Education Health Center Toolkit
March 2011

A partnership between the Northwest Regional Primary Care Association, the Community Health Association of Mountain/Plains States, the University of Washington Department of Family Medicine, and the Family Medicine Residency Network
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Preamble

A decade into the 21st century, Community Health Centers (CHCs) and Family Medicine Residencies (FMRs) face both enormous challenges and opportunities. Both have central roles as health care reform legislation enacted in 2010 begins to be implemented in the real world; CHCs are expected to expand to care for an estimated 20 million new patients and FMRs are challenged to attract and train tens of thousands of new family physicians to care for those patients.

Collaboration or “linkages” between community health centers and family medicine residencies have existed in various forms for over 30 years. Almost 25% of family medicine residency programs offer some training in a community health center and over 30 use a CHC as its primary continuity training site. (Morris et al 2010) This number is likely to increase further with 230 million dollars of targeted funding under the Patient Protection and Affordable Care Act.

Since the EHCI developed the Education Health Center concept, national momentum grew behind the Teaching Health Center and culminated in legislation enacted through the Patient Protection and Affordable Care Act of 2010. Below is a brief definition of EHC and TCH for the purposes of this toolkit.

Educational Health Center (EHC): a community health center which serves as a training site for health professions students and residents. (This is a generic term)

Teaching Community Health Center (THC): A specific type of educational health center described in The Patient Protection and Affordable Care Act (PPACA) of 2010. More detailed information summarizing the THC content in the PPACA can be found in the Appendix. A Teaching Health Center is a health center that is responsible for the academic and financial administration of the residency program, including –

- The health center sets the mission of the residency program
- The health center has a shared mission of service and education
- The health center is the sponsoring institution for accreditation purposes
- The residency director is staff at the health center
- The health center contracts with the hospital to provide required inpatient training

The Health Resources and Services Administration released guidance on November 29, 2010 for the first cycle of their Teaching Health Center Graduate Medical Education Payments Program.

To access the full THC announcement and grant guidance, see:

This toolkit has been produced with funding support from The Josiah Macy, Jr. Foundation, and is intended to assist health centers and Family Medicine Residency programs to take advantage of this new funding stream to successfully affiliate. The toolkit is very timely in that it can be used to help potential affiliation partners determine if they can successfully compete for funding through HRSA’s THC GME Payment Program.

Note: CHCs may be the primary sponsor of either EHCs or THCs. The primary difference is the source of funding to operate the program.

How is the toolkit organized?

What it will take to develop a Teaching Health Center demands Leadership, Collaboration, Time and Money. There are four known key areas that all of these demands center around:

- Mission and Governance
- Administration and Operations
- Finance
- Legal

The toolkit is built around these four areas. Each of these areas has its own section in the toolkit and is a stand-alone piece. These tools are, therefore, intended to be used in part or in whole depending on the needs of the interested parties. Other resources relevant to information provided in the toolkit, are found through links in the text of the toolkit or in the Appendix to the toolkit. Ideally, the toolbox will be used by someone knowledgeable about EHCs and THCs and who can help partners work through how their particular circumstances interact with the common central tenants of creating these complex training and service entities. EHCI can refer you to a consultant who can provide this assistance.

How do I get started with the Toolkit?

The current legislative definition and specific language in HRSA’s THC GME Payment Program guidance make it difficult for partners new to this concept to become a THC rapidly. The first step in the Toolkit is a Decision Support Tool to assess preparedness for the first wave of THC funding. Going through this decision support tool process is critical to understanding what you will need to focus on in the above four areas. If you find you are not ready for the first wave of HRSA funding, and are still interested, EHCI recommends you review the remaining content of the toolkit and then consider drawing on the support of a consultant to help make the THC a reality in your own situation.

Limitations

The information presented in the EHCI Toolkit is focused on training family medicine residents in community health centers. CHCs also serve effectively as training sites for other types of residents (e.g. internal medicine and pediatrics) as well as other health professions students such as nurse practitioners and physician assistants. For information about these types of linkages, the following sources may be helpful:

Pediatrics residency training requirements:


UCLA Pediatrics residency program which collaborates with a CHC:
Internal medicine residency training requirements:

http://www.acgme.org/acWebsite/downloads/RRC_progReg/140_internal_medicine_07012009.pdf

Nurse Practitioner Residency Training In FQHCs - HRSA Workforce Summit: Preparing for primary care practice careers in FQHCs, August 11, 2009:


While this toolkit will hopefully serve as a useful reference and starting point, it cannot be overemphasized that there is no single blueprint for a successful educational health center. No two community health centers are identical and likewise every residency is unique. Each setting will have its own set of strengths and challenges. Organizations which decide that they can and should develop an educational health center will likely need consultative and technical assistance from one or more persons who can take into account these site-specific differences and make recommendations for how to proceed further.

Finally, while every effort has been made to provide comprehensive and accurate information, this first edition of the EHCI Toolkit will undoubtedly have some gaps and mistakes. Some readers will likely find some sections lack clarity or sufficient practical information. We welcome your feedback! Since this information will be available on the internet at http://teachinghealthcenter.org, we hope to update it regularly.

EHCI Steering Committee

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PART I: DECISION SUPPORT TOOL
1. Decision Support Tool

This tool has been prepared by the Educational Health Center Initiative (EHCI) and represents the best available information as of the date of this version.\(^1\) Rules for implementing the Teaching Health Centers were released by HRSA and the Bureau of Health Professions (BHPr) on September 6, 2011 and can be found at [https://grants.hrsa.gov/webExternal/FundingOppDetails.asp?FundingCycleId=ECEDECC6-0F42-4A75-961C-582E4AB85EA2&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=&pageNumber=&version=&NC=&Popup]. Application deadline is October 11, 2011, with notice of awards anticipated for November, 2011. This tool will be updated as information becomes available.

Can My CHC Qualify to be a THC?\(^2\)

### Which of the following scenarios best describes your path to becoming a THC?

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Inquiry</th>
<th>Decision</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My CHC clinic is currently the site for the continuity clinic of an accredited primary care residency training program.(^3)</td>
<td>The program is accredited and the community-based non-profit entity is the sponsoring institution?(^8)</td>
<td>Yes.</td>
<td>You probably can qualify to apply for funding under the THC program.</td>
</tr>
<tr>
<td>2. My CHC is collaborating with an existing primary care residency training program to become (through ownership, partnership, purchased service agreement or other) the site for its continuity clinic experience.(^4)</td>
<td>The program is accredited and the community-based non-profit entity is the sponsoring institution?(^7)</td>
<td>No.</td>
<td>You probably can qualify to apply for funding under the THC program.</td>
</tr>
<tr>
<td>3. My CHC is developing a new primary care residency training program with the continuity outpatient experience located at the CHC.(^5)</td>
<td>The program is accredited and the community-based non-profit entity is the sponsoring institution?(^6)</td>
<td>Yes.</td>
<td>You probably can qualify to apply for funding under the THC program.</td>
</tr>
<tr>
<td>4. My community-based clinic is the continuity clinic for a primary care residency, and is becoming a FQHC (330 grantee or Look-Alike).(^9)</td>
<td>The community-based clinic is the sponsoring institution for the accreditation, and the FQHC status will be in place by the THC application deadline?(^10)</td>
<td>Yes.</td>
<td>You probably can qualify to apply for funding under the THC program.</td>
</tr>
</tbody>
</table>

\(^1\) Developed under the “Educational Health Center Initiative”. You have permission to use these material solely for personal use and research purposes, provided that you do not make modifications. For permission to use this material for any other purpose, including commercial purposes, contact adavis@uw.edu.
THC = Teaching Health Center: the GME funding mechanism as provided in section 5508 of the PPACA.

“Primary care”, for the purpose of this section is defined (per the PPACA) as: family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics. “Continuity” outpatient experience is defined, for each primary care subspecialty, within the respective accreditation requirements. (References and links available at http://www.nwrpca.org/education-health-center-initiative.html)

To qualify for FY’12, the collaboration must put the residents and continuity clinic at the CHC by 1 July, 2012.

The new program must begin in time for the 2012-13 academic year (approx. 1 July, 2012).

To qualify on the basis of being a 330 grant recipient, anticipate that grant would need to be in place now. There is no opportunity to achieve this goal between now and the expected application deadline. If the GME program intends to qualify for THC funds under the Look-Alike designation, that should be in place now. Unless a pending application is in a very late stage of HRSA review, or has been approved at the HRSA level and sent on to CMS, it is unlikely that designation will be achieved prior to the THC application deadline.

The ACGME process for changing the institutional sponsor for the accredited program is fairly straight-forward and may be achieved in a timely fashion. The decision-making within a community may be complex. This specification is written into the statute. HRSA rules only allow the clinic as defined in the Funding Opportunity Announcement, or a consortium of which the clinic is a fundamental part, to hold the institutional sponsorship.

New programs are granted provisional accreditation. EHCI anticipates that this would qualify the entity to apply for the THC program.

Accreditation information, and information regarding changing the institutional sponsorship is available at http://www.acgme.org or at http://www.osteopathic.org/inside-aoa/accreditation/postdoctoral-training-approval/Pages/default.aspx

See ix above.

See ix above.

See ix above.
PART II: MISSION
2. Getting Started

Many existing linkages are very successful and have resulted in significant benefits for both residents and the communities served by CHCs. But there have also been notable failures. It cannot be underestimated what a significant undertaking it is to train residents in a CHC.

To help determine whether to become part of a linkage, the following questions are worth considering:

1. Is there a history of the parties working collaboratively on other projects?
2. Who are the key stakeholders? Is there support for this at the highest levels of the involved organizations?
3. Who is most in favor? Who is most opposed or most reluctant?
4. What are the similarities and differences between CHCs and FMRs? How are their missions similar and how do they differ?
5. What benefits to you hope to receive? What and whose problems do you hope a CHC/residency affiliation will improve?
6. What type of educational health center is the best fit for our needs and resources?
7. What are the alternatives to the affiliation?
8. What problems might result from an affiliation?
9. What do you see as the most difficult challenges to getting the affiliation started?
10. What do see as the most difficult challenges in the early phases of the affiliation?
11. What do see as the most difficult challenges as the affiliation matures?
12. Are there any issues which need to be kept confidential/not shared in public?

(Note – In answering these questions, it may be helpful to seek advice from someone experienced with EHCs to determine if your expectations are realistic. The point here is that CHC-FMR linkages are not a panacea for every problem. It is critical to begin with realistic expectations.)
3. Similarities and Differences in Mission Between Community Health Centers and Family Medicine Residencies

While CHCs and residency training programs are, in many ways, natural allies, there are also notable differences in their core missions and cultures. In order to decide if a linkage makes sense, these differences need to be appreciated. One caveat is the adage: “If you’ve seen one community health center, you’ve seen one community health center” and, likewise, “If you’ve seen one residency program, you’ve seen one residency program.” Nevertheless, there are some basic characteristics common to both organizations which can help with this challenge.

3.1 Community Health Centers - What FMRs Need to Know

Community health centers are independent, non-profit, community-based organizations. Begun in the 1960s as part of the “War on Poverty” today there are over 1200 CHCs providing care to 20 million Americans in all 50 states. Care is provided without regard to ability to pay. Uninsured patients are charged according to a sliding fee scale. Some health centers are relatively small while others operate multiple sites, employ many medical providers and serve 20,000 or more patients. Many, but not all, CHC’s receive a federal grant which is intended to subsidize care of uninsured patients. CHCs are governed by a volunteer Board of Directors which, by federal requirement, must include a minimum of 51% users of health center services. Community health centers have enjoyed broad and bipartisan support from many local, state and national leaders. The Patient Protection and Affordable Care Act of 2010 calls for significant expansion of CHCs to accommodate many of the people who will obtain health insurance beginning in 2014. In addition, there is new funding aimed to increase the number of educational community health centers.

More information about community health centers can be found on the website of the National Association of Community Health Centers (NACHC): http://www.nachc.org/

3.2 Family Medicine Residencies - What CHCs Need to Know

Family medicine residency programs (FMR’s) are responsible for training physicians who have completed medical school and chosen to specialize in family medicine. Family medicine residency training is 3 years in duration.

There are 5 types of family medicine residencies:

1. Community-based, non-affiliated
2. Community-based, medical school affiliated
3. Community-based, medical school administered
4. Medical school based
5. Military programs

Programs sponsored by community health centers are, by definition, community-based. While it is permissible to have no medical school affiliation, the vast majority of programs have an academic affiliation with one or more medical schools and it is strongly advised that any new program have an academic affiliation.

Like all residency training programs in the United States, family medicine programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME). Within the ACGME, each specialty is represented by a Review Committee (RC) which sets and periodically updates training requirements. Training requirements for Family Medicine residencies are extensive.
A limited summary of ACGME requirements for family medicine is included at the end of this section. The full set of written requirements specific to Family Medicine Programs can be accessed via the ACGME website:

http://www.acgme.org/acWebsite/RRC_120/120_prIndex.asp

In addition, there are general requirements which apply to all residency training programs and their sponsoring institutions. These are included in the Appendix (see “Institutional Requirements” and the “Common Program Requirements” within the Appendix). These can also be accessed at:

http://www.acgme.org/acWebsite/irc/irc_IRCpr07012007.pdf

http://www.acgme.org/acWebsite/dutyHours/dh_dutyhoursCommonPR07012007.pdf

Graduates of Osteopathic Medical Schools often seek resident positions in family medicine programs. The American Osteopathic Association also provides accreditation of family medicine residencies when requested. While it is not necessary for a FMR to have such accreditation as a prerequisite for selecting a DO candidate, many residencies carry dual accreditation. Information on the AOA accreditation, can be found in the Appendix and at:

4. Benefits of Becoming or Collaborating with an Educational Health Center

Successful collaborations between organizations only work if both perceive and actually realize more benefits than costs. It is equally important to not underestimate potential drawbacks. In the most successful collaborations, the parties seek and achieve a synergistic relationship and avoid minimizing potential problems. The starting point is for each party to identify potential benefits and drawbacks in becoming a Educational Health Center. The linkages are enhanced when the graduates of the residency stay in the community for practice either at the CHC or in a practice affiliated with the partnering hospital.

