Placing TREES in Rural Places
Training and Rural Health professions Education that is community Engaged and Sustainable
January 2019

Randall Longenecker MD, Executive Director, The RTT Collaborative
David Schmitz MD, Associate Director for Research and Development

Initially developed in collaboration with Western Montana Family Medicine Residency in 2015 and funded in part by a HRSA Residency Training in Primary Care grant #DSHP23226 and the RTT Technical Assistance Program cooperative agreement #1 UA9 RH 2607-01-00 for the years 2010-2016. Revisions are now the responsibility of The RTT Collaborative.

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, together meeting 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.

Randall Longenecker 2015

Background

This packet outlines a process for academic-community engagement and collaborative decision-making. It was developed by Randall Longenecker MD and David Schmitz MD in collaboration with Family Medicine Residency of Western Montana in 2015 and initially funded by a HRSA Residency Training in Primary Care grant and the RTT Technical Assistance program grant. Initially called “CERE-R” it has been renamed “TREES” for Training and Rural health professions Education that is community Engaged and Sustainable. This current edition reflects modifications in use by The RTT Collaborative with rural communities over the past three years.

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.1,2 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.3 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 benefit of both community and learners

Such an approach parallels the approach taken by proponents of place-based education.4,5 Organic design of a place-based education starts with what is local (assets as well as challenges) and builds from there. It modifies and uses bits and pieces of many educational frameworks, rather than imposing any one model. It embraces the importance of context in education and training, as much as its content.6 Place-based approaches are framed around the assumption, now anchored in a growing

3 Strasser R; Worley P; Cristobal F; Marsh DC; Berry S; Strasser S; Blaway R. “Putting Communities in the Driver’s Seat: The Realities of Community-Engaged Medical Education,” Academic Medicine, November 2015;90(11):1466-70.
body of evidence, that learning to live well as a physician in a rural place is critical to the professional development, recruitment, and retention of rural physicians.\textsuperscript{7,8} Engaged communities of rural people and rural medical educators are in the best position to facilitate that kind of learning.

Community engaged residency education (graduate medical education or GME) was a new term introduced into medical education through this document. Although this package of tools is situated in the specialty of family medicine, it outlines a process that in concept can be applied to other ACGME accredited specialties and even other disciplines (e.g. nurse practitioners). The prototypical models of GME 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\textsuperscript{9}
2. Separately accredited integrated rural training tracks (IRTT), including rural programs in the 1-2 format (the prototypical “1-2 RTT”), where residents spend >50% of their time training in a rural location\textsuperscript{10}
3. Rural pathways, or areas of concentration designed within separately accredited, much larger, and urban programs (“IRTT-like”), with 24 months or more of continuity practice in a rural place, as well as rural pathways with longitudinal or cumulative rural experience of lesser duration\textsuperscript{11}
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 >35% of residency graduates in a rural initial place of practice (as calculated from a 3-year rolling average)

The basic requirements for accreditation and finance can be met in a variety of ways by creatively choosing elements of each of the above options for rural training and designing a program appropriately sized to the local community. Thresholds for development and implementation of a program are generally dictated by 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). These thresholds are best addressed through a careful capacity inventory of rural community resources and partnerships with other institutions. Thoroughly understanding the rules that govern accreditation and finance, and paying attention to sustainable governance, are essential to this task.

Some communities, in spite of capacity, will choose a way forward based upon a preferred style or scale rather than simply going by the numbers. And some communities may not wish to expend their full capacity for health profession education on training physicians in particular. Others 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 professional faculty. Healthy communities are generally “learning communities,” communities eager to learn and improve and who embrace health professions education and training as contributing to their community’s health — “growing (their) own” health professionals, in whichever sector a community chooses.

Finally, residency design with an eye to sustainability has as much to do with the indirect benefits to rural communities in the long-term as it does with a financial pro forma in the short-term.\textsuperscript{12}

\textsuperscript{7} Hancock C; Steinbach A; Nesbitt TS; Adler SR; Auerswald CL. “Why doctors choose small towns: A developmental model of rural physician recruitment and retention,” \textit{Social Science & Medicine} 2009; 69:1368–76.
\textsuperscript{9} Using at least 2 federal definitions from Am I Rural? \url{https://www.ruralhealthinfo.org/am-i-rural} (Accessed 9-29-2017)
\textsuperscript{11} Evans D; Patterson D; Andruilla CH; Schmitz D; Longenecker R. Do Residencies that Aim to Produce Rural Family Physicians Offer Relevant Training? \textit{Fam Med} 2016;48(8):596–602.
Although difficult to measure, indirect benefits to both hospital and community have been estimated to be quite substantial, including:

- Reduced recruiting costs (estimated at $100,000 per primary care physician)\textsuperscript{13,14,15}
- Enhanced recruitment of both family physician faculty and specialty physicians who wish to teach
- Enhanced retention of both family physician faculty and specialty physicians who wish to teach (replacement costs for a primary care physician is estimated at $250,000 or more, and is generally greater for sub-specialty physicians)
- "Contribution margin" and downstream revenue to hospitals (although difficult to quantify directly, many hospitals use this calculation in budgeting)
- Leadership development of existing medical staff
- Improved quality of care (Direct involvement of faculty and residents in quality efforts, indirect effect of a learning culture)
- Reputation as a teaching hospital
- Increased primary care clinical capacity and community access to care
- Other health professions education and training (a graduate medical education infrastructure becomes the framework for an interprofessional campus of learners)
- Economic benefit to the community (Every faculty physician or resident recruited or retained has been shown to lead to $1-2 million in economic benefit to the community annually, particularly for those family physicians who practice obstetrics.\textsuperscript{16,17}
- Community leadership by physicians and their families (many family physicians wear hats in their community outside medicine)
- Civic engagement by both faculty and residents and their families
- Creativity and innovation

Although the costs of physician education are substantial and can be predicted with some certainty, the benefits are not as easily counted. In developing the value proposition for a new residency program, these future benefits should not be predicated upon assumptions from the past that may not be relevant to the future. They should not only be calculated in terms of short-term economic benefit to the hospital alone, but rather in terms of direct and indirect benefits to the community as a whole.\textsuperscript{18} Included in this package is a tool that allows any community to choose its own assumptions to arrive at an estimated community impact specific to that community.

**The process**

The process of community engaged GME begins with identifying a rural place and proposing that community as a site for health professions education and training. [Am I Rural?](http://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention) is a good place to start, since this website not only identifies a specific street address as rural by several federally recognized definitions, but also characterizes an address, zip code or census tract as to its underserved status (HPSA, MUA/P). Once a rural place is identified (preferably by several

\textsuperscript{13} Recruitment and Retention for Rural Health Facilities [https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention](https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention) (Accessed 1-18-2019)


\textsuperscript{17} Avery DM; Hooper DE; McDonald JT; Love MW; Tucker MT; Parton JM. The Economic Impact of Rural Family Physicians Practicing Obstetrics, J Am Board Fam Med 2014; 27:602-610.

