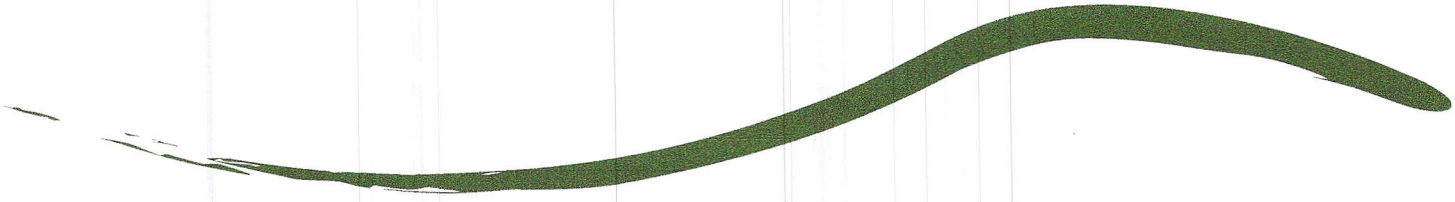
# Commission on Family Medicine

# STRATEGIC PLAN
# &
# BUDGET REQUEST:
# FY 2011/2012



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**Commission on Family Medicine: Budget Request FY 2011/2012**

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# COMMISSION ON FAMILY MEDICINE

***PROGRAM DESCRIPTION; July 1, 2010***

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**STATE LEGISLATURE**

**COMMISSION ON FAMILY MEDICINE (COFM)**
**$1,738,846 for Family Medicine Residency Training**

**EXECUTIVE DIRECTOR: Antonio Prado-Gutierrez, MPH, MA**

**FTE: 0**

The Long Bill reports zero FTE for COFM, which does not have statutory budget authority, and thus, cannot hire staff. The three employees responsible for carrying out the administrative and programmatic functions of COFM are formally employed (as explained in "Background Information" by the Colorado Association of Family Medicine Residencies (CAFMR), a not-for-profit organization that supports and complements the legislative mandate of COFM. The result is a highly effective and unique private-public model, which has been a key player in helping to address Colorado's need for family (primary care) physicians. The Director of Health Care Policy and Director of Operations work under the immediate supervision of the Executive Director, who reports directly to both the chair of COFM and the President of CAFMR.

**Funding**

*CFE:* $1,738,846

*MCF: $1,738,846*
*MGF: $869,423*

*Note:* All of the state funding is disbursed to each of the nine Family Medicine residencies in an equal amount ($193,205) for FY 2010/11) to support directly the training of family medicine residents. No state dollars are used to support the administrative and programmatic functions of COFM.

## Background Information

Introduction: The Key Benefits of the Public-Private Enterprise

The Commission on Family Medicine (COFM) is a twofold collaborative and successful model of valuable service to the people of Colorado in a vital area: health care. First, it is a public-private venture--an enterprise that brings together nine private health care facilities to benefit the welfare of the State in collaboration with citizen representatives (consumers of health care) from Colorado's seven Congressional Districts. Secondly, the Commission brings together these nine businesses (the family medicine residencies and their sponsoring hospitals) to coordinate their efforts in training family physicians to meet the needs of the people living in Colorado for primary care.

The Commission is an effective illustration of what can be achieved when vision is broadened to include **all** of Colorado and a tradition of cooperation and teamwork is fostered. The fact that the components of the Commission are not individual departments or divisions but distinct programs, that are controlled by competing health care systems, heightens this value of collaboration.

The legislation underpinning this public-private collaboration is brief and explicit in its charge. However, comprehending and valuing the dual, effective collaboration that defines the Commission requires reflection on three striking themes.

*Why Should the State Fund the Commission?*

The first topic usually comes in the form of a question: **Why should the State participate in this endeavor? Simply put, State funds form the nucleus that spawns into the highly effective collaboration of Colorado's nine Family Medicine residencies.** With $869,423 of (Medicaid) General Funds (plus an equal amount of federal Medicaid matching funds), Colorado leverages over 59.3 million dollars expended, **in the aggregate,** by the nine family medicine residencies to train 188 residents during FY 2010/11. **It is significant to note that these funds are not in the hands of COFM. COFM has not responsibility for the expenditure of these funds. These are dollars that the nine affiliated hospitals expend in operating a Family Medicine Residency.** This is a great return on investment! Furthermore, State funding influences and positions the individual residencies to focus on the welfare of the entire State rather than simply concentrating on meeting the specific needs of its sponsoring hospital and service area. This partnership positively impacts five significant areas:

- Recruitment of Family Physicians to rural and underserved communities;
- Retention of family physicians in rural and underserved communities by requiring Family Medicine residents training in Colorado to complete a rotation in a rural or underserved community;
- Health care for uninsured, Medicaid and Medicare patients; and

- Recruitment of medical students to train in the State's Family Medicine residencies, especially in a time of a radical decrease in medical students' interest in primary care.
- Collaboration in the three-year Patient Centered Medical Home Project described in "Hot Issues".

**While State funds are a small percentage of the total dollars required to training Family Physicians in Colorado, without State funding, the Commission ceases to exist, since it has no other sources of revenue, and the collaboration of the nine Family Medicine residencies ceases**. All funding for the Commission is captured under the line item "Residency Training". COFM receives no State funding for its administrative and programmatic functions. The Colorado Association of Family Medicine Residences, as explained below, agreed with the Joint Budget Committee to fund all programmatic and administrative activities and functions of COFM. Furthermore, State funding is an incentive for the residencies to collaborate in the areas noted above, as well as in other projects such as promoting primary care as an essential element in framing a cost-effective, quality health care system. State funding to the residencies also provides a strong rationale for the residencies to:

- Require their residents to complete a rotation in a rural and underserved community: Residencies may not be reimbursed by Medicare Graduate Medical Education funding when a resident is away from the program. In these instances. State funding helps to offset this loss of revenue.
- Allow their directors to spend several days a month on Commission business.
- As of FY 2004/05, support all of the Commission's operational expenses through the Colorado Association of Family Medicine Residencies (CAFMR), described below.

The presence of a Family Medicine residency is a strong asset for providing the needed supply of primary care physicians in Colorado. This funding results in a steady supply of Family Physicians to Colorado. Historically 85%-90% of the residents come from outside of Colorado to train in Colorado's nine nationally recognized programs. The FY 10/11 applicants to the nine Family Medicine residencies came from 110 medical schools outside of Colorado. The new first year residents now training in the State's Family Medicine residencies are graduates of 40 medical schools from states outside of Colorado. With no office responsible for recruiting physicians into Colorado, but because of the Commission's operations, Colorado boasts a strong presence of Family Physicians (54% of primary care physicians), including in rural areas, where Family Physicians make up 73% of all primary care physicians. The collaborative effort has created a cadre of strong programs, which, coupled with Colorado's reputation as a desirable place to live, are key marketing points in recruiting medical students from throughout the country to train as family physicians and stay in Colorado. As noted in the "Hot Topics" section, the significant decrease over the past ten years in the number of medical students opting for Family Medicine has gravely escalated the competition for this shrinking pool.

*Collaborative Competition*

The second consideration emphasizes that the participating residencies are not only in contention with each other for residents but are departments of competing hospital systems. "Collaborative Competition" is the title that the

Commission's Executive Director has given to a presentation on the history, operations and effectiveness of this organization. The development and impact of this feat cannot be exaggerated. Without state intervention and financial participation, this collaboration to benefit all the people of Colorado, especially rural and underserved areas, would not exist.

A Health Care Safety Net

The third theme is the direct contribution made by the residencies to increase access to primary care services, especially for the vulnerable populations of the State. This contribution extends beyond meeting its mandates dictated in statutes. **While this legislation is silent about the residencies' role as providers of primary care, the Family Medicine training centers are part of Colorado's "safety-net**". COFM data estimate that the combined number of Medicaid (35.5%) Medicare (13.6%) and uninsured (21.4%) patients represent 70.5% of the 73,000 patients served by the medical practices of Colorado's nine Family Medicine residencies during FY 2009/10. The net result is that 51,465 Medicaid, uninsured and Medicare patients receive their health care at one of the nine Family Medicine residencies. This is a 3.7% increase over last year. The federally funded safety net clinics (Community Health Centers) are already hard-pressed to carry out their mandate of caring for indigent populations. Waiting lists of up to six months for Medicaid patients to receive service at these centers are not uncommon and up to two years for individuals without insurance. Without the presence of the Family Medicine residencies, access for the Medicaid, uninsured and Medicare populations would further deteriorate. COFM expects that the number of patients in these three categories served by the nine Family Medicine residencies increased this past year because of the current economic climate.

In addition, the gratuitous and discounted medical care provided by the faculty and residents at the nine Family Medicine residencies exceeds many times over the $1,738,846 state funding appropriated for this fiscal year. Not to be overlooked is the "downstream" savings that result from access to primary care as a deterrent to more costly emergency, specialty and hospital care.

An exacerbating factor in meeting the needs of these vulnerable populations is the increasing lack of mental health services. Training in basic mental health is part of a Family Medicine residency's curriculum. All residencies have mental health professionals on staff. One residency business manager or administrator succinctly captured this issue. She writes: "We are seeing more and more patients who have mental health issues and have nowhere to be seen. Our mental health provider is hard to get into. There are people on the streets that should not be out there."

Colorado's Family Medicine residencies have also created unique programs designed to be preventive and keep their community's population out the emergency room and the hospital. These include the following:

- Early intervention with parents of children two years and younger to learn the different stages of development and immunization needs;

- Community based education to prevent youths smoking and increasing children's use of bicycle helmets;
- Medication Brown Bag: Forums to educate patients with multiple prescriptions about proper use of medications;
- HIV/AIDS clinics;
- Clinic for migrant farm workers;
- Prenatal care clinics;
- Rx Health Project: A program designed to prevent obesity;
- A program that provides cardiac risk assessment and education for low income patients at risk of heart disease;
- Support group for people with Hepatitis C and Type II Diabetes;
- Case management addressing the multiple psycho-social unmet needs of indigent patients before these become serious enough to require high-cost care;
- Providing mental health services under a collaborative model in a primary care setting;
- Group visits for chronically ill patients;
- Integrated care leading to change in patients' health behavior; and
- Public health programs within the community.

In summary, as centers of education in Family Medicine residency training, Colorado's Family Medicine residencies through the Commission not only fulfill the legislative mandate of meeting the State's need for Family Physicians, but also provide health care to populations who increasingly are finding it difficult to access needed care. It is important to note that providing this value-added service to the State is becoming progressively more challenging as meeting the demand for service by indigent populations encroaches on the Family Medicine residencies' chief mandate and mission: train Family Physicians. Through COFM the nine family Medicine Residencies have developed the objective of having Medicaid, Medicare and indigent patient represent at least 60% of the people they serve in their training centers.

Funding

The Commission Expenses budget line did not exist prior to FY 1991/92. A routine audit of the University of the Colorado Health Sciences Center, the fiscal agent for the Commission, recommended that the Commission parcel out from the Residency Training line the funding used to support its projects, activities and administration. Expense and Travel lines (totaling $97,466) were added to the FY 1992/93 Long Bill and the Residency Training line was reduced by this amount. Several years later, the JBC accepted its staff recommendation that the two expense lines be combined into "Commission Expenses". A number of JBC mandated reductions for travel account for the $85,868, which were integrated into the Residency Training line, as noted above, in FY 2004/05.

With no increases in State funding for Commission Expenses since the creation of the line, CAFMR has consistently expanded its financial support of the Commission's projects and operations. CAFMR is a derivative of and works in tandem with the Commission to meet its legislative charge. The residency directors, who by statute are members of the Commission, formed this association in 1988 and incorporated as a 501-C-6 in 1995. While CAFMR focuses on education, the Commission concentrates on the welfare of the people of Colorado. CAFMR's work fully supports the

Commission's legislative mandate. CAFMR has significantly strengthened the collaboration between the nine residencies, and, thus, has enhanced the scope and effectiveness of the Commission. Simply put, by its very nature CAFMR is but a different face of the Commission. All of CAFMR's projects and activities directly support the Commission and bolster its effectiveness in fulfilling its legislative mandate.

In addition, CAFMR has supplemented State funding in support of the Commission's operations and scope as these evolved to meet the demands of a health care system that has become more complex and chaotic. Also, CAFMR serves as the employer for the Commission's staff. This is a critical role since the Commission does not have the legislative authority to hire staff as employees. In addition, the Association has piloted projects or conducted (including funding) the initial phases of a program before turning over to Commission staff for ongoing management. CAFMR has also collaborated with COFM over the past several years to secure several grants from The Colorado Trust and The Colorado Health Foundation. Funding for the Rural/Underserved Rotation ($309,000), Rural training ($65,000), the Patient Centered Medical Home Residency Project (2.8 million dollars, Director of Operations ($223,238), and $50,000 to professionally create a music-based video to add to COFM's recruitment program. are the most recent examples.

COFM Membership

The statutes creating the Commission on Family Medicine (25-1-901 through 25-1-904, CRS) call for all of Colorado's Family Medicine residencies to work together with the citizens of the State to address issues both in Family Medicine training and Colorado's health care. A key focus of the Commission is to meet the needs of rural and urban underserved communities for Family Physicians. Nationally, the Commission is a unique organization. In addition to the directors of the training programs, members of the Commission include Governor-appointed citizens from each of the seven congressional districts as representatives of health care consumers, the Dean of the University of Colorado School of Medicine, and a representative of the Colorado Academy of Family Physicians.

Family Medicine residencies, for all practical purposes, are departments of their sponsoring hospitals. Accordingly, the legislation supporting the Commission does not expect the Commission to intervene in the internal operations of the residencies. Rather, State funding and a range of efficiencies resulting from the collaboration created through the Commission serve as powerful incentives for the directors of these programs to be active members of this organization. Cooperation and collaboration exist, even as competing hospital systems own and operate the residencies. These **teaching hospitals** fortunately are located in every quadrant of the State.

The sponsoring hospital and location are listed below in parenthesis for each of the residencies, unless the name of the affiliated hospital is included in the residency's title.

- A.F. Williams Family Medicine Residency (Central Denver/University of Colorado Hospital and Denver Health)
- Fort Collins Family Medicine Residency (Poudre Valley)

- North Colorado Family Medicine Residency (Greeley, with a rural training track in Wray and an underserved urban track in the Sunrise Community Health Center)
- Rose Family Medicine Residency (Southeast Denver)
- Saint Anthony Family Medicine Residency (Northwest Denver and Westminster)
- Saint Joseph Family Medicine Residency (Central Denver)
- Saint Mary's Family Medicine Residency (Grand Junction)
- Southern Colorado Family Medicine Residency (Saint Mary Corwin, Pueblo)
- Swedish Family Medicine Residency (Littleton)

## Programs

### *Introduction*

COFM's structure does not include "divisions" or "programs" in the formal definition used by OSPB. The two "programs" noted below do allow for grouping and describing the Commission's projects and activities. The two sections flow from the structure of the Commission as a consortium or collaborative structure of nine independent entities.

### A. *Residency Training*

Through the Commission on Family Medicine, the State provides funding to train Family Physicians in Colorado's nine Family Medicine residencies. The appropriation is designated directly for residency training and not for the operating expenses of the teaching hospital with which the programs are affiliated. The Commission has established criteria for funding in accordance with the legislative declaration that supports the organization. The Commission has no legal authority over the residencies. It has no power to intervene in the operations of the programs or dictate to the sponsoring hospitals. State funding and the recognized efficiencies resulting from an ongoing, collaborative and statewide perspective for training Family Physicians have served as the prime incentives for the individual residencies to form this unique alliance.

