

## Community Engaged Residency Education in Rural Places (CERE-R)

### Conducting a Rural Residency Capacity and Sustainability Assessment

Randall Longenecker MD, Executive Director, The RTT Collaborative

David Schmitz MD, Associate Director for Research and Development

In collaboration with Western Montana Family Medicine Residency and funded in large part by a HRSA Residency Training in Primary Care grant #D58HP23226 and the RTT Technical Assistance Program.

*Community Engaged Residency Education in Rural Places is an organic place-based process for discerning community capacity for residency education, building upon the assets of rural places and the distributed expertise of communities and medical educators in order to together meet the healthcare needs of rural people. Like the organic architecture launched by Frank Lloyd Wright over a century ago, it starts with what is and imagines what could be – any rural place has some capacity.*

### Background

This packet outlines a process for academic-community engagement and collaborative decision-making. Developed by Randall Longenecker MD and David Schmitz MD in collaboration with Family Medicine Residency of Western Montana, this project was funded in large part by a HRSA Residency Training in Primary Care grant and the RTT Technical Assistance program grant.

Community engaged medical education (CEME) is a strategy and process described by Roger Strasser and others in developing a medical school in rural places in Northern Ontario.<sup>1,2</sup> A subsequent article reviews the history of community engagement in medical education over the past century and a progression from education “about” communities, to education “in” communities, to education “with” communities.<sup>3</sup> This evolution can be described as follows:

- Community-oriented medical education – Communicating a body of knowledge to students about practicing in communities
- Community-based medical education – Finding a place to train students and residents in context
- Community-engaged medical education – Following a strategy that addresses a specific community’s needs, for the mutual benefit of community and learners

Such an approach parallels the approach taken by proponents of place-based education.<sup>4,5</sup> Like community-engaged medical education, place-based strategies are not new but have more fully emerged in the medical education literature over the past decade. Organic design of a place-based education starts with what is local (assets as well as challenges) and builds from there. It’s about modifying and using bits and pieces of many educational frameworks, rather than imposing any particular one model. Place-based approaches are framed around the assumption, now anchored in a growing body of evidence, that learning to live well as a physician in a rural place is critical to the

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<sup>1</sup> Tesson G; Hudson G; Strasser R; Hunt D, Editors. *The Making of the Northern Ontario School of Medicine: A Case Study in the History of Medical Education*. Montreal/Kingston: McGill-Queen’s University Press, 2009.

<sup>2</sup> Strasser R, Hogenbirk JC, Minore B, et al. Transforming health professional education through social accountability: Canada’s Northern Ontario School of Medicine. *Med Teach* 2013; 35:490-6.

<sup>3</sup> Strasser R; Worley P; Cristobal F; Marsh DC; Berry S; Strasser S; Ellaway R. “Putting Communities in the Driver’s Seat: The Realities of Community-Engaged Medical Education,” *Academic Medicine*, Published ahead of print, May 2015.

[http://www.researchgate.net/profile/Rachel\\_Ellaway2](http://www.researchgate.net/profile/Rachel_Ellaway2)

<sup>4</sup> Longenecker R. “Curricular Design: A Place-Based Strategy for Rural Medical Education,” in Bell E; Zimmitat C; Merritt J Eds. *Rural Medical Education: Practical Strategies*, New York: Nova Science, 2011.

<sup>5</sup> Gruenewald DA, Smith GA. *Place-based education in the global age: Local diversity*, New York: Lawrence Erlbaum Associates; 2008.

professional development, recruitment, and retention of rural physicians.<sup>6,7</sup> Engaged communities of rural people and of rural medical educators are in the best position to facilitate that kind of learning.

The prototypical models that have been implemented and are options in rural family medicine residency education are several, and can be categorized as follows:

1. Separately accredited and rurally located residency programs
2. Separately accredited integrated rural training tracks, including rural programs in the 1-2 format (the prototypical “1-2 RTT”)
3. Rural tracks designed within separately accredited, much larger, and usually more urban programs (the prototypical “1-2 like RTT,” with 24 months or more of continuity practice in a rural place, as well as rural tracks with lesser durations of longitudinal or cumulative rural experience)
4. Rurally located rotations of any duration, either in block (e.g. 4 weeks) or in longitudinal configurations (e.g. one day a week for a year)
5. Urban programs with a rural focus, as demonstrated by placing >50% of residency graduates in a rural initial place of practice (as calculated from a 3-year rolling average)

Thresholds for implementation among these options are generally dictated by numeric capacity (e.g. the number of available patients in meeting the requirements for accreditation, the availability of interested physician faculty or preceptors in number and time, and/or the number of external and internal dollars that can be committed to the effort). The minimums for accreditation and finance can be met in a variety of ways by creatively choosing elements of each option and designing a hybrid appropriately sized to the local community. Thoroughly understanding the rules that govern accreditation and finance is essential to this task.

Some communities, on the other hand, will make a decision, not on the basis of numbers, but on the basis of preferred style or scale. And some communities may not wish to expend their full capacity on rural medical education. They may for good reason focus their efforts on another health profession or area of education. These are local decisions, shaped by community leaders and potential physician faculty. Healthy communities are learning communities, and “growing our own,” in whichever sector a community chooses, is important to community health.

Finally, residency design with an eye to sustainability has as much to do with relationships between individuals and institutions in a sustaining network as it does with financing.<sup>8</sup> Although the costs of physician education are substantial and can be predicted with some certainty, the benefits leading to sustainability are less easily counted. In the program development phase, these future benefits are often predicated on basic assumptions and an uncertain future, are usually framed in the longer term (and not simply short-term cash), and while substantial, are often indirect.

Community engaged residency education is a new term introduced into medical education through this document. This particular project is situated in the specialty of family medicine and explores options not available in other ACGME accredited specialties at the present time.

## The process

The process begins with identifying a rural place and proposing that community as a site for physician education. [Am I Rural?](#) is a good place to start, since this website not only identifies a particular location as rural by several federally recognized definitions, but it also characterizes a particular address, zip code or census tract as to whether or not it is underserved. Once identified by

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<sup>6</sup> Hancock C; Steinbach A; Nesbitt TS; Adler SR; Auerswald CL. “Why doctors choose small towns: A developmental model of rural physician recruitment and retention,” *Social Science & Medicine* 2009; 69:1368-76.

<sup>7</sup> Cutchin M. “Physician Retention in Rural Communities: The perspective of experiential place integration,” *Health & Place* 1997; 3(1):25-31.

<sup>8</sup> Longenecker R. “Sustaining Engagement and Rural Scholarship,” *J of Higher Education Outreach and Engagement*, Fall 2002/Winter 2003; 8(1):87-97.

a champion (or preferably several champions conspiring together) community engaged residency education design proceeds in the following fashion. These may occur in sequence, but more likely occur concurrently and in iterative cycles, potentially over the several years that are required to develop and launch a fully accredited residency program.

1. Engage with the Community
  - a. Build a coalition, following “rules of engagement”
    - i. Purposed in community health, development and improvement
    - ii. Characterized by respect for autonomy
    - iii. Built upon community assets within the limits of community resources
    - iv. Deployed with transparency and local community partnership
    - v. Integrated with Societal, Institutional, Program and Individual perspectives in addition to the local community environment
  - b. Identify the community’s readiness for change (like motivational interviewing in patient care):
    - i. Pre-contemplation
    - ii. Contemplation
    - iii. Preparation
    - iv. Action

**Pause:** If unable to build or sustain a coalition for the period of time necessary to implement the residency program; carefully document the process to this point and list the gaps and challenges for future reference, should the situation change

2. Explore Community Capacity for Medical Education
  - a. Use on-site interviews, templates, and focus groups to identify assets and limits, opportunities for achieving synergy and for mitigating deficits, in both the local medical and non-medical community, as well as the relevant academic and corporate community or communities,
  - b. Study and learn the rules of accreditation and finance through self-directed learning, attendance at meetings, and/or tutoring from local experts in GME within a regional health care system or teaching hospital. Become thoroughly familiar with the [ACGME Family Medicine Review Committee](#) website and all that it has to offer, including an email or phone conversation with FM-RC staff. The [STFM Residency Accreditation Toolkit](#) is a good guide as well but requires either a membership in STFM or a purchase fee of \$250 for non-members. (The expense of a NIPDD fellowship should probably be deferred to the following step)
  - c. Enlist potential and committed leaders, faculty and staff
  - d. Collect examples and templates from others (See Toolbox in this package as a start)
  - e. Consult with experienced local, regional or national peers and experts (engage the rural medical education community) in residency program accreditation, finance and governance. Some of these consultations are provided at no cost to the community.  
  
[RTT Technical Assistance Program](#)  
[The RTT Collaborative](#)
  - f. Consider partnering with regional residency programs and/or medical schools in designing medical student and/or resident rotations, either as a way of easing into medical education or in recognition of the community’s limited capacity. **It is very important, however, to not jeopardize residency financing in the future. Resident rotations in hospitals and CMS “provider settings” other than Critical**

**Access Hospitals can permanently ruin future attempts to finance residency education under our current system.** These rotations are best accomplished in “non-provider settings.” ([A CMS definition](#))

**Pause** (and either temporarily suspend or redirect efforts): If the necessary conditions cannot be met, either locally or through collaboration with regional urban centers; list the gaps and challenges for future reference, should the situation change

3. Design the program and curriculum for the purpose of accreditation, using an organic approach – Modify the various prototypes and options for program design to the local context
  - a. Use examples and templates from others (See Portfolio of Templates and Samples in this package as a start)
  - b. This is the point at which formal consultation with entities with deep knowledge of the rules of accreditation and finance can be very valuable, e.g. [The RTT Collaborative](#) or [Residency Program Solutions](#).
  - c. Attend the [RTT Collaborative](#) Annual Meeting
  - d. Consider investing in faculty development for the potential program director(s): [NIPDD](#), [ACGME Navigation](#), or others

**Pause** (and either temporarily suspend or redirect efforts): If accreditation is denied for a proposed program or continuity site, list the gaps and challenges for future reference, should the situation change

4. Develop a business plan with an eye to practical operations and sustainability – pro forma’s, affiliations, letters of commitment, contracts, and other agreements; this is best done in concert with an accountant who is familiar with graduate medical education finance, including an in depth understanding of the financing rural programs (rural hospitals, rural health clinics, critical access hospitals, etc. and the nuances peculiar to them)

**Pause** (and either temporarily suspend or redirect efforts): If needed affiliation agreements cannot be forged, or the fiduciary agent (sponsoring institution or participating hospital or clinic) refuses to approve implementation because of financial predictions; list the gaps and challenges for future reference, should the situation change

The following toolbox includes:

1. A [template](#) for exploring community assets (and challenges that may need mitigation)
2. A [capacity inventory](#) of existing and potential resources, e.g. community financing, social support, motivated faculty and administration
3. A [crosswalk](#) of important factors to be considered, from multiple perspectives
4. [A [plan](#) for recruitment of additional faculty and new residents – In development]
5. A [portfolio](#) of other Links, Templates and Samples
6. [References](#)

This approach discourages an “all or nothing (go, no go)” approach, always leaving open the option for medical or other health professions education in any rural place, even if not at the present time, then at least at some time in the future. Sticking one’s “toe in the water” is possible by starting small and engaging first in almost any type of health professions student education. **Because of the complexities of graduate medical education accreditation and finance, however, it is wise to seek counsel before initiating resident (or fellow) education, so as to avoid pitfalls like premature caps on the number of residents a hospital can train or inadvertent triggering of a low “per resident amount” for GME funding.**

Periodic assessments of capacity should always be considered **formative summaries** along the path to developing and sustaining GME activities and/or expanding any and all options for rural rotations for residents, medical students and other health professions students to capacity. These formative

assessments are always anchored to a point in time and can be constructed following this simple outline or template for capturing the hospital and community's current and future potential for the development of one of the prototypical residency options described above:

1. Title, date, and authorship (including a history of updates)
2. A summary statement regarding community preparedness for GME activities, i.e. stage of change and progress to date
3. A list of active members of the coalition
4. A current draft of the "Template for Exploring Community Assets"  
A current draft of the "Inventory of Real and Potential Resources"  
A current draft of the "Capacity Crosswalk"
5. Accumulated examples of best practices from others, including a list of references from the web and from the literature
6. A summary of identified gaps
7. Suggested next steps for closing the gaps, if applicable, and further steps in the development of existing resources
8. A decision to pause or proceed – never stop!

