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Colorado Commission on
Family Medicine

Commission on Family Medicine

Strategic Plan

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Budget Request

FY 2016-2017

Colorado Commission on
Family Medicine

Commission on Family Medicine

STRATEGIC PLAN

FY 2016-2017

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Introduction

The strategic plan of the Commission on Family Medicine addresses the growing need in the state for well-trained family physicians, particularly in rural and underserved areas, as well as the need to prepare family physicians for a new delivery model characterized by team-based, integrated care. The core objectives, outlined later in this plan, are designed to increase the number of family physicians trained in our state, increase the number of graduates practicing in rural and undeserved areas, and ensure training occurs in a patient-centered medical home. Recognizing the increased need for primary care physicians, the Colorado General Assembly recently allocated funds to add more family medicine training positions in rural areas and in existing residency programs. The strategic plan addresses the expansion of existing training programs. Also, the strategic plan ensures that 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.

<u>The Commission on Family Medicine</u>
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. In other states, it is common 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, including the need to place more family physicians in rural areas of the state. 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 recruitment program, rural rotations, the patient-centered medical home project, and advocating for graduate medical education (GME) payment reform.

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 represents all nine programs at recruitment fairs and in marketing materials.

Rural 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 and increases their consideration of rural practice.

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 project, starting in 2009, will continue as an important part of the future strategic plan.

GME Payment Reform. Medicare GME payments are an important source of funding for residency training in all states. In the current structure, federal funding supports the training of more sub-specialists and fewer primary care physicians. COFM has been actively involved educating policymakers that the GME payment system needs to be changed in order to build the primary care physician workforce needed by the country and Colorado. The current payment system makes it difficult to expand the number of family medicine training positions in our state. In June, 2014, COFM successfully coordinated a major event in Washington, D.C. to educate policy-makers about changes needed in Medicare GME payments to increase the primary care physician workforce. A follow-up conference is planned early November 2015 in Denver. These activities are conducted in collaboration with the Colorado Institute of Family Medicine, University of Colorado Department of Family Medicine, Rocky Vista University College of Osteopathic Medicine, and the Colorado Academy of Family Physicians.

<u>Contributors to Colorado's Patient Care Safety Net</u>

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, five challenges face family medicine education in Colorado.

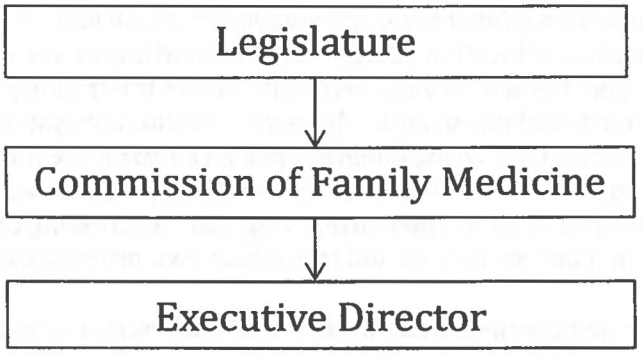
- *First is training enough family physicians to meet the primary care health care needs of the state.* With health care reform, an increasing population, and retirement of practicing family physicians, Colorado will need more primary care physicians. Medical students typically graduate with high debt and, therefore, select sub-specialties with higher salaries.
- *The second challenge is finding sustainable funding for training family physicians.* Residency training is also called graduate medical education (GME). As described above, the current federal 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. In Colorado, each family medicine residency typically has a deficit of $.5M to $1.0M annually that is covered by their sponsoring hospitals. Addressing this challenge requires that states seek methods to fund and train their own primary care workforce.
- *A third challenge is placing family medicine graduates in rural and underserved areas of the state.* The shortage of primary care physicians in rural areas is long-standing. Obstacles to rural practice include spousal satisfaction and professional isolation. Strategies to increase the likelihood of rural practice include increasing the exposure to rural settings during training and providing loan repayment.
- *A fourth challenge is the lack of qualified faculty to teach family medicine residents.* Many practicing family physicians do not provide full-scope primary care, including obstetrics and inpatient medicine, required of faculty physicians. Also, family physicians in full-time clinical practice are paid more than family physicians that teach in residency programs. Both of these factors make it challenging to recruit family medicine faculty physicians. Financial incentives, such as loan repayment awards, is one approach to attract family physicians to teach in the residency programs.
- *A fifth challenge is to train family physicians in the new model for delivering health care: the patient-centered medical home.* This new model of care is characterized by team-based care, coordinated care, quality-based outcomes, population management, and improved patient access. The residency programs continue their progress as PCMHs. Although there is ample evidence that a PCMH improves health outcomes and lowers costs for patients, the current payment system does not cover the costs for the additional personnel needed to create a PCMH. The payment system continues to be based on the volume of care rather than the quality of care, making the financing of the PCMH a challenge.