In addition to the projects listed in the following section, other key activities that help bond this partnership include:

- Collaboration with the State Office of Primary Care and its J-1 and Loan Repayment Programs, Colorado Academy of Family Physicians, the Colorado Medical Society, Colorado Rural Health Center, Colorado Community Health Network, Copic Insurance Company, Colorado AHEC, ClinicNet and other similar organizations;
- Joint research (e.g., determining training costs, salary surveys, residents' debt load, assessing Colorado's need for Family Physicians, and studying consumers' perspectives about their care);
- Exchange of information and common problem solving;
- Hosting educational conferences for residents (a value-added incentive to train in Colorado);

- Collaboration in transforming the residencies' curricula and practices as Patient Centered Medical Home Models; and
- Operating programs of high quality.

Historically the Long Bill listed Residency Training and Commission Expenses as line items. This changed in FY 2004/05 as a result of the legislature accepting a decision item by the Commission to delete this line and increase Residency Training by a corresponding amount. This allows for increasing the federal match for this line.

Residency Training refers to funding in direct support of Family Medicine residency training. Recent information collected from the nine residencies indicates that State funding makes up approximately 2.9% of the $59.3 million that **in the aggregate** the nine Family Medicine residencies have budgeted to train 188 residents in FY 2010-11. (This number does not include the 6 residents training at the Denver Health track at the University Family Medicine Residency. Denver Health does not qualify for Commission/Medicaid Cash Funds.). The significance of this funding is immense, as other sources of revenue to support family medicine residency training become limited. A unique feature of State funding is the exclusive designation for the **education** of Family Medicine residents. The range of the percent that State funding represents in the budget of specific residencies varies significantly from residency to residency.

State funding provides some flexibility to all of the residencies and is important to the educational component of the programs. These dollars are critical in that they are totally earmarked for education and allow the directors to fund projects and activities that the sponsoring hospital may not otherwise fund.

In its early history, the Commission used a complicated formula to allocate the State appropriation. The methodology included such factors as number of residents in training, number of graduates, and number of graduates retained in Colorado, with a greater weight to those selecting to work in a rural community. This procedure led to serious disagreement about the "fairness" of the formula and was counterproductive to the collaborative structure of the Commission. The detailed formula was abandoned for an approach that evenly distributes State dollars across the Family Medicine residencies that meet the Commission's six basic requirements:

- Accredited by the Council on Graduate Medical Education ACGME) or the American Osteopathic Association (AOA);
- Operates an integrated three-year program;
- Trains at least four residents in each of the three years of training;
- Has graduated at least one class;
- Requires that residents complete a rotation in a rural or underserved community from the list approved by the Commission; and
- Submits a copy of the letter of accreditation from the AOA or ACGME after each review period, including notification of any immediate performance issue and adverse action taken by these accrediting organizations.

This simplification has worked well for over 20 years and contributes to keeping intact the collaborative framework of the Commission. The Commission reinforced these criteria during its strategic planning session on June 19, 2002.

B. *Commission Operations*

The Commission's Executive Director staffs the Commission's meetings and executes its directives. The Executive Director also maintains a working relationship with the residency directors and other key personnel at the nine training programs. The Executive Director represents the Commission at various community meetings or conferences. He also acts as its agent both with numerous organizations and the University of Colorado School of Medicine, with special focus on the Department of Family Medicine. The Executive Director holds a Masters in Public Health, with an emphasis in Health Care Policy and Management, as well as Master in Clinical Psychology. He completed his 17th year with COFM on June 30, 2010. In addition to his sixteen years of working in primary care through COFM, the Executive Director worked in public health administration and in community health centers (both in direct service and administration). COFM's two other staff have worked with COFM for over nine years. The Director of Health Care Policy is an attorney. A full-time Director of Recruitment, funded through a two year grant from The Colorado Health Foundation, joined the COFM/CAFRM staff on July 1, 2009.

Commission staff coordinates the participation of the residencies in the required rural/underserved rotation, joint recruitment of residents, joint recruitment of faculty, retention of graduates, the regional job fairs/educational conferences, and other similar activities and projects organized to benefit all other Family Medicine residencies. The Commission's office is also a centrally located source of residency program data, such as number of residents in training, training costs, and employment choices of graduating residents. The Executive Director is responsible for all administrative functions of the Commission, including personnel, accounting and liaison with the OSPB and JBC offices.

The listing noted below represents the programs and projects managed and/or coordinated by the Commission and provides an **estimate** of staff time devoted to these areas. This information is presented to indicate the scope of work carried out by the Commission staff and the efficient use of resources, which is a critical byproduct of the collaborative nature of the Commission. As noted above, legislative response to the Commission's decision item resulted in elimination of a State appropriation to support this element. The Colorado Association of Family Medicine Residencies agreed to totally fund these programs, projects, and administrative activities.

The following outline summarizes the Commission's participation in each area.

**Total Appropriation for FY 2009/10: $1,738,846**

(1) *Residency Training*: $1,738,846

(2) *Commission Operations and Administration*: 0

Planned Allocation of Staff Time to Programs and Key Projects: FY 2009/10

- Rural Training 10%
- Placement of Graduates 24%
- Recruitment of Residents and Faculty 30%
- Staffing of Commission 4%
- Coordination of Activities with Residencies 10%
- Collaboration with CU School of Medicine 8%
- Partnership with Community Organizations 10%
- Research Activities 2%
- Management and Administration 2%

- **Rural/Underserved Training**: The Commission has established a set process for reviewing requests from Colorado's rural communities to serve as formal training sites for the Family Medicine residents. There are seven active partners involved in this program. These sites are located in: Buena Vista, Canon City, Julesburg, Yuma, Plan de Salud Community Health Center and Valley-Wide Community Health Center. The latter two sites have multiple clinics. Valley-wide serves the San Luis Valley and La Junta area. Plan de Salud covers the underserved communities north of metro- Denver from Fort Morgan, Fort Lupton, Commerce City, Frederick and Longmont. The training sites and supervising physicians receive no reimbursement for their service and must provide housing for the residents and their families. Unfortunately, the demand from communities for approval as a rural training site for family medicine residents exceeds the number needed to operate this program efficiently and effectively. The Commission limits the number of sites and months available for training in order to maximize the number of residents training in a particular community. This approach establishes a "training environment" at the community-based practices such that the volunteer physicians become effective teachers and the patients/community appreciate the perspective and expertise of the residents. Sixty Family Medicine residents are scheduled to participate in this program during FY 2010/11, with 93% (56 if the 60) training in a rural community. In addition, the Greeley and Grand Junction residencies require additional training in a rural setting. Furthermore, the six first year residents from the Ft. Collins program spend a week at the COFM training site in Julesburg as an early introduction to rural family medicine.

  The benefit to the volunteer physicians and community include the following: additional medical care from a licensed Family Physician without added cost, relief for on-call scheduling, camaraderie with other Family Physicians, opportunity to keep abreast of new practice models and procedures, creating a pool from which to recruit Family Physicians in the future, and a source for hiring a *locum tenens*. (The latter is a substitute physician that covers for the community doctor while she/he is away on vacation or some other reason.) To qualify for funding the residencies must have their residents complete a month's rotation with one of the seven approved partners. The Commission's staff coordinates the statewide schedule, collects the form residents use to evaluate their rural experience and prepares an

annual report for the Commission on this program. Staff also serves as a liaison between the communities and the residencies, especially in resolving issues that may arise.

COFM secured a grant of $309,000 (from April of 2005 through March of 2009) from The Colorado Trust to heighten the importance of this rotation and persuade at least 75% of the residents completing this rotation to do so in a rural community rather than in an urban underserved area. The difficulty of recruiting a Family Physician to a rural area is greater than to an urban underserved community because of life-style issues. The 75% target was exceeded in each of the four years of the grant. An evaluation conducted by Research Strategies, the independent firm hired by The Colorado Trust to conduct the review, firmly documents the value and effectiveness of the rotation. The Executive Summary states:

"The Commission on Family Medicine's Rural Rotation was reported to be a very positive experience for family medicine residents. Both the quality of the preceptors and the overall experience achieved very high ratings in both open-and close-ended survey items.

"Resident ratings of the rotation on their likelihood of eventually practicing in a rural setting increased from 62% to 71% afterwards (p-value =.001). This increase in the likelihood to practice in a rural setting was confirmed as statistically significant. Thus, the rotation experience may have an important impact on the eventual selection of a rural practice location."

- **Placement of Graduates**: Until nine years ago, the Commission hosted a two-day recruitment and educational conference. Residents were charged a token fee as an incentive to attend the event. The Commission covered most of the costs for this event with the fees charged to health care systems and practices attending the conference to recruit Family Physicians. A changing employment market and evolution of the Internet created an environment that made the conference obsolete. The Commission now partners with Copic Insurance Company (Colorado's largest malpractice insurer) in providing the educational component of the conference; these are management and business-oriented forums providing education in areas required by the body that accredits Family Medicine residencies. Copic totally underwrites the event. The Commission staff works closely with residency staff in developing an active listing of positions available for Family Physicians in Colorado. Also, the residency directors have become increasingly active in working to retain their graduates for work in Colorado. Finally, the Commission joined the Rural Health Center (CRHC) in its effort to create and fund the Colorado Physician Recruitment Program (CPR). This is a not-for-profit venture that emphasizes placing primary care physicians in rural and underserved areas of the State. There is no charge to the physician and the cost to the community is exceedingly less than what a for-profit firm charges. The Commission facilitates CPR's and the National Health Service Corps' (federal loan repayment) visits to the Family Medicine residencies as part of its efforts to recruit graduates of COFM's programs to rural and underserved communities. In addition, the COFM Director of Recruitment has formed a strong, working relationship with CRCH and the Colorado Community Health Network. COFM has also added a recruitment component to its website, in collaboration with CRHC. COFM and CAFMR

have established of retaining at least 60% of graduating residents in Colorado, with a third of these opting for practice in a rural community. Overall results for the 2005-2010 are: 74%, 65% 69%, 70%, 60% and 68% respectively. However, 20%, 29%, 16% 42%, 46% and 35% of those remaining in Colorado over this period chose a rural or urban underserved area. Life-style issues and a significant increase in the number of jobs available for family physicians in urban areas of the state are perceived to be underlying challenges to attracting physicians to rural and underserved areas. Sixty-three Family Medicine residents graduated in 2010. Forty-three stayed in Colorado to practice; eight of these chose a rural community and seven an urban underserved setting. This significant accomplishment is strongly rooted in the collaborative recruitment program of COFM and the cooperative environment generated by COFM. The accomplishment is highlighted by the fact that 85%-90% of Colorado' Family Medicine residents are from medical schools outside of the State. Robert Bowman, a Family Physician who studies physician workforce trends, notes that retention for graduating residents from outside a state is 21.7% and 42.4% for residents from the state.

The Commission's Director of Recruitment is a Governor-Appointed member of the Colorado Health Corps, which is responsible for the State Loan Repayment Program. In addition, the Director of Operations has been appointed by the Governor to serve on the J-I Advisory Committee, which was organized by the Department of Health and Environment to review applications from foreign physicians to practice in underserved areas of Colorado.

- **Recruitment of Residents**: The Commission has always held this project at the highest priority, as detailed under its outcome measures and objectives. Over the years, the Commission has significantly increased its staff resources to this initiative. This reallocation of resources corresponds to the intense competition for medical students opting for Family Medicine. The pool of medical students interested in Family Medicine has frighteningly decreased over the past ten years. Until six years ago, the Commission attended only the National Conference of students interested in Family Medicine (a national residency fair organized by the American Academy of Family Physicians). **Now the Commission participates in thirty residency fairs in states from which COFM knows it has historically attracted residents to Colorado, as well as to those medical schools with a reputation for emphasizing rural Family Medicine**. Over 3,000 students visited with COFM representatives at these events. This data is compiled from a survey conducted by the Commission and completed by every medical student who interviews in one of Colorado's Family Medicine residencies. At the start of this intense campaign, CAFMR engaged the services of a professional advertising firm to develop recruitment materials and a website that appeal to the current generation of medical students. It is important to highlight that historically 85%-90% of all residents training in the State's family medicine programs came from outside of Colorado. COFM's recruitment efforts extend coast-to-coast and includes both allopathic (MD) and osteopathic (DO) schools of medicine. Although none of Colorado's family medicine residencies are osteopathic programs, the current first year class is made up of 33% graduates from DO schools of medicine. COFM recruits at all of the 10 osteopathic schools from Chicago to California and also two DO schools in Pennsylvania and one in Florida.

During the just completed recruitment program for the new class of residents, the number of medical students interviewing in one of the State's Family Medicine residencies increased by 20% over last year. The 339 graduates of US medical schools (an additional 12 US students were graduates of foreign medical schools) that interviewed in Colorado represent 29% of the total number of US graduates that interviewed in a Family Medicine residency.

All of the 17 medical students from the CU School of Medicine opting for family medicine applied to at least one of the State's Family Medicine residencies. Seven (41% of the 17) matched in the State. Recruiting more of the students from the University of Colorado interested in Family Medicine and working with the CU School of Medicine to interest more medical students in Family Medicine will help ease the intense national competition for Family Medicine residents. COFM, supported by CAFMR, has developed a strong, working relationship with the Family Medicine Interest Group for the medical students at the University of Colorado and the student component of the Academy of Osteopathic Family Physicians at Rocky Vista University, the new Osteopathic School of Medicine in Colorado. Also, COFM and CAFMR annually host the interested medical students to a "Residency Night". This is a dinner and reception for the medical students to meet with residents and faculty from the nine Family Medicine residencies. The Commission's role is to coordinate the efforts of the nine residencies to increase the number of medical students interviewing in Colorado—to market the values of training and living in Colorado. The Commission maintains a high level of coordination with the residencies, which, in turn, are willing to collaborate even as they compete with one another because of the Commission's influence.

At the same time, COFM/CAFMR are committed to maintain the national recruitment net is has painstakingly established over the past seven years. It is unrealistic to expect that all 65 first year residency positions could be filled with graduates of CU and RVU. Also, if revisions to the Medicare rules governing funding for residency training change in favor of primary care as called for in the new health care reform bill, Colorado's Family Medicine residencies will have an opportunity to expand. Depending on how changes are structured, hospitals without residency training may have incentives to create a Family Medicine residency. These developments could require a significant increase to the number of medical students applying to Colorado's Family Medicine residencies.

- **Joint Faculty Recruitment**

The residency directors have informed COFM that it is becoming increasingly difficult to recruit competent faculty to their programs. As with recruiting medical students to train in Colorado's Family Medicine residencies, the competition for faculty is equally as challenging. What further compounds the problem is that some of the candidates for faculty do not provide the full scope of practice, especially OB; nor do they want to work full-time or take on-call. Generally, the residencies have been rather successful in recruiting their graduates to join the programs as faculty. The directors have formally agreed to pool their recruitment efforts for faculty. The website was recently edited to include a section on faculty positions open in all of the nine residencies. This feature is also meant to provide on-going or "light" recruitment throughout the year—even then a program may not have a vacancy. Also, the Director of Recruitment has added this activity to her agenda as she participates in residency

fairs across the country. CAFMR has intensified this endeavor as of FY 2008/09 by making this a formal project under the direction of the Executive Director. CAMR has approved a line item in the COFM/CAFMR annual budget to fund a national advertisement program for this joint recruitment effort. The Director of Recruitment now annually contacts all Family Physicians practicing in Colorado to inform them of faculty positions in the State's Family Medicine residencies. The Directors have learned that "word-of-mouth" is the best recruitment tool. They diligently share information about candidates and recognize that a particular Family Physician may be an excellent faculty but may be appropriate for one program but not for in theirs.

