Rural Medical Training Collaborative

"Rural Strong: Pathways to Peaks Bridging the Gaps"

The RMT Collaborative Annual Meeting

Wednesday - Friday, April 10-12, 2024

DoubleTree by Hilton Hotel Asheville-Biltmore, 115 Hendersonville Rd, Asheville, NC

The RMT Collaborative is completing its eleventh year of existence as a nationwide cooperative of rural programs and is happy to announce that the 2024 RMTC Annual Meeting is hosted by our participating programs in North Carolina. We reference the Rural Strong: Pathways to Peaks-Bridging the Gaps as we look forward to navigate the future of rural health professions education. With a growing recognition of the need to provide for better rural healthcare, there is a renewed emphasis on rural healthcare training.

The AAFP has reviewed The RTT Collaborative 2024 Annual Meeting Rural Strong: Pathways to Peaks-Bridging the Gaps and deemed it acceptable for up to 18.25 Live AAFP Prescribed credit(s). Term of Approval is from 04/10/2024 to 04/12/2024. Physicians should claim only the credit commensurate with the extent of their participation in the activity. AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMAPRA Category 1 credit(s) ™toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed, not as Category 1.

***Please note that the CME's are listed under The RTT Collaborative (not the new name RMTC)*

RMTC
Rural Medical Training Collaborative

Join other educators and learners from rural health professions education and training programs around the nation, and leave with the knowledge to:

1. Understand different models of healthcare education uniquely suited for rural environments

2. Design or expand a rural training program to serve the broad needs of a community

3. Adapt and implement novel ideas for your own program design and structure

4. Better prepare your program to meet the requirements of accreditation and community needs

5. Implement at least 1 innovative strategy for teaching learners to provide a broad scope of care

6. Become part of a growing national network of programs and people training health professionals, throughout the continuum of education

Shading	Limited Attendance	Plenary	Break	Invited Presentations
	(U): UME	(G): GME	(F): Fellowship	(S): Students
	(R): Residents	(P): PDs	(A): All	

Wednesday, April 10: *Pre-Conference*	
10:15 AM **Vanderbilt**	Rural Masterfile Meeting: Invite Only
11:45 AM	*Break*
12:00 PM – 2:00 PM **Vanderbilt**	RMTC Executive Board Meeting: Invite Only
1:00 PM – 4:45 PM **Stuyvesant**	WCGME Coordinators Leadership Institute Workshop – Must be registered for Institute to attend - Rural GME Coordinators Network — WCRGME 4:15p-4:45p – Graduation Ceremony – ALL WELCOME
2:00 PM	*Break*
2:15 PM **Vanderbilt**	RRCLC (Rural Residency Consultant Learning Committee): Invite Only
4:45 PM	*Break*
5:00 PM **Stuyvesant**	Scholarly Intensive Kick Off
5:45 PM	*Break*
6:00 PM – 8:00 PM **Burghley**	**Welcome Banquet and Opening Plenary:** Hearing the Lived Experience: The Use of Oral History and Storytelling to Build Understanding • **Raymond Christian, EdD (NC)**

Thursday, April 11	
7:00 AM	Breakfast
8:00 AM **Burghley**	**Town Hall Q/A with ABFM** • **Warren Newton, MD, MPH; President and CEO, American Board of Family Medicine (KY)**
9:15 AM	*Break*
SESSION 1 BREAKOUTS	
9: 30 AM **Stuyvesant**	Conflict in Small Rural Programs 2: When Relationships Turn Sour, Finding the Sweetness **(G, A)** • **Robert Gobbo, MD (WA)** • **Rosie Hunter, PhD (TX)** • **Randy Longenecker, MD (VA)**
9:30 AM **Vanderbilt II**	(a) Resident Patient Panels, Continuity, Team-Based Care, and Reassignments: How One Program Meets the New ACGME Requirements **(G)** • **John Boll, DO (PA)** • **Tim Heilmann, MD (PA)**
	(b) Interprofessional Education and Practice: Lessons Learned from First Year Rural Residency Programs **(G, S)** • **Brianna Lombardi, PhD, MSW (NC)** • **Lisa de Saxe Zerden, PhD, MSW (NC)** • **M. Justin Byron, PhD (NC)** • **Emily Hawes, PharmD, BCPS, CPP (NC)** • **Shelby Rimmler, MPH (NC)** • **Erin Fraher, PhD, MPP (NC)**
9:30 AM **Amhearst**	(a) Rotations Designed to Recruit and Retain **(G)** • **Sara Martin, MD, MSc (NC)** • **Amber Gilmore, MD (CA)**
	(b) Rural Longitudinal Curriculum in Western North Carolina: A 15 Year Perspective **(G)** • **Daniel Yoder, MD (NC)** • **Bryan Hodge, MD (NC)**
9:30 AM **Vanderbilt I**	(a) Ideas for Diversity Training and It's Importance in Rural Health **(G, U, R, S)** • **Alexis Jennings, M2 (TN)**
	(b) Direct Primary Care for the Rural and Underserved: Stories of Success **(R, S, G, U)** • **Olivia Dhaliwal, MS4 (OH)**
10:30 AM	*Break*

SESSION 2 BREAKOUTS	
10:45 AM **Amhearst**	Panel Discussion: Rural Life/Career After Training **(R, S)** Panelists: • **Amanda Vaglia, DO; PD, IRMC Rural FM Residency (IN)** • **Daniel Yoder, MD; PD, MAHEC Hendersonville FM Residency (NC)** • **Sarah Davis, DO; Chief Resident, FM Residency of Western MT, Kalispell (MT)** • **Mathew Hansen, PD, Washington State University IM Residency (WA)** Facilitators: • **Robin Rodriguez, MD; Resident Representative, RTT Collaborative (IN)** • **Olivia Dhaliwal, MS4; Student Representative, RTT Collaborative (OH)**
10:45 AM **Stuyvesant**	(a) Out of Site, Out of Mind? The Value of Peer Site Visits post ACGME Changes **(G)** • **Molly Ormsby, MA (WA)** • **David Evans, MD (WA)** • **Jeff Haney, MD (WA)**
	(b) Connections: Fostering Commitment and Retention of Preceptors through Faculty Development **(U, G)** • **Meghan Meyers, MPH, MHA (MO)** • **Kevin Frazer, MD (MO)** • **Jana Lee, MS (MO)**
10:45 AM **Vanderbilt I**	(a) One Year Later – Lessons Learned from Starting a FM Residency in a Rural CAH **(G)** • **Stephen Hall, MD (WA)** • **David Aufdencamp, MBA (WA)** • **Molly Thompson, MD, FAAFP (WA)**
	(b) Rural/Frontier Health Care and Education – Creating a Rural Training Track in a state void of federal GME funding **(G)** • **Travis Bomengen, MD (WY)**
10:45 AM **Vanderbilt II**	Playing the Long Game for the Long Run: Benefits of a "Long"itudinal Curriculum **(G)** • **Jennifer Snyder, MD (WA)** • **Tobe Harberd, MD (WA)** • **Tessa Moore, MD (WA)**
POSTERS AND LUNCH	
11:45 AM **Gallery**	**Poster Session** (through 12:45)
12:15 pm **Burghley**	Lunch
1:15 PM	*Break*

