



Building and Maintaining an RTT. The Oldest and Newest. Innovations etc.

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Objectives

1. Review our oral and pictorial history
2. Outline the process of the development of the Hood River RTT and Colville's Help
3. Describe Recruiting Process for Medical Students
4. Learn about working with FQHC's and CHC's
5. Understand Developing and Maintaining the Longitudinal Curriculum
6. Building a Academic and Mentoring Faculty and Community
7. How do we cross "T's" for the ACGME
8. Preparing for a financial future in this uncertain world



Goals of our RTT's

- Incorporate the rigors of academic based training with a real world experience in a small community away from urban academic centers
- Training to achieve a broad skill set to care for vulnerable and underserved peoples in rural communities
- Mentored by faculty physicians with rural experience
- RTT graduates
 - will practice in small, rural communities and address health professional shortages
 - have the skills to care for a diverse patient population, maintain life balance and enjoy life long learning.



The Granddaddy: Spokane-Colville RTT



- 29 years of a 1-2 program
- 80% of graduates practice in small and rural communities
- Residency affiliations with the Spokane Family Medicine Residency

North Eastern Washington Physicians



Providence Colville



Mike Snook: the Father and Director of the Colville RTT for 20 years

Emphasis on procedural training



Hood River RTT Program Development



Development

- RTT Conclave
- Visiting Other Sites and Collaborating with Colville
- NIPPD Fellowship
- RPS Consultation
- Business Plan and Triple Aim with Health System
- Critical Mass and Mandate



Country Doctor and Apprentice



What and Why – 1-2 Rural Training Track?

- **What:** A “1-2” RTT characterized by one year of medical residency training in an urban environment, followed by two years of residency in a rural environment.
- **Why:**
 - First train in a resource-rich urban center,
 - Followed by training in a relationship-rich rural community.
 - 1-2 RTT provides more comprehensive learning opportunities than training solely in either location.
 - More likely to practice in rural areas.
 - RTTs are an important tool in addressing physician shortages in rural areas.

Development of a Rural Residency Track in Hood River

- 2010-11 – Local interest, RPS Consultant, NIPPD Project and Business Plan
- La Clinica - outpatient primary care practice
- Providence approval to make ACGME application 12/11
- ACGME Application will be submitted by March 1st
 - Site Visit August 2012
 - Approval/Denial September 2012
- HRSA Funding Application – October 2012



RPS Consultant Report- Lou Sanner MD

- **Factors Associated with Success**
 - Recruiting Excellent Residents
 - “Distractingly Beautiful”
 - Institutional Commitment
 - Local Physician Leadership and Local Support
- **Bottleneck Issues**
 - CAH designation precludes standard GME funding
 - Legislative influence
 - La Clinica footprint will need expansion
 - Spanish “fluency”



Why Hood River and Why OCH?

- Hood River is an ideal place for an RTT
 - Strong primary care and specialty clinician leadership
 - Long standing and valued FQHC serving poor and vulnerable population.
 - State of the Art facilities
 - Proximity to Portland
 - Support of PHS and associated with excellent core program in Portland now in its 11th year with 24 residents.



Proposal 1-2 RTT Program

- 2 Residents/year beginning in 2013 or 2014
- 1st year at PMH yet some participation in HR
- 2nd and 3rd Year at Hood River
 - Family Health Center: La Clinica del Carino – Now One Community Health
 - Rotations and Longitudinal – Most in HR, some intense ones in Portland
- Funding through:
 - HRSA THC Grant
 - Medicare GME



Providence Milwaukie Hospital Residency since 2002



Hood River Hospital Since 1932 and remodel 2010



Things that have gone well

- Community Physician Support has been spectacular
- Hospital CEO Ed Freysinger and Providence DIO, Glenn Rodriguez MD DIO
- Matched 6 excellent physicians thus far
- Small Community PMH FP Residents consistently rate the HR rotation as their best
- Student Interest has been remarkable
- PHRMH Hospital Week very successful
- We have plenty of patients



Things that have been or are challenging

- ACGME Board approval was pushed back 6 months expected
- HRSA THC Funding was unavailable
- La Clinica - OCH Restructuring and new leadership. Value Merging and Friction
- Providence's overall fiscal plan impacted by:
 - ACA and changes in Health Care Environment
 - Care Transformation with CCO's
 - EPIC Implementation
 - Incorporation of Swedish Med Center in Seattle



