Schoen Consulting

CURRENT STATE OF CALIFORNIA HEALTH CENTER RESIDENCY PROGRAMS

A Summary of Findings for CPCA

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Current State of California Health Center Residency Programs

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I. INTRODUCTION AND BACKGROUND

Present and future workforce shortages in health centers have been well documented in reports such as the CPCA-commissioned *Horizon 2030: Meeting California's Primary Care Workforce Needs*[1]. The current physician workforce is aging, and the number of primary care physicians in training is not sufficient to meet the growing need. As reported in *Horizon 2030*, "According to the AAMC, California has the second oldest physician population in the country (AAMC, 2014). This, combined with expanded coverage and population growth, means that at current utilization rates California will need an estimated 8,243 primary care providers by 2030." This is resulting in increasing competition for the few trained primary care physicians. Health center provision of residency training programs is a viable option for helping to address these shortages by providing valuable training opportunities and exposing residents to community-based primary care and population health management. Additionally, residents can support the health center workforce and provide much needed care to health center patients. The Association of Teaching Health Centers reports that 36% of residents from Teaching Health Centers (THCs) stay in the safety net compared with 2% of traditional residents, although not necessarily within the organizations where they trained[2].

To expand CPCA's understanding of the current state of residency programs in California's Health Centers, Schoen Consulting completed an environmental scan between June 2017 and February 2018. CPCA was also interested in the postgraduate training of nurse practitioners and physician assistants (NP/PAs) given their impact on workforce development in health centers. A total of 35 California health center and consortium staff and experts were interviewed for this report, and on-line research was conducted as well; please see the full list of interviewees in the appendix. This report summarizes the current range of residency programs in health centers, along with challenges and learnings.

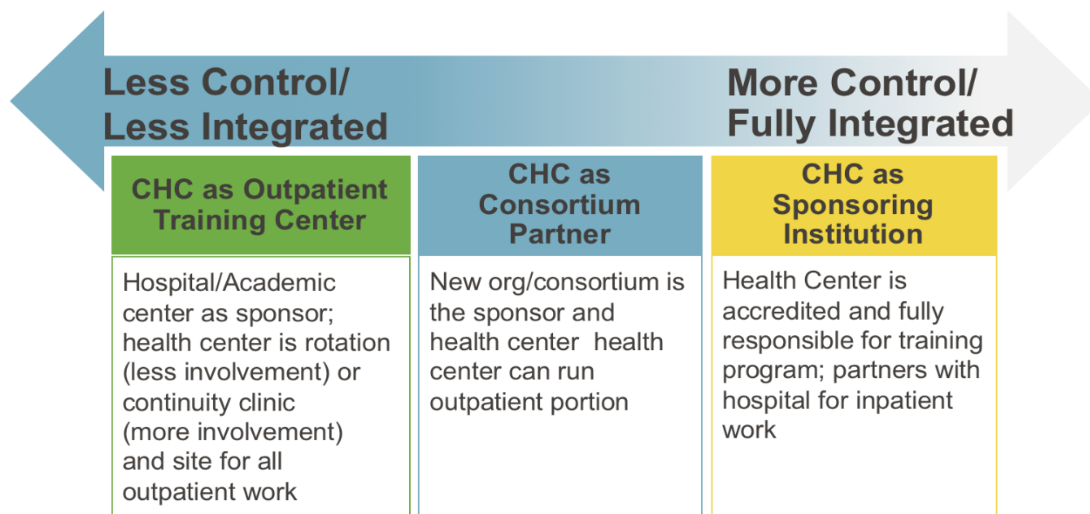
[1] Horizon 2030: Meeting California's Primary Care Workforce Needs, Jeff Oxendine and Kevin Barnett, California Primary Care Association, January 2016

