Becoming an Education Health Center: *Strategies for Success*

NWRPCA/CHAMPS
October 21, 2013
Seattle

Mike Maples, MD
- Community Health of Central Washington

Kiki Nocella, PhD, MHA
- BelieveHealth, LLC

The questions that we said we would answer…..

- What are the 3 major models of EHCs?
  - Structure
  -
- What are the 3 major models of EHCs?

  Structure
- Development

Who needs to collaborate with you, and how do you engage them?

What does your Board need to appreciate?

Rapid Culture Shift

- What we heard from CHCs in the not too distant past:

  "We have a service mission…..Not an educational mission."

-
  - What we heard from CHCs in the not too distant

mission."

What we hear from CHCs today:

Graduate Medical Education in Perspective

	GME	THC	notes
Current Field Strength	111,596	331	.3%
Number Programs	8967	44 (funded entities)	
Specialties	150	7 + Dental (FM, IM, Peds, Ob/ Gyn, Geriatrics, Med-Peds, Psych)	Policy Focused
Annual Expenditure	$12.5 Billion	$40 Million	.3%

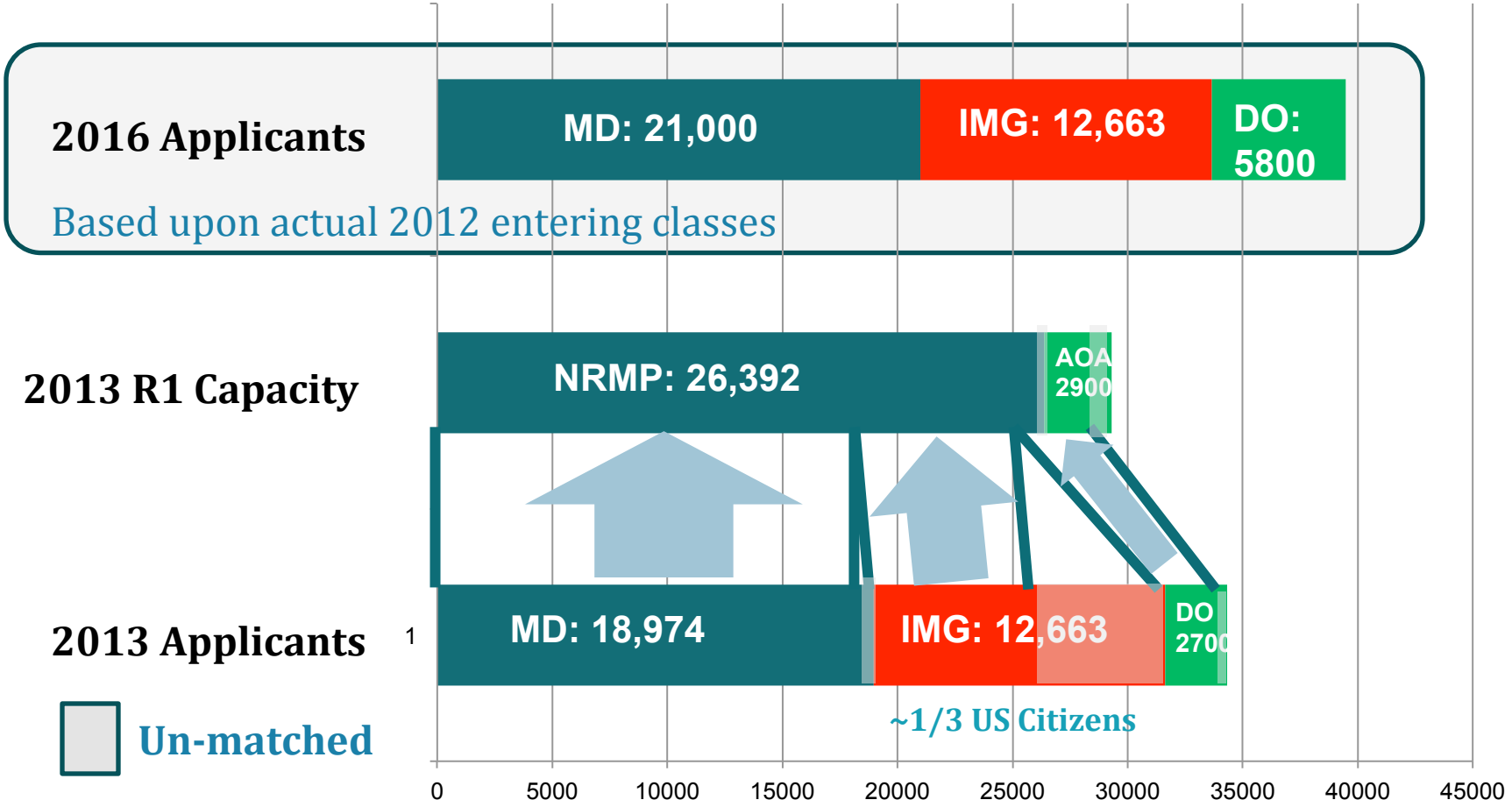
The value of the THC legislation has little to do with the output of the program, and will be realized through the thousands of discussions in communities who were interested in THC, but did something else.
Anything that gets you to the table to talk about education is good.

