Title: The Teaching Health Neighborhood: Funding graduate professional education in rural and underserved communities

Authors:
Randall Longenecker, MD, Senior Advisor, The RTT Collaborative, and Assistant Dean Emeritus of Rural and Underserved Programs and Professor of Family Medicine, Ohio University Heritage College of Osteopathic Medicine, Athens, Ohio

> ***Randall Longenecker, MD*** practiced comprehensive family medicine in Logan County, OH, for 30 years including maternity care, 15 of those years as Program Director of a rural training track in family medicine. In the past 20 years he has designed and established more than a dozen programs in undergraduate and graduate medical education and in continuing professional development. He has consulted in the design of many others. He is Assistant Dean Emeritus for Rural and Underserved Programs and Professor of Family Medicine at the Ohio University Heritage College of Osteopathic Medicine, in Athens, Ohio, where he initiated the Rural and Urban Scholars Pathways program among other programs in preparing students and residents for work in rural and underserved urban communities. Having founded the organization and served as executive director for 10 years, he is now Senior Advisor to The RTT Collaborative, a national non-profit board-directed cooperative of rural programs established in 2012 and devoted to sustaining health professions education in rural places, providing technical assistance to developing and existing programs, and pursuing research in rural health professions education and training.

Bryan Hodge, DO, Director of Rural Programs, Mountain Area Health Education Center (MAHEC), and Assistant Clinical Professor of Family Medicine, University of North Carolina, Asheville, North Carolina

> **Bryan Hodge, DO** is the Director of the MAHEC Center for Health Professional Education and Rural Health Initiatives. His roles include pipeline programming with an emphasis on medical student, resident, and interdisciplinary rural health education. He is an Assistant Clinical Professor with the University of North Carolina Department of Family Medicine. As a former National Health Service Corps Scholar, he has committed his career to providing high-quality relational care and transforming the health of communities through education and innovation. Professional passions include alternative models of care delivery for vulnerable patients, professional well-being, and community health.

Neither author has any conflict of interest to declare. The views expressed here are our own and do not represent those of either The RTT Collaborative or the North Carolina Mountain AHEC.

Published: September 14, 2022

Premise
Funding community engaged health professions education in the place that needs the workforce and in the manner that graduates are expected to clinically practice will increase the rural and urban underserved workforce, mitigate health disparities in access to care, and promote health equity.

Proposal
With this essay we are proposing a concept for funding graduate training in underserved communities, both rural and urban and in multiple professions and select specialties. It is a place-based approach that we are calling "Teaching Health Neighborhood Graduate Professional Education," or THN-GPE, expanding funding for Graduate Medical Education (GME) to Graduate Professional Education (GPE) to meet the complex workforce needs of rural and underserved urban places and set a pattern for interprofessional practice.

Workforce Training Systems Perpetuate Fragmentation and Inequity
Over more than a century, the locus and funding for graduate health professions education and training, in particular medical education and training, has moved from a simple proprietary clinically funded enterprise prior to Flexner, to the complicated primarily government-funded academic health centers, teaching hospitals, and teaching health centers of today. While the standards of accreditation have been raised and have become more rigorous, the outcomes have been mixed. In the past several decades, despite many medical and technological advances, individual and population health in the United States have lagged compared to other high-income countries around the world. Health inequities in geography, race, and ethnicity have become more pronounced, and in the last few years, overall life expectancy has declined. Care has become more fragmented and more specialized, and the workforce more poorly distributed.

Evidence-based Recommendations Have Been Published but not Implemented
There is abundant evidence that robust primary care – first contact, comprehensive, and continuing care, coordinated through interprofessional teams in the context of family and community, leads to better health. Unfortunately, attempts to transform our current system in preparing the health workforce have thus far gone largely unrealized.

Current funding for graduate medical education remains entitled, overly restricted to physician training, without social accountability, and entrenched in the vagaries of hospital finance. What has been recommended by the Institute of Medicine is a system of funding that is simpler, rational, transparent, expanded beyond physician training, and tied to measurable outcomes, including population health.

Transformation Best Starts in Specific Communities, Growing from the Margin and not the Center
Modifying GME funding mechanisms could be a key lever to transforming the system. We propose a funding mechanism for training that occurs in the places of prioritized need, many of them marginal to the currently centralized pattern of health system oversight. THN-GPE engages the community, involves multiple health professions, and is publicly accountable for program outcomes.

Place-based interventions supported by the Health Resources and Services Administration (HRSA) have generated early successes upon which to build. The RTT Technical Assistance Program, and its emergent cooperative, The RTT Collaborative; Teaching Health Center Graduate Medical Education (THC-GME); the Academic Units for Primary Care Training Enhancement (AU-PCTE); the Rural Residency Planning and Development grant program, and the Teaching Health Center Planning and Development program together represent a coherent strategy building towards a workforce that serves communities of need.

An ecological approach, building on the assets of rural places, and encouraging collaboration among the health professions is foundational to the place-based design of rural health professions education. Dr. Longenecker first proposed the concept of a 'rural health professions campus network' to his medical school administration in Ohio in 2003 and later to the National Rural Health Association's Rural Medical Educators in 2004. Quentin-Burdick funding for interprofessional education from the Health Resources and Services Administration (HRSA) aimed to increase recruitment/retention of health care practitioners in multiple professions from rural areas and make rural practice a more attractive career choice However, it lost funding in 2005 and was archived from the federal code in 2010. HRSA's Advisory Committee on Interdisciplinary, Community-Based Linkages continues to meet and annually produces a report advocating for such education and training, and successful interprofessional programs and competency frameworks have been established at the undergraduate level. The consortium model has been successful in sponsoring THC-GME for physicians, but it has not been promoted as a framework for interprofessional training.

