Providence Oregon Family Medicine Hood River Rural Training Track vs. Program

ONE COMMUNITY HEALTH

PROVIDENCE Health & Services

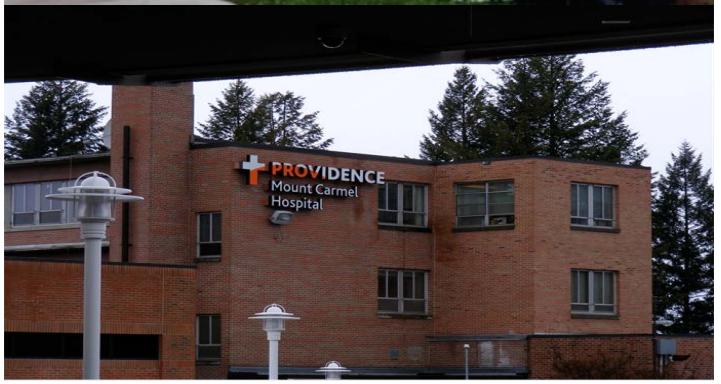
Objectives

- Understand the ACGME definitions for what constitutes a Program vs. a Track
- Know the resource and budget implications for 1-2 Rural Training Programs
- Learn what can be done to ensure ACGME compliance

So let's describe the journey on "el Rio RTT"

Hood River RTP History The Formative Years

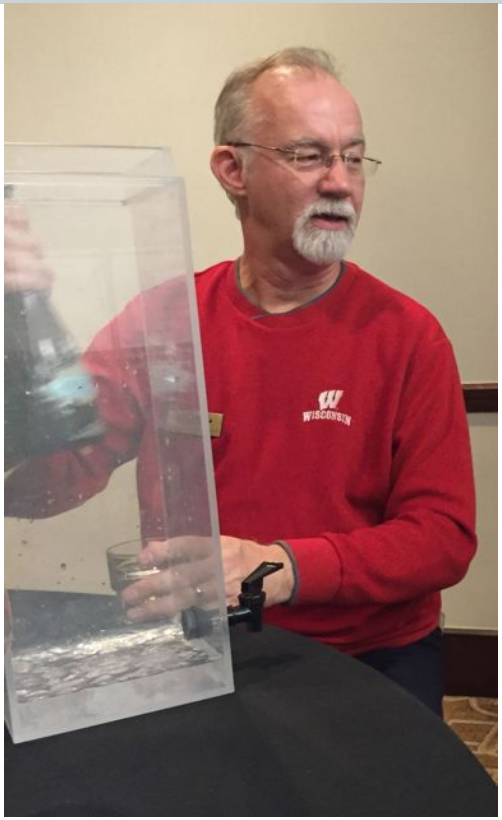
- Program Director's first practice was at La Clínica del Cariño Family Health Center in 1988.
- Hood River Memorial Hospital is acquired by Providence in 2000
- POFMR Milwaukie established small community rotation in Hood River 2008
- Due diligence 2009-2011, RAP Consultant, NIPPD project.
  - Colville, Washington served as example, RTT Collaborative support
- One Community Health Board (La Clinica) approves being FMP for residency February 2012
- Financial Analysis by RAP and Providence GME Budget Office



Don't Build It Unless it Will Be an Excellent Program

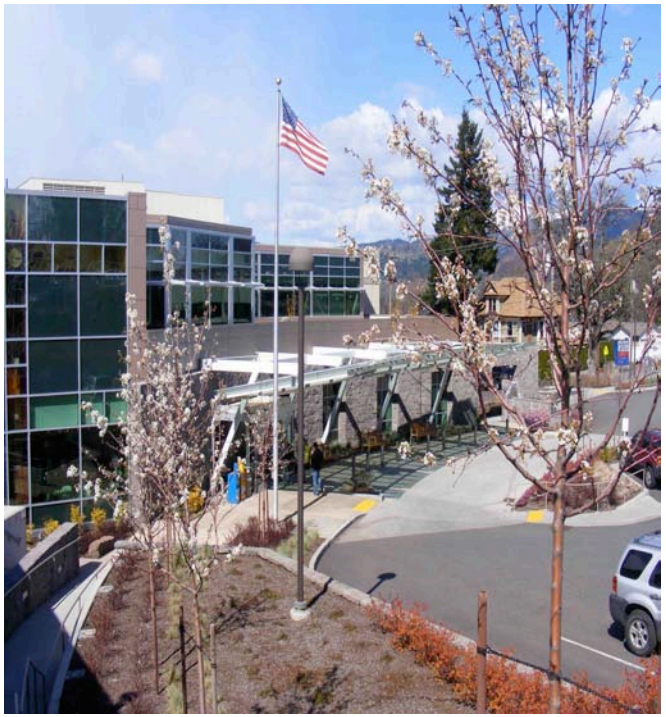
- There are three key general features that drive long-term viability for RTTs
  - **Sustainable recruitment of high-quality residents**.
  - **Institutional commitment by the core program, the local rural hospital, the local practice community, and parent organizations).**
  - **Local physician leadership and broad local support for the mission and process of educating residents.**

Lou's Original Scorecard



- Hood River
  - ✓ Strong primary care and specialty clinician leadership
    - ✓ more interest in teaching than there will likely be a day-to-day opportunity to do so.
  - ✓ Partnership with OCH FQHC as our family medicine center
    - ✓ Diverse and vulnerable population
    - ✓ Excellent Patient mix and volume
    - ✓ Innovative CHW programs
    - ✓ - + Spanish requirement
  - ✓ Proximity to Portland for electives
  - ✓ Both urban and rural hospitals are part of the same health system
    - ✓ larger organizational understanding of the significant "downstream" economic value

The Budget: The Critical Access Hospital Dilemma



Few residency programs that are sited at CAHs

CAH do not get Medicare reimbursement via the usual prospective payment system (the DRG system).

- *Medicare pays a CAH based on costs as occurred by the hospital in caring for all patients which then generates a per diem rate.*
- *Medicare then pays the CAH for total Medicare "bed days" times this overall per diem rate (plus 1%)*

- *No IME*
- The (Urban) Hospital increases its Medicare GME reimbursement via the additional Cap provided for the "1" year in the "1-2" RTT.

