



Educational Health Centers: Teaching and Learning in the Community

Executive Summary

November 2015

What are Educational Health Centers?

Health centers* have been involved in training health professionals for decades, but some health centers have uniquely embraced this educational role in their core identity and mission. What they do goes beyond narrow program definitions, such as those in the Affordable Care Act (ACA). Instead, these health centers have committed to ***an integrated, community-owned mission of health care for and with the underserved plus interprofessional health professional education in community-based settings***. They are leading the way to providing better health care and training better health professionals for the health needs of a 21st century America.

Many other health centers are seeking to begin or expand their role in training the next generation of health professionals to serve communities of greatest need, but are not sure how to get started or what obstacles they must overcome to become a full-fledged teaching health center. The National Association of Community Health Centers, Inc. (NACHC) commissioned this report with the National Center for Primary Care at the Morehouse School of Medicine in order to learn from the masters, e.g., to listen to the champions of integrating service and education in common mission. We present here just a few of the many “best practice” exemplars of educational health centers across the nation.

Examples of “Best Practice” Educational Health Center Sites:

- Albany Area Primary Health Care; Albany, GA
www.aaphc.org/
- CHS Health Systems; Knoxville, TN
<http://www.CHShealth.com/>
- Community Health & Social Services (CHASS) Center, Inc.; Detroit MI
<http://www.chasscenter.org/>
- Community Health Center, Inc.; Middletown CT
www.chc1.com/
- Family Health Care Network; Visalia, CA
<http://www.fhcn.org/>
- Heart of Texas Community Health Center; Waco, TX
<http://www.wacofhc.org/>

Are All Educational Health Centers Alike?

Educational health centers share in common a sense of mission and purpose. They integrate commitment to two core values: (1) their commitment to excellence in providing health care and improving health outcomes in partnership with underserved communities; and (2) their commitment to training the next generation of health professionals trained 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.

At the same time, each of our exemplar health centers has chosen to engage in very different approaches to health professional training. Community Health Center, Inc. in Connecticut has been a national pioneer in the

* Includes community health centers, migrant health centers, healthcare for the homeless health centers, and primary care in public housing health centers.

movement to create Nurse Practitioner (NP) residency training programs. CHS Health Systems in central Tennessee has drawn trainees from mental health, behavioral health, nursing and medical care into their culture of fully-integrated, team-based collaborative care. While the CHASS-Center focuses on inner-city Detroit, the Family Health Care Network of clinics serves more agricultural areas of California's San Joaquin Valley. In Waco, Texas, the family medicine residency program came first, and the Heart of Texas Health Center came decades later; in Albany Georgia, the health center came first and the Family Medicine residency came later.

On the next page, we present a common list of "**Lessons Learned**" that were articulated by more than one of our exemplar health centers. On pages thereafter, we present brief case studies to highlight the unique circumstances and wisdom of each health center we interviewed.

Lessons Learned

What Obstacles Did These Educational Health Centers Overcome?

Health centers acknowledged challenges or obstacles overcome in some or all of the following areas:

- Direct financial costs of clinical and administrative leadership and staff time.
- Lost revenue related to decreased productivity.
- Academic institutions treating the health center as an unequal partner.
- Scheduling disruptions, often related to academic partner or students themselves neglecting the impact of training rotations on teamwork and patient care within the health center.

Were there any potential barriers that simply did not occur?

- We expected to hear how these organizations had to work through conflicts between their commitment to education versus their historic mission of healthcare service to the underserved. Instead they reported synergies – the teaching helped them to create constantly learning organizations, to push for a continuously higher standard of excellence in healthcare, and to recruit and retain health professionals who knew how to do excellent health care with the underserved, having trained in these very settings. More than one health center champion said something like this -- *“We’re surprised you’re asking the question. Our service and educational missions are one.”*

What Lessons Were Learned Across the Educational Health Centers?

- Teaching and service missions reinforce one another, providing synergy rather than tension.
- The most obvious directly measurable effect of these programs is on both recruitment and retention. A number of centers report hiring particularly postgraduate trainees (e.g., NP, dental, and family medicine residents, Licensed Clinical Social Workers (LCSW), and post-doc psychologists), while others report enhanced ability to retain clinicians who enjoy teaching and being part of a culture of excellence.
- Students and postgraduate trainees should expect an immersion experience which blends learning about specific skills for serving underserved populations with broader learning about practicing on interprofessional teams in a constantly learning organizational culture which seeks excellence in the provision of culturally competent and respectful care in partnership with communities.
- Centers that have achieved a high level of effectiveness in integrating teaching and education as one mission typically have at least one enthusiastic clinician champion, who has then spread their passion to others until the vision and mission are woven into the fabric of the health center’s mission, organizational culture, and day-to-day work. Managing the teaching programs will require “protected time” for at least one clinician and some administrative support staff.
- Not all clinicians will necessarily enjoy or be good at teaching roles. Some health centers encourage clinicians to differentiate into the roles which provide them the greatest professional satisfaction.
- There are various approaches to generating revenues to support the educational mission and to overcoming lost productivity, but it is clearly possible to create financially sustainable models.
- Some academic institutions behave better than others in treating their health center partners with respect and a spirit of equally valued partnership in the negotiation of financial arrangements, input into curricula and education of trainees, support of health center professionals as valued teachers, and in the day-to-day operational implementation of student or trainee scheduling.
- Academic partnerships must be managed proactively in order to assure that the health center integrates teaching and patient care effectively with appropriate staffing and orientation of students.
- Health centers which strongly value the educational experience they provide can negotiate assertively and be selective about the academic institutions with which they choose to partner.
- There is a positive spillover effect or benefit of having teaching and learning as a daily part of the health center team experience. It helps create a constantly-learning organizational culture for staff, a continuing push for excellence and embracing the change necessary to achieve it, and a more interprofessional team approach to patient care. Patient education also may benefit.
- While a health center may start small, with just one training program or affiliation, it may be difficult to stay in the “toe-dipping” stage for long. These “best practice” health centers have embraced teaching the next generation of health professionals to serve the underserved and have each integrated an expanding portfolio

of training programs into their sense of *“what we do”* and *“how we staff and organize ourselves”* and *“what our business model is”* and, ultimately, *“why we’re here”*.

Educational Health Centers: Case Studies

Case Study: Albany Area Primary Health Care (Albany, GA)

Health Center Organization:

- Albany Area Primary Health Care
 - Multiple clinic sites throughout Southwest Georgia
 - Website: www.aaphc.org

Philosophy and Mission:

- *“Albany Area Primary Health Care, Inc. develops partnerships with our patients in the context of family and community, and is governed by a board of local citizens. As a community health center, it is our goal to offer a broad range of primary care services. We strive to provide comprehensive, coordinated, and continuous care to all who access our services.”*

Key Informant(s) or Champion(s) of Health Professions Training:

- Tary L. Brown, MHA, Chief Executive Officer
- Shelley Spires, MSM, Associate Chief Executive Officer
- James A. Hotz, MD, Clinical Services Director



Overview and History:

Albany Area Primary Health Care (AAPHC) is a non-profit community health center serving Southwest Georgia since 1979, with offices in six Georgia counties. The health center organization was born out of a community-planning process, and continues to follow community leadership in determining services and programs. They provide primary medical, dental, and behavioral health services; and have had a strong history of growth and expansion in their service to underserved segments of their communities. They work closely with a local hospital to provide women’s health services, and also offer school-based healthcare in partnership with Emory University and the Healthcare Georgia Foundation. All of the AAPHC clinical locations are recognized Patient Centered Medical Homes by the National Center for Quality Assurance. Their role in being a catalyst for health professions education is strong. AAPHC played a central role in developing the regional Area Health Education Center (AHEC) program, and also in building the Southwest Georgia Family Medicine Residency Program, whose primary mission is to train family physicians to practice in rural Southwest Georgia. They now also provide training to medical students (both allopathic and osteopathic) from various institutions as well as to physician assistant (PA) and NP students. They have a strong relationship as well with Frontier Nursing University’s nurse midwifery training program. AAPHC’s goal is to train students in the settings in which they are most needed; teaching them how to practice in underserved settings as well as nurturing a commitment to the core values of service, mission, and making a difference in the world.