[2] http://aathc.org/know-the-facts/

Range of Programs in California's Health Centers

California's health centers participate in residency programs and train residents through a range of models and participation levels – continuity clinics, consortium partners, and accredited residency programs. Community Health Centers that obtain program accreditation as the sponsoring institution through the Accreditation Council for Graduate Medical Education (ACGME), like Teaching Health Centers, take full responsibility for programs, and oversee both outpatient and inpatient training provided through hospital relationships. Moving down the control spectrum, some community health centers serve as outpatient training centers in partnership with consortia or other accredited residency programs, such as those found in universities or hospitals. In these cases, the community health center does not directly hold ACGME accreditation but hosts residents in their continuity clinics through regular monthly rotations or as elective rotation sites. Residents in these programs rotate through community health centers for all or some their ambulatory care work, and the associated hospitals or schools provide the faculty. In some cases, health center physicians are also the faculty.

Range of Programs in California Health Centers



Source: Models of Education Health Centers, Kiki Nocella, PhD, MHA, July 2013;
http://teachinghealthcenter.org/resources/EHCI_2013_WhitePaper.pdf
"Building a Teaching Health Center", Presentation by Dr. Chris Gordon, Family Health Centers of San Diego, April, 2018

For more information on the range of models and the advantages and disadvantages of each, see the Northwest Regional Primary Care Association report *Models of Education Health Centers* by Dr. Kiki Nocella (http://www.nwrpca.org/news/169077/Models-of-Education-Health-Centers.htm).

The following report provides a summary of learnings followed by details on residency program successes and challenges broken out by program models, specifically, non-teaching health centers that host residents, Teaching Health Centers, and NP/PA postgraduate “residencies” or fellowships.

II. OVERALL KEY FINDINGS

The following outlines the overall key learnings on residency programs in health centers.

Wide Range of Models

There is no standard model used by community health centers in California. Each health center chooses the model that works for them based on organizational capacity, local relationships, regional politics, and community needs. A large number of community health centers participate in residency training as continuity sites, but more are considering moving to ACGME accreditation as the sponsoring institution given an increase in state and federal funds available to develop newly accredited residency programs. However, the time-limited funding (e.g. two years of funding only) may impact these transitions.

Residency Programs to Support Workforce Development: “Grow Your Own”

Health centers and experts interviewed agree that the residency programs support workforce development in the safety net, and for most, this was the primary reason for developing the program. Health centers often considered this a “grow your own” strategy. Some interviewees understood that the residents might leave their organizations after receiving training but these health centers were still willing to make the investment to support overall workforce development.
Many of those interviewed are trying to establish or expand their programs depending

*“We are willing to invest in our residency program
because it is a workforce pipeline for the organization
but it also supports overall investment
in the primary care workforce.
Their experience with us can help them understand the mission
and serving the underserved.”*

on their workforce needs and are willing to invest to move further along the control continuum, although they may be hampered by financial investment requirements or local partnership issues.

Impact of Residency Programs on Workforce Recruitment and Retention

California's experience, as learned through the interviews, aligns with the national data showing that participation in residency programs positively affects workforce development. Anecdotal information shows that many center leaders hired residents they trained and some residents were hired by other community health centers. The majority of health center interviewees also reported a positive impact on retention; many physicians—although not all—have appreciated the opportunity to teach and this has supported the retention of current health center physician staffs. For some health centers, retention was also a strong driver of establishing a training program. Additionally, in some cases, offering residency training programs had helped health centers recruit new physicians due to the teaching opportunities.

"Our physicians really appreciated being able to teach residents and be aligned with the university. This really helped decrease our physician burnout."

Interviewees from a number of health centers that have long been involved in residency programs reported that even if they didn't hire their residents, they often used their networks of graduates to support patient referrals and other clinical needs.

The Struggle for Expansion

A number of health center interviewees described their current program development and expansion efforts. Many residents are not being placed, and interviewees felt that this was a missed opportunity. Staff at some centers struggled with finding appropriate partners or securing stable funding, but health center interviewees felt that these challenges needed to be overcome given the benefits and were exploring creative ways to address them.

