Across Time and Place: UME to GME and Beyond
Training for Rural Practice

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Objectives

- Start with some assumptions that we mostly accept about the conditions we live with and our mission
- Identify the forces and conditions that we have to work with
- Revise our goals and develop the strategies and tactics to reach them

7 assumptions

- Rural health disparities exist
- The physician workforce is mal-distributed across specialties and geographies
- Rural areas are disproportionately short of physicians
- There is an imbalance of retiring rural physicians v. new grads going rural
- Primary care is the most valuable specialty to health
- Family Medicine IS rural healthcare and we are physicians, not “providers”
- PAs, APNs and telehealth are important but do not replace well-trained, versatile rural physicians

3 more assumptions/facts

- Medical school rural tracks are helpful (about 30)
  - **Admissions, Curriculum and Rural clinical experience**
  - **High % primary care choice: 65%**
  - **High % rural practice choice: 44%**
- FM residency rural training tracks work (about 45)
  - **35% practice rural**
  - **56% to 50% practice in a primary care HPSA years 1 to 7.**
- Academic medical centers often discourage primary care and rural practice


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S. Harris
"NOW I'LL SHOW YOU WHAT TURNS A $6000 OPERATION INTO A $17000 OPERATION."

Training for Rural Practice
We know what the critical elements are

Downey, Wheat, Leeper, Florence, Boulger, Hunsaker: Five essential elements for rural medical education programs (focused on undergraduate).

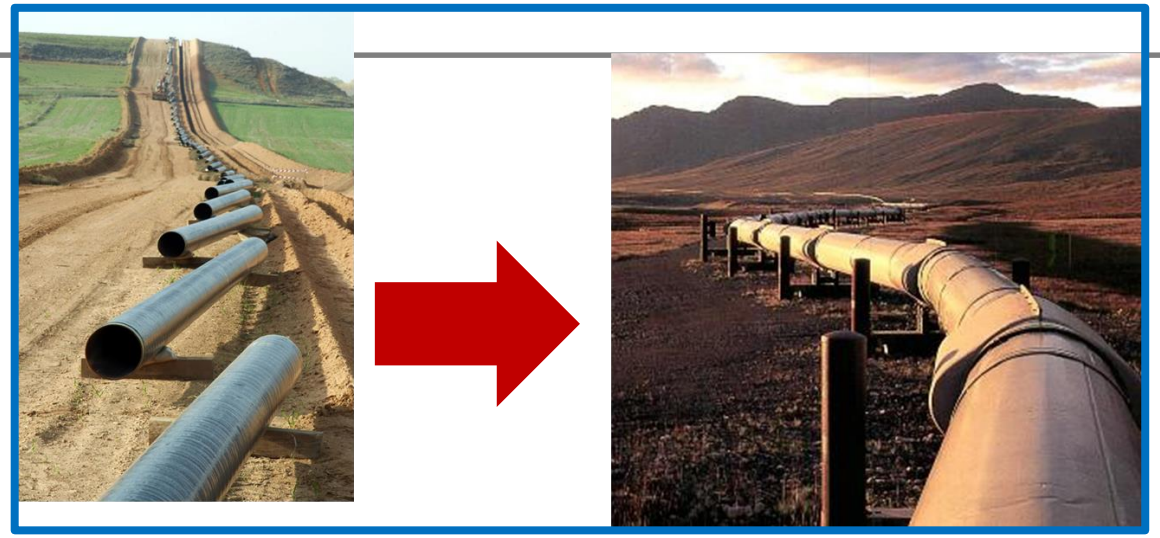
- **Admit the right students**
- **Include required curriculum in rural training sites**
- **A cadre of rural physicians dedicated to education of their successors**
- **Secure financial and relational support for the program**
- **Evaluate program progress**

https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1748-0361.2010.00334.x

Where do we go from here to accomplish our goals?

- Connect the UME-GME pipeline and extend it to pre-UME and post-GME
- Face the "scope of care" and "identity" issues in light of 21st century realities

Connect the UME (or earlier) -GME pipeline



- NRMP all-in exception based on “rural scholars program” application for individual programs or networks
- Graduating students are NOT required to use ERAS
- Residency programs ARE allowed to tell applicants that they intend to list the applicant “within our quota”

21st Century rural realities affecting workforce

- Generational expectations
- Educational costs
- Practice business model changes
- Medical technology ~~advances~~ evolution
- Information access
- Communication options
- Expectations of ~~patients~~ consumers
- Hospitalized patients are sicker
- Rural hospital CEOs and boards who don't understand the value and capacities of Family Physicians.
- Contracting scope of care by FPs – scope of care and our identity

Generational changes and expectations

- Gender evolution
  - More women in medicine, Family Medicine and rural practice
  - Requires attention to changing work/life time and effort allocation at various career and life stages
- Desire for better balance between work and personal life regardless of gender
- Income expectations
- Tolerance of “shift work”
- The new generation is being trained to USE and EXPECT teamwork
- It WILL take 1.5 “new” FTEs to replace 1.0 “old” FTEs.
- Very willing to prolong education (ie: fellowships and additional degrees)

Information, technology and communication

- Nobody owns information anymore
- Delivery of medical care involves more technology that is more expensive and requires more training
  - Point-of-care testing
  - Diagnostic imaging modalities - often combined with therapeutics
- Hospitalized patients are sicker
- Faster, “fancier” communication increases access to information and consultation – should increase the capabilities and effectiveness of rural primary care physicians

Rural patient expectations

- Population mobility brings people without a rural lens
  - Less self-reliant and less resilient
  - Expect immediate access to a technological approach to care
  - Have been trained to expect subspecialty "____ologist" care via the urban medical arms race
- Community Health Needs Assessments (CHNAs) for healthcare are conducted with an urban subspecialty bias and yield the expected results

Are we preparing our learners for the past or the future?

