

# HR



## *HUMAN RESOURCES SERIES*

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## Using Affiliations with Residency Training Programs to Increase Your Health Center's Clinical Capacity

The last decade has seen an increasing number of federally qualified health centers (FQHCs or health centers) establishing collaborations with teaching hospitals and freestanding medical residency programs nationwide.<sup>1</sup> Given the increasing concern regarding shortages of primary care physicians, this heightened level of collaboration is not surprising. While the majority of these collaborations involve the establishment of community-based residency rotations at new or established health center delivery sites, freestanding residency programs located in medically underserved areas are also exploring the possibility of converting into an FQHC. This Information Bulletin provides information and guidance to health centers who are considering an arrangement with residency programs.

<sup>1</sup> Medical residency training programs provide new physicians an opportunity to develop their "hands-on" clinical skills and attain general competencies in a particular area of expertise after graduation from medical school. Residency programs are broadly distributed on a national basis, including both urban and rural settings. Most residency programs require residents to undertake clinical rotations in both an inpatient hospital environment, and outpatient/ambulatory care settings.

The Bulletin:

- ◆ Provides information on key considerations as relates to collaborations on teaching/training activities and clinical service delivery activities.
- ◆ Summarizes federal Graduate Medical Education (GME) reimbursement principles and provides an update of the key regulatory amendments since 2003 that are likely to have a direct impact on health center residency rotations;
- ◆ Addresses the “upsides” and “downsides” of residency collaborations on health center operations; and
- ◆ Examines the collaborative experiences of three health centers to ascertain whether the “traditional” expectations for a residency-health center collaboration are substantiated by experience (particularly, the impact on physician recruitment and retention).

*This Information Bulletin provides information and guidance to health centers who are considering an arrangement with residency programs.*

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## **HEALTH CENTER – RESIDENCY PROGRAM COLLABORATION**

Historically, several factors have encouraged collaborative arrangements between FQHCs and residency programs.

### **From the residency program perspective –**

- ◆ Programs have found it advantageous to offer residents the opportunity to develop their clinical and professional skills in primary care specialties in a community-based setting that serves a diverse and underserved patient population.
- ◆ In the competitive battle to attract highly-qualified medical student graduates, residency programs report success in marketing this unique rotation opportunity to prospective residents who are seeking a well-rounded educational experience.
- ◆ An academic collaboration with an FQHC can create the foundation for a relationship that can be expanded to include collaborations in other areas of interest, such as clinical research.

## From the FQHC's perspective –

- ◆ The infusion of additional practitioners (both teaching faculty/preceptors and residents) into the health center has been a means of alleviating a shortage in physician capacity and/or increasing the scope and breadth of services offered to health center patients.
- ◆ Adding residents and academic faculty to the clinical team can create a dynamic environment within a health center, fostering the collegial exchange of information and enhancing a health center staff's ability to keep abreast of emerging treatment regimens and technological advances, and their application in a community-based setting.
- ◆ Collaboration with a well-recognized teaching hospital or residency program can serve to enhance the status of the health center to its staff, the community and/or other third parties, just as the teaching hospital's reputation and credibility in the community may be enhanced by its linkage with the health center.

## From an economic perspective –

- ◆ Hospitals or freestanding residency programs have incurred losses on their ambulatory care sites as a consequence of serving significant numbers of people without any or adequate compensation, and low Medicare and Medicaid reimbursement rates.
- ◆ Health centers have received increases in Section 330<sup>2</sup> grant funds to support services at new primary care access points, to expand medical capacity and services including oral health, behavioral health, and chronic care management.
- ◆ FQHCs are entitled to cost-related Medicare and Medicaid reimbursement.
- ◆ Changes in federal reimbursement rules for providing Graduate Medical Education (GME) helped promote the economic viability of establishing and maintaining health center-based residency rotations by allowing teaching hospitals who receive GME to count the time spent by residents at health center sites in GME

reimbursement calculations. These rules also create the opportunity for a health center itself to seek GME reimbursement; however, there are limitations that may not make this an appealing option.

As a result, health centers and teaching hospitals (and to a lesser extent, freestanding programs) have increasingly negotiated more complex arrangements pursuant to which the health center assumes ownership of clinical sites previously operated by the hospital and hosts the continued operation of the residency programs at such sites.<sup>3</sup>

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2 Section 330 of the Public Health Service Act, 42 U.S.C. §254b

3 As part of these arrangements, it is common for a health center to secure some level of the clinical capacity for such sites through the physician preceptors, either by contract or by the transfer of physicians to the health center's workforce.

