Graduate Medical Education in the FQHC Setting

Opportunities & Challenges

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Today’s Objectives:
• Identify need for more postdoctoral training slots, especially in primary care
• Highlight GME opportunities afforded by FQHCs and incentives for new programs
• Summarize benefits and barriers
• Share experiences of recent FQHC GME program initiatives
• Provide tips and resources for programs interested in starting a GME program in a FQHC

Why are we looking at primary care training in Community-Based Health Centers?
Because we are facing a nationally anticipated shortage of primary care providers…
1. Growth and aging of U.S. population
2. Many current physicians nearing retirement*
3. Decreasing number of medical graduates seeking primary care residency training spots
4. CAP makes it difficult to expand existing GME programs.

FQHCs as Teaching Health Centers
• ACA of 2010 Section 5508 provides for Increased Teaching Capacity through THCGME Program
  • Provided through HRSA grants
  • $230 M, 5-yr initiative (2011-2015) to support increased number of primary care physicians and dentists trained in community-based ambulatory care settings
  • Payments cover direct (DGME) and indirect (IME) costs
  • FQHCs are the “primary sponsors” of the residency and may receive up to $150,000 per resident per year

Enter FQHCs…
• FQHC = Federally Qualified Health Centers
• Provide quality, affordable, comprehensive primary care services for those whom other providers do not serve, regardless of ability to pay
• Non-profit or public community-based health care clinics
• Must be located in a Medically Underserved Area (MUA) or provide services to a Medically Underserved Population (MUP)

Projected doctor shortage

FQHCs = Federally Qualified Health Centers
Benefits of Training Primary Care Residents in FQHC Setting

#1 Opportunity

Recruitment of more physicians to work in underserved and rural areas-

“CHC trained physicians are more than twice as likely as their non-CHC trained counterparts to work in an underserved area.”


Benefits of Training Primary Care Residents in FQHC Setting

- Postdoctoral positions at FQHCs not subject to Federal CAP restrictions
- FQHCs have greater support networks for referrals to specialist services
- Broad scope and variety of patient cases, high volume of patient visits
- Can sign residents outside the Match

Benefits of Training Primary Care Residents in FQHC Setting

- Affiliated teaching hospitals have opportunities to reallocate CAP space by utilizing FQHC residents for hospital primary care services
- Partnering with FQHC to provide resident continuity clinics saves money over hospital owned clinics & generates revenue

Recruitment is perceived as the most important advantage for training activities.
Challenges of Training Primary Care Residents in FQHC Setting

- Lack of physical space
- Tension between two parts of CHC Mission
  - Improving access to care (training the next gen of PCPs)
  - Providing access to high-quality patient care (more difficult with space and staff time constraints)
- Recruiting and/or training qualified (and willing) teaching staff

Establishing Community-Based Osteopathic GME in Michigan

A Tale of Two Cities

Authority Health GME Consortium

- Collaboration initiated by Detroit Wayne County Health Authority
- DWCHA, MSUCOM, + 5 FQHC Members
- Total of 26 Ambulatory Clinic sites
- Affiliation agreements with 4 hospitals
- No previous postdoctoral training programs

Authority Health GME Consortium

- Clear Goals:
  - Address the need to attract and retain physicians to practice in underserved areas around Greater Detroit
  - Collaborate with a recognized academic leader – MSUCOM & SCS to provide solid education
- Proposed 85 new osteopathic residency spots:
  - (18 FM, 12 IM, 12 OBGYN, 21 Peds, 20 Psych, 2 Ger)
- Started HRSA Grant Application simultaneously with AOA Program Applications (Fall 2012)

- Four Steps in the Process:
  1. Creation of GME Consortium
  2. AOA Residency Program Accreditation/Approval
  3. HRSA THCGME Grant Application/Award
  4. Residency Start Up Operations
     Need 3 S’s: Space, Staff, Start-up $$
Key Issues:
1. Timing
   - Out of sync with recruitment season

2. THC providers – availability and interest
   - Not all sites wanted to train residents
   - Current providers stretched
   - Recruitment/integration of external providers

3. Timing issue #2 – receipt of HRSA grant funds not immediate
   THC must cover initial costs of salaries and other start up activities

4. Base Training Site(s)
   - 26 physical clinics – which locations can provide sufficient case volumes? Is there space for residents?