Recruiting Medical Students

- St. Francis House
- High School Medical Biology Curriculum
- Mentorship Program for College Students
- Med School Family Medicine Interest Groups
- Offering Subinternships
- AAFP National Medical Student Conference
- ERAS
- Website, Facebook and Social Media
- ERAS
- Traindocsrural.com



La Clínica del Corazón
Family Health Care Center



Working with FQHC

- Understand their history, culture and process
- Teach them about yours, realize you are still a "visitor" in their house
- Agreements:
 - Must be a Win – Win
 - Budget must be budget neutral at least
 - Be clear like any contract outlining responsibilities
 - Include compensation for non-clinical (academic) duties
- Respect their values
- Make residents' schedules consistent as possible
- Avoid late changes.
- Meet frequently with leadership and board.

Letter to my PD from med director of the FQHC

- My request is that the residency program respect our (and your own) scheduling guidelines....We ask that all resident OCH clinic days be confirmed 8 weeks in advance of any given month. The call schedules can be added in later if needed. ---- **What this means is once the schedule is finalized (occurring 6 weeks prior to any given month) that everyone is committed to their schedule and NO CHANGES ARE MADE. Of course there are exceptions – however this should be for true exceptions only – illness, emergencies, etc. What has been happening is that after the Final schedule is made --- the RTT program continues to make changes to it – fairly regularly – and this is where all of the problems start. I won't go into details of the problems this has caused in this email. But I can review those details if wanted or needed.**
- In the affiliation agreement on page 3, there is a statement under 2)c.:
"the program will do its best to ensure resident and site director schedules are provided in a timely manner in order for the clinical site to build as efficient a schedule to ensure residents and preceptors are well matched to provide the best patient access as well as ensuring optimal utilization of the Clinical Site's personnel."

Developing and Maintaining an RTT Curriculum



What is a Longitudinal Curriculum and why would we attempt teaching that way?

- Traditionally medical education is taught in blocks,
- With each rotation you learn about the area in a concentrated way and evaluate and treat many of the same type of patient.
- Why... We do this because specialists are felt to have the best body of knowledge on a topic, so we spend a month with specialists in _____.
 - We also feel that seeing various manifestations of disease can be helpful in developing depth of knowledge.
- Continuity care in most specialties is taught almost as an afterthought.
- But what if we:
 - Don't have enough patients to teach a topic in a block
 - Don't have specialists where the students are
 - Have a different reason for spreading out the learning, such as work logistics

Longitudinal Curriculum is a Good Idea for RTT's and Family Medicine



- Allows Visiting or Rotating Specialists to rural tracks to sync their schedules with GME
- Incorporates Skill of Shifting Gears necessary in Rural Family Medicine
- Builds relationships with Specialty Colleagues over time
- Produces better environment for adult based learning
- Help residents build continuity practice
- Enhance continuity of patient care by overlapping with hospitalists.
- Avoid rounding rush prior to 9am clinic

Traditional Block Model

1	2	3	4	5	6	7	8	9	10	11	12	13
Peds IP	Gyn	Ophth Uro	FM IP	Addict ions	OB	Peds OP	Public Hlth	Nwbn /NICU	FM IP	Beh Hlth	Pract Mgmt	Derm ENT

Challenges

- Programs & coordinators
- Specialists/volunteer physicians
- Residents

Traditional Block Model

1	2	3	4	5	6	7	8	9	10	11	12	13
Peds IP	Gyn	Ophth Uro	FM IP	Addict ions	OB	Peds OP	Public Hlth	Nwbn /NICU	FM IP	Beh Hlth	Pract Mgmt	Derm ENT

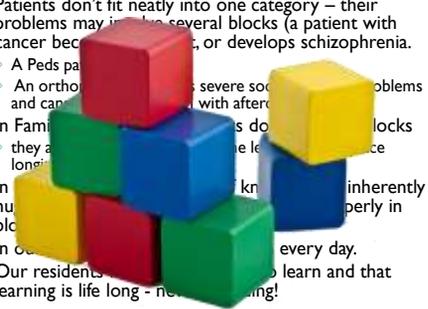
MegaBlock Model

1	2	3	4	5	6	7	8	9	10	11	12	13
Women and Children's Health					FM IP	Sub-Specialties			FM IP	Community Care and Leadership		
Peds IP	Gyn	OB	Peds OP	Nwbn /NICU		Ophth Uro	Addict ions	Derm ENT		Public Hlth	Beh Hlth	Pract Mgmt

still have the "one and done" problem and is not integrated

What if there are problems with block learning?

