Rural Program Development: An Overview

RANDALL LONGENECKER MD

EXECUTIVE DIRECTOR

THE RTT COLLABORATIVE

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The RTT Collaborative

in rural health professions education and training

Growing our own...together

A rural health professions education network and a cooperative extension service

“a community of practice”

http://www.rttcollaborative.net

Rural Program - Definition

An accredited residency program in which residents spend the majority of their time training (more than 50%, as reported to CMS and/or HRSA) in a rural place. The location of a rural program in Family Medicine is defined by the geographic location of the primary Family Medicine Practice (FMP) where residents meet the ABFM requirement for 24 months continuing practice.

CMS FY2004 regulations defining an integrated rural training track, Department of Health and Human Services, Center for Medicare and Medicaid Services. *Federal Register* August 2003; http://edocket.access.gpo.gov/2003/pdf/03-19363.pdf (Accessed 6-16-2016)

Am I Rural? A web-based tool using federal definitions that are regularly updated and hosted by the RHI hub in the North Dakota Center for Rural Health, https://www.ruralhealthinfo.org/am-i-rural. (Accessed August 1, 2016)

United States Department of Agriculture Economic Research Service Rural Classifications http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications.aspx. (Accessed August 1, 2016)

Integrated Rural Training Track (I-RTT):

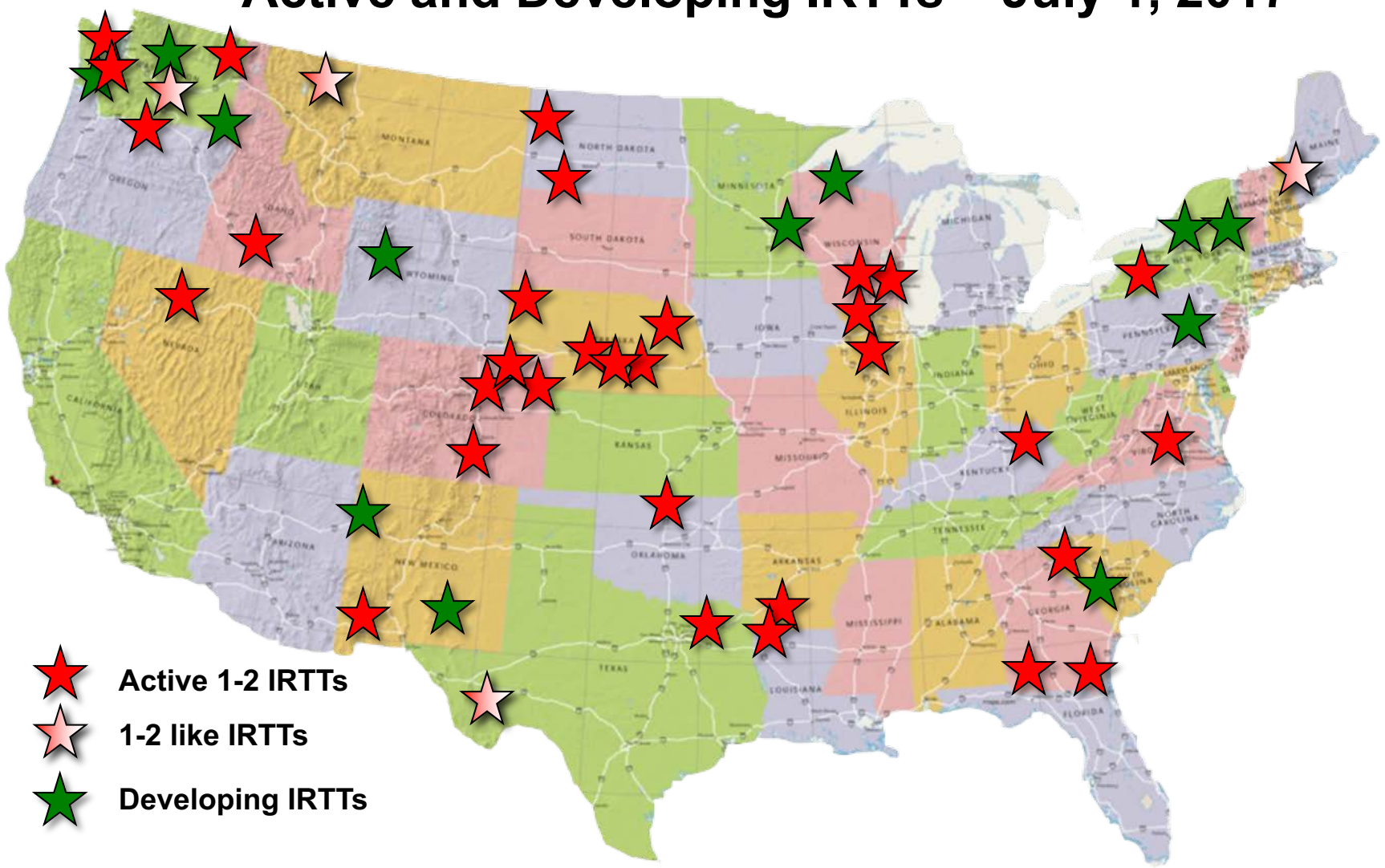
A **rural program** that is **separately accredited** and because of its generally smaller size is **substantially integrated** with a larger, often more urban residency program:

