BUDGET REQUEST: FY 2022-2023

Commission on Family Medicine

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On behalf of the Commission on Family Medicine
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VISION AND MISSION OF THE COMMISSION ON FAMILY MEDICINE

Our Vision

To promote high quality health care for all Coloradans by *enhancing access to primary care*, including rural and underserved communities, through the training of exceptional family physicians.

Our Mission

Convene key leaders & stakeholders who support family medicine training to:

- *Cultivate* and develop a highly qualified family physician workforce in Colorado to appropriately meet the needs of the population, including rural and underserved communities, through recruitment, education, advocacy, and resource sharing.
- *Evaluate* and inform community, state, and national policy that impacts the delivery of advanced primary care and positive health outcomes for Coloradans.
- Be a powerful *voice* to elevate health care delivery for all Coloradans.

Background Information

INTRODUCTION

The Commission on Family Medicine (COFM) was established in 1977, through legislative mandate, to support the education of family physicians for Colorado. COFM brings together citizen representatives (consumers of health care) from Colorado's seven Congressional Districts and the program directors from each family medicine residency. 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 and unique nationally as these are independent programs that operate within competing health care systems.

EXECUTIVE SUMMARY

The Colorado Commission on Family Medicine plays a vital role in making primary health care in Colorado available and accessible.

Thank you for your support in reinstating COFM funds in 2021-22, your commitment to making family medicine physicians available to Coloradoans experiencing access issues is much appreciated. *COFM is asking that the 2022-2023 fiscal year appropriation is made based on 2019-2020 funds.* For 2022-23, we will be requesting an increase over 2021-22 levels of $189,000 to bring the residency training program funding back to full 2019-20 levels (FMAP increase excluded). When line items 440 and 476 in the HCPF budget were combined, line 476was not restored to the 2019-20 level. We are requesting this increase to restore those funds to the level of line 440. To allow for completion of the resident physician three-year training cycle and ongoing patient care provided by these physicians, the state's ongoing support, plus the federal match we benefit from, must be sustained. The legislature's support and continued foresight is highly valued by the Commission, and we are committed to being efficient stewards of the funds provided.

The Commission's primary mission is to train family physicians to practice in the state. Continued state funding is essential for the following reasons:

- **Advanced Primary Care Delivery**: Programs provide direct patient care through advanced primary care delivery models based on national standards. This commitment ensures family physicians are trained in team-based, integrated care delivery, known to help improve health outcomes and manage cost. COFM coordinates these efforts on behalf of the programs.

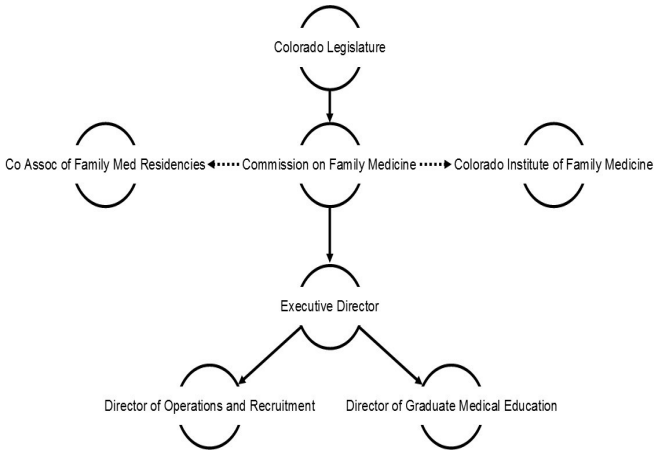
- **Rural training programs**: The three rural training tracks have been established and are training family physicians in rural communities. These rural programs graduate six family physicians per year with an increased likelihood to practice in rural areas.
- **Collaboration of programs**: Enables 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 has enabled the existing programs to maintain their current level of base funding.
- **Additional trainees in existing programs:** Five positions were added to existing residency programs. Graduates commit to three years of practice in rural/underserved areas of the state in exchange for loan repayment. In addition, one new training position was added to the University of CO program.

Recent increases in COFM funding have added to the number of family physician graduates by 12. Rather than 68 graduates per year, the residencies now produce 88 graduates. Moreover, the new positions are specifically targeted to increase the primary care physician workforce in rural and underserved areas of the state. These newer projects (rural training programs and expansion of existing residencies) require sustained state funding to accommodate the minimum of three years of funding for trainees to complete training. Reduction or elimination of funding results in no increase in primary care physicians where improved access and health care are critical. Finally, the addition of two new family medicine residency programs added 16 additional graduates in 2019, for the grand total of 88 per year.

The action of the Governor and legislature to address primary care physician shortages in rural and underserved areas is a stellar example of a state training physician workforce to meet the needs of its citizens.

PROGRAM DESCRIPTION

Organizational Chart

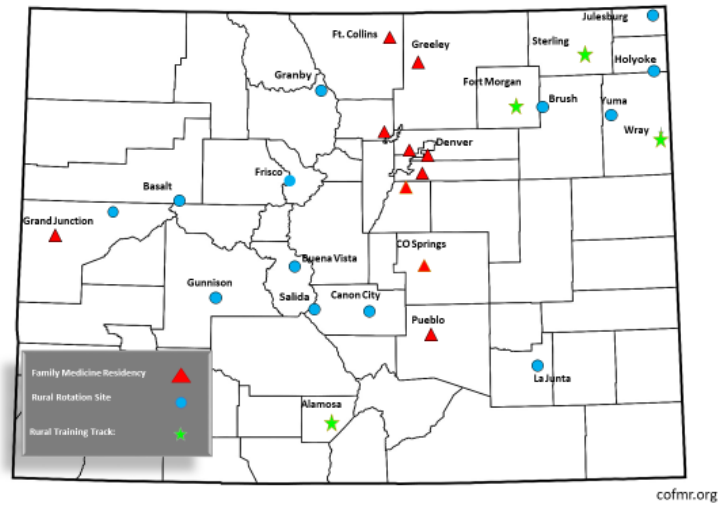


The Long Bill reports 0.0 FTE for the Commission on Family Medicine (COFM). COFM does not have statutory budget authority, therefore, the staff are employed by the Colorado Association of Family Medicine Residencies (CAFMR). CAFMR is a not-for-profit organization that supports and complements the legislative mandate of COFM. There are currently two staff members, Lynne Jones, Executive Director and Julie Herzog, Director of Operations and Programs.

COFM Membership

The statute creating the Commission (25-1-901 through 25-1-904) calls for all Colorado family medicine residencies to collaborate with citizens 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 School 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.

Colorado Family Medicine Training Sites



BENEFITS OF COLLABORATION

State funds are vital to the Commission's success and form the nucleus for a nationally unique collaboration among the CO residency programs which:

- Yields **improved primary care physician supply and quality**
- **Enhances access** in rural areas & communities experiencing disparities
- **Exposes residents to rural practice** through a mandatory rural rotation
- **Recruits medical students jointly** for all programs, avoiding duplication of effort and cost
- Recruits for high quality, experienced faculty
- Pools **training resources** which provide **optimization** of statewide networking & best practice educational opportunities
- Allows for a **statewide view** in addressing primary care needs on issues like **equity, workforce, and social determinants** attention
- Supports programs in delivering **care to the state's most under-resourced** – Medicare, Medicaid and uninsured
- **Would cease to exist without state funding**

- **Fort Collins Family Medicine Residency** (Fort Collins)
- **North Colorado Family Medicine Residency** (Greeley; rural training tracks-Sterling & Wray; underserved urban track - Greeley's Sunrise Community Health Center-FQHC)
- **Peak Vista Family Medicine Residency** (Colorado Springs-FQHC, homeless clinic urban rotation)
- **Saint Anthony's Family Medicine Residency** (Westminster)
- **Saint Joseph's Family Medicine Residency** (Central Denver)
- **Saint Mary's Family Medicine Residency** (Grand Junction)
- **HealthOne at Medical Center of Aurora Family Medicine Residency** (Aurora)
- **Southern Colorado Family Medicine Residency** (Pueblo; rural training track in Alamosa)
- **Swedish Family Medicine Residency** (Littleton)
- **University of Colorado Family Medicine Residency** (Denver; Denver Health track; rural training track - Fort Morgan)

Funding Overview

The Commission on Family Medicine is requesting $4,520,084 reflecting *no increase* in funding from the 2019-2020 pre-pandemic fiscal year.