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## ALLOCATION OF AUTHORITY – Teaching/Training Versus Clinical Service Delivery

It is critical that a health center and a residency program appropriately define their respective authorities for clinical service delivery versus teaching when establishing the collaborative arrangement.

### From the residency program perspective –

- ◆ **Accreditation Standards** – The residency program must maintain authority and control over training activities as is necessary to meet applicable accreditation standards established by the Accreditation Council for Graduate Medical Education (ACGME) (or other applicable body).<sup>4</sup>
- ◆ **Teaching/training Activities** – The residency program would typically retain primary responsibility and control (even in instances where health center-employed clinicians act as preceptors) of activities such as:
  - Classroom teaching
  - Faculty appointment
  - Orientation programs

- Faculty/program meetings
- Curriculum development
- Resident recruitment, selection and evaluation
- General teaching program administration and evaluation

### From the FQHC’s perspective –

- ◆ **Scope of Services** – The health center must maintain responsibility for, and control over, activities related to clinical service delivery at health center sites, including decisions regarding the scope, location, and scheduling of services.<sup>5</sup> This would include both existing health center sites as well as former residency program facilities leased by the health center to furnish clinical operations and included in the health center’s approved scope of project.

**Service Delivery Activities** – At the individual clinician level, characteristics of clinical service delivery activities typically include:

- Diagnosis/treatment-related activities (*i.e.*, history, examination and medical decision-making) by employed and/or contracted clinical staff
- Direct patient involvement/interaction
- Generation of a bill for the services provided
- Quality assurance activities related to primary care clinical service delivery. Residents and preceptors providing services on the health center’s behalf should be required to reasonably participate in such activities.

For an in-depth analysis of these allocation principles, as well as the key terms for a written agreement to implement a FQHC-based residency rotation, see NACHC Issue Brief #26, *Key Considerations in Developing Residency Training Program Collaborations*, pp. 3 – 7.

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4 The particular allocation of authorities may vary, as each type of residency program (e.g., family practice, internal medicine, pediatrics, OB-GYN) may have unique programmatic requirements.

5 Health centers should periodically evaluate clinical operations to ensure that the full scope of services is available to all health center patients, regardless of whether the patient presents at a teaching site or a non-teaching site.

## ALLOCATION OF COSTS – Teaching/Training Versus Clinical Service Delivery

In addition to the need to appropriately allocate authority for teaching activities versus clinical service delivery for accreditation and licensing/billing purposes, it is equally important that the health center and its residency program partner be able to distinguish between the costs of the teaching program versus the costs of clinical service delivery.

- ◆ **On the teaching side,** this distinction is critical because federal GME reimbursement rules require a GME recipient to cover all or substantially all of the training costs.
- ◆ **From the clinical/health center side,** this distinction is important to assure grant funds and third party payments for clinical services are not subsidizing teaching.

## GME Cost Reimbursement Principles

Hospitals typically receive federal reimbursement for certain allowable costs incurred in conducting an accredited residency training program. To properly allocate costs and related payment obligations between a hospital (for teaching activities) and the health center (for clinical service delivery), it is important to understand the two kinds of federal GME reimbursement, which is paid through the Medicare program:

- ◆ **Direct GME**, commonly referred to as DME; and
- ◆ **Indirect GME** or IME.<sup>6</sup>

### Reimbursement for Direct Costs of Medical Education

The purpose of DME is to reimburse institutions, on a cost-basis, for the direct costs incurred by institutions involved in operating training programs.<sup>7</sup> Generally, in order to receive DME, the DME recipient must

incur all or substantially all of such direct training costs.

