

The Education Health Center Initiative



Findings and Future Directions

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5/22/08

The Education Health Center Initiative



- Introduction
- Overview of CHC-residency partnerships
 - Workforce impact
 - Growth and distribution
 - Benefits/barriers
- Future directions
 - Support current and future partnerships
 - New models

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Grassroots Partnership

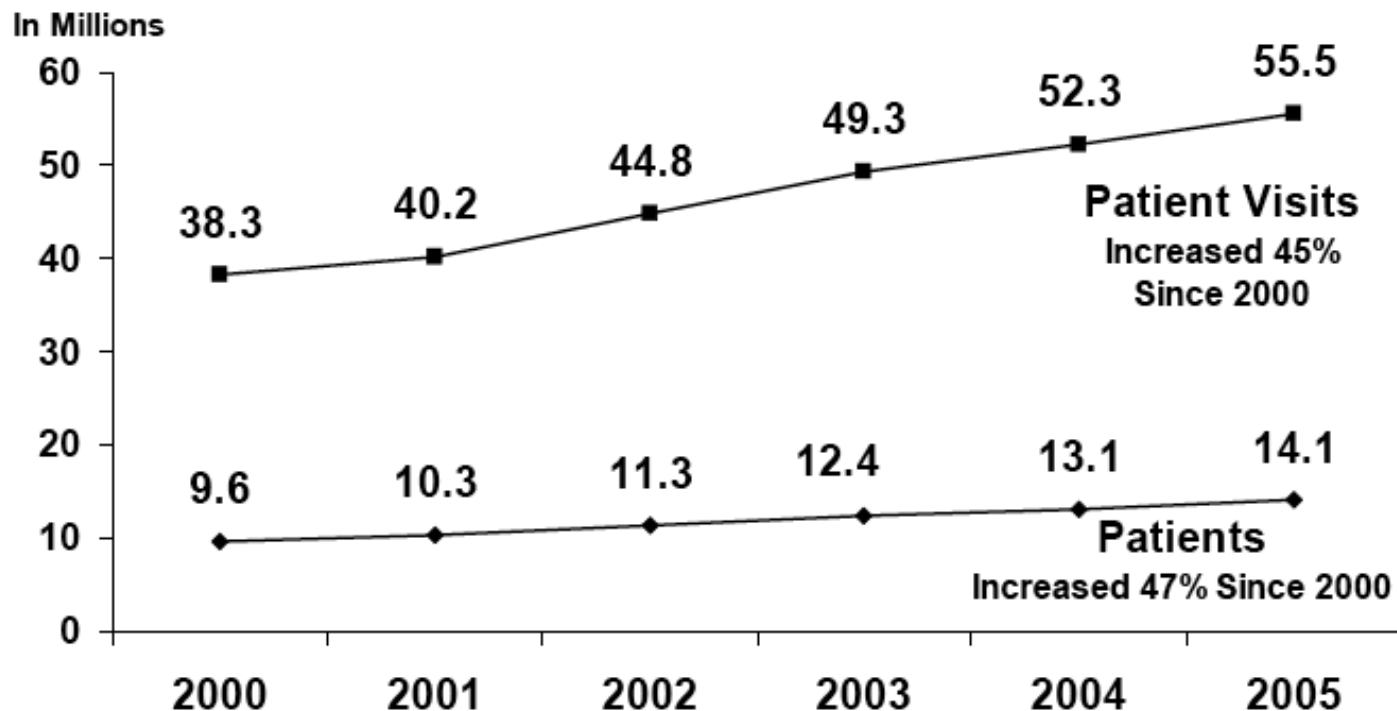


- **Region VIII/X Health Centers**
 - Lil Anderson, Exec. Dir. Deering Clinic
 - **WWAMI FMR Directors**
 - Kevin Murray/Ardis Davis
 - **Northwest Regional Primary Care Assoc.**
(Region X)
 - Bruce Gray
 - **University of Washington Dept. Fam. Med.**
 - Carl Morris/Freddy Chen
- 

CHC Expansion

Figure 2.1

The Number of Health Center Patients and Patient Visits Continues to Grow



Note: Excludes patients at non-Federally funded health centers, which treat an additional 1.5 million patients annually.

