# Commission on Family Medicine

## Strategic Plan

## and

## Budget Request

FY 2015/ 2016


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# STRATEGIC PLAN: FY 2015-2016

# Commission on Family Medicine

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## Introduction

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. COFM brings together 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 was created in 1977 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. 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.

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

*GME Summit.* COFM successfully coordinated a major advocacy activity in June, 2014. The goal of the activity was to educate policy-makers about changes needed in Medicare GME payments in order to increase the primary care physician workforce. COFM raised funds from non-profit organizations to pay for the two-day activity in Washington, D.C. This effort addressed a fundamental obstacle to increasing the number of family medicine training positions in Colorado. That is, the current funding system supports the training of more sub-specialists and fewer primary care physicians. The activity, conducted in collaboration with the Colorado Institute of Family Medicine, University of Colorado Department of Family Medicine, and Rocky Vista University College of Osteopathic Medicine, may lead to legislation to modify GME funding regulations.

*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 68 positions to fill annually. The two medical schools in Colorado (CU Medical School and Rocky Vista University of Osteopathic Medicine) are not able 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.

*Rural/Underserved Rotations.* As part of their training, residents are required to complete a one-month rotation in a rural location. The intent of this experience is to increase a resident's propensity to select a rural site for practice upon graduation. Urban underserved sites provide an alternative in special circumstances. COFM selects and approves sites and helps coordinate the rotation schedule. Based on evaluations, the experience is rated positively by residents as well as the rural family physicians who provide the training.

*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 is in it's sixth year and will continue as an important part of the future strategic plan.

Contributors to Colorado's Patient Care Safety Net

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 2013/14, 71.1% of the 64,226 patients served by the family medicine residencies were Medicaid (39.8%), Medicare (13.1%), or uninsured (18.2%). It is noteworthy that Medicaid patients increased 2.8% while uninsured patients decreased 2.3% from the previous 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 find it difficult to access needed care.

Challenges Facing Family Medicine Education

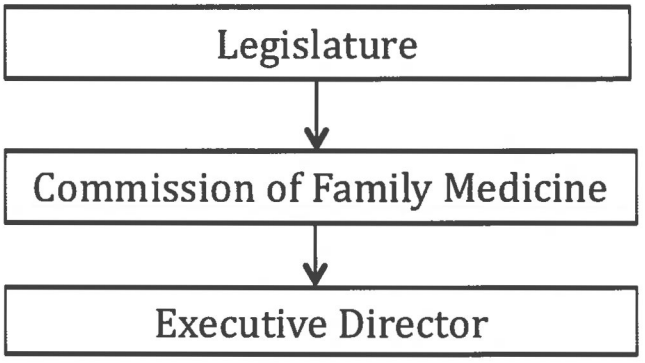
Looking ahead, three major challenges face family medicine education in Colorado. First is training enough family physicians to meet the primary care health care needs of the state. With health care reform, an increasing population, and retirement of practicing family physicians, Colorado will need more primary care physicians. This challenge is closely linked to the second challenge: finding sustainable funding for training family physicians. Residency training is also called graduate medical education (GME). The current GME payment system, largely 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. To control GME costs, Congress placed a cap on the number of training slots in 1997. Addressing this challenge requires that states seek methods to training their own primary care workforce. This is addressed by developing recommendations to the General Assembly, especially leveraging federal Medicaid dollars to increase GME in Colorado. A third major challenge is to train family physicians in the new model for delivering health care: the patient-centered medical home. 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 Goal #2.

In summary, for over 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) developing rural training programs in the state 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 (August, 2013).

**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 reflect the continued commitment to training high quality family physicians for Colorado and the need to prepare family physicians to practice in the new model of care. The residency programs are responsive to changes in the fundamental way that health care is being delivered. The patient-centered medical home (PCMH) emphasizes team-based care, coordinated care, quality-based outcomes, population management, increased patient access, and new payment methods. 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.

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 11-12 Actual | FY 12-13 Actual | FY 13-14 Actual | FY14-15 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
- Participate in at least 30 recruitment events 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 11-12 Actual | FY 12-13 Actual | FY 13-14 Actual | FY14-15 Proposed |
|---|---|---|---|---|---|
| **Program Director positions open more than 12 months** | Benchmark | 0 | 0 | 0 | 0 |
| | Actual | 0 | 0 | 0 | Pending |

| Performance Measure | Outcome | FY 11-12 Actual | FY 12-13 Actual | FY 13-14 Actual | FY14-15 Proposed |
|---|---|---|---|---|---|
| **Faculty physician positions open more than 12 months** | Benchmark | 0 | 0 | 0 | 0 |
| | Actual | 0 | 0 | 2 | 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
- Continue to work with DPHE on possible loan repayment program for new faculty

