Rural Program Development: An Overview

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THE RTT COLLABORATIVE

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The RTT Collaborative

in rural health professions education and training

Growing our own...together

A rural health professions education network and a cooperative extension service

“a community of practice”

http://www.rttcollaborative.net

Our Participating Programs

https://rttcollaborative.net/rural-programs/#participating-programs

Participating Program Map

Agenda

- Rural Program Definitions
- An organic approach to rural residency design, development, and sustainability
- Additional resources
- Group interaction - Questions

Rural Program - Definition

An accredited residency program in which residents spend the majority of their time training (more than 50%, as reported to CMS and/or HRSA) in a rural place. The location of a rural program in Family Medicine is defined by the geographic location of the primary Family Medicine Practice (FMP) where residents meet the ABFM requirement for 24 months continuing practice.

CMS FY2004 regulations defining an integrated rural training track, Department of Health and Human Services, Center for Medicare and Medicaid Services. *Federal Register* August 2003; http://edocket.access.gpo.gov/2003/pdf/03-19363.pdf (Accessed 6-16-2016)

Am I Rural? A web-based tool using federal definitions that are regularly updated and hosted by the RHI hub in the North Dakota Center for Rural Health, https://www.ruralhealthinfo.org/am-i-rural. (Accessed August 1, 2016)

United States Department of Agriculture Economic Research Service Rural Classifications http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications.aspx. (Accessed August 1, 2016)

Integrated Rural Training Track (I-RTT):

A **rural program** that is **separately accredited** and because of its generally smaller size is **substantially integrated** with a larger, often more urban residency program:

- **I** ntegrated in a substantive way
- **R** urally located and rurally focused
- Engaged in **T** raining and/or education – residency +/- medical school experiences
- A **T** rack or pathway – deliberately structured over at least 2-3 years in family medicine, including a 24-month continuity practice in a rural location (often in the 1-2 format)