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. Objectives have been modified to increase the number of graduates practicing in Colorado by 1) developing and maintaining rural training programs in the state and 2) expanding the number of trainees in existing residency programs.

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 growing need in the state for well-trained family physicians, particularly in rural and underserved areas, as well as the need to prepare family physicians to practice team-based, integrated care.

1. Goal: Train family medicine resident physicians 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 12-13 Actual	FY 13-14 Actual	FY 14-15 Actual	FY15-16 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

- Expand effort to send recruiting materials to medical schools and student organizations
- Participate in at least 20 recruitment events across the country; target medical schools with high percent of students selecting family medicine
- 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 12-13 Actual	FY 13-14 Actual	FY 14-15 Actual	FY15-16 Proposed
Program Director positions open more than 12 months	Benchmark	0	0	0	0
	Actual	0	0	0	Pending

Performance Measure	Outcome	FY 12-13 Actual	FY 13-14 Actual	FY 14-15 Actual	FY15-16 Proposed
Faculty physician positions open more than 12 months	Benchmark	0	0	0	0
	Actual	0	2	3	Pending

Strategies:

- Use 2015-16 allocation of state funds to the CDPHE Primary Care Office to recruit new faculty physicians by offering the incentive of faculty loan repayment
- 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

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. We will closely track the outcome of the faculty loan repayment program administered jointly with CDPHE.

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, including care coordination services.

Performance Measure	Outcome	FY 12-13 Actual	FY 13-14 Actual	FY 14-15 Actual	FY15-16 Proposed
Number of residencies NCQA-certified as PCMH	Benchmark	9	9	9	9
	Actual	7	8	9	Pending

Performance Measure	Outcome	FY 12-13 Actual	FY 13-14 Actual	FY 14-15 Actual	FY15-16 Proposed
Number of residencies providing care coordination services	Benchmark	N/A	9	9	9
	Actual	N/A	9	9	Pending

Strategies:

- Each residency program will continue to renew their NCQA certification under the updated 2011 guidelines
- Each program has identified a staff member as a Quality Improvement Coach. A two-year grant extension from the Colorado Health Foundation allows the residencies to continue semi-annual PCMH learning collaboratives. This will enable the programs to continue functioning as PCMHs after the grant funds have ended.
- State funding allocated to the residencies for care coordination started in 2013-14 and continues to be used for PCMH-specific needs.

Evaluation of Success in Meeting Benchmarks:
All nine programs have been certified at the highest level (Level 3) by the National Committee on Quality Assurance. This is a remarkable accomplishment. Another indicator of success is the continuation of semi-annual PCMH learning collaboratives that involves all of the residency programs.

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

Objective 1: Increase the supply of family physicians in Colorado

Performance Measure	Outcome	6/30/13 Actual	6/30/14 Actual	6/30/15 Actual	6/30/16 Proposed
Annually retain 60% of graduating residents	Benchmark	60%	60%	60%	60%
	Actual	68%	54%	71%	Pending

The number of graduates retained in the state this year was above the 60% benchmark. Over the last 43 years, since the first family medicine residents completed training in Colorado in 1972, 60% of the graduates are currently practicing in the state. That is a total of 1,004 family physicians.

Performance Measure: Add 5 new training positions to existing residency programs.

The Colorado General Assembly allocated $2.7M to add five new positions to existing programs starting in 2015-16. The number of graduates per year will increase from 68 to 73. The five participating programs will each recruit an additional resident to begin training in July 2016. The new funding also includes loan repayment awards to ensure the new graduates practice in rural and underserved areas of Colorado upon completion of training. At this stage, we are preparing to recruit the additional residents. The ultimate performance measure will be in 3 years when the additional trainees graduate and add to the primary care physician workforce in the state.