Is this us?

1932-1958

Is this us?

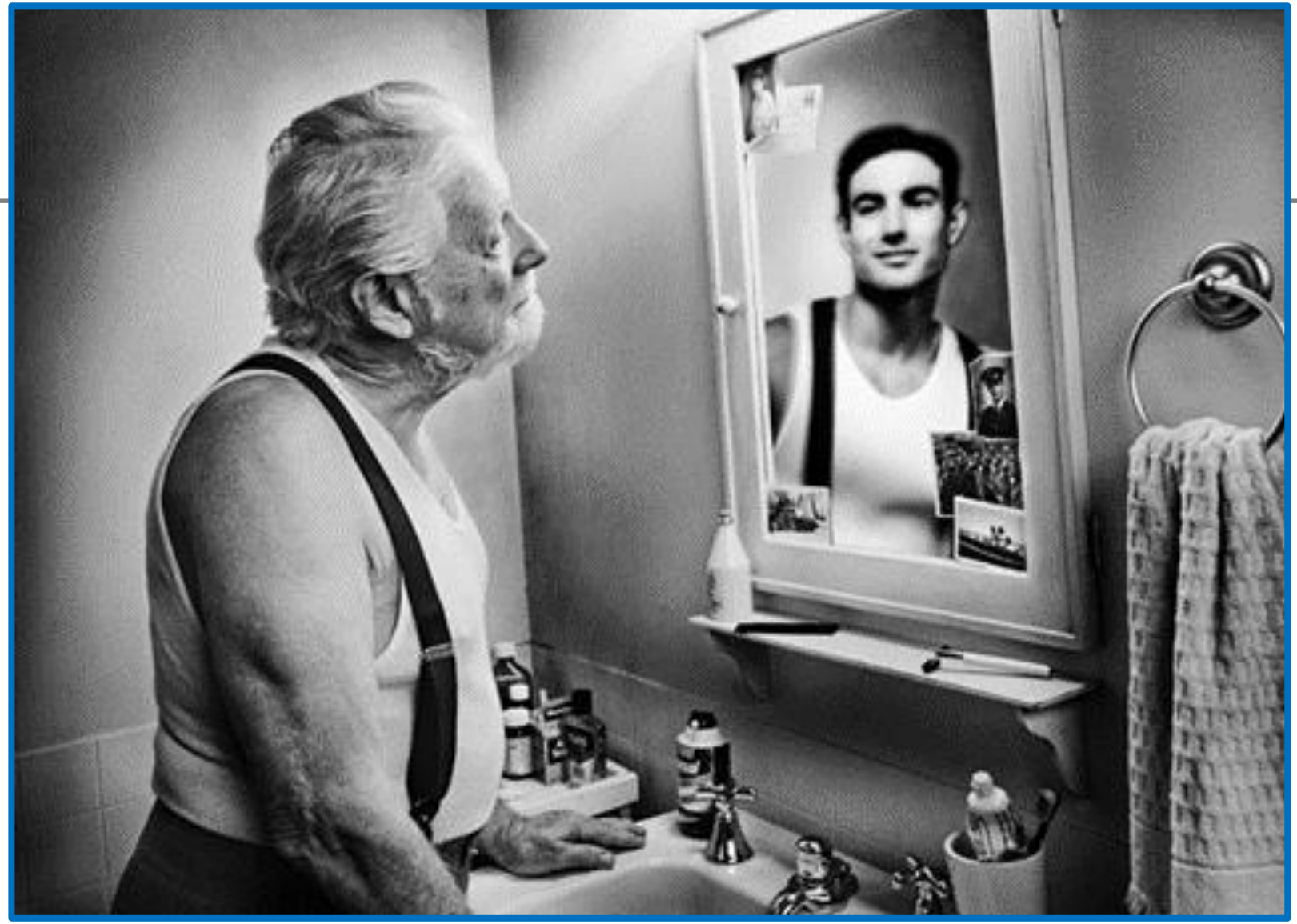
http://time.com/3456085/w-eugene-smiths-landmark-photo-essay-country-doctor/

