Issue Brief #7 – Teaching Health Center Initiative

In accordance with the Balanced Budget Act of 1997's sanctioning of Graduate Medical Education (GME) consortia, eight of Connecticut's fourteen Federally Qualified Health Centers (FQHCs) together with the Community Health Center Association of Connecticut (CHCACT) have formed the Connecticut Teaching Health Center Coalition to establish and operate jointly one or more primary care medical residency programs. Together these centers serve most of the state of Connecticut:

- Optimus Health Care — Bridgeport
- CIFC Greater Danbury Community Health Center — Danbury
- Cornell Scott-Hill Health Center — New Haven
- Fair Haven Community Health Center — New Haven
- First Choice Health Centers — East Hartford
- Generations Family Health Center — Willimantic
- United Community and Family Services — Norwich
- StayWell Health Center — Waterbury

The Coalition is considering six primary care disciplines:

- Internal Medicine
- Family Medicine
- Pediatrics
- Psychiatry
- OB GYN
- Dentistry

The Coalition may establish up to several residency programs, depending on logistics and resources.

Greater Danbury Community Health Center and the Connecticut Institute for Communities will provide leadership since, with Health Resources and Services Administration (HRSA) funding, they have recently implemented an internal medicine residency program that is accredited by Accreditation Council for Graduate Medical Education (ACGME) and whose residents are supported by a HRSA Primary Care Residency (THC) Grant. Ramin Ahmadi MD MPH, *Chair, Department of Medical Education and Research Danbury Hospital, Western Connecticut Health Network* who helped spearhead the development of Danbury's program, will serve as project director for the Coalition's effort. The University of Connecticut Health Center (UCHC) will provide technical assistance on meeting ACGME requirements and on administering medical and dental residency programs. The University of Connecticut School of Dental Medicine already has dental resident rotations in Connecticut FQHCs, and is willing to participate in a new program. Our intent is to earn ACGME accreditation for the new THC residency program(s) and to secure DGME and or HRSA support for the residents. For years, DGME slots for hospital-based residencies have been capped, but Medicare is expressing a willingness to cover new community-based residency programs.

The cap on hospital-based residents is a primary reason why Connecticut's teaching hospitals will be interested in participating in our THC initiative. Danbury Hospital, Griffin Hospital, St. Vincent's Hospital, Yale-New Haven Hospital, Bridgeport Hospital, St. Francis Hospital, Hartford Hospital, Connecticut Children's Medical Center, Windham Hospital and John Dempsey Hospital are all potential sites for hospital rotations—leadership at several hospitals have already been approached and have indicated their support.

As outlined below, the Connecticut Teaching Health Center Coalition is seeking SIM support for a two person team—Dr. Ahmadi as project director and a project coordinator with administrative support through CHCACT—to work with the community health centers to craft a proposal to HRSA for a Teaching Health Center Graduate Medical Education (THCGME) grant to develop and launch the program. THCGME was authorized under Section 5508 of the Affordable Care Act and would be expanded under a pending reauthorization. Once up and running, the program will be sustained by DGME payments, which the Coalition expects to receive not only because Medicare has stated its interest in supporting community based residency programs, but also because THC programs per resident are considerably less expensive for Medicare than are hospital-based programs.

Connecticut's community health centers are the optimal venue for educating primary care clinicians for the care delivery envisioned in our State Healthcare Innovation Plan (SHIP). The plan calls for care that is patient centered, culturally sensitive, evidence based, coordinated, that includes community-based supports, that promotes population health, that redresses health disparities and that is integrated in clinical networks of primary, specialty and institutional providers—all of which are included in federal requirements for FQHCs, and all of which are imbued in the care provided by Connecticut's FQHCs. FQHCs are rooted in their communities, focused on the health of the populations in these communities, and focused on the wellbeing of individuals, not just their clinical status. They are required to have and do have protocols for continuous quality improvement. They network with community-based services, medical specialists and hospitals to ensure a continuum of care for their patients. SHIP calls for flexible hours and community health centers provide after hour care. SHIP calls for payment methodologies other than fee-for-service. Medicaid, which is the principal payer of FQHC care in Connecticut, pays community health centers per visit, within broad limits, whatever that visit requires—which fosters both efficiency and flexibility. SHIP calls for team approaches to care. Clinicians at community health centers work in care teams. SHIP is concerned with serving the complex needs of patients who have multiple comorbidities and whose lives are complex and challenging. Health centers serve patients with complex needs and who live in complex circumstances. In our view, primary care clinicians who work within communities are better trained in community practices with hospital rotations than in hospitals with community practice rotations.

We expect that clinicians doing their residencies at our Teaching Health Centers will be better prepared and more inclined to serve disadvantaged communities, which sorely need well trained primary care clinicians. Studies have shown this to be the case(ref?) However, we also anticipate that some of the residents the coalition trains will ultimately serve the general population, which will also be a positive development since, in our view, clinicians exposed to the challenges that community health centers face will be altogether better prepared primary care clinicians.