- **Joint Faculty Development**

  The Residency Review Committee (RRC), which is the national organization that accredits residencies of all specialties, requires that: "There must be a structured program of faculty development that involves regularly scheduled faculty development activities." Faculty development has been defined as efforts which facilitate faculty members' commitment to and ability to achieve their own goals and their institution goals. In the past, RRC has been lenient with this requirement; however, it recently communicated that this criterion will be taken more seriously. Creating and maintaining a faculty development program is a costly endeavor. The first and critical step in implementing such a program is to conduct a thorough assessment of the faculty's needs in this area and to identify individuals within the residencies with the expertise to meet at least some of these documented needs for ongoing professional and clinical development. COFM joined CAFMR in submitting a proposal to The Colorado Health Foundation to fund this initial step, "A formal, state -wide Faculty Development Needs Assessment." The Foundation awarded a grant of $24,765 to carry out this project. The assessment was completed in March of 2009. The next step calls for the development of a state-wide, on-going program, with Leadership Training identified as a key starting point. This initiative most likely will be conducted in collaboration with the Patient Centered Medical Home Residency Project described under "Hot Topics". In mirror image of the Needs Assessment, this project has flagged this issue as an important faculty development item. A somewhat recent initiative (still evolving) is the formation of the Curriculum Review and Evaluation Workforce (CREW). This is a state-wide project initiated by the residencies' faculty to bring together representatives from the nine Family Medicine residencies to share educational resources, assure that curricula are on the "cutting-edge" of Family Medicine, and provide a forum for problem-solving and professional development. These two efforts will anchor faculty morale and strengthen the residencies' recruitment efforts both of faculty and residents.

- **Staffing of the Commission**: This includes a variety of functions, such as working with the Governor's Office of Boards and Commission, educating the consumer members on the intricacies of health care and Family Medicine residency training and developing agendas that keep the Commission members interested and active in the work of the organization. Staff believes that the volunteers' role and perspectives should not be minimized and/or the Commission be dominated by staff. The Executive Director, highly trained in volunteer management, works closely with the Commission's chair, who historically is selected from the ranks of the individuals representing the State's Congressional Districts.

- **Coordination of Activities with Residencies**: State legislation serves as an incentive for the Family Medicine residencies to work together. The State cannot dictate this collaboration, since the programs are departments of autonomous, private institutions. The cooperation begins at the level of the directors and moves forward to collaboration with the residencies' key staff. Commission staff is resolute in establishing collegial relationships with these staff to carry out the statewide perspective and work of the Commission. Residency staff are, understandably, prone to have the welfare of its affiliated hospital and service area in mind. The Commission's collaborative structure translates that attention to concern for the welfare of all of the people in Colorado. Key areas of coordination are: participation of residents in the Practice Management Workshops supported by Copic, recruiting graduates to remain in Colorado, interaction with medical students at the University of Colorado School of Medicine and RVU who are interested in Family Medicine, and collection of a variety of information used for the annual Joint Budget Committee Comparative Data Report, this document, and other reports. The new collaborative venture of transforming the residencies' curricula and practices into Patient Centered Medical Home models requires significant more involvement of COFM staff with the residencies' staff.

- **Collaboration with the CU School of Medicine and RVU School of Medicine**: State statutes include the Dean of the School of Medicine at the University of Colorado as a member of the Commission. The Commission's Executive Director extends his communication with the Dean beyond the Commission's meetings and serves on the Medical School's Diversity Council, which advises the Dean on expending the resources the School of Medicine budgets for diversity projects and activities. Commission staff is housed at the Department of Family Medicine at the CU School of Medicine on a barter arrangement. The Department of Family Medicine (DFM) provides office space and all supporting services in exchange for the Commission's assistance and participation in identified areas of expertise. Since RVU is a new school of medicine in Colorado, current state statutes do not identify its dean as a member of COFM. The Commission plans on taking steps during the next legislative session to rectify this situation. Meanwhile, COFM has established at office at RVU and makes sure that its students participate in the "Residency Night" described above.

  A recent development at the School of Medicine has created a new partnership for the Commission that is expected to benefit the State's rural communities. A new position of Associate Dean for Rural Health at the School of Medicine has been created. The director of the program is a Family Physician on faculty at DFM and has a history of working with the residencies through the Commission. This Associate Dean and another Family Physician on staff at the Department of Family Medicine are the co-directors for the new Rural Training Track at the CU School of Medicine.

  This new initiative uses an admission process different from that used for evaluating students not in the Rural Training Track. The program is modeled after a highly successful enterprise at the Jefferson School of Medicine in Philadelphia and admits 12 students per year. This track graduated its first class in 2009. The anticipation is that most of these students will go into primary care, especially family medicine and will stay in Colorado by training in

one of the State's Family Medicine residencies. The objective of this track is twofold: (1) ease the challenge of recruiting medical students into primary care; and (2) direct these students into the State's rural communities. The residencies are working with the co-directors of the Rural Training Track to accomplish this two-fold objective. COFM and CAFMR are included in a major grant received by the Department of Family Medicine to address Colorado's needs for primary care physicians, especially in the rural areas, by developing a comprehensive approach to the physician "pipeline". This calls for the creation of programs aimed at interesting students at an early age in the sciences as well as moving the graduates of the rural training track into Colorado's Family Medicine residencies then into the State's rural communities. RVU has established a similar Rural Track.

- **Partnership with Community Organizations**: The Commission has spread its influence and maximized its resources through its collaboration with a diverse set of public and community-based organizations. These are not casual partnerships but involve active participation by Commission staff on boards and committees of these organizations. Not formally taken into account in this activity is the number of associations that the directors maintain as a way of meeting their and the Commission's mandates to operate premier residencies and funnel most of their graduates into Colorado communities. A partial list of organizations include: Colorado AHEC, Department of Health and Environment, Division of Insurance, Copic Insurance Company, Rural Health Center, Colorado Medical Society, Colorado Academy of Family Physicians, Coalition for the Medically Underserved, Regional Office of the Centers for Medicare and Medicaid, Health Care Policy and Finance, The Colorado Trust, The Colorado Health Foundation, Rose Foundation, Area Health Education Center, Community Health Centers Network, National Health Service Corps, and the Colorado Consumer Health Initiative. A key student organization at the CU School of Medicine is the Family Medicine Interest Group and its counterpart at RVU. COFM and CAFMR support a number of programs and activities for these organizations as a way for supporting their interest in primary care and Family Medicine, as well as recruiting them into the State's Family Medicine residencies. The Director of Health Care Policy is a key representative of COFM and CAFMR with these and other community organizations, especially from the health care arena.

- **Research Activities**: Additional staff and financial resources are needed to increase the Commission's participation in this area. Research activities are managed by the Executive Director and have focused principally on physician workforce. The Commission, through CAFMR, has had discussions with the DFM to engage the residencies in practice base research. DFM initiated a research rotation for the State's Family Medicine residencies. This is a monumental step, since it is becoming increasingly necessary that family physicians engage in or become most knowledgeable about practice-based research. This work represents an effort to improve patient care by studying the patient-physician interaction at the point of delivering care. The St. Anthony Family Medicine Residency hosts an annual Research Form for Family Medicine residents from across the state to present their research projects. These programs will benefit the residencies by helping them meet the new accrediting standards. Patients will also benefit since the research will not be laboratory based but practice based; in other words, the intent is to improve ambulatory care by identifying methodologies and approaches that increase the quality and effectiveness of primary care.

Additional resources would allow the Commission to statistically document the value of a Family Medicine residency to sponsoring hospitals. Such a study would help the directors make a case for their program in their budget negotiations with their hospital administrators and generally buttress the hospitals' heavy financial support for training family medicine residents. Another area of interest is determining more accurately how much it costs to train a family medicine resident in Colorado. The data collected for the Joint Budget Committee Comparative Data Report is uneven and estimated in some areas. A few of the residencies do not have a financial system to account for all costs; in other words, as departments of a hospital, there are many items that the hospital covers without allocating a portion to the residency. A third area of importance is conducting annual salary surveys to help the residency directors in their challenge of recruiting faculty. CAFMR has contracted for research projects with the Department of Family Medicine. The Executive Director serves as project manager in these instances.

- **Management and Administration**: Included in this item are all of the generic activities required to keep an organization functional—from paying bills to preparing the annual budget request. The Executive Director estimates that the time needed to fulfill this function has decreased over the past two years for two primary reasons. First, the Commission's Director of Operations is now fully trained and most familiar with the organization's programs and administrative structure. Secondly, she brings to the job magnificent computer skills, especially in software that underpins the majority of the Commission's programs and projects.

## Hot Issues

*Reforming Health Care: An Elusive Enterprise Whose Time May Have Come*

The recently enacted "Patient Protection and Affordable Care Act" (PPAC) lays out legislation for national health care reform. However, the $940 billion health-care overhaul will take nearly a decade to roll out in full. Time, politics, economic recovery, and rules developed to guide the implementation of the Act, which does not deal with key tax issues until 2018, will come into play as the structure of this "elusive enterprise" is developed Past efforts to reform the US health care system have identified seemingly intractable elements in the country's approach to delivering health care. The current debate on the wisdom, affordability and effectiveness of the PPAC echo previous contested discussions. These elements include:

- Coming to grips with whether creating a system that provides health care for all is a key for addressing the specter of no ceiling to health care costs.
- If health care is a consensus-driven objective, hewing an approach that is acceptable to the US financial, workforce, and cultural environments.
- Fashioning a structure to sustain an equitable financing plan deemed equally responsible by all payers, including the "consumer."
- Agreeing on government's role in health care: Is it only a "safety net" for indigent and uninsured?

- If health care for all is agreed to, what is the core benefit package afforded all?
- How will quality be measured?

The current the challenges to reforming the country's health care, from a reductionist perspective, are:

- The "appropriate balance" between government and the private sector, especially health care plans;
- Paying for the "new" system; and
- Creating the workforce to meet increased access and avoid the experience of Massachusetts (not having the primary workforce to meet the increased demand for services resulting from expanded coverage).

The latter is obviously of special interest to COFM and CAFMR, as discussions on reform include transforming Graduate Medical Education and reimbursement rates to promote primary care. It is important to note that the collaboration of the State's nine family medicine residencies through COFM and CAFMR place Colorado in a strong position to greatly benefit from health care reform that includes primary care as one of its principal building blocks, especially increasing the number of family medicine residents trained in Colorado. With only 2% of graduating Internists entering primary care, Family Physicians are the mainstay of the physician primary care workforce.

PPCA introduced grants over five years to immediately begin funding up to 500 new primary care residency positions. The flaw in this step is twofold. First of all, the funding is in the form of a grant that covers the three years of residency training for a primary care physician but no indication that this support will continue after this period. Secondly, the grants are limited to $80,000 per resident. This falls far short from the $300,000+ that the Colorado Family Medicine residencies indicate it will take to train one Family Medicine resident in FY 2010-2011. PPCA also allows for residency training to occur in a Teaching Community Health Center (TCHC). This modality has potential for increasing the number of primary care physicians, especially those opting for a rural or urban underserved community. However, the rules governing this program have not been developed. Funding this program and allocating funds directly to a TCHC (rather than to a hospital as currently required by Medicare) are fundamental issues that must be resolved before this training can occur.

However, neither proposal gets to the fundamental issue of the need to reform how residency training (Graduate Medical education or GME) is funded. To this end, at its July 21, 2010, COFM/CAFMR crafted a new goal area with three corresponding objectives that include a **bold, far-reaching** initiative to address the underlying flaws with GME. This proposed initiative is detailed on pages 45-47of the Goals and Objectives section of the Strategic Plan.

Paul Ginsburg, a leading health care economist and author, outlined in the **New England Journal of Medicine** ("Controlling Health Care Costs", October 14, 2004) four basic options for slowing the trends in health care spending. His observations continue to be relevant as the wisdom and practicality of PPCA are argued:

"One can increase the efficiency of health care delivery; increase the financial incentives for patients to limit their use of medical services; increase the administrative controls on the use of these services; or limit the resources available to the health care system."

Commenting on this observation, Alan Nelson, M.D., special advisor to the CEO of the American College of Physicians and former president of the American Medical Association, notes:

"The American public would likely have difficulty accepting aspects of all of these options, except the first—increasing efficiency, which I define as the reduction of unnecessary services and care of marginal value……(One) way to increase efficiency is to reward primary care providers for coordinating care among the various specialists who treat patients with multiple chronic illnesses. Care coordination can help to avoid duplication of effort and deter use of specialty services with marginal value, such as unnecessary imaging. It will have to be implemented in a way to avoid the 'gatekeeper' stigma associated with managed care. True care coordination can prevent the fragmentation of care that lowers quality and wastes resources."

COFM and CAFMR firmly hold that primary care physicians and specialists must collaborate and communicate more closely to ensure timely, well-planned care. No Family Physician (and her/his primary care colleagues) wants to practice without being able to send the right patient to the right specialist at the right time. Specific care for individual conditions may have better outcomes when delivered by specialists. However, studies have shown that close involvement of generalist (primary care) physicians in specialty care leads to more cost-effective and better health. Furthermore, although the evidence is small at this time, there is indication that patients who are referred for procedures by a primary care physician have better outcomes than do patients who have gone directly to specialists. Appropriate triage (screening) helps ensure that specialists spend most of their time applying their skills where they are critically needed. A Family Physician is skilled in evaluating patients with undifferentiated symptoms. For instance, are chest pains due to angina (cardiac disease) or panic disorder? A Family Physician is trained to match a patient's needs with the available resources. This approach minimizes potential over-treatment and corresponding higher costs or under-treatment and exacerbation of a condition, which also leads to higher costs. The Patient Centered Medical Home (PCMH) and Accountable Care Organizations show promise of moving this critical aspect of health care reform significantly forward. The participation of the nine Family Medicine Residencies in a unique PCMH collaborative project is described below.

### *Growing Need for Primary Care Physicians*

#### Projected Deficit

Jack Colwill, a member of the National Academy of Sciences Institute of Medicine, and his research team, cite a skewed compensation system that rewards specialists increasingly more than primary care practitioners, as a key component of projections that point to serious deficit of primary care physicians. Over the past decade the number of generalist or primary care graduates (Family Physicians, General Internists and General Pediatricians) has fallen by 22% and declines

continue as medical school graduates enter other specialties. At the same time, the US population is increase about one per cent per year, with the Census Bureau predicting that the number of adults will increase by 21% and the number of Americans 65+ by 73% by 2025. The authors project that the supply of family physicians and general internist will increase less than 5%.

The Association of American Medical Colleges recommends that medical schools increase their enrollment by 30%; however, they have not indicated specific specialty areas for the increase. Colwill states that this enrollment increase could result in more specialists but little increase in primary care physicians, if the incentive for becoming generalists is not examined soon. Determining the correct physician-to-population ratio is not an exact science, with workforce studies usually showing variability due to models used, calculating FTE's and distribution of the physician workforce. COFM and CAFMR are comfortable with the following statistics from the American Academy of Family Physicians (AAFP). This organization developed a complex formula that factors in a number of key, workforce elements, e.g. the contribution of nurse practitioners, physician assistants and residents to the availability of primary care. The AAFP model calls for 83.2 primary care physicians per 100,000, with 41.6 being Family Physicians. This approach forms the basis for reaching the recommendation of the Council on Graduate Medical Education of primary care physicians representing 50% of all physicians—rather than the current ratio of only 33% being primary care physicians.