- Patients don't fit neatly into one category – their problems may span several blocks (a patient with cancer becomes depressed, or develops schizophrenia).
 - A Peds patient with severe social problems
 - An orthopedic patient with after-school problems and cancer
- In Family Medicine, residents do not have blocks
 - they are always on call
 - longitudinal learning
- In Family Medicine, residents know inherently how to learn and that learning is life long - never ending!



Block vs. Longitudinal

- Question Answer from ACGME FAQ
- Is a block month in a particular experience equivalent to 100 hours if it is done longitudinally?
- Yes, a number of required experiences can be done in either block or longitudinal format.
- If done longitudinally, the program will need to document 100 hours of the required experience.
 - (Program Requirements II.A.4)

Longitudinal & Integrated Training

- Longitudinal: repeated exposure across years
- Strategic repetition = better retention
- Integrated: multiple content areas inform each
- Other
 - **Adult based education research**
 - **Public health component**
- Help see holistic picture
- Patient as integrator (central focus)
- Didactics and Case Base Learning integrated into schedule



ACGME Program Requirements for Graduate Medical Education in Family Medicine

Source: www.acgme.org/acme/program-requirements

ACGME General Requirements for Graduate Medical Education in Family Medicine, 2013

So let's look at
the FM
Curriculum
Requirements
and what we
can do!

First – make sure continuity is first priority

- The program needs to ensure that PGY1 level residents achieve at least 150 patient encounters and
- graduating residents achieve at least 1,650 encounters over 3 years. (1500 last 2)
- It is expected that patient visits will increase as residents progress through the program.

• (Program Requirements IV.A.5.a.2.c.iii.c)

Distilled the ACGME RRC Curricular Requirements are:

- Adult Inpatient
 - 600 hours and 750 patient encounters
 - ICU 100 hours or 15 patient encounters
- Older Adults – 100 hours or 125 patient encounters
- Emergency -200 hours or 250 patient encounters
- Pediatrics
 - Inpatient 200 hours or 250
 - Ambulatory 200 hours or 250
 - Neonatal 40 encounters
- Surgery - 100 hours
- Musculoskeletal - 200 hours
- Gyn - 100 hours
- Obstetrics - 200 hours
- Health System Management -100 hours
- Electives – 300 hours
- Total: Hours = 2100
- Continuity
 - 1650 encounters over 3 years or
 - 1500 over 2 years of PG2/3
- Total Encounters: 3315
- No Hours
 - Behavioral Health
 - Derm
 - Surgical Subspecialty
 - Community Health
 - Radiology and imaging

Goals of Colville RTT Longitudinal Adult Medicine Experience



- Increase continuity of resident presence in the hospital to maximize exposure to learning opportunities and various aspects of patient care
 - care conferences,
 - procedures,
 - availability for anything interesting happening in the hospital

How did we implement? THE COLVILLE RTT EXPERIENCE:



First implemented academic year 2013-2014, now nearing the end of 18 months
Initially - R2 and R3 alternate "hospital" and "clinic" weeks

Now – Hospital and Clinic Blending
Initial trial done 6 months in a row to "blitz" hospital physicians and staff with resident presence and help, placing them firmly on everyone's radar so they get in the habit of calling the resident first for admits and procedures.

Hospital Week



The "Hospital Week"

- Incorporates inpatient medicine, ambulatory medicine/continuity clinic, ICU, cardiology, pulmonary medicine, and some ER (as well as access to anything OB happening in the hospital) in a nearly seamless manner...which is what FAMILY MEDICINE is all about!!
- (Surgery, Peds, Ortho, and others still done as block, you can't have everything...yet)

Clinic Week

- ½ day per week hospital week
- 3-4 ½ days per week continuity clinic per week on clinic week
- Specialty clinics on clinic week cardiology, pulmonary med, GI, nephrology, oncology, radiology
- Varies with availability of visiting and in house specialists (scheduling can get tricky)



Scheduling

- Can develop offset schedules "Resident A" and "Resident B", plug into Outlook with repeats, then simply put appropriate resident initials in the daily occurrences as appropriate...
- Or a variation on this theme, where you do one resident's schedule based on (paper) template with repeat every other week for the duration of the longitudinal block.

