Outcomes from the HRSA Rural Residency Planning and Development Program

Rural Residency Planning and Development - Technical Assistance Center

A partnership between

NORTH CAROLINA AHEC

WCRGME
WISCONSIN COLLABORATIVE for RURAL GME

UNC SCHOOL OF MEDICINE

UW Medicine
UW SCHOOL OF MEDICINE

OHIO UNIVERSITY
Heritage College of Osteopathic Medicine

The RTT Collaborative

School of Medicine and Public Health
UNIVERSITY OF WISCONSIN–MADISON

UNC THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

RuralGME.org

Disclosures

RRPD-TAC is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement #UK6RH32513. The content are those of the presenters and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Rural Residency Planning & Development Technical Assistance Center (RRPD-TAC)
Lead PI: Cristy Page

HUBS
Advisor Pairing & Regional Coordination

CONTENT EXPERTS
Ad hoc Technical Advisory Resources

KEY PARTNERS
Network, Consultant, Education & Research Support

KEY STAKEHOLDERS & EXTERNAL PARTNERS
Assistance and/or Resources

Western Hub
U Washington
Lead: Chen
Advisor Specialties
FM | IM | Psy | OB | GS | PM

Central Hub
U Wisconsin
Lead: Spencer
Advisor Specialties
FM | IM | Psy | OB | GS | PM

Eastern Hub
UNC-CH
Lead: Page
Advisor Specialties
FM | IM | Psy | OB | GS | PM

Networks
- RTTC - The RTT Collaborative
- WWAMI - Residency Network
- WCRGME - Wisconsin Collaborative for Rural GME

Consultant Organizations*
- RTTC - The RTT Collaborative
- RPS - Residency Program Solutions
- PKF Health - Perry, Krumsiek, & Francazio, LLC

Education and Research
- NC AHEC - North Carolina Area Health Education Centers
- Sheps - Cecil G. Sheps Center for Health Services Research
- UWSMPH - University of Wisconsin School of Medicine
- UWSOM - University of Washington School of Medicine

***Consultant Disclaimer**: Other consultant organizations may be considered upon approval by HRSA and TAC.*

KEY
- RRPD-TAC Hub
- RRPD Awardees
- Content Expert
- RTTC Network
- WWAMI Network
- WCRCME Network
- NC AHEC Network

