Rural Training Tracks: New approaches to a proven strategy

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June 4, 2012

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Participants will be able to:

- Describe the variations of "1-2" RTTs that have emerged from the original 1-2 RTT prototype (Spokane Model)
- Understand current limitations in sustaining such training streams
- Articulate evolving conditions and design other place-based strategies for rural training

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History of 1-2 RTTs: Accreditation

- 1985 – Proposed by Bob Maudlin of Family Medicine Spokane as a strategy to graduate more physicians to rural practice and to better prepare them professionally and personally to practice and live in rural places
- 1986 – ACGME approval as an “experimental pathway”

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History of 1-2 RTTs: Accreditation

- 1996 – Additional formal requirements by the RRC in Family Medicine, including a separate PIF
  - Minimum of 2 residents at the rural site (1 PGY2, 1 PGY3 or 2 every other year)
  - 50% precepting rule
  - Mandated 24 months of continuity, with the exception of 2 elective months away each year

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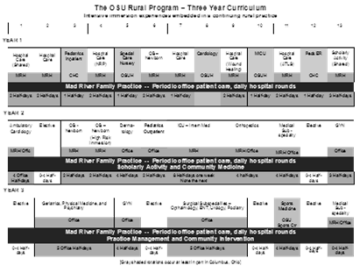
History of 1-2 RTTs: Accreditation



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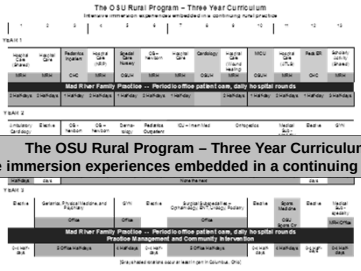

The OSU Rural Program – Three Year Curriculum
Intensive immersion experiences embedded in a continuing rural practice

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History of 1-2 RTTs

- Rosenthal et al, Academic Medicine 1992
- Maudlin et al, Journal or Rural Health 2000
- Maudlin and Newkirk, Family Medicine 2010
- For additional history and information see the RTT Technical Assistance Program site – www.raconline.org/rtt

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History of 1-2 RTTs: Funding

- Medicare and Medicaid GME funding of RTTs is very state and intermediary-dependent (Most CMS intermediaries have only one or two RTTs, and states have their own rules around Medicaid GME)
- Most RTTs, to remain financially viable, depend on state government subsidies; AHECs; local hospital, clinic, and community support; patient care revenues; or grant funding

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History of 1-2 RTTs: Funding

- Prior to BBA1997, which established a cap on GME positions funded through Medicare based on FY1996, RTTs were primarily funded in traditional ways, although few were able to access IME at the rural site
- BBRA 1999 created an exception for urban hospitals seeking to establish a “1-2 RTT” or an “integrated RTT”
- For lack of a definition, CMS did not implement the latter, until October 1, 2003, when they also approved an exception for programs in which >50% of the resident’s training occurs in a rural place

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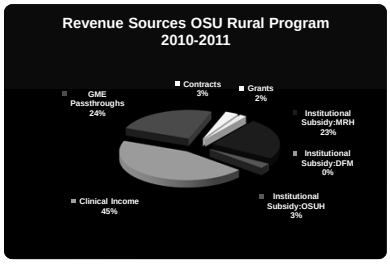
History of 1-2 RTTs: Funding



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History of 1-2 RTTs: Recruiting

- Recruiting of residents has very much been influenced by the rise and fall of US student interest in Family Medicine and the increasing importance of international medical graduates
- US student interest peaked in 1997, then began a decade long fall
- IMG applications were impacted by the events of September 11, 2001

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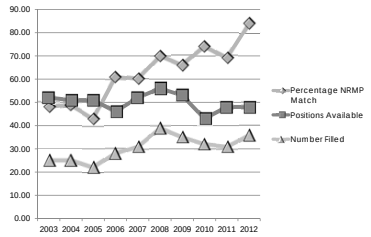
RTT NRMP Trends 2003-2012



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RTT Technical Assistance Program

"A consortium of organizations and individuals committed to sustaining RTTs as a strategy in rural medical education"

www.raconline.org/rtt/

NRHA

RAC Rural Assistance Center

Rural Training Track
technical assistance program

NOSORH

RURAL HEALTH RESEARCH CENTER

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RTT Technical Assistance Program

1. Sustain established RTTs
2. Assist in the development of new RTTs
3. Increase the number of students who match to RTTs through student initiatives and alliances
   - Focus groups and dine outs
   - Parallel web site www.traindocsrural.org
   - NRHA Student Constituency Group Blog
   - Medical School Rural Training Track inventory and network (Deutchman)

