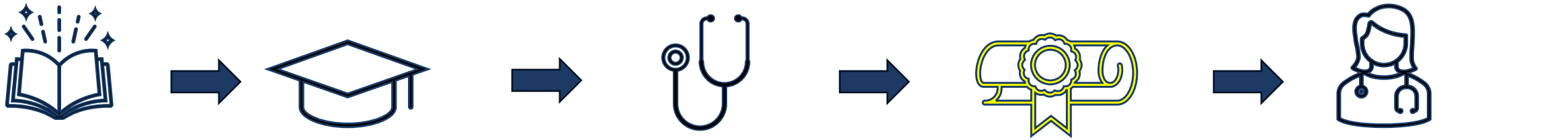
Learning Objectives

By the end of this session, participants will be able to

- Articulate the value of GME in FQHCs for patients, providers, and communities.
- Assess organizational readiness using a structured evaluation framework
- Compare CHC-led and PCA-led sponsorship models and understand forthcoming policy implications.
- Identify and pursue sustainable funding sources, including HRSA THCGME, Medicare/Medicaid GME, and state-level options.
- Design mission-driven curricula that align with CHC values of equity, access, and community health.
- Establish outcome metrics to measure retention, patient care quality, and community impact.

What is Graduate Medical Education?

- GME = Residency + Fellowship (post-medical school training)
- Required for state licensure and board certification
- Lasts 3–7 years depending on specialty
- Where a doctor trains is the #1 predictor of where they'll practice



K-12
13 years

College
4 years

Medical School
4 years

GME or Residency
3-7 years

Practicing Physician
Career

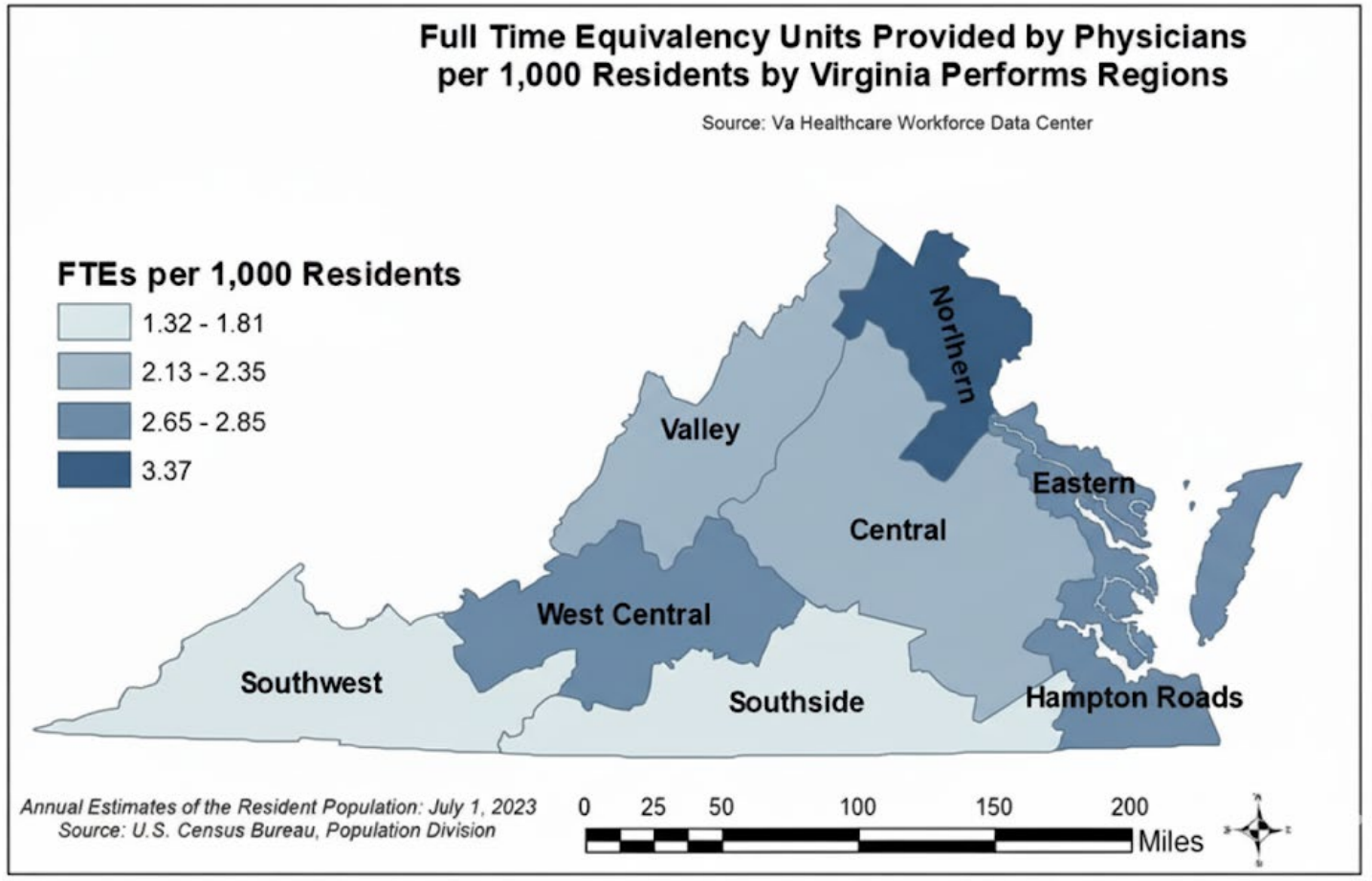
What is Graduate Medical Education?

Strategic lever for workforce strategy

Most effective tool to address physician shortages, especially in rural or underserved areas

Not investing in GME risks workforce gaps, higher recruitment costs, and diminished influence over the future physician pipeline

Setting the Stage



Virginia will require an additional 1,622 primary care physicians by 2030

https://www.aafp.org/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Virginia.pdf?_gl=1*1tt4x6*_gcl_au*MjcyNzA2OTAuMTc1ODYzNDM3Mg..*_ga*MTc0MzY1MDEyNi4xNzU4NjM0Mzcz*_ga_Z7TFXMJE70*czE3NTg2MzQzNzMkbzEkZzEkdDE3NTg2MzQzODgkajQ1JGwwJGgw
file:///Users/amypaul/Desktop/Materials%20for%20fqhc%20workshop/DHP%20MD%20workforce%20report%202024.pdf

Virginia's Training Landscape

Medical Schools in state (6)

- University of Virginia
- Virginia Commonwealth
- Eastern VA Medical School
- VA Tech Carilion – Roanoke
- Liberty University – Lynchburg
- Edward Via (VCOM) – Blacksburg

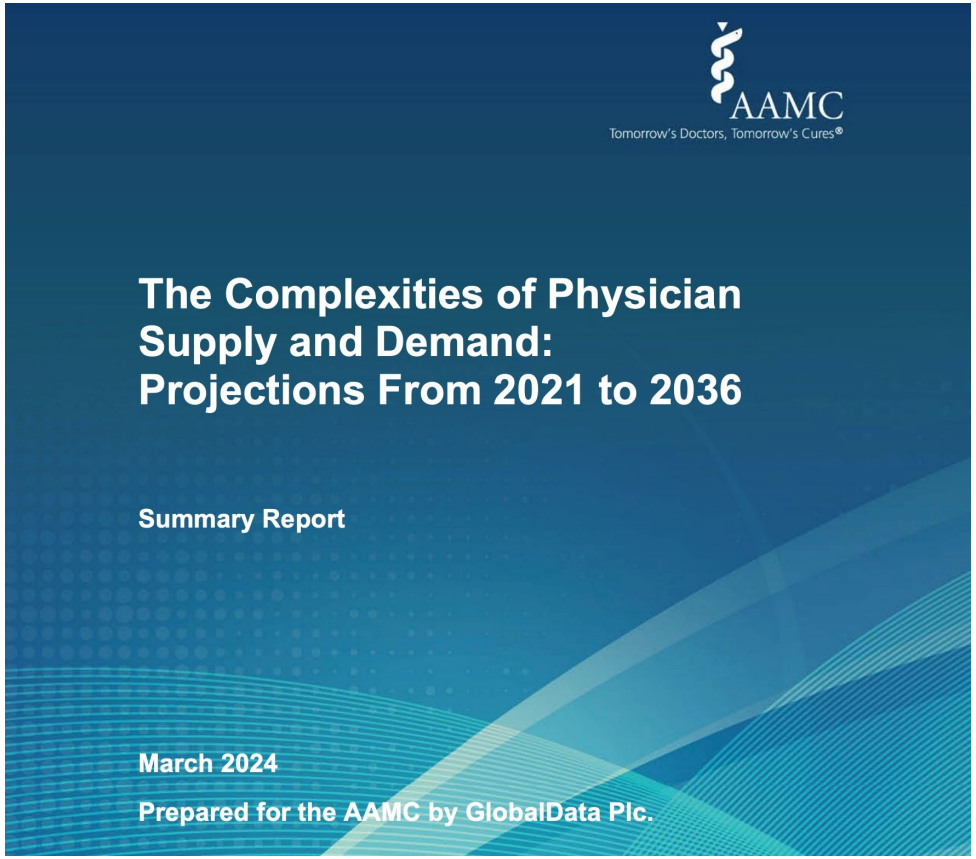
- **1,300** Medical School graduates annually