SESSION 3 BREAKOUTS	
1:30 PM **Vanderbilt II**	(a) Creating a Coordinator Retention Revolution **(G)** • **Lori Rodefeld, MS (WI)** • **Jennifer Crubel, BS (WI)** • **Danielle Etheridge (WI)** • **Bonnie Spittle (SC)**
	(b) Rural Program Director Development **(G)** • **Rob Epstein, MD (WA)** • **Roger Bush, MD (NC)**
1:30 PM **Amhearst**	(a) Establishing a Rural FM OB Fellowship with a Primary Urban Site and Network of Rural Partner Hospitals **(G, F, R)** • **Jillian Landeck, MD (WI)**
	(b) Seeding Hope: Cultivating Rural Oncology Training for Rural and Community Care **(G)** • **Wade Swenson, MD MPH, MBA, FACP (MN)** • **Zachary Schroeder, BA (KS)** • **Emily Westergard, DO**
1:30 PM **Stuyvesant**	Substance Use Disorder Treatment Curriculum Development for Rural Residency Programs **(G)** • **Daniel Elswick, MD (WV)**
1:30 PM **Vanderbilt I**	(a) So Your Rural Clinic is GME Naïve? **(G)** • **Glenn Gookin, MD (CA)** • **Matt Personius, MD (CA)**
	(b) Using Simulation to Train Rural Medical Students and Residents **(U, G)** • **Tiffani Maycock, DO (AL)** • **Lisa Berrgman, MSN, RN, CEN, CHSE**
2:30 PM	*Break*
2:30 PM - 5:00 PM **MAHEC Sim Center**	Skills Sessions / Simulation **(R, S)** (PRE-REGISTRATION REQUIRED) DoubleTree Shuttle will transport attendees to the MAHEC Simulation Center
SESSION 4 BREAKOUTS	
2:45 PM **Stuyvesant**	(a) The Emerging Landscape of Rural Residency Training: Defining Program Types and Assessing Their Value **(G, U, S)** • **Davis Patterson, PhD (WA)** • **Randy Longenecker, MD (VA)** • **Darin Bell, MD (MT)**
	(b) Interview and Match Outcomes Over Time: Learnings from a Large, Regional Network **(G, U, S)** • **Amanda Weidner, MPH (WA)**

	• **Molly Ormsby, MA (WA)** • **Justin Glass, MD (ID)** • **Jenny Hall, C-TAGME (MT)**
2:45 PM **Vanderbilt II**	(a) Primary Care Pathway Program (PCPP): Bridging the Gaps to Reach Higher Peaks **(U, G)** • **Annette Smith, MD (TX)** • **Joseph Schenkmman, MS (TX)**
	(b) Rural Residency Roots–Longitudinal Medical Student Rotations **(G,U)** • **Bethany Enoch, MD (KS)**
3:45 PM	*Break*
SESSION 5 BREAKOUTS	
4:00 PM **Vanderbilt II**	Bridging the Gaps: How NCFM Collaborates between Core and Rural Programs to Strengthen All **(G)** • **Asa Ware, MD (CO)** • **David Smith, MD (CO)** • **Sarah Moore, MD (CO)** • **David Reed, MD (CO)**
4:00 PM **Stuyvesant**	(a) Building Rural Practice Competencies and Retention Through a Community Health Project-based Curriculum **(G, U)** • **Diana Curran, MD (NC)**
	(b) "You wear many hats, you're not just a doctor": A Qualitative Study of Unique Training Needs for Rural Family Medicine Practice **(G)** • **Annie Koempel, PhD, RD, LD (KY)** • **Dave Schmitz, MD (ND)** • **Andrew Bazemore, MD, MPH (KY)**
4:00 PM **Vanderbilt I**	(a) Meeting the Needs of Washingtonians – Training Internal Medicine Residents in Rural Washington through Program Development and Rural Rotations **(G, IM)** • **David Aufdencamp, MBA (WA)** • **Matthew Hansen, MD (WA)**
	(b) Enhancing Medical Residency and Fellowship: The Case for Rural Rotations **(G, U)** • **Zachary Schroeder, BA (KS)** • **Wade Swenson, MD MPH, MBA, FACP (MN)**
RECEPTIONS	
5:00 PM **Gallery**	Rural Residency and Teaching Health Center Planning and Development Technical Assistance Centers Reception – ***All Attendees Welcome**

5:00 PM **Burial Forestry Camp**	Student / Resident Reception (R, S) Students and residents will walk to the Burial Forestry Camp
5:00 PM	Dinner / Evening on own

Friday, April 12	
6:30 AM	Breakfast
7:15 AM **Burghley**	**Plenary:** State and Federal Forces Shaping Physician Workforce Shortages • **Emily Hawes, PharmD, BCPS, CPP (NC)** • **Erin Fraher, PhD, MPP - RRPD (NC)**
8:00 AM **Burghley**	**Plenary:** Storytelling and Advocacy: Why We Must Tell Our Stories • **Benjamin Gilmer, MD (NC)** • **Steve Buie, MD (NC)**
9:15 AM	*Break*
SESSION 6 BREAKOUTS	
9:30 AM **Stuyvesant**	(a) Medicare GME Funding for Rural Residencies – hot issues with rule changes and reclassification of hospitals **(G)** • **Louis Sanner, MD (WI)** (b) Recruitment of Residents to Rural Programs: Early Outcomes of RRPD Cohort 1 **(G, S)** • **Amanda Weidner, MPH (WA)** • **David Evans, MD (WA)** • **Ryan Spencer, MD, MS, FACOG (WI)** • **Davis Patterson, PhD (WA)**
9:30 AM **Vanderbilt II**	Empowering Healthcare in Rural Communities: MAHEC's Innovative Rural Fellowship Program **(G, F, R)** • **Benjamin Gilmer, MD (NC)** • **Kylie Agee, MPA (NC)**
9:30 AM **Vanderbilt I**	(a) Population Health Management of Opioids for Chronic, Non-Malignant Pain **(G)** • **John Boll, MD (PA)** (b) Creative Solutions to Providing Housing for Rural Residency Programs **(G, U, S)** • **Adam Zolotor, MD, DrPH (NC)** • **M. Justin Byron, PhD (NC)** • **Emily Hawes, PharmD, BCPS, CPP (NC)** • **Randy Longenecker, MD (VA)**

9:30 AM **Amhearst**	(a) Bridging the Gap for Rural Medical Education through Creative Partnerships **(G, U)** • **Keri Bergeson, MD (MN)** • **Nitika Moibi, M.P.P. (MN)** • **Melissa Stevens, MA (MN)**
	(b) Diversity and Collaboration of Ohio's Medical Schools on Rural Programming: The Rural Physician Training Pathways (RPTP) Model **(U)** • **Alex Heintzelman, MD (OH)** • **Sharon Casapulla, EdD, MPH (OH)** • **Jayna Vossler, MS (OH)** • **Sharron DiMario, MHA**
10:30 AM	*Break (and start COTM: Boone – see below)*
10:30 AM	**Conference on the Move: Boone** – Load Bus and Depart (PRE-REGISTRATION REQUIRED)
SESSION 7 BREAKOUTS	
10:45 AM **Amhearst**	NIPDD scholar Presentations • **Brad Walsh, MD (AR)** • **Eli Burks (?)**
10:45 AM **Stuyvesant**	Building From The Floor Up: Introducing a residency inpatient service into an existing rural hospitalist group model **(G)** • **Sara Martin, MD, Msc (NC)** • **Amber Gilmore, MD (CA)**
10:45 AM **Vanderbilt II**	Faculty Time and CBME – It's Possible **(G, U)** • **Jeff Haney, MD (WA)**
10:45 AM **Vanderbilt I**	Pathways to Peaks: Optional Tracks to Climb to Success **(G)** • **Asa Ware, MD (CO)** • **David Smith, MD (CO)**
11:45 AM	*End of Main Conference*
12:00 PM	**Conference on the Move: Hendersonville** Load Bus and Depart (PRE-REGISTRATION REQUIRED)

Plenary Sessions

Hearing the Lived Experience: The Use of Oral History and Storytelling to Build Understanding

Raymond Christian, EdD

- Participants will be familiarized with the use of oral history and storytelling in qualitative research
- Participants will gain insight into the process of developing personal narrative
- Participants will be familiarized with methods of obtaining oral history
- Participant will be familiarized with methods of communicating the lived human experience

Town Hall Q/A with ABFM

Warren Newton, MD, MPH; President and CEO, American Board of Family Medicine

*Please review these articles in preparation for this session

- *"What Assessments Are Being Used in Family Medicine Residencies?"* https://www.jabfm.org/content/37/1/155
- *"Implementing Competency Based ABFM Board Eligibility"* https://www.jabfm.org/content/36/4/703

State and Federal Forces Shaping Physician Workforce Shortages

Erin Fraher, PhD, MPP

Emily Hawes, PharmD, BCPS, CPP

Bryan Hodge, MD

- Understand state policy and regulations shaping physician workforce shortages
- Describe federal policy and regulations impacting physician workforce training
- Illustrate the impact through examples, including in North Carolina

Storytelling and Advocacy: Why We Must Tell Our Stories

Benjamin Gilmer, MD

Steve Buie, MD

- Examine the power of storytelling in translating our rural stories
- Explore a framework for creating a pathway to creative advocacy
- Introducing themes of relational leadership through story

Session Descriptions

Session 1

Conflict in Small Rural Programs 2: When Relationships Turn Sour, Finding the Sweetness

Gobbo, Hunter, Longenecker

This workshop will be a follow-up to last year's well attended and reviewed workshops by the presenters. This workshop will carry the themes of conflict in small rural residencies and the concept of transforming those conflicts. This workshop will focus on best practices for addressing conflict and highlight practical consideration using case studies and group participation. Cases will highlight interpersonal conflicts and their potential transformations between individual Faculty, Residents, and Leadership. Dr Hunter will facilitate the group discussion and sharing best practice tools and concepts that can be successfully utilized to repair, reimagine and transform situations that may seem impassable.