CHC Workforce



Shortages of Medical Personnel at Community Health Centers Implications for Planned Expansion

Roger A. Rosenblatt, MD, MPH

C. Holly A. Andrilla, MS

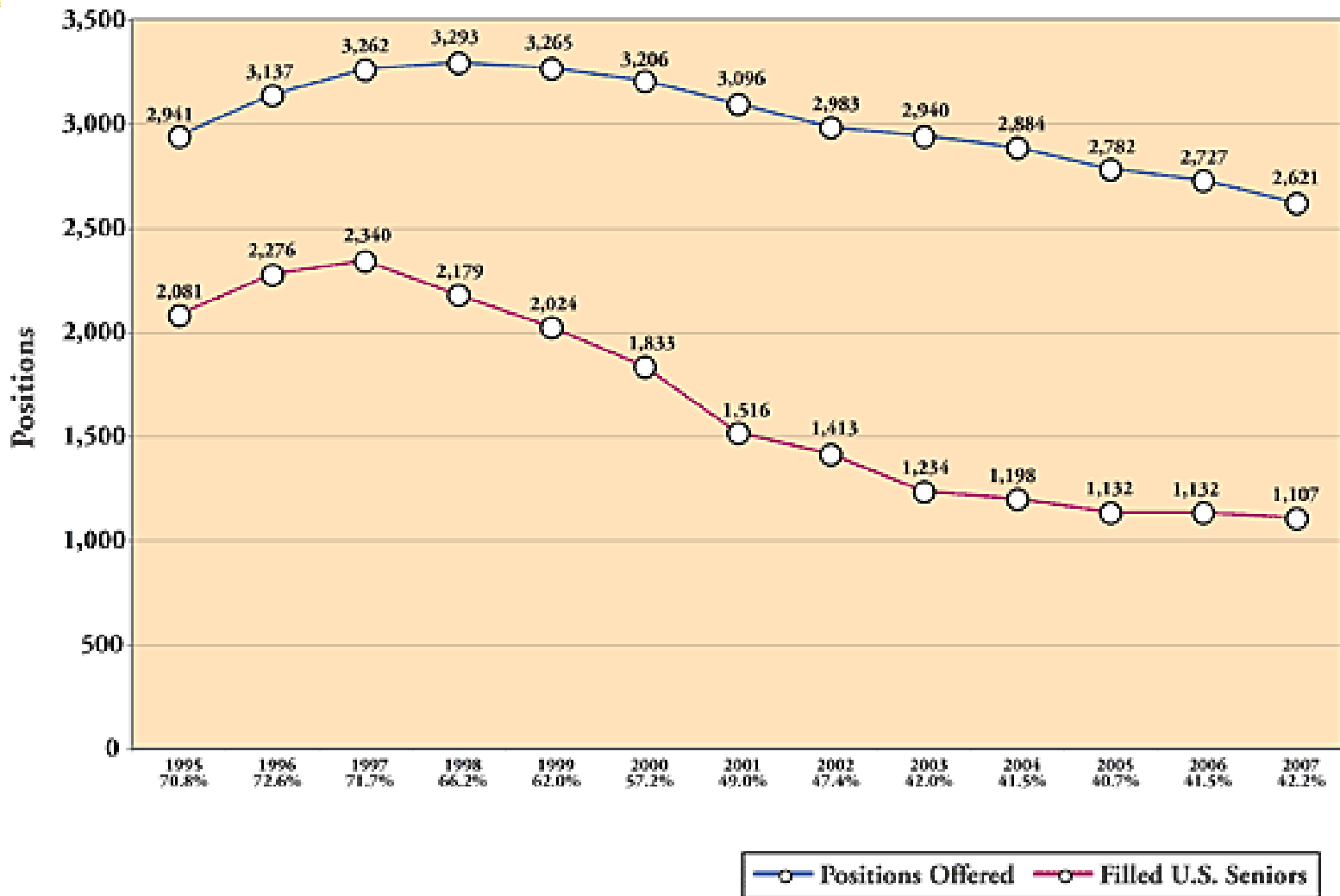
Thomas Curtin, MD

L. Gary Hart, PhD

Context The US government is expanding the capacity of community health centers (CHCs) to provide care to underserved populations.

Objective To examine the status of workforce shortages that may limit CHC expansion.