Before exploring the wide range of potential benefits and costs from both CHC and residency perspectives, it is important to consider the issue of finances. This topic is explored in greater depth in the Finance section of this toolkit. The key point to be made here is that whether teaching residents in a CHC makes or costs money from either organization’s perspective will depend on a variety of factors including:

- Which costs and revenues will be allocated to the teaching program?
- How will costs and revenues be allocated to the teaching program?
- How and whether so-called opportunity costs are considered
- How and whether non-monetary costs and benefits are considered
- Where will the funds for developing the program come from?
- Many local variables

The bottom line is that the financial analysis is a critical determinant in the decision to develop a teaching affiliation and how its partners view its success over time.

4.1 Potential Benefits to Community Health Centers

- Enhanced recruitment and retention of providers through:
  Physicians trained in CHCs 3x more likely to work in underserved areas (Morris et al; Fam Med; 2008)
  Enhanced job satisfaction for CHC providers who are given a teaching role
  Shared on-call arrangements with residency faculty providers
- Access to additional services for patients (e.g., specialty clinics, residency inpatient care teams, etc)
- Enhanced reputation as a teaching site (This needs to be communicated clearly and thoughtfully to avoid concerns that patients will be getting substandard care from inexperienced providers. The perception of most CHCs is that quality of care has been improved by the presence of the residency program)
- Enhanced job satisfaction for non-provider staff members. Although there are often some growing pains associated with CHCs beginning a FMR residency linkage, many staff members ultimately come to enjoy and appreciate their roles as true educators of residents.
- Access to resources from a hospital or medical school (e.g. information technology, research support, etc)
- Strengthening of clinical affiliations with
hospitals and medical schools

- Specific services to CHC clients may be enhanced because of educational needs. E.g. behavioral health skills attainment is an important component of the residency curriculum which nicely coincides with CHC service development in the area of mental health counseling.

- See National Health Service Corps comments below which also have a positive benefit for the CHC

### 4.2 Potential Benefits to Family Medicine Residency Programs

**Financial:**

- CHCs receive Medicaid reimbursement based on 100% of allowable costs.

- Malpractice insurance is available for CHC-employed faculty members and residents at no cost through the Federal Tort Claims Act. (Significant restrictions apply—see [http://bphc.hrsa.gov/ftca/](http://bphc.hrsa.gov/ftca/) for more information)

- Title VII Residency Training Grants often have priority and/or preference for underserved patient populations

**Access to additional services for patients:**

- Low-cost prescription drugs through the 340B pharmacy program

- Social workers, case managers, interpreters, others who are commonly found in CHCs

- Enhanced recruitment and retention of both faculty and residents:

- Access to various state and federal student loan repayment and forgiveness programs

- Many potential FM residents seek to care for underserved patients

- Shared on-call arrangements with CHC providers

- The National Health Service Corps offers expanded benefits to both residents and faculty working at CHC, e.g. official recognition of teaching time in place of patient visit targets is provided to faculty, senior residents may be able to qualify for loan forgiveness payments, part-time faculty will be eligible for loan forgiveness payments in the future.

**Educational:**

- Enhanced access to specific patients/clinical problems (e.g., prenatal patients, pediatric patients, patients from varied ethnic, linguistic and socioeconomic backgrounds)

- Overall education at a CHC for 3 years of residency provides a true high quality service learning experience in providing patient centered care to multi-cultural populations that often are affected by the social determinants of health, particularly poverty. Such experiences at a CHC will prepare very realistically the next generation of family physicians, whether they continue at a CHC or not, to better care for the vulnerable and newly insured in the US.
5. Drawbacks of Becoming or Collaborating with an Educational Health Center

5.1 Potential Drawbacks for Community Health Centers

• Scheduling of faculty and residents is significantly more complex than scheduling mostly full-time clinicians. This is primarily due to the fact that faculty and residents are in the outpatient setting on a part-time basis particularly in the first and second years.

• Residents “turn over” every three years necessitating frequent re-assignment of patients.

• There is the potential for the community to perceive residents as inferior providers compared to fully-trained providers.

• Residents, especially early in their training, are slow and inefficient compared to non-resident providers. They also use more exam rooms per patient seen.

• Increased administrative complexity.

The drawbacks noted above can have beyond the system challenges highlighted financial implications to the operation of the CHC. It behooves the CHC to closely monitor these expenses and bring them to review and negotiation tables as the program begins, develops and continues. The ability to track costs and to verify them will be critical to resolving funding issues.

5.2 Potential Drawbacks for Residency Programs

• Increased administrative complexity.

• There may be a concern that the clinical needs of the CHC will overshadow the educational needs of the residents.

• Analogous to the importance of monitoring the cost implications of teaching it will be important for the residency to continuously monitor the education experience at the CHC assuring that the resident is not solely a clinical provider, but participates actively in the residency curriculum which provides sufficient didactic and reflective time at the CHC to effectively educate the resident and involve the faculty.
6. What Type of Education Health Center is Best?

CHC/FMR linkages range from fairly limited (e.g., the health center serves as a site for elective experiences), to CHCs where all continuity ambulatory care education is provided, to very small number where the health center is the sponsoring organization which administers all aspects of the program and employs the faculty and residents. In recent years, the number of linkages has increased and will likely to increase further with targeted funding under the Patient Protection and Affordable Care Act which became law in 2010.

Different Linkage Models

While there are many types of CHC/FMR linkages, this manual will focus on programs where the residency is either sponsored by the health center or where a family medicine program utilizes the CHC as a continuity training site for its residents. Key determinants of each collaboration include:

Funding Source

- Traditional Graduate Medical Education (GME) funding through add-on payments from Medicare and Medicaid to teaching hospitals
- Teaching Health Center funding through HRSA (New Section PHS III, part of 2010 Health Care Reform legislation, details not fully worked out)
- Other (e.g., special grants from the federal government, state Medicaid Programs and private foundations, etc.)

Note: Regardless of funding source, the CHC and the teaching hospital have to agree on appropriate allocation of both revenue and expenses.

Leadership in Accreditation and Sponsorship

- Traditional
  A hospital (typically) or other entity (e.g., a medical school or an AHEC) administers the residency. It is the sponsoring organization and has ultimate responsibility for the training program. Core faculty members and residents are employed by this entity. In this model, residents are “out posted” in a community health center for a portion of their training.

- CHC Sponsored
  In this model, the CHC is the primary administrator or sponsor of the program. A teaching hospital serves as a critical and necessary supporting partner. Core faculty members and residents are employed by the health center or a separate not-for-profit education organization. Typically, the hospital passes a substantial portion of the GME funding it receives from Medicare, Medicaid and other sources through to the CHC.

Examples of this model are described in Appendix B.

Based on the characteristics of funding source and sponsoring organization, there are therefore three possible models:

- **Traditional -- Hospital-sponsored, GME-funded.** The CHC serves as a continuity training site for some or all of a program’s residents.

- **Educational Health Centers -- CHC-Sponsored**, traditional GME funding goes to the affiliated teaching hospital

- **Teaching Health Centers -- CHC-sponsored**, funding through the Health Resources and Services Administration (HRSA) called for by the Health Care Reform Bill.
7. The Imperative of Finding Synergy

CHC's and FMR's have much in common. Both are focused on primary care. Commitment to underserved communities is central to the mission of CHC's and a focus of many FMR's. Both organizations have long been challenged to recruit and retain key employees – providers in the case of CHC's and resident physicians in the case of FMR's. Both struggle to attract sufficient financial and other resources to fulfill their missions.

Community Health Centers and Family Medicine residencies also have some significant differences. The core mission of Health centers is patient care while that of Family Medicine residencies is education. Residencies have traditionally been run by hospitals with an inpatient focus and often a power-structure which favors specialty care.

As summarized above, linkages between community health centers and residency training programs offer both entities many benefits and often few insurmountable obstacles. Despite the obvious and tangible benefits to both parties, real and perceived differences in culture, mission and vision are often present. These must be identified, acknowledged and addressed. Failure to do so will destroy the most logically conceived of linkages.

7.1 The Mission of Community Health Centers – What Residency Programs Need to Know

The primary mission of Community Health Centers is to improve the health of its patient population and to provide services without regard to ability to pay. When CHCs began in the mid 1960's and early 1970's, it was not uncommon for health centers to prohibit students or trainees from seeing patients. This was due, in part, to the experience of many underserved communities of that they had too long "guinea pigs" for students, trainees and researchers from the teaching hospital or medical school. Only when CHCs matured and developed ways to negotiate on a more even playing field, did they begin to realize the benefits of collaborating with training programs. An additional mission of many CHCs, sometimes stated explicitly and sometimes not, is empowerment and development of the community being served. The importance of patient education is also widely accepted in CHCs.

7.2 The Mission of Family Medicine Residencies – What CHCs Need to Know

The primary mission of residency training programs is academic. Residency training programs exist to educate physicians and promote scholarly work of faculty through research and publication. Many, perhaps most, also state an explicit commitment to serving their patients and communities. A substantial number of FMR were initiated by state legislatures to assure an on-going source of family physicians for their state or region. There is a widespread belief that residents must be part of a system that provides great care in order to learn how to provide great care.

7.3 Potential Areas of Conflict and Finding the Common Ground

Conflicts between patient care and health professional education are not unique to Educational Health Centers. Academic medical centers and teaching hospitals have long struggled with balancing their “service” and “educational” missions. This will also be a challenge for Educational Health Centers. While there will no doubt be times when one mission will necessarily take precedence over the other, framing this challenge as a “balancing act” leads to the notion that it is necessarily a zero-sum game: provide more education and you will provide less service and vice-versa. Some THC failures have resulted when the two missions remained at odds
with each other. In order to create a successful Educational Health Center, the service and educational missions must both be respected. In the most successful programs, the aim is to make the missions not just compatible but synergistic.

In order to find synergy between the clinical and educational missions, leaders at all levels need to be committed to this approach. To accomplish this, everyone needs to understand and acknowledge, in concrete terms, how the educational program both affects and enhances the clinical mission and how clinical activities both affect and enhance the educational process. The maxim “patients come first” still applies as long as current and future patients of residents are included. Family medicine educators need to fully support the idea that providing exceptional care is a necessary condition for an exceptional education. Similarly, CHC administrative and clinical leaders must embrace the idea that attracting the best residents and faculty members requires a strong educational program and without great faculty and residents, patients will not receive the great care. Everyone must recognize the power of connecting the educational and clinical missions. A great education attracts and produces great residents, faculty and staff and they, in turn, provide great care to patients. With this commitment, both the education and patient care will spiral upward. Ignore it and both can spiral downward.

Many successful CHC: Residency linkages have revised their mission statements to reflect both educational and clinical missions. Examples are included in Appendix C.

This is important at all times but two specific situations are especially challenging. The first is a new partnership between a community health center and a residency and the second is in an older established affiliation when new leaders join an organization.

There is no substitute for regular, (ideally monthly) meetings between the executive staff of the CHC including the CMO, with the Residency staff leadership, and the sponsoring, hosting or partnering academic institution. Such meetings need to have defined agendas, minutes and action follow-up. Boards of all participating organizations should be apprised of these meetings. THC should make a point of sharing the existence of these meetings with BPHC project officers.
8. Developing a Shared Mission and Vision

Questions for Everyone

Describe your ideal Educational Health Center. What would this program look and feel like?

How will becoming an educational health center advance our mission?

How will our current mission change if we become part of an educational health center?

Questions for Individuals

How will this project impact my job?

What are the strengths of our organization? What value does our participation bring to a potential partner?

What changes is our organization willing to make in order for the collaboration to be successful?

Questions for Residency Staff

What are my (our) preconceived ideas about community health centers?

What assurances do we need from CHC administration that they will support the educational mission?

Questions for Health Center Staff

What are my (our) preconceived ideas about residents and residency programs?

What assurances do we need from the residency program that they will support the clinical mission?

Because residents may not be as accessible as faculty or staff clinicians, who do we assure continuity and quality of care to the patient?

Resources about Shared Mission and Vision

- The Fifth Discipline by Peter Senge (See Chapter 11, “Shared Vision”)
- Building Shared Vision: The Third Discipline of Learning Organizations by Marty Jacobs
- Shared vision: A Key to Project Success by Donna Fitzgerald
- Co-Creating a Shared Vision
  [http://www.baldrige.com/criteria_leadership/co-creating-a-shared-vision](http://www.baldrige.com/criteria_leadership/co-creating-a-shared-vision)
Examples of Mission Statements of Existing Educational Health Centers

Greater Lawrence Family Health Center, Lawrence, MA, Sponsor of the Lawrence Family Medicine Residency

“The mission of the Greater Lawrence Family Health Center is to improve and maintain the health of individuals and families in the Merrimack Valley by providing a network of high quality, comprehensive health care services and by training care professionals to respond to the needs of a culturally diverse population.”

Community Health of Central Washington, Yakima, WA Sponsor of the Central Washington Family Medicine Residency

“Community Health of Central Washington provides access to quality healthcare through service and education.”

Community Health Connections, Fitchburg, MA CHC partner of the Fitchburg Family Medicine Residency

“Our mission is to provide high quality, comprehensive medical and behavioral health care, preventive and restorative dental care and pharmacy services to all residents of North Central Massachusetts, responsive to a culturally diverse population, without regard to income, insurance status or past medical history; and to participate in health care training programs.”

Family Medicine Residency of Idaho, Boise, ID

“The mission of our program is three-fold:

Train superb medical school graduates to become outstanding physicians;

Prepare broadly trained family physicians to practice all across Idaho especially in rural and underserved Idaho; and

Serve the underserved in a high quality Patient Centered Medical Home.”
9. A Limited Summary of Requirements for Family Medicine Residencies

These excerpts from ACGME requirements for Family Medicine Residency Programs are a small fraction of the total requirements. Additional Requirements address the following issues:

- Work-hour restrictions (referred to as “Duty Hours”)
- Required curricular elements including specific content and time requirements
- Program, faculty and resident evaluation

**General Requirements**

Residencies in family medicine must offer three years of training after graduation from medical school. Residencies must be structured so that a coherent, integrated, and progressive educational program with progressive resident responsibility is ensured.

