Commission on Family Medicine

Budget Request
FY 2012-2013

Colorado
Family Medicine Residencies

Family Medicine with an Altitute...

Mail Stop F496, Room 3402
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REQUEST BUDGET

For the Fiscal Year

2012-2013

COMMISSION ON FAMILY MEDICINE

Commission on Family Medicine: Budget Request FY 2012/2013

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COMMISSION ON FAMILY MEDICINE

PROGRAM DESCRIPTION; July 1, 2010

Organizational Chart

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, Director of Operations and Director of Recruitment 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 2011/12) 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 $62 million, which is the total amount budgeted by the nine family medicine residencies to train 194 residents during FY 2011/12 (plus an additional 8 at Denver Health, which does not qualify to receive state funding). **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 funded by The Colorado Health Foundation to transform the practices at our residencies into Medical Home Models and achieve NCQUA Level II accreditation.

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 2011/12 applicants to the nine Family Medicine residencies came from 103 (from a total of 159) US medical schools outside of Colorado. The new first year residents now training in the State's Family Medicine residencies are graduates of 45 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. 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 (33.2%) Medicare (13.1%) and uninsured (25.3%) patients represent 71.6% of the nearly 75,000 patients served by the medical practices of Colorado's nine Family Medicine residencies during FY 2010/11. The net result is that this past fiscal year, 53,700 Medicaid, uninsured and Medicare patients received their health care at one of the nine Family Medicine residencies. This is a 4.3% increase over FY 2008/09. The economic environment has increased the number of patients from these populations to seek care at the Family Medicine residencies. 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;
- An outreach clinic for the homeless in the Grand Junction area;
- A group pain clinic;
- A walk-in clinic for patients of the Ft. Collins program that has significantly reduced ER visits;
- 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 and the newly created Colorado Institute of Family Medicine as a 501-c- 3 have 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 the Caring for Colorado Foundation, the Copic Foundation, and The Colorado Health Foundation. Funding for the Rural/Underserved Rotation ($309,000), Rural training ($101,000), 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 the Colorado Medical Society Foundation, 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.
- Leadership training for the Chief Residents, who are the liaison between the residents and faculty.

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 2.8% of the $62.2 million that **in the aggregate** the nine Family Medicine residencies have budgeted to train 195 residents in FY 2011-12. (This number does not include the 8 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 18th year with COFM on June 30, 2011. 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 20011/12: $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	12%
• Placement of Graduates	25%
• Recruitment of Residents and Faculty	24%
• Staffing of Commission	5%
• Coordination of Activities with Residencies	12%
• Collaboration with CU School of Medicine	5%
• Partnership with Community Organizations	10%
• Research Activities	2%
• Management and Administration	5%

- **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. Seventy-four Family Medicine residents are scheduled to participate in this program during FY

2011/12, with 67 of the 74 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 ten 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. The likelihood is high that all or most of these will remain in Colorado.) 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 past June, 62 residents graduated. Sixty-three percent are now working in Colorado, with 33% of these choosing a rural or urban underserved community in the state. These significant accomplishments are 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**: All 69 first year positions were filled with graduates of US medical schools during the recent matching process. This was achieved even as four new slots were added this year, with three geared towards practice in an urban underserved community and one in a rural area. 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 40 residency fairs and other recruitment events 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.**

- About 2,000 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 include 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 20% graduates from DO schools of medicine. COFM recruits at all of the 13 osteopathic schools from Florida to Chicago to California and at the National Conference of the osteopathic student chapter of the American Council of Osteopathic Family Physicians.

  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 35% over last year. The 400 graduates of US medical schools represent 23% of the total number of US graduates that secured a position in a Family Medicine Residency through the National Residency Matching Program.

  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 69 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. 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. As first-ever participation in the national conference of the Academy of Uniformed Family Physicians proved to hold great potential for building a pool of faculty candidates. A similar experience with the Society of Teachers in Family Medicine proved to be unsuccessful, even though "theoretically" this organization is seen to be a likely place for recruitment of faculty. From a high of 6-8 vacancies this past year, there are only one or two vacant faculty positions.

- **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.

- **Chief Residents Training:** The Chief Residents are critical to the day-to-day operations of a residency. Simply put, they are the middle managers. They have responsibility for creating on-call schedules, resolving conflicts between their resident colleagues, and being intermediaries with faculty (including the residency director).

