REFLECTIONS ON RURAL TRAINING IN WISCONSIN

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DIO, WiNC GME Consortium

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DISCLOSURES

Nothing to disclose except I really like this stuff

OBJECTIVES

Brief look back at the development of FM GME in Wisconsin

Review of RTT development as an alternative training site

Review of the Antigo RTT as a case study in the promise and perils of RTTs

A brief peek forward into the future

ACGME

Selected Publications and Resources Pertaining to Rural GME

Disclaimer: Statements or opinions expressed in the listed publications and resources reflect the views of the author(s) and do not necessarily reflect the official policy or views of the ACGME or its staff members.

Pertaining to Rural Tracks/Programs:

1. Cultivating Healthy Governance in Rural Programs (April 2021)
2. A Roadmap to Rural Residency Program Development (August 2020)
3. Preparing Physicians for Rural Practice: Availability of Rural Training in Rural-Centric Residency Programs (October 2019)
4. Family Medicine Rural Training Track Residencies: Risks and Resilience (2019)
5. Rural Medical Education Programs: A Proposed Nomenclature (June 2017)
6. Training Psychiatrists for Rural Practice: A 20-Year Follow-up (October 2014)
7. Training Physicians for Rural Practice: Capitalizing on Local Expertise to Strengthen Rural Primary Care (January 2011)
8. A Residency Training in Rural Psychiatry (September 2009)
9. Putting "Rural" Into Psychiatry Residency Training Programs (November 2007)
10. A Process for Developing a Rural Training Track (February 1998)
11. Rural Training Tracks in 4 Family Medicine Residencies (October 1992)

*Pertaining to Predictors of Rural Practice and Graduate Outcomes (*indicates UME focus):*

12. Rural Workforce Years: Quantifying the Rural Workforce Contribution of Family Medicine

Resources for Starting Rural Tracks/Programs:

56. The RTT Collaborative
57. RuralGME
58. Starting a Rural Training Track (Wisconsin Collaborative for Rural GME)
59. Area Health Education Center (AHEC)

UNIVERSITY OF WISCONSIN DEPARTMENT OF FAMILY MEDICINE

Founded in 1970, 1 of the first 15 FM residencies in the United States

Two key physicians in the creation of the Residency, Marc Hansen, a pediatrician and William Sheckler, an internist

John Renner, MD, hired to lead the program, and was recognized as Chair of the newly named University of Wisconsin, Department of Family Medicine and Practice in 1993

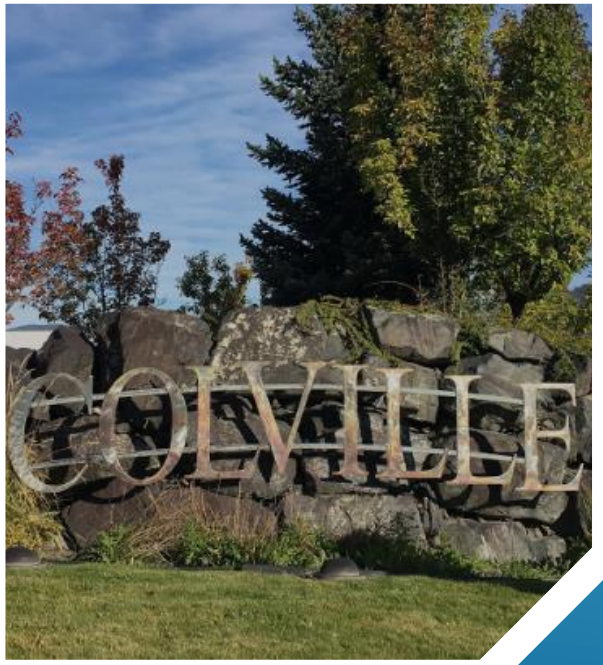
Dr Renner adopted the Wisconsin Idea, for the growth of the Department – "the boundaries of the campus are the boundaries of the State."