Scope of care

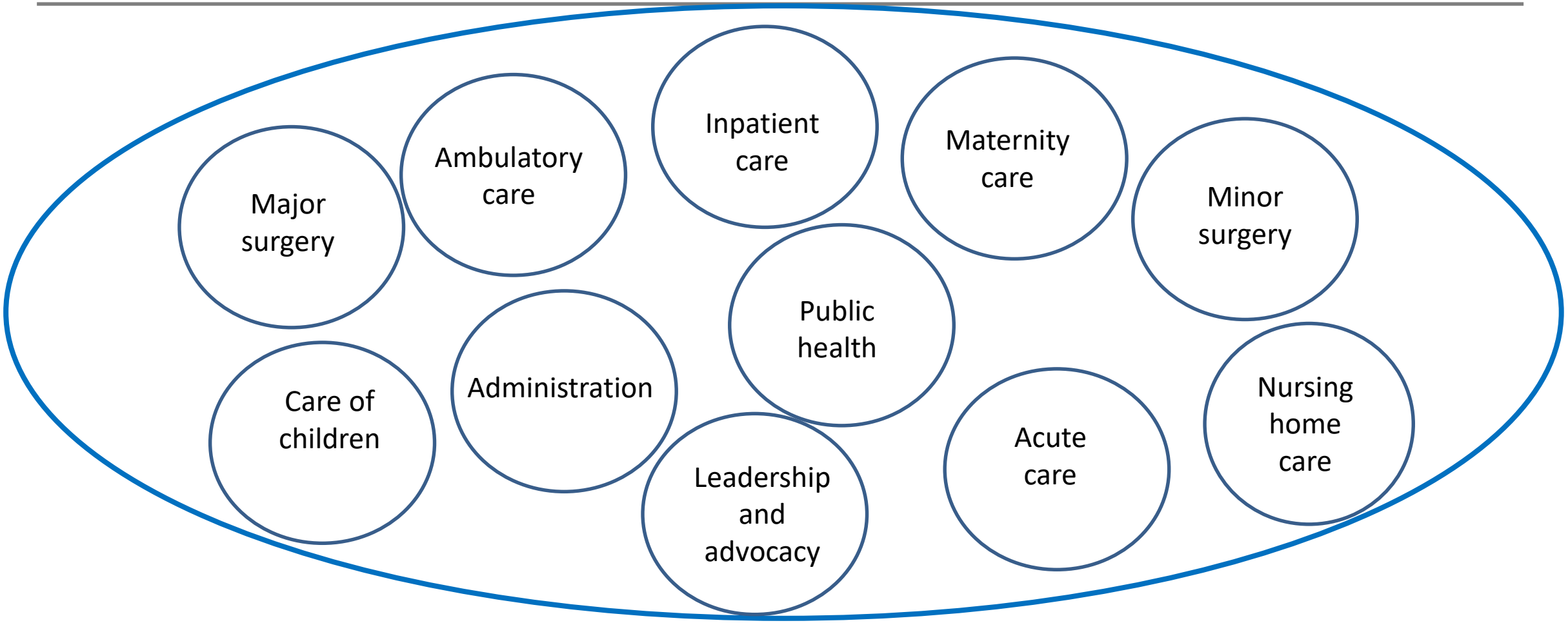
Rural physician workforce:
We have met the enemy and he/she/they is us!

Rural FM identity crisis

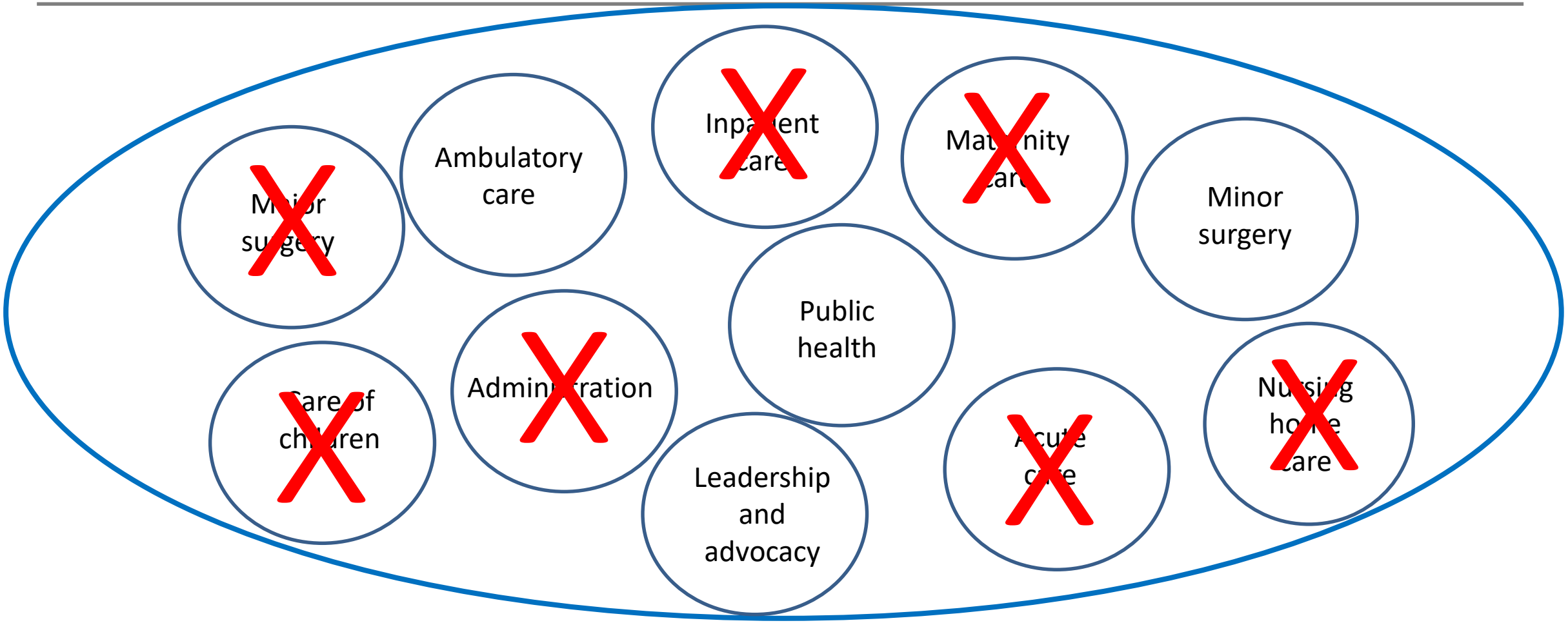
- Who are we?
- How do our learners see us?
- How do patients see us?
- How do administrators see us?
- What do we do (and not do)?
- What is unique and indispensable about what we do?
- How and what do we communicate to the outside?