Scheduling

- Done via Outlook, with specific RTT Calendar
- Calendar managed by RTT Site Director
- Residents, reception, Spokane coordinator (and a few others) have shared access to view, Colville program assistant has access to make changes
- Calendar is emailed to hospitalists, ER, nurse managers, OB dept., visiting specialists, etc.

Hood River



Providence Oregon Hood River 1-2 RTT



- Completed 11 months
- Doing Hospital Week
 - FP/IM blended hospitalist
 - Taking advantage of all service environments
 - By 2015 every week will have a resident
 - Buy in from Hospitalists, FP, Surgery ObGyn and ED and NURSES has been great
- Challenge is coordinating it all.....but I am optimistic!!!!

RI Schedule

R2 Block Rotation Schedule
Academic Year: 2014 - 2015

	Block 1 6/24-7/13	Block 2 7/14-7/23	Block 3 7/24-8/2	Block 4 8/3-8/12	Block 5 8/13-8/22	Block 6 8/23-9/1	Block 7 9/2-9/11	Block 8 9/12-9/21	Block 9 9/22-10/1	Block 10 10/2-10/11	Block 11 10/12-10/21	Block 12 10/22-10/31
Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine
Emergency	Emergency Medicine	Emergency Medicine	Emergency Medicine									
Obstetrics/Gynecology	Obstetrics/Gynecology	Obstetrics/Gynecology										
Family Medicine	Family Medicine	Family Medicine										
General Surgery	General Surgery	General Surgery										
Neurology	Neurology	Neurology										
Psychiatry	Psychiatry	Psychiatry										
Cardiology	Cardiology	Cardiology										
Pediatrics	Pediatrics	Pediatrics										
Orthopedics	Orthopedics	Orthopedics										
Radiology	Radiology	Radiology										
Pathology	Pathology	Pathology										
Pharmacy	Pharmacy	Pharmacy										
Public Health	Public Health	Public Health										
Community Medicine	Community Medicine	Community Medicine										

R2 Academic Year

R2 Block Rotation Schedule
Academic Year: 2014 - 2015

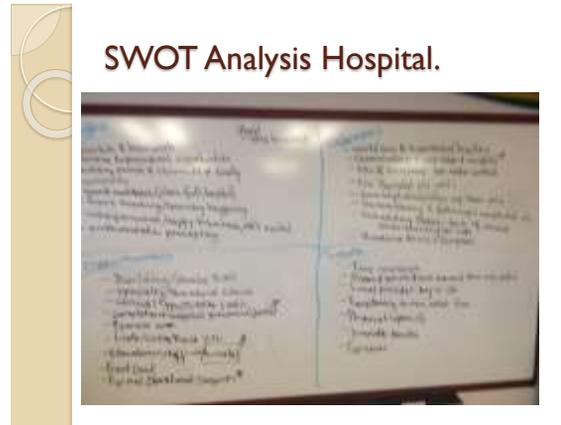
	Block 1 6/24-7/13	Block 2 7/14-7/23	Block 3 7/24-8/2	Block 4 8/3-8/12	Block 5 8/13-8/22	Block 6 8/23-9/1	Block 7 9/2-9/11	Block 8 9/12-9/21	Block 9 9/22-10/1	Block 10 10/2-10/11	Block 11 10/12-10/21	Block 12 10/22-10/31
Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine	Internal Medicine
Emergency	Emergency Medicine	Emergency Medicine	Emergency Medicine									
Obstetrics/Gynecology	Obstetrics/Gynecology	Obstetrics/Gynecology										
Family Medicine	Family Medicine	Family Medicine										
General Surgery	General Surgery	General Surgery										
Neurology	Neurology	Neurology										
Psychiatry	Psychiatry	Psychiatry										
Cardiology	Cardiology	Cardiology										
Pediatrics	Pediatrics	Pediatrics										
Orthopedics	Orthopedics	Orthopedics										
Radiology	Radiology	Radiology										
Pathology	Pathology	Pathology										
Pharmacy	Pharmacy	Pharmacy										
Public Health	Public Health	Public Health										
Community Medicine	Community Medicine	Community Medicine										



