

# Pathways to Residency

*Community Health Center Models for  
Graduate Medical Education*



## California Primary Care Association

The California Primary Care Association (CPCA) was formed in 1994 and is the statewide leader and recognized voice representing the interests of California community health centers (CHCs) and their patients. CPCA represents more than 1,300 not-for-profit CHCs and Regional Clinic Associations who provide comprehensive, quality health care services, particularly for low-income, uninsured and underserved Californians, who might otherwise not have access to health care. CPCA provides advocacy, education, and services to lead and position CHCs as key players in the health care delivery system in order to improve the health status of their communities.

## California Community Health Centers

CHCs are nonprofit, tax-exempt clinics that are mission driven to minimize the impact of barriers to health and health care access including poverty, lack of health insurance, immigration status, ethnicity, language and culture, disability, homelessness, geographic isolation and other diverse needs. California's CHCs offer a proven delivery model that can serve as a quality benchmark for meeting the needs of California's diverse and disenfranchised populations. As providers for the most vulnerable Californians, CHCs understand that in order to achieve the goal of access to health for all, California cannot rely entirely on incremental expansion of existing publicly funded health insurance programs. Access to healthcare will require expanding and diversifying our physician workforce to meet the needs of California's diverse patient population.

### CONTENTS

California's Primary Care Physician Shortage	3
Community Health Center Residency Road Map	4
About this Resource	5
What is Graduate Medical Education?	6
Critical Community Health Center Partners in Graduate Medical Education	7
Graduate Medical Education in Community Health Centers	9
Community Health Center Residency Models	10
References	33

# California's Primary Care Physician Shortage

California has faced a primary care workforce shortage for many, many years and each year it gets worse. According to *California's Primary Care Workforce: Current Supply, Characteristics, and Pipeline of Trainees*, "only two [out of nine] regions in California have ratios of primary care physicians per population above the minimum ratio recommended by the Accreditation Council on Graduate Medical Education (60 primary care physicians per 100,000 population)" (Coffman, Geyn, & Himmerick, *California's Primary Care Workforce: Supply, Characteristics and Pipeline of Trainees*, 2017). This report indicates that the current primary care physician supply in most regions of California is not adequate to serve the population.

Future forecasts also cause concern. *California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030* demonstrates that "by 2030 California is projected to demand between 39,331 and 44,188 primary care clinician full-time equivalents (FTEs), an increase of 12 percent to 17 percent above the current demand" (Coffman, Geyn, & Spetz, *California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030*, 2017). In addition, "the supply of primary care MDs is projected to decrease between 8 percent and 25 percent because insufficient numbers of new primary care MDs are completing residency programs to replace physicians who are projected to retire" (Coffman, Geyn, & Spetz, *California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030*, 2017).

These stark forecasts, coupled with the fact that only 9 percent of primary care physicians in California practice in CHCs and public health clinics, demonstrate that more physician training is needed in community-based settings to recruit and retain providers who will stay in underserved areas (Coffman, Geyn, & Himmerick, *California's Primary Care Workforce: Supply, Characteristics and Pipeline of Trainees*, 2017). Teaching Health Centers (THCs), which provide primary care medical and dental residency programs in community-based ambulatory patient care settings have already shown significant success in this area. Over one-third of the THC graduates have taken jobs at community health centers while only 2 percent of residents overall choose to work in community health centers (Andrew Bazemore, et al., 2015). CHCs are also ideal training sites because they educate physicians to focus on social determinants of health and transdisciplinary care within their clinical practice.

# Community Health Center Residency Road Map

In an effort to address the devastating primary care physician shortage, CaliforniaHealth+ Advocates, CPCA's advocacy affiliate, led a successful coalition effort in fiscal year 2017-2018 to secure \$97 million over three years in the California State Budget for primary care residencies. In collaboration with the California Medical Association, California Hospital Association, American College of Physicians, California Children's Hospital Association, Osteopathic Physicians and Surgeons of California, and Planned Parenthood, we ensured that this funding was available to support the development of new, existing, and expanding primary care residency programs in California, including those in CHCs.

Several CHCs have taken advantage of this funding to sustain, expand, and develop new residency programs. Many other CHCs continue to explore the potential of residency program and partnership development to grow their workforce. As a result, CPCA developed the Community Health Center Residency Road Map to offer a series of trainings and resources that support the development of CHC residency programs.

*As part of this program, we strive to:*

- Develop comprehensive trainings and resources for CHCs desiring to implement or sustain residency training programs or partnerships;
- Increase the number of new CHC residency partnerships and accredited programs to expand primary care GME in California; and
- Strengthen and sustain existing CHC residency partnerships and accredited programs to maximize ongoing efforts that train primary care residents in community-based settings and underserved areas.

This program was developed with the generous support of the Northern and Southern California Kaiser Permanente Community Health Programs and in partnership with Wipfli, LLP. Through this work, CPCA created a number of different toolkits and offered several in-person meetings whose presentations were converted to webcasts.

## Community Health Center Residency Road Map Resources

### ADDITIONAL RESOURCES

- Preparing for Accreditation: Community Health Center as Sponsoring Institutions
- Graduate Medical Education Funding: Community Health Center Resources for Residency Training
- Self-Assessment and Action Plan: Community Health Center Sponsoring Institution and Residency Program

### TRAINING WEBCASTS

- Training Physician Residents in Community Health Centers
- ACGME Accreditation: Community Health Centers as Sponsoring Institutions
- Cultivating Community-Based Graduate Medical Education

ALL MATERIALS developed through the Community Health Center Residency Road Map program can be accessed at [www.cPCA.org/residency](http://www.cPCA.org/residency).