Strategies:

- Oversee the expansion of 5 programs that are adding a new resident

- Inform residents of employment opportunities in Colorado; maintain a file at each residency of positions available
- Continue to aggressively pursue reform of federal graduate medical education (GME) funding; basic changes are needed in order to further increase the number of training positions in Colorado's family medicine residency programs.
- Work closely with 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

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

Performance Measure	Outcome	6/30/13 Actual	6/30/14 Actual	6/30/15 Actual	6/30/16 Proposed
30% of graduating residents working in CO opt for rural or urban underserved area	Benchmark	30%	30%	30%	30%
	Actual	42%	44%	49%	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
- Host the Rural Training Track (RTT) National Conference in 2016 with a focus on building a pipeline between medical school rural programs and the RTTs under development in our state
- 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
- 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 recruit their first residents.

Strategies:

- Oversee the development of the three RTT sites; provide administrative support, including consultants and project management, as needed
- Assist the RTTs in their recruitment efforts
- Assist the new rural sites as they complete the accreditation process
- Use state funds to ensure that the RTTs can be maintained into the future by building reserve accounts for each rural site
- Continue the Advisory Committee to make recommendations to the Commission board on the development and stability of the RTTs

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 family medicine physician trainees in the state, 2) the number of residents choosing to practice in

the state upon graduation, 3) the number of graduates who practice in areas designated as rural or underserved, 4) placing trainees in the three new rural training tracks.

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 12-13 Actual	FY 13-14 Actual	FY 14-15 Actual	FY 15-16 Proposed
60% of patients served by the FM residencies covered by Medicare, Medicaid, or uninsured	Benchmark	60%	60%	60%	60%
	Actual	73.6%	71.1%	Pending	Pending

Strategies:

- Residency programs continue to provide care for patients who are uninsured, underinsured, and on Medicaid and Medicare
- Continue to provide care coordination services to address the prevalent social determinants of health that affect the underserved patient population
- Residency programs continue to seek alternative, supplementary funding sources, such as grants, to defray the cost of uncompensated patient care services

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. Data for the 2014-15 year are being collected from the nine residency programs. These results will be available by the end of August 2015. Based on the trend in past years and the increase in Medicaid patients throughout the state, it is highly likely the goal of 60% will be exceeded.

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PROGRAM DESCRIPTION

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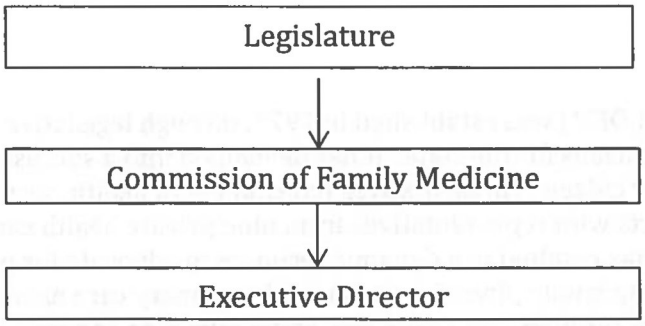

The Long Bill reports 0.0 FTE for the Commission on Family Medicine (COFM). COFM does not have statutory budget authority and, thus, cannot hire staff. The Executive Director of COFM is Kim Marvel, Ph.D. Dr. Marvel and two staff members (the Association Coordinator and Resident Recruiter) carry out the 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 2015-16. For details, please see the rationale for the request on pages 3-6 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

Without state funding, the Commission would cease to exist, since it has no other source of revenue, and the collaboration of the nine family medicine programs would likely discontinue. 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 an increased supply of primary care physicians in the state, particularly in rural and underserved areas, improved quality of family medicine education, economic benefits, and improved 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 119 US medical schools outside of Colorado. Historically, over 60% of the graduates stay in Colorado after completing their training. This year COFM conducted a study to identify the practice location of graduates from 1972 (the first graduating class of the Colorado residencies) to the present. Since 1972, 1,950 family physicians have graduated from Colorado's residency programs. Of those graduates currently practicing, 61% (1,012) are in the state. This is clear evidence that the citizens of Colorado benefit from the presence of strong family medicine residency programs. In addition ensuring high-quality training programs and the collaborative recruitment of medical students, state funding influences the individual residencies and their sponsoring hospitals to focus on the welfare of the entire state rather than solely on their own patient population. 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 work together in 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
- Development of three rural training tracks designed to place graduates in rural areas of the state
- 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. The rural rotation would no longer be required of all residents, likely decreasing the number of graduates practicing in rural areas.

Funding

COFM is requesting for 2016-17 that state funding remain unchanged from the 2015-16 budget. All funding for the Commission comes from the state and is captured under the Commission on Family Medicine line item in the state budget.