- Understand key components of what cause work relationships to unravel
- Learn about different best practices to help mediate, survive ad even transform conflict
- Gain wisdom though case discussion, self-reflection and peer discussion

Resident Patient Panels, Continuity, Team-Based Care, and Reassignments: How One Program Meets the New ACGME Requirements

Boll

In 2023, the ACGME released new requirements for patient panels, continuity of care, and team-based care. Family medicine residency programs each have unique resources to accomplish these requirements but ultimately need to show compliance to the ACGME. Over the last decade, our program has maintained a system for designating each patient's resident primary care physician (PCP) and care team in the electronic health record and a process for reassigning each resident's patient panel to a new resident PCP (from the same team) at the time of the current resident PCP's graduation. Such a process allows monitoring of residents' ACGME requirements and ultimately ensures appropriate education for rural practice.

- Review the latest ACGME requirements and changes regarding resident patient panels and continuity
- Outline our process for assigning patients to residents and teams
- Discuss the mechanisms by which we keep family groups together with the same PCP and monitor continuity within the office visits

Interprofessional Education and Practice: Lessons Learned from First Year Rural Residency Programs

Lombardi, de Saxe, Zerden, Byron, Hawes, Rimmler, Fraher

Rural residencies are primed to expand interprofessional education and practice (IPEP) in communities and increase the likelihood that future physicians practice within team-based care (TBC) models. We offer research findings on IPEP in HRSA-funded Rural Residency Planning and Development training programs: the prevalence and composition of interprofessional training, the degree to which IPEP is designed around local population health needs, types of learning opportunities rural residencies offer, and the barriers and facilitators to enhancing rural TBC. As rural residency programs continue to

expand, understanding how IPEP and TBC can be strengthened will benefit rural residency programs and ultimately team-based care in rural communities.

- Identify areas of growth for IPEP in rural residency programs.
- Describe key factors contributing to successful interprofessional education and team-based care models in rural residency settings.
- Identify two solutions to grow IPEP models for team-based care based on audience member's location/site needs.

Rotations Designed to Recruit and Retain

Martin, Gilmore

The community founded our residency in 2019 with a clear mandate: recruit family medicine physicians who are likely to stay in our rural county and train them to thrive while serving community needs. As a new residency, we were building the curriculum from scratch, so we were able to align our rotations with this mission. The resulting rotations and the process of creating them have taught us invaluable lessons on how to maximize available learning resources, mitigate limitations, and build a network of enthusiastic specialists that support our residents both during and after residency. All rotations are designed to expose residents to the unique attributes of practicing medicine in our rural county and hopefully encourage them to stay.

- Review the process for assessing opportunities (and limitations) for rotations within rural communities.
- Establish a local post residency network for residents and graduates for the purpose of retention.
- Gain ideas for how to expose to the wide variety of rural opportunities and practices.

Rural Longitudinal Curriculum in Western North Carolina: A 15 Year Perspective

Yoder, Hodge

Beginning in 2008 as part of the P4 project, MAHEC Hendersonville began placing residents in rural practice sites with a preceptor on a longitudinal basis rather than for isolated blocks of time. This model was continued to be mutually beneficial, both exposing residents to rural practice to allow them to make an informed decision about their interest in rural practice and disseminating evidence-based information to local preceptors that would allow them to improve their clinical knowledge and practice over time.

- Identify opportunities to train residents for rural practice in their environment
- Understand how to obtain data on resident and preceptor experience
- Reflect on the opportunities within a regional network of likeminded practices or FQHC

Ideas for Diversity Training and Its Importance in Rural Health

Jennings

This presentation will discuss some of the challenges and resistance to diversity training in medical education, and its potential impacts on social determinants of health, and specific importance to medical practitioners in rural areas. This presentation is intended to serve as a replicable diversity training template that demonstrates a framework for providing inclusive care and an opportunity to show compassion through medicine.

- Gain a new framework for thinking about Diversity, Equity, and Inclusion trainings
- Understand Cognitive Dissonance and how to use it as a tool for learning and self reflection
- Participants will practice a framework for thinking about ideas, beliefs, and cultures that may be different from their own by using scenarios that demonstrate the impact of providing inclusive care on patient outcomes.

Direct Primary Care for the Rural and Underserved: Stories of Success
Dhaliwal

Direct Primary Care is a cash-based model increasingly utilized by family physicians across the country. It is criticized for being exclusionary to patients who lack financial capital -particularly those reliant on Medicare and Medicaid - because inherent to the model is its complete separation from insurance-based payment for care. In this lecture, we will learn about several practices in rural places across the US where DPC practices are successfully meeting the needs of their underserved communities.

- Define the model of DPC.
- Name obstacles to care that rural, underserved patients face, and how DPC does and does not address these various obstacles.
- Become familiar with practices successfully meeting their community needs for primary care using the DPC model.

Session 2

Out of Site, Out of Mind? The Value of Peer Site Visits Post ACGME Changes
Ormsby, Evans, Haney

The Accreditation Council for Graduate Medical Education (ACGME) process for continued accreditation continues to evolve. Recent de-emphasis of site visits, first during COVID, and now with the 2023 announcement of no further 10-year site visits represents a significant process change for residencies, Regardless of ACGME changes, outside observation of programs can be a key part of continuous quality improvement. The WWAMI Family Medicine Residency Network is a regional collaboration of residency programs in Washington, Wyoming, Alaska, Montana, and Idaho with 33 core programs and 10 rural training tracks/programs. For nearly 20 years we have coordinated review teams with appropriate skills and experience to provide consultative services.

- List the changes to the ACGME continued accreditation process
- Describe the importance of undergoing a program review or mock site visit, regardless of ACGME site visits
- Identify GME partners to coordinate program reviews or mock site visits

Connections: Fostering Commitment and Retention of Preceptors through Faculty Development
Meyers, Frazer, Lee

Continuous faculty development is essential when recruiting and retaining community-based faculty preceptors, as making efforts to provide meaningful faculty development opportunities fosters preceptors' commitment to teaching medical students. For many years, the University of Missouri School of Medicine Rural Scholars Program has worked to provide effective faculty development

opportunities to all community-based faculty. This presentation will provide information on the widely successful faculty development sessions held by the University of Missouri Rural Scholars Program, which include an annual leadership retreat where rural training sites share best practices, as well as online orientation and development sessions held each spring.

- Understand the faculty development sessions provided to University of Missouri School of Medicine community-based faculty members.
- Understand the importance of providing continuous faculty development to preceptors.
- Be able to identify opportunities for faculty development at their institution.

One Year Later – Lessons Learned from Starting a FM Residency in a Rural CAH
Hall, Aufdencamp, Thompson

Our FM program started in 2023 on a new frontier – a stand-alone program in a rural CAH. After years of prep that included creating strong partnerships with members of the community, developing faculty, and establishing an environment of advocacy, and support, the program is up and running. Even though the program is going well, few obstacles were encountered during the start of the residency training. The presentation focuses on these, and the lessons learned, things the team wished knew up front including faculty depth, curriculum and block schedule design, feedback and evaluations, orientating and acclimating the hospital to new learners, recruitment to small town USA, and how to keep the program moving forward with limited resources.

