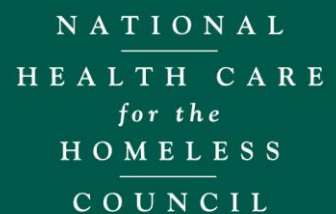


Teaching Health Centers: A Case Study

*Exploring Experiences and Benefits in
Seeking Accreditation*

National Health Care for the Homeless Council
February 2013



NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

DISCLAIMER

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TABLE OF CONTENTS

I.	Introduction	1
II.	Background	1
	Primary Care Physician Shortage	1
	The Affordable Care Act and Its Role in Educating Residents	2
	Teaching Health Center Model	3
	Benefits of Implementing the THC Model	4
III.	Experiences of HCH Grantees in Educating Students	5
	Survey Findings	5
	Obstacles Experienced in Educating Students	5
IV.	Spotlight on an HCH Grantee	7
	Health Center Background	7
	University Hospitals Case Medical Center Collaboration	7
	Current Structure as a Teaching Health Center	8
	Process of Seeking Accreditation	9
V.	Action Steps for HCH Grantees	11

INTRODUCTION

Health center program grantees play an important role in providing primary care to vulnerable populations, including individuals and families experiencing homelessness. These health centers collaborate with many entities, including academic institutions, to meet the health care and social services needs of the populations they serve. Collaborations between health centers and academic institutions provide opportunities for students and residents to receive education and hands-on training directly from health professionals who serve low-income, underserved, and homeless populations. Initiating and maintaining these partnerships are vital.

Many health centers recognize the benefit of having students and residents serve patients and learn at their sites, and thus, consider themselves “Teaching Health Centers.” A Teaching Health Center (THC) is a community-based primary care program that provides education and training to health professionals. However, many of these health centers do not receive additional funding for providing educational opportunities to students and residents. This lack of financial support presents a barrier, leaving many health centers strapped for personnel and budgetary resources, and limits the number and types of health professionals they are able to accommodate at their facilities.

Pursuing health center accreditation to provide Graduate Medical Education (GME) is a possible solution for alleviating some of the financial burden of educating residents. The Patient Protection and Affordable Care Act (commonly called ACA) provides funding to eligible THCs that operate new or existing primary care residency programs. Becoming an accredited Teaching Health Center that provides Graduate Medical Education (THCGME) renders benefits not only to the health center but also to the health center staff, residents who participate in the program, and the community where the health center is located.

BACKGROUND

The state of health care in the United States is on the brink of change. New health reform laws will allow states to expand Medicaid to millions of low-income individuals who were previously ineligible for assistance.¹ While numerous efforts will be made to enroll these newly eligible individuals, work must also be done to attract and retain primary health care professionals to a shrinking workforce.

Primary Care Physician Shortage

Research has indicated that the provision of primary care has the ability to lower health care costs while sustaining quality of care. Diagnosing and treating illnesses early is known to improve patient health and increase quality of life.² In spite of this evidence, there exists a current physician shortage in the area of primary care. Efforts to improve primary health care have placed emphasis on the shortage of primary care providers, especially in medically underserved areas.³ Evidence suggests family physician

¹ Kaiser Commission on Medicaid and the Uninsured. (2010). Expanding Medicaid to low-income childless adults under health reform: Key lessons from state experiences. Retrieved from <http://www.kff.org/medicaid/upload/8087.pdf>

² American College of Physicians. (2006). The impending collapse of primary care medicine and its implications for the state of the nation's health care: A report of the American College of Physicians. Retrieved from http://www.acponline.org/advocacy/events/state_of_healthcare/statehc06_1.pdf

³ Teitelbaum, J. (2011, January 5). Teaching Health Centers. *Health Reform GPS: Navigating Implementation*. Retrieved from <http://www.healthreformgps.org/wp-content/uploads/1.5.11-Teitelbaum-Teaching-Health-Centers.pdf>

vacancies have increased astronomically with more than one-third of Community Health Center (CHC) physician vacancies remaining open for more than seven months.⁴