\textsuperscript{18} Pugno PA; Gillanders WR; Kozakowski SM. The Direct, Indirect, and Intangible Benefits of Graduate Medical Education Programs to Their Sponsoring Institutions and Communities. Journal of Graduate Medical Education: June 2010, 2(2):154-159. [https://doi.org/10.4300/JGME-D-09-00083](https://doi.org/10.4300/JGME-D-09-00083) (Accessed 9-29-2017)
administrative and physician leaders, rural and urban, conspiring together), program design can proceed in the following fashion:

1. Engage with the Community
   a. Build a coalition, following "rules of engagement"
      i. Purposed for the health, development and improvement of the community
      ii. Characterized by respect for autonomy
      iii. Built upon community assets and within the limits of community resources
      iv. Deployed with transparency and meaningful and respectful partnerships
      v. Integrated from multiple societal, institutional, program and individual perspectives, but all within the context of the local community
   b. Identify the community’s readiness for change (as for 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 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 either STFM or AFMRD 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)
      Consult with experienced local, regional or national peers and experts (engage the rural medical education community) in residency program accreditation, finance and governance. Join The RTT Collaborative, a community of practice in rural health professions education and training. Although the Collaborative provides formal consultation to participants at a reduced cost, the advice of a network of peers comes at no cost, and that can be invaluable to a developing program.
   e. 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. Scheduled 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 ambulatory or other “non-provider settings.” (Provider status is a CMS definition19)

Pause (and either 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 accreditation, using an organic approach – creatively adapting the various prototypes, examples, 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 who have 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, the Program Directors Workshop (PDW) and/or Residency Program Solutions (RPS) Workshop.20

   d. Consider investing in faculty development for the potential program director or site director: NIPDD, ACGME Navigation, or others

Pause (and either 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 – proforma’s, affiliations, letters of commitment, contracts, and other agreements; this is best done in concert (1) with an accountant who is familiar with graduate medical education finance, including an in depth understanding of the financing of rural programs (rural hospitals, rural health clinics, critical access hospitals, etc. and the nuances peculiar to them), and (2) with a consultant in governance of rural GME.

Pause (and either 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

These steps may occur in sequence, but more likely occur concurrently and in iterative cycles, potentially throughout the two to three years that are required to develop and launch a fully accredited residency program.

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 now, 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, 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 options for rural rotations for

---


residents, medical students and other health professions students to capacity. These formative assessments should always be anchored to a point in time and can be documented following this simple 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 current coalition
4. A current draft of the “Community Assets and Capacity Inventory”
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!

The toolbox for design and development that follows includes:

1. A template for exploring community assets (and challenges that may need mitigation) including a capacity inventory of existing and potential resources, e.g. community financing, social support, motivated faculty and administration
2. A crosswalk of important factors to be considered, from multiple perspectives
3. A calculation of estimated community impact and return on investment
4. A portfolio of other Links, Checklists, Templates and Samples
5. References
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 promote thoughtful explorations of and consideration of the perspectives of multiple people and interested parties. While not meant to be exhaustive, sharing the entirety of even a partially completed template or inventory with each of the participants in the process promotes active engagement and meaningful conversation. As individuals consider these tools, they may have an increased appreciation of the necessary partnerships and the level of collaboration that is required in the construction of a graduate medical education (residency) program. 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.

Community Assets and Capacity Inventory: A template for exploring community assets, challenges, and capacity for rural medical education and training

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

The template simultaneously investigates a number of quantitative and qualitative factors important to program accreditation, financing and governance. Sharing the template with stakeholders allows the leaders of the process and participants to identify next steps, prompting additional conversations. Completing this inventory should identify key existing and potential local community and institutional partnerships and unique community-specific factors that can impact partner engagement, program development, and recruitment.

Crosswalk: Concept Mapping for Community Engaged Residency Education

Use of this tool promotes conceptualization of important interfaces between the goals of a proposed medical education program and the context in which these goals may be operationalized. 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 affect the assets identified 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.

Community Impact

This simple EXCEL worksheet is intended to generate discussions among community members and partnering institutions. By entering basic assumptions, a general return on investment (ROI) can be calculated. Of course, community impacts and benefits are not easily measured and many are indirect. Not every benefit can be claimed as the result of a residency program alone, but this tool at least attempts to expand the conversation about ROI beyond an annual cash proforma.
Community Assets and Capacity Inventory (Available as a WORD attachment)
A template for exploring community assets, challenges, and capacity for rural medical education and training

Rural Community: [Town, State & Zip]
Completed: [Date]
By: [Name or names]

General Questions for the Rural Community:

1. What do you consider your community’s greatest assets?

2. What makes your community special or unique?

3. Why would anyone want to live in this rural community?

4. Are there unique assets that can be employed for recruitment/retention of physicians and their families?
   [e.g. recreational opportunities, opportunities for spouse/significant other and family, proximity to the amenities of a larger community]

5. Does the community have full and reliable cellular phone service?

6. What is the availability of housing for students and residents (either for limited rotations or longer-term)?

7. How does the community view newcomers, visitors and outsiders?

8. Please list single words and brief phrases that characterize this community:
Health Professions Education in the Community

1. What are the local rural community’s goals for participation or expansion of activities in health professions education?

2. From your perspective how prepared is the community for initiating or expanding medical education activities?

3. What local community resources have potential mission alignment with medical education?
   [Consider: Chamber of Commerce, service clubs, community or technical colleges, religious organizations and faith communities, charitable organizations and foundations, economic development initiatives – financial assets as well as expertise]

<table>
<thead>
<tr>
<th>Community Asset</th>
<th>Key contact, with email and/or phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Who are the individual community leaders and champions in the support of medical education activities? What are their roles?

4. Have there been medical student and other health profession student training activities? Are there established relationships, teaching experience and an established culture of teaching?

What is the history of graduate medical education/residency training in this community? ...Under what affiliations?

[Specify location and historical facts such as timeline of when these occurred, as it can affect accreditation (e.g. faculty experience level) and finance (e.g. Medicare funding for residency training)]

<table>
<thead>
<tr>
<th>Health Profession/Stage of Training</th>
<th>Location/Facility &amp; Town</th>
<th>Dates (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have these activities been aligned and cooperative, or has there been competition for teaching resources?

Have these learners ever been taught as a team or in an interactive way?
Community Concerns or Challenges

1. What reservations does your community have regarding a new medical education endeavor?

2. What unique barriers can you identify 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)]
**Prospective Rural Family Medicine Practice**

*Name:*

*Address: [Town, State and Zip]*

1. What is the clinic’s goal in participating in medical education activities?

2. Who is (are) the most capable local physician “champion(s)” or leader(s) invested in residency development? How is this person associated with this practice – are they a member?

3. Who is (are) the local physician(s) most prepared for administrative duties? How is this person associated with this practice – are they a member? [May or may not be the same as previously identified above]

4. Who is (are) the administrative champion(s) of the proposed program? Is this person most associated with the clinic or hospital?

5. How prepared is the clinic to begin medical education activities (or expand if currently ongoing)?

6. If not presently, is there a perceived timeline for preparedness for beginning or expanding medical education activities? What are the most pertinent issues?

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

8. What is the financial stability position of the clinic? Is there a preparedness to contribute financially to the GME activities? Please describe.