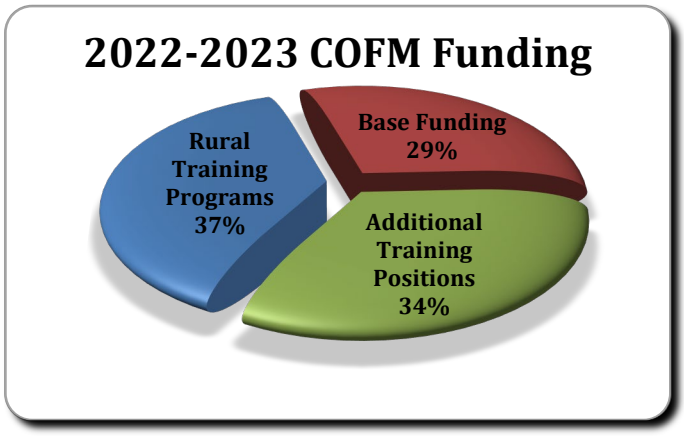
State funds allocated to COFM are matched by federal Medicaid dollars, effectively doubling the state funding. Thus, in the current budget (2021-22), the state funding is matched 50-50 in federal Medicaid funds. NOTE*: In response to COVID-19, federal match was increased by 6.2% through December 2021.*

Key Numbers:

- Over 50% of currently licensed CO family med physicians attended CO residency programs
- 80+% of medical students come from outside Colorado
- 60+% residents remain to practice near where they complete training
- Over 10% practice in rural CO
- Loan repayment supports physicians practicing in CO HPSA regions and entities

***State funding supports**:*

- Unparalleled collaboration
- Synced recruitment of medical students
- Best practice integration statewide
- Rural practice exposure
- Increased potential for practice in rural and underserved areas
- Consolidated efforts to enhance diversity of physician workforce



FAMILY MEDICINE RESIDENCY FUNDING PRIORITIES

1. Base Funding ($1,670,084)
Funded incrementally since the 1970's and distributed directly to each residency program for training purposes, collaborations and care coordination.

2. Rural Training Funds ($1,500,000)
Initiated in FY 2013-14 to develop and maintain three rural training tracks.

3. Residency Expansion Funds ($1,350,000)
Initiated in FY 2015-16, funds are allocated to add five training positions to existing programs. *Each of the distinct uses of the budget line item is described in more detail in Appendix B.*

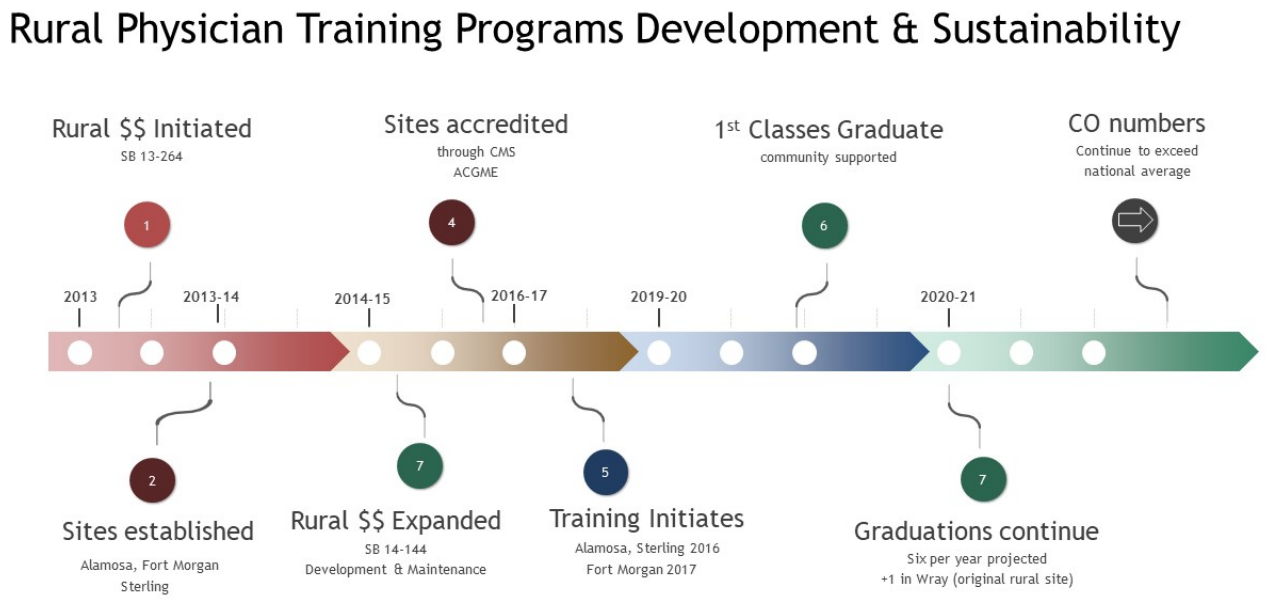
1. Base Funding to Support Training in Residency Programs.

$3,340,168 in base funding will be distributed directly from HCPF to the 10 family medicine residency programs for training expenses including but not limited to:

- Collaborative statewide recruitment of residents to Colorado
- Resident and faculty salaries
- Statewide educational programming
- Rural rotation support and coordination
- Care coordination and integrated services

Funds are used for training expenses, such as faculty and resident salaries, educational programming, rural rotation support and care coordination. COFM base funding was increased to the 2019-2020 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 enhance the recruitment program.

2. Develop and Maintain Rural Training Programs.



In 2013-14, the legislature supported establishment of three rural training programs in Alamosa, Fort Morgan and Sterling, Colorado. In 2022-23, $1,500,000 ($1,606,164 in 2021-22 due to increased federal match (53.1% vs. 50%) is being requested (plus any federal match available) of state funding support for three rural training tracks.

State support at the current level is essential to the successful sustainability of the three rural training programs. Each rural training track requires an average of $600,000 per year or $1,800,000 overall to cover expenses for training the six residents in each program. These funds subsidize support for the programs and confirm continued support from rural hospital administrations that would not continue to host programs without assurance that the deficit they incur will be covered into the future.

To allow for sustenance of the rural programs into the future, COFM has established a reserve account for each RTT to cover the training costs for completion of a full cohort of residents. COFM also actively seeks financial support from other sources to attempt to reduce reliance on the state:

- Regional foundations, including the A. F. Williams Foundation in Fort Morgan.
- Working with CMS to determine hospital eligibility for Medicare GME payments.
- Advocating for congressional action to revise CMS policies for rural training programs. COFM is partnering with several states on 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 and workforce development.

3. Add new positions to existing residency programs.
$1,350,000 ($1,002,920 in 2020-21) of state funds (matched by federal Medicaid funds for a total of $2,700,000/$2,005,840) allows for an expanded number of training positions in existing programs and to provide loan repayment awards for graduates to practice in rural and underserved areas upon graduation.

Additional Resident Project progress to date:

Twenty-two graduating residents receive loan repayment awards in return for a three-year service commitment at HPSA sites in the state:

Practice Site	Employer	Practice City	Practice County	Rural/Urban	PracticeZip
Pecos	Clinica Family Health Services	Denver	Adams	Urban	80221
Federal Heights	Clinica Family Health Services	Westminster	Adams	Urban	80031
Thornton	Clinica Family Health Services	Thornton	Adams	Urban	80229
Aurora	Plan de Salud Del Valle	Aurora	Arapahoe	Urban	80011
Aurora Health and Wellness Plaza	Stride Community Health Center	Aurora	Arapahoe	Urban	80010
South Aurora Family Health Services	Stride Community Health Center	Aurora	Arapahoe	Urban	80014
Pagosa Springs	Pagosa Springs Medical Center	Pagosa Springs	Archuleta	Rural	81147
Pagosa Springs	Pagosa Springs Medical Center	Pagosa Springs	Archuleta	Rural	81147
Lafayette Clinic	Clinica Family Health Services	Lafayette	Boulder	Urban	80026
Buena Vista Health Center	Heart of the Rockies Regional Medical Center	Buena Vista	Chaffee	Rural	81211
Federico F. Pena SW Family Health Center	Denver Community Health Services	Denver	Denver	Urban	80219
Park Hill Family Health Center	Denver Community Health Services	Denver	Denver	Urban	80207
Lowry Family Health Center/Best Babies Clinic	Denver Community Health Services	Denver	Denver	Urban	80230
Lowry Family Health Center/Best Babies Clinic	Denver Community Health Services, Inc	Denver	Denver	Urban	80230
Lowry Family Health Center/Best Babies Clinic	Denver Community Health Services	Denver	Denver	Urban	80230
Peak Vista Community Health Center	Peak Vista Community Health Centers	Colorado Springs	El Paso	Urban	80917
Estes Park	Plan de Salud Del Valle	Estes Park	Larimer	Urban	80517
Fort Morgan	Plan de Salud Del Valle	Fort Morgan	Morgan	Rural	80701
Medication Assisted Recovery Center	Health Solutions	Pueblo	Pueblo	Urban	81001
Mt. San Rafael Hospital	Mt. San Rafael Hospital	Trinidad	Las Animas	Rural	81082
Blue Spruce Clinic	Salud Family Health Centers	Fort Collins	Larimer	Urban	80524
Union Square Plaza at JCMH	STRIDE Community Health Center	Lakewood	Jefferson	Urban	80401

In 2017, one additional resident slot was allocated 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 resulted in three additional trainees (one per class) and an additional graduate each year from the University program. This funding was eliminated via the elimination of appropriation 476 for 2020-21 but was restored for 2021-22.