GME Needs CHCs

- Most people, including the press and politicians, don't understand that a medical school diploma prepares you for exactly one job:

to be a resident physician

Residency Position & Applicants



Projected 2017 matriculating class: MD 21,434; DO 6,675; Total 28109

Teaching Health Centers

- Section 5508 of the ACA
- Appropriated $230 M for a five year project
- Round one: 11 programs: 41 slots
  - Residents started July 2011. Entering 3rd year now
- Round two: 11 new + 3 expanded programs: 51 slots
  - Residents started 2012

THCs continued…

- Round three preliminary data: 23 new and 3 expanded THC programs. Brings total field strength to 331 FTEs.
  - Started training this July.
  - Appropriation ends after 2yr 3mos (9/30/15)
    - About $60M will remain in program, but need authorization to extend
- Round four notice due out soon….
  - Not for the timid (Program or Resident)

The THC Program Requirements

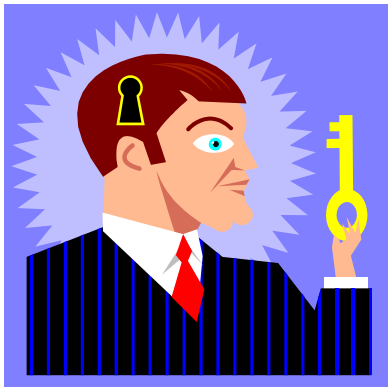
- The sponsoring entity for the educational program accreditation in one of 7 primary care fields, or general or pediatric dentistry.

THC Advocacy

- American Association of Teaching Health Centers
  - Created May 2013
  - Most awardees joined
  - First meeting: DC, June 4-5
  - Lobbyist engaged
  - Advocacy Goals: renew appropriation ($800M/5 yr)
    1. Maintain current field strength
    - Expand program
- Collaborating with NACHC advocacy and others.

Eyes on the Prize

- The Goal:
  - Solve community problems with Community-Based educational solution
- Keep an open mind
  - The path
  - The partners
  - The product



Models of Residency Program – CHC relationships

- CHC as sponsor
- Consortium as sponsor
- Hospital or AHC as sponsor
- AHEC or other entity as sponsor
- CHC as rotation site

Models

- Case Studies
  - Idaho – CHC as sponsor, and a THC
  - Central California – Consortium as sponsor
  - Coastal California – Hospital or AHC as sponsor
  - Rural North Carolina – AHEC or other entity as sponsor
  - Pennsylvania - CHC as rotation site
  - Wenatchee, Washington – CHC as sponsor, but not a THC

Idaho – CHC as sponsor and a THC

- Residency program originally accredited in 1976
- Later became a FQHC Look-Alike
- CHC is the sponsoring institution
- CHC receives THC funding for additional resident slots in 2011.
- THC funding supported expansion of residency in rural regions of Idaho as well as decentralization of base residency program in urban setting

CHC Model (THC and GME Support)