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 11-12 Actual | FY 12-13 Actual | FY 13-14 Actual | FY14-15 Proposed |
|---|---|---|---|---|---|
| **Number of residencies NCQA-certified as PCMH** | Benchmark | 9 | 9 | 9 | 9 |
| | Actual | 7 | 7 | 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
   - Additional state funding allocated to the residencies for 2013-14 and continued in 2014-15 will be used for PCMH-specific needs, specifically care coordination

   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 indicator of success is documentation that each program has reached at least Level 1 of the certification. NQCA certifies clinics at three levels. Our objective is Level 3 for all programs by the end of this year. Two programs recently submitted applications for Level 3. One received certification in late July, 2014 and the final program is expecting to receive word soon.

3. Goal: Address the need for primary care physicians in Colorado

   Objective 1: Increase the supply of family physicians in Colorado

| Performance Measure | Outcome | 6/30/12 Actual | 6/30/13 Actual | 6/30/14 Actual | 6/30/15 Proposed |
|---|---|---|---|---|---|
| **Annually retain 60% of graduating residents** | Benchmark | 60% | 60% | 60% | 60% |
| | Actual | 65% | 68% | 54% | Pending |

   The number of graduates retained in the state decreased this year. The primary reason cited by graduates was to live closer to their extended family. While this is a common reason graduates leave the state, it was higher this year. We see this as a natural variation and not a trend. We are confident that the strategies we use to retain graduates are effective. We are currently studying additional strategies, such as a more aggressive loan repayment program, and will make recommendations to the legislature in early 2015.

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
- Annually contact family medicine clinics in the state to identify open positions; inform residencies of these employment opportunities
- Continue to aggressively pursue reform of graduate medical education (GME) funding; basic changes are needed in order to increase the number of training positions in Colorado's family medicine residency programs.

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

| Performance Measure | Outcome | 6/30/12 Actual | 6/30/13 Actual | 6/30/14 Actual | 6/30/15 Proposed |
|---|---|---|---|---|---|
| **30% of graduating residents working in CO opt for rural or urban underserved area** | Benchmark | 30% | 30% | 30% | 30% |
| | Actual | 31% | 42% | 44% | Pending |

Strategies:

- Develop and maintain rural training tracks in Alamosa, Fort Morgan, and Sterling
- Continue the required one-month rotations in rural and/or underserved urban sites; support residents and preceptors in rural 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
- Collaborate with the Colorado Rural Health Center's physician recruitment and placement service, specifically by promoting the loan repayment program

Objective 3: Develop rural training programs in the state.

Performance measure: The three rural training tracks will apply for accreditation.

Strategies:

- Continue to rely on an advisory committee to prioritize projects and support the development of rural training programs
- Continue to use part-time staff (Project Coordinator, Community Assessment Specialist) to work with residencies and communities
- Assist the new rural sites as they complete the accreditation application
- Support the plan using funds allocated by the General Assembly for this purpose (SB 13-264) and in the state budget for 2014-15

Objective 4: Advocate for an increase in the number of family medicine training positions in Colorado

Performance Measure: Submit specific recommendations to the General Assembly for increasing training positions and improving retention of graduates in rural and underserved areas.

Strategies:

- To meet the requirements of SB144, COFM will establish a steering group and four work groups to develop recommendations
- Contact experts within the state and other states to identify best practices, such as leveraging federal Medicaid funding to expand primary care GME in Colorado
- Collaborate with the Colorado Health Institute to complete the study and the final report

Performance Measure: The outcome will be measured by submitting a report to the General Assembly by March 1, 2015.

Evaluation of Success in Meeting Benchmarks:
The intent of Goal #3 is to increase the number of family physicians in Colorado, especially in rural and urban underserved areas. Success will be evaluated by 1) the number of residents choosing to practice in the state upon graduation, 2) the number of graduates who practice in areas designated as rural or underserved, 3) the development of three rural training tracks, and 4) submission of written recommendations to the General Assembly by March 1, 2015. A long-term goal is to increase the number of training positions in the family medicine residencies. If successful, the strategies of Objectives 3 and 4 will eventually result in an increase in the number of family physicians in the state. The eventual overhaul of Medicare GME financing will require action by Congress.

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 11-12 Actual | FY 12-13 Actual | FY 13-14 Actual | FY 14-15 Proposed |
|---|---|---|---|---|---|
| **60% of patients served by the FM residencies covered by Medicare, Medicaid, or uninsured** | Benchmark | 60% | 60% | 60% | 60% |
| | Actual | 70.5% | 73.6% | 71.1% | 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

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 by analyzing the payer mix of residency patients. This information is collected annually from the residency programs and will be available as an outcome.