Our team today

Emily Hawes, PharmD

Amanda Weidner, MPH

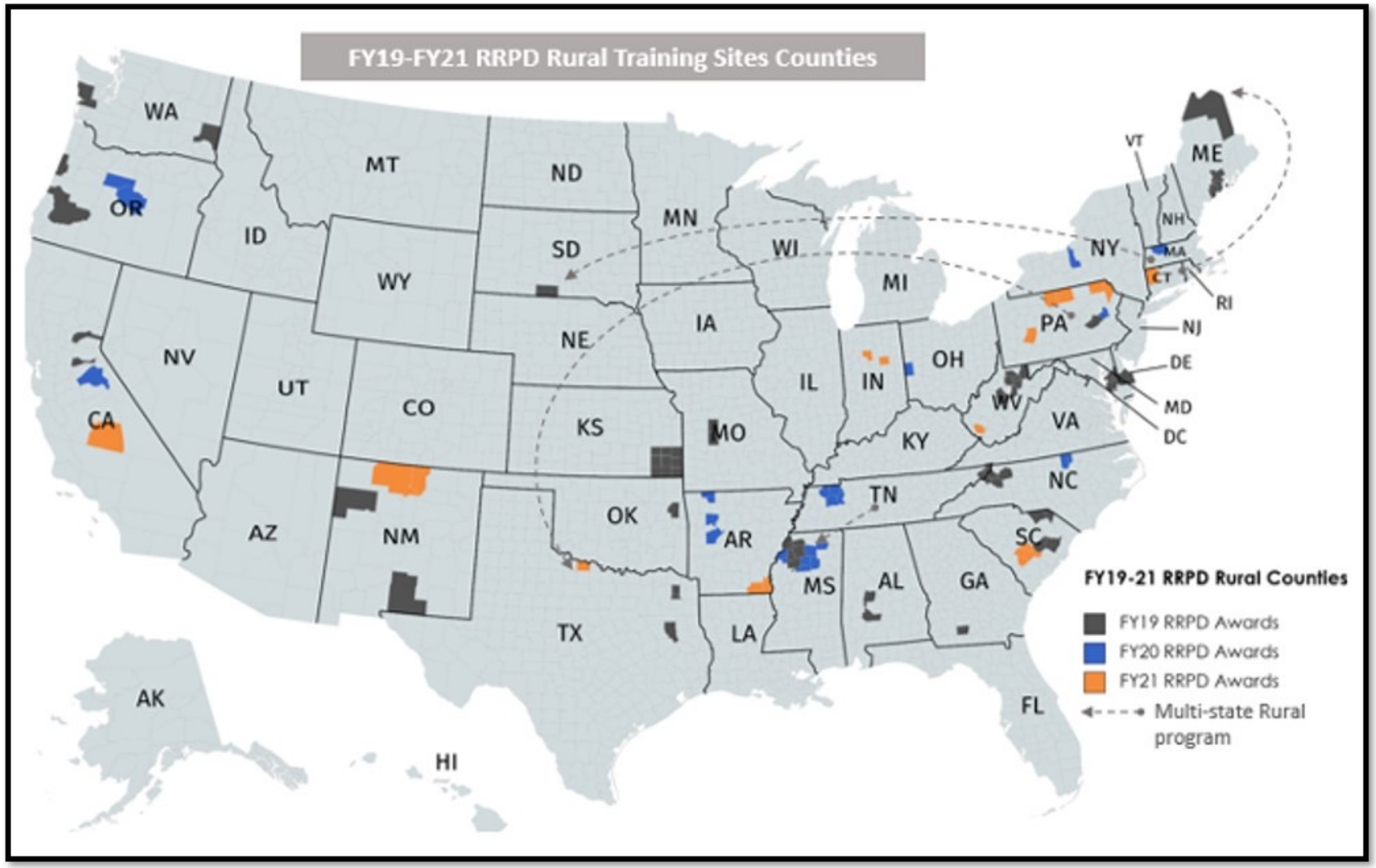
Frederick Chen, MD, MPH

Judy Pauwels, MD

Objectives

By the end of this session, attendees will:

1. Understand quantitative and qualitative findings from the Rural Residency Planning and Development (RRPD) program.
2. Evaluate key facilitators and barriers to rural program development.
3. Elicit feedback on the evaluation strategy to help ensure broad impact for rural program development and sustainability.


FY19-FY21 RRPD Rural Training Sites Counties
WA
OR
CA
ID
NV
MT
WY
UT
AZ
CO
NM
ND
SD
NE
KS
OK
TX
MN
IA
MO
AR
LA
WI
IL
MS
MI
IN
KY
TN
AL
OH
WV
GA
FL
SC
NC
VA
PA
NY
VT
ME
NH
MA
CT
RI
NJ
DE
MD
DC
AK
HI
FY19-21 RRPD Rural Counties
FY19 RRPD Awards
FY20 RRPD Awards
FY21 RRPD Awards
Multi-state Rural program

STAGE 1 Exploration

Community Assets

Identify community assets and interested parties.

Leadership

Assemble local leadership and determine program mission.

Sponsorship

Identify an institutional affiliation or sponsorship. Begin to consider financial options and governance structure.

To advance to the next stage:
Make an organizational decision to proceed with investing significant resources in program development.

STAGE 2 Design

Initial Educational & Programmatic Design

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

Financial Planning

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

Sponsoring Institution Application

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

To advance to the next stage:
Finalize a draft budget. Complete program design to include curriculum outline and site mapping. Submit a Sponsoring Institution (SI) application & receive initial accreditation.

STAGE 3 Development

Program Personnel

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

Program Planning & Accreditation

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

To advance to the next stage:
Achieve initial program accreditation – requires successful site visit and letter of accreditation from the ACGME.

STAGE 4 Start-Up

Marketing & Resident Recruitment

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

Program Infrastructure & Resources

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

Matriculate

Welcome and orient new residents.