Federal regulations require hospitals as the GME recipient to reimburse health centers for all or substantially all of the direct costs incurred by a health center related to its rotations. The key costs to be reimbursed are salary and fringe benefits (including travel and lodging where applicable) of the residents; and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to supervisory teaching activities.<sup>8</sup>

### Reimbursement for Indirect Costs of Medical Education

IME reimbursement, which represents the far greater portion of Medicare's GME support, is meant to reimburse a hospital for the generally higher operating costs experienced by hospitals that sponsor/house residency training programs. These higher operating costs typically arise from increased resource utilization and clinical inefficiency due to the inclusion of an additional layer of less experienced staff involved in the delivery of patient care.<sup>9</sup>

Federal regulations do not require a hospital to reimburse a health center for its indirect costs (*e.g.*, higher marginal costs due to lost productivity; inappropriate utilization or over-utilization of space, equipment and supplies; inappropriate ordering of laboratory services) associated

<sup>6</sup> In order to receive GME reimbursement (whether DME or IME), the program must be an approved medical or dental residency program. 42 C.F.R. §413.75(a) (2); 42 C.F.R. §412.90(g).

<sup>7</sup> 42 C.F.R. §413.75(a)

<sup>8</sup> 42 C.F.R. §413.75(b)

<sup>9</sup> IME is typically paid through a boosted inflated inpatient visit rate for applicable teaching hospitals through a complex formula based on the number resident FTEs and other site-specific factors (42 C.F.R. §412.90(g), §412.105).

with the training program, even if the FQHC can document costs such as residents ordering more laboratory services. Nevertheless, many health centers require hospital sponsors to cover some or all of these indirect costs as a condition of the collaboration.

## Cost Reimbursement and Health Center Rotations

The Social Security Act authorizes hospitals to include the time a resident spends in patient care activities at a non-hospital setting in its direct and indirect GME full-time equivalency (FTE) count if the hospital incurs all or substantially all of the costs of training at that non-hospital setting.<sup>10</sup>

### Health Centers' Eligibility for Training Reimbursement

- ◆ **Eligible for DME** – In 1998, FQHCs were added to the list of institutions eligible to directly receive DME reimbursement, regardless of whether or not the FQHC is the sponsoring institution of the residency program, provided that the FQHC incurs all or substantially all of the direct training costs at the FQHC site(s).
- ◆ **Ineligible for IME** – FQHCs were not eligible to receive reimbursement for indirect costs.

- ◆ **Low Reimbursement Payments** -- In addition, the methodology for determining health center DME reimbursement is not favorable for health centers. Payment is limited to the ratio of Medicare visits to the health center's total number of visits. For example, if Medicare represents 20% of a health center's payor mix, the DME reimbursement will equal only 20% of the allowable DME costs that the health center must incur.<sup>11</sup>

The lack of IME reimbursement, coupled with the unfavorable methodology for FQHC DME reimbursement, has effectively prevented FQHCs from seeking GME reimbursement. Hospitals have remained the GME recipient in the vast majority of health center-residency program collaborations.

### Changes to Federal Regulations

Prior to 2004, federal regulations allowed the time spent by residents in non-hospital settings, such as health centers and physician offices, to be included by the hospital in its FTE count if 1) the resident spent his/her time in patient care

activities and 2) the hospital and non-hospital site had a written agreement providing that the hospital would incur all training costs at the non-hospital site – including resident salaries and fringe benefits and the costs for supervisory teaching activities – and that the hospital would provide reasonable compensation for such costs to the non-hospital site.<sup>12</sup>

In August 2004, the Department of Health and Human Services (DHHS) issued a final rule modifying the written agreement requirement so that a written agreement was made optional as long as the hospital reimbursed the non-hospital site for all or substantially all of the costs of training at such site on at least a quarterly basis. NOTE: *While the existence of a written agreement is now optional, we continue to advise that the key terms of a health center residency rotation be memorialized in the written agreement between the hospital and health center.*

In the preamble to the final rule, DHHS stated that “precepting” – the supervision of residents in patient care activities – inherently includes some level of supervisory teaching activities which, by law,

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10 See Sections 1886(d) (5) (B) (IV) and 1886(h) (4) (E) of the Social Security Act; 42 U.S.C. §1395ww. This policy is further clarified in the federal regulations at 42 C.F.R. §413.78(e) and 42 C.F.R. §412.105(f) (1) (ii).

11 See 42 C.F.R. §405.2468(f)

12 This requirement, originally codified at 42 C.F.R. §413.86(f) (4), was re-codified as 42 C.F.R. §413.78 (e).

must be incurred / reimbursed by the hospital GME recipient.

This position was highly controversial, as it conflicted with a common practice of treating physician preceptors as volunteers who were not compensated for any portion of the time spent in precepting activities.

In May 2007, DHHS issued another final rule which contained major changes of importance to health center rotations. *See 72 Fed. Reg. 26870* (May 11, 2007).

