

# Education Health Center Guide



The **Education Health Center Initiative (EHCI)** is a partnership of the Northwest Regional Primary Care Association and Community Health Association of Mountain/Plains States, linking Clinical Education with Primary Care in urban and rural settings. For more information on the EHCI, visit <https://educationhealthcenter.org>.

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<https://educationhealthcenter.org>

# Education Health Center Guide

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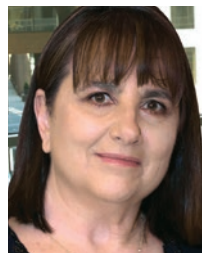
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# Education Health Center Guide

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# PREAMBLE

As we approach the 2020s, community, migrant, public housing, and homeless health centers, called Community Health Centers and Health Center Program grantees, and Primary Care Residency Programs (PCRPs) continue to face both enormous challenges and exciting opportunities. In this document, unless otherwise noted the term “CHCs” is used to refer to organizations that receive grants under the Health Center Program as authorized under Section 330 of the Public Health Services Act, as amended. It does not refer to FQHC Look-Alikes or clinics that are sponsored by tribal or Urban Indian Health Organizations, except those that receive Health Center Program grants.

CHCs are expected to care for over 29 million patients in an ever-changing health care environment, and PCRPs are expected to attract, train, and retain as many as 50,000 new primary care physicians.

The CHC movement cannot continue to effectively [serve one out of every twelve Americans](#) without a high-quality, appropriately trained clinical workforce to care for their patient population now and in the years to come. The issue is one primarily of overall numbers needed (i.e., students, residents, and practitioners entering primary care, adequate residency capacity to meet the projected provider need and an equitable distribution, geographically and otherwise,) of those entering and providing primary care. According to the Association of American Medical Colleges (AAMC), ***the U.S. will have a shortfall of 12,000–50,000 primary care providers by 2030.***<sup>1</sup> To address this shortfall, it is critical that the U.S. increase the number of medical students overall, especially the number of medical students entering primary care. In order to meet the current and projected primary care provider shortfall, it has been recommended that, in addition to increasing the number of students in general, each year at least 25% of all residency match placements be in primary care.<sup>2</sup> As of the 2018 match, 12.1% of all residency matches,

1. Association of American Medical Colleges News. (2018). *New research shows increasing physician shortages in both primary and specialty care* [Press release]. Retrieved from [https://news.aamc.org/press-releases/article/workforce-report-shortage\\_04112018/](https://news.aamc.org/press-releases/article/workforce-report-shortage_04112018/)
2. American Academy for Family Physicians. (2018). *2018 match results for family medicine*. Retrieved from <https://www.aafp.org/medical-school-residency/program-directors/nrmp.html>



## [ PREAMBLE ]



Albany Area Primary Health Care (AAPHC)  
[See profile on page 6.](#)



Cherokee Health Systems (CHS)  
[See profile on page 22.](#)



Community Health and Social Services Center (CHASS)  
[See profile on page 12.](#)

less than half the recommended 25%, were in primary care, indicating a need for increased focus on enhancing and expanding current primary care workforce pipelines.<sup>3</sup>

Innovation in clinical workforce development will play a crucial role in CHCs and PCRPs successfully meeting these challenges. Collaboration or “linkages” between CHCs and PCRPs have existed in various forms for over 40 years. By 2010, nearly 25% of PCRPs offered some training in a CHC and over 30% used a CHC as its primary Continuity Clinic (clinics where patients receive care over time in a cooperative process between patient and a physician-led care team in order to provide high-quality, cost-effective medical care). (Currently there are 57 residency programs with over 700 residents in 27 states and the District of Columbia which receive Teaching Health Center Graduate Medical Education (THCGME) funding directly through the Health Resources and Services Administration (HRSA).)<sup>4</sup>

### Background and Definitions

The Education Health Center Initiative (EHCI) is a partnership between the Northwest Regional Primary Care Association (NWRPCA) and Community Health Association of Mountain/Plains States (CHAMPS). EHCI originally involved the University of Washington Family Medicine Residency Network and the University of Washington Department of Family Medicine as partners before transitioning to a sole focus on CHCs in 2012. The mission of EHCI is to improve the quality of primary care training by supporting effective affiliation between CHCs and PCRPs which ultimately improves quality of care.

Since 2005, EHCI has worked to develop and promote the concept of an Education Health Center (EHC) by conducting state, regional, and national trainings, providing direct technical assistance to CHCs, developing resource materials such as this Guide, and posting research and other resource materials to its website: <https://educationhealthcenter.org>.

3. Ibid.
4. American Association of Teaching Health Centers. (n.d.). *AATHC programs: Teaching health center programs across the United States*. Retrieved from <http://aathc.org/thc-programs/>



## [ PREAMBLE ]

As EHCI started promoting development of Education Health Centers, national momentum grew behind support for Teaching Health Centers (THCs), culminating in legislation enacted through the Patient Protection and Affordable Care Act (ACA). The ACA, signed into law on March 23, 2010, created a five-year demonstration project called Teaching Health Center GME (THCGME).

This program, administered by HRSA, supports new and expanded primary care medical and dental residency programs in community-based ambulatory patient care settings. To date, the [THCGME program](#) has supported as many as sixty new programs and over 750 primary care and dentistry residents.

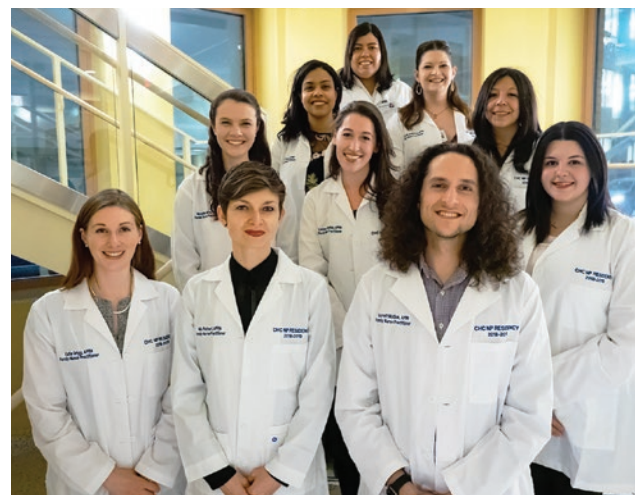
The impact of having residents train in programs sponsored by CHCs and other ambulatory clinics is significant as it has been demonstrated that over 60% of residents stay within 100 miles of their residency site, and up to 75% of residents stay within the state where they completed their residency.<sup>5</sup>

This Guide was originally produced in 2011 with funding support from The Josiah Macy Jr. Foundation and has been revised and updated with additional funding support from HRSA. The Guide is intended to assist CHCs and PCRP with utilizing both traditional Graduate Medical Education (GME) and the more recent THCGME funding. CHC/PCRP linkages range from limited (e.g., the CHC serves as a site for elective experiences) to extensive (e.g., the CHC provides all the continuity ambulatory care education) to comprehensive (e.g., the CHC is the Sponsoring Institution which administers all aspects of the program and employs the faculty and residents). While there are many types of CHC/PCRP linkages, this Guide will focus on programs where the residency is either sponsored by the CHC or where a primary care program utilizes the CHC as a Continuity Clinic for its residents.

5. Fagan, E.B., Gibbons, C., Finnegan, S.C., Petterson, S., Phillips, Jr, R.L., Bazemore, A.W. (2015). Family Medicine graduate proximity to their site of training: policy options for improving the distribution of primary care access. *Society of Teachers of Family Medicine*, 47 (2), 124-130. Retrieved from <https://www.stfm.org/FamilyMedicine/Vol47Issue2/Fagan124>



Community Health Care Tacoma (CHCT)  
[See profile on page 30.](#)



Community Health Center, Inc. and its Weitzman Institute (CHC, Inc.) [See profile on page 36.](#)



Family Health Center (FHC)  
[See profile on page 46.](#)

## [ PREAMBLE ]

Below are brief definitions of EHC and THC for the purposes of this Guide.

**An EHC is a CHC that serves as a training site for health professions students and/or residents. EHCs share in common a sense of mission and purpose.**

EHCs integrate commitment to two core values:

- Providing excellent health care and improving health outcomes in partnership with underserved communities; and
- Training the next generation of health professionals in real-world settings to have the inter-disciplinary and culturally-relevant skills needed to provide health care for patients with high levels of clinical and social complexity.

In addition, EHCs typically seek to retain quality residents in the community for practice either in their system or in a practice affiliated with a partnering hospital.

**A THC is a type of EHC that provides training at health centers and similar sites in order to ensure a viable primary care workforce for low-income communities.**

This may include:

- Setting the mission of the residency program;
- Having a shared mission of service and education;
- Being the Accreditation Council for Graduate Medical Education (ACGME) accredited Sponsoring Institution (SI);
- Obtaining and maintaining ACGME specialty program accreditation;
- Developing curriculum and monitoring program quality;
- Employing the Residency Program Director (RPD), core faculty, and/or residents; and
- Contracting with the hospital to provide required inpatient training.

To access more complete information on the federal government's THCGME program, visit HRSA's [Teaching Health Center Graduate Medical Education \(THCGME\) Program](#) website.

There may be terms in this Guide that are new to CHCs. For a comprehensive glossary of GME terms, please visit the [ACGME Glossary of Terms](#).

### **Guide Overview**

It will take leadership, collaboration, time, and money to develop an Education Health Center.

## [ PREAMBLE ]

There are five key areas to address:

- 1 **Overview and Mission**
- 2 **Governance**
- 3 **Administration and Operations**
- 4 **Finance**
- 5 **Legal**

Each area has its own chapter in the Guide and is a stand-alone piece. The Guide is designed to be used in part or in whole to meet the needs of interested parties. Other resources relevant to information provided in the Guide are found through links in the text of the Guide.

Primary care is defined here, per the Patient Protection and Affordable Care Act, as: family medicine, internal medicine/pediatrics (med/peds), general obstetrics and gynecology (OB/GYN), psychiatry, general/pediatric dentistry, and geriatrics.

Health centers can also serve effectively as training sites for other types of residents as well as other health professions students, such as nurse practitioners and physician assistants. For organizations considering development of a Nurse Practitioner residency program, please consult [Community Health Center, Inc.'s National Nurse Practitioner Residency Program](#) website.

While this Guide may serve as a useful reference and starting point, it cannot be overemphasized that there is no single blueprint for a successful EHC. This document provides general advice on the multiple models by which CHCs can be engaged in Graduate Medical Education (GME), how CHCs might identify which model works best for them, and how the information provided here fits the organization's needs and vision. *Every residency is unique.* Each setting will have its own set of strengths and challenges. Organizations which decide that they can and should develop an EHC will likely need consultative and technical assistance from one or more persons who can take into account these site-specific differences and make tailored recommendations for how to proceed. EHCI is happy to provide this assistance.

Finally, while every effort has been made to provide comprehensive and accurate information, every program is distinct and so this second edition of the Guide will undoubtedly have gaps. This Guide is available online at <https://educationhealthcenter.org> and will be updated periodically. If you have any questions or would like more information, please don't hesitate to be in touch. Your feedback is welcomed so please email [ehci@nwrpca.org](mailto:ehci@nwrpca.org) with suggestions for improvements.

Thank you for your interest in Education Health Center residency development.





# OVERVIEW AND MISSION

Many CHCs are interested in beginning or expanding their role in training the next generation of health professionals to serve those communities in greatest need but are unsure how to get started or how best to identify those obstacles they must overcome to become full-fledged Education Health Centers. While a fair number of CHC-residency models have been very successful and have resulted in significant benefits for both residents and the communities served, there have also been notable failures. It cannot be overstated what a significant undertaking it is to train residents in a CHC.

To help determine whether or not to pursue such a model, the following questions are worth considering:

- Is there a history of the parties working collaboratively on other projects?
- Who are the key stakeholders?
- Do these key stakeholders include the people who can make and enforce the decisions made?
- Is there a history of shared leadership and problem solving?
- Is there support for this at the highest levels of stakeholders?
- Who is most in favor?
- Who is most opposed or most reluctant?
- How are the parties similar and how do they differ?
- What benefits does the CHC hope to receive?
- What and whose problems does the CHC hope a CHC/residency affiliation will address?
- What type of Education Health Center is the best fit for the CHC's needs and resources?
- What are the alternatives to the affiliation?
- What problems might result from an affiliation?
- What does the CHC see as the most difficult challenges to getting the affiliation started?
- What does the CHC see as the most difficult challenges in the early phases of the affiliation?
- What does the CHC see as the most difficult challenges it will likely face as the affiliation matures?
- Are there any issues that need to be kept confidential/not shared in public?

## [ Chapter 1: OVERVIEW AND MISSION ]

*Note: In answering these questions, it may be helpful to seek advice from someone experienced with EHCs to determine if expectations are realistic. The point here is that CHC/PCRP linkages are not a solution for every problem. It is critical to begin with realistic expectations.*

### Similarities and Differences in Mission between Community Health Centers and Primary Care Residency Programs

While CHCs and residency training programs are, in many ways, natural allies, there are also notable differences in their core missions and cultures. In order to decide if a linkage makes sense, these differences need to be appreciated. Nevertheless, there are some basic characteristics common to both organizations that can help with this challenge.

### Primary Care Residency Programs—What Community Health Centers Need to Know

PCRPs are responsible for training physicians who have completed medical school and chosen to specialize in primary care.

There are five types of primary care residencies:

- 1 Community-based, non-affiliated;**
- 2 Community-based, medical school-affiliated;**
- 3 Community-based, medical school-administered;**
- 4 Medical school-based; and**
- 5 Military and Veterans programs such as those provided by the Uniformed Services University and the Veterans Health Administration.**

Programs sponsored by CHCs are considered community-based. While it's permissible to have no medical school affiliation, the vast majority of programs have an academic affiliation with one or more medical schools and it is strongly advised that any new program have such an academic affiliation. Like all residency training programs in the United States, PCRPs are accredited by the ACGME. Within the ACGME, each specialty is represented by a Review Committee (RC), which sets and periodically updates training requirements.

Training requirements for PCRPs are extensive. The full set of written requirements specific to Family Medicine and other primary care programs can be accessed via the [ACGME website](#). In addition, there are general requirements which apply to all residency training programs and their Sponsoring Institutions. These can also be accessed at the ACGME website.



## Making the Business Case: Benefits of Becoming or Collaborating with an Education Health Center

*Successful collaborations between organizations only work if both partners perceive and actually realize more benefits than costs.* It is equally important to not underestimate potential drawbacks. In the most successful collaborations, the parties seek and achieve a synergistic relationship and minimize potential problems. The starting point is for each party to identify potential benefits and drawbacks in becoming an Education Health Center. The linkages are enhanced when graduates of the residency stay in the community for practice either at the CHC or in a practice affiliated with the partnering hospital.

Before exploring the wide range of potential benefits and costs from both CHC and residency perspectives, it's important to consider the issue of finances. This topic is explored in greater depth in the Finance chapter of this Guide. The key point here is that, *from either organization's perspective, whether teaching residents in a CHC makes or costs money will depend on a variety of factors, including:*

- Which costs and revenues will be allocated to the teaching program.
- How costs and revenues will be allocated to the teaching program.
- How and whether so-called opportunity costs are considered.
- How and whether non-monetary costs and benefits are considered.
- Where the funds for developing the program will come from.

The bottom line is that the *financial analysis is a critical determinant in both the decision to develop a teaching affiliation and how its partners view its success over time.*

## Potential Benefits to Community Health Centers

- Increased recruitment of providers as physicians trained in CHCs are twice as likely to work in underserved areas.<sup>6</sup>
- Enhanced job satisfaction among, and ideally retention of, providers in teaching roles.
- Additional skills development for precepting providers, especially for advanced practice clinicians and providers.
- Access to additional services for patients (e.g., specialty clinics, residency inpatient care teams, etc.).
- Enhanced reputation as a teaching site.
- Shared on-call arrangements with residency faculty providers which can enhance provider recruitment efforts and augment service coverage.

6. Levin, Z., Meyers, P., Peterson, L, Habib, A., and Bazemore, A. Practice intentions of family physicians trained in teaching health centers: the value of community-based training. (2019). *Journal of American Board of Family Medicine*, 32 (2), 134-135. Retrieved from <https://www.jabfm.org/content/32/2/134>

## [ Chapter 1: OVERVIEW AND MISSION ]

- Enhanced job satisfaction for non-provider staff members.
- Access to resources from a hospital or medical school partner (e.g., information technology, research support).
- Strengthened clinical affiliations with hospital or medical school partners.
- Enhanced services to CHC patients as a result of meeting program curriculum needs (e.g., behavioral health skills development).
- Enhanced expertise at the CHC, such as access to the newest practices and quality models.
- Positive changes to overall organizational culture from increased emphasis on learning.

**“Kids go into this wanting to change the world.  
We put people in a nurturing environment,  
and they really want to  
make a difference in the world.”**

—Jim Hotz, MD  
Clinical Services Director, AAPHC, Albany, GA

### Potential Benefits to Academic Institutions and Primary Care Residency Programs

#### Financial:

- CHCs are eligible for FQHC Medicare/Medicaid reimbursement rates.
- Malpractice insurance may be available for CHC-employed faculty members and residents at no cost through the [Federal Tort Claims Act](#).
- Title VII Residency Training Grants often prioritize programs serving underserved patient populations.
- Academic and hospital partners can potentially benefit from facility development cost savings.
- CHC support in GME funding advocacy. CHCs have a strong voice and are already doing much of this work, so it is an easy change to add GME advocacy to current CHC processes.
- Additional administrative support from the CHC beyond faculty, including care coordination, call center, case management, billing, outreach and enrollment, etc.
- Eligibility for additional grant opportunities covering both facilities.
- Increased patient referrals from hospital partners. Many unassigned patients choose to follow up with the resident at the CHC.

Improved patient care through expanded access to additional services and support, including:

- [Eligibility to participate in the 340B Drug Pricing Program.](#)
- Social workers, case managers, interpreters, and other allied health care providers commonly found in CHCs.
- Enhanced recruitment and retention of faculty and residents, specifically those most interested in providing care for underserved patients, leading to increased trust of providers and positive health outcomes.<sup>7</sup>
- Shared on-call arrangements with CHC providers, thereby increasing continuity of care to patients.