- **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

Continued Challenge of Training the Primary Care Workforce to Meet the Needs of the Country for Cost-Effective Care

The Commission notes that:

- Medical students' continuing weak interest in Family Medicine/primary care, resulting from a significant differential in salary between a primary care physician and a specialist. The differential totals $3 million over a career.
- Medical schools' environment favoring contact with specialist physicians.
- A general lack of value for primary care exists in academic health centers.
- An estimate from the American Academy of Family Physicians (AAFP) that the country will need 44,000 primary care physicians by 2015, with half being Family Physicians.
- The AAFP model calls for 83.2 primary care physicians per 100,000 people, with 41.6 being Family Physicians.
- With a population of 5.1 million, this AAFP model indicates that Colorado needs 4,243 primary care physicians, with 2,122 being Family Physicians.
- COFM estimates that in 2010 Colorado needs an additional 1,012 primary care physicians, with 393 being Family Physicians. These numbers become more dramatic for rural communities when the distribution of these physicians is considered.
- Nationally, Family Physicians make up 41.6% of primary care physicians but 54% in Colorado;
- Across the country, Family Physicians make up 61.7% of primary care physicians in rural areas but 73% in rural Colorado;
- Finally, AAFP estimates that nationally 14.8% of practicing physicians are Family Physicians. In Colorado the percentage is 17.9%.
- The 20th Report of the Council on Graduate Medical Education(COGME) strongly recommends that primary care physicians make up at least 40% of the country's physician workforce
- Rural health is fragile by nature and requires constant attention.

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 2011-2012. 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.

The GME Initiative

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 action resulted from the Commission "going on record" that a concerted effort is need to increase the number of Family Medicine residents training in Colorado, as well as create additional residencies in Family Medicine. The Commission set out to reach this goal by systematically educating our Congressional delegation of how the country's GME structure and financing system was fundamentally detrimental to addressing the workforce issues noted above. Senator Mark Udall recommended to the Commission that it extend its collaborative style to a regional level and, at least to begin with, involve the western states in working towards a reform of GME that would lead to transforming GME to be more favorable to primary care. The Commission took up the challenge, recruited experts in Family Medicine residency training form 10 states and the District of Columbia and interested consumers of health care, held a lengthy organizational conference call and an all-day forum this past July at the DIA Marriott. Funding for these initial steps was provided by a private institution. While several members of the Commission are involved in the GME Initiative, this project has developed beyond and independent of COFM.

Creation of the 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 and a third year of funding ($157,000) for the Recruitment Program.

The **Vision** of CIFM is: A Colorado in which Family Medicine training and practice are sufficiently supported so that everyone has access to comprehensive, effective care.

The **Mission** of CIFM is: To support primary care to lead to a healthier Colorado.

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 2011 show a significant increase for last year. It is reasonable to attribute this success to having a full-time Director of Recruitment. The success noted below now allows for more selective recruiting. Also, 400 interviews is most likely the maximum that the state's network of Family Medicine residencies can process. The interview "season" and process is very labor intensive and disrupts the flow of training and taking care of patients.

Number of Residency Fairs Attended:

2003	2004	2005	2006	2007	2008	2009	2010	2011
6	16	22	20	20	23	23	29	40

Number of Unduplicated Medical Students Interviewing in Colorado for Family Medicine

