

How Can We Support Small and Rural Residency Programs as Unified ACGME Accreditation Approaches in 2020?

**Collaborative for Rural Primary care
Research, Education, and Practice
(Rural PREP)**

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Study objectives

- Review top challenges of rural residency programs in the transition to a single allopathic and osteopathic accreditation system.
- Describe strategies residencies are using and supports they need to sustain rural graduate medical education.

Rural and/or small programs

- Beginning in 2020, the Accreditation Council on Graduate Medical Education (ACGME) will be the single accrediting body for all physician residency programs, allopathic and osteopathic.
- Smaller and rural residencies, particularly osteopathic programs, face vulnerabilities in achieving and maintaining accreditation under this unified accreditation system.

Definitions

- **Rural-centric** – An accredited residency program that trains residents in a rural location (self-reported or by RUCAs*) for at least 8 weeks over the duration of their residency training
- **Small** – A residency program with fewer than the required minimum resident complement per year (e.g., <4 per year in family medicine, <5 in internal medicine, <3 in psychiatry)
- **Rural location** – Rural location of continuity clinics, rotations, or the program itself according to RUCAs*

* RUCAs: Rural-Urban Commuting Area codes (RUCAs) 2014 version 3.1 ZIP approximation (codes 4.0-10.6 excluding 4.1, 5.1, 7.1, 8.1, and 10.1)

Methods

Sample: 238 small or rural-centric American Osteopathic Association (AOA) and ACGME-accredited residencies in:

- family medicine
- general internal medicine
- general pediatrics
- obstetrics/gynecology
- psychiatry
- general surgery
- emergency medicine

38 small rural-centric
135 not small rural-centric
65 small urban

11 Interviews of program directors to inform survey development (at least one in each specialty)

Methods

Surveyed program directors, April-November 2018:

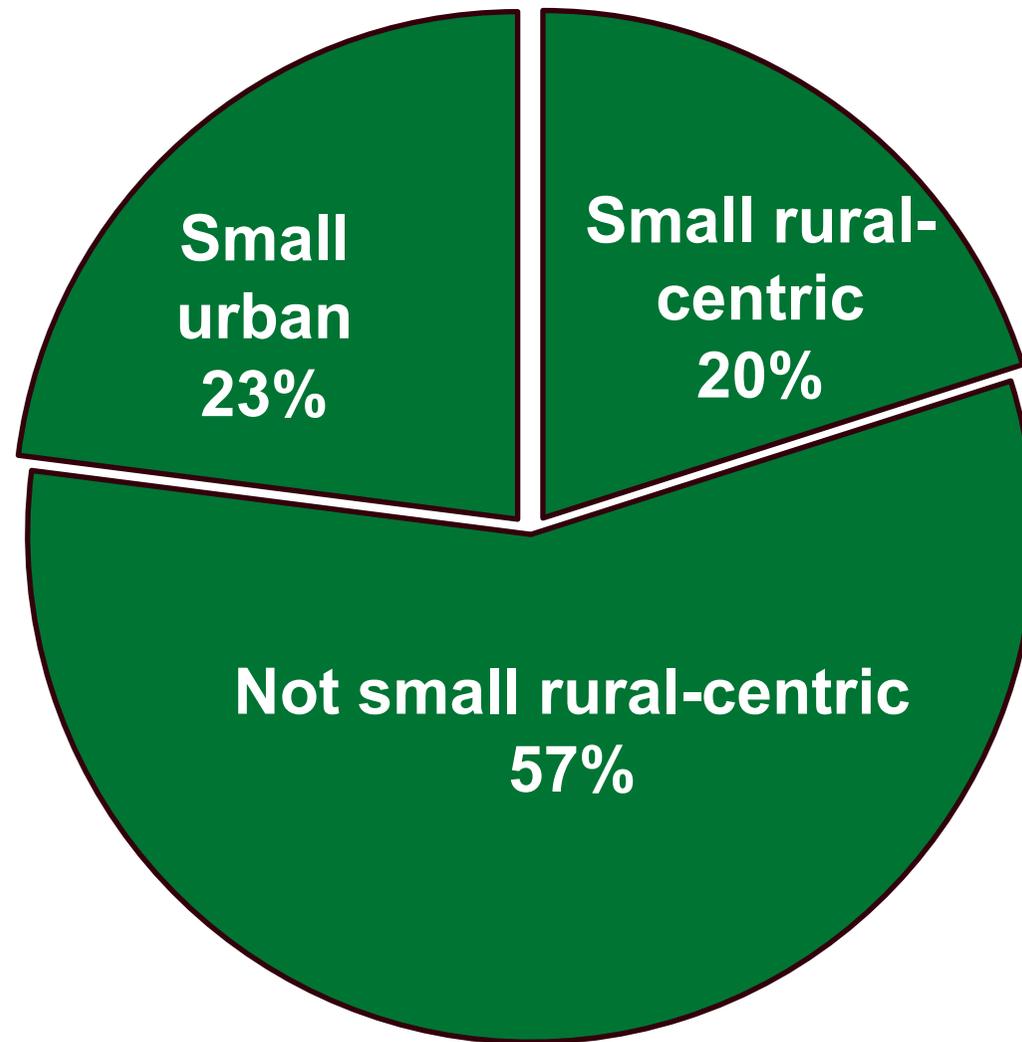
- challenges in obtaining ACGME accreditation
- supports
- resources
- recommendations for similar programs

