STRATEGIC PLAN: FY 2013-2014

Commission on Family Medicine

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2013-2014 Strategic Plan
Commission on Family Medicine

Introduction

This section of the strategic plan provides the background of the Commission on Family Medicine, how the state benefits from the presence of the Commission, and outlines challenges facing family medicine.

The Commission on Family Medicine

The Commission on Family Medicine (COFM) is a collaborative model for providing primary care to the people of Colorado. It is a public-private venture. Nine private health care facilities collaborate with citizen representatives from Colorado's seven congressional districts. Additionally, COFM brings together these nine businesses (the family medicine residencies and their sponsoring hospitals) to coordinate their efforts in training family physicians to meet the primary care needs of Colorado. The Commission is a great example of what can be achieved when vision is inclusive of all of Colorado in a tradition of cooperation and teamwork.

The Commission is celebrating its 35th anniversary in 2012. In 1977, Harvey Phelps, MD, a pulmonologist and State Senator from Pueblo, toured his district and determined 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 family medicine, a new specialty requiring residency training and board certification. Family medicine was developed 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 recognized the need for this type of physician, especially in rural and other underserved areas of the state. At the same time, Tillie Bishop, a 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 on Family Medicine to meet Colorado's need for primary care, especially in rural and 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 to provide a high quality of training

COFM today is a unique, national model. The degree of collaboration among the state's nine family medicine residencies is unmatched in the country. The programs work together to recruit medical students and faculty, create patient-centered medical homes, and share expertise between programs. The norm in other states is for residency programs to compete with one another, requiring each program to replicate efforts, driving up costs to recruit and develop internal resources. The vital role of citizen representatives from all seven congressional districts has assured that the training of family physicians corresponds to the health care needs of Coloradans. Examples are the rural rotations required of all family medicine resident physicians and the current initiative to change how Graduate Medical Education (GME) funds are allocated to support primary care. With an eye on the health care needs of the people of Colorado, members of the COFM board actively shaped the objectives presented in this strategic plan.

Three examples of successful collaboration are the recruitment program, rural rotations, and the patient-centered medical home project.

Recruitment Program. From a national perspective, over 450 family medicine residency programs compete to recruit medical students interested in family medicine. Colorado's nine family medicine residency programs have 69 positions to fill annually. The two medical schools in Colorado (CU Medical School and Rocky Vista University of Osteopathic Medicine) cannot be expected to graduate enough students with an interest in family medicine to fill all of these slots. Through COFM, the residency directors have created a national recruitment program. COFM's recruitment program, staffed by a Residency Recruiter, represents all nine programs at recruitment fairs and in marketing materials. As a result, this past year all 69 positions were filled with high quality medical students.

Rural/Underserved Rotations. As part of their training, residents are required to complete a one-month rotation in a rural or urban underserved site. The intent of this rotation is to increase a resident's propensity to select a rural or underserved site for practice upon graduation. COFM selects and approves sites and helps coordinate the rotation schedule. Based on evaluations, the experience is rated positively by both residents and the on-site training physicians.

Patient-Centered Medical Home Project. COFM is collaborating with other organizations to transform the residencies' curricula and practices into the Patient-Centered Medical Home (PCMH) model. The PCMH model is a building block of the new method of health care delivery. Through "learning collaboratives", the nine residency programs have worked together to learn from and support each other. This work will continue and is an important part of the future strategic plan.

In addition to training family physicians, the nine residency programs play a vital role as providers of primary care. The family medicine training centers are part of Colorado's patient care "safety net". COFM data indicate that in 2011/12, over 70% of the nearly 66,000 patients served by the family medicine residencies were Medicaid (34.3%), Medicare (13.8%), or uninsured (22.3%). These results are consistent from year to year. Without the presence of the family medicine residencies, access for Medicaid, Medicare, and uninsured populations would further erode. As centers of education, Colorado's family medicine residency programs 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.

Looking ahead, two major challenges face family medicine education in Colorado. First is the current method of funding Graduate Medical Education (GME or residency training). The current system, funded through Medicare, favors the training of non-primary care specialists or hospital-based physicians. Moreover, the current system does not fund new training slots, thereby freezing training slots at the January, 1997 level (69) in the state. Changes in this outdated policy are addressed in this strategic plan, specifically the GME Initiative described in Goal #5. A second major challenge is the need to provide a new model for delivering health care. This includes changes in the reimbursement system. For example, in the current system, physicians are paid much more to "do something", such as a procedure, compared to preventive medicine, such as promoting a healthy life style. The new delivery system also is characterized by team-based care. The family physician, as a member of an integrated care team, can help address the health needs of the "whole" patient. The need to establish team-based care and, equally important, to train our future family physicians in this model of care, are addressed in the strategic plan as described in Goals #2 and #4.

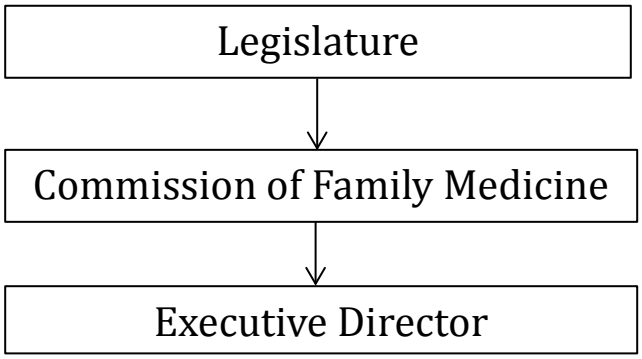
In summary, for 35 years the Commission has played an important role in training family physicians for practice in Colorado. The unique private-public collaboration has been a national

model others seek to emulate. The collaboration among the nine residency programs and the citizen representatives has strengthened primary care in Colorado. The core goals continue to be 1) address the state's need for family physicians, 2) assure that Colorado's family medicine residencies are of high caliber, 3) recruit medical students from across the country to fill the positions with high quality candidates, 4) recruit qualified faculty physicians to teach the residents, and 5) retain graduates to practice in Colorado, especially rural and underserved areas. New objectives have been added to assure that the training of family physicians remains relevant to the needs of Colorado by 1) advocating for GME funding that supports primary care and 2) preparing family physicians to practice in a new model of delivering health care.

Statutory Authority

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

Vision Statement

Through a unique statewide 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 health care through the power of primary care.

Core Objectives and Performance Measures with Evaluation

The core objectives of the Commission on Family Medicine have been enhanced this year to specifically address the need to prepare family physicians to practice in the new model of care. This thematic change does not affect the core objectives of training family physicians to practice in Colorado. However, it does indicate that the residency programs are responsive to changes in the fundamental way that health care is being delivered. While the new delivery system has different titles, it is characterized by team-based care, coordinated care, quality-based outcomes, population management, increased patient access, and new payment methods. In the new model, the patient receives personalized care for a wide range of health-related needs in a Patient Centered Medical Home (PCMH). A substantial body of research indicates that this delivery system results in

improved health outcomes and decreased costs. Preparing a family physician to thrive in the new model requires changes in how we train family physicians during residency. The rationale for this change is that better education will lead to better care management, resulting in better health of citizens and, therefore, decreased costs.

The Colorado family medicine residencies must be on the forefront of this nation-wide transition by training family physicians in the new model of care. Graduates of the programs must be fully prepared to practice in a PCMH. Family medicine residents must be trained in integrated team-based care, coordinated care, and tracking quality-based outcomes. The COFM must assure that programs modify their learning environment and curriculum so that family medicine residents meet the needs of Colorado patients served now and in the future. For example, team-based care requires that the family physician communicate effectively and work collaboratively with the patient, family, and other team members, including the nurse practitioner, physician's assistant, care coordinator, receptionist, medical specialists, and all staff members. Moreover, family physicians must be trained in change management skills necessary to help transform clinical practices into Patient-Centered Medical Homes. Many existing practices in the state are built on traditional methods of health care delivery. New family physicians coming into the system will be instrumental in helping traditional practices transform into the new model. In the current strategic plan, new objectives have been added to assure that Colorado residencies prepare family physicians to seamlessly step into their new roles upon graduation.