Programs and Operations Overview

Introduction

COFM's structure does not include "divisions" or "programs" in the formal definition used by OSPB. The four "programs" described below highlights how the state funding flows to each of the Commission's projects and activities.

Total appropriations for FY 2021-2022 (state funds + federal Medicaid match): $8,950,725*
*This figure represents a $189,000 shortfall due to the previous line 476 funds being restored at 2020-21 levels vs. 2019-2020.

1) Residency Training in Existing Programs: $2,847,300
2) Develop and Maintain Rural Training Programs: $3,212,329
3) Addition of Five Training Positions: $2,891,096

Below is a summary of the three funding streams for family medicine residency training in Colorado with requested 2022-23 funding.

Base Funding ($1,670,084)	Rural Training Track ($1,500,000)	Added Resident Positions ($1,350,000)
• Distributed from HCPF to programs • Supplements Medicare GME and other funding sources & patient revenue to defray expense of resident training • Peak Vista (Colorado Springs) and Sky Ridge (Lone Tree) became accredited programs in 2018 • 2018- 2019: request for additional $607,302 ($303,651 Medicaid GME match of state funds) to support two additional programs • 2019-2020: No additional funds were requested.	• Initiated in SFY 2014-15 • Tracks established in Alamosa, Fort Morgan, Sterling • Six graduates/ year upon full ramp up • Rural trained residents highly likely to practice in rural areas (approximately 60%) • Rural training requires sustained support and investment for training and retention • Rural "pipeline" is established through medical student recruitment from University of Colorado and Rocky Vista University and other medical schools across the country	• Initiated in SFY 2015-16 • 5 programs added additional position each • Note: in 2017, Univ. of CO family medicine receives this funding through State University Teaching Hospitals-Univ. of CO Hospital Authority line item, Appropriation 476) • Programs successfully graduated first cohort of 5 residents in 2017-18 • Residents commit to 3 years of practice in rural/underserved communities in exchange for loan repayment support • Loan repayment recipients currently practice in: Adams, Arapahoe, Archuleta, Boulder, Chaffee, Denver, El Paso, Larimer, Morgan, Pueblo & Weld counties

More detail is available in Appendix A

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, CHSC, the JBC, and a number of community organizations. COFM 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 other similar activities that benefit all residency programs. The Commission's office is also a central source of residency program data, such as residents in training, training costs, and employment choices of graduates.

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.

a)	Rural/Underserved Training	20%
b)	Recruitment of Residents and Faculty	20%
c)	Placement of Graduates	3%
d)	Staffing the Commission	12%
e)	Coordination of Activities with Residencies	15%
f)	Collaboration with CU School of Medicine and Rocky Vista University of Osteopathic Medicine	4%
g)	Partnerships with Community Organizations	6%
h)	Research Activities	2%
i)	Management and Administration	18%

a) 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 benefits, challenges and value of rural practice and consider it as a career option. Staff coordinates the statewide schedule, collects resident evaluations of their rural experience, reviews and approves new sites, and reports results to the Commission. Staff also serves as a liaison between the communities and the residencies. The current sites are in Basalt, Brush, Buena Vista, Canon City, Frisco, 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 (for family reasons or other extenuating circumstances), an alternative experience occurs 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.

From a Rural Training Track Clinic: We are so fortunate to have residents willing to go above and beyond this past year, including:

- A 3rd year resident took additional shifts at Denver Health to help with COVID surge
- A faculty member gave a presentation on monoclonal antibody therapy to all residents, attending physicians and advanced practice providers to help us obtain these services for our patients.
- They also volunteered to help with several sessions of our COVID vaccine clinics, which are ongoing.
- One of our 2nd year residents agreed to pilot a program of seeing "sick" patients (those showing COVID symptoms) in our clinic here at Salud Family Health Center (FQHC). He jumped right in with no trepidation!

Staff commit substantial time providing oversight to the three rural training track programs as well. The COFM Executive Director coordinates this project.

b) Recruitment of Residents and Faculty: The Commission holds recruitment as one of its highest priorities, as detailed in the Strategic Plan. This allocation of resources aligns with the intense competition for medical students opting for family medicine. Last year, the Commission participated in over 15 VIRTUAL residency fairs and other recruitment events. Over 1,000 students visited with COFM representatives at these events. All intern positions were filled through the annual match process. The Commission maintains a high level of coordination with the residencies which, in turn, are willing to collaborate even as they compete with one another 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 duties in promoting faculty position opportunities through the COFM website, contacts with practicing physicians about faculty positions, recruiting nationally, 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 collaborate with the Primary Care Office to facilitate its faculty loan repayment awards.

Benefit of Additional Training Positions…from the Programs:

…In Fort Collins we were able to grow our residency to meet the primary care needs of an additional 1,000 patients in a safety net clinic (70% Medicaid) in addition to providing better coverage for our complex and busy inpatient services.

…At the University of Colorado program, we took on the additional slot to expand our Denver Health Track, which has a focus on urban underserved care, especially of refugee and immigrant populations. Having this additional slot has allowed us to provide more primary care to this needy population as well as increase the size of our inpatient service at Denver Health.

c) Placement of Graduates: Staff assists extensively with placement of graduates in Colorado. First, they work with COPIC Insurance Company to provide educational opportunities 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 on the Colorado Health Service Corps Advisory Council to provide loan repayment to graduates. COFM hosts a recruitment component via its website. Finally, the CAFMR Director of Operations and Programs is a liaison between soon-to-graduate residents and practice opportunities in Colorado.

d) Staffing the Commission: Staff play a variety of roles for the Commission related to operations and communication in support of the programs. Duties include education and recruitment of board members, facilitation of meetings, strategic planning, educating citizen representatives about family medicine education and health care issues, arranging visits to residencies, interacting with community stakeholders, and working with the Governor's Office of Boards and Commissions and other state entities.

e) Coordination of Residency Activities: Commission staff coordinate various networking opportunities for residency staff groups across the state and acts as a conduit for information exchange among the programs. The Commission staff help coordinate over 30 activities annually, including: the Rocky Mountain Research Forum (approximately 100 attendees), the Primary Care Innovation Collaborative (approximately 80 attendees), the New Faculty Development Program, bi-annual leadership workshops for chief residents, periodic networking activities within different residency roles, and an annual retreat for the residency program directors.

f) 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 with both CU and RVU to create rural presence in the state.

g) Partnership with Community Organizations: Commission staff collaborate with a diverse array of public and community-based organizations such as 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, the Colorado Health Service Corps, and the National Health Service Corps.

h) Research Activities: 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, monitoring financial investment and return of programs, documenting the value of rural rotations for resident physicians, assessing the programs' capacity to meet the needs of delivering access, and collecting data on chief resident leadership and new faculty development workshops.

i) Management and Administration: Includes representing the Commission in the community and at the state and federal levels and activities required to keep the organization functioning, such as supervising staff, overseeing the operational budget and audit, writing grants, paying bills, and preparing board and state reports.

Productivity 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.

CAFMR Medical Student Interview Data
2010-2021

	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Recruitment Events Attended	29	39	33	33	29	21	13	16	17	16	10
Students Interviewed	351	400	471	415	456	446	409	462	574	508	472
Number of Interviews*	902	983	1130	925	868	869	831	923	1002	1047	

*Some students interview at more than one residency program

Hot Issues Impacting Family Physician and Primary Care Training

The last year and a half have presented unprecedented challenges for ALL of healthcare, not just physicians in training, yet their ability to flex and adapt has been uniquely summoned. As the fact sheet at the end of this document demonstrates, all ten of the residency programs were impacted by the pandemic, in meeting training requirements, in addressing staff shortages and burnout, and financially. And yet, similar to other specialties that were asked to step up, however few they may be, family physicians met the charge and showed their true resilience and commitment to their patients and their profession.

The glaring inequities and disparities apparent in the pandemic also rose to the surface in the physician and healthcare professions. All ten residency programs have engaged in diversity, equity, and inclusion work as a result of the injustice and lack of representation in medicine displayed across the board. This work, however, is a marathon, not a sprint, and although efforts have been valiant, much more is needed.

Recent priorities identified need to be addressed, however, traditional challenges in training and recruiting quality family physicians are still very much present. A few of these are addressed here.