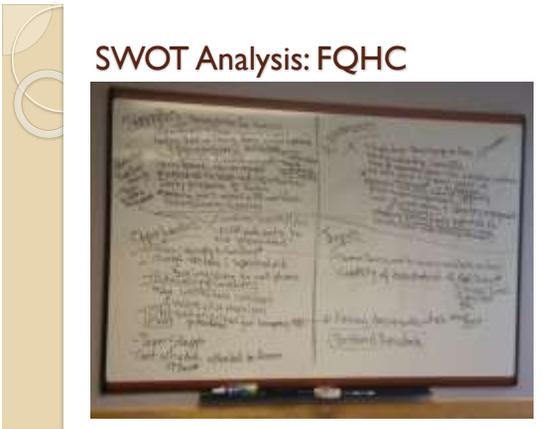


- Taking each Block and “Customize”
- Others can see schedule
- Automatically tracks curriculum hours
- Links with evaluations automatically
- Can be built for entire year
- Residents will have access from smart phone or web based browser

Block #	Block Name	Start Time	End Time	Day	Location	Resident	Supervisor
Block 1	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident A	Attending A
Block 2	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident B	Attending B
Block 3	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident C	Attending C
Block 4	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident D	Attending D
Block 5	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident E	Attending E
Block 6	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident F	Attending F
Block 7	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident G	Attending G
Block 8	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident H	Attending H
Block 9	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident I	Attending I
Block 10	Internal Medicine	08:00 - 09:30	09:30 - 11:00	Mon-Fri	Internal Med	Resident J	Attending J



SWOT Analysis Hospital.



SWOT Analysis: FQHC

- Different Priorities**
- Residents – keep the spaghetti that sticks and get varied experiences that they cannot get at the RTT site
 - FQHC – have some consistency with resident’s schedule that allows for efficiency
 - Cover Core Program’s Requested Needs.
 - Local Specialists – not impact productivity
 - Hospital Physicians – regular reliable resident shifts, consistency.



What mistakes have we made

- Too many rotation commitments in “big city”
- Pulling residents out of the FQHC FMC
- Trouble with patients accepting residents as their MD due to “dynamic” nature of the schedule.
- Rotations that were “observership” only
- Remote attendance and use of PolyCom has been problematic due to poor training of technology

Longitudinal 2.0 Priorities: For HR RTT

- Have the Residents' PCMH - OCH clinic schedules be able to be built out for the year (once the Hospital Weeks, Away rotations and Vacations are blocked) with no changes except for unforeseen emergencies and catastrophic world events.
- Ensure the residents are in Hood River and clinic enough to have continuity with their panel of patients, be available for their deliveries, PCMH team and provider meetings, and easily achieve the 1650 bench mark for encounters..
- Cover the Hood River Hospital on average 3 weeks per month. Medicine Week Saturday - Thursday with clinic all day Friday.
- Allow for elective and regional as well as international experiences that would not compete with each other and provide balance to the RTT
- Provide ample slots for residents to take advantage of opportunities in Portland if they are not available in HR or TD.
- Provide Support for the Portland Milwaukie Program for Week 7 (Night Float and Senior Medicine) of each Quarto and the 4 weeks of Block 4

Plan – Do – Study - Act

- SWOT Analysis
- Survey Monkey
- Talking
- Rethinking priorities
- Develop an agreement of priorities to develop a framework to an agreement to a map out a plan and implement another plan.



