BUDGET REQUEST: FY 2018-2019

Commission on Family Medicine

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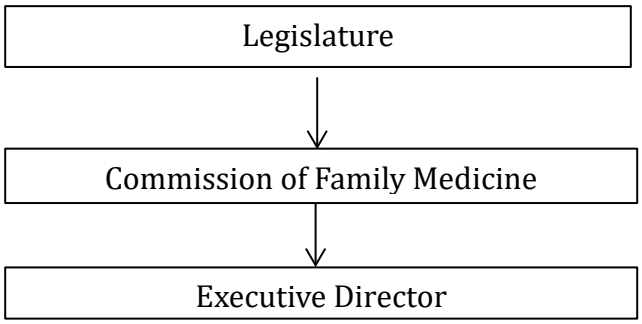
PROGRAM DESCRIPTION

Organizational Chart



The Long Bill reports 0.0 FTE for the Commission on Family Medicine (COFM). 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 Program Administrator and Education Specialist) 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 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 family medicine residency 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 family medicine residency programs in Colorado.

- Fort Collins Family Medicine Residency (Fort Collins)
- North Colorado Family Medicine Residency (Greeley, with rural training tracks in Sterling and Wray and an underserved urban track in the Sunrise Community Health Center)
- *Peak Vista Family Medicine Residency (Colorado Springs)
- 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)
- *Sky Ridge Family Medicine Residency (Lone Tree)
- Southern Colorado Family Medicine Residency (Pueblo, with a rural training track in Alamosa)
- Swedish Family Medicine Residency (Littleton)
- University of Colorado Family Medicine Residency (Denver, with the Denver Health track and a rural training track in Fort Morgan)

* Two new family medicine residencies started in July 2016. Both will become members of COFM upon receiving accreditation this year (2017).

Background Information

Introduction

The Commission on Family Medicine (COFM) was established in 1977, through legislative mandate, to support the education of family physicians for the state. It has developed into a successful model of collaboration. COFM brings together citizen representatives (consumers of health care) from Colorado's seven Congressional Districts with the program directors from the family medicine residencies. 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 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 family medicine programs would likely discontinue. State funds form the nucleus that supports the highly effective collaboration among Colorado's 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, and improved access to health care for indigent and low-income 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 residency programs work together to recruit medical students. Historically, 80%-85% of the residents come from outside of Colorado to train in Colorado's nationally recognized programs. Historically, over 60% of the graduates stay in Colorado after completing their training. Last year COFM conducted a study to identify the practice location of graduates from 2010-2016. *Over those 7 years, 443 family physicians graduated from Colorado's residency programs. Sixty percent (266) are practicing in the state. Forty-four practice in 23 rural counties.* This is clear evidence that the citizens of Colorado benefit from the presence of strong family medicine residency programs. In addition to 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 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, the Rocky Mountain Research Forum, and training for new faculty as well as chief residents
- The requirement that residents complete a rotation in a rural or underserved community
- Maintenance of four 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 programs who share similar responsibilities, such as program coordinators, program administrators, behavioral faculty, quality improvement staff, and curriculum directors
- Bi-annual conferences to help the residency clinics become advanced primary care practices

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.

State funding also is required to maintain the three new rural training tracks (Alamosa, Fort Morgan, Sterling) as well as the addition of five resident positions to existing residency programs. Funding for these two projects started in 2013 (the rural training programs) and 2015 (the additional resident positions). The two projects will increase by 11 the number family medicine graduates likely to practice in rural areas of the state.

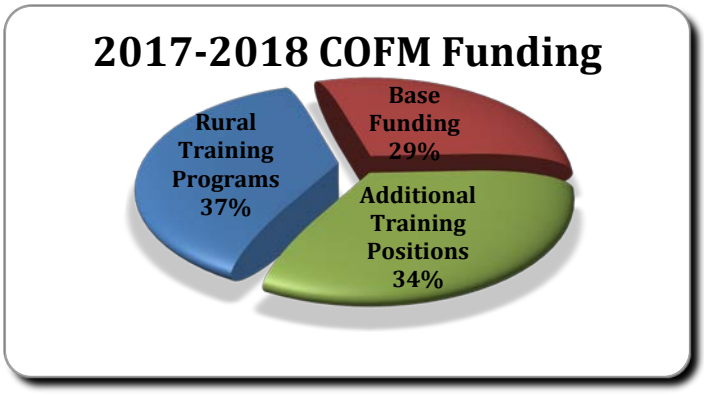
Funding

The Commission on Family Medicine is requesting an increase of $600,000 ($300,000 General Fund and $300,000 federal Medicaid GME matching funds) to provide base funding for the two new family medicine residency programs (Peak Vista and Skyridge), equal to the base funding for the existing residency programs.