1. Goal: Train Family Medicine Residents in Colorado

   Objective 1: Recruit high-quality medical students from across the country to train in one of Colorado's family medicine residencies

Performance Measure	Outcome	FY 09-10 Actual	FY 10-11 Actual	FY 11-12 Actual	FY12-13 Proposed
Annually fill 100% of available training positions	Benchmark	100%	100%	100%	100%
	Actual	100%	100%	100%	Pending

   Strategies:

   - All nine residencies partner to recruit medical students nationally by maintaining a joint website, developing collaborative public relations materials, and equally sharing recruitment costs
   - Fund the Director of Recruitment to be a permanent position on the CAFMR staff
   - Participate in at least 30 "residency fairs" across the country; target medical schools from which applicants graduate from Colorado's residencies
   - Support activities of the Family Medicine Interest Group at the CU School of Medicine and the Rocky Vista University of Osteopathic Medicine
   - Each residency hosts medical students from across the country for a fourth-year clerkship to experience family medicine residency training in Colorado

   Objective 2: Consistently meet the faculty ratio required for full accreditation

Performance Measure	Outcome	FY 09-10 Actual	FY 10-11 Actual	FY 11-12 Actual	FY12-13 Proposed
Program Director positions open more than 12 months	Benchmark	0	0	0	0
	Actual	0	0	0	Pending

Performance Measure	Outcome	FY 09-10 Actual	FY 10-11 Actual	FY 11-12 Actual	FY12-13 Proposed
Faculty physician positions open more than 12 months	Benchmark	0	0	0	0
	Actual	0	0	0	Pending

Strategies:

- All nine residencies partner to recruit directors and faculty; share in faculty recruitment costs
- Maintain a joint website, post faculty vacancies, and proactively market to national and regional audiences
- Attend job fairs for physicians
- Advocate for competitive salaries for faculty physicians

Evaluation of Success in Meeting Benchmarks:

The first goal is to train family medicine residents. Our benchmarks are very objective: filling all available training positions with high quality medical students, maintaining a full complement of faculty physicians and program directors to teach and administer the programs, and maintaining full accreditation for the programs. Progress on these factors will be available on an annual basis as the programs complete their recruiting seasons in March.

2. Goal: Prepare Family Medicine Residents to Provide Health Care in the New Delivery System to Meet the Future Needs of Colorado Citizens

Objective 1: Train family medicine residents in a clinical environment that is certified as a Patient-Centered Medical Home

Performance Measure	Outcome	FY 09-10 Actual	FY 10-11 Actual	FY 11-12 Actual	FY12-13 Proposed
Number of residencies NCQA-certified as PCMH	Benchmark	9	9	9	9
	Actual	0	0	8	Pending

Strategies:

- Each residency program will apply for NCQA certification under the updated 2011 guidelines
- A PCMH coach will work with each program to assist in the process to attain NCQA certification. The coach is provided by a Colorado Health Foundation grant.
- The nine programs will continue to participate in the bi-annual PCMH Collaborative Conferences funded by a Colorado Health Foundation grant and administered by the Department of Family Medicine, HealthTeamWorks, and CAFMR
- The Commission on Family Medicine will request increased state funding targeted at PCMH-specific needs, such as care coordinators, IT development to track quality indicators, and modifications of clinics to support team-based care

Objective 2: Train family medicine residents with the skills needed to be successful in the new health care delivery system

Performance Measure	Outcome	FY 09-10 Actual	FY 10-11 Actual	FY 11-12 Actual	FY12-13 Proposed
Number of residencies with curriculum* for new model	Benchmark	9	9	9	9
	Actual	0	0	1	Pending

*Curriculum includes team-based care, population management, and tracking quality indicators of improved outcomes.

Strategies:

- The curriculum in each residency will be modified to enable residents to develop skills specific to working in a PCMH
- Residency faculty and residents will receive instruction and hands-on application related to the PCMH model
- Specific faculty members in each program will receive faculty development sessions aimed at developing a PCMH curriculum
- The Commission on Family Medicine will request increased state funding targeted to assist residency programs to receive support for resident training on PCMH-related skills, such as monitoring quality indicators, team-based skills, communication, and resident leadership development
- The nine programs will continue to participate in the bi-annual PCMH Collaborative Conferences funded by a Colorado Health Foundation grant and administered by the Department of Family Medicine, HealthTeamWorks, and CAFMR
- Residency programs will integrate components of PCMH curriculum developed by other organizations, such as the American Academy of Family Physicians, the Department of Family Medicine, and HealthTeamWorks

Evaluation of Success in Meeting Benchmarks:

Our intent with this goal is to prepare residents to practice in the delivery model of the future. An easily quantified indicator of success of the first objective (residency clinics meet NCQA-certification as PCMH) is documentation that each program has reached at least Level 1 of the certification. NQCA certifies clinics at three levels. Our objective is Level 1 for all programs this year. As this benchmark is achieved, we will upgrade the objective to a higher level in the future. Although this is an easy objective to quantify, attaining certification at Level 1 requires major efforts such as tracking quality indicators. A challenge faced by all clinics seeking Level 1 is reconfiguration of the electronic medical record to enable providers to derive valid and reliable clinical outcomes. The additional personnel, software, and hardware can be very costly. Despite difficulties with increased costs and educating hospital administrators of the need for NCQA certification, all of the programs are committed to pursue this objective.

Evaluating the second objective (PCMH curriculum at each program) will also be determined by documentation. Each program will provide evidence that residents, by the end of their third year, have received training in team-based care, population management, and tracking quality indicators. The program will also provide evidence that the resident has achieved the appropriate level of competence in these three skills.

3. Goal: Address the Need for Primary Care Physicians in Colorado

   Objective 1: Increase the supply of family physicians in Colorado

Performance Measure	Outcome	6/30/10 Actual	6/30/11 Actual	6/30/12 Actual	6/30/13 Proposed
Annually retain 60% of graduating residents	Benchmark	60%	60%	60%	60%
	Actual	70%	63%	65%	Pending

Strategies:

- Inform residents of employment opportunities in Colorado; maintain a file at each residency of positions available
- Actively involve the physician recruitment and placement service (CPR) of the Colorado Rural Health Center
- Collaborate with COPIC Insurance Company and other physician groups to maintain a balanced tort environment in Colorado
- Continue to aggressively pursue a change in the way graduate medical education (GME) is funded and structured; basic changes are needed in order to increase the number of training positions in Colorado's family medicine residency programs. (Additional strategies are described below under the GME Initiative.)

