A Study of Physician Recruitment and Retention Using Residency Development

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CONTENTS

OVERVIEW

Aim. This article introduces residency development within a community health center (FQHC based teaching center) setting as a form of workforce development that can be used for physician recruitment and retention in South Los Angeles.

Background. South Los Angeles has a shortage of well over five hundred physicians. This physician shortage contributes to the current issue of healthcare access. Through better physician recruitment and retention strategies we can increase physician numbers and thus healthcare access with the hope of improving medical services and treatment availability for impoverished regions.

Methods. Assessment of need in South LA through mapping of Los Angeles County residency programs, hospitals and community health centers. A descriptive study of themes and best practices during residency development which were generated through interviews conducted with five successful Community Health Center residency programs. A survey of 189 medical students from three medical schools to assess the most important factors and incentives when applying to and accepting residency positions.

Results. NEEDS ASSESSMENT: No residency programs currently exist within SPA 6, a region commonly used to define the boundaries of South LA. RESIDENCY DEVELOPMENT: Six categories were used to compare the five interviewed residency programs: Program Affiliation, Timeline, Funding, Recruitment, Pros, and Cons. There is much overlap between each program. All five interviewees indicated that the residency program makes a significant difference in recruitment and retainment of physicians in their region. RESIDENCY RECRUITMENT: Interestingly mission to serve an underserved population and number of residents per attending ranked higher than salary when medical school students were asked which factors are most important when applying to a residency program. This is fortuitous because obtaining financial resources is a challenge for community health centers. Many medical students additionally felt program atmosphere including faculty attitude was an important factor when choosing a residency program.

Discussion. Community health center (CHC) residency program development is a strategy to consider for physician recruitment and retainment within an underserved community such as South LA. The CHC setting may create a pipeline of physicians into the community, and while it will not resolve the physician shortage within South LA, it does have the potential to stem current and future physician shortages.

BACKGROUND

With the implementation of the Patient Protection and Affordable Care Act (ACA), the United States health care system will face many challenges over the next few years. One of which being the influx of Americans receiving health insurance for the first time as adults. It is my opinion that this will cause a flood of need which will exacerbate the current nationwide physician shortage crisis. Current projections suggest the physician shortage will reach 63,000 by 2015.[4] South Los Angeles is not exempt from this medical predicament as it has been projected that the ACA will increase health care coverage to between four and six million Californians.[1]

The lack of medical resources in South LA has been a well known problem for many years. Recent data from The Camden Group presented a physician needs analysis stating of the following three primary care specialties: Family Practice, Internal Medicine and Pediatrics, there is currently a 500 MD FTE physician shortage in a region that serves more than a million people. This information was obtained through Community Health Councils' (Los Angeles) personal correspondence with a member of The Camden Group.[2] The low physician to population ratio creates an enormous burden on an already struggling community. Through better physician recruitment and retention strategies in South LA we can increase MDs and thus healthcare access with the hope of improving medical services and treatment availability for impoverished regions.

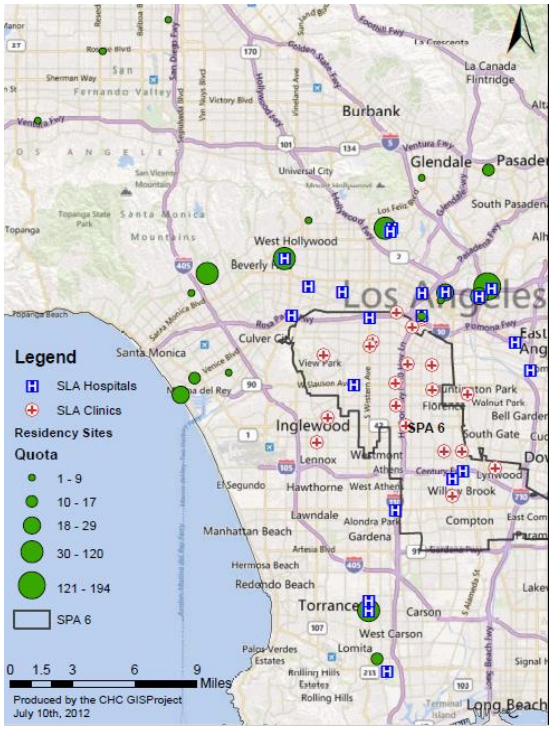
There are many strategies used by community planners in physician workforce development. Some of which include an increase in residency programs, physician incentives, telemedicine, recruitment of midlevel practitioners, and international medical graduate programs. It is imperative to understand that a single approach to workforce development will not resolve the physician shortage crisis. A multi-pronged effort should be made, and all approaches should be attempted, particularly in an underserved community such as South LA.

The objective of this paper is to address one aspect of physician recruitment and retention, residency program development within established community health centers (FQHC based teaching center). Following an assessment of the need for residency programs within South LA, I used Semi-structured interviews of current community health center (CHC) residency programs in an attempt to understand some of the common themes and best practices used during the development of each program. To further assist in efficient and effective residency implementation, a survey was conducted of 189 medical students to assess which factors were of highest importance when applying to residency programs and which incentives would be most effective for recruitment.

NEEDS ASSESSMENT

BACKGROUND

Physicians who have lived or worked in an underserved area are more likely to choose the location of their practice based on personal motivators, such as a mission to serve an underserved community, versus career motivators, like set hours of work and lifestyle. However, if a physician has never lived or worked in an underserved area they are significantly less likely to choose their practice location based on personal motivators and more likely to choose based on career motivators.[5]



METHODS

Residency programs within Los Angeles County were located and mapped. Hospitals which serve the Service Planning Area 6 (SPA 6) population and CHCs within SPA 6 were mapped alongside the residency programs. The SPA 6 area is used for precise region delineation.

RESULTS

SPA 6 contains zero residency programs. However, one residency program (California Hospital Medical Center (LA)/University of Southern California) borders SPA 6, and this program's patient population is primarily residents of South LA.

CONCLUSION

Based on the lack of residency programs in South Los Angeles, I believe a successful strategy in physician recruitment and retainment should include residency development as part of a multi-pronged effort in workforce development to stem current and future physician shortages. The process of residency development will be further explored to assess themes and best practices associated with implementation of a program and the sustainability of those programs.

RESIDENCY DEVELOPMENT

BACKGROUND

The Los Angeles County Martin Luther King, Jr. Medical Center closed in 2007. With that closing, 250 medical resident slots were lost, resulting in a 15% reduction of total residency positions within Los Angeles (LA) County.[7] In my opinion, termination of this large residency program has caused an increased strain on the already significant physician shortage in South LA. While there are some hospitals in the SPA 6 region, I believe the Community Health Center-Teaching Health Center model of a "community-based, ambulatory patient care center" which "operates a primary care residency program" could be an effective approach to residency development in response to the South LA physician shortage.[9]

METHODS

I designed a questionnaire to give a general assessment of the timeline and costs associated with developing a CHC residency program. The questionnaire also included a geographic profile, patient profile, strategies for recruitment, advantages of a CHC residency program, and challenges of a CHC residency program. By understanding the experiences of previously established CHC residency programs, we can use this information to better determine if their approach during development can be successfully implemented within the South LA community.

Five questionnaires were completed. Four interviews were conducted by telephone, and one was administered in person and supplemented by a written questionnaire. Each telephone interview was digitally recorded and transcribed. Some information was obtained via online resources.

RESULTS

For complete copies of the questionnaires see Appendices A-E.

Program Affiliation: Four of the five residency programs used a similar tripartite model made up of a CHC, a University, and a hospital. In general, the FQHC provided the residency site, the University oversaw the education aspect including accreditation, and the hospital allowed for inpatient training rotations, funding, and/or planning.

Timeline: The timeline from conception to implementation ranged from half a year to greater than two years. The half a year timeline is unusual and was actually an expansion to an already existing residency program.

Funding: There was a significant variance in cost as well as a large range of funding sources.

Recruitment: While recruitment may have been difficult initially, over time there have been no significant issues with filling their program slots.

Pros: All five interviewees indicated that the residency program makes a significant difference in recruitment and retainment of physicians in their region. Two of the interviewees indicated the residency program increases innovation and encourages maintenance of current standards of care.

Cons: Each interviewee discussed the financial challenges of starting and maintaining a residency program. Four of five interviewees stated that starting a residency program is difficult and complex. Three of five interviewees associated a perceived decrease in the quantity and quality of care from a lack of consistency of the residents' schedule. Three of five interviewees indicated that changing the community health center mission from a patient centered mission to a dual mission of education and quality care to be extremely challenging.

CONCLUSION

Start up of a residency program is a difficult process. Despite the challenges, the benefit of physician recruitment in an area that has a shortage of physicians could make a significant difference in the access to health care provided to that community. It is my opinion that for a CHC to be truly committed to patient care it also has a duty to quality training of residents. Through the adoption of evidence based guidelines such as a patient-centered medical home model and a physician-led care team approach, many of the residency start-up difficulties could be absolved, particularly the financial and the perceived decrease in quantity and quality of care.[3]

While a residency program will not in itself solve difficulties with physician recruitment and retainment, it may improve the situation and should be investigated along with lookalike models. Examples of lookalike models include implementing a one month rotation at a CHC or hosting medical students for a month. This exposure to an underserved region impacts the career choices of medical professionals and increases their personal motivation to work in an impoverished community.[6]

RESIDENCY RECRUITMENT

BACKGROUND

Recruitment to a new residency program may be a challenge. The added aspect that South LA is an urban minority community with a high percentage of residents living under the federal poverty level and using social service programs such as Medicaid and CHIP, may add an additional hurdle in the recruitment process. A survey was conducted to better understand what factors are primary motivators for medical students and what incentives are the most significant.