- Gain an understanding of the hurdles encountered during the start-up of a Family Medicine program in a critical access hospital.
- Get insight into how these hurdles were managed and what the team wishes they would have done differently including curricular design and systems for assessment and feedback
- How to manage a program with a small team of faculty with limited resources

Rural/Frontier Health Care and Education – Creating a Rural Training Track in a State Void of Federal GME Funding
Bomengen

After several years of struggling to recruit and retain physicians, our rural community of Thermopolis, Wyoming (population ~4000) pursued the development of a rural training track to help build a pipeline of physicians for the community and state. We partnered with the University of Wyoming Family Medicine program in Casper to develop this inaugural rural training model. Expansion of resident training has been uniquely difficult in Wyoming due to limited federal GME funding in the state-a decision that was made in the 1970s and has led to unintended funding challenges since. In the multiyear journey of developing and implementing our RTT, there have been several obstacles to overcome. By utilizing resources and assistance from our WWAMI Network.

- Outline our story and model for success
- Demonstrate financial sustainability is attainable in rural training expansion utilizing, ingenuity, preparation, and partnership to overcome barriers
- Demonstrate the wide-ranging rewards of RTT implementation for physician education and wellbeing, rural healthcare delivery, and the overall rural/frontier community.

Playing the Long Game for the Long Run: Benefits of a "Long"itudinal Curriculum
Snyder, Harberd, Moore

A longitudinal curriculum offers an alternative to the more traditional block system of residency training programs. Particularly in the case of smaller rural programs, this style of curriculum offers flexibility for subspecialty training, ample time in clinic with continuity patients, the ability to follow patients across multiple venues of care, and continuous learning opportunities with time to reinforce subspecialty training. Similar to a career in rural medicine, treatment of the kidneys does not stop when your nephrology block comes to an end. The results include increased connectivity to local specialists, increased knowledge retention, availability for local community involvement and increased preparedness for rural practice.

- Describe the layout of a longitudinal model of resident training and give an example of a standard week
- List three benefits of training in a longitudinal model in relationship to a career in rural medicine
- Identify one major barrier to utilizing this model in your current system/developing program and one plausible solution.

Panel Discussion: Rural Life/Career After Training
Vaglia, Yoder, Davis, Hansen

- Understand the difference between rural and urban medicine and how rural residency training prepares for rural practice
- Learn about the wide variety of rural careers, and the different training options to meet the needs of rural communities
- Recognize the challenges of rural practice and life, and explore ways to make a rural career sustainable both during and after training

Poster Session

- Building Towards a Community Advisory Board for a Rural Residency Track
- Addressing the Rural Health Crisis: A Pilot Pathway Program for Rural Medical Education in Pennsylvania
- Developing an Obesity Medicine Track in a Rural Family Medicine Residency
- Increasing Rural Mental Health Awareness Among Adolescents through Community Education
- 5 Approaches to Rural Psychiatric Workforce Shortages
- Intensive Lifestyle Modification: 8 Week in Clinic Full Plate Living Class
- Developing an Addiction Medicine Track in a Rural Family Medicine Residency
- Central Wisconsin Integrated Survey Portal (CWISP): A tool for beating survey fatigue and improving feedback
- Medical Error: Fostering a Culture of Resilience and Safety
- Pathways to Rural Psychiatry Practice: Creating an Engaging Pipeline Event for Motivational Interviewing
- Street Medicine: Where Rural Residency Curriculum and Compassion Collide
- Rewiring Resilience: The Potential of tDCS in Rural Mental Health Care

- Ensuring Health Care Accessibility for the Migrant Worker Population in Indiana County: An IRMC Rural Family Medicine Residency Initiative
- Implementation of the Tuscaloosa Rural Pre-medical Internship Program
- STUDY IN PROGRESS: Investigating Resident Physicians Well-being Initiatives in Rural Residency Programs
- LASSO as an Educational Tool in a Rural Interprofessional Training Setting
- Rural Curriculum in a Suburban Family Medicine Residency Program: A 3-part Rural Health Training for Resident Doctors
- Embracing New Beginnings: Refugee Resettlement in Indiana, PA Collective Endeavor Alongside International Hospitality Center
- Discovering the Overlap in Global Health and Rural Medicine: One Family Medicine Resident's Volunteer Experience in Tanzania

*Additional posters available for viewing on the RTT Collaborative Website

Session 3

Creating a Coordinator Retention Revolution

Rodefeld, Crubel, Etheridge, Spittle

What factors impact retention of a rural program coordinator? Drawing upon insights from a recent study on Program Director retention, a parallel study focused on reasons why coordinators stay in their roles. The team used a combination of qualitative and quantitative methodologies to identify strategies for rural GME programs to effectively hire the right coordinator, meet their needs, and provide development that will lead to increased satisfaction. Retaining the right coordinator can contribute to the overall success of a rural residency program.

- Explore characteristics of coordinators from rural and community-based programs who have been in their role for more than 5 years.
- Understand the program level attributes which contribute to coordinator retention.
- Examine strategies to support retention of program coordinators.

Rural Program Director Development

Epstein, Bush

I have noticed when working with developing Rural Residency Programs that one of the most common handicaps is the absence of a Program Director (PD) as the residency is being developed. Many institutions that are developing a rural residency are often looking to hire an experienced PD from outside the organization. There are very few experienced residency faculty looking for a rural job, the more practical approach is often to develop a PD from inside the organization. I would like to present some of the reasons why this approach is often more practical for a developing rural programs, as well as some resources to help develop rural PDs.

- See the advantages of developing rural PD from within the organization
- Understand what a developing program PD does
- Resources for developing rural IDs

Establishing a Rural FM OB Fellowship with a Primary Urban Site and Network of Rural Partner Hospitals

Landeck

From 1997 to 2018, the number of rural Wisconsin OB units decreased from 61 to 35. Rural pregnancy care providers are needed. Until this year, Wisconsin has not had an FMOB fellowship. The University of Wisconsin Department of Family Medicine and Community Health (UW DFMCH) received a state-funded planning grant to start a rural FMOB fellowship. The fellowship will be based in Madison and has 10 rural Wisconsin hospital partners. Fellows will perform scheduled cesareans in rural hospitals near Madison and will have block rotations at more distant sites. The urban component will provide volume and experience managing pregnancy complications while the rural components will give the fellow rural experiences including mobilizing OR crews and transferring patients. Rural experiences will allow fellows to gain comfort in the setting they wish to practice. We will share our planned training model and will discuss how the partnerships to start this program developed, as well as important lessons learned. We aim to foster a discussion around overcoming challenges to strengthen obstetrical training in family medicine.

- Describe the structure of a unique rural FMOB fellowship with an urban base and 10 partner rural hospitals
- Explain function of the fellowship Advisory Board
- Review the challenges faced and lessons learned to date

Seeding Hope: Cultivating Rural Oncology Training for Rural and Community Care

Swenson, Schroeder, Westergard

Rural communities face a critical shortage of specialized healthcare services, with oncology care being one of the most significant gaps. This shortage not only affects the immediate health outcomes of rural populations but also their long-term well-being. The proposal for Rural Oncology Training (ROT) is a call to action, addressing the urgent need to prepare healthcare professionals to deliver oncology care in rural settings. This talk will outline the necessity of ROT, showcase proposed training models, and discuss strategies for integrating ROT into rural healthcare systems to improve access and quality of care.

- Understand the critical need for specialized oncology training in rural healthcare settings.
- Describe potential models of ROT and their key components.
- Formulate strategies for implementing ROT to enhance rural healthcare delivery.

Substance Use Disorder Treatment Curriculum Development for Rural Residency Programs

Elswick

There are well documented deficits in access to substance use disorder (SUD) treatment programs in most of rural America. Rural areas have SUD related challenges that have led to poor health outcomes and an overall shorter life expectancy. The growing number of rural residency training programs in the country are uniquely positioned to help address SUD treatment workforce needs. This workshop is designed to collaboratively explore effective development and implementation of SUD programming for rural residencies regardless of specialty. While there is not a “one-size-fits-all” solution to SUD training among different programs, there are many areas that are fundamental to assure quality and sustainability for a rural residency curriculum.