CMS-GME Funding

THC Funding

Hospital

Affiliation Agreement

CHC Sponsoring Institution

Affiliation Agreements

University

Ambulatory Sites

Hospitals

Employment Agreements

Faculty

PD

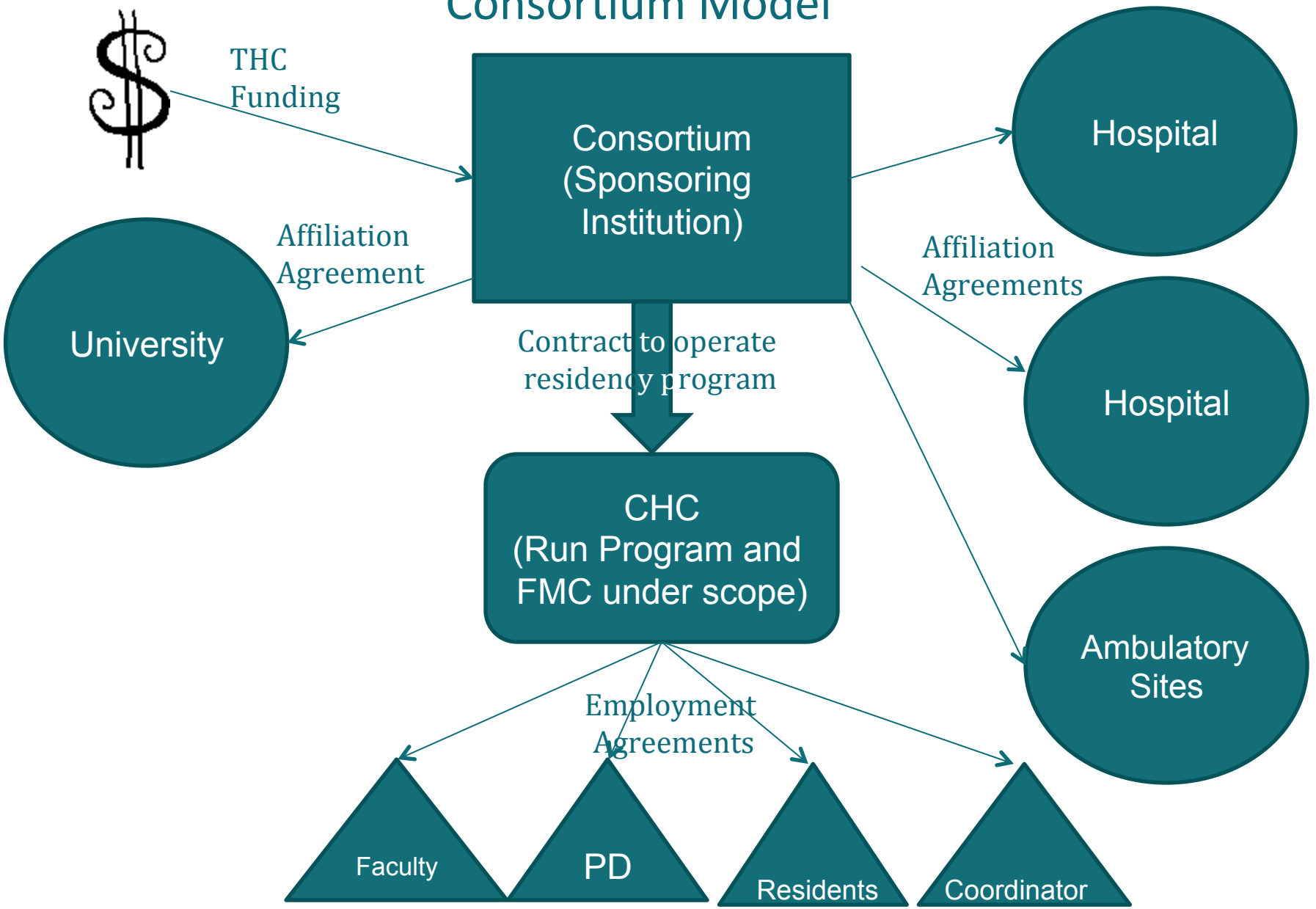
Residents

Coordinator

Central California – Consortium as Sponsor

- Consortium: an existing nonprofit organization consisting -12 health care & community organizations
  - working together
  - to improve access for medically underserved
- Concern about risk to other FM residency program -- created a community based model of FM training
- Member CHC –
  - planning & implementation of FMC
  - employs all faculty and residents (FTCA etc.)
- Raised ~ $500K for planning & implementation
- Applied & received THC funding
- First 4 residents began July 1, 2013
- Selected for willingness to stay in region. Matched 4/10 top slots