9. 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?

10. What access do patients have to mental health services?

11. What is the number of FM physicians? ...FTE? ...Demographics (e.g. approximate age, gender, experience)?
   - (This can affect role modeling, recruitment of students)

12. What is the number of patients seen by FM physicians annually in this clinic?
13. 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?

14. What technological capabilities do you have that could be employed in resident education?
   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?
   Other technology?

15. Has the practice transformed to a PCMH? What level?

16. Is the practice part of a more recent practice transformation initiative?

17. What is the level of experience and interest among the physicians in teaching, how many, how much and how strong?

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

19. What other specialties and sub-specialties, if any, share the clinic environment? How willing and interested are these sub-specialists in teaching?
Participating Rural Hospital

Name:
Address: [Town, State and Zip]
Web:

1. What is the hospital’s goal in participating in medical education activities?

2. How do you perceive the past, current and sustaining level of support for medical education training by administration and the governing body (e.g. Board)? Who is the governing body (e.g. local community Board, a corporate entity located elsewhere)?

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

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

5. What has been successful in motivating and sustaining staff support of other long-term projects in the past? [This question can prompt conversations regarding a culture of effective leadership, communication and teamwork – regardless of the project, implemented change or challenge that was addressed (e.g. new EMR, quality projects, PCMH designation)]

6. What is the geographic size and population of the hospital’s service area (HSA)?

7. What is the rural status of the participating hospital’s geographic location (Am I Rural)?

8. Are either located in a HPSA or MUA/P (Am I Rural)?

9. Is the local hospital designated a rural hospital (For the purpose of its CMS cost report), a critical access hospital (CAH), a sole community hospital (SCH), a Medicare-dependent hospital (MDH), a rural referral hospital (RRH), or a prospective payment system hospital (IPPS)?

10. Is this hospital part of a larger system and if so, what is the governance structure?

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

12. Does this hospital have a pre-established per resident amount or cap for graduate medical education (GME) due to prior resident activity and if so, what is that number? (If uncertain, consult the Rural GME Analyzer)

13. What is the number of admissions per year?

14. What is the percentage of Medicare, Medicaid, Medicare/Medicaid, self-pay, and other payer types?

15. What are the leading diagnoses for admissions if available?
16  What is the average daily census?

17  How many patients are seen in the emergency department annually?

18  Does the hospital have televideo availability for administrative/teaching purposes?
    Does the hospital have televideo availability for patient care purposes?

19  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?

20  What is the financial stability position of the hospital?

21  Is there a preparedness to contribute financially and invest in graduate medical education?

22  Are there any anticipated changes or plans for change in the physical plant in the next 5 years?

**Hospital Scope of Services**

1  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?

2  Does the hospital offer maternity services?
   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?

3  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?

4  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?
5. 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?

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

7. What is the highest level of care available for adult patients (e.g. ICU, telemetry)?
   Does the hospital have access and use tele-ICU?

8. Are there any associated long-term care facilities?

9. Are there any associated mental and/or behavioral care facilities?

**Hospital Medical Staff**

1. Describe the recent (3-5 years) recruitment history for family medicine and other specialty physicians in this community? Is the hospital currently recruiting (hospital and/or clinic)?
   [This group of questions may be pertinent to the quality of the teaching (which is generally improved with stable medical staff and administration 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)]

2. Describe the stability and longevity of the primary care physician workforce? (Family physicians, general internists, general pediatricians)

3. Describe the stability and longevity of other specialty physicians in the community? (e.g. General surgeons, obstetrician-gynecologists, psychiatrists)

4. Who are the local physicians interested in teaching and resident interaction?

5. How many medical staff live within 15 minutes of the hospital?

6. Does the hospital utilize hospitalists or ER/hospitalist physician staff?

7. Are there visiting sub-specialties?

8. Are any of these physicians providing telehealth patient services?
9. 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.)

10. Is there a medical staff development plan for the hospital?

Please provide a roster or list of all medical staff members including specialty

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

Does your hospital have existing by-laws for resident care of patients (such as limited staff privileges category)? Please provide a copy.
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*
Factors for Consideration in each Domain:21

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

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

Reference:
David Schmitz, MD†, Davis G. Patterson, PhD*, Sherry Adkins, MD/MPH**, Belinda Vail, MD, MS^, 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; ^Department of Family Medicine, University of Kansas School of Medicine; ‡Ohio University Heritage College of Osteopathic Medicine.
Institutional (Urban Institution or Urban Program) - Continued

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

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
A Portfolio of Resources, Links, Templates and Samples for Residency Development

Common Program Requirements for all specialties
https://www.acgme.org/acgmeweb/tabid/429/ProgramandInstitutionalAccreditation/CommonProgramRequirements.aspx

Family Medicine Review Committee (FM-RC) Program Requirements and Application for a 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 B: Stages of Design and Development (The RTT Collaborative)
This outline, developed from the collective experiences of successful rural programs, can serve as a general guide to planning and a measure of progress.

Appendix C: RTT Accreditation Guide (Longenecker)

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

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

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

Appendix G: Federal Definitions and Regulations – 2017 Review (Longenecker)

Appendix H: An Independent Academic Health Care System Perspective on Developing a RTT: Workforce Planning, Market Analysis and Return On Investment – RTT Collaborative presentation 2017 (Brill et al)

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

ROTATION SITE
- Assemble Core Team
- Identify Partners
- Additional Education
- Simple Budget
- Market Rotation
- Accept Residents

INTEGRATED RURAL TRAINING TRACK (IRTT) RESIDENCY
- Assemble Core Team
- Identify Partners
- Additional Education
- Proforma
- Board Approval
- Curriculum
- Budget
- Market Rural FMC Track
- Interview Applicants
- Accept Residents

FELLOWSHIP PROGRAM
- Assemble Core Team
- Identify Partners
- Additional Education
- Proforma
- Board Approval
- Curriculum
- Budget
- Submit for Accreditation (if applicable)
- Market Fellowship
- Interview Applicants
- Accept Fellows

RURAL TRAINING TRACK RESIDENCY (RTT)
- 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
Stages of Residency Development
Taxonomy and Sample Staging
The RTT Collaborative

Design Phase

I. Educational and Programmatic Design
   a. Consultative services to include recommendations concerning:
      i. Identification of rural training natural resources
      ii. Academics
      iii. Program structure
      iv. Resident recruitment and marketing
      v. Faculty (hiring and development)
      vi. Curriculum development
      vii. ACGME Accreditation
      viii. Synergistic opportunities with Florence campus
      ix. Start-up and ongoing operational needs

II. Financial Planning
   a. Consultative services to include recommendations concerning:
      i. Strategic financial planning/reimbursement options
      ii. Protecting and maximizing PRA and Cap
      iii. CMS audit/Medicare Cost Report
      iv. Detailed pro forma
      v. Line item budgets and start-up cost estimates
      vi. Synergistic opportunities with Florence campus
      vii. Opportunities for other sources of external funding support