- Describe critical areas such as: Medication Assisted Treatment training, overdose demographics, pharmacology, and social determinants of health that impact SUD.
- Explore solutions to challenges related to starting or sustaining SUD educational experiences in rural residencies.
- Describe the "Diseases of Despair" (Case and Deaton) that are a major contributor to shorter life expectancy in rural areas.

So Your Rural Clinic is GME Naïve?
Gookin, Personius

The continuity clinic is the backbone of family medicine residency training and critical for other subspecialties. A busy rural clinic can be a challenging venue to introduce change. This lecture discussion will focus on a few practical examples, workflows and tools utilized in the creation of two different rural residency training programs in rural Northern California. We will briefly compare and contrast challenges and success stories at both programs given differences between an integrated health system rural clinic model, and a tribal federally qualified health center partnership.

- Introduce graduate medical education to a rural health clinic
- Create your initial resident continuity panel size
- Write a workflow for onboarding residents at their continuity clinic

Using Simulation to Train Rural Medical Students and Residents
Maycock, Berrgman

Critical care and procedural skill training are integral components of undergraduate and graduate medical education. This training is best initially delivered in a simulated environment, but it is often difficult to deliver high quality procedural simulation in rural under-resourced environments. In an effort to meet this need, a comprehensive simulation curriculum was developed, deployed and evaluated utilizing high fidelity simulation equipment, critical care simulated cases and procedural simulation workshops. The learners agreed that the experiences would improve their future clinical practice and underscores the value of innovative collaborations across systems and the value of teaching critical care skills in a low stakes environment.

- Consider different resources available to enhance medical training through simulation
- Discover ways to incorporate simulation into the training of medical students and residents
- Brainstorm what resources may be available to enhance you simulation training of medical students and residents

Session 4

The Emerging Landscape of Rural Residency Training: Defining Program Types and Assessing Their Value
Patterson, Longenecker, Bell

Investments in diverse rural residency training options are growing. Important differences in rural training experiences include residency location (rural or urban) and degree of resident participation in rural training (e.g., through a "track" or elective rotations). Experts and board members of The RTT Collaborative have developed a framework that defines six types of residency programs based on rural training configurations and rural practice yields. In this session, we describe the typology

and invite feedback from session participants. We also describe a study to quantify the number of each program type in family medicine, the distribution of resident positions by type, and the yield to rural practice for graduates of each type.

- Describe existing evidence on rural training types and outcomes.
- Identify the six proposed types of rural residency programs.
- Contribute to the collective knowledge base on effective training models that produce rural physicians.

Interview and Match Outcomes Over Time: Learnings from a Large, Regional Network
Weidner, Ormsby, Glass, J. Hall

The Family Medicine Residency Network (FMRN) comprises 33 family medicine residency programs, 10 rural training tracks, and more than 700 residents across Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI). With an established collaborative culture, the FMRN has been able to gather sensitive data; this presentation will share longitudinal data on FMRN programs' application and Match outcomes, including outcomes from the Supplemental Offer and Acceptance Program; data on how the FMRN programs have decided to interview in post-COVID years, i.e. in person, virtual, or hybrid, with a deeper dive into those who chose a hybrid strategy, and their application and Match outcomes; and ways they have attempted to mitigate bias in interviews.

- Describe what average application and interview numbers look like across a collective of programs
- Highlight outcomes of the residents who match in SOAP
- Identify the pros and cons of each interview strategy (hybrid, in person, virtual) and the ways to mitigate bias in the interview process

Primary Care Pathway Program (PCPP): Bridging the Gaps to Reach Higher Peaks
A. Smith, Schenkman

TCOM has just graduated its first PCPP cohort. Introduced to the RTT Collaborative in 2021, this session will serve as a follow-up providing PCPP data and details on how the program has fared through the first seven years. The session will focus on the innovative solutions used to address basic life needs at rural training sites, bridge gaps created by a shorter timeline but not a shortened curriculum, meet the training requirements and COCA standards in healthcare deserts, expand the breadth of skills and technology to meet the community needs while dealing with the day-to-day administrative, academic, and altruistic expectations for medical students.

- Identify key challenges (gaps) and solutions (bridges) revealed in the expedited pathway to becoming a physician
- Describe the mutual benefits of a pipeline program for all stakeholders
- Articulate innovative strategies designed to help institutions develop or strengthen academic partnerships increase the number of rural healthcare providers

Rural Residency Roots – Longitudinal Medical Student Rotations
Enoch

Developing a new rural residency requires significant background medical educational expertise and can be simplified by partnering with existing institutions. This lecture will describe the process taken

by a rural FQHC with the ultimate goal of starting a Family Medicine Residency, beginning with accepting medical students for a few weeks at a time from the University of Kansas School of Medicine and growing a relationship with KUSOM. This partnership was then leveraged to create a longitudinal student rotation experience which paved the way for developing a joint Family Medicine residency with KUSOM as the sponsoring institution and the FQHC as the primary practice site.

- Describe the benefits of partnering with existing medical schools to develop new rural residency programs.
- Describe methods of progressing from medical student education to resident education.
- Describe key personnel connections that can assist in creating new rural residencies from medical student programs.

MAHEC Simulation Skills Session

- Blindfolded codes
    - Communicate effectively using closed loop communication during an high intensity code scenario.
    - Initiate timely and effective CPR via ACLS algorithm.
- Sepsis Escape Room
    - Demonstrate a guidelines-based approach to the management of a patient with severe sepsis using escape room clues to unlock appropriate treatments.
- PPH
    - Assess volume of potential blood loss
    - Identify and manage postpartum hemorrhage
    - Demonstrate closed loop communication
- Respiratory Distress
    - Determine appropriate initial assessment of patients with respiratory distress.
    - Practice the key skill of providing bag mask ventilation and intubating a person in respiratory distress.
    - Demonstrate management of patients presenting with respiratory distress

Session 5

Bridging the Gaps: How NCFM Collaborates between Core and Rural Programs to Strengthen All
Ware, D. Smith, Moore, Reed

Each of our ACGME programs has unique strengths and some weaknesses. We wish to share how we have learned to collaborate between our rural and core program educational sites in order to leverage a programs' individual strengths and improve weaknesses through cross-pollination amongst our different program locations. We also wish to assist our audience in identifying the strengths and weaknesses of their training sites and brainstorm how to create more collaboration between the program locations in order to produce even better family medicine graduates.

- Participants will be able to identify unique strengths and weaknesses among each of their educational sites.
- Participants will be able to advocate for collaboration between their training sites.
- Participants will be able to design each of their sites curriculum to take advantage strengths and improve weaknesses.

Building Rural Practice Competencies and Retention Through a Community Health Project-based Curriculum

Curran

Rural training programs aspire to graduate physicians competent and willing to practice in rural settings. Our Community Health curriculum helps achieve these outcomes. Through a longitudinal community project, resident learn to address health problems on a population level, a cornerstone of Community-Oriented Primary Care. The expectations include two oral presentations and a scholarly work. A survey of 53 graduates from 1999-2017 show 93% of respondents work or worked in rural settings, and two-thirds of them worked on community health in their careers. Among the 8 competencies in rural practice (Longenecker), respondents felt the project experience impacted them the most in Integrity, and Collaboration and Community Responsiveness.

- Learn the elements of a project-based community health curriculum
- Understand how this curriculum supports outcomes competency and retention for graduates in rural practice
- Learn about the opportunities for faculty and residents to work on community health improvement initiatives and scholarly work.

"You Wear Many Hats, You're Not Just a Doctor": A Qualitative Study of Unique Training Needs for Rural Family Medicine Practice

Koempel, Schmitz, Bazemore

Amidst new Review Committee guidelines, it is important to elucidate unique challenges and opportunities involved in preparing residents for rural family medicine. To assess key competencies for rural practice, focus groups led by a qualitative researcher were conducted during the 2023 RTTC Annual meeting. According to participants, rural practice demands full scope medicine, lifelong learning, leadership skills, emotional resiliency, and navigating life and work in a small community. Strategies to prepare residents focused on direct experiences and modeling or mentoring. These results build on other residency competence models and form the basis of a larger qualitative study aimed at developing supplementary milestones for rural practice.