Results

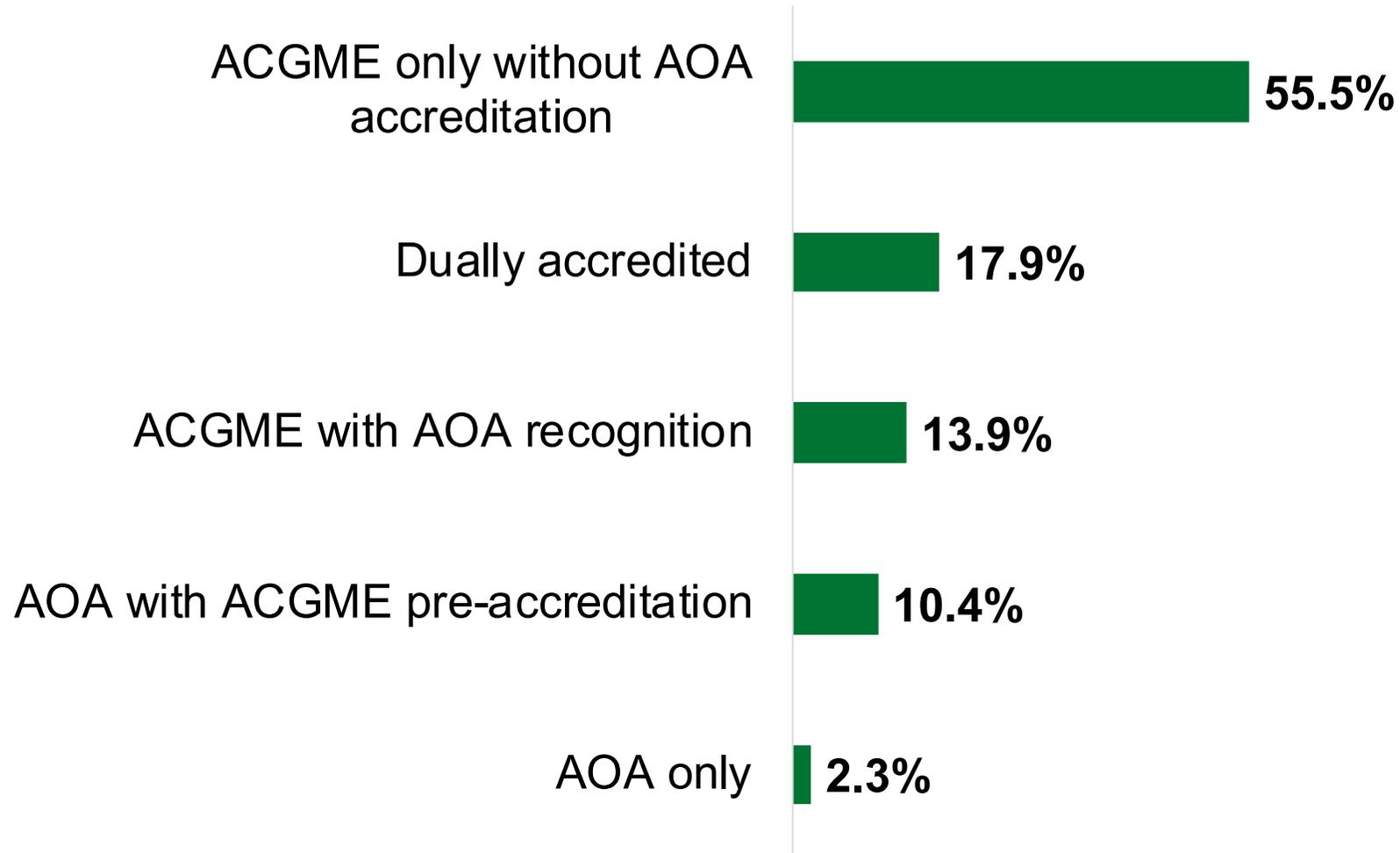
Overall response rates: 73% (174/238)