# About this Resource

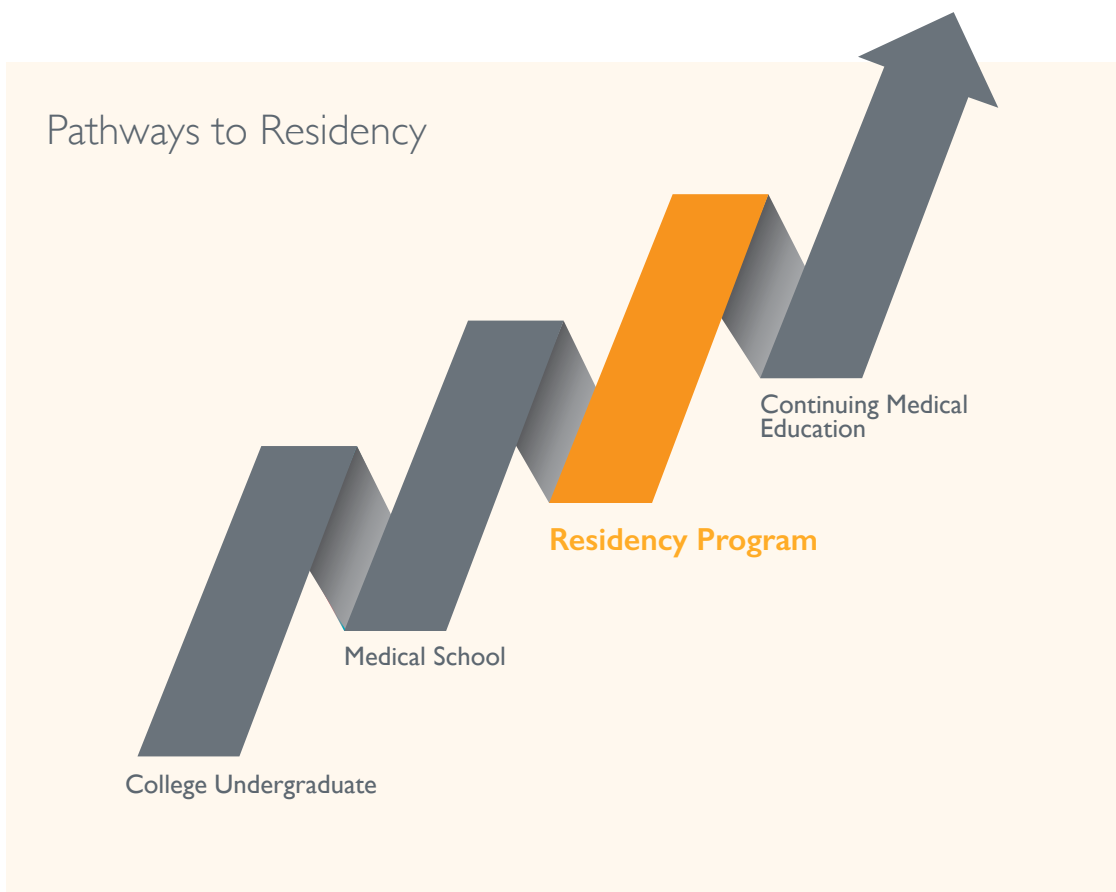
## Pathways to Residency

### *Community Health Center Models for Graduate Medical Education*

CPCA strives to create value for CHCs by creating resources designed to aid the success of CHCs and ease the burden of having to develop individual solutions for each organization. Pathways to Residency (Pathways) was developed to help CHCs understand the differences in staffing, finances, operations, and other components amongst four residency training models used commonly in CHCs – CHC as a sponsoring institution, consortium partner, continuity clinic, and rotation site. CPCA established a 14-member Residency Advisory Group made up of subject matter experts in CHCs, university graduate medical education programs, and partner associations to gather feedback on the development of residency programs and partnerships. The feedback provided by the Residency Advisory Group was incorporated into the development of Pathways.

# What is Graduate Medical Education?

The Accreditation Council for Graduate Medical Education (ACGME) defines graduate medical education as “the period of didactic and clinical education in a medical specialty which follows the completion of undergraduate medical education and which physicians for the independent practice of medicine in that specialty or subspecialty” (ACGME Glossary of Terms, 2018). Also referred to as residency or fellowship education, GME allows physicians to progressively achieve autonomy to provide high-quality patient care without supervision through a rigorous training program (ACGME Glossary of Terms, 2018). Residency training is required to become a fully licensed physician eligible for Board certification. As a result, GME plays a significant role in determining the number and type of physicians practicing in a state.



# Critical Community Health Center Partners in Graduate Medical Education

## **ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME)**

The ACGME is “a private, 501(c)(3), not-for-profit organization that sets standards for US graduate medical education (residency and fellowship) programs and the institutions that sponsor them, and renders accreditation decisions based on compliance with these standards” (Accreditation Council for Graduate Medical Education, 2018). ACGME accreditation assures that a Sponsoring Institution and program satisfies quality standards (Institutional and Program Requirements) of a certain specialty. A Residency Review Committee (RRC) made up of specialty experts establishes accreditation standards and offers peer evaluation to specialty residency programs. Similar to the specialty accreditation oversight, Sponsoring Institutions are accredited and reviewed by the ACGME Institutional Review Committee (“IRC”) which is also comprised of volunteer experts. For more information, visit their website at: [www.acgme.org/](http://www.acgme.org/).

## **HRSA TEACHING HEALTH CENTER GRADUATE MEDICAL EDUCATION (THCGME) PROGRAM**

The Health Resources and Services Administration (HRSA), “an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable” (Health Resources and Services Administration, 2018). Comprising of five bureaus and eleven offices, HRSA provides leadership and financial support to health care providers in every state and U.S. territory.

HRSA is responsible for overseeing the Bureau of Health Workforce, which “administers programs designed to strengthen the health workforce and connect skilled professionals to rural, urban, and tribal underserved communities nationwide” (Health Resources and Services Administration, 2019). The HRSA Teaching Health Center Graduate Medical Education (THCGME) Program was authorized and initially appropriated through the Patient Protection and Affordable Care Act. It helps support the direct and indirect medical education expenses of training residents in new or expanding community-based primary care medicine and dentistry residency programs. For more information, visit their website at: <https://bhw.hrsa.gov/grants/medicine/thcgme>.

## **CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS)**

Since 1965, CMS has administered the Medicare Program and monitors the Medicaid Programs run by each state. Included in those programs is GME funding. Medicare GME is now the largest source of funding for GME. While CHCs cannot directly access Medicare GME funds, hospital partners may pay the CHCs for the cost of teaching at their sites. For more information, visit their website: [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html).

Behind Medicare, Medicaid GME has become the second-largest source of GME funding. According to an analysis done by the Association of American Medical Colleges in 2016, forty-two states and the District of Columbia (D.C.) have established a Medicaid GME strategy in their states in order to offset a portion of the GME costs incurred by training entities (Henderson, 2016). California is one of eight states that do not have a Medicaid GME payment structure at this time (Henderson, 2016).

## STATE GOVERNMENT

In the State of California, the creation of a teaching program at the CHC is a triggering event for the CHC Prospective Payment System (PPS) rate, which might be a help to the CHC. California State Plan Amendment (SPA) 18-0032, which was approved by CMS on September 21, 2018, authorizes reimbursement under the PPS methodology for services performed by qualifying Teaching Health Center Graduate Medical Education primary care resident physicians at participating Federally Qualified Health Centers and Rural Health Clinics. The THCGME program is required to be accredited by ACGME and be sponsored by the HRSA THCGME Program or state funds. The effective date of this SPA is April 1, 2018. For more information, visit [www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA18-0032ApvPkg.pdf](http://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA18-0032ApvPkg.pdf).

The Song-Brown Act was passed by the state of California in September, 1973. Funding is administered by the California Office of Statewide Health Planning and Development and is awarded by the Song-Brown Workforce Commission. The Song-Brown Program funds institutions that train primary care health professionals (physicians, nurse practitioners, physician assistants, and registered nurses) to provide health care in California's medically underserved areas. More specifically, they fund programs that attract and admit under-represented minorities, train residents in underserved areas, and place graduates in underserved areas. Recent and successful coalition efforts led by CaliforniaHealth+ Advocates, the California Academy of Family Physicians, California Medical Association, California Hospital Association, American College of Physicians, California Children's Hospital Association, Osteopathic Physicians and Surgeons of California, and Planned Parenthood allocated \$100 million in state funds for primary care physician training over three years starting in fiscal year 2017. For additional information, visit <https://oshpd.ca.gov/loans-scholarships-grants/grants/song-brown/>.

In 2016, the California Medical Association, California Hospital Association, and Service International Employees Union-United Healthcare Workers West sponsored Proposition 56. Proposition 56 was approved by voters and allocated \$40 million of funding towards GME to sustain, retain, and expand California residency positions in primary care and emergency medicine. The University of California is the designated recipient of the funding and contracted with Physicians for a Healthy California (PHC) to administer in January 2019 approximately \$40 million in grants allocated from Proposition 56 through the CalMedForce Program. Eligible residency programs include ACGME-accredited residency programs that may want to apply for support of either expanded and/or existing residency positions in California. Funding is specifically available for family medicine, internal medicine, obstetrics/gynecology, pediatrics, and emergency medicine residency programs that serve medically underserved populations and areas. For more information, visit [www.phcdocs.org/Programs/CalMedForce](http://www.phcdocs.org/Programs/CalMedForce).

