Rural Residency Planning and Development – Technical Assistance Center (RRPD-TAC)

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NORTH CAROLINA AHEC

UNC SCHOOL OF MEDICINE Family Medicine

OHIO UNIVERSITY Heritage College of Osteopathic Medicine

UW Medicine UW SCHOOL OF MEDICINE DEPARTMENT OF FAMILY MEDICINE

UNC THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

RuralGME.org

Introduction—Steve Crane, MD

- Former health economist—CBO during Carter administration
- Training: CWRU Cleveland, University MO Columbia
- Rural clinician—previous full scope. Now geriatrics/addiction medicine. FQHC (x 2); residency practice; hospital practice, private practice
- Former Rural program director
- Former CMO FQHC x 2; regional hospital system
- UNC Full Clinical professor
- AAFP program consultant (RPS)
- RRPD-TAC program advisor

Disclosures

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Background

- In 2019, HRSA funded 27 Rural Residency Planning and Development (RRPD) Programs
  - 1 in Internal Medicine, 4 in Psychiatry, 22 in Family Medicine

- HRSA also funded a Technical Assistance Center to help support the development of new rural residency programs (and other communities interested in starting programs)

- HRSA recently released a second NOFO with a deadline of **June 30, 2020**
  - Expanded to General Surgery, Obstetrics & Gynecology, Preventative Medicine