- Small rural-centric (92%)
- Not small rural-centric (73%)
- Small urban (62%)

Responses by program type (n=174)

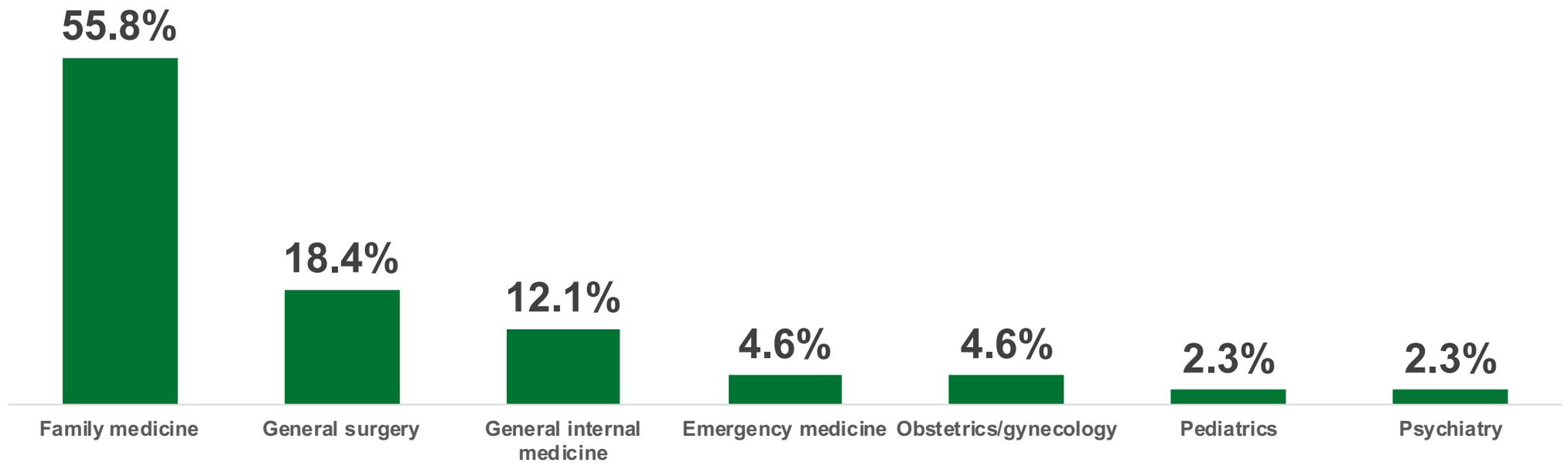


Accreditation status, 2018*

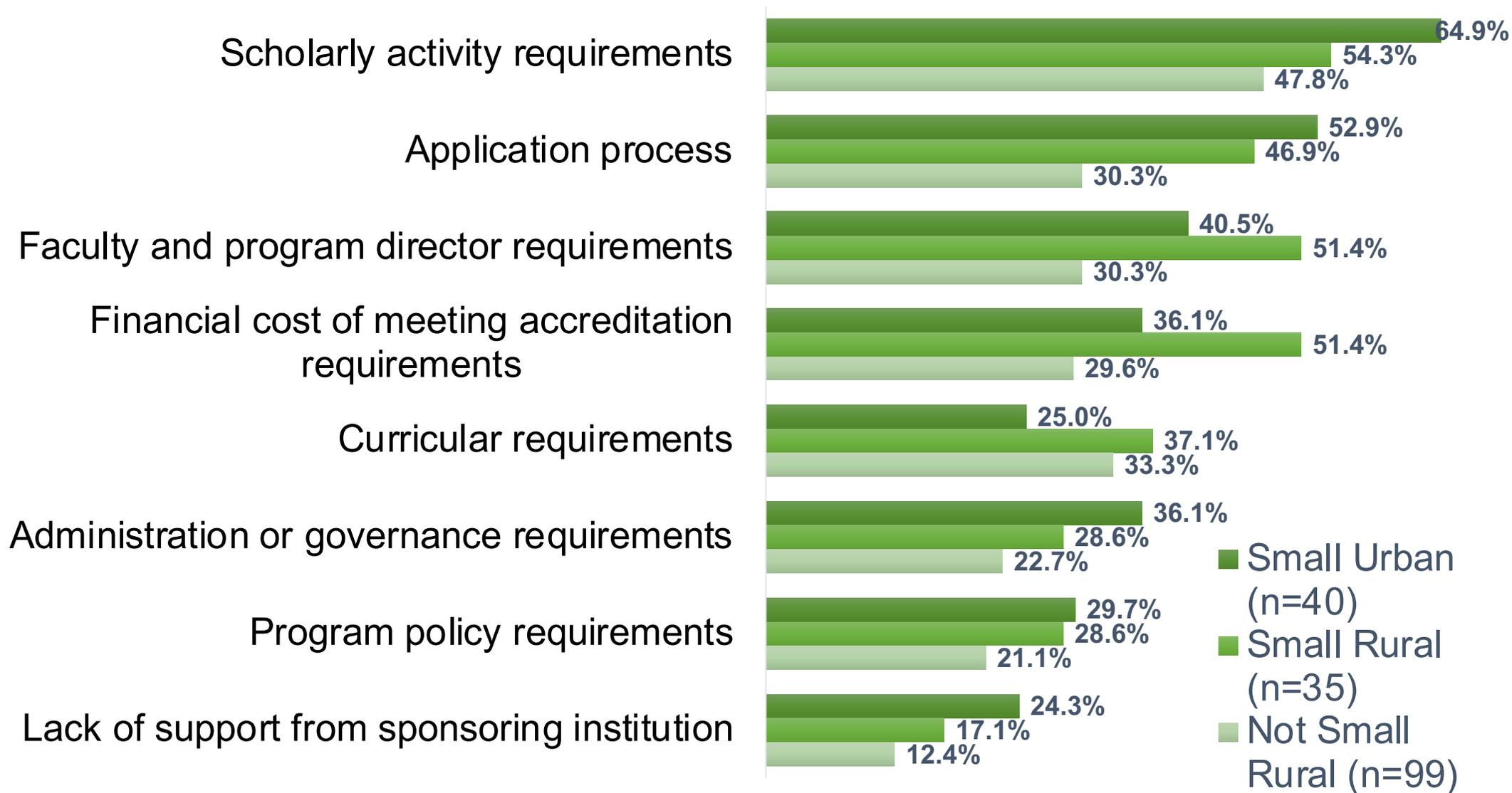


* At time of survey completion

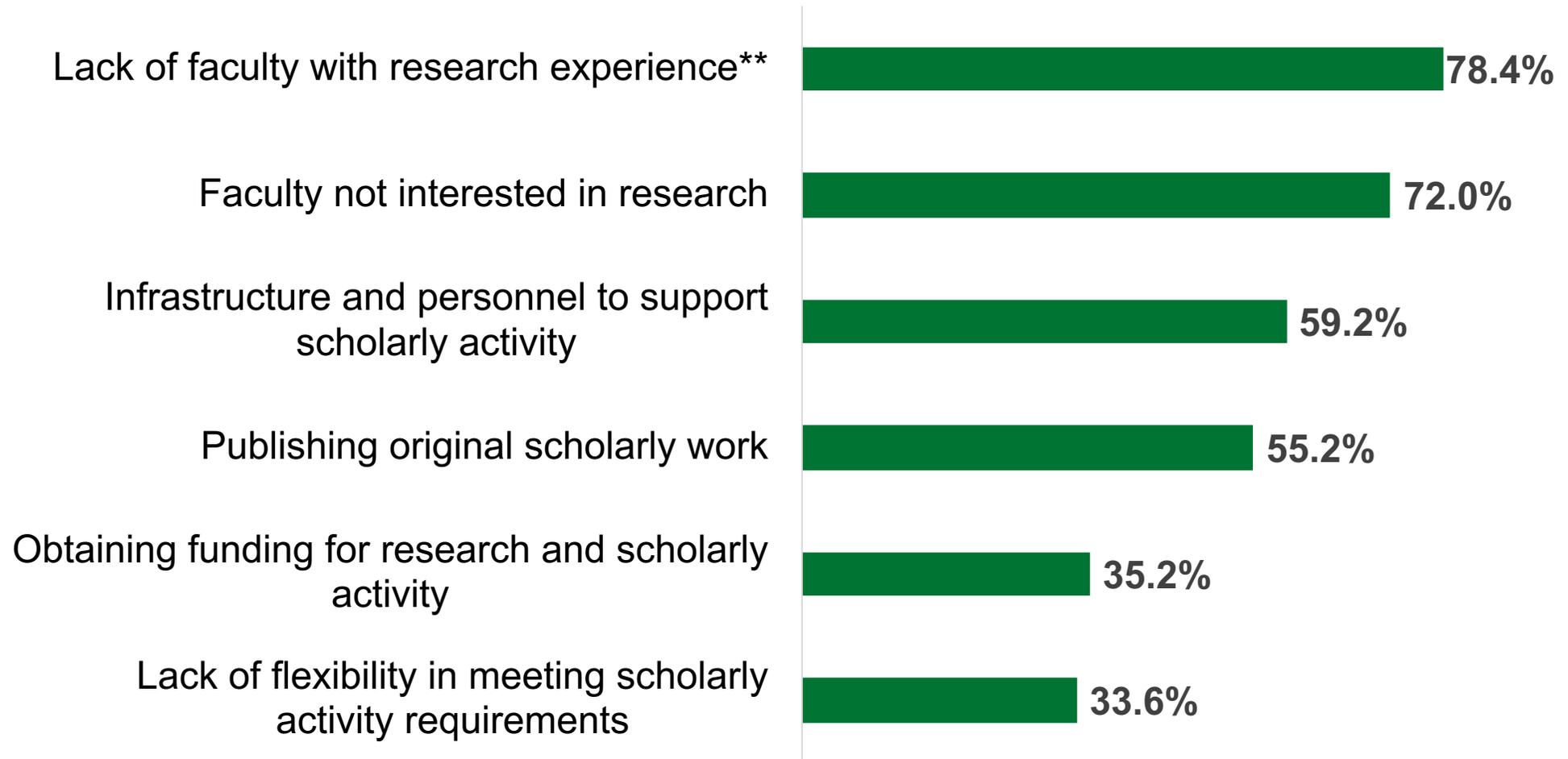
Program specialties



“Moderate” or “significant” challenges achieving/maintaining accreditation



Challenges meeting ACGME scholarly activity requirements*



*Of programs reporting challenges

**100.0% for AOA-only accredited programs vs. 74.3% for all others

Scholarly activity challenges

“As a working clinician for 20 years, I have not had any experience in training with publishing articles, performing research, etc. All of our faculty are community family physicians with limited academic experience.”

“Almost all of the faculty work in a RVU environment. There is no reimbursement provided for scholarly activities.”