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

Family medicine residency programs should provide opportunity for the residents to learn in multiple settings (e.g., hospital, ambulatory settings, emergency rooms, home and long-term care facilities), those skills and procedures that are within the scope of family medicine.

**Program Director**

There must be a single program director with authority and accountability for the operation of the program. The program director must:

- Oversee and ensure the quality of didactic and clinical education in all sites that participate in the program.
- Approve a local director at each participating site who is accountable for resident education.
- Approve the selection of program faculty as appropriate.
- Evaluate program faculty and approve the continued participation of program faculty based on evaluation.
- Monitor resident supervision at all participating sites.
• Provide each resident with documented semiannual evaluation of performance with feedback.

**Faculty**

At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

• Devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities.

• Demonstrate a strong interest in the education of residents, and administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

• Establish and maintain an environment of inquiry and scholarship with an active research component.

• Regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

**Family Medicine Center**

The primary setting for training in the knowledge, skills, and attitudes of family medicine is the model office or FMC, where each resident must provide continuing, comprehensive care to a panel of patient families. The facility must be clearly and significantly identified as a Family Medicine Center and must be for the exclusive use of the residency program.

Programs that involve training in Community, Migrant Health Centers (C/MHCs) or Federally Qualified Health Centers (FQHC) must provide assurance that these facilities meet the criteria for an FMC, as outlined below, unless an exception is approved by the Family Medicine Review Committee.

**Administration and Staffing**

The program director must have control of the educational activities that occur in the FMC, and of the activities of the support personnel. The program director must participate in and provide leadership for decisions affecting the FMC.

The FMC must be appropriately staffed with nurses, technicians, clerks, administrative personnel and other health professionals to ensure efficiency of operation and adequate support for patient care and educational requirements.

The FMC must be close enough to the hospital to require minimal travel time. It may not be at such a distance as to require travel that interferes with the residents’ educational opportunities, efficiency, or patient care responsibility.
A suitable resident work space and a separate private area for resident precepting, as well as an office library resource must be included. Computer access to electronic resources must be readily available for all of the physicians practicing in the Center.

Two examining rooms that are large enough to accommodate the teaching and patient care activities of the program must be available for each physician faculty member and resident when they are providing patient care. Additional space for individual and small group counseling must be included.

Faculty offices, if not in the FMC, must be immediately adjacent to the Center.

The program must have a conference room that is conveniently accessible and readily available, as needed, and that is large enough to accommodate the full program. In programs using multiple FMCs, there must be a meeting room within or immediately adjacent to each FMC that is large enough for smaller meetings of all faculty, residents, and staff who work at that site.

**Equipment**

There must be the following:

- Appropriate diagnostic and therapeutic equipment in the FMC to meet the basic needs of an efficient and up-to-date family medicine office, and an acceptable educational program for residents in family medicine.
- Diagnostic laboratory and imaging services in the FMC or nearby to afford prompt and convenient access by patients and residents for patient care and education.
- Tests commonly included as waived or point-of-service (e.g., urine analysis and wet mounts) and which may require efficiency of physician interpretation should be available within the FMC.
- Programs not currently using an electronic medical record system should document their plan for conversion to one in the near future.

**Source of Income**

The fiscal operation of the FMC must reflect an appropriate balance between education and service. Service demands must not adversely affect educational objectives.

**Outpatient Care**

Resident panels must include continuity patients requiring home care and care in long-term care facilities to provide each resident with continuity experience in those settings.

Residents must receive training to perform those clinical procedures required for their future practices.
in the ambulatory and hospital environment

In order to coordinate and integrate each patient’s care and to optimize each resident’s continuity training, the program must require that each resident maintain continuity of responsibility for some of his or her patients in all settings when such patients require urgent or emergent care, home care, long-term care, hospitalization or consultation with other providers. Continuity of responsibility should include active involvement in management and treatment decisions, and interactive communications about management and treatment decisions.

In the second and third years of residency, when other curricular responsibilities temporarily prevent a resident from providing continuity of responsibility in any of these settings, that continuity must be provided by another resident or faculty from the program (i.e., the inpatient team or the physician on-call for the practice). When a substitute physician, such as a member of a family medicine team, is involved in continuity of care, there must be a mechanism to transfer information clearly and expeditiously to the primary continuity physician.

Faculty Supervision

Whenever residents are performing clinical duties in the FMC, there must be an appropriate number of family physician faculty who, without other obligations, are engaged in active teaching and supervision of the residents. The appropriate number of faculty must be determined in relation to the level of training of the residents, the number of patients being seen in a clinic session, and the competency of the residents. In general, there should be at least one supervising family physician faculty member who is freed of all other activities for every four residents working in the clinic at any given time. If only one resident is seeing patients in the FMC, a single faculty member may be engaged in other activities to a maximum of 50%, but the teaching and supervision of the resident must take priority.

It must be the goal of the program that residents be scheduled to see their own patients (i.e., those with whom they have developed an ongoing doctor-patient relationship). The program must document the availability of a stable patient population in the FMC of sufficient number and variety to provide all residents with an adequate experience in the comprehensiveness of the specialty. It should be documented that each resident has experience with all age groups having adequate gender distribution, in volumes sufficient to achieve competency in all aspects of family medicine.

Residents’ FMC assignments over the course of three years of training must include progressive responsibility for increased patient visit volume and visit
efficiency.

The three-year FMC experience for each resident must include a documented total of at least 1650 patient visits, with at least 150 visits occurring in the first year.

Inpatient Care

The resident must develop the skills required to treat male and female patients of all ages and those having various levels of severity of illness who are hospitalized. In-patient care must include the continuity of care of adults and children from the residency patient panel. This inpatient experience should occur primarily on a family medicine or an internal medicine service, and must involve teaching and role-modeling by family physician faculty.

Daily faculty rounds must occur to ensure appropriate supervision and teaching. Each resident must also receive clinical experience caring for hospitalized patients in special care units including medical intensive care, coronary care, and newborn nursery. The length, breadth, and intensity of the experience must ensure that every resident becomes competent diagnosing and managing common inpatient problems of adults and children as seen by the family physician.

Residents must demonstrate direct management of patients to include initial evaluation, admission of patients, repeat evaluations, development of a plan of care, ongoing management, performance of basic procedures of medicine, appropriate consultation and discharge planning and continuing care. Residents must demonstrate the ability to write appropriate admitting orders and to modify them daily according to changes in the patient’s condition.

Residents are expected to maintain involvement in the care of their hospitalized patients whenever possible, even if the program uses the services of hospitalists. Upon completion of training, residents must be competent to provide hospital care.

By the conclusion of the residency, residents should have developed competence in knowledge, attitudes, and skills to care independently for hospitalized patients without supervision, and to utilize appropriate consultation by other specialists.

Institutional Requirements

The Sponsoring Institution must provide sufficient institutional resources to ensure the effective implementation and support of its programs in compliance with the Institutional, Common, and specialty/subspecialty specific Program Requirements.

The Sponsoring Institution must ensure that program directors have sufficient financial support and protected time to effectively carry out their educational and administrative responsibilities to
their respective programs.

Residents must have ready access to specialty/subspecialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

The Sponsoring Institution must have formal written policies and procedures governing resident duty hours.
PART III: GOVERNANCE
10. Similarities and Differences in Governance Between Community Health Centers and Family Medicine Residencies

Concerns about governance and administrative complexity were cited by 29% of respondents as a significant barrier to CHC-FMR linkages in a 2007 survey of FMR program directors. (7). The governance structure needed varies according to what type of Educational Health Center is being developed. A starting point is to understand how CHCs and FMRs are governed.

10.1 Community Health Center Governance - What FMRs Need to Know

Community Health Centers are independent, non-profit organizations. Federal regulations also require that at least 51% of the members of the Board of Directors be clients or patients of the health center and must be representative of the community served. The CHC board of directors is responsible for:

• Hiring and firing of the Chief Executive Officer
• Establishing policy regarding the conduct of the center
• Establishing personnel policies and procedures
• Adopting policy for financial management practices among other fiduciary responsibilities
• Evaluating health center activities including scope of services, location and hours of service, progress toward accomplishing the mission, productivity, quality of care and patient satisfaction, etc.
• Responsible for maintaining, monitoring and complying with federal responsibilities detailed in the Section 330 Grant Award
• Becoming a Educational Health Center or establishing an academic affiliation would have to be discussed and approved by the board of directors

Each CHC has a Medical Director or Chief Medical Officer who reports to the CEO.

10.2 Family Medicine Residency Governance - What CHCs Need to Know

Like all residency training in the United States, Family Medicine programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME). Within the ACGME, each specialty is represented by a Review Committee (RC) which sets and periodically updates training requirements. Training requirements for Family Medicine residencies are extensive. Every family medicine residency is led by a Residency Program Director who is almost always a family physician. The Program Director has specific and broad authorities which are delineated in the ACGME requirements.

A limited summary of ACGME requirements for Family Medicine Residencies can be found in appendix A. The full set of written requirements specific to Family Medicine Programs can be accessed via the ACGME website: http://www.acgme.org/acWebsite/RRC_120/120_prindex.asp

In addition, there are general requirements which apply to all residency training programs and their sponsoring institutions. There can be found in the Appendix (see “Institutional Requirements” and the “Common Program Requirements” in the Appendix) and they can also be accessed at:

http://www.acgme.org/acWebsite/irc/irc_IRCpr07012007.pdf

http://www.acgme.org/acWebsite/dutyHours/dh_dutyhoursCommonPR07012007.pdf
10.3 Potential Areas of Conflict

- Selection of providers and staff
- Selection of residents
- Allocation of costs and expenses
- Allocation of provider time
- Pursuit of grants and other funding opportunities – which ones?
- During periods of budget tightening/cuts
- Effects on provider and staff scheduling caused by the presence of residents
- Effects on continuity of patient care by the presence of many part-time outpatient providers
- Residents may come with language skill issues, particularly if they are international medical school graduates
11. Affiliation Agreements

Health centers and residency programs which ultimately decide to collaborate need to develop a written affiliation agreement. In the case of CHCs which sponsor the residency program, an affiliation agreement with the teaching hospital will be needed. Although each affiliation agreement will be unique, most should include the following elements:

- Time period covered by the agreement
- Reasons, time course and process for termination of the agreement
- Guidance on how the affiliation can be renewed and continued
- What are the responsibilities of each party including regular meetings between the CHC executive staff, the residency leadership, and the partner agencies when appropriate
- Careful and specific financial agreement which includes:
  - Periodic reconciliation
  - Specificity about costs and revenue allocation, i.e., who pays how much for what?
  - Commitment to transparency
  - Productivity expectations for both faculty and residents
  - Levels of clerical and clinical support expected for faculty and residents
- Agreement in advance on how key leaders, faculty members and residents will be recruited and selected. This can include who will participate on search committees.
- By what measures will the program be evaluated
- Periodic, regular discussion of education and service at the CHC Board of Directors meetings
- How disputes will be resolved
- Responsibility for scheduling residents and how scheduling conflicts and changes are made

While the affiliation agreement need to cover many specific issues and scenarios, the ultimate success or failure of the affiliation will depend on many other factors, all of which cannot be articulated in a legal document. Personal relationships and a deep commitment to common goals and shared values are equally important.
12. Finding and Sustaining the Common Ground: Ideas to Consider

Hospital-Sponsored Programs

- Regular, scheduled meetings of CHC and hospital leaders (CEOs, CMOs, CFOs)
- Careful discussion and agreement about how conflicts and changes in faculty and resident schedules will be addressed and resolved (these are inevitable!)
- Periodic, regular reports from the Residency Program Director to the CHC board of directors
- Scheduled, organized contact between members of the CHC Board of Directors and residents. This can be educational in both directions.
- For existing CHC’s which are contemplating starting a new residency or merging with an existing residency program, revising the mission statement to include commitment to education is both an important exercise to spur discussion and also provide benchmarks for evaluation of the relationships

CHC-Sponsored Programs

- Consider who the Residency Program Director reports to

There is not likely to be a one-size fits all answer to this question. For THCs funded through HRSA, it is a requirement that the residency Program director be an employee of the CHC. Other types of EHCs will have their own unique set of considerations. In some programs the CHC Medical Director or CMO will also serve as the Residency Program Director. In larger CHCs or ones who’s Medical Director or CMO is not a family physician, this may not be possible or desirable. If that is the case, the options are generally for the Residency Director to report to the CEO or to the CMO. There are benefits and trade-offs to each model.

- Consider how CHC providers with both faculty and clinical responsibilities will be compensated compared to CHC providers who’s job is 100% patient care.

The goal is for everyone to feel their contributions are both valued and fairly compensated. It is advisable to avoid the situation where people choose to teach or not teach primarily because of the effect on their salary. You want the best teachers teaching and you want to avoid conflict or jealousy between providers who teach and those who don’t. You need both! This becomes even more important when the CHC is responsible for several sites, not all of which host or sponsor the residency program.