Expansion of Programs included Milwaukee in 1974, Eau Claire in 1975, Wausau in 1978 and Fox Valley in 1980

The three "upstate" programs, not technically rural, but had substantial rural focus and hired many rural family doctors as faculty

Rural Training Options (for 3-year Family Medicine Residency Programs)	
Separately accredited and rurally located residency program	This type of program consists of training in a rural area for all (3) years of residency.
Separately accredited rural training tracks (IRTT), typically in the 1-2 RTT format	For this type of program, residents spend >50% of their time training in a rural location. PGY1 training takes place at the urban/academic center; PGY2 & PGY3 training takes place at the rural clinic & hospital site.
Urban programs with a rural focus	Because of the geographical service area that this type of residency program has, a large amount of the residency training is done in rural areas, by default. Often, these residency programs place >35% of residency graduates in a rural initial place of practice (as calculated from a 3-year rolling average)
Rural Pathway/Rural Track	Some residency programs have created an area of concentration designed within the separately accredited, much larger, urban program. The rural exposures may include continuity practice in a rural place, as well as rural pathways with longitudinal or cumulative rural experience of lesser duration
Rurally located rotations	Many programs offer elective rural rotations of various duration, either in block (e.g. 4 weeks) or in longitudinal

*Some of this information is taken from *Planting TREES in Rural Places Training and Rural health professions Education that is community Engaged and Sustainable January 2019, Randall Longenecker MD, Executive Director, The RTT Collaborative, David Schmitz MD, Associate Director for Research and Development*



COLVILLE, WA

Small community of 4,500

Primary industries are agriculture, timber and mining, although tourism is increasing

1.5 hours north of Spokane

COLVILLE WASHINGTON RTT

First RTT in family medicine in the United States

The RTT concept was approved as an "experimental" family medicine pathway by the FM-RRC in 1986

Urban/parent residency was the University of Washington affiliated Family Medicine Spokane Program

Expansion of successful rural rotations for residents, community support, and desire to create an alternative track that would increase the number of rural physicians

By 1991, University of Washington had 4 rural training sites approved

EARLY RTT ADOPTERS

University of Nebraska FM programs in Omaha and Lincoln

Had required rural rotations, but still limited success in placing graduates in underserved rural practices.

Developed 4 RTTs in western rural communities, 2 in 1992 and 2 in 1993

Significant distance from urban to rural sites, ranging from 130 to 430 miles

Buffalo School of Medicine started a single RTT in 1991, only 70 miles south

Eastern Kentucky Family Medicine Residency Program started RTT in Hazard Kentucky in 1991. Of note, this was in response to a piece of legislation call the "Kentucky Health Care Reform Act of 1990", which mandated establishment of a rural family medicine program with decentralized clinical practices.

SPECIAL COMMUNICATION

A Case for the Development of Family Practice Rural Training Tracks

James R. Damos, MD, Carrol Christman, MA, Craig L. Gjerde, PhD, John Beasley, MD, Maggie Schutz, RN, MS, and Mary Beth Plane, PhD

Enthusiasm for alternate training sites has been strong among practicing family physicians and students seeking family practice residency positions in Wisconsin. The number of rural training tracks in the state is increasing rapidly. The University of Wisconsin currently has 4 residents in two rural training tracks. If 1998 recruitment is successful, there will be 12 residents in seven rural training tracks operated by two sponsoring institutions in the state. The Wisconsin rural training tracks are 1-2 programs,[1] in which the family practice resident spends the first year in the urban medical center of the home program completing appropriate rotations, such as internal medicine, pediatrics, obstetrics-gynecology, emergency medicine, surgery, and critical care, and the last 2 years in a rural community and rural hospital as an apprentice with a family practice group. During the last 2 years, the resident can receive longitudinal training in specialty areas with visiting subspecialists and can spend time away from the rural medical practice for specialty rotations not available in the rural setting.

The development of the Wisconsin rural training tracks was based in part on the pioneering

they should continue to be developed and studied for the following reasons:

Rationale for Rural Training Tracks

Family Physicians Are Urgently Needed to Provide Comprehensive Medical Services in Rural Areas

Compared with 9 percent of urban residents, 29 percent of rural residents of the United States live in areas with a shortage of health professionals.[4] Both the Council on Graduate Medical Education (COGME) and the American Academy of Family Physicians have recommended increasing the number of family physicians, in part, to meet the needs of rural and underserved areas. COGME also noted that while there are sufficient numbers of physicians, many generalists and specialists remain largely regionalized to urban and metropolitan centers.