“Time for existing faculty to participate in scholarly activity. In a rural area, faculty are often required or heavily pressured to work far above their contractual mandates.”

”

More AOA-accredited programs reported challenges than ACGME-accredited programs

- Statistically significant differences (AOA- vs. ACGME-accredited programs):
 - Application process: 73.7% vs. 33.3%
 - Faculty and program director requirements: 65.0% vs. 32.9%
 - Lack of support from sponsoring institution: 31.6% vs. 13.5%
- 41.3% of rural programs (AOA - 78.6% vs. ACGME - 35.9%) cited rural location as a challenge

Other challenges

“[The ACGME] do not seem to know what we do and try to fit us in the standard residency box...In a rural area sometimes there are excellent physicians who are not board-certified in specialties the residents need experience with, but they are not acceptable to the ACGME.”

“difficulty with family medicine RRC understanding our 1+2 rural approach”

“...time resources to get the program into compliance, some disconnect with core program for our 1st years since we are a 1-2 program.”

“Our biggest challenge is meeting ACGME requirements for pediatrics. Inpatient peds must be completed in another state at a hospital 4 hours away ... We also struggle with continuity deliveries.”

Citations based on program size

- 54.6% of small programs reported that small size was challenging

“We were cited for **not having 4 residents per year as required by ACGME**. We also received a citation for the **excessive travel between sites** (which is 50 miles each way for continuity clinic, 200+ miles for inpatient peds).”

“**Board pass rate:** Initially we had only 6 residents (2 in each year) before our expansion to a full contingent of 12. One failure sets us back several years.”

