Planting TREES in Rural Places

Training and Rural health professions Education that is community Engaged and Sustainable
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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 **T**raining and **R**ural health professions **E**ducation that is community **E**ngaged and **S**ustainable. 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

[1] *Tesson G; Hudson G; Strasser R; Hunt D, Editors. The Making of the Northern Ontario School of Medicine: A Case Study in the History of Medical Education.* Montreal/Kingston: McGill-Queen's University Press, 2009.
[2] Strasser R, Hogenbirk JC, Minore B, et al. Transforming health professional education through social accountability: Canada's Northern Ontario School of Medicine. Med Teach 2013; 35:490-6.
[3] 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,* November 2015;90(11):1466-70.
[4] Longenecker R. "Curricular Design: A Place-Based Strategy for Rural Medical Education," in Bell E; Zimmitat C; Merritt J Eds. Rural Medical Education: Practical Strategies, New York: Nova Science, 2011.
[5] Gruenewald DA, Smith GA. Place-based education in the global age: Local diversity, New York: Lawrence Erlbaum Associates; 2008.
[6] Schrewe B; Ellaway RH; Watling C; Bates J. The Contextual Curriculum: Learning in the Matrix, Learning From the Matrix. Academic Medicine November 2018; 93(11):1645–1651.

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.[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[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[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)[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.[12]

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[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," *Social Science & Medicine* 2009; 69:1368–76.
[8] Cutchin M. "Physician Retention in Rural Communities: The perspective of experiential place integration," *Health & Place* 1997; 3(1):25-31.
[9] Using at least 2 federal definitions from Am I Rural? https://www.ruralhealthinfo.org/am-i-rural (Accessed 9-29-2017)
[10] Longenecker R. Rural Medical Education Programs: A Proposed Nomenclature. *Journal of Graduate Medical Education* June 2017;9(3):283-286. https://doi.org/10.4300/JGME-D-16-00550.1 (Accessed 6-16-2017)
[11] 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.
[12] Longenecker R. "Sustaining Engagement and Rural Scholarship," *J of Higher Education Outreach and Engagement,* Fall 2002/Winter 2003; 8(1):87-97.

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)[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.[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 whole.[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?** 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

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[13] Recruitment and Retention for Rural Health Facilities https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention (Accessed 1-18-2019)
[14] Brill J; Anderson A; Simpson D; Bidwell J; Schober B. An Independent Academic Health Care System Perspective on Developing a RTT: Workforce Planning, Market Analysis and Return On Investment, presented as a workshop at the RTT Collaborative Annual Meeting, Madison, WI, May 2015. https://rttcollaborative.net/wp-content/uploads/2017/03/10_Brill-Independent-Academic-Health-Care-System.pdf (Accessed 1-18-2019)
[15] Ramas ME. Rural Recruiting, Retention Proves Daunting. AAFP blog entry, April 7, 2016. https://www.aafp.org/news/blogs/leadervoices/entry/rural_recruiting_retention_proves_daunting.html (Accessed 1-18-2019)
[16] Economic Loss to Community from Primary Care Practitioner Shortage, National Center for Rural Health Works, January 2007. http://ruralhealthworks.org/wp-content/files/PCP-Shortage-10-page-example-using-Noble-County.pdf (Accessed 9-29-2017)
[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.
[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-09-00008.1 (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 definition[19])

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

[19] Provider Certification, 2010 - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R57SOMA.pdf (Accessed 12-14-2018)
[20] Sanner L, Voorhees K. Medicare GME Payments: Background and Basics, Presentation at Program Directors' Workshop, 2018. https://www.aafp.org/dam/AAFP/documents/events/rps_pdw/handouts/res18-80-medicare-gme-payments-background-and-basics.pdf

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"
   A current draft of the "Capacity Crosswalk"
5. Accumulated examples of best practices from others, including a list of references from the web and from the literature
6. A summary of identified gaps
7. Suggested next steps for closing the gaps, if applicable, and further steps in the development of existing resources
8. A decision to pause or proceed – never stop!

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]

Community Asset	Key contact, with email and/or phone

   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)]

Health Profession/Stage of Training	Location/Facility & Town	Dates (years)

   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 medial 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?