A coalition of community health centers that spans the state jointly operating primary care residency programs will necessarily foster a corresponding coalition of teaching hospitals that spans the state since primary care residents require hospital rotations and proximity matters. The community health centers and the hospitals will learn from each other and will become more coordinated in the care they provide.

Connecticut has three academic medical centers. UCHC has already offered to assist the Connecticut Teaching Health Center Coalition. Assistance from Yale will also be sought.

HRSA has supported the development of individual Teaching Health Centers. A coalition of teaching health centers that span the state is something new, but consistent with the goal of increasing training for primary care physicians who express an interest in caring for the underserved. It is a model worth testing and potentially worth emulating.

Work plan

Phase 1: Organizing the infrastructure

During this phase, the core team, which consists of project director, project coordinator and other administrative support, will identify the primary sponsoring community health centers (CHCs), participating CHCs and key faculty at each potential new THC and begin working with them on creating a Program Information Form (PIF) for submission to ACGME. All letters of support will be drafted by the core team and sent to participating hospitals. Program Letters of Agreement (PLA) will be drafted by the core team and in collaboration with all participating institutions.

Phase 2: Faculty and Curriculum Development

During this phase, the core team will conduct workshops on faculty development for all identified teaching sites and further develop the curriculum proposed to the ACGME to ensure that each site will be successful for their ACGME site visit. The core team also will arrange for elective rotation of residents if an FQHC has never had residents' rotation and all document preparations including a practice site visit.

Phase 3: Academic Support and Maintenance

During phase 3, the core team assists in securing the HRSA grant for the lead FQHC upon the final approval of the ACGME. The core team will also assist in creating all academic affiliations for the FQHC, developing a sustainability plan, recruitment and interviewing of candidates and making the new program operational. The core team would create FQHC-based institutional structures that could meet the Residency Review Committee (RRC) and Clinical Learning Environment Review (CLER) accreditation requirements.

Deliverables:

A total of 6-8 FQHCs will be converted to THCs with HRSA funding and ACGME accreditation.

Time Table

First 3 FQHC THC conversions will be delivered during the first year. Three-five more will be delivered during years 2-4 of the project.

Year 3-5 activities will be covered by the HRSA grants.

Table 1. Work Plan: Plan and implement a new Primary Care Training Program at Sponsoring Connecticut Community Health Centers.

Objectives and Activities	Team Lead	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5	
		2013 July-Dec	2014 Jan-June	July-Dec	2015 Jan-June	July-Dec	2016 Jan-June	July-Dec	2017 Jan-June	July - Dec	2018 Jan-June
		Planning Year									
Objective 1 (Planning and Infrastructure): Create a Strategic Plan and administrative infrastructure that will support the ongoing development of a high quality PCT program											
Identify the steering committee (SC) members.											
Identify and select Program Director and faculty.											
Complete and sign a memorandum of understanding with educational partners.											
Convene SC quarterly to review and assess the curriculum in preparation for the ACGME site visit.											
Program successfully completes the required ACGME site visit and is accredited.											
Recruit trainees for the program by advertising, interviewing and hiring.											
Establish HRSA funding for all sponsoring institutions.											
Complete the strategic planning process and a SWOT analysis based on											

Table 1. Work Plan: Plan and implement a new Primary Care Training Program at Sponsoring Connecticut Community Health Centers.											
		YEAR 1		**YEAR 2**		**YEAR 3**		**YEAR 4**		**YEAR 5**	
Objectives and Activities	**Team Lead**	**2013** July-Dec	**2014** Jan-June	July-Dec	**2015** Jan-June	July-Dec	**2016** Jan-June	July-Dec	**2017** Jan-June	July - Dec	**2018** Jan-June
the faculty, SC and community partners input.											
Establish strategic direction and goals for the next five years to guide the growth											
Objective 2 (Community Health Linkages): Create new community linkages and strengthen the existing ones to teach PCT residents community health planning and intervention, and community needs and benefits assessment.											
Develop a teaching agreement and affiliation between Community Health Center/ FQHC and Public Health training programs.											
Develop a teaching agreement and affiliation for teaching of population health management, financial planning, and leadership and faculty development.											
Develop a teaching agreement and affiliation with the Connecticut Department of Public Health for placement and training of PCT residents.											
Objective 3 (Curriculum Implementation and Improvement): Implement the fully developed ACGME approved curriculum for the all residency programs and revise and monitor the implementation of the training components of the program.											
Distribute the ACGME competencies and goals											

Table 1. Work Plan: Plan and implement a new Primary Care Training Program at Sponsoring Connecticut Community Health Centers.