The press release by the American Academy of Family Physicians (AAFP) in response to the results of the 2010 National Residents Match Program presents a similar scenario: ""Physician workforce studies have consistently pointed to a worsening primary care physician shortage. In 2006, when the national had 100,431 family physicians, the AAFP workforce report indicated that United States would need 139,531 family physicians by 2020 to meet the need for primary care. That means we must graduate 4,439 family physicians each year. In our current environment, the nation is attracting only half the number of future family physicians that we will need." AAFP also notes that the country will have a shortage of 44,000 primary care physicians by 2015.

How Does Colorado Compare?

The total number of primary care physicians in the State, defined as Family Physicians, General Internists and General Pediatrics, compares favorably with the national percentage. However, where Colorado varies significantly is in the percentages represented by the three primary care specialties: Nationally Family Physicians make up 41.6% of primary care physicians but 54% in Colorado. Furthermore, across the country, Family Physicians make up 61.7% of primary care physicians in rural areas. However, in rural Colorado, 73% of primary care physicians are Family Physicians. Finally, AAFP reports that nationally 14.8% of practicing physicians are Family Physicians. In Colorado the percentage is 17.9%. (Sources: AAFP, the Graham Center, COFM's review of the AMA database, and the Windstar Physician Database.). Given that Colorado has nine Family Medicine residencies, these statistics are not surprising. Arguably, the best source of populating a state with physicians, especially Family Physicians, is a residency. Anecdotally with some support from older studies, on the average 50% of graduating residents stay in the state in which they trained.

How many Family Physicians and primary care physicians does Colorado need to cover its current population of 5.1 million? There are several models to answer this question. The COFM has adopted the AAFP model, which assumes that one full-time Family Physician can handle 3,400 patient visits per year, with the number growing to 4,200 by 2020 (as the result of improvements in efficiency and productivity from the use of information technology). The model states that 83.2 primary care physicians are needed per 100,000, with 41.6 being Family Physicians. Thus, with a population of 5.1 million, this model calls for Colorado needing 4,243 primary care physicians, with 2,122 being Family Physicians. Based on the Windstar Database cited above, Colorado currently needs an additional 1,012 primary care physicians, with 393 being Family Physicians. The numbers become more dramatic for rural communities when the distribution of these physicians is considered.

Interest of Medical Students' in Family Medicine

National Resident Matching Program results for 2010 showed that a total of 2,404 graduating medical students matched to family medicine training programs. This represents a fill-rate of 91.4% (20404 out of 2,630 positions available), which is a 0.2% increase over 2009. The good news includes the following: (1) 75 more Family Medicine positions (2.9%) were offered in 2010 compared to 2009; (2) 75 more positions (3.1%) were filled this year compared to last year; and (3) with 17,070 US seniors participating in the match in 2010 compared to 15,638 in 2009 (a 2.8% increase), the percentage of US seniors choosing Family Medicine rose from 7.4% to 7.9%. The hope is that this trend continues, as US medical schools increase their class size. Increasing education debt load ($200,000-$225,000), a reimbursement system that favors specialty care, lack of appreciation for primary care in academic medicine, and the added effort required to provide primary care in a fragmented system are some of the factors cited as the underlying drivers for medical students' shying away from family medicine and primary care in general. The percentage of Family Medicine residency positions filled by US senior medical students through the National Match Program has remained at about 41% for the past several years, with a decrease from 49% in 2002. It will take more than half of a percentage point to address the increasing need for primary physicians.

The Situation in Colorado and Financing as the Key Obstacle to Expansion

Historically the nine Family Medicine residencies fill all of their residency positions, which now number 66 in each of the three years of Family Medicine residency training. Based on information recently submitted by the nine Family Medicine residencies, COFM estimates that $297,417 were required to train one Family Medicine resident during FY 2009/10. In addition, COFM estimates that Graduate Medical Education (GME) funding from Medicare accounts for about 40% of these costs, with the sponsoring hospitals covering about 50% of the costs. Coincidentally, the most recent report (19$^{th}$) of the Council on Graduate Medical Education states that on the average Medicare GME covers 40% of a residency's (of all specialties) costs. The rest comes from patient services. The Balanced Budget Act of 1997 has made it virtually impossible for the hospitals sponsoring the states' family medicine residencies to expand. This Act capped Medicare funded positions to the 1996 level. Expansion of the number of family medicine residents training in Colorado requires a large infusion of private funding, both for personnel costs and capital expenditures that may be required to expand the

training facilities. Nonetheless, one of the residencies added one resident to its new residency class but is unsure whether the hospital will allow this increase in the future.

Nearly 55% of Colorado's primary care physicians are 45 years or older, while 57% of Family Physicians fall in this age category. Generally this holds true for both urban and rural settings. Primary care physicians make up 32% of the physician workforce in Colorado. However, family physicians make up 54% of all primary care physicians in the State but 73% in rural areas. Recent reports note that Colorado will experience another significant growth in population between 2006 and 2030. This projection, coupled with the two trends noted above, forecasts a severe shortage of primary care physicians. "Recent studies clearly demonstrate that the higher the primary care physician-to-population ratio in a state, the better the health outcomes" (**Connection**, AAFP, Summer 2003). The World Health Organization reports that of the seven industrialized countries with the highest average health rankings, five have strong primary care infrastructures. The US ranked 15th among 25 industrialized countries. And, a recent entry in Medscape Business of Medicine cites a report from the Agency for Healthcare Research and Quality that primary care physicians account for nearly half of physician office visits but only one third of expenses.

The "good news" is that over the past decade, Family Medicine is maintaining a solid base in Colorado. COFM conducted a thorough study of Colorado's need for primary care physicians in 1995. Back then, family physicians made up 57% of all primary care physicians and 73% in rural areas; these are similar to the current statistics. Also, in 1995 there were 64 primary care physicians per 100,000; today the ratio is 66 per 100,000. It is interesting to note that in 1995 Colorado's population was projected to reach 4.8 million by the year 2015. The State's population today exceeds this number).

Based on this ratio, with a population of 5.1 million people (as just noted) Colorado today needs an additional 393 Family Physicians. The ideal is that the distribution of Family Physicians within a service area matches the population living in that community. Current increasing salaries for Family Physicians alone will not reverse the strong trend of medical students opting for more profitable specialties. What is likely to happen is that more Family Physicians will opt for urban practices at the expense of rural and urban underserved communities. Loan repayment alone may not be sufficient to offset this choice.

Federally Qualified Community Health Centers, created to meet the health care needs of underserved communities, may be especially hard hit by this demand. These centers rely heavily on Family Physicians, because of the breadth of their training. Since the beginning of the 2002 fiscal year, the current Washington administration has increased its funding for community health centers by $645 million (about 48%), helping to open or expand more than 500 of the facilities and extending basic medical services to 4.5 million people. A recent article in the Washington Post highlighted the difficulty these centers are having in recruiting primary care physicians, especially Family Physicians. The article highlights the growing number of medical students who are selecting more lucrative specialties. Another factor is the shrinking number of internists and pediatricians opting for primary care. The media reports note that funds available to community health centers exceed a billion dollars.

What is hard to understand is that, while the current administration funnels these millions into expanding community health centers, it has not yet taken on the reforming of Graduate Medical Education to provide the needed primary care physician workforce. The title of the article on community health centers captures this contradictory action: "Community Health Centers Flourish but Doctors are Few." While the TCHC proposed program represents sound policy for helping to address this issue, much debate is expected on allowing GME funding to directly flow to the community health centers. Also at the top of the list of issues to address is meeting the requirements of the two bodies that accredit residency training: the American Council on Graduate Medical Education and the American Osteopathic Association.

*The Fragile Nature of Rural Medicine*

Meeting the health care work force needs of rural communities requires constant attention. The recruitment of Family Physicians to these areas is especially important, because their broad scope of training and practice allows them to care for 85%-90% of presenting cases for all ages. A growing demand for Family physicians in urban settings, increased salaries in this area for family physicians, the challenges of the rural lifestyle and (reportedly) the characteristics of the current "millennial" general do not bode well for recruiting family physicians to rural Colorado. A recent detailed report from the Graham Center ("What Influences Medical Student & Resident Choices?") adds another challenge: "Feminization of primary care, particularly pediatrics and family medicine, threatens the rural workforce without efforts to make rural practice a more attractive or viable choice for women." Sixty-five percent of the 66 new residents now training in Colorado's family medicine residencies are female. On the positive side, four of the six 2009 graduates from the Ft. Collins in Family Medicine Residency—all women—are now working in rural Colorado. The impact of loan repayment in attracting physicians to Colorado's rural and urban underserved communities is complex. The effect of the current environment outlined above requires special attention. A key question is: As salaries increase for family physicians, what level of loan repayment will attract a physician away from an urban setting? Another key question is: What are the factors that prompt the physician to stay in an underserved community beyond the timeframe required by the loan repayment? "Recruitment" and "Retention" are not synonymous.

Resolution of these issues will not be immediate. However, the collaborative natures of COFM and CAFMR have led to four important initiatives to help address the "fragile nature of rural health." The first focuses on the Rural Training Tracks at the CU School of Medicine and at RVU's School of Medicine. The creation of the Rural Health Track at both of the medical schools in Colorado is expected to add to the pool of graduating medical students interested in rural Family Medicine. This program admits up to 12 students per year who are committed to rural medicine. A special admissions process is part of the program to decrease the likelihood of admitting a student who does not opt for a rural practice. Similar programs in other medical schools establish that nearly all of the students admitted to such a program select Family Medicine as their medical specialty. The expectation is that the majority of these students will enter Family Medicine and train in one of Colorado's Family Medicine residencies. Various opportunities exist for representatives of the State's family medicine residencies to interact with the students in these Rural Training Tracks. Parenthetically, the residency directors are enthusiastic about taking advantage of these prospects.

One of key components of implementing this collaborative effort is the work of the new Director of Recruitment. One of her principal responsibilities will be to build relationships with the students in these tracks. Effort will also be made to create "shadowing" experience for these students with residents in the Family Medicine programs who intend to work in a rural community. The object is to encourage these students to opt for Family medicine and ultimately for rural medicine in Colorado.

The third initiative is the creation of an OB Fellowship at the St. Joseph Family Medicine, with a rural focus. This pilot program started on July 1, 2009, with a graduating resident from this program. This first graduate of the fellowship was hired by the residency as faculty. This assures stability to the program, which successfully recruited another of its graduates to this fellowship. After a successful completion of the pilot phase of the program, the fellowship is now open to all of the graduating residents of the State's Family Medicine residencies. A parallel program was recently initiated by the Department of Family Medicine. This initiative provides mini-fellowships both to graduates of the State's Family Medicine residencies and practicing Family Physicians wanting additional training in OB and Emergency Care, in order to provide the full scope of practice in a rural setting. The first two candidates for this program are trained at the University of Colorado Family Medicine Residency.

The fourth enterprise is the formation of a Rural Training Track at the University of Colorado Family Medicine Residency and Valley-Wide Health Services in the San Luis Valley. The project is in the planning stages and calls for two residents per year training in this track: The first at the Denver-based University program and the last two in the San Luis Valley. This model is the most effective approach for training rural family physicians. However, it is an expensive training modality and calls for special effort to recruit residents to train in the track. The Department of Family Medicine has submitted a grant proposal to HRSA and awaits a positive response. The proposal is directly in line with the HRSA guidelines and priorities, as well as with the PPCA. The Director of Recruitment will hold this special recruitment focus and will target recruiting at medical schools with a reputation for training for rural family medicine.

*New Osteopathic Medical School*

Rocky Vista Osteopathic School of Medicine admitted its first class of 150 students last year and recently admitted its third class. The school has announced that it will focus on primary care. COFM and CAFMR established a collaborative effort with this institution including opening at office at the school. RVU expect to add to the pool of medical students interested in training in Colorado's Family Medicine residencies and, particularly, for work in a rural community of the State. The inaugural first two classes at RVU participated in the Residency Night hosted by the COFM and CAFMR in 2009 and will do so in all such events, along with the students from the CU School of Medicine. RVU intends to follow the example of its counterparts in other states by hold a "Hospital Day". This event is a residency fair open to all specialties. Once initiated, COFM/CAMR will become regular participants.

*Summary of Workforce Issues*

The rural training track at the CU School of Medicine and the inauguration of Rocky Vista Osteopathic Medical School will not directly increase the number of family Medicine residents training in Colorado. The expected outcome of these initiatives is twofold: (1) The challenge of recruiting medical students to Colorado's Family Medicine residencies will ease somewhat; and (2) More graduating Family Medicine residents will remain in Colorado, especially for rural practice. **Increase in the number of Family Medicine residents in training will occur only if the RTT and increase in class size at one of the Family Medicine residencies are implemented**. **The latter requires change in the system for funding GME.** The Director of Recruitment will focus full-time in a collaborative fashion on continuing to recruit medical students from across the country to Colorado's Family Medicine residencies, recruit faculty to these programs, and retain graduates from these residencies, especially for rural Colorado.

*Reaffirming Collaboration and Joint Recruitment*

Historically the nine residencies fill all training positions. The Residency Directors hold that this success is anchored in their collaborative recruitment of residents. The Residency Directors held a retreat in September of 2005 with a focus on a single issue: Helping each other recruit to their individual residencies. They reaffirmed their commitment to this collaborative approach.

What must be emphasized is the importance of the joint recruitment carried out by COFM and CAFMR. And, what cannot be minimized is the level of trust and collaboration this project requires of the residency directors. Family medicine residencies from other states are astonished as this innovative and effective tactic. The objective of this collaborative effort is to attract medical students to interview in Colorado. COFM's collective message is: "All of Colorado's Family Medicine residencies provide outstanding training. Interview at all of them! There is a program just for you!" To this end, COFM/CAMFR participated in six residency fairs (events to bring medical students in direct contact with residency representatives) in 2003 and 29 this past year. With the addition of a full-time Director of Recruitment, nine events were added this past year to the recruitment program based on an analysis of last year's interviewees. This aggressive recruitment effort parallels the continued increase in the number of medical students (as noted under "Workload Indicators") who interview at Colorado's Family Medicine residencies. Participation in these events takes COFM/CAFMR staff and residency faculty or residents coast-to-coast. A database is in place to track the outcomes of attending these residency fairs.

The Commission surveys all medical students that interview at the Family Medicine residencies. The students strongly identify the Internet as the principal means of learning about residencies. Five years ago, the Commission and CAFMR launched a new website designed as a recruitment tool. The website was professionally designed and is interactive; this will allow the Commission and the residencies to directly contact the medical students. The site has been radically redesigned this year, with the recruitment video has a key component. COFM/CAFMR redesigned the combined, state - wide display used at the national conference of the American Academy of Family Physicians. The revisions seemed to

have added to the attraction for medical students to visit with representatives from the nine Family Medicine residencies. This event continues to be the largest grouping of medical students interested in Family Medicine. COFM/CAFMR staff coordinate Colorado's participation and each family medicine residency sends a cadre of its residents and faculty. The family medicine residency fair for the 40 schools in the Northeast and the state-wide Illinois and Minnesota fairs are two other key recruitment events for COFM. Finally, the grant from The Colorado Health Foundation allowed COFM/CAFMR to introduce several new features to participation in residency fairs: (1) covering the expenses of residents to join the Director of Recruitment a residency fairs—especially graduates of the medical schools at which the events are held; (2) raffling an attractive item at these events; and (3) offering a very special raffle prize (e.g. an I-Pad) at the National Conference.