An article in a recent American Family Physician newsletter[5] comments on maldistribution even within family medicine:

> Family medicine has provided thousands of physicians to underserved rural communities over the years. In recent years the number choosing


CIRCUS WORLD
ALDO LEOPOLD
BARABOO

WISCONSIN RTT EXPERIENCE

1st RTT in Wisconsin was the Baraboo Program

Town of 12,000, about 45 minutes north of Madison

Scenic area of the state, Devil's Lake State Park, Baraboo bluffs, home of the Ringling Brother's Circus Museum

Planning for RTT started 1993, first class matriculated 1996 in the Madison Program for their first year of training

Close, but not too close proximity to larger urban area (Madison), site champion (Jim Damos), excellent continuity OB experience with C-section training, broad scope of practice, supportive local hospital, agreed upon budget expectations

WISCONSIN RTT EXPERIENCE

Between 1996 and 1998, five additional RTTs were started in Wisconsin

Two sponsored by UW-DFM, Eau Claire/Menomonie and Wausau/Antigo

The Lacrosse-Mayo Program started three sites, Praire du Chien, Mauston and Black River Falls

A 7th RTT was considered for Fox Valley/Waupaca, but did not get past planning stages

A statewide RTT consortium was formed between the UW-DFM and Lacrosse programs to mutually support and shared best practices

Antigo Daily Journal

No One Delivers Local Like We Do

WAUSAU – ANTIGO RTT

Required 2-month rural rotation for all 2nd year residents in Antigo, Wisconsin

Antigo is small town of about 8,000, 50 minutes from Wausau

Resident lived in Antigo, small house owned by the clinic/hospital, next door to the clinic

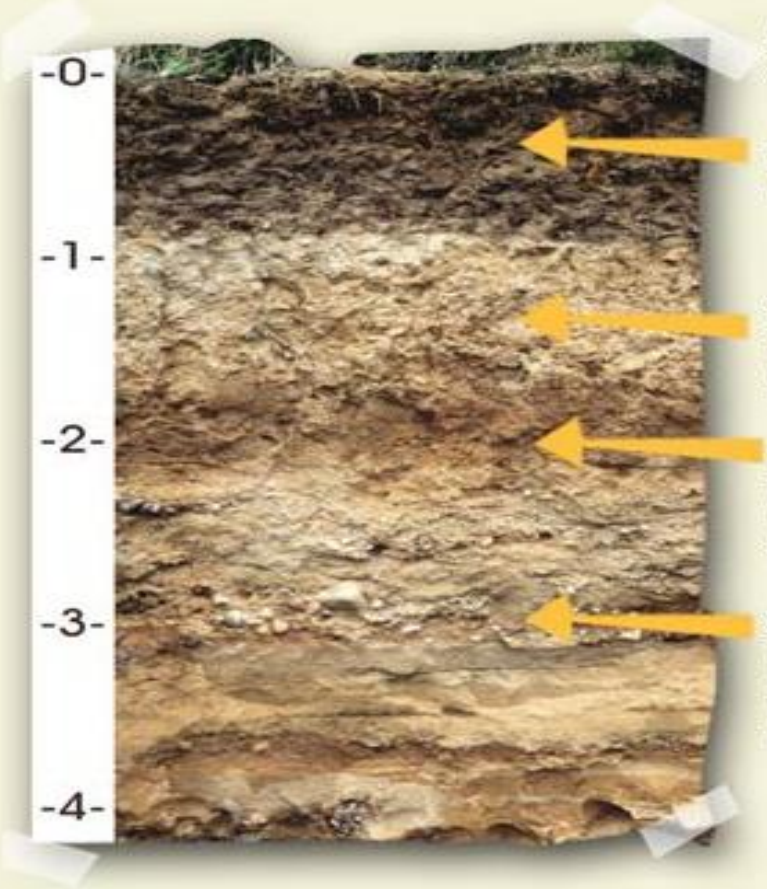
Returned to Wausau once a week for half day of clinic in am, and afternoon of didactics

Two exceptional teacher/mentors, Drs Ted Fox and John McKenna

FM centric practice, had few other specialties in the clinic, but many subspecialties from Wausau had satellite clinics in Antigo

Official State Soil: Antigo

What's in it?



ANTIGO

Old, Forest Soils

Plowing mixes surface organic matter into the top six inches.

Seeping rain washes the reddish iron and clay out of this layer, leaving it pale.

Layer is rich in reddish iron and clay. Minerals washed down from above accumulate here.

Stones were deposited by glaciers. Lower layers look similar to the whole soil profile when it first began to form.