A Path Forward Requires Substantive Changes in Funding, Structure, and Accountability

We are proposing a sustainable mechanism for graduate health professions education in rural and underserved communities that is aligned with recent calls from the Accreditation Council for Graduate Medical Education; National Academies of Sciences, Engineering, and Medicine; National Rural Health Association; Council on Graduate Medical Education; and the peer reviewed literature for such solutions. This mechanism for funding brings greater simplicity and transparency than any currently proposed place-based legislative initiatives. Ultimately, this proposal offers a more direct and enduring program funding structure for graduate health professions consortia and by operating in parallel as an alternative payment model it complements the traditional Medicare system for graduate physician education.

Teaching Health Neighborhood funding of Graduate Professional Education (THN-GPE) is proposed as a 10-year pilot within the Center for Medicare and Medicaid Innovation (CMMI), characterized as:

- A payment mechanism for graduate education and training in a *Teaching Health Neighborhood* of programs in three or more professions or specialties in a rural or urban underserved community or facility and including an interprofessional component to the curriculum (e.g., a medical residency program(s) in one or more specialties and a pharmacy residency, aligned with a social work training program and/or psychology internship)
- At least one of the programs must be independently accredited and place its trainees in the rural community and/or underserved facility for at least 50% of their initial training period (e.g., 3 years in family medicine)
- Federally funded through a direct, per-resident or per post-doctoral trainee payment linked to training a minimum of 24 weeks in a rural place and/or in an FQHC, RHC, or other underserved facility in any community – for post-doctoral training in selected professions and specialties, unadjusted for geography or Medicare patient volume
- In an amount set each year as a CPI-adjusted payment (relevant to the respective profession) /FTE resident or trainee/month or year paid to a sponsoring consortium as a new THN-GPE payment
- The entire residency period is funded if > 50% training in any of the participating programs or tracks is (1) rurally located by either Center for Medicare and Medicaid Services (CMS) or

Federal Office of Rural Health Policy (FORHP) definition and/or (2) located in an underserved or safety net facility (e.g., FQHC, RHC, or free clinic)

The governing body or sponsoring institution for a Teaching Health Neighborhood must be a non-profit consortium consisting of at least three (3) participating organizations governed by a board with greater than 50% of its members representing the rural or underserved urban communities served and the associated organizations and/or facilities and at least three (3) professions. A medical school or other health professions school or a hospital can participate but cannot have a controlling interest in the sponsoring consortium.

The consortium must sponsor and/or include accredited postgraduate training programs or tracks representing at least three (3) professions and at least two specialties. The following professions and specialties are eligible for payment under this mechanism:

- Medical residency in any of the following specialties: FM, IM, Peds, Psych, OB-GYN, Surgery
- Nurse Practitioner residency in any of the following specialties: FM, IM, Peds, Psych, OB-GYN, Surgery
- Pharmacy residency
- Dental residency
- Clinical Psychology post-doctoral internship or residency
- Social Work post-masters' degree training program

The Teaching Health Neighborhood must articulate a deliberate interprofessional curricular component of greater than eight (8) weeks each year that engages trainees from at least three (3) professions together in collaborative clinical practice.

A post-graduate program funded through a Teaching Health Neighborhood mechanism shall not also be funded for the same periods of time through traditional Medicare Graduate Medical Education (GME), Children's Hospital GME (CHGME) or Teaching Health Center GME (THCGME). Existing programs already funded in these ways and wishing to expand into a THN-GPE may elect this alternative method of funding instead. As a requirement of continued funding, these programs will furnish to CMMI annual reports of program outcomes, much like that required of the HRSA-funded THC-GME grant program.

In short, we propose an anchoring community, a sponsoring consortium, and a leading program

This change is already happening, and the concept already applies in several rural environments across the country. As an example, a partnership led by Dr. Hodge has developed in association with a mid-sized rural hospital, surrounding health systems, an Indian Health Service agency, and an academic health center in rural western North Carolina. Faced with low primary care access, maternity ward closures, and a desert of behavioral health access, planning is underway to create a cohort of rural graduate medical education training programs in Obstetrics/Gynecology, Internal Medicine, Psychiatry, and Family Medicine. Recently bolstered with Rural Residency Planning and Development funding from HRSA, the target outcome is an integrated, inter-specialty training infrastructure that intentionally incorporates earlier stages of education and training and potentially expands beyond physician education to include graduate nurse practitioners, dentists, pharmacists, psychologists, and/or social workers in training. It capitalizes on a common rural-specific curriculum emphasizing interprofessional team-based care delivery, community engagement, social determinants of health, clinical leadership,

and expanded clinical skills. Ultimately, this shared training should lead to improved recruitment, retention, and team cohesion enhancing care delivery where it is needed most.

In summary, we are proposing an alternative mechanism for funding graduate health professional education and training (1) anchored in a rural community or an underserved facility, (2) governed by a sponsoring consortium, and (3) led by at least one independently accredited program with greater than 50% training in the rural community or underserved facility. Building upon assets already present in a community with workforce needs, this funding stream could enable an existing healthy clinician community in one specialty or profession to establish or expand a training program that also address gaps in the workforce in other specialties and professions. The time for such an approach is now, the support for such an approach is growing, and the rationale for such an approach is compelling.