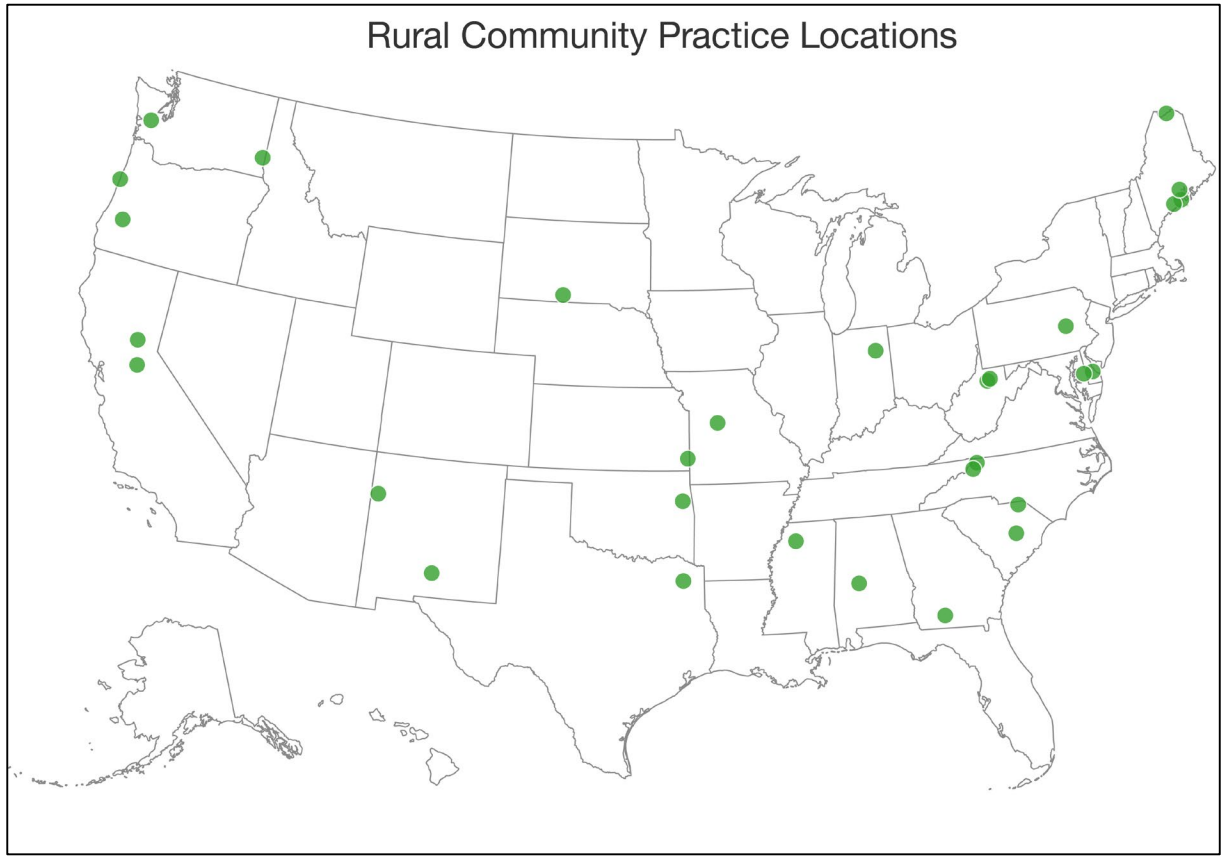
Rationale for Expanding GME Slots

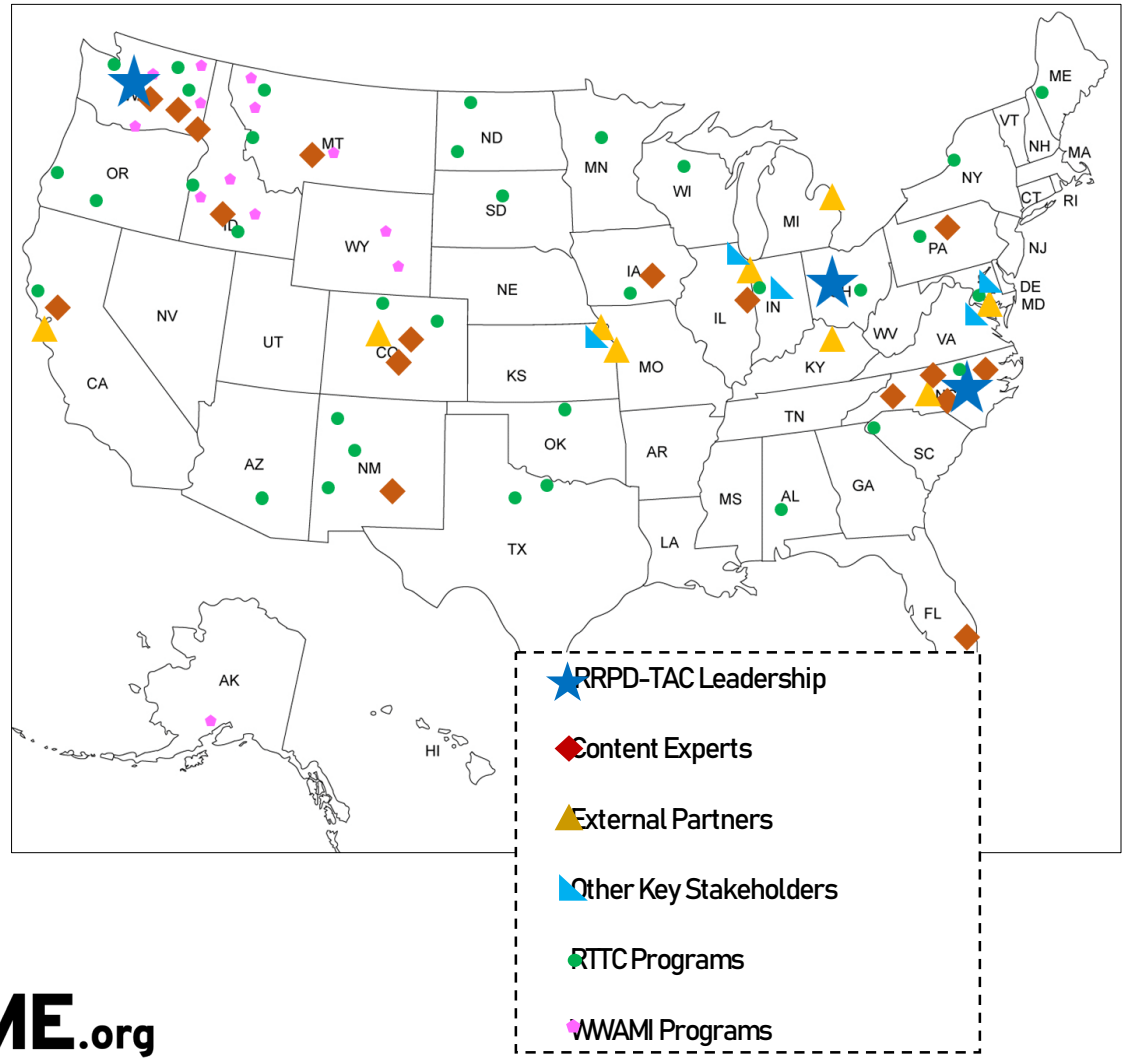
- According to AAMC, 52% increase in medical student enrollment since 2002, but only 18% increase in funded GME slots.
- Average applications for each slot have increase from approximately 10 to 60+.
- Expected physician significant physician shortage by 2030. Especially primary care, rural due to aging workforce, aging population, and population growth.