The Quarters = Quarto

	Monday	Tuesday	Wednesday	Thursday	Friday
AM		S and O, MCH	MCH	EA, PRH	S and O, EA
PM	S and O, EA	S and O, P & RH, MCH	MCH (non-cl)	EA, P & RH, MCH	EA, P RH

Quartile Elements – Making some order to “chaos”

- # 1 Surgery and Ortho
- # 2 Elective Away
- # 3 Procedures and Rural Health
- # 4 Maternal Child Health

Develop the rational and the agreement before the framework



Quarto Number 1 Surgery and Ortho Agreement to Framework

Surgery and Ortho

- OCH Clinics – Monday pm, All Day Tuesday, Friday am
- Orthopedist Stanley every Thursday except Hospital and Surgery Week
- Weds: Sports Medicine or Portland ER
- ER Call Every Other Friday pm
- PMG Women's every Monday.
- 1 surgery week only Monday through Friday (except R2's will have 2 surgery weeks)
- 1 Hospital week per month (clinic all day Friday)
- 1 week vacation
- 3 ED/Call shift per 4 weeks

Sept - June

Quarto 2

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	N/S	Peter	Peter	Matt, Jared	Matt
PM	N/S	Jared, Peter	Peter (non-ED)	Matt, Jared and Peter	Matt and Jared

Quarto 3

	Monday	Tuesday	Wednesday	Thursday	Friday
AM		Peter, Matt	Matt	Jared	Peter and Jared
PM	Peter and Jared	Peter, Matt	N/S (non-ED)	Jared and Matt	Jared

Quarto 4

	Monday	Tuesday	Wednesday	Thursday	Friday
AM		Matt, Jared	Jared	Peter	Matt
PM	Matt	Matt, Peter and Jared	Jared (non-ED)	Peter and Jared	Peter



<http://casamatmahuehue.blogspot.com/>

Faculty Development

- Monthly Faculty Meetings
- Monthly Email Newsletters
- Year Small Group Sessions
- Pay them to Play
- Build Community
- Respect their time but have them make commitments
- Teach the Milestones, Get involvement in Curricular development and the CCC



Building Community

- Make things fun
- Allow the Older Docs to share their wisdom
- Make the "Community" the "Faculty"
- Have the residents participate in community events, hospital committees
- Monthly Mentoring Dinners
- Advisors and Mentors



Who are we?

• Innovative Family Medicine RTT located in the beautiful Columbia River Gorge

• We are a multidiscipline team of Family Physicians, Specialists, Nurses, Hospital and Clinic staff, administrative professionals and educators who believe in training our residents to care for the needs of rural underserved communities in Oregon.

• We practice and teach broad spectrum family medicine in an unopposed setting centered within a 25 bed Critical Access Hospital and a Community and Migrant Health Center serving a large Spanish speaking population.

• We seek highly motivated, hardworking, flexible and accountable individuals to learn alongside with us in a welcoming, supportive, bilingual, challenging yet nurturing and changing medical environment.

• We aim to eliminate "learned helplessness" in medical education, all while striving for a sense of purpose, teamwork and work-life balance in the pursuit of remaining passionate for family medicine and life-long learning.



Herding Cats?



The ACGME

- Learning about Program Requirements
- Evaluation Milestone Process and CCC
- WebAds reporting
- Have adequate Admin Support
- Institutional Mock Survey
- Resident Survey challenges
- Program Licensing and Affiliation Agreements

The screenshot shows a user profile for Matthew Bart Sperry, MD, with a '1st Year in Residency' checklist. The checklist includes items like 'Bloomberg, Epix', 'Darell, Christine Mary Powell', 'Vid, Sara Webbaum', 'Lidman, Conal Mark', 'Liv, Rachel', 'Hess, Jason M DMD', and 'Simmons, David Ryan'. A map of Oregon is visible in the background, with a blue outline indicating a specific region.

Funding and Financial Stability

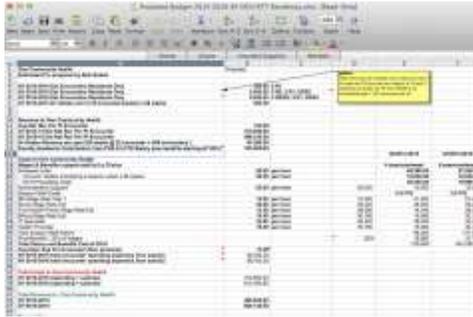


4 Legs of Financial Stability – Ted Epperly



- Institutional Support
- GME funding
 - CAH 33 + 1% of Academic Costs of DME costs Medicare cost report
- Grants
- Health Care Service Generated Revenue
 - Patient care revenue
 - Stipends
 - Contracts

Learning how to use Excel



Understand the "money" or learn the language of CEO and CFO's

Thank youAnyone want to come along on the journey....