Project Phases

I. Phase I – Initial Planning Phase
   a. Deliverables
      i. Confirm opportunity for ongoing state support allowing Phase II and III
      ii. Hire consultant(s)
      iii. Catalog local “natural resources” and synergistic opportunities (in terms of education and recruitment)
      iv. Outline community needs and desired outcomes
      v. Design program based on iii and iv above
      vi. Determine financial feasibility and develop plan allowing residents from core MRMC FM program to rotate at Cheraw without impacting cap or PRA
      vii. Identify Program Director, Faculty, and Program Coordinator
      viii. Develop proposal, including line item start-up budget and general estimated pro forma, to obtain additional state support for start-up costs. To include:
         1. Additional consultant support to develop detailed 5-9 year pro forma
         2. Additional consultant support to obtain program accreditation
         3. Additional consultant support for curriculum development
         4. Recruiting/Marketing/Website
         5. Construction costs
         6. Equipment/IT
         7. Labor

   b. Timeline
i. Program structure and proposal for ongoing support completed by Sept. 1, 2018  
ii. TBD

II. Phase II – Application Preparation and Submission

a. Deliverables  
   i. Detailed program pro forma (5 – 9 year projection)  
   ii. Hire Program Director  
   iii. Prepare and submit ACGME Application(s)  
   iv. Obtain accreditation  
   v. Written curriculum  
   vi. Detailed recruiting and implementation plan  
   vii. Website/Marketing

III. Phase III – Implementation

a. Deliverables  
   i. Complete any required construction and start-up purchases  
   ii. Hire core faculty and program support staff  
   iii. Recruit 1st class  
   iv. Matriculate 1st class
# RURAL FM PROGRAM AND INTEGRATED RTT ACCREDITATION GUIDE

Randall Longenecker MD, Executive Director, The RTT Collaborative

June 2017

<table>
<thead>
<tr>
<th>✓ Minimum time prior to anticipated implementation (it may take longer than this)</th>
<th>Task</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Make contact with The RTT Collaborative, join the listserv, and consider attending an Annual Meeting, even joining the coop as a participating program in development. The RTT Collaborative can direct you to or advise you regarding additional resources such as Residency Program Solutions, AFMRD, and STFM. It is important from the start to recognize that there are many sources of information and assistance (some free, some at a substantial cost), and it is important to associate yourself with a trusted community of practice in rural graduate medical education in guiding you through this process.</td>
<td>The RTT Collaborative <a href="http://www.rttcollaborative.net">http://www.rttcollaborative.net</a></td>
</tr>
<tr>
<td></td>
<td>Never too early!</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Engage your community and potential academic partners in conducting a capacity survey to determine the capacity of your community to support graduate medical education training. Consider a phone consultation with The RTT Collaborative, possibly a site visit. This document is primarily an accreditation guide to be followed, after general program design. For rural programs especially, general program design should always precede any financial consultations. <strong>How the program is designed will markedly affect financial projections.</strong></td>
<td>Community Engaged Residency Education for Rural Places (CERE-R; available for download) <a href="https://rttcollaborative.net/about/tools-and-assistance/">https://rttcollaborative.net/about/tools-and-assistance/</a></td>
</tr>
<tr>
<td></td>
<td>24 to 36 months If your community only has capacity for 3 or less residents per year of training, then you will need to pursue accreditation as an integrated rural training track of a larger program. Unfortunately, at this point, integrated RTTs are not defined on the ACGME site. Therefore, pay special attention to references in the ACGME instructions and application (see below) regarding a program in the “1-2” format (with the first year in an urban location and years 2&amp;3 in the rural community) to determine how this applies to your developing program. Integrated RTTs that are not in the strict “1-2” format will need to describe in this section of the application the way that they are integrated with a larger program and</td>
<td>For more information on integrated RTTs, visit <a href="https://rttcollaborative.net/wp-content/uploads/2017/03/Rural-program-nomenclature.pdf">https://rttcollaborative.net/wp-content/uploads/2017/03/Rural-program-nomenclature.pdf</a></td>
</tr>
<tr>
<td></td>
<td>36 months</td>
<td></td>
</tr>
<tr>
<td>Time Frame</td>
<td>Task Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
<td>-------</td>
</tr>
<tr>
<td>24-36 months</td>
<td>Identify a sponsoring institution (SI)</td>
<td></td>
</tr>
<tr>
<td>24-36 months</td>
<td>Is the SI currently accredited by the ACGME?</td>
<td>Y – Move to next step</td>
</tr>
<tr>
<td>24 months</td>
<td>Confirm that the Sponsoring institution is in good standing and complies with the Institutional Requirements</td>
<td><a href="https://apps.acgme.org/ads/Public/Sponsors/Search">https://apps.acgme.org/ads/Public/Sponsors/Search</a></td>
</tr>
<tr>
<td>24 months</td>
<td>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 Common Requirements, Family Medicine Requirements, Application Instructions and the New Applications document for FM programs as a working template for eventually completing the application (traditionally called the Program Information Form or PIF) online through ADS. The requirements that are current as of this coming academic year or approved and set to take effect in the future should guide your planning.</td>
<td>Common Programs Requirements: <a href="https://www.acgme.org/acgmeweb/tabid/429/ProgramandInstitutionalAccreditation/CommonProgramRequirements.aspx">https://www.acgme.org/acgmeweb/tabid/429/ProgramandInstitutionalAccreditation/CommonProgramRequirements.aspx</a> Family Medicine Requirements and Application: <a href="http://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pcatid/8/Family%20Medicine">http://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pcatid/8/Family%20Medicine</a></td>
</tr>
<tr>
<td>24 months</td>
<td>Designate a Program Director in development (can be the PD of the larger program in an integrated RTT, whether or not the program is in the strict “1-2 format”) and a Site Director for the rural site if your program is developing as an integrated RTT (This person should be Core faculty). It is also helpful to Consider preparing the new PD or Site Director through the NIPDD fellowship program.</td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>Description</td>
<td>Website</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>24 months</td>
<td>Contact the 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. Please clarify with RC-FM whether you are applying as an integrated RTT.</td>
<td><a href="http://www.acgme.org/Specialties/Overview/pfcatid/8">http://www.acgme.org/Specialties/Overview/pfcatid/8</a></td>
</tr>
<tr>
<td>24 months</td>
<td>Before proceeding further, either as a full rural program with 4 or more residents per year or as an integrated RTT, consider consultation with The RTT Collaborative. Emails and limited initial phone calls (&lt;30 minutes) are available at no cost, and it is important to know what resources are available to you as a developing program.</td>
<td><a href="http://www.rttcollaborative.net">http://www.rttcollaborative.net</a> or <a href="mailto:longenec@ohio.edu">longenec@ohio.edu</a> or (740) 597-3058 (phone messages are forwarded to email)</td>
</tr>
<tr>
<td>18 to 24 months</td>
<td>Develop a timeline for residency program development, and assign tasks for completion of the application (1) to the individual best suited to complete the task, and (2) in the order most appropriate to your institution. Completing the application will likely require someone from your sponsoring institution or from your region who can spend significant time (perhaps a day a week for several months) coaching you through this process. Existing materials from another accredited program are a great way to start, as are resources available through the Association of Family Medicine Residency Directors (AFMRD). Access to these resources requires membership in the organization.</td>
<td>Substitute dates for minimum months in this template and add your own rows; generally takes at least 18-24 months from this point.</td>
</tr>
<tr>
<td>18 months</td>
<td>After completion of the application draft, but before submission, consider external review (e.g. contact The RTT Collaborative for a formal review or ask for a peer recommendation)</td>
<td><a href="https://rttcollaborative.net/about/tools-and-assistance/">https://rttcollaborative.net/about/tools-and-assistance/</a></td>
</tr>
<tr>
<td>Timeframe</td>
<td>Action Description</td>
<td>Resource</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>18 months</td>
<td>Have DIO initiate the new program application within the Accreditation Data System (ADS)</td>
<td><a href="https://www.acgme.org/acgmeweb/tabid/159/DataCollectionSystems/AccreditationDataSystem.aspx">https://www.acgme.org/acgmeweb/tabid/159/DataCollectionSystems/AccreditationDataSystem.aspx</a></td>
</tr>
<tr>
<td>18 months</td>
<td>Program Director completes the application in ADS and supplemental materials if any</td>
<td></td>
</tr>
<tr>
<td>18 months</td>
<td>Have the institutional Graduate Medical Education Committee (GMEC) approve the application, at which point, with DIO approval, you can submit the application to the Review Committee for Family Medicine</td>
<td></td>
</tr>
<tr>
<td>Very dependent upon current backlog and time to next FM-RC meeting</td>
<td>Receive scheduled date from ACGME and prepare for Site Visit</td>
<td>Notification can occur as long as 3 months after completion of the application and as long as 6 months before the actual site visit</td>
</tr>
<tr>
<td>12 to 18 months</td>
<td>Prepare documentation for the site visit, including all affiliation agreements, program letters of agreement, curricular documentation, and policies not already completed in ADS for the initial application</td>
<td><a href="http://www.acgme.org/What-We-Do/Accreditation/Site-Visit">Site Visit Overview</a></td>
</tr>
<tr>
<td>12 months</td>
<td>Host Site Visit</td>
<td></td>
</tr>
<tr>
<td>6 to 9 months (To allow for participation in the National Residency Match)</td>
<td>Await Initial Accreditation Approval – generally following the next triennial meeting of the FM-RC, generally October, February, and May although it may vary year to year</td>
<td>For the agenda deadline for RC-FM meetings, see the right-hand column: <a href="http://www.acgme.org/Specialties/Overview/pfcatid/8/Family%20Medicine">http://www.acgme.org/Specialties/Overview/pfcatid/8/Family%20Medicine</a></td>
</tr>
<tr>
<td></td>
<td>Upon approval, set a date for implementation; consider implications for resident recruitment (e.g. Even with an October approval, you may elect to wait till the following year and implement after you have had a full year’s opportunity to recruit)</td>
<td></td>
</tr>
<tr>
<td>6 to 9 months</td>
<td>Recruit initial resident class and proceed with faculty contracts</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>[This WORD document is intended to allow you to add your own detailed timeline, rows or columns, and can be copied and pasted into an EXCEL document to make it even easier]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Family Medicine Program Requirements Crosswalk