**Educational:**

- Enhanced access to specific patient populations and clinical problems (e.g., prenatal patients, pediatric patients, and patients from varied ethnic, linguistic, and socioeconomic backgrounds).
- Enhanced access to comprehensive, holistic, culturally-competent primary care models. Three years of residency in a CHC environment provides a true high quality service learning experience in providing patient centered care to multi-cultural populations that often are affected by the social determinants of health, particularly poverty. Such experiences at a CHC will prepare the next generation of family physicians, whether they continue at a CHC or not, to better care for the vulnerable and newly insured in the U.S.

7. Gray, D. J., Sidaway-Lee, K., White, E., Thorne, A., and Evans, P. H. (2018). Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open*, 8 (6). Retrieved from <https://bmjopen.bmj.com/content/8/6/e021161.info>

## PROFILE

### Albany Area Primary Health Care (AAPHC)

Albany, GA

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



AAPHC serves SW Georgia, with offices in nine counties. AAPHC follows community leadership in determining services and programs. They provide primary medical, dental, and BH services and have a history of growth and expansion in service to the underserved. They work with a local hospital to provide women's health services, and offer school-based care.

AAPHC played a central role in developing the regional AHEC program and building the SW GA FMRP, whose mission is to train family physicians to practice in rural SW GA. They provide allopathic, osteopathic, PA, and NP training. AAPHC trains students in settings where they are most needed, nurturing a commitment to the values of service, mission, and making a difference in the world.

**Health Professions Training Programs, Trainees, and Disciplines:** FMR, Nurse Midwifery, Osteopathy, Nursing, Dental, PA, NP, Pharm D, and Lab Tech.

#### **Educational Strategies:**

**Selecting students:** AAPHC clinicians serve on the admissions committee for a public medical school, assuring students selected have a commitment to serving underserved and rural areas of GA.

**Start with residency training:** The CHC began a primary FMR teaching site and expanded by developing an affiliated PA training program.

**Educational Challenges/Academic Institutional Relationships:** Some institutions are respectful of the CHC, others less so. Some faculty may be easy to work with, but institutional leaders not. Some institutions support training financially. Negative interactions with institutions include control issues or expectations of CHC subservience. With turnover, there is at times failure to maintain continuity of previous commitments.

(Continued on page 8)



## Potential Benefits to Students and Residents

Residents training in CHCs have an opportunity to provide care in a mission-driven setting. Many residents develop a deep affinity for the mission of their CHC and enjoy the experience of serving the underserved. As a report from the National Network for Oral Health Access (NNOHA) outlines, “service learning experiences in CHCs benefit students and residents by providing them with valuable clinical and socio-health experiences. In CHCs, students are exposed to individuals from culturally, linguistically and economically diverse populations, including those with special health care needs and those with complex medical issues. In addition to enhancing students’ and residents’ clinical knowledge and cultural competence, such experiences help them learn about the societal and cultural factors that affect the health of individuals with low incomes or from underserved communities. Students’ and residents’ resulting heightened cultural sensitivity will likely increase their openness to and comfort level with treating a diverse mix of individuals throughout their professional careers. Students and residents in CHCs also practice in an integrated interdisciplinary environment. Since many CHCs now include oral health, behavioral health, pharmacy, optometry or podiatry, students and residents can observe the practical aspects of inter-professional collaboration.”<sup>8</sup>

According to a National Association of Community Health Centers’ (NACHC) report, “residents learn how CHCs employ team-based care models that leverage cost-efficient relationships among the various clinical staff to care for high cost, high need patients, and how they provide longitudinal care and population-based strategies that augment effective acute medical management with efficient prevention and advanced chronic disease and care management.”<sup>9</sup>

“Such experiences at CHCs give residents confidence in their ability to provide health care to a wide variety of patient populations, and this confidence can be carried into their future professional practice. Residents also learn about the day-to-day operations of a CHC and enhance their practice management experience by observing the clinical, health information technology, and administrative systems and practices that have been developed to maintain CHC program function.”<sup>10</sup>

Students and residents may also benefit from increased access to various state and federal student loan repayment and forgiveness programs. The [National Health Service Corps](#) offers expanded benefits to both residents and faculty working at CHCs, including official recognition of teaching time in place of patient visit targets and potential loan forgiveness eligibility for senior residents and part-time faculty.

8. National Network for Oral Health Access. (2014). *Partnering with academic institutions and residency programs to develop service learning programs: Strategies for health centers*. Retrieved from <http://www.nnoha.org/nnoha-content/uploads/2016/07/Academic-Partnerships-Paper-revised-7.12.16.pdf>
9. Nolon, A.K. Glassberg, H., Silva, M.D., Miller, D. (2017). *Growing our own: Cultivating the next generation of primary care physicians in community health centers*. Peekskill, NY: HRHCare Community Health
10. National Network for Oral Health Access. (2014). *Partnering with academic institutions and residency programs to develop service learning programs: Strategies for health centers*. Retrieved from <http://www.nnoha.org/nnoha-content/uploads/2016/07/Academic-Partnerships-Paper-revised-7.12.16.pdf>

## Making the Business Case: Drawbacks of Becoming or Collaborating with an Education Health Center

### Potential Drawbacks for CHCs

- **Direct financial costs of clinical and administrative leadership and staff time.**
- **Lost revenue related to decreased productivity.** Residents, especially early in their training, are slow and inefficient compared to non-resident providers. They also use more exam rooms per patient seen. While there are various approaches to generating revenues to support the educational mission and to overcome lost productivity, creating and maintaining financially sustainable models is not without significant challenges.
- **Potential disruptions related to organizational culture change.** Not all clinicians will necessarily enjoy or be good at teaching roles, nor will all staff appreciate what is involved in becoming and remaining an EHC. An EHC will need to encourage clinicians to engage in the roles that provide them the greatest professional satisfaction.
- **Operational coordination.** Scheduling faculty and residents is significantly more complex than scheduling mostly full-time clinicians, due in large part to the former being in the outpatient setting on a part-time basis, particularly, for residents, in the first and second years. Operational efficiency and care quality issues often arise when the academic partner or the residents themselves neglect the impact of training rotations on teamwork and patient care within the CHC.
- **Capacity.** While a primary care residency program will positively impact recruitment for primary care providers, the CHC may have decreased capacity to take other medical or

## AAPHC PROFILE *(Continued from page 6)*

### Academic Institution Support for CHC and its Clinicians:

- Faculty development
- Clinical information software licenses and/or on-line library access for CHC clinicians
- Recognition of volunteer faculty and treating CHC clinicians as academic faculty
- Providing maintenance of certification (working also with AHEC)
- Supporting infrastructure development (scheduling, transportation, housing, etc.)



### Impact (Benefits to the Community, the State, and the Nation):

AAPHC programs train hundreds of health professionals for SW GA and other rural underserved communities. They developed health-related training programs at a local community college. They provide on-going influence on academic institutions and admissions processes.

AAPHC clinicians have served on admissions and selection committees of affiliated schools and programs.

AAPHC also initiated a statewide primary care workforce summit.

## [ Chapter 1: OVERVIEW AND MISSION ]



advanced practice clinicians and providers which may in turn impact recruitment for these providers.

- **Continuity of care.** Residents graduate every three years necessitating frequent re-assignment of patients. Residents will also be unavailable in the clinic when they are doing rotations elsewhere, sometimes up to several weeks at a time. CHCs need strong processes for assuring that urgent prescription refill requests, visits, and other patient follow up is addressed during these absences. Some clinics have reported higher patient no-show rates at residency sites which may be linked to resident rotations and the increased number of hospital referrals.
- **Nursing turnover.** It is typically more challenging and demanding for a nurse serving in a residency vs. a traditional CHC. Some CHCs provide additional stipends for these positions and still struggle with turnover in the residency. Nurses manage several providers. Nurses are also harder to recruit given that a higher-level nurse is required for new providers.
- **Community perceptions.** Community members may perceive residents as inferior providers compared to more experienced providers.
- **Increased administrative complexity.** Beyond the increased complexity of a new program and expanded staffing, there may be conflicts between current CHC policy and policies required by the residency program or the policies of the hospital partner. An analysis of policies should be done to assure requirements are met for all partners and accrediting bodies. CHCs will also need to build capacity and experience with billing other organizations for non-CHC services (e.g., home visits, nursing home site visits, and specialty care for non-CHC patients.)
- **Space concerns.** There is an increased demand for space in the clinic when adding a residency program. In addition to spaces required for residents, space is also needed for faculty, preceptors, and nurses. Finding adequate space in an existing facility may present some limitations and problems.



## [ Chapter 1: OVERVIEW AND MISSION ]

- **Finding faculty and residents who work well with specific patient populations.** For example, finding bilingual preceptors and residents to work at a bilingual site may be difficult. The patient makeup of a residency program may need to differ from the CHC overall.
- **Electronic Health Records (EHR).** Deciding which EHR to use is key and must be agreed upon between the CHC and the hospital partner. The ideal EHR will meet the needs of the CHC. EHR expenses may also increase due to the increased number of providers.
- **Challenging partnership dynamics.** Academic institutions approach their partnering with CHCs in varying ways. Not all academic institutions treat their CHC partners with respect and a spirit of equally valued partnership in negotiation of financial arrangements, deciding which Electronic Health Record to use, input into curricula and education of residents, support of CHC professionals as valued teachers, and in the day-to-day operational implementation of student or trainee scheduling. According to the Growing Our Own<sup>11</sup> report, “CHCs that pursue a stand-alone residency model still need a willing academic institution partner for inpatient rotations, exposure to simulation labs, and digital libraries.” In addition, for programs where a hospital or other entity is the program sponsor, there is the possibility that the linkage could dissolve.
- **Negotiating patient rates.** There may be challenges in negotiating better patient rates for patients with hospitals other than the program partner.
- **Resident communication.** Training residents in CHC policies and procedures can be difficult with the limited time that residents have as well as the number of outside rotations they do. Communication in general can be a challenge with the residents.
- **Credentialing and privileging.** Additional time will be needed for credentialing processes and there will be additional credentialing expenses for the increased number of providers associated with the program or for preceptors who are contracted for shorter time periods.

The drawbacks noted above can have impacts beyond the challenges highlighted. There may also be serious financial implications for the CHC. It behooves the CHC to closely monitor these expenses and bring them to partners for review and negotiation as the program begins, develops, and continues. The ability to track costs and to verify them will be critical to resolving funding issues.

### Potential Drawbacks for Residency Programs

- Increased administrative complexity.
- Potential for the clinical needs of the CHC to overshadow the educational needs of the residents.

Analogous to the importance of monitoring the cost implications of teaching, it’s important for the residency to continuously monitor the education experience at the CHC to ensure that the resident is not solely a clinical provider but participates actively in the residency curriculum, with sufficient didactic and reflective time.

11. Nolon, A.K. Glassberg, H., Silva, M.D., Miller, D. (2017). *Growing our own: Cultivating the next generation of primary care physicians in community health centers*. Peekskill, NY: HRHCare Community Health

## Graduate Medical Education vs. Teaching Health Center Graduate Medical Education

Key determinants of each collaboration include:

### Funding Sources

- Traditional Graduate Medical Education (GME) funding through add-on payments from Medicare and Medicaid to teaching hospitals.
- [Teaching Health Center GME](#) funding through HRSA.
- Other (e.g., special grants from the federal government, state Medicaid Programs and private foundations, Meaningful Use and other provider incentives, etc.).

*Note: Regardless of funding source, the CHC and the teaching hospital have to agree on appropriate allocation of both revenue and expenses.*

### Leadership in Accreditation and Sponsorship

**Traditional:** A hospital (typically) or other entity (e.g., a medical school or an Area Health Education Center [AHEC]) administers the residency. It is the Sponsoring Institution and has ultimate responsibility for the training program. Core faculty members and residents are employed by this entity. In this model, residents are “out posted” in a CHC for a portion of their training.

**CHC-sponsored:** In this model, the CHC is the primary administrator or sponsor of the program. A teaching hospital serves as a critical and necessary supporting partner. Core faculty members and residents are employed by the CHC or a separate not-for-profit education organization. Typically, the hospital passes a substantial portion of the GME funding it receives from Medicare, Medicaid, and other sources through to the CHC.

Based on the characteristics of funding source and Sponsoring Institution, there are therefore three possible models:



## The Imperative of Finding Synergy

CHCs and PCRPs have much in common. Both are focused on primary care. Commitment to underserved communities is central to the mission of CHCs and a focus of many PCRPs. Both organizations have long been challenged to recruit and retain key employees—providers in the case of CHCs and resident physicians in the case of PCRPs. Both struggle to attract sufficient financial and other resources to fulfill their missions.

CHCs and PCRPs also have some significant differences. The core mission of CHCs is patient care while that of primary care residencies is education. Residencies have traditionally been run by hospitals with an inpatient focus and often an organizational culture that favors specialty care.

Linkages between CHCs and residency training programs offer both entities many potential benefits and challenges. *Despite the obvious and tangible benefits to both parties, real and perceived differences in culture, mission, and vision are often present. These must be identified, acknowledged, and addressed. Failure to do so will destroy the most logically conceived of linkages.*

## The Mission of Community Health Centers—What Primary Care Residency Programs Need to Know

The primary mission of CHCs is to improve the health of their patient populations and to provide services without regard to ability to pay. When CHCs began in the mid-1960s and early 1970s, it was common for CHCs to prohibit students or trainees from seeing patients. This was due, in part, to the experience of many underserved communities that they had been for too long “guinea pigs” for students, trainees, and researchers from the teaching hospital or medical school. Only when CHCs matured and developed ways to negotiate on a more even playing field did they begin

### PROFILE



## Community Health and Social Services Center (CHASS)

Detroit, MI

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

CHASS serves the Detroit community, emphasizing serving underserved African American and Latino populations with high-quality, culturally-relevant, affordable health care. They train FMRs from the Henry Ford Health System (HFHS). CHASS was established in response to the closing of community hospitals and the flight of medical professionals to the suburbs. CHASS contracts physician services with HFHS, creating seamless access for patients to obtain subspecialty referrals and ancillary services. HFHS FM residents in turn receive most of their OB training from CHASS providers.



**Health Professions Training Programs, Trainees, and Disciplines:** FMR, Med-Ped, NP, PA, Pharma Tech, and MA.

### Educational Strategies:

**Selecting students:** The CHC seeks bilingual and bicultural students and residents, to reflect the community. They look for students and staff who grew up and went to school in the neighborhood.

*(Continued on page 14)*



## [ Chapter 1: OVERVIEW AND MISSION ]

to realize the benefits of collaborating with training programs. An additional mission of many CHCs, sometimes stated explicitly, is empowerment and development of the community being served. The importance of patient education is also widely accepted in CHCs.

### **The Mission of Primary Care Residency Programs—What Community Health Centers Need to Know**

The primary mission of residency training programs is academic. Residency training programs exist to educate physicians and promote the scholarly work of faculty through research and publication. Many, perhaps most, also state an explicit commitment to serving their patients and communities. A substantial number of PCRPs were initiated by state legislatures to assure an ongoing source of family physicians for their state or region. There is a widespread belief that residents must be part of a system that provides great care in order to learn how to provide great care.

### **Potential Areas of Conflict and Finding the Common Ground**

***“There can be a definite conflict in the different missions of the organizations. We identified while we have two different missions, it was important to create one vision moving forward. We combined our two logos for a unique logo which incorporates both for this site.”***

—Mindy Benedetti  
Health West, Pocatello, ID

Conflicts between patient care and health professional education are not unique to Education Health Centers. *Academic medical centers and teaching hospitals have long struggled with balancing “service” and “educational” missions. This will also be a challenge for Education Health Centers.* While there will no doubt be times when one mission will necessarily take precedence over the other, framing this challenge as a “balancing act” leads to the notion that it is a zero-sum game: providing more education means providing less service and vice-versa. Some EHC failures have resulted when the two missions remained at odds with each other.

**In order to create a successful Education Health Center, the service and educational missions must both be respected.**

In the most successful programs, the aim is to make the missions not just compatible but synergistic.

In order to find synergy between the clinical and educational missions, leaders at all levels need to be committed to this approach. To accomplish this, everyone needs to understand and acknowledge, in concrete terms, how the educational program both affects and enhances the clinical mission and how clinical activities both affect and enhance the educational process. PCRP educators need to fully support the idea that providing exceptional care is a necessary condition for an exceptional education. Similarly, CHC administrative and clinical leaders must embrace the idea that attracting the best residents and faculty members requires a strong educational program and without great faculty and residents, patients will not receive great care. Everyone must recognize the power of connecting the educational and clinical missions. With this commitment, both the education and patient care will spiral upward. Ignore it and both can spiral downward.

Many successful CHC-Residency linkages have revised their mission statements to reflect both educational and clinical missions. This is important at all times but two specific situations are especially challenging. The first is a new partnership between a CHC and a residency and the second is in an older established affiliation when new leaders join an organization.

There is no substitute for regular (ideally monthly) meetings between the executive staff of the CHC (including the Medical Director/CMO), the residency staff leadership, and the sponsoring, hosting, or partnering academic institution. Such meetings need to have defined agendas, minutes, and action follow-up. Boards of all participating organizations should be apprised of these meetings.

## CHASS PROFILE *(Continued from page 12)*

**Clinical teaching:** CHASS clinicians do all clinical teaching. CHASS clinicians have access to HFHS faculty development opportunities, on-line HIPAA training, and remote access to medical library and clinical decision support tools.

**Affiliation agreements:** Students are only accepted from programs with an institutional agreement with the CHC.

**MIDocs:** In partnership with the CHC and HFHS, Wayne State University FMR created an Urban Track Residency Program. Residents match into the Track, are housed at CHASS for continuity clinic, at Henry Ford Hospital Main Campus for inpatient rotations, and at HFH and WSU FM for didactics. The goal is to train physicians to work at CHCs in comprehensive, patient-centered models of healthcare. Residents commit to practice for at least two years in an underserved MI setting. In exchange, residents qualify for loan repayment. MIDocs features enhanced curricula in ambulatory care, quality improvement, inter-professional collaboration, and care of the underserved

**Educational Challenges/Academic Institutional Relationships:** All CHASS physicians are members of the HFHS Medical Group, which provides access to sub-specialist referrals and hospital-based lab and imaging services. The hospital system relationship gives CHASS access to policies, procedures, and continuing education for all employees.

**Financial Challenges and Strategies for Supporting and Sustaining the Educational Mission:** CHASS has a high mix of uninsured patients and hospitals provide uncompensated care for CHASS patients, especially in laboratory and imaging services. In exchange, CHASS provides OB training and experience for the FMR.