Who are we and what do we do?



Where are we headed?



POLICY BRIEF

Wide Gap between Preparation and Scope of Practice of Early Career Family Physicians

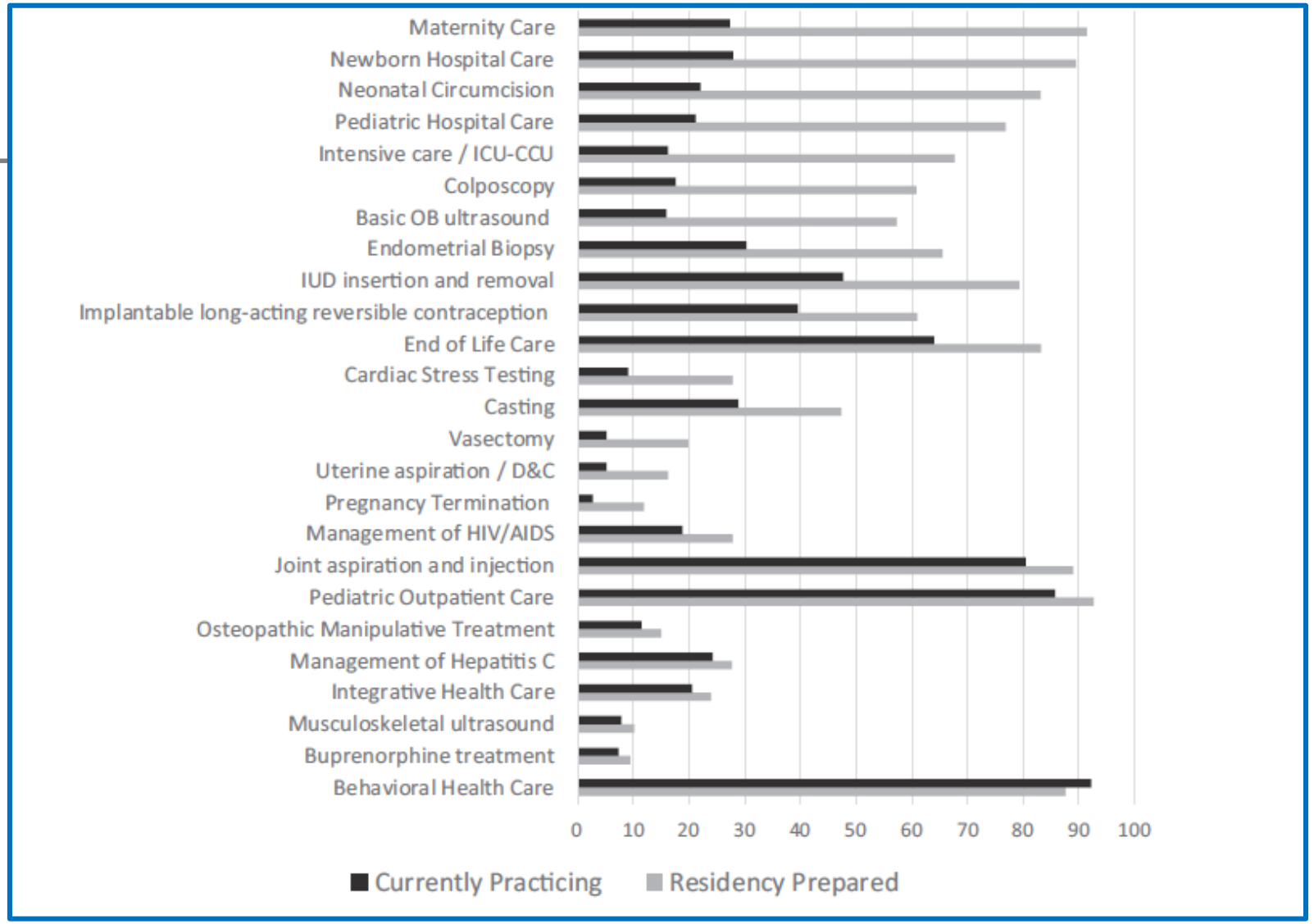
Lars E. Peterson, MD, PhD, Bo Fang, PhD, James C. Puffer, MD, and Andrew W. Bazemore, MD, MPH

We found substantial gaps between preparation for, and practice of, early career family physicians in nearly all clinical practice areas. With reported intentions of graduates for a broad scope of practice, gaps between practice and preparation suggest family physicians early in their careers may not be finding opportunities to provide comprehensive care. (J Am Board Fam Med 2018;31:181–182.)

Keywords: **Comprehensive Health Care, Family Physicians, Practice Gaps**

Scope of practice?