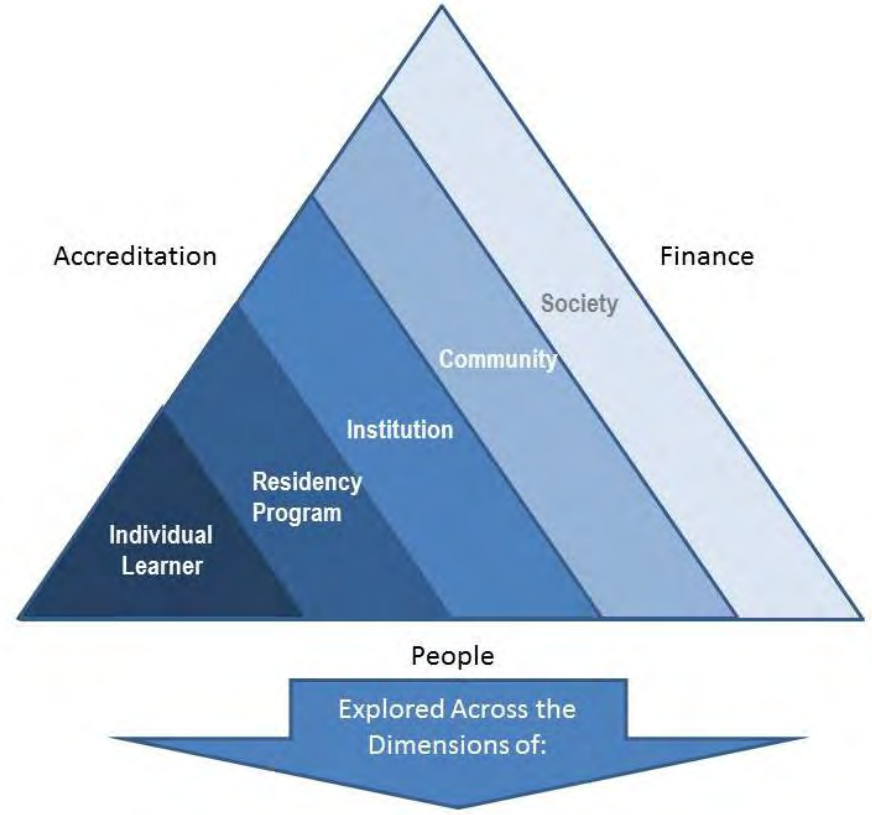
Please provide a roster or list of all medical staff members including specialty

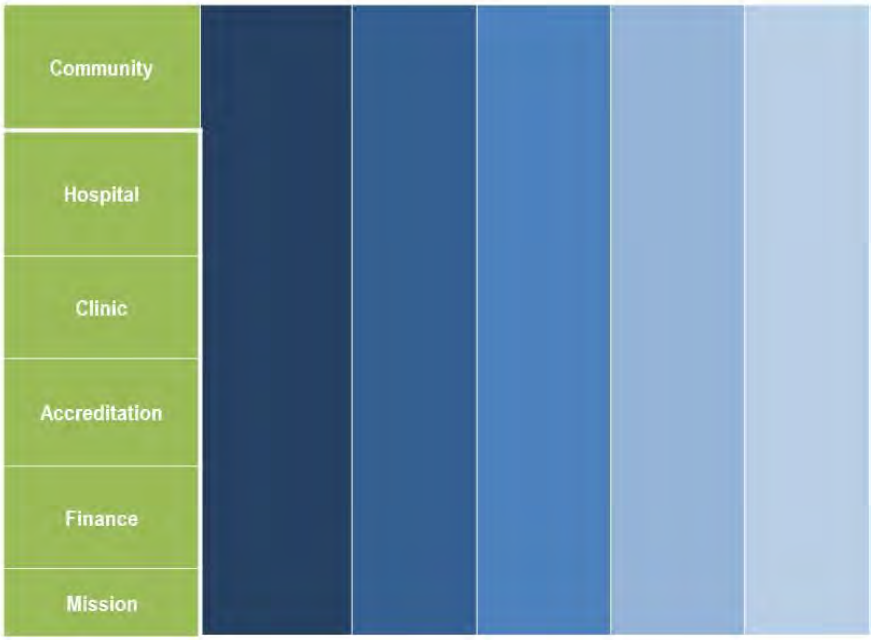
Please provide a copy of the core privileges for family medicine physicians and any other privileges held or considered special privileges for family medicine physicians.

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

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[21] Derived from a presentation and group discussion entitled "Rural Family Medicine Closure: Risk and Protective Factors" at the Annual Meeting of the RTT Technical Assistance Program, June 2014.

Reference:

David Schmitz, MD†, Davis G. Patterson, PhD*, Sherry Adkins, MD/MPH**, Belinda Vail, MD, MS^, 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)