State funds allocated to COFM are matched by federal Medicaid dollars, effectively doubling the state funding. Thus, in 2015-16, the state funding of $4,035,538 is matched by $4,105,753 in federal Medicaid funds for a total of $8,101,843.

The COFM line item is used for three distinct purposes to support family medicine training in Colorado. The "base funding" is distributed directly to the nine residency programs for training expenses and care coordination services. The "rural training funds", started in FY 2013-14, are to develop and maintain three rural training tracks. The "residency expansion funds", started in FY 2015-16, are allocated to add five training positions to the existing residency programs. Each of these distinct uses of the budget line item is described in more detail below.

Base Funding to Support Training in Residency Programs. A portion of the state funding, considered "base funding" ($2,371,076), is distributed directly from HCPF to the nine family medicine residency programs. The funds are used for training expenses, such as faculty and resident salaries, educational programming, and required scholarly activities. Prior to 2004-2005, 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 allowed for an increase in the federal match for the Residency Training. 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 to the current level in FY 2013-14. 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) is being 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. Specific uses of increased funds for care coordination include hiring care managers and patient navigators, adding care coordination functions 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.
- A portion of the increased base funding ($45,000) is being used to sustain the successful recruitment program. The increase in state funding enabled the Commission to move off of unpredictable grant funds to permanent funding, thereby sustaining this effective program.

Develop and Maintain Rural Training Programs. A portion of the COFM line item ($3,030,767) is used to develop and maintain three rural training tracks. COFM funding to develop and maintain rural training programs was started in FY 2013-14 (SB 13-264) and increased in FY 2014-15 (SB 14-144). The funds were allocated to address the well-documented shortage of primary care physicians in rural areas of the state. Rural training programs, including rural training tracks, are an effective method for increasing the primary care physician workforce in rural Colorado. Family physicians who train in rural locations are more likely to remain there to practice.

It is noteworthy that the request in 2013 to fund rural training programs was not initiated by COFM. Rather, the request was initiated by Senators Aguilar and Schwartz who contacted COFM to collaborate on Senate Bill 13-264. The COFM board agreed to support the bill, accept the funds, and implement the rural training project. SB 13-264 provided $1M ($500,000 state funds and $500,000 federal Medicaid match) to start the rural training programs.

In FY 2014-15, funds to develop rural training programs were increased by $2,030,767 ($1M in state funds and slightly more than $1M federal match) for a total of $3,030,767 (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. In other words, these funds were allocated to help maintain the new programs after they became established. This is an important distinction because the funds allocated in SB 14-144 enable the rural training programs, once up and running, to build reserve funds to continue them into the future and assure the rural hospitals sponsoring the programs that they will continue to be supported.

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 sites.

Development of a rural training program typically requires three years: Year 1 for identifying and evaluating the sites, Year 2 for accreditation, and Year 3 for recruitment. Important progress has been made the first two years of the project. In 2013-14, the rural communities of Alamosa, Fort Morgan, and Sterling were selected for the training programs. Each site has established a steering committee in the community. Other development activities in 2013-14 included establishment of an Advisory Committee, evaluation and selection of proposals, development of budgets for each site, and arrangement for national experts to evaluate each site. In 2014-15, all three sites focused on

completion of the extensive accreditation application. In 2015-16, the sites will be recruiting the first residents to begin training in July 2017.

Maintaining the three new rural training programs will require continued state support at the current level. 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. A limited portion of the expenses for each program will be offset by patient revenue generated by the resident physicians. No federal Medicare GME payments are expected for the rural training programs due to policies of the Center for Medicare and Medicaid Services (CMS). Understandably, rural hospital administrators are reluctant to start up the rural programs without assurance that the annual deficit will be covered for many years in the future. Therefore, continued state funding is essential to maintain the rural training tracks.

To maintain the rural programs into the future, COFM is establishing a reserve account for each new program to pay the training costs over the next 10 years. Continued state funding at the same level for at least the next three years will assure the maintenance of all three programs for 10 years. COFM is also actively seeking financial support from other sources to possibly reduce the reliance on state funding. First are regional foundations, including the A. F. Williams Foundation in Fort Morgan and the El Pomar Foundation in Colorado Springs. Second, COFM is working with CMS to determine whether the three rural hospitals are eligible for Medicare GME payments. Finally, COFM is advocating for congressional action to revise CMS policies for rural training programs. COFM is partnering with several other Western and Midwestern states for a bill in Congress to provide funding for new rural training tracks. If successful, Medicare GME funds would supplement the state funding for ongoing maintenance of the rural programs.