- **I** ntegrated in a substantive way
- **R** urally located and rurally focused
- Engaged in **T** raining and/or education – residency +/- medical school experiences
- A **T** rack or pathway – deliberately structured over at least 2-3 years in family medicine, including a 24-month continuity practice in a rural location (often in the 1-2 format)

Substantial Integration

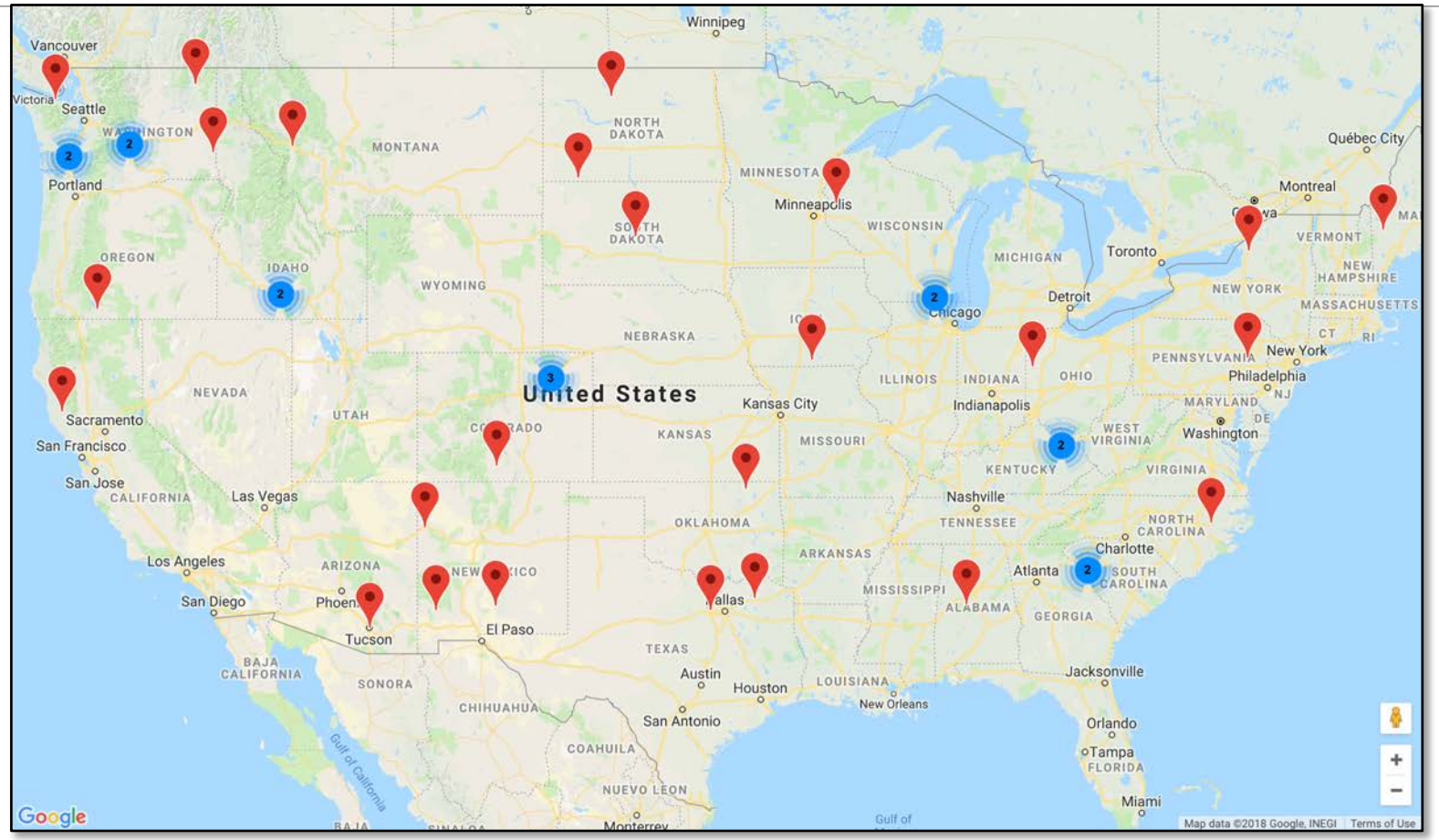
- Structured interaction among the residents of both the RTT and the larger affiliated program,
- Some sharing of faculty and/or a shared program director,
- Shared didactics and/or scholarly activity, and
- at least 4 months of structured curriculum shared by residents of both programs.