- Consider an alternative relationship which allows for a contract between the CHC and the hospital or medical school sponsored residency that is a purchase of service agreement whereby the services of both residents and selected faculty/clinical staff are purchased by the CHC from the educational institution. This is allowed under BPHC guidelines and it may offer benefits that more straight-line hiring arrangements do not.
13. Examples of Community Health Center Linkages

Traditional Structure and Sponsorship

Worcester, MA

Waco, TX

Santa Fe, NM

Community Health Center Sponsorship

Lawrence, MA

Fitchburg, MA

Yakima, WA
Examples of Community Health Center Linkages: Traditional Structure and Sponsorship

Worcester, MA

**Residency Program:** University of Massachusetts, Worcester Family Medicine Residency

**Sponsor/Accredited Organization:** University of Massachusetts Medical School

**CHC Partner:** Family Health Center of Worcester

**Hospital Partner:** UMass Memorial Health Care

**Year Established:** 1973

**Program Description:**

The Family Health Center of Worcester (“Queen Street”) is federally-funded community health center and is one of three outpatient training sites for the University of Massachusetts, Worcester Family Medicine Residency Program. It was one of the first CHCs to serve as a continuity training site for family medicine residents. Residents often choose the Queen St. site because of a specific interest in caring for an urban underserved community. The health center is a vital community resource for an ethnically diverse urban population. For more than 30 years, Worcester’s inner city residents have turned to our health center for the highest quality care regardless of their economic status, ethnicity, education or country of origin. The underserved populations who would otherwise be unable to access medical, dental, social and ancillary services are all welcome at Queen Street.

At Queen Street, residents are part of a primary care team that includes faculty physicians, physician assistants, nurse practitioners, nurses, and medical assistants. A social service advocate helps to streamline delivery of care to all patients. Additionally, a post-doctoral psychologist works with residents when interviewing individuals and families. An onsite Department of Social Services, a WIC program, dental, psychiatric counseling, pharmacy, laboratory and radiology services complete the comprehensive care model.

**Lessons learned:**

- **Communication:** Coordinated communication amongst leadership is key to maintain a longitudinal partnership.

- **Administrative Support:** Shared centralized administrative resources are essential to reduce the burden on CHC.

- **Resident Integration:** Integration of residents into health center teams is important for learning as well as for CHC function.

- **Physical Space:** It is crucial to have adequate physical space for learners, for clinical and educational work.
Examples of Community Health Center Linkages: Traditional Structure and Sponsorship

**Waco, TX**

**Residency Program:** Waco Family Medicine Residency Program

**Sponsor/Accredited Organization:** The McLennan County Medical Education and Research Foundation

**CHC Partner:** Heart of Texas Community Health Center

**Hospital Partner:** Hillcrest Baptist Medical Center and Providence Medical Center

**Year Established:** Residency established in 1970. The Heart of Texas Community Health Center was established in 1999 and at that time the residency became a wholly-owned subsidiary of the health center.

**Program Description:**

Waco Family Medicine Residency has a long tradition of providing broad spectrum training. 2010 is our 40th year of full operation. We work to provide training that gives residents their choice of practice. Interested residents can get significant OB experience including c-sections. We offer training in colonoscopies, lumbar punctures, and central lines to name a few. Many of our residents go on to practice full scope and international medicine. Our residents enjoy having autonomy to learn, grow, and treat patients with easily available faculty backup when needed and opportunities for moonlighting abound. We were a pioneer in Electronic Health Records. Our system, Epic, has been operational and continuously improving since 1997. We have a full lab at our main site and several smaller satellite labs. Family Health Center, our parent organization, is also a community health center with a staff of 12 family physicians, 10 mid level practitioners, 2 psychiatrists, and a counseling and dental department (with dental services provided to our employees).

**Lessons learned:**

All parts of the organization must understand the goals of the overall program, how decisions are made, how they can participate in those decisions, what role they have in making things work, how success is measured and rewarded.
Examples of Community Health Center Linkages: Traditional Structure and Sponsorship

Santa Fe, NM

**Residency Program:** Northern New Mexico Family Medicine Residency

**Sponsor/Accredited Organization:** Christus St. Vincent Regional Medical Center

**CHC Partner:** La Familia Medical Center

**Medical School Sponsor:** University of New Mexico

**Year Established:** The residency was accredited in 1995 and admitted its first cohort of 2nd year residents in Santa Fe on July 1, 1996.

**Program Description:**

The University of New Mexico – Santa Fe Family Practice Residency Program (Northern New Mexico Family Practice Residency Program) has evolved in response to an increasing demand for primary care physicians throughout New Mexico. In an effort to decentralize training of physicians from tertiary care settings into the community, the University of New Mexico Department of Family and Community Medicine formed a linkage with a community health center in Santa Fe, La Familia Medical Center, and a community hospital, St. Vincent Hospital. This fully-accredited program has a “1+2” designation, meaning that the initial post-graduate medical education year is spent in Albuquerque at the University of New Mexico Affiliated Hospitals and the next two years of training are spent in Santa Fe and other rural northern New Mexico communities. The 1 + 2 residency program exemplifies inter-institutional collaboration at its very best. This program is unique in that it is officially sponsored by a university (UNM), utilizes a community hospital as the primary teaching hospital (St. Vincent Hospital), and trains residents at a federally-qualified community health center (La Familia Medical Center) for their continuity patient care.
Lessons learned:

- With multiple institutional involvements, residents must have a strong sense of where their primary home base is.

- A strong ongoing working relationship must exist between the community health center and the residency program to continuously strive to balance the educational mission of the residency program and the core service mission of the community health center.

- Ongoing faculty development is a key component for both new and experienced medical staff members of the community health center.

- Protected faculty education time is vital. It is extremely important for the residency program to compensate the community health center for the time that faculty are engaged in non-revenue generating educational activities.

- Operational support to facilitate the unique needs of resident schedules at the community health center is vital to meet accreditation requirements.
Examples of Community Health Center Linkages: Community Health Center Sponsorship

Lawrence, MA

**Residency Program:** Lawrence Family Medicine Residency

**Sponsor/Accredited Organization:** Greater Lawrence Family Health Center

**Hospital Partner:** Lawrence General Hospital

**Medical School Partners:** University of Massachusetts Medical School and Tufts University School of Medicine

**Year Established:** 1993

**Program Description:**

The Lawrence Family Medicine Residency Program was the first residency program in the country sponsored by a community health center. The residency served as catalyst for dramatic growth over a prolonged period. Located in one of the poorest communities in New England, the program attracts residents who excelled academically in medical school and who aspire to careers in underserved communities. As a result of the residency program, the CHC expanded care from 9,000 patients per year to 43,000 patients (>200,000 visits) seen annually and is now the second largest CHC in Massachusetts.
Lessons learned:

- A true partnership between the health center and the hospital was critical in developing and maintaining the program.

- The program’s success paralleled its ability to find synergy in fulfilling the clinical and the educational missions.

- A great residency program is not cheap and aspiring to anything other than a great program is not worth any amount of effort and money.

- Despite declining interest in family medicine nationally, a program which provides a high quality education can attract exceptional residents.

- The presence of a strong residency program can significantly improve recruitment and retention of providers and other staff members.

- Maintain the highest standards in selecting both faculty members and residents.

- Avoid the temptation to try to be “all things to all people.” In addition to training residents who want to work in underserved areas, find a niche or two which can distinguish your program from others.
Examples of Community Health Center Linkages: Community Health Center Sponsorship

Fitchburg, MA

**Residency Program:** Fitchburg Family Medicine Residency

**Sponsor/Accredited Organization:** Department of Family Medicine, University of Massachusetts Medical School

**CHC Partner:** Community Health Connections, Inc.

**Hospital Partner:** Massachusetts/Memorial Medical Center and Health Alliance Hospitals

**Medical School Partners:** University of Massachusetts Medical School

**Year Established:** 1978 as a FMR operated by UMMS and 2002 when transferred to Community Health Connections, Inc.

**Program Description:**

Community Health Connections is a federally-qualified community health center serving all residents of North Central Massachusetts. CHC Family Health is the result of collaborative efforts of a community board, UMass Memorial Health Care, UMass Medical School, Fitchburg Family Medicine, and federal, state, and local officials to create a community-owned health center to meet the demands for increased services and access to medical care in the North Central Massachusetts area. The Fitchburg Family Medicine Residency Program has become part of this new center.

Fitchburg Family Medicine Residency has long been a key source of compassionate care for the poor and underserved in North Central Massachusetts. In 2002 the residency became part of a new federally qualified community health center (CHC Family Health Center). This allowed us to become far better equipped to manage this challenging responsibility. Through directly accessing Federal programs and participating in regional and national initiatives such as the Health Disparities Collaborative, we are in the forefront of a national movement to systematically improve care for the underserved. This residency is both ACGME accredited and AOA accredited.
Lessons learned:

- The pre-existing UMASS Family Medicine Residency in Fitchburg, Massachusetts merged in 2002 with a newly funded federally qualified health center (Community Health Connections, Inc.) building upon both organizations strengths and maintaining the responsibility of the residency with the University and utilizing the FQHC site for the ambulatory care portion of the residency.

- Implemented a unique management arrangement between the two partners with the health center managing all service responsibilities for patient care through purchasing faculty and residents from UMASS for this purpose. UMASS provides and underwrites teaching time at the health center through this arrangement. This partnership has worked effectively for both parties. Patient revenues are collected by the health center.

- The patient center primary care health home is the model of care utilized at this center with residents and faculty participating completely in this model.

- A local community hospital, operated by UMASS and its clinical affiliate, functions effectively as the inpatient teaching site for the residency.
Examples of Community Health Center Linkages: Community Health Center Sponsorship

Yakima, WA

**Residency Program:** Central Washington Family Medicine Residency

**Sponsor/Accredited Organization:** Community Health of Central Washington (CHC)

**CHC Partner:** Community Health of Central Washington (CHC)

**Hospital Partner:** Yakima Valley Memorial Hospital

**Medical School Partners:** University of Washington School of Medicine

**Year Established:** 1993

**Program Description:**

The Central Washington Family Medicine Residency Program (CWFM-R) is an 18 resident family medicine residency program owned by Community Health of Central Washington, a community health center.

The program is accredited by the Accreditation Council for Graduate Medical Education and the American Osteopathic Association. It is affiliated with the University of Washington Family Medicine Residency Network and the Appalachian Osteopathic Postgraduate Training Institute Consortium.

Primary financial support comes from Yakima Valley Memorial Hospital and Yakima Regional Medical and Cardiac Center. Collaboration with the University of Washington School of Medicine and Pacific Northwest University of Health Sciences provides a solid foundation for medical education in the Yakima Valley.

We are committed to the development of excellent, board-certified family physicians with demonstrated clinical, technical, and interpersonal competencies.
Lessons learned:

- Beware of the unwritten rules. ACGME is getting better about this. AOA lags considerably. The CHC world is filled with them. It points to the necessity of relationships with peers/peer organizations/and the agencies and organizations empowered to “assist” your efforts.

- Beware of “lip service”. All of the excitement about the teaching health center can lead to a sense that there is resounding support for the notion. Do not let this lead to complacency. Those presiding over decisions that can make or break the THC harbor deep concerns about the duality of purpose, and the fear that the cause they hold most dear may succumb to opposing forces. THC’s face intense scrutiny at all levels.

- Beware of “opportunity”. This is often a euphemism for work that nobody else wants to do, and/or has no funding attached to it. Well meaning peers and community members are enticed by the potential and resources of the THC, and will bring opportunity to you. Even when there are some funds that accompany, it is essential to examine it relative to the mission, vision and essential functions of your enterprise.

- Beware of “mandates”. When you add to list of “musts” from BPHC all of the “musts” of accreditation, the list of unfunded mandates becomes quite large. When you then add their respective lists of “shoulds” and recommendations, the money runs out very quickly. Understand the level of the requirement. Balance your commitments. Know where you are out of compliance. It may be a reasonable decision to remain so, but be prepared to defend the decision. You are not likely to lose status for a principled stand respectfully set aside some demands.
PART IV: ADMINISTRATION AND OPERATIONS
14. Introduction to Administration and Operations

Research by Dr. Carl Morris and Dr. Freddy Chen revealed that Family Medicine residencies and community health centers were both unified and separated by a set of common values and needs. The key administrative and operational challenge in the THC is to allow the best of both residency and health center cultures to not only coexist, but to thrive. As the actual rules pertaining to THCs are created, we hope they will reflect this need to merge the best of both types of organization to create a new type of health center that incorporates teaching of resident doctors into its very identity and one of its core purposes. Similarly, the residency program sponsored by and located in the health center needs to incorporate the unique governance and focus on clinical services into its fabric as a training program. Only then can the THC overcome what have historically been impediments to co-locating residency training programs in health centers.

The most essential element of this success is the adoption of a shared mission of service and education. Administrative personnel and policies must hold and express this mission as a single policy in all decisions, not as two things that must be accommodated. Having stated that, the reality is that there exist two very different sets of rules and credentialing bodies that the THC must satisfy. The rest of this section will focus on what those two entities are, where to find their critical requirements and rules, and what are the most critical areas of focus in establishing a THC.

Before embarking on the descriptions, we want to acknowledge the many health centers and residencies across the country that have found it possible and desirable to collaborate in this manner long before Teaching Health Centers became a reality. Their leadership in finding solutions can be a very useful resource for anyone who is using this manual as a guide to help establish their own THC.

Limitations

This narrative will focus on the unique aspects of family medicine residency as the educational effort in the teaching health center. If you are implementing another specialty or program, please consult with that entity to secure the unique materials and needs related to that credentialing body.

For Allopathic training programs, each independent specialty in medical training has its own Review Committee. These volunteers are selected to serve and work under the auspices of the Accreditation Council for Graduate Medical Education (ACGME). The materials shared here come from the Review Committee for Family Medicine. This can be found at the following website:

http://www.acgme.org

For Osteopathic programs, a parallel set of organizations exist. The council on Osteopathic Postdoctoral training Institutions (COPTI) reviews annual reports of the OPTIs which in turn serve as the credentialing entity for residencies. Each residency will need to affiliate with an OPTI. Several Osteopathic-specific documents and handbooks are included in the appendix to assist in learning about these.
15. Establishing a Family Medicine Residency

There is a lengthy timeline to obtain accreditation for a residency. This can be obtained by reviewing the material at the ACGME website. Open the section on review committees, and then read the material under family medicine. As you will see it takes 6 months to a year to gain approval after you have submitted your materials for the training program. Prior to that, you need to become familiar with the common and specialty program requirements (copies supplied in this toolkit), and to have prepared a program that provides an educational curriculum and structured rotation experiences that will fulfill those requirements.