At a time when the nation is experiencing an aging population, a growing incidence of chronic diseases, and the expansion of Medicaid, a limited number of graduating medical students are going into primary care when primary care physicians are needed most.⁵ Factors such as increased costs of tuition, rising debt, and disproportionate workloads have been noted as influences that have deterred medical students from pursuing family and internal medicine.^{6,7} While these factors present challenges for health centers and medical residency programs, opportunities for growth also exist. Community-based health centers and Family Medicine Residency (FMR) programs will play an important role in the health care expansion legislation enacted in 2010 and the coming implementation of the ACA in 2014.

Health center program grantees are anticipated to expand care to approximately 20 million new patients.⁸ In order to meet the growing patient care demand, the physician workforce would need to expand by an estimated 40,000 physicians.⁹ With only one in five medical students displaying interest in the field of primary care, FMR programs will be charged with the task of how to recruit and maintain new studying family physicians to meet this need.¹⁰

The Affordable Care Act and Its Role in Educating Residents

The Affordable Care Act of 2010 includes several provisions that specifically address the health care workforce and are designed to better meet the health care needs of the nation. These areas include: increasing the capacity of primary care delivery sites, increasing the quantity of health care staff, and improving health care workforce education and training.¹¹ Section 5508 of the ACA focuses on strengthening the infrastructure of the primary care workforce by providing grant funding to health centers to increase new and existing residency programs that provide Teaching Health Center Graduate Medical Education (THCGME). This section identifies the THCGME program as a way to “increase teaching capacity” and defines the THCGME program as a “supported primary care residency training program in any community based setting (i.e. residency program in family medicine, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, general and pediatric dentistry, and/or geriatrics) that provides graduate medical education.”¹² There are three components included

⁴ Morris, C.G., Johnson, B., Kim, S., & Chen, F. (2008). Training family physicians in community health centers: A health workforce solution. *Family Medicine Journal*, 40(4): 271-276.

⁵ Rieselbach, R.E., Crouse, B.J., Frohman, J.G. (2010). Teaching primary care in community health centers: Addressing the workforce crisis for the underserved. *Annals of Internal Medicine*, 152: 118-122.

⁶ Ibid

⁷ Bennett, K., Phillips, J., & Teevan, B. (2009). Closing the gap: Finding and encouraging physicians who will care for the underserved. *American Medical Association Journal of Ethics*, 11(5): 390-398.

⁸ Education Health Center Initiative (2011). Education health center toolkit. Retrieved from <http://www.teachinghealthcenter.org/resources/ehciToolkit.pdf>

⁹ Nandiwada, D.R. & Dang-Vu, C. (2010). Transdisciplinary health care education: Training team players. *Journal of Health Care for the Poor and Underserved*, 21: 26-34.

¹⁰ American College of Physicians. (2009). Solutions to the challenges facing primary care medicine: Comprehensive strategies from the American College of Physicians. Retrieved from http://www.acponline.org/advocacy/where_we_stand/policy/solutions.pdf

¹¹ Ibid

¹² Health Resources and Services Administration (n.d.) *Teaching Health Center Graduate Medical Education (THCGME)*. Retrieved from <http://bhpr.hrsa.gov/grants/teachinghealthcenters/index.html>

in Section 5508: THC Development Grants, National Health Service Corps Teaching Capacity, and Payments to Qualified Health Centers.