All funding for the Commission comes from the state and is captured under the Commission line item in the state budget.

State funds allocated to COFM are matched by federal Medicaid dollars, effectively doubling the state funding. Thus, in the current budget (2017-18), the state funding of $4,056,304 is matched by $4,088,884 in federal Medicaid funds for a total of $8,145,188.

Funds allocated to the Commission are 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 care coordination. **With the addition of two new residency programs, COFM is requesting an increase of $300,000 from the General Fund for base funding for Peak Vista and Skyridge. With the federal Medicaid GME matching funds, this will provide the two new programs with the same level of "base funding" as each of the nine long-standing residencies receive ($296,385).**

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 for the 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.

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.

Each of the three rural sites is training two family medicine residents per year for a total of six residents per program (two per class), eventually yielding six graduates per year, two per program. In these rural programs, the resident physicians 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. We have completed the development phase and now use the state funds to maintain these new programs.

Rural training track progress to date:

- In 2013-14, the rural communities of Alamosa, Ft. Morgan, and Sterling were selected for the training programs
- All three rural sites have received full accreditation
- Recruitment in 2016-17 was highly successful with all the training positions filled. In July 2017, the second class of residents for the Alamosa and Sterling RTTs started and the first class of residents for the Fort Morgan RTT began their training
- Governance agreements and budgets have been developed for the rural sites

Maintaining the three new rural training programs will require continued state support at the current level. Each rural training track requires approximately $400,000 per year to pay all costs for training the six residents in each program, for a total of approximately $1,200,000 per year. Rural hospital administrators will not continue the rural programs without assurance that their annual deficit for sponsoring the programs 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 has established a reserve account for each new RTT to pay the training costs over the next 10 years. Continued state funding at the same level for at least the next two 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. 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 programs. If successful, Medicare GME funds would supplement the state funding for ongoing maintenance of the rural programs.

Add 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.

In 2015, the General Assembly funded the COFM recommendation to add new training positions to existing family medicine programs. The recommendation was worded as follows: "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 will result in 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."

As a result of this new funding in 2015, five residencies added a new training position: Fort Collins, St. Anthony's (Westminster), St. Joseph's (Denver), St. Mary's (Grand Junction), and the University of Colorado program (Denver).

Additional Resident Project progress to date:

- The five programs have each recruited two additional residents: five that started training July 1, 2016 and five that started July 1, 2017

- The five programs will recruit the third set of residents in the fall of 2017 to begin July 2018
- Eight graduating residents have received loan repayment awards in return for a three-year service commitment at HPSA sites in the state
    - Two practice in Archuleta County (Pagosa Springs)
    - One practices in Chafee County (Buena Vista)
    - One practices in Sunrise Clinic (Greeley)
    - One practices in Lowry Clinic (Denver)
    - Three practice in Clinica Campesina (Westminster/Louisville areas)

Finally, this year one resident was added to the University of Colorado FM Residency. Supplemental Funding from the University of Colorado School of Medicine was earmarked to expand the FM Residency by one slot. This will result in three additional trainees (one per class) and an additional graduate each year.

With the addition of two new family medicine residencies that started in 2016, each with 8 trainees per year, Colorado's family medicine residencies will produce a grand total of 96 family physicians annually by 2021. Between 2014 and 2018, this is an astounding expansion of 84 trainees per year (28 per class) yielding 28 more graduates annually (from 68 in 2014 to 96 in 2021).

In summary, the COFM line item is used for three distinct purposes, all involving the training of family physicians: base funding, rural training programs, and the additional training positions to existing residencies. The COFM allocation has been increased the last four 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 12 more graduates to their current rate of 68 per year for a total of 80 graduates. 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 two new family medicine residencies will provide 16 more graduates for a total of 96.