Rationale for Rural GME Training

- Key lesson: Residents must learn to LIVE and work in a rural environment to increase chance they will choose rural health career.
- Rural rotations have little effect; evidence that they may inoculate learners FROM choosing rural health careers.
- Pipeline issues—few students from rural areas accept to medical school
  - Median family income of medical student >$100,000; top 15% of wage earners
  - Average medical student debt >$200,000
  - Performance on timed multiple choice tests favors candidates w/ training/privilege

RRPDProgram and TACenter Maps





Mean RUCA Score: 5.2 (range 2-10)
Mean % time training in rural setting over course of residency: 72% (range 50-100)

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STAGE 1 Exploration

Community Assets

Identify community assets and interested parties.

Leadership

Assemble local leadership and determine program mission.

Sponsorship

Identify an institutional affiliation or sponsorship. Begin to consider financial options and governance structure.

To advance to the next stage:
Make an organizational decision to proceed with investing significant resources in program development.

STAGE 2 Design

Initial Educational & Programmatic Design

Identify Program Director (permanent or in development). Consider community assets, educational vision, resources, and accreditation timeline.

Financial Planning

Develop a budget and secure funding. Consider development and sustainability with revenues and expenses.

Sponsoring Institution Application

Find a Designated Institutional Official and organize the GME Committee. Complete application.

To advance to the next stage:
Finalize a draft budget. Complete program design to include curriculum outline and site mapping. Submit a Sponsoring Institution (SI) application & receive initial accreditation.

STAGE 3 Development

Program Personnel

Appoint residency coordinator. Identify core faculty and other program staff.

Program Planning & Accreditation

Develop curricular plans, goals and objectives; evaluation system and tools; policies and procedures; program letters of agreement; faculty roster. Complete ACGME application and site visit.

To advance to the next stage:
Achieve initial program accreditation – requires successful site visit and letter of accreditation from the ACGME.

STAGE 4 Start-Up

Marketing & Resident Recruitment

Create a website. Register with required systems. Market locally and nationally.

Program Infrastructure & Resources

Hire core faculty and other program staff. Ensure faculty development. Complete any construction and start-up purchases. Establish annual budget.

Matriculate

Welcome and orient new residents.

To advance to the next stage:
Complete contracts and orient first class of residents. Hire all required faculty.

STAGE 5 Maintenance

Ongoing Efforts

Report annually to ACGME and the Sponsoring Institution. Maintain accreditation and financial solvency. Recruit and retain faculty. Track program educational and clinical outcomes. Ensure ongoing performance improvement.

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Baseline Characteristics of first RRPD cohort: Primary Rural Practice Sites

Ambulatory Care Site
Health-System Affiliated Primary Care Clinics (n=12)
Federally Qualified Health Centers (n=8)
Health Centers operated by the Indian Health Service [IHS] (n=3)
Behavioral Health Clinics (n=2)
Hospital-owned Primary Care Clinic (n=1)
Rural Health Clinic (n=1)

Hospital Site
Sole Community Hospitals [SCH] (n=8)
Critical Access Hospitals (n=6)
SCH/Rural Referral Centers [RRC] (n=4)
IPPS Hospitals (n=3)
RRC (n=2)
Hospitals Operated by IHS (n=2)
VA Medical Center (n=1)
Rural PPS Hospital (n=1)

Baseline Characteristics – Funding

Option	Description	N of grantees
1	**Rural Hospital Establishing New Medicare Resident FTE Cap** (rural hospital that have not triggered their PRA yet)	10
2	**Rural Hospital "New" Residency Program** (rural hospital can increase their resident cap if they start a new program by CMS definitions)	5
3	**Urban Hospital-linked Rural Training Track** (urban hospital and rural hospitals, if eligible under Option 1 or 2, can also build their cap)	13
4	**Other Public or Private Funding** (examples include VA, IHS, Medicaid, State, or other)	3