Health Professions Training Programs, Trainees, & Disciplines:

This health center has affiliation contracts with 12 different universities across the state and region, including:

- Family Medicine residency
- Nurse Midwifery students
- Osteopathic medical students
- Nursing students
- Dental students

- PA students
- NP students
- Pharm D students
- Lab Technician students

Educational Strategies:

Selecting students – AAPHC clinicians actually serve as the admissions committee for six slots in Georgia's only public medical school, in order to assure that students are selected who have a background and a commitment to serving in underserved and rural areas of Georgia.

Start with residency training -- The health center began as a primary teaching site for family medicine residents, working to start the residency program in partnership with the local hospital. They then expanded to develop an affiliated PA training program.

Teaching roles – Health center clinicians (MDs and PAs) provide all teaching for the students and residents, and do all their evaluations.. There is a need for training programs to make evaluations easier to complete without extensive paperwork or excessive log-in procedures.

Focus on the Student / Trainee experience – AAPHC provides “real-world training”, seeking to teach students and residents how to be creative and effective with treatments in under-resourced settings. In doing so, they see themselves not only teaching skills but also are proactive in teaching values such as serving patients with dignity and respect, regardless of their ability to pay. The health center is a counter-balance to university programs, which they see at times as undermining a commitment to primary care and serving those in need, and instead teaching students to give higher status to highly-paid and over-subscribed sub-specialties in settings that serve the well-insured. In the blunt assessment of one AAPHC leader,

“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.”

Affiliation Agreements – Students are only accepted from training programs that have an institutional agreement with the health center, which includes requirements for confidentiality and proof of malpractice coverage.

Educational Challenges / Academic Institutional Relationships:

Some academic institutions are very respectful of the health center in their negotiations and on-going relationships and others are less so. Sometimes the front-line faculty may be easy to work with, but institutional leaders not at all. Specific institutions are very supportive, some are neutral, and occasionally institutions or programs are quite difficult to work with.

Some institutions support training financially. The residency program, for example, pays 20% FTE of several physicians who teach in the residency program. A Pharm D program supports a Coumadin clinic, and brings students to help staff it.

Negative interactions with academic institutions include power dynamics (control issues) or an expectation of subservience by the health center (*you are here to serve the university and to meet our needs*). With faculty turnover, there is also at times a failure to maintain continuity of previously made promises or commitments.

Academic institutions provide material support for the health center and its clinicians in the following ways:

- Faculty development
- Licenses for clinicians to use **Up-to-Date** clinical information support software (\$14,000 value) and/or on-line library access for health center clinicians
- Formal recognition to volunteer faculty, and treat health center clinicians as academic faculty
- Provide Maintenance of Certification / Continuing Medical Education credits (working also with AHEC)
- Pay attention to infrastructure (scheduling, transportation, student housing, etc.); one hospital now provides housing for students from a distant school, because they are seen as future physicians for local rural communities.

Integrating the Healthcare Delivery (Service) and Educational Missions:

According to AAPHC leaders, *“Training and service really enhance each other.”*

On the other hand, the health center does have to work to assure that student training does not have a negative impact on community credibility.

Financial Challenges & Strategies for Supporting & Sustaining the Educational Mission:

In order to achieve financial sustainability for the combined service and educational mission, the health center has had to weave together a complex and constantly evolving mix of multiple strategies. These include the following:

- Managing the volume of students or trainee-load is essential to avoid seeing major losses of productivity.
- FQHC cost-based reimbursement helps.
- Residents can see more patients than students.

AAPHC has a history of initiating new services and then working through potential barriers to create financially sustainable models. This has occurred in their obstetrical and dental programs, which they started at some risk and ultimately were able to sustain.

Overcoming Obstacles:

The center has overcome numerous obstacles and challenges over the years, but the challenges related to the educational mission are closely intertwined with the on-going challenge of providing health care for underserved segments of the population. Some of these challenges and obstacles have included the following:

- The health center is clearly aware of potentially lost revenue related to decreased productivity, but sees it this way – *“yes it slows you down, but it’s worth it.”*
- The health center has achieved Patient-Centered Medical Home (PCMH) certification at all eligible sites, as part of an on-going commitment to maintaining cutting-edge excellence in patient care and training.
- Team-based, interprofessional care is just developing. AAPHC has recently hired LCSWs to enhance their behavioral health capacity, but MD and DO students and residents are largely trained and supervised by physicians. PAs may be precepted by physicians, or by PAs or NPs.
- The health center has invested in core physician-time not only for teaching, but also to develop and maintain strategic external relationships with training programs and academic institutions. The physician who serves as Clinical Services Director spends at least two half-days a week on this kind of strategic leadership.

Benefits to the Health Center

The most obvious directly measurable effect of these programs is on both recruitment and retention. AAPHC emphasizes that the educational component really helps them retain physicians and other health professionals who love to teach, as well as to serve patients.

Impact (Benefits to the Community, the State & the Nation):

AAPHC training programs have nurtured and trained hundreds of health professionals for Southwest Georgia and for dozens of other rural and underserved communities. They also developed health related training programs at a local community college, as well as the residency training program and PA program they helped to build. They provide an on-going influence on academic institutions, including influencing the admissions process. AAPHC clinicians have served on the admissions committees of affiliated medical schools and PA programs and also on the selection committee of a family practice residency program. They also have provided leadership throughout the state by initiating a statewide primary care workforce summit.

Lessons Learned / Advice for Other Health Centers

- Sometimes you have to take risks. In the words of AAPHC Chief Executive Officer Tary Brown, *“We do what it takes, and we look for ways to do it. . . You don’t always have the funding ahead of time.”*

Take-Home Message:

“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

Case Study: CHS Health System (Knoxville, TN)

Health Center Organization:

- **CHS Health System**
 - *Multiple clinic sites throughout Tennessee*
 - **Website:** www.CHShealth.com

Philosophy and Mission:

- **Mission:** *“To improve the quality of life for our patients through the blending of primary care, behavioral health and prevention services”.*
- **Philosophy of Care:** *“At CHS Health System, our philosophy is simple. 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 behavioral health 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.”*

Key Informant(s) or Champion(s) of Health Professions Training:

- **Dennis Freeman, PhD, CEO**
- **Parinda Khatri, PhD, Chief Clinical Officer** *(also Immediate Past-President of the Collaborative Family Healthcare Association)*



Overview and History:



CHS Health System (CHS) took a unique path to becoming an educational health center, by first managing a transition from being a community mental health center (CMHC) program to becoming a combined CMHC and federally-funded community health center.

From their beginnings as the Federated Women’s Clubs in 1959 and then as the Mental Health Center of Morristown in 1960, CHS grew to become a comprehensive health services organization touching tens of thousands of lives every year in

forty-five locations throughout fourteen counties of East Tennessee. Behavioral health outreach is also provided at numerous other sites, including primary care clinics, schools and Head Start Centers.

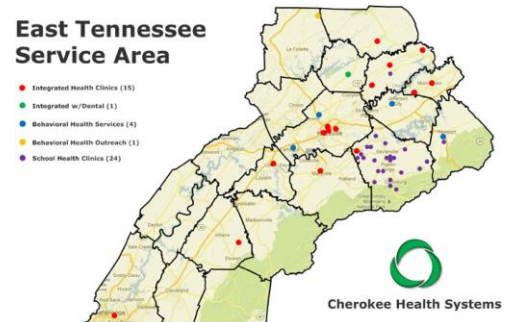
Over the past 50 years, the need for quality health care in the region prompted the expansion of CHS's scope of services and the range of staff expertise to include not only behavioral health services, but medical and dental programs as well. More than 500 professional and support staff members, including psychologists, physicians, dentists, social workers, nurses, pharmacists and specialists in public health offer a wide array of comprehensive primary care and mental health programs and services under the umbrella of CHS.

CHS is known across the country as being one of the nation’s leading “best-practice” programs in the integration of behavioral health and primary care, and they have also become known for their ability to train health professionals in this 21st-century, integrated, collaborative-care model. Their core educational program perhaps is the psychology internship, from which they have hired many psychologists and trained many others to serve in health centers across the nation. However, they also have an immersion experience in team-based collaborative care for physicians, pharmacists, nutritionists, social workers, and behavioral health professionals.