THC development grants were designed to assist health centers establish new residency programs. Funds within this grant were designed to support accreditation, curriculum development, recruitment, training and retention of residents and faculty, and/or provide salaries for faculty during development. Though this component of the ACA was legislated, it is not currently appropriated due to federal budgetary reasons. On the other hand, the National Health Service Corps (NHSC) is currently funded and provides scholarships in the form of debt repayment to graduates who train and later work in health centers that serve underserved populations. In addition to NHSC funding, the Health Resources and Services Administration (HRSA) has played an integral role in funding newly accredited or expanded THCGME programs. This funding component of Section 5508 provides payments to qualified THCs. These payments, which are based on a HRSA-calculated formula per resident and number of full time-equivalent (FTE) for each individual health center, cover direct and indirect medical expenses. Up to \$230 million has been appropriated for fiscal years 2011-2015.¹³

Through the ACA, the creation and expansion of THCs could increase workforce coverage in underserved areas. It is believed that the funding provided to health centers to start new residency programs or expand current ones will help address the primary care workforce shortage the United States has faced in the past decade. Research has shown that physicians trained at health centers are nearly three times as likely to work in a health center and have an increased likelihood to work in underserved settings.^{14,15}

Teaching Health Center Model

The Teaching Health Center model has existed for nearly three decades and has a long history of documented success educating future physicians. The model consists of a distinct shared mission of service and education that must be adopted by any health center implementing this type of learning model and seeking GME accreditation. Having staff that dedicate their time and skills to providing services to patients and also possess a shared passion for teaching students and residents is vital to the success of a THC program.¹⁶

In most cases, health center staff educate residents at their facility through clinical observation or hands-on training. However, progression toward implementing a successful THC model has been hindered for a number of reasons; primarily administrative difficulties and financial resources. Reportedly, finding health care providers in community-based settings to “actually administer, rather than participate in teaching programs” can be challenging.¹⁷ This relates to providers who simply “go-along” with the program but don’t actively take a role in educating health professionals. Although the opportunity to participate in real-life experiences for health professionals is priceless, health centers rarely receive any financial reimbursement for educating students and residents, which may have a

¹³ Ibid

¹⁴ Ibid

¹⁵ Ferguson, W.J., Cashman, S.B., Savageau, J.A., & Lasser, D.H. (2009). Family medicine residency characteristics associated with practice in health professions shortage area. *Family Medicine and Community Health*, 41(6): 405-410.

¹⁶ Morris, C.G. & Chen, F.M. (2009). Training residents in community health centers: Facilitators and barriers. *Annals of Family Medicine*, 7(6): 488-494.

¹⁷ Ibid

negative impact on staff time and productivity. As a result, some health centers have questioned the feasibility of educating health professionals at their facilities.

Benefits of Implementing the THC Model

According to HRSA staff and the literature, there are significant advantages to health centers implementing the THC model.¹⁸ First, community-based health centers that collaborate with FMR programs help address workforce issues by increasing the amount of primary care physicians who are dedicated to providing care to underserved populations.¹⁹ Practicing in a community-based environment provides residents the opportunity to gain hands-on experience in a “real-life” setting. Residents also have the chance to interact with experienced, advanced practice physicians, which helps build skills in the areas of “leadership, teamwork, patient education, and communication.”²⁰

Having residents at health centers also provides financial stability that health centers may not otherwise experience through the provision of enhanced reimbursements. These reimbursements may cover the cost of staff time, as well as direct and/or indirect expenses related to educating residents at the health center.²¹

Partnerships between FMRs and health centers, particularly those that are successful, may also generate opportunities for other collaborations in the community. These partnerships may include community-based research opportunities in medical homes. Health centers that have an academic affiliation often enhance their “image” among patients, employees, and funders.²²

Lastly, the THC model provides benefits for staff who are interested in contributing to the education of new and young health professionals. Teaching often increase staff satisfaction, and can result in job retention. Based on all the factors mentioned, health centers that adopt the THC model can succeed in creating an academic environment that focuses on the utilization of evidence-based practices, thus improving the care provided to patients.²³

¹⁸ Health Resources and Services Administration (2011, June 18) Teaching Health Center GME Program [webinar transcript]. Retrieved from <http://www.hrsa.gov/grants/apply/assistance/TeachingHealthCenters/tacallsript.pdf>

¹⁹ Ibid

²⁰ Ibid

²¹ Ibid

²² Ibid

²³ Ibid

EXPERIENCES OF HCH GRANTEES IN EDUCATING STUDENTS

In the spring of 2012, the National Health Care for the Homeless (HCH) Council conducted a survey to assess the number of 330(h) grantees that collaborate with academic institutions, are accredited, and have received THCGME funding. The survey was administered online via Survey Monkey over a six-week period (March-April 2012). All Section 330(h) grantees were invited to participate using contact information provided in the Uniform Data System (UDS) and the database of the National HCH Council.