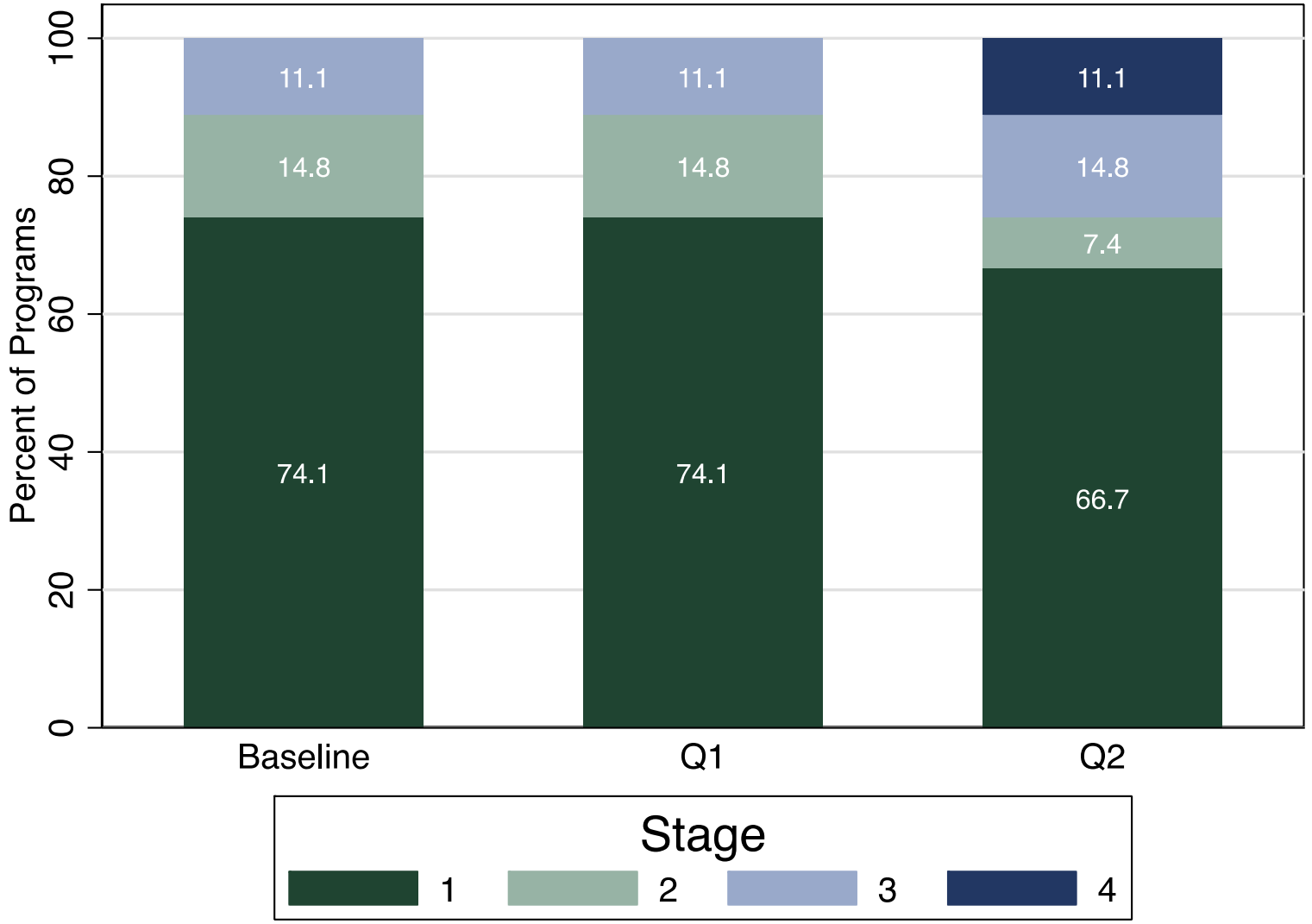
Baseline Characteristics – Program Structure

Program Sponsor
Non-profit healthcare organization (n=15)
Public/State Controlled Institution of Higher Education (n=6)
Private Institution of Higher Education (n=4)
Non-profit healthcare foundation (n=1)
For-profit healthcare organization (n=1)

Class Size Per Year
Two (n=13)
Three (n=4)
Four (n=7)
Six (n=1)
Eight (n=2)

Partners
School of Medicine Affiliation (n=26)
VA Partnerships (n=7)
Indian Health Service Partnership (n=3)

Program Readiness



Barriers to Addressing Rural Health Disparities

- GME funding model
- Cap issues
- “Free rider” problem
- Low resource/volume environments
- Recruiting issues
- State of rural practices/hospitals
- COVID and rural healthcare—some personal observations

GME Funding Model

Barriers

- Allow IME
- Medicare to pay full GME cost up to a capped amount
- Change rule
- Make permanent part of funding of FQHCs.