*Residency Practice Patient-Centered Medical Home Implementation Project*

A multi-year, 2.8 million dollar, state-wide innovative initiative is underway for the nine Family Medicine residencies to collaborate in transforming the programs' curricula and practices into formal Patient Centered Medical Homes. The project is supported by the generous funding from The Colorado Health Foundation and is a collaborative effort of COFM/CAFMR, the Department of Family Medicine, the CU School of Medicine, the Colorado Clinical Guidelines Collaborative and the Colorado Institute of Family Medicine. This pilot project is bold, with far-reaching results and potential to fundamentally change how primary care is delivered. The project is possible only because of the collaborative structure and approach to family medicine residency training in Colorado through COFM and CAFMR. The project is now in its second year and has made great headway, as evidenced by the bi-annual "Learning Collaboratives", which bring together about 150 residents, faculty, medical staff, and front-office personnel from all nine residencies, including the track at Denver Health. The initial phases of the project's evaluation have begun. While a few Family Medicine residencies in other states are involved in similar endeavors, this Colorado project is unique because it builds on the collaborative structure and environment created by the Commission and is a coordinated, state-wide initiative of all nine residencies. Thus, the project has drawn much national attention from individuals involved in primary care residency training. Staff at the CU Department of Family Medicine have made a number of presentations on this project at several national conferences. A number of publications will flow from this project. Consideration is already being given to Phase II.

<u>The Medical Home</u>

Multiple efforts are underway to redesign Family Medicine and primary care. One of the biggest advocates is IBM which expended 1.3 billion last year on health benefits for its US employees and retirees, equal to one month of the company's net income. Dr. Paul Gundy, who holds the unusual title of director of health care transformation for IBM, is a Medical Home evangelist. He led the company to start the Patient Centered Care Collaborative, a coalition of some 500 large employers, insurers, consumer groups and physicians. Part of his intent, he says is to show that "employers can drive the medical home ideas as buyers of care."

The Future of Family Medicine report, the subsequent TransforMed project, the Improving Performance in Practice project, the IHI Breakthrough Series, and others have focused on the development and implementation of a new and different model for primary care. This new model of care sets out to implement the Chronic Care Model with an emphasis on population management; preparation of a coordinated, proactive care team; encouragement of patient self-management, incorporation of improved information systems and utilization of lean redesign principles. It also encourages the coordination of care and services with other health care providers in the community, including mental health care and behavior change. The new model positions primary care practices to reliably deliver high quality chronic illness care and preventive services which meet national standards of care. The Patient-Centered Medical Home has been developed as an approach that brings together the elements of many of the ongoing redesign efforts to assure that people are provided safe, comprehensive, coordinated, and personalized health care. It is important to note that a Medical Home is not simply having a primary care physician. All of the major primary care organizations recently came together to develop the following joint principles to describe the characteristics of the patient-centered medical home:

1. ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
2. ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
3. ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
4. ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
5. ***Quality and safety*** are hallmarks of the medical home:
    a. Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
    b. Evidence-based medicine and clinical decision-support tools guide decision making.
    c. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
    d. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
    e. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
    f. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

g. Patients and families participate in quality improvement activities at the practice level.

6. ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

The patient-centered medical home model has gained a lot of traction with health care planners, payers, and employers – but most primary care practices are very poorly prepared to actually deliver on this idealized model. The reality is that practices need fairly extensive changes to fully accomplish these improvements in care, and such redesign is extremely difficult. Although many primary care physicians understand this need for change, most do not have the resources or infrastructure within their practices to implement the major modifications required. Consistent lessons learned from all of the major practice change efforts have been that this sort of practice change is very difficult, takes longer than anticipated, and requires assistance and connection to resources in order to occur optimally (or at all!)

Change in Residency Practices

It is particularly important that the primary care residency training programs serve as exemplars in this area. Clinicians are strongly influenced in their future practice patterns and behaviors by their training, with subsequent changes difficult. Family Medicine and other primary care residents need to be prepared for future practices that will serve as patient centered medical homes. However, residency education does not encompass the necessary training for many of the elements of good patient centered medical homes. Situated as academic centers of learning, residency programs surprisingly often lag behind community practices in demonstrating innovation and implementing change. Frequently these programs operate within the context of hospital or larger practice systems where not only do large systems-related barriers to change exist, but the residents and faculty members in the practice may not have control over many decisions which significantly impact the day to day delivery of patient care services. A specific example of this would be IT systems which have been chosen by the larger system which may not be well-suited for use in the primary care and residency training practices and which very difficult to change in order to accommodate elements of the Patient-Centered Medical Home. The educational needs of the residents also tend to drive the design of the residency practice, and effective methods for both the educational and clinical sides of training residents in this new model of care do not currently exist. Developing consistent systems of care across the entire practice is often a daunting task in this setting – but a necessary one, if the emerging primary care clinicians are to be able to function well in the patient centered medical homes of the future. Finally, the existing rules and restrictions that govern residency training often put up barriers that have to be skillfully circumvented during this period of rapid change.

Evaluation

There are two levels of specific outcomes that are particularly important for this program: (1) The extent to which residency practices are able to adopt the changes necessary to become patient centered medical homes. (2) The educational programs that are developed and then successfully implemented in the residency training programs. A third level of evaluation that is extremely important for this program is assessing the strategies that are successfully utilized by

the intervention program and the residency practices that lead to successful outcomes. Dissemination of these successful strategies to the other primary care residencies in this state and nationally will lead to further enhancement of care and training in primary care residencies – and long term to improved care for the larger population, as the residents carry these models of care and improvement into their future practices. The evaluation of this project will focus on all three levels.

Evaluation of the changes made by the residency practices will center on documentation of the changes made by the practices toward adoption of elements of the patient centered medical home. Standardized instruments used in other projects such as the Assessment of Chronic Care Management, the Practice Systems Questionnaire, and others will be useful both to assist practices in directing their initial change efforts and in measuring the changes made. An important element of the evaluation of the primary outcomes of the practice change elements will be the extent to which the practices have been able to attain the elements of the NCQA Physician Practice Connections – Patient Centered Medical Home Recognition Program, which has been developed with input from multiple organizations as a method for assessing whether practices have some of the primary elements of the patient centered medical home.

Evaluation of the educational programs that are developed for resident education on the patient centered medical home will center around the documentation of the curricular modules that are developed, along with descriptions of their implementation in the various residency programs. In addition, the modules will be carefully evaluated by both residents and faculty members. At this point, there are few elements of standardized tests such as the In-Training Exam given to family medicine residents during each year of training or the board certification exam of the American Board of Family Medicine that assess aspects of the patient centered medical home, although that may change in the near future; if so, scores on those aspects of the exams might provide additional external evaluation of the success of these curricular modules.

Finally, the experiences of each residency program and practice in this project will be carefully captured through a multi-method process similar to those used in multiple projects by the principal researcher and other members of the project team. A comparative case study methodology will utilize the data from the practice assessment, the observations of the QI coaches and others working in the practices, interviews of key informants, and other such sources to identify key themes regarding the change process, strategies used to successfully implement the necessary practice changes, and characteristics of the practices and residency programs that impact the process. This part of the evaluation will be done on an ongoing basis, with lessons learned fed back to the intervention team as well as to the practices and programs as part of a continuous improvement process.

*Creation of Colorado Institute of Family Medicine*

COFM and CAFMR joined to create the Colorado Institute of Family Medicine (CIFM) as a 501-c-3. This new organization is structured to bring together academic family medicine (COFM, CAFMR, and the Department of Family Medicine at the University of Colorado School of Medicine) to further the growth of Family Medicine in Colorado in

collaboration with key health care organizations in the State. These include Copic Insurance Company, Kaiser and the Colorado Association of Health Care Plans. The inaugural board for CIFM includes a representative from each of these organizations. One of the underlying principles of CIFM reflects the comments of Dr. O'Neil, Executive Director of the Center for Health Care Professions: to collaborate rather than exacerbate the highly polarized health care environment. The 501-c-3 status allows CIFM to qualify for foundation funding, which often excludes state (COFM) or 501-c-6 (CAFMR) organizations. The Patient-Centered Project described above includes CIFM as the fiscal agent for the residencies portion of the initiative. CIFM also received the two-year grant from The Colorado Health Foundation for the Director of Recruitment. Recently, the Institute was awarded $25,000 from both the Copic Foundation and the Caring for Colorado Foundation to produce the recruitment video. The mission of CIFM is: "To support the implementation, development and improvement of a patient-centered primary care system through Colorado's network of Family Medicine residencies and the Department of Family Medicine at the Colorado School of Medicine. The Dean of RVU was recently recruited to serve on CIFM's board. This mission statement will be amended to formally include RVU in the Institute's work.

"

*Conclusion: Steadfast on Mission*

Health care encompasses a complex array of intertwining elements, yet laced with conflicting policies, expectations and demands. For example, the growing need for Family Medicine/primary care physicians does not align with the financing for family Medicine residency training, reimbursement for primary care, or the status given primary care in most academic health centers. The Commission cannot control the environmental factors discussed in this section**.** However, the Commission reviews and assesses these topics and related key trends as integral to its strategic planning to stay steadfastly on **Mission**:

***To the health care needs of the people of Colorado through the education of Family Physicians and the promotion of patient centered primary care*.**

**Work Load Indicators: Statistics**

COFM's structure and relationship to its constituent family medicine residencies do not lead to multiple workload indicators. The one area where this item applies is COFM's collaborative recruitment of medical students to train in Colorado's Family Medicine residencies. However, the individual residencies are responsible for scheduling the interviews. These statistics are reflected in the following matrix. Aside from the collaboration of the State's nine Family Medicine residencies through COFM, success in the recruitment of medical students to train in these programs is the foundation for COFM's administrative and programmatic functions. There was a small drop in number of interviewees and interviews in 2009 over 2008. This may be the result of some of the residencies losing some information or reflect the continued declining in family medicine on the part of US medical students. Results for 2010 show a significant increase for last year. It is reasonable to attribute this success to having a full-time Director of Recruitment.

*Number of Residency Fairs Attended:*

| 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|
| 5 | 6 | 16 | 22 | 20 | 20 | 23 | 23 | 29 |

*Number of Unduplicated Medical Students Interviewing in Colorado for Family Medicine*

| 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|
| 224 | 202 | 225 | 242 | 251 | 268 | 297 | 282 | 351 |

*Number of Interviews*

| 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|
| 549 | 509 | 507 | 578 | 631 | 644 | 741 | 731 | 902 |

## FY 2010/2011 STRATEGIC PLAN: COMMISSION ON FAMILY MEDICINE (COFM)

### *EXECUTIVE LETTER: A Retrospective and Prospective Report on COFM*

COFM History

Thirty-three years ago, Harvey Phelps, MD, a pulmonologist and a seasoned State Senator from Pueblo, toured his district to determine its needs first-hand. His tours brought him face-to-face with a pair of Family Physicians fresh from residency training. This was not long after "General Practice" had been transformed into a board-certified, residency-trained specialty known as family medicine in response to people's need for a physician who specialized not in hospital care but in caring for "most of the problems that most of the people suffered most of the time." Dr. Phelps experienced personally the type of physician the people of Colorado needed, especially in rural and other underserved areas of the State. Tillie Bishop, a second-year State representative from Grand Junction, was intent on securing State funding to start a rural-oriented Family Medicine residency to provide primary care for the Western Slope. Senator Phelps and Representative Bishop forged a bi-partisan coalition to create the Commission of Family Medicine (COFM) to meet Colorado's need for primary care, especially in underserved areas of the state by:

- Assisting in obtaining State funding for Family Medicine residency training;
- Encouraging the State's Family medicine residencies to collaborate with the consumers of health care and with each other to address Colorado's need for Family Physicians;
- Calling for Family Medicine residencies recognized for the quality of their training.

COFM Today

COFM today is a unique, national model. The State's nine Family Medicine residencies function routinely at a level of collaboration that befuddles the directors of residencies from other states. The effectiveness of this collaborative approach to Family Medicine residency is reflective of the key accomplishments for FY 2009-10: (1) All 65 first-year positions were filled, with 89% being from 40 medical schools outside of Colorado; and (2) 68% of graduating residents are now working in the State. Thirty-five percent of the (15 out of 43 2010 graduates chose a rural community (eight) or an underserved urban practice (7). These are targets COFM annually meets and expects to accomplish in the future. However, COFM reached its niche of success through a collaborative posture after a number of contentious years.

The legislation which created COFM did not set forth a formula for allocating State funding to the individual residencies. Nor did the legislation suggest avenues for the residencies to lay aside their "special interests" on behalf of the "people of Colorado." Simply put, the value of collaboration gradually surfaced as the principle and "ethos" that would not only contribute to "the welfare of the State" but to each of the individual residencies. COFM, especially the residency directors, recognized that viewing Family Medicine training in Colorado as a "system" rather than a service of individual residencies helped to foster understanding in the State

Legislature for funding and redirected energies from debating methods for dividing State funding to other elements of residency training that benefited their individual programs. The collaborative focus became the recruitment of medical students from outside of Colorado to train in the State's Family Medicine residencies. The importance of achieving this level of collaboration of the State's Family Medicine residencies cannot be understated.

Patient Centered Medical Home Residency Project

COFM is collaborating with the HealthTeamWorks (formerly, Colorado Clinical Guidelines Collaborative), the Colorado Association of Family Medicine Residencies and the Department of Family Medicine at the University of Colorado School of Medicine in administering and implementing a 2.8 million dollar grant from The Colorado Health Foundation to transform the residencies' curricula and practices in Patient Centered Medical Home Models. This transformation is being accomplished through a collaborative structure and approach involving all of the nine family medicine residencies. In this respect, it is a unique and national venture. The project started in December 2008, with funding from The Colorado Health Foundation running through December 2011. As expected, the first year brought with it a number of procedural and didactic challenges. However, after three "Learning Collaboratives", which bring together 150 representatives (residents, faculty, medical staff and front-office personnel) from all of the nine residencies, the project is showing evidence of success. The project has garnered national attention, since it involves all of Colorado's Family Medicine residencies in a collaborative venture. Staff at the Department of Family Medicine have made presentations about the project at several national conferences. The initiative is expected to result in several publications.

Collaborative Recruitment Efforts

Realistically the residencies are competing for a set pool of medical students interested in Family Medicine. However, through COFM the residency directors have agreed to key, collaborative principles:

- A motto of "One for all! All for one!" This translates into a philosophy of the more medical students we attract to apply to Colorado's Family Medicine residencies, the higher the likelihood that all of the nine residencies will recruit quality residents.
- A second motto that reads: "There's a program just for you!" While Colorado has nine Family Medicine residencies, a range of diversity exists based on the locale of the program and particular emphases (e.g. OB, sports medicine, procedures). COFM's marketing of Family Medicine in Colorado as a "system" attracts medical students with varying interests within family medicine.
- COFM prepares a brochure that promotes each of the residencies individually but within a collaborative framework. COFM also maintains a website with this philosophical anchor.
- COFM participates in "residency fairs" across the country based on the interviews at the various residencies. The programs provide COFM with data regarding their interviewees to determine the areas of the country and specific medical schools that appear to be targets for recruitment.

