of a dual administrative structure to run a residency and a HC was a significant barrier to successful affiliation.**

**i. Discussion**

- The depth of discussion at each of the focus groups did not reach that of the other topics of mission and money. Participants felt that this discussion would be easier to have if given a specific model to work on.
- Accommodating the discontinuity of residency clinic function, increased staffing needs, providing continuity of patient care and balancing the needs of the clinic vs. those of the residency all are sources of conflict and difficulty.
- There is a continual cycle of credentialing, obtaining privileges, maintaining oversight, conducting orientations, interviewing new residents, introducing new providers into the practice. This type of work occurs on a rotating basis with new residents and is a cost and an administrative function that needs to be accounted for.
- The role of residency program director currently reports to the ACGME/RRC and sponsoring hospital. This role needs to connect with HC leadership to allow for flexibility, and share in a joint mission.
- The clinic manager and medical director roles are very difficult. We must reconcile the primary responsibility to clinic function while acknowledging the role of education. This job must be structured to avoid burning this person out. Its current structure causes too much inherent conflict with the FMR side.
- An optimal strategy for blending the administrative structures of a FMR and a CHC was not uniformly agreed upon.
- There are advantages and disadvantages to different models of affiliation: 1) FMR becomes a HC; 2) FMR folds into an existing HC; 3) A small satellite of a FMR forms within a HC. Issues of flexibility, mission conflict, productivity, administrative complexity, communication, access, and service are balanced differently depending on the model.

**ii. Recommendations and Conclusions**

- An ideal administrative structure would require a paradigm shift away from two separate administrations, HC and FMR, to one administration with a joint mission.
- Develop an organizational flow chart that delineates hierarchy, roles, and responsibilities
- Suggestions not unanimously offered:
  - Increased support for clinic manager role is needed.
  - The residency director needs to connect with HC leadership to allow for flexibility and share in a joint mission. This would avoid the pitfalls of creating “silos” of roles and responsibilities.
  - We must understand the limitations and potential areas of flexibility with the accrediting bodies (ACGME, RRC, HS 330/PHS, JCHO)
  - Allow faculty in residencies to do more than clinical work. They need to be able to do curriculum design and practice management. There needs to be an understanding that teaching can improve patient care b/c teaching makes faculty better doctors.
  - An analysis of HC-FMR clinic function is needed.
  - Faculty should have a combined role as teachers and community care innovators.
  - The administrative role of recruiting new residents needs to be accounted for in the administrative structure.
  - The clinic manager and medical director roles need to be structured to recognize and support the dual mission of education and service.
  - Clinic scheduling of residents should be primary and hospital rotations should be secondary. Currently it appears just the opposite. If clinic was primary, then clinic schedules could be set further in advance and accommodate the needs of the clinic and their patients better.
  - The size of the residency is important. Small residencies don’t last long and large residencies are harder to manage.
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**d. Governance**

**i. Discussion**

- The following governing bodies are involved in the governance of HC-FMR affiliation:
  - ACGME/RRC/AOA—All private regulatory agencies
  - AAAHC/JACCHO (Medicare)—For all residencies, you cannot receive money unless accredited
  - PHS/HS 330
  - CMS (GME\$)

- Sponsoring hospitals (funnel GME \$, provide inpatient training)
- HC Admin, CHC Board
- Residency Admin./University Admin
- We must avoid siloing into respective administrations. There must be overlap and understanding of the governance requirements of each other's governing bodies.
- HC administration must have involvement and understanding of the sponsoring hospital to understand the challenges of the work b/w HCs, FMRs, and the sponsoring hosp.
- Current HC governance does not allow for reimbursement of activities that are not clinically related.
- HC administration must have involvement and understanding of the sponsoring hospital to understand the challenges of the work b/w HCs, FMRs, and the sponsoring hosp.
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- This work is an opportunity to address RRC/ACGME/JCHO/AOA/AAAHC standards. Their standards should be aligned in the formation of a new model to accomplish the same goal.
- Demonstration projects would potentially present ways to test relaxation of the standards of the regulatory bodies.

## ii. Recommendations and Conclusions

- We must avoid siloing into respective administrations. There must be overlap and understanding of the governance requirements of each other's governing bodies.
- There needs to be a new funding line that supports shared governance. This needs to reflect a blended mission so that funds go into residents and resident education that serves patients in HCs.
- Suggestions not unanimously offered:
  - The administrative role of recruiting new residents needs to be accounted for in the cost structure.
  - The 51% community board requirement should not be changed. This was due to the mission driven nature of HCs, the concern that outside stakeholders would overwhelm boards with a variety of private sector interests. This was felt to be a line in the sand for HCs. It was felt that the community board should stay in place, but stakeholders from Residency education should be included (hospitals, residency administration, educators).
  - A Board of Directors needs to be designed that shares the mission and understands the model.
  - It is recognized that there is always change in the Board, but it is important to get the right people in at the beginning

(people who have made this their mission in work up to then) and who can then train new people as they move off.

- The multiple agencies above provide regulatory guidelines that create layers of mandates. These regulatory bodies need to be included in the discussions. They should assist with the shared model.
- First, a system of pilot models should be identified. Then a waiver system could be developed. The group could petition for an Education Health Center waiver, similar to the RRT model.
- An evaluation of the links between governing bodies and HC-FMR affiliation should be done. This evaluation would delineate issues surrounding block rotations, maintenance of continuity of care, rooms per resident, and graduated level of supervision.
- There is a cost/productivity exception in PHS 330 grants. For this new model, additional UDS outcome data would have to be developed and added to the existing system. Special consideration should be given to cost per encounter and production (for more space, more staffing ratios, more costs per part time providers, and decreased productivity).
- A separate focus group for regulatory bodies should be convened.
- We should identify models that work: Billings, Waco, Lawrence MA, Chula Vista in San Diego, Castilla De La Rocha in LA.

#### **e. Leadership**

##### **i. Discussion**

- The current models of HC-FMR affiliation require extraordinary leadership and vision on the HC and FMR sides to create and maintain affiliations.
- A change in leadership is often the cause of affiliation failures.
- Strong leadership is the key element to make affiliation work.
- Continuity of leadership is critical. Maintaining the same leaders over time that embrace and fully live by the mission is critical.
- Leaders need to know what it takes to be in the liaison role with hospitals; to retain the revenue for the HCs and balance the hospital need for training and education; leadership balances the academic focus and manages conflict around patient care issues.

##### **ii. Recommendations and Conclusions**

- The model should facilitate the mission through the structure of reimbursement, governance, and administration in such a way that it can function without dynamic leaders. We should create

a system that doesn't have too heavy a reliance on extraordinary leadership.

- Leaders should have a long term vision and mission to provide quality care and workforce for today and the future.
- Leaders should to be trained in the paradigm of a joint mission and avoid siloing.
- The administrative structure should support the leadership models.