## **Introduction to the Toolbox**

The following tools and other resources are meant to be utilized in series or in parallel, and often overlap. Together they represent thoughtful explorations of factors and goals from the perspectives of multiple people and interested parties. While not meant to be exhaustive, sharing the entirety of even a blank or partially completed template or inventory with each of the participants allows for active processing to occur. As individuals consider these, they may have an increased appreciation of the necessary partnerships and the level of sharing that is required in the construction of medical education. The exploratory process itself can help form new and functioning relationships based on a better understanding of each partners' perspective and identification of common goals.

### **Template for Exploring Community Assets/Challenges**

More than a checklist, the process of completing this template will allow for qualitative consideration of interrelated factors from the perspective of necessary partners in medical education. Examples may include persons representing hospitals, clinics and other pertinent medical and non-medical community members, stakeholders, and organizations.

The template allows simultaneous investigation of various facts and factors, both quantitative and qualitative. Sharing the template with stakeholders allows the leaders of the process and participants to identify next steps, and will prompt additional discussions.

### **Capacity Inventory of Existing and Potential Resources for Rural GME Training**

This is another inventory of prospective resources, including potential funding streams and human capital, as well as suggested next steps for closing gaps in resourcing if applicable. Completing this inventory should identify key existing and potential local community partnerships, identifying key individuals and institutions and unique community-specific factors impacting development, engagement and recruitment.

### **Crosswalk: Concept Mapping for Community Engaged Residency Education**

Use of this tool promotes conceptualization of the important interfaces between the goals of the proposed medical education program and the context in which they are operationalized. For example, by examining the proposed program or medical education activity through the "lenses" on the top (triangle) portion of the diagram, you can determine how this perspective may be effected by the elements and contexts identified using the templates referenced above.

The use of the concept map is meant to serve as a tool for identification of opportunities and gaps that may be unique to your particular situation, while also helping to prevent unintended consequences or unrecognized pitfalls. Each community and planned medical education program may have differing goals as well as unique resources, challenges and cultures as related to mission alignment.

A graphic and sample crosswalk, as well as an appendix of potential issues to be considered are provided as a reference.

## A Template for Exploring Community Assets and Challenges

### General Questions:

1. What are (or could be) the goals of the community for participation or expansion of activities in medical education?
2. How prepared from your perspective is the community for an initiation or increase of medical education activities?
3. What are the local community resources that have mission alignment with medical education?  
[Consider: Chamber of Commerce, charitable opportunities, economic development assets]
4. What are the larger community resources, regional opportunities and societal factors that may play a role?  
[i.e. area, regional, state or national opportunities may include experts, associations, grants, or other resources for resources ranging from advice to funding]
5. Who are the championing persons and what are the key relationships in the support of medical education activities?
6. What current GME activities are occurring in this community? ...Under what affiliations? What are the established relationships, teaching experience and culture of teaching?
7. What previous GME activities have occurred and what is that history? ...Under what affiliations?  
[Specify location and historical facts such as timeline of when these have occurred, as it can affect accreditation (e.g. faculty experience level) and finance (e.g. GME cap in some cases)]
8. What undergraduate medical student and other health profession student training activities are occurring or have occurred in the past, and what history may be pertinent to GME development? For example, has this been aligned and cooperative or in competition for teaching resources? ...Under what affiliations?
9. What other health care education is occurring in the community and how could this affect GME development either positively or negatively?  
[For example, alignment with the possibility inter-professional team care and learning vs. occurring in a competitive or inadvertently disorganized or disruptive manner]
10. What is the recruitment history for FM physicians in this community? Are you currently recruiting (hospital and/or clinic)?  
[This group of questions may be pertinent to the quality of the teaching (generally improved with stable medical staff and staff retained over the implementation of the program) or valuing of the program (i.e. recruitment and retention of physicians who enjoy and are committed to teaching in the program)]

11. What is the stability and longevity of FM physician workforce (hospital/clinic)?
12. What is the recruitment history for other specialty physicians in the community?

*Questions at a more granular level, intended to identify key contacts for further conversations and exploration:*

1. Who is (are) the local physician “champion(s)” for GME development?
2. Who is (are) the local physician(s) for teaching and resident interaction?
3. Who is (are) the local physician(s) for interaction with visiting and non-FM specialists?
4. Who is (are) the local physician(s) for administrative relationships and duties?  
[May or may not be the same as previously identified above]
5. Who is (are) the administrative champion(s) of the program (as indicated)?  
[i.e. may range from a simple reliable contact to a part-time FTE role]
6. What is the availability of housing for students and residents (either for limited rotations or longer-term)?
7. What is the community perception of visitors (first impression or reputation)?
8. Are there unique assets regarding recruitment/retention?  
[e.g. recreational opportunities, opportunities for spouse/significant other and family, proximity to the amenities of a larger community]
9. What unique barriers can be identified regarding recruitment/retention?  
[This question can be posed to start more difficult conversations in an honest and open way as related to experiences with providers who have left or declined to live in the community area (e.g. high crime rate, too isolated, other)]

Certain factors are more pertinent to specific medical education programming and scenarios. For example, in a 1-2RTT formatted GME program with a rural site distant from the urban site, spousal satisfaction and cost of permanent housing would be increasingly important.



## Capacity Inventory of Existing and Potential Resources for Rural GME Training

### *Hospital*

What is the hospital's goal in participation in medical education activities?  
How prepared is the hospital to begin medical education activities (or expand if currently ongoing)?  
If not presently, is there a perceived timeline for preparedness for beginning or expanding medical education activities? What are the most pertinent issues?

What do you perceive the past, current and sustaining level of support for medical education training by administration and the governance persons?

What do you perceive the past, current and sustaining level of support for medical education training by administration and the nursing staff?

What do you perceive the past, current and sustaining level of support for medical education training by administration and the physician staff?

What has been successful in motivating and sustaining staff support of medical education or other long-term projects?

[This question can reveal consideration and conversations regarding culture of effective leadership, communication and teamwork; regardless of the project, implemented change or challenge addressed (e.g. new EMR, quality projects, PCMH designation)]

What is the population size of your service area?

What is the geographic size of your service area?

What is your hospital RUCA code?

Are you located in a HPSA or MUA/P?

Is your hospital status CAH or PPS?

Is this hospital part of a larger system and what is the governance structure?

Does this hospital employ any physicians and does this hospital own or control a clinic(s)?

Does this hospital have a pre-established GME cap due to prior resident activity and if so, what is that number?

What is the number of admissions per year?

What are the leading diagnoses for admissions if available?

What is the average daily census?

Is there an associated long-term care facility?

Are hospitalists or ER/hospitalist physician staff utilized?

What is the number of obstetrical deliveries per year (may be none)?

What is the C-S rate or number of C-S per year?

What percentage of obstetrical deliveries are performed by FM physicians?

What is the number of EGDs per year (may be none)?

What physicians have these privileges?

What percentage of EGDs are performed by FM physicians?

What is the number of colonoscopies per year (may be none)?

What physicians have these privileges?

What percentage of colonoscopies are performed by FM physicians?

How many surgical admissions occur per year?

How many surgical procedures occur per year?

What are the leading types of surgical cases, if available?

What surgical privileges do FM physicians have, if any?

What is the number of pediatric admissions per year?  
What are the leading diagnoses for pediatrics (e.g. normal newborn)?

What is the highest level of care available for adult patients (e.g. ICU, telemetry)?

Please provide a roster or list of all medical staff members including specialty  
For any part time staff: What percentage of time is spent at this practice site?  
Are any of these physicians providing telehealth patient services?  
Are there other visiting sub-specialties?

What is the annual volume of ER patients?  
What percentage of these patient encounters would be considered emergent diagnoses?  
What percentage of the ER is covered by FM physicians?  
Are PAs or NPs utilized in the ER?  
Is ER service provided by on-site physicians?

Please provide a copy of the core privileges for FM physicians and any other privileges held or considered special privileges for FM physicians.

Do you have full wireless internet service?  
Do you have full and reliable cellular phone service?  
Do you have televideo availability for administrative/teaching purposes?  
Do you have televideo availability for patient care purposes?

What CME events or programs are currently offered at the hospital (e.g. journal review, all-staff M&M, Grand Rounds, tele-lectures, ACLS, etc.)

Is there a medical staff development plan for the hospital?

What EMR do you use if any for documenting patient care encounters by physicians?  
How adaptable is this EMR system to use by students for record entry (not orders)?  
How adaptable is this EMR system to use by licensed residents for record entry? order entry?  
Does your hospital have existing by-laws for resident care of patients (such as a temporary privileges category)? (Please provide a copy)

What is the financial stability position of the hospital?  
Is there a preparedness to contribute financially to the GME activities?  
Any anticipated changes or plans for change in the physical plant?

Any perceived issues with present call scheduling/workload/time away from practice for key GME-related individuals?

### ***Clinic***

What is the clinic's goal in participation in medical education activities?  
How prepared is the clinic to begin medical education activities (or expand if currently ongoing)?  
If not presently, is there a perceived timeline for preparedness for beginning or expanding medical education activities? What are the most pertinent issues?

What is the financial structure of the clinic (e.g. multi-specialty group, RHC, hospital-owned, CHC, etc.)

What are the patient demographics (look to meet FM RRC guidelines)?  
What percent (or number) of patients are under 10 years of age?  
What percent (or number) of patients are over 60 years of age?

What is the access to mental health services for patients?

What is the number of FM physicians? ...FTE? ...Demographics (e.g. approximate age, gender, experience)?

(This can have an effect on role modeling, recruitment of students.)

What is the level of interest in teaching, how many, how much and how strong?

What is the physical plant of the clinic and proximity to the hospital (potential FMC characteristics: office, precepting, library, meeting room, clinic rooms)?

What are the current experiences with teaching?

What situational and contractual characteristics effect the institutional and individual finances associated with teaching?