GME Programs in Virginia

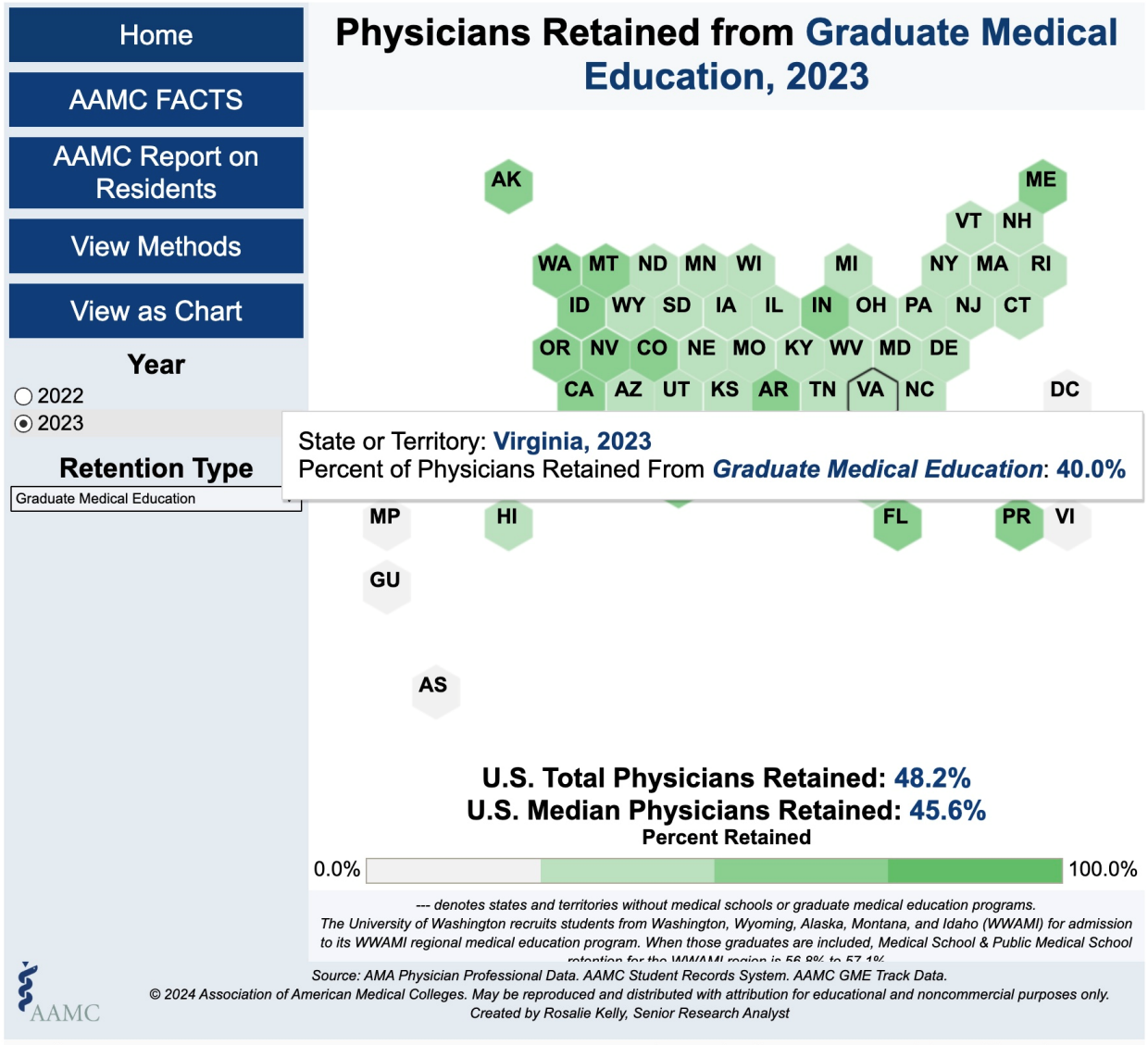
- 100+ Residency and and Fellowship Programs
- ~3,000 Residents and Fellows in training in total for all years
- We have about **1,000** first year positions for all specialties
- Total of 442 for specialties considered primary care (Family Medicine, Internal Medicine, Pediatrics, Ob/gyn and Geriatrics)

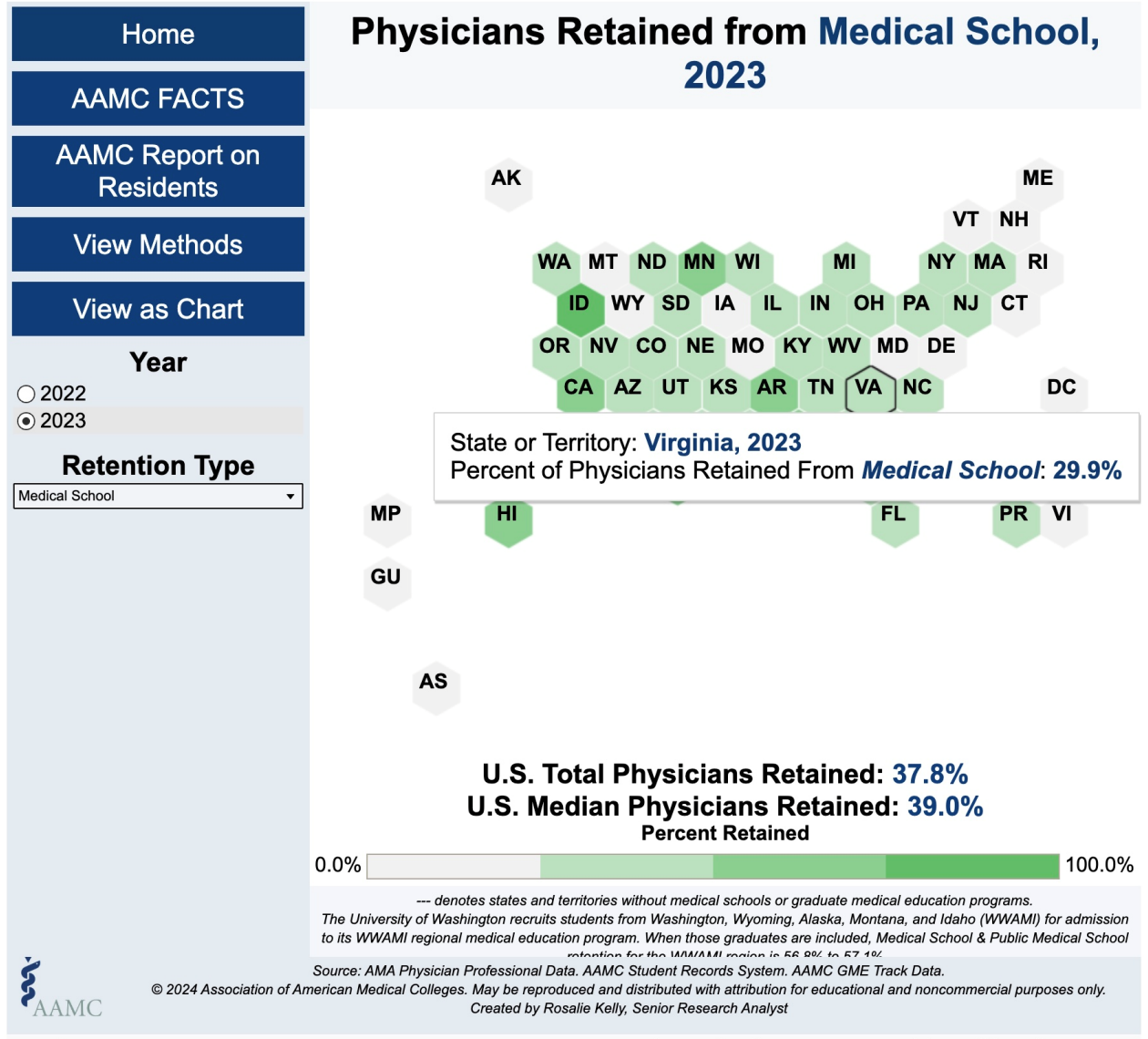
What About Retention?

- Geographic maldistribution of physicians to rural areas continues to pose issues around hospital staffing and health care access



https://wmjonline.org/wp-content/uploads/2018/117/5/208.pdf
https://www.aamc.org/media/75231/download?attachment