METHODS

I designed a survey to assess location barriers, key factors in the application process, the most appealing incentives, and what features are necessary for each medical student to accept a residency in South LA. The survey was conducted via the web through SurveyMonkey.com, LLC.[10]

The survey was emailed to current medical students graduating in 2013, 2014, or 2015. Three schools were surveyed including 347 students from Johns Hopkins University School of Medicine, 481 students from University of Oklahoma College of Medicine, and 278 students from Oklahoma State University College of Osteopathic Medicine.

RESULTS

Analysis provided by Theresa Jackson and Rad Cunningham, Community Health Councils, Inc.

Of the 1106 students surveyed over a 14 day period, 189 responded.

Respondent School	n	%
Johns Hopkins University School of Medicine	43	22.8
Oklahoma State University College of Osteopathic Medicine	73	38.6
University of Oklahoma College of Medicine	69	36.5
Unknown	4	2.1

Ranking Average of Important Factors when Applying to a Residency Program (1=Most Important)

1. Specialty (e.g. Family Medicine, Orthopedic Surgery)
2. Location
3. Prestige
4. Number of residents per attending
5. Mission to serve an underserved area or population
6. Salary
7. Research opportunity

From the survey data, 86 students commented on additional factors which are considered when applying to a residency program. Examples of responses include: fellowship opportunities, atmosphere of the program including faculty attitude, board pass rate, accreditation status, opportunity for training in other languages, global opportunities, community opportunities, time allotted for healthy lifestyle, and quality of life. 35 of the 86 comments indicated atmosphere of the program, including the faculty attitude, was of high importance when selecting a residency. Those that indicated atmosphere an important factor had a mean ranking of “a mission to serve an underserved area or population” of 4.29

versus the survey ranking average of 4.69. For a complete list of responses and how they were categorized see Appendix F.

Ranking Average of Incentives when Considering a Residency Program (1=Most Appealing)

1. Benefits (e.g. health insurance, life insurance)
2. Student Loan repayment
3. Sign-on bonus
4. Set work week with limited call and weekend hours
5. Relocation allowance
6. Vacation time
7. Free or Reduced cost housing
8. Maternity or Paternity Leave
9. Performance Bonuses
10. Onsite childcare
11. Tuition support for MPH and other degree programs

When asked about barriers to acceptance of a residency program in South Los Angeles, 95 plausible solutions were presented. These solutions were divided into 5 categories: quality residency program, financial incentives, student loan repayment, housing assistance, and lifestyle. Safety was a common response, but was not included because residency programs do not affect crime rates within a region. The following table shows the number of students that indicated a category would be necessary to accept a residency in South Los Angeles. 43 students indicated 2 or more of the following categories. For a complete list of responses and how they were ranked see Appendix G.

Barriers to Acceptance of a Residency Program in South LA	**Number of Students**
Quality Residency Program	46
Financial Incentives	36
Student Loan Repayment	33
Housing Assistance (relocation bonus or reduced cost housing)	23
Lifestyle (set work week, increased vacation time, etc.)	13

There was no significant correlation between incentive ranking when comparing students who had and had not considered a residency in an underserved area. (Chi2 Test of Significance)

There was no significant change in incentive ranking based on year in medical school. (Pearson Chi2)

Although not significant, there appears to be a trend among students who have considered a residency in an underserved area and ranked performance bonuses more highly. (Chi2 p=0.060)

Students who are considering residencies on the west coast trend less likely to rank maternity and paternity leave highly (Chi2 p=0.084) and are significantly more likely to rank free or reduced housing highly. (Chi2 p=0.025)

Students are very likely to consider residencies in the same region as their medical school (40 out of 43 for Johns Hopkins University School of Medicine, 66 out of 73 for Oklahoma State University College of Osteopathic Medicine, 61 out of 69 for the University of Oklahoma College of Medicine).

CONCLUSION

Filling residency slots may be difficult for a new residency program particularly for those serving underserved communities. By understanding the priorities of medical students, a residency program can potentially avoid challenging years with an unfilled quota. The data obtained from surveying medical students may be helpful in recruiting not only residents, but also provide incite for incentives when recruiting more experienced physicians. In an underserved region resources are often scarce. By recognizing the importance of child care, vacation time, or sign-on bonuses, etc., CHCs and other medical institutions that struggle with filling positions can use this information to better recruit quality applicants. Other avenues beneficial to medical organizations that are understaffed include more efficient recruitment. A paper by The Advisory Board Company discusses the use of pre-interview screening and personalized recruiting to reduce costs and increase placement-to-recruiter ratios.[8]

DISCUSSION

Addressing the physician shortage within South LA is an important aspect of improving healthcare access for this underserved community. While there are many strategies for addressing this problem, residency development is potentially one important aspect to medical workforce development. Because of the abundance of CHCs within South LA, a residency program within a CHC should be considered as a strategy for physician recruitment and retainment. By training residents within the unique setting of a CHC, young physicians will be encouraged to establish their future practices within the South LA community. Though residency program development will not in itself resolve the physician shortage crisis, it may reduce the shortfall in medical personnel and ultimately increase healthcare access.

It should also be noted that while improving the physician shortage is important for healthcare access, U.S. healthcare reform is a much bigger problem than strictly providing additional doctors. Enhanced population health, quality healthcare, and payment reform must be addressed to attain better health outcomes and improved patient satisfaction at a decreased cost; it is only through this triple aim approach will we be able to transform U.S. healthcare into a healthcare system which provides more efficient, more effective and cost controlled care.[3]

REFERENCES

1. Bates T, Blash L, Chapman Susan, et al. California's health care workforce. Are we ready for the ACA? Center for the Health Professions at UCSF. Revised Dec. 1, 2011.
2. Casey China. Research Associate. Community Health Councils, Inc. 3731 Stocker Street, Suite 201 Los Angeles, CA 90008. The Camden Group methodology used for their 2012 Physician Needs Analysis is currently unavailable.
3. Donald M Berwick, Thomas N, and John W. The triple aim: care, health, and cost. Health Affairs. 27, no.3 (2008):759-769.
4. Frellick, Marcia. The nurse practitioner will see you now. Advanced practice providers fill the physician gap. Hosp Health Netw. 2011 Jul;85(7):44-6, 48-9
5. Nutting Paul A, Benjamin C, William M, et al. Transforming physician practices to patient-centered medical homes: Lessons from the national demonstration project. Health Affairs. 30, no.3 (2011):439-445.
6. Odom Walker K, Ryan G, Ramey R, et al. Recruiting and retaining primary care physicians in urban underserved communities: The importance of having a mission to serve. Am J Public Health. 2010 Nov;100(11):2168-75.
7. Rosenblatt, Susanna. Hospital could lose 250 resident positions, *Los Angeles Times*, March 1, 2007.
8. The Advisory Board Company. Creating a "gold standard" physician recruitment strategy. March 23, 2004. Available at http://www.aspr.org/associations/10362/files/article-Gold%20Standard.pdf.
9. The patient protection and affordable care act of 2010, Pub. L. No. 111-148. http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.
10. Theresa Jackson, *Medical student incentive survey*, http://www.surveymonkey.com/s/YVC2KLT (July 22, 2012).

APPENDIX A

KEY ELEMENTS AND BEST PRACTICES OF SUCCESSFUL COMMUNITY HEALTH CENTER RESIDENCY DEVELOPMENT

NAME OF PROGRAM: CALIFORNIA HOSPITAL MEDICAL CENTER (LOS ANGELES)/UNIVERSITY OF SOUTHERN CALIFORNIA PROGRAM AT EISNER PEDIATRIC AND FAMILY MEDICINE CENTER

PRIMARY CONTACT: CARL COAN
PRIMARY CONTACT E-MAIL AND/OR PHONE NO.: CCOAN@PEDCENTER.ORG / 213-746-1037 EXT 3330

SECONDARY CONTACT: JIM DOUGLAS
SECONDARY CONTACT E-MAIL AND/OR PHONE NO.: JIM@JHDASSOCIATES.NET / 213-718-9499

DATES OF PROGRAM IMPLEMENTATION: 07/01/11

LOCATION OF PROGRAM: LOS ANGELES (SPA 6)

GEOGRAPHIC PROFILE:

TOTAL POPULATION: > 1 MILLION PERCENT M: 48.8 PERCENT F: 51.2

MEDIAN HOUSEHOLD INCOME: $27,303 PERCENT POPULATION BELOW FPL: 28.3%

RACE / ETHNICITY:
- 63.6% PERCENT LATINO / HISPANIC
- 32.4% PERCENT AFRICAN-AMERICAN
- 2.2% PERCENT CAUCASIAN
- 1.6% PERCENT ASIAN – PACIFIC ISLANDER
- 0.2% PERCENT OTHER

PERCENT W/ HS DEGREE: 60.7% PERCENT W/COLLEGE DEGREE OR HIGHER: 9.4%

PATIENT PROFILE:

TOTAL NO. OF PATIENTS SERVED PER YEAR: 26,211

AVERAGE AGE :
- 0-5 years 5,888 (22.46%)
- 6-12 years 3,038 (11.59%)
- 13-18 years 4,311 (16.45%)
- 19-64 years 12,597 (48.06%)
- 65+ years 377 (1.44%)

AVERAGE INCOME OF PATIENTS:
- 100% and below: 89.92%
- 101-150%: 8.45%
- 151-200%: .86%
- Over 200% .77%

SERVICES PROVIDED: PRIMARY CARE, WOMEN'S HEALTH, PEDIATRICS, DENTAL, BEHAVIORAL AND MENTAL HEALTH, PHARMACY, DIABETES MANAGEMENT

RACE / ETHNICITY:
- 88.28% PERCENT LATINO / HISPANIC
- 7.5% PERCENT AFRICAN-AMERICAN
- 1.35% PERCENT CAUCASIAN
- 1.09% PERCENT ASIAN – PACIFIC ISLANDER
- 1.79% PERCENT OTHER

PERCENT OF PATIENTS WITH PRIVATE INSURANCE: 1.29%
PUBLIC INSURANCE: 53.25%
NO INSURANCE: 45.45%

PROGRAM DEVELOPMENT: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

NAME THE FACILITIES THAT WERE INVOLVED IN DESIGNING AND IMPLEMENTING THE PROGRAM (HOSPITALS, COMMUNITY HEALTH CENTERS, COMMUNITY-BASED ORGANIZATIONS, UNIVERSITIES ETC.) WHAT ROLE DID EACH PLAY? WHAT DID EACH CONTRIBUTE?