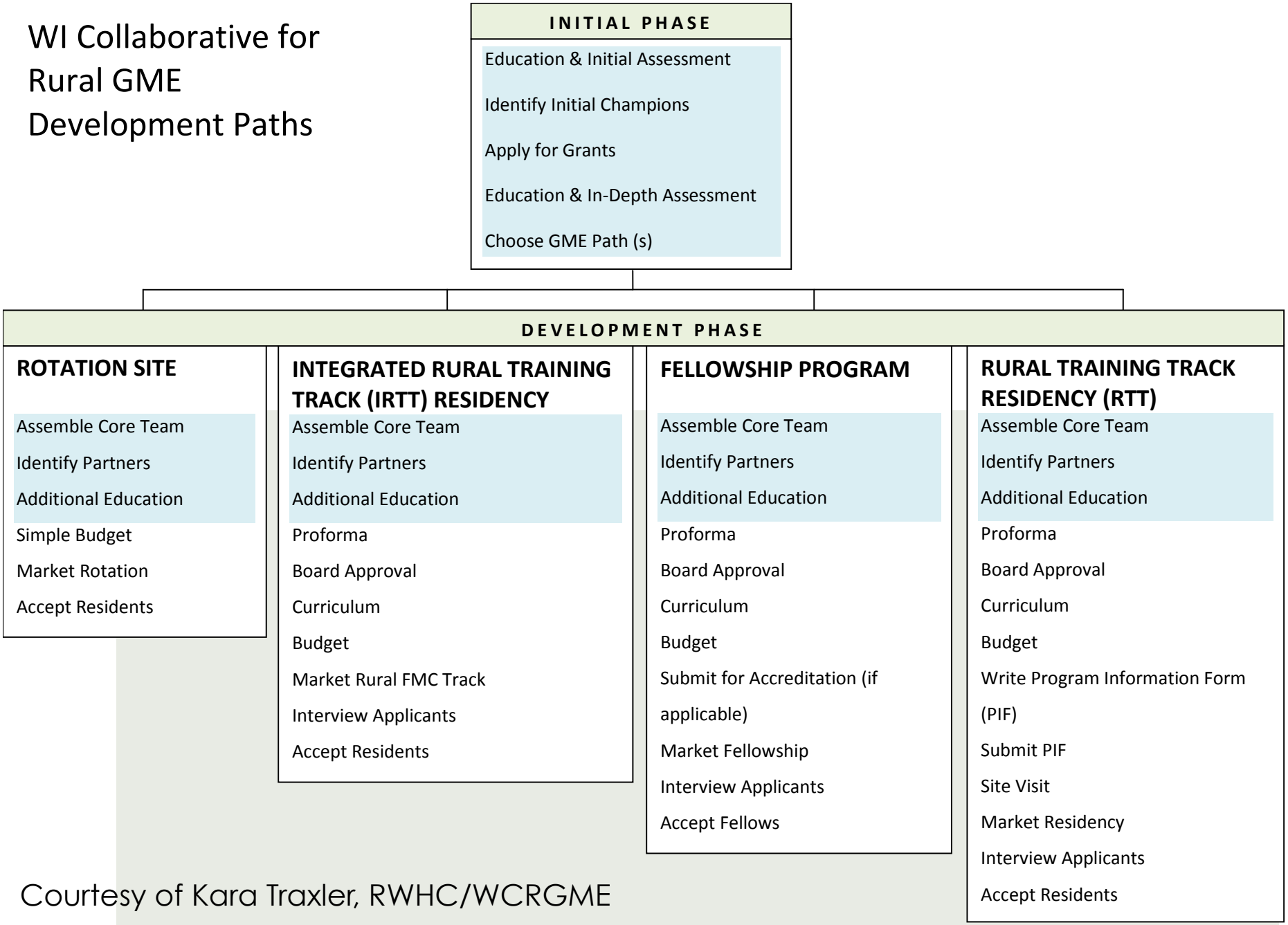
Appendix F: "Challenges (and Solutions) for Small Programs" – March 2015 (Longenecker)

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



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

√	**Minimum** time prior to anticipated implementation (it may take longer than this)	**Task**	**Detail**
	Never too early!	Make contact with The RTT Collaborative, join the listserve, 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.	The RTT Collaborative http://www.rttcollaborative.net
	36 months	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. **How the program is designed will markedly affect financial projections.**	Community Engaged Residency Education for Rural Places (CERE-R; available for download) https://rttcollaborative.net/about/tools-and-assistance/
	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&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	For more information on integrated RTTs, visit https://rttcollaborative.net/wp-content/uploads/2017/03/Rural-program-nomenclature.pdf

		participating urban hospitals (e.g. shared faculty, shared didactics, and/or shared months of rotations spaced through the three years).	
	24-36 months	Identify a sponsoring institution (SI)	
	24-36 months	Is the SI currently accredited by the ACGME?	
		Y – Move to next step	**N-**For information on how to apply for institutional accreditation, contact the Administrator for the Institutional Review Committee. https://www.acgme.org/acgmeweb/tabid/158/ProgramandInstitutionalAccreditation/Institutions/InstitutionalReview.aspx The Sponsoring Institution must be approved before proceeding further.
	24 months	Confirm that the Sponsoring institution is in good standing and complies with the Institutional Requirements	https://apps.acgme.org/ads/Public/Sponsors/Search
	24 months	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.	Common Programs Requirements: https://www.acgme.org/acgmeweb/tabid/429/ProgramandInstitutionalAccreditation/CommonProgramRequirements.aspx Family Medicine Requirements and Application: http://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pfcatid/8/Family%20Medicine
	24 months	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.

		designate a dedicated, and at least part-time, administrative staff person to assist in development.	http://www.afmrd.org/page/about-the-nipdd-fellowship The RTT Collaborative offers a limited number of scholarships for this program in May of each year.
	24 months	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.	http://www.acgme.org/Specialties/Overview/pfcatid/8
	24 months	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 (<30 minutes) are available at no cost, and it is important to know what resources are available to you as a developing program.	http://www.rttcollaborative.net longenec@ohio.edu or (740) 597-3058 (phone messages are forwarded to email)
		New programs should follow the "Approved but not currently in effect" program requirements.	e.g. Common Program Requirements, July 1, 2017; Family Medicine, July 1, 2016
	18 to 24 months	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.	Substitute dates for minimum months in this template and add your own rows; generally takes at least 18-24 months from this point.
	18 months	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)	https://rttcollaborative.net/about/tools-and-assistance/

