

**THE TEACHING HEALTH CENTER ROUNDTABLE – PREPARING RESIDENTS FOR PRIMARY CARE PRACTICE  
HOSTED BY THE MEDICAL EDUCATION FUTURES STUDY  
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WASHINGTON, DC**

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## MEETING SUMMARY

On October 27, 2009, the Medical Education Futures Study (MEFS) convened a group of experts in the implementation, administration and policy of Teaching Health Centers (THCs).

While patient care increasingly occurs in ambulatory settings, medical education occurs mainly in inpatient hospital facilities. This produces a health care workforce whose skills and experiences are poorly matched to the primary care needs of the population. The THCs model moves residency education from the hospital to the community. Developing residency programs within community-based ambulatory primary care settings such as health centers, with the appropriate infrastructure investment, will ultimately produce a primary care workforce ready to deliver health care in a reformed, cost-effective system. Teaching in health centers will also bolster the health center workforce by increasing recruitment and retention for existing staff and providing a pool of graduates to recruit in the future.

The purpose of the meeting was three-fold:

1. Increase the general understanding of current academic and financial models of existing Teaching Health Centers.
2. Assess challenges and needs.
3. Identify opportunities for advancing the Teaching Health Center model.

### CURRENT TEACHING HEALTH CENTER MODELS

In order to increase the general understanding of current academic and financial models of existing Teaching Health Centers, a number of experts in THC research and implementation were invited to present. All presentation are available on the MEFS website ([www.medicaleducationfutures.org](http://www.medicaleducationfutures.org)).

### Presentation Summaries

Frederick Chen, MD MPH, University of Washington – Teaching Health Centers: Reviewing the Evidence. Dr. Chen described the trend of increasing workforce needs in Community Health Centers coupled with the increasing challenges facing family medicine residency programs. In response to these trends, a partnership was established between the WWAMI Family Medicine Residency network, Region VIII/X Health Centers, Northwest Regional Primary Care Association and the University of Washington Department of Family Medicine – the Education Health Center Initiative ([www.nwrpca.org](http://www.nwrpca.org)) - to promote research, collaboration and outreach around the THC concept. Dr. Chen also described three research studies. The first, a cross-sectional survey of family physicians who trained in WWAMI residency program, found health center trained physicians were 3.4 times more likely to work in a health center and 2.7 times more likely to work in an underserved setting.<sup>1</sup> The second, a currently unpublished

<sup>1</sup> Morris CG, Johnson B, Kim S, Chen F. Training Family Physicians in Community Health Centers: A Health Workforce Solution. Health Services Research 2008;40:271-276.

national survey of Family Medicine residency programs with an 80% (354/439) response rate, found 23% (83) reported some health center training and 9% (32) reported a main continuity clinic in a health center. The third study, currently in press, describes four key themes in the Community Health Center – Family Medicine residency program relationship: mission, money, quality and administrative/governance complexity.<sup>2</sup>

Michelle Proser, MPP, National Association of Community Health Centers – NACHC Update on Related Research and Policies. Ms. Proser described two research projects. The first, a collaboration between NACHC, the Robert Graham Center and George Washington University, evaluates the current and future needs of Community Health Centers, finding a current shortage of 1,843 primary care providers and a future shortage of 15,585 – 19,428 primary care providers if health centers are to reach the goal of serving 30 million patients. The second is a National Health Professions Training survey from 2007 that found 65% of health centers indicate they participate in resident physician training and many also report training medical students, nurses, nurse practitioners and physician assistants. Health centers indicated participation in health professions training was important for improved workforce recruitment and retention, a chance to influence students' future practice and affiliation with academic health centers, teaching hospitals and universities. Greatest challenges included loss of productivity due to teaching, cost, space and continuity of patients in light of resident and student turnover. Ms. Proser also indicated NACHC is currently planning case studies of existing teaching health centers.

Mick Huppert, MPH, Community Health Connection, Inc., Fitchburg, MA – How to Grow Your Own Family Physicians. Mr. Huppert described three THC models in Massachusetts. Each program has a unique history and financing structure – ranging from a health center whose MD salaries are paid by the University of Massachusetts Medical School with some education and research expenses subsidized by the University to a health center which received all Medicare direct and indirect graduate medical education payments from the affiliated hospital to fund the residency program. The experience in Massachusetts has found 50% of graduates have stayed in Massachusetts and graduates trained in health centers are more likely to practice in underserved settings.