UniHealth Foundation = Planning Grant = funding
California Hospital = NAP application + planning grant
USC = NAP application + project evaluation
Eisner PFMC = NAP application, licensing application, budget development, legal review,
Latham & Watkins + Locke Lord LLP = legal review

HOW MANY PHYSICIAN FTES WORKED AT THE COMMUNITY HEALTH CENTER WHEN PROGRAM DEVELOPMENT BEGAN? ____

PHYSICIAN ASSISTANTS/NURSE PRACTITIONERS? 3.1
REGISTERED NURSES?
CERTIFIED NURSE MIDWIVES? 0
LICENSED VOCATIONAL NURSES? 0.5
DENTISTS? 0
MEDICAL ADMINISTRATORS? 13.5

Note: The residency clinic was not an FQHC when development started.

PLEASE DESCRIBE THE TIMELINE FOR PROGRAM DEVELOPMENT.

Initial discussions began in 2010. NAP LOI & application filed in August and December 2010. Decision to make a CIS (change in scope) required in February 2011. CIS, license and key agreements signed in June 2011.

WHAT WERE THE FINANCIAL COSTS TO DEVELOP THE PROGRAM? HOW WAS PROGRAM DEVELOPMENT FUNDED (E.G. PUBLIC OR PRIVATE GRANTS)

About $250,000 in a grant from UniHealth Foundation. Grant submitted by California Hospital Foundation.

DID YOU USE A RESIDENCY PROGRAM CONSULTANT TO HELP FACILITATE START UP AND DEVELOPMENT? IF SO, WHAT WERE THE COSTS INVOLVED WITH THAT SERVICE? WHAT WAS MOST HELPFUL?

Jim Douglas – lead private consultant
Teri Jolin – Developed NAP application
Curt Degenfelder – finance consultant
Latham & Wakins + Locke Lord LLP - Legal

WHAT ADDITIONAL RESOURCES DID YOU UTILIZE? USC Attorneys

PROGRAM BASICS: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

WHAT TYPES OF RESIDENCY PROGRAMS DO YOU OFFER? (E.G. PRIMARY CARE, INTERNAL MEDICINE)

OVERALL, EPFMC IS INVOLVED IN RESIDENCY TRAINING IN

- Family Practice
- Pediatrics
- OB/GYN
- Adolescent Medicine (fellowship)

HOW MANY PGY-1 RESIDENTS ARE MATCHED ANNUALLY? DO YOU EVER NOT MATCH ALL SLOTS?

8 Residency Slots

WHAT IS THE AVERAGE PGY-1 ANNUAL SALARY NOT INCLUDING BONUSES, RELOCATION ALLOWANCES OR ANY OTHER INCENTIVES?

	CALIFORNIA HOSPITAL MEDICAL CENTER/UNIVERSITY OF SOUTHERN CALIFORNIA PROGRAM AT EISNER			**LOS ANGELES COUNTY-HARBOR-UCLA MEDICAL CENTER PROGRAM**			**UCLA MEDICAL CENTER PROGRAM**		
Grad Year	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**
1	$44,100	4	5	$43,956	4	8	$48,259	4	12
2	$48,300	4	5	$49,176	4	8	$50,003	4	12
3	$51,500	4	5	$53,284	4	8	$52,069	4	12

WHAT IS THE AVERAGE HOURS PER WEEK ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? 68 hours
WHAT ARE THE MAXIMUM CONSECUTIVE HOURS ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? 16 hours
WHAT ARE THE AVERAGE NUMBER OF 24-HOUR OFF DUTY PERIODS PER WEEK DURING FIRST YEAR? 1.2
DOES THIS PROGRAM ALLOW MOONLIGHTING? YES
DO YOU OFFER A RELOCATION ALLOWANCE? NO
DO YOU OFFER RENT/HOUSING ASSISTANCE FOR RESIDENTS? NO
DO YOU OFFER PERFORMANCE BONUSES TO RESIDENTS? NO
DO YOU OFFER ON-SITE CHILD CARE? NO

WHAT ARE SOME ADDITIONAL CRITICAL COMPONENTS OF THIS RESIDENCY PROGRAM?

Exposure to other programs of EPFMC such as M.H., peds, and dental.

WHAT ARE SOME PROS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

Helps in recruitment. Keeps graduates in the community.

WHAT ARE SOME CONS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

The family practice residency has a prescribed physical plant requirement.
Can slow down productivity

HOW MANY RESIDENTS GO ON TO PRACTICE MEDICINE IN YOUR COMMUNITY? Don't know exact number.

THANK YOU FOR PARTICIPATING IN OUR SURVEY. YOUR INPUT IS VERY VALUABLE TO US AS WE WORK TO IMPROVE OUR COMMUNITY AND ACCESS TO QUALITY HEALTHCARE IN OUR COMMUNITY.

REFERENCES

1. Coan, C E. Interview + Questionnaire. June 28, 2012
2. Eisner Pediatric & Family Medical Center. Available at http://www.pedcenter.org/
3. Key Indicators of Health by Service Planning Area. Available at http://publichealth.lacounty.gov/wwwfiles/ph/hae/ha/keyhealth.pdf
4. Service Planning Area 6 – Disease Burden Profile. Available at http://149.142.76.35/interventions/coordinated_networks/SPA6_profile_061003.pdf

APPENDIX B

KEY ELEMENTS AND BEST PRACTICES OF SUCCESSFUL COMMUNITY HEALTH CENTER RESIDENCY DEVELOPMENT

NAME OF PROGRAM: NORTHERN NEW MEXICO FAMILY PRACTICE RESIDENCY PROGRAM

PRIMARY CONTACT: JOHN CASSIDY
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SECONDARY CONTACT: DR. MARIO PACHECO
SECONDARY CONTACT E-MAIL AND/OR PHONE NO.: mario.pacheco@stvin.org / 505-913-3985

DATES OF PROGRAM IMPLEMENTATION: 1998

LOCATION OF PROGRAM: SANTA FE, NM

GEOGRAPHIC PROFILE: *PLEASE PROVIDE THE FOLLOWING POPULATION DEMOGRAPHICS FOR THE CITY, COUNTY, REGION, OR OTHER LOCATION IN WHICH THE PROGRAM WAS IMPLEMENTED.*

TOTAL POPULATION: 67,947 PERCENT M: 47.4% PERCENT F: 52.6%

AVERAGE HOUSEHOLD INCOME: $34,428 PERCENT POPULATION BELOW FPL: 14.8%

RACE / ETHNICITY:

48.7%	PERCENT LATINO / HISPANIC
1.0%	PERCENT AFRICAN-AMERICAN
46.2%	PERCENT CAUCASIAN
1.5%	PERCENT ASIAN – PACIFIC ISLANDER
2.6%	PERCENT OTHER

PERCENT W/ HS DEGREE: 88.1% PERCENT W/COLLEGE DEGREE OR HIGHER: 44.3%

PATIENT PROFILE: *PLEASE PROVIDE THE FOLLOWING INFORMATION FOR YOUR PATIENT POPULATION. (TO THE BEST OF YOUR ABILITY).*

TOTAL NO. OF PATIENTS SERVED PER YEAR: 19,700

AVERAGE INCOME OF PATIENTS: <$15,000 AVERAGE AGE : 25

SERVICES PROVIDED: MEDICAL, OB, DENTAL, BEHAVIORAL HEALTH

RACE / ETHNICITY:

75%	PERCENT LATINO / HISPANIC
2%	PERCENT AFRICAN-AMERICAN
20%	PERCENT CAUCASIAN
2%	PERCENT ASIAN – PACIFIC ISLANDER
1%	PERCENT OTHER

PERCENT OF PATIENTS WITH PRIVATE INSURANCE: 5%

PUBLIC INSURANCE: 25%
NO INSURANCE: 70%

PROGRAM DEVELOPMENT: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

NAME THE FACILITIES THAT WERE INVOLVED IN DESIGNING AND IMPLEMENTING THE PROGRAM (HOSPITALS, COMMUNITY HEALTH CENTERS, COMMUNITY-BASED ORGANIZATIONS, UNIVERSITIES ETC). WHAT ROLE DID EACH PLAY? WHAT DID EACH CONTRIBUTE?

University of New Mexico – institution support, accreditation and previously provided some program preceptors
La Familia Medical Center – all staff support and supervision of residents; outpatient clinic
St. Vincent's Regional Medical Center – inpatient training

CAN YOU GIVE A SENSE OF THE SIZE OF THIS COMMUNITY HEALTH CENTER WHEN PROGRAM DEVELOPMENT BEGAN?

	FTE STAFF AT PROGRAM DEVELOPMENT	CURRENT FTE STAFF
PHYSICIAN	4	12
PHYSICIAN ASSISTANT/NURSE PRACTITIONER	2	5
REGISTERED NURSE	2	6
CERTIFIED NURSE MIDWIVES	0	2
LICENSED VOCATIONAL NURSES	6	6
DENTISTS	1	5
MEDICAL ADMINISTRATORS	1	1 MEDICAL & 1 DENTAL

PLEASE DESCRIBE THE TIMELINE FOR PROGRAM DEVELOPMENT.

The residency program did not start up immediately. For the first two years, La Familia was a rotation site for a residency program in Albuquerque. By allowing the community health center to begin as a rotation site, it allowed the CHC faculty to become familiar with the mission of education. During this period the hospital and university helped fund the faculty salary that was needed to oversee the residents at La Familia. One barrier to a CHC becoming a rotation site is who pays the resident salary during the period they are not working at the hospital. In this situation the hospital paid the salaries because they felt that they were investing in their future workforce.