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 2017/2018 (state funds plus federal Medicaid match): $8,145,188

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 family medicine residencies. This portion of the COFM funding is sent directly to the residency programs to be used 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 requirements for residencies that receive state funds:

- Program must be accredited by the ACGME single-accreditation system
- Residents must complete a one-month rotation at a COFM-approved rural/underserved site
- New programs will be eligible for a share of the COFM state funding one calendar year after they receive accreditation, starting the following State Fiscal Year (July 1). This one-year period will allow COFM to find new funding sources for the new program(s), thereby avoiding a funding decrease for the existing residency programs due to dividing previously allocated state funds among more programs.

Related to the third bullet above, **COFM is requesting an increase of $600,000 ($300,000 from the General Fund and $300,000 matching federal Medicaid dollars) in order to provide base funding for the two new family medicine residencies as they become fully participating COFM members. This new funding will avoid a funding decrease for the existing residency programs due to dividing the current base funding among more programs.**

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 use 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 (base funding) that are distributed directly to the residency programs to improve physician training, the rural training funds are used to develop and maintain three new rural training tracks. 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
- Conducted numerous meetings and conference calls with personnel at the three sites, including rural hospital administrators, host residency administrators, and residency directors, to develop governance structures and budgets
- Prepared marketing and recruiting materials
- The rural training programs have started to train their first residents.

Addition of Five Training Positions

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

- 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)
- Ten additional residents have started training (five July 1, 2016 and five July 1, 2017)
- Eight graduating residents received loan repayment awards in return for a three-year service commitment at Colorado HPSA sites

Commission Operations

The Executive Director executes the COFM board directives, maintains a working relationship with the residency directors and other key personnel at the residency programs, and is responsible for all administrative functions of the Commission including personnel, accounting, and liaison with OSPB, HCPF and the JBC. 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, faculty development, state-wide learning collaboratives and a research forum, 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 in Colorado complete a month-long rotation at a rural or underserved clinical site. The purpose is to expose residents to rural practice so they better understand the challenges and benefits of rural practice and will consider such as placement after graduation. 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 Alamosa, Basalt, Brush, Buena Vista, Canon City, Granby, Gunnison, Holyoke, Julesburg, La Junta, Yuma, Salida. For the minority of residents who are not able to spend a month in a rural setting (such as for family reasons), an alternative experience is at COFM-approved urban underserved sites. The rural training sites and supervising physicians receive no reimbursement for their service and provide housing for the residents and their families.

Staff commit substantial time to develop the three new rural training programs. The COFM Executive Director is coordinating this project.

- Recruitment of Residents and Faculty: The Commission has always held recruitment as a high priority, as detailed in the Strategic Plan. This allocation of resources corresponds to the intense competition for medical students opting for family medicine. Last year the Commission participated in over 15 residency fairs and other recruitment events. Over 1,000 students visited with COFM representatives at these events. All of the 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. (See the Hot Issues section below for a more detailed explanation.) 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. Additionally, state funds allocated to the CDPHE provide loan repayment awards to recruit and/or retain family medicine residency faculty. COFM staff have worked closely with staff in the Primary Care Office to set up and operate the faculty loan repayment program. **For 2018-19, COFM is supporting the request of CDPHE for an additional $225,000 for the faculty loan repayment program**.

- 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 works with the Colorado Rural Health Center and its 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 CAFMR Program Administrator 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, recruiting and 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 Residency Activities: The Commission staff help 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 Rocky Mountain Research Forum (approximately 200 attendees), the Primary Care Innovation Collaborative (approximately 130 attendees), the New Faculty Development Program, bi-annual leadership workshops for chief residents, and an annual retreat for the program directors of the residency 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 collaborate with a diverse set of public and community-based organizations. A partial list of organizations includes the Colorado Area Health Education Centers, COPIC Insurance Company, the Colorado Rural Health Center, Colorado Academy of Family Physicians, The Colorado Health Institute, The Colorado Trust, The Colorado Health Foundation, Caring for Colorado, HealthTeamWorks, Kaiser Foundation, the Colorado Health Service Corps, and the National Health Service Corps.