What other specialties and sub-specialties also share the clinic environment?  
How willing and interested are these sub-specialists in teaching?

What is the number of patients seen by FM physicians annually in this clinic?

What EMR do you use if any for documenting patient care encounters by physicians?  
How adaptable is this EMR system to use by students for record entry (not orders)?  
How adaptable is this EMR system to use by licensed residents for record entry? order entry?  
Is the clinic EMR integrated with the admitting hospital system EMR?

Do you have full wireless internet service?

Do you have full and reliable cellular phone service?

Do you have televideo availability for administrative/teaching purposes?

Do you have televideo availability for patient care purposes?

What characteristics or intent is in place regarding transformation to a PCMH?

What do you perceive the past, current and sustaining level of support for GME training by administration and the governance persons?

What do you perceive the past, current and sustaining level of support for GME training by administration and the nursing staff?

What do you perceive the past, current and sustaining level of support for GME training by administration and the physician staff?

What has been successful in motivating and sustaining staff support of GME or other long-term projects?

What is the financial stability position of the clinic?

Is there a preparedness to contribute financially to the GME activities?

### ***Other***

Have Medical Students or other healthcare professional learners been engaged in the community?

What is the priority of engaging such learners other than resident physicians?

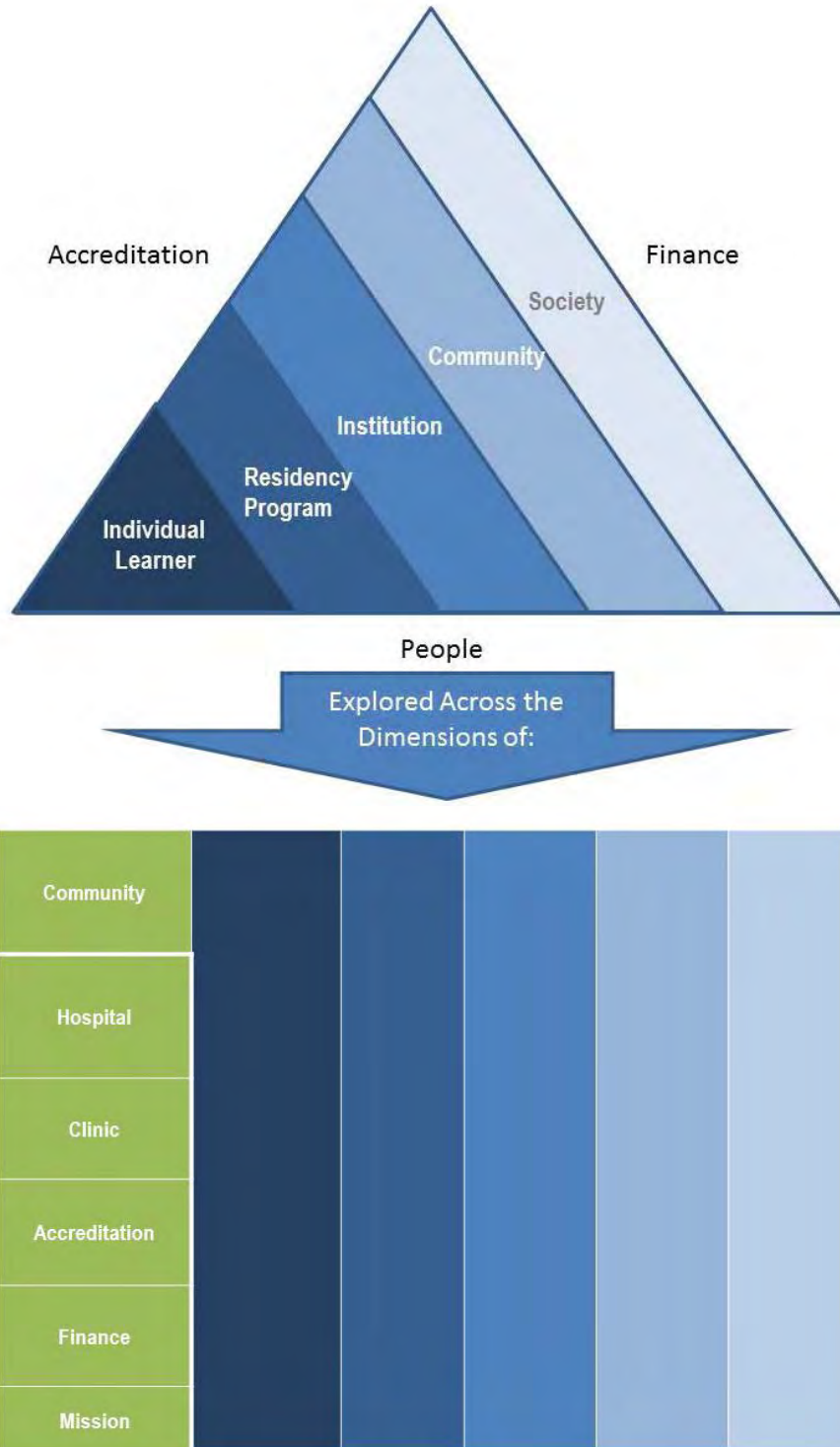
Have these learners ever been taught as a team or in an interactive method?

How aligned are the sponsoring programs of these different learners?

Have Fellowship GME opportunities been discussed or explored (e.g. a rural fellowship program)?

**Crosswalk for Community Engaged Residency Education**

*An organic architectural approach to building a community centered educational home for medical students and residents in a rural neighborhood and a larger academic community of practice*



**\*See Crosswalk Worksheet for a sample of how this can be operationalized – EXCEL attachment**

Values and Capacity Crosswalk for CERE-R					
	Individual Learner	Residency Program	Institution	Community	Society
<b>Community</b>	How will the learner experience the local community? e.g. community activities, spousal employment, commute time	How will the core program integrate community input to the program? e.g. rural advisory board formation	How is the Sponsoring Institution related to this community? e.g. identify collaborative relationships or opportunities for improvements (i.e. healthcare delivery systems might apply here)	How will the values of the community align with or challenge the existing community resources for leadership and culture with regard to a rural program?	How will this community set an example for societal values with regard to this rural program? e.g. regional positive publicity and aligned community development opportunities
<b>Hospital</b>	How will the learner need to interface with the hospital? e.g. hospital-based subspecialist teaching, privileges	How can the core program have a better program from the involvement of the rural hospital? e.g. curricular areas (i.e. surgery, emergency, other)	How does the rural hospital presently align with the requirements and resources of the sponsoring institution? Any challenges? e.g. any healthcare system issues?	How does the hospital and community interface function and how will this affect the rural program? e.g. community support of hospital, perception of quality of care	How will the hospital be affected by the societal pressures or changes in healthcare and how will this affect the program? e.g. less hospitalization of patients
<b>Clinic</b>	How will goals of the learner be met in the clinic? e.g. physical space and layout, PCMH characteristics	How will the goals and educational needs of this program be related to the capacity and culture of the clinic? e.g. if accredited, the FMP	How does the clinic presently align with the requirements and resources of the sponsoring institution? Any challenges? e.g. any healthcare system issues?	How does the training clinic and community interface function and how will this affect the rural program? e.g. community support of clinic, perception of quality of care	How will the clinic be affected by the societal pressures or changes in healthcare and how will this affect the program? e.g. telemedicine, group visits
<b>Accreditation</b>	How will the individual learner curriculum be flexible within accreditation standards? e.g. electives, curricular emphasis variation between residents	How will the core program curriculum meet the accreditation requirements? e.g. practice management hours, volume of pediatrics for all PGY1 residents	How does the role of the proposed sponsoring institution serve to meet accreditation goals and requirements? e.g. accreditation type AOA, ACGME	How might community factors affect accreditation-related goals? e.g. opportunities for practice management curriculum in population health, underserved populations	How does societal trends affect accreditation requirements that may uniquely apply to this rural program? e.g. how will work hours rules be implemented? (i.e. home call)
<b>Finance</b>	How will the financial stability of the program serve stability for the residents in the program? e.g. is there expiring funding beyond graduation of this recruitment year?	How will the core program's finance be affected by the rural programming? e.g. budget expenses and support	How will the local institution support the cost of rural GME? e.g. how is the GME CAP affected by this program?	How could the local community have an impact on funding or the finances of the rural program? e.g. payor mix of the community, local charitable support	How could the program finances be affected by recognition of value on a societal level? e.g. financial support from sources such as grants, legislative, foundations or community support
<b>Mission</b>	How will learners be attracted to and affected by the mission of the the rural program and its community context?	How will the core program mission and this rural program align or interface? e.g. does the core program have a rural mission?	How will the institutional goals and mission interface with this rural program? e.g. does the institutional goals align with rural training and community outreach?	How does the community align with the mission of this rural program? e.g. valuing education, rural access to care, workforce goals	How is this program aligned with societal recognition of values reflected by the project? e.g. grant opportunities, positive publicity, legislative or other support

## **Additional Factors for Consideration in each Domain:<sup>9</sup>**

### **Community (Rural Community Ecosystem)**

Environmental factors – housing, climate, significant other opportunities, perception of community, socio-demographic factors, factors for family (if applicable)  
Relation to core site – distance, political, economic, experience, precedent  
Patients – volume, demographics, attitude toward teaching  
Economics – funding, support, completion within service area  
Political – desire, practical need, understanding/appreciation  
Community perceptions/bias of medical education  
Community integration with program  
Community cultural resources  
Community financial resources  
Community political accessibility and resources  
Community experience as a resource  
Physician champion as related to community

### **Institutional (Urban Institution or Urban Program)**

Political relationship of urban program within the institution  
Alignment of institutional mission with the program to rural site objectives  
Economics of institution and urban program (stability/resources)  
History of GME activities  
Experience of institution and urban program with distance/rural training  
Academic history/recruitment history of institution/program  
Complimentary educational resources  
Geographic characteristics and relation to rural site  
Technology resources and utilization (e.g. telecommunication)  
Admissions as aligned with learner match for rural site (e.g. track)  
Curriculum as aligned with rural site utilization (i.e. elective/required)  
Mission alignment  
Leadership stability for maintaining mission  
Administrative support services  
Funding support/stability  
Partnerships and evaluation for improvement  
Flexible and broad training resources  
Technical knowledge and resourcing  
Appreciation of function/value  
Understanding of necessary resources  
Finance knowledge

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<sup>9</sup> Derived from a presentation and group discussion entitled “Rural Family Medicine Closure: Risk and Protective Factors” at the Annual Meeting of the RTT Technical Assistance Program, June 2014.

Reference:

David Schmitz, MD†, Davis G. Patterson, PhD\*, Sherry Adkins, MD/MPH\*\*, Belinda Vail, MD, MS<sup>^</sup>, Randall Longenecker, MD‡. Rural Training Track Program Closure and Resilience Study, Poster presentation, Program Directors Workshop, March 2015.

†Family Medicine Residency of Idaho; \*WWAMI Rural Health Research Center, University of Washington

\*\*Family Health Community Health Center, New Madison, Ohio; <sup>^</sup>Department of Family Medicine, University of Kansas School of Medicine; ‡Ohio University Heritage College of Osteopathic Medicine.