Health Professions Training Programs, Trainees, & Disciplines:

CHS has affiliation contracts with twelve different universities across the state and region. Their trainees include the following:

- Medical students
- Family Medicine residents
- Behavioral Medicine fellows (fellowship for MD/DOs after completion of Family Medicine residency training)
- Nursing students
- NP students
- Pharm D students; at least nine to 10 months out of the year, six Pharm D students stay one month in Advanced Pharmacy Practice Experience (APPE) rotations
- Master's program in Nutritional Counseling
- On-site Masters of Social Work program
- Graduate social workers (during clinical supervision phase for clinical licensure)
- Pre-Doctoral Psychology Internships
- Clinical and Health Psychology Post-Doctoral Program
- Practicum Experiences
- Integrated Care Training Academy
- AHEC programs



Educational Strategies:

Health Center-Driven “Immersion” Training: The health center organizes the training, and health center clinicians provide most of the teaching (a few university psychology faculty and one faculty physician from the family medicine residency spends time in the health center). The health center conducts its own orientation program for each student/trainee, and organizes how they will spend time with patients, preceptors, and collaborative care teams. They describe it as an immersion experience in collaborative, team-based care.

Integrated care: Integrating behavioral health and primary care is a cornerstone of CHS’s approach to both patient care and in education. They are not only training health professionals in-house, but they provide integrated care academies for clinicians from their own state and from around the nation. They have become a leading advocate and national “best-practice” model of integrating behavioral health and primary care in a team-based approach to whole-person care in the context of family and community.

Team-based care and training: All students are taught in a team-based interprofessional team culture, learning to practice in a collaborative way, using an integrated electronic health record across a behavioral and medical care continuum. Students from one discipline shadow professionals from other disciplines, but also experience moment-to-moment collaborative care interactions between and among all the professionals serving the same patients.

Distance Learning: – CHS uses distance learning technologies not only for didactic sessions for students, but also for supervision of behavioral health post-doctoral trainees in their progression to full clinical licensure. This required some assertive negotiations with the state licensing board.

Educational Challenges / Academic Institutional Relationships:

CHS has found most academic institutions to be great to work with and very respectful of the health center’s mission of quality care in underserved communities, but some not so much. The health center has found a way to be respectfully assertive (“...*don’t steamroll us*”) and has declined to work with some institutions.

Key elements of good behavior by academic institutions include trust and communication.

Example: Occasionally, training programs will attempt to just call a clinic manager and place a student at one of the CHS sites without going through their established processes. The health center has to remind and reinforce with the institution (and their own staff) their policies and procedures for accepting students.

One source of inequity in the relationship is that the health center typically receives “*no tangibles or intangibles*” from grants the university may obtain for training students in these settings.

Malpractice coverage by the academic institution is required for students, and is defined in the institutional contracts. CHS provides coverage for interns and fellows who are actually employed by the health center.

Integrating the Healthcare Delivery (Service) and Educational Missions:

CHS Health System 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 & Strategies for Supporting & Sustaining the Educational Mission:

In order to achieve financial sustainability for the combined service and educational mission, the health center has had to weave together a complex and constantly evolving mix of multiple strategies. These include the following:

- None of the affiliated universities or training programs pays CHS to train their students or residents. In fact, CHS pays \$100K to one university (\$10K per student per year) for the opportunity to train these health professionals!
- CHS does receive about \$500 for the pharmacy students and receives \$60,000 from the regional Area Health Education Center (AHEC) program.
- Because of its unique role as both a health center and a licensed community mental health center (CMHC), CHS can sometimes bill for trainee-provided behavioral health services, so long as the encounters are appropriately supervised.
- CHS also receives a training grant from HRSA to train psychologists in the practice of integrated care (integrated behavioral health and primary care). These grants usually are awarded to academic institutions.
- CHS has achieved designation as a migrant health center and has received expansion grants for developing new services and delivery sites, and also became the East Tennessee Center for Meharry Medical College's Area Health Education Center (AHEC).
- CHS has been successful in obtaining additional grant funding for innovative programs related to their mission, including funding from HRSA's Maternal and Child Health Bureau, Rural Health Outreach grants from the Office of Rural Health Policy, and a \$1 million Community Access Program grant to link area safety net primary care providers through an integrated service delivery model.
- Aside from HRSA funding, CHS has also obtained United Way funding to provide health homes for uninsured residents of Knox County, and was designated the East Tennessee Center of Excellence for Services to Children in, or at risk for, state custody.
- CHS has also been nimble in responding to changes in the health care financing arena, having negotiated behavioral health “carve-out contracts” with behavioral health organizations, and becoming a designated Behavioral Health Organization for managed care organizations under TennCare (Tennessee's Medicaid managed care model). They have been able to demonstrate significant improvements in overall utilization and costs for their patient panels.

Overcoming Obstacles:

The center has overcome numerous obstacles and challenges over the years, but the challenges related to the educational mission are closely intertwined with the on-going challenge of providing health care for underserved segments of the population. Some of these challenges and obstacles have included the following:

- The health center is clearly aware of potentially lost revenue related to decreased productivity, but has found strategies to achieve financial sustainability.
- Space is always an issue, especially with the large number of trainees flowing through CHS, and the large number of patients served. New sites are designed and built with adequate space to support both training and service delivery components of the mission.
- Scheduling and other coordination issues come up, such as coordinating orientation sessions for trainees across disciplines and across five different university calendars of semesters and rotations, as well as allowing residents to leave for their continuity clinics at the residency program.
- One strategy is to conduct regular orientation for students and other trainees in an interprofessional team-based format, the same as they will experience in their training and in the collaborative care delivery.

- Logistics are also a challenge.
Example: Making sure trainees have computers or laptops and all the appropriate sign-ins for secure electronic health records.

Benefits to the Health Center:

The most obvious directly measurable effect of these programs is on both recruitment and retention.

- CHS leaders consider training health professionals to be *“one of the best recruiting strategies you can do”* and *“a definite asset for both recruiting and retention.”* CHS has hired more than half of the psychology interns they have trained, and many of the rest are working at community health centers around the country.
- Recruiting health professionals for underserved settings is always a challenge, and CHS sees the core strategy as being to *“grow your own.”* At the same time, this strategy leads to a capacity for hiring graduates who understand and have skills for practicing not only in an underserved setting, but in the collaborative practice style and positive values embedded in the CHS organizational culture.
- There is also a broad impact seen in a commitment to excellence and constant learning throughout the organization.

Impact (Benefits to the Community, the State & the Nation):

CHS has become one of the leading programs in the country for implementing fully-integrated behavioral health and primary care, and for teaching others how to make the transition to this collaborative health care model. Their trainees are practicing in underserved settings all across the country. CHS is also taking the model to scale not only through their own implementation and local training programs, but also through presentations at national meetings, leadership of national organizations (e.g., *Collaborative Family Healthcare Association*), hosting of site visits by clinicians, executives, and policymakers from around the country, and the development of their Integrated Care Training Academy.

Lessons Learned / Advice for Other Health Centers:

- Doing training and service together facilitates creation of the constantly learning organization, the innovation, and the excellence that all health centers seek.
- There is a cross-fertilization of knowledge that comes by training and working with other health professionals in an interprofessional collaborative care team, and it means developing interprofessional competencies. That needs to be not only the formal curriculum and training experience, but the core culture of the organization.
- Health centers seeking to replicate the psychology or behavioral health internships need core faculty, which is a real cost. This is a funding opportunity for HRSA. Another strategy would be for several health centers to form a consortium, and to share the faculty who are needed for appropriate supervision.
- Similarly, many family medicine residency training programs would like to see residents trained in the model, but are only able to send residents for a one-month rotation (due to accreditation issues such as the continuity patient care experience and hospital-centric control of graduate medical education funding for resident salaries). This would be another area for pilot programs or policy change at the federal level.

Take-Home Message:

“One of my favorite things to see is that we have had a number of our clinical staff who trained with us and now they are hired on and are supervising and training others. You talk about paying it forward, and it’s really lovely to see.”

-- Parinda Khatri, PhD, Chief Clinical Officer, CHS

[Being an educational health center] . . . is not an easy thing to do.