During this two year rotation period, it allowed La Familia and UNM to explore their interest in a residency program. They concluded that the best avenue would be a one year internship in Albuquerque followed by two years at La Familia.

WHAT WERE THE FINANCIAL COSTS TO DEVELOP THE PROGRAM? HOW WAS PROGRAM DEVELOPMENT FUNDED (E.G. PUBLIC OR PRIVATE GRANTS)

Initially the University lost a lot of money until 2002/3 when legislation allowed for redistribution of residency slots. They now are able to receive some Medicare funding however the hospital does take about a $400,000/year loss. However, the hospital still sees the residency program as beneficial because most residents stick around and are recruited into the hospital or La Familia.

Total Cost = $600,000 / year (~$100,000 per resident)

- Robert Wood Johnson Foundation = $10,000 for start-up costs
- Medicare GME Funding to St. Vincent's = the hospital pays resident salaries ($50,000/ resident / year)
- LFMC receives ~$200,000 for residency training costs from the hospital's GME funding
- HRSA Grant = $150,000/year for 3 years

DID YOU USE A RESIDENCY PROGRAM CONSULTANT TO HELP FACILITATE START UP AND DEVELOPMENT? IF SO, WHAT WERE THE COSTS INVOLVED WITH THAT SERVICE? WHAT WAS MOST HELPFUL?

Dr. Pacheco was the primary residency developer however he utilized the expertise of the residency director in Albuquerque and the chair of the family medicine residency program. This allowed them to save a little money with start-up costs by not paying a consultant.

WHAT ELSE SHOULD I KNOW ABOUT THIS RESIDENCY PROGRAM?

The biggest advantage for this program was having three different institutions interested in developing a residency program, but none of them able to do it on their own. However on the one hand they all feel responsible to each other, but at the same time no one took full ownership of the program.

St Vincent was not able to collect GME funding, and UNM, at that time, needed residents in the hospital to collect Medicare funding. That would be an issue since most of a family medicine residency is spent at other sites.

PROGRAM BASICS: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

WHAT TYPES OF RESIDENCY PROGRAMS DO YOU OFFER? (E.G. FAMILY MEDICINE, INTERNAL MEDICINE)

Family Medicine w/ a strong focus on OB

HOW MANY PGY-1 RESIDENTS ARE MATCHED ANNUALLY?

PGY-1 = 4
PGY-2 = 4
PGY-3 = 3

WHAT IS THE AVERAGE PGY-1 ANNUAL SALARY NOT INCLUDING BONUSES, RELOCATION ALLOWANCES OR ANY OTHER INCENTIVES?

	LA FAMILIA MEDICAL CENTER RESIDENCY PROGRAM			UNIVERSITY OF NEW MEXICO (ROSWELL) RURAL PROGRAM			MEMORIAL MEDICAL CENTER (LAS CRUCES) PROGRAM		
Grad Year	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**
1	$46,131	3	21	$46,131	3	5	$43,000	3	5
2	$48,007	3	21	$50,776	3	5	$45,000	3	5
3	$49,740	3	21	$52,509	3	5	$47,000	3	5

WHAT IS THE AVERAGE HOURS PER WEEK ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? 70 hours
WHAT ARE THE MAXIMUM CONSECUTIVE HOURS ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? 16 hours
WHAT ARE THE AVERAGE NUMBER OF 24-HOUR OFF DUTY PERIODS PER WEEK DURING FIRST YEAR? 1.0
DOES THIS PROGRAM ALLOW MOONLIGHTING? YES
DO YOU OFFER A RELOCATION ALLOWANCE? IF SO HOW MUCH? YES, $1000 FROM ALBUQUERQUE TO SANTA FE AND AN ADDITIONAL $500/MONTH DURING THEIR 2ND AND 3RD YEARS SPENT IN SANTA FE
DO YOU OFFER RENT/HOUSING ASSISTANCE FOR RESIDENTS? NO
DO YOU OFFER PERFORMANCE BONUSES TO RESIDENTS? NO
DO YOU OFFER ON-SITE CHILD CARE? NO

ARE THERE ANY CHALLENGES ASSOCIATED WITH RECRUITMENT?

They generally have no difficulty recruiting residents to fill the program slots. The community health center setting draws many residents to the program, along with the strong OB focus and the lifestyle that Santa Fe allows.

WHAT ARE SOME PROS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

Our providers enjoy the teaching responsibility. It also serves as a recruiting mechanism for our business. It has been fairly common to hire residents directly out of the residency program.

WHAT ARE SOME CONS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

La Familia's mission is to provide care to the underserved. Residents shift the attending's focus to teaching. This decreases the number of patients who are served and can cause a financial strain thus exacerbating the challenge of lack of resources that is associated with many residency programs and community health centers.

Another hurdle is the difficulty of managing a resident's practice since they are often part time at La Familia. For example, if a patient is seen on Monday, they may be unaware that this resident only works on Mondays. So when they call Thursday with questions, it creates a problem with who takes their call and helps with management of care. La Familia's solution has been to have each resident cover for each other. In a sense, they are each a partner and take each other's calls throughout the week. If a question is to complex a patient will certainly be referred to an attending.

HOW MANY RESIDENTS GO ON TO PRACTICE MEDICINE IN YOUR COMMUNITY?

80% of residents trained at LFMC remain in New Mexico versus only 25% trained at UNM. Those that do leave tend to continue working in community-based careers.

IS THERE ANYTHING ELSE PERTINENT THAT YOU WOULD LIKE US TO KNOW?

Starting a residency program is a challenge. It is key that your providers are excited about teaching and attending. When John Cassidy began at La Familia he met with the physicians and discussed at great length whether the residency program was something everyone wished to continue. The response he got was an overwhelming desire to continue the mission of education.

Another important point to keep in mind is residency programs are very expensive. La Familia has gotten extensive money from UNM and had amazing leadership through the help of Dr. Pacheco. Even so, the residency program can cause a financial strain and is not always budget neutral. It is imperative that the community health center is financially stable before taking on the challenge of incorporating a residency program.

THANK YOU FOR PARTICIPATING IN OUR SURVEY. YOUR INPUT IS VERY VALUABLE TO US AS WE WORK TO IMPROVE OUR COMMUNITY AND ACCESS TO QUALITY HEALTHCARE IN OUR COMMUNITY.

MAY WE CONTACT YOU WITH ADDITIONAL QUESTIONS? YES

REFERENCES

1. Cassidy, John. Telephone interview. July 10, 2012
2. Health Center's Contributions to Training Tomorrow's Physicians: Case Studies of FQHC-Based Residency Programs and Policy Recommendations for the Implementation of the Teaching Health Centers Program. Available at: http://www.nachc.com/client/FINAL%20THC%20REPORT%20-%2010222010-1.pdf
3. Pacheco, M F. Telephone interview. July 11, 2012
4. U.S. Census Bureau Quick Facts. Available at: Source: U.S. Census Bureau, http://quickfacts.census.gov/qfd/states/35/3570500.html

APPENDIX C

KEY ELEMENTS AND BEST PRACTICES OF SUCCESSFUL COMMUNITY HEALTH CENTER RESIDENCY DEVELOPMENT

NAME OF PROGRAM: NORTHWESTERN MCGAW FAMILY MEDICINE RESIDENCY PROGRAM

PRIMARY CONTACT: DR. DEBORAH EDBERG

PRIMARY CONTACT E-MAIL AND/OR PHONE NO: DEDBERG@ERIEFAMILYHEALTH.ORG / 312-432-4556

DATES OF PROGRAM IMPLEMENTATION: 2010

LOCATION OF PROGRAM: CHICAGO, IL

GEOGRAPHIC PROFILE: *PLEASE PROVIDE THE FOLLOWING POPULATION DEMOGRAPHICS FOR THE CITY, COUNTY, REGION, OR OTHER LOCATION IN WHICH THE PROGRAM WAS IMPLEMENTED.*

TOTAL POPULATION: 2,695,598 PERCENT M: 48.5% PERCENT F: 51.5%

AVERAGE HOUSEHOLD INCOME: $27,148 PERCENT POPULATION BELOW FPL: 20.9%

RACE / ETHNICITY:

28.9%	PERCENT LATINO / HISPANIC
32.9%	PERCENT AFRICAN-AMERICAN
31.7%	PERCENT CAUCASIAN
5.5%	PERCENT ASIAN – PACIFIC ISLANDER
1.0%	PERCENT OTHER

PERCENT W/ HS DEGREE: 79.4% PERCENT W/COLLEGE DEGREE OR HIGHER: 32.2%

PATIENT PROFILE: *PLEASE PROVIDE THE FOLLOWING INFORMATION FOR YOUR PATIENT POPULATION.*

TOTAL NO. OF PATIENTS SERVED PER YEAR: 37,500

AVERAGE INCOME OF PATIENTS: 83% below FPL AGE : 45% are under the age of 19

SERVICES PROVIDED:

- Adult & Senior Health Services
- Behavioral Health/Counseling
- Case Management
- Children's Health Services
- Dental Care
- Health and Wellness
- HIV/AIDS Care
- Prenatal Health Services
- Teen Health Services
- Women's Health Services

PERCENT MALE: 30% PERCENT FEMALE: 70%

RACE / ETHNICITY: 84% Latino / Hispanic

PERCENT OF PATIENTS WITH NO INSURANCE: 37%

PROGRAM DEVELOPMENT: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

NAME THE FACILITIES THAT WERE INVOLVED IN DESIGNING AND IMPLEMENTING THE PROGRAM (HOSPITALS, COMMUNITY HEALTH CENTERS, COMMUNITY-BASED ORGANIZATIONS, UNIVERSITIES ETC.) WHAT ROLE DID EACH PLAY? WHAT DID EACH CONTRIBUTE?