**Benefits to the CHC:** CEO, Dr. Felix Valbuena, was a student at the CHC before becoming CMO and then CEO. Many CHASS providers came through the CHC as students. They are clinicians with the right perspective on community. Says Dr. Valbuena, *"...a lot of the students who come through are from the community. We tend to focus on that as much as we can...I think that having the training program will allow us in the long run to provide better care for the community."*



## Developing a Shared Mission and Vision

### Questions for Everyone:

- Describe the ideal Education Health Center. What would this program look and feel like?
- How will becoming an EHC advance our mission?
- How will our current CHC mission change if we become an Education Health Center?

### Questions for Individuals:

- How will this project affect my job?
- What are the strengths of our organization?
- What value does our participation bring to a potential partner?
- What changes is our organization willing to make in order for the collaboration to be successful?

### Questions for Residency Staff:

- What are my (our) preconceived ideas about CHCs?
- What assurances do we need from CHC administration that they will support the educational mission?
- How can we provide residents with examples of continuity of care and quality of care to individual patients when they provide part-time care? Is having them be part of the inter-professional healthcare team enough to meet that goal?



### Questions for Community Health Center Staff:

- What are my (our) preconceived ideas about residents and residency programs?
- What assurances do we need from the residency program that they will support the clinical mission?
- Because residents may not be as accessible as faculty or staff clinicians, how do we assure continuity and quality of care to the patient?



Creating a residency program can have an incredibly positive impact on a CHC and the community it serves, especially in provider recruitment and retention.

Therefore it is of utmost importance to take the time to create organizational clarity regarding the effect of a residency program on the mission of the CHC, and, if the CHC elects to move forward with developing a residency or providing clinical rotation(s), *to evaluate and update the organization mission in a way that fully encompasses the needs of the organization, the patients, and the residents.*

*“We get as many students as we can to get them excited about what we do, so that they work here when they’re done with their training or work at one of the 12,000 CHC service delivery sites across the country that provide the same kind of services that we do.”*

—Felix Valbuena, Jr., MD, FAAFP  
CEO, CHASS, Detroit, MI





# GOVERNANCE

Governance and administrative complexity are frequently cited issues for CHCs that are considering becoming an Education Health Center and entering into sponsorship of, or partnership with, a residency program. There are important facts to consider on both sides of the CHC-residency linkage. Recommendations for governance must be tailored to the specifics of the CHC and the residency.

Many CHCs participating in resident education are training future family doctors. This is particularly true where the CHC is the Sponsoring Institution or is the Continuity Clinic for the program. Where CHC participation is limited to clinical rotations, a wider variety of physician trainees is represented.

## Community Health Center Governance: Considerations for Residency Participation

*Participation of a CHC in the education of resident physicians (or any health workforce program) should only be undertaken with the full understanding and support of its board of directors.*

Board members and other leaders of the CHC often struggle with the transition from being a “service organization” to an organization that provides both service and education, but such determinations are a natural extension of the required duties of board members.

- **Needs Assessment:** As with all efforts that CHCs undertake, need should be a driving factor. The CHC is required to perform periodic needs assessments and to engage its board members to interpret and respond to its findings. The shortage of primary care providers is a persistent national problem that is often especially acute for marginalized populations served in CHCs.<sup>12</sup> Without an appropriate primary care workforce, CHCs cannot achieve their primary responsibilities and objectives. Needs assessments can drive the board to its conclusion to support engagement in workforce training.
- **Mission and Vision:** The board has responsibility for setting the overall priorities of the CHC. If need dictates the CHC’s substantial engagement with education, it is important to articulate a clear message about that direction through inclusion of workforce goals in its mission statement, vision statement, or other governing documents of the organization.

12. U.S. Department of Health and Human Services. (2016). *National and regional projections of supply and demand for primary care practitioners: 2013–2025*. Retrieved from <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf>

## [ Chapter 2: GOVERNANCE ]

- **Strategic Plan:** The board is required to “provide direction for long range planning, including identifying...CHC priorities”.<sup>13</sup> Sponsoring or participating in resident education should certainly have a prominent place in the strategy of a CHC whose leadership and board have determined that engagement in physician education is an important means to address the needs of its community of patients.

It is certainly within the board’s authority to support and authorize management to engage in an educational strategy, but *it is important that leadership demonstrate that the strategy advances the CHC’s mission and does not jeopardize or harm the CHC*. This requires informed decision-making on the part of the board. Aside from advancing workforce education, the board is authorizing that services at the center will be provided by a workforce that is, in whole or in part, made up of resident and faculty physicians that participate in the residency training program. To make an informed decision, management should provide the board with supported documentation of the pros and cons of the decision.

*Residency accreditation does not affect a CHC’s Section 330 awardee/look-alike status* which is a critical funding line that relates to a CHC’s function as a deliverer of health services of specified scope, type, and quality to a population meeting certain federal criteria. The [THCGME Program](#) does not change this.<sup>14</sup> A CHC’s ability to seek federal grants and funding will not be affected by THCGME status. Residencies are not prohibited from such efforts.

Interactions with the CHC board offers an opportunity for residents to appreciate the unique role that patient board members play in the governance of a CHC. *Board members can become part of the faculty and engage residents in the mission of the center, and residents can learn about the operations and governance and management through engaging with the board as part of their residency curriculum.*

In addition to the operational aspects of care delivery in the CHC, the board should consider features that will be introduced to the organization as part of resident education:

- **Risk Management:** It is often assumed that engaging residents in patient care may be a source of increased errors and claims of injury. That conclusion is not supported by the evidence. However, management and the board must be aware that, even in the scenario where the center directly employs the resident(s), the required education will expose them to care that will likely not be deemed to be covered by the Federal Tort Claims Act (FTCA). Wraparound or “gap” insurance is especially important in this scenario. (See the Legal chapter of this Guide for further details on FTCA.)

13. Health Resources and Services Administration. (2018). Health Center Program Compliance Manual. Retrieved from <https://bphc.hrsa.gov/programrequirements/compliancemanual/>

14. Health Resources and Services Administration. (2018). Teaching health center graduate medical education (THCGME) program. Retrieved from <https://bhw.hrsa.gov/grants/medicine/thcgme>

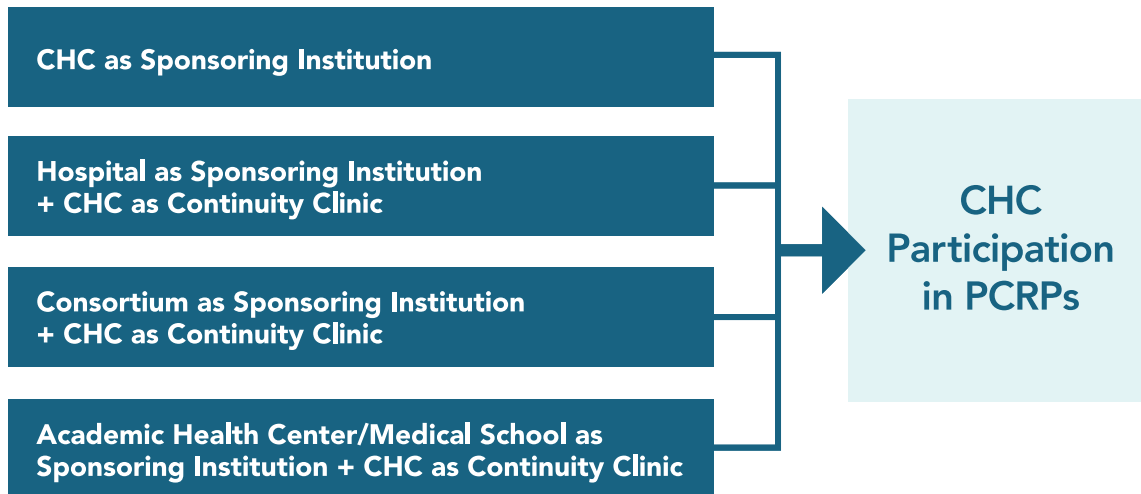


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- **Board Composition:** It may be tempting to include representation from the residency program on the CHC board. This may be desirable, but there is no exemption from HRSA's rules regarding board composition.<sup>15</sup>

### Models of Community Health Center Residency Participation

There are four common paths to CHC participation in PCRPs:



### The Community Health Center as Sponsoring Institution of the Primary Care Residency Program

The Accreditation Council for Graduate Medical Education accreditation rules are composed of two distinct and hierarchical sets of requirements. All programs must have one ACGME-accredited Sponsoring Institution. The SI must comply with the [ACGME Institutional Requirements](#).<sup>16</sup> *The SI is the organization that assumes ultimate financial and academic responsibility for the program.* The Institutional Requirements establish the roles and responsibilities of the SI. Every accredited program must comply with both the ACGME Common Program Requirements and the requirements specific to the specialty of the program.

When the CHC is the SI, it is typical that the CHC sponsors a single program and that the program is Family Medicine.<sup>17</sup> *The two-tiered structure of accreditation may seem needlessly complex. It is best*

15. Health Resources and Services Administration. (2018). Health Center Program Compliance Manual. Retrieved from <https://bphc.hrsa.gov/programrequirements/compliancemanual/>
16. Accreditation Council for Graduate Medical Education. (2018). ACGME institutional requirements. Retrieved from <https://www.acgme.org/Portals/0/PFAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf?ver=2018-02-19-132236-600>
17. Accreditation Council for Graduate Medical Education. (2018). ACGME program requirements for graduate medical education in family medicine. Retrieved from <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120FamilyMedicine2018.pdf?ver=2018-06-15-112624-307>



## [ Chapter 2: GOVERNANCE ]



*understood in the larger framework of GME.* The institution sponsoring a single program is the exception. The accreditation system is designed to respond to most SI. They are academic medical centers and teaching hospitals that typically sponsor specialty training in several disciplines.

In the single program sponsor model, it may be challenging to adapt to the requirements. The Institution's responsibilities include:

- Oversight of the selection of a Residency Program Director, faculty, staff and residents, and assurance that appropriate policies are in place for their management;
- Establishment and maintenance of a learning and working environment that meets all requirements;
- Establishment of a Graduate Medical Education Committee (GMEC) to oversee these responsibilities; and
- Appointment of a Designated Institutional Official (DIO), who chairs the GMEC and has responsibility for institutional accreditation.



Where the CHC is the Sponsoring Institution, it must constitute the GMEC in accordance with ACGME requirements.<sup>18</sup> The SI has some latitude in the appointment of the DIO. ACGME does not have a preference as to the co-identification of the Residency Program Director with the DIO in the single program sponsor model, provided that the RPD has the protected time and ability to perform both roles. If the RPD/DIO roles are not combined, the RPD must report to the DIO.

### **The Community Health Center as a Partner with Substantial Responsibility for Primary Care Residency Training and Experience**

*CHCs can have a significant role in resident education without becoming an SI.* Every teaching hospital, academic

18. Accreditation Council for Graduate Medical Education. (2018). ACGME institutional requirements. Retrieved from <https://www.acgme.org/Portals/0/PFAAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf?ver=2018-02-19-132236-600>

medical center, or other institution that operates or seeks to operate a PCRFP must provide for a practice site. CHCs easily meet the requirements to be the practice site for an accredited residency.<sup>19</sup> Especially where the SI's mission is the training of primary care physicians to care for underserved patients, is located in proximity to underserved populations, and shares those populations with the CHC, working together may be the natural solution. CHCs should be cautious as well, since a driving factor for hospitals and academic institutions to partner is the reimbursement CHCs receive and the belief that this will be a less expensive option than having the practice site in a hospital-based clinic.

*As the practice site for a program sponsored by another institution, the CHC may achieve its objectives regarding participation in workforce development with less risk and responsibility.*

In turn, the CHC relinquishes much control to its partner institution. Clear understandings between partners are essential. Regarding governance, it is advised that:

- The CHC is represented on the Sponsoring Institution's GMEC (or an appropriate subcommittee), with appointment of a representative who can speak authoritatively for the CHC;
- The Residency Program Director play an integral and collaborative role in the leadership of the CHC and the center's clinic that serves as the practice site; and
- The Residency Program Director is an ex-officio member of the CHC's board of directors and provides reports regularly to it.

19. Accreditation Council for Graduate Medical Education. (2018). *ACGME program requirements for graduate medical education in family medicine*. Retrieved from <https://www.acgme.org/Portals/0/PFA-sets/ProgramRequirements/120FamilyMedicine2018.pdf?ver=2018-06-15-112624-307>

## PROFILE

**Cherokee  
Health  
Systems  
(CHS)**

Knoxville, TN

[www.cherokeehealth.com](http://www.cherokeehealth.com)



*"We care about people and we believe the best approach to wellness involves treating both the body and mind. That's why we offer a full range of health care services. Whether a person needs medical, dental, or BH care, our compassionate, dedicated staff is here to help. We strive to improve the well-being of our clients by becoming their partner in healthcare. We work together... enhancing life."*

CHS is a comprehensive health services organization touching tens of thousands of lives every year in fourteen counties of East TN. BH outreach is provided at numerous sites, including primary care clinics, schools, and Head Start Centers. The need for quality care in the region prompted expansion of CHS's scope of services and range of expertise to include BH, medical, and dental programs. Staff members, including psychologists, physicians, dentists, social workers, nurses, pharmacists, and public health specialists, offer an array of comprehensive primary care and BH services. CHS is known as being one of the nation's leading programs in PC/BH integration, and has become known for training health professionals in a 21st-century, integrated, collaborative-care model.

### **Select Educational Strategies:**

**Integrated care:** CHS is a national "best-practice" model of PC/BH integration in team-based whole-person care. CHS trains professionals in-house and provides integrated care academies for clinicians from across the nation.

**Team-based care and training:** Students are taught in a team-based inter-professional culture while learning to use an integrated EHR that applies across the care continuum. Students shadow professionals from other disciplines and

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## The Community Health Center as Host for Residency Rotations

*For many CHCs, hosting residency rotations is the preferred model for participating in resident education as it provides the benefits of having a resident on-site with less time and resources than other, more involved models.* Alliances for such educational experiences can be achieved, as mutually agreed, through the execution of a simple program letter of agreement (PLA). *Evidence suggests that training curricula and rotations focused on underserved or rural communities, particularly during residency, have strong correlation to retention in primary care.*<sup>20,21</sup> However, these rotations are not as commonplace as the CHC might wish. Primary care residents are primarily committed to their practice site for their training in ambulatory medicine. PCRP accreditation requirements tightly limit the amount of time that a resident may be absent from care to their continuity patient panel at the practice site. Meeting all of the educational experiences required of the accredited program leaves little latitude for the program to create an alternative primary care experience, or for the resident to create an elective in a CHC setting.

A CHC wishing to make a substantive commitment to workforce training through the education of primary care residents is not likely to meet their objectives with this model.

## Collaborative Agreements

CHCs and residency programs which ultimately decide to collaborate need to develop a written Program Letter of Agreement (PLA).<sup>22</sup>

The PLA should:

- Identify the faculty who will assume both educational and supervisory responsibilities for residents;
- Specify faculty responsibilities for teaching, supervision, and formal evaluation of residents;
- Specify the duration and content of the educational experience; and
- State the policies and procedures that will govern resident education during the assignment.

When the CHC is the SI, an affiliation agreement with the teaching hospital will be needed.

Although each affiliation agreement will be unique, most should include the following elements:

20. Phillips, R.L., Doodoo, M.S., Petterson, S., Xierali, I., Bazemore, A., Teevan, B....Rudd, J. (2009). *Specialty and geographic distribution of the physician workforce: What influences medical student and resident choices?* Washington, DC: The Robert Graham Center. Retrieved from <https://www.graham-center.org/dam/rgc/documents/publications-reports/monographs-books/Specialty-geography-compressed.pdf>
21. Brooks, R.G., Walsh, M., Mardon, R.E., Lewis, M., Clawson, A. (2002). The roles of nature and nurture in the recruitment and retention of primary care physicians in rural areas: A review of the literature. *Academic Medicine Journal of the Association of American Medical Colleges*. 77(8) 790-798. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/12176692>
22. Accreditation Council for Graduate Medical Education. (2017). *ACGME common program requirements*. Retrieved from <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120FamilyMedicine2018.pdf?ver=2018-06-15-112624-307>



## [ Chapter 2: GOVERNANCE ]

- Time period covered by the agreement;
- Reasons, time course, and process for termination of the agreement;
- Guidance on affiliation renewal and continuation;
- Responsibilities of each party, including regular meetings between the CHC executive staff, the residency leadership, and the partner agencies when appropriate; and
- Careful and specific financial agreement which includes:
  - Periodic reconciliation;
  - Specificity about costs and revenue allocation;
  - Commitment to transparency;
  - Productivity expectations for both faculty and residents; and
  - Levels of clerical and clinical support expected for faculty and residents.

It is imperative that both partners have a clear understanding of their roles and responsibilities. It may seem like a burden to outline processes and procedures for items such as addressing resident and faculty concerns, HIPAA violations, providing inappropriate care, etc., before the program has even begun, but both partners will benefit from this clarity.

### Finding and Sustaining Common Ground: Ideas to Consider

#### The Community Health Center-Hospital Relationship

Whether the CHC is the Sponsoring Institution or collaborates with a teaching hospital to participate in resident education, the need for high levels of dialogue and joint decision-making may be unfamiliar to the CHC. *It is important to build a relationship on trust and communication.*

### CHS PROFILE *(Continued from page 22)*

experience moment-to-moment collaborative care interactions among all the professionals serving the same patients.

**Distance learning:** CHS uses distance learning for student's didactic sessions, and for supervision of BH post-doctoral trainees. This required assertive negotiations with the state licensing board.

**Integrating the Healthcare Delivery (Service) and Educational Missions:** CHS leaders consider the educational programs to be part of their essential mission. *"We want to give the next generation of providers a good experience in serving the underserved,"* said CEO Dennis Freeman.

#### Financial Challenges and Strategies for Supporting and Sustaining the Educational Mission:

- None of the affiliated universities or training programs pay CHS to train their students or residents. CHS pays one university for the opportunity to train their health professionals.
- CHS receives funding for pharmacy students from the regional AHEC program.
- Because it is both a CHC and a licensed CMHC, CHS can sometimes bill for trainee-provided, appropriately supervised, BH services.
- CHS received a training grant from HRSA to train psychologists in the practice of integrated care.
- CHS is the East TN center for Meharry Medical College's AHEC.
- CHS obtained grant funding for innovative programs, including HRSA's Maternal and Child Health Bureau funding, Rural Health Outreach grants, and a Community Access Program grant to link area safety net primary care providers through an integrated service delivery model.
- CHS obtained United Way funding to provide health homes for uninsured residents of Knox County, and was designated the East TN Center of Excellence for Services to Children in, or at risk for, state custody.