- ◆ **90% of Costs** -- DHHS clarified that the requirement that hospitals cover “all or substantially all” of the costs of a training program in a non-hospital setting would be satisfied if it incurred at least 90% of these costs (*i.e.*, “substantially all” equals 90%).<sup>13</sup> *NOTE: While this reduces the financial obligation a hospital must incur in order to legitimately receive GME reimbursement, health centers will still need to seek payment of all costs that are not attributable to patient care activities from their residency program partner (e.g., hospital or university), in order to avoid inappropriately subsidizing teaching activities.*

- ◆ **Teaching Supervision Reimbursement Standard** – In addition, the rule provided much-needed guidance regarding the scope and related cost of a teaching physician’s supervisory teaching activities for GME reimbursement purposes. The rule establishes a proxy methodology that may be used (in lieu of, or in combination with, actual cost/time data) to calculate the GME costs incurred at a non-hospital site and, in particular, the cost of supervisory teaching activities. Specifically, DHHS establishes a presumptive standard that a teaching physician spends 3 hours per week in supervisory teaching activities at the non-hospital site. This presumptive 3 hours may then be divided by the number of hours the non-hospital site is open per week to determine the percentage of a teaching physician’s salary and benefits that should be attributed to supervisory teaching activities (and incurred by the hospital). For example, if a non-hospital site is open 30 hours a week and a physician’s compensation

package is \$100,000, the attributable GME cost for the teaching physician would be \$10,000 ( $3 \div 30$  (10%) times \$100,000 = \$10,000) in accordance with this approved methodology.

The establishment of the presumptive standard alleviates considerable confusion in how to treat preceptors’ time as either a “training cost” or a “clinical cost.” Precepting, by its very nature, includes a teaching/training component, yet also involves a preceptor’s supervision of direct patient care for which, in the majority of cases, a bill will be generated by the health center. The proxy methodology simplifies the calculation of the teaching costs related to patient care incurred at a health center residency rotation, especially where actual cost/time data has not been maintained.

13 DHHS further clarified that “in kind” compensation to the non-hospital site is allowable, provided documentation exists to support the valuation of such “in kind” support.

## Community Support and Redistribution of Costs Principles

In 2003, DHHS codified the two controversial principles of “community support” and “redistribution of costs” in the federal GME regulations. See 68 Fed. Reg. 45434.

- ◆ Community support is defined as “funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including state and local government appropriations.”<sup>14</sup> If a community has undertaken to bear the costs of medical education through community support, the costs supported by the community support may not be considered GME costs to the hospital for purposes of Medicare payment.
- ◆ Redistribution of costs occurs when a hospital counts resident FTEs for GME cost purposes, even though the costs of the program had previously been incurred by an educational institution and financed through community support.<sup>15</sup> The costs of training residents that constitute a redistribution of costs from

an educational institution to the hospital may not be considered GME costs for purposes of federal GME payments.<sup>16</sup>

The impetus for codifying these principles was the perceived exploitation by hospitals, and primarily dental schools, of a loophole involving the rules capping resident FTEs for GME reimbursement purposes – namely, the non-application of the cap to dental residents. In response, DHHS amended the rules to incorporate the “community support” and “redistribution of costs” principles.

DHHS also added a requirement that, in order for the hospital to count the FTE residents, it must continuously incur the direct GME costs of resident training in a particular program at a training site since the date the residents first began training in that program.<sup>17</sup>

### Example of Community Support and Redistribution of Costs

The application of these principles on an existing residency rotation site can be best understood through example. Take the following scenario:

A free-standing residency program begins in 1995 training five residents through one precepting teaching physician at one site, at a cost of \$100,000 annually, funded by state and

local grants. No hospital seeks GME reimbursement for the residents’ time at this site until 2000. In 2001, the site begins training ten residents through two precepting physicians at a cost of \$200,000 funded entirely by federal GME reimbursement to a hospital that enters into an agreement with the residency program. For the period from 1995 through 2000, the state and local grant funding would be deemed “community support,” as it was utilized to bear the costs of such pre-GME educational activities.