Family Medicine Residencies



CHC-FMR Affiliation



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Evaluation of HC-FMR Affiliation



- Recruitment, retention, training quality
 - Post-graduate data
 - Growth and extent of affiliation
 - National survey of FMRs
 - Benefits and barriers
 - Key informant interviews/focus groups
 - Focus groups
 - HC-FMR Summit
- 

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The Practice Characteristics of Family Physicians

Following Training in CHCs

Methods

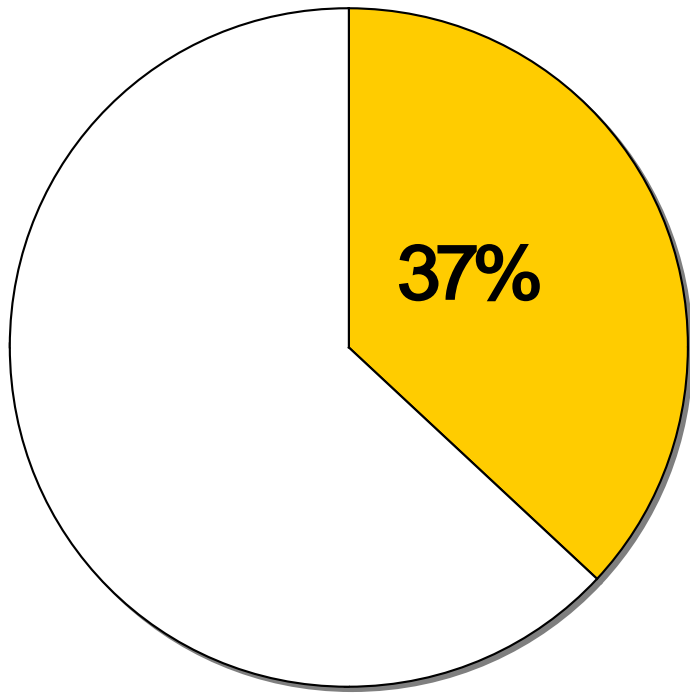
- Cross-sectional survey
- Graduates of WAMI FMRN from 1986-2002
- Cohort of CHC vs Non CHC-Trained
- Definition of “CHC resident”

Results

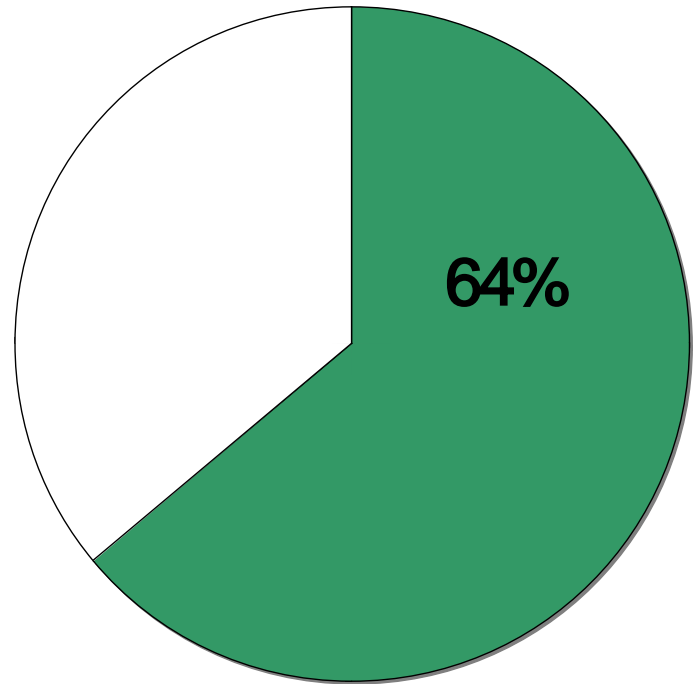
- 919 of 1312 total surveys returned
- 70% response rate
- 72 CHC-Trained graduates
- 6 CHC-affiliated residencies
- 9 Non CHC-affiliated residencies