### **Program (Proposed Rural Program or Rural Academic Sites)**

History of collaboration/competition, relationships  
Stability/instability of leadership  
Administrative support and experience  
Economic stability and resources  
HR resource management  
Competing obligations  
Modes of communication/collaboration – economy of effort  
Teaching resources – physician champion, core faculty, specialty faculty, primary care integration of learner into outpatient practice, academic resources (didactic, library, connectivity)  
Academic processes quality and processes for measurement/improvement  
Connectivity and communication with urban academic partner  
Experience and history of rural GME  
Internal to program: communication, processes and quality improvement  
Administrative support  
Innovation/flexibility  
Clinical volume and breadth (details in GME rural site survey)  
Funding amount security and diversity  
Intrinsic factors to location/plant/practical aspects (e.g. distance clinic to hospital)  
Preparation/support/connectivity/aftercare of learner in rural site  
Local support of learner at rural site

### **Individual (Actual or Proposed Learners)**

Resilience/flexibility/dedication/persistence  
Mission alignment  
Insight and understanding of intrinsic goals/existential role to program  
Characteristics of learners including communication, dedication, self-awareness, self-efficacy, commitment, adaptability, engagement, requesting support when needed, mission alignment, ability

### **Society (Macro Factors and State or Regional Affairs)**

State or regional support factors  
Experience with or culture of rural learners/rotations in area of influence  
Local environmental history/precedent  
Identification and amelioration of any societal or socioeconomic confounders  
Workforce factors/valuation of GME/medical education  
Macro economic factors  
Patient/system (e.g. EMR, privileging) service vs. culture of education  
Role modeling

## **A Portfolio of Links, Templates and Samples for Residency Development**

Common Program Requirements of all specialties

<https://www.acgme.org/acgmeweb/tabid/429/ProgramandInstitutionalAccreditation/CommonProgramRequirements.aspx>

Family Medicine Review Committee (FM-RC) Program Requirements and Application for New Program

<http://www.acgme.org/Specialties/Overview/pfcatid/8>

Appendix A: Wisconsin Collaborative for Rural GME Development Paths (Traxler); for additional resources and examples from Wisconsin visit:

<http://wcrgme.org>

Appendix B1: RTT Accreditation Guide (Longenecker) – WORD attachment

Appendix B2: Rural Residency Rotation Templates: Building teaching capacity in residency education (Schmitz)

*Appendix B3: [RTT Financial Guide (In development)]*

Appendix C: RTT Development Sample Timeline (Brill)

Appendix D: ACGME Minimums Worksheet (Temple) – EXCEL attachment  
“Can your practice and community support these numbers?”

Appendix E: Faculty Listing page from New Residency Application (ACGME Archive) – WORD attachment

Appendix F: “Challenges (and Solutions) for Small Programs” – March 2015 (Longenecker)

Appendix G: 2-2-2 Curriculum Graphic 2010 – Integrated “2-2-2” RTT (Longenecker)



# WI Collaborative for Rural GME Development Paths

INITIAL PHASE
Education & Initial Assessment
Identify Initial Champions
Apply for Grants
Education & In-Depth Assessment
Choose GME Path (s)

DEVELOPMENT PHASE			
<b>ROTATION SITE</b> Assemble Core Team Identify Partners Additional Education Simple Budget Market Rotation Accept Residents	<b>INTEGRATED RURAL TRAINING TRACK (IRTT) RESIDENCY</b> Assemble Core Team Identify Partners Additional Education Proforma Board Approval Curriculum Budget Market Rural FMC Track Interview Applicants Accept Residents	<b>FELLOWSHIP PROGRAM</b> Assemble Core Team Identify Partners Additional Education Proforma Board Approval Curriculum Budget Submit for Accreditation (if applicable) Market Fellowship Interview Applicants Accept Fellows	<b>RURAL TRAINING TRACK RESIDENCY (RTT)</b> Assemble Core Team Identify Partners Additional Education Proforma Board Approval Curriculum Budget Write Program Information Form (PIF) Submit PIF Site Visit Market Residency Interview Applicants Accept Residents

Courtesy of Kara Traxler, RWHC/WCRGME

## RTT ACCREDITATION GUIDE

Randall Longenecker MD, Senior Project Adviser, RTT Technical Assistance Program  
August 2015

1	Make contact with The RTT Collaborative, join the listserve, and consider attending an Annual Meeting <a href="http://www.rttcollaborative.org">http://www.rttcollaborative.org</a>	
2	Identify a sponsoring institution (SI)	
3	Is SI currently accredited by ACGME?	
4	Y – next step	N-For information on how to apply for institutional accreditation, contact the Administrator for the Institutional Review Committee. <a href="https://www.acgme.org/acgmeweb/tabid/158/ProgramandInstitutionalAccreditation/Institutions/InstitutionalReview.aspx">https://www.acgme.org/acgmeweb/tabid/158/ProgramandInstitutionalAccreditation/Institutions/InstitutionalReview.aspx</a>  The Sponsoring Institution must be approved before proceeding further.
5	Confirm that the Sponsoring institution is in good standing and complies with the Institutional Requirements	<a href="https://www.acgme.org/acgmeweb/tabid/158/ProgramandInstitutionalAccreditation/Institutions/InstitutionalReview.aspx">https://www.acgme.org/acgmeweb/tabid/158/ProgramandInstitutionalAccreditation/Institutions/InstitutionalReview.aspx</a>
6	Access the current and proposed Common and specialty specific Program Requirements on the home page for accreditation of Family Medicine programs, become familiar with the links on this page, especially the FAQ's for Family Medicine and New Programs, and download the Application Instructions from the Common Requirements page and the New Applications document for FM programs as a working template for completing the application (traditionally called the Program Information Form or PIF) online. Pay special attention to instructions regarding a program in the "1-2" format to determine if this applies to your developing program.	<a href="https://www.acgme.org/acgmeweb/tabid/429/ProgramandInstitutionalAccreditation/CommonProgramRequirements.aspx">https://www.acgme.org/acgmeweb/tabid/429/ProgramandInstitutionalAccreditation/CommonProgramRequirements.aspx</a>  <a href="https://www.acgme.org/acgmeweb/tabid/132/ProgramandInstitutionalAccreditation/MedicalSpecialties/FamilyMedicine.aspx">https://www.acgme.org/acgmeweb/tabid/132/ProgramandInstitutionalAccreditation/MedicalSpecialties/FamilyMedicine.aspx</a>

7	Designate a Program Director in development (may be the PD of the larger program in a RTT in the “1-2 format”) and a Site Director (Who will be Core faculty). It is also helpful to designate a dedicated at least part-time administrative staff person to assist in development.	
7	Contact ACGME specialty Review Committee staff with any questions (Upper right of FM web page); it’s a good idea to get to know them. They can be a big help, although to the uninitiated, information regarding RTTs can be confusing.	<a href="https://www.acgme.org/acgmeweb/tabid/132/ProgramandInstitutionalAccreditation/MedicalSpecialties/FamilyMedicine.aspx">https://www.acgme.org/acgmeweb/tabid/132/ProgramandInstitutionalAccreditation/MedicalSpecialties/FamilyMedicine.aspx</a>
8	Before proceeding further, consider consultation with the RTT Technical Assistance Program; through August 31, 2016, these are available at no cost	<a href="http://www.raconline.org/rtt/">http://www.raconline.org/rtt/</a>
9	New programs should follow the “Approved but not currently in effect” program requirements.	e.g. Common Program Requirements, July 1, 2016; Family Medicine, July 1, 2016
10	Develop Timeline for residency program development (See Sample; substitute dates for numbers in this template; generally takes at least 18-24 months from this point)	
11	After completion of the application draft, but before submission, consider external review (e.g. contact the RTT Technical Assistance program)	
12	Have DIO initiate the new program application within the Accreditation Data System (ADS)	<a href="https://www.acgme.org/acgmeweb/tabid/159/DataCollectionSystems/AccreditationDataSystem.aspx">https://www.acgme.org/acgmeweb/tabid/159/DataCollectionSystems/AccreditationDataSystem.aspx</a>
13	Program Director completes the application in ADS and supplemental materials if any	
14	Have the institutional Graduate Medical Education Committee (GMEC) approve the application, at which point, with DIO approval, you can submit the application to the FM Review Committee	
15	Receive scheduled date from ACGME and prepare for Site Visit	
16	Host Site Visit	
17	Await Initial Accreditation Approval – generally following the next triennial meeting of the FM-RC	

18	Upon approval, set a date for implementation	
19	Recruit initial resident class and proceed with faculty contracts	
	[Add your own...]	

Date

Dear Name, title:

Thank you so very much for working with our residents/fellows from the name of residency program. We have enjoyed our relationship over the years and I indeed hope that you have found this beneficial as well. Please find attached a Memorandum of Understanding (MOU) between hospital/medical center and the residency program. This MOU is completed annually to help meet the requirement for an affiliation agreement between your institution, hospital, and the name of residency program. As you may know, in order to receive Medicare Graduate Education (GME) funds the hospitals are required to incur all or substantially all of the costs associated with the residents/fellows. The MOU confirms that you are willing to work with our residents/fellows with no expectation of reimbursement from either name of hospital, or from the name of residency program, or any other person or entity; therefore because there are no costs associated with your assistance to the residents/fellows, there are no costs that the hospitals are failing to incur. I very much appreciate you donating your time to help with the training of our residents/fellows.

In return for that service our residents/fellows will work with you at no cost to you and in addition, you can become university clinical faculty if you so desire. If you have an interest in this please contact name at email and we will work toward getting that accomplished for you. This will give you access to the healthcare resources library at university.

Again, I hope you find this a value add to your practice for many reasons. We certainly appreciate your time and efforts in extending your knowledge to our residents/fellows as they train to be family physicians for name of state and the region's future. This MOU is this year's version updated to include our fellows, and we would greatly appreciate your getting it back to us as soon as is possible for this academic year. Please return this document to name and do not hesitate to contact name at phone number if there are any questions about this MOU.

Sincerely yours,

Name

Residency Official

## MEMORANDUM OF UNDERSTANDING BETWEEN

### **name of hospital** **Name of residency program.,** **AND AFFILIATED TRAINING SITE**

This Memorandum of Understanding ("MOU") is entered into as of the Effective Date set forth below by and between **name of hospital ("the Hospital")**, **name of residency program ("Program")**, and the physician's office/clinic whose name appears below ("Affiliated Training Site").

Affiliated Training Site: **name of training site**

Effective Date: **date**

#### BACKGROUND

The Hospitals help sponsor medical education for the purpose of providing family medicine residency training to residents and fellows. This sponsorship is provided in conjunction with the **name of residency program**.

In order to provide residents/fellows with the curricular elements necessary for optimum education and accreditation, the Hospitals have a need to identify and partner with non-hospital training sites.

In order to meet this need, Affiliated Training Site agrees to provide teaching supervision for residents/fellows at no costs to the Hospital or to any other person or entity. The Affiliated Training Site will perform the services required under the terms of this MOU as an independent entity and this MOU will not be construed to create a partnership, joint venture, or employment relationship between the Affiliated Training Site and Hospital. The Hospital, Affiliated Training Site, and **name of residency program** shall each be responsible for its own acts and omissions, including the respective agents of each entity.

