

Clinica Family Health Services – Colorado Family Medicine Residency Experience



Need in Service Area

- Northglenn, Fed Heights, Westminster, Broomfield, Lafayette, Louisville, Boulder, Nederland
 - 628,000 People (1 in 10 Coloradans)
 - 150,000 Low income
 - 80,000 Uninsured
- **Capacity**
 - 135,000 medical visits
 - 37,000 medical patients – 1/3 of low income population
 - 1,700 Dental patients - < 2%

Partnered with CU FP Residency From 1993 to 2001

- One clinic with 2 docs and 3 NPs by 1993 – added a doc to be residency director
- CU approached us at urging of HRSA
- 2-2-2 program
- Outpatient care at Clinica
- Inpatient care at Avista Adventist Hospital
- Separate in the match
- Clinica docs were faculty (we had 2 docs at the time)
- Residency director and resident salaries paid by CU

Our Grads

- 8 (62%) ended up in Community Health Centers in Colorado.
- 1 of our grads is now our VP of Clinical Services
- 1 (8%) ended up at a Planned Parenthood clinic in California
- 2 (15%) ended up at Kaiser where the system of care is similar)
- 2 (15%) ended up in private local practice – one of these still assists Clinica with deliveries



What was good about it?

- We and other safety net sites got some great clinicians who were trained to work in CHC team environment and were committed to our mission...and were bilingual
- Our staff docs loved the teaching opportunity
- Residents challenged our docs to “stay current”
- Residents were enthusiastic and hard working
- Call was easier for staff docs

What were the challenges?

- Working out an equitable financial arrangement with CU proved impossible once Federal grant support dried up.
- Hard to meet training requirements in site so distant from “the U.”
- Struggled with complexities of resident scheduling and “prime directive” of continuity.
- Cost of having doc available to residents was not covered by resident productivity.
- Community specialists not committed to care of underserved or education of family docs.



Why reconsider

- We've gone from a 5 practitioner CHC to a 45 practitioner CHC with 20 docs on staff
- Recruitment is a much larger ongoing challenge and expense
- Potential partner is a 9-9-9 program which may improve efficiency
- Potential to bring the only two providers of primary care to underserved in community under "one roof" and share benefits of FQHC, GME, and image
- Help with call for 40,000 users and growing to meet needs of 80,000



All progress is precarious, and the solution of one problem brings us face to face with another problem... **Although all progress is precarious, within limits real social progress can be made.**

Martin Luther King Jr

Feasibility Study

- 150K grant from TCHF for a one year review of the feasibility of our proposed relationship – Administrative and Clinical Merger? Clinical Cooperation?
- One year compensation of 0.2 FTE for a Family Doctor to facilitate the project. Has been at Clinica Pecos Site for 3 years and is a graduate of the St Anthony Family Medicine Residency with a junior faculty chief year in the interim.

Work Group

**Comprised of Administrative Members
from Both Organizations**

SAN Hospital and Family Medicine Residency:
CMO, CFO, Residency Director and Business
Administrator and Senior Faculty Member

Clinica Family Health Services:

Medical Director, VP of Clinical Affairs, CFO,
VP of Operations and FP/AMD

Time Line

- Initial meeting utilized to put germane issues on the table and reach a consensus regarding our commitment to the feasibility study. Emphasis that there is no obligation or guarantee that a joint venture will result.
- Review of the materials and resources currently available. Sought primarily through The Teaching Health Center and NACHC websites as well as pertinent internet searches.

Time Line

- Review of literature supporting EHC formation
- Review of currently existing “EHC” models
- Consideration of potentially dramatic changes with GME funding at the federal level
- Brainstorming meeting:
 “Immutables” “Desires” “Requests”

Time Line

- Attendance at this conference with move towards consolidation of ideas into a collaborative prospectus which can be presented to legal and financial consultants.
- Understanding financial infrastructure associated with the potential merger (GME vs FQHC dollars) is first and foremost in our efforts. This will enable us to move forward into delineation of the clinical, administrative and operative details of this prospectus.

Moving Targets

- GME funding
- HRSA and Federal Health Care Reform
- Hospital Sponsorship and ACO Maneuvering
- Anticipation of Cultural Clashes

Next Steps....

As Drs. Morris and Chen have elucidated:

A health center administrator with years of CHC-FMR experience said it well:

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

Next Steps...

You're bound to become a buddha if you practice.

If water drips long enough

Even rocks wear through.

It's not true thick skulls can't be pierced;

People just imagine their minds are hard.

~ Shih-wu (1272-1352)