## HEALTH INSURANCE COMPANIES

In recent years, some Medi-Cal managed care organizations in the state have made significant investments in the planning and/or ongoing operations of primary care residency programs. Any organization considering a new program and any organization that is facing operational deficits should meet with their local initiative representatives to determine if there is financial support available. Lead time of at least six months needs to be given from the time of the initial ask to a possible decision.

## PRIVATE FUNDERS

While rare, some organizations have received support from private funders to start their residency program development. CHCs often seek these opportunities in their local area, which vary depending on each region's priorities.

# Graduate Medical Education in Community Health Centers

## COMMUNITY HEALTH CENTERS ACTIVELY ENGAGED IN RESIDENCY TRAINING

The HRSA THCGME Program paved the way for a new model of training physician residents. Traditional residency programs are based in hospitals and the THCGME Program focuses its education in community-based ambulatory patient care settings such as Federally Qualified Health Centers. This program was born out of the Affordable Care Act and seeks to improve the distribution of the primary care workforce and increase access to quality care for underserved communities and population (Health Resources and Services Administration, 2018). California is fortunate to have eight THCGME programs across six program sites that are providing training to over one hundred residents (Coffman, Fix, & Himmerick, *Preparing Physicians to Care for Underserved Patients: A Look at California's Teaching Health Centers*, 2016). More CHCs are working towards this model and striving to achieve ACGME accreditation as a result of newly available state funds.

While there is increasing momentum for CHCs to become a Sponsoring Institution, a significant number of CHCs also function as a primary care continuity clinic or rotation site for a residency program in a hospital or academic institution. CHCs are ideal training sites for residents, especially those dedicated to serving underserved communities and disadvantaged areas of the state. They provide valuable training opportunities that both expose residents to community-based primary care and population health management, but also increase the likelihood of fully licensed providers staying in that community to serve.

## WHY COMMUNITY HEALTH CENTERS START A RESIDENCY PROGRAM OR PARTNERSHIP

- Positive learning environment
- Thriving social mission to the underserved
- Vibrant local primary care workforce
- Improved recruitment and retention efforts
- Provider satisfaction
- Community development
- Health care innovation
- Increased access to quality healthcare
- Strong local partnerships

CPCA commissioned a report, *Current State of California Health Center Residency Programs*, alongside Schoen Consulting between June 2017 and February 2018 to expand the existing knowledge set of current residency programs and partnerships in California's health centers. Through a total of 35 interviews with California health center and consortium staff, CPCA found that CHCs engage in residency training because it helps foster the benefits outlined above.

**Specialties Commonly Trained in CHC Residency Programs:  
Family Medicine, Internal Medicine, Pediatrics, and Psychiatry.**

# Community Health Center Residency Models

## COMMUNITY HEALTH CENTER AS A

### **Sponsoring Institution**

CHCs that operate as a Sponsoring Institution have the ultimate responsibility for the academic and financial integrity of the residency training program(s). In order to implement this model, a CHC must seek and obtain both sponsoring institution and specialty accreditation by ACGME to operate a residency program, a process which can take approximately one to two years.

## COMMUNITY HEALTH CENTER AS A

### **Consortium Partner**

Some CHCs that have a HRSA THCGME grant also collaborate as a consortium partner alongside two or more organizations, hospitals, or institutions that have come together to pursue common goals objectives in graduate medical education. In this model of residency training, the consortium seeks sponsoring institution and specialty accreditation. As a result, the consortium provides a neutral ground for joint decision making and has bylaws and agreements that protect each entity. The consortium and affiliated organizations have a collective responsibility to meet ACGME training requirements and remain in compliance.

## COMMUNITY HEALTH CENTER AS A

### **Continuity Clinic**

CHCs that function as a continuity clinic serve as a facility designated for clinical instruction and work with residents to provide continuous patient care through longitudinal relationships. In this model of residency training, residents spend a portion of their time in a CHC, but are based in a residency program within a university or hospital.

## COMMUNITY HEALTH CENTER AS A

### **Rotation Site**

CHCs provides episodic educational training over a limited period of time (usually 4-6 weeks) that may occur one or more times during a resident's entire training. The residents are based out of a residency program within a university or hospital.

## Varying Responsibilities and Requirements

Each model of residency training requires varying levels of responsibilities, resources, and ownership on behalf of the CHC. The most ownership and control lies in operating a sponsoring institution compared to a continuity clinic. Prior to engaging in one of these models, it is critical that the CHC evaluate its internal capacity and resources to successfully implement a residency program or partnership. The information that follows is intended to provide CHCs a general sense of some of the core components of residency training under the four different models. Due to similarity in requirements and administration, the continuity clinic and rotation site models were incorporated together in the descriptions below.



# Residency Model Comparison

CATEGORY	CHC AS SPONSORING INSTITUTION	CHC AS CONSORTIUM PARTNER	CHC AS CONTINUITY SITE OR ROTATION SITE
Business Model	CHC owns and operates residency program	CHC is core partner with shared responsibility for consortium	CHC is a training site with no ownership of the residency program
Leadership Buy-In	CHC Board and leadership approve residency relationship and financial impact	CHC Board and leadership approve residency relationship and financial impact	CHC Board and/or leadership approve residency relationship and financial impact
Partner Establishment	CHC is required to directly form training partnerships to meet all ACGME requirements	CHC works alongside other consortium members to secure additional partners	CHC is not required to secure in-patient training sites and is only responsible for meeting ACGME requirements as a continuity clinic
Program Personnel	CHC needs to recruit a Program Director, Coordinator, Core Faculty, residents, etc.	Consortium hires residency program personnel, CHC assigns staff time to training and administration of program	CHC medical director serves as liaison, providers serve as core faculty
Residents	CHC is responsible for recruiting, interviewing, selecting, and onboarding residents	CHC supports consortium efforts in recruiting, interviewing, selecting, and onboarding residents	CHCs may, but often have no role in recruiting, interviewing, selecting, and onboarding residents
Operations	CHC is responsible for establishment of several committees that oversee the operations and decisions of the residency program	CHC participates in committees that oversee the operations and decisions of the residency program	CHC may, but often do not, participate in committees
Financial Resources	CHC directly pursues funding opportunities through the federal and state funding, community benefit grants, etc. to support the cost of training a resident	All consortium partners contribute to residency expenses and consortium pursues local, state, and federal funding	CHC seeks financial support from residency program and community benefit grants to be kept whole
Capitol Construction and Equipment	CHC may build or lease a new infrastructure to accommodate residents or set aside existing space for the residency program in order to meet any ACGME specialty requirements	CHC may either fit residents into existing building structure or build or lease a new structure to accommodate residents	CHC may either fit residents into existing building structure or build or lease a new structure to accommodate residents
Policies and Procedures	CHC is responsible for developing Sponsoring Institution and specialty program policies and procedures that are required by ACGME	Consortium develops policies and procedures of its own, as required by ACGME	Policies and procedures must be reviewed to make sure that CHC policies and program policies are synergistic
Curriculum	CHC must develop a curriculum that remains in compliance with all institutional, common, and specialty requirements	CHC works with the consortium to develop curriculum that meets ACGME requirements	CHC implements curriculum developed by the residency program and assist in evaluation of resident for the CHC specific rotations
Legal	CHC legal counsel reviews all policies, procedures, and agreements that are created for the residency program	Consortium legal counsel is responsible for reviewing all related documentation of the residency program	CHC legal counsel may review edits to existing policies that are in place at the CHC
Community Engagement	CHC is directly responsible for immersing residents in the community	CHC shares responsibility with consortium to engage residents in the community	CHC supports community exposure through involvement in local projects, as approved by the Program Director and incorporated into the formal curriculum
Retention Strategy	Residents have greatest exposure to the CHC therefore, may experience greater retention	CHC must find ways to continuously engage residents that are located in different settings to retain them	CHC must find ways to continuously engage residents that are based out of an academic institution or hospital to retain them