Possible Solutions

- Sole community hospital—DME only
- CAH--% Medicare share bed-days
- “Virgin hospital” trap—zero PRA
- THC—reauthorization
- Place-based rural per resident payment S289 (Gardner Bill)

Cap Issues

Barriers

- One-time RTT cap expansion
- Hospital systems determine how to distribute cap among difference programs.

Possible Solutions

- Open RTT cap
- Set rule on % total cap is for primary care or other needed specialties
- Eliminate rural cap

“Free Rider” Issue

Barriers

- Rural hospitals/states often subsidize GME in their facility expecting recruitment of grads
- Grads frequently leave community/state to practice elsewhere.
- This creates a “free rider” issue regarding GME funding
- Service vs. education

Possible Solutions

- Create market mechanism to redistribute benefits/costs of GME.
- Full federal GME funding
- Have not observed this as a problem in rural programs

Low Resource/Volume Environments

Barriers

- ACGME standards
  - % protected administrative time
  - Core faculty standards
  - Professional modeling
- Board standards
  - Case mix
- CMS supervision standards
  - Telehealth/telephone
  - Counseling time

Possible Solutions

- Flexibility for rural programs to meet standards
- Evidence based outcomes vs. proscribed processes
- Tweaking primary care exception

Recruiting Issues

Barriers

- Only 40% family medicine residents U.S. grads
- IMG important source of rural residents/practitioners
- Unknown impact of recent visa restrictions
- Educational loans for US grads

Possible Solutions

- Preserve J1 visa program for primary care physicians.
- Expanding federal loan repayment for needed specialties

State of Rural Practice/Hospitals

Barriers

- Rural hospital financial crisis, particular in states that didn't expand Medicaid.
- Rural practices struggle financially in usual fee for service environment.

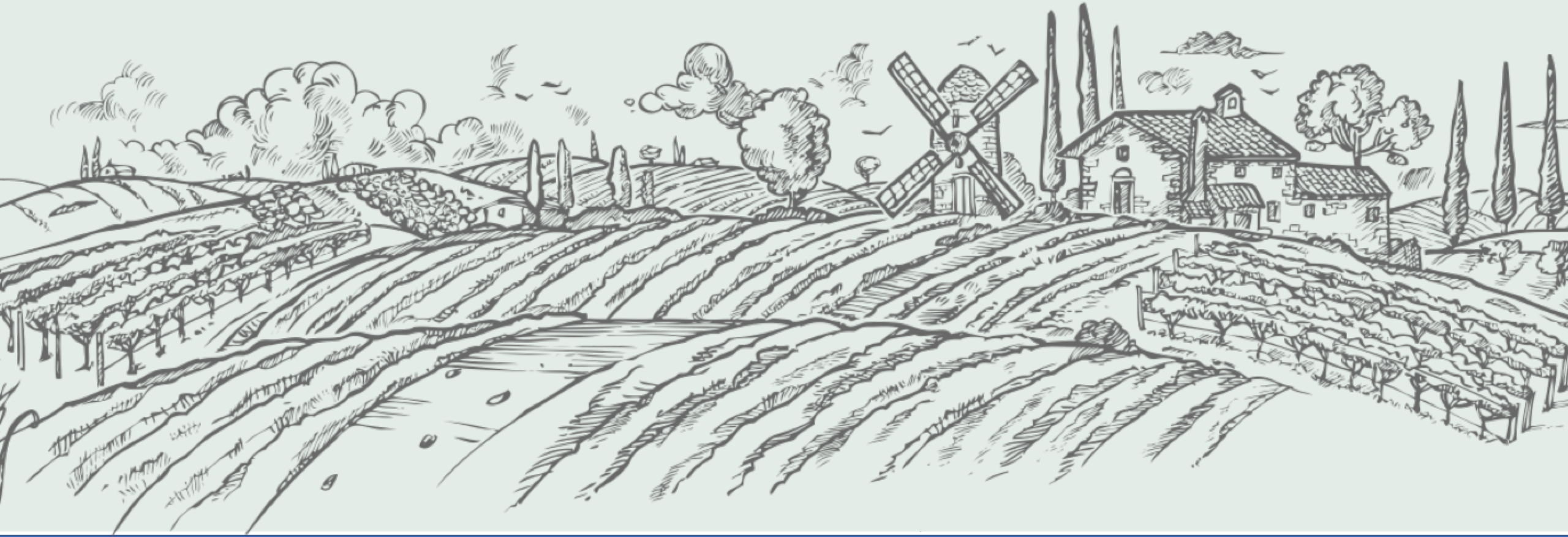
Possible Solutions

- Further incentives for all states to expand Medicaid.
- Rural practice cost-based reimbursement similar to FQHCs
- Expand 340B eligibility to rural health clinics that provide consulting pharmacy services

COVID and Rural Health Care—personal observations

- Social isolation
- Opioid deaths
- Delayed urgent care
- Homelessness
- Financial stress and practice/rural hospital closures
- Further fragmentation of the social safety net

Time is short. . .