To advance to the next stage:
Complete contracts and orient first class of residents. Hire all required faculty.

STAGE 5 Maintenance

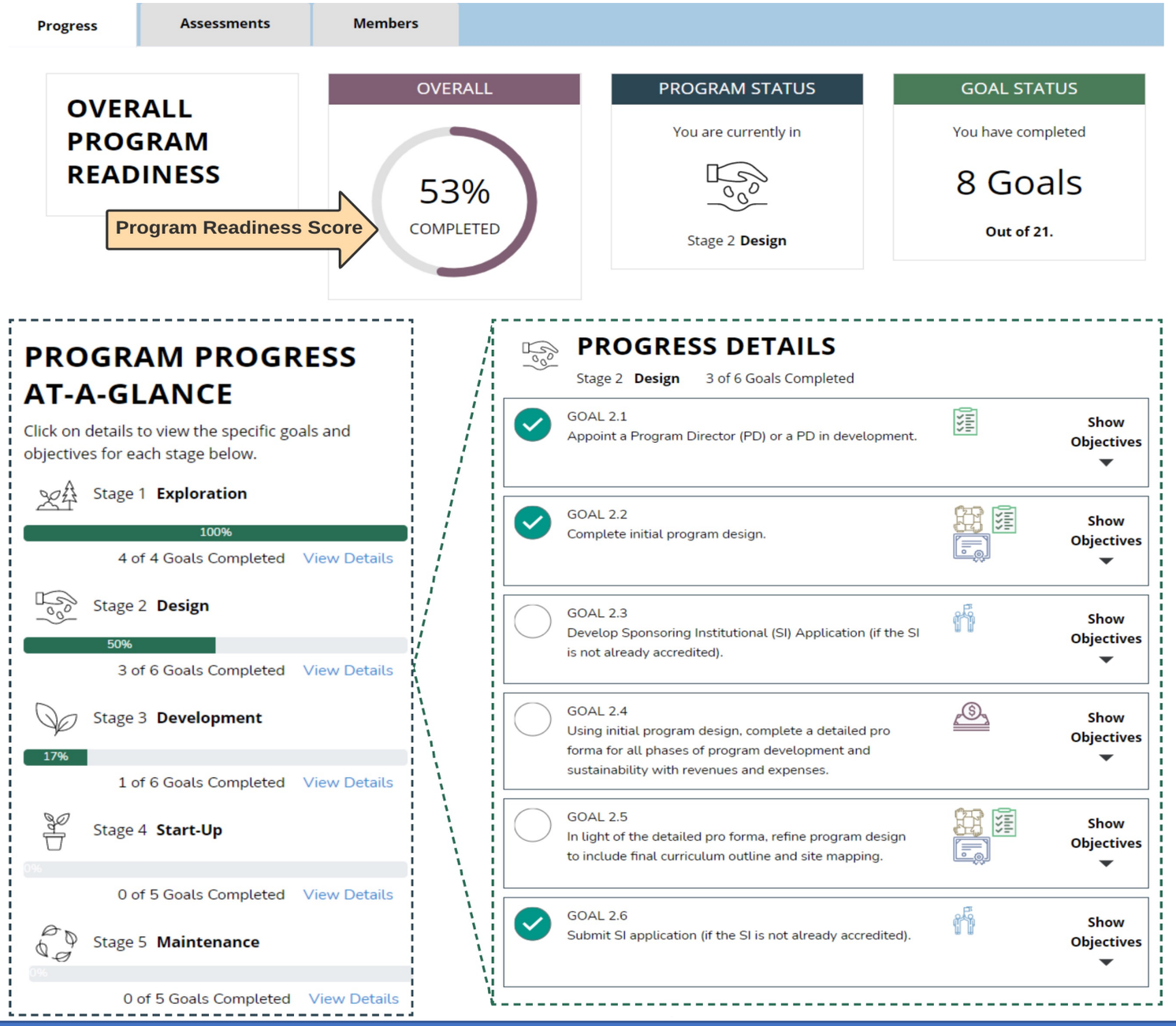
Ongoing Efforts

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

RuralGME.org

J Grad Med Educ. 2020 Aug;12(4):384-387. doi: 10.4300/JGME-D-19-00932.1.