2003	2004	2005	2006	2007	2008	2009	2010	2011
202	225	242	251	268	297	282	351	400

Number of Interviews

2003	2004	2005	2006	2007	2008	2009	2010	2011
509	507	578	631	644	741	731	902	983

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	FY 2009-10 Actuals	FTE		FY 2010-11 Actuals	FTE		FY 2011-12 Appropriated	FTE		FY 2011-12 Estimate	FTE		FY 2012-13 Request	FTE
HB 08-1375, SB 09-259, HB 10-1376 Prior Year Appropriation (Long Bill)														
Total Funds	$1,932,052	0.0		$1,738,846	0.0		$1,738,846	0.0		$1,738,846	0.0		$1,391,077	0.0
General Fund	$966,026			$667,891			$700,620			$700,620			$695,538	
General Fund Exempt	$0			$0			$0			$0			$0	
Cash Funds	$0			$0			$0			$0			$869,423	
Cash Funds Exempt / Reappropriated Funds	$0			$0			$0			$0			$0	
Federal Funds	$966,026			$1,070,955			$1,038,226			$1,038,226			$695,539	
SB 09-187, HB 10-1300 (Agency Supplemental Bill)														
Total Funds	($193,206)	0.0		N/A	0.0		N/A	N/A		N/A	N/A		N/A	N/A
General Fund	($96,603)			N/A			N/A			N/A			N/A	
General Fund Exempt	$0			N/A			N/A			N/A			N/A	
Cash Funds	$0			N/A			N/A			N/A			N/A	
Cash Funds Exempt / Reappropriated Funds	$0			N/A			N/A			N/A			N/A	
Federal Funds	(96603			N/A			N/A			N/A			N/A	
SB 09-259, HB 10-1376 (Long Bill Add-ons)														
Total Funds	$0	0.0		N/A	0.0		N/A	N/A		N/A	N/A		N/A	N/A
General Fund	($201,532)			N/A			N/A			N/A			N/A	
General Fund Exempt	$0			N/A			N/A			N/A			N/A	
Cash Funds	$0			N/A			N/A			N/A			N/A	
Cash Funds Exempt / Reappropriated Funds	$0			N/A			N/A			N/A			N/A	
Federal Funds	$201,532			N/A			N/A			N/A			N/A	
Total Appropriation														
Total Funds	**$1,738,846**	**0.0**		**$1,070,955**	**0.0**		**$1,038,226**	**0.0**		**$1,038,226**	**0.0**		**$1,564,962**	**0.0**
General Fund	**($298,135)**			**$0**			**$0**			**$0**			**$0**	
General Fund Exempt	**$0**			**$0**			**$0**			**$0**			**$0**	
Cash Funds	**$0**			**$0**			**$0**			**$0**			**$869,423**	
Cash Funds Exempt / Reappropriated Funds	**$0**			**$0**			**$0**			**$0**			**$0**	
Federal Funds	**$1,070,955**			**$1,070,955**			**$1,038,226**			**$1,038,226**			**$695,539**	

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	FY 2009-10 Actuals	FTE		FY 2010-11 Actuals	FTE		FY 2011-12 Appropriated	FTE		FY 2011-12 Estimate	FTE		FY 2012-13 Request	FTE
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
General Fund	$0			$0			$201,532			$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			($201,532)			($201,532)				
Total Spending Authority / Request without Early Supplementals														
Total Funds	**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,391,077**	**0.0**
General Fund	**$667,891**			**$667,891**			**$902,152**			**$902,152**			**$695,538**	
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	**$1,070,955**			**$1,070,955**			**$836,694**			**$836,694**			**$695,539**	
#REF!														
Total Funds	N/A	N/A		$0	N/A		$0	0.0		$0	0.0		$0	0.0
General Fund	N/A			$32,729			($32,729)			($32,729)				
General Fund Exempt	N/A			$0			$0			$0			$0	
Cash Funds	N/A			$0			$0			$0			$0	
Cash Funds Exempt / Reappropriated Funds	N/A			$0			$0			$0			$0	
Federal Funds	N/A			($32,729)			$32,729			$32,729				
Early Supplemental Total														
Total Funds	**N/A**	**N/A**		**$0**	**N/A**		**$0**	**0.0**		**$0**	**0.0**		**$0**	**0.0**
General Fund	**N/A**			**$32,729**			**($32,729)**			**$0**			**$0**	
General Fund Exempt	**N/A**			**$0**			**$0**			**$0**			**$0**	
Cash Funds	**N/A**			**$0**			**$0**			**$0**			**$0**	
Cash Funds Exempt / Reappropriated Funds	**N/A**			**$0**			**$0**			**$0**			**$0**	
Federal Funds	**N/A**			**($32,729)**			**$32,729**			**$32,729**				

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Total Spending Authority / Request

	FY 2009-10 Actuals	FTE		FY 2010-11 Actuals	FTE		FY 2011-12 Appropriated	FTE		FY 2011-12 Estimate	FTE		FY 2012-13 Request	FTE
Total Funds	**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,391,077**	**0.0**
General Fund	**$667,891**			**$700,620**			**$869,423**			**$869,423**			**$695,538**	
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	**$1,070,955**			**$1,070,955**			**$869,423**			**$869,423**			**$695,539**	