McGaw Medical Center of Northwestern University School of Medicine – McGaw is a rotation site for residents in addition to other sites such as Children's. McGaw oversees all the education aspects: accreditation, curriculum and advocates for the residency program. Northwestern also provides a lot of resources such as a simulation lab and research assistants, labs, etc.

Norwegian American Hospital – Provides some inpatient training rotations. It is located down the street from Erie Family Health and is a safety net hospital for the region.

Erie Family Health – Community Health Center outpatient clinic: the primary teaching location

CAN YOU GIVE A SENSE OF THE SIZE OF THIS COMMUNITY HEALTH CENTER WHEN PROGRAM DEVELOPMENT BEGAN?

Currently the Erie Family Health Center has eleven sites which includes five school based health centers, a teen health center and two oral health centers.

The resident to faculty ratio requirement is 1 faculty for every 6 residents; however this program has a ratio closer to 1:4-5.

PLEASE DESCRIBE THE TIMELINE FOR PROGRAM DEVELOPMENT.

2009 - Northwestern gave Erie Family Health Center a 1.8 million dollar grant for residency development.

April 2009 - Dr. Edberg and other faculty including a program coordinator were hired. This grant ran out in October 2010.

July 2009 - Residency recruitment began for the class of 2010.

January 2010 – Application for HRSA Teaching Health center Grant.

July 2010 – HRSA grant money was awarded.

WHAT WERE THE FINANCIAL COSTS TO DEVELOP THE PROGRAM? HOW WAS PROGRAM DEVELOPMENT FUNDED (E.G. PUBLIC OR PRIVATE GRANTS)

The Residency program was initially funded by a 1.8 million dollar grant from Northwestern University. About a year later the program was awarded the HRSA grant money from the Affordable Care Act and that now covers the majority of the cost of the program. There are however a few faculty and seed grants that contribute a little.

When the HRSA grant ends in 2015 they hope to sustain the program because they were awarded some GME slots. They are also optimistic that HRSA funding may be extended.

DID YOU USE A RESIDENCY PROGRAM CONSULTANT TO HELP FACILITATE START UP AND DEVELOPMENT?

Dr. Deborah Edberg developed the residency program.

PROGRAM BASICS: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

WHAT TYPES OF RESIDENCY PROGRAMS DO YOU OFFER? (E.G. PRIMARY CARE, INTERNAL MEDICINE)

Family Medicine

HOW MANY PGY-1 RESIDENTS ARE MATCHED ANNUALLY?

8 residents annually

WHAT IS THE AVERAGE PGY-1 ANNUAL SALARY NOT INCLUDING BONUSES, RELOCATION ALLOWANCES OR ANY OTHER INCENTIVES?

	NORTHWESTERN MCGAW FAMILY MEDICINE RESIDENCY PROGRAM			**UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT CHICAGO PROGRAM**			**UNIVERSITY OF CHICAGO (NORTHSHORE) PROGRAM**		
Grad Year	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**
1	$49,242	20 days		$47,100	4	24	$49,291	3	5
2	$50,519	20 days		$49,140	4	24	$51,455	3	5
3	$53,122	20 days		$51,300	4	24	$53,186	3	5

WHAT IS THE AVERAGE HOURS PER WEEK ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? It depends. During in-patient months they get close to 75-80 hours. Most of the other rotations are between 50 and 60 hours per week.
WHAT ARE THE MAXIMUM CONSECUTIVE HOURS ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? 16 hours
WHAT ARE THE AVERAGE NUMBER OF 24-HOUR OFF DUTY PERIODS PER WEEK DURING FIRST YEAR? Always 1 in 7, however most of the time they get more.
DOES THIS PROGRAM ALLOW MOONLIGHTING? Yes, when they are licensed in their third year.
DO YOU OFFER A RELOCATION ALLOWANCE? NO
DO YOU OFFER RENT/HOUSING ASSISTANCE FOR RESIDENTS? NO
DO YOU OFFER PERFORMANCE BONUSES TO RESIDENTS? No, they do occasionally give a Starbucks card reward but currently no monetary bonuses.

HAVE THERE BEEN ANY RECRUITMENT CHALLENGES?

There have been no significant recruitment challenges. They have been able to fill all slots each year. Part of this success is in part due to how strongly they feel about their mission of serving the underserved. Additionally they are very transparent about the teaching health center situation and funding.

WHAT ARE SOME ADDITIONAL CRITICAL COMPONENTS OF THIS RESIDENCY PROGRAM?

This residency program allows for more flexibility in their outpatient rotations because of their funding. For example they allow for more global rotations because they don't lose their salary when the residents are gone.

WHAT ARE SOME PROS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

The most important thing is what the outcome is going to be and that their mission corresponds to these young professionals who have a similar mission. It is exciting to interact with these folks that have that as their priority.

WHAT ARE SOME CONS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

It is very hard starting a residency program particularly because this is a resource poor setting. They are lucky because they have the grant, but they still have challenges in their curriculum. For example just as patients cannot find a dermatologist in their region, this residency program cannot find a dermatologist to allow their residents to rotate with them.

There is also always a struggle with balancing the priorities of education and service while protecting the education of the residents.

IS THERE ANYTHING ELSE PERTINENT THAT YOU WOULD LIKE US TO KNOW?

If you have all the players then it is important to always bring them back to what the mission is. Don't let them get bogged down by who is paying for what. Money is always the issue, but don't forget about the vision.

THANK YOU FOR PARTICIPATING IN OUR SURVEY. YOUR INPUT IS VERY VALUABLE TO US AS WE WORK TO IMPROVE OUR COMMUNITY AND ACCESS TO QUALITY HEALTHCARE IN OUR COMMUNITY.

MAY WE CONTACT YOU WITH ADDITIONAL QUESTIONS? YES

REFERENCES:

1. Edberg, D L. Telephone interview. July 9, 2012
2. Erie family Health Center. About Erie. Available at http://www.eriefamilyhealth.org/about-erie
3. Northwestern University School of Medicine. Department of Family and Community Medicine, Family Medicine Residency Program. Available at http://www.familymedicine.northwestern.edu/residency/
4. U.S. Census Bureau Quick Facts. Available at: Source: U.S. Census Bureau, http://quickfacts.census.gov/qfd/states/17/1714000.html

APPENDIX D

KEY ELEMENTS AND BEST PRACTICES OF SUCCESSFUL COMMUNITY HEALTH CENTER RESIDENCY DEVELOPMENT

NAME OF PROGRAM: UNIVERSITY OF MASSACHUSETTS FAMILY MEDICINE PROGRAM

PRIMARY CONTACT: FRANCES ANTHES
PRIMARY CONTACT E-MAIL AND/OR PHONE NO.: FRANCES.ANTHES@UMASSMED.EDU / 508-860-7975

SECONDARY CONTACT: DANIEL LASSER (CHAIR OF THE RESIDENCY DEPARTMENT)
SECONDARY CONTACT E-MAIL AND/OR PHONE NO.: 508- 856-2246

DATES OF PROGRAM IMPLEMENTATION: 1974

LOCATION OF PROGRAM: WORCESTER, MA

GEOGRAPHIC PROFILE: *PLEASE PROVIDE THE FOLLOWING POPULATION DEMOGRAPHICS FOR THE CITY, COUNTY, REGION, OR OTHER LOCATION IN WHICH THE PROGRAM WAS IMPLEMENTED.*

TOTAL POPULATION: 181,045 PERCENT M: 48.7% PERCENT F: 51.3%

AVERAGE HOUSEHOLD INCOME: $24,326 PERCENT POPULATION BELOW FPL: 18.3%

RACE / ETHNICITY:

20.9%	PERCENT LATINO / HISPANIC
11.6%	PERCENT AFRICAN-AMERICAN
59.6%	PERCENT CAUCASIAN
6.1%	PERCENT ASIAN – PACIFIC ISLANDER
1.8%	PERCENT OTHER

PERCENT W/ HS DEGREE: 84% PERCENT W/COLLEGE DEGREE OR HIGHER: 29.6%

PATIENT PROFILE: *PLEASE PROVIDE THE FOLLOWING INFORMATION FOR YOUR PATIENT POPULATION. (TO THE BEST OF YOUR ABILITY).*

TOTAL NO. OF PATIENTS SERVED PER YEAR: >33,000

PERCENT OF PATIENTS WITH PRIVATE INSURANCE: 16%
PUBLIC INSURANCE: ~60%
NO INSURANCE: 24%

PROGRAM DEVELOPMENT: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

NAME THE FACILITIES THAT WERE INVOLVED IN DESIGNING AND IMPLEMENTING THE PROGRAM (HOSPITALS, COMMUNITY HEALTH CENTERS, COMMUNITY-BASED ORGANIZATIONS, UNIVERSITIES ETC.) WHAT ROLE DID EACH PLAY? WHAT DID EACH CONTRIBUTE?

This Community Health Center is a site that is one of three residency program sites through the University of Massachusetts Medical School. The other two are hospital run practices not Community Health Centers.

University of Massachusetts Medical School – The University provides the teaching aspect.

UMass Memorial Health Care System (UMMHC) – The resident hospital work is done at UMass Memorial Medical Center

HOW MANY PHYSICIAN FTES WORKED AT THE COMMUNITY HEALTH CENTER WHEN PROGRAM DEVELOPMENT BEGAN? 19.7 (17.95 family medicine, 1.74 internists)

NURSE PRACTITIONERS? 10.81
PHYSICIAN ASSISTANTS? .58
REGISTERED NURSES? 23.35
CERTIFIED NURSE MIDWIVES? 1.16
DENTISTS? 6.19
ADMINISTRATION? 35.34

PLEASE DESCRIBE THE TIMELINE FOR PROGRAM DEVELOPMENT. N/A

WHAT WERE THE FINANCIAL COSTS TO DEVELOP THE PROGRAM? HOW WAS PROGRAM DEVELOPMENT FUNDED (E.G. PUBLIC OR PRIVATE GRANTS)

$370,000 grant / yr from UMASS + resident billing in the health center

The resident salary is paid by UMass Memorial medical Center.