Quarterly Data Collection



Quarterly Data Collection

		*STAGES										READINESS SCORE									
		'19	2020				2021				'22	'19	2020				2021				'22
Specialty - Location		Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
COHORT 1																					
	FM	○	○	○	○	(relinquished)						11	10	10	10	(relinquished)					
	FM	○	◑	◑	◕	◕	◑	◑	◑	◑	◕	65	76	82	85	85	86	86	89	96	98
	FM	○	○	○	○	◔	◔	◔	◔	◔	◔	9	20	29	34	37	45	45	45	47	52
	FM	○	○	○	○	◑	◑	◑	◑	◑	◑	23	26	26	26	75	80	80	81	86	88
	FM	○	○	○	○	○	○	○	◑	◑	◕	12	38	40	74	74	74	74	82	91	94
	FM	◑	◕	◕	◑	◑	◑	◑	◑	●	●	80	88	92	94	94	94	94	94	100	100
	FM	○	○	○	○	○	○	(relinquished)				29	29	29	28	28	28	(relinquished)			
	FM	◔	◑	◑	◑	◑	◑	◑	◕	◕	◕	65	70	93	96	96	96	96	98	98	98
	FM	○	◔	◔	◔	◔	◑	◑	◑	◑	◑	13	38	51	53	77	84	84	86	91	92
	FM	◑	◑	◑	●	●	●	●	●	●	●	83	88	96	100	100	100	100	100	100	100
	FM	○	○	○	○	○	◕	◕	◕	◕	◕	76	93	96	96	96	99	99	99	99	99
	FM	○	○	○	○	◔	◔	◔	◑	◑	◑	19	28	30	33	44	50	50	59	62	69
	FM	◔	◑	◕	◕	◕	◕	◕	◕	●	●	53	79	83	88	91	93	93	99	100	100
	FM	○	○	◔	◔	◔	◔	◔	◑	◑	◑	22	26	41	54	57	62	62	72	72	88
	FM	○	○	○	○	○	○	○	○	◑	◑	10	10	18	54	59	59	59	61	77	77
	FM	○	○	○	○	○	○	○	◑	◑	◑	15	29	36	46	58	68	68	75	76	76
	FM	○	○	○	◔	◔	◑	◑	◑	◑	◑	57	72	74	77	85	88	88	92	96	96
	FM	◑	◕	◕	◕	◕	◕	◕	◕	◕	◕	92	94	98	98	99	99	99	99	99	99
	FM	○	○	○	○	○	○	○	○	◔	◔	11	15	15	20	26	38	38	38	47	47
	FM	○	○	○	○	○	○	○	○	◔	◔	15	23	30	41	49	65	65	68	78	79
	FM	○	○	◔	◔	◑	◑	◑	◑	◕	◕	21	29	35	51	68	78	78	80	82	82
	FM	○	○	○	○	◔	◔	◔	◔	◔	◔	66	69	85	85	88	85	85	91	92	92

1=red
51=yellow
100=green

RuralGME.org

Quarterly Data Collection

Specialty - Location		*STAGES '19 Q4	2020 Q1	Q2	Q3	Q4	2021 Q1	Q2	Q3	Q4	'22 Q1	READINESS SCORE '19 Q4	2020 Q1	Q2	Q3	Q4	2021 Q1	Q2	Q3	Q4	'22 Q1
	IM	○	○	○	○	○	○	○	○	○	○	11	12	12	15	25	28	28	28	33	46
	Psy	◔	◔	◔	◔	◑	◑	◑	◑	◑	◑	32	34	39	39	87	88	88	88	90	90
	Psy	○	○	○	○	○	○	○	◑	◑	◕	20	20	33	33	33	56	56	77	79	87
	Psy	○	○	○	○	○	◑	◑	◑	◕	●	35	44	44	44	46	83	83	83	96	100
	Psy	○	○	○	○	◔	◔	◔	◔	◔	◔	14	25	36	44	46	53	53	53	65	65
COHORT 2																					
	FM					○	◔	◔	◔	◑	◑					41	61	61	73	91	91
	FM					○	◔	◔	◔	◔	◔					16	40	40	62	65	70
	FM					○	○	○	○	◑	◑					59	74	74	84	89	89
	FM					○	○	○	○	○	◔					14	15	15	18	27	55
	FM					○	○	○	○	◔	◔					1	3	3	1	53	61
	FM					○	○	○	◑	◑	◑					33	47	47	61	69	78
	FM					○	○	○	○	○	◔					23	28	28	39	49	63
	FM					○	○	○	○	○	○					9	19	19	41	42	42
	IM					◑	○	○	○	●	●					78	90	90	94	100	100
	IM					◔	○	○	◔	◔	◑					40	45	45	67	67	71
	Psy					○	◔	◔	◔	◔	◔					65	66	66	66	66	66