Expenditures

Total Funds	$1,738,844	0.0		N/A	0.0		N/A	N/A		N/A	N/A		N/A	N/A
General Fund	$667,890			N/A			N/A			N/A			N/A	
General Fund Exempt	$0			N/A			N/A			N/A			N/A	
Cash Funds	$0			N/A			N/A			N/A			N/A	
Cash Funds Exempt / Reappropriated Funds	$0			N/A			N/A			N/A			N/A	
Federal Funds	$1,070,954			N/A			N/A			N/A			N/A	

Under/(Over) Expenditures

Total Funds	**$2**	**0.0**		**$0**	**0.0**		**N/A**			**N/A**	**N/A**		**N/A**	**N/A**
General Fund	**$1**			**$0**			**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**			**$0**			**N/A**			**N/A**			**N/A**	

Total without Decision Items

Total Funds	**$1,738,844**	**0.0**		**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,391,077**	**0.0**
General Fund	**$667,890**			**$700,620**			**$869,423**			**$869,423**			**$695,538**	
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	**$1,070,954**			**$1,038,226**			**$869,423**			**$869,423**			**$695,539**	

Grand Total

Total Funds	**$1,738,844**	**0.0**		**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,738,846**	**0.0**		**$1,391,077**	**0.0**
General Fund	**$667,890**			**$700,620**			**$869,423**			**$869,423**			**$695,538**	
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	**$1,070,954**			**$1,038,226**			**$869,423**			**$869,423**			**$695,538**	

SCHEDULE 4

SOURCE OF FINANCING-DIRECT REVEUNUES

DEPARTMENT: Health Care Policy and Finance

AGENCY: Commission on Family Medicine

	Actual FY 2009-2010	Actual FY 2010-2011	Appropriation FY 2011-2012	Estimate FY 2011-2012	Request FY 2012-2013
ADVISORY COMMISSION ON FAMILY MEDICINE					
Schedule 3 Total	1,932,052	1,738,846	1,738,846	1,738,846	1,391,077
GF	0	0	0	0	0
CFE	1,932,052	1,738,846	1,738,846	1,738,846	1,391,077
MCF	1,932,052	1,738,846	1,738,846	1,738,846	1,391,077
MGF	966,026	667,891	700,620	700,620	695,538
Residency Programs	1,932,052	1,738,846	1,738,846	1,738,846	1,391,077
GF	0	0	0	0	0
CFE	1,932,052	1,738,846	1,738,846	1,738,846	1,391,077
MCF	1,932,052	1,738,846	1,738,846	1,738,846	1,391,077
MGF	966,026	667,891	700,620	700,620	695,538
Commission Expenses	0	0	0	0	0
GF	0	0	0		0
CFE	0	0	0	0	0

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CONGRESSIONAL DISTRICTS 2, 4, and 7: Appointments are pending.

***Designates Family Medicine Residency Director**

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Revised: 10/25/11

APPENDIX II

*RESIDENCY FUNDING PROFILE: FIVE YEAR TREND

RESIDENCY	2008-09	2009-10	2010-11	2011-2012	Request 2012-13
Ft. Collins	214,672	193,205	193,205	193,205	154,564
North Colorado	214,672	193,205	193,205	193,205	154,564
Rose	214,672	193,205	193,205	193,205	154,564
St. Anthony	214,662	193,205	193,205	193,205	154,564
St. Joseph	214,672	193,205	193,205	193,205	154,564
St. Mary	214,672	193,205	193,205	193,205	154,564
Southern Colorado	214,672	193,205	193,205	193,205	154,564
Swedish	214,672	193,205	193,205	193,205	154,564
University/AF Williams	214,672	193,205	193,205	193,205	154,564

***Rounded to the nearest whole dollar.**

Commission on Family Medicine

Strategic Plan
FY 2011-2012

Colorado
Family Medicine Residencies

Family Medicine with an Altitute...