Social Justice and Diversity, Equity, and Inclusion in Healthcare

Proactively taking on pursuit of family medicine residency candidates who are members of "underrepresented in medicine" populations is a priority for COFM. Several intentional actions are in place to address this priority:

- Revision of candidate assessment and interviewing processes
- All programs are interviewing virtually as required by the governing bodies to assess the impact on bias in the selection process, and relieve some of the financial burden on medical students applying for residency
- All COFM training, strategic planning, and staff development is built with an equity lens
- COFM staff, board members, and training physicians participate actively in efforts to reduce disparities and achieve equity, for their patients, profession, and organizations.

One resident physician completed training and initiated the first LGBTQI+ fellowship in partnership with Denver Health and serves on the faculty there as well.

Below is a chart noting the ethnic/racial percentage for the past 8 year of residency classes. It should be noted that all 2020 recruitment events and interviews were virtual due to the pandemic. Also of note is that the average percentage of URM residents has increased since the inception of the activities note above and the initiation of the additional residency slots loan repayment award for practice in HPSA areas.

	2013	2014	2015	2016	2017	2018	2019	2020
Native American	1%	1%	1%	1%	1%	1%	1%	0%
Asian	8%	16%	10%	11%	8%	11%	13%	9%
African American	2%	2%	2%	2%	2%	4%	6%	1%
Hispanic	4%	5%	6%	5%	5%	11%	16%	4%
Mid-Eastern/N. African*								3%
Caucasian	85%	76%	81%	81%	84%	73%	64%	75%
Prefer not to disclose*								7%

*First year data was collected

Sustainable Funding for Training Primary Care Physicians

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

- Patient Revenue**:** Residents in primary care specialties like family medicine are required to complete most of their training in outpatient clinics. Reimbursement rates for care provided in outpatient settings, (management of chronic conditions, preventive care, etc.) are considerably lower than that of hospital-based medical specialties. In addition, many patients seen by residents are uninsured, or covered by Medicaid or Medicare, which pay less for services than commercial insurance. Due to these limitations, revenue from patient care in family medicine residencies covers only about half of the cost of operating.
- Medicare GME Payments: These payments from the federal government cover about one-third of the costs of the programs. Due to a cap put in place in 1997, new or additional training slots do not receive Medicare GME payment support.
- Medicaid GME Payments: State funds, such as those provided by Colorado and 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 which *does 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 approximately $500,000 to $1 million annually. Some sponsoring hospitals periodically consider closing the family medicine residency programs due to the perceived negative financial impact.

Although primary care physicians provide most of the 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 training sub-specialty physicians can 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. Federal funding to support primary care training has not increased in some time, so state funding has been instrumental in expanding rural training programs and existing residencies to serve these under resourced populations.

The Commission continues to actively pursue GME payment reform on a national level. In 2014, COFM conducted the "GME Summit" in Washington, D.C. and continues to convene subject matter experts committed to GME reform. These events, funded by contributions from non-profit and educational organizations, create awareness among policy makers about the need for Medicare GME reform and expansion of 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

Filling faculty physician roles becomes more difficult as the health systems sponsoring residency programs are challenged with decreased revenue and patient visits due to the pandemic. Several programs have been mandated to leave these positions unfilled while others have been forced to furlough staff or take mandatory leave to accommodate health system challenges.

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.

1. 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.
2. A second obstacle for recruiting faculty is the medical school debt faced by most recent residency graduates which averages $170,000. While some would consider teaching, clinical practice provides higher compensation than faculty positions, allowing a shorter timeline to pay off loans.
3. A third obstacle for recruiting faculty, related to the item above, is that clinical practice provides higher compensation than teaching in 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 often OB services, and receive lower compensation than their private practice colleagues who often do not provide full-spectrum family medicine care.

Residency faculty loan repayment for new or recently hired faculty is a solution to this issue that Colorado has helped to provide. In the 2015-16 CDPHE budget, the General Assembly approved $270,000 for family medicine residency faculty loan repayment. In 2018-19, the state generously funded an additional $225,000 to allow each of the ten programs to provide a faculty loan repayment award. These funds provide ten awards of $45,000 and the faculty receiving the awards commit to two years on faculty at the residency. Since inception of this program, seven new physician faculty were recruited and 34 were retained (junior faculty with school debt are retained in their faculty positions by the award). This program is valuable to the programs and highly regarded by their directors as a tool to enhance the quality and productivity of their faculty. It provides a tool to augment their faculty recruitment efforts and to retain their junior faculty who otherwise may be lured away to a higher-paying clinical job.

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

An ongoing challenge to primary care access is placing and retaining primary care physicians in rural and underserved areas. 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 inequitable distribution and lack of diversity of PCPs is well documented.

There is recent energy at the federal level to support growth of rural medicine training and practice and COFM is staying current on those efforts. In addition, there are additional requirements for family medicine resident physicians to participate in community engagement as part of their training

Training family physicians in rural areas where they are more likely to remain after graduation, is a documented strategy for retention, and so the Commission 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 crucial and well spent to build the primary care physician workforce in underserved areas.

COFM is active in several workforce development and pipeline strategies being implemented in the state. One of the benefits of the pandemic has been the influx of funding, albeit short term, for addressing systemic and infrastructure change. COFM hopes to be an integral player in addressing workforce issues in healthcare and thereby impacting physician access in communities where they are most needed.

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.

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COVID 19 Pandemic & Family Medicine Pandemonium

100% Residency Programs and Patient Care Impacted

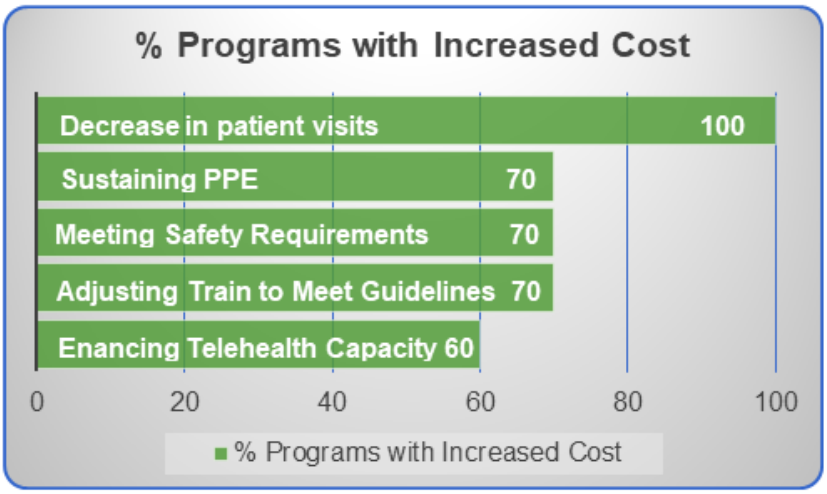
Resident Physicians stepped up

- Support for inpatient intensivists increasing ability to manage more patients
- Caring for patients directly on floor and ICU
- Prep residents to be surge-ready
- COVID specific team delivering 25% of care at one point in time
- Redeploy residents to COVID step down unit

Primary Care physicians, and specifically family medicine in Colorado, are uniquely capable to assist and adapt to patient and community needs. They train and practice in clinics, ICUs, critical care units, long term care centers, public health, research, and community settings like homeless shelters, free clinics, public events, and school districts.

Residents Benefit Communities

- If residency programs weren't here, access to PC is more difficult
- Enhance safety net capacity
- Direct patient care provided to average **105,000** individual patients annually
- Free outreach and care throughout year
- Expose FM docs to rural and underserved practice
- Increase in community support via clinic food pantry



"Family Medicine resident teams provided ICU coverage and floor coverage specifically to care for COVID patients"

COLORADO COMMISSION ON FAMILY MEDICINE

SCHEDULES (2020 legislative reductions not reflected here)

Commission on Family Medicine Residency Training Programs						
HB18-1322 FY 2018-19 Long Appropriation Act	$8,196,518	0.0	$4,098,259	$0	$0	$4,098,259
FY 2018-19 Final Appropriation	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**
FY 2018-19 Final Expenditure Authority	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**
FY 2018-19 Actual Expenditures	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**
FY 2018-19 Reversion (Overexpenditure)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2018-19 Total All Other Operating Allocation	***$8,196,518***	***0.0***	***$4,098,259***	***$0***	***$0***	***$4,098,259***

Commission on Family Medicine Residency Training Programs

FY 2019-20 Starting Base	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**
TA-41 Budget Object Code Technical Correction	$0	0.0	$0	$0	$0	$0
FY 2019-20 Base Request	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**
FY 2019-20 Governor's Budget Request	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**
Personal Services Allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
Total All Other Operating Allocation	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**