Lou's Parting Advice

- The general rule for a new stand alone Family Medicine residency is to not attempt this unless you have "a million dollars in the bank and five years of patience before you see your first graduate".
- For an RTT, the patience needed is similar and the costs are some considerable proportion (?40-50%?) of what is called for to start a stand-alone residency.
- "Do not do this unless you can build an excellent program".
- A Hood River RTT has the potential to be both an excellent training environment AND to be successful in attracting superbly qualified applicants.
- *The consultant believes the program will never be a money maker in the direct comparison of costs and revenues – unless the whole system of financing residency training is reformed*.
- A Hood River RTT should, however, have a high value to the local community and the state which is in clear need of well-trained, rural-focused Family Physicians

Louis Sanner, MD December 2010

Let's Do This…..

Our initial PIF……

- **Providence Health and Services, Portland Oregon and La Clínica del Cariño Family Health Center, Hood River Oregon**
- **Application for a New 1-2 Formatted <u>Rural Training Track</u> Residency program in Family Medicine**
- **March 26TH 2012**
- **Sent to: THE RESIDENCY REVIEW COMMITTEE FOR FAMILY MEDICINE**
  - 515 N State, Ste 2000, Chicago, IL 60654 • (312) 755-5000 • www.acgme.org

Excerpts from our PIF….
RTT Site Director

- The Rural Track Site Director is a full time position providing approximately 300 hours/year in direct outpatient care at the Family Health Center at La Clínica del Cariño.
  - The RTSD will share call, supervision of the residents' clinical duties in the Family Medicine Center at La Clînica and inpatient responsibilities at PHRMH with faculty.
  - The RTSD will share teaching responsibilities in the Core Didactic Program.
- The remainder of the RTSD's time is spent in teaching and program administration (1600-1700 hrs/year using PIF format).
  - This includes overall supervision of curriculum development and implementation, hiring, evaluating, and compensating faculty, in addition to developing and managing the budget for both the educational and clinical parts of the program.
- The RTSD has overall responsibility for resident recruiting with the assistance of the Residency Coordinator, other faculty and the residents.
- The RTSD represents the Hood River Rural Track of the Providence Family Medicine Residency in meetings.
- The RTSD will report directly to the Providence Family Medicine Residency Program Director.

Meanwhile back at the ACGME: March 2012

Alternate Tracks or Sites (e.g., Rural, Urban)
Review Committee for Family Medicine
ACGME

ACGME

- The Review Committee is **receptive** to proposals for the use of alternate tracks/sites.
  - If a track is planned within an existing program, the residents in the track **must have 20** months of education in common with the other residents.
  - If that is not the case, the **proposed track could possibly qualify as a separate program**, as is the case with those that operate in the 1-2 format.
  - "A proposed arrangement may be considered as part of an accredited residency, the equivalent of a separate program that should be accredited independently, or as an entity accreditable as a separate 1-2 program.
  - **Generally, if less than 20 months of education will be in common with the core program, the proposal will be considered a separate program rather than as a track within an accredited program.**

In all cases, the Review Committee will expect documentation that:

Alternate Tracks or Sites (e.g., Rural, Urban)
Review Committee for Family Medicine
ACGME

1. Residents will have the required experiences during their three years of education;
2. At least two residents at the alternate site (i.e., one PGY-2, one PGY-3), and that some degree of interaction with the parent program will be maintained;
3. Adequate volume and mix of patients;
4. Adequate and stable financial support for the proposal
5. Appropriate supervision is ensured
6. Residents' experience in the provision of continuity of care will be satisfactorily addressed
7. The program director will have appropriate authority over the educational activities in the additional facilities.

Additional Notes Regarding Programs in the 1-2 Format

- Program directors should be sure they have the most current version of the PIF
- The instructions that are attached to the PIF provide some guidelines for describing a proposed program that will operate in the 1-2 format, with the first year taking place in an accredited program, and the second and third years being at a different site.

- Note that both the ABFM and the Review Committee require that the last two years (24 months) involve continuity of care for a panel of patients.
- In some 1-2 programs, the first year is not identical to that of residents remaining at the same site for the entirety of the three-year program.
- Some additional tertiary care experiences are offered in the first year to the residents in the 1-2 program. Such arrangements should be clearly described in the PIF for the 1-2 program.
- Per the PIF instructions, program directors are asked to prepare a cover letter giving an overview of the program and brief outline of how it functions.