# BUDGET REQUEST: FY 2015-2016

# Commission on Family Medicine

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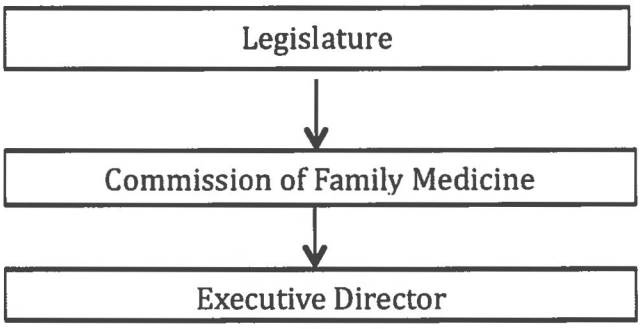
## BUDGET REQUEST: FY 2015-2016
## Commission on Family Medicine

**PROGRAM DESCRIPTION**

**Organizational Chart**




The Long Bill reports 0.0 FTE for the Commission on Family Medicine (COFM). COFM does not have statutory budget authority and, thus, cannot hire staff. The Executive Director of COFM is Kim Marvel, Ph.D. Dr. Marvel and two staff members (the Association Coordinator and Resident Recruiter) carry out the administrative and programmatic functions of COFM. They are 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. The two staff members report directly to the Executive Director, who reports to the chair of COFM and the chair of CAFMR.

*COFM Membership*

The statute creating the Commission (25-1-901 through 25-1-904) calls 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 Deans of the University of Colorado School of Medicine and Rocky Vista University of Osteopathic Medicine, and a representative of the Colorado Academy of Family Physicians. Current members of the COFM board are included at the end of this document.

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)

**Background Information**

The Commission on Family Medicine is requesting a continuation of funding received in FY 2014-15. For details, please see the rationale for the request on pages 3-5 below.

*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 and a coordinated effort for 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 independent programs controlled by competing health care systems. With a national reputation, it is a unique example of cooperation and teamwork that ultimately benefits the people of Colorado.

*Why State Funding is Vital for 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, including increasing the supply of primary care physicians in the state, improving the quality of family medicine education, yielding economic benefits, and improving access to health care for indigent patients.

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, 80%-85% 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. Historically, 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 and their sponsoring hospitals to focus on the welfare of the entire state. 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.

State funding is an incentive for residency programs to collaborate and, consequently, improve the quality of family medicine education. 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.

In FY 2013-2014, the total appropriation for COFM was $3,371,077 (General Fund plus federal Medicaid matching funds). Of that amount, $1,000,000 was allocated for development of rural training programs. The base funding of $2,371,077 was distributed directly to the nine residency programs. During that same year, Colorado leveraged over $60 million, which is the total cost for the nine family medicine residencies to train 192 residents during FY 2013/2014 (plus an additional 12 at Denver Health, which does not qualify to receive state funding). COFM does not have responsibility for the expenditure of these base funds distributed to the residencies. 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 ($296,385 per program) to support the training of family medicine residents. For the past two years, the programs have directed a portion of the funds for developing care coordination services. 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.

Finally, as contributors to Colorado's patient care "safety net", the family medicine residencies increase access to primary care services, especially for the vulnerable populations of the state. The combined number of Medicaid (39.8%), Medicare (13.1%) and uninsured (18.2%) patients represent 71.1% (45,652) of the 64,226 patients served by the residency practices in FY 2013/2014. The federally funded safety net clinics (Community Health Centers) are already hard-pressed to carry out their mandate of caring for indigent populations. Without the presence of the family medicine residencies, access for underserved patients would deteriorate. The 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 the establishment of patient advisory committees, community education on weight loss for children and their parents, school programs on smoking cessation and bicycle helmets, clinics for migrant farm workers, HIV/AIDS clinics, group visits for diabetes and other chronic illnesses, prenatal care clinics, and medication brown bag forums. In addition, the residencies provide mental health services under an integrated 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 have difficulty accessing needed care.

*Funding*

All funding for the Commission comes from the state and is captured under the Commission on Family Medicine line item. The state funding, however, is not used to pay for COFM administrative functions. Rather, 100% of the funds are used to support family medicine training programs.