Objective 2: Increase the availability of family physicians in rural and urban underserved areas of Colorado

Performance Measure	Outcome	6/30/10 Actual	6/30/11 Actual	6/30/12 Actual	6/30/13 Proposed
30% of graduating residents working in CO opt for rural or urban underserved area	Benchmark	30%	30%	30%	30%
	Actual	46%	33%	Pending	Pending

Strategies:

- Continue the required rotations in rural and/or underserved urban sites; support residents and preceptors in underserved training sites
- Recruit nationally at medical schools with an emphasis on rural medicine
- Implement training that includes the full scope of family medicine to assure residents are prepared to practice in underserved areas
- Continue to provide training tracks in rural and underserved sites, such as Wray, the Sunrise Clinic, and Denver Health
- Support the development of rural training tracks as training sites for residents
- Collaborate with the Colorado Rural Health Center's physician recruitment and placement service, specifically by promoting the loan repayment program

Evaluation of Success in Meeting Benchmarks:
The intent of this goal is to increase the number of family physicians in Colorado, especially in rural and urban underserved areas. Success will be evaluated by the number of residents choosing to practice in the state upon graduation. Additionally, we will track the number of graduates who practice in areas designated as rural or underserved. A long-term goal is to increase the number of training positions in the family medicine residencies. If successful, this strategy, described in goal 5 below, would result in a significant increase in the number of family physicians in the state.

4. Goal: Contribute to Colorado's Patient Care Safety Net

Objective 1: Family medicine residencies will contribute to Colorado's safety net

Performance Measure	Outcome	FY 09-10 Actual	FY 10-11 Actual	FY 11-12 Actual	FY12-13 Proposed
60% of patients served by the FM residencies covered by Medicare, Medicaid, or uninsured	Benchmark	60%	60%	60%	60%
	Actual	70.5%	71.6%	70.5%	Pending

Strategies:

- Residency programs continue to provide care for patients who are uninsured, underinsured, and on Medicaid and Medicare
- Residency programs continue to seek alternative, supplementary funding sources, such as grants, to defray the cost of uncompensated patient care services
- Residencies participate in ClinicNet, a collaborative of Colorado health care organizations that provide care for the indigent and underserved but are not federally qualified clinics

Objective 2: Family medicine residencies will enhance their care coordination services for patients by establishing a care management collaborative among the nine programs

Performance Measure: Accomplishment of this objective will be measured in two ways. First, a care management collaborative will be established and will meet on a routine basis. Second, the residencies will provide data showing the number of patients served in an integrated manner by the care coordinator.

Strategies:

- The CAFMR staff will help coordinate quarterly meetings with care coordinator representatives from the nine residency programs. The goal of the meetings is for the care coordinators to share best practices, exchange ideas, and gain support from one another. The long-term goal of the collaboration is to improve the quality of care coordination provided to patients and to reduce the turnover of care coordinators.
- The CAFMR staff will assist the care coordinators to develop a viable method to communicate ideas and questions between meetings. Examples are a newsletter, a list serve, and/or a wiki or some other form of social media.
- Costs for the care coordinator meetings will be covered by CAFMR. This strategy is to remove the potential barrier of residency costs that could prevent a care coordinator from routinely participating in the collaborative.
- Care coordination is a major component of the new model of care. The role of a care coordinator is addressed during the PCMH Collaborative Conferences offered twice yearly to all residency programs
- Care coordination is also an aspect of certification as a PCMH. Each program will develop care coordination as part of their NCQA certification.

Evaluation of Success in Meeting Benchmarks:

This goal is aimed at providing quality care to the underserved. Success in meeting this goal will be evaluated, in part, by analyzing the payor mix of residency patients. This information is collected annually from the residency programs and will be available as an

outcome. A second indicator of success will be meetings attended by the care coordinators. Evidence of the meetings will be minutes of the proceedings. We will solicit feedback periodically to assess the satisfaction of participants with the meetings. The collaboratives will be considered successful if care coordinators are exchanging best practices and indicate that the meetings add value to their ability to conduct their work. Finally, the residency clinics will provide data showing the number of patients served in an integrated manner by the care coordinator.

5. Goal: Expand the Presence of Primary Care in Colorado by Reforming the Structure and Financing of Graduate Medical Education (GME)

   This goal is intended to provide a long-term solution to the shortage of family physicians in Colorado. GME needs to be restructured to allow for an increase in the number of family medicine training positions. Additionally GME funding should be redirected to support primary care residency education in community-based ambulatory centers and teaching health centers rather than academic and/or tertiary hospitals.

   Strategies:
   - Inform policy-makers, business leaders, health care leaders and educators, and the general public of the issues facing primary care graduate medical education
   - Monitor progress of the Institute of Medicine study that was initiated in response to the GME paper authored by the Commission on Family Medicine

   Performance Measures:
   One measure of this goal is the progress reported from the Institute of Medicine study on graduate medical education. A second measure is the publication of the GME initiative in a peer reviewed medical journal

   Evaluation of Success in Meeting Benchmarks:
   Success of this long-term goal is likely to be demonstrated over several years. The eventual overhaul of the GME structure and financing may require the completion of the IOM study and subsequent action by congress to make changes. Such changes will require time. Completion of the IOM study is predicted to occur in 2014. Subsequent action by congress, based on the IOM study, may require additional years. Therefore, success within the next year must be realistic, demonstrated through progress with the IOM study and publication of an article in a medical journal. The publication will be an important method to educate and mobilize interest about GME issues among medical leaders and educators.

BUDGET REQUEST: FY 2013-2014

Commission on Family Medicine

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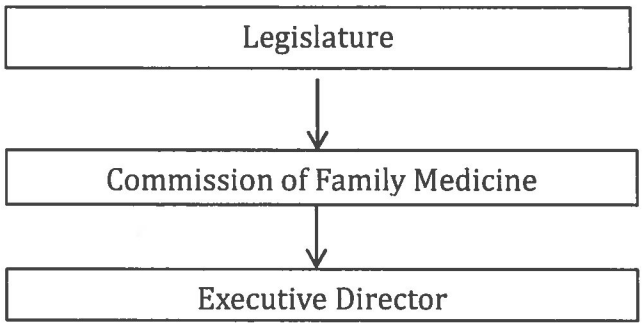
PROGRAM DESCRIPTION

Organizational Chart



The Long Bill reports 0.0 FTE for the Commission on Family Medicine (COFM). The COFM does not have statutory budget authority and, thus, cannot hire staff. The Executive Director of the COFM is Kim Marvel, Ph.D. Dr. Marvel and three employees responsible for carrying out the administrative and programmatic functions of COFM are formally employed by the Colorado Association of Family Medicine Residencies (CAFMR). CAFMR is a not-for-profit organization that supports and complements the legislative mandate of COFM. In addition to the Executive Director, the staff includes an Association Coordinator, Resident Recruiter, and Health Care Advocate (contract position). The staff reports directly to the Executive Director, who reports to the chair of COFM and the chair of CAFMR.

Background Information

Introduction

The Commission on Family Medicine (COFM) was established in 1977, through legislative mandate, to support the education of family physicians for the state. It has developed into a successful model of collaboration. COFM brings together citizen representatives (consumers of health care) from Colorado's seven Congressional Districts with representatives from nine private health care facilities. This public-private venture has resulted in a dynamic resource to advocate for primary care in Colorado. A second form of collaboration occurs when the nine businesses (the family medicine residencies and their sponsoring hospitals) coordinate their efforts in training family physicians to meet the primary care needs of Coloradans. The cooperative sharing of resources and expertise among the nine residency programs is quite remarkable because these are distinct programs controlled by competing health care systems. Nationally, it is a unique example of cooperation and teamwork that ultimately benefits the people of Colorado.

Why Should the State Fund the Commission?

State funds form the nucleus that supports the highly effective collaboration among Colorado's nine family medicine residencies. The collaboration yields several benefits to the people of Colorado. A more detailed response to the question can be answered from three different perspectives, including the provision of primary care in the state, financial benefits, and improved education for family physicians.

The family medicine residencies play a prominent role providing the needed supply of primary care physicians in Colorado. State funding results in a steady supply of family physicians to Colorado.