## COMMUNITY HEALTH CENTER AS A Sponsoring Institution

CHCs that operate as a Sponsoring Institution are responsible for maintaining the academic and financial integrity of the residency program by securing partnerships with in-patient facilities and maintaining the academic infrastructure. While this can be the most challenging residency model to implement, it provides the greatest opportunity for retention, particularly of residents committed to serving underserved communities. It also allows the CHC to retain the greatest level of control and decision-making power compared to all other residency training models.

### BUSINESS MODEL

The CHC owns and is fully responsible for the operations of the Sponsoring Institution, which must be in compliance with ACGME institutional requirements. In addition, the CHC is responsible for ensuring that their residency program is in compliance with the ACGME common and specialty-specific program requirements. This requires full investment of financial, clinical, educational, and human resources, which is recommitted every five years through a written statement by the Designated Institutional Officer, a representative of the Sponsoring Institution's senior administration, and a representative of the Governing Body.

### LEADERSHIP BUY-IN

Given the complexity and significant investment that is needed to establish an ACGME-accredited residency program, it is critical that CHC leadership be fully devoted to this process. This requires buy-in not only from organizational leadership, but also from the CHC Board of Directors. The Chief Executive Officer, Chief Medical Officer, Chief Financial Officer, HR Director, and Quality Director of the CHC are critical players in moving the preparation and implementation work forward. However, the Board also needs detailed information on desired goals, organizational capacity, and financial investment needed to carry out this accreditation process. With the support of their Board, some health centers have chosen to add the development of a new residency program in their CHC's strategic plan. This has been done to ensure that all levels of the CHC leadership and staff support this project and are held accountable to implement the residency program in the appropriate timeline.



#### Tips

- Engage your board early in the process of exploring this potential.
- When informing their Board about the opportunities available in developing a residency program, other CHCs have found it beneficial to explain their CHC's successes to-date in training healthcare professionals, the impact training has on CHC culture and patient access, and the benefits of potentially enhanced provider recruitment and retention.
- In attempt to provide just the right information and not overwhelm their Board, some CHCs have shared some of the fundamental information needed to understand the requirements and nuances of Graduate Medical Education (e.g., phases of ACGME accreditation, required partnerships, etc.).
- Consider providing a training session for your board on GME and their role.
- Incorporate your medical staff into the pitch for a residency program.

## SPONSORING INSTITUTION

### PARTNER ESTABLISHMENT

Sponsoring institutions are required to meet all institutional, common, and program requirements set forth by ACGME. These requirements involve teaching within an in-patient setting to learn procedures that are not performed in a community health center outpatient setting. In addition, scholarly activities are required separate from clinical training. As a result, health centers that function as sponsoring institutions are directly responsible for securing strategic partnerships with hospitals, academic institutions, and other participating sites via official program letters of agreement (PLA). The program must monitor the clinical learning and working environment at all participating sites.



#### Tips

- Start looking for your partners early as possible and leverage any existing relationships you may have with academic institutions and hospitals.
- When searching for training partners, evaluate if their patient volume is sufficient to meet ACGME training requirements, but also make sure there exists alignment between each organization's missions, values, and goals.
- Trust in each organization's staff, work, and problem solving strategies is a critical component of developing GME relationships.
- Depending on the training capacity of each partner, it is possible that you may only need one or several training partners to meet all ACGME requirements.
- All training partners should be clear on what they can and cannot offer to the residency program.

### PROGRAM PERSONNEL

CHCs that serve as a Sponsoring Institution must ensure that the Designated Institutional Officer, Program Director, Core Faculty, and Program Coordinator have the sufficient financial and protected time to effectively carry out his or her educational, administrative, and leadership responsibilities. In addition, they must engage in professional development applicable to his or her responsibilities as an educational leader and have the sufficient salary support and resources for effective GME administration. Some of the key personnel that are required to operate a residency program through the CHC's Sponsoring Institution include:

#### **DESIGNATED INSTITUTIONAL OFFICER (DIO)**

The individual in a Sponsoring Institution who has the authority and responsibility for all of that institution's ACGME-accredited programs.

#### **PROGRAM DIRECTOR (PD)**

The individual designated with authority and accountability for the operation of a residency program. The Program Director is responsible for developing, overseeing, and improving residency or fellowship programs, implementing changes based on the current accreditation requirements, and preparing for accreditation site visits and review by the ACGME Review Committees.

#### **PROGRAM COORDINATOR**

The individual who assists the Program Director and performs managerial duties related to planning, directing, and coordinating academic and operational activities of the program.

#### **FACULTY**

The group of individuals (both physician and non-physician) assigned to teach and supervise residents/fellows.

## SPONSORING INSTITUTION

### CORE FACULTY

All physician faculty members in a specialty program who have who have documented qualifications to instruct and supervise. All core faculty members evaluate the competency domains; work closely with and support the program director; assist in developing and implementing evaluation systems; and teach and advise residents. The number of core faculty and the required FTE time that is needed for a residency program varies per specialty.



#### Tips

- Securing ACGME accreditation is a team effort, and the Program Director will play a critical role in leading all efforts to move this work forward and let CHC leadership know when issues arise.
- Carve out and protect provider time to teach residents.
- It is important to create a positive learning environment and training culture amongst faculty and residents, but also among all CHC staff who may come into contact with the residency program (e.g., support staff, administrative staff, etc.). Residents will interact with all levels of CHC staff during the course of their residency program.
- Find ways to connect training providers across all training sites and organizations. One CHC shared that they frequently bring hospital faculty to the CHC to conduct collective orientations and trainings that enhance team dynamics and build strong relationships that support innovative ideas and strategic solutions.

### RESIDENTS

CHCs who operate as a Sponsoring Institution are directly responsible for recruiting, interviewing, selecting, and onboarding residents every year. While this requires a significant time investment due to participation in the National Resident Matching Program, there is a significant reward in being able to set criteria and make decisions based on residents' fit with the organization. In this model, CHCs have a direct role in setting resident criteria that matches the needs of their organization and community. In addition, they play a key role in making the final decision on resident selection. While there is significant benefit in choosing residents under this model, CHCs who are Sponsoring Institutions are responsible for developing a positive learning experience, ensuring resident wellness, and mitigating resident fatigue.



#### Tip

- Select specific criteria and a point structure that rewards candidates that fit your regional, local, and organizational needs.

### OPERATIONS

The Sponsoring Institution is responsible for oversight and documentation of resident engagement in: patient safety, quality improvement, transitions of care, supervision and accountability, clinical experience and education, professionalism, and well-being. This is often completed through different committees and policies that are established by the Sponsoring Institution.

### GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)

Required to meet once per quarter to 1) provide oversight of institutional and program accreditation and 2) review and approval of various actions. Oversight includes routine monitoring of program and institutional accreditation as well as the formalized Annual Institutional Review (AIR) and special review processes.