- ◆ Applying the “community support” principle, that \$100,000 of costs could not ever be considered GME costs for Medicare payment purposes.
- ◆ Applying the “redistribution of costs” principle, the hospital’s act of seeking GME reimbursement for the residents time at the site would be deemed to be an inappropriate redistribution of costs, as the costs of the program had previously been incurred by the residency program, *i.e.*, through the community support.<sup>18</sup>

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14 42 C.F.R. §413.75(b)

15 42 C.F.R. §413.75(b)

16 42 C.F.R. §413.81(a)

17 42 C.F.R. §413.81(b)

18 42 C.F.R. §413.75(b)



- ◆ The hospital would be eligible to retain GME reimbursement for the “new” \$100,000 of costs represented by the addition of the five residents and one preceptor in 2001 since these costs were incurred by the hospital since the date those residents began training.
- ◆ However, because of the requirement that the hospital incur “all or substantially all” of the training costs at the site, the hospital must still incur the full costs of training, *i.e.*, \$200,000 for ten residents in order to receive GME reimbursement of \$100,000 for those five residents.

The application of these principles depends on the unique history of each residency rotation site. In at least one instance, a health center – which directly received GME reimbursement for operating a residency program that prior to the establishment of the health center was operated by a university and funded locally without federal GME – was barred from seeking future GME reimbursement. *See* 68Fed Reg. 45454.

Accordingly, in instances where health centers agree to host or operate residency rotations, it is important to consider the funding history of the training program to determine eligibility for and/or level of GME reimbursement for training costs incurred at those sites regardless

of whether a teaching hospital or the FQHC is the direct GME recipient. For new residency programs and/or new training rotations, the lesson is clear: GME funding should be sought at the outset if this is assumed to be a long-term funding source to support the program and/or rotation.

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## IMPACT OF RESIDENCY PROGRAM COLLABORATIONS ON HEALTH CENTER OPERATIONS

### The Upsides of Residency Program Collaborations

- ◆ **Recruitment and retention tool** – Residency collaborations have also been seen as an important recruitment and retention tool. By exposing residents to community-based medicine during their training experience and by acquainting residents with the health center and its comprehensive clinical practice approach, it is anticipated that residents will be motivated to join the health center’s clinical workforce after graduation (or to at least stay to practice medicine a medically underserved area). Residency program collaborations may also provide a tool for attracting (or retaining) experienced physicians to the health center. For experienced physicians, the opportunity to become part of a residency program’s teaching faculty (or otherwise affiliate with such program) can serve as an attraction to join the health center’s staff.
- ◆ **Increased clinical capacity** – The upsides of residency rotations are numerous. The establishment of a health center as a rotation site may increase and enhance the health center’s clinical capacity. In addition to expanding the number of physicians (both preceptors and residents) available to serve health center patients, such collaborations may enable a health center to increase the scope and breadth of services offered to its patients by accessing physicians with high levels of experience and expertise.
- ◆ **Enhanced staff morale** – Similarly, it is believed that provider morale may be enhanced if health center clinicians are offered the opportunity to get involved in teaching activities. The infusion of energetic residents and faculty preceptors who may be contracted from a residency program can also serve to enhance staff morale and create a dynamic

environment within the health center – fostering the collegial exchange of information and thereby enhancing a health center staff’s ability to keep abreast of emerging treatment regimens and technological advances, and their application in a community-based setting.

- ◆ **Improved community relationships** – Residency collaborations may also enhance the health center’s status within the community, through both the health center’s association with a well-recognized residency program as well as its ability to “tap into” a greater level of expertise / experience. Ultimately, this could result in improved community relationships, potentially providing access to services and partners previously unavailable to the health center, as well as additional opportunities with the residency program itself (*e.g.*, clinical research).

## The “Downsides” of Residency Program Collaborations

- ◆ **Decreased clinical productivity** – Conversely, collaboration with a residency program can have notable downsides if not anticipated and well-managed. The most prevalent shortcoming typically is a negative impact on clinical productivity caused by the fact that residents generally take longer to see patients. This problem can be exacerbated by a pattern of disruptions in staffing (clinical and support staff alike) due to last minute changes to resident or preceptor schedules.
- ◆ **Increased costs** – In addition, residents typically order more diagnostic tests than experienced clinicians; the increased testing may be costly, as is the support staff needed to follow-up.