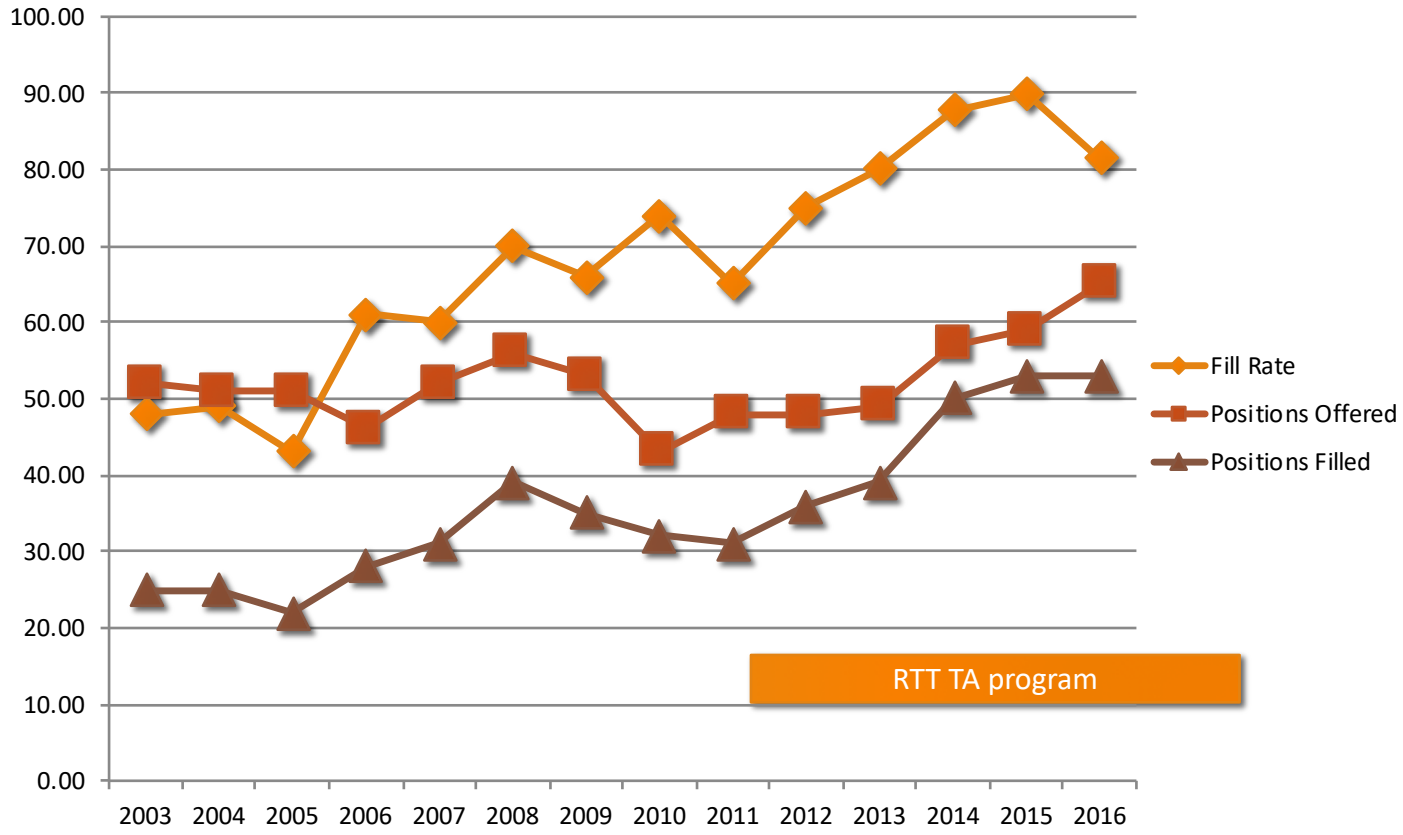
Substantial Integration

- Structured interaction among the residents of both the RTT and the larger affiliated program,
- Some sharing of faculty and/or a shared program director,