Active and Developing IRTTs – July 1, 2017

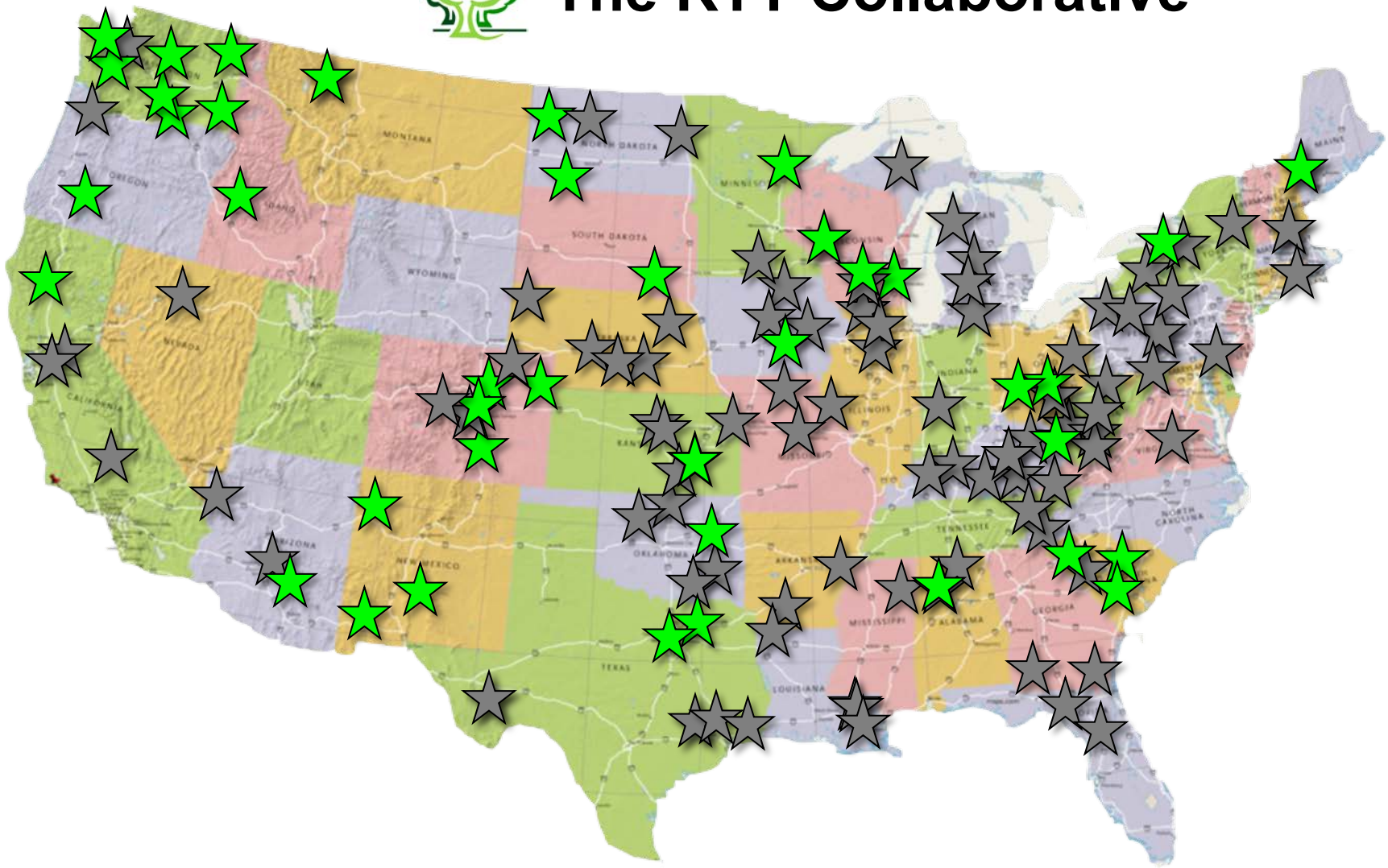


Updated as of 7-1-2017, Randall Longenecker, Executive Director, The RTT Collaborative