Mail Stop F496, Room 3402
12631 W. 17th Avenue
Aurora CO 80045

STRATEGIC PLAN: FY 2011 – 2012

Commission on Family Medicine

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STRATEGIC PLAN: FY 2011 – 2012

Commission on Family Medicine

FY 2011/2012 STRATEGIC PLAN: COMMISSION ON FAMILY MEDICINE (COFM)

EXECUTIVE LETTER: A Retrospective and Prospective Report on COFM

COFM History

Thirty-four 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 2010/11 Residency Matching Program: (1) All 69 first-year positions were filled, with 90% being from medical schools outside of Colorado; and (2) 64% of the 2011graduating residents are now working in the State. Thirty-five percent of the graduating residents (14 out of 41) either chose a rural community (ten) or an underserved urban practice (four). 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. Furthermore, four residency positions were added in 2011: three with a focus on working in an urban underserved area and one in a program with a high potential of serving in a rural community.

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 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 (TCHF) 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.

Not surprisingly, the first year of the project brought with it a number of didactic and procedural challenges. However, after five "Learning Collboratives", which bring together 150 representatives (residents, faculty, medical staff and front-office personnel) from all of the nine residencies, the project has shown evidence of success. The residencies have learned from and supported each other. A key outcome of this initiative is to gain Level 3 Recognition (the highest category) as a Patient Centered Medical Home. A proposal for an additional three years of funding has been well-received by TCHF.

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:

- With 69 residency positions to fill annually, a strong, national recruitment program is fundamental to populating Colorado with family physicians. The (now) two medical schools in Colorado cannot be expected to graduate enough students with an interest in family medicine to fill all of these residency slots.
- 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.
- A unique feature was added this past year through the support of the Copic and Caring for Colorado Foundations: A professionally produced recruitment video is now an important component to our concerted efforts to attract highly competent medical students to train in a Colorado Family Medicine Residency.
- 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 six years ago with a grant from The Colorado Trust and continued for two additional years with support from the Colorado Area Health Education Center. The Caring for Colorado Foundation recently awarded a two-year grant to continue this important incentive for FY 2011/12 and FY 2012/13. For FY 2011/12, 67 residents are scheduled to complete this rotation.

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').
- Continuation for an additional year for a grant 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 62 million dollars expended, **in the aggregate,** by the nine family medicine residencies to train 194 family medicine residents during FY 2011/12 (plus an additional eight at Denver Health, which does not qualify for state funding through COFM). This is an increase from 188 last year. 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. 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 COFM operations.

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 four (beginning with FY 2011/12) family medicine residents per year, with an emphasis on working in an urban underserved community.

A Health Care Safety Net

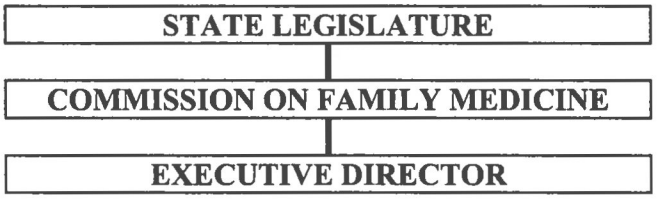
While the legislation which created COFM is silent about the residencies' role as providers of primary care, the family medicine training centers are part of Colorado's "safety-net". COFM data indicate that during this past year 71.6% of the nearly 75,000 people served by the family medicine residencies were Medicaid (33.2%), Medicare (13.1%) or uninsured (25.3%). These results are consistent from year-to- year. Without the presence of the family medicine residencies, access for the Medicaid, uninsured and Medicare populations would further erode.

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 grow only slightly, even as a number of medical schools have expanded their class size and several new schools of medicine have been created. The 2010/11 match resulted in an increase from 7.9% to 8.4% of US medical students opting for family medicine residency training for an increase of 133. While a two-year trend can be viewed as encouraging, the small numbers 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 at COFM's August 17, 2011 Strategic Planning Session.

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 66 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. A new goal area was developed for FY 2010/11 relative to this issue. COFM achieved notable success in moving forward with this **BOLD, LONG-TERM** goal, which, as noted below in the evaluation of this goal developed for FY 2010/11, has been transformed into a GME Initiative reaching beyond Colorado and now a venture independent of COFM.

