Important Content Note:

This technical assistance resource was developed prior to the August 2017 release of the Health Center Compliance Manual by the Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care (BPHC). The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

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

The last decade has seen an increasing number of health centers establishing collaborations with teaching hospitals and freestanding medical residency programs nationwide. Over the last five years, there has been an acceleration of such collaborations with the enactment of the Teaching Health Centers Graduate Medical Education Program (“THCGME”) as part of the Affordable Care Act. The THCGME Program established a mechanism to cover the direct and indirect expenses incurred by qualified Teaching Health Centers for new or expanded primary care residency programs.

Given the increasing concern regarding shortages of primary care physicians, this heightened level of collaboration is not surprising. The majority of these collaborations continue to involve the establishment of community-based residency rotations at new or established health center delivery sites or freestanding residency programs located in medically underserved areas exploring the possibility of converting into a health center. However, there has been a substantial increase in the number of health centers becoming Teaching Health Centers and establishing new residency programs for which they (or a related consortium) serve.

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

2 Section 340H of the Public Health Service Act, as added by Section 5508 of the Patient Protection and Affordable Care Act of 2010 (P. L. 111-148)
as the institutional sponsor. This Information Bulletin provides information and guidance to health centers who are considering entering into an arrangement with residency programs and/or becoming a Teaching Health Center.

The Bulletin:
♦ Provides information on key considerations as they relate to collaborations on teaching/training activities and clinical service delivery activities.
♦ Summarizes federal Medicare Graduate Medical Education reimbursement principles, including an update of the key regulatory amendments since 2007 that are likely to have a direct impact on health center residency rotations;
♦ Summarizes the Federal THCGME Program;
♦ Addresses the “upsides” and “downsides” of residency collaborations on health center operations; and
♦ Examines the collaborative experiences of three health centers to ascertain whether the “traditional” expectations for a residency-health center collaboration are substantiated by experience (particularly, the impact on physician recruitment and retention).

KEY CONSIDERATIONS RELATED TO HEALTH CENTER – RESIDENCY PROGRAM COLLABORATION

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

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

From the health center’s perspective –
♦ The infusion of additional practitioners (both teaching faculty/preceptors and residents) into the health center has been a means of alleviating a shortage in physician capacity and/or increasing the scope and breadth of services offered to health center patients.
Adding residents and academic faculty to the clinical team can create a dynamic environment within a health center, fostering the collegial exchange of information and enhancing the ability of the health center staff to keep abreast of emerging treatment regimens and technological advances, and their application in a community based setting.

Collaboration with a well-recognized teaching hospital or residency program can serve to enhance the status of the health center to its staff, the community and/or other third parties, just as the teaching hospital’s reputation and credibility in the community may be enhanced by its linkage with the health center.

From an economic perspective –

Hospitals or freestanding residency programs have incurred losses on their ambulatory care sites as a consequence of serving significant numbers of people without any compensation (or inadequate compensation).

Health centers have received increases in grant funds under Section 330 of the Public Health Service Act to support services at new primary care access points and to expand medical capacity and services including oral health, behavioral health, and chronic care management.

Health centers can qualify as Teaching Health Centers and receive direct and indirect Graduate Medical Education (“GME”) reimbursement to cover residency program costs for new or expanded residency programs for which the health center is directly involved in sponsoring and establishing the rotations and other key aspects of such program.

Changes in federal reimbursement rules for supporting Medicare GME helped promote the economic viability of establishing and maintaining health center-based residency rotations by allowing teaching hospitals who receive GME to count the time spent by residents at health center sites in GME reimbursement calculations. These rules also create the opportunity for a health center itself to seek Medicare GME reimbursement; however, there are limitations that may not make this an appealing option.

As a result, health centers and teaching hospitals (and to a lesser extent, freestanding programs) have increasingly negotiated more complex arrangements. Many of these involve a health center assuming ownership of clinical sites (such as family medicine centers) previously operated by the hospital (or freestanding program) and hosting the continued operation of the residency programs at such sites. In addition, with the establishment of the THCGME Program, many health centers have created new residency programs whose ambulatory care rotations occur primarily (if not exclusively) at the health center’s clinics.