DID YOU USE A RESIDENCY PROGRAM CONSULTANT TO HELP FACILITATE START UP AND DEVELOPMENT? IF SO, WHAT WERE THE COSTS INVOLVED WITH THAT SERVICE? WHAT WAS MOST HELPFUL?

Yes, UMASS provided a consultant.

WHAT ADDITIONAL RESOURCES DID YOU UTILIZE?

Yes, additional resources were utilized through UMASS.

PROGRAM BASICS: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

WHAT TYPES OF RESIDENCY PROGRAMS DO YOU OFFER? (E.G. PRIMARY CARE, INTERNAL MEDICINE)

Family Medicine

HOW MANY PGY-1 RESIDENTS ARE MATCHED ANNUALLY?

12 Medical Residents/yr + 2 Nurse Practitioner Residents/yr + 2 Dental Residents/yr

WHAT IS THE AVERAGE PGY-1 ANNUAL SALARY NOT INCLUDING BONUSES, RELOCATION ALLOWANCES OR ANY OTHER INCENTIVES?

	Family Health Center of Worcester			**Tufts University at Cambridge Health Alliance Program**			**Greater Lawrence Family Health Center Program**		
Grad Year	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**
1	$52,408	3	15	$55,080	4	15	$53,000	4	NGO
2	$54,375	3	15	$57,293	4	15	$55,000	4	NGO
3	$57,470	3	15	$59,522	4	15	$57,500	4	NGO

NGO = Negotiable

WHAT IS THE AVERAGE HOURS PER WEEK ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? 65 hours
WHAT ARE THE MAXIMUM CONSECUTIVE HOURS ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? 16 hours
WHAT ARE THE AVERAGE NUMBER OF 24-HOUR OFF DUTY PERIODS PER WEEK DURING FIRST YEAR? 1.5
DOES THIS PROGRAM ALLOW MOONLIGHTING? YES
DO YOU OFFER A RELOCATION ALLOWANCE? YES; $10,000
DO YOU OFFER RENT/HOUSING ASSISTANCE FOR RESIDENTS? NO
DO YOU OFFER PERFORMANCE BONUSES TO RESIDENTS? No, but they are considering performance bonuses at this time.
DO YOU OFFER ON-SITE CHILD CARE? YES

WHAT TYPE OF RECRUITMENT CHALLENGES DOES THIS RESIDENCY PROGRAM FACE?

Initially recruitment was a challenge but now they have a 30 year history which helps significantly. At the moment there are between seventy and eighty medical students interviewing each year.

WHAT ARE SOME ADDITIONAL CRITICAL COMPONENTS OF THIS RESIDENCY PROGRAM?

The diverse patient population and the added challenge of providing care in multiple languages is a real incentive for some individuals. Also, the long standing history of the program and the opportunity to work with Dr. Lucy Candib (who has been teaching at this residency program since the inaugural year) are both significant draws for medical students.

WHAT ARE SOME PROS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

Residency programs within a CHC means you are on top of cutting edge medical care, and we are developing the books on evidence based medicine. Teaching Health Centers ensure commitment to high quality care.

WHAT ARE SOME CONS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

Continuity of care for patients is a challenge because you must pull physicians out for precepting, and the residents schedule is not always available for the convenience of patients. So, it is not as easy to get "your doc".

There is also a financial cost that is not usually carried by reimbursement.

HOW MANY RESIDENTS GO ON TO PRACTICE MEDICINE IN YOUR COMMUNITY?

50% of resident graduates work with underserved patients and 50% stay in Massachusetts. In fact these graduates are four to five times more likely to practice in an underserved region than graduates from the other two non CHC based sites.

IS THERE ANYTHING ELSE PERTINENT THAT YOU WOULD LIKE US TO KNOW?

Use your advocacy group to work for adequate reimbursement.

Remember this is a very challenging process. You need a commitment to work with underserved populations and to train great physicians to work with underserved populations. This is a workforce issue and if you want people to work across language and cultural barriers than you have to be willing to do the training, and you must be willing to accrue the cost and make it work even though you are losing money on the residency program. So use your resources and look for extra dollars in the state.

THANK YOU FOR PARTICIPATING IN OUR SURVEY. YOUR INPUT IS VERY VALUABLE TO US AS WE WORK TO IMPROVE OUR COMMUNITY AND ACCESS TO QUALITY HEALTHCARE IN OUR COMMUNITY.

MAY WE CONTACT YOU WITH ADDITIONAL QUESTIONS? YES

REFERENCES:

1. Anthes, F M. Telephone interview. July 9, 2012
2. Erie family Health Center. About Erie. Available at http://www.eriefamilyhealth.org/about-erie
3. Northwestern University School of Medicine. Department of Family and Community Medicine, Family Medicine Residency Program. Available at http://www.familymedicine.northwestern.edu/residency/
4. U.S. Census Bureau Quick Facts. Available at: Source: U.S. Census Bureau, http://quickfacts.census.gov/qfd/states/25/2582000.html

APPENDIX E

KEY ELEMENTS AND BEST PRACTICES OF SUCCESSFUL COMMUNITY HEALTH CENTER RESIDENCY DEVELOPMENT

NAME OF PROGRAM: WRIGHT RESIDENCY PROGRAM

PRIMARY CONTACT: DR. LINDA THOMAS-HEMAK

PRIMARY CONTACT E-MAIL AND/OR PHONE NO.: THOMASL@THEWRIGHTCENTER.ORG / 570-954-5758

DATES OF PROGRAM IMPLEMENTATION: JULY 2011

LOCATION OF PROGRAM: SCRANTON, PA

GEOGRAPHIC PROFILE: *PLEASE PROVIDE THE FOLLOWING POPULATION DEMOGRAPHICS FOR THE CITY, COUNTY, REGION, OR OTHER LOCATION IN WHICH THE PROGRAM WAS IMPLEMENTED.*

TOTAL POPULATION: 76,089 PERCENT M: 48.2% PERCENT F: 51.8%

AVERAGE HOUSEHOLD INCOME: $19,068 PERCENT POPULATION BELOW FPL: 18.8%

RACE / ETHNICITY:	9.9%	PERCENT LATINO / HISPANIC
	5.5%	PERCENT AFRICAN-AMERICAN
	80.1%	PERCENT CAUCASIAN
	3.0%	PERCENT ASIAN – PACIFIC ISLANDER
	1.5%	PERCENT OTHER

PERCENT W/ HS DEGREE: 83.1% PERCENT W/COLLEGE DEGREE OR HIGHER: 18.6%

PROGRAM DEVELOPMENT: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

NAME THE FACILITIES THAT WERE INVOLVED IN DESIGNING AND IMPLEMENTING THE PROGRAM (HOSPITALS, COMMUNITY HEALTH CENTERS, COMMUNITY-BASED ORGANIZATIONS, UNIVERSITIES ETC.) WHAT ROLE DID EACH PLAY? WHAT DID EACH CONTRIBUTE?

The Wright Center has active affiliations with community based hospitals that receive CMS funding for residency training. In addition, they are affiliated with a VA program, multiple community-based organizations and some FQHCs.

The funding aspect for the residency programs comes mainly from CMS funding, some grants and the new THC (teaching health center) was expanded through HRSA. HRSA requires that you are the sponsoring institution which can create some challenges for sustainability in the future if funding is not continued past the 2015 guarantee.

The education aspect of the THC is provided through a clinical faculty practice plan.

HOW MANY PHYSICIANS WERE NEEDED TO SUPPORT THE COMMUNITY HEALTH CENTER RESIDENCY PROGRAM?

There were initially nine residents per year with a resident to faculty ratio of 3:1 because they believe in very tight supervision.

PLEASE DESCRIBE THE TIMELINE FOR PROGRAM DEVELOPMENT.

Because the Wright Center was already a qualified sponsoring institution due to other residency programs that were currently up and running, there was very little leg work other than notification of accreditors that they were expanding the current training.

They only needed to expand the residency program through new venues and FQHCs thus establish new learning environments. In the beginning, the FQHCs had a 1:1 resident to faculty ratio because many of the physicians had never taught before. It is now a 2:1 ratio.

Prior to January 2011- recruitment and interviews in preparation for HRSA funding
January 2011– notification of HRSA funding
January – July 1 2011- planning of learning environment

DID YOU USE A RESIDENCY PROGRAM CONSULTANT TO HELP FACILITATE START UP AND DEVELOPMENT? IF SO, WHAT WERE THE COSTS INVOLVED WITH THAT SERVICE? WHAT WAS MOST HELPFUL?

No, they did not use a consultant because they have been around for 35 years. However, accreditors, educators and most institutions will share their resources, curriculum, etc.

WHAT ADDITIONAL RESOURCES DID YOU UTILIZE?

- ACGME (Accreditation Council for Graduate Medical Education) provides information on general program requirements, specialty specific requirements, steps and requirements of becoming a sponsoring institution etc.
- Next, find a qualified program director. They will assess who the key core faculty and educators will be.
- For the process of accreditation you can use MyEvaluations.com to assist you. They also have a great new curriculum mapping module.
- Other resources include organizations like the American Board of Internal Medicine.

PROGRAM BASICS: *PLEASE PROVIDE A DESCRIPTION OF THE FOLLOWING ELEMENTS OF YOUR PROGRAM.*

WHAT TYPES OF RESIDENCY PROGRAMS DO YOU OFFER? (E.G. PRIMARY CARE, INTERNAL MEDICINE)

Internal Medicine

HOW MANY PGY-1 RESIDENTS ARE MATCHED ANNUALLY?

Initially they began with 9 residents annually, but now they have 10.

WHAT IS THE AVERAGE PGY-1 ANNUAL SALARY NOT INCLUDING BONUSES, RELOCATION ALLOWANCES OR ANY OTHER INCENTIVES?