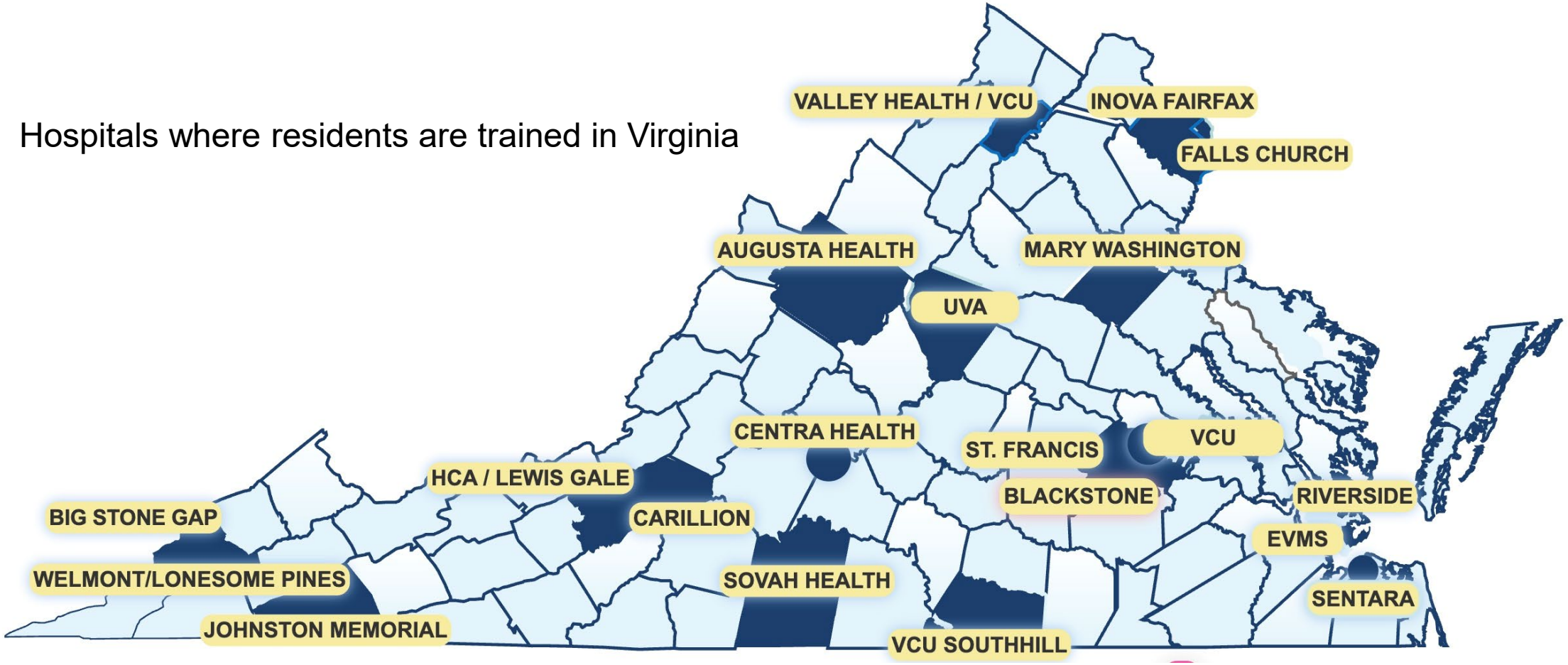




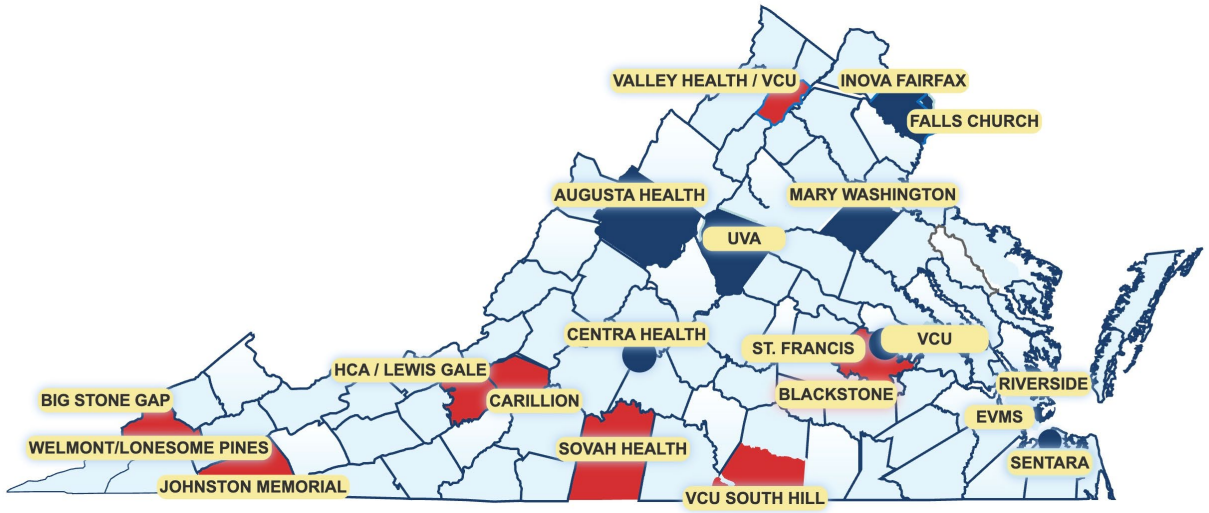
https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard

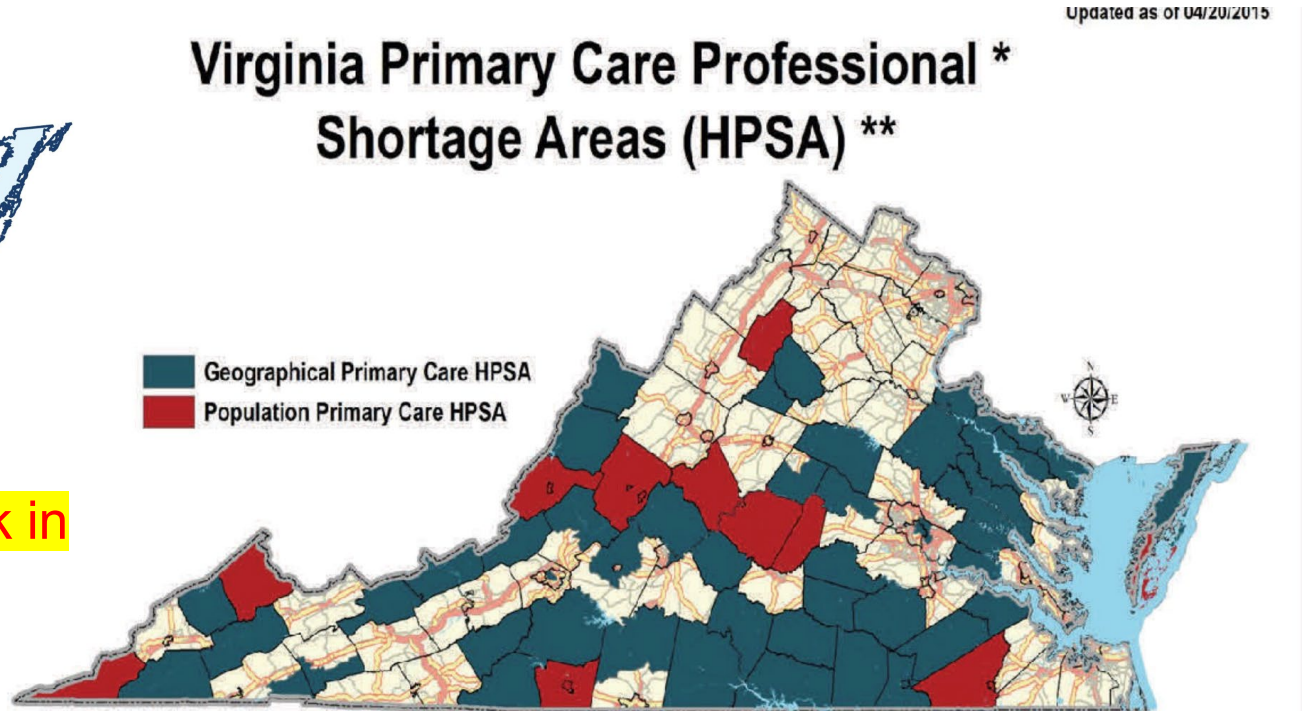
Where are we training our physicians?

Hospitals where residents are trained in Virginia



Where is Graduate Medical Education Training Needed?





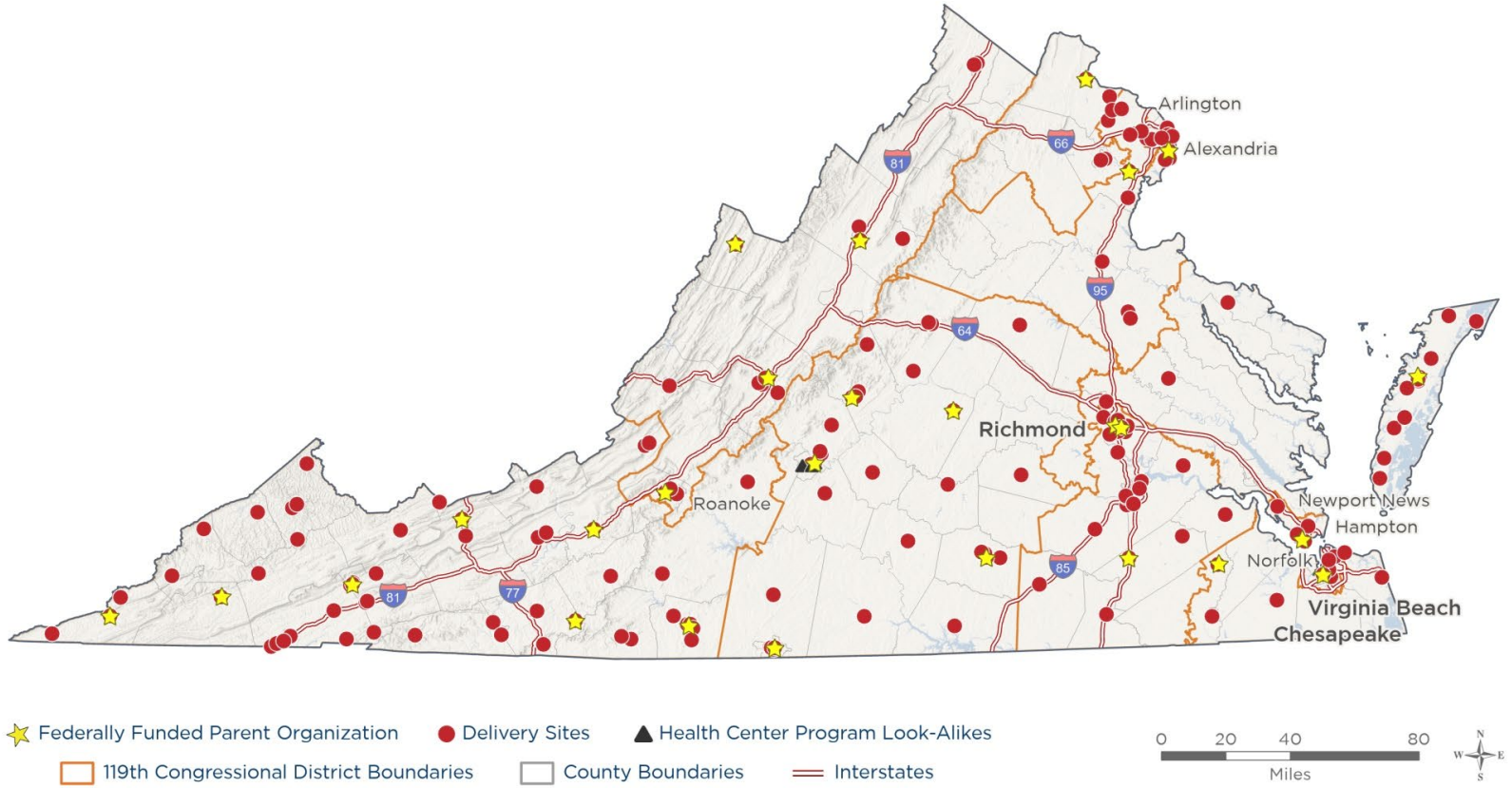
6% of Virginia's physician workforce work in non-metropolitan areas of the state.