J Am Board Fam Med 2018;31:181-182



Once upon a time …

- There was a small town with a critical access hospital
- 15+ ER visits/day
- Service area: 10,000+ and 150 births/year
- Seasonal population fluctuations
- 7 FM physicians and 4 PAs in private practices
- 2 general surgeons serving this and another town
- Various visiting consultants
- Hospital board with a banker, rancher, teacher, retired MD …..
- CEO recruited by a national search company

Care and access model

- Admit their own inpatients
- Some night/weekend call sharing
- Share intrapartum care within their group and collaborate across groups when needed.
- Are paid by hospital to see ER patients on case-billed basis and covered on call on rotation
- Mixed ages – 2 considering retirement
- Ambulatory clinic office hours are 8-6 M-F and ½ day Sat.
- Acute visits accommodated daily; non-acute scheduled in a few days to a week or two.
- Seasonal population fluctuations
- “Downstreams” they generate are neither tracked nor valued

Facing 21st century healthcare

- Generational expectations re: work/life balance
- Expectations of the public
- Hospital care is more complex and time consuming
  - Sicker patients
  - More complex “disposition” problems
  - Documentation
  - Benchmarks and CQI
- More ER visits – but many not true emergencies
- Running an ambulatory practice is increasingly complex and expensive

Increasing ED visits

RESEARCH LETTER

Trends in Emergency Department Visits and Admission Rates Among US Acute Care Hospitals

Hospital-based care accounts for approximately one-third of US health expenditures, and increasingly, most hospitalizations originate from emergency departments (ED).[1-3] Value-based payment programs have focused on decreasing avoidable ED visits and hospitalizations. We describe trends in ED visits and admission rates among US acute care hospitals from January 1, 2006, through December 31, 2014.

Editor's Note

Results | From 2006 through 2014, annual ED visits increased by 18.4%, from 89.6 to 106.0 million, and total ED hospitalizations increased by 6.8%, from 17.4 to 18.6 million. During the same period, ED admission rates fell from 19.4% to 17.5%, a 9.8% relative decline.

https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2706174

Hospital and ER care "solution"

- Hire hospitalists
  - Local V. agency ?
  - Leave the nights and weekends to the local physicians to lower cost
  - Local physicians need to turn over care to hospitalists to pay for them (who are paid ++)
  - Negative effects on scope of care, practice satisfaction and continuity
- Hire full time emergency physicians
  - Local V. agency?
  - Hospital promotes ED visits to pay for the docs (who are paid ++)
  - Can local physicians participate?
  - Negative effects on scope of care, practice satisfaction and continuity

Repeat process and lose …

- Maternity care
- Care of children
- Gyn care
- GI
- ….

Justified by CHNA …

- Public wants increased convenience of access
- Public equates better **xyz-**care with presence of **xyz-**ologist.
- Hospital administration sees opportunity to grow its service line and market share

Financial consequences

- Some increased revenue, but it is expended on large subsidies of partialists that cannot be recouped by volume.
- Erosion of FM scope of care
- Primary care is neglected and underfunded
- Access problem to primary care is not improved
- Solitary partialist unhappy without a second one of same.

Rural hospitals emulate the worst of urban

https://www.denverpost.com/2018/10/04/colorado-health-care-costs-escalate/

DP Coloradans pay more as hospital building spree…

NEWS › COLORADO NEWS

Coloradans pay more as hospital building spree leads to empty beds and profits nearly twice the national average

Construction boom "invited a corruption of the system," top state administrator warns

Healthcare Information and Management Systems Society [US] | https://www.healthcarefinancenews.com/news/salaries-hospital-executive...

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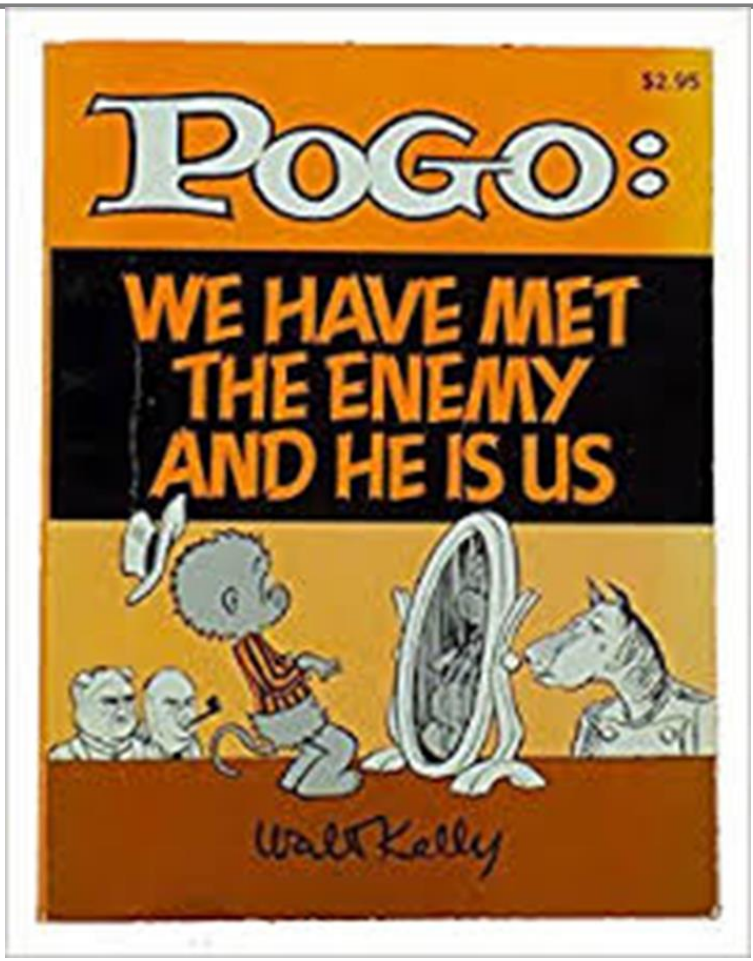
OCT 08 | MORE ON WORKFORCE