## [ Chapter 2: GOVERNANCE ]



Regular, scheduled meetings of CHC and hospital leaders (Chief Executive Officers, Chief Medical Officers, and Chief Financial Officers) are critical to the partnership. Both parties should be members of the sponsor's Graduate Medical Education Committee (GMEC).<sup>23</sup> Joint representation in other decision-making bodies including respective boards and finance committees may also be advisable.

It is also necessary to have careful discussion and agreement about how conflicts, changes in faculty, and resident schedules will be addressed and resolved.

### Community Health Center-Sponsored Programs

When the CHC is the Sponsoring Institution, it is important to provide regular Residency Program Director reports to the CHC board of directors. *Planned interaction between board members and resident physicians can be valuable to both the provider and the board of directors in ensuring a high-quality program.*

For existing CHCs contemplating a new residency or merging with an existing program, revising the CHC mission statement to include commitment to education is an important exercise to spur discussion and provide benchmarks for evaluation of the program and relationships.

It is also important to consider how CHC providers with both faculty and clinical responsibilities will be compensated compared to the CHC provider whose job is 100% patient care. The goal is for everyone to feel their contributions are both valued and equitably compensated. It is advisable to avoid the situation where people choose to teach or not teach primarily because of the impact on their wages (preceptor providers are often paid more than non-preceptors). This becomes even more important when the CHC is responsible for several sites, including those not hosting or involved with the residency program. There are many compensation models that health



23. Accreditation Council for Graduate Medical Education. (2018). *ACGME institutional requirements*. Retrieved from <https://www.acgme.org/Portals/0/PFAAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf?ver=2018-02-19-132236-600>

## [ Chapter 2: GOVERNANCE ]

centers have deployed to compensate core faculty; selection of a model is dependent on the unique characteristics of each CHC and their program.

### Hospital-Sponsored Programs

An alternative relationship to consider which allows for a contract between the CHC and the hospital or medical school-sponsored residency is a purchase of service agreement whereby the services of both residents and selected faculty/clinical staff are purchased by the CHC from the educational institution.

In any substantial participation in residency training, the CHC and its board are choosing to deploy residents and faculty of the teaching program to achieve their primary goal: the delivery of safe and effective primary care. Residents and faculty physicians spend most of their time in learning, teaching and administration of the program. In a purchased service setting, the CHC limits their liability by contracting only for the clinical practice portion of their work. To further limit financial risk, the health center contract should consider the reasonable wages of the provider, and their potential for productivity. The latter is particularly important when considering the work of the new resident in the clinic. For example, a first-year resident sees about five patients per clinic on average. The center's cost to maintain and staff the clinic may exceed the revenue projected, and the health center should negotiate accordingly.

Starting a new residency program or partnering in an existing residency program is a serious undertaking for a CHC. *It is important that CHC leadership work closely with the board of directors to properly evaluate the mission impact of a residency program* as well as the many other considerations discussed throughout this Guide.

**Clear communication is vital at every level throughout the process and once the program is established. However difficult it may be to embark on this complex process, it is important to keep in mind the potential pitfalls and challenges, as well as the benefits to the residents, the CHC, and the population served.**







# ADMINISTRATION AND OPERATIONS

## Residency Administration and Operations

Residencies and CHCs are unified and separated by a set of common values and needs.<sup>24</sup> *The key administrative and operational challenge in an Education Health Center (EHC) is allowing the best of both residency and CHC cultures to not only coexist, but to thrive and complement each other.*

The CHC must understand and incorporate the accreditation and training requirements of the residency program. Similarly, the residency program located in the CHC needs to incorporate the CHC governance and integrate the CHC's clinical services into its fabric as a training program. Only then will the Education Health Center overcome what have historically been perceived impediments to co-locating residency training programs in CHCs.

An essential element of this success is the adoption of a shared mission of an equal commitment to service and education.

The administrative, clinical, and academic personnel of the CHC, the program, and the Sponsoring Institution (if different than the CHC) must work together to implement this shared vision and prevent differences from providing high quality care and training.

Historically, residency programs have been hospital-based with the Continuity Clinic in hospital-licensed space. As such, they have been regulated and operated to meet the hospital's strategic objectives. This has been changing since the implementation of the [Balanced Budget Act of 1997](#) when hospitals were for the first time able to claim, provided certain requirements were met, Indirect Medical Education (IME) funds from the Centers for Medicare and Medicaid Services (CMS) for training time in ambulatory

24. Morris, C.G., Johnson B., Kim, S., and Chen, F. (2008). Training family physicians in community health centers: a health workforce solution. *Family Medicine*, 40 (4), 271-276. Retrieved from <https://fammedarchives.blob.core.windows.net/imagesandpdfs/fmhub/fm2008/April/Carl271.pdf>

## [ Chapter 3: ADMINISTRATION AND OPERATIONS ]

sites.<sup>25</sup> Much like other clinical services moving to outpatient sites, residency education shifted to more ambulatory training. Even with different regulatory agencies, policies, and outcome metrics, there is increasing recognition among CHCs, hospitals, medical schools, and residency programs that quality of care and quality of training require similar solutions.

### Operations

A CHC has many choices in how to engage with residency training. This chapter is intended to address operational considerations that a CHC may face within its continuity practice when evaluating whether to engage in resident training.

Residency programs have various positions as required by the Accreditation Council for Graduate Medical Education (ACGME) Common and Specialty Requirements.<sup>26, 27</sup> Specialty Requirements will vary by specialty, while Common Requirements apply to all ACGME-accredited programs. The positions may be different in nature than what a CHC may be accustomed to. A residency program may have some of the following positions required by ACGME:

- Residency Program Director;
- Associate Residency Program Director (supporting Residency Program Director, required for Internal Medicine, optional for Family Medicine);
- Residency Program Coordinator (provides administrative support for residency program);
- Core Faculty (definition of “Core” varies by specialty, see [ACGME](#) for all requirements);
- Residents; and
- Chief Resident.

The above individuals will not solely see patients in the Continuity Clinic as they will have educational responsibilities such as precepting in the inpatient and outpatient environments, mentoring residents, curriculum development, lectures, and evaluations.

The CHC may or may not employ all, some, or none of the aforementioned positions. Things to consider with the employment decisions are:

- Clarity and consistency of management and vision should a Residency Program Director and/or Residency Program Coordinator be employed by an entity other than that which employs the Core Faculty;

25. Centers for Medicare and Medicaid Services. (2014). *Indirect medical education (IME)*. Retrieved from <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/indirect-medical-education-ime.html>

26. Accreditation Council for Graduate Medical Education. (2017). *ACGME common program requirements*. Retrieved from <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120FamilyMedicine2018.pdf?ver=2018-06-15-112624-307>

27. Accreditation Council for Graduate Medical Education. (2017). *ACGME specialties requiring a preliminary year*. Retrieved from <https://acgme.org/Portals/0/PFAssets/ProgramResources/PGY1Requirements.pdf?ver=2017-09-08-114529-173>

- Cost and coverage of fringe benefits;
- Impact of [Ethical and Religious Directives for Catholic Health Care Services](#) (ERDs) on access to training;<sup>28</sup>
- Federal Tort Claims Act (FTCA) coverage; and
- Access to National Health Service Corps (NHSC) Loan Repayment and other loan repayment programs.

### The Residency Program Director

*The Residency Program Director (RPD) job description calls for a protected percentage of administrative and teaching time and, as such, creates a new role in CHC administration.* In order to integrate the teaching and clinical missions, the RPD should be part of the program's operational team and have an appropriate voice in system decisions that can impact and enhance the educational and clinical activities of the EHC. When the CHC is not the SI of the residency, the RPD may or may not be an employee of the CHC. This will require negotiations with the SI partner about how the RPD will work with CHC leadership and staff, reporting needs, and so on. These structures will vary with each partnership and should be outlined clearly and agreed to by both partners before moving forward.

There are some ACGME RPD requirements that apply to personnel that are unique and will operate in addition to the usual human resources processes. These requirements include;

- GMEC approval of the RPD;
- RPD input and approval in hiring faculty physicians;

28. United States Conference of Catholic Bishops. (2018). *Ethical and religious directives for Catholic health care services, 6th Ed.* Retrieved from <http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf>

### PROFILE

**Community Health Care (CHCT)**

COMMUNITY  
HEALTH  
*Care*  
MEDICAL • DENTAL • PHARMACY

Tacoma, WA

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

CHCT began as a volunteer organization through the Pierce County Medical Society. After growth and association with local physicians, government, and private organizations, CHCT became a non-profit organization focused on meeting the needs of the underserved, growing into a network of five medical and four dental clinics serving more than 45,000 patients each year. CHCT expanded its mission of clinical education with the opening of CHCT's Hilltop Regional Health Center, which serves as home base to the residency program.



There is an overwhelming need for primary care providers who are equipped to care for a diverse population. CHCT responded to this demand by developing one of the nation's first inter-disciplinary residency programs with a focus on providing quality healthcare accessible to everyone. This is a unique approach to primary care residencies with multi-disciplinary providers teaching, learning, and working alongside each other. CHCT is a HRSA designated THC.

(Continued on page 32)

## [ Chapter 3: ADMINISTRATION AND OPERATIONS ]

- RPD involvement in faculty physician evaluations; and
- RPD oversight of resident selection.

In the ACGME application for Family Medicine, the specialty application must address whether the Director of the Family Medicine Practice reports to the Residency Program Director. Negative responses require a justification, which is doable when training occurs in CHCs. *However, the presence of this question demonstrates the expectation of the senior-level involvement of the RPD and the importance of the RPD having control of all educational aspects of the Continuity Clinic. Mechanisms must be put in place to adhere to the intent of this question and the Residency Program Director is key to that process.*

The Residency Program Director is responsible for implementing and ensuring compliance with policies and procedures for grievance and due process, duty hours, selection, evaluation and promotion of residents, and disciplinary action and supervision of residents. In many of these areas they will work closely with the CHC Medical Director/CMO and human resources and compliance staff.

Institutions and/or programs will have additional policies and procedures. These policies and procedures should be given to all residents and faculty in print format and/or made available on a residency program website to assure all are knowledgeable about these important issues. Therefore the Residency Program Director should be involved as well in the overall recruiting, screening, and hiring processes. In addition, Residency Program Directors should be familiar with and comply with policies and procedures as outlined in the ACGME [Manual of Policies and Procedures](#), available on the [ACGME website](#).

The Residency Program Director must also be directly responsible for the resident performance evaluations, documenting educational experiences, and verifying completion of training and board eligibility of the graduates. *RPDs are responsible for ensuring the quality of the didactic and clinical education experiences and supervision of the residents in all systems the residents work in.* The RPD must oversee resident promotion and any disciplinary actions taken. The RPD submits detailed reports at required intervals to the ACGME documenting resident performance, experiences, and progress. *The RPD provides reports to the GMEC of the SI as well*, giving performance reports, and receiving approval for any major program changes. Any areas of concern or program citations raised by the ACGME are the responsibility of the RPD to correct, often in collaboration with other system leaders.

Residency Program Directors must also be knowledgeable about the CHC requirements, compliance needs, and reporting requirements. They must ensure that educational systems do not violate CHC



required functions or interfere with required data collection and measurements.

### Core Faculty and Faculty

Residency Faculty is defined as “The group of individuals (both physician and non-physician) assigned to teach and supervise residents/fellows”.

Core Faculty is defined as “All physician faculty members in a specialty program who have a significant role in the education of residents/fellows and who have documented qualifications to instruct and supervise.

Core faculty members devote at least 15 hours per week to resident education and administration.”<sup>29</sup>

Core faculty can be existing CHC staff who want to teach or may be new individuals recruited into the CHC. In some cases, core faculty can be leased from an academic institution or other entity to provide teaching and clinical services.

It is imperative that the program meets the appropriate definition of Core Faculty and at all times meets the minimum number of Core Faculty FTEs as detailed by the Specialty. Some residency programs only utilize Core Faculty for teaching in the Continuity Clinic. Others use a mix of the required number of Core Faculty plus other part-time and/or volunteer faculty. While some physicians will have a primarily clinical role, and some primarily teaching and supervision, ***all providers should understand that part of their role in a truly integrated EHC will be working and caring for patients alongside resident learners and supervising their care.***

### Facilities

Certain specialties, such as Family Medicine, have very specific space requirements regarding the Continuity

29. Accreditation Council for Graduate Medical Education. (2018). *Glossary of terms*. Retrieved from [https://www.acgme.org/Portals/0/PDFs/ab\\_ACGMEglossary.pdf](https://www.acgme.org/Portals/0/PDFs/ab_ACGMEglossary.pdf)

### CHCT PROFILE *(Continued from page 30)*

**Family Medicine Residency:** CHCT’s FMR program is affiliated with the UW Family Medicine Residency Network and with Pacific Northwest University. The program accepts six residents each year, 18 residents for the three-year program. CHCT’s FMR emphasizes training family physicians in the full-spectrum care of a diverse urban patient population—including outpatient, inpatient, and OB.

**Nurse Practitioner Residency:** CHCT’s Family Advanced Nurse Practitioner (ARNP) Residency trains two NPs in an intensive one-year program. The goal of the program is to prepare NPs for a career in public health by providing the opportunity to develop knowledge and hone skills in a CHC setting.

**Dental Residency:** CHCT operates a Dentistry Residency in affiliation with New York University Medical Center. This one-year program trains two residents by providing extensive training in underserved communities. In the training year, these residents conduct approximately 1,500 patient procedures.

**Pharmacy Residency:** This program trains two residents per year and is associated with the UW School Of Pharmacy. The program focuses on the clinical pharmacist role, which emphasizes team-based care needed in a CHC.

**School Partnerships:** CHCT trains students from UW, WSU, and Pacific Northwest University medical schools, and accepts clerkships from various NP schools in WA and elsewhere. UW’s MEDEX PA program recently opened a branch in Tacoma; CHCT developed a special six-month continuity clerkship in community medicine to train and recruit such PAs.

**The goal of these programs is two-fold:** to create high-quality health care providers specializing in primary care family medicine in a CHC setting, and to train these providers specifically for CHCT. CHCT has been able to hire three physicians, four NPs, one dentist, one pharmacist (out of only one class so far), and one PA (again, after only the first class). CHCT is also developing an ‘administrative residency’, which will provide leadership training in finance, HR, operations, and management to administrative personnel.



Clinic. These requirements include number of exam rooms per resident while in clinic, presence of faculty offices, precepting rooms, resident work space, conference rooms, and more. The ACGME [Family Medicine Standards and Application](#) should be consulted for details.

### Scheduling

Every July the Continuity Clinic welcomes a new first-year class of residents who can be added to the clinic schedule and start seeing patients. ***Scheduling patients and providers in the Continuity Clinic is different for a residency program.***

First-year residents are in clinic only one to two half-days each week. CHCs have patients that need continuity care and the residents are required to have a panel of continuity patients that meet certain demographic and condition requirements. Scheduling so that all needs are met is a complex situation that involves the clinic scheduling staff, the Residency Coordinator and, if available, the Chief Resident. ***Key to patients and residents getting the necessary access to care and training is the existence of care teams.*** Residents and faculty being on designated care teams allow for the residents' patient panels to be covered by others who are known by the patient, thereby maintaining access to care for the patient when the resident is not present in the clinic.



The existence of care teams also supports patients in embracing the presence of the residents as learners as there is a team of individuals supporting the patient, not just the resident and preceptors. Some CHCs have found it highly beneficial to proactively engage patients in the process of educating residents, as ***the patient is also teaching the resident about their own physical, behavioral, and psycho-social elements.***



Residency programs work on an academic calendar of July to June; new residents begin and existing residents promote each July, resulting in a new year of resident schedules being developed. Residency schedules are broken down into either twelve or thirteen blocks each year, with an individual resident not always in Continuity Clinic during certain

## [ Chapter 3: ADMINISTRATION AND OPERATIONS ]

blocks. The residency program will provide CHCs with the upcoming year's block rotation no later than June of each year, but vary significantly as to when they can provide information on what half-days each week a resident will be in clinic. This can be an area of difficulty for CHCs and so it is critical that understandings and expectations are made and documented as to how long in advance the residency program will provide the clinic schedule. Without this, it is impossible for the CHC to schedule patients for appointments.

Residents are limited as to how much vacation they can have and they must use all of their vacation each academic year. Most programs only allow residents to take one week of vacation at a time, but this can vary. Vacation requests are always approved by the Residency Program Director with the process and amount of notice varying by program. It is important that the CHC is aware of the vacation request policies of the residency program so that the impact to the clinic and schedule is minimized. Similarly, there can be tensions between the CHC and the residency program when there are unanticipated changes to the schedule with minimal or no notice. ***It is critical that there is good communication between the CHC scheduler and the Residency Coordinator as well as clear policies for the residents.*** Some CHCs have established rates that the residency program must pay the CHC for any clinic cancellations with short notice that cannot be covered by another resident or faculty member.

Residents are also restricted to specific duty hour schedules that limit the work hours per day and length of breaks between work assignments. [ACGME duty-hours requirements](#) address both the specific number of hours as well as modifications around wellbeing/fatigue. The requirements also define exceptions for very specific patient care scenarios where residents' presence obligation supersedes hour limits. The Residency Program Director is responsible for ensuring program-wide compliance with these standards. The health center must be supportive of the resident and his/her sleep and well-being needs.

### Supervision of Residents

There are very strict Medicare rules regarding payment for supervision. These supervision rules are found on the [CMS website](#). Additionally, each state, CMS, and HRSA have regulations pertaining to the definition of an allowable provider. ***All CHCs must abide by these regulations and show documentation that the guidelines are followed.*** Some states have additional requirements extending to Medicaid patients as well. The management and fiscal team, including the Residency Program Director, must become well versed on the billing and supervision requirements for Medicare and Medicaid patients, and all other health insurance plans that cover patients' services.

These rules specify the ratio of residents to supervising faculty, the direct/face-to-face or indirect supervision of each visit and documentation as a requirement for reimbursement for this visit.