Commission on Family Medicine Residency Training Programs						
SB 17-254 FY 2017-18 General Appropriation Act	$7,747,298	0.0	$3,798,649	$0	$75,000	$3,873,649
HB 18-1161 Supplemental Appropriation - HCPF	($150,780)	0.0	($390)	$0	($75,000)	($75,390)
FY 2017-18 Final Appropriation	**$7,596,518**	**0.0**	**$3,798,259**	**$0**	**$0**	**$3,798,259**
EA-04 Statutory Appropriation or Custodial Funds Adjustment	$0	0.0	($380)	$0	$0	$380
FY 2017-18 Final Expenditure Authority	**$7,596,518**	**0.0**	**$3,797,879**	**$0**	**$0**	**$3,798,639**
FY 2017-18 Actual Expenditures	**$7,596,518**	**0.0**	**$3,797,879**	**$0**	**$0**	**$3,798,639**
FY 2017-18 Reversion (Overexpenditure)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**

Commission on Family Medicine Residency Training Programs						
HB 16-1405 General Appropriation Act (FY 2016-17)	$7,597,298	0.0	$3,786,304	$0	$0	$3,810,994
FY 2016-17 Final Appropriation	**$7,597,298**	**0.0**	**$3,786,304**	**$0**	**$0**	**$3,810,994**
EA-04 Statutory Appropriation or Custodial Funds Adjustment	$0	0.0	($2,122)	$0	$0	$2,122
FY 2016-17 Final Expenditure Authority	**$7,597,298**	**0.0**	**$3,784,182**	**$0**	**$0**	**$3,813,116**
FY 2016-17 Actual Expenditures	**$7,597,298**	**0.0**	**$3,784,182**	**$0**	**$0**	**$3,813,116**
FY 2016-17 Reversion (Overexpenditure)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2016-17 Total All Other Operating Allocation	**$7,597,298**	**0.0**	**$3,784,182**	**$0**	**$0**	**$3,813,116**

Commission on Family Medicine Residency Training Programs						
HB18-1322 FY 2018-19 Long Appropriation Act	$8,196,518	0.0	$4,098,259	$0	$0	$4,098,259
FY 2018-19 Final Appropriation	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**
FY 2018-19 Final Expenditure Authority	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**
FY 2018-19 Actual Expenditures	**$8,196,518**	**0.0**	**$4,098,259**	**$0**	**$0**	**$4,098,259**
FY 2018-19 Reversion (Overexpenditure)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2018-19 Total All Other Operating Allocation	***$8,196,518***	***0.0***	***$4,098,259***	***$0***	***$0***	***$4,098,259***

Appendix A
Additional Program Funding Background and Detail

Base Funding

Through the Commission, the state provides funding to Colorado's family medicine residencies training family physicians. This portion of the COFM funding is distributed directly to the residency programs specifically for residency training, not for the operating expenses of the teaching hospitals with which the programs are affiliated. State funding provides some flexibility for the residencies and provides important support for the educational priorities of the programs.

The Commission has established criteria for funding in accordance with the legislative declaration that guides 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
- Programs must agree to recruit medical students into their programs jointly.

A portion of the residency training funds ensure that resident family physicians learn to work in a team-based, patient-centered, advanced care delivery clinical environment. Care coordination services are an important component of a comprehensive primary care delivery model.

- A portion of the increase in base funding is used to train residents in the advanced skills needed to provide exceptional team-based, coordinated care. 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 utilizer patients and connect them with needed resources.
- An additional portion of the increased base funding is used to sustain our successful, collaborative recruitment program. The increase in state funding support enabled the Commission to move from unpredictable grant funds to permanent funding sustaining this uniquely effective program and enhancing recruiting activity.
- A request to adjust the distribution of the base funding amount was made for 2021-22. The total funding amount will not change from the 2019-20 level. With the closure of the Rose program in 2018, the number of residencies decreased from eleven to ten. Through 2020, the funds historically allocated to Rose were distributed to the programs that took on the displaced residents which were allocated a proportionate share of their annual allocation. The last of those residents graduated in 2020. We requested and maintained the funds previously allocated to Rose be distributed equally among the existing programs, a positive adjustment of $30,365 per program. This does not change the total allocation to programs.

Rural Training Funding
Rural Training Program Development and Maintenance

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 programs to enhance physician training, the rural training funds are used to maintain three new rural training tracks

The rural training programs all produced graduates in 2020. The work of the Commission and these communities to create a robust, high-quality experience exemplifies the true benefit allowed for by the state's support of the collaboration that the presence of the Commission generates.

Each of the three rural sites trains 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. The rural track resident physicians spend the first year at a "home" residency program followed by two years at the rural sites.

Development of Colorado's rural training program took the typical three years: Year 1 for identifying and evaluating the sites, Year 2 for accreditation, and Year 3 for recruitment. The development phase is complete and state funds maintain these programs.

Rural training track progress:

- 2013-14: Rural communities of Alamosa, Ft. Morgan, and Sterling selected as training sites
- 2013-14: Governance agreements and budgets developed for the rural sites
- 2016-17: All three rural sites received full accreditation from CMS (ACGME)
- 2016-17: Highly successful recruitment; all the training positions filled.
- July 2017: Second class of residents for the Alamosa and Sterling RTTs and the first class of residents for the Fort Morgan RTT began their training
- 2019-20: All RTTs graduated their first classes of residents

COFM funding for the rural training programs began in FY 2013-14 (SB 13-264) and increased in FY 2014-15 (SB 14-144). The funds are allocated to address the well-documented shortage of primary care physicians in rural areas of the state. Rural training programs, like rural training tracks, are a proven 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). With the passage of SB 14-144, the COFM statute was revised to pursue both *development* and *maintenance* to assure sustainability of the rural training programs. These programs continue to thrive with state support but will be impacted if funding is not restored.

New training positions funding background
Five Additional Training Positions

COFM is actively engaged with this project. State funds are disbursed to the five participating programs. COFM's support for this project includes:

- Complete memorandums of understanding between COFM and each sponsoring hospital to ensure appropriate use of funds - resident training and loan repayment
- Work closely with the program directors of participating programs
- Work closely with Primary Care Office staff administering the Colorado Health Service Corps (loan repayment program) funds

Twenty additional residents have started training (five each in July of 2016 through 2019). In addition, nineteen graduating residents received loan repayment awards in return for a three-year service commitment at Colorado HPSA sites.

In 2015, the General Assembly funded the following COFM recommendation to add new training positions to existing family medicine programs: "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 phased them in by adding five, first-year positions each year over three years. Residents filling the state-funded positions are required to commit to practice in rural or underserved locations meeting HPSA status in the state for three years following graduation. In return, they receive a loan repayment package. This requires 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 an additional training position: Fort Collins, St. Anthony's (Westminster), St. Joseph's (Denver), St. Mary's (Grand Junction), and the University of Colorado program-for which funding was originally eliminated in 2020-21 (Denver).

APPENDIX B:
Commission on Family Medicine History Timeline

Date	Colorado Commission on Family Medicine Milestones
1977	Commission on Family Medicine established by state statute, prompted by pulmonologist practicing in Pueblo who, in collaboration with family physicians, pursued the idea of a free-standing commission.
1980	COFM establishes rural rotation requirement for all family medicine residents in Colorado.
1988	Colorado Association of Family Medicine Residencies created, comprised of PDs from each residency and a CO Association of Family Physicians liaison. Serves as operating board for COFM.
1990s	Colorado FMRs graduated 50 family medicine physicians. Began process of moving COFM out of University DFM which administered the commission and its state funds. First female program director among FMRs.
1993-95	First COFM Executive Director. General Assembly requested study on current/future FM physicians need. Incorporation of CO Family Practice Director's Council; began developing CAFMR program networking.
2000s	Match results: national 79%, CO 90%. Joint recruitment policy and program contributions approved. State funds distributed directly to programs with combined line item, funds matched. Developed recruitment strategy.
2007	CO Institute of Family Medicine established, a 501c3 for grants (PCMH transformation, offset rural rotation expenses). Focus: innovation/reforming Medicare GME to support primary care. 60% resident retention.
2011	GME Initiative (supported by CIFM) formed to reform the Medicare GME payment system to support primary care workforce through policy change. Established: Research Forum and Primary Care Innovation Collaborative.
2013	Developed 3 new rural training tracks (Alamosa, Fort Morgan, Sterling), resulting in 6 additional resident graduates per year
2015	State Legislature supports 5 expansion slots in established residency programs. Faculty loan repayment program initiated, funded by legislature (oversight: CDPHE, PCO). Transitioned educational programs to COFM.
2016	New FMRs: HealthOne, Lone Tree; Peak Vista, Colorado Springs, 16+ graduates/year by 2020. GMEI consultant hired to lead GME Medicare payment reform/advocacy. Started New Faculty Development Program.
2017	By 2017, 28 additional training positions per year added, from 68 grads per year to 96 grads per year by 2021. Hired Director of GME, to lead the educational offerings from CAFMR for the programs, and to run the GME Initiative.
2018	Two new residency programs (HealthOne, Peak Vista) officially funded. Faculty Loan Repayment Program expanded to one per residency program.
2019	Each of the RTTs and new programs graduated their first classes. Grew faculty loan repayment opportunities for all 10 programs.
2020	COVID 19 Pandemic impacted COFM budget by about 13%. All interviews, recruitment virtual, new efforts toward diversity in recruitment
2021	Resident interviews and visits still virtual, continued efforts in diversity, equity & inclusion and workforce development pursued