A total of 223 HCH program administrators were emailed individually at their respective programs. The email invitation requested completion of the survey within a two-week period and provided a link to access the survey via the assigned unique identifier created for each health center. The National HCH Council followed-up with HCH program administrators via telephone to increase the response rate and the survey completion period was extended. One-hundred seventeen (117) programs responded to the survey (52% response rate), with 107 fully completing the survey.

Survey Findings

All health center program grantees included in this survey received HCH funding. Additional funding streams often included Community Health Center 330(e) (49%), Ryan White HIV/AIDS (29%), and Migrant Health 330(g) (15%). More than half (62%) of the respondents were administrators, with 24% reporting dual roles as administrator and clinician. When respondents were asked about collaborating with an academic institution, 87% indicated they collaborated with a university, medical school, or allied health professions school to educate students (i.e., for observational purposes or service provision) at their HCH program. Close to 90% of these programs indicated they collaborate with more than one institution. Of the programs that indicated they did not have a current collaboration with an academic institution, 67% reported they would be interested in establishing a collaboration (See Graphic 1).

When these HCH programs were asked if they considered themselves “Teaching Health Centers,” almost half indicated “no,” while 44% responded “yes.” Nearly six in 10 HCH programs that participated in this survey indicated interest in becoming accredited. Less than 10% of these programs reported they were a THCGME. Among the reported THCGMEs, 83% indicated they were accredited through the Accreditation Council for Graduate Medical Education (ACGME). Less than one-quarter (13%) of all the respondents were aware of the Patient Protection and Affordable Care Act (PPACA) Title VII grant program, which provides funding for new and expanding residency programs at health centers (See Graphic 1).