- COFM's Director of Recruitment is the spokesperson for Colorado's Family Medicine residencies at these residency fairs. Having a full-time staff dedicated to recruitment has strengthened an already successful program.
- The Copic Foundation and the Caring for Colorado Foundation each awarded a grant for $25,000 to create a professionally produced music-based recruitment video, which has received significant plaudits from medical students, residents, and recruiters from other states.

The residencies' collaborative efforts also extend into staffing the rural/underserved rotation required of all Family Medicine residents training in Colorado. COFM has selected sites for this rotation based on a Request for Proposals. COFM staff coordinates the schedule for completing the rotation and collection of the residents' evaluations of the rotation. This collaborative approach leads to an experience that is generally positive for the residents and on-site training physicians, as well as to the training communities' recruitment efforts. The results of the past several years have demonstrated the importance of awarding the residents a stipend of $300 to cover travel and meals. This practice started four years ago with a grant from The Colorado Trust. At that time less than 60% of the residents were opting for a rural setting to complete this requirement; the urban site at a Plan de Salud Community Health Center was gaining popularity because it afforded a daily commute. For FY 2010/11, 56 of the 60 (93%) residents scheduled for this rotation have selected one of the rural communities that partner with COFM in this important program.

Other Collaborative Efforts

Success in collaborating to recruit medical students to Colorado and in implementing a required rotation in a rural or underserved community has led to collaboration in areas fundamental to training residents. These include:

- Statewide Leadership Training for Chief Residents, who serve as middle managers in the residencies, because of their roles as liaisons between their colleagues and the director/faculty. These are potentially future residency faculty and leaders of the profession. Their role is vital to maintaining a productive environment and morale in the residencies, as well as in recruiting faculty and medical students to their programs.
- Joint recruitment of faculty: COFM's Director of Recruitment is the point-person for this collaborative endeavor, which has been developed as a fundamental strategy for addressing the mounting difficulty of recruiting Family Physicians as residency faculty.
- State-wide faculty development project, which aims at the continuing medical education of the residencies' faculty as well as their professional (e.g. leadership) development. As with joint recruitment of faculty, this is the key strategy for recruiting faculty as well as residents to the Colorado programs.
- Curriculum Review and Evaluation Workforce Project, which is a new initiative that brings together a representative of each residency to work on maintaining strong, up-to-date curricula in all of the Colorado Family Medicine residencies and to cross-train (sharing their expertise rather than looking outside the state for "experts').
- Administration of a two-year grant (with an option to request funding for an additional year) from The Colorado Health Foundation to hire a full-time Director of Recruitment,

with the responsibility of managing an even more intense program to recruit (1) residents to Colorado's Family Medicine residencies; (2) faculty to the programs; (3) and graduating residents to work in Colorado, especially in rural and underserved areas of the State.

## ***INTRODUCTION***

A Public-Private Enterprise

The Commission on Family Medicine (COFM) is a collaborative and successful model for providing valuable service to the people of Colorado in a vital area: health care. First, it is a public-private venture--an enterprise that brings together nine private health care facilities to benefit the welfare of the State in collaboration with citizen representatives (consumers of health care) from Colorado's seven Congressional Districts. Secondly, the Commission brings together these nine businesses (the Family Medicine residencies and their sponsoring hospitals) to coordinate their efforts in training Family Physicians to meet the needs of the people living in Colorado for primary care. The Commission is an effective illustration of what can be achieved when vision is broadened to include **all** of Colorado and a tradition of cooperation and teamwork is fostered.

Why should the State participate in this endeavor?

With $869,423 of General Funds (plus an equal amount of federal matching funds), Colorado will leverage 59.3 million dollars expended, **in the aggregate,** by the nine family medicine residencies to train 188 family medicine residents during FY 2010/11. State funding leads to a partnership of the nine Family Medicine residencies with four significant outcomes:

- Collaborative recruitment of medical students from across the country to train in the State's Family Medicine residencies, especially in a time of a radical decrease in medical students' interest in primary care.
- Recruitment of Family Physicians to Colorado, especially to rural and underserved communities;
- Retention of Family Physicians in rural and underserved communities by requiring Family Medicine residents training in Colorado to complete a rotation in a rural or underserved community; and
- Health care for uninsured, Medicaid and Medicare patients.

**Without State funding, the Commission would cease to exist, since it has no other sources of revenue. This would also spell the demise of the longstanding, successful collaboration of the State's Family Medicine residencies**. All State funding to COFM directly supports the training of Family Medicine residents. COFM receives no State funding for its administrative and programmatic functions. The Colorado Association of Family Medicine Residencies, a private not-for-profit professional organization of the residency directors, funds all of the administrative and programmatic functions of COFM.

The presence of family medicine residencies in Colorado is a strong asset for providing the needed supply of primary care physicians in the State. Family Physicians represent 55% of all primary care physicians in Colorado and 75% in the rural areas of the State. Historically 85%-90% of the residents come from outside of Colorado to train in Colorado's nine nationally-recognized programs. The collaborative effort has created a cadre of strong programs, which, coupled with Colorado's reputation as a desirable place to live, are key marketing points in recruiting medical students from throughout the country to train as family physicians and stay in Colorado. The residencies and their affiliated hospitals are located in Ft. Collins (Poudre Valley), Grand Junction (St. Mary's), Greeley (North Colorado), Pueblo (St. Mary Corwin), Littleton (Swedish), Westminster (St. Anthony North) and Denver (Rose, St. Joseph and University). In addition, Denver Health operates a track (in affiliation with the University program) to train two Family Medicine residents per year, with an emphasis on working in an urban underserved community. Also, the Greeley program operates a Rural Training Track in Wray and an urban underserved track at the Sunrise Community Health Center.

A Health Care Safety Net

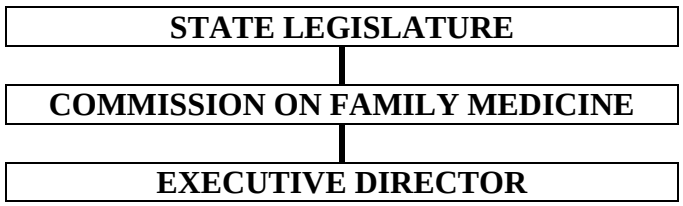
While the legislation which created COFM is silent about the residencies' role as providers of primary care, the family medicine training centers are part of Colorado's "safety-net". COFM data indicate that during this past year 70.5% of the 73,000 people served by the family medicine residencies were Medicaid (35.5%), Medicare (13.6) or uninsured (21.4%). Without the presence of the Family Medicine residencies, access for the Medicaid, uninsured and Medicare populations would further deteriorate.

In summary, as centers of education in Family Medicine residency training, Colorado's Family Medicine residencies not only fulfill the legislative mandate of meeting the State's need for Family Physicians, but also provide health care to populations who increasingly are finding it difficult to access needed care. The Family Medicine residencies thrive, in substantial part, due to the efforts of the Commission.

## ***STATUATORY AUTHORITY***

The statutory authority for the Commission on Family Medicine is found at Title 25-1-901 through 25-904, Colorado Revised Statues (1997).

## ***ORGANIZATIONAL CHART***



## MISSION STATEMENT

*To address the health care needs of the people of Colorado through the education of Family Physicians and the promotion of patient-centered primary care (***Revised: 7/15/09).**

## *VISION STATEMENT*

*Through a unique state-wide public-private collaboration, lead the nation's premier Family Medicine residencies in providing quality Family Physicians for the people of Colorado, while positively impacting health and healthcare through the power of primary care (***Revised: 7/15/2009**).

Comment: Rationale for Revisions

At its 7/15/09 strategic planning session, COFM engaged in a fundamental review of both its Mission and Vision Statements. The members strongly affirmed the fundamental importance of training Family Physicians for Colorado, as consistently supported by formal research and more recently by voluminous anecdotal data found in the print and electronic media. These sources strongly support the fundamental relevance of primary care to transforming the nation's health care approach into a system that is accessible to all, affordable, and built on patient safety and personal responsibility for one's health. Specifically, the importance of Family Medicine to this endeavor has received greater focus, as the number of medical students entering the other two primary care specialties of General Internal Medicine and General Pediatrics continues to decline.

Moreover, the percentage of US medical students opting for Family medicine continues to remain flat, even as a number of medical schools have expanded their class size and several new schools of medicine have been created: The 2009 Residency Matching Program noted that 7.9% of all US senior medical students went into family medicine, a 0.5% increase from last year but a decline from 8.15% in 2008. This does not bode well for the future for three fundamental reasons: (1) the ageing of the Family Physician workforce; (2) the absolute increase in Colorado's and the nation's population; and (3) the significant bump in older people expected as a result of the "baby-boomers."

In discussing this scenario, the Residency Director facilitating this segment of the session observed that the Mission and Vision Statements did not identify the "outcome" or specify the contribution of Family Physicians to healthcare. The revisions to both statements are crafted to simply state "why" Family Physicians are important to Colorado's and the nation's healthcare. Also couched in these revised declarations is COFM's intent to engage and educate decision-makers (relative to paying for health care as well as developing policy) and consumers of health care (patients) about primary care. This perspective was reaffirmed and expanded at the July 21, 2010 COFM Strategic Planning Session. Specific strategies are noted in the Goals and Objectives section of this Strategic Plan.

On-Going Concerns

Three areas of health care policy stand in the way of reversing the trends noted above and increasing the number of family medicine residents trained in Colorado either through expansion of the current programs or creating new residencies. The first is changing the funding for Graduate Medical Education (GME or residency training). The current system significantly favors the training of non-primary care specialists or hospital-based physicians; it actually stifles the development of a cost-effective approach for training Family Physicians. Second, the current reimbursement system favors subspecialty care at the expense of primary care. Physicians are paid to "do something" (complete a procedure) rather than care for the "whole" patient in a manner that fosters a relationship, helps the person navigate through a complex, health care system, and promotes preventive medicine (a healthy life style). Finally, a patient-centered model of care that integrates the various services needed by a patient is foreign to how health care is generally delivered in this country.

At a fundamental level, the Mission and Vision Statements reflect COFM's efforts to fulfill its legislative mandate (the "vision" articulated by Dr. Phelps thirty-two years ago as he witnessed the tangible outcome/benefits of family physicians) and anchor its basic, nitty-gritty work and value to the health of the people in Colorado: (1) assuring that Colorado's Family Medicine residencies are of high caliber; (2) recruiting medical students from across the country to fill its 65 positions in each of the three years of Family Medicine residency training; and (3) addressing the State's need for Family Physicians. The Statements also imply taking on the more challenging aspect of changing health care policy relevant to: (1) the funding of Family Medicine GME; (2) recognition of the value of primary care and, thus, appropriate compensation for primary care physicians; and (3) developing a patient-centered model of care that offers an integrated approach to the delivery of health care. COFM is committed to participating in efforts to achieve these changes in health care policy, as well as exploring opportunities to initiate collaborative efforts to achieve these needed developments.

The new Goal, with three corresponding objectives, are intertwined with these issues. COFM initiated its commitment to work towards change with the attached letter (Attachment III).

The entire State funding is devoted to implementing COFM's Mission and Statements. State funding anchors the collaboration of the family medicine residencies with each other and with the "consumers of health care". Without this funding, the structure supporting this collaboration vanishes. Also, State funding forms the basis for the residencies to make an annual contribution to the Colorado Association of Family Medicine Residencies (CAFMR) to fund all of COFM's administrative and programmatic functions. **Without State funding, it is inconceivable that the residencies' sponsoring hospitals would fund the programs to financially support COFM.**

## COMMISSION ON FAMILY MEDICINE CORE OBJECTIVES AND PERFORMANCE MEASURES

### 1. Training Family Medicine Residents in Colorado

*Objective:* Recruit high quality medical students from across the country to train in one of Colorado's Family Medicine residencies.

| Performance Measure | Outcome | FY 08-09 Actual | FY 09-10 Actual | FY 10-11 Approp. | FY 11-12 Request |
|---|---|---|---|---|---|
| Annually fill 100% of available training positions | Benchmark | 100% | 100% | 100% | 100% |
| | Actual | 100% | 100% | 100% | Unknown |

Strategies:

- All nine residencies partner to recruit nationally on a cooperative basis, principally by maintaining a joint website, developing collaborative public relations materials, equally sharing recruitment costs, and working from a principle of "All for one! One for all!"
- Participate in at least 30 "residency fairs" across the country based on the medical schools from which applicants to Colorado's Family Medicine residencies graduate.
- Recruit nationally both in allopathic and osteopathic medical schools.
- Financially and programmatically support activities of the Family Medicine Interest Groups at the Schools of Medicine at CU and RVU.
- Host a "Residency Night" for students from the CU and RVU Schools of Medicine to visit with representatives from each of Colorado's Family Medicine residencies.
- Each residency hosts medical students from across the country for a fourth-year clerkship to experience Family Medicine residency training in Colorado.
- Expand the scope of outreach to medical students by employing a structured program for using new internet-based tools.
- Show the recruitment video at all residency fairs at which COFM participates.
- Request a three-year extension from TCHF for funding the Director of Recruitment

Evaluation of Success in Meeting Benchmark

Historically, 85%-90% of the residents training in Colorado's nine Family Medicine residencies are from medical schools outside of Colorado. This trend continued with the current new group of residents, with 89% coming from 40 medical schools outside of Colorado. Also, COFM's collaboration with the residencies resulted in filling all 65 first year positions in these programs with graduates of US medical schools (one graduated from Ben Gurion University in Israel, which is a US-type medical school because of its affiliation with Columbia University). The percentage of residents training in the State's Family Medicine residencies from medical schools outside of Colorado may change over the next few years as the Rural Training Track at the University of Colorado graduates its first class of 12 in 2009. Additionally, Rocky Vista University of Osteopathic Medicine opened with the 2008 academic year and anticipates educating 160 students per year. Nonetheless, COFM will continue its intense collaborative approach to recruiting medical

students from across the country to train in Colorado's Family Medicine residencies. The number of medical students interviewing in Colorado in 2010 increased by 24.5% over 2009 (from 282 t0351, with a parallel drop in interviewees from non-US medical schools from 21 in 2009 to 12 this year.)

The American Academy of Family Physicians describes the results of this year's match as showing a "slight uptick in the number of medical students choosing primary care specialties…(However) The majority of positions offered and filled in the National Residency Matching Program continue to be in non-primary care subspecialties. This continued trend is worrisome, as a shortage of primary care physicians negatively affects the nation."

As stated earlier, 91.4% of positions offered were filled through the match. The "scramble" is a process that allows for medical students who did not find a position through the match to be hired by a residency that did not fill all of its positions through the match. After the "scramble was completed, 3,306 of the 3,316 Family Medicine resident positions offered were filled. Graduates of US medical schools filled 61.6% of these positions and 38.4% (1,270 of the 3,306) filled by graduates of foreign medical schools (771 US citizens and 499 non-US citizens). Thus, Colorado's Family Medicine residencies reached a very high level of success.

Given these trends, COFM will continue its recruitment efforts at least 30 "residency fairs" from coast-to-coast; these are events aimed at having residency representatives meet with medical students. The ageing of the physician workforce and the growing Colorado population (especially in the elderly component) put further pressure on making sure that through COFM's collaborative efforts the residencies annually fill their training positions.

**2. Demand for Primary Care**

*Objective:* Address Colorado's Increasing Need for Family Physicians

| Performance Measure | Outcome | FY 08-09 Actual | FY 09-10 Actual | FY 10-11 Approp. | FY 11-12 Request |
|---|---|---|---|---|---|
| Annually Retain 60% of graduating residents | Benchmark | 60% | 60% | 60% | 60% |
| | Actual | 70% | 60% | 68% | Unknown |

Strategies

- Increase the number of residents training at the Denver Health Track by two per year (aimed at meeting the needs of urban underserved communities).