The nine residency programs work together to recruit medical students. Historically, 85%-90% of the residents come from outside of Colorado to train in Colorado's nine nationally recognized programs. Last year, applicants to the nine family medicine residencies came from over 100 US medical schools outside of Colorado. Over 60% of the graduates stay in Colorado. Colorado benefits from a strong presence of family physicians (54% of primary care physicians), including rural areas, where family physicians make up 73% of all primary care physicians. In addition to collaborative recruitment of medical students, the state funding influences the individual residencies to focus on the welfare of the entire state rather than concentrating on meeting the needs of its sponsoring hospital and service area. This partnership positively impacts health care by recruiting family physicians to rural and underserved communities and by providing health care for uninsured, Medicaid, and Medicare patients.

In FY 2011-2012, the total appropriation for COFM was $1,738,846 (General Fund plus 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 2011/2012 (plus an additional 8 at Denver Health, which does not qualify to receive state funding). COFM does not have responsibility for the expenditure of these funds. These are dollars that the nine affiliated hospitals expend in operating a family medicine residency. For the state, this is a great return on investment. The state funding is disbursed to each of the nine family medicine residencies in an equal amount ($193,025) to support the training of family medicine residents. Without state funding, the Commission ceases to exist, since it has no other sources of revenue, and the collaboration of the nine family medicine programs would likely discontinue.

State funding is an incentive for residency programs to collaborate. With oversight from the COFM board and support from the CAFMR staff, the programs collaborate several ways, including:

- Recruitment of high quality medical students to train in the state's family medicine residencies
- Recruitment of qualified faculty family physicians to teach in the residency programs
- Excellence in training of family physicians when the programs are able to share expertise and pool training resources, such as the Patient-Centered Medical Home project and leadership training for chief residents
- The requirement that residents complete a rotation in a rural or underserved community
- Program Directors meet monthly to address common residency training issues
- Quarterly collaborative meetings among program staff from all nine programs who share similar responsibilities, such as program coordinators, program administrators, behaviorist faculty, and curriculum directors
- Bi-annual conferences to develop a patient-centered medical home at each residency clinic

Without state funding, this degree of collaboration would not continue. The Colorado residency programs would regress to the norm of family medicine programs in other states, characterized by competition and duplication of efforts. Each program would conduct recruitment and quality improvement projects independently, resulting in redundancy and increased costs.

A Contributor to Colorado's Patient Safety Net

The family medicine residencies increase access to primary care services, especially for the vulnerable populations of the state. This contribution extends beyond the COFM mandate of training family physicians. However, it is important to highlight that the training centers are a part of Colorado's patient "safety net". The combined number of Medicaid (34%), Medicare (14%) and uninsured (22%) patients represent 70% (46,453) of the nearly 66,000 patients served by the residency practices in FY 2011/2012. The federally funded safety net clinics (Community Health Centers) are already hard-pressed to carryout their mandate of caring for indigent populations.

Without the presence of the family medicine residencies, access for underserved patients would further deteriorate. The discounted medical care provided by the faculty and residents at the residency clinics exceeds many times the annual state funding, again demonstrating the value of the residency programs to the state.

Colorado's family medicine residencies have created programs designed to keep their community's population healthy and out of the emergency room. Examples include community education on smoking and bicycle helmets, clinics of migrant farm workers, HIV/AIDS clinics, group visits for diabetes and other chronic illnesses, prenatal care clinics, and medication brown bags forums. In addition, the residencies provide mental health services under a collaborative model.

In summary, as centers of family medicine training, the 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.

Funding

All funding for the Commission is captured under the Residency Training line item. COFM receives no state funding for its administrative and programmatic functions. Historically, the Long Bill listed Residency Training and Commission Expenses as separate line items. This changed in 2004/2005 when the legislature accepted a decision item by the Commission to delete the Commission Expense line and increase Residency Training by a corresponding amount. This allows for increasing the federal match for the Residency Training line. The residency directors, who by statute are members of the Commission, formed the Colorado Association of Family Medicine Residencies (CAFMR) in 1988 and incorporated into a 501-c-6 in 1995. CAFMR's work fully supports the Commission's legislative mandate. CAFMR serves as the employer of the Commission's staff. This is a critical role since the Commission does not have the legislative authority to hire staff as employees. CAFMR has strengthened the collaboration between the nine residencies and, thus, has enhanced the scope and effectiveness of the Commission.

COFM Membership

The statutes creating the Commission (25-1-901 through 25-1-904) 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. Members of the Commission include the nine program directors, 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.

Listed below are the nine residency programs and sponsoring hospitals. The hospital and location is in parenthesis unless the name of the affiliated hospital is apparent in the residency 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 (Central Denver)
- Saint Anthony Family Medicine Residency (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" described below allow for grouping and describing the Commission's projects and activities. The two sections flow from the structure of the Commission as a consortium of nine independent entities.

Total appropriations for FY 2011/2012:	$1,738,846
1) Residency Training:	$1,738,846
2) Operations and Administration:	$0

Residency Training

Through the Commission, 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 hospitals with which the programs are affiliated. 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.

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. The prime incentives for the individual residencies to form this unique alliance are the state funding and the recognized efficiencies resulting from an ongoing collaborative and statewide perspective for training family physicians. The Commission has established six requirements for residencies that receive state funds:

- 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 ACGME or AOA after each review period, including notification of any immediate performance issue and adverse action taken by the accrediting organization.

Commission Operations

As noted earlier, the legislative response to the Commission's decision item in 2004/2005 resulted in elimination of a state appropriation for Commission expenses. The Colorado Association of Family Medicine Residencies agreed to fund Commission programs, projects, and administrative

activities. In the last five months, several changes have been made in staff positions. The former Executive Director retired after 19 years and two other staff members have been replaced. The new Executive Director and staff are dedicated to continuing to carry out the mission and vision of COFM.

The Executive Director staffs the Commission's meetings and executes its directives, maintains a working relationship with the residency directors and other key personnel at the nine residency programs, and is responsible for all administrative functions of the Commission including personnel, accounting, and liaison with the OSPB and JBC offices. Staff coordinates the participation of residencies in the required rural/underserved rotations, joint recruitment of residents, joint recruitment of faculty, retention of graduates, the regional job fairs, and similar activities that benefit all the residency programs. The Commission's office is also a central source of residency program data, such as number of residents in training, training costs, and employment choices of graduating residents.

The listing below provides an estimate of staff time devoted to Commission programs and projects. A more detailed description of each activity is provided in the following paragraphs.

• Rural/Underserved Training	10%
• Placement of Graduates	15%
• Recruitment of Residents and Faculty	30%
• Staffing the Commission	10%
• Coordination of Activities with Residencies	10%
• Collaboration with CU School of Medicine and Rocky Vista University of Osteopathic Medicine	5%
• Partnerships with Community Organizations	10%
• Research Activities	3%
• Management and Administration	7%

- Rural/Underserved Training: Family medicine residents complete a month-long rotation at a rural or underserved clinical site. The staff coordinates the statewide schedule, collects resident evaluations of their rural experience, and prepares an annual report for the Commission. Staff also serves as a liaison between the communities and the residencies. The Commission has established a process for reviewing requests from Colorado's rural communities to serve as training sites. The current sites are located in Buena Vista, Canon City, Julesburg, Yuma, Plan de Salud Community Health Center, Valley Wide Community Health Center, and Westwood Clinic in Lakewood. Plan de Salud covers the underserved communities north of metro Denver from Fort Morgan, Fort Lupton, Commerce City, Frederick, and Longmont. Valley Wide serves the San Luis Valley and La Junta. The training sites and supervising physicians receive no reimbursement for their service and provide housing for the residents and their families.