Salaries of hospital executives nearly doubled, while physicians see more modest increases

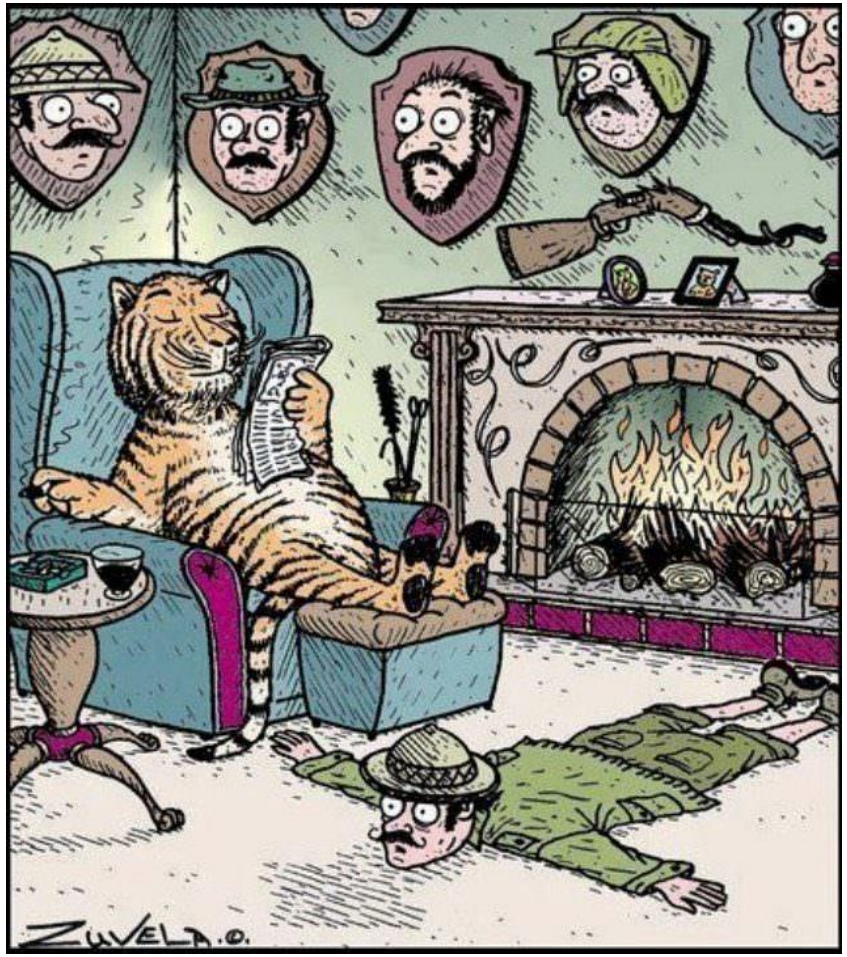
Between 2005 and 2015, average CEO compensation jumped from $1.6 million to $3.1 million, an increase of 93 percent.

Jeff Lagasse, *Associate Editor*

Why is this not happening?



In an alternative universe …



The alternative …

- Subsidy $ used to support recruitment of 3 to 4 new FPs:
  - Weekly hospitalist rotation system (solves clinic disruption issue)
  - ER coverage with diversion to clinic (solves ER overuse)
  - Enhanced after-hours clinic care with continuity (decreases ER use)
- Virtual or visiting consultations in specialty areas geared to population needs. Local physicians continue care.
- Virtual ICU consultation (after “stroke bot” model)

Making the clinical, financial and policy case for rural Family Medicine

- The AMCs are not doing this
- Our national organizations have good intentions
- The public does not understand – “upsize” analogy
- Rural hospital boards and CEO’s need help understanding FM
- It is possible to develop a template for rational rural workforce planning to meet access, quality, affordability and survivability.
- Is rural Family Medicine a new specialty?

http://news.doximity.com/entries/14087954?referrer_uri=https%3A%2F%2Fwww.doximity.com%2Fnewsfeed%2Fcollections%2Fdocnews

Nope, “provider” still doesn’t work

by Jennifer Weiss | Sep 12, 2018 | Uncategorized | 25 comments
kevinmd.com published a version of this story on Sept 12, 2018

In November of 2015, Dr. Suneel Dhand and William J. Carbone penned, “Physicians are not providers: An Open Letter to the AMA (American Medical Association) and medical boards.” The authors ended their piece with the following plea: “The word “provider” is a non-specific and

Emergency Department Visits in Rural Colorado Critical Access Hospitals: Is Family Medicine Training Adequate Preparation?

University of Colorado Anschutz Medical Campus

Brittany Shilling, MS-IV and Mark Deutchman, MD

University of Colorado School of Medicine | Department of Family Medicine

- 78,000 ED visits from 20 of the 29 Colorado rural critical access hospitals in 2012
- Principal ICD-9 diagnosis codes were re-coded into clinically meaningful clusters
- 3,576 principal procedures were re-coded using diagnosis code titles,
- Frequency and percentage of each cluster or procedure code was determined
- Compared to current family medicine residency curriculum guidelines

- FM residency curriculum guidelines included the top 95% of principal diagnosis clusters seen in rural Colorado critical access hospital EDs
- All of the principal diagnosis clusters for deceased patients in rural Colorado critical access hospital EDs in 2012 were included in FM residency curriculum guidelines
- FM residency curriculum guidelines also included the performance or indications for over 95% of the principal procedures carried out in rural Colorado critical access hospital EDs in 2012
- If additional training for infrequent and acute problems is required by FPs, focused courses such as ACLS, ATLS, PALS, and even rural ED fellowships are available

A rural workforce success story

https://www.politico.com/magazine/story/2018/05/26/kansas-hospital-rural-healthcare-218407

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LETTER FROM KANSAS

How a Tiny Kansas Town Rebooted Its Struggling Hospital into a Health Care Jewel

An innovative exec found a way to recruit doctors, help refugees and make money delivering babies.