Thomas Bacon, Dr. P.H., North Carolina AHEC Program – Primary Care Residency Training in AHEC Settings: The North Carolina Experience. Dr. Bacon described the North Carolina Primary Care Residency Training Experience in their statewide AHECs. AHEC based residency programs include Family Medicine, Internal Medicine, Pediatrics, Ob-Gyn and General Surgery. Programs are generally jointly sponsored between the AHEC and local teaching hospital and funding is a mix of State AHEC funds, clinical income, and Medicare GME funding through the hospital. Primary care residents who trained in AHECs are more likely to remain in NC to practice (53%) than non-AHEC residents (34%). Observations from residency programs in AHEC settings included wide variations of costs of training resident across settings, but Dr. Bacon did note that training was generally less expensive away from a teaching hospital. He also noted

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<sup>2</sup> Morris CG, Chen FM. Training Residents in Community Health Centers: Facilitators and Barriers. *Annals of Family Medicine* 2009;7 (in press).

that for Internal Medicine, Pediatrics, Ob-Gyn and General Surgery, access to sub-specialty faculty is a key factor in the cost of a program.

Ted Epperly, MD, Family Medicine Residency of Idaho – Teaching Health Center. Dr. Epperly described the history of the Family Medicine Residency of Idaho – initially started as a residency program in 1975, the health center converted to a Federally Qualified Health Center Look Alike in 2007 under increasing financial pressures. The health center currently receives Medicare direct GME payments from the affiliated hospital for 13 of its 36 Family Medicine residents. Only 13 residents qualify for Medicare GME reimbursements due to the hospital's Medicare GME cap. Additional funds to support training in the health center come from the ability to include educational costs into the Medicaid cost-based reimbursements calculations in Idaho. The Idaho program has placed 56% of its residents in Idaho and 42% in rural/underserved Idaho communities.

Roland Goertz, MD MBA, Heart of Texas Community Health Center, Inc. – Teaching Health Centers: The Heart of Texas CHC. Dr. Goertz was invited to speak but was unable to attend the meeting. The Heart of Texas Family Medicine residency program, established in 1971, is one of the earliest THC models. Dr. Goertz's slides are available on the MEFS website.

Two additional presentations were given describing the current health center and THC legislation in the health care reform bills.

Candice Chen, MD MPH, George Washington University – Teaching Health Center Legislative Update. Dr. Chen described the current Medicare GME payment system which is closely tied to hospitals, key THC legislative components including sufficient GME payment, start-up grants for new and expanding residency programs and a change in National Health Service Corps practice requirements to include teaching, and current proposed legislation in the House and Senate. The Senate Finance bill currently includes:

- THC Development Grants under Title VII to support health centers establish new or expanding primary care residency programs.
- THC program to provide direct and indirect payments for the costs of graduate medical education, funded at \$230 million over 5 years.

The House Tri-Committee bill includes:

- A Medicare Demonstration Program that will allow health centers to receive Medicare direct GME payments for the time residents spend in the health center as well as the affiliated hospital.
- A Training of Medical Residents in Community-Based Settings, under Title VII, that will provide both start-up and operational funds for primary care residency program in community-based settings.
- Change in NHSC to allow 20% of obligated service to be spent in teaching activities.

Kaitlin McColgan, National Association of Community Health Centers – NACHC Update on Related Research and Policies. Ms. McColgan described current health center health reform priorities, including ensuring health center participation in reformed health system, guaranteeing adequate payment for FQHCs by all payers, and significantly growing the health centers' model with guaranteed funding. Ms.

McColgan detailed how these key health center priorities were all present in the 5-committee passed bills to varying degrees. Health centers' workforce priorities include: expansion of NHSC, strengthening Title VII of the PHS Act, and supporting residency training in health centers. She stressed the importance of making residency funding flexible and reliable given the variability of health center residency models.

Ms. McColgan also presented a comparison of the House and Senate community-based residency training/Teaching Health Center provisions. She noted:

- Both the House and Senate programs are funded via trust fund: the House at \$221 million/5 years out of the newly created Public Health Investment Fund (PHIF); the Senate at \$230 million/5 years out of the Medicare Part A Hospital Insurance Trust Fund.
- Both House and Senate bills would provide new, dedicated streams of funding for the operation of new and existing community-based residency programs. The House bill also provides dedicated funding for development of these programs while Senate bill provides authorized funding for this purpose.
- The eligibility criteria for the House and Senate programs is slightly different. The House program includes Federally-Qualified Health Centers (including look-alikes), rural health clinics, participants in a new teaching health centers demonstration created by the bill, and those applying to become one of the eligible entities. The Senate bill makes "teaching health centers" eligible, defined as: community-based, ambulatory patient care centers that operate residency programs.

## TEACHING HEALTH CENTERS DEFINITION

The presentations made it clear that the degree of teaching in health centers can vary widely. The strictest definition of a Teaching Health Center is a health center that is responsible for the academic and financial administration of the residency program, including –

- The health center sets the mission of the residency program
- The health center has a shared mission of service and education
- The health center is the sponsoring institution for accreditation purposes
- The residency director is staff at the health center
- The health center contracts with the hospital to provide required inpatient training

It was generally agreed that should GME and start-up funding become available for a THC program, it should initially be targeted to new and expanding primary care residency programs that meet this definition. However, the group also stressed the importance of next steps to include more flexible funding to support models of THCs where the health center may not be the sponsoring institution for accreditation purposes or the residency director may be dually appointed between the health center and medical school or hospital. In addition, increased community-based training in traditional hospital-based residency programs should continue to be encouraged.