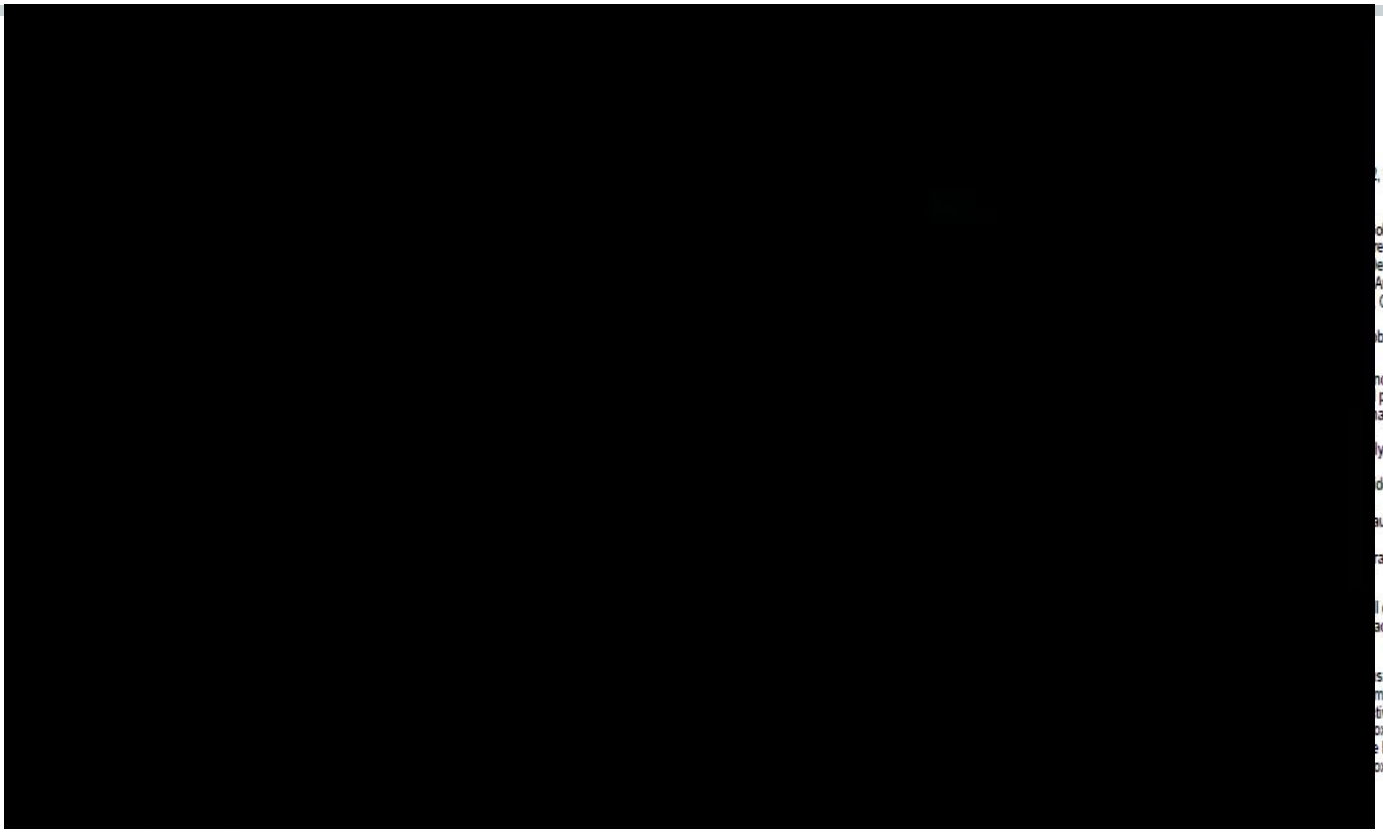
Ignorance is Bliss, Love is Blind

- ….but can Stupidity be rewarded?...
- or…is it better to be lucky than good?

Our PIF was already in the mail….

- **PIF submitted to ACGME March 2012**
- The ACGME RTT/RTP Guidance was published the same month
- PIF described a "MASH UP PROGRAM/TRACK" from a Curriculum standpoint but a "TRACK" from a budget standpoint
  - R1 residents have continuity clinic in Hood River (not 40 weeks though)
  - R2 and R3 spend bulk of time in Hood River and 10 weeks a year in Urban
  - Site Director 50% and only Full Time Faculty

So….without knowledge of this document and 9 months later



ACGME

, 2013

obbo, MD
ector
el Carino Community Health Center
Avenue
OR 97031

bbo,

ncy Review Committee for Family Medicine, functioning in accordance with the
procedures of the Accreditation Council for Graduate Medical Education
as reviewed the application for accreditation submitted by the following program:

ly medicine

dence Health & Services/Hood River Rural Program
Providence Milwaukie Hospital
aukie, OR

ram 1204000729

l of the information available to it at the time of its recent meeting, the Review
accredited the program as follows:

s: Initial Accreditation
mum Number of Residents: 6
tive Date: 07/01/2012
oximate Date of Next Site Visit: 01/01/2016
e Length: 3 Year(s)
oximate Date of Internal Review 07/14/2014

The Approved Budget

	2013	2014	2015	2016	
Resident FTEs at PMH	21 (8-6-7)	20.4 (8-6-6)	19.4 (8-6-6)	19.4 (8-6-6)	Resident FTEs at PMH
Resident FTEs in Hood River	-	2.60	4.60	4.60	Resident FTEs in Hood River
Preceptor FTEs (both HR and PMH)	7.00	7.00	7.00	7.00	Preceptor FTEs
Urban Resident FTEs	21.00	21.00	20.00	20.00	Resident FTEs
Urban Preceptor FTEs	7.00	6.50	6.00	6.00	Preceptor FTEs
Education and Certification dollars	$263,696	$263,696	$263,696	$263,696	Education and Certification dollars
Supplies/Lisc/Travel/Courses	$3,450	$3,450	$3,450	$3,450	Supplies/Lisc/Travel/Courses
RTT Resident FTEs	-	2.00	4.00	4.00	Resident FTEs
RTT Preceptor FTEs	-	0.50	1.00	1.00	Preceptor FTEs
Education and Certification dollars	$-	$271,697	$372,270	$372,270	Education and Certification dollars
Supplies/Lisc/Travel/Courses		$10,025	$18,850	$18,850	Supplies/Lisc/Travel/Courses
0.6 Resident FTE from Core Program for SCR	$38,160	$38,160	$38,160	$38,160	.6 Resident FTE from Core Program for SCR

Budget of the RTT was acceptable because to PHS Leadership because

- **Overall Faculty FTE was not increased**
- **RTT took 0.6 Resident FTE of the Main Program Resident FTE (reducing non-cap load)**
- **RTT gave 2.0 Resident FTE to the Main Program (not affecting their cap – for the 2 RTT R1's)**
  - **Core Program saw a reduction in its # residents over the cap.**
    - **Core 18 residents + 2 (RTT R1) plus RTT 4.6 FTE**
      - **Previously 15.5 Residents under cap.**
      - **Increased to 17.5**
      - **RTT FTE = 4.6 (4 plus 0.6 of the Core R2 FTE)**
- **RTT only had 0.6 FTE faculty budget for the Site Director (Only FTT Faculty)**
- **For the PHS Family Medicine (Core + RTT) GME total the net revenue changed to a positive.**

Program Years	7/1/2013 - 6/30/2014	7/1/2014 - 6/30/2015	7/1/2015 - 6/30/2016	7/1/2016 - 6/30/2017	7/1/2017 - 6/30/2018	7/1/2018 - 6/30/2019
Net of Incremental Cost and Revenue	$79,787	$23,635	$24,441	$17,263	$9,869	$2,254

The HR RTT was essentially taking one for “the team”

AY's 2013-2015
Floating along under the guise as an "RTT"

- Costs kept low by having a "Site Director" as the only FT Faculty.
- Some tension and growing pains
  - RTT Residents pulled for rotations and coverage in urban program
  - FQHC and residents found schedule "chaotic" vs. "dynamic"
- Did not have 40 weeks of Continuity in R1 –
  - No clinic for some rotations (Peds, IM and ICU)
  - RTT R1 residents saw 250 patient first year
    - (compared to 150 Urban)
- Urban Program has RTT R2 for 12 weeks in AY 2014-2015 (Ob, Med, NF)
- RTT Hospital CEO very supportive
  - Increases budget to provide part time PC, increase compensation to "local faculty"
    - 2014-2015 Budget increase $100,000 - Argues at system level and uses "Community Benefit" dollars

Encountered a lot of white water May 2015

Outgoing DIO does a Mock Site visit May 2015 – near end of new R2's year

- Worse day of my life?!

cy

The Savior or Reaper…..New DIO

- Steve Salerno MD
- New Providence Director of GME
- My sensai and warden

Difference between a Rural Training Program and a Rural Training Track.