	Wright Center for Graduate Medical Education Program			St Luke's Hospital Program Bethlehem, PA			University of Pennsylvania Program Philadelphia, PA		
Grad Year	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**	**Salary Compensation**	**Vacation Weeks**	**Sick Days**
1	$45,881	3	NGO	$50,461	3	12	$50,087	4	NGO
2	$47,257	3	NGO	$53,539	3	12	$51,455	4	NGO
3	$48,675	3*	NGO	$55,682	3	12	$52,993	4	NGO

NGO = Negotiable

* Seniors receive 1 week of CME (continuing medical education) to study for boards

WHAT IS THE AVERAGE HOURS PER WEEK ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? 74 hours
WHAT ARE THE MAXIMUM CONSECUTIVE HOURS ON DUTY DURING FIRST YEAR (EXCLUDING BEEPER CALL)? 30 HOURS
WHAT ARE THE AVERAGE NUMBER OF 24-HOUR OFF DUTY PERIODS PER WEEK DURING FIRST YEAR? 1.0
DOES THIS PROGRAM ALLOW MOONLIGHTING? NO
DO YOU OFFER A RELOCATION ALLOWANCE? NO
DO YOU OFFER RENT/HOUSING ASSISTANCE FOR RESIDENTS? NO
DO YOU OFFER PERFORMANCE BONUSES TO RESIDENTS? NO
DO YOU OFFER ON-SITE CHILD CARE? NO

WHAT ARE SOME OF THE ADDITIONAL CRITICAL COMPONENTS OF THIS RESIDENCY PROGRAM?

This program is innovative and has a curriculum that will better prepare future practicing physicians in the new world of the ACA.

WHAT ARE SOME PROS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

Teaching Health Centers are all about renewal of man power, relevance of your practice and making sure the educational system stays accountable for serving the public. It takes the mission of the graduate medical education which is "excellent training of doctors" and puts them in venues that have a governing board mission that is patient predominant and needs driven. At an FQHC, a residency program will bring innovation, quality and expansion.

WHAT ARE SOME CONS OF RUNNING A RESIDENCY PROGRAM WITHIN A COMMUNITY HEALTH CENTER SETTING?

Currently we do not know if THCs in CHCs (Community Health Centers) are sustainable. We also do not know if there will be continued funding through grants such as HRSA past 2015. However, as a profession the generation and renewal of manpower needs to be part of our mission and professional responsibility. The federal government and the ACA are vested in working with us to fix health care nationally, and you cannot do that without physician leaders. We hope that this sustainability issue will be addressed by them.

Despite the risk of losing funding in 2015, the Wright Center took on the mission of creating a CHC-THC with the mindset that if they only are able to train one hundred extra doctors then they have accomplished their national duty and professional responsibility to renewal of manpower.

Another issue is the mission of the CHC is not workforce development. They are providers of patient care with a single mission of patient care. CHCs will need to expand to a dual mission of training the new workforce to serve the people. This mission includes providing an excellent learning environment to train physicians who hopefully will lead the profession. By learning within the walls of the FQHC (which is the future), residents can learn how to be responsive to the needs of the community.

HOW MANY RESIDENTS GO ON TO PRACTICE MEDICINE IN YOUR COMMUNITY?

Over 50% stay in the Scranton, PA area.

THANK YOU FOR PARTICIPATING IN OUR SURVEY. YOUR INPUT IS VERY VALUABLE TO US AS WE WORK TO IMPROVE OUR COMMUNITY AND ACCESS TO QUALITY HEALTHCARE IN OUR COMMUNITY.

MAY WE CONTACT YOU WITH ADDITIONAL QUESTIONS? YES

REFERENCES:

1. Thomas-Hemak, L J. Telephone interview. July 2, 2012
2. U.S. Census Bureau Quick Facts. Available at: Source: U.S. Census Bureau, http://quickfacts.census.gov/qfd/states/42/4269000.html

APPENDIX F

Responses which indicated importance of atmosphere and faculty attitude when selecting a residency program:

"feel"

Dynamic among residents

How the residents are treated.

Interaction among residents

protected study hours. Number of cases directly involved in. If fellows are present or not. How well I interact with the current residents and faculty. How many residents get fellowships and what type of fellowships. Time allotted to staying healthy (30 min-1hr/day scheduled workout time).

Quality of life during residency, future career opportunities, collegiality among residents, and faculty

family friendliness

The feeling I get when visiting for that city

overall gut impression

Personality of the faculty

Work environment - how friendly, welcoming, and happy other residents are (this is very high on the list)

I would prefer a good working environment with a strong team component and lack of "malignant" individuals

"fit" with the program - how well I get along with everyone, and they with me

The people.

getting along with program director, residents, and staff at resident clinic

The most important factor is that it needs to be a pleasant environment. I don't want to deal with petty drama, or rude people. I want to feel comfortable and be in a good learning environment, not hating every day of residency.

personal fit with other members of the residency program

How I feel I fit in the program

Professional environment

That I feel like I fit well in the program

atmosphere and personality of the program

Attitudes/goals of residents and attendings

It is really important to me that I am compatible with the physicians and other residents.

How well the residents, nurses, etc. work together

Attitude of Residents/Attendings

I good atmosphere with those in the program

Atmosphere/ character of the program

resident's attitudes during interviews

Personality match with program

Atmosphere of program (is the program malignant or not)

Demeanor and stress level of residents

friendliness

nice people, good work environment, work hours

The goals of the leadership of the program. The direction and attitudes are driven from the top.

Personality of the program and current residents/attendings

All other responses pertaining to additional important factors when selecting a residency:

Ability of my husband to also find work
Ability to apply for good fellowships after completion of residency.
Ability to couples match
Are there any other factors that are of high importance to you when selecting a residency program?
Attitude toward D.O.s.
being able to be somewhat close to family
Benefits
Benefits/Work Schedule/Vacation
Call hours
Commitment to public health initiatives, board pass rate, acgme accreditation status, opportunity for training in other languages than english, and opportunity for foreign travel.
Conscience protections
Curriculum
Environment, Weather, Pollution, Traffic, Living expenses of the area.
Excellent services for children with Autism is a must
Family and spouse employment -- "research opp" for me also includes health policy opp
Family- friendly atmosphere, call schedule
Family-friendly/Flexibility
Family's opinion
fellowship opportunities
Fellowship opportunity
Happiness
How many of the redidents have children.
How much exposure the residents receive.
How my family will fit in
I'd prefer to be close to family and friends
If the residency program is family friendly
Just getting in!
lifestyle satisfaction of residents
Matching with a significant other...
Moving assistance
My husbands acceptance in same city
My husband's career.
Overall satisfaction with education and quality of life during residency
Percent of residents who pass boards
Practice options in that location
Program's willingness to accommodate family concerns
proximity to family
Quality of training at the hospital
Religious community
Significant other job possibilities
Significant other.
Staying close to home to be able to help my parents with my older brother who is terminal with brain cancer
strong academics and plenty of residents to share call load.
Teaching at the point of care

What opportunities are available in the community
Where friends and family may be living at the time.
Where I know faculty/people.
Where I would be happiest.
Where significant other finds a job
Wife
yea where family and friends are located

APPENDIX G

Quality Residency Program Responses:

I would go if my specialty was offered in South LA.
Knowing that I will have good teachers and get enough experience to be a more than competent doctor within whichever field I choose.

A hospital with a high quality of training

A prestigious hospital with ample research opportunities in the specialty of my choice in the area.

Good residency program in the speciality I choose.

A strong residency program where I would get great training.
I would want to know that I would be able to learn a lot, hands on. Also, it doesn't seem right that residents would be under the poverty level when they are supposed be learning how to save lives.
I would need to be convinced that I would receive the same level of education as at a big hospital with a well established residency program. Also, if the residency was in Oklahoma, Arkansas, or Missouri, I would be much more likely to consider it.
It would be difficult. When it comes to choosing a residency program, I would be more concerned about furthering professional knowledge than service.

The specialty of my choice at that time would have to be available in that area.

Depends on the training I'll receive.

The promise of great training and opportunities for fellowship traing afterwards.

Good Facilities, accountability programs with patients
Research and fellowship opportunities are really the primary considerations for me. Anything else is less important.
Good program that prioritized producing well rounded physicians and treated residents with respect. Not a "good ole boys" system.

Good personality match with program, committed faculty to teaching/mentoring.

It would depend on how I fit in with the residency program, and how much I like the community I would be living in

getting a good education and training

A residency program that provided outstanding training

Available research opportunities. Relocation of family.

A supportive program that is well respected and will allow me to gain good knowledge and skills.

The residency training I needed and the program to match it.
The main thing I am looking for in residency is the quality of the program and what attendings will be teaching me. No matter where I go I want to learn as much as I can during that time so I will be confident going out on my own after I'm finished.

A solid academic program with low attending to resident ratios

Good research opportunities.

Assurance that there was a good teaching/learning structure in place there

excellent training opportunities and resident support programs
If there was a quality program for the specialty I desire and the residency felt like a good fit for me and my family (I have children) I would consider it.

if they had a great training program there that would really prepare me in that specialty
Depends on what field I decide to go in to. As long as I get into a well respected program where I will get tons of experience and coming out as a great physician, I could easily find myself in south LA for 4-7 years.

Financial Incentive Responses:

Still receiving the same benefits/salary that I might possibly receive in any other area of the country.

Very high salary to offset price I living in California.

Available specialty with plenty of incentives.

Higher salary in order to offset cost of living.

Pay that makes LA more affordable.

above average incentives

Sign on bonuses.

high salary and reduced living costs

Money

Student Loan Repayment Responses:

Assistance with student loan repayment

Make sure my family would be safe and that my son would have access to a good education. Also, I would need to be able to pay back student loans and provide adequately for my family.

No loans that means pay me $200000

For all my relatives to relocate to the area and a great tuition repayment plan

Loan repayment

Housing Assistance Responses:

Access to affordable housing in a good neighborhood that is a short commute to South LA.