- ◆ **Disruption to effective operations** – A failure to sufficiently train and orient new residents /preceptors to the health center’s policies and protocols and to appropriately introduce them to the health center’s current staff (and vice versa!) can disrupt health center operations. If residency program staff and the health center’s clinical or administrative staff have not had the opportunity to work closely prior to implementing the training program (*i.e.*, during the planning process), personnel and/or clinical practice issues may emerge (*e.g.*, clash of clinical cultures; health center staff may become insecure regarding stability of their jobs).

Fortunately, all of these problems can be addressed through careful planning before launching the collaboration and, thereafter, through continued meetings and timely action taken by a proactive, collaborative leadership focused on ensuring the mutual gains to be achieved by the collaboration.

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## “REAL LIFE” CASE STUDIES: THE COLLABORATIVE EXPERIENCES OF THREE HEALTH CENTERS

A key objective in developing this information bulletin was to address the following questions:

1. Are “traditional” expectations (both positive and negative) of health center-residency program collaborations substantiated by experience?
2. If not, where does “real life” diverge from theory?
3. What is the impact of such collaborations on a health center’s clinical capacity?
4. Do such collaborations benefit a health center as a recruitment and retention tool?

To help answer these questions, we interviewed senior clinical managers at three health centers currently involved in residency program collaborations.

### Case Study #1:

**Community Health Center, Inc.  
Middletown, Connecticut  
(Main Office)**

Founded in 1972, Community Health Center, Inc. (CHCI), a private, nonprofit organization, was originally operated as a free clinic. It became a Section 330-funded health center in 1995. Today it has 70,000 patients in its medical, dental, and behavioral health departments located in 12 cities and over 140 service sites across the State of Connecticut. It serves as a rotation site for three residency programs in the fields of family medicine (8 residents), dentistry (3 residents) and psychiatry (2 residents), as well as hosting an innovative pilot residency program for family nurse practitioners (4).

The family medicine residency collaboration, which began over 20 years ago, is with a family medicine residency program affiliated with a local hospital and involves residents rotating to CHCI sites in Middletown and Clinton, Connecticut for their obstetrical/prenatal experience. Both parties hoped the collaboration would serve to improve pregnancy outcomes and provide woman-centered care. The hospital wanted to provide residents a local OB rotational experience. For CHCI, particularly compelling was the ability to staff its OB practice with highly-qualified

and respected teaching physicians provided by the family medicine residency program, and the program’s willingness to accommodate CHCI’s integrated care model. The family medicine program’s teaching physicians, both obstetricians and OB-privileged family medicine physicians, precept residents, both at CHCI and in the inpatient intrapartum setting.

CHCI’s collaborations with University of Connecticut-affiliated medical school and dental school residency programs to provide dental and psychiatric rotations in New Britain are relatively new, each less than five years old. CHCI-employed dentists supervise the dental residents. CHCI has a contractual arrangement with UCONN Health Center psychiatry department to precept the psychiatric resident rotation.

Observing the positive impact of the FQHC-based residency rotations had in preparing primary care physicians to practice in the challenging FQHC setting, CHCI recognized the need to train all new primary care providers to this model of care. Accordingly, CHCI developed, sponsored and is now operating the nation’s first residency program for primary care nurse practitioners. Viewing nurse practitioners as ideal primary care providers in health centers, and believing that the complexity and challenges inherent in providing care in a

health center requires advanced, resident-level training akin to physicians, CHCI initiated its nurse practitioner residency program in 2007.

The program emphasizes training in an integrated model of care that includes prevention, acute care and chronic disease management for special populations.<sup>19</sup> Nurse practitioner residents are hired as CHCI employees and provide patient care services to a full range of CHCI patients (including geriatric and patients with HIV), both at CHCI primary care sites and at other community locations (schools, homeless shelters). Residents also participate in outside specialty rotations with other community providers. Residents share in emergency “call” and staff weekend clinic sessions, and benefit from the same kind of dedicated faculty precepting by other CHCI medical staff members (physicians and nurse practitioners) typically found in a medical residency program.

◆ As a recruitment tool for new physicians, the family medicine rotation has been highly successful. CHCI has been able to recruit a number of graduating residents to its physician staff over the years, including three physicians in the last year alone. Most of these residents identify their residency experience with CHCI as a major factor in seeking a position

at CHCI. Similarly, of the first graduating class of nurse practitioner residents, two of the four graduates are working at CHCI, while the other two graduates were hired by other community health centers.

