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Research Update: RTT Resilience and Closure

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Rural Training Track
technical assistance program

Disclaimer DRAFT

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Tracking RTT graduate outcomes

- 4 surveys 2011-2015 RTT programs that were active at any time from 2007-2015.
- 28/42 (67%) programs responded to at least one survey.
- 21 programs identified 253 graduates 2008-2015.
- We matched graduates to National Provider Identifier (NPI) and AMA Physician Masterfile data (practice locations, background characteristics)
- Practice location ZIP codes were classified using Rural-Urban Commuting Area (RUCA) codes; ArcGIS coding for Health Professional Shortage Areas (HPSAs)

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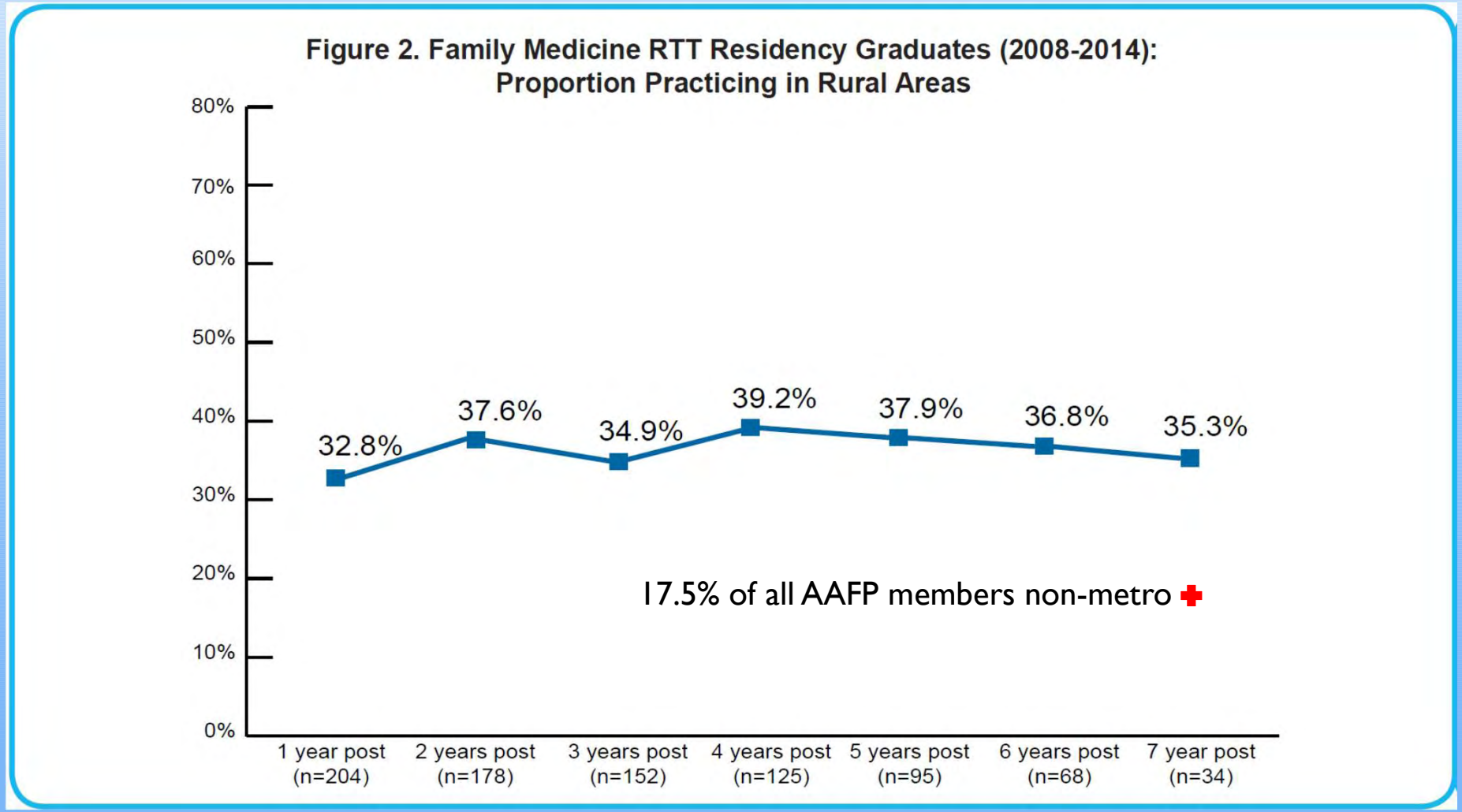
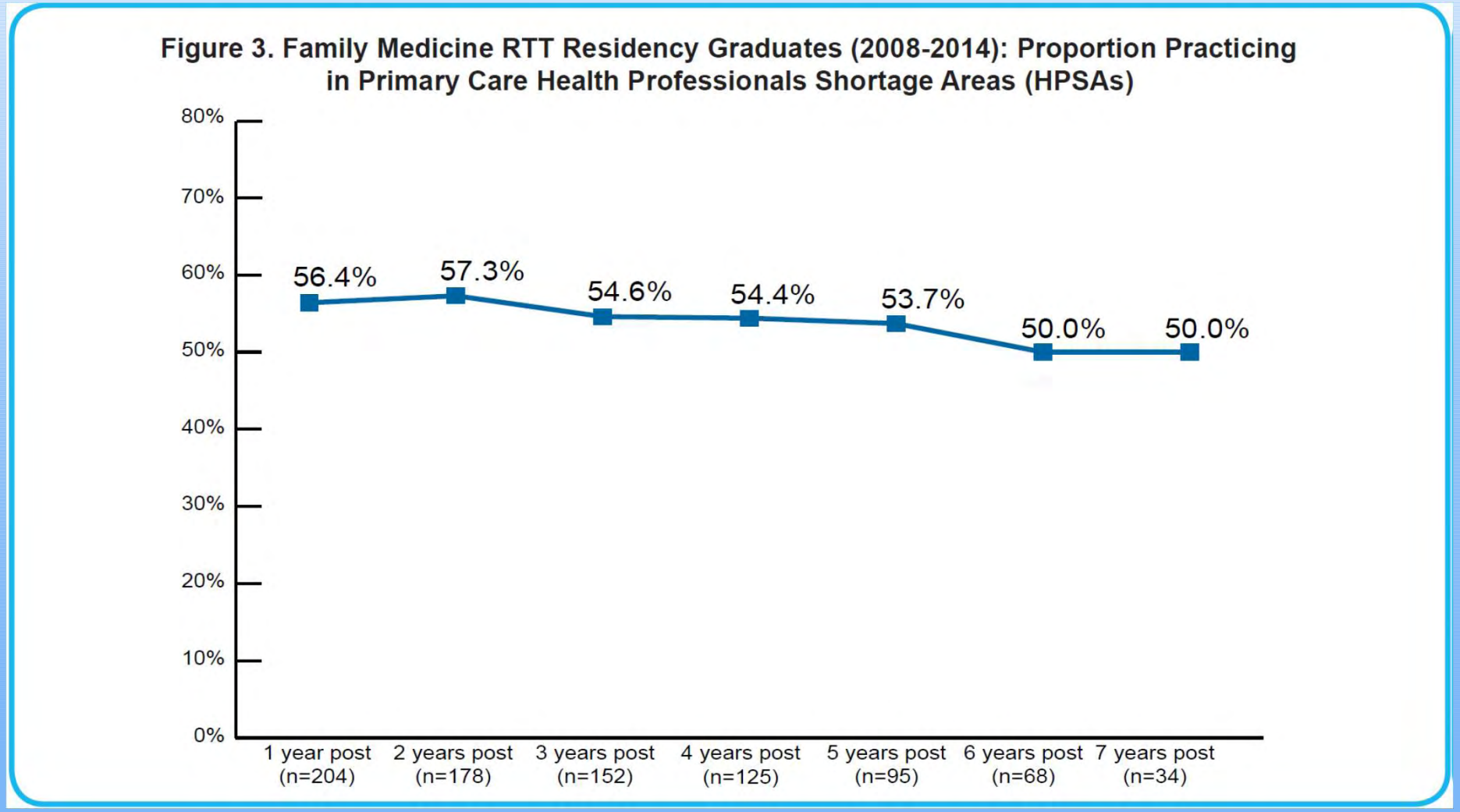
Graduate outcomes
2008 through 2015

33%-39% practice in rural areas in years 1 to 7 post-residency



Data sources: graduates NPI practice ZIP codes classified by RUCAs.