- Increase the number of residents training at the Greeley program by one per year, specifically at the Sun Rise Community Health Center to meet the needs of urban underserved communities.
- Maintain a file on third year residents with information relevant to their practice preferences.
- Maintain active file at each residency of positions available in Colorado for Family Physicians.
- Active involvement of the physician recruitment and placement service (CPR) of the Colorado Rural Health Center with each of the State's Family Medicine residencies.
- Post vacancies in Colorado for Family Physicians in the COFM/CAFMR website
- Collaborate with Copic Insurance Company and other physician groups to maintain a balanced tort environment in Colorado.
- Maintain collaboration with staff from Colorado's congressional delegation relative to federal funding for Graduate Medical Education (residency training).
- Support the mature development of the Colorado Institute of Family Medicine as a key vehicle for securing additional resources for educating and training Family Physicians for Colorado.

*Objective:* Specifically Address the Need for Family Physicians in Rural and Urban Underserved areas of Colorado

| Performance Measure | Outcome | FY 08-09 Actual | FY 09-10 Actual | FY 10-11 Approp. | FY 11-12 Request |
|---|---|---|---|---|---|
| 30% of graduating residents working in Colorado opt for a rural or urban underserved area of the State | Benchmark | 30% | 30% | 30% | 30% |
| | Actual | 42% | 46% | 35% | Unknown |

Strategies

- The Director of Recruitment has a strong working relationship with the staff at the Colorado Rural Health Center and Colorado Community Health Network who are responsible for physician recruitment.
- The Director of Recruitment represents COFM on the State's Loan Repayment Program.
- CPR actively recruits the state's Family Medicine residents by visiting and making a presentation at each of the nine residencies, specifically by promoting the available loan repayment programs.
- Continue to refine and emphasize the rural rotation required of all Family Medicine residents training in Colorado.
- Recruit nationally at medical schools with an emphasis on or reputation for training in rural medicine.

- Build on the grant from The Colorado Trust to craft a public relations program to help rural communities articulate and publish the benefits of rural medicine in their respective areas.
- Develop a structured process for the graduates of the Rural Training Track at the University of Colorado School of Medicine to train in one of the State's Family Medicine residencies.
- **(Pending results of HRSA Gran)** Develop a rural training track (RTT) through the University Residency at Valley-Wide Health Systems, which operates a number of clinics in the San Luis Valley. This would mean an additional two trainees per year. An RTT is an effective modality for recruiting and training medical students who opt for rural family medicine. However, the model is costly. Also, the interest in family medicine and rural practice, in particular, continues to wane. Nonetheless, the University Program with the full support of the Department of Family Medicine is actively working with Valley-Wide in conducting a feasibility study. COFM secured a $10,000 planning grant from the Colorado Rural Health Center to move the project forward.

Evaluation of Success in Meeting Benchmarks

One of the potential pitfalls of the fact that 85%-90% of residents training in Colorado's Family Medicine residencies graduate from medical schools out of state is that most of the graduating residents will return "home". Historically this has not been the case, especially over the past 10 years. The residency directors look for "the Colorado connection" as an unstated component of the selection process. Also, Colorado's national reputation as a "desirable place to train, practice and live" is the anchor for COFM's marketing and advertising initiatives. The overall percentage of graduating residents choosing to practice in Colorado had been at 65% or above the past three years. The Greeley Residency Director observed that the fact that none of his 2009 graduates chose to practice in Colorado contributed to the decline from 70% that year to 60% in 2009. He reflected that this could be a result of the disagreement that occurred with the affiliated hospital over the focus of the program; the 2009 graduating class was immersed in this conflict from the start of its training. The competition for recruiting these residents is intense. COFM's noticeable difficulty in this area is in obtaining graduates' commitment to practice in a rural or urban underserved area. Recruiting physicians to rural communities is the more difficult of the two "underserved" areas, because of the rural "life-style" and the professional challenges facing a family physician in the less populated communities of Colorado.

This year's results continue the success achieved in 2008. Eight of the 2010 graduates are now working in a rural community of Colorado and seven in an urban underserved area. Nine of these 15 graduates received loan repayment. It may also be telling that nine of the sixteen graduating residents who chose a rural practice outside of Colorado also received loan repayment. These numbers differ from the last several years and may indicate a growing importance of loan repayment. Fortunately, Colorado funding for loan repayment has improved the past several years.

This year's success in recruiting 15 of the 43 graduates (remaining in Colorado) to a rural or urban underserved area of Colorado is the result of COFM and the residencies' staff's efforts to highlight rural practice. A grant from The Colorado Trust has provided COFM with ample resources to emphasize the rural aspect of the rural/underserved rotation required of all Family Medicine residents training in the State. The grant ended in March of 2009; however, COFM secured additional funds to continue key components of this program.

**3. Colorado's Family Medicine Residencies Maintain an Earned Reputation for Excellence**

*Objective:* Consistently meet the faculty-ratio required by accrediting bodies

| Performance Measure | Outcome | FY 07-08 Actual | FY 08-09 Actual | FY 09-10 Approp. | FY 10-11 Request |
|---|---|---|---|---|---|
| Number of Residency Director positions open for more than 12 months | Benchmark | 0 | 0 | 0 | 0 |
| | Actual | 0 | 0 | 0 | 0 |

| Performance Measure | Outcome | FY 07-08 Actual | FY 08-09 Actual | FY 09-10 Approp. | FY 10-11 Request |
|---|---|---|---|---|---|
| Number of faculty positions open for more than 12 months | Benchmark | 0 | 0 | 0 | 0 |
| | Actual | 0 | 0 | 0 | 0 |

Strategies:

- Formally recruit faculty in a joint manner: Previously the collaborative approach to recruiting directors and faculty was informal—a verbal agreement to do so. The key trigger for this initiative is the fierce competition for faculty and residency directors. One of the key responsibilities of the new Director of Recruitment is to develop a structured, nationally-focused program in this area, including new recruitment models.
- Continue the formal, leadership training program for Chief Residents. (Note: Chief Residents are selected by residency faculty to serve as liaison between them and the residents; for practical purposes, they are "junior" faculty and serve a vital role in residency training. Chief Residents are critical to the morale and professional ambience in a residency. Their role and work impacts both the recruitment and retention of faculty, as well as recruitment of medical students as residents.)
- Residencies will continue their collaborative effort to transform their curricula and practices into Patient-Centered Medical Home models by participation in the project funded by TCHF.

- **(New)** Develop language/statements to articulate the emerging status (the incubation period) of the Patient-Centered Medical Home and to educate "the public" about its benefits and value.
- **(New)** Create a formal process for training faculty and residents in "transformational change", in order to sustain on-going reform of health care and move beyond the PCMH model.

Evaluation of Success in Meeting Benchmarks

The competition for residency directors and faculty is arguably fiercer than for residents. The three director positions which were open during 2008/09 were filled early in 2009. Two vacancies were filled from within the residencies. One of the directors (who has been in his position for 20 years) will resign as of September 30, 2010. An interim director has been named. The outgoing director planned for his success by sending to internal candidates for the position to the National Institute for Program Directors. This is an intensive, two year training for future Family Medicine residency director.

Five faculty positions were filled during FY 209-2010. However, an additional five faculty positions are now open at three of the residencies. The directors have agreed that an on-going faculty recruitment effort is necessary. Seemingly, as one position is filled another opens up. Formal, year-around faculty recruitment will be sustained. The directors discovered that "word-of-mouth", with a focus on graduates of their programs is the best marketing tools. Also, the Director of Recruitment recognized that practicing Family Physicians may not recognize the opportunities available as residency faculty.

One of the successful approaches for filling faculty openings on an interim basis is to hire former graduates practicing near the residency on a part-time, piecemeal basis. To their credit, the directors work collaboratively in filling these positions—to the point of referring candidates if their qualifications do not match the position for which the program is recruiting. This collaboration, as noted above, took on a more formal characteristic by creating a joint recruitment advertisement/recruitment effort with the Director of Recruitment as the point-person.

One of the outcomes of the collaborative Faculty Development Project is both the retention of current faculty and recruitment of new faculty. The literature supports the positive effects on recruitment and retention of a formal effort to provide ongoing training of faculty—both medically and professionally. A strong Faculty Development Program also leads to sustaining a positive morale within the faculty, which helps to recruit residents and provide strong role models.

The new strategies are anchored primarily on the revised Vision Statement, COFM's consistent success in strongly meeting its legislative mandate, involvement of Representatives from Colorado's Congressional Districts (consumers of health care), and the three-year, 2.8 million dollar grant from The Colorado Health Foundation to transform the residencies' curricula and practices into PCMH models. Furthermore, at its strategic planning session, COFM observed that the "patient voice" has not been

identified as integral to health care reform (the recent heated debates over proposed reform not-withstanding) nor is there a forum for a "patient voice" to impact "health and healthcare through the power of primary care." COFM will investigate taking a leadership role in this arena.

**4. Contribution to Safety-Net**

**(Formulated as an objective in 2008)** Historically, the family medicine residencies have served populations regularly served by Colorado's "safety-net; COFM has reported statistics relative to this topic. However, this marks the first year that COFM will report this service as an objective with a corresponding performance measure. Specific information for Medicaid, Medicare and Indigent populations will be presented in the evaluation section.

*Objective:* Family Medicine Residencies are formally recognized as part of Colorado's Safety-Net

| Performance Measure | Outcome | FY 08-0 Actual | FY 09-10 Actual | FY 10-11 Approp. | FY 11-12 Request |
|---|---|---|---|---|---|
| 60% of patients served by the nine family medicine residencies are covered by Medicare or Medicaid or are uninsured | Benchmark | 60% | 60% | 60% | 60% |
| | Actual | 68.6% | 66.8% | 70.5% | Unknown |

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Strategies

- Residencies maintain a sliding fee scale or refuse no one based on financial circumstances.
- Residencies participate in ClinicNet, which is a collaborative of Colorado's healthcare organizations, which serve the indigent and underserved but are not federally qualified clinics.

Evaluation of Success in Meeting Benchmarks

Information gathered from the nine family medicine residencies for this past fiscal year indicates that in the aggregate 70.5% of the people served by the residencies were Medicaid (35.5%), Medicare (13.6%) or uninsured (21.4%) patients. Two residences report that nearly 91% of its patients fall into these categories; another two in the 83% range. Two key factors account for the latter: (1) Where the residencies are located; and (2) The availability of private practices for Medicaid and Medicare patients. While the residencies serve as part of the "safety-net" in their service area, it is important to note that the program's mission and mandate are to train Family Physicians. Thus, the provision of service, especially to these "vulnerable" populations, must be balanced with assuring that the residents receive the training required by the accrediting bodies.

**NOTE: THE FOLLOWING IS A NEW GOAL AREA AND OBJECTIVES WERE DEVELOPED AT THE JULY 21, 2010 STRATEGIC PLAN, SPECIALLY AIMED AT GRADUATE MEDICAL EDUCATION. COFM WILL REVIEW AND REFINE THESE ITEMS AT ITS MEETING OF OCTOBER 20, 2010. OBJECTIVE #3 IS BOLD AND EXPANSIVE. COFM HAS TAKEN INITIAL STEPS TO SECURE FUNDNG TO HOST A MEETING OF SELECT LEADERS IN FAMILY MEDICINE RESIDENCY TRAINING AND CONGRESSIONAL MEMEMBERS TO TEST THE FEASIBILITY OF THIS FAR-REACHING INITIATIVE. THE TIMELINES AND SPECIFICS OF THE PROJECT WILL CHANGE AS IMPLEMENTATION PROGRESSES.**

**GOAL: Establish primary care as a building block of the health care system.**

**Objective #1**

**Develop and implement a formal communications plan to inform, educate and influence all sectors of the population to demand a health care system anchored on primary care.**

***Strategies***

- Position COFM as an organization with an allegiance to meeting the fundamental health care needs of the people of Colorado and with no self-serving interest.
- Engage the Districts Representatives in promoting the benefits of COFM to the people of Colorado.
- Identify and segment audiences.
- Develop a menu of documents, segmented by specific audiences that describe the value and benefits of primary care.
- Create anecdotes to exemplify the benefits and value of primary care.
- Train Colorado's Family Medicine residents to become active participants in the communications plan.
- Be an active participant in the Governor's Health Care Reform Workforce Initiative and the Primary Care Collaborative initiated by The Colorado Trust, as well as other similar endeavors that may arise.
- Create a "Call to Action" that specifies steps that individuals/organizations can take, appropriate to their area of responsibility, influence, or interest, that establishes primary care as an essential component of a health care system.
- Establish working partnerships with key business, community and civic organizations.

***Outcome Measure***

- COFM is identified by such segments as business organizations, health care plans, and state government as a thought leader in the design and delivery of primary care, as well as the expert in Family Medicine workforce issues.

**Objective #2**

**Respond to opportunities in the new health care reform bill for adding resident positions.**

***Strategy***

- Select residencies submit applications to expand their programs.

***Outcome Measures***

- Three additional positions are added for the 2011 match
- Four additional positions are added for the 2012 match

**Objective 3#**

**Revamp the system for funding Graduate Medical Education (GME) to meet the current and anticipated demand for Family Physicians, including removing the current cap on GME positions.**

***Strategies***

- Meet individually and collectively with members of Colorado's Congressional Delegation and their staff to propose changes to GME to train the needed physician primary care workforce.
- Meet with elected officials and other policy- and decision makers participating at the AAFP National Conference being held in Denver from September 29 – October 2, 2010.
- Organize a Western Regional forum to expand beyond Colorado support for the initiative to redesign the GME system.
- Draft legislation, as supported by this western consortium, to revise the GME system.
- Coordinate recruiting members of Congress from the states participating in the Western Regional Forum to support the legislation and identify who will introduce the proposal for Congressional review and action.
- Identify other supporters for the legislation (e.g. AAFP, national and local associations of community health centers) to solicit their support and coordinate lobbying activities.

***Outcome Measure***

- Legislation is introduced in the 2011 Congressional session and adopted by Congress in December of 2012.