If you’re going to do it, do it well. “It’s so much a part of our core...It enriches who we are and what kind of organization we are.”

-- Dennis Freeman, PhD, CEO, CHS

Case Study: Community Health & Social Services (CHASS) Center (Detroit, MI)

Health Center Organization:

- **Community Health & Social Services (CHASS) Center**
 - Several clinic sites in Detroit Michigan.
 - Website: www.chasscenter.org

Philosophy and Mission:

- *The Community Health and Social Services (CHASS) Center, Inc., is a community-based, not for profit organization formed to develop, promote, and provide comprehensive, accessible and affordable quality primary health care and support services to all residents of the community, with special emphasis on the underserved African-American and Latino population. CHASS is committed to the overall well-being of the community.”*

Key Informant(s) or Champion(s) of Health Professions Training:

- **Felix M. Valbuena, Jr., MD, FAAFP, CMO**

Overview and History:

Community Health & Social Services (CHASS) Center has been serving the community with high-quality, culturally-relevant, affordable health care for over forty-five years. For most of this time, they have also been engaged with training family medicine residents from the Henry Ford Health System.

CHASS was established more than 40 years ago in response to the closing of several community hospitals in Southwest Detroit and the subsequent flight of medical professionals to suburban practices. The CHASS story is one of community determination, of a group of people saying that less is not enough and inequality is unacceptable. In 1970 Hispanic leaders negotiated the first-ever joint venture with local and state public health officials and CHASS began providing limited medical services to the uninsured and underinsured population of Detroit. In 1993, as the need for expanded services grew, CHASS became a federally-funded community health center under the Health Resource Services Administration's Bureau of Primary Health Care. Today, CHASS is a nationally acclaimed model of quality health care to underserved urban populations, with two Detroit locations that provide comprehensive primary health, dental and wellness care to all, regardless of insurance status.

CHASS educational programs and clinical service delivery are both well-served by a unique partnership with the Henry Ford Health System (HFHS). CHASS contracts for physician services with HFHS, creating seamless access for CHASS patients to obtain subspecialty referrals and ancillary services through a voucher program. HFHS family medicine residents in turn receive most of their obstetrical training from CHASS providers. Other student programs and educational affiliations round out the center's commitment to providing high-quality, culturally-relevant care and training the next generation of health professionals to carry on this mission.

Health Professions Training Programs, Trainees, & Disciplines:

This health center has affiliation contracts with the following:

- 1 Family Medicine residency
- 1 Medicine-Pediatrics residency
- 3 NP programs
- 2 PA programs
- Pharmacy tech students
- Medical Assistants (MA)

Educational Strategies:

Selecting students – The health center specifically seeks out bilingual and bicultural students and residents, since two-thirds of their patients prefer speaking Spanish. They also look for students who have a connection to the community, and recently hired a NP who trained in their center but who also grew up and went to school in the neighborhood.

Managing volume – Sometimes the health center has requests to host more students than they can effectively manage, so they consciously limit the volume to no more than one student or rotator per provider per session. They have had to turn down some students in a given semester because of the volume, and reinforce with the academic institutions that they are limited in capacity and give preference to students with community connections and/or bilingual and bicultural backgrounds.

Clinical teaching – All of the clinical teaching is done by CHASS clinicians. Because of the relationship with Henry Ford Health System, they all have access to various faculty development training opportunities, as well as on-line HIPAA training and remote access to their medical library and clinical decision support systems. One of the CHASS clinicians was recently given the “up-and-coming teacher” award from an academic partner.

Affiliation Agreements – Students are only accepted from training programs that have an institutional agreement with the health center, which includes requirements for confidentiality and proof of malpractice coverage. For this reason they do not accept volunteer students, who might not be covered by their institution or by the Federal Tort Claims Act (FTCA).

Educational Challenges / Academic Institutional Relationships:

CHASS has a very unique relationship with the Henry Ford Health System. All of its physicians are members of the Henry Ford medical group, which then allows direct access to sub-specialist referrals, as well as to hospital-based lab and imaging services. Center leaders estimate that this may be valued at up to \$10 million per year in ancillary services for their patients.

The relationship with the hospital health system also gives CHASS access to various policies, procedures, and continuing education for all the CHASS employees.

CHASS has also occasionally received some sub-contracted funds from training grants obtained by university programs, but these are often time-limited and end when the grant runs out.

Integrating the Healthcare Delivery (Service) and Educational Missions:

CHASS patients appear to embrace the educational mission as well, as long as they have access to high quality care. Occasionally they may ask specifically for Dr. Valbuena to see them without a student, but if they have received services at CHASS long enough they also saw Dr. Valbuena as a student coming through and ultimately becoming the chief medical officer. They see a NP who was a CHASS patient, who came through as a student, and who is now employed with the center so they can see live examples of how the training helps the center and are generally very supportive of the training programs.

Financial Challenges & Strategies for Supporting & Sustaining the Educational Mission:

In order to achieve financial sustainability for the combined service and educational mission, the health center has had to weave together a complex and constantly evolving mix of multiple strategies. These include the following:

- CHASS has a very high mix of uninsured patients (>80% before the ACA), so the hospitals have been providing upwards of \$10 million in uncompensated care per year for CHASS patients, especially in laboratory and imaging services. In exchange, CHASS agreed to provide obstetrical training and experience for the family medicine residents, due to the large volume of obstetrical care provided in CHASS facilities.
- Although the health center could not quantify its direct costs associated with teaching, they note that they maintain scheduling and patient volumes for days or months when they have students the same as they do for times when students are not present.

Overcoming Obstacles:

The center has overcome numerous obstacles and challenges over the years, but the challenges related to the educational mission are closely intertwined with the on-going challenge of providing health care for underserved segments of the population. Some of these challenges and obstacles have included the following:

- The health center administrative leadership team is clearly aware of potentially lost revenue related to decreased productivity, and at times reminds the clinician-teachers to make sure that they are keeping the bottom line stable even as they are teaching the students.
- Very rarely the health center encounters a student who is not a good fit for the mission or is excessively slowing the clinicians down. Instead, most students report that they have a great clinical experience, and often request to come back for elective rotations.
- CHASS is seeking to create interprofessional team-based care, with particular attention to the integration of behavioral health and primary care. They are participating in a learning collaborative with the Institute for Health Improvement to work through the details of implementing the integrated care model.

Benefits to the Health Center

The track record of recruiting and retention speaks for itself. Eight current providers--six physicians and two NPs--came through the center as students. They are also 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. There's actually a NP who just graduated that we are looking to hire who grew up in the neighborhood, went to high school in the neighborhood, and came through during her training and did rotations with us. So I think that having the training program will allow us in the long run to provide better care for the community."

Impact (Benefits to the Community, the State & the Nation):

CHASS is demonstrating a strong model of partnership between a large academic hospital / health system and a community health center. The relationship is bidirectional, with win-win benefits for both organizations, and a common commitment to seeing that patients receive high-quality care that is seamless between primary care and specialty or hospital settings. In addition, they are training students and residents who have the skills and sense of mission to serve diverse, underserved communities, whether in Detroit or around the country.

Lessons Learned / Advice for Other Health Centers

- Partnerships with hospital health systems can create new opportunities both for patient care and for training the next generation of community-directed health center clinicians.

Take-Home Message:

"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 9000 centers across the country that provide the same kind of services that we do.

***-- Felix Valbuena, MD, FAAFP,
CMO, CHASS***

Case Study: Community Health Centers, Inc. (Middletown, CT)

Health Center Organization:

- **Community Health Centers, Inc.**
 - Primary care centers in 13 sites, 200 service delivery locations throughout Connecticut
 - Website: www.chc1.com

Key Informant(s) or Champion(s) of Health Professions Training:

- **Kerry Bamrick, MBA, Senior Program Manager**
- **Mary Blankson, APRN, Chief Nursing Officer**
- **Robert Block, CPA, Chief Financial Officer**
- **Veena Channamsetty, MD, Chief Medical Officer**

Overview and History:

Community Health Center, Inc. (CHC, Inc. is building a world class primary health care system that is committed to special populations, and that is focused on improving health outcomes for patients as well as building healthy communities. Since 1972, CHC, Inc., been one of the leading health-care providers in the state of Connecticut, comprehensive primary care services in medicine, dentistry, and behavioral health to patients from nearly every city or town in Connecticut.