5. Hospital Affiliation Agreements
   - Sufficient capacity and inpatient volume
   - Proximity (continuity of care)
   - Existing faculty buy-in
   - Effect on hospital CAP numbers – possible partnership advantages

6. Meeting Specialty College Requirements
   e.g. OBGYN continuity of care and deliveries

Key Issues (cont’d):
7. Blending of FQHC residents with hospital residents, procedures, schedules, etc.
   - Hospital privileges
   - EMR
   - Fairness issues, problem-resolution

8. Conflicting Data Management Systems

9. Faculty Development needs
   - Inexperienced or new teaching faculty
   - Allopathic faculty awareness of osteopathic treatment modalities

Moving Forward…

Authority Health GME Consortium:
• Started with 27 residents
• Working out challenges with scheduling and data management systems
• Planning to add Dental residency program and working on CODA accreditation
• Organized Faculty Development sessions beginning and ongoing

Authority Health GME Consortium

Hamilton Community Health Network

Hamilton Community Health
• Serving Greater Flint area
• 5 Clinic Sites
• One Program Application – Family Medicine
• Consulted with Germane Solutions
• Previous PIF submitted to ACGME
• Already connected with Hurley hospital, UofM, and MSUCHM for student rotations
• Beautiful facilities and adequate space
Hamilton Community Health

Key Issues:
1. Timing – program approval not received until June 2013 for July 2013 program start
2. Almost no existing D.O. faculty
3. Limited understanding of AOA Application process & OPP Core competency elements

Key Issues (cont’d):
4. Budget planning
5. Planning/Design of program
   - Allocation of approved spots – still aiming for dual approval
   - Leadership & coordinator (what coordinator?)
   - D.O. faculty recruitment and D.O./M.D. faculty development
6. Carryover request

Moving Forward…

- Has been assured funding will carryover and submitting new budget
- Setting up infrastructure and staff
- Revisiting plans for dual-accreditation

Other Case Examples (NACHC Report)

Early case studies on the impact of community-based residency training on local and national primary care workforce needs in underserved areas. (Pre-HRSA Grants)

In-depth interviews with CEO’s, CFO’s, Medical Directors & staff at 4 FQHCs

Family Health Center of Worcester, Worcester, MA
- Ambulatory teaching site of Univ. of Mass. Medical School

Heart of Texas Community Health Center, Waco, TX
- Private, non-profit clinic established by local county medical society, became FQHC in 1999

La Familia Medical Center, Santa Fe, NM
- FQHC since 1987. Residency program is partnership with Univ. of New Mexico School of Medicine and St. Vincent Regional Medical Center

Community Health of Central Washington, Yakima, WA
- Started in 1992, became FQHC in 2003. Dual-accredited FM residency program, affiliated with both Univ. of Washington Seattle and Pacific Northwest University of Health Sciences in Yakima

NACHC Study Findings
1. Large proportions of graduates choose to stay and practice at their training sites or other CHCs
2. Patient satisfaction is reportedly high
3. Increased access to specialty physicians
4. Lack of adequate financial funding (pre-HRSA grants)
5. Struggle of balancing teaching mission with service mission
6. Issues with resident scheduling to allow for adequate continuity of care visits balanced with in-patient rotation requirements
In Summary

- Work with Academic Center or Teaching Hospital – solid understanding of Graduate Medical Education, resources, and support.
- Anticipate obstacles and consult with support organizations – NACHC, MPCA, HRSA, Germaine Solutions, etc.
- Balance service and teaching missions, determine how well the residency program will achieve continuity of care goals for residents and patients.
- Carefully plan for in-patient rotations, and integration of FQHC residents into hospital resident schedules and curriculum.
- Allocate staff and funds up front for start up expenses.

Thank you!

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