% Working in Underserved Area

statistically significant difference, $p < 0.001$



■ Non-CHC

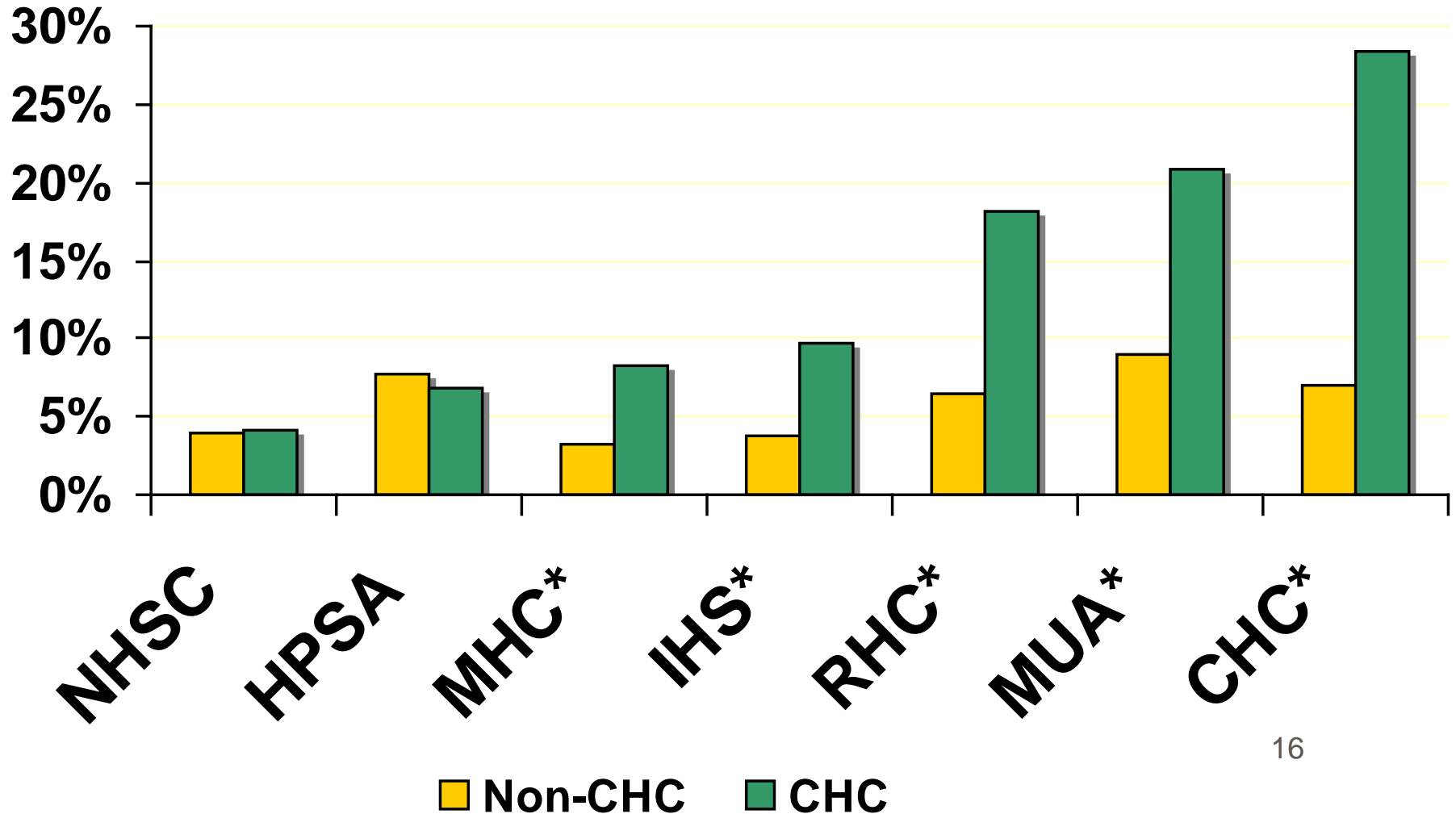


■ CHC

15

% Working in Underserved Settings

* Indicates statistically significant, $p < 0.05$



Summary Results



- Similar training/practice characteristics
 - Residency preparation, spectrum of practice, and practice satisfaction
- Difference in underserved workforce
 - Recruitment
 - 2.7x as likely to work with underserved
 - 3.7x more likely to work in a CHC
 - Retention

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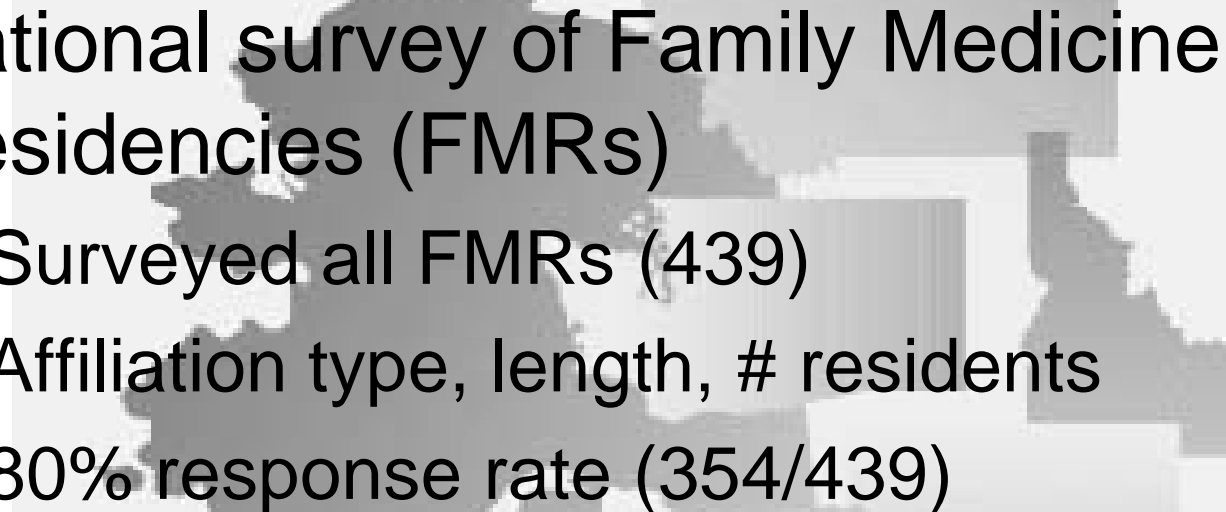
HC-FMR Training Survey