Add five (5) new positions to existing residency programs. The final portion of the COFM line item ($1,350,000 of state funds matched by federal Medicaid funds for a total of $2,739,448) is being used to expand the number of training positions in existing programs. The funds also are used for loan repayment awards for the new trainees to practice in rural and underserved areas in the state following graduation.

SB 14-144 required that the Commission conduct a study and provide recommendations to the legislature for increasing the number of family physicians in rural and underserved areas of the state. The study was conducted from June to December 2014. In March 2015, the Commission submitted to the legislature the report "Family Medicine Residency Education in Colorado: Recommendations to Increase Training and Retention of Family Physicians In Rural and Underserved Areas". Based on the report findings, the General Assembly funded the recommendation to "Add new training positions to existing family medicine programs."

Wording from the report: "We recommend providing state funding to add five new training positions, which would yield an additional 15 residents in training at any one time – five first-year residents, five second-year residents, and five third-year residents. This would mean five additional graduates per year. We propose phasing them in by adding five first-year positions each year over three years. Residents who fill the state-funded positions will be required to commit to practice in rural or underserved locations in the state for three years following graduation. In return, they will receive a loan repayment package. This will require a minimum of three years of state funding in order to graduate at least one cycle of trainees."

Five residencies have been identified to add the new training positions: Fort Collins, St. Anthony's (Westminster), St. Joseph's (Denver), St. Mary's (Grand Junction), and the University program. Each

of these programs will recruit an additional resident to begin July 2016 and will continue adding a new resident over the subsequent two years. After three years, each of the five programs will have an additional first-year resident, second-year resident, and third-year resident. State funds will pay training expenses for the additional residents ($144,600 per resident per year), loan repayment (a $90,000 award per graduate) for three years of service after graduation in a rural or underserved area, and a 3% administrative fee to COFM for overseeing the program. A memorandum of understanding between the Commission and the sponsoring hospitals will ensure that the state funds are used exclusively for resident training and loan repayment.

In summary, the COFM line item used for three distinct purposes, all involving the training of family physicians: base funding, rural training programs, and the addition of five training positions to existing residencies. The COFM allocation has been increased the last two years specifically to place more graduates in rural and undeserved areas of the state. Between the rural programs and the expansion of existing residencies, the family medicine residencies will add 11 more graduates to their current rate of 68 per year. These additional graduates will likely practice in areas of greatest need in the state due to their training in rural locations (rural training programs) or loan repayment at HPSA sites (five additional resident positions). The action of the Governor and legislature to address the shortage of primary care physicians in rural areas is an outstanding example of a state training it's physician workforce to meet the needs of the citizens.

Programs

Introduction

COFM's structure does not include "divisions" or "programs" in the formal definition used by OSPB. The four "programs" described below allow for grouping and describing the Commission's projects and activities.

Total appropriations for FY 2015/2016 (State funds plus federal Medicaid match): $8,141,291

1) Residency Training in Existing Programs:	$2,371,076
2) Develop and Maintain Rural Training Programs:	$3,030,767
3) Addition of Five Training Positions	$2,739,448
3) Operations and Administration:	$0

Residency Training in Existing Programs:

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.

A portion of the residency training ensures that resident family physicians learn to work in a team-based care clinical environment. Care coordination services are an important component of the patient-centered medical home. The residency programs apply some of the state funds to ensure that residents learn the benefits of care coordination services by working in an integrated, team-based clinical setting.

Development and Maintenance of 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 three new training sites. The Commission has taken several steps to develop the rural training programs:

- Established an Advisory Committee
- 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
- 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 (A.F. Williams Family Foundation and El Pomar Foundation) 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
- Worked on accreditation applications
- Prepared and coordinated accreditation site visits
- Prepared marketing and recruiting materials

Addition of Five Training Positions

COFM is actively engaged with this new project. The state funds will soon be disbursed to the five participating programs. COFM has taken several steps to implement this project:

- Identified five residencies capable of expanding their training programs
- Created a memorandum of understanding between COFM and each of the sponsoring hospitals to ensure the funds are used exclusively for resident training and loan repayment
- Worked closely with the program directors of participating programs
- Worked closely with Primary Care Office staff that administer the Colorado Health Service Corps (loan repayment program)