- Autonomous from the PMH Oregon Program
- Have our own infrastructure and curriculum
- Share resources, faculty and personnel
- Do not have 18 months in common with Urban program
- Must have one dedicated FT Faculty in addition to PD.
- Program director's time schedule needs to reflect 70% admin, teaching, and clinical supervision.
- Continuity clinic must be 40 weeks each year – even in R1

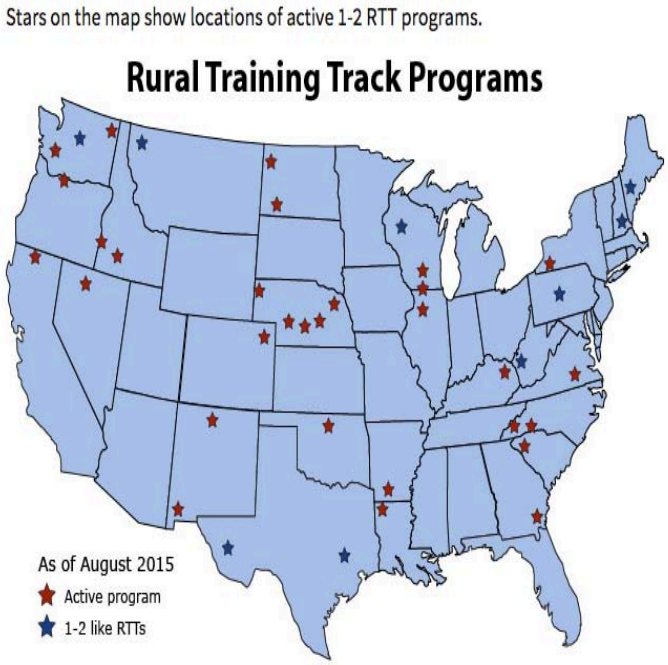
Could it be more confusing then this….

- RL: “review of the public ACGME indicate to me that HR is a separately accredited rural **program** (i.e. in the 1-2 format), and
- named, "Providence Hood River Memorial Hospital Family Medicine Residency Rural Training **Track**,” ….

…..(until my last WebADS)

Randy's Input

- 31 of the "RTT's" tracked are accredited.
- The ACGME considers them a separate stand-alone program (simply with a "1-2 format" waiver of the minimum requirement of 4 residents a year)
  - Some rural tracks that exist within a main program that are simply "tracks" and not separately accredited.
    - Those we now refer to as the "1–2 like" RTTs, as long as the continuity requirement of 24 months is met in a rural place.
    - Ellensburg, WA, is an example of that.



Misassumption Reckoning

1. **Urban hospital is not a parent or our core program**.

PMH is a major participating site for PHR due to the 6.5 months in the PGY-1 year. It otherwise has no special oversight of the PHR rural training program.

2. **HR RTT is an autonomous training program** and not a rural training track of PMH.

Rural training programs have program requirement of the minimum resident complement waived by the ACGME.

3. **As an autonomous program,**

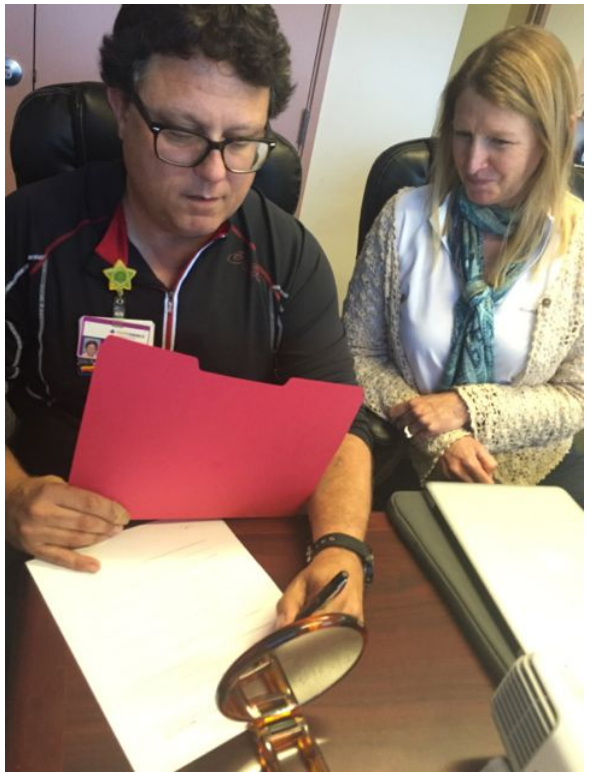
- **HR RTT has always needed 1 core faculty (in addition to PD)** from the moment we started training residents in our 1st year
- **HR RTT has always had to have the components of an autonomous training program:**
  - such as a PEC, APE, and CCC.
  - **the amount of time the Site Director** has to budget to run the program as program director of a tiny program (HR RTT) is the same as a larger program like (Urban PMH).

After several weeks of denial, anger, bargaining, depression came… acceptance

- ACGME Program Requirements that effect us.
  - Core faculty
  - Curriculum Assignments
  - Advisor Assignments
  - CCC, Program Evaluation and Curriculum Committee
  - 40 weeks of Continuity each PGY

This was a big deal……

- To remain a stand-alone Rural Program and ensure we must be budgeted adequately to satisfy the accreditation requirements,
  - PROGRAM DIRECTOR to spend 70 % in admin and supervision
  - Additional 1.0 FTE Faculty who spends 24 hours week supervision, scholarly and administrative
  - Own CCC, Curriculum Committee and Program Evaluation Committee