Obstacles Experienced in Educating Students

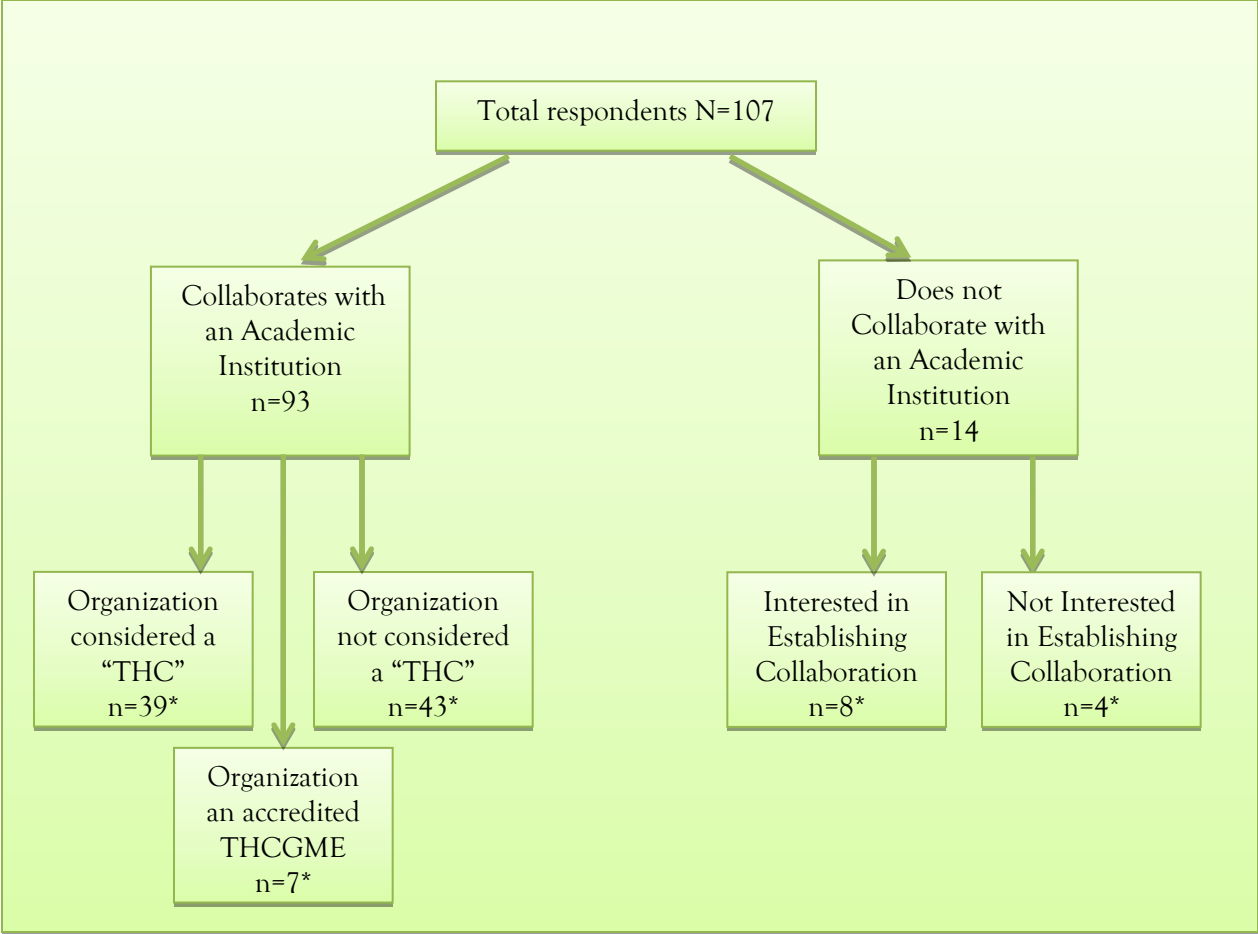
Among respondents who reported they do not collaborate with an academic institution, 28% indicated their organization lacked several pieces necessary to develop a collaboration, including: 1) knowledge on how to establish a collaboration with an academic institution, 2) staff to educate students, and 3) financial resources and physical space to accommodate students. In addition, 21% reported they lacked the time needed to take on this type of responsibility.

Information gleaned from qualitative data analysis revealed that staff time and productivity were mentioned most often as challenges specific to educating students. Comments included but were not

limited to: “students and residents slow down the preceptor,” “mid-levels are frustrated with teaching time,” and “[teaching] exhausts staff.”

The majority (90%) of respondents who indicated a collaboration with an academic institution, reported they do not receive financial resources to support the education of health professions students. However, 60% reported there are costs to the organization for supporting student education. In spite of this, 56% reported that maintaining their current collaboration with an academic institution was very important.

Graphic 1:



***Note:** The reported (n) is the total number of respondents who answered the reported question.

SPOTLIGHT ON AN HCH GRANTEE

Care Alliance is a health center program grantee in Cleveland, OH. A brief description of the health center is provided below to provide a contextual understanding. The following information was self-reported by the health center during the interview process.

Health Center Background

Care Alliance, is “the leading provider of medical and dental services” to patients who are either experiencing homelessness or live in and around public housing establishments in the metropolitan Cleveland area. The health center was established in the 1980s (originally as Cleveland Health Care for the Homeless). In 1993, the health center became an independent, non-profit organization receiving 330(h) funds from HRSA and expanded its services in 1998 to receive 330(i) funds as well.²⁴ Care Alliance operates as an HCH stand-alone facility in downtown Cleveland with two clinic locations on the East and West sides of the city, which are located in public housing developments. They also provide outreach services in clinics within shelters, locations where individuals experiencing homelessness tend to gather on the streets, and transitional housing locations.