	18 months	Have DIO initiate the new program application within the Accreditation Data System (ADS)	https://www.acgme.org/acgmeweb/tabid/159/DataCollectionSystems/AccreditationDataSystem.aspx
	18 months	Program Director completes the application in ADS and supplemental materials if any	
	18 months	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	
	Very dependent upon current backlog and time to next FM-RC meeting	Receive scheduled date from ACGME and prepare for Site Visit	Notiication can occur as long as 3 months after completion of the application and as long as 6 months before the actual site visit
	12 to 18 months	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	Site Visit Overview http://www.acgme.org/What-We-Do/Accreditation/Site-Visit FAQ's http://www.acgme.org/Portals/0/fs_faq.pdf http://www.acgme.org/What-We-Do/Accreditation/Site-Visit/Site-Visit-FAQs
	12 months	Host Site Visit	
	6 to 9 months (To allow for participation in the National Residency Match)	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	For the agenda deadline for RC-FM meetings, see the right-hand column: http://www.acgme.org/Specialties/Overview/pfcatid/8/Family%20Medicine
		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)	

	6 to 9 months	Recruit initial resident class and proceed with faculty contracts	
		[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]	

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

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

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

Procedures (ambulatory and hospital)				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				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.

Practice Management	100 hours (1 month) dedicated to health system management experience			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.
Dermatology				Residents must have experience in diagnosing and managing common dermatologic conditions.
Radiology				The curriculum should include diagnostic imaging interpretation and nuclear medicine therapy pertinent to family medicine.

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

The OSU Rural Program – Three Year Curriculum

Intensive immersion experiences embedded in a continuing rural practice

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

YEAR 1

Hospital Care (Shared)	Hospital Care	Pediatrics Inpatient	Hospital Care (NRP)	Special Care Nursery	OB – Newborn	Hospital Care	Cardiology	Hospital Care (Wound Healing)	MICU	Hospital Care (ATLS)	Peds ER	Scholarly Activity (Shared)
MRH	MRH	CHC	MRH	OSUH	MRH	MRH	OSUH	MRH	OSUH	MRH	CHC	MRH
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	2 Half-days	1 Half-day	3 Half-days

YEAR 2

Ambulatory Cardiology	Elective	OB - Newborn	OB – Newborn (High Risk Immersion)	Derma-tology	Pediatrics Outpatient	ICU – Intern Med	Orthopedics	Medical Sub - specialty	Elective	GYN
MRH/Offic		MRH	MRH	Office	Office	MRH	MRH/Office	MRH/Office		Office
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

Elective	Geriatrics, Physical Medicine, and Psychiatry	GYN	Elective	Surgical Subspecialiies – Opthalmology, ENT, Urology, Podiatry	Elective	Sports Medicine	Elective	Medical Sub - specialty
	Office	Office		Office		OSU Sports Ctr		MRH/Office
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:
   https://www.youtube.com/watch?v=siqx4PbqJ6s (Accessed 1-3-2015)

See attached EXCEL template

Duty Hours and Call

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

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

The RTT Collaborative
in rural health professions education and training
Growing our own…together

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[1]

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.[2]

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[3] in a rurally located continuity clinic or Family Medicine Practice site (FMP) is considered an IRTT-like program.

Basic Federal Regulations Relevant to Rural Training Tracks (from the Electronic Code of Federal Regulations, Title 42 → Chapter IV → Subchapter B → Part 413, accessed July 11, 2017)

Subpart F, Specific Categories of Cost, Direct GME payments, **42 §413.75 to 413.83**
http://www.ecfr.gov/cgi-bin/text-idx?SID=55bcffa0cfd9538a10a9abaf84f42c6b&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=55bcffa0cfd9538a10a9abaf84f42c6b&node=42:2.0.1.2.13&rgn=div5#se42.2.413_179

Specific Federal Register Final Rule Notices
(Accessed July 11, 2017)

FY01 IPPS Final Rule, August 1, 2000, Implementation of BBRA, page 47032ff ("Rural track FTE limitation" determined, page 47033-47): https://www.gpo.gov/fdsys/pkg/FR-2000-08-01/pdf/FR-2000-08-01.pdf

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

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[1] Longenecker R. Rural Medical Education Programs: A Proposed Nomenclature. *Journal of Graduate Medical Education* June 2017;9(3):283-286. https://doi.org/10.4300/JGME-D-16-00550.1 (Accessed 6-16-2017)
[2] Aligns with CMS FY2004 regulations defining an integrated rural training track, Department of Health and Human Services, Center for Medicare and Medicaid Services. *Federal Register* August 2003; http://edocket.access.gpo.gov/2003/pdf/03-19363.pdf (Accessed 6-16-2016)
[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): https://www.gpo.gov/fdsys/pkg/FR-2009-08-27/pdf/FR-2009-08-27.pdf

FY15 IPPS Final Rule: August 19, 2014, Reclassification of rural hospitals to urban, example calculation of FTE limitation (cap), pages 50116 – 50117: https://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf

FY17 IPPS Final Rule: August 1, 2016, Policy Changes Relating to Rural Training Tracks at Urban Hospitals – Cap building period, other; pages 57026 – 57031: https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

[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]

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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

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Why are you here?