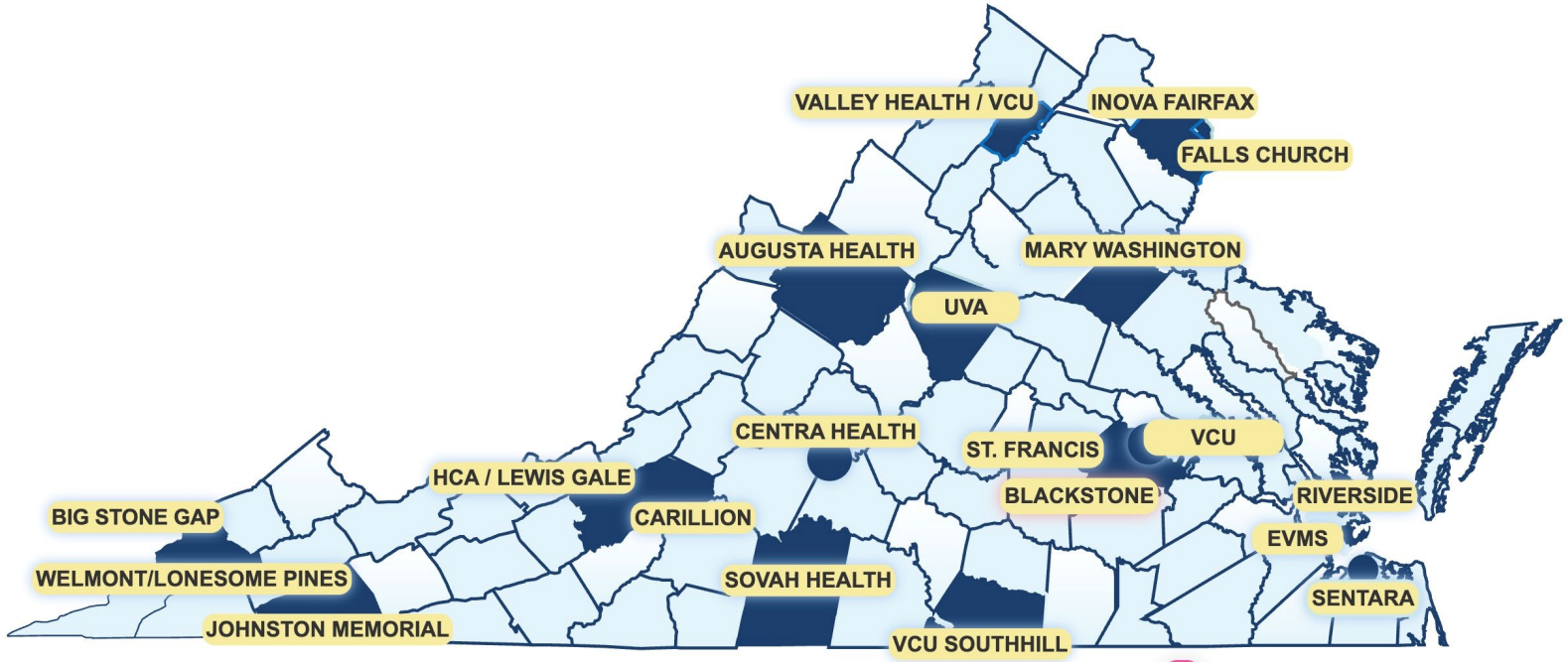
NATIONAL ASSOCIATION OF Community Health Centers®

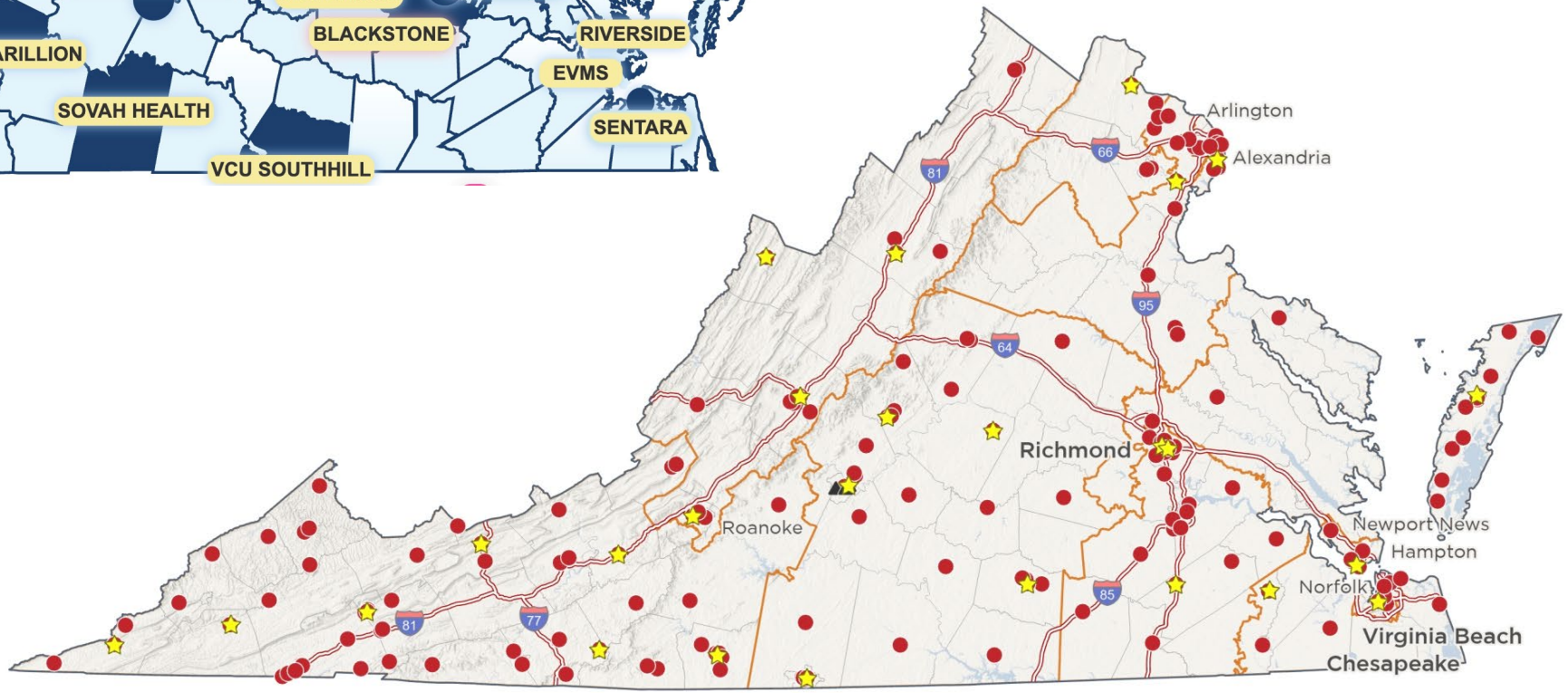
VIRGINIA

217 Health Center Delivery Sites

The 26 federally-funded health center organizations in Virginia leverage **$89,087,649** in federal investments to serve **392,646** patients, 18% of whom are uninsured and 40% of whom are covered by Medicaid.