- Shared didactics and/or scholarly activity, and
- at least 4 months of structured curriculum shared by residents of both programs.

Interactive Rural FM Map

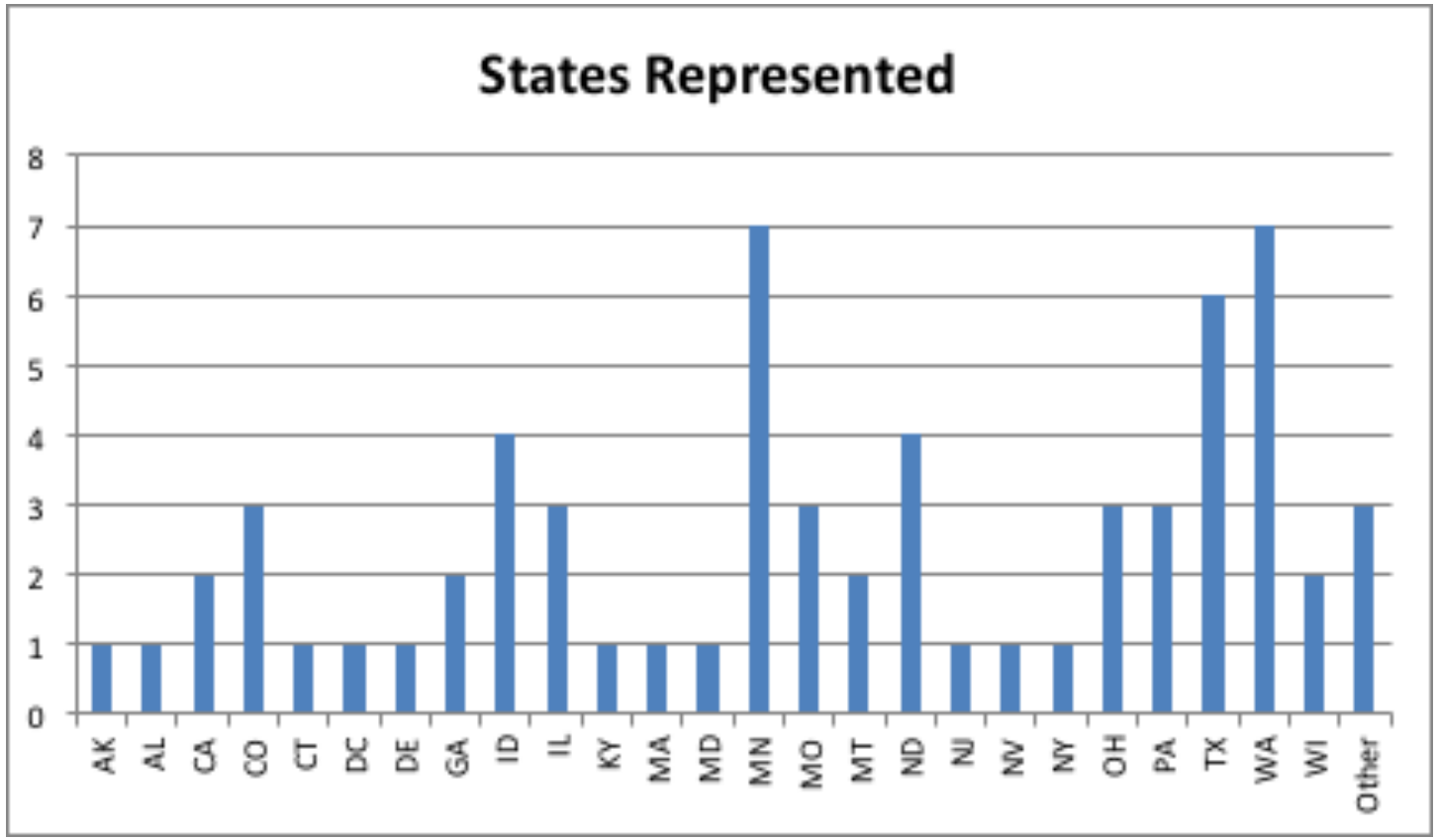
https://rttcollaborative.net/rural-programs/residency-map/