The Osteopathic accreditation process is similar but has significant differences. A copy of “The Basic Documents” and “Application for a New Residency” are included in the appendix. The timeline for accreditation sponsored by the American College of Osteopathic Family Physicians can be shorter than the allopathic accreditation. Their documents specify a timeline of 4-6 months for accreditation review as versus the 6-12 months in allopathic credentialing. The requirements are somewhat less strenuous for initial accreditation than the allopathic residencies as you will see by comparison of the two sets of documents included in the appendix.

There are extensive requirements related to hospital and non-hospital teaching rotations, detailed policies regarding employment, selection, benefits, due process, etc. There are also assurances that need to be clear on standards of evaluation, promotion or termination, stability of the program sponsorship, etc. Sufficient clinical volume is necessary for the resident’s learning and the ability to track the residents’ practice experience by age, gender, diagnosis, procedure, etc must be clear. You will be expected to be able to report these things and have documentation for them for each resident for each year they train with you.

There are also many expectations stated related to program director time, faculty supervision of residents, faculty credentials, etc. There are specific requirements of all residents of all specialties in terms of maximum duty hours and acquisition of competencies. These rules can also change from time to time but require compliance and records showing such compliance.
16. Program Director

Family Medicine has specific requirements regarding the Program Director. Below is excerpted specific relevant language from the Family Medicine Common Program Requirements. The full set of Common Program Requirements for Family Medicine (Effective July 7, 2007) can be found in the Appendix.

Also in the Appendix is a slide presentation made to the Board of a CHC in Seattle, WA, which illustrates the various organizational and administrative considerations the Board of the CHC needed to address in thinking about collaboration with a family medicine residency.

There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

(Some specialties require RC approval before such changes are final. See specialty-specific program requirements.)

The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

Qualifications of the program director must include:

• requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

• current certification in the specialty by the American Board of ________, or specialty qualifications that are judged to be acceptable by the Review Committee; and,

• current medical licensure and appropriate medical staff appointment.

The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

• oversee and ensure the quality of didactic and clinical education in all institutions that participate in the program;

• approve a local director at each participating institution who is accountable for resident education;

• approve the selection of program faculty as appropriate;

• evaluate program faculty and approve the continued
participation of program faculty based on evaluation;

• monitor resident supervision at all participating institutions;

• prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

• provide each resident with documented semiannual evaluation of performance with feedback;

• ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

• provide verification of residency education for all residents, including those who leave the program prior to completion;

• implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
  
  distribute these policies and procedures to the residents and faculty;

  monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements

  adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

  if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

• monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

• comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents.

• be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

• obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the ACGME information or requests for the following:

  all applications for ACGME
accreditation of new programs; 
changes in resident complement; 
major changes in program structure or length of training; 
progress reports requested by the Review Committee; 
responses to all proposed adverse actions; 
requests for increases or any change to resident duty hours; 
voluntary withdrawals of ACGME-accredited programs; 
requests for appeal of an adverse action; 
appeal presentations to a Board of Appeal or the ACGME; and, 
proposals to ACGME for approval of innovative educational approaches.

- obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
  - program citations; and,
  - request for changes in the program that would have significant impact, including financial, on the program or institution.

The requirements call for continuity of program director leadership. The average length in years between program director appointment dates in the core specialties is 7.06 years (range 4.62 – 11.36).

Based on turnover since 2001, this data comes from the 2007 Average Length in Years Between Program Director Appointment Dates Report from the Department of Operations and Data Analysis, ACGME. This and a number of other reports can be accessed at the ACGME website under “Search Programs/Sponsors.”

Programs that have a history of frequent changes may trigger additional inquiry into the cause(s) in order to determine if the learning environment has been adversely affected. A single person (program director) must have authority for the operation of the program. Qualifications for program directors include: specialty expertise, educational and administrative experience, current medical licensure, appropriate medical staff appointment, and current certification in the specialty by ABMS. Some Review Committees will consider alternative specialty qualifications but approval should be obtained in advance of appointing such a program director.

The CPR contains a list of Program Director responsibilities (II.A.4.). This extensive list is intended not only to communicate the specific responsibilities of the position so that the individual will be effective as a program director, but also to communicate to the sponsoring institution (e.g., DIO, GMEC, department chair) the role and responsibilities of this position and why the program director needs sufficient protected
time and financial support (CPR I.A) to fulfill these responsibilities. By assuring that each of the listed duties occurs on a regular basis, the program director will facilitate an enhanced learning environment. For example, the program director “must approve the selection of program faculty as appropriate.” Typically, the department chair will make such assignments, but program directors must have input into these decisions so that faculty with both clinical and teaching expertise are given responsibilities in the program.

The program director is responsible for implementing and ensuring compliance with policies and procedures for grievance and due process, duty hours, selection, evaluation and promotion of residents, disciplinary action and supervision of residents. See IR II.A-D. for minimum institutional requirements. Institutions and/or programs may have more extensive policies and procedures. These policies and procedures should be given to all residents and faculty in print format or made available on a residency program website to assure they are knowledgeable about these important issues.

A program handbook is not required but it is a convenient approach to collecting and updating all the information that must be made available to residents and faculty (policies and procedures, schedules, educational program goals, goals and objectives for each major assignment, and information on all required sites). Such a handbook could be either paper or electronic (located on a website, CD or other digital medium).

In addition, program directors should be familiar with and comply with policies and procedures as outlined in the ACGME Manual of Policies and Procedures, available on the ACGME website. (See Section II, Accreditation Policies and Procedures.) When preparing for a site visit, program directors are cautioned to prepare the PIF document carefully to avoid inaccuracies, discrepancies and/or inconsistencies.
17. Key Issues

These are things that your residency director or other faculty delegate should become expert at. The CEO and Board must understand the issues as presented by the program director and support solutions.

17.1 Residency Slots

Currently, over half of all family residency positions are filled each year by non-allopathic or non-US senior grads. Osteopathic applicants, older graduates, and international grads make up this large pool of potential applicants. They can be selected outside the Match and offer another way of filling your residency slots if you choose.

17.2 Funding

New resident slots in new programs may or may not qualify for Graduate Medical Education (GME) payments. This is a very complex system that funds residency training through the Medicare program. CMS determines who qualifies and who does not. They also use data from new programs to determine what the amount of support will be. At the current time, the traditional GME payments flow through hospitals as sponsors of programs. A teaching Health Center by definition will be sponsored by the Health Center, so the hospital will not be a logical recipient of GME payments. While the legislation for THCs will designate specific resident reimbursement to health centers for at least the first five years, the GME methodology for Medicare funds is unclear at this time. The rules have not been written. Whether or not hospitals that teach your residents will receive any such funds is unknown at this time. More detail on this very important area is included in the section on finance.

Your director of business operations, the CEO, and the Board must be aware of the obligations that are attached to any graduate medical education funds from the federal government. As will be outlined elsewhere, there are specific guidelines about what activities and locations of those activities are acceptable for accounting purposes to justify GME funds. Certain types of expenses that can be identified as uniquely related to medical education can be used to justify some types of GME. Most programs rely on the residency program director and a sponsoring institution administrative person to be “experts” and accountable for this aspect of funding.

17.3 Revenue

However, in addition to the resident support specified in the THC legislative language and in addition to possible GME or grant funds, residents will generate health center revenue in the form of billing for the services they provide while under the supervision of a faculty member. There are very strict rules by Medicare for payment of these services. These “supervision rules” are found at the CMS site. All THCs must become aware of these regulations and abide by them with evidence they do follow those guidelines.

Become expert on the billing and supervision requirements for Medicare patients and other carriers in your state. Some locations extend the Medicare rules to all payers, some to Medicare and Medicaid, and some only to Medicare. You must be certain.

At this time the more essential elements of the rules include supervising a resident at a ratio of no more than 1 faculty person per 4 residents. The faculty member must have no other assigned duties There are two ways of meeting the supervision and record keeping function required of the supervising faculty. A current copy of the CMS requirements in this regard is included at the back of this section.
17.4 Resident Supervision

The CMS rules for resident supervision must be followed in order to bill for services. You are committing fraud if you fail to comply. The residency language is a bit more vague. It requires that residents have adequate supervision for all their clinical duties. However, that supervision is to allow personal and professional growth as well as to allow increasing autonomy as the individual resident’s skills allow. This is true in the hospital as well as all non-hospital settings. The supervision is called precepting and it must be “readily available”. These terms are more explicitly described with respect to labor and delivery management.

Recently the “duty hours” language has been changed to reflect a greater level of complexity for supervision of residents at different training levels. The specific language is included in the latest version of the common program requirements in the appendix of this toolkit. The residency program director will be held accountable to ensure there is program wide compliance with these standards.

17.5 330 Status

The residency accreditation will not directly affect your 330 grant status. This is a critical funding line that relates to your function as a deliverer of health services of specified scope, type, quality and to a population meeting certain federal criteria. The THC legislation does not change this.

Your ability to seek grants, etc will not be affected by THC status. Residencies are not prohibited from such efforts.

17.6 Faculty and Hospital Relationships

Residents will be obligated to do hospital training rotations and to show continuity of care for their own patients in the clinic and in the hospital. You must have, or develop, an active hospital practice. Residents must deliver babies and deliver prenatal care and also do the delivery of some of their own prenatal patients.

You must have at least one faculty member who does OB themselves.

Residents must have clinical care role models on their faculty. These can be part time faculty members who are mainly clinicians, or they can be mainly teachers who are part time clinicians.

All faculty members are required to maintain clinical activity and privileges.

Hospitals have traditionally seen family medicine residencies as a financial drain due to the inefficiencies of their offices. Embedding a residency in an existing office system has the potential to minimize this effect. THCs also will be able to gain higher reimbursement for certain care of a subset of federally insured patients as compared to traditional residencies. On the other hand, THCs may well see a larger volume of uninsured patients than traditional residencies. It becomes imperative to have clear discussions with your hospital about who pays for what. If the THC is the sponsor, it is unlikely that the hospital will subsidize the THC residency, especially if the hospital does not get GME flowing to it. Some hospitals do support local health centers with a wide variety of arrangements and for a wide variety of reasons. This is one area that will benefit if you already have good relationships with the hospital you will be using for training. However, it has also been an area of great challenge and misunderstanding in traditional hospital-sponsored family medicine residencies in the past.

Make sure the CEO, program director, and Medical director are all clear on the relationship with the hospital. What is expected of each party is critical to success. Often the hospital will not be aware of the services provided by a health center that
actually reduces a hospital’s uncompensated care in avoided ED visits and admissions. Providing a resident staff with their own hospital supervision can sometimes be a tremendous winning service for the Health Center to offer the hospital and reduce the uncompensated care obligations amongst some of the rest of the hospital staff.

This is a critical area that is uniquely determined for your community and your program. There is no “one size fits all” with regard to hospital relationships. If this is an area of challenge, asking similar programs how they addressed it or obtaining a consult to your area and program may be of great help.

17.7 Community Relationships

Health Centers have always needed to forge clinical care relationships with consultants, hospitals, etc. Residency teaching programs need additional relationships for the educational rotation of their trainees. These specialists may be the same ones who provide clinical consultations to your patients or they may relate to the program only in an educational role.

Forging these relationships will be a critical function of your residency program director, clinical medical director, and faculty. The CEO and Board will need to be understanding of this delicate balance and its critical role in education. Unless the required rotations can be provided in the community, you will either need to make complicated arrangements for residents to leave your practice area to get the required training or you will be unable to sponsor an accredited residency program.

Sometimes, the community medical leaders become incredibly influential supporters of the residency. They can be valuable sources of financial support as well as political support. This is one thing that is very similar for residencies and health centers. It would be ideal if the supporters of each role (health center service and residency training) came to understand the mutually reinforcing relationship such service and education programs provide. In that way, support in the community could be broadened rather than split into different areas. This will require enthusiasm, clarity, and education both internally to staff and externally to the community.

One often neglected aspect of community relationships for THCs relates to the referral of patients for specialty care. While not scientifically studied, there is widespread agreement amongst our colleagues who run THCs (as we would now define them) that their health center practices experience fewer problems in referral of their patients for specialty care than their non-teaching health center colleagues. In other words, these residency leaders feel they have an easier time getting their patients seen by referral specialists in their community than they did before they began teaching, or as compared to their non-teaching counterparts in other health centers. You may or may not experience this. It is speculated by at least one of these leaders, that the level of connectedness to the rest of the medical community might be higher in THCs than in HCs in general. Certainly involving the community providers in training your residents, and the faculty interactions to review and maintain those relationships, represent a significant added points of contact with the rest of the medical community. It is possible that this may also represent a value added reason to consider becoming a THC that melds educational mission with improved service mission for the patients. Such a message could be valuable in the administrative offices and in the board room as it will be hard to measure in current standard metrics of education, RVUs, or service volumes.

17.8 Academic Requirements

Residency requirements focus on experiences, time spent on educational rotations, acquisition
of diagnostic and procedural skills, professional development “competencies”, certain required work conditions and contract provisions, and assured limitation of work hours. All of this must be structured in your resident experience and it must be measurable for reporting purposes. While it is the residency program director’s responsibility to ensure the training program is in compliance with these rules, he or she will require substantial assistance in the administrative support of this.

Administrative support for the documentation and tracking of a multitude of educational and clinical experiences are required for the residency as a whole and each individual resident. Examples of the current expectations can be found on the ADS report and the Review committee Program Information Form. Blanks of these are included in the appendix of this toolkit for your review. It will be critical to successful THC implementation to be able to create an educational program that complies with these items and is able to consistently track and document it. Accreditation depends on it!

Initial accreditation will also require that your site is judged to have an adequate patient volume for resident training and that the dedicated support functions for these items are in place or at least adequately planned and resourced.

Your site will need to be academically accredited before it can be considered by HRSA to be a THC.

### 17.9 Facilities

Every residency must have a clinical home for each resident. Ideally they will be in the same facility so there is resident interaction and mentoring. Each resident will be expected to have a personal workspace with secure storage for personal belongings. They must have at least two exam rooms to see patients when the residents are in the clinic. (Many programs strive to have three rooms for each faculty member or 3rd year resident in a clinic due to their higher volume of patients per clinic than the first or second year residents.)