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 (CAFMR) agreed to provide Commission 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. CAFMR 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 20%
- Recruitment of Residents and Faculty 20%
- Placement of Graduates 5%
- Staffing the Commission 10%
- Coordination of Activities with Residencies 13%
- Collaboration with CU School of Medicine and Rocky Vista University of Osteopathic Medicine 5%
- Partnerships with Community Organizations 5%
- Research Activities 2%
- Management and Administration 20%

- 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 recruitment as a high 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 20 residency fairs and other recruitment events. Over 1,000 students visited with COFM representatives at these events. 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 and an annual retreat for the program directors 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. 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

Sustainable Funding for Training Primary Care Physicians

The funding of family medicine residency programs is inadequate and complex. Financial support for Colorado's family medicine GME programs comes from four main sources:

- Patient Revenue: Residents in primary care specialties, such as family medicine, complete most of their training in outpatient clinics. Reimbursement rates for the main types of outpatient primary care, such as the management of chronic conditions and preventive care, are lower than hospital-based medical specialties. In addition, many patients seen by resident trainees are uninsured, underinsured, or covered by Medicaid or Medicare, both of which pay less for services than commercial insurance carriers. In Colorado, revenues from patient care in family medicine residencies cover about half of the cost of operating the programs.
- Medicare GME Payments: These payments from the federal government cover about one-third of the costs of the programs. Due to a cap in place since 1997, additional training slots do not receive Medicare GME payments.
- Medicaid GME Payments: State funds are matched by federal Medicaid funds and allocated to the residencies through the COFM. These funds cover about three percent of the total program costs. In addition, hospitals that sponsor residency programs receive a supplemental payment to care for Medicaid clients. These supplemental payments do not directly support the cost of the residency programs.
- Sponsoring Hospitals: The sponsoring hospitals pay the balance of the costs of the program. In Colorado, most sponsoring hospitals provide $500,000 to $1 million annually. Some sponsoring hospitals have considered closing the family medicine residency programs due to the financial deficits.

Although primary care physicians provide the majority of care in rural and underserved areas and decrease overall health care costs, the training programs for primary care physicians, compared to training programs for sub-specialty physicians, are more costly for sponsoring hospitals. Residencies that train sub-specialty physicians are able to increase patient revenue through hospital-based procedures that are reimbursed at a higher rate. In contrast, the care of chronic conditions and preventive care, common in family medicine residencies, is reimbursed at a lower level. With no increases in federal funding to support primary care training, state funding has been instrumental for adding rural training programs and expanding the existing residencies.

The Commission continues to actively pursue GME payment reform on a national level. In 2014, COFM conducted the "GME Summit" in Washington, D.C. A similar event will be held in Denver November 2015. These events, funded entirely by contributions from non-profit and educational organizations, educate policy makers about the need for Medicare GME reform in order to expand the primary care physician workforce.

Placing and Retaining Primary Care Physicians in Rural and Underserved Areas of Colorado

An ongoing challenge is placing and retaining primary care physicians in rural and underserved areas of the state. 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. 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 Medicare GME funding is minimal or nonexistent for new rural training programs. Therefore, state funding leveraged by Medicaid GME dollars and regional foundation support is necessary to build the primary care physician workforce needed in underserved areas.

Loan repayment is another strategy for placing graduates in rural and undeserved areas. COFM participates in the Colorado Health Service Corps. The recent allocation of state funds to add five positions to existing residency programs includes loan repayment to ensure the graduates will practice in designated Health Professional Shortage Areas in the state.

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. 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 seventh year. All nine of residency programs are now PCMH-qualified at the highest level according to criteria of the National Committee on Quality Assurance (NCQA).

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 for health care is often based on the fee-for-service model. As residency programs transition to quality-based outcomes and population-based care, the traditional volume-based payment system often does not adequately reimburse for quality indicators. This poses a financial challenge to the residency programs. COFM, in partnership with the Colorado Academy of Family Physicians, is actively involved in the Colorado Primary Care Collaborative (CPCC) to advocate for payment reform with third-party payers.

Challenge of Recruiting and Retaining Qualified Family Medicine Faculty Physicians

The vacancies in faculty physician positions in Colorado's family medicine residencies have increased in recent years. The recruitment and retention of faculty physicians has become more challenging for two reasons. First, fewer practicing family physicians do full-spectrum care,

including OB and inpatient medicine. In contrast, residency programs are required to teach all aspects of family medicine to trainees. Program directors seek applicants capable of teaching ambulatory care, inpatient medicine, as well as OB. However, the pool of qualified candidates doing full-spectrum care is limited.