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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."
    - » EH Gonzalez, RL Phillips, Jr, PA Pugno. Fam Med 2003;35(10):706-10

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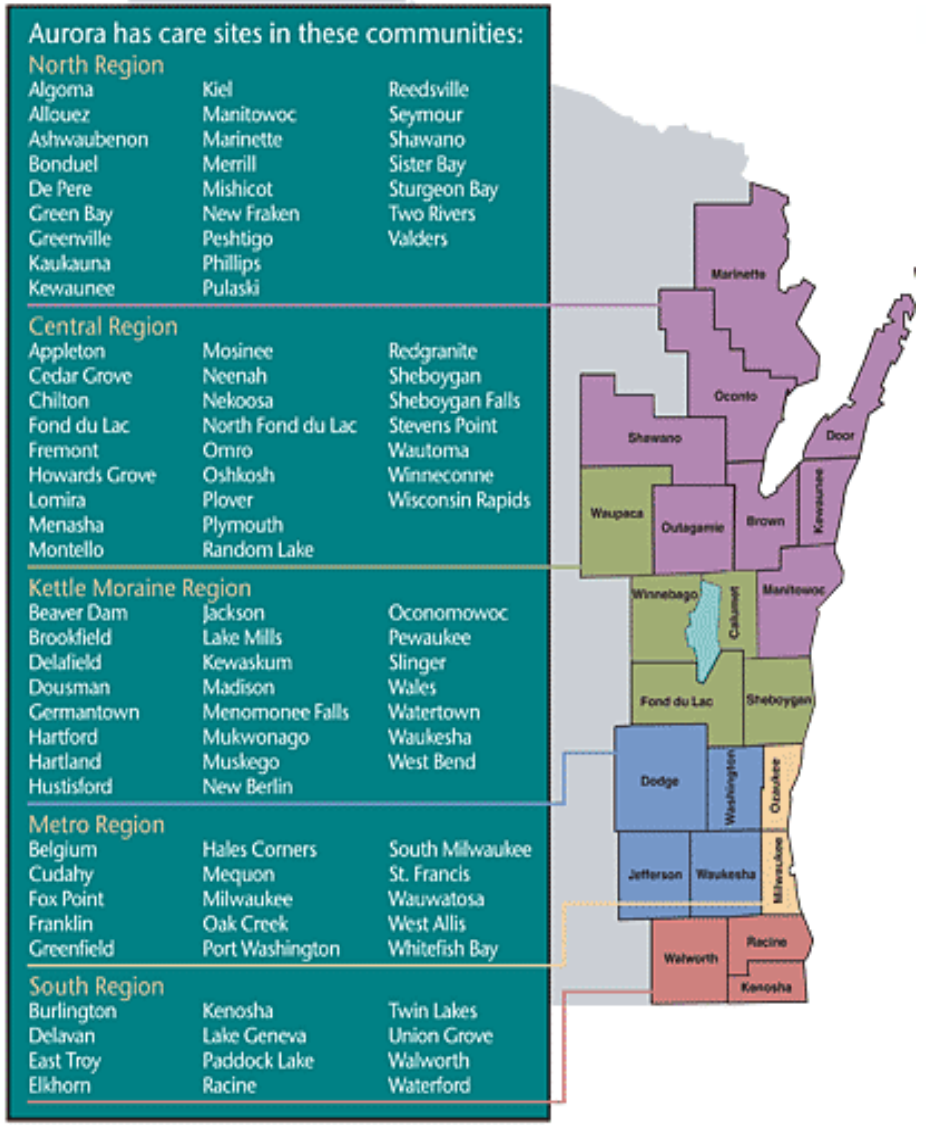
About us:
Aurora Health Care

- 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



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AHC Academic Affairs

- 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

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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."

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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

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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