## SPONSORING INSTITUTION

### **CLINICAL COMPETENCY COMMITTEE (CCC)**

A required body within a specialty program comprising three or more members of the active teaching faculty that is advisory to the program director and reviews the progress of all residents or fellows in the program. The CCC is required to meet at least twice a year.

### **CLINICAL LEARNING ENVIRONMENT REVIEW (CLER)**

**Program:** An ACGME program designed to provide US teaching hospitals, medical centers, health systems, and other clinical settings affiliated with ACGME-accredited Sponsoring Institutions with periodic feedback in Focus Areas specific to the safety of the clinical learning environment. A Sponsoring Institution will establish a CLER sub-committee in order to prepare for its CLER visit.

### **PROGRAM EVALUATION COMMITTEE (PEC)**

Conduct and document the Annual Program Evaluation as part of the specialty program's continuous improvement process; must be comprised of at least two program faculty members, at least one whom is a core faculty member and one resident who is selected by his/her peers.



#### **Tip**

- Include faculty from partnering hospitals and universities in GMEC

## FINANCIAL RESOURCES

A report titled *The Cost of Residency Training in Teaching Health Centers* demonstrates that the median cost of training a resident in a Teaching Health Center in fiscal year 2017 was \$157,602 (Regenstein, Nocella, Jewers, & Mullan, 2016). These costs are associated with resident salaries and benefits, faculty and other staff compensation, educational expenses (including administration and overhead), supplies, information technology infrastructure, malpractice insurance, licensing fees, occupancy costs, and clinical expenses incurred to operate a residency in an ambulatory clinic setting. This significant investment can be offset through a combination of clinical revenues from patient visits, state grants available through the Song-Brown and CalMedForce Programs, philanthropic grants, PPS rate changes, and other federal and state funding opportunities. Residency programs should not count on resident productivity alone to sustain the residency program.



#### **Tips**

- Health plans and foundations may be able to match funds or offer a grant to offset GME cost.
- Secure long-term funds to develop and sustain the residency program for five years.
- Pay close attention to deadlines to ensure that your organization is taking advantage of all federal and state funding available.

## SPONSORING INSTITUTION

### CAPITAL CONSTRUCTION AND EQUIPMENT

Sufficient physical space must be available to meet ACGME requirements for resident examination rooms, preceptor rooms, work stations, Program Director and Coordinator offices, or any other required space. In order to be in ACGME compliance, the Sponsoring Institution must also ensure safe sleeping facilities and safe transportation options for residents while they are working and training. In addition, the Sponsoring Institution must offer clean and private facilities for lactation. Some CHCs have reorganized their clinic space or leased a building in order to accommodate these requirements, but others have also built new space, therefore, requiring a significant additional financial investment for the residency program. Sponsoring institutions are also required to provide faculty and resident access to educational tools such as medical literature, adequate communication resources, and technological support. Some health centers have entered into a financial arrangement to share these resources with a nearby hospital or academic institution.



#### Tips

- Begin your space planning early. Sleeping facilities are provided by the hospitals where the residents rotate.
- Food, call rooms, lactation rooms, etc. should all be part of your legal agreement with the hospitals.

### POLICIES AND PROCEDURES

The Sponsoring Institution must develop written policies and procedures for resident recruitment; agreement of appointment/contract; promotion, appointment renewal and dismissal; grievances; professional liability insurance; health and disability insurance; vacation and leaves of absence; resident services; supervision; clinical and educational work hours; vendors; written and electronic communications; non-competition; disasters; impaired physicians; and closures and reductions, amongst others.



#### Tips

- Allow for sufficient time (i.e. six months) to write the policies and procedures. Each of these policies must be approved by your GMEC prior to submission of your Sponsoring Institution application. Other CHCs have noted that this process takes a significant investment in time and human capital to complete.
- Reach out to your partners to share templates and ideas for policies and procedures. Try not to recreate the wheel.

## SPONSORING INSTITUTION

### CURRICULUM

The curriculum developed by a residency program must contain: a set of program aims consistent with Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; competency-based goals and objectives for each educational experience; delineation of responsibilities for patient care; broad range of structured didactic activities; and advancement of residents' knowledge of ethical principles and principles of scientific inquiry.

Both common program requirements and specialty requirements must be implemented into a residency program's curriculum. As a resident progresses throughout their residency program, the following competencies are assessed by faculty and reported back to ACGME:

#### **PROFESSIONALISM**

Commitment to professionalism and an adherence to ethical principles.

#### **PATIENT CARE AND PROCEDURAL SKILLS**

Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health; perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

#### **MEDICAL KNOWLEDGE**

Demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge of patient care.

#### **PRACTICE-BASED LEARNING AND IMPROVEMENT**

Investigate and evaluate their care to patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

#### **INTERPERSONAL AND COMMUNICATION SKILLS**

Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

#### **SYSTEMS-BASED PRACTICE**

Awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.



#### **Tip**

- CHCs have a unique richness in their patients, outreach opportunities, and mission. Make sure to incorporate that richness into your curriculum. Your goals and objectives are the foundation of your curriculum.

## SPONSORING INSTITUTION

### LEGAL

The CHC Sponsoring Institution's GMEC is required to directly oversee ACGME compliance and submit all appropriate documentation. The DIO and the GMEC will need the CHC's legal team involved as necessary to review all agreements, policies, and procedures that are created for the residency program.



#### Tips

- Securing the appropriate malpractice insurance can be challenging, so ensure that there are sufficient resources to covering this cost. Your organization may need to purchase additional policies to wrap around residents and teaching faculty that may see patients not associated with the CHC and outside of CHC facilities.
- Build in sufficient time into your overall timeline to ensure that legal counsel has time to review all necessary components of the application and implementation process.
- You must submit all of your PLAs with your specialty application. These do not address business points such as payments. Business points are addressed in Affiliation Agreements, Professional Services Agreements, and Community Benefit Grants. Make sure all of these are executed before interviewing residents as once you submit your rank list, it is binding.

### COMMUNITY ENGAGEMENT

Research shows that 70 percent of residents tend to stay in the areas in which they practice (Dill, Jones, & Fisher, 2017). For this reason, CHCs have made significant efforts to ensure that their residents feel welcomed into the community and engaged throughout their training. This is done with the intention of fostering resident interest in the community such that it would promote provider retention with the CHC.



#### Tips

- Some CHCs host a community welcome and graduation ceremony to celebrate each class of residents.
- Some CHCs find ways to organize public health activities amongst different organizations in the community (i.e. public health department).
- Family Medicine has a required Community Medicine rotation. Use this time to both address ACGME requirements and involve the residents in meaningful and robust community based training opportunities.

## SPONSORING INSTITUTION

### RETENTION STRATEGY

CHCs engage in residency training to “grow their own”. It is important to foster a positive working environment during training and engage with them frequently to promote their interest in working in a CHC, underserved area, and for an underserved population long-term. It is recommended that the leadership of your organization get to know the residents throughout the entire length of their training, not upon graduation.



#### Tips

- One health center has actively sought ways to offer innovative, out of the box strategies that promote resident retention. For example, this health center hires a financial consultant for residents to utilize and plan their finances so that they can pay off their medical education debt.
- Help the residents and their significant others develop ties to your community through local groups or opportunities.
- Support pipeline development efforts in your community. Students who are from your local community and are able to train in that area are more likely to stay.
- Don't start a residency program unless you know your plan for retaining the residents. With the physician shortage, many residents receive job offers during their second year of residency. They will be quickly snapped up – so have a plan before you start.