- Background
- Previous estimate
 - 25 fully-affiliated partnerships (1993)




HC-FMR Training Survey



- National survey of Family Medicine Residencies (FMRs)
 - Surveyed all FMRs (439)
 - Affiliation type, length, # residents
 - 80% response rate (354/439)
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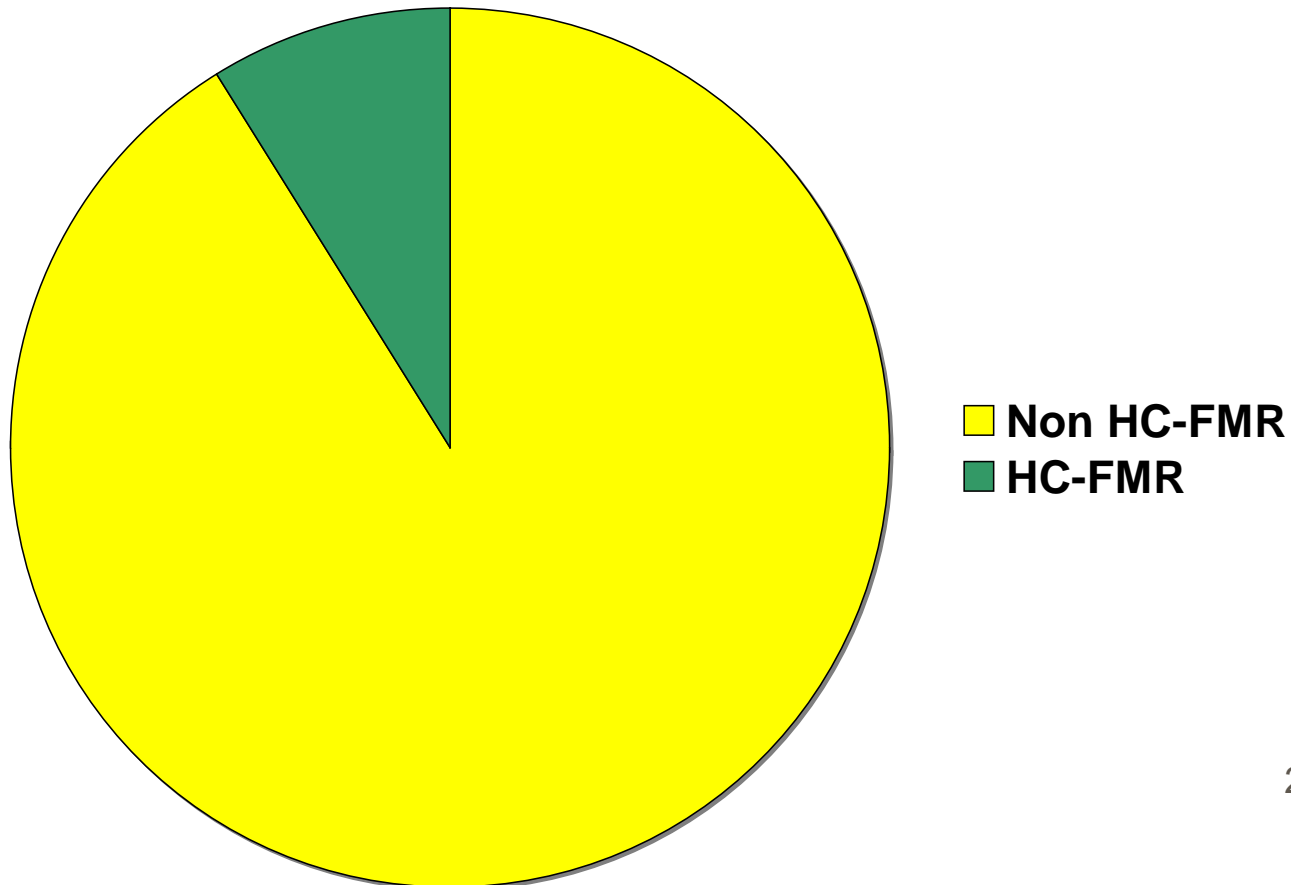
HC-FMR Training Survey