- Placement of Graduates: The staff assists several ways with the placement of graduates in Colorado. First, they work with the COPIC Insurance Company to provide an educational conference to inform residents of future practice options, including rural and underserved locations. Second, the Commission joined the Colorado Rural Health Center in its effort to create and fund the Colorado Physician Recruitment Program. This is a not-for-profit venture that emphasizes placing primary care physicians in rural and underserved areas of the state. The Commission staff facilitates National Health Service Corps presentations to residents to recruit graduates to rural and underserved communities. COFM has added a recruitment component to its website. Finally, the Residency Recruiter is a liaison between

soon-to-graduate residents and job openings in the state. Since 2005, Colorado has retained at least 60% of the graduates with a third of these opting to practice in rural or urban underserved sites.

- Recruitment of Residents and Faculty: The Commission has always held this project at the highest priority, as detailed in the Strategic Plan. Over the years, CAFMR has increased its staff resources for this activity. This allocation of resources corresponds to the intense competition for medical students opting for family medicine. Last year the Commission participated in well over 30 residency fairs and other recruitment events. About 2,000 students visited with COFM representatives at these events. Colorado's nine residency programs interviewed 471 students, a number that represents 35% of all U.S. graduates going into family medicine. All of the 69 intern positions were filled in the match. The Commission maintains a high level of coordination with the residencies that, in turn, are willing to collaborate even as they compete with one another for quality medical students.

  The recruitment of faculty physicians has become increasingly challenging. Many potential candidates do not provide the full scope of practice, especially OB; nor do they want to work full time or take call. The program directors have agreed to pool their recruitment efforts for faculty. This has led to increased staff efforts by posting faculty openings on the COFM website, contacts with practicing physicians about faculty positions, recruiting at a national conference, and an effort to recruit graduates to faculty positions.

- Staffing the Commission: This includes as variety of functions such as preparing agendas and minutes for board meetings, educating the citizen representative on family medicine education and health care issues, and working with the Governor's Office of Boards and Commissions.

- Coordination of Activities with Residencies: The Commission staff helps coordinate many meetings of residency staff across the state and acts as a conduit of information exchange among the programs. The Commission staff help coordinate over 30 meetings annually. Included are the bi-annual leadership workshops for chief residents of the nine programs.

- Collaboration with CU School of Medicine and Rocky Vista University (RVU) of Osteopathic Medicine: Commission staff work with administrators and faculty from both of Colorado's medical schools. The Dean of the CU School of Medicine is a member of the Commission. Commission staff meets with the Family Medicine Interest Group at both schools. The Commission collaborates on efforts at both CU and RVU to create rural training tracks in the state.

- Partnership with Community Organizations: Commission staff collaborates with a diverse set of public and community-based organizations. A partial list of organizations include the Colorado Area Health Education Center, Copic Insurance Company, Rural Health Center, Colorado Academy of Family Physicians, The Colorado Trust, The Colorado Health Foundation, Caring for Colorado, HealthTeamWorks, ClinicNet, Rose Foundation, Kaiser Foundation, and the National Health Service Corps. COFM and CAFMR support of number of programs and activities of these organizations as a way for supporting their interest in primary care and family medicine.

- Research Activities: The staff participates in research activities related to family medicine education. Examples include consulting with the Department of Family Medicine to engage the residencies in practice-based research, developing a database to track the correlation

between resident performance during training and long-term career success, documenting the value of a family medicine residency to the sponsoring hospital, and collecting data on recruiting activities.

- Management and Administration: Included in this item are the activities required to keep an organization functioning, such as supervising staff, paying bills, and preparing annual reports.

Hot Issues

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

An ongoing hot issue is to create the primary care workforce to meet increased needs for access to cost-effective care. The Patient Protection and Affordable Care Act (PPAC) lays out legislation for national health care reform. A clear challenge will be providing a primary care workforce to meet the increased demand for services resulting from expanded coverage. In Colorado, we face a similar challenge, especially in rural and urban underserved areas. Many sources advocate for an increased primary care workforce to meet health care needs in a cost-effective manner:

- The American Academy of Family Physicians (AAFP) estimates the country will need 44,000 primary care physicians by 2015, with half 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
- The Council on Graduate Medical Education's 20th Report strongly recommends, for cost-effective care, that primary care physicians make up 40% of the physician workforce
- With an aging physician workforce, there is an increased need for family physicians to replace those who will be retiring

The Workforce Collaborative will further clarify the health care workforce needs of Colorado. Team-based care and other modifications in how health care is delivered will be part of the solution. A strong primary care presence, particularly in rural and underserved areas, will be a necessary component to the future health care model.

Increasing the primary care physician workforce in Colorado faces several obstacles:

- Medical students show weak interest in family medicine/primary care
- Salary differential favors medical sub-specialties over primary care
- Federal funds for physician residency education (Graduate Medical Education - GME) are distributed unequally, favoring hospital-based specialties, academic centers, and heavily populated geographical centers. Family medicine residencies receive less funding in the current GME structure.
- The number of training positions for family physicians is capped at the 1997 level based on GME funding.

The Commission's response to these issues is outlined in the strategic plan. Part of the solution is a proactive, aggressive recruitment program. This objective will assure that Colorado's family medicine residency programs have an adequate number of high quality medical students to fill the residency positions. Additionally, the recruitment of qualified physician faculty will assure the quality of training remains strong. The retention of graduates in the state is another component of the Commission's strategic plan. A long-term strategy is to modify the way GME is funded. The Commission has spearheaded a bold initiative to change GME funding to be more favorable to primary care training and to increase the number of family medicine residents training in Colorado. The "GME Initiative" was started by COFM in 2011 and, with support from collaborators in 10

western states and the District of Columbia, has been accepted by the Institute of Medicine for study. The resulting recommendations may result in fundamental changes in the funding of residency training, especially primary care. A second long-term strategy was the creation of the Colorado Institute of Family Medicine (CIFM). COFM and CAFMR joined to create the CIFM. As a 501-c-3 organization, CIFM qualifies for foundation funding. This opens new avenues to increase the funding for family medicine education. CIFM has received grants that support a variety of education-related projects, including the patient-centered medical home, rural rotations, and recruitment.

The *Incremental Funding Change for FY 2013-14* submitted with this Budget Request addresses this "hot issue" by sustaining our proactive, aggressive recruitment program. For the past three years we have had unprecedented success recruiting medical students to complete their graduate training in one of Colorado's residency programs. In three successive years, we have documented increases in the number of medical student contacted about our residencies, the number of medical students completing applications, and the number of medical students interviewing in the state. The importance of this success is reflected in the fact that 100% of the available positions were filled in the match. Given our track record of placing a significant number of graduates in the state, the importance of an aggressive, comprehensive recruitment program is self-evident. A second goal of our recruitment program is filling vacant faculty positions with qualified family physicians. It has become increasingly more difficult to attract and retain faculty physicians to teach in the residency programs due to highly competitive salaries offered from full-time practices and the challenge of finding family physicians qualified to teach the full scope of family medicine, including knowledge of the new model of care.

Our success the past three years recruiting medical students and filling faculty vacancies can be attributed to hiring a full-time recruiter. As a member of the CAFMR staff, the recruiter travels to recruiting events at medical schools across the country, maintains contact with interested and qualified medical students, and personalizes the recruitment materials and process. The recruiter works closely with the programs to identify faculty vacancies and contact potential candidates. All nine Colorado residency programs benefit from the recruitment program. The cost for this program has been supported entirely through grant funds that have come to an end. The position has been difficult to maintain due to the uncertainty of year-to-year funding. An increase in funding will enable the Commission to sustain this effective program.