1-2 RTT Match Trends 2003-2016



Source: Personal communication from Randall Longenecker MD, Senior Project Advisor, the RTT Technical Assistance Program, March 22, 2016; revised May 23, 2016

AAFP National Conference 2018 – Rural Interest

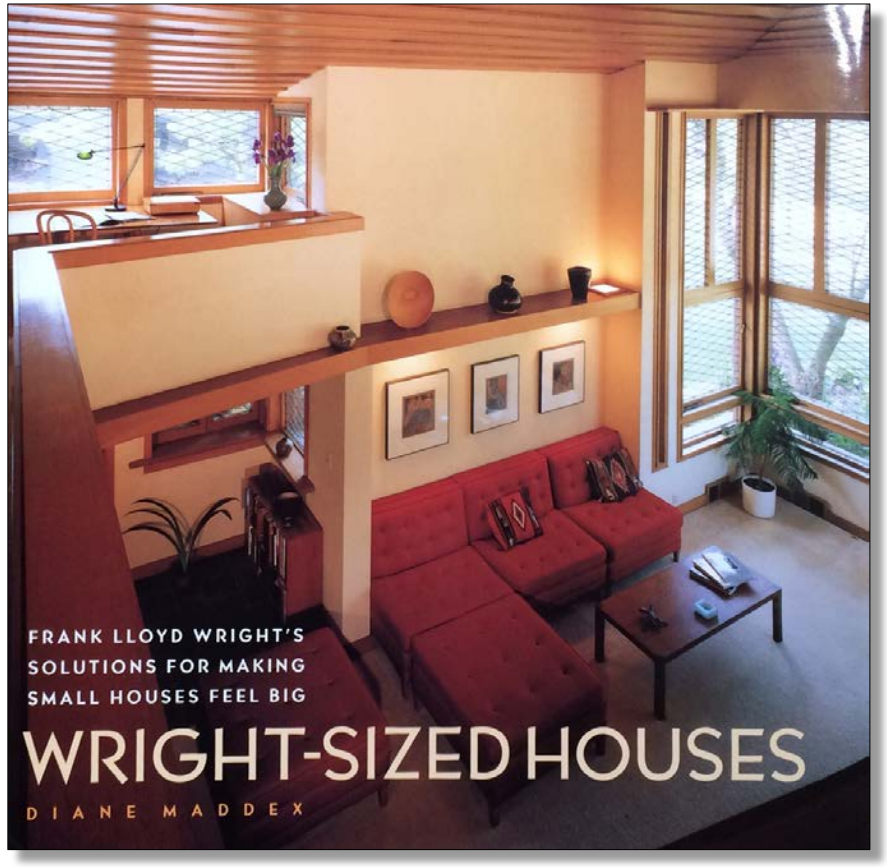


65 individual student contacts through booth visits or student breakfast

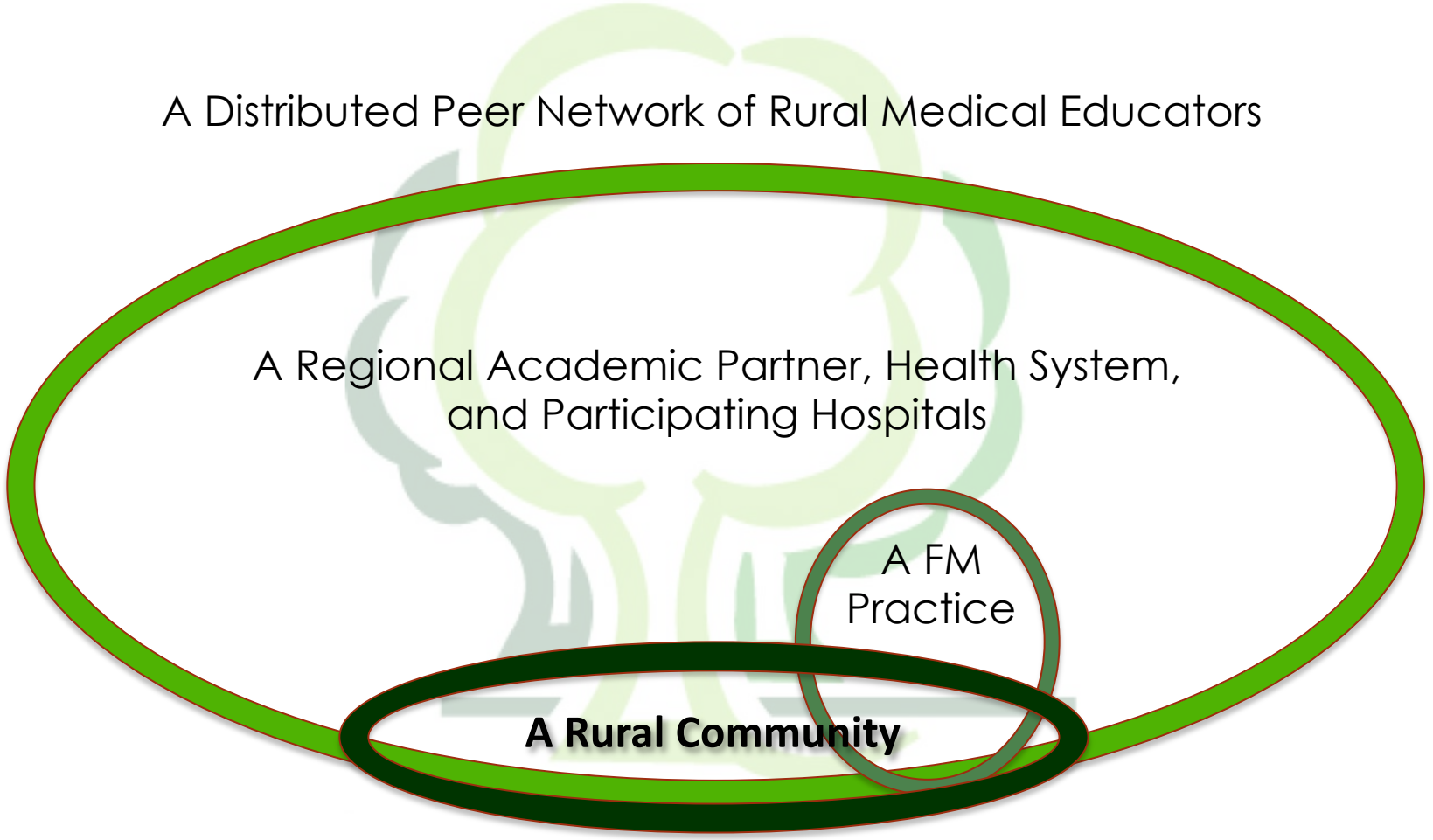
An Organic Approach

Designed to fit the assets and capacity of the rural community, all within the rules of accreditation and finance, but creatively adapting those rules to local realities