# Commission on Family Medicine
FY 2011-12 Budget Cycle
Schedule 3

| | FY 2008-09 | | FY 2009-10 | | FY 2010-11 | | FY 2010-11 | | FY 2011-12 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actuals | FTE | Actuals | FTE | Appropriated | FTE | Estimate | FTE | Request | FTE |
| HB 08-1375, SB 09-259, HB 10-1376 Prior Year Appropriation (Long Bill) | | | | | | | | | | |
| Total Funds | $2,173,558 | 0.0 | $1,932,052 | 0.0 | $1,738,846 | 0.0 | $1,738,846 | 0.0 | $1,738,846 | 0.0 |
| General Fund | $1,086,779 | | $966,026 | | $667,891 | | $667,891 | | $700,620 | |
| General Fund Exempt | $0 | | $0 | | $0 | | $0 | | $0 | |
| Cash Funds | $0 | | $0 | | $0 | | $0 | | $0 | |
| Cash Funds Exempt / Reappropriated Funds | $0 | | $0 | | $0 | | $0 | | $0 | |
| Federal Funds | $1,086,779 | | $966,026 | | $1,070,955 | | $1,070,955 | | $1,038,226 | |
| SB 09-187, HB 10-1300 (Agency Supplemental Bill) | | | | | | | | | | |
| Total Funds | $0 | 0.0 | ($193,206) | 0.0 | N/A | N/A | N/A | N/A | N/A | N/A |
| General Fund | $0 | | ($96,603) | | N/A | | N/A | | N/A | |
| General Fund Exempt | $0 | | $0 | | N/A | | N/A | | N/A | |
| Cash Funds | $0 | | $0 | | N/A | | N/A | | N/A | |
| Cash Funds Exempt / Reappropriated Funds | $0 | | $0 | | N/A | | N/A | | N/A | |
| Federal Funds | $0 | | ($96,603) | | N/A | | N/A | | N/A | |
| SB 09-259, HB 10-1376 (Long Bill Add-ons) | | | | | | | | | | |
| Total Funds | $0 | 0.0 | $0 | 0.0 | N/A | N/A | N/A | N/A | N/A | N/A |
| General Fund | $0 | | ($201,532) | | N/A | | N/A | | N/A | |
| General Fund Exempt | $0 | | $0 | | N/A | | N/A | | N/A | |
| Cash Funds | $0 | | $0 | | N/A | | N/A | | N/A | |
| Cash Funds Exempt / Reappropriated Funds | $0 | | $0 | | N/A | | N/A | | N/A | |
| Federal Funds | $0 | | $201,532 | | N/A | | N/A | | N/A | |
| **Total Appropriation** | | | | | | | | | | |
| **Total Funds** | **$2,173,558** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** |
| **General Fund** | **$1,086,779** | | **$667,891** | | **$667,891** | | **$667,891** | | **$700,620** | |
| **General Fund Exempt** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds Exempt / Reappropriated Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |

Commission on Family Medicine
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| | FY 2008-09 | | FY 2009-10 | | FY 2010-11 | | FY 2010-11 | | FY 2011-12 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actuals | FTE | Actuals | FTE | Appropriated | FTE | Estimate | FTE | Request | FTE |
| **Federal Funds** | **$1,086,779** | | **$1,070,955** | | **$1,070,955** | | **$1,070,955** | | **$1,038,226** | |
| Request Year Base and Other Adjustments (see Reconciliation for details) | | | | | | | | | | |
| Total Funds | $0 | 0.0 | $0 | 0.0 | $0 | 0.0 | $0 | 0.0 | $0 | 0.0 |
| General Fund | $0 | | $0 | | $0 | | $0 | | $201,532 | |
| General Fund Exempt | $0 | | $0 | | $0 | | $0 | | $0 | |
| Cash Funds | $0 | | $0 | | $0 | | $0 | | $0 | |
| Cash Funds Exempt / Reappropriated Funds | $0 | | $0 | | $0 | | $0 | | $0 | |
| Federal Funds | $0 | | $0 | | $0 | | $0 | | ($201,532) | |
| **Total Spending Authority / Request without Early Supplementals** | | | | | | | | | | |
| **Total Funds** | **$2,173,558** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** |
| **General Fund** | **$1,086,779** | | **$667,891** | | **$667,891** | | **$667,891** | | **$902,152** | |
| **General Fund Exempt** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds Exempt / Reappropriated Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Federal Funds** | **$1,086,779** | | **$1,070,955** | | **$1,070,955** | | **$1,070,955** | | **$836,694** | |
| # | | | | | | | | | | |
| Total Funds | N/A | N/A | N/A | N/A | $0 | 0.0 | $0 | 0.0 | $0 | 0.0 |
| General Fund | N/A | | N/A | | $0 | | $32,729 | | ($32,729) | |
| General Fund Exempt | N/A | | N/A | | $0 | | $0 | | $0 | |
| Cash Funds | N/A | | N/A | | $0 | | $0 | | $0 | |
| Cash Funds Exempt / Reappropriated Funds | N/A | | N/A | | $0 | | $0 | | $0 | |
| Federal Funds | N/A | | N/A | | $0 | | ($32,729) | | $32,729 | |
| **Early Supplemental Total** | | | | | | | | | | |
| **Total Funds** | **N/A** | **N/A** | **N/A** | **N/A** | **$0** | **0.0** | **$0** | **0.0** | **$0** | **0.0** |
| **General Fund** | **N/A** | | **N/A** | | **$0** | | **$32,729** | | **($32,729)** | |
| **General Fund Exempt** | **N/A** | | **N/A** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds** | **N/A** | | **N/A** | | **$0** | | **$0** | | **$0** | |

# Commission on Family Medicine
FY 2011-12 Budget Cycle
Schedule 3

| | FY 2008-09 | | FY 2009-10 | | FY 2010-11 | | FY 2010-11 | | FY 2011-12 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actuals | FTE | Actuals | FTE | Appropriated | FTE | Estimate | FTE | Request | FTE |
| **Cash Funds Exempt / Reappropriated Funds** | **N/A** | | **N/A** | | **$0** | | **$0** | | **$0** | |
| **Federal Funds** | **N/A** | | **N/A** | | **$0** | | **($32,729)** | | **$32,729** | |

**Total Spending Authority / Request**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Funds** | **$2,173,558** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** |
| **General Fund** | **$1,086,779** | | **$667,891** | | **$667,891** | | **$700,620** | | **$869,423** | |
| **General Fund Exempt** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds Exempt / Reappropriated Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Federal Funds** | **$1,086,779** | | **$1,070,955** | | **$1,070,955** | | **$1,038,226** | | **$869,423** | |

Expenditures

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Total Funds | $1,932,052 | 0.0 | $1,738,844 | 0.0 | N/A | N/A | N/A | N/A | N/A | N/A |
| General Fund | $825,226 | | $667,890 | | N/A | | N/A | | N/A | |
| General Fund Exempt | $0 | | $0 | | N/A | | N/A | | N/A | |
| Cash Funds | $0 | | $0 | | N/A | | N/A | | N/A | |
| Cash Funds Exempt / Reappropriated Funds | $0 | | $0 | | N/A | | N/A | | N/A | |
| Federal Funds | $1,106,826 | | $1,070,954 | | N/A | | N/A | | N/A | |

**Under/(Over) Expenditures**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Funds** | **$241,506** | **0.0** | **$2** | **0.0** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| **General Fund** | **$261,553** | | **$1** | | **N/A** | | **N/A** | | **N/A** | |
| **General Fund Exempt** | **$0** | | **$0** | | **N/A** | | **N/A** | | **N/A** | |
| **Cash Funds** | **$0** | | **$0** | | **N/A** | | **N/A** | | **N/A** | |
| **Cash Funds Exempt / Reappropriated Funds** | **$0** | | **$0** | | **N/A** | | **N/A** | | **N/A** | |
| **Federal Funds** | **($20,047)** | | **$1** | | **N/A** | | **N/A** | | **N/A** | |

**Total without Decision Items**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Funds** | **$1,932,052** | **0.0** | **$1,738,844** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** |
| **General Fund** | **$825,226** | | **$667,890** | | **$667,891** | | **$700,620** | | **$869,423** | |
| **General Fund Exempt** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |

# Commission on Family Medicine
FY 2011-12 Budget Cycle
Schedule 3

| | FY 2008-09 | | FY 2009-10 | | FY 2010-11 | | FY 2010-11 | | FY 2011-12 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actuals | FTE | Actuals | FTE | Appropriated | FTE | Estimate | FTE | Request | FTE |
| **Cash Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds Exempt / Reappropriated Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Federal Funds** | **$1,106,826** | | **$1,070,954** | | **$1,070,955** | | **$1,038,226** | | **$869,423** | |

**Grand Total**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Funds** | **$1,932,052** | **0.0** | **$1,738,844** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** | **$1,738,846** | **0.0** |
| **General Fund** | **$825,226** | | **$667,890** | | **$667,891** | | **$700,620** | | **$869,423** | |
| **General Fund Exempt** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Cash Funds Exempt / Reappropriated Funds** | **$0** | | **$0** | | **$0** | | **$0** | | **$0** | |
| **Federal Funds** | **$1,106,826** | | **$1,070,954** | | **$1,070,955** | | **$1,038,226** | | **$869,423** | |

**SCHEDULE 4**

**SOURCE OF FINANCING-DIRECT REVEUNUES**

**DEPARTMENT: Health Care Policy and Finance**

**AGENCY: Commission on Family Medicine**

| | Actual FY 2008-2009 | Actual FY 2009-2010 | Appropriation FY 2010-2011 | Estimate FY 2010-2011 | Reqeust FY 2011-2012 |
|---|---|---|---|---|---|
| **ADVISORY COMMISSION ON FAMILY MEDICINE** | | | | | |
| **Schedule 3 Total** | 1,932,052 | 1,738,844 | 1,738,846 | 1,738,846 | 1,738,846 |
| GF | 0 | 0 | 0 | 0 | 0 |
| CFE | 1,932,052 | 1,738,844 | 1,738,846 | 1,738,846 | 1,738,846 |
| MCF | 1,932,052 | 1,738,844 | 1,738,846 | 1,738,846 | 1,738,846 |
| MGF | 825,226 | 667,890 | 667,891 | 700,620 | 869,423 |
| | | | | | |
| **Residency Programs** | 1,932,052 | 1,738,844 | 1,738,846 | 1,738,846 | 1,738,846 |
| GF | 1,932,052 | 0 | 0 | 0 | 0 |
| CFE | 0 | 1,738,844 | 1,738,846 | 1,738,846 | 1,738,846 |
| MCF | 1,932,052 | 1,738,844 | 1,738,846 | 1,738,846 | 1,738,846 |
| MGF | 825,226 | 667,890 | 667,891 | 700,620 | 869,423 |
| | | | | | |
| **Commission Expenses** | 0 | 0 | 0 | 0 | 0 |
| GF | 0 | 0 | 0 | | 0 |
| CFE | 0 | 0 | 0 | 0 | 0 |

# APPENDIX 1

## Colorado Commission on Family Medicine (COFM)


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***Designates Family Medicine Residency Director**

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**Revised: 10/8/2010**

## APPENDIX II

### *RESIDENCY FUND PROFILE: FIVE YEAR TREND

| RESIDENCY | 2007-08 | 2008-09 | 2009-10 | 2010-11 | **Request** 2011-2012 |
|---|---|---|---|---|---|
| Ft. Collins | 211,506 | 214,672 | 193,205 | 193,205 | 193,205 |
| North Colorado | 211,506 | 214,672 | 193,205 | 193,205 | 193,205 |
| Rose | 211,506 | 214,672 | 193,205 | 193,205 | 193,205 |
| St. Anthony | 211,506 | 214,662 | 193,205 | 193,205 | 193,205 |
| St. Joseph | 211,506 | 214,672 | 193,205 | 193,205 | 193,205 |
| St. Mary | 211,506 | 214,672 | 193,205 | 193,205 | 193,205 |
| Southern Colorado | 211,506 | 214,672 | 193,205 | 193,205 | 193,205 |
| Swedish | 211,506 | 214,672 | 193,205 | 193,205 | 193,205 |
| University/AF Williams | 211,506 | 214,672 | 193,205 | 193,205 | 193,205 |

*__Rounded to the nearest whole dollar.__

**ATTACHMENT III**

**LETTERHEAD**

May 1, 2010

Dear President Obama (as well as Colorado's Senators and Representatives):

I write on behalf of Colorado's Commission on Family Medicine (COFM), which was created in 1977 through a bipartisan effort of the state legislature to focus on family medicine residency training as a fundamental means of addressing the needs of the people of Colorado for primary care. The purpose of my letter is to address COFM's concerns with the methodology outlined in the new health care law for reallocating unused Graduate Medical Education (GME) positions.

First, I present a little background information on COFM. Pursuant to the original legislation, COFM is both a structure and a forum for Colorado's nine family medicine residencies to work together in collaboration with health care consumers, who are appointed by the Governor to represent each of Colorado's congressional districts. As you know, Family Physicians do not spring from the doors of medical schools around the world – they must complete three-year post-medical school residencies before they are sufficiently trained to independently handle patient care. COFM has a thirty-three year history of not only recruiting medical students from across the country to train in Colorado, but also placing graduates throughout the state, including in rural and other under-served communities. Historically, eighty-five to ninety percent of our residents are from medical schools outside of Colorado and at least sixty-five percent of graduates remain in Colorado, with at least thirty-percent choosing to practice in a rural or urban under-served area. Our nine residencies are located in Denver, Fort Collins, Grand Junction, Greeley, and Pueblo. They train one hundred ninety-eight residents at a time, sixty-five in each of the three years of family medicine residency training.

The increasing nationwide demand for primary care, which is principally provided by Family Physicians, calls for expanding our residency programs. COFM's historical success in recruiting residents gives us confidence that our residencies could fill additional residency positions even as the pool of medical students interested in Family Medicine remains stagnant. *The cap imposed by Medicare on GME is the main stumbling block to increasing the number of Family Physicians who our residencies train.* We applaud your efforts to increase the number of primary care resident positions in the new health care law. However, we urge you to consider other factors in determining how to allocate unused GME positions in the future.

According to section 5503(D) of the new law, priority for increasing resident positions will be given to (i) hospitals located in a state with a resident-to-population ratio in the lowest quartile (as determined by the Secretary); (ii) hospitals located in a state, territory or the District of Columbia designated as among the top ten in health professional shortage areas; and (iii) hospitals located in rural areas.

Although the above criteria are important to consider in reallocating unused resident positions, we urge you to consider the points below:

- States with low resident-to-population ratios may have to remove obstacles which have resulted in such ratios. Allocating more resident positions to such states does not mean that more residents will choose to train there or remain in practice there. Most importantly, such states *must* have hospitals that are willing and able to finance and support new or expanded residencies.

- In order for residency training to work, hospitals must have the capacity to recruit residents for the new positions. Recruitment is critically important because the pool of medical students interested in primary care is woefully inadequate to meet the growing demand for primary care physicians.

- In order for residency training to work, hospitals must have the capacity to recruit faculty and staff to new or expanded residencies. In our experience, recruiting faculty is even more challenging than filling resident positions.

- Recruiting primary care physicians to rural settings is especially challenging. Rural hospitals may not have the resources to develop or expand residency training. While graduates of urban residencies may choose to practice in rural communities, creative solutions to address this issue are needed, such as partnerships between urban hospitals and their rural counterparts.

- **Fair and meaningful allocation of new family medicine residency positions should be determined after submission of state-wide plans which document the state's historical ability to fill residency positions, retention of graduates, and the number of graduates who opt for a rural community.**

- Congress or the appropriate federal agency should undertake a thorough review of unused resident positions in *every* field of medicine, and reallocate such positions as demand for medical services dictates.

- Allocation of unused resident positions should be accomplished in light of the "Teaching Health Centers" created in the new health care law. We urge you to support early publication of the rules governing development and operation of such centers. Partnership of family medicine residencies with Federally Qualified Community Centers and/or Teaching Health Centers will strengthen residency

training, provide resources for expansion of such training, and create greater access to primary care for Medicaid, Medicare and indigent populations.

COFM will hold its annual strategic planning session on July 21, 2010. Careful review of the new health care law will be a key segment of our deliberations. We will forward additional comments and suggestions which may assist you in revamping Graduate Medical Education to meet Colorado's and the nation's current need for primary care physicians to avert a crisis in the future.

Thank you. Please feel free to contact COFM's Executive Director, Antonio Prado-Gutierrez (303-724-9734; tony.prado-gutierrez@ucdenver.edu), or myself (Kristen_L_Mix@cod.uscourts.gov; 303-335-2774) with questions or to arrange a meeting with the Commission.

Very truly yours,

Hon. Kristen L. Mix
Chair, Colorado Commission on Family Medicine
1st Congressional District Representative