Citations based on program size described:

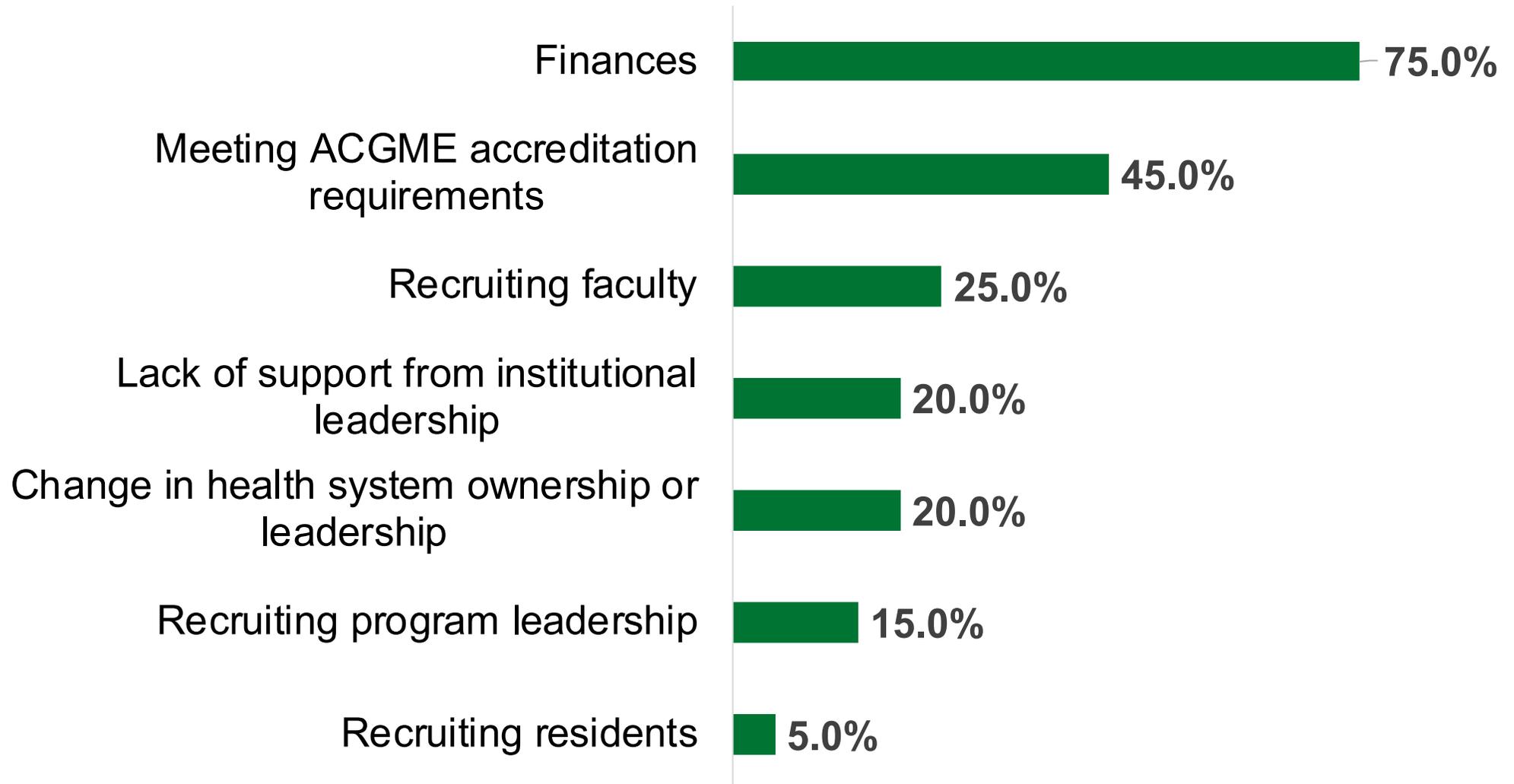
1. **Faculty board certification** - retired FP still precepting but did not recertify at last scheduled time.
2. **Nephrologist not board certified** and residents going to his clinic for experience with him.
3. **Scholarly activity**
4. **Lack of support in pulling data for reports for ACGME** causing errors and leading to citation
5. **Lack of ACGME understanding of the logistics of supervision** in a program where the clinic is less than 4 blocks from the hospital. Faculty can be in attendance in less time than faculty in a large medical center.
6. **Lack of understanding of the initial approval** of the program.