A second obstacle for recruiting faculty is the medical school debt faced by most recent residency graduates. The average medical school debt is $170,000. While some recent graduates would consider teaching, clinical practice pays substantially more than starting faculty jobs. A solution to the increasing shortage of residency faculty is loan repayment for new or recently-hired faculty.

The General Assembly approved $270,000 in the CDPHE budget for 2015-16 for faculty loan repayment. Although these funds are not in the COFM line item, the Commission fully supports continuation of the CDPHE funds for faculty loan repayment.

Summary

COFM plays a vital role providing primary health care in Colorado. The primary mission is to train family physicians to practice in the state. Continued state funding at the current level is essential for the following reasons:

- Collaboration of programs: Enables the nine residency programs to collaborate, including recruitment and the coordination of rural rotations, thereby saving money and avoiding duplication. Base funding allows for continued collaborative projects among the programs.
- Patient-centered medical homes: All nine programs are certified PCMHs based on national standards. This statewide project ensures family physicians are trained in a team-based, integrated model. The project would not continue without coordination through COFM.
- Rural training programs: The three rural training tracks are in the third year of development. Once established, the rural programs will graduate six family physicians per year with a high likelihood to practice in rural areas.
- Additional trainees in existing programs: Five positions are being added to existing residency programs. Graduates will commit to three years of practice in rural and underserved areas of the state in exchange for loan repayment.

The recent increases in COFM funding will increase the number of family physician graduates by 11. Rather than 68 graduates per year, the residencies will produce 79 graduates. Moreover, all of the new training positions are specifically designed to increase the primary care physician workforce in rural and underserved areas of the state. The new projects (developing rural training programs and expanding existing residencies) require sustained state funding. A minimum of three years of funding is required to get the new trainees through three years of training. The reduction or elimination of funding for the new projects would result in no increase in primary care physicians in areas of the state that are in need of improved health care.

COFM also strongly supports the continuation of faculty loan repayment funds in the CDPHE budget. The availability of qualified faculty physicians is essential to maintain the quality of the family medicine residency 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.

	2008	2009	2010	2011	2012	2013	2014	2015
Recruitment Events Attended	23	23	29	39	33	33	29	21
Students Interviewed	297	282	351	400	471	415	456	446
Number of Interviews*	741	731	902	983	1,130	925	868	869

*Some students interview at more than one residency program

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*Indicates residency program directors

Commission on Family Medicine — FY 2015-16 — Schedule 3

Long Bill Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Long Bill Line Item 1						
FY 2013-14 Actual						
FY 2013-14 Long Bill, S.B. 13-230	$2,371,077		$1,185,538			$1,185,539
Special Bill #1 FY14	$0	0.0	$0	$0	$0	$0
Special Bill #2 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
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 Actual						
FY 2014-15 Long Bill, 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
		0.0		$0	$0	
Final FY 2014-15 Appropriation	**$5,401,843**	**0.0**	**$2,660,002**	**$0**	**$0**	**$2,741,841**
FY15 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY14 Total Available Spending Authority		**0.0**		**$0**	**$0**	
FY15 Expenditures	$0	0.0	$0	$0	$0	$0