Challenge of Preparing Family Physicians for New Methods of Delivering Health Care

With increasing pressure to provide health care services to more people at a lower cost, new models of health care delivery are emerging. Colorado is actively engaged in new models of care, such as the Regional Collaborative Care Organization pilot project. As described in the Strategic Plan, the Colorado family medicine residencies must be on the forefront of changes in health care delivery by training family physicians in the new model of care. Graduates of the programs must be fully prepared to practice in a Patient-Centered Medical Home (PCMH). The transformation of residency clinics into PCMHs is a complex and expensive undertaking. Part of the transformation involves changes in the infrastructure, including a highly functional electronic medical record and re-arrangement of rooms to foster team-based care. The transformation also involves changes in staffing, such as adding care coordinators. Additionally, the transformation involves the training of staff, including family physicians, in a new way of caring for patients. Training includes new ways of communication within the team, team-based care, and the tracking of quality indicators to inform care decisions. Making these changes is an enormous challenge to residency programs. Planning time is limited. The residencies are busy, demanding environments in which patient care and physician education require the full attention of faculty and program directors. Faculty, trained in a

more traditional model of care, may lack the in-depth knowledge of newer models of care and require further training. Finally, reimbursement is often based on the fee-for-service model so that changes to population-based care may not show immediate results in decreased costs.

The residency programs have started the transformation to becoming PCMHs. A grant from the Colorado Health Foundation has enabled the Department of Family Medicine, HeathTeamWorks, and CAFMR to collaborate on a statewide PCMH project that is now into its fourth year. Several programs are now PCMH-qualified according to criteria of the National Committee on Quality Assurance (NCQA). A PCMH steering committee is active in each residency program. Some programs are developing a curriculum designed to prepare residents for the new model of care. The program directors are well aware of the need to continue this transformation. The transformation of the residencies and developing a curriculum to prepare residents for the practice of the future is a high priority for COFM.

The *Incremental Funding Change for FY 2013-14* submitted with this Budget Request addresses this "hot issue" as well. Increased state funding will be used to assure each residency provides team-based patient care and residents develop the skills necessary to be an effective member of the health care team. Increased state funding will be used for two specific aspects of transforming the training environment for resident physicians. Care coordination has been shown to improve health outcomes and decrease costs by encouraging patient follow-through and acting as a liaison between the patient and physician. In the new model of care, family physicians must work closely with other members of the team to assure effective care coordination. Care coordination can be enhanced in several ways, such as hiring care coordinators and purchasing software to create accurate patient registries. Each residency program must provide the training environment in which resident physicians learn how to coordinate care for improved patient outcomes. We are requesting funds for the improvement of care coordination. Second, additional faculty time will be necessary to transform the traditional medical curriculum into one that fully prepares residents to practice in a PCMH. Residents will need skills in team communication, change management, tracking quality indicators, and population management. A PCMH curriculum does not exist to be imported into a residency program. To be successful, curriculum changes must be tailored to current procedures and reflect the unique patient population of a practice. This transition in the curriculum will become an ongoing task and require protected time for one faculty physician from each program. The increase in funding will provide a team-based learning environment as well as protected time for faculty physicians to assure that residents develop the appropriate skills for practicing in a PCMH.

Summary

The COFM plays a vital role providing primary health care in Colorado. The primary mission is to train family physicians to practice in the state. The changing model of delivering health care requires the education of family physicians that can fill an important role providing team-based, cost-effective care. The entire state funding to COFM goes directly to the residency programs. State funding anchors the collaboration of the family medicine residencies with each other and with the citizen consumers of health care. The state funding allows the residencies to support the Colorado Association of Family Medicine Residencies (CAFMR) that provides the Commission's administrative and programmatic functions. While state funds are a small percentage of the total dollars required to train family physicians, without state funding, the Commission would cease to exist. Consequently, since the Commission has no other revenue sources, the collaboration of the nine family medicine residencies would likely discontinue. Continued funding will allow the Commission to continue its valuable mission. Increased funding will enable the Commission to

sustain an effective recruitment program and prepare residents to be successful providers in the new model of care.

Work Load Report

COFM's structure and relationship to the family medicine residencies do not lead to traditional workload indicators. The one area where a workload indicator applies is COFM's collaborative recruitment of medical students to train in Colorado's family medicine residencies. Data are shown below. The recent increases in all three areas can reasonably be attributed to having a full-time recruiter beginning in the 2009-2010 season.

	2005	2006	2007	2008	2009	2010	2011	2012
Residency Fairs Attended	22	20	20	23	23	29	39	33
Students Interviewed	242	251	268	297	282	351	400	471
Number of Interviews*	578	631	644	741	731	902	983	1,130

*Some students interview at more than one residency program

Commission on Family Medicine	FY 2013-14					Schedule 3
Long Bill Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Long Bill Line Item 1						
FY 2010-11 Actual						
FY 2010-11 Long Bill, H.B. 10-1376	$1,738,846	0.0	$667,891	$0	$0	$1,070,955
Special Bill #1 FY11	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY11	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation S.B. 11-xxx	$0	0.0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$1,738,846	0.0	$667,891	$0	$0	$1,070,955
FY11 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$1,738,846	0.0	$667,891	$0	$0	$1,070,955
FY11 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$1,738,846	0.0	$667,891	$0	$0	$1,070,955
FY 2011-12 Actual						
FY 2011-12 Long Bill, S.B. 11-209	$1,738,846	0.0	$700,620	$0	$0	$1,038,226
Special Bill #2 FY12	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY12	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation H.B. 12-xxxx	$0	0.0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$1,738,846	0.0	$700,620	$0	$0	$1,038,226
FY12 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$1,738,846	0.0	$700,620	$0	$0	$1,038,226
FY12 Expenditures	$0	0.0	$0	$0	$0	$0

FY 2011-12 Reversion \ (Overexpenditure)	$1,738,846	0.0	$700,620	$0	$0	$1,038,226
FY 2012-13 Appropriation						
FY 2012-13 Long Bill Appropriation (S.B. 11-209)	$1,741,077	0.0	$870,538	$0	$0	$870,539
Special Bill #3 FY13	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY13	$0	0.0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$870,539**
FY13 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request						
Final FY 2012-13 Appropriation	$1,741,077	0.0	$870,538	$0	$0	$870,539
Restore PERA Adjustment S.B. 11-076	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY13	$0	0.0	$0	$0	$0	$0
FY 2013-14 Base Request	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$870,539**
Decision Item #1	$630,000	0.0	$315,000	$0	$0	$315,000
Decision Item #2	$0	0.0	$0	$0	$0	$0
FY 2013-14 Total Request	**$2,371,077**	**0.0**	**$1,185,538**	**$0**	**$0**	**$1,185,539**
FY13 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Long Bill Line Item 2						
FY 2010-11 Actual						
FY 2010-11 Long Bill, H.B. 10-1376	$0	0.0	$0	$0	$0	$0
Special Bill #1 FY11	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY11	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation S.B. 11-xxx	$0	0.0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0

FY11 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY11 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2011-12 Actual						
FY 2011-12 Long Bill, S.B. 11-209	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY12	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY12	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation H.B. 12-xxxx	$0	0.0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0
FY12 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY12 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2012-13 Appropriation						
FY 2012-13 Long Bill Appropriation (S.B. 11-209)	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY13	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY13	$0	0.0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request						
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0
Restore PERA Adjustment S.B. 11-076	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY13	$0	0.0	$0	$0	$0	$0

FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Decision Item #2	$0	0.0	$0	$0	$0	$0
Decision Item #3	$0	0.0	$0	$0	$0	$0
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Long Bill Line Item Final						
FY 2010-11 Actual						
FY 2010-11 Long Bill, H.B. 10-1376	$0	0.0	$0	$0	$0	$0
Special Bill #1 FY11	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY11	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation S.B. 11-xxx	$0	0.0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0
FY11 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY11 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2011-12 Actual						
FY 2011-12 Long Bill, S.B. 11-209	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY12	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY12	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation H.B. 12-xxxx	$0	0.0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0
FY12 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY12 Expenditures	$0	0.0	$0	$0	$0	$0

FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2012-13 Appropriation						
FY 2012-13 Long Bill Appropriation (S.B. 11-209)	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY13	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY13	$0	0.0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request						
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0
Restore PERA Adjustment S.B. 11-076	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY13	$0	0.0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Decision Item #4	$0	0.0	$0	$0	$0	$0
Decision Item #5	$0	0.0	$0	$0	$0	$0
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Division Total						
FY 2010-11 Actual						
FY 2010-11 Long Bill, H.B. 10-1376	$1,738,846	0.0	$667,891	$0	$0	$1,070,955
Special Bill #1 FY11	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY11	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation S.B. 11-xxx	$0	0.0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$1,738,846	0.0	$667,891	$0	$0	$1,070,955

FY11 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$1,738,846	0.0	$667,891	$0	$0	$1,070,955
FY11 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$1,738,846	0.0	$667,891	$0	$0	$1,070,955
FY 2011-12 Actual						
FY 2011-12 Long Bill, S.B. 11-209	$1,738,846	0.0	$700,620	$0	$0	$1,038,226
Special Bill #2 FY12	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY12	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation H.B. 12-xxxx	$0	0.0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$1,738,846	0.0	$700,620	$0	$0	$1,038,226
FY12 Allocated Pots	$0	0.0	$0	$0	$0	$0
Roll-forward expense to FY 2011-12	$0	0.0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$1,738,846	0.0	$700,620	$0	$0	$1,038,226
FY12 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$1,738,846	0.0	$700,620	$0	$0	$1,038,226
FY 2012-13 Appropriation						
FY 2012-13 Long Bill Appropriation (S.B. 11-209)	$1,741,077	0.0	$870,538	$0	$0	$870,539
Special Bill #3 FY13	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY13	$0	0.0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$870,539**
FY13 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request						
Final FY 2012-13 Appropriation	$1,741,077	0.0	$870,538	$0	$0	$870,539
Restore PERA Adjustment S.B. 11-076	$0	0.0	$0	$0	$0	$0

Special Bill #4 FY13	$0	0.0	$0	$0	$0	$0
FY 2013-14 Base Request	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$870,539**
Decision Item #1	$630,000	0.0	$315,000	$0	$0	$315,000
Decision Item #2	$0	0.0	$0	$0	$0	$0
Decision Item #3	$0	0.0	$0	$0	$0	$0
Decision Item #4	$0	0.0	$0	$0	$0	$0
Decision Item #5	$0	0.0	$0	$0	$0	$0
FY 2013-14 Total Request	**$2,371,077**	**0.0**	**$1,185,538**	**$0**	**$0**	**$1,185,539**
FY13 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY13 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**

0						
FY 2012-13 Total Appropriation	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$870,539**
FY 2013-14 Base Request	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$870,539**
FY 2013-14 Total Request	**$2,371,077**	**0.0**	**$1,185,538**	**$0**	**$0**	**$1,185,539**
Percentage Change FY 2012-13 to FY 2013-14	**36.18%**	**#DIV/0!**	**0.00%**	**#DIV/0!**	**#DIV/0!**	**36.18%**

APPENDIX

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REQUEST FOR INCREMENTAL FUNDING INCREASE

Commission on Family Medicine

COMMISSION ON FAMILY MEDICINE

FY 2013-14 Funding Request
November 1, 2012

John W. Hickenlooper
Governor

Kim Marvel, Ph.D.
Executive Director

_____
Signature Date

Base Operating Increase to Strengthen Recruitment Program and Train Family Physicians for New Model of Health Care Delivery

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
	$630,000	$315,000	0

Request Summary:

The Commission on Family Medicine is requesting $630,000 to address two ongoing hot issues. One is to sustain the program designed to recruit medical students to Colorado's family medicine residency programs, recruit qualified faculty physicians to teach in the programs, and retain graduates to practice in the state. The second issue is to train family medicine residents for practice in the new health care delivery model. The funds will be used to support transformation of the residency clinics into patient centered medical homes. The funds also will be used to train residents in team-based, integrated care so they are well prepared to transition into the cost-effective practice of the future.

Problem or Opportunity:

Among the challenges of health care reform is to meet the primary care workforce needs that result from expanded coverage and decreased resources. The shortage of family physicians will be exacerbated by the retirement of a significant portion of those currently in practice. Placement of family physicians in rural and urban underserved sites will continue to be a critical workforce need in the future. In addition to increased numbers, Colorado will need family physicians prepared for the new model of health care delivery. Graduates of the state residencies must be fully prepared to practice in a Patient-Centered Medical Home (PCMH). The transition of a clinic to become a PMCH requires additional resources. Moreover, additional resources are needed to transform the curriculum so family physicians develop the specific skills to perform as an effective member of a PCMH.

Brief Background:

The Colorado family medicine residencies must be on the forefront of changes in health care delivery by training family physicians in the new model of care. Preparing residents for the new model of care requires 1) a team-based clinic environment in which the resident is trained, and 2) a comprehensive curriculum to teach the family medicine resident with the specific skills needed to flourish in the new model of care.

First is to assure each residency clinic provides team-based patient care. An important aspect of team-based care is care coordination. Care coordination has been shown to improve health outcomes and decrease costs by encouraging

patient follow-through and creating a close working relationship between the patient, staff, and physician. Pilot projects in Colorado have indicated that physician leadership and the presence of high quality care coordination are the two most important factors in the successful transition to a PCMH. In the new model of care, family physicians must work closely with the care coordinators. Each residency clinic must have care coordination as part of the training environment.

Second, additional faculty time will be necessary to transform the traditional medical curriculum into one that fully prepares residents to practice in a PCMH. Residents will need skills in team communication, change management, tracking quality indicators, and population management. A PCMH curriculum does not exist to be imported into a residency program. To be successful, curriculum changes must be tailored to current procedures and reflect the unique patient population of a practice.

In the past three years COFM has had unprecedented success recruiting medical students to complete their graduate training in one of Colorado's residency programs. This success has occurred despite national trends in which medical students' interest in primary care has remained flat. The importance of this success is reflected in the fact that 100% of the available resident positions were filled in the match for the first time in many years. Given our track record of placing a significant number of graduates in the state, the importance of an aggressive, comprehensive recruitment program is self-evident. A second goal of the COFM recruitment program is filling vacant faculty positions with qualified family physicians. It has become increasingly more difficult to attract and retain faculty physicians to teach in the residency programs due to highly competitive salaries offered from full-time practices and the scarcity of family physicians who can teach the full scope of family medicine, including knowledge of the new model of care.

The recent success recruiting medical students and filling faculty vacancies can be attributed to hiring a full-time recruiter. As a member of the CAFMR staff, the recruiter travels to recruiting events at medical schools across the country, maintains contact with interested and qualified medical students, and personalizes the recruitment materials and process. The recruiter works closely with the programs to identify faculty vacancies and contact potential candidates. All nine Colorado residency programs benefit from the recruitment program. The cost for this program has been supported entirely through grant funds that have come to an end. The CAFMR operating budget is able to cover only part of the cost of the recruitment program.