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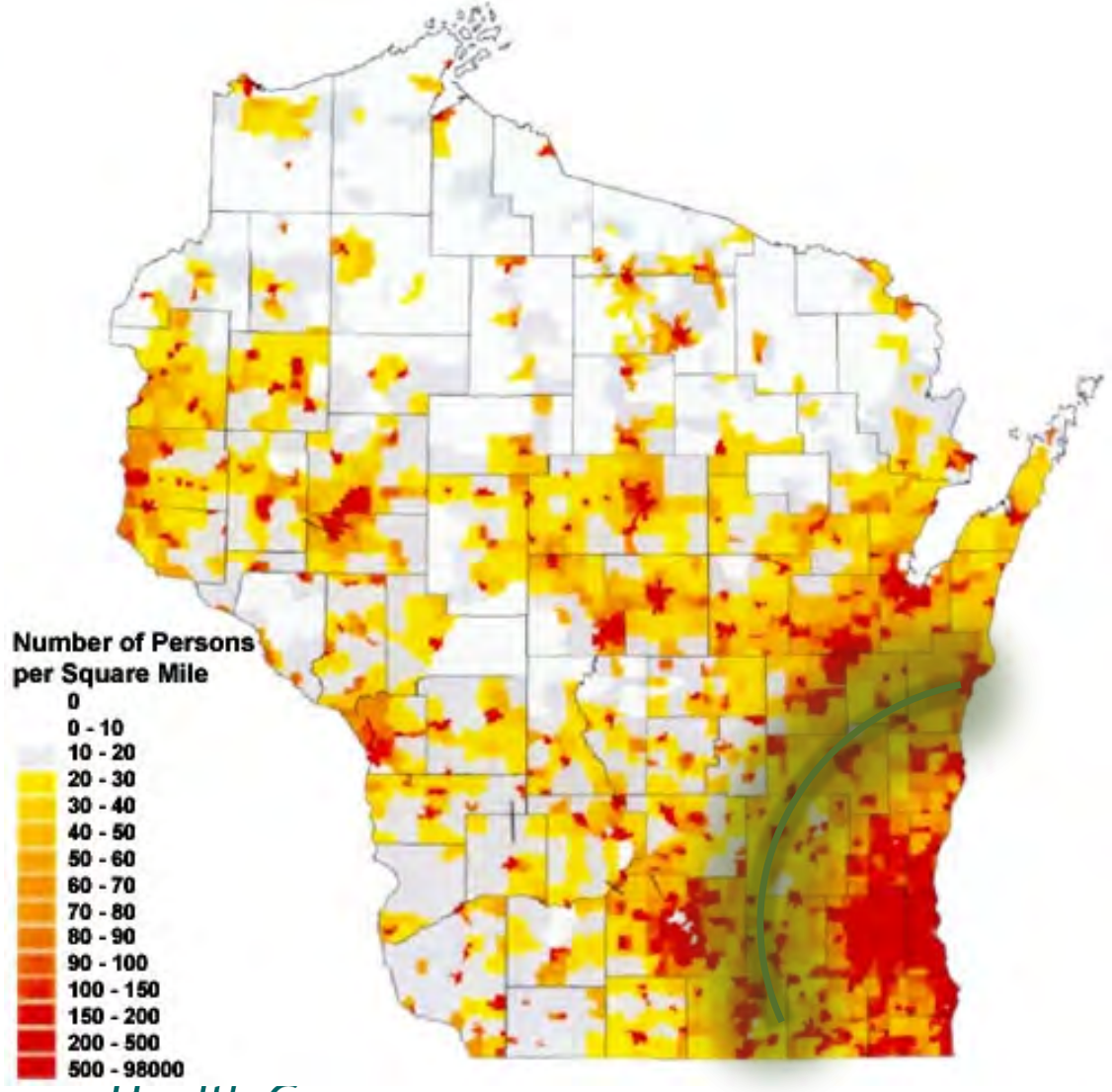
WHERE?



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Rural defn (state, federal), AHC facilities, FM Champions, Other

Region	Location	Size	County	>15m to city >20K ?	AHC facilities	Champions	Comments
Fox Valley	Kewaunee	2952	Kewaunee	30 m to Green Bay	BayCare, Two Rivers (both ~30m away)		One of smallest sites Health Provider Shortage Area
Fox Valley	Sturgeon Bay	9144	Door	44 m to Green Bay	Sturgeon Bay Med Ctr (Clinic)		Sign distance to AHC hospital Hospital not Aurora
Fox Valley	Two Rivers	11712	Manitowoc	7 m to Manitowoc (33K)	Two Rivers Med Ctr, clinics	Roman, Hester-Diez	Site for WARM*
Fox Valley	Shawano	9305	Shawano	40 m to Green Bay	Shawano Clinic	Hiltgen	Sign distance to AHC hospital Site for WARM Hospital not Aurora
Fox Valley	Howard, Suamico	17339, 11346	Brown	6,10 m to GB	BayCare	Rob Stevens	Suburban population
Fox Valley	De Pere	23880	Brown	6 m to GB	BayCare		Suburban population AHC looking to expand site
Fox Valley	Marinette	10943	Marinette	54 m to GB	Mult Clinics		Not AHC hospital currently** Numerous AHC docs 3 hr from MKE
Central	West Bend	31078	Washington	n/a	Mult Clinics		18m/30min to Hartford
Central	Kewaskum	4004	Washington, Fond du Lac	8 m to West Bend (34K)	Clinic		Significant distance to hospital
Central	Waupun	11340	Dodge, Fond du Lac	20 m to Fond du Lac	None		Corrections population. Non-AHC hospital
Central	Plymouth	8445	Sheboygan	15m to Sheboygan	AHC clinic, Sheboygan Med Ctr	Gavin, Smith	WARM site Fledgling CHC in Sheboygan
Central	Hartford	14223	Dodge	16 m to West Bend	Hartford Med Ctr		Suburban population
Central	Slinger	5068	Washington	11 m to West Bend	Hartford Med Ctr		Suburban population
Central	Jackson	6753	Washington	9 m to West Bend	Jackson Clinic	Holcomb	12m, 20min to Hartford
Lk Michigan	Cedarburg	11412	Ozaukee	4 m to Mequon	Grafton Med Ctr		Suburban population
Lk Michigan	Grafton	11459	Ozaukee	8m toMequon (23K)	Grafton Med Ctr		Suburban population
I-94 corridor	Oconomowoc	15759	Waukesha	20 m to Waukesha	Wilkinson Clinic, Summit Med Ctr		
I-94 corridor	Watertown	23861	Dodge/ Jefferson	36 m to Waukesha	Wilkinson Clinic		Hospital not AHC; 30 min to Summit Med Ctr
Southeastern Wisconsin	Burlington	10464	Racine, Walworth	25 m to Mt Pleasant	Burlington Med Ctr	Taylor	Student rotations from RFU
Southeastern Wisconsin	Delavan	8463	Walworth	20 m to Janesville	Lakeland Med Ctr		
Southeastern Wisconsin	Elkhorn	10084	Walworth	26 m to Janesville	Lakeland Med Ctr		
Southeastern Wisconsin	Whitewater	14769	Walworth/ Jefferson	21 m to Janesville	None		Non-AHC hospital
Southeastern Wisconsin	Lake Geneva	7651	Walworth	27 m to Pleasant Prairie	Lakeland Med Ctr	Gerber	
Southeastern Wisconsin	Twin Lakes	5989	Kenosha	26m to Kenosha	AHC clinic		
Southeastern Wisconsin	Paddock Lake	2992	Kenosha	16m to Kenosha	AHC clinic		One of smallest sites
Southeastern Wisconsin	Waterford	5368	Racine	16m to Waukesha	AHC Clinic, Burlington Med Ctr		