*Support of Existing Residency Programs.* A portion of the state funding, considered "base funding" ($2,371,077), is distributed directly from HCPF to the nine family medicine residency programs. 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 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 base funding was increased for FY 2013-14 and was continued in FY 2014-15 at a level of $2,371,077. In 2013, COFM requested an increase of $315,000 (matched by federal Medicaid dollars for a total of $630,000) to improve care coordination in the residency programs and stabilize the recruitment program.

- A portion of the increase in state funding ($585,000) continues to be used to advance team-based care, specifically care coordination. Residents need to develop the skills necessary to be an effective member of the health care team and to understand how coordinated care benefits patients. State funds are being used to enhance care coordination, shown to improve health outcomes and decrease costs by encouraging patient follow-through and acting as a liaison between the patient and physician. The increased funding assures that residents develop the appropriate skills for practicing in a PCMH. Specific uses of increased funds for care coordination include hiring a part-time or full-time care coordinator (78% of programs) such as care managers and patient navigators, adding care coordination functions (67% of programs) such as transition care management from hospital to clinic and "hot spotting" to proactively identify high utilizers and connect them with needed resources, and using state funds to introduce care coordination into the resident curriculum (33% of programs).
- A portion of the increased base funding ($45,000) allows COFM to sustain our proactive, aggressive recruitment program. For the past four years we have had unprecedented success recruiting medical students to complete their graduate training in one of Colorado's residency programs. Our recent success can be attributed to hiring a full-time recruiter with grant funds. The increase in state funding has enabled the Commission to move off of unpredictable grant funds to permanent funding, thereby sustaining this effective program.

*Develop and Maintain Rural Training Programs.* COFM funding also was increased in FY 2013-14 by $1,000,000 ($500,000 state funds and $500,000 federal match) to develop rural training programs. This budget increase was not requested by COFM. Rather, the increase was initiated by Senators Aguilar and Schwartz who sponsored Senate Bill 13-264. COFM was informed of the plan to fund the development of rural training programs late in the 2013-14 legislative session. Because the development of family medicine rural training programs is a worthy goal and aligns with the COFM objectives, the COFM board agreed to support the bill, accept the funds, and implement the rural training project. There is a well-documented shortage of primary care physicians in rural areas of Colorado. Family physicians who train in rural locations are more likely to remain there to practice. Rural training programs, including rural training tracks, are an effective method for increasing the primary care workforce in rural Colorado. The federal government placed a cap on new residency positions in 1997. However, rural training tracks are considered an exception to the cap and, therefore, are eligible for Medicare GME payments.

In FY 2014-15, funds for developing and maintaining rural training programs were increased by $2,030,766 ($1M in state funds and slightly more than $1M federal match) for a total of $3,030,766 (including the $1M from 2013-14). Also, with the passage of SB 14-144, the COFM statute was revised to not only *develop* rural training programs, but to *maintain* them. The initial funds of $1M have been used to get three rural training tracks into the early stages of development. The rural sites of Alamosa, Fort Morgan, and Sterling are in the stages of applying for accreditation. Many steps have been taken during the first year of this project, including establishment of an Advisory Committee, evaluation and selection of proposals, development of budgets for each site, arrangement for national experts to evaluate each site, and establishment of a community steering committee at each rural site. The funds for FY 2014-15 will be received in October, 2014 ($1M) and January, 2015 ($2, 030,766). These funds will be used to help maintain the new programs as they become established. COFM is requesting continuation of funds at the same level to maintain the three new programs and to support a new rural fellowship.

*Maintaining the New Rural Training Programs.* Each of the three rural sites is being designed to train two family medicine residents per year for a total of six residents per program (two per class). The three rural programs, once up and running, will graduate six residents each year, two per program. The resident physicians will spend the first year at an existing urban residency program followed by two years at the rural site. Results of the financial consultant's assessment shows an average cost of approximately $700,000 per program per year to pay all costs for training the six residents in each program, for a total of approximately $2,100,000 per year. Part of the costs for each program will be offset by Medicare GME payments to the urban hospital (and average of $300,000 per program) and by increased practice income at the rural site (an average of $60,000 per program). This leaves an annual deficit of approximately $340,000 per program. State funds will be used to cover a significant portion of the deficit. Understandably, the administrators of the rural hospitals are reluctant to start up the rural programs without assurance that the deficit will be covered for many years in the future. Therefore, COFM will arrange for each new program to have an escrow account to pay the deficit over the next 10 years. This will require approximately $3.4M per program to cover the deficit over 10 years. Continued state funding at the same level for the next two years will assure the maintenance of all three programs. COFM is also actively seeking financial support from three other sources to possibly reduce the reliance on state funding. First are regional foundations, including the A. F. Williams Foundation and the El Pomar Foundation. Second, COFM is working with the Center for Medicare and Medicaid Services to determine whether the three rural hospitals are eligible for additional Medicare GME payments. Finally, COFM is advocating for congressional action to provide funding for new programs in Community Health Centers. If successful, Teaching Health Center funds would supplement the state funding for ongoing maintenance of the rural programs. Without ongoing state funding for at least two more years to build up the escrow accounts for each program, the rural hospitals will not be willing to sponsor the new residency programs and none of the three will open.