## COMMUNITY HEALTH CENTER AS A Consortium Partner

This model of residency training is built on the idea that the whole is greater than the sum of its parts. While it can be a vehicle for THCGME funding, it puts the Program Director and/or DIO in a situation of reporting to a board of individuals from different organizations, which can pose significant challenges. All organizations have a lifecycle, and consortiums if developed as a brand new entity, will move through these lifecycles in a sometimes chaotic manner. This can make it challenging for the residency program to survive and thrive. Conversely, because the consortium draws from different sources for financial support, a residency program is not at significant risk of shutting down when one major source of funding can no longer sustain it.

### BUSINESS MODEL

The consortium is the Sponsoring Institution and as such owns and operates its residency programs. Given the number of different organizations involved to form this consortium, a master affiliation agreement must be established amongst all parties. In addition, program letters of agreement must be created with all training sites and a professional services agreement must be developed with the participating CHC for the positions the CHC is employing.



#### Tip

- It rarely makes financial sense to form a consortium to begin only one residency program. If you do so, know that you are doing it for reasons other than financial.

### LEADERSHIP BUY-IN

CHC organizational leadership and Board of Directors must be committed to fully carrying out the responsibilities of the consortium alongside the partners involved. While in this model the CHC is not the sole organization responsible for carrying out ACGME requirements, it is equally accountable as the other organizations involved to make sure that the Sponsoring Institution and residency program remain in compliance. As a result, the financial investments and risks incurred are shared.



#### Tip

- Never stop talking to your Board about workforce development and consider adding it to your strategic plan to enhance conversations about training in the CHC.

## CONSORTIUM PARTNER

### PARTNER ESTABLISHMENT

CHCs in this model of residency training often serve as a main ambulatory training site for residents. If not already in place, the consortium must seek inpatient training partners to collaborate and/or join the consortium. Any affiliated CHC who is a member must therefore partake in the establishment, or at least ultimately approve new training partnerships as needed alongside the consortium.



#### Tip

- Work closely with the Program Director to develop partnerships to meet the academic needs of the program.

### PROGRAM PERSONNEL

The Consortium is responsible for either hiring or contracting for the program personnel. Often the consortium will contract with the CHC, with the CHC then responsible for hiring the Program Director and Core Faculty. The CHC might even employ the residents and the Program Coordinator; but all of this is part of the negotiations. Since California has Corporate Practice of Medicine laws, lay entities cannot be the employer for the clinical time, which includes precepting time, of the clinical staff. This is why the CHC often employs residency faculty; however, other medical entities that are consortium members may be the residency faculty employer, and provide contracted faculty physician time to the CHC. The CHC is not the sole entity responsible for securing the appropriate number and type of faculty as the CHC will not be employing the sub-specialty faculty that also teach the residents, such as surgeons, cardiologists, orthopedists and others. The consortium as a whole carries the responsibility of ensuring that the right program personnel are available and trained to carry out all the responsibilities of a residency program. The consortium is also responsible for offering professional development opportunities for all faculty.



#### Tip

- There are many issues to consider from the legal, business, and academic perspectives when starting a consortium and developing the contractual relationships. Work with individual lawyers and consultants who have the knowledge, experience and track record developing these relationships.

## CONSORTIUM PARTNER

### RESIDENTS

CHCs that function as a consortium partner have a shared commitment and ability to influence the criteria and resident selection process. While the consortium is the entity that officially engages in the National Physician Match Program, the CHC maintains a shared decision-making ability, granted through the by-laws of the consortium and the definitive legal agreements, to select the profile of residents that best fit the needs of a respective community and consortium partners involved.



#### Tips

- Make sure to negotiate the CHC role in both interviewing and ranking the residents.
- Establish a weighting of the selection metrics that rewards those that are a fit with your mission and with your retention goals.

### OPERATIONS

Any consortium that is a Sponsoring Institution is accountable for implementing and supporting the series of different committees and sub-committees that are needed to meet and maintain ACGME accreditation and ensure resident success. As a result, the CHC should be engaged in a combination of committees, which include the Graduate Medical Education Committee, the Sub-committee for Internal Review, the Special Review Sub-committee, the Clinical Competency Committee, and the Program Evaluation Committee.



#### Tips

- Always refer to the ACGME Sponsoring Institution, Common, and Specialty requirements regarding which people are required to be on a given committee or sub-committee.
- Codify the CHC role in each in your consortium by-laws or definitive agreements.
- Show up! If you have a role on a committee or sub-committee, your participation is vital.
- Educate yourself – attend the ACGME annual meeting and/or other meetings that provide education on GME requirements and operations.

### FINANCIAL RESOURCES

A consortium has administrative expenses separate from each member organization. Additionally, a consortium often does not have an existing fund balance to pay for any operating deficits or fund cash flow. Consortium members must negotiate how the aforementioned expenses will be funded to insure the consortium is fiscally viable. The CHC may make a portion of the financial investment that is needed, depending on the negotiations and the by-laws of the consortium. There is no “typical” amount of investment.



#### Tips

- Develop a minimum five year consortium operating budget and manage that budget monthly.
- Create a consortium fund balance to protect from cash flow issues.
- Some organizations establish a zero interest line of credit for the consortium to assist with cash flow. Negotiate and memorialize in your operating agreement with the consortium the exact investment of each consortium member.

## CONSORTIUM PARTNER

### CAPITAL CONSTRUCTION AND EQUIPMENT

As the continuity clinic site, the CHC must meet ACGME requirements for the specialty. This is quite extensive in Family Medicine. Any capital construction must be identified early on, both for purposes of the ACGME Family Medicine application and for budget and timing purposes. Once identified, the costs of the capital construction and equipment are discussed at the consortium board level and a plan developed as to how this is funding. Sometimes the funding is from the CHC, sometimes from the consortium members, and sometimes from foundation or federal funding.



#### Tips

- Work closely with your Program Director on the requisite capital needs. Categorize expenses by “Should have” and “Must have”. Sub-categorize by clinical or educational.
- The CHC should only pay for that which is revenue producing for the clinic. Anything that is an additional educational cost is typically part of the residency budget.

### POLICIES AND PROCEDURES

The Consortium must develop and approve a variety of required Sponsoring Institution and Specialty policies and procedures. As members of the consortium and as a requirement of the Program Letter of Agreement between the consortium and the CHC as a major teaching site, the CHC will need to integrate the Consortium policies and procedures with their own. This does not imply that the CHC must replace some of their existing policies with the Consortium’s, but instead that the CHC must review all policies, add those that are new, and make changes where policies are not in synchrony. Since there are multiple entities involved in the consortium, this process will take significant time.



#### Tips

- Start early. Some of the policies will be different from what a CHC is used to. Others will require a fair amount of internal discussion.
- If the CHC employs the residents or faculty, there will be requirements that are different from what the CHC is accustomed to. If so, bring HR, Compliance, and Legal into the process early.

## CONSORTIUM PARTNER

### CURRICULUM

The Sponsoring Institution holds the ultimate authority for the academic integrity of its residency programs. To the extent that the CHC holds seats on the board of the consortium, it shares the responsibility for creating all didactic training and educational activities to ensure that physician residents are meeting the educational competencies. The CHC plays a critical role offering feedback to the consortium partners to ensure that the needs of the CHC -- and advantages of the CHC for quality care of underserved patients -- are well represented and addressed in the potential development and implementation of a new residency program



#### Tip

- Maximize the curriculum at the CHC, to the extent allowable within the ACGME Common and Specialty Requirements. CHCs are a rich curricular resource with their community health, outreach, patient acuity, and other characteristics.