As part of these arrangements, it is common for a health center to secure some level of the clinical capacity for such sites through the physician preceptors, either by contract or by the transfer of physicians to the health center’s workforce.
When a health center is not the institutional sponsor of a program and is incorporating a residency rotation into its clinical sites, it is critical that the health center and the residency program appropriately define their respective authorities for clinical service delivery versus teaching when establishing the collaborative arrangement.

From the residency program perspective –

- **Accreditation Standards** – The residency program must maintain authority and control over training activities as is necessary to meet applicable accreditation standards established by the Accreditation Council for Graduate Medical Education (or other applicable body).  

- **Teaching/Training Activities** – The residency program would typically retain primary responsibility and control (even in instances where health center-employed clinicians act as preceptors) of activities such as:
  - Classroom teaching
  - Faculty appointment
  - Orientation programs
  - Faculty/program meetings
  - Curriculum development
  - Resident recruitment, selection and evaluation
  - General teaching program administration and evaluation

From the health center’s perspective –

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

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

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

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

5 Health centers should periodically evaluate clinical operations to ensure that the full scope of services is available to all health center patients, regardless of whether the patient presents at a teaching site or a non-teaching site.
ALLOCATION OF COSTS – Teaching/Training Versus Clinical Service Delivery

In addition to the need to appropriately allocate authority for teaching activities versus clinical service delivery for accreditation and licensing/billing purposes, it is equally important that the health center and its residency program partner be able to distinguish between the costs of the teaching program versus the costs of clinical service delivery.6

♦ On the teaching side, this distinction is critical because federal Medicare GME reimbursement rules require a Medicare GME recipient to cover all or substantially all of the training costs.

♦ From the clinical/health center side, this distinction is important to assure grant funds and third party payments for clinical services are not subsidizing teaching.

Medicare GME Reimbursement Principles

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

♦ Direct GME (“DME”); and

♦ Indirect GME (“IME”).7

The Social Security Act authorizes hospitals to include the time a resident spends in patient care activities at a non-hospital setting in its direct and indirect GME full-time equivalency (“FTE”) count if the hospital incurs all or substantially all of the costs of training at that non-hospital setting.8

Reimbursement for Direct Costs of Medical Education

The purpose of DME is to reimburse institutions, on a cost-basis, for the direct costs incurred by institutions involved in operating training programs.9 Generally, in order to receive DME, the DME recipient must incur all or substantially all of such direct training costs.

Prior to passage of the Affordable Care Act (“ACA”), federal regulations generally required hospitals, as the GME recipient, to directly sustain (or reimburse health centers for) all or substantially all of the direct costs incurred by the health center rotations in order to include the residents’ time at the health center in the hospital’s GME reimbursement formula. Historically, the key costs to be reimbursed included salary and fringe benefits (including travel and lodging where applicable) of the residents; and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to supervisory teaching activities.10 The ACA modified these rules to now require the hospital to incur only the salary and fringe benefits of the residents at the health center rotation for purposes of the GME reimbursement formula.

6 This would apply equally if the health center is a THCGME recipient and must carefully allocate the costs of the residency program to the THCGME funding and otherwise avoid the double counting of costs.

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

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

9 42 C.F.R. §413.75(a)

10 42 C.F.R. §413.75(b); 42 C.F.R. §413.78 (§413.78(g) for time periods after July 1, 2010).
Reimbursement for Indirect Costs of Medical Education

IME reimbursement, which represents the far greater portion of Medicare’s GME support, is meant to reimburse a hospital for the generally higher operating costs experienced by hospitals that sponsor/house residency training programs. These higher operating costs typically arise from increased resource utilization and clinical inefficiency due to the inclusion of an additional layer of less experienced staff involved in the delivery of patient care.¹¹

Federal regulations do not require a hospital to reimburse a health center for its indirect costs (e.g., higher marginal costs due to lost productivity; inappropriate utilization or over-utilization of space, equipment and supplies; inappropriate ordering of laboratory services) associated with the training program, even if the health center can document costs such as residents ordering more laboratory services. Nevertheless, many health centers require hospital sponsors to cover some or all of these indirect costs as a condition of the collaboration.

Health Centers’ Eligibility for Direct Medicare GME Reimbursement

♦ Eligible for DME – In 1998, health centers were added to the list of institutions eligible to receive DME reimbursement, regardless of whether the health center is the sponsoring institution of the residency program, provided that the health center incurs all or substantially all of the direct training costs at the health center site(s).