High proportions of graduates provide service to designated shortage areas



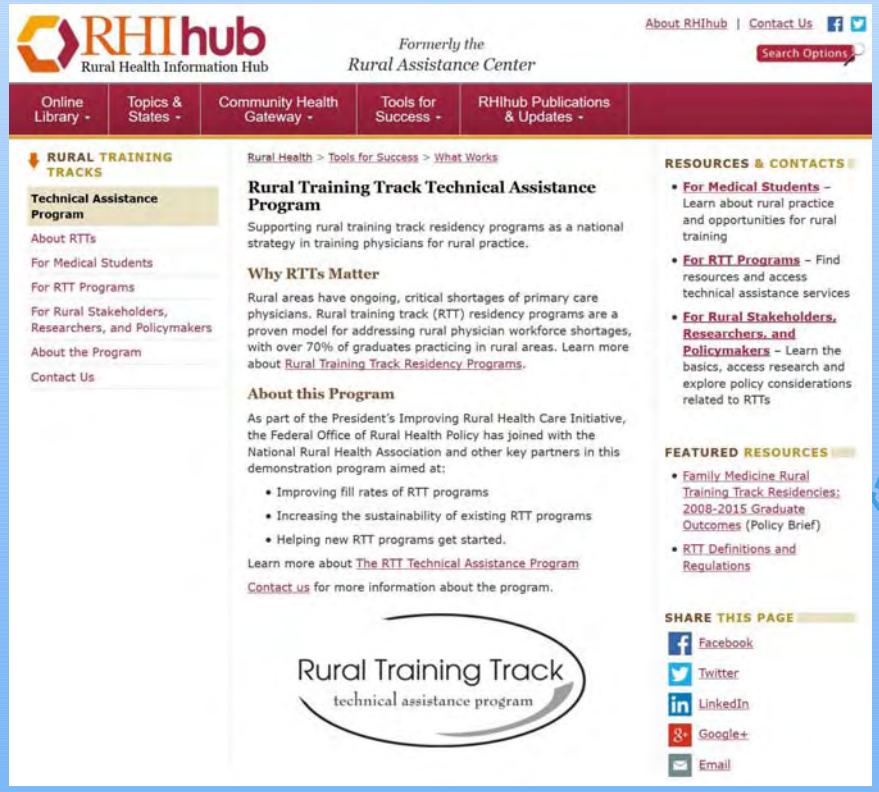
Data sources: graduates NPI practice ZIP codes classified by RUCAs, Robert Graham Center.

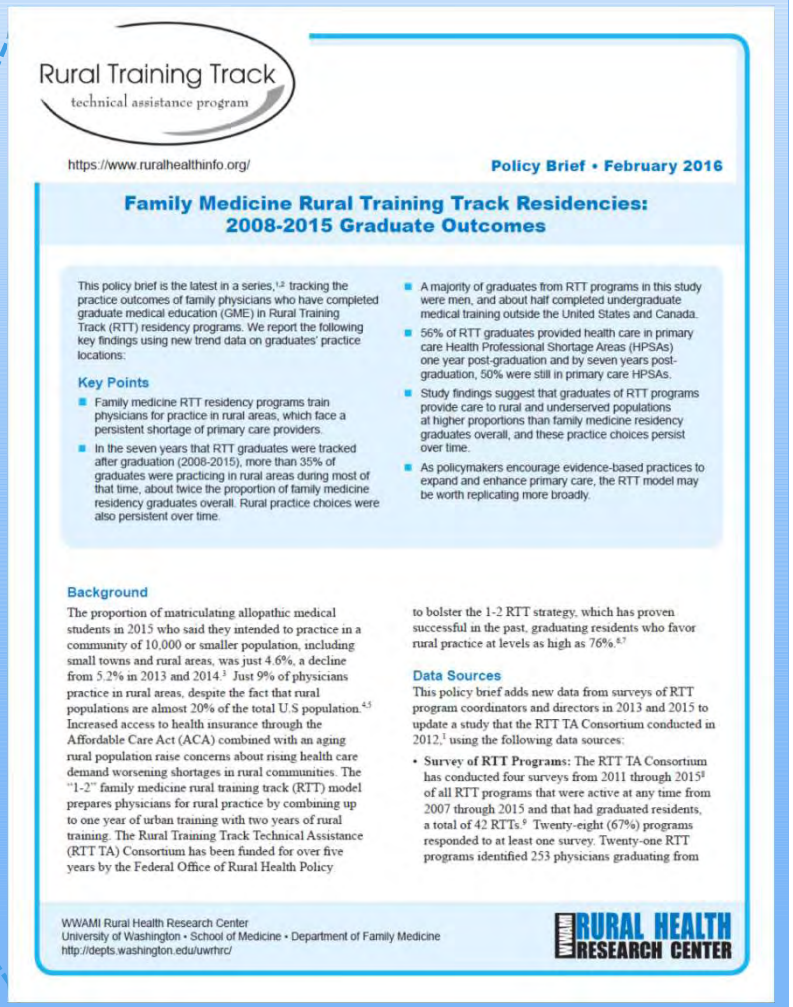
Conclusions

- About 2X as many RTT graduates practice in rural compared with family physicians overall.
- High proportions in shortage areas!
- Early practice choices (rural, HPSA) persist up to 7 years