Key: FM = Family Medicine, IM = Internal Medicine, Psy = Psychiatry

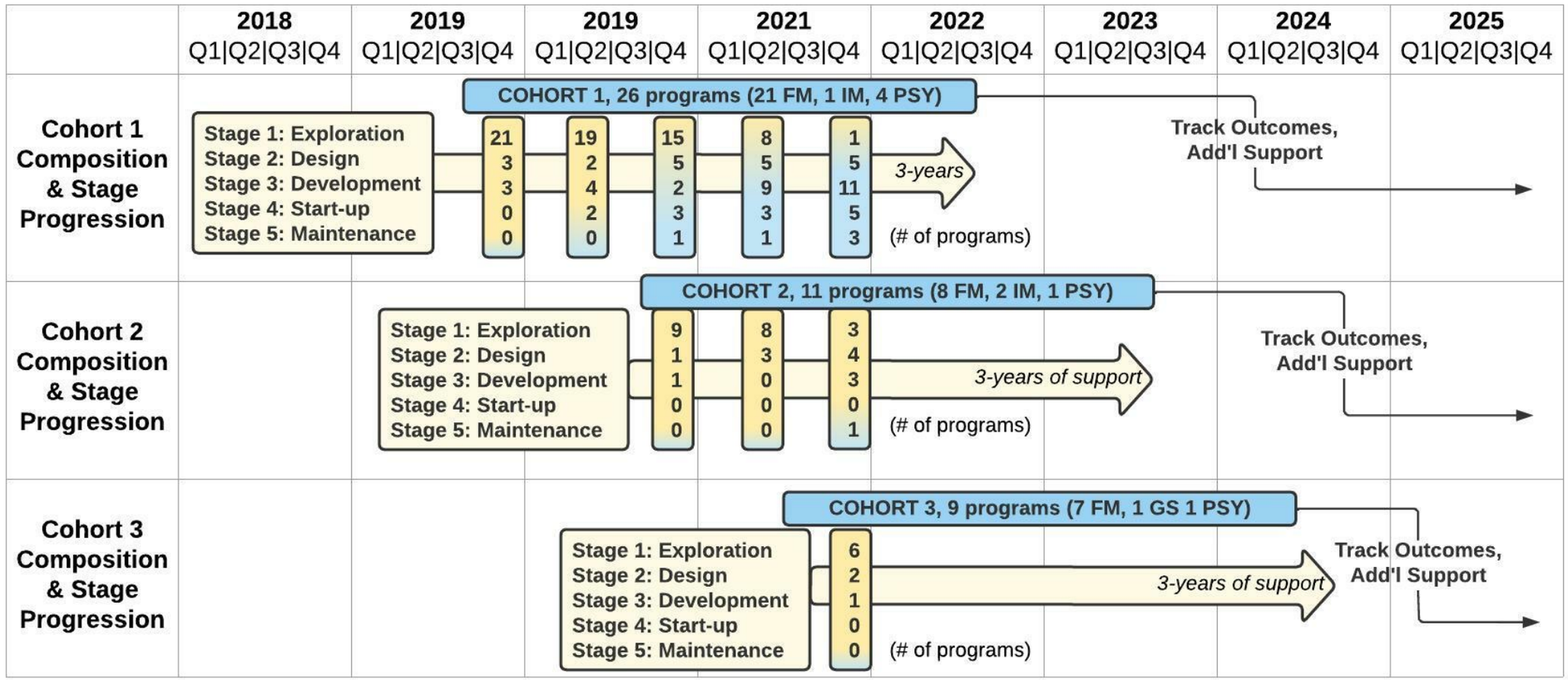
*Stages: 1, Exploration =○; 2, Design =◔; 3, Development =◑; 4, Start-up =◕; 5, Maintenance =●