The leadership of the CHC and the residency program need to understand and closely monitor the CMS and ACGME rules that regulate resident supervision of health care services provided by residents at the center. ***Failure to comply with the CMS regulations could place the CHC at risk of billing fraud with CMS and impact their Section 330 grant with HRSA.*** The ACGME has additional rules that determine

## [ Chapter 3: ADMINISTRATION AND OPERATIONS ]

proper resident supervision and failing to comply with these rules can jeopardize the accreditation of the program.

These regulations are not very different from those the CHC has to follow for its Section 330 grant, which ensures that patients receive high quality care delivered by competent, allowable providers. Resident supervision (called precepting in the ambulatory setting) rules will vary by specialty and will evolve over time, so *CHC and resident program management need to be current with the ACGME resident supervision rules*. Some examples include a set ratio of the number of supervising attendings (preceptors) to residents, protecting preceptors from other clinical duties while supervising, ensuring the preceptor has face-to-face contact with certain patients for more junior residents, and documenting proper supervision in the medical record. All payers, CMS, HRSA, and health plans, are paying for attending level care and the records need to reflect this.

The overarching goal is to ensure that residents have adequate supervision for all their clinical duties. However, that *supervision is also structured to allow personal and professional growth as well as allow increasing autonomy as the individual resident's skills allow*. This is true in the hospital as well as all non-hospital settings. The program requirements spell out the specific levels of supervision and the direct or indirect involvement of the supervising or precepting faculty in detail for each level of resident.

### Faculty and Hospital Relationships

#### Identifying a Hospital Partner

Residents are required to do some of their clinical training in hospital-based rotations, which enables residents to learn how to provide continuity of care between the CHC and the hospital. Requirements for hospital-based training will vary by specialty and by year of training, details of which are available on the [ACGME website](#).

When the CHC is the SI, the CHC needs to identify an affiliated hospital that will provide inpatient training experience and specialty faculty for the residency program. The CHC may already have a hospital that provides emergency, specialty, and inpatient services for its patients, and this hospital could offer training for the residents. The CHC and residency leadership will have to negotiate with the hospital for this training capacity using the current referring volume as part of a new business model that includes training as well as patient services. *Hospitals are well aware of the financial benefits of GME support for residency training*. However, *with the HRSA THCGME model the money flows to the CHC not the hospital*. Providing training at little to no cost is the desired goal for the CHC, as the hospital benefits from the revenue from referrals and with the additional workload capacity provided by residents.

#### Residency Faculty in the Hospital

All faculty members are required to maintain clinical activity and privileges in the settings they see patients. Some specialties require residency faculty to supervise residents in the inpatient setting.



These details are also available on the [ACGME website](#). *The CHC and residency leadership will have to address the financial and operational impact of the CHC attending physician spending time at the hospital managing inpatients and supervising residents.* The revenue from billing for these inpatient services is usually modest and will not cover the attending's time at the hospital. In order to increase efficiencies and to help control costs, consideration should be given to whether the residency program can be trained by available hospitalists, to the extent they are available, or the faculty employed by the CHC.

Attending physicians will have to obtain and maintain hospital privileges. These requirements may vary by specialty and hospital. Obtaining these privileges can become complicated. Family Medicine training requires Family Physician Faculty to have obstetric privileges, which can be a challenge. In some cases, inpatient supervision may be delegated to hospitalist teams already employed by the local hospital, but they must be accepted as faculty and ensure that they will accept the CHC patients and provide resident supervision that meets the supervision guidelines.

### Community Health Center and Hospital Finances

If the CHC is the SI, the hospital may not subsidize the CHC residency, especially if the hospital does not get GME flowing to it. If the CHC is part of a primary care network, some hospitals may support these training programs, because they are aware that the growth of their network comes from the graduates of these programs. Some hospitals do support local CHCs with a variety of arrangements and for a variety of reasons. This is one area that will benefit if a CHC already has a good relationship with the hospital it will be using for training. However, it has also been an area of great challenge and misunderstanding in traditional hospital-sponsored primary care residencies in the past.

## PROFILE

### Community Health Center, Inc. (CHC, Inc.)

Middletown, CT

[www.chc1.com](http://www.chc1.com)



CHC, Inc. provides primary care in medicine, dentistry, and BH to patients in CT. CHC, Inc. is home to the Weitzman Institute, an institute devoted to research, innovation, quality improvement, education, and training. CHC, Inc. developed one of the first postgraduate NP residency programs in the country and supports organizations in developing and maintaining NP programs nationwide. CHC, Inc. led development of an accreditation entity for NP residencies and sponsors postgraduate residencies for psych/mental health, pediatric, and adult/gerontological NPs.



CHC, Inc. operates a postdoctoral clinical psychology residency program, which trains psychologists in integrated primary care. CHC, Inc. co-founded NIMAA, which educates and trains MAs to a high performance model. These programs and the pre-professional experiences offered, focus on training for high-performance clinical care in complex populations.

(Continued on page 38)

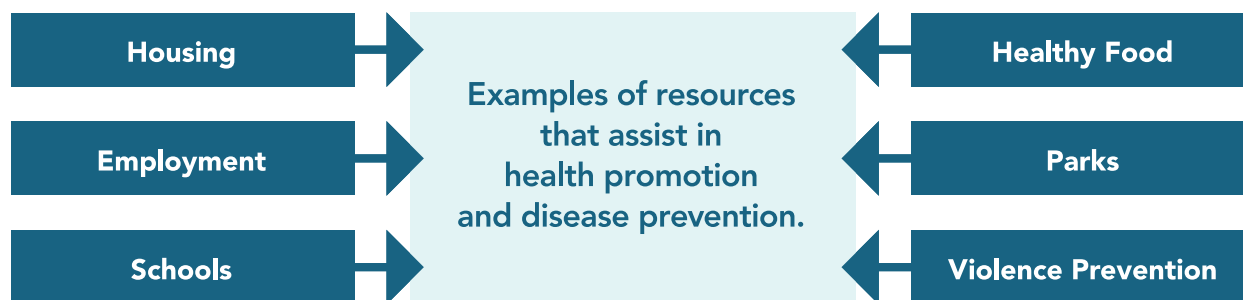
The CEO and Medical Director/CMO of the CHC as well as the Residency Program Director should be very clear on the business and financial relationship with the hospital and expectations of each partner, *as aligning the financial incentives of both organizations is crucial to establishing and sustaining a successful partnership for residency training and patient care. Often the hospital will not be aware of the services provided by a CHC that reduce a hospital's uncompensated care in preventable Emergency Department (ED) visits and admissions.* Providing faculty and resident staff to the hospital to care for these patients is often a tremendous benefit as the CHC manages patients, many who are underinsured or uninsured, limiting the hospital's financial costs for uncompensated patients. On average, over 60% of graduated residents practice within 100 miles of their training site, offering a pool of potential recruits for that system, and reducing recruiting expenses.<sup>30</sup>

CHC and hospital relationships are uniquely determined within each community. *There is no one-size-fits-all approach to developing good hospital relationships.* If this is an area of challenge, asking similar programs how they addressed it or obtaining a program consult may be of great help. Aligning incentives between the CHC and the hospital is the key to success.

[For additional information on CHC/Hospital financial relationships, please see the Finance chapter of this Guide.](#)

### Community Relationships

The community partnerships with the CHC can be just as important to the residency program as the hospital. *An important goal of training residents in CHCs is to strengthen the connection between the physician and the patient through utilizing community resources to positively impact on the Social Determinants of Health (SDOH).* Housing, schools, parks, employment, healthy food, and violence prevention are among the many resources that assist in health promotion and disease prevention. Informing residents of community-based partners and resources is a valuable step in educating residents in how leveraging community resources can improve patient care.



For a variety of economic and academic reasons, CHCs may use licensed, community-based specialists (e.g., cardiologists, infection disease specialists, neurologists, orthopedic surgeons, etc.) who serve CHC

30. American Academy of Family Physicians. (2013). *New family physicians tend to settle close to training sites.* Retrieved from <https://www.aafp.org/news/education-professional-development/20131120rgcfmgrads.html>

patients to provide training in their specialty to the residency program. The specific specialty and details of training will vary based upon the requirements of the residency curriculum. Curriculum requirements for Family Medicine (FM) include patient care and procedural skills, medical and diagnostic skills, and knowledge of evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. (For full FM curriculum requirements and other specialty curriculum requirements, see the [ACGME Program Requirements](#) curriculum section.) Compensation to the specialists for training the residents should be negotiated by building on the business model of referrals. Some specialists may welcome the opportunity to train residents and expand their professional activities beyond patient care to academic pursuits. Expanding the specialty network of the CHC to include academic experience stabilizes the specialty network that is often subject to rapid changes from health plan participation or network realignment. Unless the required rotations can be provided in the community, arrangements for residents to leave the CHC's practice area to get the required training will be required.

*Community leaders, including those from the local medical community, can become influential supporters of the residency.* They can be valuable sources of financial support as well as political support, especially when negotiating with the hospital, as specialists provide the bulk of highly-reimbursed services the hospitals depend on. This is similar for residencies and CHCs. It is ideal for the supporters of each party (CHC service and residency training) to understand the mutually reinforcing relationship such service and education programs provide. This will require clarity and education both internally of staff and of the community.

## CHC, INC. PROFILE (Continued from page 36)

The Weitzman Institute conducts research in priority areas, including chronic pain management, addressing the opioid epidemic, implementation science, and care for key populations. Weitzman's offerings include eConsults, which ensures access to specialist services through asynchronous consultations, and Project ECHO-Weitzman Institute, which provides on-going training in high priority areas.



### Educational Strategies:

**Team-based care:** Care is provided in a pod model. The Pod consists of NPs, physicians, nurses, MAs, social workers, nutritionists, pharmacists, podiatrists, psychologists, and chiropractors. Learning objectives for each program are specific to and consistent with this team-based care model.

**Educational Challenges/Academic Institutional Relationships:** It is challenging when schools send students for a rotation with no warning, or when students reach out to preceptors directly. CHC, Inc. maintains clear expectations through protocols and standards schools must adhere to.

### Financial Challenges and Strategies for Supporting and Sustaining the Educational Mission:

- Education by itself does not break even. The organization sees education, innovation, team-based care, excellence in care delivery to the underserved, and health outcomes improvement in diverse communities as interwoven and essential to achievement of the CHC mission.
- NP residents generate revenues based on encounters, but at lower productivity than experienced clinicians. A postdoctoral psychologist can make a financial margin during their residency.
- The Institute helps pay for testing and adopting innovations, and diversifies funding

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## Academic Requirements

Residency requirements include specific time spent on specific educational rotations for acquisition of diagnostic and procedural skills, professional competencies, certain required work conditions and contract provisions, and monitoring limitation of work hours. All of this must be structured in the resident experience and it must be measurable for reporting purposes. While it is the Residency Program Director's responsibility to ensure the training program is in compliance with these rules, they will require substantial assistance in the administrative support of this. *Administrative support for the documentation and tracking of educational and clinical experiences are required for the residency* and each individual resident and must be reported electronically on the Accreditation Data System (ADS). It is critical to successful residency program implementation to create an educational program that both complies with program reporting requirements and is able to accurately track and document resident educational activity. *CHCs are very familiar with the need to track and report data in the HRSA Uniform Data System (UDS) and other compliance reporting. This familiarity can be a strength that can assist in the resident data collection process.*

*Initial accreditation also requires that the residency site has an adequate patient volume and age distribution for resident training*, and that dedicated support functions and other required items are in place and adequately planned and resourced. These requirements will vary by specialty. Family Medicine requirements include a patient population whose volume and variety of clinical problems and disease is sufficient to enable all residents to learn and demonstrate competence for all required patient care outcomes, a sufficient number of patients of both genders, and a broad range of ages from newborn to the aged. (For full details on Patient Volume and other Resource requirements for all specialties, see the [ACGME Program Requirements](#).)

***“Anybody walking in can speak to an employee and ask [what does CHC, Inc. prioritize], and that employee could speak to our three pillars of clinical excellence, constant innovation, and training health care professionals of the future... They are completely interwoven in our mission and our culture.”***

—Veena Channamsetty and Mary Blankson, CMO and CNO  
CHC, Inc., Middletown, CT



## Facilities

The training facility must be able to accommodate residents seeing the appropriate number of patient visits over the course of their training. This number will vary by specialty. Every residency must have a clinical home for each resident. Ideally they will be in the same facility so there is resident interaction with the CHC systems and mentoring.

Each resident is expected to have a personal workspace with secure storage for personal belongings. They must have an adequate number of exam rooms to see patients when the residents are in the clinic.

Medical records must be available to the resident 24/7. There must be a library on site in the clinic with adequate current reference material support or an electronic equivalent. Residents must have access to limited lab facilities (e.g., a microscope for viewing specimens) for patient care and for personal learning. There must be nursing and administrative support at a level which ensures effective administration of the program as further specified by the program's Review Committee or in the specialty requirements.

**Residents must have their own identified panel of patients with measured continuity of care.**

Primary care specialties require a certain number of visits for each resident. In order to promote continuity and the principles of population health, each resident should be assigned a panel of patients and be part of a care team that includes support staff and nursing.

## CHC, INC. PROFILE *(Continued from page 38)*

streams. Granting organizations include HRSA, NIH, AHRQ, and PCORI.

- NP residents are paid less than in their first year of practice. They are fully licensed and credentialed, and can bill for visits. Preceptors are available in a two-to-one ratio. NPs count as providers for MU incentive payments.

### Overcoming Obstacles:

- NPs graduating from academic programs would come to CHC, Inc. to work and leave quickly. They were not prepared for the pace and complexity of patient care in an underserved setting.
- Commitment to a mission of excellence, innovation, and training the next generation requires buy-in and leadership from both executive and clinical leaders, as well as the community board.

### Benefits to the Health Center:

- CHC, Inc. estimates that 50% of residents want to stay with the organization after their residencies.
- Trained clinicians are committed to the mission of serving in primary care and community health, and want to learn and practice in a high-functioning environment.
- Precepting students is a key element of job satisfaction for many clinicians.
- Staff surrounded by learners seek more learning. MAs go to school to become nurses, nurses become NPs, NPs get doctoral nursing degrees, physicians get Public Health Master's degrees.

**Impact (Benefits to the Community, the State, and the Nation):** The program produces more NP graduates than CHC, Inc. can hire. CHC, Inc. designed and built a CHC-centered training program and trains clinicians to do 21st-century, team-based, pre-planned health care in an underserved setting. These programs are replicated through remote-hosting and by CHCs adopting these innovations in their communities.

*The residents should have primarily their own panel of patients or their team's assigned patients as scheduled patients.* Presumably this would build on the current staffing model of patient care at the CHC. This model will teach the resident the importance of team-based care and of a continuity relationship with their patients. This model is the foundation for successful quality outcomes in population health quality.

### Accreditation Timeline

The timeline for starting a residency in a CHC will depend on several factors. Each residency program operates under a Sponsoring Institution and each SI can oversee multiple residencies—often in different locations and operating in different clinical systems. A CHC may apply to become its own SI or may choose to start a residency program under an existing SI in their vicinity.

If the CHC chooses to partner with an established SI, the SI will have a number of required resources in place to assist in the development and oversee implementation and compliance of the specialty residency. ***The SI has a Graduate Medical Education Committee (GMEC) which is responsible for ensuring that program-specific decisions affecting both residency requirements and systems requirements are met.*** This committee consists of a group of educators, administrators, residents, and quality and safety personnel, and must meet at least quarterly. Each SI has a ***Designated Institutional Official (DIO) whose role is to ensure that the institution and its clinical systems meet all the requirements of the sponsoring body, the residencies, and promote a healthy clinical learning environment.*** The DIO reports both to the GMEC and to the [ACGME Clinical Learning Environment Review \(CLER\)](#) group.

If the CHC partners with an existing SI, and the GMEC approves the start-up of a new residency program, the CHC may begin the process of applying for accreditation of its residency.

If the CHC wishes to become the SI for its residency program, then an application to the ACGME Institutional Review Committee must be developed and submitted. Approval of a new SI requires the ACGME institutional review committee to approve the application and this process includes a site visit. The application must completely address all Institutional Requirements, and ***it is highly recommended that CHCs without experience in education consider an external review of their application prior to submission to ensure all areas of potential concern are addressed before ACGME review.*** Once the SI receives approval—and only then—can the CHC apply for residency accreditation.