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Two Frontrunners…

- Aurora Lakeland Medical Center, in *Walworth County*
- Aurora Two Rivers Medical Center, in *Manitowoc County*

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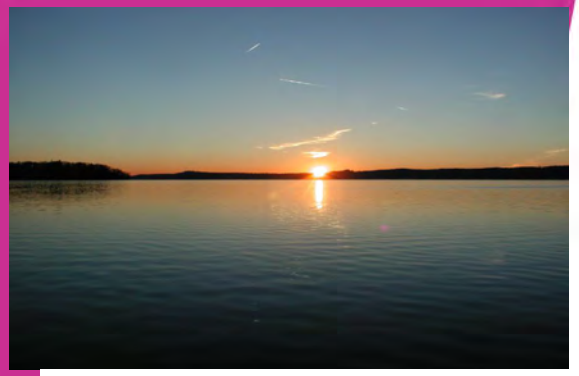

Aurora Family Medicine Residency Program

Aurora Lakeland Rural Training Track (ALRTT!)

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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

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…And the pitch…

How would you sell the Value of an RTT to an integrated health care system ?

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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/pdf/CH8854058.PDF

***Rural Residency Training for Family Medicine Physicians: Graduate Early-Career Outcomes. http://depts.washington.edu/uwrhrc/uploads/RTT_Grad_Outcomes_PB.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

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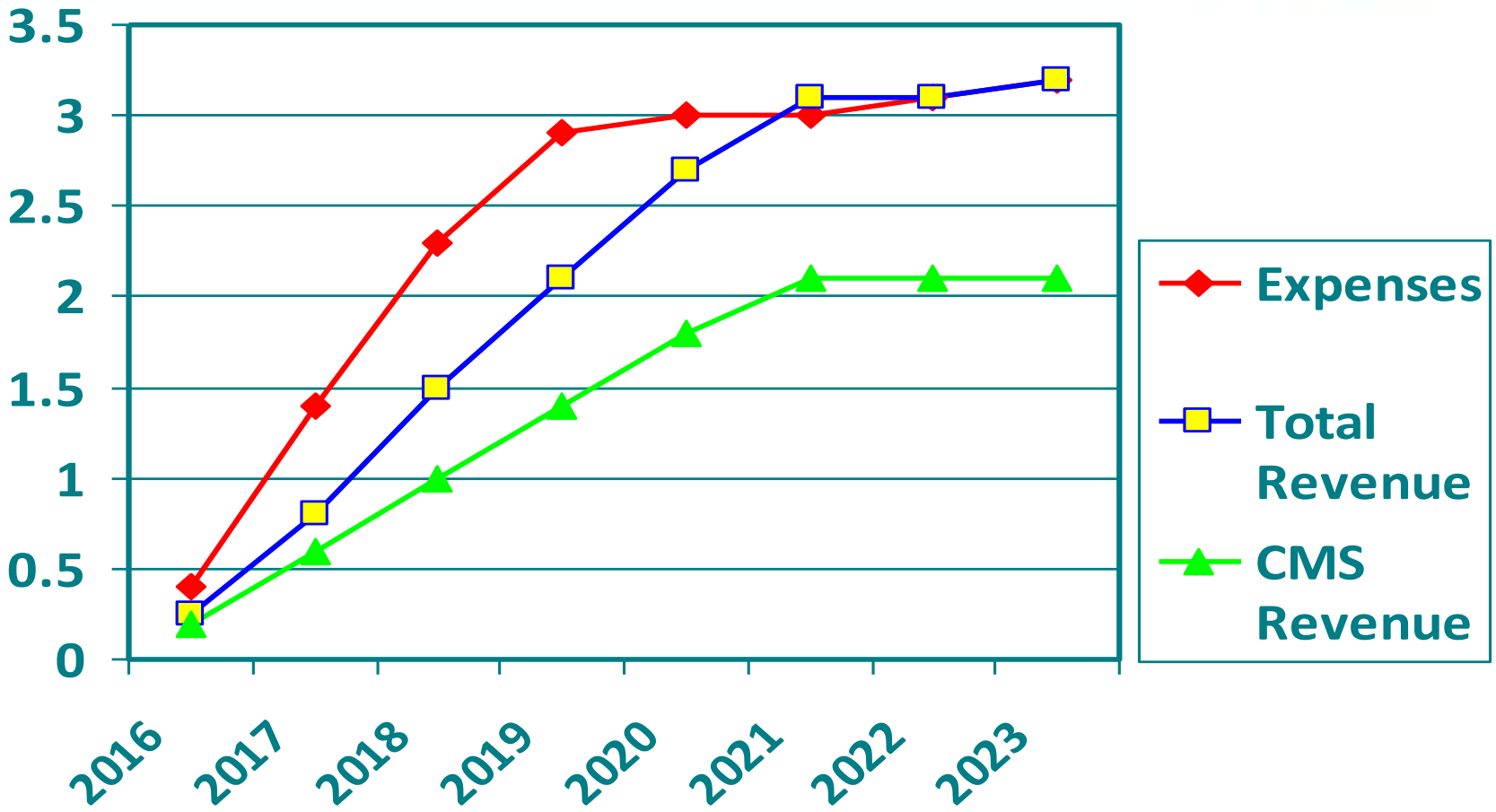
Proforma Summary
Expenses & Costs (in $M)