- National survey of all Family Medicine Residencies
 - 25% report some HC training
 - 9% (32) fully affiliated
- 

Number of Affiliations Unchanged Over 15 years

Percent HC-FMR Residencies
9%



Evaluation of HC-FMR Affiliation



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- 

Methods

- Key informant interviews
- Focus groups
- *5/22/07* Working Group

Methods

- Family Medicine Residency Directors
- Hospital Administrators
- Board Members
- FQHC Administrators
- Regional Primary Care Assoc Administrators
- Regional HC and Residency Administrators

Barriers

Governing
institutional barriers

Administrative
challenges

Advantages

Recruitment

Improved quality of
care

Enhanced teaching
environment

Mission

Money

Leadership

Summary



- 
- High Quality Training
 - Enhanced recruitment to HCs
 - Less than 10% of FMRs
 - No growth in 15 years
 - Must overcome barriers

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Support Partnerships



- Region VIII/X network of partnerships
- Web resources
- Listserve
- Accounting model
- Training sessions

New Models



- Education Health Centers
 - A Safety Net Workforce Solution
 - Demonstration Projects

Education Health Centers



Create models of community-academic affiliation that promote a shared mission of service and education.

Regional Demonstration Projects

- Education Health Centers **must have**:
 - A single governance structure to support the mission of service and education
 - A 51% community user board
 - One CEO responsible for the education and service mission
 - Responsibility to meet requirements for underserved community service and family medicine education training.

Regional Demonstration Projects



- **Legislative/Regulatory requests**
 - Medicaid and Medicare reimbursement based on 100% of allowable costs
 - Cost-based reimbursement for educational expenses
 - EHC is accredited for GME reimbursement
 - Changes in GME reimbursement

Regional Demonstration Projects



- **Legislative/Regulatory requests**
 - Loan repayment and increased salaries for residents and providers
 - Funding for EHC startup costs
 - FTCA coverage extends to all resident and faculty training locations

Regional Demonstration Projects



- **15 Education Health Centers**
 - 5 HC's becoming EHCs
 - 5 FMRs becoming EHCs
 - 5 HC and FMR becoming EHCs