CHC, Inc. has also been a leading national best-practice example of an educational health center, having developed the first postgraduate NP residency program in the country, a model which has been replicated across the country. CHC, Inc. also now remotely “hosts” post graduate NP residency programs in four other states. CHC, Inc. also has a postdoctoral clinical psychology residency training program focused on training psychologists to an integrated model of primary care and a psychiatric mental health NP residency program. CHC, Inc. will soon launch a public health dentistry residency. Each of the postgraduate residency programs, along with the pre-professional student experiences they offer (nearly 200 students per year from virtually all health disciplines) focus both on education and training to clinical care and the complexity of the CHC, Inc. population, but also training and education on a high performance model of primary care.

CHC, Inc. has also developed a unique research and development arm (the Weitzman Institute) that leads the quality improvement program of the health center but also is one of the only research and innovation centers in the country originating from and functioning within a federally-qualified community health center. The Weitzman Institute conducts research in areas that are priorities for CHC, Inc. and our communities, including chronic pain management, implementation science, and care for key populations. The Weitzman Institute sponsors the annual Weitzman Symposium at Wesleyan University, during which leaders share their work and innovations in community health and primary care. CHC, Inc. does not just study these innovations, but makes adoption of innovation a key element of their passion for excellence. Examples of innovations at CHC, Inc. include implementation of eConsults, remote retinal screening for diabetics, and Project ECHO-Ct but more important is the commitment to continuous innovation, transformation, and renewal in a constantly learning environment. The organizational culture itself has been transformed, and seeks to stay on the cutting edge by training students, residents, and fellows to practice in *“a culture of team-based, data driven, patient centered care. . . in a high-performance system.”*



their
Inc. has
providing

Health Professions Training Programs, Trainees, & Disciplines:

The program for which Community Health Centers Inc. is best-known is the innovative NP residency training program, for recent NP graduates who want to have a practical training experience in caring for underserved segments of the population. However the health center also has many other training programs, including the following:

- NP residents (family practice and psychiatric)
- Post-Doctoral Behavioral Health residency training
- Public Health Dentistry residency
- NP Students
- Medical students
- Medical residents
- Dental students
- Nursing Students (RN and MSN)
- Chiropractic students
- Social Work students
- MA students

Educational Strategies:

Innovative programs – CHC, Inc. started the first formal NP residency training program in the nation in 2007. Health center clinicians provide “99.9% of all teaching” for the students and residents. They have also developed postdoctoral psychology training fellowships. In the Fall of 2015 they will manage their first psychiatric mental health NP residency program and a dental public health residency program.

Team-based, pre-planned care – Care is built on a pod-based model, with a pod representing a full team. This interprofessional team consists of primary care NPs, physicians, nurses, MAs, social worker, nutritionist, pharmacist, podiatrist, psychologist, and chiropractor.

Learning Objectives & Curricula – CHC, Inc. establishes learning objectives related to each training program that are specific to and consistent with this team-based care model.

Expectations – Both students and their training programs understand from the outset that CHC, Inc. is a team-based, interprofessional training culture. Students train on teams, just as clinicians practice together on teams, all using the same electronic health record.

Remote Hosting – Because CHC, Inc. has been the innovator in developing NP residency training programs in underserved settings, they now manage the structure, curriculum, evaluations, weekly didactic component and many other activities of residency programs in Washington, Rhode Island, New York and Hawaii. Over 150 other health centers have inquired about the possibility of developing NP residency training programs with CHC, Inc. as the sponsoring institution and “remote-host” managing entity.

Educational Challenges / Academic Institutional Relationships:

A significant challenge is created when academic institutions try to send 15 students for a rotation with no advance warning. Another challenge is when students themselves reach out to preceptors directly to try to arrange rotations for clinical experiences. Because of some of these challenges CHC, Inc. formed the “Student and Trainee workgroup” in 2014. The workgroup was tasked with creating a clear playbook (e.g., clear guidelines and protocols) of the process on how communication should occur and what standards each school must adhere to and what types of students are appropriate. CHC, Inc. works proactively to maintain clear expectations with clinical chiefs and training program leaders from over 30 different schools.

Integrating the Healthcare Delivery (Service) and Educational Missions

The health center describes its mission as being not just to provide health care, but to make sure that the care they provide is the best it can be, and is what best meets the needs of their communities and patients.

To be a world class primary care organization, the health center is constantly working to transform itself to reflect changing needs and a changing environment. They identify at least three critical paths in this transformational work, which illustrate the blend of service and educational missions:

- Always striving for clinical excellence
- Constantly innovating and researching, seeking new ways to improve the health of their communities
- Committed to training health care professionals of the future

Financial Challenges & Strategies for Supporting & Sustaining the Educational Mission:

In order to achieve financial sustainability for the combined service and educational mission, the health center has had to weave together a complex and constantly evolving mix of multiple strategies. These include the following:

- There is clearly a sustainability issue. Education as a core function by itself is not breaking even. However, the organization sees education, constant innovation, team-based care delivery, and pursuing excellence in care delivery to the underserved and health outcomes improvement in diverse communities as all being tightly interwoven and essential to achievement of the health center mission.
- Some training programs generate revenues. NP residents are able to generate revenues based on encounters, but at a lower productivity than experienced clinicians. A postdoctoral psychologist can actually make a financial margin during their one-year residency in which they are seeking to obtain 1000 hours of supervised patient care, which they need for clinical licensure.
- Some schools pay for CHC, Inc. to train their students, and some do not. For example, CHC, Inc. is being paid for some nursing students and for family medicine residents.
- The research Institute helps to pay for testing and adopting new innovations, and also helps to diversify funding streams. Grant funding has been competitively awarded from the National Institutes of Health (NIH), the Agency for Healthcare Research & Quality (AHRQ), and the Patient-Centered Outcomes Research Institute (PCORI). Health Resources and Services Administration (HRSA) training grants have also been acquired.
- The NP residency training program can be broken down specifically in terms of costs and revenues as follows:
 - NP residents are paid a reduced salary (about 40% less than what they would earn their first year in practice). They are fully licensed and credentialed, so when they start the residency program they can bill for their own visits. During a precepted session, a preceptor is exclusively available to them in a two to one ratio. The two residents are seeing patients, and the preceptor is available but they are billing for visits. They can also be counted as providers for the purposes of meaningful use incentive payments, which amounted to about \$21,000 dollars over the past year. Finally, the cost of recruiting and retention is huge, so their ability to hire NPs who have been trained in the CHC, Inc. approach and who are committed to serving CHC, Inc. communities is a tremendous benefit.

Overcoming Obstacles:

The health center has overcome numerous obstacles and challenges over the years, but the challenges related to the educational mission are closely intertwined with the on-going challenge of providing health care for underserved segments of the population. Some of these challenges and obstacles have included the following:

- Development of the NP residency program was first a response to an observed challenge. NPs graduating from highly academic programs would come to CHC, Inc. to work, and then leave after a few months, and even leave primary care. They just were not prepared for the pace and the level of complexity of patient care in an underserved setting. So the residency was designed to build competence and confidence in parallel for recent graduates of NP training programs.
- Clinical facilities are not traditionally designed for team-based care. So the CHC, Inc. facility is now designed and built as a pod-based structure – no offices, just spaces for interprofessional team-based clinicians to sit together and to practice together.
- Federal funding to directly support NP residency training has still not been achieved. There was a move to create demonstration projects in this space, but no funding was appropriated. Similarly, the Teaching Health Center provisions of the ACA did not specifically address NP residency training.
- Commitment to an integrated mission of excellence, innovation, and training the next generation requires buy-in and leadership from both executive leaders and clinical leaders, as well as the community board.