<table>
<thead>
<tr>
<th>Curriculum</th>
<th>Time</th>
<th>#Visits</th>
<th>Exceptions</th>
<th>Inclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity Clinic</td>
<td>40wk/yr</td>
<td>1650 in person (majority must occur in residents primary FMP site)</td>
<td>no interruption &gt;8 continuous wks, periods between interruptions must be 4 wks</td>
<td>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.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>600 hours (6 months) AND 750 patient encounters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICU</td>
<td>100 hours (1 month) OR 15 patient encounters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td>Hours/Months</td>
<td>Condition</td>
<td>Patient Encounters</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------</td>
<td>-----------</td>
<td>--------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>ED</td>
<td>200 hours</td>
<td>OR</td>
<td>250 adult patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2 months)</td>
<td></td>
<td>encounters</td>
<td></td>
</tr>
<tr>
<td>Geriatrics (&gt;60 yoa)</td>
<td>100 hours</td>
<td>OR</td>
<td>125 patient</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>(1 month)</td>
<td></td>
<td>encounters</td>
<td></td>
</tr>
<tr>
<td>Pediatrics Inpt / ER</td>
<td>200 hours</td>
<td>AND</td>
<td>250 patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2 months)</td>
<td></td>
<td>encounters</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>INCLUDING 75</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>inpatient encounters with children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>75 ED patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>encounters with</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>children</td>
<td></td>
</tr>
<tr>
<td>Pediatrics Outpt</td>
<td>200 hours</td>
<td>OR</td>
<td>250 patient</td>
<td>This care must include well-child care, acute care, and chronic care.</td>
</tr>
<tr>
<td></td>
<td>(2 months)</td>
<td></td>
<td>encounters</td>
<td></td>
</tr>
<tr>
<td>Newborn Care</td>
<td></td>
<td></td>
<td>40 newborn patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>encounters; including</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>well and ill newborns</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>100 hours</td>
<td>(1)</td>
<td></td>
<td>This experience must include operating room experience.</td>
</tr>
<tr>
<td></td>
<td>(month)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSK</td>
<td>200 hours</td>
<td>(2)</td>
<td></td>
<td>must include a structured sports medicine experience</td>
</tr>
<tr>
<td></td>
<td>(months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GYN</td>
<td>100 hours (1 month) OR 125 patient encounters</td>
<td>dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and options counseling for unintended pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB</td>
<td>200 hours (2 months)</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Procedures (Ambulatory and Hospital)

| 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. |

### 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>
<table>
<thead>
<tr>
<th>Practice Management</th>
<th>100 hours (1 month) dedicated to health system management experience</th>
<th></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td></td>
<td></td>
<td>Residents must have experience in diagnosing and managing common dermatologic conditions.</td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td></td>
<td>The curriculum should include diagnostic imaging interpretation and nuclear medicine therapy pertinent to family medicine.</td>
</tr>
<tr>
<td>Elective</td>
<td>300 hours months</td>
<td>(3 months)</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------</td>
<td>------------</td>
<td>---</td>
</tr>
<tr>
<td>Long-term care facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long-term care experiences must occur over a minimum of 24 months.</td>
<td></td>
</tr>
<tr>
<td>Scholarly Activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>
### The OSU Rural Program – Three Year Curriculum

Intensive immersion experiences embedded in a continuing rural practice

<table>
<thead>
<tr>
<th>YEAR 1</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Care (Shared)</td>
<td>Hospital Care</td>
<td>Pediatrics Inpatient</td>
<td>Hospital Care (NRP)</td>
<td>Special Care Nursery</td>
<td>OB – Newborn</td>
<td>Hospital Care</td>
<td>Cardiology</td>
<td>Hospital Care (Wound Healing)</td>
<td>MICU</td>
<td>Hospital Care (ATLS)</td>
<td>Peds ER</td>
<td>Scholarly Activity (Shared)</td>
<td></td>
</tr>
<tr>
<td>MRH</td>
<td>MRH</td>
<td>CHC</td>
<td>MRH</td>
<td>OSUH</td>
<td>MRH</td>
<td>MRH</td>
<td>OSUH</td>
<td>MRH</td>
<td>OSUH</td>
<td>MRH</td>
<td>CHC</td>
<td>MRH</td>
<td></td>
</tr>
</tbody>
</table>