Policy brief available:

www.ruralhealthinfo.org/rtt





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RTT Closure and Resilience

Closure study - 2003

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Residency Education

A Study of Closure of Family Practice Residency Programs

English H. Gonzalez, MD, MPH; Robert L. Phillips, Jr, MD, MSPH; Perry A. Pugno, MD, MPH, CPE

Background: *Between July 1, 2000, and July 1, 2002, the Residency Review Committee for Family Practice had received requests for voluntary withdrawal from 27 residency programs. This number represents a significant increase in the rate of program closure over previous years.* Objectives: *We compared descriptive data on these closing programs and explored factors contributing to the closure.* Methods: *Descriptive program data were collected from the Accreditation Council for Graduate Medical Education, National Resident Matching Program, the American Academy of Family Physicians, and the American Board of Family Practice. Program directors from closing programs were invited to participate in a semi-structured interview to discuss factors contributing to the closure of their program.* Results: *Seventy-five percent of closing programs were community based, median program age was 11 years, board pass rate averaged 98%, and 69% cared for underserved communities. Financial, political, and institutional leadership changes were most frequently cited by program directors as primary reasons for program closure.* Conclusions: *The rate of program closure is increasing, affecting programs that meet most measures of high quality. Quality programs are being lost, and the ultimate impact is yet to be seen. Program directors offer warning signs and advice that is generally applicable to other family practice residency programs.*

What Factors Affect RTT Success?

- In-depth interviews (one hour +) with 20 RTT Program/Site Directors
  - 2 closed before study, 18 active programs
- Conducted 8/2014-9/2015 (Patterson, Schmitz, Longenecker, Adkins)
- "Older" programs (11) enrolled first residents >10 years ago (median 1996); "newer" programs (9) ≤ 10 years ago (median 2013)

Harvester At Work by Michal Spisak

Questions

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- What are/were the top three assets in terms of resilience and sustainability?
- What are/were the top three vulnerabilities or risk factors?
- What advice would you give to another program to avoid closure and to thrive?

Top 3 assets

Top 3 assets	n
FAVORABLE ENVIRONMENT	28
Physicians, hospital leaders, leaders of academic institutions, community, and patient support/understanding of value, e.g., RTT a tool to "grow own" providers State support (including financial support); legislators' understanding/recognition of the program's value Optimal geographic distance to urban area or sponsor	
SUPPORT	23
Specific support for program from sponsoring institution or core program, hospital, clinical staff, administrative support, RTT TA or other consultant help	
GREAT FACULTY (more older programs cited, 14:6)	20
Dedicated faculty to program, to patients; collegiality; experienced and receptive to teaching full spectrum; longevity in community Teaching opportunity facilitates physician recruitment	
LEADERSHIP	12
Strong, committed, innovative program leader or leadership team with connection to community Other strong, committed leaders (e.g., hospital, other)	
STUDENT RECRUITMENT	10
Mission-aligned and –driven, high quality students Positive learning environment/opportunities (e.g., more individual attention with smaller size)	
HEALTHY FINANCES	7
Strong financial partnerships, with diverse or guaranteed (e.g., legislative) funding	
MISSION SUCCESS	4
Good reputation at having succeeded in mission Program mission aligned with other entities' missions	
SIZE	2
Flexibility of small size	

"Strong **leadership** and **support** from the core program, especially true with regard to **accreditation**."

"Balance of the…sponsoring **hospitals working together to share revenues and expenditures**, the hospital CEO and community physician support, and collaboration of the entire program between the support we get from [core program], involvement and **connection as if I'm there** in [core program city]."

"Support of our board. I won't say the support of our administration, because I have to walk that line constantly, but the support of the board."

"Support of patients, community, hospital, faculty, doctors, **everyone** wanting this…and still positive and **willing to put up with crazy things I ask for for accreditation**."

"The **outcome product has met the mission**. You've had well trained graduate who have stayed in community. Strong local leaders who have stayed in the job. Good quality residents."

"Probably most important: **our connection with other programs**, because **emotionally** and from a **creative** point of view, it was really important to be connected to programs outside ourselves. I think we did that really well. We took the whole residency to STFM, for example."