One size does not fit all



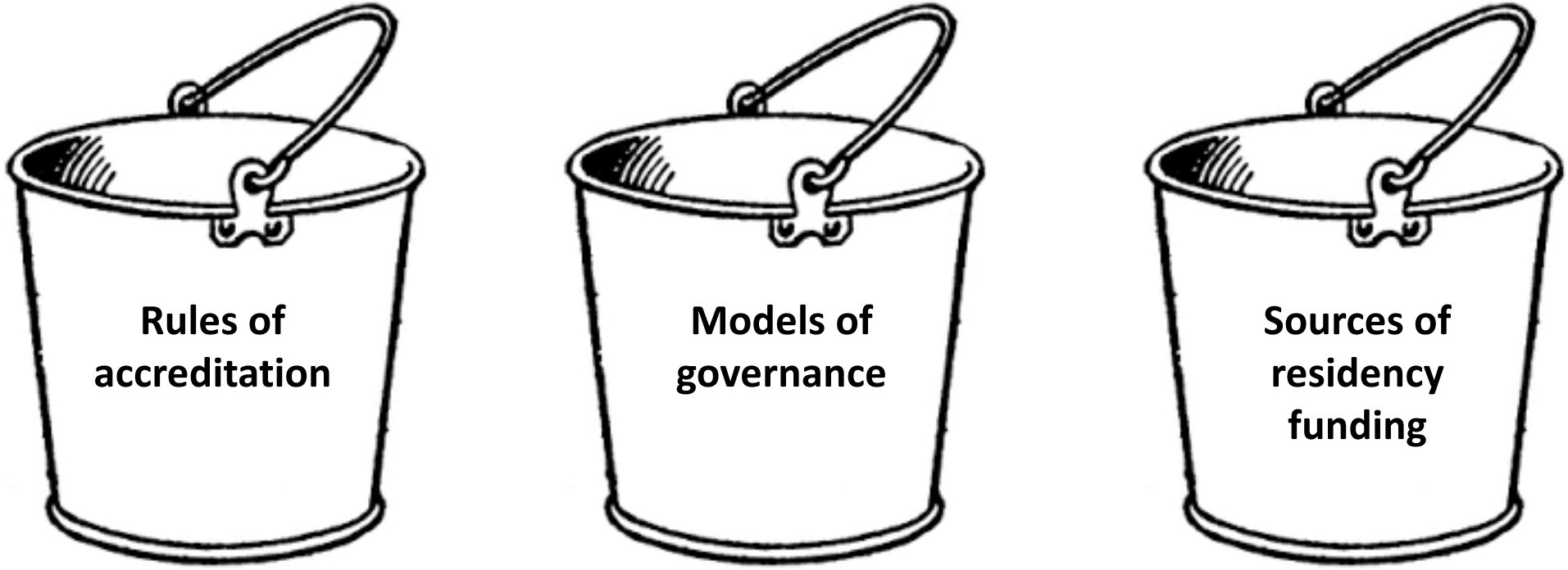
ACGME Accreditation, GME Finance, US Healthcare System



Community Engaged Residency Education

Designing a Sustainable Program

Creatively build upon community assets using:



Community Assets, Capacity, and Engagement

Timeline for Development

Sample GME Project Management/Timeline

	2017		2018				2019				2020	
	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q
Review standards for programs under consideration												
Develop standard curriculums that can be used as a baseline for rotations												
Identify locations where residents will be deployed to meet program requirements												
Draft agreements for rotations to other sites (PLA)												
Draft program information forms for each of the programs to be pursued												
Submit applications to accrediting body												
ACGME Site Visit												
Receipt of initial accreditation												
Program start date											7-2019	