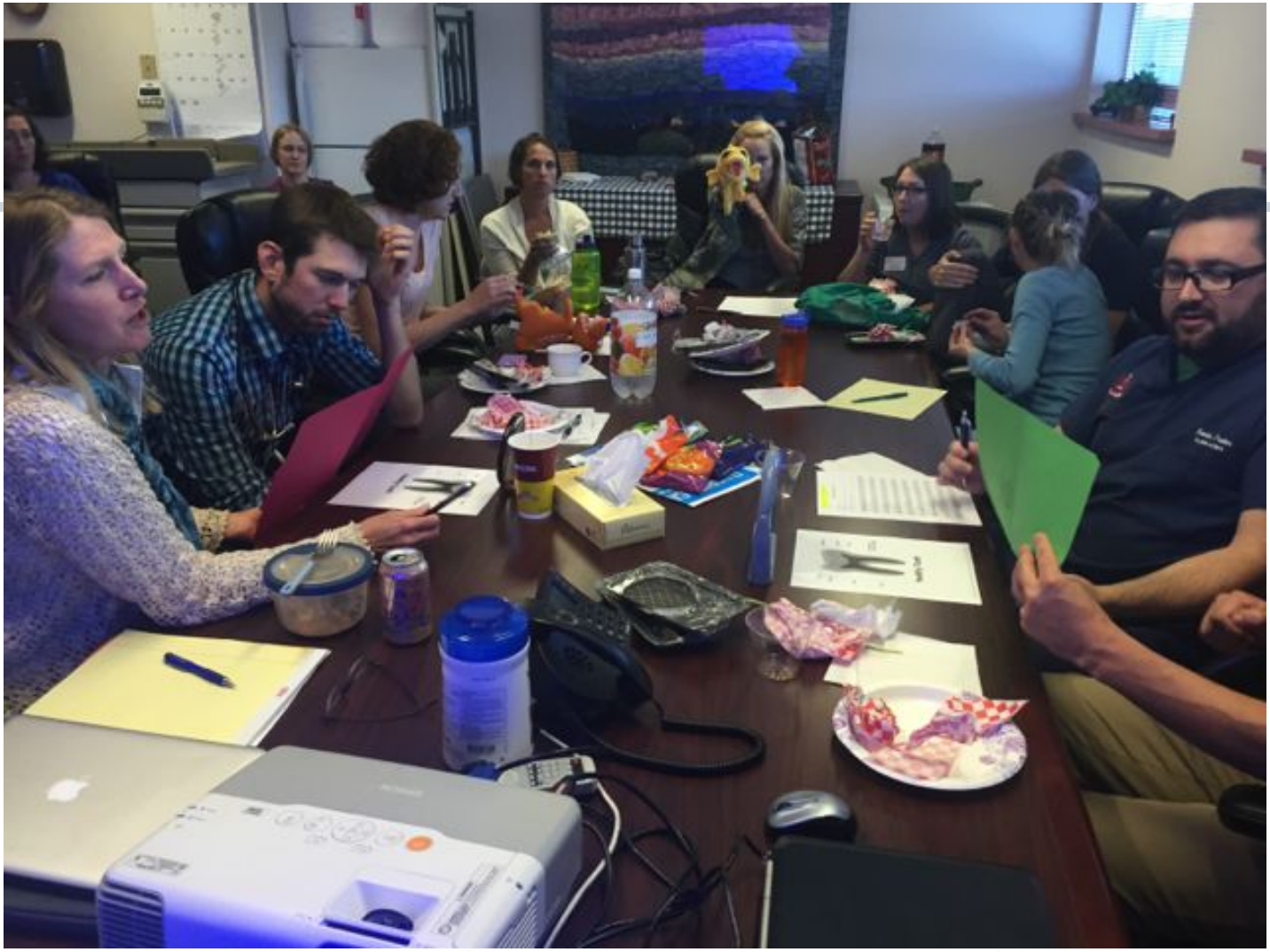
Core Faculty ACGME Definition

II.B.6. There must be at least one core family medicine physician faculty member, in addition to the program director, for every six residents in the program.

- (Core) II.B.6.a) Core physician faculty members must:
- II.B.6.a).(1) dedicate at least 60 percent time (at least 24 hours per week, or 1200 hours per year), to the program, exclusive of patient care without residents; and,
- II.B.6.a).(2) devote the majority of their professional effort to teaching, administration, scholarly activity, and patient care within the program.
- II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following: (next slide)

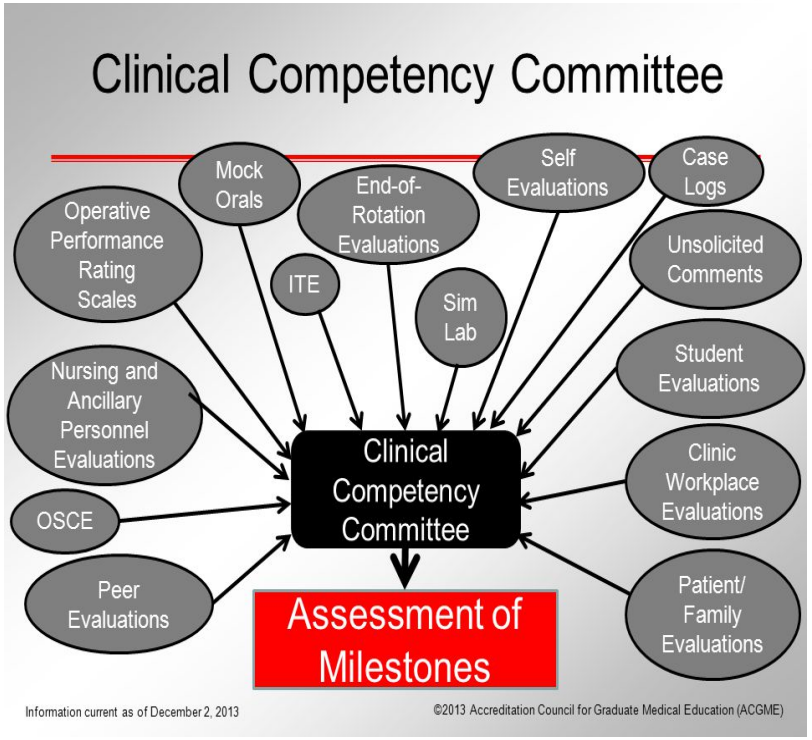
Faculty Scholarly Activity Requirements according to ACGME Common Program Requirements