Our Participating Programs



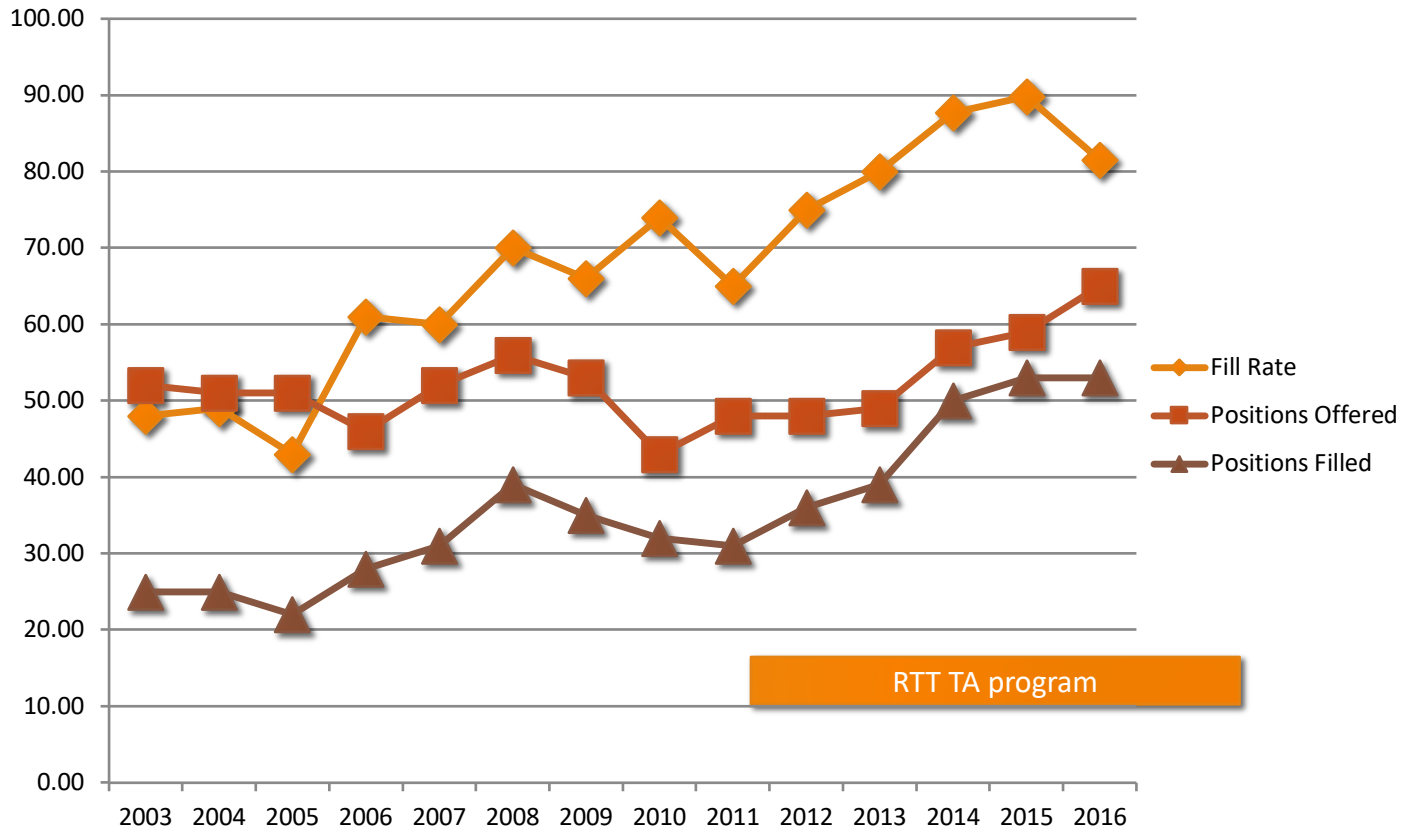
The RTT Collaborative



Participating program (Updated April 2018)