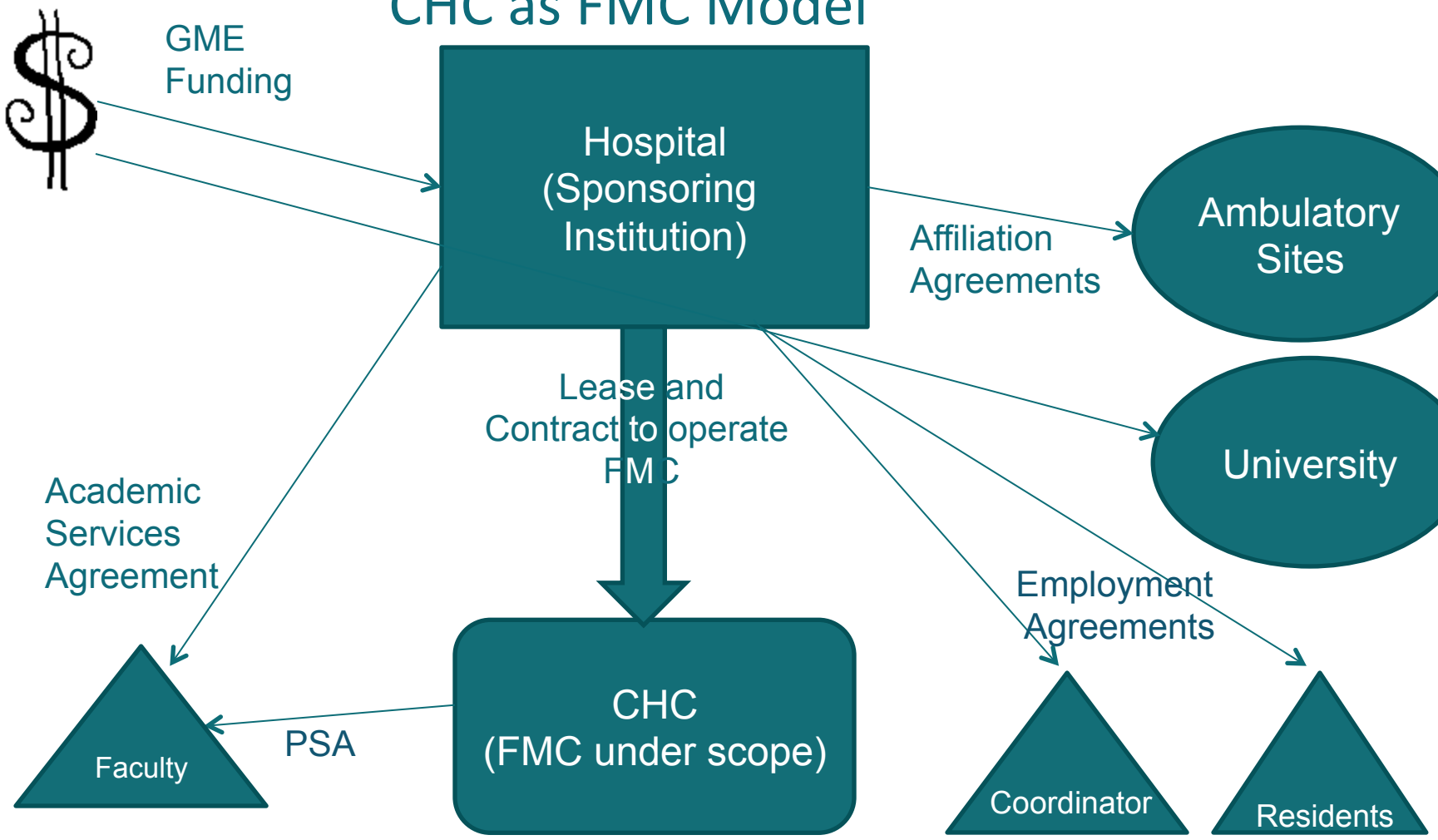
Consortium Model



Coastal California – Hospital or AHC as sponsor

- Community hospital as sponsor
- Clinic historically was under the hospital license
- Decision to put residency clinic under CHC scope
- Hospital retained sponsorship
- Professional and teaching services provided by local medical group
- Not a THC (does not qualify), but is an educational health center

CHC as FMC Model



Rural North Carolina – AHEC or other entity as sponsor

- Similar to Coastal California story
- AHEC as sponsoring institution - provides all faculty
- Hospital as Major Participating Institution
- FMC under hospital licensed space
- CHC put FMC under scope
- Qualified as THC because of consortium nature of AHEC. Developed some infrastructure so CHC will have an "integral role"
- Expanded residency using THC funding

CHC as FMC Model (THC)

GME Funding

Hospital

Non-Hospital/AHC (Sponsoring Institution)

Affiliation Agreements

Ambulatory Sites

University

Purchase services for Faculty and Residents. Affiliation agreement to operate FMC

Employment Agreements

THC Funding

CHC (FMC under scope)