Present draft financials to FI and request rate setting be made to accommodate GME cash flow

Additional Resources

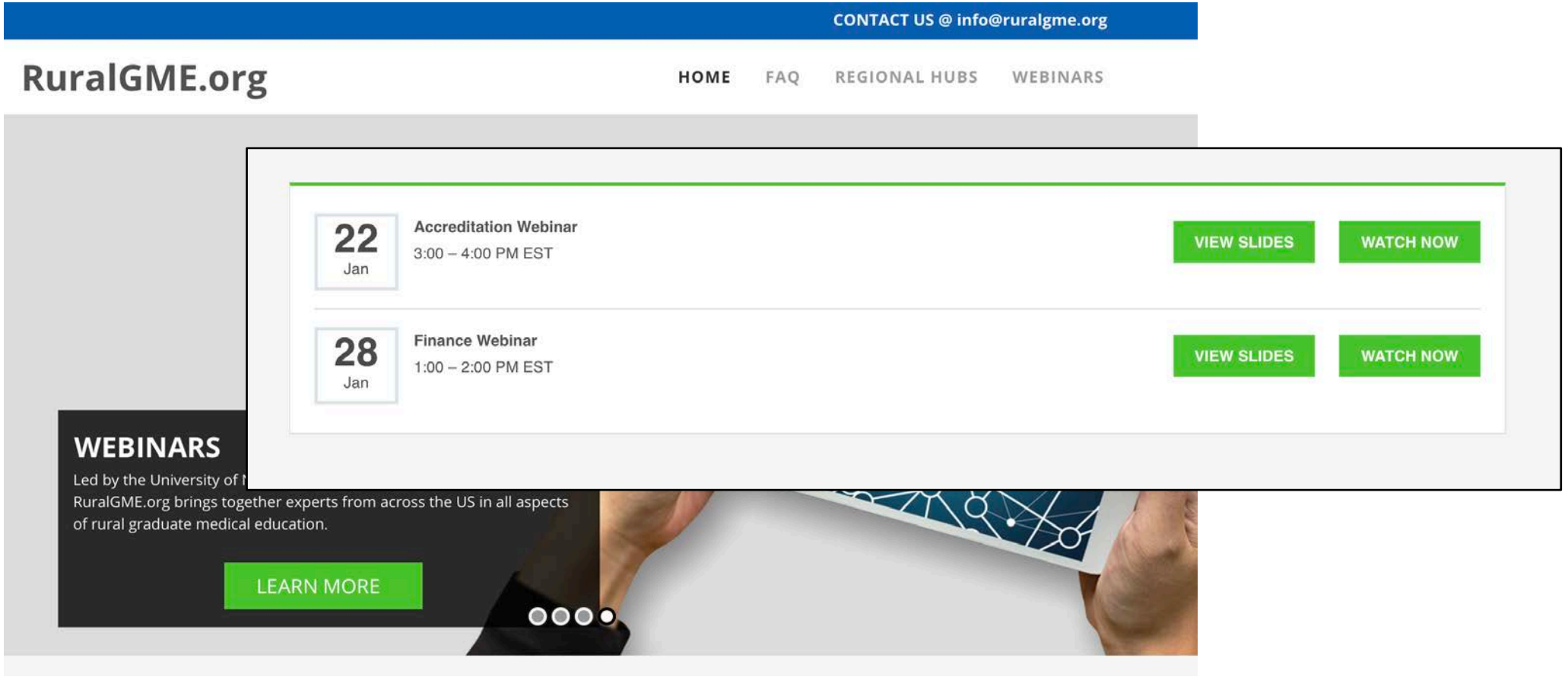
Planting TREES in Rural Places

Training and Rural health professions Education that is community Engaged and Sustainable

- Community Assets and Capacity Inventory
- Accreditation timeline
- Sample curriculum
- Community impact tool
- Other

https://rttcollaborative.net/wp-content/uploads/2019/01/TREES-2019-Optimized.pdf

Additional Resources



Questions?