By LISA RAB | May 26, 2018

A visitor enters Kearny County Hospital in Lakin, Kan., Friday, Feb. 3, 2017. | AP Photo/Orlin Wagner

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Twitter

LAKIN, Kansas—No stoplight marks the entrance to Lakin, just a gas station, a Subway, and a Dollar General. On Main Street, a

They do it with Family Medicine

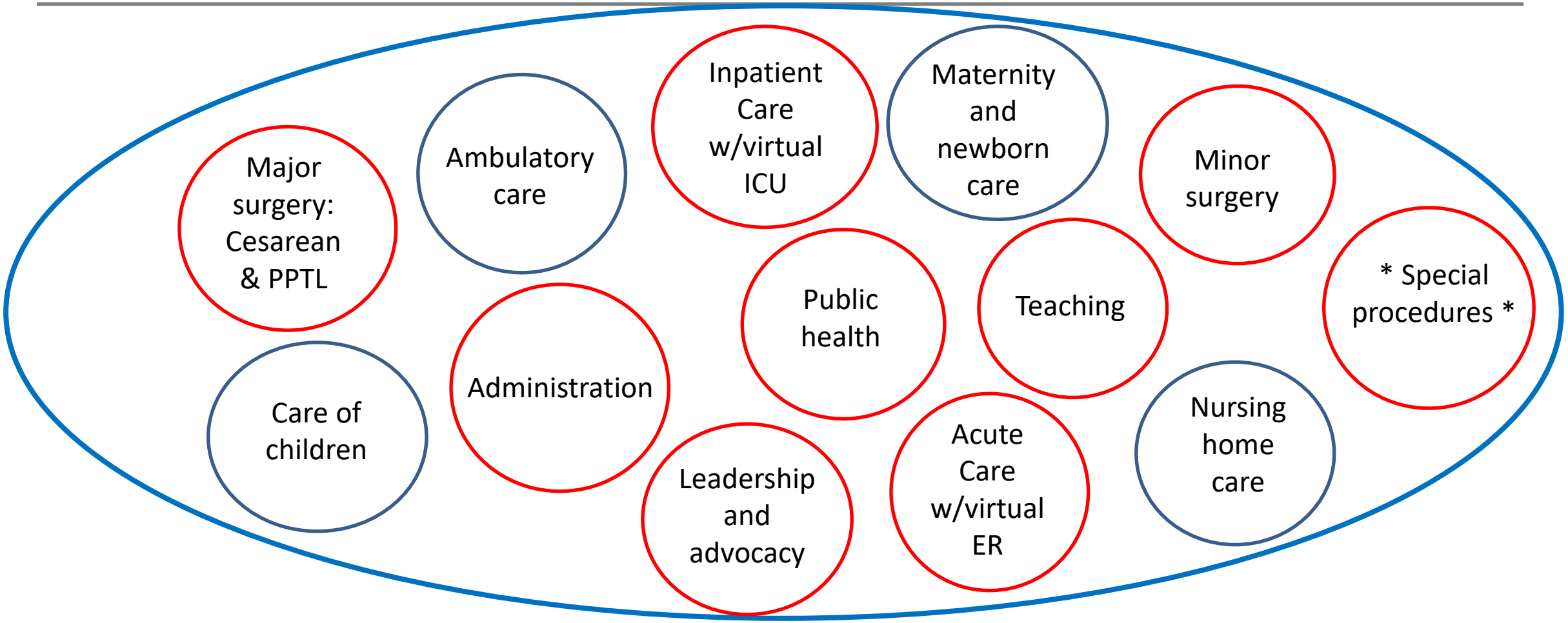
7 Family Medicine MDs
1 ENT DO
2 APNs
3 PAs

Updated 10/23/2018

Success model: Ronan MT

- Affiliation with a FM residency
- Recruit peer groups of new physicians
- Core of medical staff are full scope FPs
- Visiting consultants for subspecialty services
- Mentorship of new physicians (not “jumping off a cliff”)

Rural Family Medicine specialty



Developing/supporting the new specialty

- ? Fellowships
- Financial modeling
  - Value demonstration
  - Investment/partnering with the rural recipient site
- Placement of pairs or groups in rural sites

Financial modeling: shifting our thinking

- Currently, the value = revenue generation and is based on generating the highest cost goods and services.
- Currently the working assumption is that the amount of money available to be harvested in unlimited.
- When it is recognized that the amount of money available is finite, former revenue centers become cost centers.
- In the finite world, the value becomes:
  - Prevention of acute and chronic disease
  - Management of chronic disease that has not been prevented
  - Prompt and efficient treatment of acute conditions to decrease cost and disability
  - All in an environment that recognizes the patient within the context of family, community and population.