Coordinator

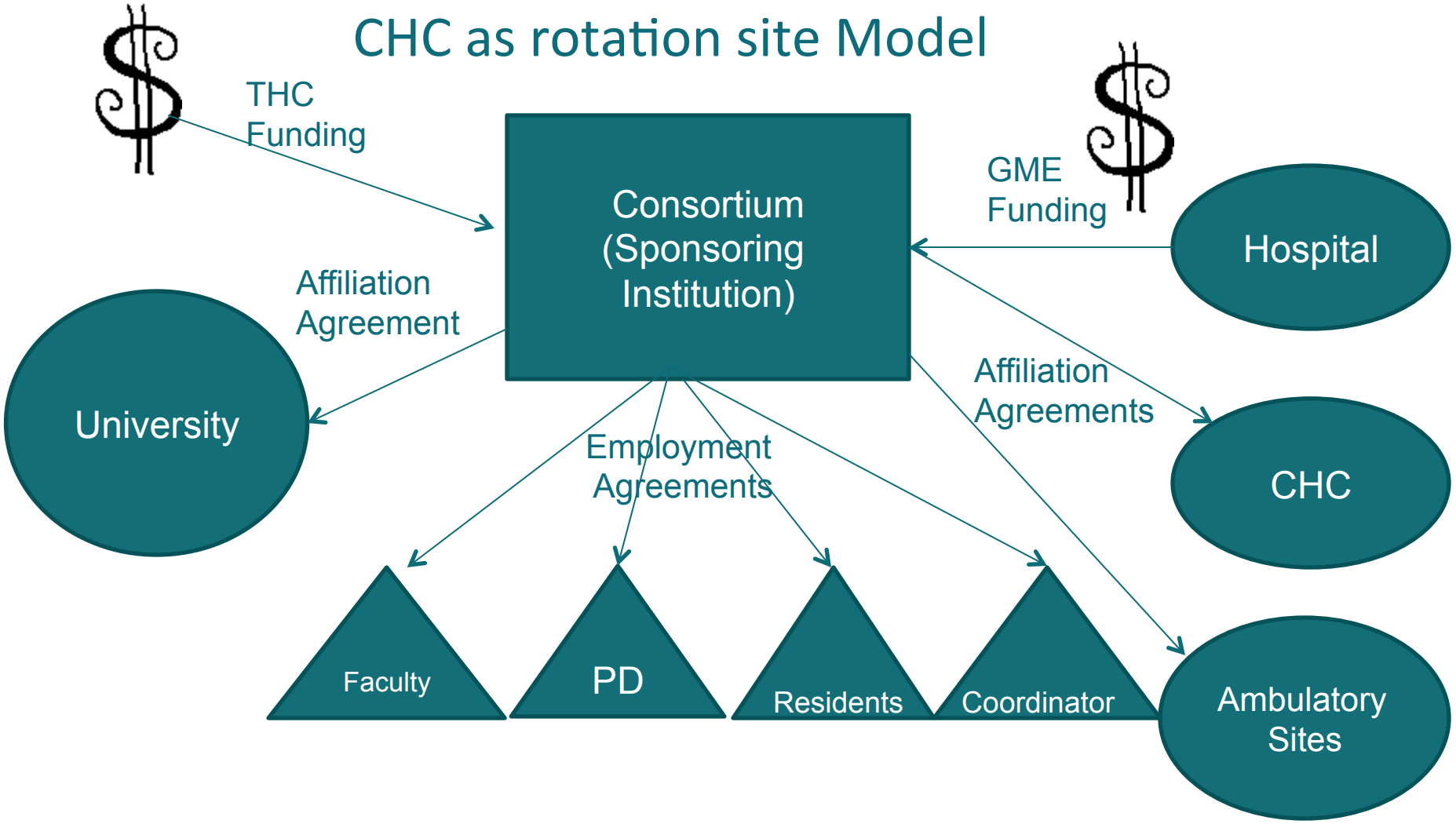
Residents

Faculty

Pennsylvania - CHC as a rotation site

- Consortium as Sponsoring Institution
- Community based private practices as main ambulatory sites
- Multiple CHCs to provide some continuity experiences and some specialized training experiences
- Mix of GME and THC funding