FY 2014-15 Reversion \ (Overexpenditure)	**$5,401,843**	0.0	**$2,660,002**	$0	$0	**$2,741,841**
FY 2015-16 Appropriation						
FY 2015-16 Long Bill Appropriation S.B. 15-234	**8,141,291**	0.0	**4,035,538**	$0	$0	**4,105,753**
Special Bill #3 FY16	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY16	$0	0.0	$0	$0	$0	$0
FY 2015-16 Total Appropriation	**8,141,291**	**0.0**	**4,035,538**	**$0**	**$0**	**4,105,753**
FY15 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY15 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2016-17 Request						
Final FY 2016-17 Appropriation	8,141,291	0.0	4,035,538	$0	$0	4,105,753
Special Bill #4 FY16	$0	0.0	$0	$0	$0	$0
FY 2016-17 Base Request	**8,141,291**	**0.0**	**4,035,538**	**$0**	**$0**	**4,105,753**
Decision Item #1	$0	0.0	$0	$0	$0	$0
Decision Item #2	$0	0.0	$0	$0	$0	$0
FY 2016-17 Total Request	**8,141,291**	**0.0**	**4,035,538**	**$0**	**$0**	**4,105,753**
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 2						
FY 2013-14 Actual						
FY 2013-14 Long Bill, S.B. 13-230	$0	0.0	$0	$0	$0	$0
Special Bill #1 FY14	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY14	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation S.B. 12-xxx	$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 Actual						
FY 2014-15 Long Bill, H.B. 14-1336	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY15	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY15	$0	0.0	$0	$0	$0	$0
Final FY 2014-15 Appropriation	$0	0.0	$0	$0	$0	$0
FY15 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY15 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY15 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2014-15 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2015-16 Appropriation						
FY 2015-16 Long Bill Appropriation S.B. 15-234	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY16	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY16	$0	0.0	$0	$0	$0	$0
FY 2015-16 Total Appropriation	**$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**
FY 2016-17 Request						
Final FY 2016-17 Appropriation	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY17	$0	0.0	$0	$0	$0	$0
FY 2016-17 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 2016-17 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY17 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY17 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Long Bill Line Item Final						
FY 201-14 Actual						
FY 2013-14 Long Bill, H.B. 13-230	$0	0.0	$0	$0	$0	$0
Special Bill #1 FY14	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY14	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation S.B. 12-xxx	$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 Actual						
FY 2014-15 Long Bill, H.B. 14-1336	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY15	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY15	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation H.B. 14-xxxx	$0	0.0	$0	$0	$0	$0
Final FY 2014-15 Appropriation	$0	0.0	$0	$0	$0	$0
FY15 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY14 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY15 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2014-15 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2015-16 Appropriation						

FY 2015-16 Long Bill Appropriation S.B. 15-234	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY16	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY16	$0	0.0	$0	$0	$0	$0
FY 2015-16Total Appropriation	**$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**
FY 2016-17 Request						
Final FY 2016-17 Appropriation	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY16	$0	0.0	$0	$0	$0	$0
FY 2016-17 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 2016-17 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**
Division Total						
FY 2013-14 Actual						
FY 2013-14 Long Bill, S.B. 13-320	$2,371,077	0.0	$1,185,538	$0	$0	$1,185,539
Special Bill #1 FY14	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY14	$0	0.0	$0	$0	$0	$0
FY 2013-14 Rural Training S.B. 264	$1,00,000	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
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 Actual						
FY 2014-15 Long Bill, H.B. 14-1336	$5,401,843	0.0	$2,660,002	$0	$0	$2,741,841
Special Bill #2 FY15	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY15	$0	0.0	$0	$0	$0	$0
		0.0		$0	$0	
Final FY 2014-15 Appropriation	**$5,401,843**	**0.0**	**$2,660,002**	**$0**	**$0**	**$2,741,841**
FY15 Allocated Pots	$0	0.0	$0	$0	$0	$0
Roll-forward expense to FY 2014-15	$0	0.0	$0	$0	$0	$0
FY15 Total Available Spending Authority	**$5,401,843**	**0.0**	**$2,660,002**	**$0**	**$0**	**$2,741,841**
FY15 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2014-15 Reversion \ (Overexpenditure)	$5,401,843	0.0	$2,660,002	$0	$0	$2,741,841
FY 2015-16 Appropriation						
FY 2015-16 Long Bill Appropriation S.B. 15-234	$8,141,291	0.0	$4,035,538	$0	$0	$4,105,753
Special Bill #3 FY16	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY16	$0	0.0	$0	$0	$0	$0
FY 2015-16 Total Appropriation	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**
FY16 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY16 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2016-17 Request						
Final FY 2016-17 Appropriation	$8,141,291	0.0	$4,035,538	$0	$0	$4,105,753
Special Bill #4 FY16	$0	0.0	$0	$0	$0	$0
FY 2016-17 Base Request	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**
Decision Item #1	$0	0.0	$0	$0	$0	$0
Decision Item #2	$0	0.0	$0	$0	$0	$0
FY 2016-17 Total Request	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**

FY16 Personal Services allocation	$0	0.0	$0	$0	$0	$0
FY16 Operating allocation	$0	0.0	$0	$0	$0	$0
FY 2015-16 Total Appropriation	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**
FY 2016-17 Base Request	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**
FY 2016-17 Total Request	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**
Percentage Change FY 2015-16 to FY 2016-17	**0%**		**0.00%**			**0%**

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