"We are leaving medical students on the sidelines. There are a significant number that we are not able to match. We just haven't been able to develop capacity for residency training."

Mission to Serve vs. Mission to Teach

There was some discussion by health center interviewees about the conflict between the mission to serve and the mission to teach. Specifically, health centers have the mission to provide health care services their communities, whereas residency programs have the mission to teach students, and these missions can sometimes come into conflict. Residency programs require resources and time, and they can affect a health center's productivity, service provisions, and facility capacity, which can all affect centers' capacity to serve their community populations. Strong leadership is required to understand this conflict and not underestimate its impact and to maintain appropriate focus on balancing these issues.

Impact on Quality

The majority of health center interviewees reported that the presence of residents had a positive impact on quality. There was a sense that the relationships with the academic institutions and faculty often brought in the latest research and clinical protocols and that residents had good questions that could lead to improvements in practices. A few did report negative impacts stemming from difficulties in documentation including residents' learning electronic heath record requirements.

"Having residents in our health centers keeps us on our toes since they are smart, energetic and ask good questions."

Strong Local Partnerships

All of the various residency program models required strong local partnerships. Some centers built on strong relationships that were already in place, and some developed these relationships as part of the residency program development. However, all interviewees reported that these relationships were critical for effective programs and required focus and dedicated leadership time; some reported developing deeper relationships that had spillover effects in allowing them to develop other programs and partnerships.

"This is about relationship building.
We started small with just a few residents for rotations and we have been able to develop more programs with our partner hospital and university.
We just needed to plant our seed to see it grow."

Leadership Commitment

It was clear in all of the health center interviews that significant leadership commitment was required to establish and maintain residency programs. Given the above challenges described, without strong leadership, board support, and a strategic vision to focus efforts, overcome the barriers, and understand the long-term benefits, these programs will not be successful.

III. ADDITIONAL FINDINGS: PHYSICIAN RESIDENCY PROGRAM IN NON-TEACHING HEALTH CENTERS

The following learnings were identified through interviews with experts and health center staff whose organizations had hosted residents in continuity clinics or through rotations and were specific to these models. These were not Teaching Health Centers

or community health centers seeking accreditation; the accredited residency programs were hosted by hospitals or universities.

Positive Impacts on Workforce

Although the health center was not the sponsoring institution, interviewees from continuity clinics felt that there were still positive impacts on their workforce. Most felt that they were aligned with their partners—hospitals, universities, or consortia—regarding the types of residents who would best fit their needs, and some were able to allow their physicians to become program faculty, which supported physician retention. This alignment on recruitment and program development was critical for these models to be successful. Other positive impacts of working with residents that were reported include:

- Increased healthcare access
- Healthcare innovations (i.e. quality care, operations, etc.)
- Direct recruitment opportunities for new providers

“The leadership and board considered the trade-off with recruiter costs and that we maybe would have a harder time getting a good fit using a recruiter.
Having residents rotate through our health center does give them a good sense of what they would get if they stay with us – especially being a rural site.”

Required Infrastructure

Although the infrastructure requirements are not as intense as those for THCs, they are still significant, including space, support staff, workflow support, etc. These types of additional support can be difficult to establish and maintain and they require investment. However, interviewees found the following best practices useful in the long-run:

- Orient and integrate residents to organizational culture
- Have dedicated staff to support the program and logistics (i.e. scheduling)
- Ensure proper training space for residents and evaluate whether the residents should integrate into a regular clinic or work in a separate clinic
- Identify and train faculty who will take on the additional role of a preceptor
- Strategically organize program and provider responsibilities to meet productivity requirements
- Consider supporting program with other members of the care team (i.e. scribes)

“Although it was a great recruitment opportunity,
we couldn’t afford to keep it going because of the infrastructure costs and the impact on productivity”

Focus on Partnerships

Because non-teaching health centers do not control their residency programs, strong partnerships are required in order to maintain the programs and meet the centers' needs from them. This takes continued effort and maintaining ongoing relationships. Centers that built their programs on long-term relationships may have required less initial development, but sharing the programs required continuous communication to avoid misunderstandings regarding responsibilities and overall goals. Some successful community health center and ACGME accredited residency program partnerships have resulting in working together to establish criteria for residents and expanding access to specialty care for community health center patients.