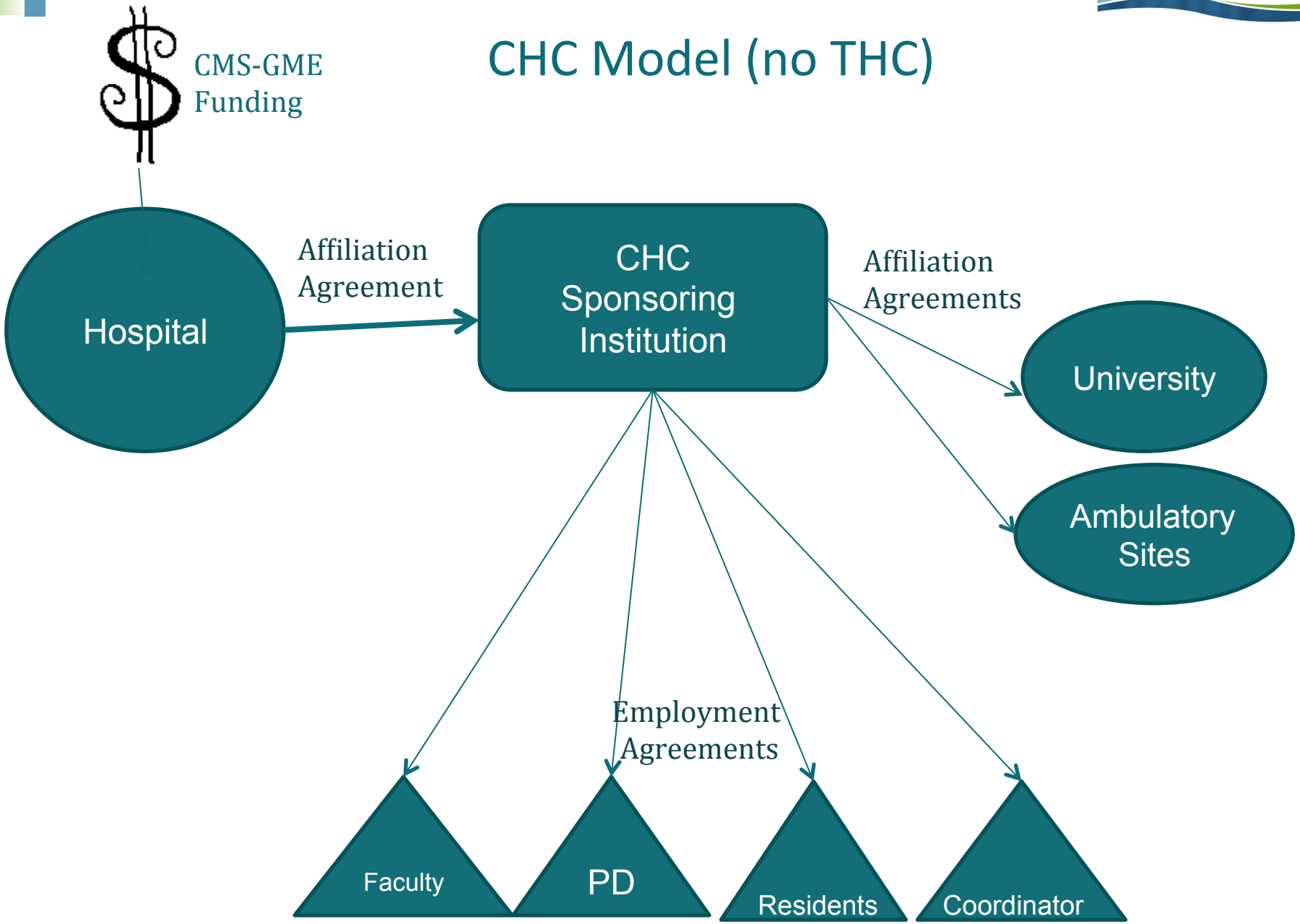
CHC as rotation site Model



Wenatchee – CHC Model (no THC)

- Strong local CHC as accredited sponsor
- Dominant hospital and clinic system
- No existing GME (no prior “cap”)
- Large need for primary care providers
- THC generated interest
- Planning and due diligence identified a solid strategy to achieve the goal

CHC Model (no THC)



Pros and Cons of various models

- Control
- Value of CHCs having the dollars flow directly to them
- THC funding has resulted in more than "just" new or expanded slots
- Even with THC funding, there will be deficits, particularly in the first year of operations
- DO NOT try this at home – these are relatively new models – get guidance from those who have gone before you

Approaching hospital partners: What you need

- A history of dialogue and relationship
- THEIR value proposition
- Willingness, ability, and capacity to do the heavy lifting
- A clear understanding of what you will need from them
  - Money
  - Specialists and Specialty Rotations
  - Call rooms
  - Etc.

Presenting to your board: A Checklist

- The Value Proposition
- Detailed 3-5 year financials, including start-up budget
- Plan to address bandwidth
- Timeline to implementation

Questions?