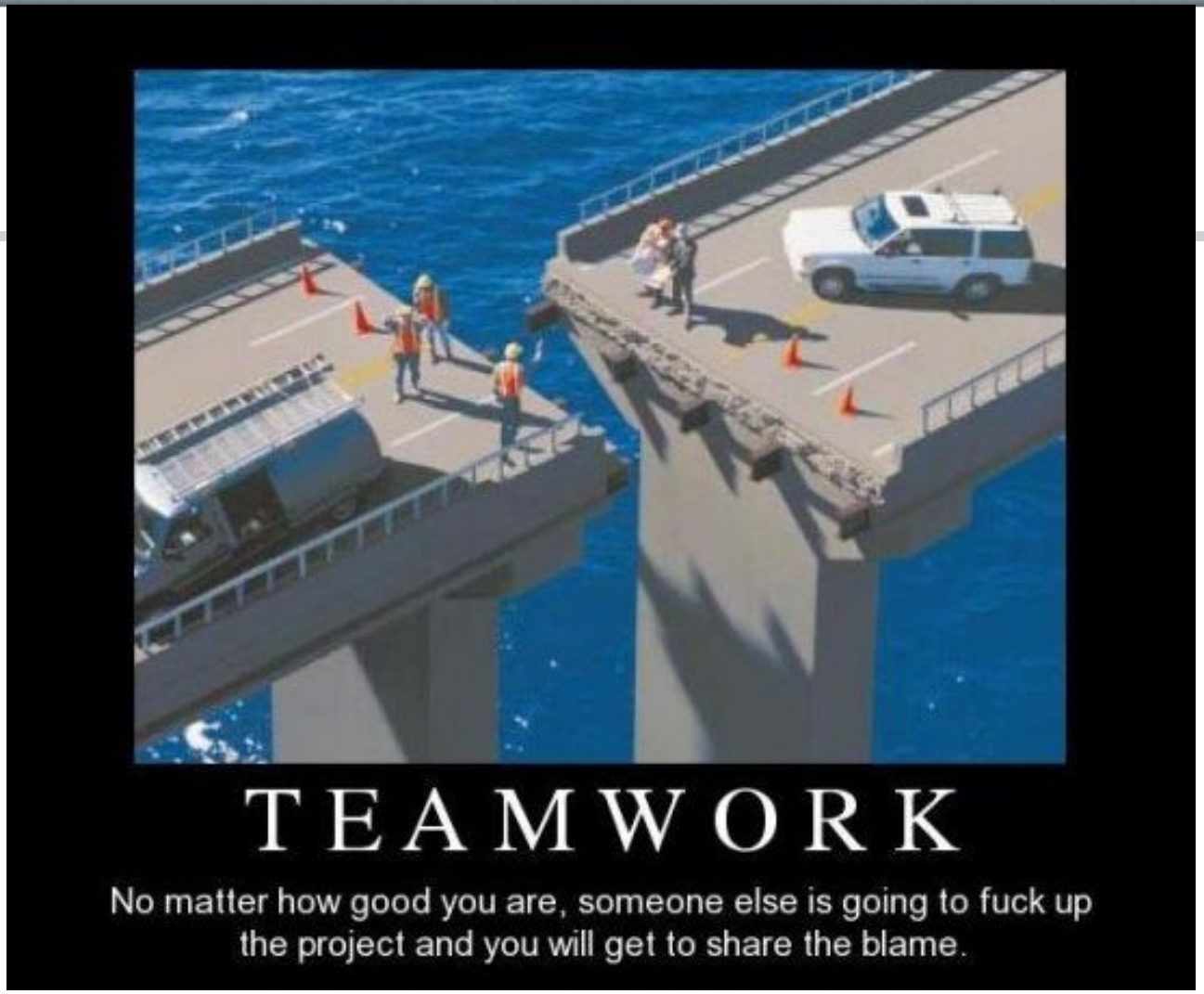
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)
  - II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)
  - II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:
    - II.B.5.b).(1) peer-reviewed funding; (Detail)
    - II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks; (Detail)
    - II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)
    - II.B.5.b).(4) participation in national committees or educational organizations. (Detail)
- II.B.5.c) Faculty should encourage and support residents in scholarly activities. (Core)

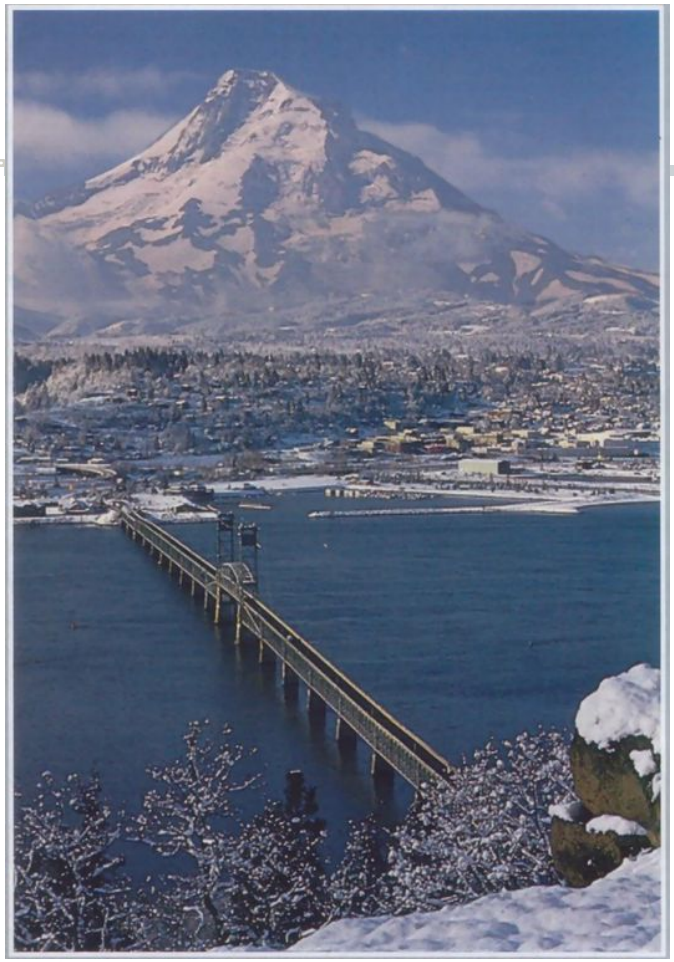


Autonomous Committees

- Clinical Competency Committee
- Program Evaluation Committee
- Curriculum Committee