- Understand unique training needs for rural family medicine residents
- Discuss strategies to prepare residents for rural family medicine practice

Meeting the Needs of Washingtonians – Training Internal Medicine Residents in Rural Washington through Program Development and Rural Rotations

Aufdencamp, Hansen

WSU Internal Medicine Residency program started in 2021 with a mission to prepare highly skilled internists for underserved and rural communities of Washington. With a 600-bed referral center as the primary site, the program established rotations at four rural sites. While these achieved the desired goals, the program overcame significant challenges achieving outcome of training skilled internists for rural Washington. This presentation reviews the approach for the development of rural rotations including overcoming challenges of supporting learners from a distance. As a new program, the presentation includes lessons learned from our approach to quickly build a curriculum for rural healthcare and considerations for future pathways.

- Learn an approach for integrating rural training in an urban-based residency program.

- Gain an understanding of the lessons learned from creating rural rotations and to navigate the hurdles.
- Understand the positive impacts and outcomes of creating rural rotations in a residency program.

Enhancing Medical Residency and Fellowship: The Case for Rural Rotations
Schroeder, Swenson

Incorporating rural clinical rotations in medical residency creates benefits for residents, rural communities, and the broader healthcare system. This presentation highlights the disparities between rural and urban healthcare, emphasizing the need for resident physicians to gain exposure to the unique challenges and opportunities in rural settings. We explore the benefits of rural rotations, including enhanced cultural competency, a broader skill set, and a deeper understanding of rural healthcare dynamics. The talk will also address potential logistical and financial challenges in implementing these rotations and propose solutions, aiming to improve healthcare delivery in underserved areas and prepare well-rounded medical professionals.

- Understand the disparities between rural and urban healthcare and the impact on resident training.
- Recognize the benefits of rural rotations for residents, including skill diversification and cultural competency.
- Explore practical strategies to overcome challenges in implementing rural rotations in residency programs.

Session 6

Medicare GME Funding for Rural Residencies – Hot Issues with Rule Changes and Reclassification of Hospitals
Sanner

We will walk through several case examples of rural residencies that have had issues in securing federal funding in the changing landscape of CMS RTP rules, hospitals reclassifying and changes in rural location delineations. Rural communities that are planning new residencies need to pay close attention to all these issues in choosing hospital partners and locating training sites. Participants should review at least one presentation that covers the basics before this workshop. Review options include: 1) RuralGME.org toolbox presentations search "Medicare GME funding". Anyone can get a free ruralgme.org login. 3) Attendance at the Residency Leadership Summit meeting in Kansas City March 25, 2024. Two workshops there that day.

- Be able to determine what is considered a “rural” location and a “rural” hospital for programs to qualify for federal funding
- Consider the funding implications of options for residency program curriculum design.
- Know which resources to use to get more detailed information about specific hospital Medicare GME funding issues

Recruitment of Residents to Rural Programs: Early Outcomes of RRPD Cohort 1
Weidner, Evans, Spencer, Patterson

Rural America has fewer physicians leading to poorer health outcomes. The Health Resources and Services Administration (HRSA) has funded a series of Rural Residency Planning and Development (RRPD) awards to develop rural residency programs in needed specialties. We explored the early recruitment and workforce outcomes of the first 25 new programs that were part of this program using exit survey data and cross-sectional methods. This session will share these data, which suggest the RRPD model is successful in creating and supporting new physician workforce training in rural communities.

- Understand the objectives and structure of the Rural Residency Planning and Development (RRPD) grant program
- Describe the characteristics and progress toward accreditation for residency programs in Cohort 1 of the RRPD program
- Compare early workforce outcomes of these new programs in rural communities from initial resident recruitment season and Match data

Empowering Healthcare in Rural Communities: MAHEC's Innovative Rural Fellowship Program
Gilmer, Agee

Join us in exploring MAHEC's Rural Fellowship program, a groundbreaking initiative designed to address healthcare disparities in WNC's most rural communities. Established in 2017, the Rural Fellowship program was implemented in response to the acute need for more primary care providers in our region. To date, 30 Fellows have completed the program and 87% of them continue to practice in rural WNC. This presentation will delve into the program's structure, objectives, and impact on improving access to quality healthcare in rural WNC. We will explore the program's innovative curriculum and opportunities for relationship building that have arguably created one of most successful recruitment and retention programs in the country.

- Identify and understand the primary components of a successful rural fellowship model
- Understand the factors that compel early career healthcare providers to remain in rural practice
- Explore how a similar model may be replicated in their own rural communities

Population Health Management of Opioids for Chronic, Non-Malignant Pain
Boll

Given evidence of increasing harm from long-term opioid therapy such as overdose and addiction, opioids for chronic, non-malignant pain (CNMP) require a structured, patient-centered approach. Such a protocolized, team-based renewal program was utilized for 10 years in a family medicine residency to improve patient care. Patients receiving Schedule II pain medications for greater than 2 months were integrated into a patient registry managed by a nurse-physician team. Using a pre and post intervention survey, physicians, nurses, and patients provided feedback about the process. The registry also allowed monitoring of PDMP, patient appointments, urine drug screens (UDS), and controlled substance agreements (CSA).

- Discuss definitions of chronic, non-malignant pain and models of treatment.
- Introduce a controlled medication renewal program for managing patients on these medications.
- Review outcomes of a controlled medication renewal program.

Creative Solutions to Providing Housing for Rural Residency Programs
Zolotor, Byron, Hawes, Longenecker

A challenge for expanding rural residency programs is securing housing for residents. Barriers include limited time between match and residency, lack of rural rentals, and limited available housing. We interviewed the leadership of 25 HRSA-funded Rural Residency Planning and Development grantees to learn how they address residents' housing. After a thematic content analysis, we found that solutions included program-owned or -rented housing, using short-term rentals, providing housing stipends, offering of rooms in local homes, rehabbing housing units, and building new housing. We will provide illustrative examples, discuss how programs may find effective solutions, and present concepts and resources around approaching funding for housing.

- Explain the specific challenges of providing housing for rural residency programs.
- Discuss two benefits of programs working to help residents secure their housing.
- Detail four or five solutions used by programs to address their housing needs.

Bridging the Gap for Rural Medical Education through Creative Partnerships
Bergeson, Moibi, Stevens

Rural graduate medical education is an integral part of building the rural workforce. With complexities in funding and staffing, building connections in state and local organizations is crucial to long term sustainability for these programs. Three years ago, the Minnesota Department of Health-Office of Rural Health and the University of Minnesota met to discuss ways to improve the rural workforce. Out of this meeting, a long-term collaboration developed and has resulted in the development of multiple rural programs and improved funding for rural GME in the state of Minnesota. This presentation will highlight how this partnership started, how it has been sustained and the mutually beneficial work that has come from it.

- Review the origins and structure of the collaboration between the University of Minnesota Department of Family Medicine and Community Health and the Minnesota Department of Health Office of Rural Health and Primary Care.
- Discuss effective strategies for building and maintaining effective collaborations between organizations with complementary goals.
- Encourage participants to think about creative partnerships that may further their rural medical education goals.

Diversity and Collaboration of Ohio's Medical Schools on Rural Programming: The Rural Physician Training Pathways (RPTP) Model
Heintzelman, Casapulla, Vossler, DiMario

Directors of Ohio's five medical schools with rural programming formed a state rural learning network – The Ohio Rural Physician Training Pathways (RPTP). Strengths of the RPTP learning network that have garnered home university support will be shared. These successes could be used by session participants to build a case for the creation of similar regional networks. Completed projects will illustrate ways in which an analogous group can enhance rural health education. Preliminary results of Ohio medical student characteristics in our pipelines will be displayed. Partners with graduates who completed residency will show initial practice patterns. Feedback from session participants will be sought on useful alterations to program design.

- Describe the structure and design of Ohio medical school rural programming

- Illustrate a collaborative learning network model among classically competitive institutions
- Preview initial characteristics of Ohio's medical students in pipelines to rural practice via shared metrics among RPTP partner institutions and preliminary outcomes of pathway participants entering independent practice.