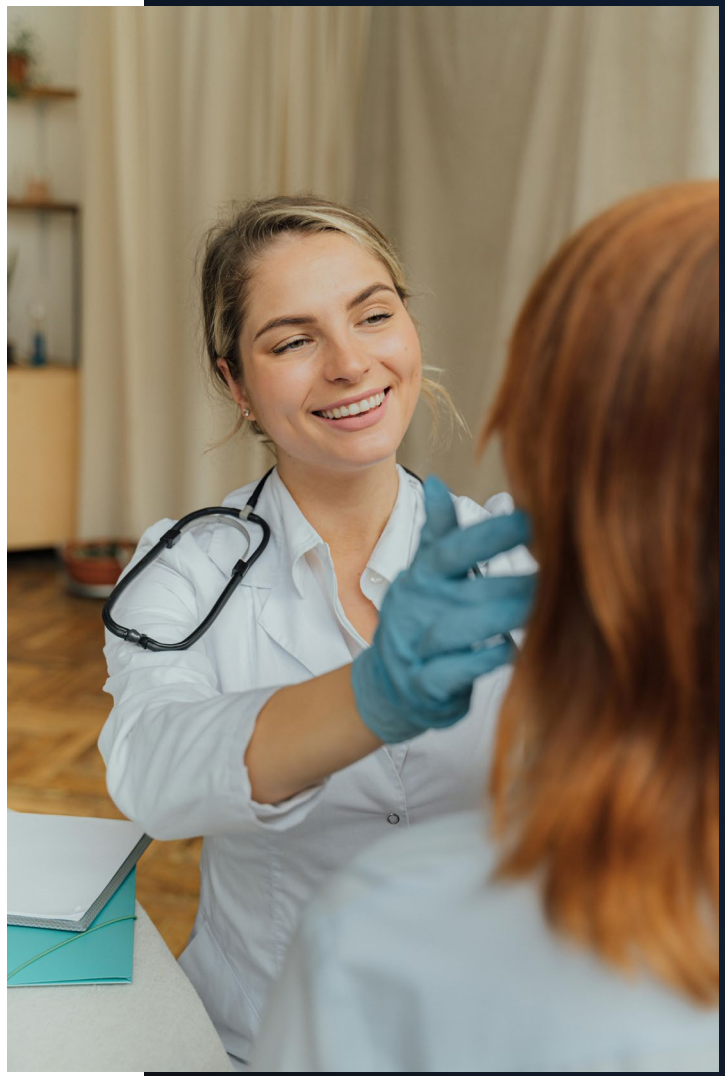



VALLEY HEALTH / VCU
INOVA FAIRFAX
FALLS CHURCH
AUGUSTA HEALTH
MARY WASHINGTON
UVA
CENTRA HEALTH
ST. FRANCIS
VCU
HCA / LEWIS GALE
BLACKSTONE
RIVERSIDE
BIG STONE GAP
CARILLION
EVMS
WELMONT/LONESOME PINES
SOVAH HEALTH
SENTARA
JOHNSTON MEMORIAL
VCU SOUTHHILL


Arlington
Alexandria
Richmond
Roanoke
Newport News
Hampton
Norfolk
Virginia Beach
Chesapeake
81
66
95
64
85
77

Why is this relevant for CHCs?

- Majority of physicians spend their careers practicing in ambulatory community-based settings.
- Without exposure to clinics, recruitment and retention are uphill task
- GME provides a way to diversify income streams
- Cannot plan for changing needs of the communities served without trainees
- Research shows that residents who train in FQHCs and FQHC Look-Alikes are more likely to practice in medically underserved areas – and to feel more prepared to do so.



The GME Value Proposition

Value (Return on Investment) = Benefit / Cost

- Cost reduction with improved patient outcomes
- Attention on patient safety and social determinants of health
- Maintain a pool of re-deployable physicians if public health emergencies arise
- Succession planning with community needs in mind
- Reducing burnout and physician turnover
- Creating an academic culture of learning

https://pmc.ncbi.nlm.nih.gov/articles/PMC8462840/pdf/ZJCH_11_1961381.pdf

What are the benefits of GME?

- Direct financial benefit
- Indirect financial benefit
- Institutional benefit
- Workforce development
- Community benefit

Direct Financial Benefit

- Facilitate stable institutional cash flow through GME and other funding
- Opportunities for additional funding streams
- Opens up Federal funding opportunities as well as grants and philanthropy

Indirect Financial Benefit

- Improved efficiency
- Improved Physician recruiting and retention
- Residencies improve quality of care with population health focus
- Graduates tend to be loyal to their institutions

Economic Impact?

Economic Activity: Each physician supports $2,097,034 in output., eg sales revenue.

Jobs: On average, each physician supports 11.69 jobs.

Wages and Benefits: Each physician supports $1,032,379 in total wages and benefits.

Tax Revenues: Each physician supports $79,770 in local and state tax revenues.

https://www.ama-assn.org/system/files/eis-report-virginia.pdf

Institutional Benefit

- Alignment with and support of institutional mission, vision, values and strategic plan
- Resident care allows attendings to be more productive
- Additional Institutional leadership
- Boosts Innovation

Workforce Benefit

- Opportunity for early incentives
- Retention of graduates in local area
- Presence of residents tends to attract specialists and other health professionals
- Creates a pipeline from our medical schools

Community Benefit

- Health care access for underserved populations
- Resident/Residency community service
- Resident community needs assessment and projects

Who is Our Community?

Local hospitals/health care systems:	• Support our training mission and vision • Can support our needed training experiences
Specialty physicians:	• Support our mission and are willing to teach our trainees
Community engagement:	• Support from local boards/leaders and local partners
Physicians to lead program	• Designated Institutional Official • Program Director • Program Faculty (Staff or community)

Benefit Case Examples

- **Community Health of Central Washington (Yakima, WA) – Long-standing CHC residency with THC track record**
- FQHC-anchored residency with integrated behavioral health, OB, procedures—federally designated THC site.
- Outcomes you can cite: **Sustained pipeline for Central WA's safety-net; federally designated THC status and ongoing class throughput supporting regional access**

https://www.directrelief.org/2024/11/a-new-generation-of-doctors-looks-to-health-centers-for-residency/

Critical conversations: *What does it take to "grow" a GME program?*

- Program mission
- Sponsoring institution
- Community support
- Training resources
- Attractiveness to applicants
- Financial viability

Are We Ready?

- What does readiness look like to you?
- Readiness assessment framework located in your packet
- What was your score?

What should our Governance Model Be?

What is a Sponsoring Institution? (SI)

- The organization (or entity) that assumes the ultimate financial and academic responsibility for a graduate medical education program consistent with the ACGME
- Financial support is required for administrative, educational, and clinical resources, including personnel.

ACGME

https://www.acgme.org/globalassets/ab_acgmeglossary.pdf

CHC-Lead?

- **Each FQHC becomes its own SI**
  - Each site would go through the entire ACGME institutional accreditation process separately which would give them:

1. Autonomy
2. Local Control
3. Direct Funding
4. Distinct brand, reputation and marketing tools

CHC- Lead?

However, in addition to a duplication of efforts, each center would incur:

1. High administrative burden and cost
2. Smaller scale of program and it's impact

This is despite the creation of strategic opportunities with

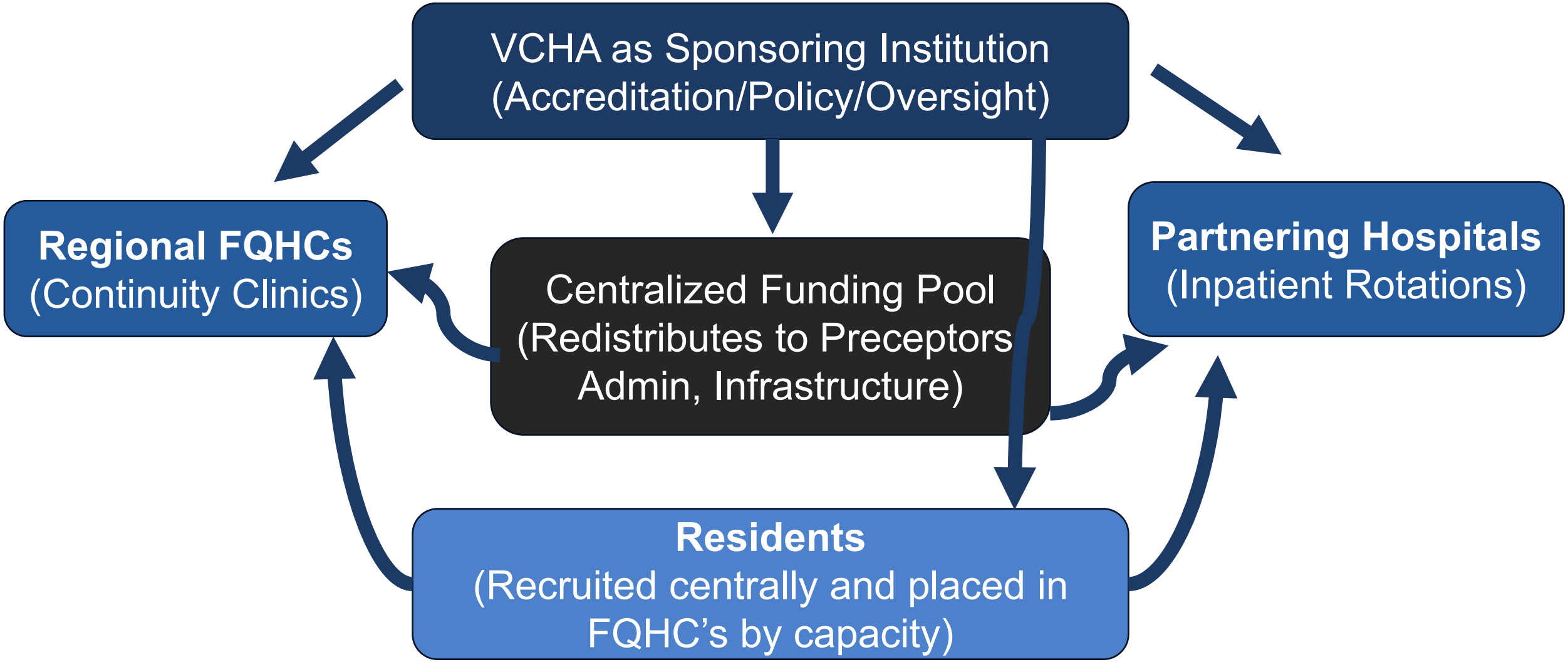
- Diverse Innovation aimed at local needs
- Competition → Excellence
- Policy Leverage

VCHA as the Sponsoring Institution?