This MOU is necessary to meet current ACGME requirements as outlined in the Institutional Requirements of the Graduate Medical Education Directory as well as CMS requirements for Medicare Graduate Medical Education funding.

#### GOALS AND OBJECTIVES

The educational goals and objectives are to expose the residents/fellows to typical health problems for the purpose of furthering their education by providing direct patient care under the supervision of a precepting physician.

#### RESPONSIBLE OFFICIALS

**Name** Designated Institutional Official (DIO) along with **name of residency Program Director** and Fellowship Director of the **name of residency program ("Program")** will assume administrative, educational, and supervisory responsibility for Program residents/fellows while on rotation at the Affiliated Training Site.

#### PERIOD OF ASSIGNMENT AND BENEFITS

The Program residents/fellows may rotate through the Affiliated Training Site throughout the term of the MOU. The Hospitals incur all or substantially all (at least 90 percent) of the total costs of the residents/fellows salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct Graduation Medical Education activities, and other miscellaneous expenses (collectively, the "total costs"). Each Hospital is responsible for its pro rata share of the total costs, in accordance with the number of interns and residents/fellows based at the Hospital. For example, if **name of hospital** has four residents/fellows who rotate through the Affiliated Training Site and **name of other hospital** has six residents/fellows who rotate through the Affiliated Training Site, **name of hospital** shall be responsible for 40 percent of the total costs and **name of other hospital** shall be responsible for 60 percent of the total costs. The financial relationship between the Program and the Hospitals is established pursuant to an arrangement separate and part from this Agreement. In exchange for the time and effort spent by the Affiliated Training Site, the residents/fellows will work at the Affiliated Training Site with no cost to the Affiliated Training Site. The Affiliated Training Site may also qualify for academic appointment at the university. This appointment would carry the ability to access the **university healthcare resources library**. The Affiliated Training Site does not incur any supervisory or teaching costs associated with the residency education and training.

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION REQUIREMENTS

1. The Affiliated Training Site will identify the faculty who will assume both educational and supervisory responsibilities for the residents/fellows.
2. The Affiliated Training Site will have responsibility for teaching, supervising, and completing an evaluation of the resident's/fellows' performance in a timely manner.
3. The Program will specify the duration and content (goals and objectives) of the educational experience.
4. The Program will provide the policies and procedures that will govern resident/fellow education during the

assignment. TERM OF AGREEMENT

This MOU shall remain in effect from the date specified above and automatically renew year to year. Any party may terminate this agreement for any reason after giving sixty (60) days written notice to the other party of its intent to terminate. In the event of termination, neither of the parties shall have any recourse against the other party as a result of such early termination;

OTHER

The Program, at its own expense, shall obtain and keep Workers' Compensation coverage in effect during the term of this MOU.

The Program warrants and represents that it maintains professional liability coverage of at least \$1 million/\$3 million in aggregate to cover the acts and omissions of residents/fellows while working at the Affiliated Training Site.

The Affiliated Training Site warrants and represents that it maintains professional liability coverage of at least \$1 million to cover the acts and omissions of its supervisory/teaching physicians and other employees who may provide patient care services at the Affiliated Training Site in conjunction with the resident/fellow.

Signatures of duly authorized representative of place this agreement

into effect. REPRESENTATIVE FOR THE AFFILIATED

TRAINING SITE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Signature)  
(Printed Name)  
Affiliated Training Site \_\_\_\_\_ Date

REPRESENTATIVE FOR name of hospital:

\_\_\_\_\_  
\_\_\_\_\_  
(Signature)  
Title \_\_\_\_\_ Date

REPRESENTATIVE FOR name of residency program:

\_\_\_\_\_  
\_\_\_\_\_  
(Signature)  
Residency Official \_\_\_\_\_ Title \_\_\_\_\_ Date

Dear Preceptor,

We are grateful that you are willing to share your practice, patients and time with a first year family medicine resident from Family Medicine Residency of Idaho. I am enclosing a copy of our formal Goals and Objectives but suffice to say the over-riding goal is to be reminded why they went to medical school in the first place. Our residency is chosen by physicians seeking experiences in rural Idaho and these “rural rotations” remain among the most highly rated in our entire program.

We would also like them to experience being part of a rural Idaho community, in both the commitment and the joy of those relationships. Through the years many residents and families have returned to Boise with a new-found or renewed love of rural life and medicine. The residents can only experience that because of you and your staff. Thanks.

**Schedule:** The resident will be in your community for 2 weeks. They are not required to take call, but can do so with the same frequency that you do. They are still governed by work hour restrictions, however, which limit the resident to 80 hours per week averaged over the 2 weeks and to work no more than 16 hours in a row. For in-hospital care the precepting physician needs to be immediately available to assist the resident if needed. Thank you for helping us maintain the required work hour rules for our residents.

**Housing:** Please let us know if you are having trouble finding housing for the resident.

**Teaching:** As you are aware, Medicare has specific rules about precepting residents for the billing of care for Medicare patients. Because these are residents you will need to see all Medicare patients and document that oversight in their chart. This is a sample of specific language that can be acceptable. “I saw and evaluated the patient. Discussed with resident and agree with the resident’s findings and plan as documented in the resident’s note.”

The guidelines from CMS can be found at <http://www.cms.gov/MLNProducts/downloads/gdelinesteachgresfetsht.pdf>.  
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf>

Example language for charts can be found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2303CP.pdf>. (See pages 7-8)

Please contact your other insurance intermediaries if there is any question about teaching documentation as other insurances may start following Medicare’s rules. First year residents are expected to precept all patients with you at least verbally. Other precepting and documentation should happen as the resident or physician feels is needed.

**Prescriptions:** First-year residents do not have DEA licenses and will need to use their preceptor’s DEA number for any prescriptions that they write while at your site. Please discuss with your resident how you would like them to precept prescriptions.

**Information:** If there is anything you would like to make sure the resident knows prior to arriving or any information that you always present, we would be happy to make sure the residents get a copy of that before they come your way. For example: maps, orientation information, web sites, contact info, pager info, good eateries, etc. Please pass it on to Diana Beahm by email at [Diana.beahm@fmridaho.org](mailto:Diana.beahm@fmridaho.org). We will be putting together an internal source for each rotation for helpful information for residents, facilitating the rotation experience.



**Evaluation:** As with all educational experiences, evaluation is a necessary tool for the learner. Enclosed you will find an evaluation form. Please make many copies for anyone that has had significant experience with the resident. We also appreciate comments from staff and patients. You will be sent a copy of this evaluation on New Innovations as well. Please fill out whatever format is easiest for you. You do not need to do both. We will ask the residents to evaluate the sites and we will make that information available to you at the end of the academic year. Each year we will send you a memorandum of understanding (MOU) to sign regarding malpractice and other administrative issues.

Our goal is to help make this a mutually beneficial experience. We would love to be a resource for needs that you might have through this relationship. One perk to remember, you can become adjunct faculty at the University of Washington School of Medicine if you precept residents or students for more than 50 hours a year and thus get access to UW Healthlinks, an internet library resource that is very valuable for patient care with resources such as UpToDate, textbooks and patient handouts. Let us know if you would like more information about this.

Also, we want your feedback. Please also let us know if there is anything we can change about this rotation to make it work better for you or if you have any questions. Thanks again for all you do, for us and for Idaho.

Sincerely,



FMRI Rural Department  
Dave Schmitz, MD, Chief Rural Officer, Program Director for RTTs  
Cell: 208-921-6360  
[dave.schmitz@fmridaho.org](mailto:dave.schmitz@fmridaho.org)

Kim Stutzman, MD, Associate Program Director and Associate Director for Rural Medicine  
Cell: 208-340-0685  
[kim.stutzman@fmridaho.org](mailto:kim.stutzman@fmridaho.org)

Diana Beahm, Administrative Assistant  
208-514-2522  
[diana.beahm@fmridaho.org](mailto:diana.beahm@fmridaho.org)

Enclosures: Rural Rotation Practice Management, Goals and Objectives, Evaluation Form

Dear Preceptor,

We are grateful that you are willing to share your practice, patients and time with a family medicine resident from Family Medicine Residency of Idaho. I am enclosing a copy of our formal Goals and Objectives but suffice to say the over-riding goal is to be a “real doctor” and to recognize that it does work. Our residency is chosen by physicians seeking experiences in rural Idaho and these “rural rotations” remain among the most highly rated in our entire program.

We would also like them to experience being part of a rural Idaho community, in both the commitment and the joy of those relationships. Through the years many residents and families have returned to Boise with a new-found love of rural life and medicine. The residents can only experience that because of you and your staff. Thanks.

**Schedule:** The resident will be in your community for 3-4 weeks. They are expected to take call with the same frequency that you do. We are still governed by work hour restrictions, however, which limit the resident to 80 hours per week averaged over the 4 weeks and no more than 24 hours in a row but with 4 hours to “wrap up” patient needs with no new patients seen after the 24 hour time line. If a resident is taking call from home and is not called in they can complete a full day of work the following day, including clinic.

We would like them to return to Boise on the Wed. night of their last week to participate in our teaching half day conference on Thursday afternoon and to review the practice management they have learned on Thursday morning. I realize that can make the time tight. The rural rotation is also one of the rotations during which we allow vacation. You will be notified by our office if the resident has requested time off during this rotation.

**Housing:** Please let us know if you are having trouble finding housing for the resident.

**Teaching:** As you are aware, Medicare has specific rules about precepting residents for the billing of care for Medicare patients. Because your clinic is not a continuity clinic for the resident for their full 2 years, you do not have a primary care exemption and will need to see all Medicare patients and document that in their chart. This is a sample of specific language that can be acceptable. “I saw and evaluated the patient. Discussed with resident and agree with the resident’s findings and plan as documented in the resident’s note.”

The guidelines from CMS can be found at

<http://www.cms.gov/MLNProducts/downloads/gdelinesteachgresfctsh.pdf>.

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf>

Example language for charts can be found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2303CP.pdf> . (See pages 7-8)

Please contact your other insurance intermediaries if there is any question about teaching documentation as other insurances may start following Medicare’s rules. Other precepting and documentation should happen as the resident or physician feels is needed.

**Prescriptions:** Some second-year residents do not have DEA licenses yet and will need to use their preceptor’s DEA number for any prescriptions that they write. Please discuss with your resident how you would like them to precept prescriptions.

**Information:** If there is anything you would like to make sure the resident knows prior to arriving or any information that you always present, we would be happy to make sure the residents get a copy of that before they come your way. For example: maps, orientation information, web sites, contact info, pager info, good eateries, etc. Please pass it on to Diana Beahm by email at [Diana.beahm@fmridaho.org](mailto:Diana.beahm@fmridaho.org). We will be putting together an internal source for each rotation for helpful information for residents, facilitating the rotation experience.

**Practice Management:** As you may know, the push to develop patient centered medical homes is strong and we are trying to teach our residents what that looks like. One of the new features of the rural rotation will be to look at current practices and evaluate them based on those criteria developed by the AAFP and other organizations. This is not to put the practice in a negative light. (We suspect most rural practices already meet most of those criteria.) It is to help the resident learn skills in practice management and evaluation so that they may be ready to seek their own place in the world.