**Mad River Family Practice -- Periodic office patient care, daily hospital rounds**

- 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
- 1 Half-day
- 3 Half-days

### YEAR 2

<table>
<thead>
<tr>
<th>Ambulatory Cardiology</th>
<th>Elective</th>
<th>OB – Newborn</th>
<th>OB – Newborn (High Risk Immersion)</th>
<th>Dermatology</th>
<th>Pediatrics Outpatient</th>
<th>ICU – Intern Med</th>
<th>Orthopedics</th>
<th>Medical Sub-specialty</th>
<th>Elective</th>
<th>GYN</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRH/Office</td>
<td>MRH</td>
<td>Office</td>
<td>Office</td>
<td>MRH</td>
<td>MRH/Office</td>
<td>MRH/Office</td>
<td>Office</td>
<td>Office</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mad River Family Practice -- Periodic office patient care, daily hospital rounds**

**Scholarly Activity and Community Medicine**

- 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

<table>
<thead>
<tr>
<th>Elective</th>
<th>Geriatrics, Physical Medicine, and Psychiatry</th>
<th>GYN</th>
<th>Elective</th>
<th>Surgical Subspecialities – Ophthalmology, ENT, Urology, Podiatry</th>
<th>Elective</th>
<th>Sports Medicine</th>
<th>Elective</th>
<th>Medical Sub-specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Office</td>
<td></td>
<td>Office</td>
<td>Office</td>
<td></td>
<td>OSU Sports Ctr</td>
<td></td>
<td>MRH/Office</td>
</tr>
</tbody>
</table>

**Mad River Family Practice -- Periodic office patient care, daily hospital rounds**

**Practice Management and Community Intervention**

- 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]
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, (Core)
I.A.4.b) provide support for a full-time residency coordinator and other support personnel required for the operation of the program. (Detail)

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, (Core)
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. (Detail)

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. (Detail)

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; (Detail)
II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b).(4) participation in national committees or educational organizations. (Detail)

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. (Core)

II.B.6.a) Core physician faculty members must:

II.B.6.a).(1) dedicate at least 60 percent time (at least 24 hours per week, or 1200 hours per year), to the program, exclusive of patient care without residents; and, (Detail)

II.B.6.a).(2) devote the majority of their professional effort to teaching, administration, scholarly activity, and patient care within the program. (Detail)

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. (Core)

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. (Detail)

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. (Detail)

III.B.3. The program should have at least 12 on-duty residents. (Detail)

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. (Core)

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

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. (Outcome)

IV.A.5.a).(1).(c).(i) distinguishing abnormal and normal pregnancies; (Outcome)
IV.A.5.a).(1).(c).(ii) caring for common medical problems arising from pregnancy or coexisting with pregnancy; (Outcome)
IV.A.5.a).(1).(c).(iii) performing a spontaneous vaginal delivery; and (Outcome)
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:
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. (Core)

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. (Core)

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”. (Detail)

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.

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.
RTTs: A Two-Page Reference Regarding Federal Definitions and Regulations
Prepared by Randall Longenecker MD, Executive Director, The RTT Collaborative
July 2017

A Common Nomenclature: The RTT Collaborative

A rural program is an accredited residency program in which residents spend the majority of their total training time (i.e. more than 50%, as reported to CMS and/or the Teaching Health Center program) in a rural place.  

An Integrated Rural Training Track (IRTT) is a sub-type of rural program that is separately accredited and because of its generally smaller size and variable resources is substantially integrated with a larger, often more urban residency program. Many of these programs function in a 1-2 format, in which residents train the first year in the more urban location, and then spend years 2 and 3 in a rural place.

An identified training track within a larger program, not separately accredited (i.e. without a separate accreditation program number), in which the tracked residents meet their 24-month continuity requirement in a rurally located continuity clinic or Family Medicine Practice site (FMP) is considered an IRTT‐like program.


Subpart F, Specific Categories of Cost, Direct GME payments, 42 § 413.75 to 413.83
http://www.ecfr.gov/cgi-bin/text-idx?SID=55bcaffa0cfd9538a10a9aaba8f42c6b&node=42:2.0.1.2.13&rgn=div5#se42.2.413_175
[Search for these sections for “rural” and “GME,” especially]

Residents training in rural track programs, 42 CFR 413.79, scroll to (k): http://www.ecfr.gov/cgi-bin/text-idx?SID=55bcaffa0cfd9538a10a9aaba8f42c6b&node=42:2.0.1.2.13&rgn=div5#se42.2.413_179

Specific Federal Register Final Rule Notices


FY02 IPPS Final Rule, August 1, 2001, Responses to public comments from August 1, 2000 interim final rule and to finalize the rule, page 39901ff: http://www.gpo.gov/fdsys/pkg/FR-2001-08-01/pdf/01-18868.pdf

FY04 IPPS Final Rule, August 1, 2003, Integrated rural training track defined; residents must train more than one-half of the program duration in rural areas for urban hospitals to qualify for a rural FTE limitation, page 45454ff: https://www.gpo.gov/fdsys/pkg/FR-2003-08-12/pdf/03-20280.pdf

3 Continuity requirement as defined by the ACGME Family Medicine Review Committee and the American Board of Family Medicine
FY10 IPPS Final Rule, August 27, 2009, Clarification of definition of new medical residency training program (74 FR 43908 - 43919):


[Note: To search any of these documents for relevant regulations, I recommend the reader search (or “find”) the terms "rural training" or "rural track;" in addition, for a summary of all of the regulations to date, one can read the last Final Rule, which generally references the previous rules in a Background section]
An Independent Academic Health Care System Perspective on Developing a RTT: Workforce Planning, Market Analysis and Return On Investment

John Brill, MD, MPH
Andy Anderson, MD, MBA
Deb Simpson PhD
Jake Bidwell, MD
Barb Schober, RNC, MBA
Why we’re here/Goals

- Share our journey
- Independent Academic HC System
- Starting an RTT ‘de novo’
  - Workforce Projections
  - Market and Location Analysis
  - Value argument
  - Where we are now
Why are you here?
We already have a program; What’s the point?

- **A Study of Closure of Family Practice Residency Programs**
  
  Primary reasons for closure included: “insufficient resources to stand alone,” “inaccurate valuation of the family practice residency program,” and “being seen as a poor investment.”
  
About us:
Aurora Health Care

- Integrated health system
- Eastern WI and N. Illinois
- 17 Hospitals
- 172 Clinical sites
- 30K Caregivers
- 1800 Physician employees
- 150 Pharmacy sites
- Home care
- $4B annual budget
- CEO: Nick Turkal, MD, FM
• **GME:** 150 housestaff, all in Milwaukee
  - FM (Geriatrics, Women’s Health): 30
  - IM (GI, Geriatrics, Cards, EP): 70
  - OBG: 12
  - Radiology: 16
  - TY: 16

• **UME:** Primary Affiliation with Uwisc
  - WARM Program in Green Bay, 6 students/year
  - Med Coll WI, Des Moines, CCOM, 75 other US
  - ~500 medical student rotations/year
  - ~400 PA and NP student rotations/year
Why create a rural family medicine residency track?