Relocation allowance. Housing in an area that is save and has a good school district. (If these means a distance further then the mandated time limit that that time/distance limit would have to be waved) I will not compromise my children's education or safety for my education.

It would need to be an unopposed program so I could get lots of experience as an FM physician. Nice, safe housing close to the hospital is a must.

Relocation allowance

Lifestyle Responses:

1. safe place for a family to live 2. ample vacation time with subsidized airfare to visit extended family in the Midwest

Good hours, a healthy amount of vacation time, a safe place to live, a very friendly staff

Responses which fall under 2 or more categories:

Financial incentives and vacation time and compensation for travel which would be required for me to stay connected with my family.

Student loan repayment, and relocation allowance

Free/reduced housing and a set schedule

Higher salary, shorter hours, research opportunities, fewer on-call times

Substantial benefits (monetary, vacation, bonuses, etc.)

Money, partnerships with research institutions in the SoCal area.

Loan forgiveness, relocation cost (because LA is so expensive),
I don't have much personal interest in the LA area. I like the idea of working in an urban, under-served minority community, but the large city/location doesn't appeal to me. To go there I think I would need multiple incentives including help with student loans, benefits and bonuses.

Loan repayment incentive and housing help

Loan repayment, safety, high pay since LA is expensive
Housing and practice where I felt safe. Moving bonus. Access to affordable food and housing. Student loan/debt repayment options.
loan repayment and financial needs supported so I can care about serving and helping the population I am with and not about my own needs being met.

Payback of student loans plus competitive salary

Moving allowance, specialty of choice (EM), loan repayment

Bonuses as well as student loan repayment.

Set work week, student loan repayment, specialty of choice.

A huge student loan repayment and benefits to outweigh leaving my extended family.

Increased salary, easy commute to work, student loan forgiveness, visit the program and feeling safe. .

An orl program, some loan repayment options, safe and secure housing close to the hospital.

Better Salary Better Benefits Loan Forgiveness

free or reduced cost housing and more pay

Several incentives and relocation reimbursement

Good residency program. Good housing and transportation support. Free and safe parking.
Attendings and residents that are in medicine to teach and heal, a non-judgmental atmosphere, and help financially since I would be moving quite a distance.
A pediatrics residency program with a high board pass rate, availability of sub-specialty training, commitment to public health, opportunities for domestic and foreign training, ACGME accreditation with cycle length of 4-5 years, good benefits, and opportunities for federal loan repayment.
A strong program with excellent teaching and learning opportunities. A good community program. Loan repayment would be a big incentive.
A lot, but only because LA isn't my favorite place. In terms of a place "like" south LA I think many people would be drawn to it if the health care team was dedicated and amicable. Incentives related to student loan repayment would be a bonus.

higher pay, more opportunities to perform skills, opportunities to learn

Loan repayment and the specialty I want available.

A high quality training environment and decent pay
If they have they have the specialty I am interested in that is well known for it's program and limited call time are the most important aspects to me.
They would have to be able toprovidego the education quality I wanted and they would have to want me to be there because of my abilities, not just because they need doctors. Salary would have to be better than places closer to home and the program would need to be better than options closer to home.
A good general surgery residency, that can be a stepping stone to a fellowship if I decide to seek one. Has to have good benefits and overall great colleagues. Lastly, since I don't really care to live in California the pay would have to really incentivize it.

Prestigious program with good pay.
Loan repayment, Free SAFE Housing (LA is EXPENSIVE), Relocation Allowance, Sign on Bonus, Slightly Higher pay than other residencies.

Very good hours, benefits, safe housing.

Moving help, sign on bonus/loan repayment, etc.

Affordable housing in a safe neighborhood with protected parking. Help with student loans. Research options. Well-respected residency program with good community atmosphere (this atmosphere cannot be over-emphasized).

I probably would not consider it. Having been born, raised, and schooled on the east coast it would be too difficult for me to transition to the west coast. It would take a high quality residency program with outstanding faculty mentoring me. The pay would have to be significantly high to draw me over there or loan repayment be available.

Relocation bonuses, help in repaying student loan debt, and a set work week. For me the main detractor is the distance from my family.

Not being accepted in my preferred area, loan repayment, relocation allowance, adequate vacation time, employment assistance for spouse.

Salary Work hours Benefits Loan repayment

It would take complete medical school tuition repayment, reduced cost housing, and a quality residency program with research opportunities.

A large salary,student loan repayment, housing, benefits to cover my family

financial incentives, such as, a decent salary, reduced cost housing and relocation expenses covered. A realistic work schedule would also be good.

Response which were not categorized:

A change in the entire healthcare system of America.

A dermatology spot :)

a lot

A Miracle. LA and New York are the two cities in which I will not be applying for residency. It has nothing to do with the underserved issue and everything to do with the city

A place to live in a nice area, but with an easy, safe commute to work.

A place to live outside LA and a way to commute to the hospital or clinic without driving. As outdoor life and quiet living are very important to me it is unlikely that I would accept a position in such a large city with no way of getting away.

Because I have never considered the west coast, this would be a difficult decision. Most importantly, my wife who is one year ahead of me will be accepting her residency first, so we will need to be in the same area, if not the same town. Otherwise, as long as I am doing the residency that I want, it would make no difference if I was seeing patients in poverty and/or with no insurance.

Body guard

Every bonus/incentive known to man. I don't want to live in the city...certainly not that one.

Faith-based mission statement.

Family and friends living nearby

freedom

Good orthopedic opportunities with lots of exposure to trauma surgery

Have no desire whatsoever to live in California ever so would have to be a sweet ass deal

I am in a military residency so I cannot.

I am not opposed to working in an urban minority community, but I am opposed to moving to the West Coast. I would work in a similar community if it was on the East Coast with minimal incentives. I would probably only move to LA if my parents also moved out there and I was in a strong residency program.

I am not willing to live in that part of the country at this time, so it would be impossible to get me to apply for residency there.

I do not speak spanish, so I would like to have spanish classes offered before or during residency.

I do not want to live in South Los Angeles.

I don't think anything could get me to accept a residency in South LA

I don't think I would ever consider a residency in South LA. I am not applying to west coast programs.
I doubt that I would want to move to that area, especially since I want to start a family during residency. I am also more attracted to rural programs.

I hate big cities, so that is not something I would ever consider.

I have no desire to work in California.
I need to do some soul searching to determine if this is right for me personally; not many external incentives could influence me

I probably would not accept under any condition.

I would actually not be opposed to it.

I would enjoy it because I want to inner city health. But, I don't know if LA is really a place I want to live.

I would have to be happy with the work environment, neighborhood, hours, salary and vacation.

I would need enough support systems that I would not run the risk of having to use Medicaid
I would never consider a residency there. I don't like California, their gun laws and other policies at the state level are not acceptable.
I would not be interested in living or working in LA. There are few cities in the US where I would be unhappy living but LA is on that list (and surrounding areas). I would love an urban area but it's not near any family connection and halfway across the country.

I would not consider relocating my family from Oklahoma.

I would not move to California because my family is in Oklahoma, and I want to remain close to my family.

I would not work there under any circumstances.

I would probably love it, although I do want to focus more on rural.

I wouldn't because I can't move out of state

It is a dangerous city, so I would avoid it at all costs.

It would have to be the only program in my specialty that wanted me

It would have to be the right fit of a combination of the above factors.

It would require major incintives

It would take a lot. I've never lived in a city like that.

It's just too far from home.
It's too far from home. I would work in a similar community in St. Louis or Chicago, or even Baltimore, if they give fair compensation to make up for the location.
Less restriction on the services reimbursebed by social service programs. I feel I couldn't not provide the best healthcare to those undeserved when government reimbursement levels are so low and regulations are so numerous.

Little chance I'd do this for any reason.
Little/no desire to live in California...however I'm applying for a competitive residency so if by chance S LA was the only place I matched, I'd go.

Lots of money

Match-I intend to apply to programs in the region.

More than everything listed above.

My family all lives in the OK and TX area, so it would take a great deal to move so far away.
My main concern is safety, for me and my family. I've never been to South LA, but I have a strong impression of it as the home turf of both the Crips and Bloods. None of these incentives mentioned earlier would be enough for me to move my family to a dangerous area. For me to accept a residency in South LA, I would have to come for a visit and see for myself what this community is like. If I don't feel comfortable there, no amount of bonuses would convince me to live there for 3+ years.

My top three incentives as listed above would be enough to motivate me to accept a residency there.
Never considered it because I don't know enough about area. I would have to get more educated on south LAt before I can answer this question or even make a decision on whether or not this would interest me.

no prior comitments such as family

Not likely

Not much
Not much. I do a lot of volunteer work for local clinics that care for the uninsured and I like it. Also, I want to be a surgeon (possibly a trauma surgeon), and I imagine that some areas of South LA have considerable gang activity that would allow me to train and serve well in a trauma setting.

Not sure, but there would have to be something specific or unique to the residency that would draw me in.

Not sure.

Nothing

Opportunities for both my husband and I; otherwise, I would be willing to go just about anywhere

opportunity to work with great people in a supportive environment and help finding housing
Personally indifferent to the patient population that I'm helping. I view all patients equally. If they need my help, I am happy to help them. I don't care if they are rich or poor, White of Hispanic, urban or rural ... if they need my expertise as a physician, then I'm eager. Consequently, when a residency is trying to appeal to me, it is a matter of will this residency prepare and enable me to reach the next step in my career (be it a job position or fellowship position), and what kind of lifestyle will I be able to live in the location of this residency.

Safe and secure environment with adequate physician reimbursement

Safe place to live.
Safe, productive work environment where I could grow as a physician and feel that I was legitimately making a difference in the health care of my patients

Safety for my family is the highest concern. I can live on next to nothing, but it would be difficult with a family.

Specialty of my choice, not beIng in California

The end of the world
The knowledge that my son would be safe in the area and would have a good school to go to while there. The demographics of the community heighten my interest as well as the location.

There is nothing that could encourage me to accept that residency

To feel led by God

Yes