Benefits to the Health Center:

- The most obvious directly measurable effect of these programs is on both recruitment and retention. CHC, Inc. estimates that eight of ten current residents want to stay with the organization as clinicians after their residencies, and over the years that proportion has been at least 50% each year.
- The clinicians that CHC, Inc. trains are committed to the mission of serving in primary care and community health, and really want to learn and practice in a high-functioning environment.
- Retention is also a factor – precepting student trainees is a key element of job satisfaction for many clinicians.
- The CHC, Inc. model also encourages team-based learning, because when the clinical provider is precepting, there is a whole pod of clinical staff learning and collaborating. This has a broader impact in those teams' commitment to excellence, innovation, and constant learning throughout the organization, in order to achieve a better quality of care for all.
- It also has an impact on career paths for CHC, Inc. staff – MAs go to school to become nurses, and nurses go to school to become NPs. NPs are going back to school to get their doctoral nursing degrees. Physicians are getting Master's degrees in Public Health. The culture and the context of being surrounded by learners make each person want to seek more learning.
- Finally, CHC, Inc. leaders report that *“patients absolutely love having a NP resident treat them,”* in part because they can spend more time with the patient.

Impact (Benefits to the Community, the State & the Nation):

The core training program is now a net producer of more NP residency graduates than CHC, Inc. can actually hire, so their graduates are seeking out new places to serve and to practice in other underserved settings across the country. Perhaps even more impactful is the educational innovation which has designed and built a training program in which a community-owned health center is central, and which has the capacity to train clinicians to do 21st-century, team-based, pre-planned health care in an underserved setting. These educational programs are now being replicated through remote-hosting and by other health centers seeking to adopt these innovations in their own communities across the nation.

Lessons Learned / Advice for Other Health Centers:

- Not every clinician who wants to be a teacher or preceptor will be good at it. They need to be really committed to training and really want to have students and trainees with them.
- The blending of service and education is part and parcel of a commitment to excellence and innovation.
- The commitment to “training the next generation” needs to be an agency wide (top-to-bottom) commitment.

Take-Home Message:

“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.***

Case Study: Family HealthCare Network (Visalia, CA)

Health Center Organization:

- **Family HealthCare Network**
 - Fourteen clinical sites in Tulare and Kings County, California
 - Website: www.fhcn.org

Philosophy and Mission:

- Family HealthCare Network has the following mission:
“We provide quality health care to everyone in the communities we serve.”
- President & CEO Kerry Hydash describes their approach in her message to the community:
 - *“As a Patient Centered Medical Home, our services are focused on you and your family, and coordinated by a health care team to assure your health care needs are addressed comprehensively. Our service approach is focused on compassion and respect for every person who walks through our doors or who is touched through our community programs.”*

Key Informant(s) or Champion(s) of Health Professions Training:

- **Kerry Hydash, President & Chief Executive Officer**
- **Henry Cisneros, Jr., DDS, Chief Clinical Officer**
- **Carolina Quezada, MD, Medical Director**
- **Isaac Navarro, DMD, Clinical Dental Director**

Overview and History:

Since 1976, Family HealthCare Network (FHCN) has grown from a small renovated gas station that was used as an outpatient health center in Porterville with the primary mission of serving the underserved farmworking community to a multi-site primary health care network serving over 188,000 patients from Tulare and Kings Counties.

FHCN is the only Community Campus in California for students from A.T. Still University's (ATSU) School of Osteopathic Medicine based in Mesa, Arizona. ATSU students study, train and complete their clinical rotations during their last three years of medical school at FHCN. In 2008, a dental partnership was formed with ATSU in which fourth year students spend a portion of the year studying at FHCN. A dental residency program with Lutheran Medical Center Dental (LMC Dental), based in Brooklyn, New York also places residents at FHCN for comprehensive general dentistry training. PA students from ATSU also spend their second year at the FHCN campus, after spending their first year at the Mesa Arizona campus.

FHCN's commitment to training and education is meshed with a strong commitment to organizational and clinical excellence. FHCN has been dually recognized by The Joint Commission and the National Committee for Quality Assurance (NCQA) for achievements as a Patient-Centered Health Home. In 2012, the NCQA recognized the organization as a Level-Three Patient Centered Medical Health Home, and the next year they were also recognized by The Joint Commission with its Gold Seal of Approval as a Primary Care Medical Home.

For more than 37 years, FHCN has advanced the development of community-based primary health care delivery systems to address the health care needs of underserved and vulnerable populations. Increasingly, their commitment to high levels of excellence as a health care organization are closely tied to their commitment to training the next generation of health professionals in the skills and values needed to provide high quality, culturally-relevant clinical care to diverse and underserved populations.

Health Professions Training Programs, Trainees, & Disciplines:

This health center has affiliation contracts with over twelve different universities across the state and region, including:

- Dental residency programs
- Medical students
- Dental students
- NP students

- PA students



Educational Strategies:

Selecting students and residents – Students coming for rotations or longitudinal training are vetted first by the academic program and then by FHCN to make sure they are focused on learning in a community health setting and to make sure that FHCN is the right place for them. Students from less mission-driven institutions often self-select for a mission-driven experience.

Setting expectations – FHCN works from the first interactions with students to lay the groundwork for them to understand the mission (*“this is why you are here”*), and to create an expectation that they are going to have a great experience in part because of that mission. There is an on-boarding process for each type of student, with a more formal three to five-day orientation for residential students, during which they come to understand FHCN’s mission and history, as well as the community being served. Residential students are the students who are relocating to FHCN’s area and spending an extended amount of time at FHCN. The dental residents and PA students spend 12 months and the DO students spend three months at FHCN. Students from all other affiliations and various other training programs spend four to six weeks at a time and go through a redacted version of the onboarding process.

Aligning health center and student mission – FHCN does extended interviews with longitudinal or residential PA students, DO students, and residents. In part this is designed to choose the right persons, those who embody the same commitment to the mission, and often in this process the student who may not really know their purpose or have it well-defined begins to identify with the mission of the organization, and their own personal sense of mission begins to come into focus.

Balance Distance-Learning & Local Educational Support – Medical students get podcast or web-cast lectures from their home institution, but an on-site course director or regional director facilitates small-group learning in the context of the health center.

Interprofessional team-based care and learning – Students and residents learn to practice in a team-based care model, with “team rooms” that enhance collaboration and “warm-handoffs” of patients, as well as daily huddles and moment-to-moment interactions of health care team members from all disciplines working together.

Educational Challenges / Academic Institutional Relationships:

FHCN has formed their largest academic alliances with educational institutions (e.g., ATSU, NYU Lutheran Dental, etc.) that also share a mission of training health professionals for serving the underserved. For this reason, they have found these schools to be very respectful of the FHCN mission with a high level of communication as *“a true partnership.”*

Integrating the Healthcare Delivery (Service) and Educational Missions:

FHCN leaders see the educational component as *“enhancing the mission”*, not in conflict in any way. Students are given high levels of responsibility and patients bond with them as one of their clinicians, as well as seeing FHCN clinicians as professors, so the community sees education overall as a positive attribute of the center.

Financial Challenges & Strategies for Supporting & Sustaining the Educational Mission:

In order to achieve financial sustainability for the combined service and educational mission, the health center has had to weave together a complex and constantly evolving mix of multiple strategies. These include the following:

- FHCN receives a small amount of financial support from its primary university partner, plus FTE support for clinician-teachers. Specifically, health center clinicians serve as the Regional Directors of Medical Education (RDMEs) for ATSU, which pays the health center for a portion of their salary.
- Residential students pay their own way with regard to housing and living expenses.
- Dental residents (and even 4th-year students, with appropriate supervision) add productivity, and generate revenues sufficient to support their costs.
- Some other universities send students with no financial reimbursement, other than that the students bear their own living expenses.
- No state grants or Medicaid GME funding is specifically directed to the center.

Overcoming Obstacles:

The center has benefitted from having a strong and respectful academic partner with which it share a strong sense of mission. Some specific issues that they have worked through include the following:

- The academic institution initially sought to make the regional directors of medical education employees of the school, but in conversation with FHCN and other health centers, and hearing their concerns for maintaining the health center's mission, they all agreed that the health center would employ the regional directors and the school would pay the health center for a portion of their salaries.
- With such a large number of students and residents, it may happen that a trainee is struggling or not fitting in with the mission, or perhaps is having a difficult time in their personal life. Clinical leaders at FHCN have often taken those students under their wings in a mentorship role, working with them one-on-one to help the student become their best self. If circumstances dictate, the center may work closely with the school to help the student resolve their issues, or perhaps even take time off from their training. There is a significant time-commitment to this approach, and it reflects the passion FHCN leaders have both for service to the community and for cultivating the next generation of mission-driven clinicians.
- Some preceptors want to stop and have a long discussion after a patient before moving on, but the center chooses instead to emphasize teaching students and residents how to think quickly and move at the pace of community health center primary care practice. As a result, clinicians they train are much more productive and able to see patients at a more rapid pace than clinicians who trained at a university-based program.