- 2012 AHC Graduate Medical Education (GME) Topic Committee
- Purpose:

“To assess the current state of physician residency and fellowship programs at Aurora Health Care and develop a strategic approach to determine CMS supported/CMS non-supported graduate medical education positions that meet the physician work force and strategic needs of Aurora Health Care and its communities, as well as the State of Wisconsin.”
TOPIC Committee Outcomes

- Reviewed system residencies & fellowships
- Compared to anticipated workforce projections
- Recognized critical need for more rural primary care physicians
- Recommended creation of a Family Medicine rural residency training program
WHERE?

What would you look for in an RTT site?

- Meets requirements
- Hospital
- Patient volume
- Physician Champion(s)
- Administrative Champion(s)
- Growth
- Resident Recruitment Potential

© Aurora Health Care, Inc.
WHERE?
### Rural defn (state, federal), AHC facilities, FM Champions, Other

<table>
<thead>
<tr>
<th>Region</th>
<th>Location</th>
<th>Location Code</th>
<th>County</th>
<th>Size</th>
<th>County Code</th>
<th>+15m to city &gt;20k</th>
<th>AHC facilities</th>
<th>Champions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fox Valley</td>
<td>Kenosha</td>
<td>5368</td>
<td>Racine</td>
<td>16m</td>
<td>to Waukesha</td>
<td>None</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
</tr>
<tr>
<td>Fox Valley</td>
<td>Sturgeon Bay</td>
<td>1043</td>
<td>Racine</td>
<td>16m</td>
<td>to Waukesha</td>
<td>None</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
</tr>
<tr>
<td>Fox Valley</td>
<td>Two Rivers</td>
<td>12371</td>
<td>Geneva</td>
<td>7m</td>
<td>to Manitowoc</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fox Valley</td>
<td>Shawano</td>
<td>9305</td>
<td>Washington</td>
<td>40 m</td>
<td>to Green Bay</td>
<td>Shawano Clinic</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
</tr>
<tr>
<td>Fox Valley</td>
<td>Howard, Suamico</td>
<td>17338, 13346</td>
<td>Brown</td>
<td>710 m</td>
<td>to GB</td>
<td>None</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
</tr>
<tr>
<td>Fox Valley</td>
<td>De Pere</td>
<td>23880</td>
<td>Brown</td>
<td>6 m</td>
<td>to GB</td>
<td>None</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
</tr>
<tr>
<td>Fox Valley</td>
<td>Marinette</td>
<td>10943</td>
<td>Racine</td>
<td>54 m</td>
<td>to GB</td>
<td>None</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
</tr>
<tr>
<td>Central</td>
<td>West Bend</td>
<td>31078</td>
<td>Washington</td>
<td>n/a</td>
<td></td>
<td>None</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
</tr>
<tr>
<td>Central</td>
<td>Kewaskum</td>
<td>4004</td>
<td>Washington, Fond du Lac</td>
<td>8 m</td>
<td>to West Bend</td>
<td>None</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
</tr>
<tr>
<td>Central</td>
<td>Waupun</td>
<td>11340</td>
<td>Racine</td>
<td>20 m</td>
<td>to Fond du Lac</td>
<td>None</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
</tr>
<tr>
<td>Central</td>
<td>Plymouth</td>
<td>8445</td>
<td>Sheboygan</td>
<td>15m</td>
<td>to Sheboygan</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>Hartford</td>
<td>14223</td>
<td>Dodge</td>
<td>16 m</td>
<td>to West Bend</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>Slinger</td>
<td>5068</td>
<td>Washington</td>
<td>11 m</td>
<td>to West Bend</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>Jackson</td>
<td>6753</td>
<td>Washington</td>
<td>10 m</td>
<td>to West Bend</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Lt Michigan</td>
<td>Cedarburg</td>
<td>11412</td>
<td>Ozuake</td>
<td>8 m</td>
<td>to Mequon (23K)</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Lt Michigan</td>
<td>Grafton</td>
<td>11459</td>
<td>Ozuake</td>
<td>8 m</td>
<td>to Mequon (23K)</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>I-94 corridor</td>
<td>Oconomowoc</td>
<td>15759</td>
<td>Waukesha</td>
<td>20 m</td>
<td>to Waukesha</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>I-94 corridor</td>
<td>Watertown</td>
<td>23861</td>
<td>Dodge/ Jefferson</td>
<td>36 m</td>
<td>to Waukesha</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Southeastern Wisconsin</td>
<td>Burlington</td>
<td>10464</td>
<td>Racine, Walworth</td>
<td>25 m</td>
<td>to Pleasant</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Southeastern Wisconsin</td>
<td>Delavan</td>
<td>8463</td>
<td>Walworth</td>
<td>20 m</td>
<td>to Janesville</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Southeastern Wisconsin</td>
<td>Elkhorn</td>
<td>10084</td>
<td>Walworth</td>
<td>26 m</td>
<td>to Janesville</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Southeastern Wisconsin</td>
<td>Whitewater</td>
<td>14769</td>
<td>Walworth/ Jefferson</td>
<td>21 m</td>
<td>to Janesville</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Southeastern Wisconsin</td>
<td>Lake Geneva</td>
<td>7651</td>
<td>Walworth</td>
<td>27 m</td>
<td>to Pleasant Prairie</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Southeastern Wisconsin</td>
<td>Twin Lakes</td>
<td>5989</td>
<td>Kenosha</td>
<td>26 m</td>
<td>to Kenosha</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Southeastern Wisconsin</td>
<td>Paddock Lake</td>
<td>2992</td>
<td>Kenosha</td>
<td>16 m</td>
<td>to Kenosha</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
<tr>
<td>Southeastern Wisconsin</td>
<td>Waterford</td>
<td>5368</td>
<td>Racine</td>
<td>16 m</td>
<td>to Waukesha</td>
<td>AHC Clinic, Sheboygan Med Ctr</td>
<td>Gavin, Smith</td>
<td>WARM site Fledging CHC in Sheboygan</td>
<td></td>
</tr>
</tbody>
</table>
Two Frontrunners…

• Aurora Lakeland Medical Center, in Walworth County
• Aurora Two Rivers Medical Center, in Manitowoc County
Aurora Family Medicine Residency Program
Aurora Lakeland Rural Training Track (ALRTT!)
Why Aurora Lakeland?

• Need
  – High ED volume of non-PCP patients
  – Many PCPs nearing retirement: 50%>55
  – Growing communities: 20% by 2040

• Meets Requirements
  – Federal: Rural County
  – WI legislative definition of ‘rural’
  – Family physician maternity care (ACGME)

• Advantages
  – Supportive leadership & medical staff
  – Geographically attractive for recruiting
  – Available facility space for clinic
  – Large migrant worker population

© Aurora Health Care, Inc.
How would you sell the Value of an RTT to an integrated health care system?
Why an RTT?