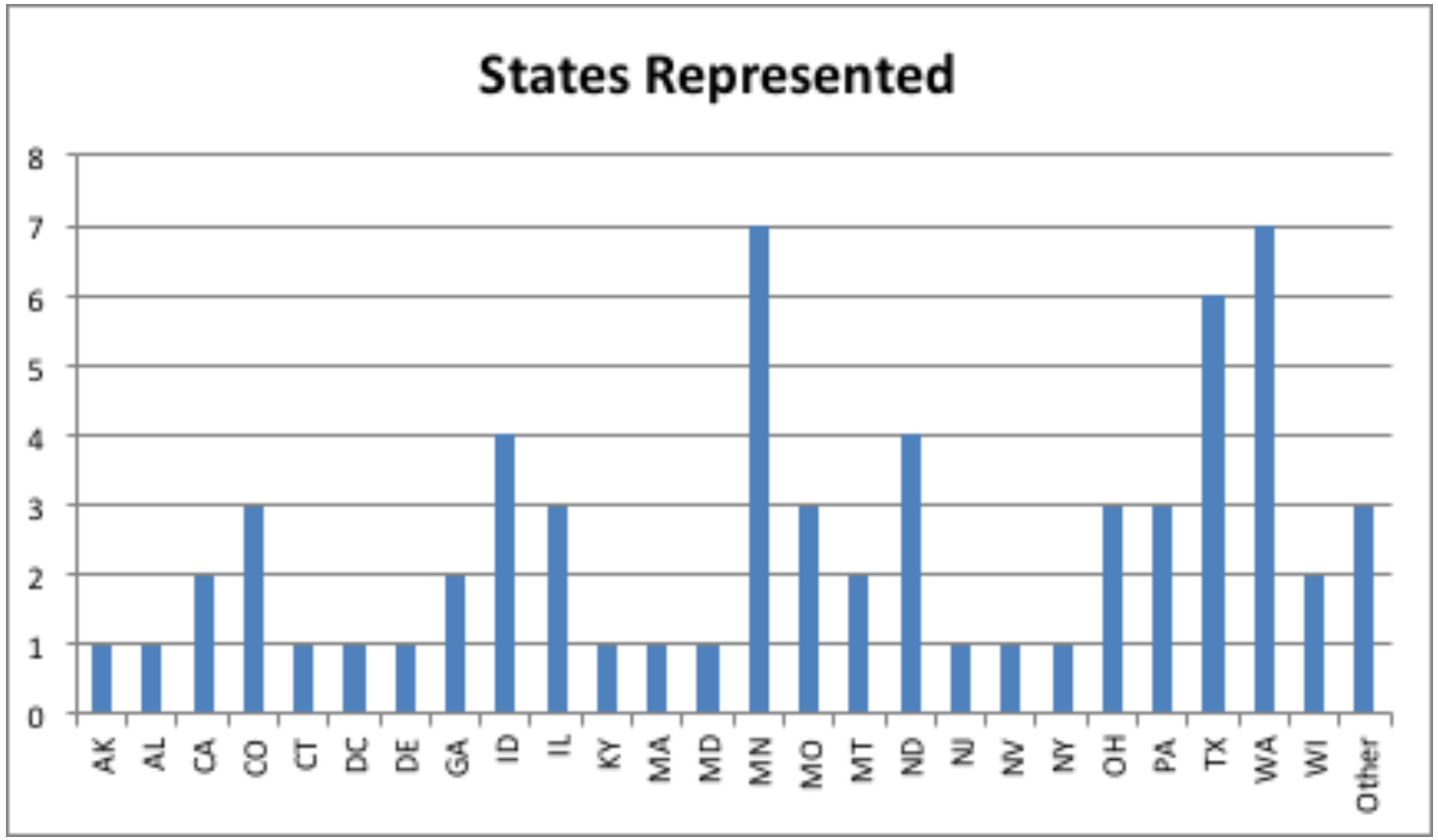
RTTC 2017-2018

1-2 RTT Match Trends 2003-2016



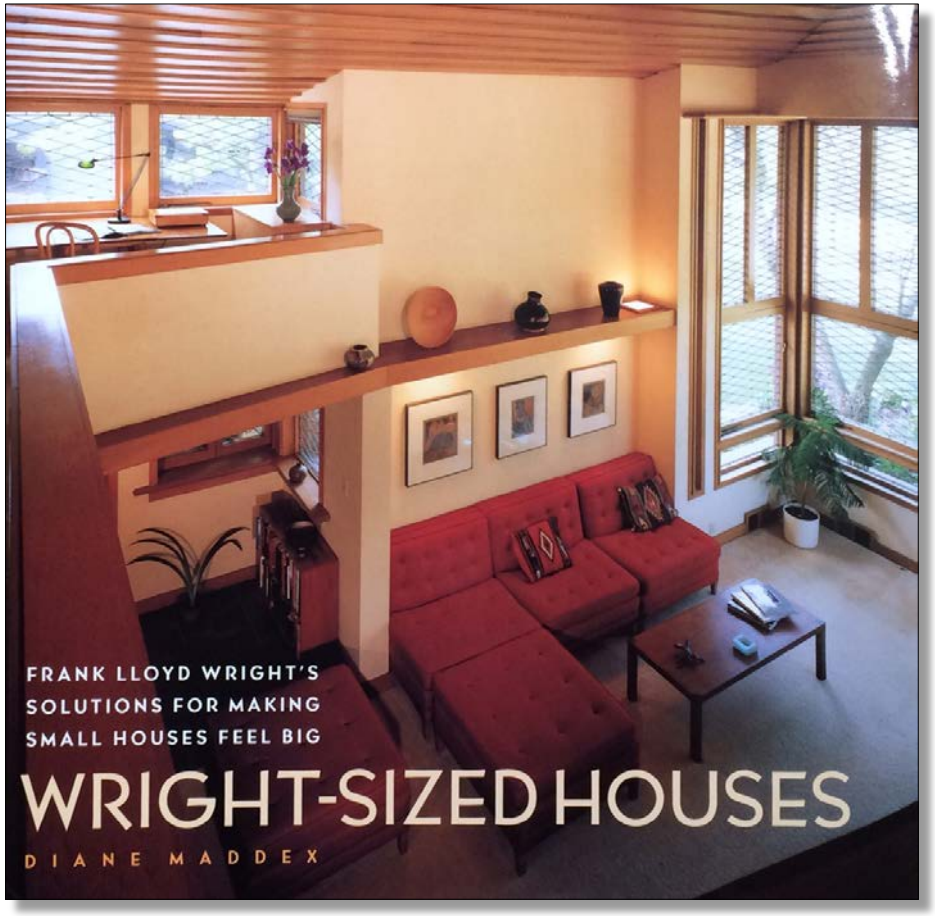
Source: Personal communication from Randall Longenecker MD, Senior Project Advisor, the RTT Technical Assistance Program, March 22, 2016; revised May 23, 2016