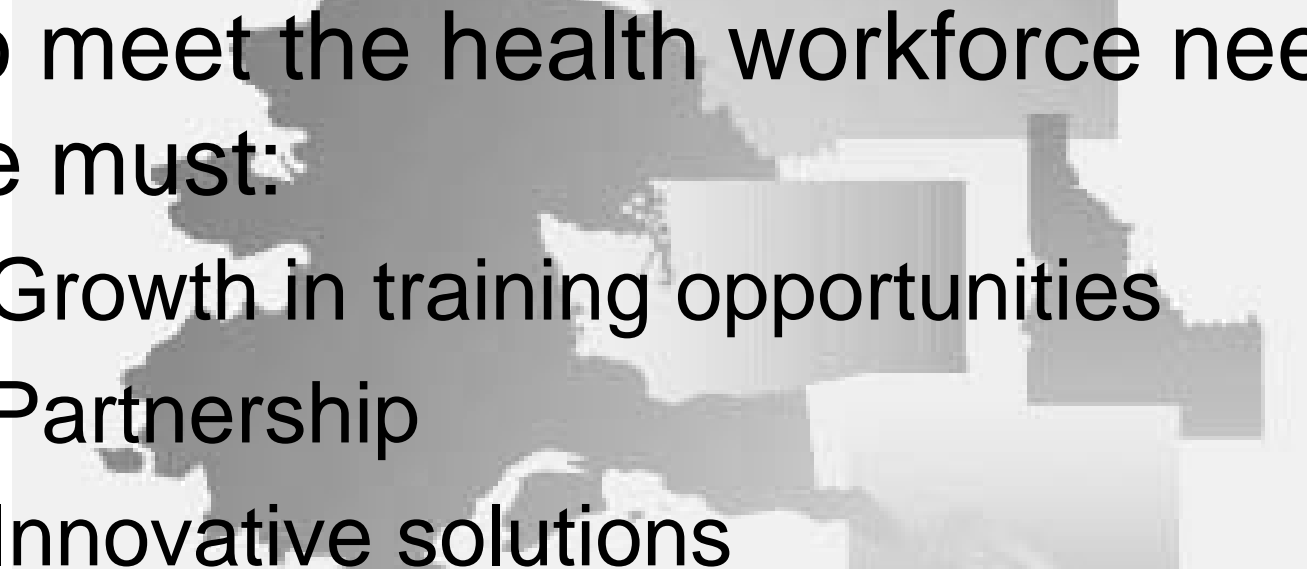
Summary



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Summary



- 
- To meet the health workforce needs we must:
 - Growth in training opportunities
 - Partnership
 - Innovative solutions



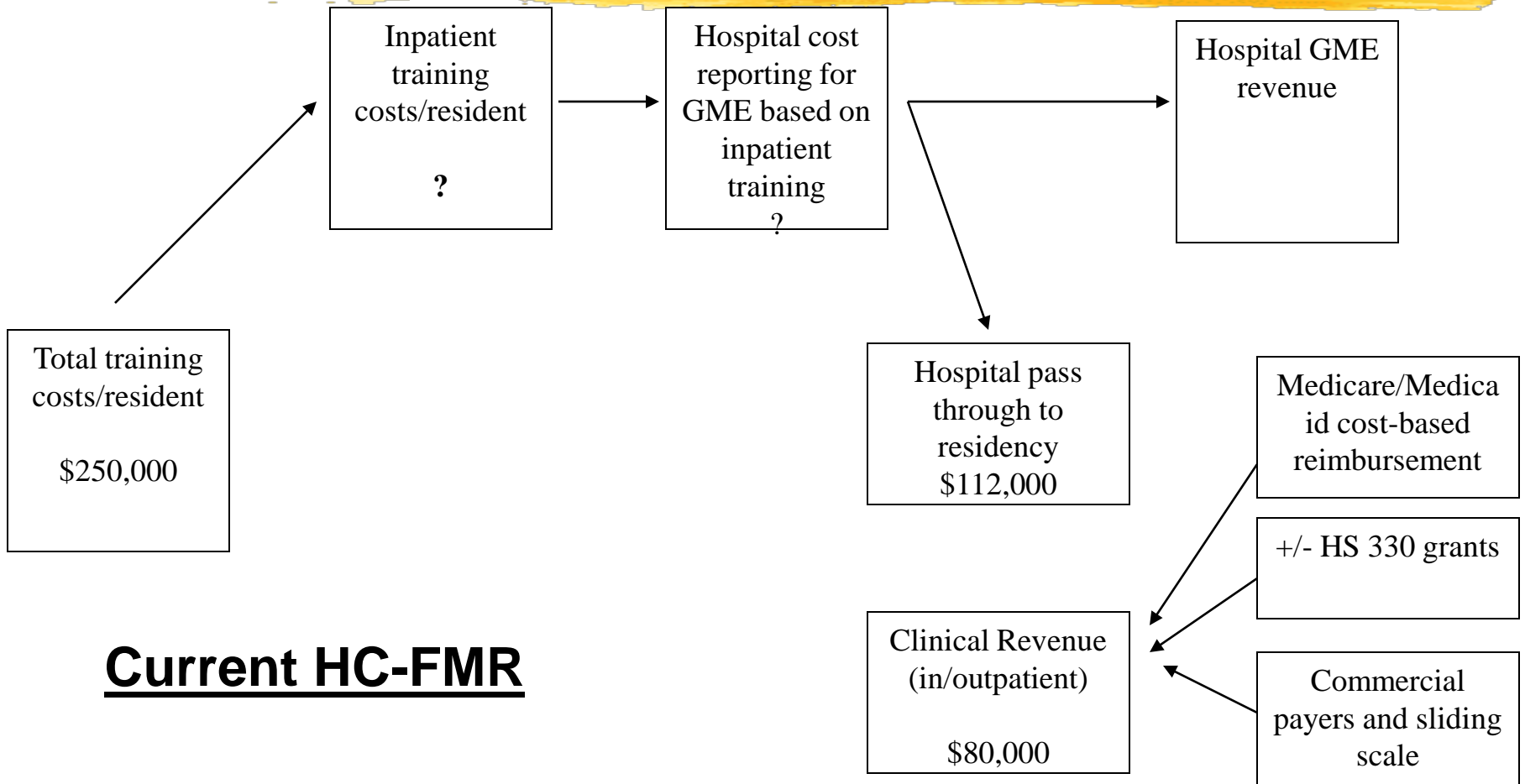
“I still believe it’s a match made in heaven. It’s a little rocky path to heaven sometimes.”