• Physician Recruitment:
  – Lengthier recruitment in rural (400 days vs 200*; 2 rural positions recently vacant x 2.5+ years)
  – Vacant FM position = downstream revenue loss of $172K/month (ModernHealthCare 2013**) 
  – AHC 10/14: 46 PCP vacant, 75% non-urban*

• Physician Retention: Doctors who train in rural areas are over twice as likely to stay in rural areas***


*Craig Miller  **http://www.modernhealthcare.com/assets/docs/CH8854058.PDF
Why an RTT--now?

- Funding: Federal GME & state funding only for new rural training programs
- Resident Candidates: Expanded size and number of US medical schools
- Health care system consolidations & affiliations, ACOs
Proforma Summary
Expenses & Costs (in $M)
ROI

$2.2M Investment / 5 years → 9 grads, ~5 AHC recruits

$244K/graduate, $440K/placed graduate

- Recruitment & Retention of Residents
  - AHC FMRP: >50% AHC hires → 5 New FPs
  - AHC 1<sup>st</sup> care recruit cost: $56K* (higher in rural)
  - Retention: National Avg ~$1M 1<sup>st</sup> care replacement cost**
  - Vacant Position Costs (National Avg $172K/month)
  - On-boarding Costs:*** Graduates acculturated to AHC

- Recruitment & Retention of Teaching Physicians
- Academic environment, quality, innovation
- 1<sup>st</sup> Care Access & Downstream Revenue/Referrals
- Medicaid/Medicare pt mix (offload AMG practices)
- External funding opportunities (WRPRAP, DHS, philanthropy)

*Craig Miller 10/10/14  **Waldman JD et al. The Shocking Cost of Turnover in Health Care. HCMgmtRev 2004: 29(1) 2-7  ***Up to $250K http://www.beckershospitalreview 1/7/13
Keys to success

• System Support and Financial Investment
• Personnel Recruitment
  – Program Director
  – Residents
  – Preceptors
• Practice Development
  – ED, Independent physicians, Retiring physicians
  – Community engagement and partnerships
• Linkages to student programs & AHC physician recruitment
Back in Time to October 2014: What’s the timeline?

- March 2014: presented plan to AUWMG Board of Directors.
- August 2014: Presented proposal to South Market leadership
- August –October 2014: Present proposal to AHC South PSM President, AHC CMO, Integration Team

- Oct 2014: Capital budget for build-out
  - Operating budgets for PD hire
- Oct 2014-May 2015: Prepare new Program Information Form and submit to ACGME
- Oct 2014-May 2015 Recruit Site Director & Faculty
- Oct 2014-Oct 2015: Site facility modifications, faculty and staff recruitment and development
- October 2014: WRPRAP Education Grant
- By June 2015: ACGME site visit
- By Sept 2015: ACGME new site approval
- October 2015 WI DHS Grant Application
- November 2015: Recruiting for new residents
- July 2016: Interns start at Metro
- July 2017: PG2 Residents start at Lakeland
The Ask

Approval to submit application to ACGME
• $2.1M Investment / 5 years
  $1.7M Capital Request for 2016
• Initiate Recruitment of Site Director
Where are we now?

Project Leadership Identified 4th quarter 2014:

1) Executive Sponsor: Dr. Andy Anderson

2) Project Leader: Dr. John Brill
Multidisciplinary team formed

• Physician Leaders – existing Aurora residency programs
• Residency Coordinators - existing Aurora residency programs
• Government Affairs
• Finance
• Physician Recruitment
• Human Resources
• Operations Project Manager
• Aurora Facilities Planning
• Walworth Market President
• Walworth Vice-President
• Walworth Clinic Leadership
• Information Technology
2 Focus Areas

1. Accreditation
   - Analysis of accreditation options
   - Have elected to apply for ACGME accreditation
   - Data collection underway
   - Await successful recruit of Program Director to complete

2. Facility Design and Construction
   - Nearing completion of architectural drawings
   - Cost analysis to follow
   - Awaiting space to vacated
   - Construction to begin 1st quarter 2017.
Discussion

Questions?
Discussion?
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 that 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.”


Please contact your other insurance intermediaries if there is any question about teaching documentation as other insurers 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. 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 adjuvant 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

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

Diana Beahm, Administrative Assistant
208-514-2522  
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.”


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. 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 adjuvant 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
References:

Community Engaged Medical Education


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


Place-Based Medical Education


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.


Rural Medical Education and Rural Training Tracks: History


Parlier AB; Galvin SL; Thach S; Kruidenier D; Fagan EB. The Road to Rural Primary Care: A Narrative Review of Factors That Help Develop, Recruit, and Retain Rural Primary Care Physicians. *Acad Med.* 2018;93:130–140.


**Rural Medical Education and Rural Training Tracks: Other**


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 2013;32(1):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.

Evans D; Patterson D; Andrilla CH; Schmitz D; Longenecker R. Do Residencies that Aim to Produce Rural Family Physicians Offer Relevant Training? Fam Med 2016;48(8):596-602.

Fahey P; Cruz-Huffmaster D; Blincoe T; Welker C; Welker MJ. Analysis of Downstream Revenue to an Academic Medical Center from a Primary Care Network, Acad Medicine 2006; 81(8):702-207.


Mian O; Hogenbirk JC; Warry W; Strasser RP. How underserviced rural communities approach physician recruitment: Changes following the opening of a socially accountable medical school in northern Ontario, Can J Rural Med 2017; 22(4):139-147.


Perry A. Pugno, William Ross Gillanders, and Stanley M. Kozakowski (2010) The Direct, Indirect, and Intangible Benefits of Graduate Medical Education Programs to Their
Sponsoring Institutions and Communities. *Journal of Graduate Medical Education* June 2010; 2(2):154-159.

Skariah JM; Ransmussen C; Hollander-Rodriguez J; Carney PA; Dexter E; Waller E; Eiff P. Rural Curricular Guidelines Based on Practice Scope of Recent Residency Graduates Practicing in Small Communities, *Family Medicine* September 2017;49(8):594-9.


Rural Medical Education and Rural Training Tracks: Online

Rural Health Information Hub (RHIhub)
This national library of resources for rural health is invaluable in exploring resources for teaching, for program development, for grant assistance, and for research. 
https://www.ruralhealthinfo.org

- Search site for “RTT” or “Rural medical education and training”
- Rural Workforce Education and Training: https://www.ruralhealthinfo.org/topics/workforce-education-and-training

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 2014-present 
  https://rttcollaborative.net/meetings/annual-meeting-archives/
- Resources and information for students, including a list of rural residencies 
  https://rttcollaborative.net/students/
- Technical assistance for existing and developing rural programs in medical school or residency 
  https://rttcollaborative.net/about/tools-and-assistance/
- And much more...

National Organization of State Offices of Rural Health (NOSORH)
Webinar slide sets regarding RTTs can be found at: 

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. 


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


Definitions of Rural

Rural Assistance Center
Am I Rural? – Geocoding tool and discussion of rural definitions, including links to the USDA Economic Research Service 
http://www.raconline.org/amirural

WWAMI Rural Health Research Center
For information regarding definitions of rural: "Rural Urban Commuting Area (RUCA) codes". http://depts.washington.edu/uwruc/