In 2011, Care Alliance served nearly 10,000 individuals. The majority of patients served at the health center had incomes below 100% of the federal poverty line, were uninsured, and typically postponed seeking health care services until conditions could not be ignored. About half (43%) of their patients are diagnosed with chronic illnesses, including HIV/AIDS. The majority (90%) of patients seen for dental services have periodontal disease.²⁵ Recently, Care Alliance was recognized by the National Committee for Quality Assurance as a Level Three Patient Centered Medical Home (PCMH), the highest level of achievement according to accreditation standards. This re-affirms their commitment to providing the highest quality of care to all of their patients.

University Hospitals Case Medical Center Collaboration

Care Alliance established a formal collaborative relationship with University Hospitals Case Medical Center (UHCMC) nearly a decade ago when the current Family Medicine site director was in her last six months of a fellowship in Faculty Development. At the time, Care Alliance was seeking a new Family Medicine physician but was unable to hire someone on a full-time basis or pay a market rate salary, so it presented an opportunity to split time between the health center and academic location. The shared position was a good fit for all involved stakeholders. Currently, the two entities have a standard formal affiliation agreement, which outlines the objectives and commitment to achieve a shared goal for residency education. This has allowed the site director to continue her dual appointment at each organization.

Prior to hiring this site director, medical students who had rotations at Care Alliance observed and provided services at the clinic on a rather erratic basis and residents did not rotate to any of the Care Alliance clinics. With a clear vision and hard work, the health professions program has “grown exponentially” over time. When discussing the site director’s role in this growth between the two entities, the Chief Executive Officer (CEO) stated, “because of the longevity she has with Care Alliance

²⁴ Care Alliance Health Center. (n.d.) *Mission and History*. Retrieved from <http://www.carealliance.org/about-us/mission-and-history/>

²⁵ Ibid

[and UHCMC] it has made the relationship stronger and deeper.” Having a central point person who understands the intricacies involved in a university residency program and can facilitate the process on both sides of this collaborative relationship has offered the health center a champion; as she is fully knowledgeable of both sides of the collaboration. Administrators at Care Alliance affirm that the dual-appointed physician serving as the site director has been a tremendous benefit to the program.

Care Alliance staff also feel that their collaboration with UHCMC has enhanced their image. According to the CEO, other community entities want to be affiliated with Care Alliance because of this academic partnership. This has greatly assisted the organization’s ability to recruit and hire highly qualified individuals – an opportunity that a smaller organization may not be able to achieve without outside assistance.

Current Structure as a Teaching Health Center

Care Alliance has established their organization as a “teaching location” that provides education to resident learners and is in the process of seeking accreditation to provide Graduate Medical Education. Over the years, the organization has accepted a number of different learners to participate in clinical education and experiences. While the medical learners have primarily been residents from Family and Internal Medicine, fourth-year fellows from Family Medicine doing additional training in Obstetrics and Faculty Development have also received continuity clinical training at Care Alliance.

The Family Medicine Residency (FMR) operated by Care Alliance, will be a 3-year program coordinated by the site director, a physician who oversees the program and precepts on a limited basis. The structure of the program will include clinical rotations, which vary each year based on specified requirements for Family Medicine resident education, and include a balance of inpatient, specialty outpatient, and continuity clinical rotations. Residents will maintain their continuity clinic experience at Care Alliance varying from one clinic a week in their first year of training to four half-day clinics a week in their third year.

Approximately six months ago, the health center hired a new Family Medicine physician who is primarily responsible for precepting the residents at the clinic. This new physician completed a residency program and fellowship with UHCMC (including continuity clinic at Care Alliance in his fellowship year), and consequently has a good understanding of the program structure and the challenges faced by residents involved in the program.

While there are a limited number of actual preceptors for resident learners, staff at Care Alliance described a strong culture for teaching and education among the entire staff, which has made clinical education successful at their health center. All staff at Care Alliance consider themselves part of the teaching program and willingly embrace the residents who rotate through the health center. To highlight this strength, the site director stated, “studies have shown that people in the medical profession who are involved in teaching stay more on top of what is clinically relevant [which] improves patient satisfaction. For our patients who are very vulnerable in particular, I think we frame it as, you’re helping educate these doctors too and it gives them some ownership in the program and many of my continuity patients know I have a helper who they will also work with.”