ANTIGO RTT DEVELOPMENT

Antigo rural rotation rated as one of the best rotations by residents

Valued characteristics included high degree of autonomy and independence, talented and highly skilled FM mentor/teachers, strong maternity care with FM doing C-sections, wide variety of procedures performed by FM, and wide-open scope of practice, "womb to tomb"

Lived in Antigo 5-6 days out of the week continuously, immersive

Social interactions with staff (Holiday parties, summer picnics, Thursday night bowling), as well as being seen as a community member (attend Friday night high school football games, shopping in local stores)


Clinic and Hospital Main Entrance
4x4


ANTIGO
440

ANTIGO RTT DEVELOPMENT

STFM study done in early 1990s looking at successful placement of FM graduates in rural practices

Wausau ranked in the top 10 over the previous 5 year period of time out of 350+ programs

Study identified several factors as possible reasons for successful programs; 2 or more months of rural rotations, strong maternity care curriculum and rural focused faculty

Early 1990s, UW-DFM faculty development conference, guest speaker, Thomas Rosenthal, MD, Director of Office of Rural Medicine at SUNY at Buffalo School of Medicine

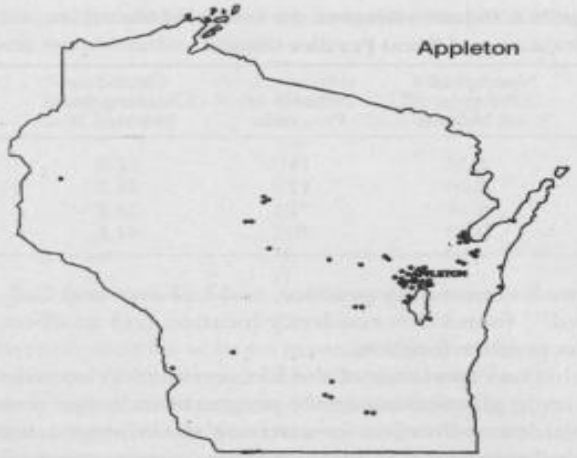
Baraboo RTT started in 1996

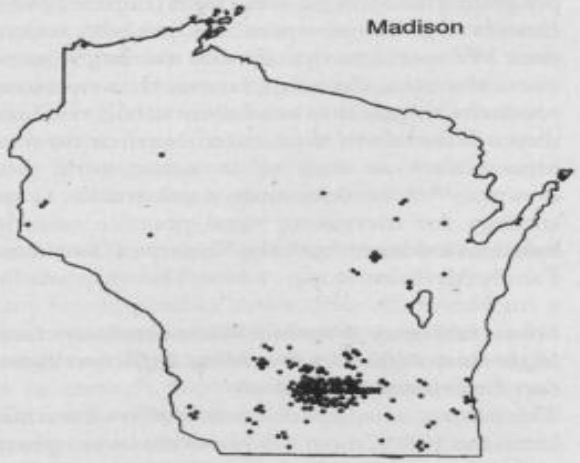
1993, John Frey, MD, Chair of UW-DFM, appointed new Program Director at Wausau FM Residency

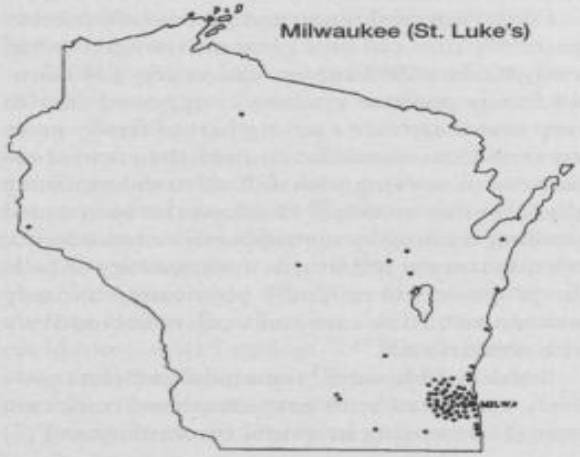
Figure 1. Locations of University of Wisconsin family practice residency graduates (1973-1996) practicing in Wisconsin.