References

Longenecker R. “Curricular Design: A Place-Based Strategy for Rural Medical Education,” in Bell E; Zimmitat C; Merritt J Eds. Rural Medical Education: Practical Strategies, New York: Nova Science, 2011.

Strasser R; Worley P; Cristobal F; Marsh DC; Berry S; Strasser S; Ellaway R. “Putting Communities in the Driver’s Seat: The Realities of Community-Engaged Medical Education,” Academic Medicine 2015 Nov;90(11):1466-70.

Training and **R**ural health professions **E**ducation that is community **E**ngaged and **S**ustainable (TREES) https://rttcollaborative.net/wp-content/uploads/2019/01/TREES-2019-Optimized.pdf

Rural Residency Planning and Development Technical Assistance Center – various resources, webinars and toolbox in development https://ruralgme.org

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Addendum Slides

Consortium as a Sponsoring Institution

- Under the ACGME, every residency must be nested in an accredited sponsoring institution (Academic medical center, medical school, community teaching hospital, consortium)
- The sponsoring institution is the fiduciary agent for its sponsored programs, responsible for oversight of the quality of education and financial sustainability

Consortium as a Sponsoring Institution

- New program – must apply through the DIO of the sponsoring institution
- Existing program – must contact the Executive for the appropriate specialty Review Committee

  Transfer of sponsorship requires a letter from the program's current Sponsoring Institution (the DIO and the institution's senior administrative official) indicating willingness to relinquish sponsorship, and a letter from the proposed Sponsoring Institution (the DIO and the institution's senior administrative official) indicating willingness to sponsor the program.

https://www.acgme.org/Portals/0/FAQ_NewProgSI_Mergers.pdf?ver=2018-09-17-111155-457

Consortium as a Sponsoring Institution

- Advantages:
  - Separate from hospital finance
  - Better able to function over distance
  - Allows for multiple funding streams, including community benefit, without compromising Medicare GME funding
- Disadvantages:
  - Requires negotiated CMS affiliation agreements and aligned Program Letters of Affiliation (PLA) among the various teaching sites, including hospitals and non-hospital settings

Consortium as a Sponsoring Institution

Consortium Sponsor (e.g. Academic institution, Alliance or 501(c)3)