Objectives and Activities	Team Lead	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5	
		2013 July-Dec	2014 Jan-June	July-Dec	2015 Jan-June	July-Dec	2016 Jan-June	July-Dec	2017 Jan-June	July - Dec	2018 Jan-June
and objectives of the curriculum to all training sites and preceptors.											
Begin the residency rotations according to ACGME guidelines on accreditation, competencies and evaluations.											
Collect feedback data from faculty, residents, patients and community partners on the value and impact of the program.											
Begin the residency rotations according to ACGME guidelines on competencies and evaluations.											
Collect feedback data from faculty, residents, patients and community partners on the value and impact of the program.											
Complete the ACGME site visit and secure new accreditation status.	ALL										
Convene the Steering Committee quarterly to review the progress of the											

Table 1. Work Plan: Plan and implement a new Primary Care Training Program at Sponsoring Connecticut Community Health Centers.

Objectives and Activities	Team Lead	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5	
		2013 July-Dec	2014 Jan-June	July-Dec	2015 Jan-June	July-Dec	2016 Jan-June	July-Dec	2017 Jan-June	July - Dec	2018 Jan-June
program.											
Collect and analyze the recommendations of the FQHC and other community partners to further revise and improve the training components.											
Objective 4 (Evaluation and Dissemination): Develop and implement a plan for determining detailed outcomes of the program including assessing the integration of Clinical and Public Health skills, a comprehensive evaluation, and a plan for dissemination of the model to the other institutions and communities.											
Identify the program outcome measures and all relevant metrics for evaluation.											
Design a comprehensive evaluation program and a database to collect the data necessary for the evaluation of the program.											
Assess the integration of clinical and public health skills using competency mapping.											
Design a plan and protocol for dissemination of the project and lessons learned through national and regional presentations,											

Table 1. Work Plan: Plan and implement a new Primary Care Training Program at Sponsoring Connecticut Community Health Centers.

Objectives and Activities	Team Lead	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5	
		2013 July-Dec	2014 Jan-June	July-Dec	2015 Jan-June	July-Dec	2016 Jan-June	July-Dec	2017 Jan-June	July - Dec	2018 Jan-June
publications and the web.											
Writing/disseminating of a "How to Manual" to other institutions interested in developing a similar program.											
Measurement of changes in preventive services and health outcomes at clinic sites.											

BUDGET

Personnel Costs

Personnel costs include fringe benefits (described below) and, where possible, 3% annual salary increases. Though not required, the NIH salary maximum of $199,700 was used whenever key personnel salary exceeded the NIH maximum.

Year	**1**	**2**	**3**	**4**	**5**
Total					
Senior/Key Personnel					
Ramin Ahmadi, MD, MPH					
% effort (% funding requested)	**10**	**10**	**10**	**0**	**0**
Funding requested	**19,970**	**19,970**	**19,970**	**In-kind**	**In-kind**
Salary	199,700	199,700	199,700	199,700	199,700
Project Director: Dr. Ahmadi will serve as the project director and will be responsible for the supervision and quality of all project-related activities including the development of the curriculum and the acquisition and promotion of all residencies and for the evaluation to assess the effectiveness of the program.					
PROJECT COORDINATOR, TBA CHCACT					
% effort (% funding requested)	**100**	**100**	**100**	**100**	**100**
Funding requested	**67,000**	**67,000**	**67,000**	**67,000**	**67,000**
Salary	**67,000**	**67,000**	**67,000**	**67,000**	**67,000**
Primary Care Residency Program Coordinator: This coordinator with background and knowledge of ACGME, RRC, and legal and medical education expertise will oversee the development of the programs.					

FQHC Key Faculty					
% effort (% funding requested)	**20**	**20**	**20**	**20**	**20**
Funding requested (for 4 each year)	**39,940**	**39,940**	**39,940**	**39,940**	**39,940**
Salary Sub Total	126,910	126,910	126,910	106,940	106,940
The ***FQHC/CHC faculty*** position will be responsible for the teaching and supervision of the new primary care residents at the FQHC and working with the core team to establish accreditation and funding.					

Direct Administrative Support by CHCACT					
% effort (% funding requested)	**100**	**100**	**100**	**100**	**100**
Funding requested	**40,000**	**40,000**	**40,000**	**40,000**	**40,000**

In addition CHCACT fringe benefit cost is 26% of salary; Occupancy cost is based off FTE and not included in indirect, therefore an allowance $15,000 must be included; as well as CHCACT Indirect at CHCACT's federally approved indirect rate of 26.20% on all direct costs.					
Fringe Benefits at 26%	32,997	32,997	32,997	27,804	27,804
Occupancy	15,000	15,000	15,000	15,000	15,000
All Direct Sub Total	174,907	174,907	174,907	149,744	149,744
Federal Indirect at 26.2%	45,826	45,826	45,826	39,233	39,233
TOTAL:	**220,733**	**220,733**	**220,733**	**188,977**	**188,977**