Benefits to the Health Center:

- FHCN has hired and retained a large proportion of its 27 dentists from the dental training program. The medical program is more recent, but they express confidence that this too will pay off for the organization in terms of recruiting physicians. It also is a benefit in terms of retention of clinicians who love to teach, and draw fulfillment and satisfaction from it, although this role is not for all clinicians.
- FHCN sees the investment in training as having a long-term return on investment. *"You are investing in your future"*, they say, and the payoff is in *"recruiting the right clinicians, and retaining those clinicians"*.
- One additional FHCN goal is to expand the culture of education to the general staff as well, through formal grand rounds as well as through more informal "lunch-and-learn" sessions. Feeding off one another [*the health center and the academic institutions*] has made our culture of continuous learning stronger.

Impact (Benefits to the Community, the State & the Nation):

FHCN training programs are building the models of 21st century community-based medical and dental education, in strong partnership with mission-driven academic institutions. Students and residents are trained in the settings where they are most needed, and learning to practice at the pace and style of community health practitioners in diverse cultural settings.

Lessons Learned / Advice for Other Health Centers:

- FHCN leaders advise that both formal and informal orientation needs to be up-front and continuous in order to shape expectations, especially among students who initially may come with a misunderstanding of the health center environment.
 - Be clear at orientation, about the mission and the commitment to service.
 - Expect students to treat patients with dignity and respect, but also to be respectful of providers.
- FHCN is clearly all in, with regard to being an educational health center. They say, “. . . *the best approach is to decide if you're in or out, and then embrace the partnership. Take some risks.*”
- FHCN embraces the academic program, and makes it a part of their identity. “*Put a sign on the outside of your buildings*”, they advise, to let the community know that you are part of training the next generation of health professionals.
- At the same time, once a health center has found an academic partner in synch with their mission, they advise “*don't try to do everything yourself*”. Rely on the partner. When problems arise, work it out together. Complete openness and transparency is key to a good long-term relationship. “*If it feels like a negotiation, or us-against-them, or who should get the best deal, then you have the wrong partner.*”

Take-Home Message:

“It's much like medicine. It costs more to do preventive care, but in the long run it saves you a lot of headaches and costs. We are investing in our future workforce. . . . We are trying to set these folks up to be successful in life and in community health and in public health.”

***-- Henry Cisneros, DDS,
Chief Clinical Officer, FHCN***

Case Study: Heart of Texas Community Health Center, Inc. (Waco, TX)

Health Center Organization:

- **Heart of Texas Community Health Center, Inc.**
 - **Family Health Center** (*multiple clinic sites plus McLennan County Medical Education and Research Foundation, Waco Family Practice Foundation and **Texas AHEC East – Waco Region***) – Waco, TX
 - **Website:** www.wacofhc.org

“The Heart of Texas Community Health Center, (dba Family Health Center) is a nonprofit Federally Qualified Health Center delivering medical, dental and behavioral services to the underserved citizens living in McLennan County, Texas. Most of these patients have little or no access to healthcare without the Family Health Center. These assets not only give us the ability to provide the finest care available to our patients, but also enhance the learning environment for our nationally ranked family medicine residency program.”

Key Informant(s) or Champion(s) of Health Professions Training:

- **Roland Goertz, MD, MBA, Chief Executive Officer**

Overview and History:

Heart of Texas Community Health Center illustrates an alternative path to the development of an educational health center. They began with a family medicine residency program that was accredited for its first-class to start in 1970 and are now in their 44th year of running a residency program. However, they only acquired federal funding as a community health center and designation as a federally qualified health center in 1999.

Their origins go back to 1969 when the organization was created by a community wide effort that included business leaders, the hospitals, and the County Medical Society. As Dr. Goertz describes it, *“forward-thinking health care people going back all the way to when a tornado devastated the downtown area in 1953 and killed 107 people, put whatever payments they were receiving into a fund to be [held by] the County Medical Society, and to be used to support a significant community effort. In the mid-60s with all the other things happening around the country the community came together and identified that they needed docs because there was a lack of them and there wasn’t a good structure of support for the hospitals and the ERs and it was hurting economic development. So those entities came together and created . . . the family practice training program which [evolved into] a formal foundation called McLennan County Medical Education and Research Foundation. The commitment for the program was always to serve the community. It was the original mission for the program and has been intact ever since. We have about 122 family docs in the county and over half were trained by our program. Both hospitals have uniformly supported the program through the years.”*

The Heart of Texas Health Center came decades later. Dr. Goertz says, *“we were five days from bankruptcy in 1999 and we had some great people working with us out of the Dallas office”* (Region VI, HHS), managing a transition from a family medicine residency training program to becoming a federally-funded community health center. Many benefits flowed from this, and many challenges still remained, but to this day the health center retains an integrated mission of providing health care to those in need, and training the health professionals needed to serve the community.

Health Professions Training Programs, Trainees, & Disciplines:

This health center has affiliation contracts with over twelve different universities across the state and region, including:

- Family Medicine residents

- Family NP students
- PA students
- Pharmacy students
- Associate's degree nursing program
- On-site Masters of Social Work program
- Behavioral health / counselor supervision

Educational Strategies:

Selecting students – The health center selects and approves students for each rotation, and manages the entire residency program (including selecting residents). Preference is given to students who envision careers in primary care settings, especially for the underserved, and the health center reserves the right to refuse any student.

Teaching roles – Health center clinicians provide all teaching for the students and residents, except in the associate degree nursing program, which requires that they have one faculty member from the local community college on site to maintain a ratio of one faculty to ten students. The Center maintains strong ties with the local college because it supplies over 80% of the allied health and nursing workforce to the local community.

Integrated care -- Integrating behavioral health and primary care is an important theme in patient care and in education. Sometimes this follows a co-location model, with urgent needs addressed by clinical social workers, and in-house referral to psychologists and the center is pushing for psychology schools and clinical social work schools to embrace the “quick intervention” model (quick interventional psychology). They see the long-term goal as being the integrative behavioral health model, and give credit to primary care training programs and community health centers in leading the way to this transformation of health care.

Affiliation Agreements – Students are only accepted from training programs that have an institutional agreement with the health center, which includes requirements for confidentiality and proof of malpractice coverage.

Educational Challenges / Academic Institutional Relationships:

A recurring challenge is that the expansion of university-affiliated and hospital-sponsored training programs (especially for nurse and NP training), has sometimes put the burden of finding clinical clerkships on the students themselves. The students may reach out to individual clinicians or staff within the health center to arrange clinical experiences (“*you gotta help me or I won't get my credit-hours*”). Often the school has provided only a preceptorship manual. The health center has had to establish policies, and then struggled to enforce these policies with their good-hearted clinicians, that no students may be trained without a formal institutional agreement between the health center and the academic training program.

Integrating the Healthcare Delivery (Service) and Educational Missions:

The health center's vision statement clearly focuses on access, quality, and health outcomes, but the educational component is key to fulfilling that mission.

- *To enhance the health of the community by improving access to excellent primary and preventive healthcare services to the vulnerable and underserved residents of the Heart of Texas and by educating tomorrow's Family Physicians and other healthcare professionals”.*

Says Dr. Goertz, “. . . the marriage of a federally qualified health center 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 seen as being completely interwoven. While the residency program might cost a sizable amount in additional investment, the governing board sees it as worthwhile for achieving the long-term purpose of the center.