Program #1 | Program #2 | Program #3 | Program #4 | Program #5

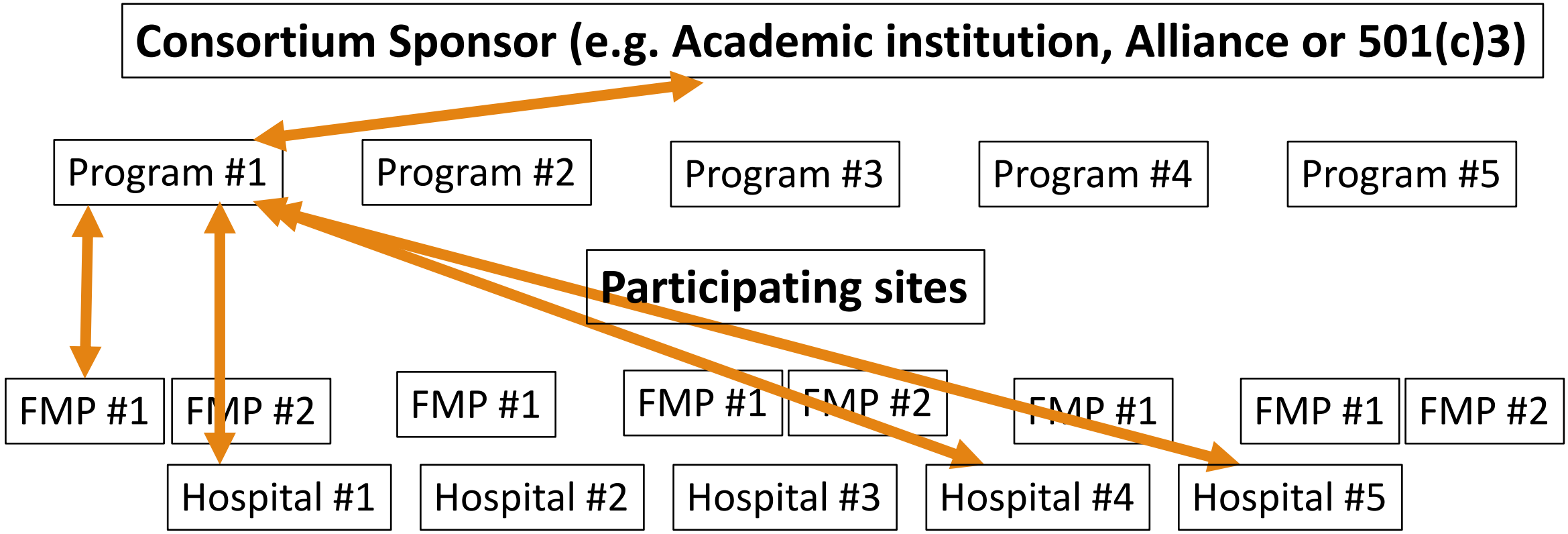
Participating sites

FMP #1 | FMP #2 | FMP #1 | FMP #1 | FMP #2 | FMP #1 | FMP #1 | FMP #2

Hospital #1 | Hospital #2 | Hospital #3 | Hospital #4 | Hospital #5

Non-provider settings

Consortium as a Sponsoring Institution



What about the money?

Consortium as a Sponsoring Institution

- New CMS rules of affiliation and aggregated caps effective July 1, 2019
- New teaching hospitals cannot participate until 5 years following completion of the 5-year cap-building period

CMS Final Rule 8-17-2018 – Pages 41492-41498

https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf

Consortium as a Sponsoring Institution

Financial Considerations for Medicare GME

Generally, two or more hospitals may form a Medicare GME affiliated group if the hospitals have a shared rotational arrangement and are either located in the same urban or rural area or in contiguous urban or rural areas, are under common ownership, or are jointly listed as program sponsors or major participating institutions in the same program.

Questions?

An Organic Approach

Starts with a rural place and it's assets

Uses various models, options for program design, modified rather than imposed upon the local context (organic medical education)

Follows a developmental process that is community engaged, i.e. **T**raining and **R**ural health professions **E**ducation that is community **E**ngaged and **S**ustainable (TREES)

https://rttcollaborative.net/wp-content/uploads/2019/01/TREES-2019-Optimized.pdf

Basic principles

Join the community - establish a relationship

Begin with the community’s assets and build from there

Set a clear vision and a specific task

Collaborate for mutual benefit

Community Assets and Capacity Inventory

Define the community

Engage the community

Determine assets & capacity

Design for accreditation

Build for sustainability

All at the same time!

Community Engaged Residency Education

1) Engage the Community – Coalition building, following “rules of engagement” (like motivational interviewing in patient care: Pre-contemplation, Contemplation, Preparation, Action)

Community Engaged Residency Education

2) Determine Community Capacity – Helpful tools, Consultations
   a. Template for Exploring Community Assets/Challenges
   b. Capacity Inventory of Existing and Potential Resources
   c. Crosswalk: Concept Mapping

Community Engaged Residency Education

3) Design the program and curriculum for the purpose of accreditation and education
   a. Accreditation Guide
   b. Sample timeline
   c. Requirements Crosswalk

Community Engaged Residency Education

3) Design the program and curriculum for the purpose of accreditation and education
   d. Faculty roster
   e. Challenges and solutions
   f. Sample curriculum

Community Engaged Residency Education

4) Develop a business plan – pro formas, affiliations, letters of commitment, contracts, and other agreements

Community Engaged Residency Education

Define the community

Engage the community

Determine assets & capacity

Design for accreditation

Build for sustainability

All at the same time!

Community Engaged Residency Education

Community Engaged Residency Education (initially coined CERE-R, now modified by RTTC as TREES) was developed by Drs. Longenecker and Schmitz, in collaboration with Western Montana Family Medicine Residency and funded in large part by a HRSA Residency Training in Primary Care grant #D58HP23226 and the RTT Technical Assistance Consortium, in a cooperative agreement with HRSA's Federal Office of Rural Health Policy.

Questions?