*Rural Fellowship.* In addition to development and maintenance of the three new rural training programs, state funds will be used to start a rural fellowship. The fellowship will provide additional training in obstetrics and emergency medicine for one family physician per year at the University of Colorado School of Medicine. Participation in the one-year fellowship is contingent upon practice in a rural setting in Colorado for at least one year following graduation. The rural fellowship will be under the supervision of Mark Deutchman, M.D., in the Department of Family Medicine. Start-up funds for the rural fellowship will be $110,000. These monies will pay for the fellow salary and benefits as well as administrative costs for the program. After the first year, the fellow salary and benefits will be self-sustaining by patient care, so only the program administrative cost will continue at approximately $10,000.

**Programs**

*Introduction*

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

Total appropriations for FY 2014/2015 (State funds plus federal Medicaid match): $5,401,843

1) Residency Training: $2,371,077
2) Develop and Maintain Rural Training Programs: $3,030,766
   (According to HCPF, the $1.5M allocated by the General Assembly was matched by federal Medicaid dollars at a slightly higher percent this year, resulting in an additional $30,766 for the rural training programs.)
3) 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.

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.

*Development of Family Medicine Rural Training Programs*

As described above, in 2013, SB 264 was passed to develop new training programs for family physicians. In 2014, SB 144 recognized the need to maintain the new programs after initial development. Unlike the Residency Training funds that are distributed directly to the residency

programs to improve physician training, the rural training funds are used to develop and maintain new training sites. State funding that was allocated in 2013 was delayed due to the process of matching state funds with CMS funds. Funds became available to COFM in January, 2014. The Commission has taken several steps to develop the rural training programs:

- Established an Advisory Committee and hired a Project Coordinator to oversee parts of this project
- Requested proposals and selected three sites for development: Alamosa, Fort Morgan, and Sterling
- Contracted with two national experts to assess the training sites for 1) accreditation potential and 2) financial viability
- Established steering committees at each rural site
- Paid for two representatives from each rural site to attend a national conference on Rural Training Tracks
- Prepared for a statewide RTT conference September 8, 2014 to assist the three sites as they seek accreditation
- Conducted numerous meetings and conference calls with personnel at the three sites, including rural hospital administrators, host residency administrators, and residency directors
- Met with two regional foundations to establish a partnership to provide long-term financial support for the RTTs
- Consulted with national experts to address obstacles to federal funding at the sites
- The Commission is currently working with all three sites to identify a method for maintaining the programs once they are established. Understandably, administrators of the rural hospitals are reluctant to start new rural programs without assurance of ongoing funding to cover the financial deficit. State funds will be instrumental for addressing the financial gap over an extended period.

*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.

The Executive Director executes the COFM board 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 supports board meetings, 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 25%
- Recruitment of Residents and Faculty 25%
- Placement of Graduates 8%
- Staffing the Commission 7%

- Coordination of Activities with Residencies 10%
- Collaboration with CU School of Medicine and Rocky Vista University of Osteopathic Medicine 5%
- Partnerships with Community Organizations 5%
- Research Activities 3%
- Management and Administration 12%

- 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 reports results to the Commission. Staff also serves as a liaison between the communities and the residencies. The current sites are located in Basalt, Buena Vista, Canon City, Gunnison, Julesburg, Leadville, Yuma, Plan de Salud Community Health Centers (Ft. Morgan, Ft. Lupton, Commerce City, Frederick, and Longmont), Valley Wide Community Health Center (San Luis Valley and La Junta), and Westwood Clinic in Lakewood. The training sites and supervising physicians receive no reimbursement for their service and provide housing for the residents and their families.

  Development of New Rural Training Programs: With funding provided by SB 13-264 and the long bill in 2014, the COFM staff is putting substantial time to develop rural training programs. The COFM Executive Director is coordinating this project with guidance provided by an Advisory Committee.

- 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 over 30 residency fairs and other recruitment events. Over 1,000 students visited with COFM representatives at these events. Colorado's nine residency programs interviewed 456 students, a number that represents 24% of all U.S. graduates going into family medicine. All of the 68 intern positions were filled in the match program. 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.

- 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 COFM Executive Director participates in the Colorado Health Service Corps board to provide loan repayment to graduates. 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.