♦ Ineligible for IME – Unlike hospitals, however, health centers are not eligible to receive reimbursement for indirect costs.

♦ Low Reimbursement Payments – In addition to the exclusion of IME reimbursement, the methodology for determining health center DME reimbursement is not favorable for health centers. Payment is limited to the ratio of Medicare visits to the health center’s total number of visits. For example, if Medicare represents 20% of a health center’s payer mix, the DME reimbursement will equal only 20% of the allowable DME costs that the health center must incur.¹²

The lack of IME reimbursement, coupled with the unfavorable methodology for health center DME reimbursement, has effectively prevented health centers from seeking direct Medicare GME reimbursement under health center – residency program collaborations. Thus, hospitals have remained the GME recipient in the vast majority of these collaborations.

Material Changes to Federal Regulations Since 2007

Historically, federal regulations have allowed the time spent by residents in non-hospital settings, such as health centers and physician offices, to be included by the hospital in its FTE count if: (1) the resident spent his/her time in patient care activities; and (2) the hospital and non-hospital site had a written agreement providing that the hospital would incur all training costs at the non-hospital site – including resident salaries and fringe benefits and the costs for supervisory teaching activities – and that the hospital would provide reasonable compensation for such costs to the non-hospital site.¹³

¹¹ IME is typically paid through a boosted inflated inpatient visit rate for applicable teaching hospitals through a complex formula based on the number resident FTEs and other site-specific factors (42 C.F.R. §412.90(g), §412.105).

¹² See 42 C.F.R. §405.2468(f)

¹³ This requirement, originally codified at 42 C.F.R. §413.86(f) (4), was re-codified as 42 C.F.R. §413.78 (e).
In both 2004 and 2007\textsuperscript{14}, the Department of Health and Human Services (DHHS) issued final rules tweaking these requirements. For example:

- The written agreement requirement was made optional as long as the hospital reimbursed the non-hospital site for training costs at such site on at least a quarterly basis.

- The determination of “all or substantially all” of the training costs that must be included for GME purposes was modified.

- A formula for determining the amount of costs to attribute to “supervisory teaching activities” was established, thus alleviating the considerable confusion regarding whether to treat preceptors’ time as either a “training cost” or a “clinical cost” for GME reimbursement purposes.

In particular, Sections 5504 and 5505 of the ACA\textsuperscript{15} substantially modified the rules governing the inclusion of resident time spent at a health center for purposes of Medicare GME reimbursement, as follows:

- The GME recipient hospital(s) must incur only the costs of the salaries and fringe benefits of the resident during the time the resident spends in the non-provider setting (i.e., health center), thus removing the requirement for reimbursement of the supervisory teaching activities;

- The GME recipient is allowed to include a resident’s time at the non-provider setting spent in both patient care activities and in non-patient care activities, such as didactic conferences and seminars (excluding research not associated with the treatment or diagnosis of a particular patient).

Application of Community Support and Redistribution of Costs Principles

In 2003, DHHS codified the two controversial principles of “community support” and “redistribution of costs” in the federal Medicare GME regulations. See 68 Fed. Reg. 45434. These principles remained unaffected by the ACA for Medicare GME. In addition, they were effectively incorporated into the requirements established by the Health Resources and Services Administration (“HRSA”) for the THCGME Program by limiting such reimbursement to covering only the costs of new resident FTEs in either a new or expanded residency program.

- Community support is defined as “funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including state and local government appropriations.”\textsuperscript{16} If a community has undertaken to bear the costs of medical education through community support, the costs supported by the community support may not be considered GME costs to the hospital for purposes of Medicare payment.


\textsuperscript{15} Federal regulations were subsequently modified to reflect the statutory changes at 78 FR 50968, Aug. 19, 2013, including the addition of 42 C.F.R. §413.78(g).

\textsuperscript{16} 42 C.F.R. §413.75(b)
Redistribution of costs occurs when a hospital counts resident FTEs for GME cost purposes, even though the costs of the program had previously been incurred by an educational institution and financed through community support. The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital may not be considered GME costs for purposes of federal GME payments.