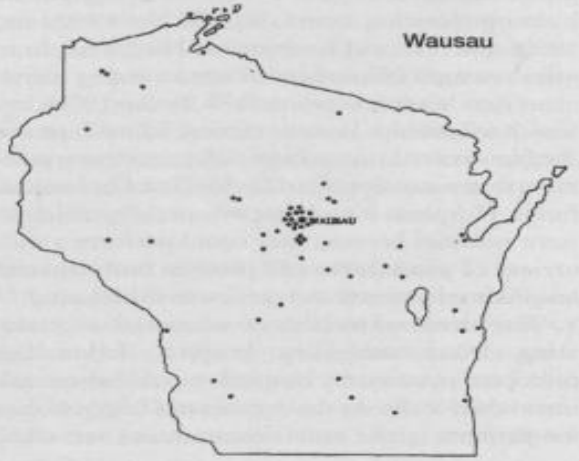
Program	Total Graduates No.	Graduates in Wisconsin* No.(%)
Appleton	87	53 (61)
Eau Claire	109	68 (62)
Madison	289	149 (52)
Milwaukee	129	73 (57)
Wausau	88	57 (65)

*Confirmed number, 10-15% might be lost to follow-up.
Note: each dot = 1 graduate.









ANTIGO RTT

Planning began in 1996, ACGME application 1997, with approval to start July 1998, matched 1st resident, Scott Moore

Langlade Hospital under leadership of CEO David Schneider, fully supportive of concept, agreed to provide funding for all local costs, including salary for site director and local coordinator

Local physicians (FM, OB/Gyn, Gen Surgery and ER), enthusiastic teachers, with most subspecialist from Wausau involved in longitudinal curriculum

UW-DFM hired core faculty in Wausau Program fully supportive, such as providing didactics, continued as paired faculty/mentors, provided administrative support

Unfortunately, the next 3 residents were not filled through the Match

THE DECLINE OF WISCONSIN RTT

Rapid increase in RTTs over the 1990 decade

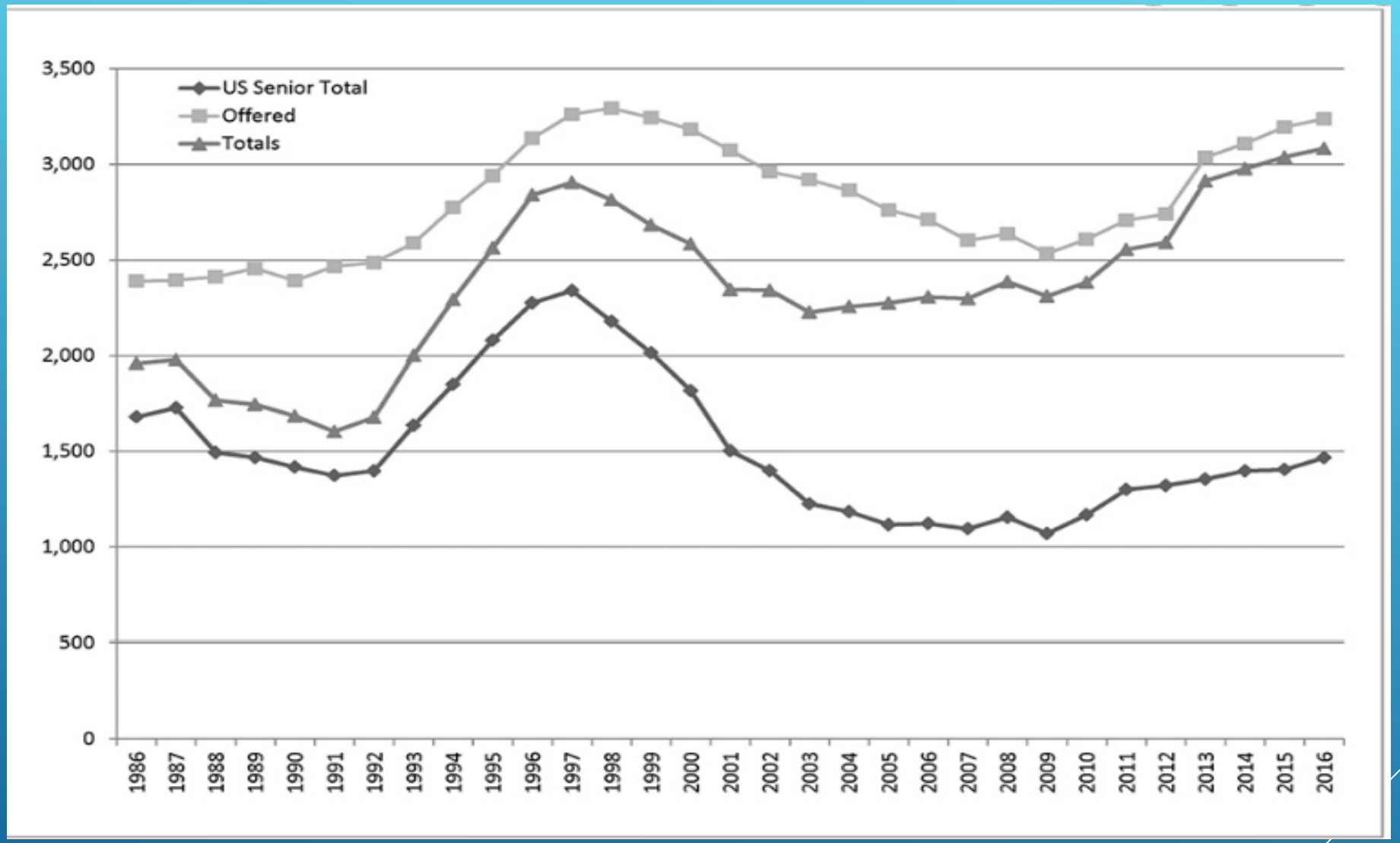
By 2000, 35 active 1-2 RTT programs in 14 states