Exec. Dir. CHC

Training Your Own Workforce:

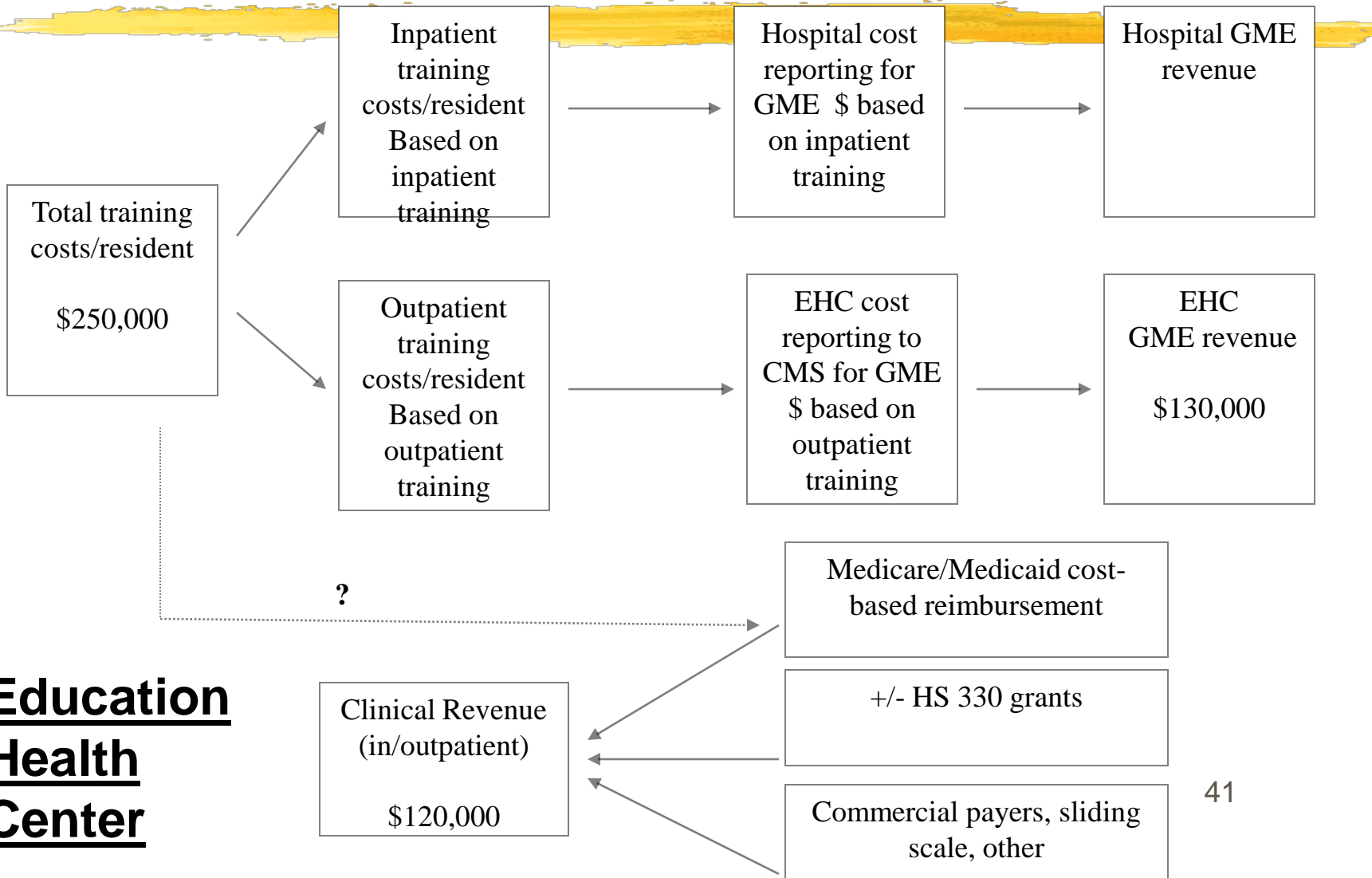


Financing Changes



Current HC-FMR

Financing Changes



Education
Health
Center