## CHALLENGES, NEEDS AND OPPORTUNITIES

A number of challenges, needs and opportunities were identified during the meeting:

- 1. Costs of Training in Health Centers.** It was generally agreed by the meeting participants that the costs of running a residency program, including the loss of clinical revenues from staff while teaching, is a significant challenge for existing THC's and for establishing new programs. Health centers generally operate at a smaller margin than hospitals. In order for THC's to succeed, they will need a reliable and sufficient source of funding. In this respect, the Senate Finance Teaching Health Center proposed legislation was agreed to be strong, providing start-up grants to establish or expand THC's and paying both direct and indirect GME payments to health centers to operate residency programs.

A need recognized in regard to costs is the need for developing a greater understanding of the costs and revenues of teaching in health centers. The current system is generally opaque with many residency program directors unclear on the amount of GME payments received by their hospitals and the amounts passed through to the residency programs. In addition, the costs of residency training are highly varied and inconsistently reported. For example, while some programs account for clinical revenues generated by residents in reporting the costs of residency training, some will not. A better understanding of the true costs of residency training and a consistent method for reporting these costs is a first step toward building a more stable and accountable GME system in the future.

- 2. Framework for Teaching Health Centers.** The group recognized the great potential for THC's to contribute to the primary care and health center workforce. However, the group also suggested that a framework for developing THC's to ensure high quality education and service would strengthen the movement. Priority for funding for THC's should be given to those health centers that have implemented patient centered medical homes, multi-disciplinary training, electronic health records and community-based participatory research models. In addition, THC's should develop methods for ensuring patient continuity with residents and faculty development for teaching faculty.
- 3. If you build it, who will come?** The issue of recruitment to THC's was raised by a number of participants. The group generally agreed that at the initial level of funding proposed in the Senate Finance language, there is enough existing interest in training in community-based settings by medical students to fill new residency positions. However, moving forward the THC movement will need a branding and marketing campaign – emphasizing the benefits of training in a THC to the health center, the community and the resident. A first step toward establishing a marketing campaign will be to create a directory of available positions in THC's.
- 4. Administrative Relationships.** Relationships to two organizations – the Health Resources and Services Administration (HRSA) and the Accreditation Council on Graduate Medical Education (ACGME) - will be critical to the future success and expansion of the THC model. HRSA administers Title VII of the PHS Act and the Section 330 Community Health Center (CHC) program. HRSA will be involved in managing any THC start up funds that are enacted. Additionally, the effects of teaching in CHCs on the operational efficiency, financial stability and quality of care will need further examination. In the case that adding teaching to a CHC affects that CHC's ability to meet HRSA

requirements, the possibility of working with HRSA to address this challenge will need to be pursued. A relationship with HRSA also offers the opportunity to implement innovations in THCs. One opportunity may be to partner with NHSC to provide some loan repayment to start during residency training for residents in THCs. Another would be to partner with diversity programs to initiate pipeline programs in THCs.

The ACGME and its Residency Review Committees (RRC) are another organization whose current requirements may create administrative barriers to expanding the THC model. While family medicine residency programs located in health centers have successfully received accreditation in the past, internal medicine, pediatrics and ob-gyn residency programs may face greater challenges in accreditation due to current requirements for patient case-mix exposure and specialty faculty requirements. One possibility for addressing this challenge is to establish strong affiliations with medical schools or hospitals to meet accreditation requirements. Another is to re-examine accreditation requirements in light of desired outputs of residency programs.

- 5. Evaluation.** Finally, the group stressed the need to establish measures of success for THCs and methods for following graduates and evaluating the impact of the THC programs.

## CONCLUSIONS

The Teaching Health Centers model has the potential to be a leader in moving the health care system to a greater primary care focus. THCs change the paradigm of graduate medical education, focusing the mission of residency programs on producing physicians ready to provide community-based primary care. Physicians who are thus trained will provide greater preventative and coordinated care that will ultimately prevent hospitalizations and provide better quality to patients and cost-savings to the system.

Existing Teaching Health Centers currently represent the dedication of health centers and educators to develop partnerships and innovative funding strategies. The expansion of THCs will require stable and sufficient GME funding, a framework that ensures high quality education and service in THCs, branding and marketing of the concept, coordination with administrative and accreditation bodies and a robust evaluation system. THCs also represent great potential for innovations including expanded community based training for other health professions, a training venue for the patient centered primary care home, and the development of pipeline programs for diversity that will further advance the future health care workforce.

This meeting is seen as a first step towards advancing the understanding and mission of Teaching Health Centers. We encourage continued support for THC legislation, research and implementation.