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

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

Example of Community Support and Redistribution of Costs

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

A freestanding residency program begins in 1995 training five residents through one precepting teaching physician at one site, at a cost of $100,000 annually, funded by state and local grants. No hospital seeks GME reimbursement for the residents’ time at this site until 2000. In 2001, the site begins training ten residents through two precepting physicians at a cost of $200,000 funded entirely by federal GME reimbursement to a hospital that enters into an agreement with the residency program. For the period from 1995 through 2000, the state and local grant funding would be deemed “community support,” as it was utilized to bear the costs of such pre-GME educational activities.

Applying the “community support” principle, that $100,000 of costs could not ever be considered GME costs for Medicare payment purposes.

Applying the “redistribution of costs” principle, the hospital’s act of seeking GME reimbursement for the residents’ time at the site would be deemed to be an inappropriate redistribution of costs, as the costs of the program had previously been incurred by the residency program, i.e., through the community support.

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

The application of these principles depends on the unique history of each residency rotation site. In at least one instance, a health center that directly received GME reimbursement for operating a residency program that prior to the establishment of the health center was operated by a university and funded locally without federal GME, was barred from seeking future GME reimbursement. See 68Fed Reg. 45454.
Accordingly, in instances where health centers agree to host or operate residency rotations, it is important to consider the funding history of the training program to determine eligibility for and/or level of GME reimbursement for training costs incurred at those sites regardless of whether a teaching hospital or the health center is the direct GME recipient. For new residency programs and/or new training rotations, the lesson is clear: GME funding should be sought at the outset if this is assumed to be a long-term funding source to support the program and/or rotation.

THE TEACHING HEALTH CENTERS GRADUATE MEDICAL EDUCATION (THCGME) PROGRAM

The ACA’s Teaching Health Center (“THC”) legislation established an important new source of federal GME reimbursement (both direct and indirect) unrelated to Medicare GME. The statutory definition of a THC is defined (1) a community-based, ambulatory patient care centers that (2) operates a primary care residency programs. Health centers, community mental health centers, and rural health clinics are among the entities specifically identified in the statute as potential THCs. The ACA established substantial funding for the THCGME program through a mandatory appropriation capped at $230 million over the period from FY 2011 through FY 2015. As of January 1, 2015, the THCGME program included over 55 active grants over 25 states with grants ranging from $300,000 to $4.7 million.

In order to be eligible for THCGME, the applicant organization must be the sponsoring institution of an eligible residency program, or part of a GME “consortium” where the consortium entity is the institutional sponsor and the community-based ambulatory patient care center, itself, must play an integral role in the academic, financial and administrative operations of the residency. Eligible primary care residency programs under the THCGME program are family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, or geriatrics.

The THCGME payment formula for direct GME expenses was largely based on the methodology used for the Children’s Hospital GME program (42 U.S.C. §256e) (rather than Medicare GME). Although HRSA was directed to establish a final methodology to implement the THCGME Program, as of January 1, 2015, HRSA had established an interim rate of payment equal to $150,000 per resident full time equivalent (FTE) intended to cover both direct and indirect cost. In determining the total resident FTE for funding purposes, only new resident FTEs in a newly-established program or new resident FTEs in a pre-existing residency program may be counted.

IMPACT OF RESIDENCY PROGRAM COLLABORATIONS ON HEALTH CENTER OPERATIONS

The Upsides of Residency Program Collaborations

The upsides of residency rotations are numerous, as demonstrated below.

♦ Increased clinical capacity – The establishment of a health center as a rotation site usually increases and enhances the health center’s clinical capacity. In addition to expanding the number of physicians (both preceptors and residents) available to serve health center patients, such collaborations may enable a health center to increase the scope and breadth of services offered to its patients by accessing physicians with high levels of experience and expertise.
Recruitment and retention tool – Residency collaborations have been seen as an important recruitment and retention tool. By exposing residents to community-based medicine during their training experience and by acquainting residents with the health center and its comprehensive clinical practice approach, it is anticipated that residents will be motivated to join the health center’s clinical workforce after graduation (or to at least stay to practice medicine in a medically underserved area). In fact, this is one of the underlying principles for the establishment of the THCGME Program. Residency program collaborations may also provide a tool for attracting (or retaining) experienced physicians to the health center. For experienced physicians, the opportunity to become part of a residency program’s teaching faculty (or otherwise affiliate with such program) can serve as an attraction to join the health center’s staff.