RuralGME.org

1=red, 51=yellow, and 100=green

Program Readiness Scoring

Program Readiness Scoring	
Baseline readiness score (Year 1 Quarter 1)	Median Readiness Score: 21% (range 2-91%)
Cohort 1 current readiness score (Year 2, Quarter 4)	Median Readiness Score: 88% (range 10-100%)
Cohort 2 current readiness score (Year 1, Quarter 4)	Median Readiness Score: 66% (range 27-100%)



KEY: FM = Family Medicine, IM - Internal Medicine, PSY = Psychiatry, OB = Obstetrics and Gynecology, GS = General Surgery, PM= General Preventive Medicine

Program Outcomes – Pre-Accreditation

Developmental Outcomes	Count
Programs that completed a **detailed pro-forma** for all phases of program development to ensure sustainability with expected revenues and expenses	28 (62%)
Programs that have **developed a governance structure**	39 (87%)
Programs that obtained **Sponsoring Institution accreditation**	40 (89%)
Programs that have **recruited a Program Director**	37 (82%)
Programs that have **recruited core faculty members**	21 (47%)
Programs that have completed a detailed **community asset inventory**	42 (93%)
Programs that have **designed the curriculum** (including site mapping)	30 (67%)

Program Outcomes - Accreditation

Developmental Outcomes	Count
Programs that have submitted an **ACGME application**	27 (60%)
Programs that **obtained ACGME accreditation**	24 (53%)
ACGME **approved resident positions** (at full complement) **251 FM, 36 IM, 32 Psych**	319
Residents matched into the 12 programs who recruited residents (2022 Match)	94

Common Barriers

Challenge Identified	#
Financial Planning (e.g. Medicare funding for rural hospitals, Medicare cap limitations, GME funding sustainability issues)	94
Faculty Recruitment (e.g. difficulty finding faculty, retiring providers, variable teaching interest in community faculty)	91
Curricular Design (e.g. limited rotation experiences, low patient volumes)	20
Electronic Health Record Adaptation for Residency (e.g. no templates or co-signature)	20
Faculty Development (e.g. faculty with limited academic experience, low admin time)	18
Accreditation (e.g. patient encounter standards, distance traveled for rotations)	13
Resident Recruitment	7

Actions to Address Common Challenges

Actions to Address Challenges
Longitudinal advising and coaching with expert in new program development
In-depth financial consultations, including external consultations
Monthly webinars and online tools targeted to specific areas
In-depth community asset inventory early in development to identify needs and strategize specific local solutions
Connection with peer support networks and specific specialty organizations

Broader Impacts of RRPD

Recent changes to ACGME:

- Creation of new programmatic unit for Medically Underserved Areas/Populations and GME
- Rural Track Program designation

Accreditation Council for Graduate Medical Education

Recent changes to Medicare: Consolidated Appropriations Act, 2021

- Section 126: Distribution of Additional residency Positions
- Section 127: Promoting Rural Hospital GME Funding Opportunity
- Section 131: Adjustment of Low Per Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals

CMS.gov
Centers for Medicare & Medicaid Services

Toolbox

Community Engagement

Program Design & Development

Financial Planning

Institutional Sponsorship

Program Accreditation

Program Implementation

Evaluation

1. Technical Assistance
   - Onboarding, Program Readiness, Consultations Utilized, Toolbox Usage, Webinar Attendance, Consultants Developed
2. Program Development
   - Community Engagement, Institutional Sponsorship, Accreditation, Financial Sustainability, Program Design, Resident Recruitment, Faculty Recruitment and Retention, Program and Training Site Characteristics
3. Program Impact & Sustainability
   - Training Site - Characteristics, Clinical Services
   - Resident-in-Training and Graduate Characteristics

Discussion

Questions?

Gaps in knowledge?