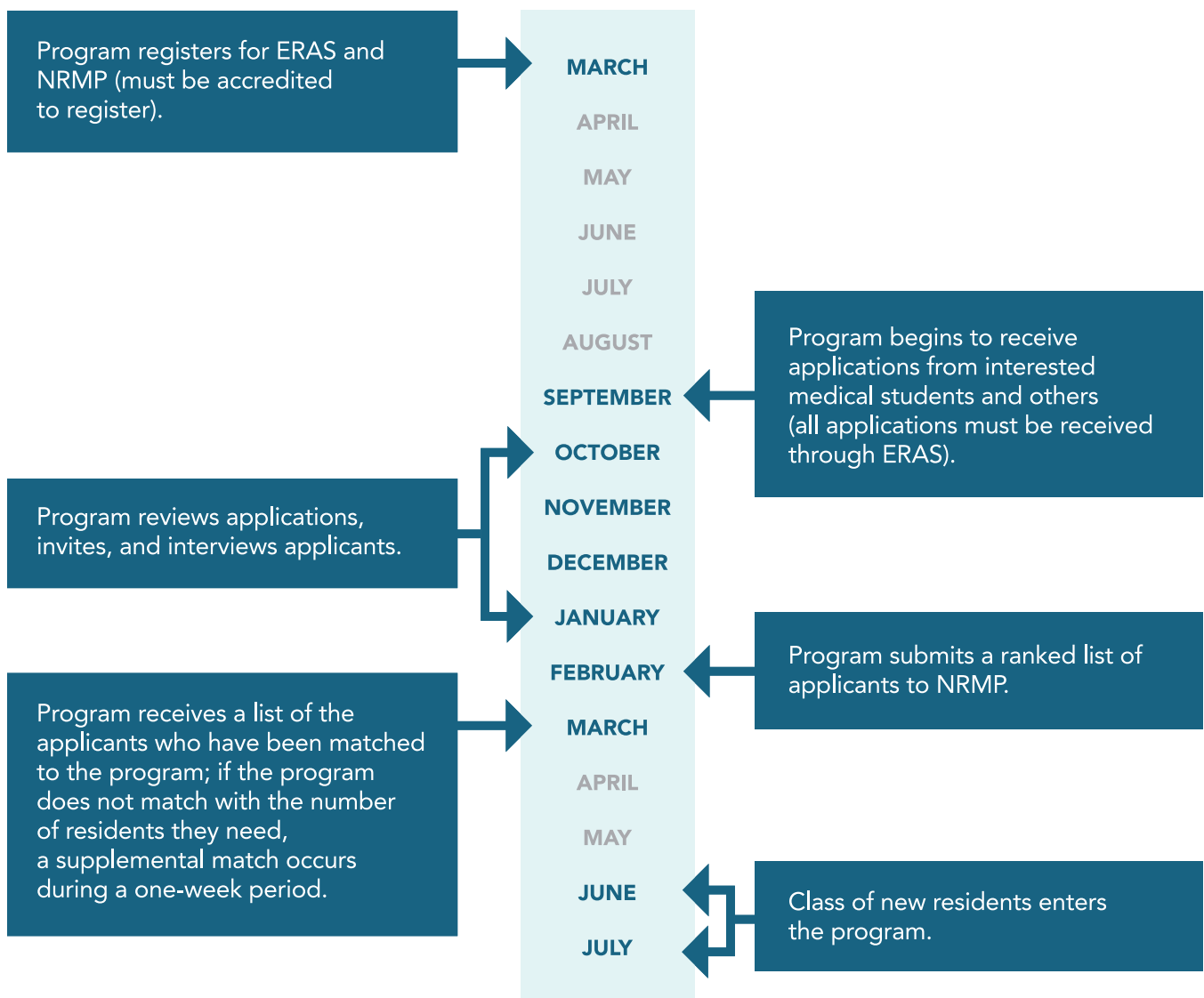
Once an SI is in place, the program application can be made. The CHC can work on the specialty application while awaiting SI accreditation but may not submit until accredited. ***The submission of the residency accreditation application also requires a Residency Program Director with the required qualifications to be hired and identified.*** Therefore while the SI application is in process it may be wise to proceed with the recruitment and onboarding of the future Residency Program Director. This individual can then be an active part of the development of the residency accreditation application, as they will be responsible for implementing the educational activities described. The CHC should also identify the required faculty for the residency as they will need to be in place and meeting all requirements when the first residents enter the program.

## [ Chapter 3: ADMINISTRATION AND OPERATIONS ]

*The timeline for receiving accreditation for a residency can often take up to one year, as the specialty review committees meet only a few times a year to review new applications.*

Once the residency receives accreditation, the program can register for the resident match, which also has a specific timeline for registration, participation, receipt of applications, interviews, selection of candidates, ranking, and matching with the next academic year residents. All residents, with very few and specific exceptions, must be recruited through the [National Residency Matching Program \(NRMP\)](#) on their schedule. The match operates, from the residency point of view, from September through March. Applications to a residency are made through the [Electronic Residency Application Service \(ERAS\)](#) and the program must be registered with both to obtain applications.

Briefly, this timeline is:







# FINANCE

This chapter endeavors to provide a decision-making framework to develop financial assumptions for CHCs interested in developing post-graduate primary care training programs.

## Funding for Residency Training

### Start-Up Funding

Estimates of start-up funding requirements vary widely, especially if one includes capital costs of building Continuity Clinics, resident spaces, or other capital expenses. In 2018, Congress appropriated funding for Rural Residency Program Planning Grants and some individual states have developed funding opportunities for feasibility studies and planning. Due to the lack of start-up funding, most CHCs fund these expenses through either foundation support or operating funds.

### Operations Funding

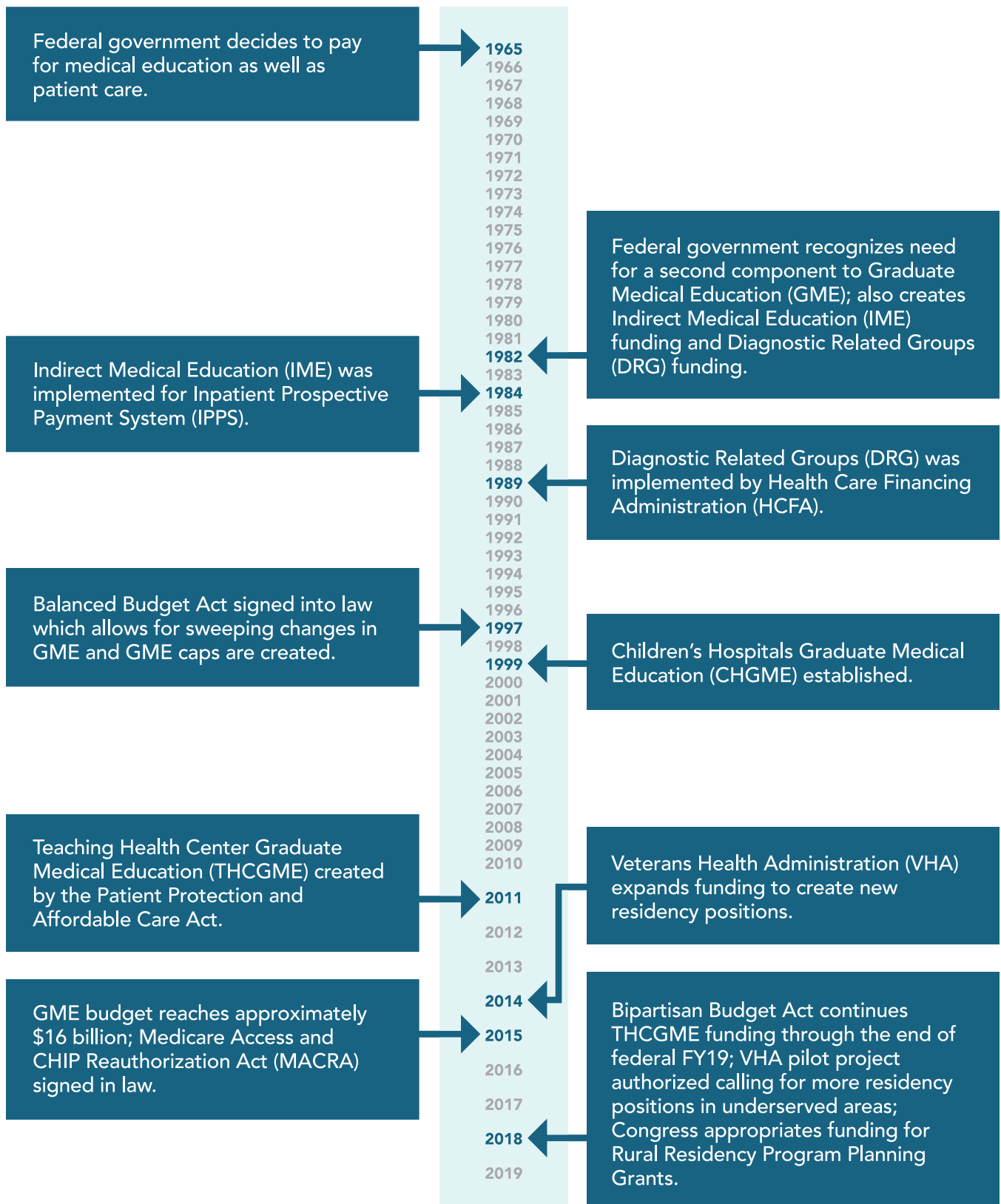
#### Centers for Medicare and Medicaid Services

Historically, the funds for primary care training have come from Medicare to hospitals in the form of Direct and Indirect Graduate Medical Education payments.

With the passing of Medicare in 1965, a decision was made by the federal government to pay for medical education as well as patient care. It was seen as an interim measure “until the community undertakes to bear such education costs in some other way; that a part of the net cost of such activities should be borne to an appropriate extent by the hospital insurance program”.

[ Chapter 4: FINANCE ]

Historical Highlights Since 1965:



By 1982 the need for a second component to GME financing was recognized by the federal government in order to *offset the additional costs hospitals incur due to having interns and residents involved in patient care. Indirect Medical Education (IME)* was implemented in 1984.

The Balanced Budget Act of 1997 (BBA 1997) was signed into law on August 5, 1997 with the goal of balancing the federal budget by 2002. The BBA addressed many aspects of healthcare, with GME experiencing sweeping and dramatic changes. The stated objective of the GME changes was to address issues of physician supply, specialty mix, and maldistribution by changing the incentives for training that existed at that time. It is this legislation that “capped” hospitals at their 1996 levels of Direct GME (DGME) and IME full-time equivalents (FTEs).

For full CMS definitions of IME and DGME, see: [Indirect Medical Education](#) and [Direct Graduate Medical Education](#).

### Direct Graduate Medical Education Payments

CMS funding of GME is the most substantial sum of GME payments. *It is estimated that approximately \$16 billion was invested in GME in 2015, of which Medicare comprised \$10.3 to \$12.5 billion.* Medicare pays a share of allowable teaching costs, meaning that it does not pay 100% of the teaching costs but rather a percentage of the allowable costs that ties to the Medicare patient load at a given acute hospital facility. The direct component of GME was designed to pay for Medicare’s share of residents’ salaries, benefits, supervising physician compensation, certain administrative expenses, and malpractice.

### Indirect Medical Education Payments

Indirect Medical Education (IME) funding was created in 1982 alongside Diagnostic Related Groups (DRG)

## PROFILE

### Family Health Center (FHC)

McLennan County, TX

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



*Your Family is Our Specialty*

## Family Health Center

FHC illustrates an alternative path to the development of an EHC. They began with an FMR program accredited for its first-class to start in 1970. They only acquired federal funding as a CHC in 1999.

**Health Professions Training Programs, Trainees, and Disciplines:** FMR, family NP, PA, and pharmacy. FHC provides an associate’s degree-nursing program, an on-site Masters of Social Work program, and BH/counselor supervision.

### Educational Strategies:

**Teaching roles:** FHC provides all teaching for students and residents, except in the associate degree-nursing program, which requires a faculty from the community college on-site. FHC maintains ties with the community college as it supplies over 80% of the allied health and nursing workforce to the community.

**Affiliation agreements:** FHC established policies that no students train without a formal institutional agreement between the CHC and the academic training program. The expansion of university-affiliated and hospital-sponsored programs, especially for nurse and NP, has sometimes put the burden of finding clerkships on the students.

*(Continued on page 48)*

## [ Chapter 4: FINANCE ]

funding. DRGs significantly changed healthcare in the United States in that payment rates were set for specific disease conditions rather than paying all hospitals a percentage of their costs. Suddenly, hospitals were incentivized to move care to the ambulatory environment as it was less costly than the inpatient environment. At a time when hospitals were establishing new systems to manage care and costs within the parameters of a DRG payment, IME was implemented in order to compensate hospitals for the extra utilization that a teaching program causes in the inpatient environment. A strongly held belief developed from the initial IME rationale; that the IME funds are the hospitals' since, even with DRGs, there is excess utilization due to the presence of residents. In fact, it has been found that reducing or eliminating GME programs would have a negative impact on a hospital's bottom line, meaning that at least for some hospitals, the IME payments more than offset any possible excess utilization. This becomes important when one begins negotiations with a hospital over the level of financial support that will be provided to the CHC.

IME is paid as an add-on to a hospital's DRG payment. In most situations, the total IME funding per resident is substantially greater than the total DGME payment per resident. Its calculation is based primarily on the intern/resident-to-bed ratio (IRB). This is not a fee for service payment, it is a payment based on the number of allowable interns or residents of all specialties at the institution overall as compared to the total number of beds in the institution.

Hospitals also receive IME capital payments. This is a smaller payment for the hospital's capital costs and is based on the residents-to-average daily census ratio (RADC).

Knowing all the types of Medicare GME payments is important as often CHCs are not aware of the residency revenue a hospital receives.

### Medicare IME Operating and Capital Adjustment Formulas:

<b>IME Operating Adjustment</b>	$= 1.35 \times ((1 + \text{IRB})^{0.405} - 1)$	<b>IME Capital Adjustment</b>	$= (e^{0.2822 \times \text{RADC}} - 1)$
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Source: Congressional Research Service analysis of Title XVIII and relevant regulations.  
 Notes: IRB = intern/resident-to-bed ratio; RADC = residents-to-average daily census ratio.  
 Calculations are different for Critical Access Hospitals (CAHs) and sole community hospitals.

### Graduate Medical Education Cap

Both DGME and IME are paid up to a hospital's Medicare GME caps. Each hospital that has trained residents has either intentionally or unintentionally triggered their Direct GME Cap, their Indirect GME cap, or both. GME Caps were created via the BBA 1997 in response to predictions of a surplus of physicians. Hospitals will be paid only for the substantiated time and training of resident and fellow FTEs up to their GME Caps, based on the DGME and IME formulas. Twice since 1997 there has been federal



legislation that took a percentage of unused GME Cap from any hospital that was not fully utilizing its cap and reallocated this cap to other hospitals that needed the additional resource. The last time this happened, in 2011, the Cap was redistributed to hospitals in the thirteen states with the lowest physician to population ratios.

### Teaching Health Center Funding

The ACA created a five-year demonstration project called [Teaching Health Center GME \(THCGME\)](#). This program, administered by the Health Resources and Services Administration (HRSA), supports new and expanded primary care medical and dental residency programs in community-based ambulatory patient care settings. At its peak, the THCGME program had sixty new programs and over 750 primary care and dentistry residents. Although small, the impact of having residents train in programs sponsored by CHCs and other ambulatory clinics is significant as it has been demonstrated that over 60% of residents stay within 100 miles of their residency site, and up to 75% of residents stay within the state where they completed their residency.<sup>31</sup>

The payment per resident from HRSA started at \$150,000, however it dropped to \$95,000 per resident when funding was continued beyond the initial funding period through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Bipartisan Budget Act of 2018 (BBA 2018) continued THCGME funding through the end of federal FY19 at a level of \$150,000 and created funding for new Teaching Health Centers as well.

31. Fagan, E.B., Gibbons, C., Finnegan, S.C., Petterson, S., Phillips, Jr, R.L., Peterson, L.E....Bazemore, A.W. (2015). Family medicine graduate proximity to their site of training: Policy options for improving the distribution of primary care access. *Society of Teachers of Family Medicine*, 47 (2), 124-130. Retrieved from <https://www.stfm.org/FamilyMedicine/Vol47Issue2/Fagan124>

### FHC PROFILE *(Continued from page 46)*

#### **Integrating the Healthcare Delivery (Service) and Educational Missions:**

The CHC's vision focuses on access, quality, and health outcomes, with education key to fulfilling that mission. Says Dr. Roland Goertz, former CEO, *"...the marriage of an FQHC and teaching efforts are made to be together, because of the unique experiences that you can give in that environment."*

The education and service missions are interwoven. While the residency program is a sizable investment, it is worthwhile for achieving the long-term purpose of the CHC.

#### **Financial Challenges and Strategies for Supporting and Sustaining the Educational Mission:**

- The residency received support from partner hospitals because it provided most of the county's indigent care.
- HRSA grant funding only supports a portion of FHC's budget. Issues included how to count residents in the FTE count, and how to get them covered by FTCA.
- After complex negotiations, the hospital partners agreed to pay their share of time and costs for residents for the training inside the hospital. This payment to the CHC covered resident salaries.
- The hospitals have never claimed FHC as a training site, so Medicare IME and DME guidelines do not apply to residents' time in FHC's clinics. This means preceptors get Medicare cost-based reimbursement for appropriately supervised resident care encounters. The hospitals do not claim or pay the residents for this time.
- The hospitals recognize the impact the CHC has on reducing ER visits. Both hospitals are supportive of the CHC and find additional value as they pursue the CHC to be part of their ACOs and community networks.
- FHC maintains support from local officials, with city and county contributions to uncompensated care.

*(Continued on page 50)*

### Children's Hospitals Graduate Medical Education

Children's Hospitals Graduate Medical Education (CHGME) was established in 1999 due to concern of a shrinking pediatric physician workforce since children's hospitals received negligible GME funds due to low Medicare volumes. By creating this funding source, 58 children's hospitals have been successful in growing their pediatric specialty and subspecialty training programs.

Although not a traditional source of funding for residents in CHCs, CHGME is a potential funding source for CHCs to consider. CHCs are continuity sites for pediatric programs and as such need to be aware that the CHGME funding exists. Additionally, due in part to pediatric specialty requirements in Family Medicine, many programs have their inpatient pediatrics and pediatric emergency medicine rotations occur at children's hospitals.

### Veterans Health Administration

Over recent years, the Veterans Health Administration (VHA) has become a more viable funder for Education Health Centers. The VHA is required by statute to train health professionals and, as such, is an active partner with teaching hospitals and academic medical centers to achieve this. In 2014, there was an expansion of VHA funding to create 1,500 new residency positions in primary care, mental health, and other specialties of need for the VHA system. In 2018, a pilot project was authorized calling for no fewer than 100 new positions out of the 1,500 positions authorized in 2014 to be filled in CHCs and other underserved areas. This project allows for residents' salaries and benefits to be paid by the VHA regardless of whether a resident trains in a VHA facility.

### State Funding through 1115 Waivers and State Plan Amendments

Many states, recognizing their own physician workforce needs and the challenges of obtaining federal GME funding, have taken the initiative of including GME funding in their Medicaid 1115 waivers and/or State Plan Amendments. There is a variety of ways that states have requested utilization of the funding; including payment for individual residency slots. CHCs with strong relationships at their state level are advised to explore funding opportunities through partnering with their state Medicaid office.

***"I know we help people towards their goals, whether that means being the best family doc or NP or PA or clinical pharmacist, or whoever it is. And that means a lot to me... but you have to have some help. You can't do this by yourself."***

—Roland A. Goertz, MD, MBA  
CEO, Heart of TX Community Health Center, McLennan County, TX

## Considerations in Seeking Funding Sources

Each of the aforementioned funding entities have different requirements for receiving funds.

Since Medicare is the dominant funding mechanism for GME and, since many programs model all or part of Medicare's eligibility requirements, this section will focus primarily on obtaining Medicare DGME and IME funding.

*The first step when considering starting a new program is to determine if the hospital partner(s) are GME-Naïve (not having detectable prior GME funding). This means finding out if the hospital has ever claimed any residents on their Medicare cost report or ever had any residents training in hospital licensed space.* If residents were claimed previously on the hospital cost report, then the hospital is capped unless the hospital triggered their cost report with residents during the past five years. If the hospital is capped, there are only a few ways to increase their cap, including starting a [Rural Training Track](#) (as defined by CMS) or doing an annual affiliation agreement with a hospital that has excess cap.