We would also appreciate any feedback you could give the resident on their production and billing, again, only for educational purposes. Being able to recognize the connection between their work and funding the clinic and themselves can really open their eyes. As you know, if you do not have those skills, it is hard to keep the doors open.

**Community Medicine:** To help the resident become more involved in the community in the short time they are there we would like them to provide a community educational event. The resident can give a Tar Wars presentation to a fifth grade class with you or a community Meth Education presentation, a suicide prevention presentation or talk on any topic you feel the community needs. It would also be possible to give an in-service to MA's and other office staff on Stroke. Just let us know what would work best in your community.

**Evaluation:** As with all educational experiences, evaluation is a necessary tool for the learner. Enclosed you will find an evaluation form. Please make many copies for anyone that has had significant experience with the resident. We also appreciate comments from staff and patients. You will be sent a copy of this evaluation from the program as well. Please fill out whatever format is easiest for you. You do not need to do both. We will ask the residents to evaluate the sites and we will make that information available to you at the end of the academic year. Each year we will send you a memorandum of understanding (MOU) to sign regarding malpractice and other administrative issues.

Our goal is to help make this a mutually beneficial experience. We would love to be a resource for needs that you might have through this relationship. One perk to remember, you can become adjunct faculty at the University of Washington School of Medicine if you precept residents or students for more than 50 hours a year and thus get access to UW Healthlinks, an internet library resource that is very valuable for patient care with resources such as UpToDate, textbooks and patient handouts. Let us know if you would like more information about this.

Also, we want your feedback. Please also let us know if there is anything we can change about this rotation to make it work better for you or if you have any questions. Thanks again for all you do, for us and for Idaho.

Sincerely,



FMRI Rural Department

Dave Schmitz, MD, Chief Rural Officer and Program Director of FMRI RTTs,  
[dave.schmitz@fmridaho.org](mailto:dave.schmitz@fmridaho.org)

Kim Stutzman, MD, Associate Director of Education and Rural Medicine  
[kim.stutzman@fmridaho.org](mailto:kim.stutzman@fmridaho.org)

Diana Beahm, Administrative Assistant  
208-514-2522  
[diana.beahm@fmridaho.org](mailto:diana.beahm@fmridaho.org)

Enclosures: Rural Rotation Practice Management, Goals and Objectives, Evaluation Form

## **AURORA RTT PLANNING**

Aurora Family Medicine Residency Program, Milwaukee, WI

John R. Brill, MD, MPH, Former Program Director, Aurora Family Medicine Residency Program

Jacob L. Bidwell, MD, Program Director

(For a June 2013 grant application)

This grant will support further planning and development of the Lakeland site suitable for establishing a Rural Training Track of the Aurora Family Medicine Residency Program. The expected outcome of this phase is presentation of a business plan to the Aurora Health Care Board of Directors to obtain funding to hire a program director, who would then lead the accreditation and establishment of the program.

### **Elements of the proposal will include:**

- Site: as stated above.
- Size: One sites with two to four residents per year.
- Facilities: Floor plans will be reviewed and proposal drafted for required changes to meet Residency Review Committee (RRC) requirements, as well as ensure training consistent with the future needs of family medicine physicians.
- Curriculum: A three-year curriculum detailing rotation sites will be created and reviewed to ensure adherence to all RRC requirements as well as optimizing funding.
- Funding mechanisms: Although it is unlikely that the rural training program will be financially independent, models will be weighed that maximize the program value in terms of recruitment, revenue, resources and redirection of un/under-insured patients from emergency room (ER) and hospitalization.
- Recruitment: Difficulties with attracting students have been the downfall of several Wisconsin rural training tracts. A quantitative and qualitative assessment of “recruitability” for the finalist sites will be part of the final recommendations.

Aurora has a strong tradition of recruiting and retaining Wisconsin and upper Midwest family physicians. Aurora has set a goal to recruit at least 30 percent of its incoming residents from the University of Wisconsin School of Medicine and Public Health or the Medical College of Wisconsin. It has met this goal for the last two years. In addition, the program’s dual accreditation through the American Osteopathic Association has facilitated the recruitment of natives of Wisconsin and the upper Midwest who have pursued osteopathic medical training. Currently, 33 percent of the program residents fall into this category.

Ultimately, it is anticipated that the Aurora Family Medicine rural training program will produce three to five rurally-oriented family physicians to serve Wisconsin each year.

### **The timeline for the grant period is:**

- July 2013-March 2014– August 31: Visits to finalist sites. Interview leaders, evaluate physical facilities, collect floor plans. Develop tables of strengths and challenges, potential champions and faculty.
- July– August 2013: Consult with Baraboo Rural Training Track Program regarding funding, curriculum and other issues.
- August 2013-March 2014: Develop business plan, in consultation with Aurora Health Care financial analysts.
- Oct 2013: Present Preliminary proposal to Aurora University of Wisconsin (UW) Management Committee.
- Nov 2013: Present plan to AUWVG (Aurora University of Wisconsin Medical Group) Board of Directors.
- January – June 2014: Finalize Proforma
- January – Dec 2014: Site facility planning, faculty and staff recruitment and development (in progress)
- July-Dec 2014: Prepare new Program Information Form and submit to ACGME.
- ~March 2015: ACGME site visit.
- ~July 2015: ACGME new site approval.
- July 2015: Register for Electronic Residency Application Service (ERAS).

- October 2015: Begin interviewing residency applicants.
- June 2016: New residents' orientation for first class.
- July 2017: PG2 residents transfer to Rural Training Track (RTT).
- June 2019: Graduation of first class.

<b>Family Medicine Program Requirements Crosswalk</b>				
Richard Temple, MD, FAAFP CDR MC USN Program Director, Camp Lejeune Family Medicine Residency 2015				
<u>Curriculum</u>	<u>Time</u>	<u>#Visits</u>	<u>Exceptions</u>	<u>Inclusions</u>
Continuity Clinic	40wk/yr	1650 in person (majority must occur in residents primary FMP site) - 165 encounters <10yoa - 165 encounters >60yoa	no interruption >8 continuous wks, periods between interuprions must be 4 wks	acute, chronic care, and wellness care for patients of all ages. Residents must be primarily responsible for a panel of continuity patients, integrating each patient's care across all settings, including the home, long- term care facilities, the FMP site, specialty care facilities, and inpatient care facilities. Residents should participate in and assume progressive leadership of appropriate care teams to coordinate and optimize care for a panel of continuity patients.
Inpatient	600 hours (6 months) <b>AND</b>	750 patient encounters		
ICU	100 hours (1 month) <b>OR</b>	15 patient encounters		

ED	200 hours months) <b>OR</b>	(2	250 adult patient encounters	
Geriatrics (>60 yoa)	100 hours month) <b>OR</b>	(1	125 patient encounters	The experience must include functional assessment, disease prevention and health promotion, and management of patients with multiple chronic diseases. The experience should incorporate care of older patients across a continuum of sites.
Pediatrics Inpt / ER	200 hours months) <b>AND</b>	(2	250 patient encounters <b>INCLUDING</b> 75 inpatient encounters with children 75 ED patient encounters with children	
Pediatrics Outpt	200 hours months) <b>OR</b>	(2	250 patient encounters	This care must include well-child care, acute care, and chronic care.
Newborn Care			40 newborn patient encounters; including well and ill newborns	
Surgery	100 hours month)	(1		This experience must include operating room experience.
MSK	200 hours months)	(2		must include a structured sports medicine experience



GYN	100 hours month)	(1 <b>OR</b>	125 patient encounters	dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and options counseling for unintended pregnancy
OB	200 hours months)	(2		dedicated to participating in deliveries and providing prenatal and post-partum care. This experience must include a structured curriculum in prenatal, intra-partum, and post-partum care. Programs should provide an experience in prenatal care, labor management, and delivery management. Some of the maternity experience should include the prenatal, intra-partum, and post-partum care of the same patient in a continuity care relationship.

Procedures (ambulatory and hospital)				<p>The program director and family medicine faculty should develop a list of procedural competencies required for completion by all residents in the program prior to graduation. This list must be based on the anticipated practice needs of all family medicine residents. In creating this list, the faculty should consider the current practices of program graduates, national data regarding procedural care in family medicine, and the needs of the community to be served.</p>
Behavioral Health				<p>The curriculum must be structured so behavioral health is integrated into the residents' total educational experience, to include the physical aspects of patient care. There must be a structured curriculum in which residents are educated in the diagnosis and management of common mental illnesses.</p>

Practice Management	100 hours (1 month) dedicated to health system management experience			<p>There must be a structured curriculum in which residents address population health, including the evaluation of health problems of the community. This curriculum should prepare residents to be active participants and leaders in their practices, their communities, and the profession of medicine. Each resident should be a member of a health system or professional group committee. Residents must receive regular reports of individual and practice productivity, financial performance, and clinical quality, as well as the training needed to analyze these reports. Residents must attend regular FMP business meetings with staff and faculty members to discuss practice-related policies and procedures, business and service goals, and practice efficiency and quality.</p>
Dermatology				<p>Residents must have experience in diagnosing and managing common dermatologic conditions.</p>
Radiology				<p>The curriculum should include diagnostic imaging interpretation and nuclear medicine therapy pertinent to family medicine.</p>

Elective	300 hours months)	(3		
Long-term care facilities				Long-term care experiences must occur over a minimum of 24 months.
Scholarly Activity				The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. Residents should complete two scholarly activities, at least one of which should be a quality improvement project.