Program closure

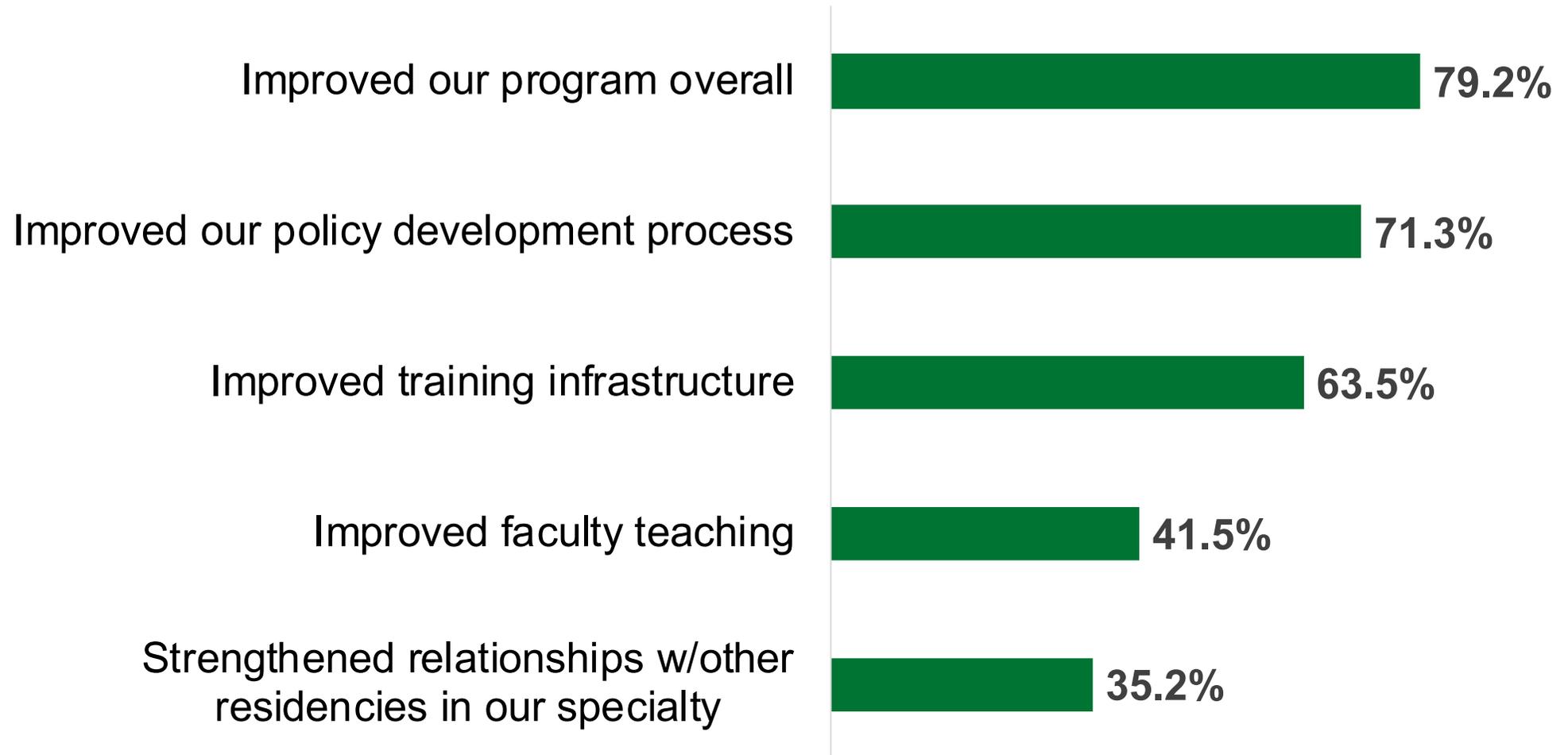
20 programs (12.7%) considered closure in past 3 years:

- 8 (32%) of rural-centric and small family medicine programs
- 12 (9%) of all other programs