Process of Seeking Accreditation

Care Alliance and its associated staff are dedicated to providing optimal care to their patients and also have a passion for educating medical residents; this mission and vision is shared with their partners at UHCMC. The site director indicated that during her tenure, residency program graduates have been hired by Care Alliance, so seeking accreditation as a THCGME is an attempt to “formalize the process and have a better pipeline [to workforce development].” In addition to this, residents bring in “fresh faces... new ideas, [and] keeps the [organization] up-to-date” in providing high quality care. Resident graduates who do not work for Care Alliance are employed at other CHCs in the Cleveland area and around the country. The administrative staff at Care Alliance believes they are providing exposure to “real patients,” which makes residents well-rounded, producing better doctors in the primary care workforce.

As indicated earlier, Section 5508 within the ACA has legislated funding for the development of new THC, but the funding has not been appropriated. The first wave of funding for this initiative was granted primarily to existing THCs that had accredited residency programs and were seeking to expand to accommodate more residents. Recognizing the benefits of the THC model, Care Alliance has begun the process to meet the requirements of accreditation through the Accreditation Council for Graduate Medical Education (ACGME). This goal toward accreditation is supported through their collaboration with UHCMC. Through this collaboration, the Family Medicine Department Chair, worked with Care Alliance in developing a “pitch” to a local entity, Saint Luke’s Foundation, to further expand their partnership and shared mission to develop high quality primary care physicians. Saint Luke’s granted UHCHC \$1 million dollars as seed money over the next three years to develop its health care workforce and urban health initiatives. This gift of benevolence began Care Alliance’s move toward becoming an accredited THC. The CEO explained that while the money does not fully fund everything being sought for accreditation, it has helped a great deal. The philanthropic funders have specified the money be used toward educating residents and supporting administrative personnel to oversee the program.

As Care Alliance pursues accreditation as a FMR program, they have discovered the rigidity of the guidelines and requirements, further emphasizing the importance of having a site director with knowledge of both the health center and residency program. However, the organization remains committed to the process and understands that they cannot seek THCGME funding if they are not accredited. Included in ACGME accreditation guidelines are a full list of curricula, space requirements, and inpatient rotations. In reference to the availability of inpatient rotations, Care Alliance administrative staff acknowledge that as a stand-alone health center program grantee, it is important that they have hospital support to fulfill these rotations.

Concurrently, the health center is making plans for expansion, including a new free-standing clinic. The organization received \$5.5 million in federal grants to finance the construction of a new health center and renovate one of their existing clinics. The new building will be 30,000 square feet and will allow them to comply with the requirements of ACGME by allowing more flexibility in space for their residents. Certain sections of the new building will be specifically dedicated to the residency program, including a library and resident workspace. Even with many requirements outside of continuity clinic, “the goal is that the residents will be doing their entire continuity clinic at Care Alliance as their medical learning home.” Of special note, the new building will be located in a neighborhood that is populated by high-risk populations with little to no health insurance or access to care. The site director

stated, “what a place to be able to put a Family Medicine Teaching Health Center – in the middle of [an] underserved area – the opportunity that it provides us, as a provider to serve the patient and... [the] opportunity that [it] provides to residents to learn.”

Care Alliance staff stated that without receiving the federal capital development dollars in addition to the bridge funding from Saint Luke’s, they would not have been able to seek accreditation at this time due to how costly this process can be. These funds have played a major role in the organization’s ability to seek full ACGME accreditation. In the meantime, they have taken a step in pursuing certification through ACGME for one of their clinics as a second continuity site for their existing residency program.