Another concern is whether a resident has ever trained in the hospital's licensed space. This is more difficult to determine. However, CMS has taken the position that if a resident has been educated in the hospital licensed space and if the hospital did not claim the costs and did not pay the costs of teaching, then the costs are zero. Based on the aforementioned formula for DGME, the payment is calculated on the lessor of costs. Since the costs are zero, that becomes the lessor of costs with anything being multiplied by zero resulting in a payment of zero dollars. When this occurs, which it unfortunately has quite frequently, the hospital inadvertently sets their Per Resident Amount (PRA) at zero. It is therefore very important to think about where residents are rotating, and if residents have ever been educated in a space under the hospital's license, before starting that rotation.

## FHC PROFILE *(Continued from page 48)*

### Strategies for Overcoming Obstacles:

- FHC sees benefits in the overall quality of care in the CHC and believe they have fewer malpractice claims.
- Accreditation of the residency is an on-going burden. Faculty spends an estimated 15% of their time on paperwork related only to evaluation requirements.
- The CHC must maintain positive relationships with two competing hospital-centered health systems, which creates challenges and opportunities as both systems seek to build ACOs or risk-based contracts.
- Medicaid revenue growth has been slower than the growth of self-pay patients. Because TX made various cost-cutting decisions and chose not to accept Medicaid expansion, FHC has struggled with deficit spending.



**Impact (Benefits to the Community, the State, and the Nation):** The CHC and the TX Higher Education Coordinating Board closely track the program graduates. They estimate 46% of graduates have gone to underserved areas, outperforming all other family FMRs in TX for which they have data.

**Lessons Learned/Advice for Other Health Centers:** FHC has a very low incident rate with FTCA cases, which they relate directly to the teaching going on all the time ("people must stay on their toes when they have learners around them").



## [ Chapter 4: FINANCE ]



It is the hospital CEO's responsibility to take the risk for the eligibility of GME funding.<sup>32</sup> Regardless of what the Medicare Administrative Contractor (MAC) or CMS tells a hospital, it is ultimately the responsibility of the hospital CEO to accurately determine whether the hospital is GME-Naïve. For this reason, it is a good idea to have the hospital or their cost report consultant be responsible for their cost report calculations, and not the CHC.

A helpful tool for an initial assessment of whether a hospital partner is GME-Naïve is [HRSA's Rural Graduate Medical Education Analyzer](#). However, this tool should not be used for final assessment of whether a hospital qualifies for GME payments and does not replace having conversations with the organization's MAC and completing a full cost report analysis with internal review.



DGME and IME are only triggered if a new program is started at a GME-Naïve hospital. "New" program was defined by CMS in 2009 and includes a new Residency Program Director, new faculty, and new residents along with ACGME accreditation as a new program. This is a very high bar in certain situations and is a definition that other funders have used.

### Teaching Health Center Graduate Medical Education Funding in a Graduate Medical Education-Naïve Hospital

Caution must be taken before planning a THCGME funding residency program with any rotations at a GME-Naïve hospital. HRSA and CMS do not allow for a resident to be funded by both entities. And, by virtue of a new residency program having rotations at a GME-Naïve hospital, the hospital's PRA and CAP will be established.

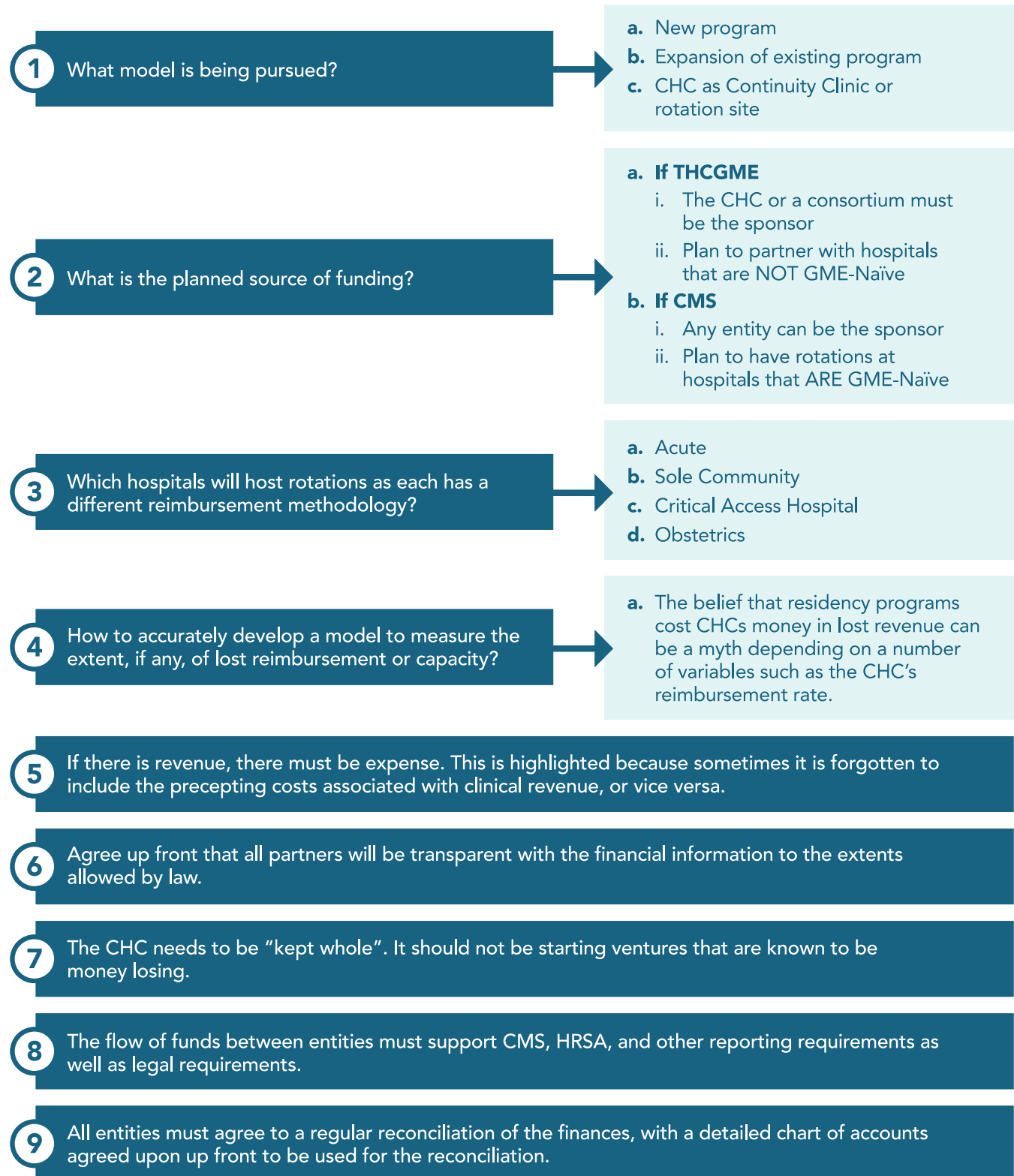


32. 42 CFR Parts Sections 413.75 and 413.79



## Ground Rules and Assumptions for Developing Financial Pro-Formas

When embarking on the development of a financial pro-forma, a CHC is wise to consider the following:



## Start-Up Cost Estimates

The costs incurred during this active development phase can vary widely.

In general, the start-up costs are between \$350,000 and \$750,000, not including capital expense.

Sample start-up costs can be found in Appendix A. This Appendix is the HRSA costing tool that was developed as part of their [THCGME program evaluation](#). The costing tool was reviewed and approved by the Office of Management and Budget (OMB) in 2018. As there is no universally agreed upon chart of accounts, it provides a chart of accounts that has been approved federally through a robust research process.

## Sponsoring Institution Expenses

If the CHC sponsors the residency program(s), it will have certain expenses above and beyond those required for a specialty residency program. Those expenses include, but are not limited to:

- DIO;
- GME Administrator;
- Administrative support;
- Conferences and travel;
- Consulting;
- Legal; and
- Accreditation fees.

## Operational Expenses

Operating Expenses can be found in [Appendix A: Teaching Health Center Costing Instrument](#).

(Note: This will be a link. Site in development.) As referenced under “Start-Up Cost Estimates”, this tool was developed out of a robust research process funded by HRSA in 2018 to determine the cost of a teaching health center resident.<sup>33</sup>

33. Regenstein M., Nocella K., Jewers, M.M., Mullan, F. (2016). The cost of residency training in teaching health centers. *New England Journal of Medicine*, 18 (7). 612-614. Retrieved from <https://www.ncbi.nlm.nih.gov/pub-med/27376580/#fft>









# LEGAL

*\*Please Note: Materials in this chapter have been prepared by attorneys of Feldesman Tucker Leifer Fidell LLP. These materials are being issued with the understanding that the authors are not engaged in rendering legal or other professional services. If legal assistance or other expert assistance is required, the services of a competent professional with specific knowledge of given circumstances should be sought.*

*The materials in the chapter have not been prepared by, reviewed, or vetted through HHS Office of General Counsel, General Law Division, or the Department of Justice, each of which may assume significant roles in certifying or determining whether or not a given activity falls within the scope of employment, for purposes of FTCA coverage.*

## Introduction

This chapter will explore the various types of arrangements and agreements that CHCs and their partners may utilize to incorporate residency programs in CHC operations. Additionally, this chapter discusses how such arrangements and agreements address certain CHC-specific compliance issues, including governance autonomy, contracting for substantive programmatic work, and the Federal Tort Claims Act (FTCA), as well as potential liability that may arise under the Anti-Kickback Statute (AKS).

## Agreements and Arrangements

CHCs and their partners enjoy considerable flexibility to tailor their collaboration model to meet their particular objectives for hosting a residency program at CHC sites. These arrangements range from allowing residents simply to rotate at a CHC site, to the CHC operating its own residency program. There are other collaborative arrangements, such as referral agreements and leases of personnel that CHCs can utilize to enhance the services they provide to their patients in conjunction with residency program initiatives.

**CHCs have significant flexibility to enter into collaborative arrangements and agreements to educate residents in a CHC setting.**

CHCs should consult HRSA's [Compliance Manual and FTCA Health Center Policy Manual](#) when considering any arrangement described in the sections below.<sup>34</sup>

### Residency Training Agreements

If a CHC desires to participate in the education and utilization of residents to provide services to its patients but does not want to run the residency program directly, the CHC may seek to enter into a residency training agreement with a freestanding residency program or teaching hospital. In such arrangements, a CHC typically designates one or more of its CHC sites to serve as a residency rotation site. The arrangements typically take one of three forms:

1. An existing CHC site(s) serves as a rotation for a residency program.
2. The CHC establishes a new CHC site(s)<sup>35</sup> to serve as the residency program Continuity Clinic with a partnering teaching institution.<sup>36</sup>
3. The CHC assumes operational control over an existing teaching hospital or freestanding residency program site(s).

Example: A teaching hospital operates an outpatient, primary care facility staffed by residents and their preceptors. As part of the residency training agreement, the CHC would acquire or lease the hospital outpatient facility, assume operational control of the facility, and request approval from HRSA to bring the site in-Scope (site, services, and providers must be in-Scope and site must also meet criteria for being added to Scope.) The educational elements of the residency program, however, would continue to be directed by the teaching hospital, while the CHC would direct all clinical care activities at the site. The patients would now be CHC patients, at least for all in-Scope services.

***Under each of the three residency program arrangements, the roles and responsibilities of the CHC and its partnering organization are largely the same*** (unless modified by the parties' agreement). Generally, the residents are employees of the teaching hospital. The teaching hospital or residency program maintains control and responsibility for all teaching activities, including classroom teaching, orientation programs, curriculum development, resident recruitment and evaluation, and program administration. On the other hand, the CHC maintains responsibility for and authority over all activities related to services furnished directly to patients at the CHC teaching site(s), including all operational activities (e.g., Scope of Project, locations, hours of services, quality assurance and compliance, billing and collections, etc.).

Under such arrangements, the educational costs are borne by the residency program. Specifically, the residency program is responsible for faculty (whether or not directly employed) and residents'

34. U.S. Department of Health and Human Services Health Resources and Services Administration. (2014). *Federal tort claims act health center policy manual*. Retrieved from <https://bphc.hrsa.gov/sites/default/files/bphc/ftca/pdf/ftcah-cpolicymanualpdf.pdf>

35. Depending on state law, a health center could establish its new location near or on a hospital system's campus. Such arrangements could facilitate additional collaborative relationships discussed below.

36. In some instances, a medical school is also a party to the arrangement.

[ Chapter 5: LEGAL ]

salaries, benefits, and malpractice insurance, as well as any other GME costs. Even if a teaching activity is performed at a CHC site, the residency program retains responsibility for all costs related to faculty and residents' time spent in educational activities. The CHC is responsible for the costs associated with clinical activities at its training sites and may compensate the residency program pursuant to a lease of personnel agreement for the clinical service time spent by faculty employed by the program, if applicable. Notably, residency programs may agree to make additional payments to CHCs to support losses associated with the residents' lower productivity and greater utilization of support staff, space, diagnostic testing, and related supplies.

**Roles and Responsibilities in Residency Training Agreements**

The CHC	The Residency Program
<ul style="list-style-type: none"> <li>● Diagnostic or treatment related activities performed by employed and/or contracted clinical CHC staff</li> <li>● Generating bills for services provided</li> <li>● Quality assurance activities related to primary care clinical service delivery**</li> <li>● Compliance</li> </ul> <p>** In residency training agreements, the Sponsoring Institution's residents and preceptors should be required to participate in such activities.</p>	<ul style="list-style-type: none"> <li>● Classroom teaching</li> <li>● Orientation programs</li> <li>● Faculty/program meetings</li> <li>● Curriculum development</li> <li>● Resident/program evaluation</li> <li>● Research</li> <li>● Publication activities</li> <li>● Resident recruitment and selection</li> <li>● General teaching program administration</li> <li>● Billing GME</li> </ul>

In addition to the considerations described above, the CHC and partnering organization should also consider the following key questions:

- What is the role of the Residency Program Director?
- Who is responsible for the selection and oversight of the residents providing services at the CHC?
- What productivity expectations should the CHC have with respect to services furnished by residents?
- Does the residency program need space to perform educational activities at the CHC site? If so, is the residency program going to lease the space?
- How will the CHC allocate its staff's time, facility space, and other resources to support teaching efforts at the CHC?
- How will the parties align clinical and teaching policies and procedures?
- What authority does the CHC have to remove residents from the CHC service sites for cause?

## CHC Residency Programs

A CHC may establish a new teaching CHC with or without support from the Teaching Health Center Graduate Medical Education (THCGME) Program.<sup>37</sup>

In this model, the residents and preceptors are typically employees of the CHC (but may be leased from third parties). Further, the CHC is responsible for all teaching, recruiting, and administrative activities associated with the residency program that would have typically been the responsibility of the CHC's partnering organization, as well as remaining responsible for all CHC operations. It is important in this model that costs are allocated appropriately and cost centers are maintained distinctly in order to clearly distinguish educational and clinical costs.

## Related Collaborative Efforts

In addition to the residency program models described above, CHCs and partnering organizations may wish to enhance training efforts and/or access to the services available to CHC patients through related collaborative agreements to facilitate the use of residents and efficient utilization of resources. Such arrangements include, but are not limited to, referral arrangements, co-located referral arrangements, lease of personnel and/or services, and community benefit grants. These additional arrangements are highly adaptable to any broader residency arrangement.

## Referral Arrangements

In a referral arrangement, the CHC and its partnering organization enter an arrangement to refer certain patients to each other. In such an arrangement, the parties may agree that one party may refer patients to the other, or they may both agree that each party may refer patients to one another, as necessary. In a referral arrangement, each party remains financially, clinically, and legally responsible for claims related to services that the provider directly furnishes to patients. Each provider's policies, procedures, and internal standards govern its own provision of services. Further, each provider bills and collects payment for the services that it directly furnishes to referred patients. Each provider should offer the other party assurances (and documentation) regarding its providers' professional qualifications, eligibility to participate in federal and state health care programs, and standards of care.

While a referral arrangement is largely straightforward, it can create some logistical issues. For instance, the Parties should develop policies and procedures to determine how referrals will be made and managed, including how patients will be tracked as they move from one provider to the other, and to set forth how

37. Health Resources and Services Administration. (2018). *Teaching health center graduate medical education (THCGME) program*. Retrieved from <https://bhwh.hrsa.gov/grants/medicine/thcgme>



the providers will share medical records for treatment purposes. Additional terms may be required if the arrangement is to be protected by the federally qualified CHC safe harbor. See 42 C.F.R. § 1001.952(w).<sup>38</sup> In such cases (discussed in the Anti-Kickback Statute section below), the CHC must ensure that the partnering organization will agree to accept all patients referred to it regardless of their ability to pay (subject to reasonable capacity limitations). For “in-Scope” services, the [HRSA Health Center Program Compliance Manual](#) states that the CHC must ensure that the partnering organization’s discount policies are consistent with HRSA sliding fee discount requirements<sup>39</sup> or are more generous than the CHC’s discount policies.

Referral arrangements between a CHC and a hospital may enable the parties to implement an emergency care coordination arrangement. In these arrangements, the parties may agree that the hospital will offer to refer patients determined through the appropriate Emergency Medical Treatment and Active Labor Act (EMTALA) screening to be presenting non-emergency conditions to a nearby CHC location.

### Co-located Referral Arrangements

Co-located referral arrangements are similar to referral arrangements except for one important aspect—the provider receiving the referrals is physically located in the facility of the entity making referrals (e.g., the CHC establishes a new CHC site within the hospital or a hospital co-locates radiology services in a CHC facility). As with ordinary referral arrangements, the provider receiving referrals is financially, clinically, and legally responsible for services the provider directly furnishes to patients.

While the logistical and compliance concerns associated with ordinary referral arrangements remain, such arrangements raise new questions. First and foremost, the providers must ensure that patients can distinguish between CHC providers and the partnering organization providers through, for example, appropriate signage or separate entrances for the co-located provider. Such separation helps ensure that neither provider will be liable for the other provider’s actions and may be required for billing purposes. A second issue to address is whether the co-located provider will need to lease space or equipment from its partnering entity and, if so, determining whether any fair market value compensation is appropriate.