Financial Challenges & Strategies for Supporting & Sustaining the Educational Mission:

In order to achieve financial sustainability for the combined service and educational mission, the health center has had to weave together a complex and constantly evolving mix of multiple strategies. These include the following:

- A very few programs pay a token \$500 per preceptor, which clearly does not cover the health center's cost. There are various approaches to generating revenues to support the educational mission and to overcoming lost productivity, and one must work to create financially sustainable models.
- The residency program grew until 1996 when the GME ceilings were put on, and received support from both hospitals because they did essentially all of the indigent care in the county.
- In 1977, Texas began funding (via legislative directives) a certain level of funding directly to residency programs (originally 20% of the overall cost of the program). This has ranged from a low of \$6000 per resident per year to a current level of \$8300 to a one-time high of \$15,000 per resident per year. This is paid to the health center's education and research foundation through the Texas Higher Education Coordinating Board.
- Medicaid has been the lifeblood of the residency program even before it became a federally qualified health center. Physicians in the private medical community, many of whom were trained by the health center, commonly direct all Medicaid patients to the health center for care with the acknowledgment that the health center needs some source of paying patients. There is also a community-wide acknowledgment that without the health center, the emergency department would be inundated by Medicaid and uninsured patients. The health center estimates that they provide 80% of all Medicaid-funded care in the county. It represents 60% of the health center's \$46 million revenue base.
- It was not until 1999 that the residency training program and its educational foundation decided to pursue FQHC status and HRSA funding as a community health center. The region was rebounding from the oil market collapse, Medicaid payments had been cut, and the health center was close to bankruptcy. The alternative was to hope that one of the two hospitals would take over the residency program, or pursue alternative models.
- The actual HRSA grant funding only supports about 5% of the health center's budget. Issues that had to be overcome included how to count residents in the FTE count, and how to get them covered by FTCA.
- Revenue increases from cost based reimbursement had a much more dramatic impact. In addition, the health center estimates that FTCA coverage saved the center \$2 million a year, before the Texas legislature passed tort reform. In addition, pharmacy cost reductions from participation in 340b pricing saved the center almost a million dollars in the first year.
- After a complex set of negotiations based on cost factors and data points derived from the IRIS Medicare cost reports, each of the hospitals entered into agreements to pay their full share of time and costs for the residents during the portion of training inside the hospital walls. This represents 80 to 90% of their graduate medical education reimbursements being passed to the health center to cover resident salaries, for a total of about \$3.8 million.
- At the same time, the health center has never been claimed by either of the hospitals as their training site, so the Medicare indirect medical education (IME) and direct medical education (DME) guidelines do not apply to the time the residents spend in the Center's clinics, which also means that the preceptors can get Medicare cost-based reimbursement for resident care encounters, as long as they are supervised appropriately. So the hospitals do not claim the residents for this time and do not pay the residents (the health center does), so there is a contractual relationship for residents to work with the hospitals and an arms-length agreement between the health center and the hospital to avoid concerns about "double-dipping".
- The hospitals also recognize the impact that the health center has on keeping uninsured people out of the emergency room, by providing over a quarter million primary care visits a year. As a result, hospital CEO leadership at both hospitals are quite supportive of the health center at this point, and because of this primary care patient base, they find additional value as they pursue the health center to be part of their ACOs and community networks.
- The health center maintains political support from local officials, with city and county contributions to uncompensated care at approximately \$700,000.
- Funding and staffing an integrated behavioral health care requires creativity, including the use of Medicaid 1115 waiver dollars and behavioral health interns. The integrated care model does not completely pay for

itself at this time, but provides better care for the whole patient. And there have been changes made to payment methodologies that hopefully will make the model a break even process.

Strategies for Overcoming Obstacles:

The center has overcome numerous obstacles and challenges over the years, but the challenges related to the educational mission are closely intertwined with the on-going challenge of providing health care for underserved segments of the population. Some of these challenges and obstacles have included the following:

- The health center is clearly aware of potentially lost revenue related to decreased productivity. They note published studies estimating that a really good preceptor might lose up to 30 to 40 minutes of productivity for each half day that they work with family medicine residents. And they clearly understand the faculty requirements of running a residency program. However, because the health center does run the residency program, and because of the way funding from the hospital is structured, they are able to bill (with FQHC cost-based reimbursement) for encounters seen by the resident physicians-in-training, as long as they are appropriately supervised by the Health Center employed faculty. This however does not cover the full cost of the program.
- The health center sees clear benefits of the educational programs on the overall quality of care and teaching of MAs and other staff in the health center. They believe that they have had fewer malpractice claims and better overall care, for example. However, one challenge is that their care is spread out across fourteen different sites, not all of which are teaching sites. They consolidate their teaching at specific sites, even as they seek to assure that all sites receive some benefit from the educational programming.
- Accreditation of the residency is an on-going burden with regard to paperwork, documentation, processes, and rules or requirements which the health center perceives as going beyond what evidence would suggest is effective or impactful. For example, they estimate that faculty now spend 15% of their time in pure paperwork related only to evaluation requirements. The risk is that teaching programs may not be able to sustain this burden of administrative processes and the added costs it creates for the programs. At some point in time accreditation entities will have to pay “some” attention to what is actually working and how much cost they are adding to the process. There is a finite limit to how much cost can be sustained.
- The health center has successfully navigated the early phase of electronic health record meaningful use documentation, and has achieved PCMH level III certification at 12 of their 14 sites, but again raises concerns that regulatory compliance may cost more than the core cost of operations.
- The health center must maintain neutrality and positive relationships with two competing hospital-centered health systems, which may create new challenges and opportunities as both systems seek to build ACOs or risk-based contracts on the health center’s primary care patient base.
- Medicaid revenue growth has been slower than the growth of self-pay patients. For example, among 54,000 unduplicated patients, the health center’s patient mix has fallen from 43% Medicaid to about 38% Medicaid and the proportion uninsured has grown from 32% to 39%. Because Texas has made various cost-cutting decisions and chosen not to accept expansion of Medicaid, the health center has struggled with deficit spending of \$2.3 to \$3.6 million in each of the past two years. As a result, the health center board has determined that it will allow deficits for two years, and use that time to restructure the minimum payments sliding fee scale system for the patients, look into other revenue generation options and restructure and look at all of their cost centers to break even if possible unless the area is acquired or necessary service.
- Although the ACA gave at least a nod towards “teaching health centers”, the definitions were somewhat narrow and did not include hybrids like Heart of Texas. There now is a coalition model for which the center might qualify, but the potential benefit does not yet seem to justify the effort that would be required to compete for this designation.

Benefits to the Health Center:

The most obvious directly measurable effect of these programs is on both recruitment and retention. For Heart of Texas, this is specifically evidenced by the hiring of medical providers (physicians, NPs and PAs), 80% of who have been trained in-house by the program. Benefits also include the capacity for hiring other professionals who have been trained through an affiliation agreement.

Broader impact is seen in a commitment to excellence and constant learning throughout the organization, which has a directly measurable impact in terms of low rates of malpractice claims and better quality of care to all.

Impact (Benefits to the Community, the State & the Nation):

The core training program is the family medicine residency program, whose graduates are tracked closely by the health center and the Texas Higher Education Coordinating Board. They estimate that 46% of residency graduates in the last five years have gone to underserved areas, which outperforms all other family medicine residency programs in Texas for which they have data. The health center believes that this outcome is directly attributable to how and where they train clinicians, e.g., you train them where they are needed most and teach them how to practice in that setting for diverse populations. The larger benefit is that underserved patients get the care they need in primary care settings (rather than emergency departments) in their own community by clinicians who understand and are skilled at addressing their unique needs. This transcends the care and training offered by the traditional academic center.

Lessons Learned / Advice for Other Health Centers:

- Becoming an educational health center does have costs and it does take expertise -- so don't go into it blindly.
- You may have to do some restructuring, some redesigning, and some rethinking; but the offset is that if you have a learning environment you're going to improve everything.
- As a spillover effect of this teaching activity, Heart of Texas has a very low incident rate with FTCA cases compared to their patient volume, which they relate directly to the teaching going on all the time ("people must stay on their toes when they have learners around them").
- The center brings everyone together from all sites every other month for an "all staff" meeting to share information about all parts of the Center, for staff get to meet each other and to make sure the benefits and knowledge of all pieces of "what we do" are spread to all sites.
- These models need continued funding, even as health centers manage costs very carefully.

Take-Home Message:

"I can go home at night, I don't care how bad the day has been, I know we helped people. 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 so 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 Texas Community Health Center