STRATEGIC PLAN: FY 2022-2023

Commission on Family Medicine

Submitted by Lynne Jones, Executive Director
On behalf of the Commission on Family Medicine
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Introduction

The Commission on Family Medicine addresses the documented need in the state for well-trained family physicians, particularly in rural and underserved areas, in an ever-changing, dynamic environment. This plan ensures that residency programs are responsive to changes in the fundamental way that health care is being delivered, the ongoing need for primary care in rural and underserved communities in Colorado, and the impact of industry developments like payment reform and health crises. Preparing a family physician to thrive in advanced primary care practice requires ongoing modification and involves training in an educational environment that emphasizes team-based, coordinated care, quality-based outcomes, population management, and enhanced patient access.

Our Vision

To promote high quality health care for all Coloradans by *enhancing access to primary care*, including rural and underserved communities, through the training of exceptional family physicians.

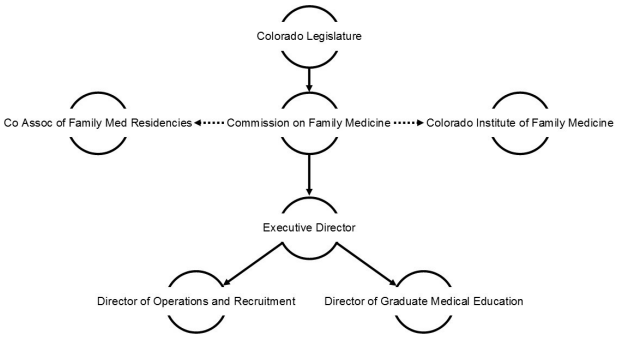
Our Mission

Convene key leaders & stakeholders who support family medicine training to:

- *Cultivate* and develop a highly qualified family physician workforce in Colorado to appropriately meet the needs of the population, including rural and underserved communities, through recruitment, education, advocacy and resource sharing.
- *Evaluate* and inform community, state, and national policy that impacts the delivery of advanced primary care and positive health outcomes for Coloradans.
- Be a powerful *voice* to elevate health care delivery for all Coloradans.

Organizational Chart

The Commission on Family Medicine (COFM) is a collaborative model providing primary care directly to the people of Colorado. Ten unique health care facilities form a public-private venture together with citizen representatives from Colorado's seven congressional districts. COFM convenes the family medicine residencies and their sponsoring hospitals to coordinate efforts in recruiting and training family physicians to meet the primary care needs of Colorado. The vital role and participation of citizen representatives from all seven congressional districts has assured that the training of family physicians aligns with the health care needs of Coloradans, including the need to place more family physicians in rural areas of the state. The Commission epitomizes what can be achieved when vision embodies a spirit of cooperation and teamwork.



The Commission, established in 1977, addresses Colorado's need for primary care by:

- ✓ Assisting in obtaining state support for family medicine residency training
- ✓ Promoting collaboration between the state's family medicine residencies and consumers of health care to address Colorado's need for family physicians, including:
  - ➢ A national, state and regional recruitment program
  - ➢ Rural rotations and training tracks growth and development
  - ➢ Professional development and education for the Colorado primary care community
  - ➢ Advocating for graduate medical education (GME) payment reform
- ✓ Pursue a calling for family medicine residencies to provide high quality training

COFM is a unique, national model. The degree of collaboration among the state's ten family medicine residencies is unmatched in the country. The programs work together to recruit medical students and faculty, implement unique experiences for resident physician training, and share expertise between programs. Defying the norm of competition among residency programs, Colorado collaborates and thereby avoids replication of efforts, and reduces the cost of recruitment and resource development costs.

Contributors to Colorado's Patient Care Safety Net
Family medicine residency programs and their resident physicians play a vital role as providers of primary care to underserved and vulnerable populations. Their training centers are part of Colorado's patient "safety net". COFM data indicate that in 2020-21, 71% of the 105,377 patients served by the family medicine residencies were Medicaid (46%), Medicare (13%), or uninsured (9%). Medicaid numbers are up 3% over last year. Without the presence of the family medicine residencies, access for Medicaid, Medicare, and uninsured populations would further erode.

Initiatives and Services Fostered by COFM
Rural Rotations and Rural Training Tracks (RTTs). All family medicine resident physicians in Colorado are required to complete a minimum of a one-month rotation in a rural location as part of their training. The intent of this experience is to increase a resident's propensity to choose to practice in a rural community after completing their training.

In 2013, COFM, with state support, expanded Rural Training Track sites from one (Wray) to four (Alamosa, Ft. Morgan, Sterling) where resident physicians are hosted for their last two years of training and are, as research indicates, more likely to remain in rural practice after training. (Keeping Physicians in Rural Practice, AAFP Position Paper, 2013).

Advanced Primary Care Model Implementation. COFM uses the learning collaboratives established during the PCMH process (funded by TCHF in 2017) to expose the programs and the larger primary care community to innovations, best practices, and trends. Social determinants of health, community engagement, behavioral health integration, and diversity-equity-inclusion are subjects brought forward in current times. Networked sharing remains a key component of COFM's mission.

Joint Recruitment of Medical Students. COFM's unique collaboration includes recruiting medical students into Colorado residencies at the state, regional and national levels. This allows efficiency in use of resources, and the opportunity to address COFM priorities like building a family physician base that is serving rural communities and representative of the patient populations they serve.

Graduate Medical Education Payment Reform. Medicare GME payments are an important source of funding for residency training in all states. In the current structure, imbalance in federal funding supports the training of less primary care physicians and more sub-specialists. Current CMS regulations inhibit the expansion of family medicine training positions in our state; COFM takes an active role in educating policymakers regarding the necessity to reform the GME payment system in order to build a sufficient primary care physician workforce nationally, through several channels:

These activities are conducted in collaboration with the Colorado Institute of Family Medicine, University of Colorado Department of Family Medicine, Rocky Vista University School of Osteopathic Medicine, the Colorado Academy of Family Physicians and several national partners.

In summary, for almost 45 years the Commission has played an important role in training family physicians for practice in Colorado. The unique public-private collaboration is a model others seek to emulate nationally. The collaboration among the family medicine 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) retain graduates to practice in Colorado, especially rural and underserved areas, 3) assure that Colorado's family medicine residencies are of high quality, 4) recruit medical students from across the country to fill positions with high quality candidates, 5) recruit qualified faculty physicians to teach the residents. We also strive to increase the number of graduates practicing in Colorado by 1) developing and maintaining rural training programs and 2) expanding the number of trainees in existing residency programs where possible.

The COVID story behind the #s

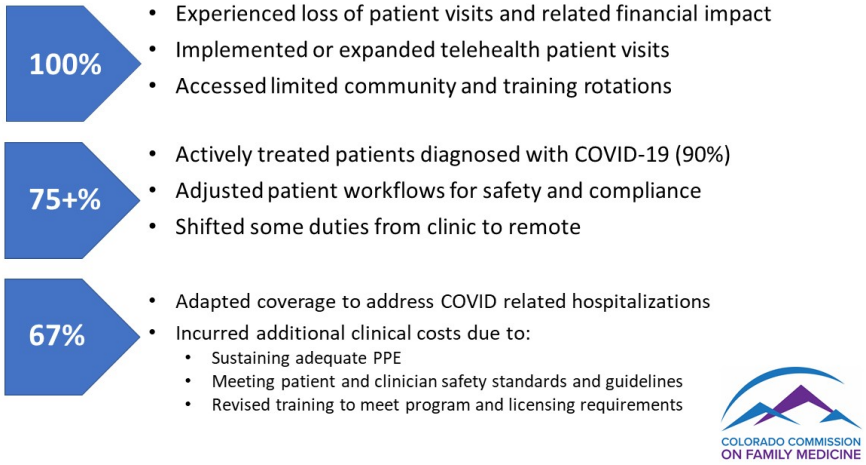
- "…if our residents weren't here, our patients may have difficulty accessing care…"
- "Every day I see examples of our residents going above and beyond to help vulnerable patients…doing a home visit…connecting severely depressed pregnant patient with community resources…"
- Residents setting up and contributing to patient care in ICU and COVID units

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).