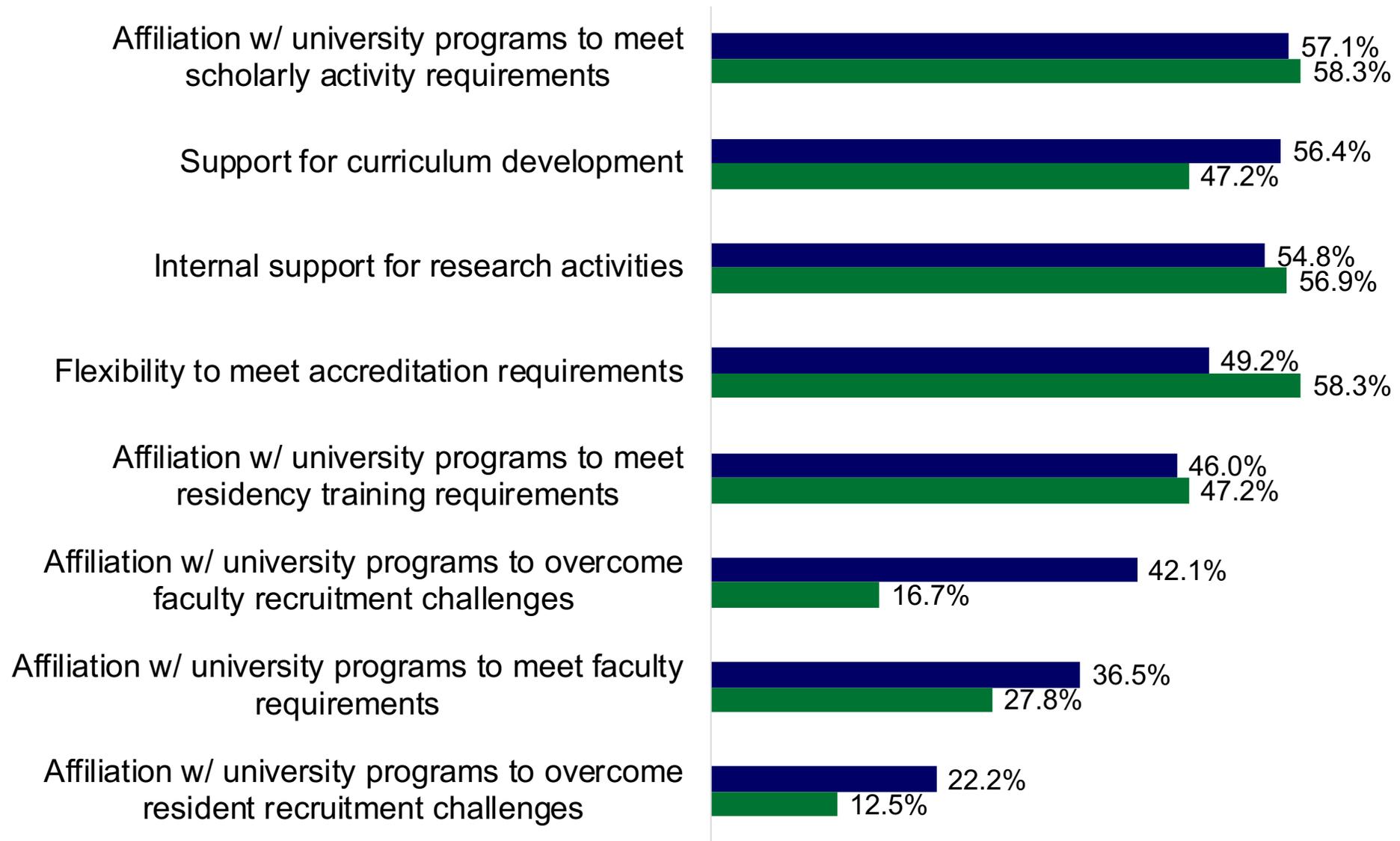
Contributing factors to considering program closure



“Somewhat”/“strongly” agree that the ACGME accreditation process...



Recommendations to support rural/smaller programs to achieve/maintain accreditation



■ Recommendations for rural programs (n=134)*

■ Recommendations for smaller programs (n=75)*

Conclusions

What challenges do rural-centric and smaller urban residency programs face in obtaining or maintaining ACGME accreditation?

- No one challenge unique to rural and small programs, even if challenges may play out differently
- Small rural programs experience many of the same challenges as larger ones, but have less margin in financial resources and personnel, with almost 1/3 of them considering closure in the past 3 years
- Finances, much more than accreditation, was the greatest challenge

Conclusions

- A substantial minority of rural-centric programs reported rural location was a challenge, and more than half of smaller programs reported small size was a challenge for accreditation.
- Yet both rural-centric and smaller programs reported benefits from being smaller and rural:
 - Perceived their residents were more independent learners
 - Rural-centric program leaders thought their programs helped to prepare and recruit physicians who would stay local.

Conclusions

What supports, resources, and strategies do they need for success?

- Flexibility in meeting accreditation requirements
- Financial resources and coaching/faculty development support for scholarly activity

Parting advice

- Learn to "grow your own...together" – Join the community of practice in rural residency education*
- Collaborate with others, rather than attempting to meet the requirements of scholarly activity and research completely within the resources of your own program and institution – “Go large!”
- Follow the path less travelled: Pursue efficiencies of small scale in finding creative solutions – “Go small!”

Rural PREP: <https://ruralprep.org>

RTT Collaborative: <https://rttcollaborative.net>

Discussion

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http://bit.ly/rttc_residency