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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 1^0 care recruit cost: $56K* (higher in rural)
  - ↑ Retention: National Avg ~$1M 1^0 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
- 1^0 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

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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

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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

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Where are we now?

Project Leadership Identified 4th quarter 2014:

1) Executive Sponsor: Dr. Andy Anderson

2) Project Leader: Dr. John Brill

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The Project Team Members

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

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Project Design

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.

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Discussion

Questions ?

Discussion?

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Date

Dear Name, title:

Thank you so very much for working with our residents/fellows from the name of residency program. We have enjoyed our relationship over the years and I indeed hope that you have found this beneficial as well. Please find attached a Memorandum of Understanding (MOU) between hospital/medical center and the residency program. This MOU is completed annually to help meet the requirement for an affiliation agreement between your institution, hospital, and the name of residency program. As you may know, in order to receive Medicare Graduate Education (GME) funds the hospitals are required to incur all or substantially all of the costs associated with the residents/fellows. The MOU confirms that you are willing to work with our residents/fellows with no expectation of reimbursement from either name of hospital, or from the name of residency program, or any other person or entity; therefore because there are no costs associated with your assistance to the residents/fellows, there are no costs that the hospitals are failing to incur. I very much appreciate you donating your time to help with the training of our residents/fellows.
In return for that service our residents/fellows will work with you at no cost to you and in addition, you can become university clinical faculty if you so desire. If you have an interest in this please contact name at email and we will work toward getting that accomplished for you. This will give you access to the healthcare resources library at university.

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

Sincerely yours,

Name
Residency Official

MEMORANDUM OF UNDERSTANDING BETWEEN
name of hospital
Name of residency program.,
AND AFFILIATED TRAINING SITE

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

Affiliated Training Site: name of training site

Effective Date: date

BACKGROUND

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

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

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

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

GOALS AND OBJECTIVES

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

RESPONSIBLE OFFICIALS

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

PERIOD OF ASSIGNMENT AND BENEFITS

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

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION REQUIREMENTS

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

assignment. TERM OF AGREEMENT

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

OTHER

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

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

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

Signatures of duly authorized representative of place this agreement

into effect. REPRESENTATIVE FOR THE AFFILIATED

TRAINING SITE:

_____ (Signature)
_____ (Printed Name)
_____ Affiliated Training Site _____ Date

REPRESENTATIVE FOR name of hospital:

_____ (Signature)

_____ Title _____ Date

REPRESENTATIVE FOR name of residency program:

_____(Signature)

Residency Official _____ Title _____ Date

Dear Preceptor,

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

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

Schedule: The resident will be in your community for 2 weeks. They are not required to take call, but can do so with the same frequency that you do. They are still governed by work hour restrictions, however, which limit the resident to 80 hours per week averaged over the 2 weeks and to work no more 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."

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

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

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

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

Information: If there is anything you would like to make sure the resident knows prior to arriving or any information that you always present, we would be happy to make sure the residents get a copy of that before they come your way. For example: maps, orientation information, web sites, contact info, pager info, good eateries, etc. Please pass it on to Diana Beahm by email at Diana.beahm@fmridaho.org. 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
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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."

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

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

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

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

Information: If there is anything you would like to make sure the resident knows prior to arriving or any information that you always present, we would be happy to make sure the residents get a copy of that before they come your way. For example: maps, orientation information, web sites, contact info, pager info, good eateries, etc. Please pass it on to Diana Beahm by email at Diana.beahm@fmridaho.org. 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

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

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

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

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

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

Definitions of Rural

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

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