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 40 "residency fairs" (increased from 30 for FY 2010/11) 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 Group (FMIG) at the University of Colorado School of Medicine and Rocky Vista University of Osteopathic Medicine.
- Host a "Residency Night" for students from the CU School of Medicine and the Rocky Vista Osteopathic Medical School 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 approach for using new internet-based tools (social media).
- (Reframed) Develop a working relationship with the administration and student body (especially the Student Chapter of the AOA Family Physicians) at the Rocky Vista University, which opened in August of 2008.
- Show the above-noted video at all recruitment events.
- Request an extension to the grant from TCHF for the recruitment program.

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 90% of the 69 new residents coming from 40 different US medical schools. Also, COFM's collaboration with the residencies is critical in filling all 69 first year positions in these programs. 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 is fully developed. 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.

This past year, 400 US medical students interviewed in at least one of Colorado's family medicine residents. These students represented 103 of the 149 US medical schools. This national scope and number of interviewees forms the basis for a solid retention rate (as noted below) of graduates. Also, this volume of interviewees allows for selective recruiting. The one challenge that this accomplishment has triggered is managing this large number of interviewees. The interview process is very labor-intensive and competes with meeting the demand for primary care at our residencies.

Given these trends, COFM will continue its recruitment efforts at 40 "residency fairs" and other similar events 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	6/30/09 Actual	6/30/10 Actual	6/30/11 Approp.	FY 10-11 Request
Annually Retain 60% of graduating residents	Benchmark	60%	60%	60%	60%
	Actual	60%	68%	64	63%

Strategies

- 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.
- 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).

NOTE: The following strategies are likely to be integrated into the GME Initiative outlined below:

- Increase the number of residents training at the Denver Health Track by two per year to meet the needs of urban underserved communities.

- Prepare a series of focused statements relative to promoting the benefits and value of family medicine/primary care, as well as addressing challenges to meeting Colorado's need for family physicians.
- Host forums with business leaders relative to addressing issues key to reforming health care.
- Support the development of the Colorado Institute of Family Medicine as a key vehicle for securing additional resources for educating and training family physicians for Colorado.
- Conduct visits to various communities in Colorado (including hold a COFM meeting in these locales).
- Invite select guests (business leaders and decision-makers, community leaders, and others interested in health care reform) to COFM meetings.
- Secure funding and build capacity for expanding family medicine residencies in Colorado by forming partnerships with Colorado's Congressional Delegation and other key organizations (including foundations).
- Structure a program to schedule at least annual visits of COFM members (especially the District Representatives) with Colorado's Congressional Delegation

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

Performance Measure	Outcome	6/30/2009 Actual	6/30/2010 Actual	6/30/2011 Actual	6/30/2011 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%	34	33

Strategies

- CPR actively recruits the state's family medicine residents, 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.
- **(On-going)** 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.

Objective: Assure the financial viability of the Colorado's Family Medicine Residencies **(Newly formulated as of FY 2011/12)**

Strategies

- Maintain statistics and anecdotal data to demonstrate value of the collaboration COFM creates between the state's family medicine residencies.
- Maintain statistics to demonstrate the contributions of the family medicine residencies to Colorado's Safety-net
- Maintain data to demonstrate the areas populated by graduates of Colorado's family medicine residencies.
- Continue with building the GME Initiative, as outlined below.

Outcomes (to evaluate objective over the course of the year)

- Maintain state financial support for family medicine residency training.
- Obtain funding from philanthropic organizations and other private entities.
- Relationships with affiliated hospitals remain positive.
- Create collaborative partnerships with organizations supportive of COFM's Vision and Mission.

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% last year to 60% this year. 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. Ten of the 2011 graduates are now working in a rural community of Colorado and four in an urban underserved area. Eight of these 16 graduates received loan repayment. It may also be telling that last year nine of the sixteen graduating residents who chose a rural practice outside of Colorado also received loan repayment. These numbers differ from the previous years and may indicate a growing importance of loan repayment. Fortunately, Colorado funding for loan repayment has improved the past several years. Not all of the 2011 graduates have submitted their exit survey, which contains information relative to loan repayment.

This year's success in recruiting 14 of the 41 graduates 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, as stated above, COFM secured additional funds from two foundations to continue key components of this program at least through FY 2013.

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.
- 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.
- Develop and maintain effective collaborative relationships and partnerships with key business and community organizations, foundations (local and national), medical and educational institutions, the media, and elected officials (individually and collectively).
- Systematically collect and publish information relative to promoting COFM's Mission and implanting its Vision.