- Research Activities: The staff participate 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, documenting the value of the rural rotation for resident physicians, and collecting data on the chief resident leadership workshops.

- Management and Administration: Included in this item are the activities required to keep an organization functioning, such as supervising staff, overseeing the operational budget and annual requested audit, 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 functions 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. Due to these limitations, revenues from patient care in family medicine residencies cover only 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, new or additional training slots do not receive Medicare GME payments.
- Medicaid GME Payments: State funds, such as those described in this document, are matched by federal Medicaid funds and allocated to the residencies through the COFM. These funds cover 3-5% 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, cost more 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 was held in Denver November 1-3, 2015. A third "Summit" was sponsored in January 2017 in Albuquerque with a focus on state-based initiatives to support the training of primary care physicians. 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. Colorado has developed a national reputation as a leader in GME payment reform under the leadership of COFM.

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. Currently three faculty positions have been vacant for over 12 months. The recruitment and retention of faculty physicians has become more challenging for three 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 faculty physicians 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, allowing the graduate to pay off their school loan more rapidly..

A third obstacle for recruiting faculty, related to the item above, is that clinical practice provides a higher pay rate than teaching at a family medicine residency program. Faculty at the family medicine residencies must possess a "love of teaching", for they work long hours, provide hospital care and OB services, and are paid at a lower rate than their private practice colleagues who often do not provide full-spectrum family medicine.

A solution to the increasing shortage of residency faculty is loan repayment for new or recently-hired faculty.

In the 2015-16 CDPHE budget, the General Assembly approved $270,000 for faculty loan repayment at the family medicine residencies. These funds provide six awards of $45,000 each year. The faculty receiving the awards commit to two years as a faculty member at the residency. Over the first two years of this program, three new physician faculty have been recruited and six have been retained (junior faculty who still have medical school loans are retained in their faculty positions by the award). This program is immensely popular with the program directors of the family medicine residencies. It provides a tool for them to augment their faculty recruitment efforts and to retain their junior faculty who otherwise may be lured away to a higher-paying clinical job. Because there have been nine residencies and two more will soon be added, only a portion of the programs can offer a faculty loan repayment award each year with the current level of funding.

Although these funds are not in the COFM line item, the Commission fully supports the increase of CDPHE funding by $225,000 per year to expand the faculty loan repayment program. By expanding the funding from the present level of $270,000 to $495,000 (an increase of $225,000), all of the 11 programs will be able to offer a faculty loan repayment award each year. Currently, the funding enables only six programs to offer an award each year.

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 has established 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 advanced primary care practices. 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 over the past eight years. 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 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.

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 is essential for the following reasons:

- Collaboration of programs: Enables the 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. With the addition of two new family medicine residencies, an increase in base funding will enable the existing programs to maintain their current level of base funding.
- Rural training programs: The three rural training tracks have been established and are training family physicians in rural communities. These 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 have been added to existing residency programs. Graduates commit to three years of practice in rural and underserved areas of the state in exchange for loan repayment. In addition, one new training position has been added to the University of Colorado program.
- Patient-centered medical homes: All programs are certified PCMHs based on national standards. This statewide project ensures family physicians are trained in a team-based, integrated model. This ongoing project depends on coordination from COFM.

The recent increases in COFM funding will eventually increase the number of family physician graduates by 12. Rather than 68 graduates per year, the residencies will produce 80 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. Finally, the addition of two new family medicine residency programs will add 16 more graduates by 2019, for a grand total of 96 per year.

COFM also strongly supports an increase 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 sustained increases in medical student recruiting can reasonably be attributed to state funding used exclusively for recruitment.