- **VHCA holds the ACGME accreditation umbrella.**
  - FQHCs function as clinical training sites rather than each pursuing SI status individually, which

1. Reduces administrative burden on smaller FQHCs who may lack compliance infrastructure.
2. Ensures Central Oversight
3. VHCA would appoint a GME leadership and compliance teams
4. Implementation of standardized policies, evaluation tools, resident contracts, and reporting
5. Unified voice for advocacy

What Does This Look Like?



What Does This Look Like?

- **VHCA GME Office** → runs accreditation, policy, oversight.
- **Regional FQHC Clusters** → serve as continuity clinics.
- **Partnering Hospitals** → provide inpatient rotations.
- **Residents** → recruited centrally, placed in FQHCs based on capacity.
- **Funding** → centralized pool, redistributed to support preceptors, admin, and infrastructure.

- VHCA-as-SI would make it far easier for FQHCs to participate by lowering barriers, but it requires a robust governance structure, trust among members, and a transparent funding redistribution model. Also gives more leverage for policy advocacy

What About An External Sponsor?

- **External SI (e.g., VCU/Wright Center)**
  - These universities/academic centers already hold ACGME institutional accreditation.
  - FQHCs participate as **affiliated training sites**, not as SIs themselves.
  - GME leadership, policies, accreditation, and compliance sit within the external SI

- **Shared Responsibility**
  - Curriculum, faculty development, and evaluations run through the external SI.
  - FQHCs provide continuity clinic experiences and designated faculty/preceptors.

What About An External Sponsor?

Benefits?

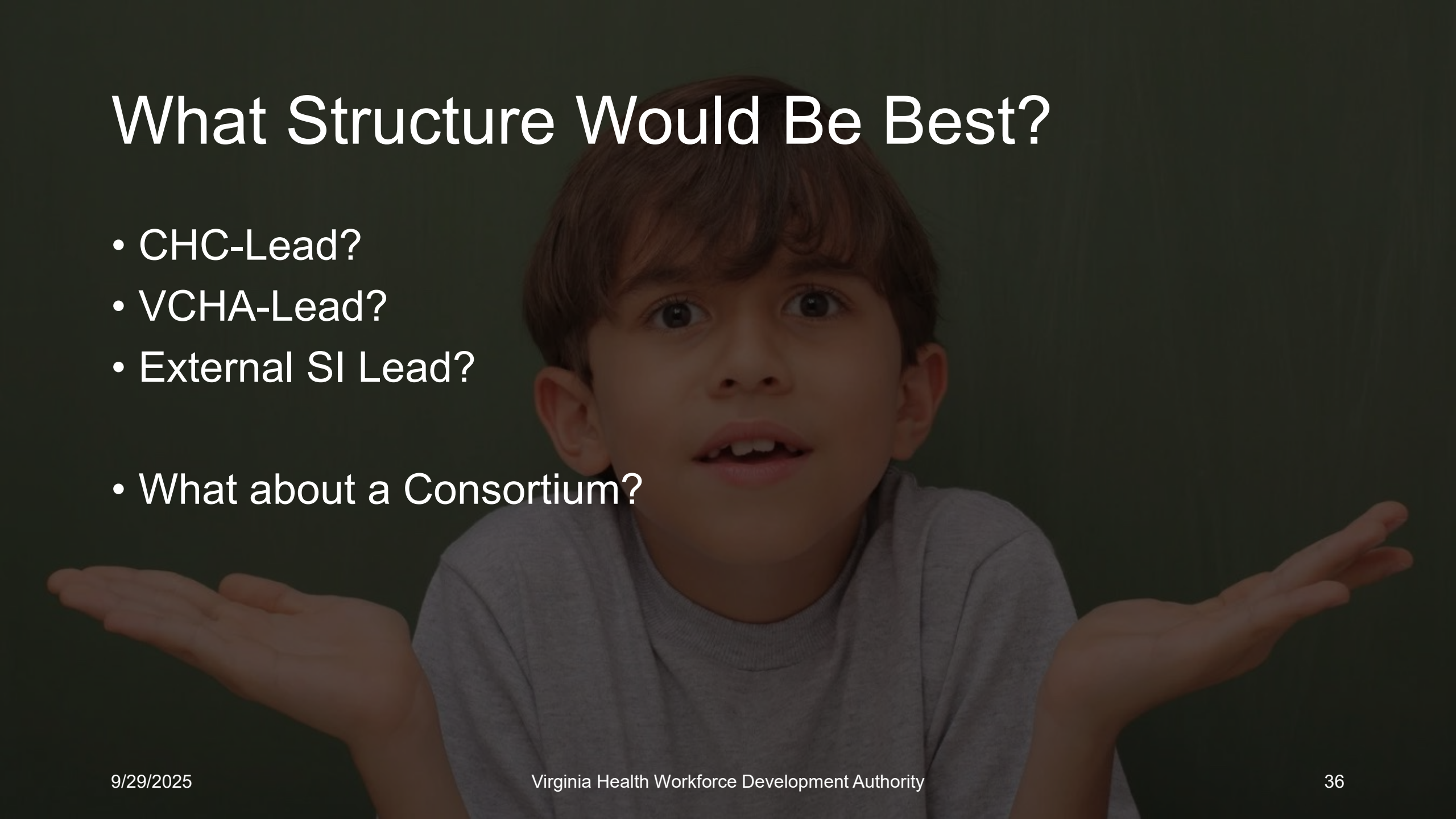
- Minimal Administrative Burden
  - The external SI carries the accreditation load.
  - FQHCs don’t need to develop their own GME office or DIO structure
  - Can be up quickly
- Established Systems
  - Access to mature faculty development, evaluation, wellness, and recruitment systems.
  - Standardized policies reduce compliance risk.
- Credibility & Recruitment
  - Residents may be more attracted to a program under the umbrella of a well-known academic SI.
  - Stronger brand recognition can help retain graduates in-state.

What About An External Sponsor?

Challenges? Risks?

- **Less Control**
- FQHCs don’t “own” the program; major decisions are set by the SI
- Resident allocation may favor university priorities over FQHC workforce needs.
- **Funding Distribution**
- THC GME funds flow to the external SI, which must redistribute fairly to FQHCs.
- **Potential Mission Misalignment**
- Universities may be more focused on academic prestige or hospital-based needs rather than community-driven, primary care workforce development.

What Structure Would Be Best?



- CHC-Lead?
- VCHA-Lead?
- External SI Lead?

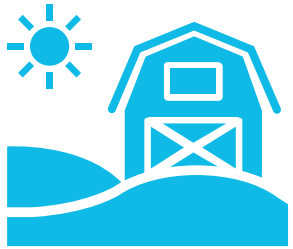
- What about a Consortium?

What Will We Teach?

- Primary Care:
  - Family Medicine
  - General Internal Medicine
  - General Pediatrics

- Specialty Care:
  - Psychiatry
  - General Surgery
  - Obstetrics/Gynecology

Residency Program Models



Rural Training Program:

Associated with a core program in a larger community

Greater than 50% training in rural location

1-3 residents/year

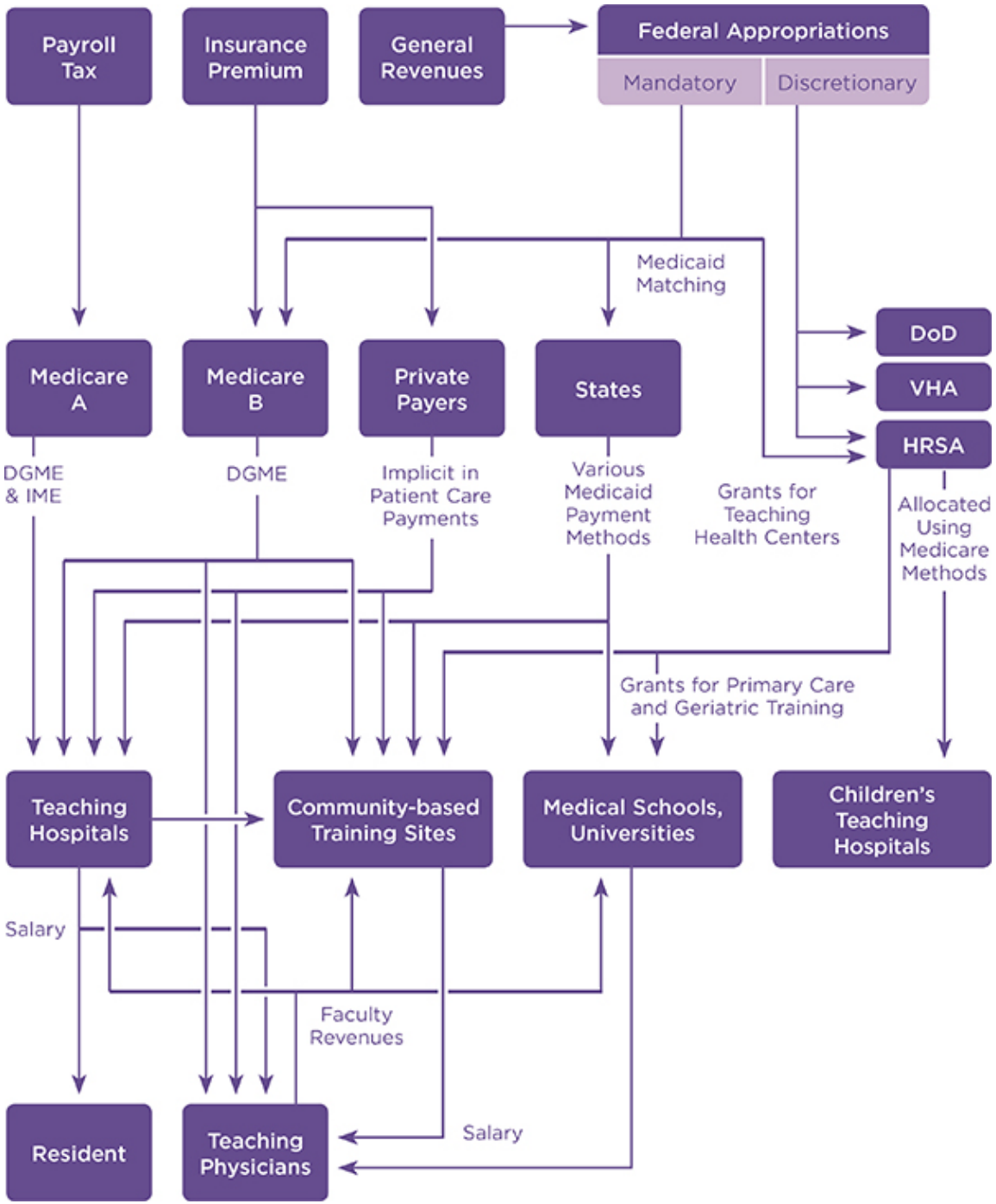
Rural Rotation:

Associated with a core program

Typically 1-2 months at rural location; can be longer

1 resident at a time

How Do We Pay For This?