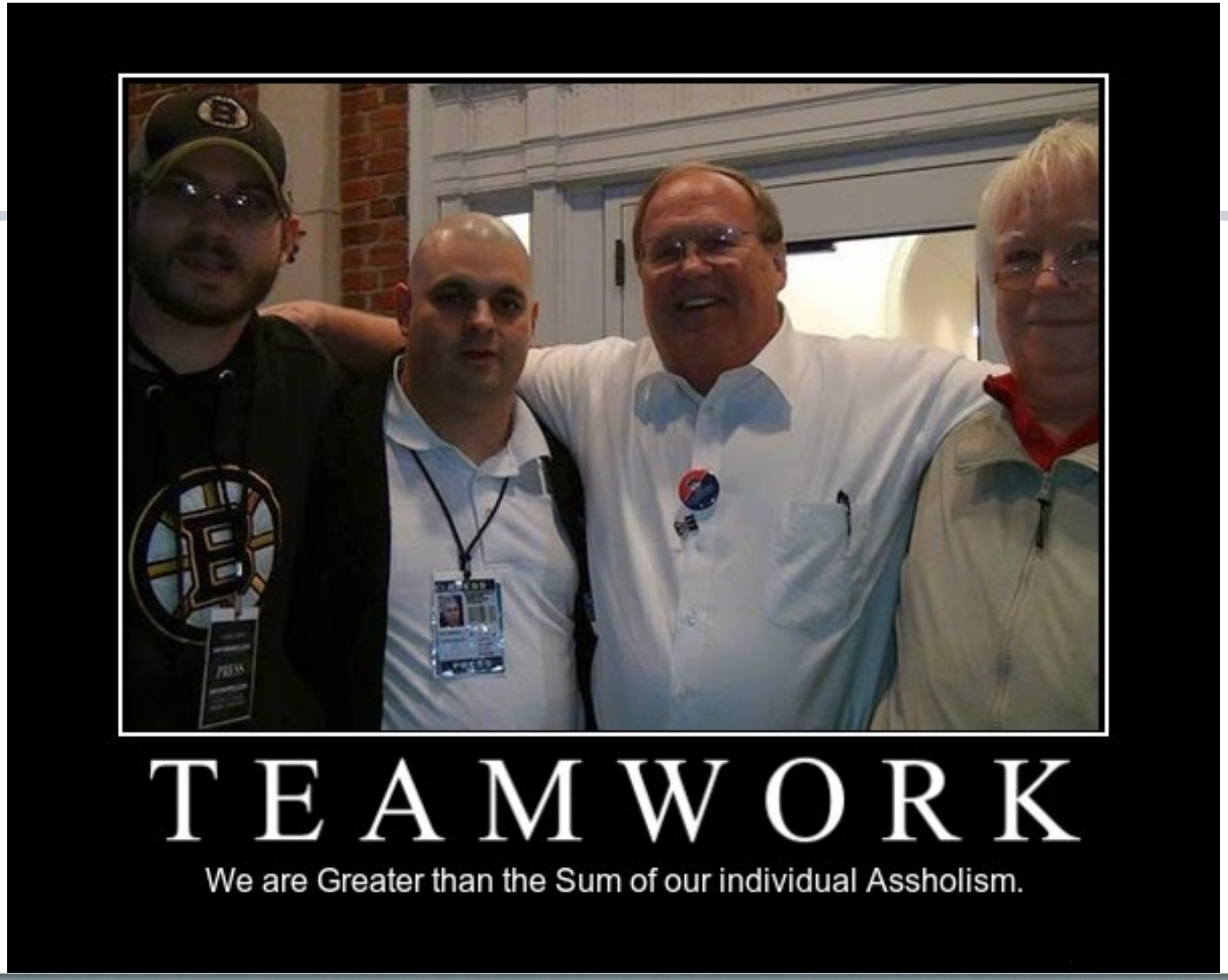



TEAMWORK
No matter how good you are, someone else is going to fuck up the project and you will get to share the blame.



So what did we do….

- Option 1: Spend the money, time, resources needed to have the personnel and infrastructure to be a "program"
- Option 2: Request to the ACGME that due to this "error"
  - Withdraw Program Status
  - Reapply as an RTT with 20 month in common curriculum
  - Have PD of Urban program become PD of RTT
- Option 3: Close the program
  - Reassign existing residents to Urban program
  - Jeopardizing their graduation date
- What would you do (or will you do)……


TEAMWORK
We are Greater than the Sum of our individual Assholism.


T·E·A·M·W·O·R·K
Never Doubt That A Small Group Of Thoughtful,
Committed People Can Change The World.
Indeed, It Is The Only Thing That Ever Has.

TEAMWORK

Together, ordinary people can achieve extraordinary results.

What we had to do to get into "compliance" as a program

- Revise and increase our budget to reflect
  - FT PD (70% Supervisory, Teaching and PD) – 30% clinical
  - FT Faculty at at least 60% (24 hours S/T/A)
  - FT Program Coordinator
  - All Policies, Curriculum, Committees, Affiliation agreements and PLA's redone to reflect the RTP
  - Re-negotiate Agreement with FQHC to provide more compensation for faculty time
    - Designate one of the 'part time" as FT and pay 40% of her salary.
    - Accounts for 0.8 FTE salary/benefits compensated to FQHC (~210,000, year)
- Ensure all PGY years have 40 weeks of continuity clinic
  - R1 schedules had to be re-negotiated with Portland hospitals

Outline differences in Affiliation Agreement for AY 2015-2016.

- 0.6 FTE Faculty designate at OCH
- PD 0.7 FTE and my decision to only have a very small panel at OCH
- 0.5 Non-core Faculty duties, compensation plan
  - Accounting for Academic and Administrative Spreadsheet (see attached)
  - Suggested Academic Bonuses: Quarterly for defined metrics
    - Advisor meeting and documents complete x 2 a year - $???
    - > 30 Shift cards and evaluations every six months - $???
    - Presentation at Local, State, National Meeting - $???
    - Completion and Updating of assigned curriculum - $??? - Yearly Statement on
    - Professionalism and Faculty Development meeting with Program Director reviewing evaluations, curriculum, and plans $?

How did a net of **$24,441** turn into a negative of ($298,887?)

- **Costs not in Pro Forma Regardless of Track vs. Program**
  - Cost for a 0.50 Admin Assistant $17,318
  - Unbudgeted Operational costs for faculty and residents $73,456
  - **Total added expenses omitted from original pro forma** $90,774
- **Additional Costs Associated with Converting Track to a Program**
  - Another 0.25 FTE admin support (total 0.75 FTE) $27,710
  - Added Core Faculty (0.6 FTE) $154,500
  - Upgrade 0.6 FTE existing core faculty to 0.7 FTE PD $25,750
  - Costs of Upgrading Track to Program $207,960
- **Total Costs of Unexpected Expenses + Upgrading** $298,887

How can this be sustainable: Find More Money

- Critical Access Hospital
  - Cost Report
  - Community Benefit Dollars
- FQHC
  - Cost Report?
  - Urban Hospital Claims Clinic Time
  - Rewrite Affiliation Agreement
- State Grants, Funds, Donations
  - THC v3.0 HRSA?
  - Foundations
  - Oregon
- Revenue
  - Hospitalist Billings and Clinic Billings
  - Resident Food Cart

So how's it been the few months, Bob?