- Staffing the Commission: This includes as variety of functions such as preparing agendas and minutes for board meetings, communicating with and updating board members, orienting new board members, educating the citizen representatives about family medicine education and health care issues, arranging visits to residencies, 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 deans of both schools are members 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 Centers, COPIC Insurance Company, the Colorado Rural Health Center, Colorado Academy of Family Physicians, The Colorado Trust, The Colorado Health Foundation, Caring for Colorado, HealthTeamWorks, ClinicNet, Kaiser Foundation, the Colorado Health Service Corps, and the National Health Service Corps.

- 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 practice location of graduates since the 1970s, documenting the value of the rural rotation for resident physicians, 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, writing grants, paying bills, and preparing board reports.

**Hot Issues**

*Meeting the Need for More Primary Care Physicians in Rural and Underserved Areas of Colorado*

An ongoing hot issue is to create the primary care physician workforce to meet increased needs for access to cost-effective care. Recent reports from the Colorado Health Institute and the Robert Graham Center point to the need for more PCPs in the state, particularly in rural and underserved areas. Indeed, the maldistribution of PCPs is well documented. One method to address this problem is to train family physicians in rural areas where they are more likely to stay after graduation. The Commission is actively working on three rural training tracks. Due to the complex Medicare GME policies and the cap placed on training positions in 1997, federal GME funding is not assured. Therefore, the Commission is pursuing other financial resources, including Medicaid GME funding and regional foundation support. The Commission is undertaking a study of Medicaid GME to determine if state funds, leveraged by federal Medicaid dollars, can be a sustainable source for increasing the number of primary care physician training slots in the state.

The Commission conducted the "GME Summit" in Washington, D.C. June 19th and 20th, 2014. This event, funded entirely by contributions from six non-profit and educational organizations, had an audience of over 120 people. Legislative health aides were educated about the need for Medicare GME reform. The Summit drew national attention and was considered a significant success in elevating the issue of GME payment reform on the national stage. In addition to the GME Summit, the Commission is working at the state level to find Medicare GME funds to support new training programs. State funds, matched by federal Medicaid dollars, will be a vital source of funding to establish and maintain the new rural training programs.

In addition to financial challenges of opening new training programs, increasing the primary care physician workforce in Colorado faces other obstacles:

- Medical students show weak interest in family medicine/primary care
- Salary differential favors medical sub-specialties over primary care
- Medical school loans motivate students to pursue higher-paying medical specialties

The Commission's response to these challenges 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. As stated above, the development of new rural training programs is another way the Commission is addressing the challenge of training the primary care workforce. Finally, the Commission will continue to advocate for federal reform of GME funding in order to support primary care training.

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

Colorado is actively engaged developing 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 has been successful. Part of the transformation 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. The residencies are busy, demanding environments in which patient care and physician education require the full attention of faculty and program directors. 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 sixth year. The majority of residency programs are now PCMH-qualified according to criteria of the National Committee on Quality Assurance (NCQA). As of early August, 2014, eight of the nine family medicine residencies are certified at the highest level (level 3) by the National Committee on Quality Assurance. The final program submitted it's application last spring and expecting to hear about certification any day. A PCMH steering committee is active in each residency program. Programs are developing a curriculum designed to prepare residents for the new model of care.

*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. 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. The recent funding increase is enabling the Commission to sustain an effective recruitment program, prepare residents to be successful providers in the new model of care, and develop new rural training programs.

**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. The recent increases in all three areas can reasonably be attributed to having a full-time recruiter beginning in the 2009-2010 season.

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|
| Residency Fairs Attended | 20 | 23 | 23 | 29 | 39 | 33 | 33 | 29 |
| Students Interviewed | 268 | 297 | 282 | 351 | 400 | 471 | 415 | 456 |
| Number of Interviews* | 644 | 741 | 731 | 902 | 983 | 1,130 | 925 | 868 |

*Some students interview at more than one residency program

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*Indicates residency program directors