Enhanced staff morale – It is believed that provider morale may be enhanced if health center clinicians are offered the opportunity to get involved in teaching activities. The infusion of energetic residents and faculty preceptors who may be contracted from a residency program can also serve to enhance staff morale and create a dynamic environment within the health center – fostering the collegial exchange of information and thereby enhancing a health center staff’s ability to keep abreast of emerging treatment regimens and technological advances, and their application in a community-based setting.

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

The “Downsides” of Residency Program Collaborations

Conversely, collaboration with a residency program can have notable downsides if not anticipated and well-managed.

Decreased clinical productivity – The most prevalent shortcoming typically is a negative impact on clinical productivity caused by the fact that residents generally take longer to see patients. This problem can be exacerbated by a pattern of disruptions in staffing (clinical and support staff alike) due to last minute changes to resident or preceptor schedules.

Increased costs – In addition, residents typically order more diagnostic tests than experienced clinicians; the increased testing may be costly, as is the support staff needed to follow-up.

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

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

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

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

1. Are “traditional” expectations (both positive and negative) of health center-residency program collaborations substantiated by experience?

2. If not, where does “real life” diverge from theory?

3. What is the impact of such collaborations on a health center’s clinical capacity?

4. Do such collaborations benefit a health center as a recruitment and retention tool?

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

Case Study #1:
Community Health Center, Inc. Middletown, Connecticut (Main Office)

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

The family medicine residency collaboration, which began over 20 years ago, is with a family medicine residency program affiliated with a local hospital and involves residents rotating to CHCI sites in Middletown and Clinton, Connecticut for their obstetrical/prenatal experience. Both parties hoped the collaboration would serve to improve pregnancy outcomes and provide woman-centered care. The hospital wanted to provide residents a local OB rotational experience. For CHCI, particularly compelling was the ability to staff its OB practice with highly-qualified and respected teaching physicians provided by the family medicine residency program, and the program’s willingness to accommodate CHCI’s integrated care model. The family medicine program’s teaching physicians, both obstetricians and OB-privileged family medicine physicians, precept residents, both at CHCI and in the inpatient intrapartum setting.

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

Observing the positive impact of the health center-based residency rotations had in preparing primary care physicians to practice in the challenging health center setting, CHCI recognized the need to train all new primary care providers to this model of care. Accordingly, CHCI developed, sponsored and is now operating the nation’s first residency program for primary care nurse practitioners. Viewing nurse practitioners as ideal primary care providers in health centers, and believing that the complexity and challenges inherent in providing care in a health center requires advanced, resident-level training akin
to physicians, CHCI initiated its nurse practitioner residency program in 2007.

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

♦ As a recruitment tool for new physicians, the family medicine rotation has been highly successful. CHCI has been able to recruit a number of graduating residents to its physician staff over the years, including three physicians in the last year alone. Most of these residents identify their residency experience with CHCI as a major factor in seeking a position at CHCI. Similarly, of the first graduating class of nurse practitioner residents, two of the four graduates are working at CHCI, while the other two graduates were hired by other community health centers.

♦ The effect on CHCI's operations has been generally positive.

• The primary challenges have been in providing sufficient CHCI policy and electronic medical record system trainings, and optimizing the allocation of space and support staff (medical assistants, dental assistants) for clinical service activities.

• The effect on clinic productivity has been mixed. In OB, dentistry, and psychiatry, there has been no negative effect on productivity, as scheduling and staffing are established consistent with available space and support staff. The nurse practitioner program has had a negative impact on productivity since CHCI attending clinicians are scheduled to precept each team of two residents, four sessions per week.

♦ Participation in residency collaborations has fostered strong ties with the residency program's sponsoring institutions and has led to additional collaborations. These collaborations have included joint disease management (asthma, diabetes) initiatives, the establishment of arrangements for specialty care referrals, and other types of community access projects aimed at strengthening the safety net infrastructure.

♦ CHCI's nurse practitioner residency program has elevated the reputation of CHCI as a pioneer, particularly among other health centers across the country that recognize the need for, and value of, this innovative residency training approach and are interested in developing similar programs.