The outcomes of this funding request align closely with the Governor's key priorities to create a better Colorado. Specifically, our proposed solutions, described below, align with the key priority of health to "ensure efficient and effective healthcare, health care reform, and an improved system of care". Primary care physicians, with their focus on prevention and care for the whole person, play a vital role to make progress on three "winnable battles" of mental health and substance abuse, obesity, and oral health.

Proposed Solution:

The proposed solution has two parts. First is to prepare family medicine residents for a new model of health care ($540,000). A cornerstone of the new model is care coordination. For example, the patient receives follow-up contact to assure adherence to treatment, to answer questions, and to arrange for related appointments or home care. The patient, patient's family, physician, and staff work together to improve patient outcomes and reduce costs. The coordination of patient care can be enhanced in several ways, such as hiring a care coordinator, purchasing software to support an accurate and complete patient registry, or coordinating a series of conferences between residency programs to

share best practices of care coordination. Each program will differ in its need to further evolve care coordination. While some programs may need a full-time care coordinator, others may need software enhancements or contact with other programs to pick up best practices. Resident physicians will learn about the new model of care by practicing in a clinic that provides care coordination. Additionally, resident physicians will learn about the new model of care by participating in a comprehensive PCMH curriculum. The faculty at each program needs to develop a relevant, engaging curriculum that includes the practical application of PCMH concepts, such as requiring that residents complete projects related to population management or group visits. Both care coordination and a PCMH curriculum will prepare residents for the new model of care. The second part of the solution is to sustain the successful collaborative recruitment effort. The full-time recruiter for medical students, faculty, and graduate retention will require $90,000. This increase will enable the Commission to sustain this effective program.

Alternatives:

An alternative approach to developing care coordination at each residency clinic is to use existing staff for this function. Care coordination is usually provided by skilled professionals, often with a background in nursing or social work. It is a full-time role to follow-up with patients and function as a liaison between the patient, family, and physician. It is imperative to have capable care coordinators who can perform the dual role of providing patient care and helping train the resident to be an effective member of the health care team. Another potential alternative solution is to request that the sponsoring hospitals support care coordination at each residency. This approach has been tried. Some programs have been able to implement a patient registry or hire care coordinators while others have not been successful. Some hospital administrators, with a focus on inpatient issues, do not see the addition of financially non-productive, ambulatory staff positions as a high priority.

An alternative approach to the proposed recruitment program solution is to continue to seek grant funds. The drawback to this potential solution was evident this year when the highly effective recruiter decided to leave the position due to the uncertainty of continued funding from year to year. Reliance on soft funds for such an important role is not seen as a viable long-term solution.

Anticipated Outcomes:

The first anticipated outcome is that the residents that graduate from the nine family medicine residencies will be able to seamlessly transition into a PCMH. They will understand the value of care coordination. They will exhibit skills in team communication, change management, tracking quality indicators, and population management. They will value to diverse set of skills on a team that are needed to meet the health needs of an individual patient and the community. Moreover, they will be able to lead the transformation of traditional medical practices into a patient-centered medical home. If this outcome is feasible, then the programs will need to implement an effective way to train the residents in the new model. The best way to train residents is to immerse them in a clinic environment in which team-based, coordinated, integrated care is a reality. The clinic environment must be supplemented with a curriculum that reinforces the skills necessary to thrive in such a practice environment.

The availability of care coordination is a cornerstone of a PCMH. Some programs have a part-time coordinator, others have software to support a patient registry, and some programs lack either of these resources. A portion of the requested funds ($270,000) will be used to enhance care coordination. For some programs, it may be used to hire a full-time care coordinator. Others may purchase software, and other may

participate in care coordination conferences. The program directors will assess the need of each program and will distribute the funds to the programs that currently lack the needed resources.

The development of a comprehensive curriculum will require 20% of time for one faculty physician from each program. Although a portion of the curriculum can be developed by non-physicians, it will be vital to have consistent input from a family physician faculty to develop a realistic, practical approach to teach these skills to residents. Time for faculty development will also be necessary. The time for faculty involvement in this curriculum will be ongoing as the faculty physician must dedicate some time to teaching the curriculum after it is developed. This request includes an increase of $270,000 to develop a comprehensive PCMH curriculum for resident physicians.

The anticipated outcome of the second component of this request (sustain the recruitment program) is the permanent employment of a skilled, professional recruiter. This employee will continue the function of recruiting medical students to the residency programs, recruiting qualified faculty to fill vacancies, and working to place graduates in Colorado. The requested funds ($90,000) will pay for salary and benefits of this position.

Assumptions for Calculations:

The assumption for enhancing care coordination is based on the current number of residencies that lack resources. A portion of the calculation ($135,000) is based on needing 2 to 2.5 FTEs. The salary range will depend on the community of the residency. The range is $45,000 to $60,000 and includes benefits. Another portion ($120,000) is based on software enhancements to develop a patient registry for two programs ($60,000 per program) A final portion ($15,000) is for a series of care coordination conferences among the residency programs. We foresee the need for flexibility in how the funds are distributed among the nine programs from year-to-year. Annually, the program directors will assess the needs for care coordination among the nine programs.

The calculation of faculty physician time is based the assumption that a portion of one faculty member's time must be protected to work on this curriculum. One day a week would be calculated as 20% of a salary of $150,000 ($30,000). This amount is multiplied by the total number of programs (9), resulting in a total request of $270,000.

Calculating the funds for the recruiter position is based on the assumption that a full-time recruiter salary, including 25% benefits, is $75,000. The remaining $15,000 is for a portion of the travel expenses.

Consequences if not Funded:

The first part of this request pertains to preparing family medicine residents for practice in the new model of care. If not funded, the major consequence will be inconsistency in preparing residents for practice in a PCMH environment. Some programs will prepare residents very well while others will not accomplish this goal due to lack of resources. Consequently, some graduates will perform well in the new model and others will struggle and will need to learn the new skills on the job if at all. Statewide efforts to establish more cost-effective care will be less effective with those family physicians who are not prepared for the new model.

The second part of this request pertains to the collaborative recruitment program. If not funded, the Commission will likely continue to pursue grant funds. As a consequence, the success of the recruitment program may go in cycles. Also, the ability to retain highly skilled staff will be difficult due to the uncertainty of continued funding.

Impact to Other State Government Agency:

Educating family physicians in the new model of care and recruiting medical students to train as family physicians in Colorado may impact other state agencies. Poor recruitment and placement may have a negative impact on the Office of Rural Health and the ability of Community Health Centers to recruit qualified physicians familiar with state patient populations. Also, newly-trained physicians uncomfortable with the new model of care may be less likely to join Medicaid ACO's.

Cash Fund Projections:
N/A

Relation to Performance Measures:

Both components of this request relate directly to the COFM performance measures as described in the Strategic Plan. The second goal of the strategic plan is to "Train family physicians to provide health care in the new delivery system to meet the future needs of Colorado citizens". The related performance measures are the number of residencies that meet PCMH criteria and the number of residencies with a comprehensive curriculum in the new model of care. The first goal of the strategic plan is to "Train family medicine residents in Colorado". The related performance measures are to fill 100% of available training positions each year and to fill all program director and faculty physician positions within 12 months.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
N/A

Current Statutory Authority or Needed Statutory Change:

The statutory authority for the Commission on Family Medicine is found at Title 25-1-901 through 25-904, Colorado Revised Statutes (1997). This request will not necessitate a statutory change.

Additional Request Information	Yes	No	Additional Information
Is this request driven by a new statutory mandate?		**X**	
Will this request require a statutory change?		**X**	
Is this a one-time request?		**X**	
Will this request involve any IT components?		**X**	