Tools and Resources

Community Engagement

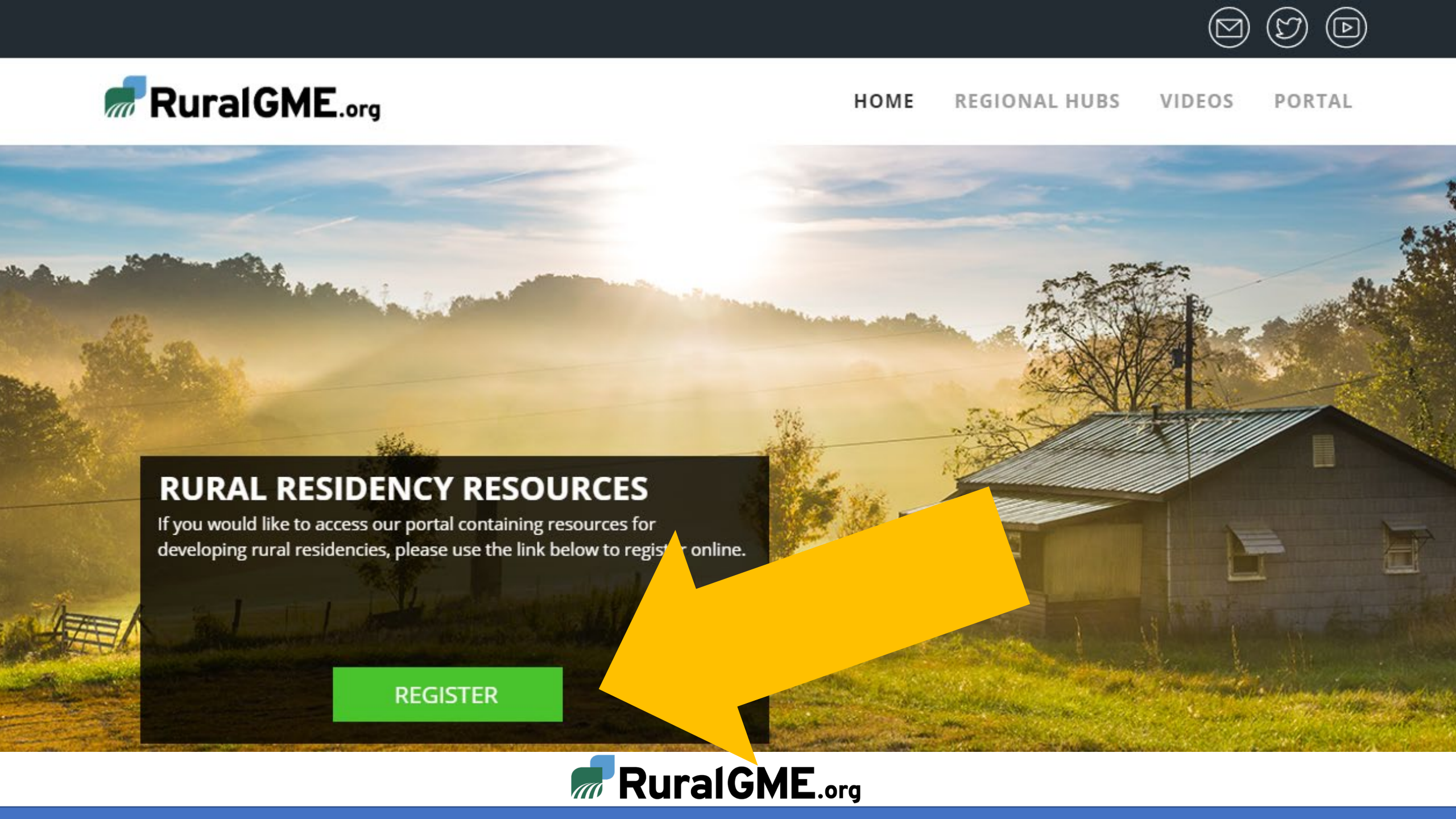
Program Design & Development

Financial Planning

Institutional Sponsorship

Program Accreditation

Program Implementation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