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

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

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

23 Financial feasibility is the most prominent barrier limiting the duplication of similar non-physician training programs. Specifically, current federal GME funding rules preclude GME support of residency training programs for providers other than physicians or dentists, such as nurse practitioners.
Case Study #2:
South Boston Community Health Center, Inc. Boston, Massachusetts

South Boston Community Health Center ("SBCHC") is a private, nonprofit organization with a long history of providing health center services to the medically underserved residents of South Boston. SBCHC currently collaborates with three residency programs, all of which are operated by teaching hospitals. SBCHC serves as the primary continuity clinic for Boston Medical Center’s ("BMC") family medicine program (12 residents on average annually). In addition, it serves as a rotation site for both BMC’s internal medicine residency (four residents) and New England Medical Center’s ("NEMC") pediatric residency program (three residents).

The family medicine collaboration is the most recent, dating back roughly 6 - 7 years, while the pediatric and internal medicine rotations began somewhere between 10 and 15 years ago. Preceptors for the family medicine rotation are all BMC-employed teaching physicians who, in addition to supervising residents, are contracted to SBCHC to provide clinical services on SBCHC’s behalf. The ability to access these physicians has significantly improved the quantity and quality of SBCHC’s physician capacity, which was a problem in years past. In addition, the utilization of SBCHC as the program’s primary ambulatory clinic rotation has resulted in the development of close relationships between SBCHC clinicians and the precepting physicians, as well as attending inpatient physicians. These relationships ultimately benefit SBCHC’s patients. The influx of energetic and highly qualified residents has created a stimulating, bilateral teaching environment, with SBCHC staff learning as much, if not more, from residents, especially with regards to residents’ inpatient experiences.

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

♦ As a recruitment tool for new physicians, the family medicine rotation has been very successful for SBCHC and the broader Boston health center community. Over the years, a large percentage of the family medicine residents have chosen to continue practicing in a community health center environment. Most emphasize their experience with SBCHC as a major reason for making their choice. In fact, one of SBCHC’s most recent hires in its internal medicine department is a physician who was both a medical student and a resident at SBCHC.

♦ Operationally, while the overall impact on SBCHC has been positive, there are ongoing challenges that arise from the additional complexities created by the rotations. Most notably, the continuous fluctuation in resident and preceptor schedules requires constant diligence and timely coordination to ensure that clinic staffing is sufficiently responsive to patient needs. In addition, the existence of the residency rotations has had a noticeable (adverse) impact on clinic productivity. Quality of care concerns are addressed by ensuring the strict oversight of residents by precepting physicians.

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

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

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

The Yellowstone City-County Health Department, now known as "RiverStone Health," is a public health center that has been providing primary care services to the medically underserved residents of Yellowstone County, Montana, since the establishment of its Deering Clinic in 1984. While it has served as the primary ambulatory rotation site since 1996, RiverStone Health became formally integrated with the Montana Family Medicine Residency Program (the "Program") in 2005. In deciding to integrate the Program within RiverStone Health, the health center embraced education – in particular, an obligation to the community and state to prepare physicians to practice in medically underserved areas of Montana – as a core part of its mission and its strategic vision.

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

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

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

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

♦ Operationally, the overall impact on RiverStone Health's clinical operations has been overwhelmingly positive even though integration of the Program has had its challenges. From a personnel perspective, the transition of the preceptors and residents to RiverStone Health's employment has resulted in employee benefit and other issues arising from the short-term nature of the resident's employment and the organization's status as a public entity.

• From a clinical perspective, it has proven difficult to maintain the desired level of continuity for patients due to resident turnover, resident involvement in other rotations, and the preceptors' juggling of clinical and teaching duties. To mitigate these factors, RiverStone Health has successfully instituted patient care “teams” whereby a team of faculty physicians, residents, non-physician providers, and clinical support staff (rather than one physician) serve as a patient's primary care provider.

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provider. The integration of the Program and the health center has served to reduce the clinical productivity and staff morale issues, as the team-oriented atmosphere has effectively eliminated the divisions between residency training and clinical service delivery.

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

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

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CONCLUSION

Health center collaborations with residency programs (including becoming a sponsoring institution of such a program) present an excellent opportunity for extending clinical capacity and strengthening ties with local hospitals and other providers, to the benefit of all involved, including health center patients. In deciding to enter into such a collaboration, it is important that the health center understand the current federal funding framework associated with residency programs, as well as the possible benefits and downsides such a collaboration may entail. It is also important to have an understanding of the key terms for agreements needed to implement this kind of collaboration. Such guidance may be found in NACHC Issue Brief #26, Key Considerations in Developing Residency Training Program Collaborations.

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