### Lease of Personnel

In many CHC-residency program partnerships, a partnering organization leases personnel to staff a CHC site, in accordance with a fair market value fee. For example, a CHC may contract with a teaching hospital to furnish preceptor services for residents rotating through or otherwise staffing a CHC site. In these arrangements, the CHC is financially, clinically, and legally responsible for all services provided on its behalf pursuant to the lease. Patients receiving services from leased personnel from a partnering organization are considered CHC patients. The CHC is solely responsible for billing and collecting from third party payors and patients, and retains all revenue secured for services provided by the leased personnel.

38. National Archives and Records Administration’s Office of the Federal Register. (2019). *Electronic code of federal regulations*. Retrieved from <https://www.ecfr.gov/cgi-bin/ECFR?page=browse>

39. See 42 C.F.R. § 1001.952(w).

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The CHC's policies, procedures, and standards govern the conduct of leased personnel providing services to CHC patients. Specifically, leased personnel furnish services in accordance with the CHC's applicable health care and personnel policies, procedures, standards, and protocols and prepare medical records consistent with the CHC's standards. Administratively, the partnering organization must provide programmatic and financial reports as required by the CHC. Finally, the CHC should ensure that leased personnel satisfy the CHC's standards and qualifications for medical providers, including licensure, credentialing and privileging, and the lease should require leased personnel to participate in and cooperate with the CHC's clinical quality and compliance activities.



Under these arrangements, the CHC retains significant oversight responsibility. For instance, the CHC may monitor, oversee, and evaluate the leased personnel's performance and compliance with CHC policies and procedures. If the CHC finds that the leased personnel lack compliance, the agreement should allow the CHC to terminate the contract entirely, and/or require the removal, suspension, and/or replacement of leased personnel.

### Community Benefit Grants

Whether CHCs use current sites, or acquire or lease new sites, to host residency programs, *there is rarely the ability to count on additional Section 330 funding to cover start-up costs or otherwise uncompensated care costs associated with an expanded patient base that typically includes low income, uninsured patients.* If the CHC wishes to add one or more sites simply through a change in Scope, it must assure HRSA that it can maintain, at worst, a break-even budget.<sup>40</sup> The most common approach to ensure a break-even budget is the award of a community benefit grant by the partnering organization



40. HRSA, Policy Information Notice 2008-01 at 20 (last revised Jan. 13, 2009); see also HRSA Health Center Program Compliance Manual, Appendix A (listing Policy Information Notice 2008-01 as an agency guidance that has not been superseded by the Health Center Program Compliance Manual).

to cover the CHC's start-up costs and anticipated otherwise uncompensated costs associated with serving additional low-income, uninsured patients. Such arrangements may implicate the Anti-Kickback Statute (AKS), particularly when other arrangements (such as referral arrangements) exist between the CHC and its collaborative partner. The AKS is discussed below.

### Section 330 Considerations

#### Maintaining Control Over Community Health Center Operations

The residency program agreement should be drafted to ensure that the CHC maintains responsibility for, and control over, activities related to clinical service delivery at its CHC sites, including the CHC-operated residency rotation sites. ***The CHC must retain exclusive control over the Scope of Project and services offered, site locations, and hours of operations.*** In addition, services must be furnished at such sites in accordance with the CHC's policies and procedures. Note that this responsibility extends to any hospital outpatient facilities that transfer to the CHC's operational authority.

#### Contracting for Preceptor Services

Despite the type of arrangement, whether a CHC residency program or a residency training agreement, ***CHCs are not required to utilize employed CHC clinical staff to serve as preceptors for the residents.*** If a CHC leases such preceptor personnel from another provider, such as a teaching hospital, the fee paid should not exceed the fair market value of those services. If a CHC uses Section 330 funding to pay for such leases, the CHC must ensure that the arrangement meets the procurement standards set forth in 45 C.F.R. Part 75.<sup>41</sup> In particular, if Section 330 funds are utilized to pay some or all of the contract fees, the CHC will need to maintain records to explain the rationale for the price paid for contracted services. In determining the fair market value of the contracted services,<sup>42</sup> in addition to considering the local market value of comparable services, the CHC should include an objective cost assessment on what the CHC would pay comparably qualified and experienced clinicians employed by or contracted with the CHC, rather than simply paying what the other entity pays its clinicians.

Further, such arrangements may require the CHC to request and receive HRSA approval before finalizing the arrangement.<sup>43</sup> Specifically, if an arrangement to lease preceptors would result in the CHC contracting for the "majority of its health care providers with a single entity," HRSA's approval is required.<sup>44</sup> ***When determining whether a lease of preceptors would result in the CHC contracting for the majority of its providers, the CHC should consider staffing across its whole CHC project*** (i.e., system-wide) rather than only those sites where the leased preceptors will furnish services.

41. See 45 C.F.R. §§ 75.326-335.

42. See 45 C.F.R. § 75.327(i).

43. See HRSA Health Center Program Compliance Manual, at 47 (last updated August 2018) (Contracts and Subawards).

44. *Id.* at 47, n.4.

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### Federal Tort Claims Act

The [Federally Supported Health Centers Assistance Act \(FSHCAA\)](#)<sup>45</sup> provides FTCA program professional liability coverage to Section 330-funded CHCs. The FTCA program covers malpractice claims or suits filed against a deemed CHC that arise from activities within the HRSA-approved Scope of Project. Under the FSHCAA, a Section 330-funded CHC, its employees, and certain contractors may be deemed to be Public Health Service employees. As a Public Health Service employee the CHC and its covered staff are immune from suit for medical, surgical, dental, or related functions.<sup>46</sup> To be deemed, the CHC must annually submit a deeming application to HRSA demonstrating that the CHC has met the requirements related to risk management, credentialing and privileging, quality assurance, and claims management published each year in a deeming application Program Assistance Letter.<sup>47</sup>

All CHC employees and certain individually contracted providers are eligible to be deemed employees. Individually contracted providers who receive Form 1099s are covered if they otherwise meet the FTCA's eligibility requirements and provide services for at least 32.5 hours per week on average for the period of the contract. The hours requirement does not apply to individually contracted providers who provide family practice, general internal medicine, general pediatric, or obstetrics/gynecological services.<sup>48</sup> Note that FTCA coverage is unavailable for Federally Qualified Health Center Look-Alikes.

***The extent of FTCA coverage applicable to individual residency program clinicians will depend on the type of arrangement and whether the individual clinician is employed by or under contract with the CHC.***

### Residents

In residency training agreements, the residents are typically employed by the partnering organization. Since they are not employees or individually contracted providers of a deemed CHC, FTCA coverage would not extend to the residents. In such arrangements, the residency program agreement should require documentation that the partnering organization provides adequate malpractice protection for the residents.

In some cases, residents in CHC residency programs are employees of a CHC. If a resident is employed by a CHC, FTCA coverage will extend to his or her activities if (i) the services are provided within the CHC's Scope of Project; (ii) if the services are within the job description, contract for services, and/or job duties required by the CHC; and (iii) the patient served by the CHC was a "health center patient" (or is otherwise approved by the Secretary of the Department of Health and Human Services [the "Secretary"]).<sup>49</sup> FTCA coverage would likely not extend to resident rotations outside the CHC facilities, (e.g., hospitals or specialty clinics) that are required as part of the program.

45. Pub. L. No. 102-501, 106 Stat. 3268 (1992) and Pub. L. No. 104-73, 109 Stat. 777 (1995).

46. See 42 U.S.C. § 233(a), (g).

47. See *id.* § 233(g)(D); see also HRSA, Program Assistance Letter No. 19-02 at 2 (Apr. 10, 2019).

48. HRSA, Federal Tort Claims Act Health Center Policy Manual at 6, 21-22 (last updated July 21, 2014).

49. See *id.* at 11; see also *id.* at 8-9 (defining "health center patient") and 9-12 (providing examples of covered services to non-health center patients).



## Preceptors

Preceptors may or may not be employees or individually contracted providers of the CHC. If the preceptor is not an employee of the CHC and is not individually contracted, the preceptor is not eligible for FTCA coverage. If, however, the preceptor is an employee or individually contracted to the CHC (and otherwise meets the FTCA's eligibility requirements, such as the 32.5 hour weekly time commitment, subject to stated exceptions), FTCA coverage will apply to the preceptors supervision of the resident, provided the service was rendered (i) to a CHC patient (or a non-CHC patient approved by the Secretary), (ii) within the CHC's Scope of Project, and (iii) within the preceptor's scope of employment or contract with the CHC.<sup>50</sup> Notably, in such instances, the FTCA only covers the resident performing services under the supervision of the preceptor if the resident is also eligible in his or her own right.<sup>51</sup>

In some arrangements, CHC-employed/individually contracted preceptors will supervise residents who furnish services to non-CHC patients at non-CHC facilities, such as a hospital. In general, this supervision would not be protected by the FTCA program. However, there are specific exceptions approved by the Secretary for FTCA coverage when caring for non-health center patients.<sup>52</sup>

## Credentialing and Privileging

Residency training agreements must address credentialing and privileging of the residents and preceptors to (i) require the partnering organization to implement certain credentialing and privileging procedures to comply with CHC standards, or (ii) allow the CHC to carefully review the partnering organization's credentialing and privileging processes to ensure they encompass the CHC's own credentialing requirements.<sup>53</sup> Alternatively, the CHC may independently credential and privilege each resident and preceptor before allowing them to furnish services at the CHC.

## Covering Every Liability

When entering a residency program arrangement, health centers must ensure that there are no gaps in liability coverage.

**Residency training agreements between a partnering organization and a CHC should specify all insurance responsibilities of the parties.**

50. See *id.* at 11.

51. HRSA, Federal Tort Claims Act Health Center Policy Manual at 11.

52. See *id.* at 9-11.

53. See HRSA, Health Center Program Compliance Manual at 29, n.7 (last updated August 2018) (Clinical Staffing).

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If the partnering organization employs both the residents and contracted preceptors, the CHC needs adequate contractual assurance that the partnering organization maintains malpractice insurance that extends to such staff's provision of services on behalf of the CHC. CHCs also may want to consider obtaining wrap-around (or “gap”) insurance to cover activities not protected by the FTCA. Such coverage would protect the CHC from liability in instances, for example, where a health-center employed preceptor supervises residents caring for non-health center patients in a hospital owned and operated clinic.

### Anti-Kickback Statute



When establishing a residency program collaboration, it is critical that the CHC and the partnering organization consider the potential implication of the Anti-Kickback Statute (AKS). The AKS makes it a criminal offense to “knowingly and willfully offer or pay any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind” to induce or reward referrals of patients whose care will be reimbursed in whole or in part under a federal health care program.<sup>54</sup>

Understanding that the broad language of the AKS implicated otherwise legitimate business activity, the Office of the Inspector General (OIG) published several regulatory exceptions to the AKS to protect such activity from enforcement.<sup>55</sup> The exceptions, called “safe harbors,” contain specific requirements. In order for the exception to apply, each requirement of a safe harbor must be met. If the safe harbor is not entirely satisfied, AKS liability is possible, but enforcement rests at the discretion of the OIG.



In October 2007, the OIG issued a final rule implementing a legislative safe harbor for federally funded CHCs to provide protection for situations where the CHC receives a financial donation or the provision of free (or discounted) services for the CHC or CHC patients.<sup>56</sup>

54. 42 U.S.C. § 1320a-7b(b)(2).

55. See 42 C.F.R. § 100.952.

56. See 42 C.F.R. § 1001.952(w).

**Any agreement to establish a residency program collaboration that includes community benefit grant support or other form of “remuneration” should be structured in accordance with the requirements of the federally funded CHC safe harbor.**

Such an agreement will likely satisfy the federally funded CHC safe harbor if it includes the following:

- (i.) The agreement is set out in writing, signed by both parties, and covers and specifies the amount of all goods, items, services, or donations (hereinafter, the “grant”) provided by the partnering organization to the CHC;
  - a. The amount of the grant provided by the agreement may be calculated by a fixed sum, fixed percentage, or fixed methodology that does not consider the volume and value of federal health care program business generated between the parties;
  - b. All separate agreements between the parties must incorporate each other by reference or if cross-reference a master list of agreements that is maintained centrally, is kept up to date, is available for review by the Secretary upon request, and maintained in a manner that preserves the historical record of arrangements;
- (ii.) The grant is medical or clinical in nature or relates directly to services provided by the CHC as part of its Section 330 project;
- (iii.) The CHC reasonably expects (and documents its expectation) that the arrangement will meaningfully contribute to the CHC’s ability to maintain or increase the availability of services, or enhance their quality;
- (iv.) At least annually, the CHC re-evaluates the arrangement (and documents the re-evaluation) to determine whether the arrangement still satisfies the third requirement;
- (v.) The partnering organization neither requires the CHC (or its affiliated health care professionals) to refer patients to a particular entity or restrict the CHC from referring patients to any particular individual or entity, nor restricts the CHC (or its affiliated health care professionals) from referring patients to any individual or entity;
- (vi.) The partnering organization offering its services without charge or at a reduced charge to the CHC must furnish such services to all CHC patients who clinically qualify for the services regardless of their ability to pay;

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(vii.) The agreement must not restrict the CHC's ability to enter into similar agreements with other providers;

(viii.) The CHC must provide effective notification to its patients of their freedom to choose any willing provider, and must disclose the existence and nature of the agreement to any patient who inquires;

and

(ix.) The CHC may elect to require that the partnering organization charge a referred CHC patient at the same rate it charges other similarly situated patients not referred by the CHC, or that that partnering organization charge a referred CHC patient at a reduced rate.

If an arrangement between a CHC and partnering organization meets each of the nine requirements listed above, it will satisfy the federally funded CHC safe harbor, shielding the parties from AKS liability. If an arrangement cannot meet this safe harbor (or any other safe harbor, e.g., the personal services and management contracts safe harbor), there is risk for AKS liability. In this event, the CHC may seek an advisory opinion from the OIG, asking whether it would pursue civil monetary penalties or sanctions for the proposed arrangement pursuant to 42 C.F.R. Part 1008.

**The flexibility afforded to CHCs and their partnering organizations to implement resident training programs tailored to their needs and expectations may greatly benefit underserved populations and communities, as well as the parties and physicians-in-training.**

While compliance issues will arise in structuring any such arrangement, the risks associated with the concerns can be mitigated with careful forethought and oversight.





# RESOURCES

- **Statutes and Regulations**

- Teaching Health Centers Development Grants – 42 U.S.C. § 2931-1  
<https://www.law.cornell.edu/uscode/text/42/2931-1>
- Program of Payments to Teaching Health Centers that Operate Graduate Medical Education Programs – 42 U.S.C. § 256h  
<https://www.law.cornell.edu/uscode/text/42/256h>
- The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards – 45 C.F.R. Part 75  
<https://www.law.cornell.edu/cfr/text/45/part-75>
- Federal Tort Claims Act – 42 U.S.C. § 233(g)-(n), (q)  
<https://www.law.cornell.edu/uscode/text/42/233>
- Federal Tort Claims Act Coverage of Certain Grantees and Individuals – 42 C.F.R. Part 6  
<https://www.law.cornell.edu/cfr/text/42/part-6>

- **Education Health Center Initiative (EHCI) Resources**

- Residency Training Partnership Opportunities Between Federally Qualified Health Centers and Residency Programs, May 2011 (Jacqueline C. Leifer, Esq.),  
<https://educationhealthcenter.org/s/leiferLegal.ppt>
- Health Center Affiliations with Residency Programs, Oct. 2008 (Jacqueline C. Leifer, Esq.),  
[https://educationhealthcenter.org/s/leifer\\_health-center-affiliations-with-residency-programs.pdf](https://educationhealthcenter.org/s/leifer_health-center-affiliations-with-residency-programs.pdf)

- **Health Resources and Services Administration (HRSA) Resources**

- Health Center Program Compliance Manual (last updated Aug. 2018)  
<https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html>
- Health Center Program Site Visit Protocol (last updated Aug. 2018)  
<https://bphc.hrsa.gov/programrequirements/svprotocol.html>

## [ RESOURCES ]

- o Federal Tort Claims Act: Health Center Policy Manual (last updated July 21, 2014)  
<https://bphc.hrsa.gov/sites/default/files/bphc/ftca/pdf/ftcahcpolicymanualpdf.pdf>
- o Teaching Health Center Graduate Medical Education (THCGME) Program,  
<https://bhw.hrsa.gov/grants/medicine/thcgme>
- o HRSA, Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes (last revised Jan. 13, 2009),  
<https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/pin2008-01.pdf>
- **National Association of Community Health Centers (NACHC) Resources**
  - o Educational Health Centers: Teaching and Learning in the Community (Nov. 2015),  
[https://educationhealthcenter.org/s/NACHC\\_EducationalHealthCenters\\_November2015.pdf](https://educationhealthcenter.org/s/NACHC_EducationalHealthCenters_November2015.pdf)
  - o Memorandum from Feldesman Tucker Leifer Fidell, LLP to NACHC re: FTCA and Health Center Residency Programs (May 5, 2014),  
<http://www.nachc.org/wp-content/uploads/2015/06/FTCA-and-Health-Center-Residency-Programs-FTLF-Memo-May-2014.pdf>
  - o Collaborative Arrangements: A Guide for Health Centers and Their Partners, at p. 46-47 (Aug. 2011),  
*For Sale at* <http://mylearning.nachc.com/diweb/catalog/item/id/264510>
  - o (Only available to NACHC members)  
Information Bulletin #12, Human Resources Series: Using Affiliations with Residency Training Programs to Increase Your Health Center's Clinical Capacity (June 2009),  
[http://iweb.nachc.com/downloads/products/HR\\_12\\_09.pdf](http://iweb.nachc.com/downloads/products/HR_12_09.pdf)
  - o Issue Brief #26, Systems Development Series: Key Considerations in Developing Residency Training Program Collaborations (Apr. 20, 2004),  
<https://docplayer.net/10253482-Issue-brief-26-systems-development-series-key-considerations-in-developing-residency-training-program-collaborations.html>
- **The Accreditation Council for Graduate Medical Education (ACGME)** is a good source for general background information on residency programs.  
<https://www.acgme.org/>
- **The Commission on Dental Accreditation (CODA)** is another valuable resource.  
<https://www.ada.org/en/coda>

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The **Education Health Center Initiative (EHCI)** is a partnership of the Northwest Regional Primary Care Association and Community Health Association of Mountain/Plains States, linking Clinical Education with Primary Care in urban and rural settings. For more information on the EHCI, visit <https://educationhealthcenter.org>.

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