Wisconsin's 6 Programs represented 17% of all RTTs

By 2012, however, only 21 programs remained, with the closure of 5 of the Wisconsin programs, leaving only Baraboo

Multiple reasons for closures; Difficulty in acquiring adequate ongoing funding, including CMS, inability to meet accreditation requirements, and significant decrease in student interest in FM and FM rural training

Common accreditation citations; lack of peer interaction, low volumes, insufficient didactic curriculum, lack of robust evaluation processes, inadequate scholarly activity, lack of faculty development opputunities


US Senior Total
Offered
Totals
3,500
3,000
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2,000
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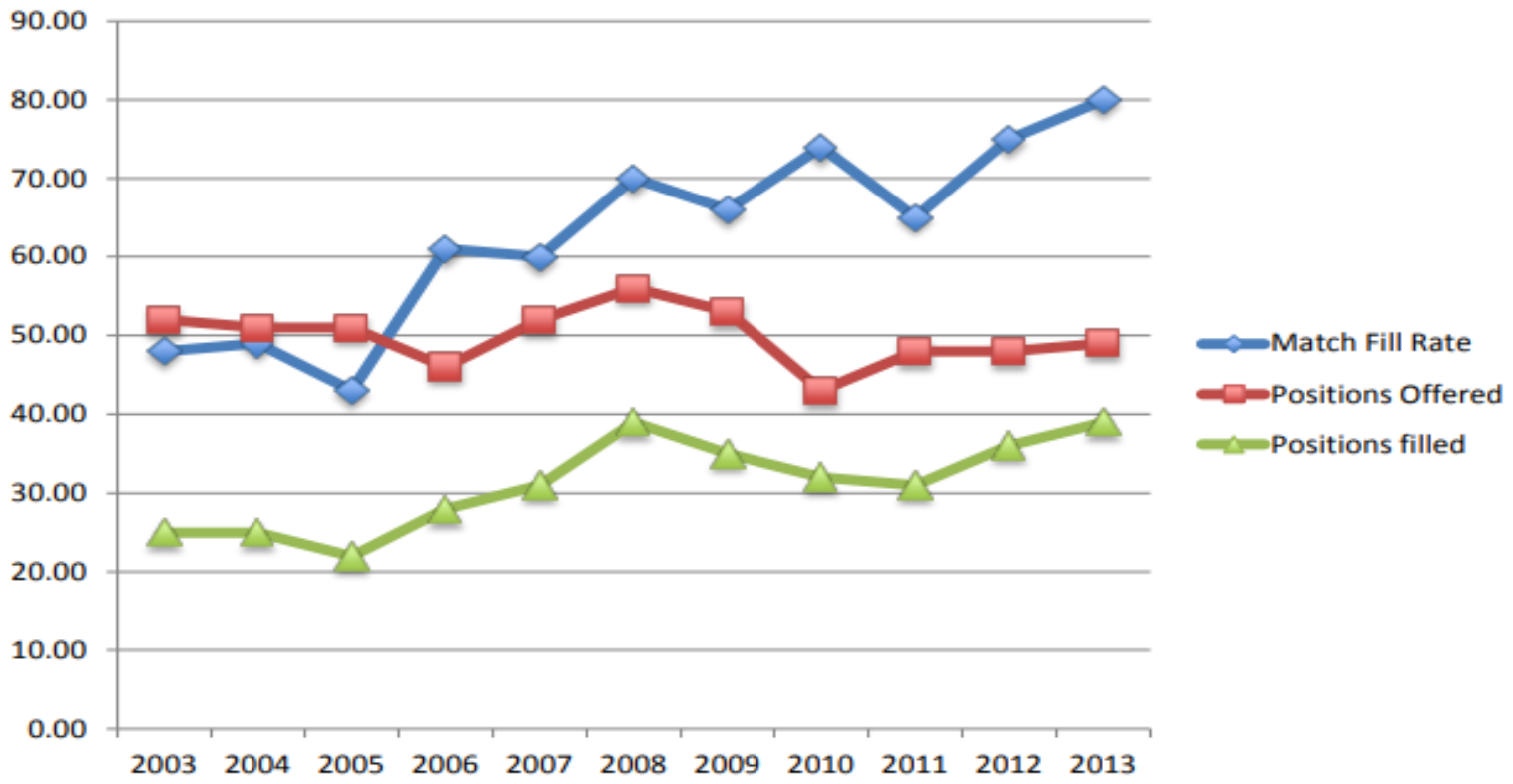
RTT NRMP Trends 2003-2013