- ◆ The effect on CHCI’s operations has been generally positive.
  - The primary challenges have been in providing sufficient CHCI policy and electronic medical record system trainings, and optimizing the allocation of space and support staff (medical assistants, dental assistants) for clinical service activities.
  - The effect on clinic productivity has been mixed. In OB, dentistry, and psychiatry, there has been no negative effect on productivity, as scheduling and staffing are established consistent with available space and support staff. The nurse practitioner program has

had a negative impact on productivity since CHCI attending clinicians are scheduled to precept each team of two residents, four sessions per week.<sup>20</sup>

- ◆ Participation in residency collaborations has fostered strong ties with the residency program’s sponsoring institutions and has led to additional collaborations. These collaborations have included joint disease management (asthma, diabetes) initiatives, the establishment of arrangements for specialty care referrals, and other types of community access projects aimed at strengthening the safety net infrastructure.
- ◆ CHCI’s nurse practitioner residency program has elevated the reputation of CHCI as a pioneer, particularly among other health centers across the country that recognize the need for, and value of, this innovative residency training approach and are interested in developing similar programs.<sup>21</sup>

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19 Unlike most medical residencies, CHCI’s nurse practitioner residency program is a one-year program and currently trains four nurse residents per year.

20 CHCI recognized this possible downside when it established its nurse practitioner program, but deemed the creation of the pilot program as a high enough priority to warrant the contribution of preceptor time with the associated effect on productivity.

21 Financial feasibility is the most prominent barrier limiting the duplication of similar non-physician training programs. Specifically, current federal GME funding rules preclude GME support of residency training programs for providers other than physicians or dentists, such as nurse practitioners.

For additional information on CHCI's residency program collaborations, please feel free to contact:

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## Case Study #2: South Boston Community Health Center, Inc. Boston, Massachusetts

South Boston Community Health Center (SBCHC) is a private, nonprofit organization with a long history of providing FQHC services to the medically underserved residents of South Boston. SBCHC currently collaborates with three residency programs, all of which are operated by teaching hospitals. SBCHC serves as the primary continuity clinic for Boston Medical Center's (BMC) family medicine program (12 residents on average annually). In addition, it serves as a rotation site for both BMC's internal medicine residency (4 residents) and New England Medical Center's (NEMC) pediatric residency program (3 residents). The family medicine collaboration is the most recent, dating back roughly 6 - 7 years, while the pediatric and internal medicine rotations began somewhere between 10 and 15 years ago.

Preceptors for the family medicine rotation are all BMC-employed teaching physicians who, in addition to supervising residents, are contracted to SBCHC to provide clinical services on SBCHC's behalf. The ability to access these physicians has significantly improved the quantity and quality of SBCHC's physician capacity, which was a problem in years past. In addition, the utilization of SBCHC as the program's primary ambulatory clinic rotation has resulted in the development of close relationships between SBCHC clinicians and the precepting physicians, as well as attending inpatient physicians. These relationships ultimately benefit SBCHC's patients. The influx of energetic and highly qualified residents has created a stimulating, bilateral teaching environment, with SBCHC staff learning as much, if not more, from residents, especially with regards to residents' inpatient experiences.

Pediatric residents are precepted by SBCHC's physicians, who have a real affinity for participating in teaching activities. SBCHC's association with two prestigious academic medical centers, with the opportunity for SBCHC physicians to become faculty to the residency program, has helped the recruitment of experienced physicians to SBCHC's staff.

- ◆ As a recruitment tool for new physicians, the family medicine rotation has been very successful for SBCHC and the broader Boston health center community. Over the years, a large percentage of the family medicine residents have chosen to continue practicing in a community health center environment. Most emphasize their experience with SBCHC as a major reason for making their choice. In fact, one of SBCHC's most recent hires in its internal medicine department is a physician who was both a medical student and a resident at SBCHC.
- ◆ Operationally, while the overall impact on SBCHC has been positive, there are ongoing challenges that arise from the additional complexities created by the rotations. Most notably, the continuous fluctuation in resident and preceptor schedules requires constant diligence and timely coordination to ensure that clinic staffing is sufficiently responsive to patient needs. In addition, the existence of the residency rotations has had a noticeable (adverse) impact on clinic productivity. Quality of care concerns are addressed by ensuring the strict oversight of residents by precepting physicians.

◆ While SBCHC does not believe that its residency collaborations have significantly elevated its reputation or status in the community, the residency collaborations have led to additional collaborative activities, particularly in the area of clinical research.