Session 7

NIPDD Scholar Presentations
Walsh, Burks

Building from The Floor Up: Introducing a Residency Inpatient Service into an Existing Rural Hospitalist Group Model
Martin, Gilmore

Prior to 2019, our 42-bed community hospital was staffed by a small hospitalist group founded in the 1980s by emergency physicians. Initially there was resistance to family physicians joining the group, but after our first residents arrived summer 2020, they quickly began to appreciate our support and flexible scope during the pandemic. We have since trialed several models of the inpatient rotation, ranging from having a resident exclusively assigned to admissions, to more collaborative team-based models. Our struggles have included staffing shortages, a trial of tele-ICU, and difficulty collaborating with advanced practitioners to share floor patients. With lessons learned, we are building a robust learning experience for our residents.

- Understand better how to win friends and influence people: creating space for family medicine.
- Review and brainstorm different models for inpatient teaching structure.
- Discuss experienced challenges and identify solutions.

Faculty Time and CBME – It's Possible
Haney

The common refrain – there is not enough time or resources to implement competency based medical education (CBME). Perhaps that is the case, especially for our rural programs – and even more so when programs are navigating Time-based Medical Education at the same time. There are ways to relook at this challenge. Utilizing lessons from parallel research and scholarship can provide clues. Learned lessons from research in physician burnout and the discipline of patient safety and quality improvement might offer clues to maximize the limited time that faculty have in moving CBME from an unfunded mandate to a sought-after outcome.

- Compare and contrast time based medical education from competency based medical education (CBME)
- Describe continuous quality improvement tools and concepts that should be utilized in the implementation of CBME
- Identify and plan for removal of one system barrier/process at the home institution

Pathways to Peaks: Optional Tracks to Climb to Success

Ware, D. Smith

The year 2008 was a low point in our program's popularity. Optional areas of concentration were discovered, designed and implemented with tremendous quantitative and qualitative improvements in our training. We wish to share how these tracks were utilized to greatly enhance our training and recruiting. We also wish to help our audience to discover their own unique opportunities to utilize optional areas of concentration for their program's and resident physicians' success.

- Participants will be able to identify their strengths to create optional tracks.
- Participants will be able to design optional areas of concentration for their programs.
- Participants will be able to enhance their program's training and recruiting.

Meet Our Speakers

Dr. Ray Christian is a combat-decorated retired Army paratrooper. He has an MA in Public History and an EdS and Doctorate in Education Leadership. He is a Fulbright Specialist Expert in Education and Storytelling Narrative (The only Specialist in this field in the country) and was recently awarded the inaugural Black Appalachian Storytelling Fellowship for North Carolina. A former adjunct professor of history and storytelling at several universities, Ray has performed at numerous storytelling festivals and stages across the US and Canada including Old North State and The National Storytelling Festival in Jonesborough, NC (Slam winner and featured teller). His stories have appeared in Reader's Digest (2016 Best Stories in America and 2017 American Heroes) and the New York Times bestselling book "How to Tell a Story, "Edited by directors from The Moth. As a competitive storyteller, Ray is a 12-time Moth Story Slam Champion and winner of the 2016 National Storytelling Festival Story Slam. His stories have been featured on radio shows produced by The Moth, Snap Judgment (Toured with the Live shows of Both Snap Judgment and the Moth) and Back Story as well as an array of podcasts including Spooked, Story Collider, AdultISH, The Confessional and Risk. Ray travels to Asheville, NC to host the monthly Moth Story Slam, but resides in the remote mountains of Watauga County, NC. From his mountain oasis, he produces and hosts his own podcast, from PRX with support from the Moth What's Ray Saying?, a show that uses history and story to explore the Black American experience from the unique perspective of the many worlds Ray inhabits.

Dr. Warren Newton

Warren Newton, MD MPH serves as President and CEO of ABFM and the ABFM Foundation. Prior to coming to ABFM, he practiced as a personal physician for 36 years in an FQHC, a Health Department and an academic practice; he also started the first hospitalist service at UNC in 1997.

Dr. Newton served as the William B. Aycock Professor and Chair of UNC Family Medicine (1999-2016), UNC School of Medicine Chief Academic Officer (2008-2013), and Vice Dean and Director of North Carolina AHEC (2013-2018). He has led clinical practice and educational transformation at the practice, region and state levels and in both undergraduate and graduate medical education. As Family Medicine Chair and AHEC Director, he was responsible for over 30 residency programs, and founded and led the I3 collaborative of almost 30 primary care residencies in practice transformation from 2006-2018. He led the Improving Performance in Practice initiative (later AHEC practice support) which expanded to help care transformation to over 1400 primary care practices. As Senior Policy Advisor to the North Carolina Secretary of Health and Human Services, he helped develop the 1115 Medicaid waiver application and developed a plan for dramatically increasing family medicine, general surgery and psychiatry residencies across the state; this plan has been partially implemented.

Dr. Newton's scholarship has focused on the organization and effectiveness of health care; he has over 180 peer reviewed publications, including over 80 published with students and residents. He has been principal investigator on grants totaling more than $50,000,000. From 2012 to 2017, he served on the Board of Trustees of the North Carolina State Health Plan.

ABFM is redesigning every aspect of its certification portfolio, including the Family Medicine Certification Longitudinal Assessment (FMCLA), a new National Journal Club, Knowledge Self Assessments, Performance Improvement activities and a major revision of its Professionalism Guidelines. The ABFM launched the Center for Professionalism and Value in Health in July 2019 in Washington, DC, runs the PRIME registry, and conducts research in the ecology of family medicine, Measures that Matter in Primary Care and other policy areas critical to the future of family medicine and primary care. Family Medicine Residency Redesign is also a major focus now, with implementation of CBME across 745+ residencies as of July1, 2023. With respect to leadership development in the specialty, the ABFM and its foundations support the Pisacano fellowship for medical students, the Puffer NAM fellowships and a variety of visiting scholarships for residents, fellows and faculty.

Dr. Newton graduated from Yale University with a double major in biology and history in 1980 and Northwestern University Medical School in 1984. After residency and chief residency in family medicine at the University of North Carolina, he completed the Robert Wood Johnson Clinical Scholars Program and an MPH at the UNC Gillings School of Global Public Health. In 2012-13, he was selected as a Society of Teachers of Family Medicine (STFM) Bishop Fellow, during which he also completed the American Council of Education Fellows program.

Dr. Emily Hawes is a professor in the Department of Family Medicine. She serves as Deputy Director of the HRSA-funded Rural Residency and Teaching Health Center Planning and Development programs. She practices as a Clinical Pharmacist Practitioner providing collaborative drug therapy management in a family medicine clinic in rural North Carolina. Dr. Hawes' research focuses on team-based primary care, health workforce policy, rural health, and graduate medical education program development in rural and underserved areas

Dr. Erin Fraher is a Professor in the Department of Family Medicine and an internationally recognized expert on health workforce research and policy. She is Deputy Director for Policy and Director of the Carolina Health Workforce Research Center (CHWRC) at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. Her research focuses on graduate medical education, interprofessional teams in new models of care, developing rigorous methodologies to project how many health workers will be needed under different possible "futures," and using life course theory to better understand health professionals' career trajectories. Dr. Fraher's research has generated substantial interest from state and federal policy makers. She is often called upon to brief Congressional staff and members, the Health Resources and Services Administration, state governors, state legislatures and other public and private sector leaders on health workforce issues. She is well known for her ability to communicate complex research findings in ways that are easily understood and policy-relevant. Dr. Fraher is an expert on comparative health workforce systems, having worked for the National Health Service in England, the Ministry of Health in New Zealand, the College of Nurses of Ontario and served for many years as a member of the International Health Workforce Collaborative, a consortium of health workforce researchers/policy analysts in the United States, Canada, United Kingdom, New Zealand, and Australia.