Resources?

Contact!

Email us

info@ruralgme.org

Follow us on Twitter

@ruralGME

RuralGME.org


RuralGME.org
HOME
REGIONAL HUBS
VIDEOS
PORTAL
RURAL RESIDENCY RESOURCES
If you would like to access our portal containing resources for developing rural residencies, please use the link below to regist online.
REGISTER
RuralGME.org

Extra resource slides

Additional Resources

- **CMS 2022 final rule home page:** https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page
- **Federal Register:** https://www.federalregister.gov/documents/2021/12/27/2021-27523/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-changes-to
- **CMS DGME website**: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME
- **ACGME Rural Tracks info:** https://www.acgme.org/what-we-do/accreditation/medically-underserved-areas-and-populations/rural-tracks/

ACGME Rural Track Program (RTP)

An ACGME-accredited program with a unique 10-digit identifier in which residents/fellows gain both urban and rural experience with more than half of the education and training for each resident/fellow taking place in a rural area (any area outside of a Core-Based Statistical Area (CBSA)).

ACGME Rural Track Related Program

A separately accredited program in the same specialty at the same Sponsoring Institution in which residents/fellows have some overlapping education and training experiences with the ACGME Rural Track Program residents/fellows and may share resources.

Rural Tracks

ACGME Rural Track Program Designation

Consistent with Section II of the MUA/P framework, the ACGME is developing processes addressing ACGME-accredited programs that are also "rural tracks" as defined in rules and regulations of the Centers for Medicare and Medicaid Services (CMS) in 42 CFR §413.79(k).

Under current CMS regulations, urban teaching hospitals have an opportunity to obtain reimbursement for direct GME (DGME) and indirect medical education (IME) financing by partnering with rural hospitals and other rural sites to create separately accredited rural track programs (RTPs). In RTPs, residents are assigned to certain types of participating sites in rural areas for more than half of the length of their residency program. While CMS does not limit the creation of RTPs to specific specialties, RTPs have historically been created in the specialty of family medicine only (some RTPs in Family Medicine are often called "1-2 programs."). Recognizing that alignment of ACGME processes with CMS regulations will facilitate the expansion of opportunities to address the health care

Quick Links

Medically Underserved Areas and Populations »

Rural Tracks »

ACGME Newsroom and Blog Updates on Medically Underserved Areas »

ACGME Specialties »

CAA Section 126: Distribution of Additional Residency Positions

Section 126: Additional Residency Slots

- Makes available an additional 1,000 FTE resident cap slots phased in at a rate of no more than 200 slots per year beginning with an allocation for 2023.
- Deadline was March 31, 2022 to apply for first 200 slots. Will have 4 more “rounds” in the coming years.

Section 126: Additional Residency Slots

The additional cap slots will be distributed to hospitals that are included in **at least one** of the following four categories (with at least 10% of slots going to each category over 5 years):

- Hospitals located in rural areas or that are treated as being in a rural area.
- Hospitals that are training residents over their cap amount.
- Hospitals located in the 35 states (listed in the rule) with new medical schools or additional locations and branches of existing campuses.
- Hospitals that train residents in a program where at least 50 percent of all residents' training time occurs at site(s) physically located in a geographic Health Professional Shortage Area(s) (HPSA).
  - Mental health geographic HPSAs can only be used for psychiatric programs.

Section 126: Additional Residency Slots

Additionally, HPSA scores will be used to prioritize ***all*** applications, not just category 4. A hospital must meet the "50 percent criterion" such that at least 50 percent of the training time of the program requesting the increased slots must occur at facilities physically located in a geographic *or* population HPSA (or 5 percent if 45 percent of the training time occurs at an IHS facility/facilities).

