RTT Impact of the new Program Requirements for Family Medicine
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I.A.2.a & b
The sponsoring institution and participating sites must:

- provide at least 70% salary support (at least 27 hours per week) for the program director as protected time to the program for administrative and non-teaching duties related to the program; (Detail)
- provide support for a full-time residency coordinator and other support personnel required for the operation of the program. (Detail)

Although a "must" is often helpful to a larger urban program in providing leverage in obtaining resources, in the case of RTTs it is often used as leverage by the larger institution to justify program closure. This is particularly true for rural programs where the Program Director is located at a rural site geographically or functionally remote from the sponsoring institution. This requirement would likely force all RTTs to move to a designation of Site Director at the rural site in all circumstances. The unintended consequence, at least in some programs, would be to remove authority from the Site Director and lead to closure if the urban PD is not as invested in continuing the program.

One solution would be to specifically reference the "alternative track" designation to allow a program in good standing to adapt to the realities of the local setting. Rural Program Directors or Site Directors would then be considered core faculty and count towards core faculty. Additionally, all teaching and precepting time must be included in their time towards the administrative duties or this will not be achievable at a rural site.

I.A.3
The sponsoring institution should provide access to an electronic health record system. In the absence of an existing electronic health record, institutions must demonstrate institutional commitment to its development, and progress towards its implementation. (Detail)

Many RTTs are located in private practices, CHCs, RHCs, or other health systems. The word "institutions" should be elaborated to indicate that it may not be the "sponsoring institution." (e.g. "the sponsoring or affiliated institution financially responsible for the FMP and/or hospital training setting")

II.A.3.p)-p). & (1)
The program director must:

- dedicate at least 27 hours per week, or 1400 hours per year, to program administration, evaluation, teaching and scholarship; and, (Detail)

  Time spent in direct patient care without the presence of residents must not be included in the 1400 hours. (Detail)

This requirement is especially burdensome to rural programs that have appropriately limited faculty resources and small numbers of residents. Counting and documenting hours is difficult to impossible when the environment actually promotes an efficiency of small scale that effectively mixes patient care, teaching and administration through the course of the day. Directors and faculty in the rural setting generally spend their time in a much more integrated fashion than their peers in an urban place, where it may make more sense to segment and protect time in siloes.

Again an explicit reference to alternative tracks acknowledging these special circumstances (even advantages) would be very helpful.

II.B.6 and following: (Core)

The Program Director and Core Faculty requirements would in many cases change the ability of a rurally located faculty member to function as Program Director. They would of necessity move them to “Core Faculty” status. As “core” requirements, these may have significant implications and an unintended but never the less harmful impact upon program governance and sustainability (See response to I.A.2.a & b).

Again an explicit reference to alternative tracks acknowledging these special circumstances (even advantages) would be very helpful.

II.B.8. There must be faculty dedicated to the integration of behavioral health into the educational program for at least 10 hours per week. (Detail)

Although this is a "detail," it is virtually impossible to attain this level of behavioral health faculty in an RTT (especially one with only 2 residents on site – e.g. a single PG2 and single PGY3), unless the faculty responsible for behavioral health is in fact a family physician.

We recommend this be reduced for an alternative track, or allow the alternative track to count the sponsoring program behavioral health faculty, just as in counting the sponsoring program PD. This of course should come with evidence of dedication of at least some of that faculty’s efforts to the rural site (or appropriate delegation to a local behavioral health faculty and integration and alignment of teaching effort).

II.C.1. There must be a program coordinator for all programs. (Detail)

It isn't clear whether this is a program coordinator for "each" accredited program (e.g. a 1-2 RTT), or one coordinator for all the programs. Some RTTs do suffer from not having a coordinator at the rural site and not devoted exclusively, for at least a portion of their time, to the RTT. Others accomplish this very admirably with a single coordinator who is very invested in the success of the rural site.

We do recommend this remain a “detail” requirement, so that integrated programs like 1-2 RTTs can make a local decision as to which is most effective.

Again an explicit reference to alternative tracks acknowledging these special circumstances (even advantages) would be very helpful.

III.B.2. To provide adequate peer interaction, a program must offer at least four positions at each level and should retain, on average, a minimum complement of at least 12 on-duty residents. (Detail)

Although this is listed as a "detail" and appropriate language is present in the current "Alternative Tracks or Sites" document to accommodate 1-2 RTTs, it is imperative to reference that document in these Requirements.