AAFP National Conference – Rural Interest

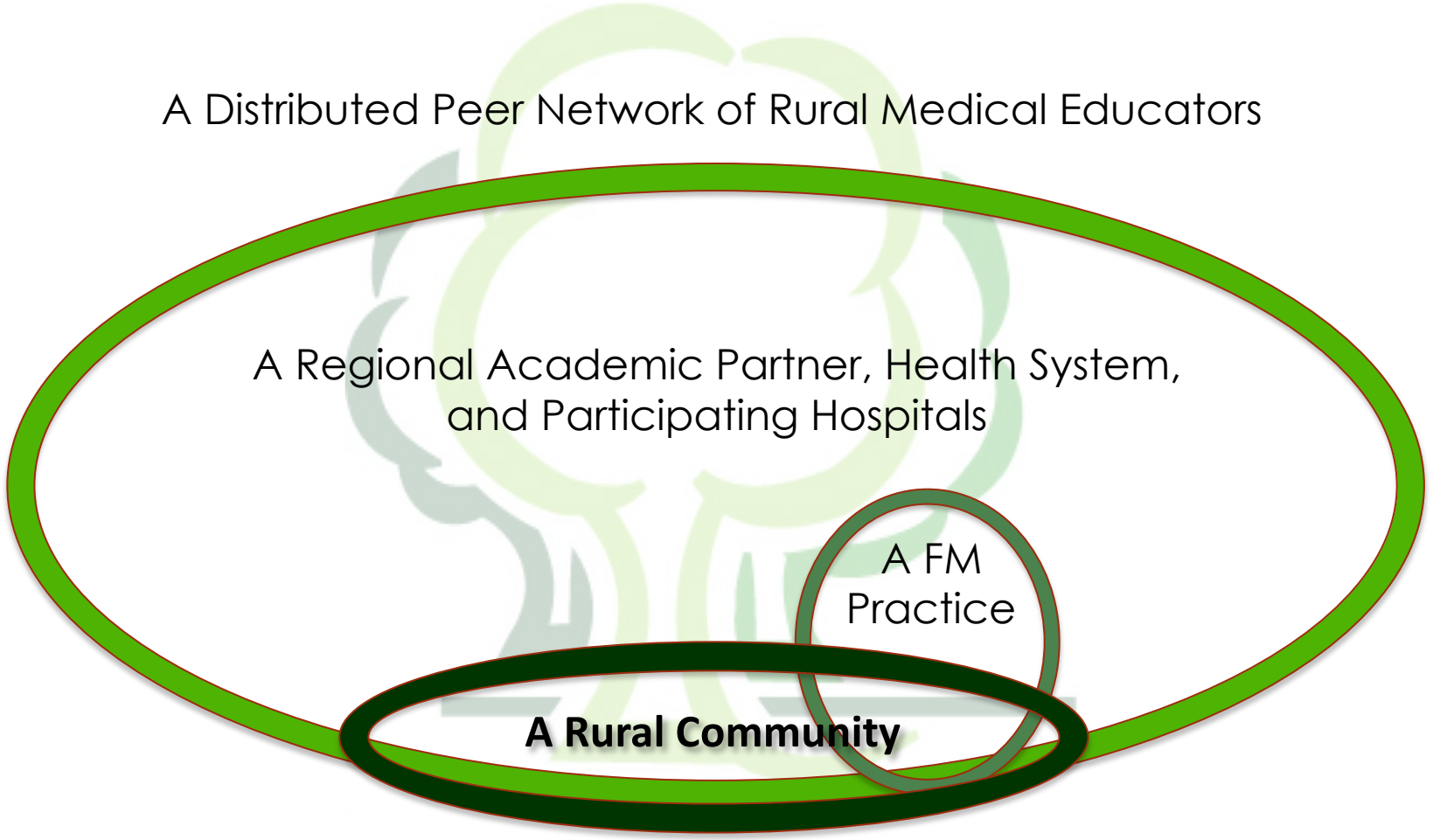


65 individual student contacts through booth visits or student breakfast