### LEGAL

The consortium will need to hire legal counsel directly for all matters and documents related to the consortium's articles of incorporation, by-laws, and affiliation agreement between the consortium parties. The CHC will need to have its own legal counsel to review these documents.



#### Tip

- Although you will want one attorney to be the drafting attorney, you will also want the attorneys involved early in order to minimize surprises or changes. There are many aspects to consider in these agreements. Spend time as a group to work out the business points of the relationship, including a plan for wind-down should the parties separate or the program terminate.

### COMMUNITY ENGAGEMENT

The consortium is made up of a number of different community partners that collectively work to find ways to engage residents in the larger community. The consortium can choose to take the lead in developing opportunities for residents to engage in the community utilizing the opportunities of all partners. All residents must satisfy scholarly activity requirements. Strong community relationships will facilitate research by the residents in issues such as social determinants of health.



#### Tip

- Consider having a community engagement sub-committee of your consortium, comprised of community leaders.

## CONSORTIUM PARTNER

### RETENTION STRATEGY

One issue that almost always come up in a consortium model is “who will get the residents”. There is never any guarantee that any one entity will retain the residents. All participants must be aware and comfortable with the fact that they will be investing in the consortium and residency program and yet may never retain a resident at their own institution. Instead, they must be ok with a return on investment of providers for the entire community.



#### Tip

- Have frank and upfront conversations about expectations and return on investment.

## COMMUNITY HEALTH CENTER AS A

# Continuity Clinic or Rotation Site

## BUSINESS MODEL

CHCs who function as a continuity clinic site for a residency program do not own or directly operate the residency program. The CHC is a participating institution and operates under PLA with the residency program hosted by a hospital or academic program. The PLA details the rotation(s) at the CHC, the goals and objectives of the rotation(s), the faculty involved, who the site director will be, when the rotations will occur, the policies that the CHC must adhere to, and the responsibility of the CHC for resident well-being, quality and patient safety.

## LEADERSHIP BUY-IN

CHCs that have operated as a continuity clinic or rotation site have taken differing approaches when it comes to securing CHC Board approval. Some CHCs made the decision to participate in residency training through the approval of the CHC's internal leadership (e.g., Chief Executive Officer, Chief Medical Officer, Human Resources Director). Other CHCs have taken this decision to their Board for final approval recognizing the financial and staff investments that are needed to host residency training on-site.



### Tips

- Evaluate your organization's capacity and create a strategic plan and budget request before making an official ask to the CHC Board.
- Never stop talking to your Board about workforce development and consider adding it to your strategic plan to enhance conversations about training residents in the CHC.
- Demonstrate to your Board the success that other CHCs or organizations have had in training residents in the CHC (i.e. retention, provider satisfaction, etc.).
- Once you obtain the required approvals to move this work forward, start to build a culture of training within the organization.

## PARTNER ESTABLISHMENT

CHCs that partner with a residency program are not directly responsible for ensuring that the appropriate training partnerships are in place to meet ACGME requirements. Instead, these requirements are placed directly on the Sponsoring Institution and residency program.



### Tips

- If a hospital or academic institution reaches out to your CHC for the potential of training residents in your continuity clinic, look for ways to incorporate unique aspects of your health care delivery into the training. For example, find ways to engage residents in delivering quality care through mobile vans, or school-based health centers.
- Set up frequent meetings in advance with the residency program staff to build these critical relationships and ensure that there is time dedicated to improving operations and clinical training at the CHC.

## CONTINUITY CLINIC OR ROTATION SITE

### PROGRAM PERSONNEL

At each participating site there must be one site member, designated by the Program Director as the site director, who is accountable for resident education at that site. Faculty employed by an academic institution may precept and practice at the CHC and/or CHC providers may receive volunteer appointments by the academic institution. Should the faculty come from an organization other than the CHC, a Professional Services Agreement (“PSA”) will be required. CHCs that engage in residency training as a continuity site also need to allocate administrative responsibilities for managing resident and faculty schedules, and tracking, data collection to an existing or new staff member.



#### Tips

- Find CHC faculty who are committed and interested in teaching. This can serve as a retention strategy for those providers who are looking to engage in activities beyond clinical care.
- Protect the portion of time that CHC physicians use to train residents.
- Meet with leadership of residency program several times a year to ensure that there is a constant exchange of updated information and issues are being resolved as necessary in order to meet ACGME compliance.
- Partner with the hospital or academic institution to offer professional development learning opportunities to the CHC providers that engage in the residency program as teaching faculty.

### RESIDENTS

Depending on the relationship a CHC has with a residency program, CHCs may or may not have the ability to influence the type of residents recruited by a residency program. In most cases, CHCs do not have a direct role in setting criteria, interviewing, and selecting the residents desired for a CHC’s workforce needs. Given this, most CHCs in this model accept the residents chosen by the hospital and/or academic institution, who may or may not share the mission of a CHC to serve the underserved.



#### Tips

- An important negotiation point for the CHC is to have the right to participate in resident interviews and ranking meetings.
- Make sure to weigh in on the resident selection criteria and how those criteria are weighted. There are many aspects, such as whether an individual has a demonstrated commitment to your community or population that can be added and weighted heavily.

### OPERATIONS

CHCs are not directly responsible for organizing any committees to meet ACGME accreditation standards. Instead, CHCs may be invited to take part in these committees to inform the development of procedures and overall training.



#### Tip

- Be involved. And, negotiate payment, if possible, for your involvement.

## CONTINUITY CLINIC OR ROTATION SITE

### FINANCIAL RESOURCES

It is a common belief that CHCs lose money by being a continuity clinic for a residency program. This belief is not universally true as it depends on the average reimbursement of the CHC continuity site, the cost of the faculty, and other variables. It is important to develop a detailed financial model that compares your clinic site before the program and after the program in order to identify the financial impact, either positive or negative, of the residency program. In the State of California, the creation of a teaching program at the CHC is a triggering event for the CHC PPS rate, which might be a help to the CHC. Many CHCs negotiate a Community Benefit Grant from the hospital partner to offset the losses associated with the expansion of services to the uninsured and underinsured due to the presence of the residency program.



#### Tip

- Speak directly of your financial needs at the beginning of the planning and negotiation process.

### CAPITAL CONSTRUCTION AND EQUIPMENT

As the continuity clinic site, the CHC must meet ACGME requirements for the specialty. This is quite extensive in Family Medicine. Any capital construction must be identified early on, both for purposes of the ACGME Family Medicine application and for budget and timing purposes. Once identified, the costs of the capital construction and equipment are discussed at the consortium board level and a plan developed as to how this is funding. Sometimes the funding is from the CHC, sometimes the hospital, and sometimes from foundation or federal funding.



#### Tips

- Be clear, upfront, about your expectations for payment of capital expenses.
- Equipment purchases that generate clinical revenue should be paid by the CHC. Equipment purchases that are educational in nature and non-revenue generating should be paid by the residency program.