There must be adequate nursing support. Medical records must be available 24/7 to the resident should he or she need to see them. There must be a library on site in the clinic with adequate reference material support. This can be electronic, print, or a mixture of both. They must have access to limited lab facilities for patient care and for personal learning. There must be adequate nursing and administrative support. Residents must have their own identified “panel” of patients with measured continuity of care.

Family Medicine requires a minimum of 1650 office patient visits over the three years of residency. The third year resident must see more patients than they did in their second year of residency. Ideally, the resident is seeing his or her own assigned patients to experience continuity. This is intended to be helpful for the patient in the quality of their care, but also to add a layer of education to the resident by benefitting from seeing the results of prior advice, treatment, etc that they did themselves.

### 17.10 Additional Requirements

Many additional specific requirements for your clinical office experience are described in the Program requirements for family medicine. You must be certain you can meet these before proceeding with the creation of a THC.

Frankly, a review of these requirements by your CEO and Medical Director should result in an easy judgment of whether or not you can do so. The actual creation and management of the structure of residency training with the balance between office and hospital learning and service will largely fall to the program director with the support of others.
18. New Accreditation Timeline

Practically speaking, it takes 2-3 years to move from contemplation of a residency to opening the doors to your first residents. This is if you already have a practice and if you are not required to build a new facility.

Remember that family medicine requires residents to spend their last two years in the same residency. Thus, plans for longevity of the residency and for resident education in the event of program closure are also required. Also, an independent residency cannot have less than four residents and must project to have at least four residents per year in training. 2-2-2 sites must be satellites rather than independent programs.

The timeline described below is for allopathic residency application to the ACGME for accreditation. As mentioned earlier, the timeline for Osteopathic accreditation can be shorter by 6-8 months.

<table>
<thead>
<tr>
<th>Variable Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate self, review guidelines, develop curriculum, etc to prepare to train residents</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year -2</th>
</tr>
</thead>
<tbody>
<tr>
<td>March: Request accreditation review from RC. (They state it can take up to one full year from time of request till accreditation given. Cannot accept residents into program unless accredited)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year -1</th>
</tr>
</thead>
<tbody>
<tr>
<td>March: Register with ERAS for the Match. Must be accredited by this time to register! Could still open but would miss the formal ERAS/Match service for recruitment.</td>
</tr>
<tr>
<td>September/October: Review applications and scheduled interviews of applicants</td>
</tr>
<tr>
<td>November-January: Interview applicants</td>
</tr>
<tr>
<td>February: Submit Match rank list</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 0</th>
</tr>
</thead>
<tbody>
<tr>
<td>March: Learn of residents you matched with.</td>
</tr>
<tr>
<td>June: Accept first class of residents for orientation</td>
</tr>
</tbody>
</table>
19. Administration and Operations Worksheets

Worksheets

Education Health Center Development Continuum

Precontemplation

Contemplation

Action

Application
Administration and Operations Worksheets

**EHCI Continuum**

<table>
<thead>
<tr>
<th>Brand New</th>
<th>Simple Education Health Center</th>
<th>Mature Education Health Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>7</td>
</tr>
</tbody>
</table>

**Precontemplation**
- What is a THC?
- No teaching experience

**Contemplation**
- Some desire to be a THC and some teaching experience

**Action**
- Strong consideration of becoming a THC and lots of teaching experience

**Apply**
- All capacities and roles

---

**Describe where you think your organization is on this scale right now:**

Where are you personally on this scale?

If there are differences, what is the source of that mismatch?

What do you need to decide if you want to move to the right on this scale?

Where and how can you get that information or shared awareness?
Administration and Operations Worksheets

Precontemplation

Why am I interested in the THC concept?
How do I think this could benefit my organization?
How do I think this could benefit my patients and community?
What are the negatives I fear about this idea?
Who else in the organization can I or should I talk to about this idea?
What are my needs/goals?
What do I hope to gain from this?
Do I (we) have a mission and vision statement that incorporates the dual mission?
Are the key stakeholders supportive of such a statement(s)? Who are they? What might it say?
Contemplation

Does my mission/Vision statement incorporate the dual mission with broad organizational support?

Who needs to engage in further discussions on this with me?

What have been the positives and negatives of our past teaching experiences? How can these projects becoming a residency site or ourselves?

Is there an existing residency to partner with or that will help advise us in formation?

Is this desirable?

Do we have physician and administrative champions for this here?

Who are they?

Can we deliver the curriculum, clinical and administrative requirements for a residency?
Administration and Operations Worksheets

**Action**

- Yes, we have the mission/vision statements and we already use them. Yes our Board, staff, executives, and clinical providers are supportive of this development.

- Yes, we have reviewed the requirements and know we can deliver them ourselves or we can arrange for their delivery by others in the community who are supportive of this.

- Do we have a clear understanding of how this will be financially supported? How?

- Does our teaching hospital get GME or will it qualify?

- Have we discussed if or how we will share those monies for resident support?

- Do we know GME rules, CMS supervision rules, and can we ensure a plan to be compliant?

- Can we truly administer the data and reporting requirements of the residency in addition to those functions we already have as a Health Center? How?
Administration and Operations Worksheets

Apply

We have all of the Action items in writing. We have reviewed the application process, created our contracts/affiliation agreements, established future teachers, curriculum, etc. We have space sufficient for residents as well as plans to supervise them, pay them, and teach them. We can create panels of patients for them and track as well as shape their clinical experiences for learning. We can incorporate the unique aspects of Health Centers as added elements of the residents’ education so they are a vital part of our mission for service and learn how a Health Center works and is structured.

We have a program director and faculty identified, or we are able to hire faculty as the residency grows.

We have good and clear agreements with our hospital as well as other community clinical providers.

What things are not done or you are not clear on? Once they are all done, you should consider applying for residency accreditation.
20. Frequently Asked Questions

20.1 ADS Update

What is the intent of the specialty specific step in ADS?

The RRC is asking programs to provide information on an annual basis on the most frequent procedures and diagnoses in the FMC, the most frequent diagnoses on inpatient rotations, and patient visit and maternity data. Using quantitative data will allow the Committee to gain a better understanding of the specialty and allow programs to track progress on these key indicators across academic years and to compare their data to national numbers.

20.2 Family Medicine Applications

What is the timetable for submission of an application for a new Family Medicine Program?

The process for an application takes approximately 12 months from the time the application is received in the RRC office until the RRC evaluates the application. Take this into consideration when planning the start date. Consult the MATCH and ERAS for their deadlines, as well. A site visit will be scheduled. When the report of the site visitor is received, the file will be prepared for review by the RRC. Residents should not be appointed prior to accreditation of the program.

Additional details can be found on the ACGME website:

http://www.acgme.org/acWebsite/home/accreditation_application_process.asp

20.3 Sponsorship Changes and Mergers

How do we move an accredited program to another hospital?

The Executive Director of the RRC should be informed of the plans and will advise regarding the steps that are needed. A program is accredited as it was constituted at the time of its last review. It may not be “moved” without approval from the RRC. If a sponsoring entity wants to relocate a residency program from one hospital to another, it may be required to submit a full PIF and probably undergo a site visit.

If the existing primary hospital wants to retain the program, it is suggested that the issue be resolved locally between the hospital and its sponsoring institution. The welfare of the residents who are currently in training must be considered.
How do we change the sponsoring institution?

In order to change the sponsor of a core program, a letter that is signed by the DIO’s of both the relinquishing sponsor and the accepting sponsoring entity should be submitted. (Two separate letters may be submitted.) The existing sponsor should agree explicitly to the change in sponsorship. The proposed sponsor should agree to assume the responsibilities of a sponsoring institution that are outlined in the ACGME Institutional Requirements. The letter should contain a statement on the impact the change will have upon the structure and curriculum of the residency. If the change is approved, the program name and listing will be changed as appropriate.
PART V: FINANCE
21. Using the Finance Toolkit

“If we build it, will they come?”

This has to be one of the first questions that partners must ask in the development of a new residency training program. Today, it is clear that the answer, emphatically, is “Yes.” The cost/benefit analysis of the program should assume that positions offered will be filled.

Over the past six years, allopathic medical schools have responded to the projected physician deficit by expanding nearly 20%. During the same time period, osteopathic medical schools have expanded by 99%. At the current rate of expansion of U.S. medical schools, we will have more physicians graduating from domestic schools annually than there are residency positions to accommodate them in 2014. This is assuming that all of the internationally trained physicians entering US residencies will be displaced along the way, as well.

There has been a steady decline for interest in primary care residencies for several years. Declining interest has been accompanied by a decline in the number of positions offered due to closure and downsizing of existing programs. To meet the current and projected needs of our population, we need a substantial increase in the number of primary care physicians trained.

This Finance Toolkit endeavors to provide the users with a framework to build realistic expectations for those interested in entering into post-graduate training of Family Physicians. Historically, the funds for family medicine training have come from CMS (Medicare) to hospitals in the form of GME payments. Soon, some “community-based ambulatory clinics” will have the option of seeking funding “Teaching Health Center (THC)” payments through HRSA. This Title III program is authorized in section 5508 of the PPACA, and will be administered by the Bureau of Health Professions (BHPPr).

Rules to implement this provision of health care reform have recently been released. HRSA will commit funds for FFY 2011 under the program. The funding opportunity guidance was issued at the end of November. For the 2011 funding round, the application deadline is December 30, 2010. HRSA intends to announce its funding decisions by January 15, 2011. This is necessary to allow residency programs to participate with the National Resident Matching Program. HRSA is aware that it is not likely that any teaching health centers will be represented among the 2011 applicants, and seems resigned to the expansion of existing EHCs in round one of the funding application.

Community health centers have participated as the continuity clinic site for family medicine residents for nearly 40 years. Today, 32 such residency training programs train their residents in CHCs, accounting for 9% of the output of FM residencies. All of the current examples are funded by the GME payment mechanism. Many more employ “satellite” models, and/or send residents to CHCs for defined experiences. We will refer to these settings generically as “educational health centers (EHCs)”, and use the THC terminology to refer specifically to the funding mechanism as authorized in the PPACA, and the programs that will operate using that revenue stream.
22. Development Costs

There are currently no reliable funding sources for the costs of development of new residency training programs. Within the PPACA (section 5508), a new Title VII program (749(a)) is authorized for planning and development of new Teaching Health Centers. However, there is no funding for the program, and little hope that an appropriation will be forthcoming.

A typical timeline for development of an accredited allopathic family medicine program is approximately two years. This assumes that the contemplation and preliminary planning have occurred. The timeline can be graphically depicted:
23. Representative Estimates

The costs incurred during this active development phase can vary widely. The table below presents some representative estimates for each aspect of the typical implementation time period. This proposed budget generates a wide range for the potential start-up costs of a new family medicine residency program - from $600k to $2.8m, depending upon the setting and the development needs. Some of these costs may be amortized and, over time, recouped. A highly motivated community may mobilize lots of volunteer and in-kind service, and get the program going with less than the $600k minimum capital need reflected here.

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Title</th>
<th>Units</th>
<th>Cost/Unit</th>
<th>Total expense</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Program Director</td>
<td>Wage+Ben $200,000 @ .5 FTE for 18 mos</td>
<td>$150,000</td>
<td></td>
<td>Acting/development faculty may, in part or in whole, volunteer time to achieve the mission. Staffing model may vary.</td>
</tr>
<tr>
<td></td>
<td>Program faculty</td>
<td>$160,000 2 Ø .5 FTE x 12 mos</td>
<td>$160,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Program Assistant</td>
<td>Wage+Ben. $90,000 X 18 mos</td>
<td>$135,000</td>
<td></td>
<td>May be provided by hospital or other partner in whole or part as “in kind contribution”.</td>
</tr>
<tr>
<td></td>
<td>Program Clerk</td>
<td>$60,000 X 12 mos.</td>
<td>$60,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruiting</td>
<td>Direct Expense</td>
<td></td>
<td>$20,000 - $40,000</td>
<td>May vary due to size and other variables</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NRMP</td>
<td></td>
<td>$500</td>
<td></td>
<td>Matching program</td>
</tr>
<tr>
<td>Accreditation</td>
<td>ACGME</td>
<td></td>
<td>$10,000</td>
<td></td>
<td>Must select at least one.</td>
</tr>
<tr>
<td></td>
<td>AOA</td>
<td></td>
<td>$10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultations</td>
<td>Legal</td>
<td></td>
<td>$10k - $20k</td>
<td></td>
<td>Consultant expenses variable dependent upon complexity of the setting and other matters. Recommend against economizing in this category.</td>
</tr>
<tr>
<td></td>
<td>Academic</td>
<td></td>
<td>$3000 - $6000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Financial</td>
<td></td>
<td>$5000 - $15,000</td>
<td></td>
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<tr>
<td></td>
<td>GME</td>
<td></td>
<td>$10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>Facilities</td>
<td></td>
<td>$20,000 - $2M</td>
<td>Depending upon availability of space vs need to develop</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equipment</td>
<td></td>
<td>$20,000-$200,000</td>
<td>Computing, teaching aids, furnishing, etc</td>
<td></td>
</tr>
</tbody>
</table>
24. Operational Costs

24.1 Direct Costs

Categories of Cost

A sample chart of accounts and budget (with notes) are attached as a separate part of this toolkit. Some major elements of the cost structure do warrant special note:

- Teaching physician salary and benefits: Typical faculty models place faculty in direct clinical care delivery ~30%, clinical teaching ~50%, and non-clinic teaching and administration (advising, lectures, research, curriculum and rotation development, etc.) ~20%.

- Program Staff: Program assistant and one clerk at a minimum. More may be required.

- Equipment: Most examples are clear cut. Some will be open to judgment. E.g.: It is typical today that residents be provided with a laptop computer, smart phone, and similar devices. They are used to run patient care applications (EMR and others), and also have educational applications. Generally, we recommend attribution to clinical expense.