Although the funding for the THCGME program is not certain, Care Alliance acknowledges that whether or not the opportunity presents itself, they will be competing with large hospitals and health centers across the country for primary care physicians. Therefore, they felt it was time to take action. The organization has invested a lot of time being proactive by establishing and maintaining relationships with local hospitals and stakeholders in the city of Cleveland – most specifically, Cleveland Clinic, UHCMC, and the Metro-Health System. The administrative staff at Care Alliance stated, “We know it is so important to work with these particular institutions that are part of the residency program... but more importantly to share the same philosophy of how [to] recruit the best primary care physicians.”

Currently, dental services are provided by Care Alliance, with dental students rotating through the clinic monthly. However, they do not have a dental residency program. Conversations are beginning to be held regarding the development of a dental residency program that would involve students from the local dental school. It appears that contract execution is very likely in the near future. However, the CEO stated, it would not be an accredited THC. The program’s Chief Administrative Officer (CAO) added “on the dental side, we’re a couple years behind, and we’re learning from our experience on the medical side but ultimately our goal would [include becoming] a comprehensive medical and dental Teaching Health Center.”

ACTION STEPS FOR HCH GRANTEES

While the organization highlighted in this case study is not fully accredited, they have taken significant steps toward this goal. This may be credited to their dedication to building and sustaining partnerships in their community and working with hospitals and stakeholders who share their mission and vision. Care Alliance has been committed to providing quality care and hiring highly qualified physicians to increase patient satisfaction, which supports the Teaching Health Center model and philosophy. Based upon the findings from the HCH grantee survey and Care Alliance's experience, the following action steps are offered:

- **Invest in building strong relationships in the local community.** Care Alliance successfully invested time and effort into seeking and building relationships in their local community, which has resulted in a wealth of assets, including individuals and organizations. As a result of seeking relationships, Care Alliance was able to locate a foundation in the local community that shared a commitment to their goals and was willing to provide seed money to push forward Care Alliance's vision.
- **Ensure that there is a high level of trust that exists between collaborating organizations.** Developing a trusting relationship between your health center and local hospitals and/or academic institutions is very important. If trust is lacking between the entities, there will be difficulty moving any ideas forward. The results of the HCH grantee survey revealed that 57% of the respondents indicated they had a successful collaboration because the relationship was characterized by "trust and transparency."
- **Locate a "champion" who can act on both sides of the partnership.** Care Alliance staff emphasized how important the role of the site director is in successfully executing the residency program and the overall partnership. While it is extremely difficult for one person to wear both hats (health center employee and academic faculty), the ability to do so enhances the opportunity for the partners to focus on maintaining a shared commitment. Having a person that understands and is aware of the culture at each organization is vital.
- **Build a culture of teaching within the organization.** Care Alliance shared that their staff are highly committed to teaching and participating actively in the education of residents. As indicated, the THC model is most successful when service to patients and education to students are included in the mission of the organization.
- **Be very clear in the area of focus and decide what type of accreditation to seek.** There are many organizations that provide accreditation. However, there are three entities that are eligible through the HRSA THCGME program. These include Accreditation Council of Graduate Medical Education (ACGME), American Osteopathic Association (AOA), and Commission on Dental Accreditation (CODA). Each of these bodies has specific rules and guidelines for applying. Accreditation instructions and requirements, costs associated with accreditation, and the typical length of the process can be found on their respective websites or by contacting a representative at the organization. Care Alliance has decided to seek a Family Medicine Residency through ACGME because they believe this is the best fit for their organization and the patients they serve. For more information on the HRSA-THCGME program, visit their website (<http://bhpr.hrsa.gov/grants/teachinghealthcenters/index.html>), which provides specific guidance on the types of residency training programs that are eligible to apply for THCGME funding.
- **Be proactive! Remain up-to-date on the Affordable Care Act implementation as it relates to Teaching Health Centers.** While funding for the THC initiative has been appropriated, funds are currently not available to develop or start new THCs. However, it is essential for organizations to begin taking the steps to plan and move forward if they believe that accreditation would be beneficial. It is important that an organization is positioned to take advantage of this opportunity once funding becomes available.