	2010	2011	2012	2013	2014	2015	2016	2017
Recruitment Events Attended	29	39	33	33	29	21	13	16
Students Interviewed	351	400	471	415	456	446	409	462
Number of Interviews*	902	983	1,130	925	868	869	831	923

*Some students interview at more than one residency program

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*Indicates residency program directors

Commission on Family Medicine FY 2018-19 Schedule 3

Long Bill Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Long Bill Line Item 1						
FY 2015-16 Actual						
FY 2015-16 Long Bill, S.B. 15-234	$8,141,291		$4,035,538			$4,105,753
Special Bill #1 FY15	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY15	$0	0.0	$0	$0	$0	$0
	$0	0.0	$0	$0	$0	$0
Final FY 2015-16 Appropriation	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**
FY16 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY15 Total Available Spending Authority	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**
FY16 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2015-16 Reversion \ (Overexpenditure)	$8,141,291	0.0	$4,035,538	$0	$0	$4,105,753
FY 2016-17 Actual						
FY 2016-17 Long Bill, H.B. 16-1405	$8,145,188	0.0	$4,056,304	$0	$0	$4,088,884
Special Bill #3 FY17	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY17	$0	0.0	$0	$0	$0	$0
		0.0		$0	$0	
Final FY 2016-17 Appropriation	**$8,145,188**	**0.0**	**$4,056,304**	**$0**	**$0**	**$4,088,884**
FY17 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY15 Total Available Spending Authority		**0.0**		**$0**	**$0**	
FY17 Expenditures	$0	0.0	$0	$0	$0	$0

FY 2016-17 Reversion \ (Overexpenditure)	**$8,145,188**	0.0	**$4,056,304**	$0	$0	**$4,088,884**
FY 2017-18 Appropriation						
FY 2017-18 Long Bill Appropriation S.B. 17-	**$8,145,188**	0.0	**$4,056,304**	$0	$0	**$4,088,884**
Special Bill #3 FY18	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY18	$0	0.0	$0	$0	$0	$0
FY 2017-18 Total Appropriation	**$8,145,188**	**0.0**	**$4,056,304**	**$0**	**$0**	**$4,088,884**
FY17 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY17 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2018-19 Request						
Final FY 2018-19 Appropriation	**$8,745,188**	0.0	**$4,356,304**	$0	$0	**$4,388,884**
Special Bill #4 FY18	$0	0.0	$0	$0	$0	$0
FY 2018-19 Base Request	**$8,745,188**	**0.0**	**$4,356,304**	**$0**	**$0**	**$4,388,884**
Decision Item #1	$0	0.0	$0	$0	$0	$0
Decision Item #2	$0	0.0	$0	$0	$0	$0
FY 2018-19 Total Request	**$8,745,188**	**0.0**	**$4,356,304**	**$0**	**$0**	**$4,388,884**
FY18 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY18 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Long Bill Line Item 2						
FY 2015-16 Actual						
FY 2015-16 Long Bill, S.B. 15-234	$0	0.0	$0	$0	$0	$0
Special Bill #1 FY16	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY16	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation S.B. 12-xxx	$0	0.0	$0	$0	$0	$0
Final FY 2015-16 Appropriation	$0	0.0	$0	$0	$0	$0
FY16 Allocated Pots	$0	0.0	$0	$0	$0	$0

FY15 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY16 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2015-16 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2016-17 Actual						
FY 2016-17 Long Bill, H.B. 16-1405	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY17	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY17	$0	0.0	$0	$0	$0	$0
Final FY 2016-17 Appropriation	$0	0.0	$0	$0	$0	$0
FY17 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY17 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY17 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2016-17 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2017-18 Appropriation						
FY 2017-18 Long Bill Appropriation S.B. 17-xxx	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY18	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY18	$0	0.0	$0	$0	$0	$0
FY 2017-18 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY18 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY18 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2018-19 Request						
Final FY 2018-19 Appropriation	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY19	$0	0.0	$0	$0	$0	$0
FY 2018-19 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 2018-19 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY19 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY19 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Long Bill Line Item Final						
FY 2015-16 Actual						
FY 2015-16 Long Bill, S.B. 15-234	$0	0.0	$0	$0	$0	$0
Special Bill #1 FY16	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY16	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation S.B. 16-xxx	$0	0.0	$0	$0	$0	$0
Final FY 2015-16 Appropriation	$0	0.0	$0	$0	$0	$0
FY16 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY16 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY16 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2015-16 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2016-17 Actual						
FY 2016-17 Long Bill, S.B. 16-1405	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY17	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY17	$0	0.0	$0	$0	$0	$0
Supplemental Appropriation S.B. 17-xxxx	$0	0.0	$0	$0	$0	$0
Final FY 2016-17 Appropriation	$0	0.0	$0	$0	$0	$0
FY17 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY17 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0
FY17 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2016-17 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0
FY 2017-18 Appropriation						