- Supplies: typically for educational curriculum

- Resident recruitment: Annual cost of selecting residents for the program.

- Graduation

Allocation of Cost

- Teaching physician salary and benefits:

  It is essential to establish a defensible tool and rationale for the allocation of this major expense. First: We recommend that all clinical teaching time be charged as a clinic expense. This is true of time spent in inpatient and hospital settings, and in providing E&M services as well as procedural services. All billing goes out in the name of the teaching physician, and it is essential that his/her expense be booked as clinical during that activity. Residents participate in billable services, but are not credentialed or licensed and therefore cannot perform any billing. There is no educational program revenue generated by patient care activity. Residents should not be recorded on the UDS report. Their visits should be attributed to the teaching physician.

- Occupancy:

  Facility expenses should be prorated depending upon the portion of space occupied by the program

- Resident physician salary and benefit: 100% educational expense.

24.2 Indirect Costs

The notion of indirect expenses in GME is well recognized and is institutionalized in the CMS payment to hospitals. And, while it is recognized that the rationale is equally applicable to the outpatient setting, there has never been a serious attempt to quantitate that cost for the simple reason that there has been no payment for those expenses. With the PPACA, there is a need to understand these costs as they are explicitly reimbursable under the language of the legislation. Not surprisingly, this has been a thorny issue for HRSA in the rule-making process.

To define and understand their indirect expenses, we recommend that educational health centers adopt a method that compares its expenses and revenues associated with the operation of the EHC with those that would be expected from...
the same clinic if it were to operate under its customary practice model. This methodology captures both the true differences in net revenue (cost) of operating the center, as well as the lost opportunity associated with the model. An example of the analysis is as follow:

**Step 1:**

For the subject clinic, operating a defined schedule, determine the total of all expenses, including support staff, occupancy costs, supply costs, allocated costs, etc. Note that the teaching physician cost should be fully included, but that resident costs should be excluded (as they are educational rather than clinical expenses). Add back all net revenue generated by this staffing model.

**Step 2:**

Do a similar projection of expenses and revenue that would be attributed to the same space, operating the same schedule, if it were to operate under the typical model of the agency. Ideally, the agency would have other internal comparators. The use of externally established benchmarks will likely lead to an overestimation of the indirect expenses.

**Step 3:**

Subtract the product of Step 2 from the product of Step 1. The result should be a reasonable and rational estimation of the indirect expense.

We expect that the typical result will demonstrate that the EHC model is slightly less efficient, on average, than the customary practice model. There are many reasons for this, but paramount among them is that the space and staffing requirements of a resident physician providing outpatient services is essentially the same as for an employed family physician, but the anticipated visit volume is substantially lower. The above exercise is prudent to permit the board to arrive at an informed decision. We believe that the decision to deploy a resident and faculty work force to provide primary care at a center of the agency should be a board decision.
25. Revenue

25.1 Educational Program Revenue

There is limited revenue related to the educational program. Remember that revenue generated from patient care, even when a resident participates in that care, should be classified as clinical revenue. Many states do provide some budget support in order to support an appropriate supply of primary care physicians. Typically, this is limited. Some medical schools pay for student rotations, especially if the site regularly participates in providing education to meet the students’ core curriculum requirements. If such student rotations are the responsibility of the residency program, then the revenue (expense) of the rotation should be a part of that budget. Typically, such payments only cover the costs of hosting the student(s).

25.2 Clinical Revenue

All revenue from patient care services must be billed under the credentialed and licensed physician. In an educational encounter, that will always be the teaching physician, and never the resident physician. As discussed previously (III. B. Indirect Costs) the residency program does not generate a net positive balance when compared to the other opportunities to deploy the resources and staff needed to produce visits and revenue. It is useful to align the revenues and expenses as recommended here so that participating hospitals and other partners can clearly see that the enterprise is not generating clinical revenue to pay for the teaching program. Other revenues are needed to entirely fund educational expenses.

Furthermore, if the teaching hospital does not demonstrate payment of certain expenses, they cannot claim the resident on their cost report(s), and will not receive payment for the resident. These “pass-through” payments are made by CMS ($9B per year) and, in most states, by Medicaid ($3B per year). GME payments from Medicaid and Medicare have been the predominant source of support for all residency training programs historically, including those that operate in community health centers (educational health centers). These payments will likely consider to be an important source of support even when “Teaching Health Centers” become a reality, as it appears likely that CMS will work with HRSA to make such payments for the portion of the THC resident FTE that is rotating in the teaching hospital.

The point has been made that there is currently no source of funding for start-up costs of a residency program. This creates a significant cash flow issue for teaching hospitals and sponsors. Hospitals may request interim payments once residents begin rotating as part of a new program. These are subject to reconciliation once the cost report is finalized.

It is in the advantage of all participants to maximize transparency in the collaboration needed to conduct the program. The teaching hospital depends upon the educational program so that accurate reports can be prepared and revenues maximized, and those revenues are a matter of public record.

25.3 Partner/Hospital Revenue

Teaching hospitals are, by far, the largest payer of residency expenses. The simple reason is that teaching hospitals are the largest recipient of payments specifically for residency education.

CMS GME Payments

While both Medicare and Medicaid make GME payments, we will only discuss those payments made through the CMS/Medicare IPPS program. Only 41 state Medicaid programs fund GME. Typically, they follow the system established by
Medicare to identify educational costs on the cost report and to repay them, but the amounts and exact methods vary widely. Discussing Mcd GME is beyond the scope of this summary, and is thoroughly presented in a recent summary.

**Direct (GME)**

Covers Teaching institutions for costs directly related to educating residents:

- Residents’ stipends/fringe benefits
- Salaries/fringe benefits of supervising faculty
- Other direct costs
- Allocated overhead costs

Covers costs “proportionate” to the use of the teaching hospital by Mcd beneficiaries.

Is deemed, by Mcd, to be payment in full for all services provided by the resident. Mcd has complex rules to insure that they are only paying for the services provided by the “teaching physician”.

Basic methodology underlying DGME payments:

- Step 1: Determine hospital-specific per resident base year cost amount (PRA) (generally 1984)
- Step 2: Update (to current year) base-year per resident amount (PRA) for inflation
- Step 3: Multiply the updated PRA by the number of residents in the current year (this amount capped by BBA resident limits)
- Step 4: Multiply by the hospital’s ratio of Medicare inpatient days/total days

The PRA is a critical variable. It is assigned to the teaching hospital and is based upon:

- The rate established if the institution was a teaching hospital in 1984; or
- The lesser of the audited actual allowable costs or the average PRA of a group of comparison hospitals.

GME consultants can assist in clarifying both the allowable cost bases PRA, and the CMS comparator generated by averaging the geographic peers.

It is important to note that per resident costs in family medicine programs are substantially higher than any other program. No other discipline requires the level of commitment to a continuity ambulatory practice that family medicine does. The facilities and staffing required drive that expense. Consistent with that, it is typical that approx. 2/3 of the GME funds received are for direct expenses, and 1/3 for IME. In the rest of the GME world, that ratio is exactly reversed.

Payments are limited by the resident FTE “cap”, which is based upon the 1996 level of resident participation in the institution. For NEW teaching hospitals, the cap is established based upon the FTE residents in the institution 3 years following the start of the first sponsored program.

**Indirect (IME)**

Compensates teaching hospitals for higher inpatient operating costs due to:

- unmeasured patient complexity not captured by DRG system
- other operating costs associated with the presence of GME programs (more tests, lower productivity, etc)

It is a percentage add-on payment to basic Medicare per case (DRG) payment

IME payments are made only to hospitals.

Calculating the IME Operating Adjustment:

The IME adjustment is based on statistical analysis using intern and resident-to-bed ratios (IRB)

- % per case add-on =
• Multiplier X ((1 + IRB)0.405 - 1)

• IRB = intern to resident bed ratio (reiterating MCR’s “proportionate” payment)

• Short hand for IME: Hospitals get about a 5.5% increase in DRG payments for every 10-resident increase per 100 beds

Community Benefit

Many hospitals provide program support that exceeds their GME payment amounts. The teaching hospital can readily make the case such payments are a contribution to “community benefit”.

Other Partners

A few residency programs are lucky enough to have another significant payer. Typically, this is an endowment or a local charitable trust. Others receive operational gifts the old fashioned way: they beg for them. Grants (HRSA title VII and others) are useful if the proposed project fits well with the mission and vision of the enterprise (or, ideally, is a project that there was a need or strong desire to achieve regardless of a grant opportunity). Typically, such funds can be used for start-up and capital costs, but do not fund operations. HRSA section 330 grants are, of course, the notable exception to that rule.

25.4 Teaching Health Center

For the FFY 2011 funding opportunity, HRSA has announced a funding level of up to $150,000 per resident full-time equivalent (FTE) per year. The PPACA language specifies that the act provides for payment of both direct and indirect expenses incurred by the THC. HRSA has adopted an adjusted CMS per resident amount (PRA) as its basis for determination of the direct GME component. It is anticipated that the adjusted national PRA will be approximately $100,000 per resident FTE per year. HRSA makes it clear that they do not have a mechanism for determination of the indirect GME expenses. They invite applicants in this initial round to present mechanisms to support their requests for indirect GME to cover the costs in the THC. Anticipate that a defined mechanism will be presented in the application for 2012 new positions.

(Editorial comment: The maximum award amount may be sufficient, in most settings, to cover the incremental costs of expansion of an existing program. They will likely fall short of fully funding a new residency program and, specifically, do not cover start-up capital. To the extent that funds are adequate to cover the amortized start-up costs, there is the potential of reimbursement of a portion of the expense over time.)
26. Finance References

- PDF of AAMC/AOA ppt presentation to congress re: GME financing, 4/22/2009
  
  http://www.aamc.org/newsroom/presskits/gme-thebasics.pdf

  Summary of the GME program, and impact of the PPACA.

- Medicaid Direct and Indirect Graduate Medical Education Payments: A 50 State Survey 2010: AAMC; pdf
  

  This is an extremely useful tool for understanding Medicaid participation in GME in your state. The author has been helpful in making state specific information accessible.

- Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident and Advisor Needs to Know (PDF) AAMC
  

  A primer on GME and IME payments.

- Medicare Direct Graduate Medical Education (DGME) Payments (AAMC, pdf)
  

  Two page summary of the GME program and its legislative history.

- Medicare Indirect Medical Education (IME) Payments (AAMC, pdf)
  

  Two page summary of the IME program and its history.
• AAMC Summaries of DGME and IME Sections of the Health Reform Bill and CMS Proposed Rules Implementing These Provisions


This 37 pg AAMC publication provides a detailed view of the changes to the GME program pursuant to the PPACA.


This is a detailed look at EHC’s in Waco, Texas; Santa Fe, NM, Yakima, WA; and Worcester, MA.

• Family Medicine Residency Training in Community Health Centers: A National Survey Academic Medicine; Issue: Volume 85(10), October 2010, pp 1640-1644; Morris et al

• Shortages of medical personnel at community health centers: implications for planned expansion. JAMA. 2006 Mar 1;295(9) Rosenblattt et al

**Accreditation**

• ACGME: Allopathic (MD) Accreditation: Family Medicine Menu

http://www.acgme.org/acWebsite/navPages/nav_120.asp

Web site only. Links to all essential documents, forms, and applications.

• AOA: Osteopathic (DO) Accreditation Standards for Family Practice


**Academic Family Medicine**

• Residency Program Solutions

Knowledgable consultancy on all aspects of Family Medicine residency education available.

- Society of Teachers of Family Medicine
  
  http://www.stfm.org/

- Osteopathic Residency Assistance Program
  
  http://www.acofp.org/education/ORAP.aspx

- Link to AAFP/Robert Graham Center site specific to GME funding, where most recently available tables of actual GME payments to teaching hospitals can be downloaded. This is for existing teaching hospitals only, and provides only totals for all GME programs of the hospital.


**Educational Health Center Resources**

- Educational Health Center Initiative
  
  http://nwrpca.org/education-health-center-initiative.html

  The resource site of the collaboration of NWRPCA, CHAMPS, and the University of Washington School of Medicine, Department of Family Medicine and WWAMI Program.

- GWU: Medical Education Futures Study
  
  http://www.medicaleducationfutures.org

  Search: teaching health center

- HRSA guidance for THC GME application:
  
  https://apply07.grants.gov/apply/UpdateOffer?id=22673
27. Some Financial Notes regarding Residency Expenses and Reporting

Revenue sources to support a residency include:

- **GME**
  
  Sponsoring hospital passes money through to the residency. An agreement must be in place and will define what the payment will include.

- **Medicare Cost Report**
  
  Faculty outpatient time is included as a direct cost on the cost report, just as a physician’s time is included on a cost report. The calculated rate will be reimbursed, up to your UPL.

- **State Medicaid**
  
  Not all states have a Medicaid reimbursement for residencies. For those states that do, payment is typically made to the teaching hospital.

- **Grants**
  
  Federal and State Grants (and other state budget support) may be available. HRSA has awarded some funds and others will be awarded for Teaching Health Centers when the regulations are developed.

*Expenses of a Residency*

Residencies should be separated from other programs and expenses should be tracked accordingly. Examples of expenses specific to a residency include:

- **Resident Wages and Benefits (~50% of program budget)**

- **Faculty time spent in a classroom setting or administering the non-patient care related activities, such as preparing for classroom time, curriculum administration, resident recruitment and advising, etc. (~25% of program budget)** Note that this does not include the clinical teaching (precepting) by the faculty in the CHC.