"It does take a lot of time to manage the relationships – which are complicated- but we took the long view. We had to slowly influence the residency program – including the selection process – and we developed a robust orientation to our health center to ensure understanding of our programs and services."

Funding

Developing and maintaining residency programs in any capacity does require financial investments by participating health centers, although the financing options vary by program type. Health center leaders partnering with a sponsoring institution can secure funding through a variety of ways including:

- Negotiating with the Sponsoring Institution to receive financial support through the GME Medicare funds that the residency program obtains
- FQHC billing for resident services
- Local grants

Leaders need to consider how to monetize their services and ensure that they are able to strongly negotiate their positions. Some health centers have found that it can be more cost-effective to train a resident than hire full-time physicians.

"You need to be thoughtful about developing the partner relationships. We should not be taken advantage of. We have a strong role to play and need to understand our value."

IV. ADDITIONAL FINDINGS: PHYSICIAN RESIDENCY PROGRAMS IN TEACHING HEALTH CENTERS

The following findings are based on interviews with experts and interviewees from community health centers that were federally designated and accredited Teaching Health Centers or that were in the process of seeking accreditation for becoming THCs.

Control of Program and Resident Selection

One of the most salient reasons for becoming a THC pertained to maintaining control of programs and resident training and filling the need for primary care residencies. Some THCs might provide the only residency programs in their geographic areas, and some center leaders just wanted full control of the resident selection process. Some health center leaders wanted to select residents with ties to the local community (to increase their likelihood of staying after they completed their programs), dedication to community-based primary care, and/or cultural competency. Most THC interviewees confirmed previous findings that THC residents are more likely to stay with their health centers or within the safety net than residents in traditional programs.

"Our ability to select the residents that we believe will more likely stay with us—local ties to our community, dedication to serving the safety net—
means we have a higher payoff for our workforce development."

Infrastructure Needs

The Accreditation Council of Graduate Medical Education has significant requirements for becoming a Teaching Health Center. In addition to space, support staff, and faculty oversight needs, there are program management requirements that may entail hiring additional staff as well as requirements for oversight through hospital or other partner relationships. Fulfilling these requirements necessitates significant upfront investments and leadership dedication to ensure that programs are appropriately developed, which can take years. Some health centers have developed a Graduate Medical Education department to alleviate these needs and support the residency program's development and residents.

"We looked closely at becoming a teaching health center. Our main challenge is financial; we would have to pay faculty and all the support staff—for example MA, scheduling, supplies, etc.—and all the infrastructure requirements. We would need certain productivity to cover costs, and we weren't prepared for that. Plus we don't have good partners to work with us."

Funding

There is funding available for THCs including HRSA THC grants and Song-Brown funding in California. However, this funding is not guaranteed to continue year to year, so health center leaders need to be clear about the financial implications of taking residents for a three-year program when they might not have guaranteed funding for the full three years. Additionally, many interviewees reported that the funding available did not always fully cover all costs.

"The investment is significant and to have only a commitment in the short term for funding can be quite difficult. There has to be significant leadership and board support to maintain this program"

V. POSTGRADUATE PROGRAMS FOR NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

These findings are based on interviews with experts and staff from health centers that had postgraduate training programs for NPs and/or PAs. These programs (called residencies or fellowships even though those who complete them are not physicians) were between six months and one year long and included both didactic and clinical elements. Several health centers had had such programs in the past but had discontinued them due to costs and resource needs for managing them. Input from staff from these centers is included in these findings.