CAA Section 127: Promoting Rural Hospital GME Funding Opportunity

Effective for cost reporting periods beginning on or after October 1, 2022

RuralGME.org

Section 127 – Rural Track Programs

- **New definition** and language aligned with the ACGME process for pre-accreditation endorsement as a “rural track program (RTP)” for tracks beginning in the first cost-reporting period after 10-1-2022
- New opportunity to create “**not separately accredited**” programs in multiple specialties
- New opportunity for urban hospitals to expand an already established, and separately accredited, RTT (previous terminology) that they sponsor or in which they participate, now an “RTP,” to **additional rural sites**; a rural hospital can only do so with another “RTP” of an urban program
- **No 3-year rolling average** during the 5-year cap-building period

Section 127 – Rural Track Programs

New CMS definition:

A ‘rural track program’ is a program, whether separately accredited or not, where residents spend time in both urban and rural settings and the time spent training in a rural place is > 50% of the total training time for residents in the program (or track) as a whole.

CAA Section 131:
Adjustment of Low Per Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals

Section 131: PRA/cap resets

- Allows a **PRA reset** for some hospitals with low (including zero) PRAs.
- Allows certain hospitals very low historic caps to **add cap positions** for new residencies.
- For hospitals with no prior claims of GME training, no PRA will be set or cap clock started until the first cost report year when resident FTEs >= 1.0.

Section 131: categories for possible reset

Category A: IPPS hospitals that became teaching hospitals before Oct 1997, with PRA and cap based on <=1.0 FTE (either or both of DGME and IME).

Category B: IPPS hospitals that became teaching hospitals after Oct 1997 through Jan 2021, with PRA and cap based on <=3.0 FTE (either or both of DGME and IME).

"GME naïve": IPPS hospitals that have never had GME trainees

"Never claimers": IPPS hospitals that HAVE had GME trainees but never claimed them on their CMS cost reports.

Section 131: process for possible reset: Category A or B hospitals

- **Consult CMS HCRIS files NOW to determine and verify your data about PRA and caps.**
- If you meet definitions, you are potentially eligible for a PRA reset if PRA low, for **both established and/or new trainees**.
- If you meet definitions, you are potentially eligible for cap adjustments, only for trainees in **new programs** that *start* training residents after December 27, 2020, and before December 26, 2025, and will add to original cap. Any expansion that occurred between original cap date and 12/20 will NOT be included.
- Reset established in first full cost report year where the minimum FTEs are met after 12/27/2020 and before 12/26/2025; hospitals currently above the minimum can choose to use *either* FY22 or FY23 cost report as a basis for resetting their PRA.

Section 131: process for possible reset: Category A or B hospitals

- ***Relevant dates:***
  - **If you disagree with HCRIS data and believe you are truly eligible for a reset, then you must electronically submit complete and unambiguous documentation to your MAC no later than July 1, 2022.**
  - If applying for PRA reset AND currently training >=1 (Category A) or >=3 (Category B) FTE residents, then submit request for reset to your MAC by July 1, 2022. Note that resetting a PRA is NOT automatic.
  - If currently training fewer residents, then you have until 12/26/25 to again start training >=1 or >=3 FTE and apply for a reset.
  - If you start trainees in *new* programs after 12/27/20 and *before 12/26/25,* request additional cap.

Section 131: process for new GME claims: ”GME naïve” or “never claimer” hospitals

- **Consult CMS HCRIS files NOW to verify that your PRA and caps are indeed zero (or empty cells).**
- For currently “GME naive” hospitals, no PRA will be triggered (or cap clock started) until the fiscal cost report year when resident FTEs claimed >= 1.0.
- No claim need be made if hospital *always* trains <1.0 residents in a year. Going forward, a hospital ***is*** required to fill out IME and DGME cost report worksheets if it trains at least >=1.0 FTE - or the “zero-PRA” risk continues!
- *Note*: if a hospital voluntarily enters into a **Medicare GME affiliation agreement** (cap sharing from other hospital) then it *will* trigger a PRA even if it claims <1.0 FTE in a year.

Section 131: process for new GME claims : ”GME naïve” or “never claimer” hospitals

- ***Relevant dates:***
  - If no HCRIS entries and you have *not* trained >=1 FTE in a cost report year starting after 12/27/20, then do nothing (unless you are in a Medicare Affiliation Agreement).
  - **If no HCRIS entries and you *have* trained or *are* training >=1 FTE in a cost report year starting after 12/27/20, you MUST claim them on IME and DGME cost report worksheets. Note that this WILL set your PRA, and *may* start your cap clock if there is a new residency.**