Toward rational workforce planning

Community size, geography, service area, demographics …

Physician workload expectations: days in clinic, hospital and ER as well as meaning of an FTE

Expected patient diseases, conditions and patient volumes for ambulatory, inpatient, maternity, ECF and ER visits

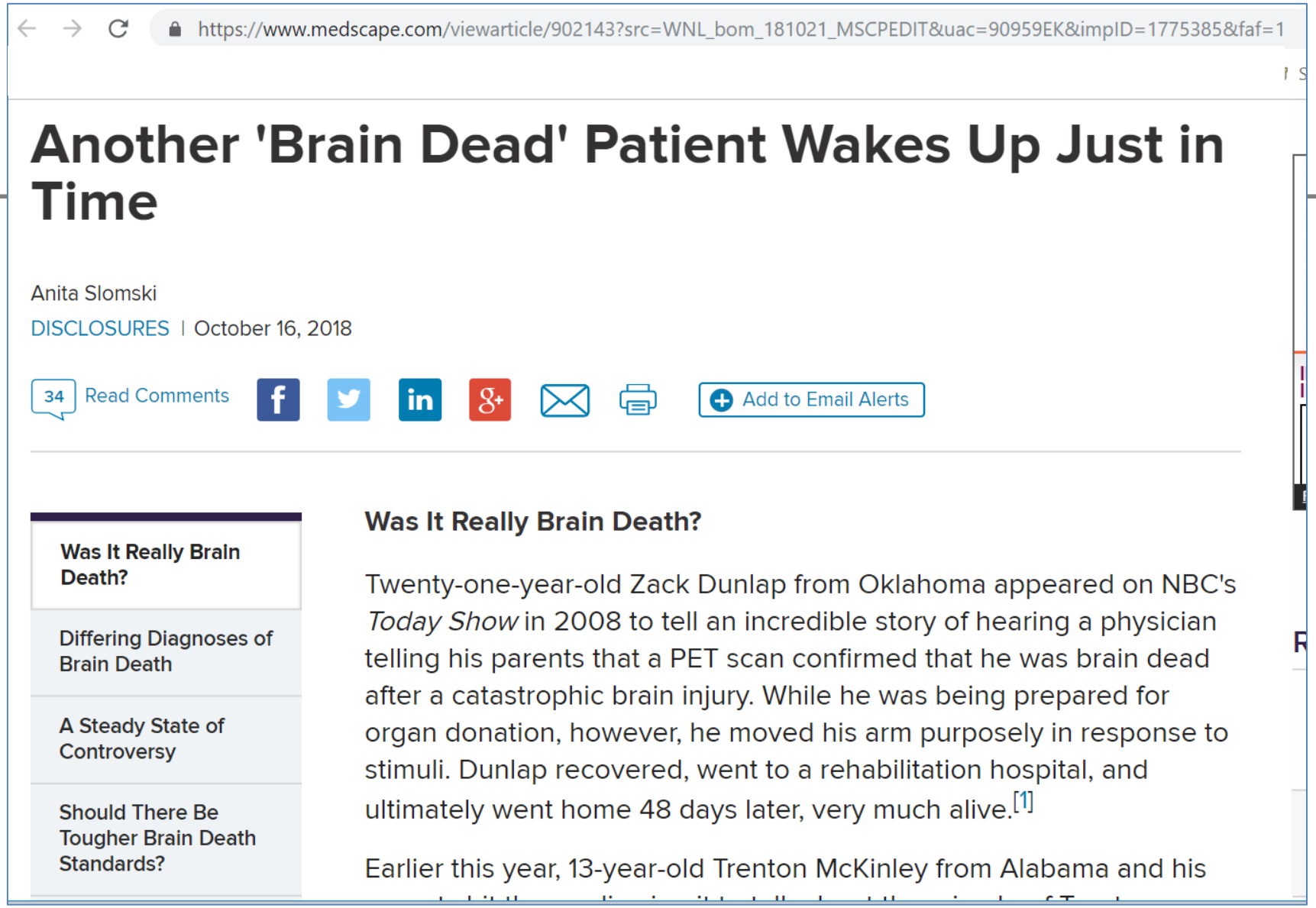
Calculation of Family Physician FTEs required assuming all have requisite scope of care

Calculation of PA/APN to replace some FP time and fill in to free up FPs with most in-demand skills

Calculation of conditions for which a visiting or virtual subspecialist is needed or may be self-sufficient.

Financial modeling: value

- Basing the workforce on Family Medicine creates a deep, versatile and resilient base of human capital
- Pool the $ for ambulatory, inpatient and ER care
- Count downstreams including referrals and case management


https://www.medscape.com/viewarticle/902143?src=WNL_bom_181021_MSCPEDIT&uac=90959EK&impID=1775385&faf=1
Another 'Brain Dead' Patient Wakes Up Just in Time
Anita Slomski
DISCLOSURES | October 16, 2018
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Was It Really Brain Death?
Differing Diagnoses of Brain Death
A Steady State of Controversy
Should There Be Tougher Brain Death Standards?
Was It Really Brain Death?
Twenty-one-year-old Zack Dunlap from Oklahoma appeared on NBC's Today Show in 2008 to tell an incredible story of hearing a physician telling his parents that a PET scan confirmed that he was brain dead after a catastrophic brain injury. While he was being prepared for organ donation, however, he moved his arm purposely in response to stimuli. Dunlap recovered, went to a rehabilitation hospital, and ultimately went home 48 days later, very much alive.[1]
Earlier this year, 13-year-old Trenton McKinley from Alabama and his