The "Alternative Tracks or Sites" document must be referenced somewhere in the proposed Program Requirements so that 1-2 training tracks (or alternative tracks of whatever variety) are acknowledged and do not run into issues of where these definitions fit in the overall scheme. We recommend placing this reference in a section of it's own, e.g. II.C, prior to "Other Program Personnel."

Inserting the entire document here would help avoid having two documents with various editing lives that track separately and disjointedly. However, including "Alternative Tracks and Sites" in the Institutional or Common Program Requirements would allow it to be applied to any specialty, at the discretion of each RC.

IV.A.6.a).(4) and following [Hourly and counting requirements for resident experience]

We are concerned with the level of detailed tracking that is required of the residents and administrators within this section. Residents in 1-2 RTT's are divided in their training experience between urban university-based hospital based systems and smaller rural hospitals, many of them in a longitudinal manner. Smaller hospital systems especially are not able to track every resident encounter, leaving it up to the resident to keep track of these numbers for the program and leaving no way of validating those numbers. In addition to the concern of even larger programs that the NAS or new Program Requirements not place an undue administrative burden on our residents and distract them from patient care and learning, a small program is at a particular disadvantage statistically if even one resident fails to adequately accomplish this.

If residents in all programs are going to be given this administrative burden, then an "App" for accomplishing this certainly needs to be developed (Perhaps even an implantable GPS chip, or ankle bracelet)! Seriously, we urge the RC to establish standards of interoperability (or establish a task force for this purpose) for the vendors who already are pursuing this.

Finally, small programs should be given the statistical benefit of the doubt by applying this over 5 years.

V.C.3. At least 95% of the program's eligible graduates from the preceding five years must have taken the ABFM certifying examination. (Outcome)

V.C.4. At least 90% of the program's graduates from the preceding five years who take

the ABFM certifying examination for family medicine for the first time must pass. (Outcome)

These two sections definitely need to be revised to accommodate alternative tracks with fewer than 12 active residents. We suggest that there be an alternative to the use of percentages for such programs, e.g. for V.C.3. “no more than one resident shall fail to take the ABFM certifying examination,” and for V.C.4. "Of residents taking the examination in the past five years, no more than 2 residents, for programs with greater than 10 graduates in that time, and no more than 1 resident in the past five years, for smaller programs, shall fail."

V.C.6.a) Over a three-year period, the program should retain 85% of the residents it accepted. (Detail)

Again, for programs with fewer than 12 active residents, this needs to be stated in numeric terms, not percentages, and it needs to be applied over five years. E.g. “Over 5 years, no more than 2 residents accepted into the program, for programs with greater than 10 graduates in that time, and no more than 1 resident in the past five years, for smaller programs, shall fail to complete the program or, with the agreement of the ABFM, transfer to another." In addition, the program must not be unduly penalized if in good faith it is dismissing residents based on poor quality. The program should not be punished for doing the “right thing” to ensure the public’s safety.

VI.D.3.b) Indirect Supervision:
VI.D.3.b). (1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)

I realize this is a "core" common program requirement, but for alternative tracks like RTTs, couldn't each program simply be required to define this for their specific practice setting and indicate how they are in fact meeting the spirit of this rule? For example, “immediately available” could be defined (and has been defined for medical staff at some rural hospitals) as a certain distance or a certain number of minutes for rural programs, where it may be easier to get to the resident in the hospital from the faculty's home or from an office location in a separate building than it is for a faculty person in a large institution to get there from another location in the same building! One RTT program director states, “If I live 2 blocks from the hospital and am on call half the time, I may not wish to spend every night on call there!”

Here is language from the end of the “Alternative Tracks” document supporting this suggestion:

“** If the proposal involves the suspension of a program requirement, explain how an alternate arrangement will be used to accomplish the goals of that requirement.”

In summary, alternative tracks and sites need to be more explicitly referenced and accommodated in light of their very legitimate special circumstances and needs, or they will not be sustained or valued in the future. References to resources, both financial resources/commitments and personnel, must be framed in a way that does not overly burden smaller programs. Requiring every small program to have the instrument panel

of a jumbo jet will most certainly lead to the crash of their small single engine or other “special purpose” plane!

Meaningful integration, an important element of a successful RTT, is hard to measure in quantitative ways, but if it cannot be counted, it should never the less be addressed by explicit reference in the Program Requirement. Giving percentages the statistical power to put RTTs in the “yellow bucket” of the NAS and denying them continuing and full accreditation is simply not evidence-based.