COVID-19 Impact on Family Medicine Resident Physician Training

Unfortunately, the impact of the pandemic on the residency programs continues. An additional challenge is the uptick in burnout and lack of joy in practice. Below are other impacts:



Core Objectives and Performance Measures with Evaluation

1. **Goal: Train family medicine resident physicians in Colorado**

Objective 1: Recruit quality medical students from across the country to train and practice in one of Colorado's family medicine physician residency programs

Performance Measure	Outcome	FY 18-19 Actual	FY 19-20 Actual	FY 20-21 Actual	FY 21-22 Proposed
Fill 100% of available training positions annually	Benchmark	100%	100%	100%	100%
	Actual	100%	100%	100%	100%

Strategies:

- All family medicine residencies partner to recruit medical students nationally through COFM staff representation, joint promotional materials, and digital presence, and equally sharing recruitment costs
- Participate in 12+ recruitment events nationally; target medical schools with high percent of students historically selecting family medicine and underrepresented in medicine
- Pursue engagement with CU School of Medicine, Rocky Vista University of Osteopathic Medicine, & family medicine interest groups nationally, including those in rural tracks
- Residencies host select students for 4th-year clerkships to experience family medicine residency training in Colorado

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

Performance Measure	Outcome	FY 18-19 Actual	FY 19-20 Actual	FY 20-21 Actual	FY21-22 Actual
Program Director positions open more than 12 months	Benchmark	0	0	0	0
	Actual	0	0	0	0

Performance Measure	Outcome	FY 18-19 Actual	FY 19-20 Actual	FY 20-21 Actual	FY21-22 Actual
Faculty physician positions open more than 12 months	Benchmark	0	0	0	0
	Actual	4	3	3	2

Strategies:

- Optimize continued state funds allocated to the CDPHE Primary Care Office loan repayment program to recruit new and retain faculty physicians
- All family medicine residencies partner & share expense to recruit leadership/faculty
- Maintain a joint digital presence, post faculty vacancies, proactively market to national, regional and local audiences, and recruit virtually
- Participate in faculty recruiting events (AAFP FMX and AFP Uniformed Services)

Evaluation of Success in Meeting Benchmarks:

The first goal is to train family medicine residents. Our benchmarks are very objective:

- fill all available training positions with high quality medical students
- maintain a full complement of faculty physicians and program directors to teach and lead
- maintain full accreditation for the programs

We closely track the outcome of the faculty loan repayment program administered jointly with CDPHE. To date, the awards have been used to recruit or retain 36 faculty across programs.

2. **Goal: Prepare family medicine residents to provide health care in advanced primary care practices to meet the future needs of Colorado citizens.**

Objective 1: Train family medicine residents in a clinical environment committed to executing advanced primary care delivery models, including care coordination and behavioral health services.

Performance Measure	Outcome	FY 18-19 Actual	FY 19-20 Actual	FY 20-21 Actual	FY21-22 Actual
# of residencies providing care coordination services	Benchmark	10	10	10	10
	Actual	10	10	10	10

Strategies:

- Each residency program will train in advanced primary care best practice emphasizing coordinated, integrated care in practice
- Each program has staff and/or faculty to support and coordinate quality improvement projects.

Evaluation of Success in Meeting Benchmarks:
Semi-annual learning collaboratives involving all programs are conducted. Several networking groups meet regularly to share best practice and program expertise (quality improvement, behavioral science, education and curriculum, program coordinators, program directors).

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

Objective 1: Increase the supply of family physicians in Colorado

Performance Measure	Outcome	6/30/19 Actual	6/30/20 Actual	6/30/21 Actual	6/30/22 Proposed
Annually retain 60% of graduating residents	Benchmark	60%	60%	60%	60%
	Actual	57%	63%	51%	Pending

The number of graduates retained in the state this year was below the 60% benchmark. COFM conducted a study recently showing that slightly over 60% of residency graduates over the last 7 years are currently practicing in the state. According to CDPHE database information, since 1979, over 52% of Colorado residency program physician graduates are currently licensed in Colorado.

Performance Measure	Outcome	7/1/19 Actual	7/1/20 Actual	7/1/21 Actual	7/1/22 Proposed
Number of residents in new training positions	Benchmark	16	16	16	16
	Actual	16	16	16	16

Five additional positions: In 2015-16, the Colorado General Assembly allocated $2.7M to add five new residency positions to existing programs. The five participating programs (Ft. Collins, St. Anthony's, St. Joseph's, St. Mary's, University of Colorado) each recruited an additional resident over 4 years. 2021 -2022 should produce ten as well. One new position: added in 2018 at UCDFMR family medicine residency (University of Colorado Supplemental Payment). One additional resident is recruited each year for 3 resident physicians-in-training.

Performance Measure	Outcome	7/1/19 Actual	7/1/20 Actual	7/1/21 Actual	7/1/22 Proposed
# of graduates with 3-year loan repay awards	Benchmark	10	15	15	15
	Actual	16	19	22	Pending

Funding for the five new positions (est'd. 2015-16) includes loan repayment awards in exchange for a three-year commitment to practice in rural/underserved (HPSA) areas of Colorado upon completion of training. Five awards are available each year. Three awards were disseminated in 2020-21. The 21 recipients are serving in the Denver area (10 at FQHCs), Evans (1 at FQHC), Colorado Springs (1 at FQHC), Archuleta County (2 in Pagosa Springs), Lafayette (1), Estes Park (1), and Chaffee County (1 in Buena Vista), Morgan County (1), and Pueblo (1 at Mental Health Center).

Strategies:

- Support the five programs with an additional resident (including the loan repayment program) and the one added hosted through UCDFMR
- Inform residents of employment opportunities in Colorado; post on the COFM website
- Continue to aggressively pursue reform of federal graduate medical education (GME) funding which is needed to expand the number of training positions in Colorado's family medicine residency programs. COFM has worked with Colorado's federal legislators to support new rural training programs funding.
- Work closely with the Colorado Rural Health Center recruitment and placement service (CPR)

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

Performance Measure	Outcome	6/30/19 Actual	6/30/20 Actual	6/30/21 Actual	6/30/22 Proposed
30% of graduating residents working in CO opt for rural or urban underserved area	Benchmark	30%	30%	30%	30%
	Actual	44%	36%	44%	Pending

Strategies:

- Maintain the rural training tracks in Alamosa, Fort Morgan, Sterling, and Wray
- Continue required one-month rotations in rural and/or underserved urban sites, support residents and preceptors in rural training sites
- Work closely with the University of Colorado School of Medicine and Rocky Vista University College of Osteopathic Medicine to build a pipeline between their medical student rural programs and the RTTs under development in our state
- Provide loan repayment awards for resident graduates who go on to practice in HPSA sites
- Recruit nationally at medical schools with an emphasis on rural medicine
- Support implementation of 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: Maintain the rural training programs in the state.

Performance Measure	Outcome	7/1/18 Actual	7/1/19 Actual	7/1/20 Actual	7/1/21 Actual
Number of accredited Rural Training Tracks	Benchmark	4	4	4	4
	Actual	4	4	4	4

Since 1992, Colorado hosted one accredited rural training track in Wray training 3 residents per year (one first-year, one second-year, and one third-year resident). Two additional RTTs were accredited in 2014 (Alamosa, Sterling) and one RTT was accredited in 2015 (Ft. Morgan).

Performance Measure	Outcome	7/1/18 Actual	7/1/19 Actual	7/1/20 Actual	7/1/21 Actual
Number of positions filled in Rural Training Tracks	Benchmark	13	19	19	19
	Actual	13	19	19	19

The Wray RTT has filled their single training position each year since 1992. In July 2016, two first-year residents began in each of the Alamosa and Sterling RTTs. In July 2017, six new first-year residents began in the RTTs of Alamosa, Sterling, and Fort Morgan, resulting in 13 residents-in-training among the four RTTs (3 in Wray, 4 in Alamosa, 4 in Sterling, and 2 in Ft. Morgan). In July 2018, all seven first-year positions filled for a total of 19 residents-in-training (3 in Wray, 6 in Alamosa, 6 in Sterling, 4 in Ft. Morgan). The first RTT residents graduated in June 2019. In July 2020, all 19 training slots were filled.