## Commission on Family Medicine — FY 2014-15 — Schedule 3

| Long Bill Line Item | Total Funds | FTE | General Fund | Cash Funds | Reappropriated Funds | Federal Funds |
|---|---|---|---|---|---|---|
| | | | | | | |
| **Long Bill Line Item 1** | | | | | | |
| **FY 2012-13 Actual** | | | | | | |
| FY 2012-13 Long Bill, H.B. 12-1335 | | | | | | |
| Special Bill #1 FY13 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #2 FY13 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Supplemental Appropriation S.B. 12-xxx | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **Final FY 2012-13 Appropriation** | **$1,741,077** | **0.0** | **$870,538** | **$0** | **$0** | **$870,539** |
| FY13 Allocated Pots | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY13 Total Available Spending Authority** | **$1,741,077** | **0.0** | **$870,538** | **$0** | **$0** | **$870,539** |
| FY13 Expenditures | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2012-13 Reversion \ (Overexpenditure)** | $1,741,077 | 0.0 | $870,538 | $0 | $0 | $870,539 |
| | | | | | | |
| **FY 2013-14 Actual** | | | | | | |
| FY 2013-14 Long Bill, S.B. 13-230 | $2,371,077 | 0.0 | $1,185,538 | $0 | $0 | $1,185,539 |
| Special Bill #3 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #4 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY 2013-14 Rural Training S.B. 264 | $1,000,000 | 0.0 | $500,000 | $0 | $0 | $500,000 |
| **Final FY 2013-14 Appropriation** | **$3,371,077** | **0.0** | **$1,685,538** | **$0** | **$0** | **$1,685,539** |
| FY14 Allocated Pots | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY13 Total Available Spending Authority** | **$3,371,077** | **0.0** | **$1,685,538** | **$0** | **$0** | **$1,685,539** |
| FY14 Expenditures | $0 | 0.0 | $0 | $0 | $0 | $0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2013-14 Reversion \ (Overexpenditure)** | $3,371,077 | 0.0 | $1,685,538 | $0 | $0 | $1,685,539 |
| | | | | | | |
| **FY 2014-15 Appropriation** | | | | | | |
| FY 2014-15 Long Bill Appropriation H.B. 14-1336 | $5,401,843 | 0.0 | $2,660,002 | $0 | $0 | $2,741,841 |
| Special Bill #3 FY15 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #4 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2014-15 Total Appropriation** | **$5,401,843** | **0.0** | **$2,660,002** | **$0** | **$0** | **$2,741,841** |
| **FY15 Personal Services allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15 Operating allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| | | | | | | |
| **FY 2015-16 Request** | | | | | | |
| Final FY 2014-15 Appropriation | $5,401,843 | 0.0 | $2,660,002 | $0 | $0 | $2,741,841 |
| Special Bill #4 FY15 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2015-16 Base Request** | **$5,401,843** | **0.0** | **$2,660,002** | **$0** | **$0** | **$2,741,841** |
| Decision Item #1 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Decision Item #2 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2015-16 Total Request** | **$5,401,843** | **0.0** | **$2,660,002** | **$0** | **$0** | **$2,741,841** |
| **FY15 Personal Services allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15 Operating allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| | | | | | | |
| **Long Bill Line Item 2** | | | | | | |
| **FY 2012-13 Actual** | | | | | | |
| FY 2012-13 Long Bill, H.B. 12-1335 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #1 FY13 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #2 FY13 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Supplemental Appropriation S.B. 12-xxx | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **Final FY 2012-13 Appropriation** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY13 Allocated Pots | $0 | 0.0 | $0 | $0 | $0 | $0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **FY12 Total Available Spending Authority** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY13 Expenditures | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2012-13 Reversion \ (Overexpenditure)** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| | | | | | | |
| **FY 2013-14 Actual** | | | | | | |
| FY 2013-14 Long Bill, S.B. 13-230 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #2 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #3 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **Final FY 2013-14 Appropriation** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY14 Allocated Pots | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY14 Total Available Spending Authority** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY14 Expenditures | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2013-14 Reversion \ (Overexpenditure)** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| | | | | | | |
| **FY 2014-15 Appropriation** | | | | | | |
| FY 2014-15 Long Bill Appropriation H.B. 14-1336 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #3 FY15 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #4 FY15 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2014-15 Total Appropriation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15 Personal Services allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15Operating allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| | | | | | | |
| **FY 2015-16 Request** | | | | | | |
| Final FY 2015-16 Appropriation | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #4 FY16 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2015-16 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 2015-16 Total Request** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY16 Personal Services allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY16 Operating allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| | | | | | | |
| **Long Bill Line Item Final** | | | | | | |
| **FY 2012-13 Actual** | | | | | | |