FY 2017-18 Long Bill Appropriation S.B. 17-xxx	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY18	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY18	$0	0.0	$0	$0	$0	$0
FY 2017-18Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY18 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY18 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2018-19 Request						
Final FY 2018-19 Appropriation	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY18	$0	0.0	$0	$0	$0	$0
FY 2018-19 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 2018-19 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY18 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY18 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Division Total						
FY 2015-16 Actual						
FY 2015-16 Long Bill, S.B. 15-234	$8,141,291	0.0	$4,035,538	$0	$0	$4,105,753
Special Bill #1 FY16	$0	0.0	$0	$0	$0	$0
Special Bill #2 FY16	$0	0.0	$0	$0	$0	$0
	$0	0.0	$0	$0	$0	$0
Final FY 2015-16 Appropriation	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**
FY16 Allocated Pots	$0	0.0	$0	$0	$0	$0
FY16 Total Available Spending Authority	**$8,141,291**	**0.0**	**$4,035,538**	**$0**	**$0**	**$4,105,753**
FY16 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2015-16 Reversion \ (Overexpenditure)	$8,141,291	0.0	$4,035,538	$0	$0	$4,105,753

FY 2016-17 Actual						
FY 2016-17 Long Bill, H.B. 16-1405	$8,145,188	0.0	$4,056,304	$0	$0	$4,088,884
Special Bill #2 FY17	$0	0.0	$0	$0	$0	$0
Special Bill #3 FY17	$0	0.0	$0	$0	$0	$0
		0.0		$0	$0	
Final FY 2016-17 Appropriation	**$8,145,188**	**0.0**	**$4,056,304**	**$0**	**$0**	**$4,088,884**
FY17 Allocated Pots	$0	0.0	$0	$0	$0	$0
Roll-forward expense to FY 2016-17	$0	0.0	$0	$0	$0	$0
FY17 Total Available Spending Authority	**$8,145,188**	**0.0**	**$4,056,304**	**$0**	**$0**	**$4,088,884**
FY17 Expenditures	$0	0.0	$0	$0	$0	$0
FY 2016-17 Reversion \ (Overexpenditure)	$8,145,188	0.0	$4,056,304	$0	$0	$4,088,884
FY 2017-18 Appropriation						
FY 2017-18 Long Bill Appropriation S.B. 17-xxx	**$8,145,188**	0.0	**$4,056,304**	$0	$0	**$4,088,884**
Special Bill #3 FY18	$0	0.0	$0	$0	$0	$0
Special Bill #4 FY18	$0	0.0	$0	$0	$0	$0
FY 2017-18 Total Appropriation	**$8,145,188**	**0.0**	**$4,056,304**	**$0**	**$0**	**$4,088,884**
FY18 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY18 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2018-19 Request						
Final FY 2018-19 Appropriation	**$8,745,188**	0.0	**$4,356,304**	$0	$0	$**4,388,884**
Special Bill #4 FY18	$0	0.0	$0	$0	$0	$0
FY 2018-19 Base Request	**$8,745,188**	**0.0**	**$4,356,304**	**$0**	**$0**	**$4,388,884**
Decision Item #1	$0	0.0	$0	$0	$0	$0
Decision Item #2	$0	0.0	$0	$0	$0	$0
FY 2018-19 Total Request	**$8,745,188**	**0.0**	**$4,356,304**	**$0**	**$0**	**$4,388,884**

FY18 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY18 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2017-18 Total Appropriation	**$8,145,188**	**0.0**	**$4,056,304**	**$0**	**$0**	**$4,088,884**
FY 2018-19 Base Request	**$8,745,188**	**0.0**	**$4,356,304**	**$0**	**$0**	**$4,388,884**
FY 2018-19 Total Request	**$8,745,188**	**0.0**	**$4,356,304**	**$0**	**$0**	**$4,388,884**
Percentage Change FY 2017-18 to FY 2018-19	**6.9%**		**6.9%**			**6.8%**