"We were losing a lot of NP/PAs shortly after they were hired. This program has really helped that turnover. It has been worth the investment"

General Findings

Based on the interviews, these programs were not as prevalent as physician residency programs; they had been developed to support hiring newly graduated NPs and PAs because leaders at many health centers felt that they had limited clinical experience and required this extra support. All interviewees did report that their programs supported or had supported workforce recruitment and retention, and many had received more applicants than they could take on. Although many felt this supported retention of newly hired NPs and PAs, they did not have any data to support this. They described that NPs/Pas that went through the programs general had improved satisfaction and confidence in their practice. Interviewees reported that these programs do require infrastructure, leadership, and staffing support but also that their needs were less intensive than those for physician residency programs; the majority reported that they used or had used Weitzman Institute resources (https://www.weitzmaninstitute.org/Our-Residency-Programs) for support.

VI. OPPORTUNITIES MOVING FORWARD

Based on these interviews, a number of opportunities were identified for CPCA to consider moving forward. Although the scope of this work did not include fully developing these recommendations, there were mentioned in the interviews and they are significant starting points for CPCA's future work. Thus, it was important to capture them nonetheless. Recommendations include the following:

- It is important to support sharing health center residency program resources and best practices, for instance within peer groups and at conferences.
- It would be helpful if there were standardized toolkits or other resources to support health center residency program development.
- Successful programs require support for partnership development. There may be an opportunity, for example, for broad support for negotiation with large institutions such as Kaiser and university and hospital systems.
- Centers that aim to become THCs require could receive centralized support such as through management service organizations or regional residency-consortia for developing their residency programs.
- Health centers require continued funding and continued advocacy to support the funding for their residency programs.

Overall, experts and staff at health centers in California believe that there are opportunities to support workforce development through expanding residency programs at health centers. There is not one ideal model, however, and thus, these programs need to be developed with flexibility based on specific health center strengths, local needs, partnerships, and politics.

VII. APPENDIX

Interviewee List

First	Last	Organization
Dolores	Alvarado	Community Health Partnership
Theresa	Azevedo	Kaiser Northern California
Eddie	Chan	North East Medical Services
Carlin	Chi	Petaluma Health Center
Janet	Coffman	University of California, San Francisco
Efrian	Coria	Gardner Health Center
Noemi	Doohan	Adventist Health Ukiah Valley
Reymundo	Espinosa	Gardner Health Services
Liz	Forer	Venice Family Clinic
Naomi	Fuchs	Santa Rosa Community Health Center
Dean	Germano	Shasta Community Health Center
Chris	Gordon	Family Health Centers of San Diego
Eric	Henley	Lifelong Medical Center
Julie	Hudman	Saban Community Clinic
John	Heydt	Borrego Health
Mark	Kal	Redwood Coast Medical Services
Joe	Lee	Community Health Center Network
Deborah	Lerner	Eisner Pediatric Family Medical Center
Panna	Lossy	Santa Rosa Family Practice Residency Director
Marty	Lynch	Lifelong Medical Care
Mary	Maddux-Gonzalez	Pacific Health Consulting
Melissa	Marshall	Communicare
Kevin	Mattson	San Ysidro Health Center
Tracy	Mendez	La Clínica de la Raza
Laura	Miller	Community Health Center Network
Benjamin	Morrison	Community Medical Centers
Sunita	Mutha	University of CA, San Francisco, Health Force Center
Kiki	Nocella	Consultant
Jean	Nudelman	Kaiser Northern California
Christine	Park	Northeast Valley Health Center
Steve	Schilling	Clinic Sierra Vista
Paramvir	Sidhu	Family Health Care Network
Hermann	Spetzler	Open Door Community Health Center
Nina	Vaccaro	Community Clinic Association of LA County
Christy	Wards	Cares Community Health