- ACGME Site Visit was 2 days ago
- Hospital CEO
- My dog Pippen is worried….
- Needing some love…..
- Just in time for the RTT Conclave

The ACGME Site Visit -

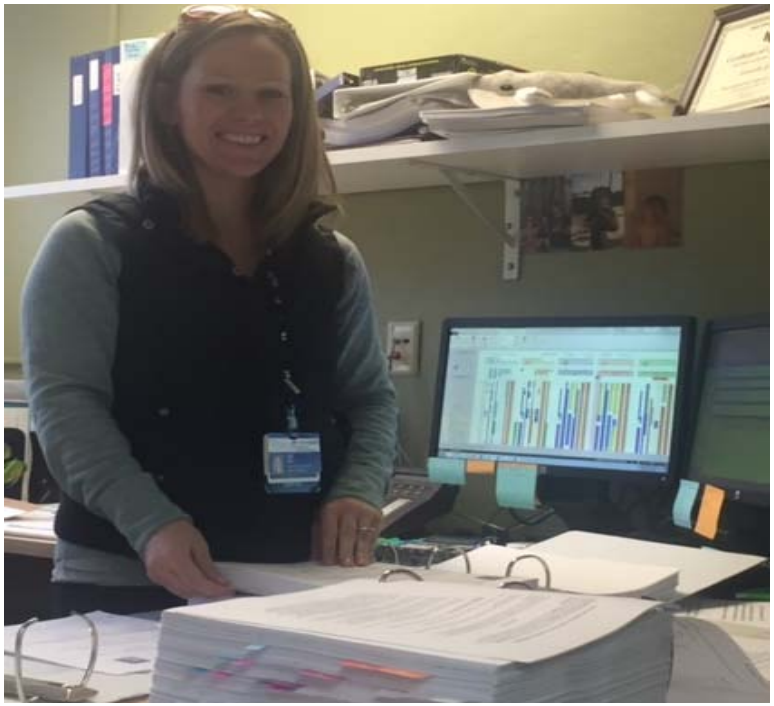
Went surprising well…..we were not shut down….won't know for certain until after RRC meets

Likely Citations.

1. Fuzzy Data: Older Patient
2. Ambulatory Peds: is not in the ED
3. Core Faculty not at 24 hours yet…

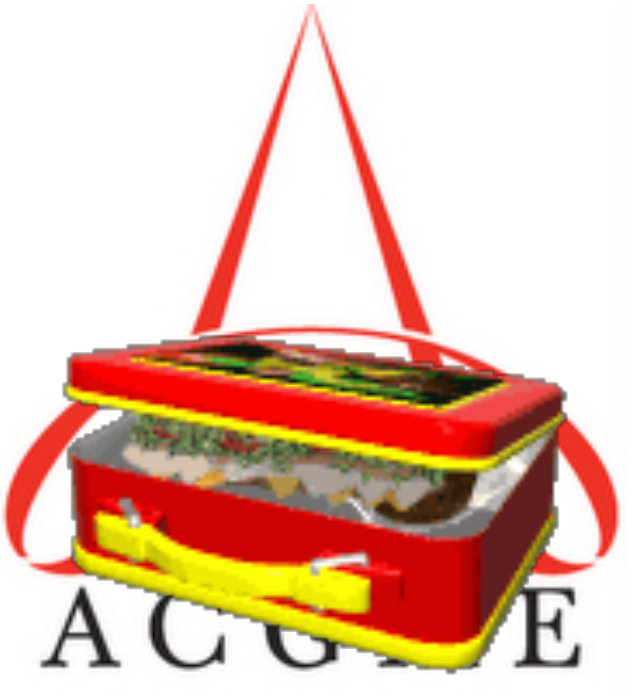
Good Stuff:

1. We are here!!!!
2. FQHC – 3 year continuity a plus
3. Ob – ton of it
4. No concern about driving/commuting 65 miles
5. Praised the collaborative nature, faculty engagement and resident grit and happiness
6. The curriculum, separate policies and procedure documentation etc. passed mustard



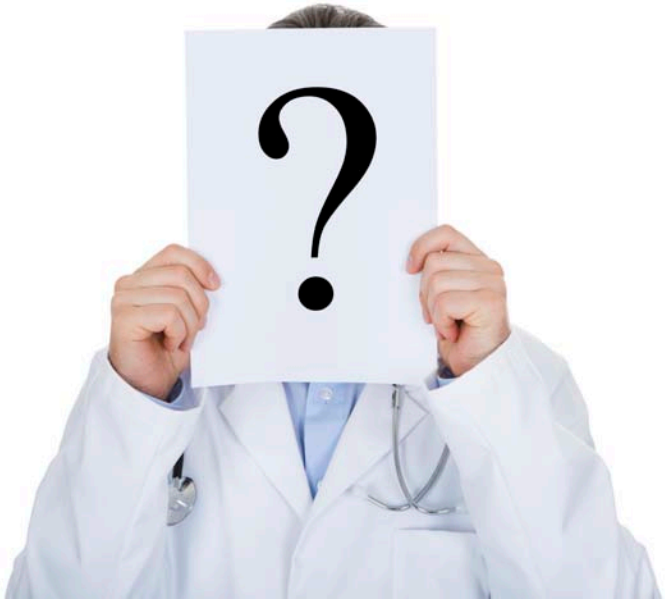
Final Thoughts

- ACGME pulled the March 2012 Document in August 2015 from their Website……and now it's back!
  - http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramResources/120_FM_Alternate_Tracks_or_Sites.pdf
- How many RTT's could be affected ?
- The requirements of a Program are quite intense to be managed by anything less than a dedicated full time PD
  - Cost and labor delta is significant but will make a stronger better experience and program
  - Budget considerations are significant
- No Free Lunch



So…are you a program or a track…

- Q#1: Does your RTT have 20 months of curriculum in common with urban program?
  - If no…..You are a Program!
- Q#2: Does your original accreditation letter say: "Dear Program Director 'Your Name'
  - If yes - You are a Program!
- Q#3: Who fills out your WebADS. If its you…y are the PD.
- Q#4: Is the PD of the urban FM residency also responsible for the track?
  - Yes: Go back to Q# 1
  - No….Congratulations.
  - You are now a program director, either way….



Thank You