Source: Personal communication from Randall Longenecker MD, Senior Project Advisor, the RTT Technical Assistance Program, March 26, 2013

A FEW LESSONS LEARNED IN NO PARTICULAR ORDER

Any new adventure clearly needs a passionate champion, but equally important, is the need for a succession plan for that passion

Serendipity happens, be open to it

The distance between the urban and rural sites is less about miles and more about relationships

If it counts, count it

Money can't buy you love, or a successful RTT, but without it, you're dead in the water

More is more

The best way to have a great Program is to have great residents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NEW GME UPDATES

CMS in December 2021 issued Final Rule for the Consolidated Appropriations Act of 2021 (CAA) which implements three provisions directly relating to GME

1. Starting in FY 2023, CMS will distribute 200 new FTE resident cap slots per year over a five year period until 1000 slots are allocated. For a hospital to be eligible, it must fall into one of four categories, one of which is located in rural area or treated as being in a rural area
2. Resetting of low or zero FTE caps or PRA (per resident amounts)
3. Create flexibility for rural training tracts, allowing for increase in FTE caps for new RTT programs, even if they do not meet prior "newness" criteria, making them eligible for adjustments in both DME and IME payments, and allows for programs to receive payment even if they are not separately accredited, and finally, RTTs are no longer limited to just family medicine

NEW ACGME RURAL TRACK PROGRAM DESIGNATION

ACGME's response to CMS guidelines to better align definitions and processes

This alignment would increase opportunities for development of new RTPs, in attempt to address health care needs in MUA/Ps

Phase 1 completed, addressing process for designation of separately accredited RTP

Phase 2 still in process, addressing non-separately accredited RTPs

ACGME Rural Track Program (RTP)

An ACGME-accredited program with a unique 10-digit identifier in which residents/fellows gain both urban and rural experience with more than half of the education and training for each resident/fellow taking place in a rural area (any area outside of a Core-Based Statistical Area (CBSA)).

Disclaimer

The ACGME RTP designation is independent of any rural track designation by the Centers for Medicare and Medicaid Services (CMS) and does not guarantee that a program will meet CMS eligibility requirements for GME or other financial support. If you have questions about the CMS rural track policy, contact your GME finance staff and/or the Prospective Payment System (PPS) hospital's Medicare Administrative Contractor (MAC).

ACGME Rural Track Program (RTP) Project Steps

June-Sept 2020

Stakeholder interviews

Policy clarification

Oct-Dec 2020

Synthesis and proposal writing

Process mapping

Internal meetings

Jan-Feb 2021

Policy changes

BOD update

ADS intake submission

Mar-May 2021

Internal work groups

ADS build

Web page build

RC preparation

External meetings

June 2021

RTP designation launch

QUESTIONS?