An Organic Approach



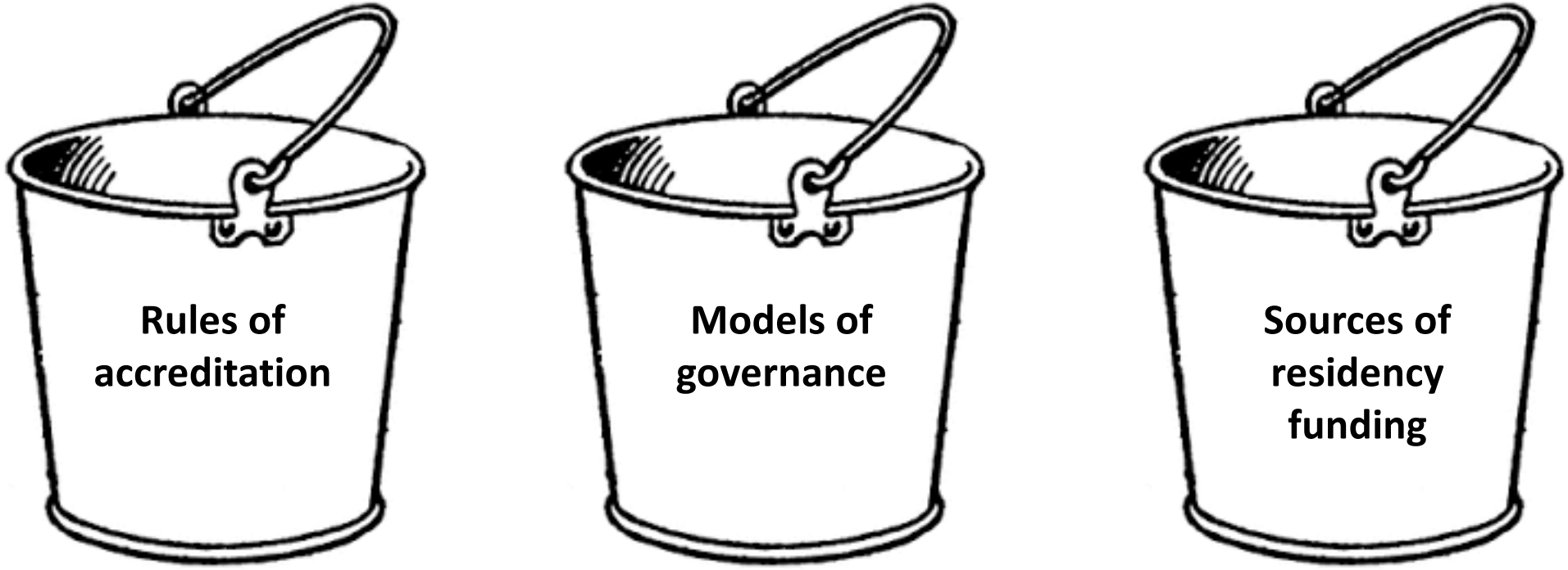
ACGME Accreditation, GME Finance, US Healthcare System