For additional information on SBCHC's residency program collaborations, please feel free to contact:

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### **Case Study #3: RiverStone Health (Previously known as Yellowstone City-County Health Department) Billings, Montana**

The Yellowstone City-County Health Department, now known as "RiverStone Health," is a public health center that has been providing primary care services to the medically underserved residents of Yellowstone County, Montana, since the establishment of its Deering Clinic in 1984. While it has served as the primary ambulatory rotation site since 1996, RiverStone Health became formally integrated with the Montana Family Medicine Residency Program (the

Program) in 2005. In deciding to integrate the Program within RiverStone Health, the health center embraced education – in particular, an obligation to the community and state to prepare physicians to practice in medically underserved areas of Montana - as a core part of its mission and its strategic vision.

From its inception, the Program has been operated as a community-based, primary care-focused residency, and the Program now primarily operates through RiverStone Health (as well as in conjunction with two local hospitals who receive the federal GME funding supporting the Program), rotating 18 residents (and one sports medicine fellow) annually. All of the teaching physician faculty and residents are RiverStone Health employees.

The integration of the Program within RiverStone Health's FQHC operations resulted in an immediate increase in the size and scope of services provided by RiverStone Health, including staffing a busy RiverStone Health OB and inpatient hospital service. The enhanced qualifications necessary to serve as a faculty physician has also materially raised the experience and expertise of RiverStone Health's physician base. RiverStone Health's affiliation with the Program has had a positive impact in recruiting experienced physicians with the opportunity to teach serving as an important attraction.

◆ The Program has also been highly successful as a recruitment tool for new physicians. RiverStone Health has recruited two graduating residents to its physician panel within the last two years. Significantly, the vast majority of the Program's residents have opted to remain in Montana to serve medically underserved areas, with a large number opting to join the clinical teams of other Montana FQHCs.

◆ From the academic perspective, the integration of the Program within an FQHC structure has also considerably improved the Program's ability to attract highly qualified residents across the nation. Interestingly, considerable numbers of medical students with a strong mission-driven service mentality are actively opting to be matched to the Program. The Program has consistently filled all resident slots through "the match" each year, attracting 300 – 400 applicants for the six intern positions.

◆ Operationally, the overall impact on RiverStone Health's clinical operations has been overwhelmingly positive even though integration of the Program has had its challenges. From a personnel perspective, the transition of the preceptors and residents to RiverStone

Health's employment has resulted in employee benefit and other issues arising from the short-term nature of the resident's employment and the organization's status as a public entity. From a clinical perspective, it has proven difficult to maintain the desired level of continuity for patients due to resident turnover, resident involvement in other rotations, and the preceptors' juggling of clinical and teaching duties. To mitigate these factors, RiverStone Health has successfully instituted patient care "teams" whereby a team of faculty physicians, residents, non-physician providers, and clinical support staff (rather than one physician) serve as a patient's primary care provider. The integration of the Program and FQHC has served to reduce the clinical productivity and staff morale issues, as the team-oriented atmosphere has effectively eliminated the divisions between residency training and clinical service delivery.

*. . . it is important that the health center understand the current federal funding framework associated with residency programs . . .*

- ◆ RiverStone Health's status and reputation within the community has benefited substantially from its residency collaboration. Local providers have embraced the Program as an important part of the community. This has helped foster a good level of trust among RiverStone Health and other community providers, as well as enhanced referral arrangements with other community providers, particularly specialists. It has also led to joint collaborative activities in the areas of telemedicine, clinical research and specialty rotations for residents.

For additional information on RiverStone Health's residency program collaborations, please feel free to contact:

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## CONCLUSION

- ◆ Health center collaborations with residency programs present an excellent opportunity for extending clinical capacity and strengthening ties with local hospitals and other providers, to the benefit of all involved, including health center patients.
- ◆ In deciding to enter into such a collaboration, it is important that the health center understand the current federal funding framework associated with residency programs, as well as the possible benefits and downsides such a collaboration may entail.
- ◆ It is also important to have an understanding of the key terms for agreements needed to implement this kind of collaboration. Such guidance may be found in NACHC Issue Brief #26, *Key Considerations in Developing Residency Training Program Collaborations*.
- ◆ Finally, as with other health center programs, learning from the experiences of your fellow health centers is an important part of the process that should not be taken lightly.



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