- **Other staffing support for the residency program, such as a Residency Coordinator. (~10% of program budget)**

- **Other costs such as: promotion of the residency, Licenses and Examinations, Supplies, Graduation, CE, etc. (~5 - 10% of program budget)**

- **Allocated Administrative Support and Occupancy expenses. (~10% of program budget)**

*Chart of Accounts (See Next Section)*

Depending upon your setting, the COA could be simpler than the example. Ideally your chart of accounts is broken into segments. As a Residency Program is started separate COA codes should be added to accurately capture costs. A good COA will enable you to capture data for the:

- **Internal Budget**

- **UDS Report**

- **Medicare Cost Report**

- **Internal Management Reporting**

*CHC Medicare Cost Report*

Faculty are the licensed physicians who oversee or precept the residents, providing education and clinical direction and judgment.
Per Medicare rules, the services provided can ONLY be billed under the licensed faculty. Residents do not bill for services. They see the patient but it is under the watchful eye of the licensed faculty.

Therefore, minimum productivity is calculated by multiplying the outpatient FTE of the faculty times the minimum productivity requirement (4,200/FTE) only. Resident FTEs are not included in the FTE calculation nor is the resident time combined or aggregated with the faculty.

Faculty spend time in the hospital, in the outpatient setting, in the residency program (lectures, advising, curriculum, etc.), and in administration of the clinic and/or corporation. These four categories are all treated differently on the cost report.

- Hospital Time
  Un-allowed on the Medicare Cost Report

- Outpatient Time
  Allowed as direct physician time on the cost report. Includes time spent in direct patient care and in clinical teaching (precepting) residents in the outpatient clinic. Maximizing these amounts will increase your cost rate.

- Residency
  This would be allocated to the residency training program and is un-allowed on the cost report

- Administration
  This is time truly spent on administration of the entire agency. This excludes time that faculty spend in administration of the residency program. The Medical Director’s administrative time is an example of this.

The allocation of Faculty expenses are generally coded between departments using a time study as the backup that supports the allocation.

The schedule used for allocation of faculty time can be quite complex. A time tracking system should be in place that enables you to track time in the hospital, in the outpatient setting, in the residency program (lectures, advising, curriculum, etc.), and in administration of the clinic and/or corporation. This creates the justification of the allocation of dollars between these cost buckets.

Example: Let's assume a physician earning 200K spends 25% of her/his time in each of the four categories noted. 50K would be direct physician time, allowable on the cost report; 50K would be carved into unallowable to the hospital; 50K unallowed to the residency and 50K would be allocated to admin. Admin costs are distributed based on the ratio of direct to unallowed, so the 50K admin would be allocated 66% unallowed and 34% allowed.

As noted, all charges are billed under the faculty physician’s license. The resident is not allowed to bill. Therefore all faculty time overseeing services of residents is included in direct allowable cost and the outpatient faculty FTE is used to calculate minimum productivity. Resident FTE is not included in the minimum productivity calculation.

Generally all other direct outpatient costs, such as nurses, M,A.s, medical supplies, etc are treated just like they are normally treated on the cost report.

If the residency has specialty physicians provide training and oversight to the residents and if a billable visit is generated, the time of these specialists should be captured under direct.

Medicare rules allow FQHCs to impute costs for volunteer professionals. This assumes the volunteers are seeing patients and producing billable visits. If this is true create systems to capture these costs.
# 28. Example Chart of Accounts

<table>
<thead>
<tr>
<th>General Ledger</th>
<th>Programs</th>
<th>When you begin a residency the only program you will need to add to your COA is Residency</th>
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</thead>
<tbody>
<tr>
<td>1000</td>
<td>General Checking</td>
<td>1 Medical</td>
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<tr>
<td>1030</td>
<td>Investments</td>
<td>2 Dental</td>
</tr>
<tr>
<td>1070</td>
<td>Petty Cash</td>
<td>3 Pharmacy</td>
</tr>
<tr>
<td>1210</td>
<td>Grants Receivable</td>
<td>4 Residency</td>
</tr>
<tr>
<td>1250</td>
<td>Pledges Receivable</td>
<td>Expenses would include the residence stipends, benefits, ed materials, faculty time spent on direct ed (class room as an example). Facility and Admin will be allocated based on the ratio of each program total to all direct program total.</td>
</tr>
<tr>
<td>1310</td>
<td>Accts Receivable</td>
<td>8 Facility</td>
</tr>
<tr>
<td>1315</td>
<td>Allowance for Bad Debt</td>
<td>9 Admin</td>
</tr>
<tr>
<td>1510</td>
<td>Prepaid Expense</td>
<td></td>
</tr>
<tr>
<td>1810</td>
<td>Furniture &amp; Equipment</td>
<td>10 Happy Valley Community Health</td>
</tr>
<tr>
<td>1815</td>
<td>Accum Depr (F&amp;E)</td>
<td>20 Friendly Faces Health Center</td>
</tr>
<tr>
<td>1820</td>
<td>Land</td>
<td>30 Joyful Family Health Center</td>
</tr>
<tr>
<td>1830</td>
<td>Buildings &amp; Improvements</td>
<td>40 Lot’s of Smiles Dental</td>
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<tr>
<td>1835</td>
<td>Accum Depr (Buildings)</td>
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</tr>
<tr>
<td>1841</td>
<td>Leasehold Improvements</td>
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<tr>
<td>1845</td>
<td>Accum Depr (LHI)</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>Accounts Payable</td>
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<tr>
<td>2200</td>
<td>Salary and Wages Payable</td>
<td>100 General Medical</td>
</tr>
<tr>
<td>2310</td>
<td>FIT Payable</td>
<td>101 Physicians/Faculty</td>
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<tr>
<td>2320</td>
<td>FICA Payable</td>
<td>102 Psychiatrist</td>
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<tr>
<td>2340</td>
<td>State L&amp;I Payable</td>
<td>103 PA</td>
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<tr>
<td>2410</td>
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<td>104 ARNP</td>
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<tr>
<td>2420</td>
<td>Dental Premiums Payable</td>
<td>105 RN</td>
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## 401K Contributions

<table>
<thead>
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<td>401K Employee Contribution Payable</td>
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<td>200</td>
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<tr>
<td>2440</td>
<td>401K Employer Contribution Payable</td>
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<td>2445</td>
<td>401K Employer Match Contribution</td>
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## Other Payables

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<td>Other Payroll Payables</td>
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<td>2493</td>
<td>Garnishments Payable</td>
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<td>2494</td>
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## Accrual Payables

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<td>Business Taxes Payable</td>
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## Current Portion of Long-Term Debt Leases

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<td>Current Portion of Long-Term Debt Leases</td>
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<td>2550</td>
<td>Current Portion under Capital Leases</td>
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## Mortgage Payables

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<td>Mortgage Payable</td>
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<td>2640</td>
<td>Pass-Through Payables</td>
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## Leases Payable

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## Reimbursement Payables

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## Residency Support

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## Other Payroll Payables

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## For detail breakdown of subsets of each program consider adding a department called residency.

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<td>Purchased Services (Locum Tenens)</td>
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<td>Purchased Services (Support Staff)</td>
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<td>Purchased Services (Technical Assistance)</td>
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<td>Contract Svcs (Interpreters)</td>
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# 29. Example Budget

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## NOTE
Typically the GL won’t include separate accounts for each department. This is a redundancy, however for ease of presentation we have broken these out by GL Account.
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Notes: This table represents a sample of data from the Education Health Center Initiative Resource Toolkit. The data includes various account codes and titles along with corresponding debit balances and control numbers. The table is used for internal financial tracking and compliance purposes.
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The Education Health Center Initiative Resource Toolkit

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# 30. Sample Cost Report

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<th>TOTAL</th>
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<td>46.02 Equipment maintenance / rental</td>
<td>18,000</td>
<td>18,000</td>
<td>213,750</td>
<td>213,750</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>46.03 interpreters services</td>
<td>18,000</td>
<td>18,000</td>
<td>213,750</td>
<td>213,750</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>47 Other Contact Services - Admin</td>
<td>18,000</td>
<td>18,000</td>
<td>213,750</td>
<td>213,750</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>48.01 EPM support</td>
<td>18,000</td>
<td>18,000</td>
<td>213,750</td>
<td>213,750</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>48.02 Bank Fees / Misc</td>
<td>18,000</td>
<td>18,000</td>
<td>213,750</td>
<td>213,750</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>49 SUBTOTAL Administrative Costs</td>
<td>745,680</td>
<td>18,000</td>
<td>763,680</td>
<td>763,680</td>
<td>763,680</td>
<td>763,680</td>
</tr>
</tbody>
</table>

84
<table>
<thead>
<tr>
<th>COST CENTER</th>
<th>COMPENSATION</th>
<th>OTHER</th>
<th>TOTAL</th>
<th>RECLASSIFICATIONS</th>
<th>ADJUST INCREASE (DECREASE)</th>
<th>NET EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>50</td>
<td>TOTAL OVERHEAD (Lines 37 and 49)</td>
<td>745,680</td>
<td>2,271,517</td>
<td>3,017,197</td>
<td>-</td>
<td>3,017,197</td>
</tr>
</tbody>
</table>

**COST OTHER THAN RHC/FQHC SERVICES**

<table>
<thead>
<tr>
<th>COST CENTER</th>
<th>COMPENSATION</th>
<th>OTHER</th>
<th>TOTAL</th>
<th>RECLASSIFICATIONS</th>
<th>ADJUST INCREASE (DECREASE)</th>
<th>NET EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>51 Pharmacy</td>
<td>120,000</td>
<td>296,098</td>
<td>416,098</td>
<td>416,098</td>
<td>416,098</td>
<td>51.00</td>
</tr>
<tr>
<td>52 Dental</td>
<td>499,200</td>
<td>475,862</td>
<td>975,062</td>
<td>975,062</td>
<td>975,062</td>
<td>52.00</td>
</tr>
<tr>
<td>53 Optometry</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>53.00</td>
</tr>
<tr>
<td>54 Residency</td>
<td>200,000</td>
<td>310,155</td>
<td>510,155</td>
<td>510,155</td>
<td>510,155</td>
<td>54.00</td>
</tr>
<tr>
<td>55 Other Non FQHC (including lab)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>55.00</td>
</tr>
<tr>
<td>56 Patient Transportation</td>
<td>4,680</td>
<td>4,680</td>
<td>4,680</td>
<td>4,680</td>
<td>4,680</td>
<td>56.00</td>
</tr>
<tr>
<td>57 SUBTOTAL - Cost Other than RHC/FQHC (Lines 51 - 56)</td>
<td>819,200</td>
<td>1,086,795</td>
<td>1,905,995</td>
<td>-</td>
<td>1,905,995</td>
<td>-</td>
</tr>
</tbody>
</table>

**NON REIMBURSABLE COSTS**

<table>
<thead>
<tr>
<th>COST CENTER</th>
<th>COMPENSATION</th>
<th>OTHER</th>
<th>TOTAL</th>
<th>RECLASSIFICATIONS</th>
<th>ADJUST INCREASE (DECREASE)</th>
<th>NET EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>58 B&amp;O Taxes (WA State)</td>
<td>150,426</td>
<td>150,426</td>
<td>150,426</td>
<td>(150,426)</td>
<td>(0)</td>
<td>58.00</td>
</tr>
<tr>
<td>59</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>59.00</td>
</tr>
<tr>
<td>59</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>59.00</td>
</tr>
<tr>
<td>60</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>60.00</td>
</tr>
<tr>
<td>64 SUBTOTAL - Non-Reimbursable Costs</td>
<td>-</td>
<td>150,426</td>
<td>150,426</td>
<td>-</td>
<td>150,426</td>
<td>(150,426)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COST CENTER</th>
<th>COMPENSATION</th>
<th>OTHER</th>
<th>TOTAL</th>
<th>RECLASSIFICATIONS</th>
<th>ADJUST INCREASE (DECREASE)</th>
<th>NET EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 TOTAL COSTS (Lines 25, 50, 57, and 61)</td>
<td>3,272,640</td>
<td>4,551,378</td>
<td>7,824,018</td>
<td>-</td>
<td>7,824,018</td>
<td>(150,426)</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>COST CENTER</th>
<th>COMPENSATION</th>
<th>OTHER</th>
<th>TOTAL</th>
<th>RECLASS TRIAL BALANCE</th>
<th>ADJUST INCREASE (DECREASE)</th>
<th>NET EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2009</td>
</tr>
<tr>
<td></td>
<td>FQHC direct</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2,750,399</td>
</tr>
<tr>
<td></td>
<td>non FQHC direct</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,905,995</td>
</tr>
<tr>
<td></td>
<td>Total Direct</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$4,656,394</td>
</tr>
<tr>
<td></td>
<td>Total Indirect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$3,017,197</td>
</tr>
<tr>
<td></td>
<td>FQHC ind</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,782,172</td>
</tr>
<tr>
<td></td>
<td>non FQHC ind</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$1,235,025</td>
</tr>
<tr>
<td></td>
<td>Total FQHC costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$4,532,571</td>
</tr>
<tr>
<td></td>
<td>Less cost of vaccines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Encounters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>42,900</td>
</tr>
<tr>
<td></td>
<td>FQHC Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$105.65</td>
</tr>
</tbody>
</table>
PART VI: LEGAL
31. Legal Resources

- EHCI Conference Presentation, October 2008 (Jacqueline C. Leifer, Esq.)
  

- Collaborations between Federally Qualified Health Centers and Residency Programs (Jacqueline C. Leifer, Esq.)
  
  http://www.teachinghealthcenter.org/resources.html

- Legislation on THCs, March 2010
  

- HRSA Resources
  
  http://www.hrsa.gov/grants/apply/assistance/teachinghealthcenters/

- NACHC Articles
  
  Issue Brief #26, Systems Development Services; Key Considerations in Developing Residency Training Program Collaborations (Apr 20, 2004)

  Info. Bulletin #12, HR Series: Using Affiliations with Residency Training Programs to Increase Your Health Center’s Clinical Capacity (June 2009)

- In addition, the ACGME website is a good source for learning about residency programs generally
  
  http://www.acgme.org/acWebsite/home/home.asp

- Other key accrediting bodies are the AOA’s Commission on Osteopathic College Accreditation
  
  http://www.osteopathic.org/index.cfm?PageID=acc_predoc

- See Toolkit Appendix for:
  
  AAMC Summary of TCH Sections in the PPCAA

  AHEC Role in Promoting Effective THCs