Dr. Steve Buie is chair of the Department of Psychiatry and Mental Wellness. He obtained his medical education at the University of the North Carolina School of Medicine. He completed a residency in internal medicine at a Columbia University training hospital in New York and a psychiatry residency at Cornell Medical College, also in New York. Dr. Buie is an adjunct associate professor of psychiatry at the University of North Carolina School of Medicine. He is a Distinguished Life Fellow of the American Psychiatric Association and was named a Distinguished Alumnus of the UNC School of Medicine. He is a past president of the North Carolina Psychiatric Association, is president of the North Carolina Psychiatric Foundation, and is a member of the American College of Psychiatrists.
He started providing psychiatric consultation at MAHEC 17 years ago, which is where he met Benjamin Gilmer. He started working with MAHEC 7 years ago to develop a psychiatry residency and psychiatry department and became a full time MAHEC employee 4 years ago.

Dr. Benjamin Gilmer is a family physician and Associate Professor at the University of North Carolina School of Medicine and Mountain Area Health Education Center's (MAHEC) Family Medicine Residency Program. He is an international Albert Schweitzer Fellow and attended Davidson College followed by medical studies at the Sorbonne in Paris, France and East Carolina University. As the Medical Director for MAHEC's Rural Health Initiative and Rural Fellowship, he is passionate about advocating for global and rural health disparities. He has worked extensively in Central and South America and West Africa.
Benjamin is committed to advancing medical education, interprofessional collaboration and inspiring students to pursue rural health

Thank you to our Participating Programs

- Cahaba + UAB Family Medicine Residency (primary program for Cahaba)
- Cahaba + UAB Family Medicine Residency (part of Cahaba consortia)
- UAB Selma Family Medicine Residency
- UAMS Regional Centers (Crossett) (part of UAMS consortia)
- UAMS Regional Centers (El Dorado) (part of UAMS consortia)
- UAMS Regional Programs Family Medicine Rural Training Program Northwest (primary program for UAMS)
- Sierra Nevada Family Medicine Residency Program
- Sutter Health Family Medicine Program - Mador Track
- Adventist Health Ukiah Valley Family Medicine Residency Program
- University of Colorado Family Medicine Residency - Morgan County Rural Training Track (part of Colorado consortia)
- North Colorado Medical Center - Sterling Rural Training Track (part of Colorado consortia)
- North Colorado Family Medicine - Wray Rural Training Track (part of Colorado consortia)
- St. Mary-Corwin Medical Center (primary program for Colorado)
- Quinnipiac University Rural Family Medicine Residency Program
- Wayne County Hospital RESST Program
- MercyOne Des Moines (or DSM Rural Family Medicine)
- Family Medicine Residency of Idaho (primary program for FM Residency of Idaho)
- Family Medicine Residency of Idaho (part of FM Residency of Idaho consortia)
- Family Medicine Residency of Idaho (part of FM Residency of Idaho consortia)
- Idaho State University Rural Program (part of WA consortia)
- University of Illinois at Chicago Family Medicine Residency
- University of Illinois (Rockford) Rural Program
- Jacksonville Memorial Hospital/Southern Illinois School of Medicine Rural Track Training
- KU Family Medicine Residency Program
- University of Kentucky Rural (Morehead) Family Medicine Program
- Central Maine Medical Center Rural Track Residency
- McLaren Health Care Corporation Program - Family Medicine
- Health Partners Western Wisconsin Rural Family Medicine Residency (part of WRPRAP consortia)
- University of Minnesota/CentraCare Willmar Rural Family Medicine Residency Program
- Bothwell - University of Missouri Rural Family Medicine Residency
- Southwest Mississippi Regional Medical Center
- Montana Family Medicine Residency
- Family Medicine Residency of Western MT

- Montana TRUST Program
- MAHEC Boone Rural Family Medicine Residency (primary program for MAHEC)
- FQHC Track - University of North Carolina Chapel Hill Family Medicine Program
- East Carolina University"
- MAHEC Hendersonville Rural Family Medicine Residency (part of MAHEC)
- UND School of Medicine and Health Sciences Rural Program (part of UND consortia)
- UND Center for Family Medicine Hettinger RTT (primary program for UND)
- Creighton University Family Medicine Residency
- University of Nebraska Medical Center Rural Training Track
- Gerald Champion Medical Center Family Medicine Residency Program GC - FMRP (part of NMPCTC)
- El Centro Family Health Graduate Medical - Medicos Del El Centro Family Medicine Residency - El Centro Family Health Education (part of NMPCTC)
- Shiprock - University of New Mexico Family Medicine Residency (part of NMPCTC)
- Hidalgo Medical Services Family Medicine Residency Program (part of NMPCTC - charged as primary program)
- University of Nevada, Reno School of Medicine Elko Rural Track Program
- University of Vermont Health Network Champlain Valley Physicians Hospital Family Medicine Residency Program
- OUHCOM Rural and Urban Scholars Pathways Program
- Wright State University Boonshoft School of Medicine Program
- Osteopathic Medical Education Consortium of Ok (OMECO/Chickasaw Nation Medical Center) Program
- Providence Hood River Family Medicine Residency Rural Training Program
- Oregon Health and Science University Cascades East Program
- Samaritan Family Medicine Residency
- OHSU FM Three Sisters Rural Track Program
- CHI Mercy Health - Roseburg Family Medicine Residency
- Walter & Irene Baran Schuylkill Family Medicine Residency
- St. Luke's University Health Network
- Indiana Regional Medical Center (IRMC) Family Medicine Residency Program
- DLP Conemaugh FMRP
- UPMC Rural Family Medicine Residency
- McLeod Family Medicine Rural Residency Program
- Sioux Falls Family Medicine Residency Program
- East Tennessee State University - Department of Family Medicine
- University of TN Chattanooga FMRP
- UNT HSC Rural Medical Education
- The University of Texas at Tyler Rural Family Medicine Residency Program
- VCU Health - CMH Family Medicine Residency
- St. Peter Family Medicine Chehalis Rural Training Program (part of WA consortia)

- Family Medicine Rural Training Track (part of WA consortia)
- Omak Rural Training Program (Multicare Health System (Omak) Program) (part of WA consortia)
- Providence St Peter - Summit Pacific Rural Family Medicine Program (part of WA consortia)
- Pullman (primary program for WA consortia)
- Swedish Cherry Hill Family Medicine Port Angeles RTT (part of WA consortia)
- University of Washington Alaska Internal Medicine Rural Residency Program
- University of Washington RTT (part of WA consortia)
- Central Washington Family Medicine Residency Program (part of WA consortia)
- Tamarack Health
- Mercy Health Family Medicine Residency Program
- University of Wisconsin (Madison) Program (part of WRPRAP consortia)
- Wisconsin Rural Physician Residency Assistance Program (WRPRAP) - Aurora Lakeland (part of WRPRAP consortia)
- Wisconsin Rural Physician Residency Assistance Program (WRPRAP) - Baraboo RTT (primary program for WRPRAP)
- University of Wisconsin School of Medicine and Public Health / SSM Monroe Rural Program
- Marshall Community Health Consortium - Marshall University SOM
- "University of Wyoming
- Family Medicine Residency Program Casper"
- Number of Active Programs in 2023-2024
- Type of Program:
- Rurally Located Program
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Darin Bell, MD, Associate Director; Assistant Director of Rural Education at FMR of Western MT, Rural Director of FMRWM, Missoula, MT
Melissa Horton, Administrative Director; Administrative Director, National Center for Rural Health Professions, University of Illinois College of Medicine Rockford, Rockford, IL
Jessica McGuire, Membership Engagement Coordinator; Rural Medical Education Program Coordinator, National Center for Rural Health Professions, University of Illinois College of Medicine Rockford, Rockford, IL
Jessica Tripp, Annual Meeting and Events Coordinator; PCTE Project & Administrative Associate Manager, Family Medicine Residency of Western Montana, Missoula, MT
Dave Schmitz, MD, Senior Research Advisor; Chair, Department of Family and Community Medicine, University of North Dakota School of Medicine and Health Sciences, Grand Forks, ND

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Lori Rodefeld, MS, Director of GME Development at Rural Wisxokson Health Cooperative, Sauk City, WI
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Olivia M. Dhaliwal, MD, Case Western Reserve University, Cleveland, OH
Robin Raquel Rodriguez, **MD, MBA**, PGY-2, Indiana Regional Medical Center Rural Family Medicine Residency Program, Indiana, PA

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