Strategies:

- Assist the RTTs in their recruitment efforts at regional and national level
- Educate medical students in the rural tracks of CU School of Medicine, RVU College of Osteopathic Medicine, and nationally, about the RTTs in the state and encourage rotations
- Oversee the continued success of the three new RTT sites
- Optimize state funds to ensure that the RTTs can be maintained into the future by building reserve accounts for each rural site

Evaluation of Success in Meeting Benchmarks:
COFM strives to increase the number of family physicians in Colorado, especially in rural and urban underserved areas by adding to the number of family medicine physician trainees and residents choosing to practice in the state, as well as enhancing the number of graduates who practice in areas designated as rural or underserved or place in the four rural training tracks.

Objective 4. Increase the number of resident physicians from URM (Underrepresented in Medicine) populations.

COFM added an additional objective under this goal to address the disparities and lack of diversity in the medical field.
Strategies:

- Revision of candidate assessment and interviewing processes
- All programs are interviewing virtually as required by the governing bodies to assess the impact on bias in the selection process, and relieve some of the financial burden on medical students applying for residency
- All COFM training, strategic planning, and staff development is built with an equity lens
- COFM staff, board members, and training physicians participate actively in efforts to reduce disparities and achieve equity, for their patients, profession, and organizations.
- Address workforce and career pathways among members of rural and underserved communities through a community driven, infrastructure transformation approach

Below is a chart noting the ethnic/racial percentage for the past 8 year of residency classes. It should be noted that all 2020 recruitment events and interviews were virtual due to the pandemic. Also of note is that the average percentage of URM residents has increased since the inception of the activities note above and the initiation of the additional residency slots loan repayment award for practice in HPSA areas. This data will serve as the performance measure for this objective.

	2013	2014	2015	2016	2017	2018	2019	2020
Native American	1%	1%	1%	1%	1%	1%	1%	0%
Asian	8%	16%	10%	11%	8%	11%	13%	9%
African American	2%	2%	2%	2%	2%	4%	6%	1%
Hispanic	4%	5%	6%	5%	5%	11%	16%	4%
Mid-Eastern/N. African*								3%
Caucasian	85%	76%	81%	81%	84%	73%	64%	75%
Prefer not to disclose*								7%

*First year data was collected

4. **Goal: Contribute to Colorado's patient care safety net**

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

Performance Measure	Outcome	FY 17-18 Actual	FY 18-19 Actual	FY 19-20 Actual	FY 20-21 Actual
60% of patients served by the FM residencies covered by Medicare, Medicaid, or uninsured	Benchmark	60%	60%	60%	60%
	Actual	66%	62%	71%	68%

Strategies:

- Residency programs continue to provide care for patients who are uninsured, underinsured, and on Medicaid and Medicare. In FY19-20, information gathered from the residency programs indicate that 71% of the 88,047 patients served by the family medicine residencies were Medicaid (43%), Medicare (17%), or uninsured (10%) patients.
- 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 participation in grant-supported programs like CMS-sponsored programs such as CPC+, to defray the cost of uncompensated patient care services

Evaluation of Success in Meeting Benchmarks:
Success in meeting the goal of delivering care to the underserved 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 2019-2020 year were collected from the 10 operating residency programs and is reflected here. It is expected that the trend of exceeding the 60 % benchmark will continue.

Impact of the Pandemic:
The impact of the pandemic on recruitment, retention, and training of family medicine physicians in Colorado is difficult to assess. The hardships of residency training have been exacerbated by the additional stressors of addressing patient and personal safety and added duties and responsibilities. All recruitment, interview, training and networking events and opportunities were virtual rather than in person. Although there have been some advantages to this, family medicine physicians are one specialty that tends to thrive on personal relationships with patients, peers, and colleagues. Burnout was expressed and experienced at a much higher rate due to this, staffing shortages, additional call duties, etc. COFM is monitoring the residency programs response and fortitude during this unprecedented time for medicine.

COVID 19 Pandemic & Family Medicine Pandemonium

100% Residency Programs and Patient Care Impacted

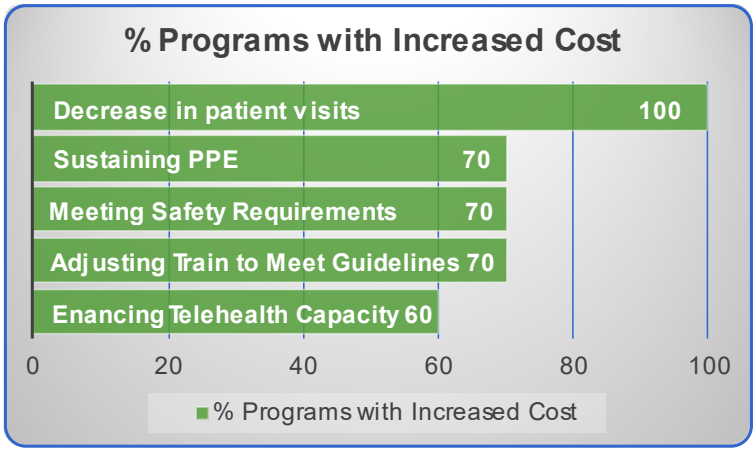
Resident Physicians stepped up

- Support for inpatient intensivists increasing ability to manage more patients
- Caring for patients directly on floor and ICU
- Prep residents to be surge -ready
- COVID specific team delivering 25% of care at one point in time
- Redeploy residents to COVID step down unit

Primary Care physicians, and specifically family medicine in Colorado, are uniquely capable to assist and adapt to patient and community needs. They train and practice in clinics, ICUs, critical care units, long term care centers, public health, research, and community settings like homeless shelters, free clinics, public events, and school districts.

Residents Benefit Communities

- If residency programs weren't here, access to PC would be more difficult
- Enhance safety net capacity
- Direct patient care provided to average of **105,000** individual patients annually
- Free outreach and care throughout year
- Expose FM docs to rural and underserved practice
- Increase in community support via clinic food pantry



"Family Medicine resident teams provided ICU coverage and floor coverage specifically to care for COVID patients"

COLORADO COMMISSION ON FAMILY MEDICINE

Appendix A

COFM Addresses Challenges Facing Family Medicine and Resident Physician Training

As it did in many aspects of our communities, COVID-19 impacted family medicine training in Colorado and nationally and continues to do so. So, in addition to the ongoing challenges that family medicine, Colorado resident physician training programs were affected in various ways.

- Rapid conversion to virtual patient visits
- Patient visit rotation restrictions (extended care, rural rotations, community work, etc.)
- Treating hospitalized patients with COVID-19, or covering other inpatient call, etc.
- Disrupted training providing challenges to meeting requirements for graduation
- Incurring risk that all physicians and healthcare workers face to continue delivering patient care during the pandemic
- All recruiting and interviewing of medical students moved to virtual platforms

Ongoing challenges:

- Physicians choosing primary care and physician burnout
- Underfunding: for residents, physicians in practice, faculty
- Physicians choosing rural/underserved practice

1. *Recruiting and training sufficient numbers and diverse representation of family physicians to meet the primary care needs of the state.* A shortage of primary care physicians is an ongoing challenge, especially in rural and underserved urban areas. Less than 10% of allopathic (M.D.) medical students select family medicine as their specialty. Medical students typically graduate with considerable debt and, therefore, tend to select higher paid sub-specialties.
2. *Placing family medicine graduates in rural and underserved areas of the state.* The retention of primary care physicians in rural areas continues to be a challenge. Obstacles to rural practice include professional isolation, spousal satisfaction, and long-term commitment to rural medicine. Strategies to increase the likelihood of rural practice include increasing the exposure to rural settings during training (such as rural training tracks) and providing loan repayment.
3. *Finding sustainable funding for training family physicians.* Family medicine residency programs typically do not generate sufficient revenue to offset program and training expenses. As described above, the current federal GME payment system, largely funded through Medicare, favors the training of non-primary care or hospital-based physicians. Moreover, the current system does not fund new training slots due to a cap placed by Congress in 1997 on the number of slots available. In Colorado, each family medicine residency reports an average deficit of $.5M annually that is covered by their sponsoring hospitals. State funding has been instrumental to help close the financial gap and train a high-quality primary care workforce.
4. *Shortage of faculty to teach family medicine residents.* The residencies find it continually more difficult to recruit faculty physicians due to two major factors:
    a. Many family physicians no longer practice full-scope primary care as they were trained, including obstetrics and inpatient medicine, required of faculty physicians.
    b. Family physicians in full-time clinical practice are compensated better than family physicians serving as faculty in residency programs.
5. *Preparing resident physicians for advanced primary care practices.* The delivery of health care is changing constantly. Residents need skills to lead practices characterized by team-based, coordinated, and integrated care, quality outcome indicators, patient access, and population-based health. The residency programs must continue their progress as patient-centered medical homes. 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, data collection and monitoring, and preventive health efforts. The payment system is gradually moving from volume-based to quality-based reimbursement, but the change is slow, making the financing of the PCMH a challenge.