Evaluation of Success in Meeting Benchmarks

All of the nine residencies have consistently maintained their accreditation with the American Council of Graduate Medical Education ACGME). One of the outcomes of the Directors' collaboration is the consultation they provide each other in preparing for the periodic reviews of the Residency Review Committee, which reports to the ACGME.

The competition for residency directors and faculty is arguably fiercer than for residents. The three director positions which were open during FY 2008/09 were filled early in 2009. Two vacancies were filled from within the residencies. Another residency director resigned in early 2011 after 20 years in his position. A faculty from within the program was selected as the new director. A director recently announced that he is resigning after two-and one-half years as of September 30, 2011. An interim director from within the program has been named. Eight faculty positions were open at four of the residencies this past year. These were all filled; however, four new vacancies have recently opened. The directors have agreed that an on-going faculty recruitment effort is necessary. Seemingly, as one position is filled another opens up.

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. Unfortunately, there are few, effective venues for recruiting faculty that are comparable to residency fairs. The Academy of Uniformed Family Physicians may prove to be a source for recruiting faculty interested in the full scope of family medicine. COFM/CAFMR attended the national conference of this organization this past year and is committed to participate regularly at this event to

develop a potential pool of faculty candidates. The number of family physicians in the military who will be leaving active duty may be significant once the US ends its involvement in wars in the Mid-East.

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 08908 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	66.8%	70.5%	71.6%	Unknown

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 74,661 patients served by the residencies were Medicaid (33.5%), Medicare (13%) or uninsured (24%) patients. Two residencies note that 93% of its patients fall into these categories; another two serve more than 85% of such patients and another two in the 65% 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.

5. Establish primary care as a building block of the health care system.

Introduction

This goal area was introduced at the FY 2010/11 Strategic Planning Session on July 21, 2010. It included three objectives: (1) develop a formal communications plan for promoting the benefits and value of primary care; (2) take advantage of a grant opportunity in the Health Care Reform bill to add primary care residency positions; and (3) work for a reform of Graduate Medical Education (the method and financing for residency training) to be more primary care friendly.

At the strategic planning meeting for the previous year, COFM and CAFMR "went on record" that the number of family medicine residents training in Colorado must increase, as well as new family medicine residencies must be created. A strategy for achieving this growth to meet the state's need for primary care was to meet with and educate our Congressional delegation about primary care and family medicine residency training, especially about the GME structure and financing structure that greatly favored specialty care over primary care. These discussions resulted in the recommendation from one of our Senators to COFM that it rely on its experience with building a collaborative approach for training and retaining family medicine residents to build a coalition of states with a reputation for supporting primary care, especially from the western region of the country.

Working towards GME reform became the "lightning rod" that has created a fledging collaboration of representatives from 10 states and the District of Columbia. This goal area has become **The GME Initiative**, which includes the intent of the three original objectives as it moves forward with crafting a strategic plan. This coalition has taken on the challenging, long-term enterprise of radically changing GME into a system that provides the primary care

physician workforce that this country needs now and in the future to help address the unsustainable health care costs and increases access to cost-effective health care. While a number of COFM members are active participants in this venture, the project is now independent of COFM.

Outcomes Resulting from the GME Initiative

The foundation to move this endeavor forward has been established this past year.

- Funding was secured from a private institution to support the formative steps of this Initiative.
- Leaders in family medicine residency training and interested consumers of health care have been recruited as the nucleus of this enterprise.
- A committee structure has been created.
- A Steering Committee representative from the various participating states is overseeing the development of the Initiative.
- Committees in the following areas have been established: Strategic Planning, Legislative, and Messaging.
- A summit of the GME Initiative was held in Denver on July 8. Staff from the offices of Senator Udall and Representatives DeGette and Coffman attended this event.
- The summit resolved to continue the Initiative and expand the number and diversity of the participants.
- Commissioned that a Position Paper being prepared to lay out an outline for potential Congressional legislation to reform GME to be more favorable to primary care.
- Prepared a one-page Fact Sheet developed to: (1) succinctly educate policy makers of the issues facing primary care GME and (2) present a proposal for fending off cuts to primary care GME as a strategy for reducing the national budget deficit. The members of this coalition distributed this document to the offices of various Congressional delegations.