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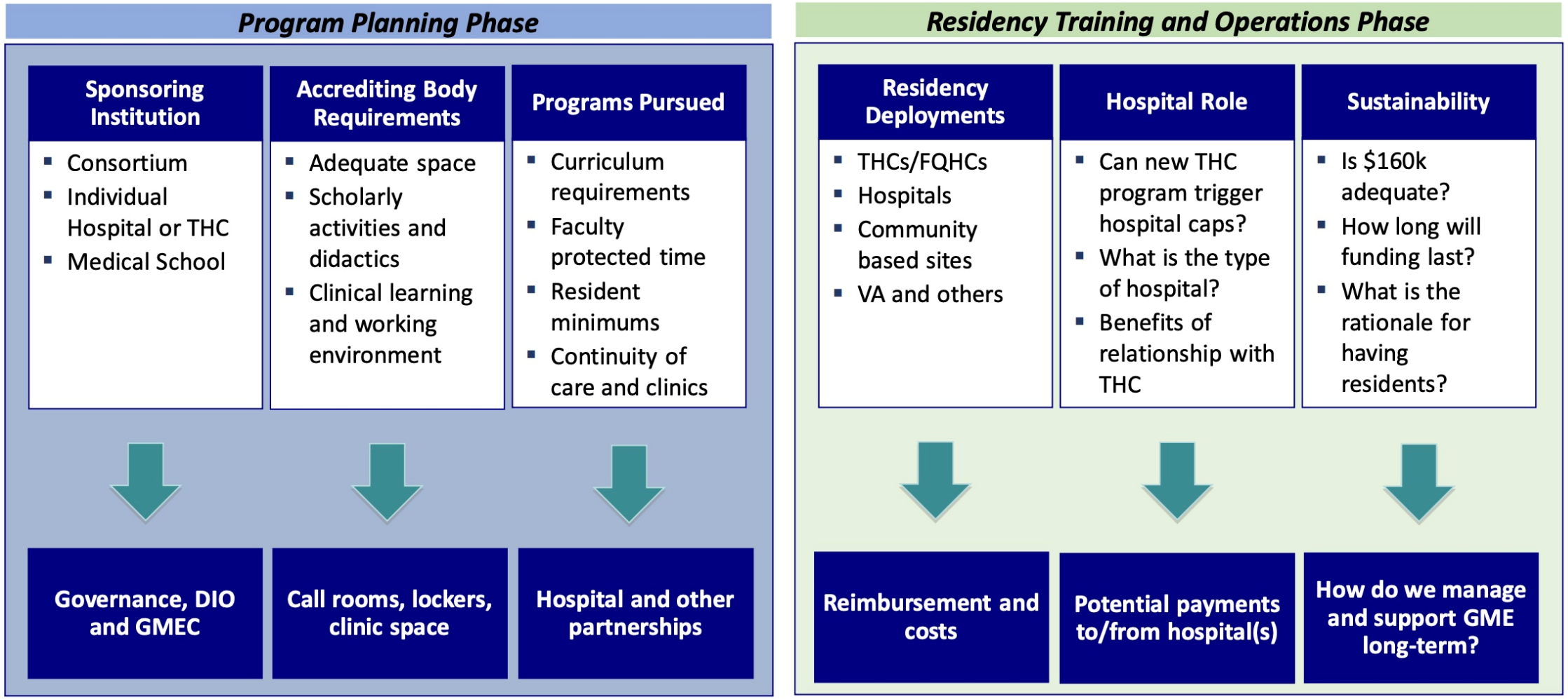


The Deep Pocket: Comparing GME financing for Health Centers versus Hospitals as the Sponsoring Institution, Christopher L. Francazio, PKFHealth, LLC

Financial Planning is Key

- Funding Projections - Revenues
- Funding Projections – Expenses

Funding can be broken into three phases:

1. Start-up
2. Program build-up and expansion
3. Continuity

https://gmecomplianceproject.org/gme-funding-accountability/

- Finances are NOT why a community starts a program, nor the only factor in the decision to do so.
- However, they ARE a critical factor in determining the viability of developing and sustaining a successful program.
- GME training is not cheap, and it depends upon government sources of funding to make it affordable for communities.

BIG Picture

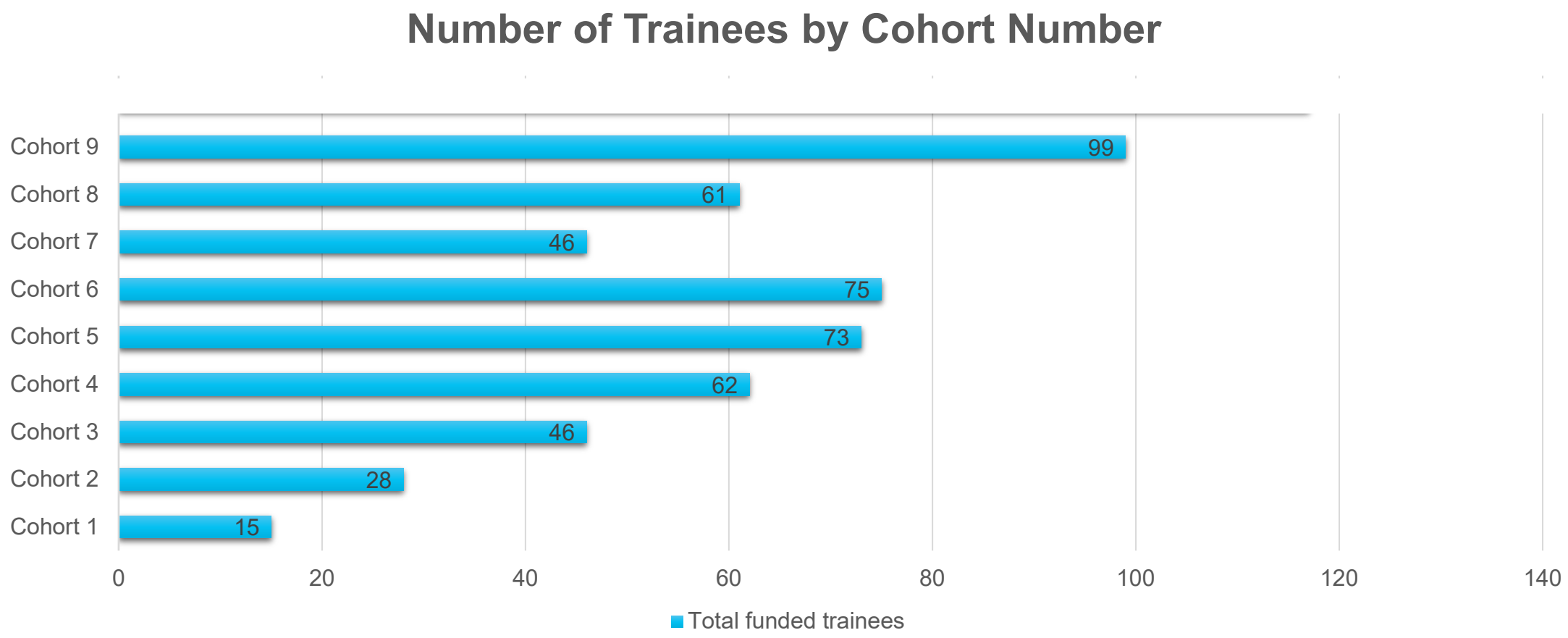
- Rough estimate – Family Medicine residency, based at a THC roughly has operating expenses that average $245,000 per resident per year (split evenly into academic and clinical care costs)
- THC funding provides $160,000 per resident per year
- Programs must have the total operating costs to be sustainable
- Revenue is split roughly in half as well (50% federal/state reimbursement and 50% clinical revenue

- Most programs will break even

VHWDA/DMAS Partnership

- Began in 2017
- Residencies are awarded $100,000 for each year of the training program for each expanded slot
- Resulted in an additional 61 slots prior to this year
- Currently at 99 supported slots
- Incentives for physicians to remain in state are not in place as yet

VHWDA/DMAS Partnership Progress



VHWDA/DMAS Partnership Progress

- Largest number of applications received for FY 2026
- Largest number of slots funded since programs' inception (55)
- Increased engagement with programs' leadership and residents in training
- This year's cycle gives programs the opportunity to place residents directly in regions where they are needed the most after graduation

Impact of Federal Medicaid Changes

- Decreased Medicaid support and decreased access to federal loans for medical school with new professional loan borrowing caps and elimination of Title VII health professional programs.
- Rural hospitals and training programs face decreased funding.
- However, there are extensions on the time programs are allowed to build their caps and expansion of tele-supervision.
- Overall, this means that we need strong collaborative efforts for continued growth and physician workforce expansion.