**Sample Faculty Curriculum Vitae**

<b>First Name:</b>		<b>MI</b> :	<b>Last Name:</b>	
<b>Present Position:</b>				
<b>Medical School Name:</b>				
<b>Degree Awarded:</b>			<b>Year Completed:</b>	
<b>Graduate Medical Education Program Name(s); include all residency and fellowships:</b>				
<b>Specialty/Field</b>		<b>Year From:</b>		<b>To:</b>
<b>Certification and Re-Certification Information</b>			<b>Current Licensure Data</b>	
<b>Specialty</b>	<b>Certification Year</b>	<b>Re-Certification Year</b>	<b>State</b>	<b>Date of Expiration (mm/yyyy)</b>
<b>Academic Appointments - List the past ten years, beginning with your current position.</b>				
<b>Start Date (mm/yyyy)</b>	<b>End Date (mm/yyyy)</b>	<b>Description of Position(s)</b>		
	Present			
<b>Concise Summary of Role in Program:</b>				
<b>Current Professional Activities/Committees:</b>				
<b>Selected Bibliography - Most representative Peer Reviewed Publications/Journal Articles from the last 5 years (limit of 10):</b>				
<b>Selected Review Articles, Chapters and/or Textbooks (Limit of 10 in the last 5 years):</b>				
<b>Participation in Local, Regional, and National Activities/Presentations - Abstracts (Limit of 10 in the last 5 years):</b>				
<b>If not ABMS board certified, explain equivalent qualifications:</b>				

## Challenges (and Solutions) for Small Programs

FM-RC Requirements – Effective 7-1-2014; Common Program Requirements 7-1-2015

Randall Longenecker MD, Executive Director, The RTT Collaborative

[These solutions have not all been vetted through the RRC, but have been used in at least some settings and have not resulted in a loss of accreditation]

### Program Director and Residency Coordinator

I.A.4. *The sponsoring institution and participating sites must:*

I.A.4.a) *provide at least 70 percent salary support (at least 28 hours per week) for the program director as protected time for administration, evaluation, teaching, resident precepting, and scholarship; and, <sup>(Core)</sup>*

I.A.4.b) *provide support for a full-time residency coordinator and other support personnel required for the operation of the program. <sup>(Detail)</sup>*

The Program Director must:

II.A.4.p) *dedicate at least 70 percent of his or her time, (at least 28 hours per week or 1400 hours per year) to program administration, evaluation, teaching, resident precepting, and scholarship; and, <sup>(Core)</sup>*

II.A.4.p).(1) *Time spent in direct patient care without the presence of residents must not be included in the 1400 hours per year total. <sup>(Detail)</sup>*

Solutions:

1. Alternative track/site of a larger program - PD and Residency Coordinator based at a Core Program
2. Consortium model of aggregated small programs, with a central PD and Residency Coordinator
3. Time studies to document minimum hours per week
4. Maximize 50% precepting rule (be aware, this does not meet the primary care exception under Medicare teaching rules; faculty must see each Medicare or Medicaid patient; also be aware this only counts for 50% time under #2)

### Travel Distance from Participating Sites

I.B.3. *Participating sites should not be at such a distance from the primary clinical site that they require excessive travel time or otherwise fragment the educational experience for residents. <sup>(Detail)</sup>*

Solutions:

1. Define the primary clinical site in such a way as to optimize travel times and minimize fragmentation – e.g. separately accredited Alternative Track vs. an Alternate Site of an accredited program (1-2 RTT vs. “1-2 like” RTT)
2. Liberal use of videoconferencing and telehealth – e.g. alternate sites for presentation of didactics and grand rounds, access specialty teaching from a remote preceptor (ECHO model, eICU, Tele-Stroke, Tele-NICU), smartphone video for remote participation in morning report or for home visit supervision

### Faculty Scholarship

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; <sup>(Detail)</sup>*

- II.B.5.b).(2) *publication of original research or review articles in peer reviewed journals, or chapters in textbooks;* <sup>(Detail)</sup>
- 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,* <sup>(Detail)</sup>
- II.B.5.b).(4) *participation in national committees or educational organizations.* <sup>(Detail)</sup>

Solutions:

1. Participate with residents in a scholarly community of small programs – e.g. The RTT Collaborative for small rural programs; or an osteopathic consortium for osteopathic recognition and research
2. Participate in national or regional database of program characteristics and outcomes, for the purpose of research, documentation of program outcomes for accreditation, and scholarly dissemination

### Teaching Faculty

- 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.* <sup>(Core)</sup>
- 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,* <sup>(Detail)</sup>
- II.B.6.a).(2) *devote the majority of their professional effort to teaching, administration, scholarly activity, and patient care within the program.* <sup>(Detail)</sup>

Solutions:

1. Optimize site directors around clusters of 6 residents – e.g. no more than six residents in an alternate rural track at the rural site, or use multiples of six aggregated over multiple sites in a consortium
2. Time studies to document minimum hours per week
3. Maximize 50% precepting rule, especially with upper level residents (Be aware, this does not meet the primary care exception under Medicare teaching rules; faculty must see each Medicare or Medicaid patient; also be aware this only counts for 50% time under #2)

### Inpatient Family Medicine Faculty (especially pediatrics)

- II.B.7. *All programs must have family medicine physician faculty members providing and teaching care for each of the following: maternity care, including deliveries; inpatient adults; and inpatient children.* <sup>(Core)</sup>

Solutions:

1. Share faculty with these qualifications from larger programs, either as an Alternate Track/Site, a consortium, or an affiliation
2. Ensure that medical staff privileges for family physicians in the small hospital setting includes the inpatient care of newborns and children
3. Rural faculty may be rotated periodically to an urban or other larger site for periods of inpatient care and teaching, both to meet this requirement, maintain clinical skills, and also bring their practice experience to the teaching of residents in the larger program



## Faculty Development

*II.B.11. There must be a structured program of faculty development that involves regularly scheduled faculty development activities designed to enhance the effectiveness of teaching, administration, leadership, scholarship, clinical, and behavioral components of faculty members' performance.* <sup>(Detail)</sup>

Solutions:

1. Become an Alternate Track/Site of a larger program with these resources
2. Negotiate with a regional medical school for these resources, in return for teaching medical students
3. Affiliate with other small programs – e.g. The RTT Collaborative for small rural programs; or an osteopathic consortium for osteopathic recognition and research

## Resident Complement

*III.B.2. The program must offer at least four resident positions at each educational level.* <sup>(Detail)</sup>

*III.B.3. The program should have at least 12 on-duty residents.* <sup>(Detail)</sup>

Solutions:

1. Become an Alternate Track/Site of a larger program
2. Consortium model of aggregated small programs

## Other Learners

*III.D. Appointment of Fellows and Other Learners*

*The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education.* <sup>(Core)</sup>

*III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.* <sup>(Detail)</sup>

Solutions:

1. Take advantage of the economy of small scale in providing Interprofessional patient care and education, by scheduling and supervising multiple learners, directly and indirectly (within the 4:1 precepting rule; remembering the primary care exception only applies to care provided by primary care residents)
2. Have residents supervise learners (enlarging their opportunities to teach, and setting a pattern for subsequent practice and roles as faculty)

## Maternity Care

IV.A.5.a).(1).(c) must demonstrate competence in their ability to provide maternity care, including: <sup>(Outcome)</sup>

IV.A.5.a).(1).(c).(i) distinguishing abnormal and normal pregnancies; <sup>(Outcome)</sup>

IV.A.5.a).(1).(c).(ii) caring for common medical problems arising from pregnancy or coexisting with pregnancy; <sup>(Outcome)</sup>

IV.A.5.a).(1).(c).(iii) performing a spontaneous vaginal delivery; and, <sup>(Outcome)</sup>

IV.A.5.a).(1).(c).(iv) demonstrating basic skills in managing obstetrical emergencies.  
(Outcome)

Solutions:

1. Engage in “shared care” with providers in a regional birth facility
2. ALSO Courses – Conducted in whole, or in part in the smaller community setting (e.g. full day in each)

### **Procedural Training**

IV.A.5.a).(2) *Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents:* (Outcome)

IV.A.5.a).(2).(a) *must appropriately use and perform diagnostic and therapeutic procedures.* (Outcome)

Solutions:

1. Use longitudinal curricular strategies, using either partial or full days over time
2. Create immersion experiences in large volume settings – e.g. one day out of a week, one week out of a month, or one month in a high volume setting

### **Spectrum of Care and Numbers of Patients**

IV.A.6.a).(2) *Experiences in the FMP must include acute care, chronic care, and wellness care for patients of all ages.* (Core)

IV.A.6.a).(5) Residents must provide care for a minimum of 1650 in-person patient encounters in the FMP site. (Core)

IV.A.6.a).(5).(a) The majority of these visits must occur in the resident’s primary FMP site. (Detail)

Solutions:

1. May use other sites, if numbers cannot be met in any one location, as long as the experience represents continuing care of patients in those multiple settings – e.g. prenatal care of continuity patients and others in a CHC setting
2. Aggregate FMP sites into a single entity, with multiple locations – e.g. CHC network
3. Most of the requirements for numbers and types of patients, except for the 1650 continuity patients and several minimums, can be met either as numbers or hours, and these can/should be tracked longitudinally

### **Clinical Competency Committee**

V.A.1. The program director must appoint the Clinical Competency Committee. (Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

Solutions:

1. These faculty do not need to be Core Faculty
2. Become an Alternate Track/Site of a larger program

3. Consortium model of aggregated small programs

### **Confidentiality of Evaluations**

- V.B.3. This evaluation must include at least annual written confidential evaluations by the residents. *(Detail)*

Solutions:

1. This is difficult to truly implement in a small program but needs to be maintained when at all possible. Evaluations of faculty can be aggregated on a multiple year rolling basis and/or delivered less than annually. However, it can be argued that providing feedback in a small residency setting is excellent training for the role of peer review in small practice settings in the future, where there will likely be a power differential between junior and senior clinicians. Residents should be encouraged to give, and faculty encouraged to receive direct feedback. Another option is to do this indirectly in a group setting, e.g. in the GMEC, with other faculty and resident support. Professional issues in particular require group validation and support.
2. Ensure confidential reporting to an external entity – e.g. access to the PD at the main program in an Alternate Track, the DIO of a consortium, or to another large residency program as a contract for such services

### **Program Evaluation and Improvement**

- V.C.1. The program director must appoint the Program Evaluation Committee (PEC).  
*(Core)*

- V.C.1.a) The Program Evaluation Committee:

- V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; *(Core)*

Solutions:

1. In a small program, there is no reason to have this be anything other than a “committee of the whole,” involving all residents and core and some volunteer faculty. This can be an annual event with an action plan as the deliverable.

### **Board Passage Rate and Other Percentages**

- V.C.5. At least 90 percent of a program’s graduates from the preceding five years who take the ABFM certifying examination for family medicine for the first time must pass. *(Outcome)*

- V.C.7.a) Over a five-year period, program attrition should not exceed 15 percent. *(Detail)*

Solutions:

1. This represents a statistical challenge for small programs, and the FM-RC has been steadfast in resisting any flexibility. It is important to remember that even a citation in this area is not a deal breaker and doesn’t necessarily place a program on probation. It does, however, place the program under greater scrutiny.

Here is where it is important to have statistics on your side. Know the confidence intervals for numbers of residents in small programs, and if a single resident was indeed an outlier, it helps if the average scores of the remaining residents were at or above the national average.

Use EXCEL to calculate confidence intervals:

<https://www.youtube.com/watch?v=sigx4PbqJ6s> (Accessed 1-3-2015)

See attached EXCEL template

## Duty Hours and Call

### VI.G.8. *At-Home Call*

VI.G.8.a) *Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.* <sup>(Core)</sup>

VI.G.8.a).(1) *At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.* <sup>(Core)</sup>

VI.G.8.b) *Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".* <sup>(Detail)</sup>

### Solutions:

1. Home call and faculty call without a resident are strategies to meet the duty hour requirements in a small program with a limited number of residents; however, since in-hospital duty must count toward the 80 limit, it may be necessary and prudent to document clock-in/clock-out, particularly if home call is moderate to heavy.
2. "Rolling jeopardy" can be used to trigger a post-call exception, in which case, a certain threshold of in-hospital duty (e.g. 4 hours) can trigger cancellation/reassignment of resident duties the following day.
3. Another option is to have a liberal "nap" policy, in which the resident (or supervising faculty) is responsible to make a judgment to remove themselves (or remove the resident) from active patient care responsibility and reassign duties to faculty or another resident.

