GRADUATE MEDICAL EDUCATION RESIDENCY PROGRAMS PARTNERING WITH FEDERALLY QUALIFIED HEATH CARE CENTERS: THE YIN AND YANG

Many healthcare systems are seeing a strengthening of the ties between community hospitals and FQHCs to meet the growing demand for Primary Care providers. Expanding health systems find themselves with hospitals in urban, rural, and underserved areas, and they struggle to onboard primary care providers who can service their diverse patient populations.

Partnerships between FQHCs and community hospitals with primary care residency programs can become a strong, balanced, and mutually beneficial endeavor where each partner has a share in the outcome, considering both their missions are partly to meet the needs of at-risk and underserved populations.

Primary care residents spend up to one-third of their training in outpatient clinics. While private or faculty practice plans typically serve commercial patients, the resident outpatient clinics face a challenging payor mix and often need more operational and partnering opportunities to run the resident clinic efficiently and economically; these clinics are sometimes viewed as an unavoidable subsidy to resident training. This is especially true for Family Medicine clinics, deemed one of the most expensive outpatient clinics to develop, given the ACGME requirements for FMP's physical infrastructure and patient population panels. Hospital administration generally views clinical training as the highest cost variable associated with resident training.

FQHCs, on the other hand, are designated community-based healthcare providers established to provide primary care services for at-risk and underserved populations and operate practices under a Patient-Centered medical home model. FQHCs receive funding from the Health Resources and Services Administration (HRSA) health center program, which is almost always more significant than the same profile in a hospital teaching clinic.

From the perspective of the residency program, the FQHC established patient population typically meets the diverse patient panel mix required by the ACGME and serves to meet the requirement that a resident must be primarily responsible for a panel of continuity patients. The resident is responsible for integrating each patient’s care across all settings, including the home, long-term care facilities, the FMP site, specialty care facilities, and inpatient care facilities. Additionally, FQHCs provide care as a cost-effective alternative to patients presenting to local emergency departments as well as providing a referral base to the affiliated hospital for inpatient procedures.

Integrating a primary care residency into an FQHC can considerably impact the center's ability to see more patients without recruiting additional attending physicians or advanced practitioners. CMS's primary care exception allows up to four residents to be supervised by one attending physician in the clinic. This rule was created with family practice, general internal medicine, geriatric medicine, pediatrics, and OB/GYN in mind, although the best practice is a 3:1 resident-to-faculty ratio. Deploying an appropriate leverage model in the outpatient setting can significantly increase the number of patients who can be seen without increasing the number of attending physicians. A well-structured training curriculum can also improve the transition of care, as resident teams can ensure timely follow-up visits for recently transitioned patients and follow-up in the acute care setting if the patient becomes hospitalized.

An additional benefit gained by the FQHC is improved quality and patient safety. Resident training requirements require the residents to participate in quality research projects which help reduce healthcare costs and promote quality in a patient-centered care model.

FQHCs often struggle to recruit physicians and caregivers because of competition for a limited number of primary care providers and their inability to offer market-competitive contracts compared to hospitals or health systems. However, a study in the Journal of Graduate Medical Education reported that exposing residents to underserved areas can significantly increase their likelihood of practicing in a similar setting post-training. Per the AAMC, 54.5% of residents remain in the state they trained in after graduation; for Family Medicine, that number is 64.3%. Much like when an AMC or hospital participates in training residents, the FQHC leadership needs to consider the ability to recruit trainees when they graduate; this is a crucial factor when deciding to partner with a residency program. Residents who train in FQHCs can apply for the National Health Service Corps (NHSC) Loan Repayment Program (LRP). This program provides primary medical, dental, and mental and behavioral healthcare clinicians the ability to have their student loans repaid while earning a competitive salary in exchange for serving in urban, rural, or tribal communities. Providers may earn up to $100,000 in loan repayment in return for three years of service at an NHSC-approved site.

Both parties need to have a deep understanding of these topics and their consequences for each organization if a joint program is pursued. Performance monitoring is an essential aspect of a successful partnership, and both organizations should develop concrete productivity goals that foster an operational environment focused on high-quality education, operational efficiency, and throughput. Critical metrics must be documented in the contractual arrangement between the teaching hospital and the FQHC. A contemporary agreement that factors in the responsibilities, decision-making, financial commitments, and operational considerations must be designed to ensure a successful partnership.

Integrating primary care residency programs into community-based FQHCs can enhance collaborative patient care, support the teaching mission, enhance delivery capacity, and improve system economics. Such training can be invaluable to meet the community's need to keep their vulnerable populations and retain primary care practitioners. Given the requirements that the FQHC maintain an autonomous board and management structure, such partnerships can be challenging to consummate. But if acceptable parameters can be agreed to and a community identity established, a high-quality program for the hospital, FQHC, and community will provide value to all participants

At ACA we work with our clients to evaluate program performance throughout the spectrum of the resident training experience. Our tailored recommendations support the alignment of academic performance goals for stakeholders, including; financial management, resource allocation, and organizational structure. Managing these academic variables is essential to maintaining viable teaching programs and ensuring their continued success.

Jim Brown
Principal
Author

Mike Benck
Principal

Joann Pavel
Senior Director