Top 3 risks/vulnerabilities

Top 3 risks/vulnerabilities	n
POLITICAL/ENVIRONMENTAL (more older programs cited, 15:6)	22
Worries about future changes in leadership, financial stability, ability to recruit great students, balance between core program and RTT Program's value not understood by external parties, mission not shared Control issues/personality conflicts	
ACCREDITATION	9
ACGME requirements: Next Accreditation System, small numbers for ACGME survey	
FINANCES	17
Funding difficulties: insufficient, unsustained, changing funding; poor payer mix, funding sources not diverse	
STUDENT RECRUITMENT	12
Difficulty attracting good students who are committed to rural medicine; significant others; match restrictions/regulations; optimal number of students	
FACULTY	11
Difficulty recruiting, faculty overburdened/burned out, insufficient funds for teaching time	
SUPPORT	7
Poor support: institutional, administrative, general Lack of a local champion for the program	
LEADERSHIP	3
Difficulty recruiting leader/team, managing succession, high turnover in the program or above	
SIZE	3
Too small	
CLINICAL EXPERIENCE	2
Not enough physicians or patients in the community, loss of patients as residents leave	

"Some things are now **corporate** decisions. Teaching for free is an endangered species, tied in with corporate medicine. Something evil happens when salary is partly production based."

"Can we keep all **volunteer** faculty **engaged**? They're willing to do the milestones, serve on the local competency committee, do what we need to do for accreditation—most of that is borne by me and associate directors, but there are still things volunteer people need to do to meet those. I think this puts as at some risk…everybody has their point where they're going to say 'I'm not going to do this anymore.'"

"A **budget cut** [from above] would not be well understood with regard to fixed costs and budget timing cycles of this unique program."

"Vulnerability of our funding coming from federal GME dollars, not enough **diversification**"

"Being an **appendage** to a larger institution that didn't completely share **mission** and **vision** is a vulnerability. You're the first to go, sort of like the last person hired is the first person fired—lack of **power** in the relationship."

Advice

Advice

"**Community** has to want you to be there, even more than the organizational support. When you have the **community** support, it's got to be something the **community** of physicians has to want."

"My biggest advice would be that program directors and associate program directors should really make sure that **hospital administration people know the nuts and bolts** and details of what you do. If they don't get the picture of how primary care feeds the hospital, they need to. I think we do a good job of **reminding them on a regular basis of how important we are to them**."

"Have a strong general community support for what you're trying to do and keep **educating the community** about what you're trying to accomplish over time and not just at startup, like that rural medical education committee I was telling you about. Here's what we're doing, here's what our finances are looking like. If you lose any one leg out of that table, you start leaning and things start rolling off the top."

Advice

"The financial stuff—it's a delusion to think you have control of that with all the changes in healthcare. Be clear on your mission—who you're trying to produce. Be good at **blowing your own horn**. My predecessor was good at making sure the hospital and the AHEC know what we're doing. **You would think they know, but they don't know**. Don't be afraid to promote yourself."

"Be involved with the local AHEC, state department of rural health—those are areas that can pay dividends over time. Be involved with the state's legislators, whether serving on rural fact-finding missions or whatever."

Advice

"Have a **residency education coordinator**—that's my number one piece of advice."

"Don't be afraid to go unmatched if you don't **have good residents that would fit with your docs.** If the docs give up and say 'I don't want to do this anymore,' we're sunk."

"Recruit good people. In a **small** program, **difficult people** can really make it difficult for the program and **have a bigger impact**."

"Recruiting is the life blood of any program. If your faculty are not enthusiastic and happy, residents aren't happy—continuing to **evaluate** those things is key. And continually reminding the sponsoring institution of the **things you have to have in order to be successful**."

Advice

"You have to make sure you have someone keeping all the plates spinning, like on the Ed Sullivan show. You have to have someone who has **energy** and **time**. And you need to have someone else who can do it if that person isn't there."

"The site director was already approaching retirement and we really had been trying to come up with a **plan—plan well ahead** of things like that. Seriously look at what things would be like when he retired."

"Having your leadership be **forward thinking** and **proactive**, about a process that's going on 5 years from now, getting a **consultant**, thinking about what the plan's going to be before it ever arrives."

"The things I got in the **NIPDD fellowship** to be able to talk about finances were extremely helpful."

"Have **people that you can talk to** for support and problems."

Gratitude

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- To the program leaders who gave their time and energy to this work

Contact

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