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**Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

**Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

**Outcome Requirements:** Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

## The OSU Rural Program – Three Year Curriculum

Intensive immersion experiences embedded in a continuing rural practice

1	2	3	4	5	6	7	8	9	10	11	12	13
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### YEAR 1

Hospital Care (Shared)	Hospital Care	Pediatrics Inpatient	Hospital Care (NRP)	Special Care Nursery	OB – Newborn	Hospital Care	Cardiology	Hospital Care (Wound Healing)	MICU	Hospital Care (ATLS)	Peds ER	Scholarly Activity (Shared)
MRH	MRH	CHC	MRH	OSUH	MRH	MRH	OSUH	MRH	OSUH	MRH	CHC	MRH
<b>Mad River Family Practice -- Periodic office patient care, daily hospital rounds</b>												
2 Half-days	2 Half-days	1 Half-day	2 Half-days	1 Half-day	2 Half-days	1 Half-day		2 Half-days	1 Half-day	2 Half-days	1 Half-day	3 Half-days

### YEAR 2

Ambulatory Cardiology	Elective	OB - Newborn	OB – Newborn (High Risk Immersion)	Derma-tology	Pediatrics Outpatient	ICU – Intern Med	Orthopedics	Medical Sub - specialty	Elective	GYN
MRH/Offic		MRH	MRH	Office	Office	MRH	MRH/Office	MRH/Office		Office
<b>Mad River Family Practice -- Periodic office patient care, daily hospital rounds Scholarly Activity and Community Medicine</b>										
4 Office Half-days	0-4 Half-days	2 Half-days	2 Half-days	4 Half-days	2 Half-days	8 Half-days one week None the next	4 half-days	4 Half-days	0-4 Half-days	3 Half-days

### YEAR 3

Elective	Geriatrics, Physical Medicine, and Psychiatry	GYN	Elective	Surgical Subspecialiies – Ophthalmology, ENT, Urology, Podiatry	Elective	Sports Medicine	Elective	Medical Sub - specialty
	Office	Office		Office		OSU Sports Ctr		MRH/Office
<b>Mad River Family Practice -- Periodic office patient care, daily hospital rounds Practice Management and Community Intervention</b>								
0-4 Half-days	5 Office Half-days	4 Half-days	0-4 Half-days	5 Office Half-days	0-4 Half-days	4 Half-days	0-4 Half-days	0-4 Half-days

[Gray shaded rotations occur at least in part in Columbus, Ohio]

## References:

### Community Engaged Medical Education

*Cairns consensus statement on rural generalist medicine*. 2015 World Summit: Rural Generalist Medicine; 2015 Apr. 8–9; Montréal. Available: [www.ruralgeneralismsummit.net/cairns-consensus-statement-on-rural-generalist-medicine](http://www.ruralgeneralismsummit.net/cairns-consensus-statement-on-rural-generalist-medicine) (accessed 2015 May 21).

Strasser R; Worley P; Cristobal F; Marsh DC; Berry S; Strasser S; Ellaway R. "Putting Communities in the Driver's Seat: The Realities of Community-Engaged Medical Education," *Academic Medicine*, Published ahead of print, May 2015.  
[http://www.researchgate.net/profile/Rachel\\_Ellaway2](http://www.researchgate.net/profile/Rachel_Ellaway2)

Strasser R, Hogenbirk JC, Minore B, et al. Transforming health professional education through social accountability: Canada's Northern Ontario School of Medicine. *Med Teach* 2013; 35:490-6.

Strasser R. Social accountability and the supply of physicians for remote rural Canada, *CMAJ*, August 11, 2015, 187(11) 791-2

*Tesson G; Hudson G; Strasser R; Hunt D, Editors. The Making of the Northern Ontario School of Medicine: A Case Study in the History of Medical Education*. Montreal/Kingston: McGill-Queen's University Press, 2009.

### Place-Based Medical Education

Cutchin M. "Physician Retention in Rural Communities: The perspective of experiential place integration," *Health & Place* 1997; 3(1):25-31.

Gruenewald DA, Smith GA. Place-based education in the global age: Local diversity, New York: Lawrence Erlbaum Associates; 2008.

Hancock C; Steinbach A; Nesbitt TS; Adler SR; Auerswald CL. "Why doctors choose small towns: A developmental model of rural physician recruitment and retention," *Social Science & Medicine* 2009; 69:1368–76.

Longenecker R. "Curricular Design: A Place-Based Strategy for Rural Medical Education," in Bell E; Zimmitat C; Merritt J Eds. *Rural Medical Education: Practical Strategies*, New York: Nova Science, 2011.

Longenecker R. "Sustaining Engagement and Rural Scholarship," *J of Higher Education Outreach and Engagement*, Fall 2002/Winter 2003; 8(1):87-97.

### Rural Medical Education and Rural Training Tracks: History

Maudlin RK; Newkirk GR. Family Medicine Spokane Rural Training Track: 24 Years of Rural-based Graduate Medical Education, *Fam Med* 2010;42(10):723-8.

Rural health: a challenge for medical education. Proceedings of the 1990 invitational symposium. San Antonio, Texas, February 1-3, 1990. Proceedings. Supplement Article in *Academic Medicine* December 1990. 65(12): S1-126.

Rural-based Graduate Medical Education: A Workshop. Proceedings of a conference. February 16-18, 2000. San Antonio, Texas, USA. Theme issue of *J Rural Health* Summer 2000; 16(3):196-306.

## Rural Medical Education and Rural Training Tracks: Other

- Bazemore, A., Bennett, K., Doodoo, M. S., Legagneur, C., Petterson, S., ... & Xierali, I. (2009). Specialty and Geographic Distribution of the Physician Workforce--What Influences Medical Student and Resident Choices?. Robert Graham Center.
- Chan BT; Degani N; Crichton T; Pong RW; Rourke JT; Goertzen J; McCready B. Duration of rural training during residency: rural family physicians prefer 6 months. *Can Fam Physician*, February 2006; 52:210-1.
- Chen C; Xierali I; Piwnica-Worms K; Phillips R. The Redistribution Of Graduate Medical Education Positions In 2005 Failed To Boost Primary Care Or Rural Training, *Health Affairs*, 32, no.1 (2013):102-110.
- DeWitt DE; Migeon M; LeBlond R; Carline JD; Francis L; Irby DM. Insights from outstanding rural internal medicine residency rotations at the University of Washington, *Acad Med* March 2001; 76(3):273-81.
- Fordyce, M., Doescher, M., Chen, F., & Hart, G. (2012). Osteopathic physicians and international medical graduates in the rural primary care physician workforce. *Family Medicine-Kansas City*, 44(6), 396.
- Pathman, D. E., Williams, E. S. and Konrad, T. R. (1996), Rural Physician Satisfaction: Its Sources and Relationship to Retention. *The Journal of Rural Health*, 12: 366-377.
- Patterson, D., Longenecker, R., Schmitz, D., Phillips R., Skillman, S. Doescher, M. (2013), Rural Residency Training for Family Medicine Physicians: Graduate Early-Career Outcomes, 2008-2012 (Policy Brief).
- Petterson, S., Liaw, W., Phillips, R., Rabin, D., Meyers, D., & Bazemore, A. (2012). Projecting US primary care physician workforce needs: 2010-2025. *The Annals of Family Medicine*, 10(6), 503-509.
- Schmitz D. "Graduate Medical Education for Rural Practice," A joint statement of the National Rural Health Association and the American Academy of Family Physicians, revised and updated November 2013 from July 2008.  
<http://www.aafp.org/about/policies/all/rural-practice.html>
- Xierali, I. M., Sweeney, S. A., Phillips, R. L., Bazemore, A. W., & Petterson, S. M. (2012). Increasing Graduate Medical Education (GME) in Critical Access Hospitals (CAH) Could Enhance Physician Recruitment and Retention in Rural America. *The Journal of the American Board of Family Medicine*, 25(1), 7-8.

## Rural Medical Education and Rural Training Tracks: Online

### RTT Technical Assistance Program

Rural Assistance Center page for this federally funded consortium of organizations and individuals devoted to sustaining RTTs as a strategy in rural medical education (Funded through August 2016):

<http://www.raonline.org/rtt/>

- Policy briefs:  
<http://www.raonline.org/rtt/policy.php>
- Medical student page:  
<http://www.traindocsrural.org/>

**The RTT Collaborative** is a board directed cooperative of participating programs and individuals committed to sustaining health professions education in rural places.

<http://www.rttcollaborative.net>

- Annual Meeting Downloads 2015  
<http://rttcollaborative.net/annual-meeting/>

### **National Organization of State Offices of Rural Health (NOSORH)**

Webinar slide sets regarding RTTs can be found at:

<http://www.nosorh.org/news/webinars.php>

Here is a very recent presentation regarding RTTs at the NOSORH Rural Health Summit in Portland, Oregon

- “Rural Training Tracks” – Longenecker, Schmitz, Patterson, September 2015  
<https://nosorh.org/wp-content/uploads/2015/08/Rural-Training-Tracks-9-1-2015-R.-Longenecker-D.-Schmitz-D.-Patterson.pdf>

### **Association of American Medical Colleges**

The AAMC provides resources to help members better understand and make use of the pathways available to engage in rural training. Developed in collaboration with others, including The RTT Collaborative's Executive Director Dr. Longenecker, this free PDF explains the intricacies of current Medicare funding for rural training tracks.

<https://members.aamc.org/eweb/upload/Rural%20Training%20Track%20Programs%20-%20A%20Guide%20to%20the%20Medicare%20Requirements.pdf>

Becoming a New Teaching Hospital: A Guide to Medicare Requirements 2014 (PDF) is available to members and to others for a \$100 fee.

[https://members.aamc.org/eweb/DynamicPage.aspx?Action=Add&ObjectKeyFrom=1A83491A-9853-4C87-86A4-F7D95601C2E2&WebCode=PubDetailAdd&DoNotSave=yes&ParentObject=CentralizedOrderEntry&ParentDataObject=Invoice%20Detail&ivd\\_formkey=69202792-63d7-4ba2-bf4e-a0da41270555&ivd\\_cst\\_key=00000000-0000-0000-0000-000000000000&ivd\\_prc\\_key=6FBD7EB0-40FB-4B60-838E-7ED61F541E4F](https://members.aamc.org/eweb/DynamicPage.aspx?Action=Add&ObjectKeyFrom=1A83491A-9853-4C87-86A4-F7D95601C2E2&WebCode=PubDetailAdd&DoNotSave=yes&ParentObject=CentralizedOrderEntry&ParentDataObject=Invoice%20Detail&ivd_formkey=69202792-63d7-4ba2-bf4e-a0da41270555&ivd_cst_key=00000000-0000-0000-0000-000000000000&ivd_prc_key=6FBD7EB0-40FB-4B60-838E-7ED61F541E4F)

## **Definitions of Rural**

### **Rural Assistance Center**

Am I Rural? – Geocoding tool and discussion of rural definitions, including links to the USDA Economic Research Service

<https://www.raonline.org/amirural>

### **WWAMI Rural Health Research Center**

For information regarding definitions of rural: “Rural Urban Commuting Area (RUCA) codes”. [http://depts.washington.edu/uwruca/\(depts.washington.edu\)](http://depts.washington.edu/uwruca/(depts.washington.edu)).