### POLICIES AND PROCEDURES

External residency programs often share their residency handbook with partnering CHCs that function as a continuity clinic or rotation site. Since it is the direct responsibility of the Sponsoring Institution to develop these policies and procedures, CHCs that work under this model do not have to deal with the direct burden of creating these documents for the residency program. However, it is recommended that CHCs be involved in the development policies that affect preceptor or resident engagement and training in the CHC. For example, some CHCs have found it helpful to work with the residency program to establish a policy for instances when in-patient preceptor responsibilities must be prioritized over the continuity clinic responsibilities. In these cases, a policy is needed to address the disruption that may result from a preceptor needing to be pulled away from the clinic and into the hospital setting.



#### Tip

- It may be helpful to review CHC internal policies and procedures and ensure that they align with the new responsibility of training residents. In the event there exists misalignment and the procedures noted in the policies of a CHC and a residency program compete (i.e. advance notice for vacations), the CHC and residency program should discuss and collaborate ways that the policies can align.

## CONTINUITY CLINIC OR ROTATION SITE

### CURRICULUM

Similar to the policies and procedures, CHCs do not have the direct responsibility for creating the curriculum of a residency program when they function as a training partner and not a Sponsoring Institution. Upon the establishment of this partnership, the external residency programs often share the developed curriculum with the CHC to lay out clear expectations and evaluation processes for implementing the established curriculum and testing resident knowledge.



#### Tip

- Share with your partners openly about the community based training opportunities.

### LEGAL

The following legal agreements are quite typical in relationships between a hospital and CHC:

- Program Letter of Agreement
- Master Affiliation Agreement
- Professional Services Agreement
- Lease Agreement
- Planning Grant
- Community Benefit Grant

*Not all of these agreements must occur, though some, such as the PLA, are required.*



#### Tip

- Only the PLAs must be completed by the time of submission of the specialty application. These agreements take significant time. They should be developed and executed prior to residents being interviewed.

### COMMUNITY ENGAGEMENT

CHCs may choose to find ways to involve the residents in community-based projects as a result of their training in a community-based ambulatory. In doing so, they can help promote resident retention in their larger community and potentially their own organization. It also provides robust opportunities for the residents when developing their research projects.



#### Tip

- Connect residents with community partners to promote engagement with the larger community.

### RETENTION STRATEGY

Because the CHC does not have day to day responsibility for the residency program, it is not able to directly impact the job decisions of the residents. However, because the residents spend a significant portion of their time training in a CHC, the CHC can still see good returns provided that they are 1) involved in interviewing and ranking residents with a commitment to the underserved and are committed to living in the region, 2) provide a quality training experience, 3) provide a clinic setting that is a pleasant and fulfilling place to work, and 4) engage in regular discussions with the residents about their future career goals..



#### Tips

- Invite residents to all CHC staff events in order to help them feel a part of the CHC family.
- To the extent possible, invite Resident representation through their Program Director to the various committees of the Health Center (e.g., CQI, Medical Informatics).

## Selecting A Model

### QUESTIONS TO SELECT A MODEL

- Why are you seeking to train physician residents? Do these goals balance the investment required to train residents in your organization?
- How much control or decision-making authority are you seeking to have and willing to give up?
- What financial resources are available to support the residency program or partnership?
- Do you have leadership and staff buy-in to develop, sustain, and/or expand your residency program or partnership?
- How much time are you and your staff willing to invest in training physician residents?
- Are you willing to develop the critical partnerships that are needed to carry out all aspects of a resident's training?
- What makes business sense to you?

### HOW NOT TO SELECT A MODEL

- Existing relationships
- Politics
- Promises

### WHAT TO WATCH OUT FOR

- Lack of transparency amongst residency training partners
- Absence of involvement in interview and ranking resident candidates
- Balance of control amongst all residency training partners
- Lack of partners' knowledge on HRSA's requirements

### HOW TO PREPARE

- Establish a multi-year budget (5 years plus start-up)
- Conduct an impact analysis
- Obtain a planning grant if available
- Evaluate payment of teaching costs
- Have available a line of credit

### IMPORTANT TO KNOW

- Your program or partnership evolves over time – what it looks like on day one is very different than what it will look like by year five
- It is critical to build a solid foundation
- Different organizations have different values, missions, and different facts
- It is important to discuss and memorialize all business and legal issues up front
- Have a pre-nuptial for right of first refusal and wind down plans, including 18 months for termination without cause.

## References

- Accreditation Council for Graduate Medical Education. (2018). *Accreditation*. Retrieved from Accreditation Council for Graduate Medical Education: [www.acgme.org/What-We-Do/Accreditation](http://www.acgme.org/What-We-Do/Accreditation)
- ACGME *Glossary of Terms*. (2018, May 8). Retrieved from Accreditation Council for Graduate Medical Education: [www.acgme.org/Portals/0/PDFs/ab\\_ACGMEglossary.pdf?ver=2018-05-14-095135-583](http://www.acgme.org/Portals/0/PDFs/ab_ACGMEglossary.pdf?ver=2018-05-14-095135-583)
- Andrew Bazemore, M. M., Peter Wingrove, B., Stephen Petterson, P., Lars Peterson, M. P., Melanie Raffoul, M., & Robert L. Phillips Jr., M. M. (2015). *Graduates of Teaching Health Centers Are More Likely to Enter Practice in the Primary Care Safety Net*. Washington: The Robert Graham Center.
- Coffman, J., Fix, M., & Himmerick, K. (2016). *Preparing Physicians to Care for Underserved Patients: A Look at California's Teaching Health Centers*. Sacramento: California Health Care Foundation.
- Coffman, J., Geyn, I., & Himmerick, K. (2017). *California's Primary Care Workforce: Supply, Characteristics and Pipeline of Trainees*. San Francisco: Healthforce Center at UCSF.
- Coffman, J., Geyn, I., & Spetz, J. (2017). *California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030*. San Francisco: Healthforce Center at UCSF.
- Dill, M., Jones, K., & Fisher, K. (2017). *2017 State Physician Workforce Data Report*. Washington, DC: Association of American Medical Colleges.
- Health Resources and Services Administration. (2018, May). *About HRSA*. Retrieved from Health Resources and Services Administration: [www.hrsa.gov/about/index.html](http://www.hrsa.gov/about/index.html)
- Health Resources and Services Administration. (2018, September). *Teaching Health Center Graduate Medical Education Program*. Retrieved from HRSA Health Workforce: <https://bhwh.hrsa.gov/grants/medicine/thcgme>
- Health Resources and Services Administration. (2019, February). *Bureaus & Offices*. Retrieved from Health Resources and Services Administration: [www.hrsa.gov/about/organization/bureaus/index.html](http://www.hrsa.gov/about/organization/bureaus/index.html)
- Henderson, T. M. (2016). *Medicaid Graduate Medical Education Payments: A 50-State Survey*. Washington, D.C.: Association of American Medical Colleges.
- Schoen, M. (2018). *Current State of California Health Center Residency Programs*. Sacramento: California Primary Care Association.

## **NOTICES AND DISCLAIMER**

The information in this resource is intended only to provide a general overview of the topics addressed. This publication is not intended to provide legal advice or to substitute for the guidance, counsel, or advice of a legal counsel on any matters particular to a specific primary care clinic.

No part of this publication may be reproduced, stored in a retrievable system, or transmitted in any form or by any means, electronic, mechanical, photocopying, and recording or otherwise without the prior written permission of California Primary Care Association. Reproduction prohibitions do not apply to the information and forms contained in this product when reproduced by a clinic for its own, non-commercial use.



**California  
Primary Care**  
ASSOCIATION

[www.cpa.org](http://www.cpa.org)

1231 I Street, Suite 400  
Sacramento, CA 95814

(916) 440-8170