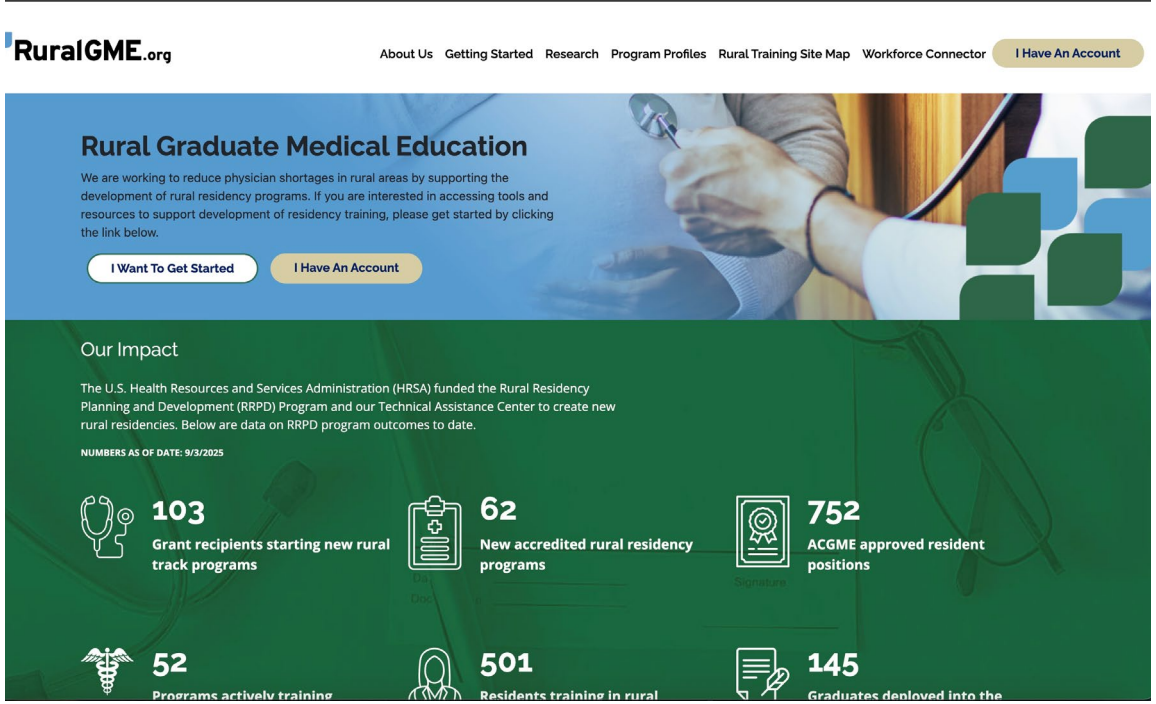
Timelines

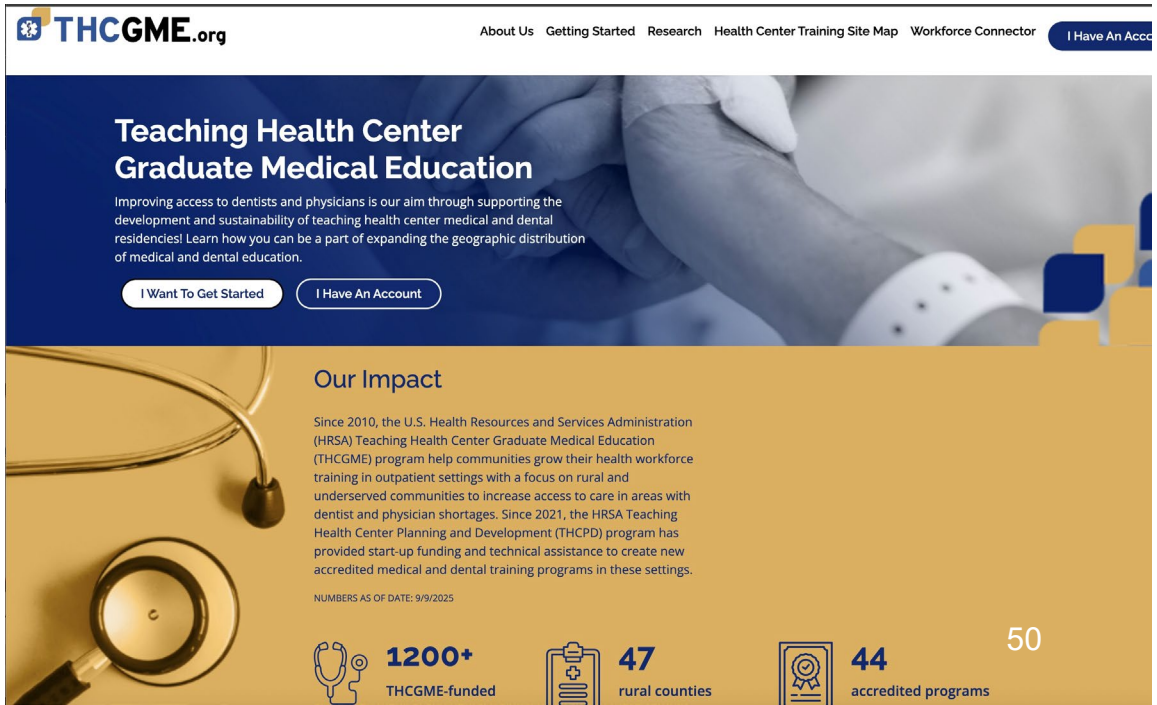
- Sponsoring Institution Accreditation: about one year
- Planning a program: one-two years
- Program accreditation: one year
- Year prior, resident recruiting: one year
- First graduate 3-5 years later

What Does Success Look Like For Us?

What Next?

- www.THCgme.org
- www.ruralgme.org
- Free resource toolkits that are informative for program creation, funding and partnership building.





RuralGME.org

Roadmap for Rural Residency Program Development

STAGE 1 Exploration

Community Assets

Identify community assets and interested parties.

Leadership

Assemble local leadership and determine program mission.

Sponsorship

Identify an institutional affiliation or sponsorship. Consider financial options and governance structure.

STAGE 2 Design

Initial Educational & Programmatic Design

Identify Program Director (permanent or in development). Consider community assets, educational vision, resources, and accreditation timeline.

Financial Planning

Develop a budget and secure funding. Consider development and sustainability with revenues and expenses.

Sponsoring Institution Application

Find a Designated Institutional Official and organize the GME Committee. Complete application.

STAGE 3 Development

Program Personnel

Appoint residency coordinator. Identify core faculty and other program staff.

Program Planning & Accreditation

Develop curricular plans, goals and objectives; evaluation system and tools; policies and procedures; program letters of agreement; faculty roster. Complete ACGME application and site visit.

STAGE 4 Start-Up

Marketing & Resident Recruitment

Create a website. Register with required systems. Market locally and nationally.

Program Infrastructure & Resources

Hire core faculty and other program staff. Ensure faculty development. Complete any construction and start-up purchases. Establish annual budget.

Matriculate

Welcome and orient new residents.

STAGE 5 Maintenance

Ongoing Efforts

Report annually to ACGME and the Sponsoring Institution. Maintain accreditation and financial solvency. Recruit and retain faculty. Track program educational and clinical outcomes. Ensure ongoing performance improvement.

Other Resources

- **HRSA - https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education**
- **Value of Training - https://www.jabfm.org/content/jabfp/32/2/134.full.pdf**
- **GME Finance Overview - file:///Users/amypaul/Downloads/JcscmTRgzBGXGqdZNJhDOevHHo0qq5tp0K1PotNz.pdf**
- **Value of Virginia CHC - https://www.nachc.org/wp-content/uploads/2025/02/2023-Value-Impact-Analysis-of-the-Virginia-Health-Center-Program.pdf**
- **AAMC Physician Dashboard - https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard**
- **DHP 2024 Physician Workforce Report - https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/medicine/0101Physician2024.pdf**
- **Robert Graham Center Physician Report Virginia - https://www.aafp.org/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Virginia.pdf?_gl=1*1tt4x6*_gcl_au*MjcyNzA2OTAuMTc1ODYzNDM3Mg..*_ga*MTc0MzY1MDEyNi4xNzU4NjM0Mzcz*_ga_Z7TFXMJE70*czE3NTg2MzQzNzMkbzEkZzEkdDE3NTg2MzQzODgkajQ1JGwwJGgw**

- Tips for Center Boards - https://www.nachc.org/wp-content/uploads/2023/04/Teaching-health-center-english.pdf
- ACGME Glossary - https://www.acgme.org/globalassets/ab_acgmeglossary.pdf
- Complexities of Physician Supply and Demand - https://www.aamc.org/media/75231/download?attachment
- The Wright Center SI - https://thewrightcenter.org/graduate-medical-education/sponsoring-institutional-framework/
- Benefits of developing graduate medical education programs in community health systems - https://pmc.ncbi.nlm.nih.gov/articles/PMC8462840/pdf/ZJCH_11_1961381.pdf

Summary

•A coordinated statewide GME model reduces administrative burden and strengthens partnerships.

•Residents gain balanced training across inpatient and community sites.

•FQHCs benefit from stable resources and workforce development.

•Virginia gains a stronger pipeline of physicians equipped to serve underserved areas.

VHWDA

VIRGINIA HEALTH WORKFORCE DEVELOPMENT AUTHORITY

Thank you!

Contact: Amy Paul

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(804) 512-4701