Community Engaged Residency Education

Designing a Sustainable Program

Creatively build upon community assets using:



Community Assets and Capacity

Designing a Sustainable Program

Community Assets and Capacity

Timeline for Development

Sample GME Project Management/Timeline

	2017		2018				2019				2020	
	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q	3rd Q	4th Q	1st Q	2nd Q
Review standards for programs under consideration												
Develop standard curriculums that can be used as a baseline for rotations												
Identify locations where residents will be deployed to meet program requirements												
Draft agreements for rotations to other sites (PLA)												
Draft program information forms for each of the programs to be pursued												
Submit applications to accrediting body												
ACGME Site Visit												
Receipt of initial accreditation												
Program start date											7-2019	

Present draft financials to FI and request rate setting be made to accommodate GME cash flow

What about the money?

Questions?

Randall Longenecker MD
Executive Director, The RTT Collaborative
Professor of Family Medicine
Assistant Dean Rural and Underserved Programs
Ohio University Heritage College of Osteopathic Medicine
Irvine Hall 126, 1 Ohio University, Athens, Ohio 45701
740-597-3058
longenec@ohio.edu

OHIO UNIVERSITY Heritage College of Osteopathic Medicine

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Addendum Slides

An Organic Approach

Starts with a rural place and it's assets

Uses various models, options for program design, modified rather than imposed upon the local context (organic medical education)

Follows a developmental process that is community engaged, i.e. Community Engaged Residency Education in Rural Places (CERE-R)

Basic principles

Join the community - establish a relationship

Begin with the community’s assets and build from there

Set a clear vision and a specific task

Collaborate for mutual benefit

CERE-R: Rural Residency Capacity and Sustainability Assessment

Define the community

Engage the community

Determine assets & capacity

Design for accreditation

Build for sustainability

All at the same time!

Community Engaged Residency Education (CERE-R)

1) Engage the Community – Coalition building, following “rules of engagement” (like motivational interviewing in patient care: Pre-contemplation, Contemplation, Preparation, Action)

Community Engaged Residency Education (CERE-R)

2) Determine Community Capacity – Helpful tools, Consultations
   a. Template for Exploring Community Assets/Challenges
   b. Capacity Inventory of Existing and Potential Resources
   c. Crosswalk: Concept Mapping

Community Engaged Residency Education (CERE-R)

3) Design the program and curriculum for the purpose of accreditation and education
   a. Accreditation Guide
   b. Sample timeline
   c. Requirements Crosswalk

Community Engaged Residency Education (CERE-R)

3) Design the program and curriculum for the purpose of accreditation and education
   d. Faculty roster
   e. Challenges and solutions
   f. Sample curriculum

Community Engaged Residency Education (CERE-R)

4) Develop a business plan – pro formas, affiliations, letters of commitment, contracts, and other agreements

Community Engaged Residency Education (CERE-R)

Define the community

Engage the community

Determine assets & capacity

Design for accreditation

Build for sustainability

All at the same time!

Community Engaged Residency Education (CERE-R)

CERE-R was developed by Drs. Longenecker and Schmitz, 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 Consortium, in a cooperative agreement with HRSA's Federal Office of Rural Health Policy.

Questions?

References

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.

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 2015 Nov;90(11):1466-70.

Community Engaged Residency Education for Rural Places (CERE-R) http://rttcollaborative.net/wp-content/uploads/2015/11/CERE-R-11-6-2015.pdf