| FY 2012-13 Long Bill, H.B. 12-1335 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #1 FY13 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #2 FY13 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Supplemental Appropriation S.B. 12-xxx | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **Final FY 2012-13 Appropriation** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY13 Allocated Pots | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY13 Total Available Spending Authority** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY13 Expenditures | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2012-13 Reversion \ (Overexpenditure)** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| | | | | | | |
| **FY 2013-14 Actual** | | | | | | |
| FY 2013-14 Long Bill, S.B. 13-230 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #2 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #3 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Supplemental Appropriation H.B. 13-xxxx | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **Final FY 2013-14 Appropriation** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY14 Allocated Pots | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY13 Total Available Spending Authority** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY14 Expenditures | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2013-14 Reversion \ (Overexpenditure)** | $0 | 0.0 | $0 | $0 | $0 | $0 |
| | | | | | | |
| **FY 2014-15 Appropriation** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| FY 2014-15 Long Bill Appropriation H.B. 14-1336 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #3 FY15 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #4 FY15 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2014-15Total Appropriation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15 Personal Services allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15 Operating allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| | | | | | | |
| **FY 2015-16 Request** | | | | | | |
| Final FY 2015-16 Appropriation | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #4 FY15 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2015-16 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 2015-16 Total Request** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15 Personal Services allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15 Operating allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| | | | | | | |
| **Division Total** | | | | | | |
| **FY 2012-13 Actual** | | | | | | |
| FY 2012-13 Long Bill, H.B. 12-1335 | $1,741,077 | 0.0 | $870,538 | $0 | $0 | $870,539 |
| Special Bill #1 FY13 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #2 FY13 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Supplemental Appropriation S.B. 12-xxx | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **Final FY 2012-13 Appropriation** | **$1,741,077** | **0.0** | **$870,538** | **$0** | **$0** | **$870,539** |
| FY13 Allocated Pots | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY13 Total Available Spending Authority** | **$1,741,077** | **0.0** | **$870,538** | **$0** | **$0** | **$870,539** |
| FY13 Expenditures | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2012-13 Reversion \ (Overexpenditure)** | $1,741,077 | 0.0 | $870,538 | $0 | $0 | $870,539 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **FY 2013-14 Actual** | | | | | | |
| FY 2013-14 Long Bill, S.B. 13-230 | $2,371,077 | 0.0 | $1,185,538 | $0 | $0 | $1,185,539 |
| Special Bill #2 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #3 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| FY 2013-14 Rural Training S.B. 264 | $1,000,000 | 0.0 | $500,000 | $0 | $0 | $500,000 |
| **Final FY 2013-14 Appropriation** | **$3,371,077** | **0.0** | **$1,685,538** | **$0** | **$0** | **$1,685,539** |
| FY14 Allocated Pots | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Roll-forward expense to FY 2013-14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY14 Total Available Spending Authority** | **$3,371,077** | **0.0** | **$1,685,538** | **$0** | **$0** | **$1,685,539** |
| FY14 Expenditures | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2013-14 Reversion \ (Overexpenditure)** | $3,371,077 | 0.0 | $1,685,538 | $0 | $0 | $1,685,539 |
| | | | | | | |
| **FY 2014-15 Appropriation** | | | | | | |
| FY 2014-15 Long Bill Appropriation H.B. 14-1336 | $5,401,843 | 0.0 | $2,660,002 | $0 | $0 | $2,741,841 |
| Special Bill #3 FY15 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Special Bill #4 FY15 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2014-15 Total Appropriation** | **$5,401,843** | **0.0** | **$2,660,002** | **$0** | **$0** | **$2,741,841** |
| **FY15 Personal Services allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15 Operating allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| | | | | | | |
| **FY 2015-16 Request** | | | | | | |
| Final FY 2014-15 Appropriation | $5,401,843 | 0.0 | $2,660,002 | $0 | $0 | $2,741,841 |
| Special Bill #4 FY14 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2015-16 Base Request** | **$5,401,843** | **0.0** | **$2,660,002** | **$0** | **$0** | **$2,741,841** |
| Decision Item #1 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| Decision Item #2 | $0 | 0.0 | $0 | $0 | $0 | $0 |
| **FY 2015-16 Total Request** | **$5,401,843** | **0.0** | **$2,660,002** | **$0** | **$0** | **$2,741,841** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **FY15 Personal Services allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| **FY15 Operating allocation** | **$0** | **0.0** | **$0** | **$0** | **$0** | **$0** |
| | | | | | | |
| **FY 2014-15 Total Appropriation** | **$5,401,843** | **0.0** | **$2,660,002** | **$0** | **$0** | **$2,741,841** |
| **FY 2015-16 Base Request** | **$5,401,843** | **0.0** | **$2,660,002** | **$0** | **$0** | **$2,741,841** |
| **FY 2015-16 Total Request** | **$5,401,843** | **0.0** | **$2,660,002** | **$0** | **$0** | **$2,741,841** |
| **Percentage Change FY 2014-15 to FY 2015-16** | **0%** | | **0.00%** | | | **0%** |