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As of July 1, 2012

- 23 active 1-2 RTTs (plus one closing, but finishing out a current resident)
- 3 accredited RTTs, but not active, two of them not yet implemented
- 9 actual 1-2 RTT programs in various stages of development in 8 states (1 prior to grant; another recently failed to get accredited)
- 9 states in the contemplative stage
- 7 states with rural training track development, but not 1-2 RTTs

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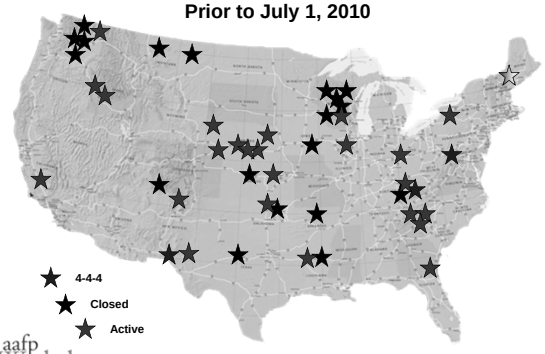
Prior to July 1, 2010



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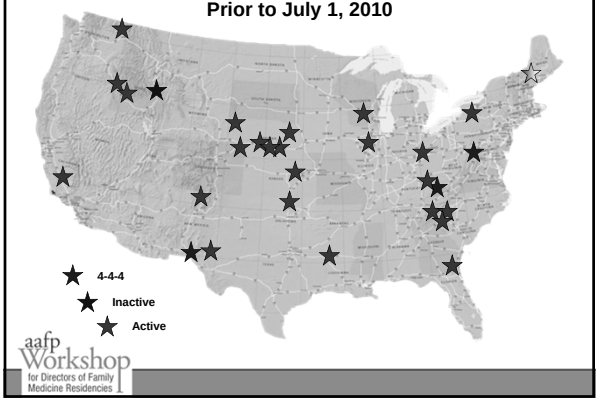

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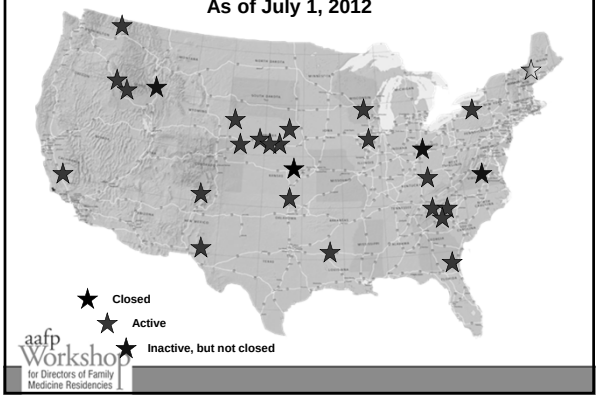

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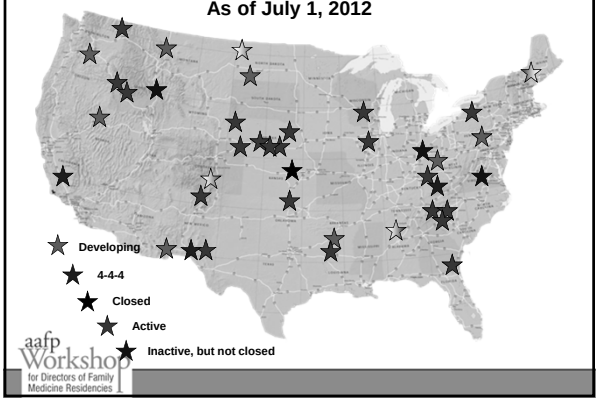

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Contemplative Stage

- Colorado – University of Colorado/Alamosa
- Florida – University of Florida; FSU
- Kansas – University of Kansas
- Maryland – University of Maryland
- Michigan – State Office of Rural Health
- Tennessee – ETSU
- Vermont – University of Vermont
- Wyoming – University of Wyoming

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Rural Training Tracks – Not 1-2 RTTs

- Florida – Mandate from state for rural training in IM, Peds, OB-GYN, as well as FM
- Missouri – PCE expansion to multiple rural continuity clinics
- New York – Accelerated DO residency in FM
- Texas – Rural continuity, Weimar, Tx, considering Foundation and an IRTT framework
- Washington – Rural continuity, Olympia/Elma, WA; Yakima/Ellensburg, WA
- Wisconsin – Rural immersion experiences, continuity sites

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Rural Training Track Characteristics and Graduates' Early-career Outcomes

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RTT "Masterfile": New data on 15 RTTs

- The RTT Technical Assistance Program is creating an RTT "Masterfile" database to answer key questions about RTT programs and their graduates.
- The RTT TAP collected information in Fall 2011:
  - 14 RTTs reported descriptive information about their programs.
  - 14 RTTs reported information on 85 program graduates from 2007-8 through 2010-11, supplemented by AMA and other data sources.

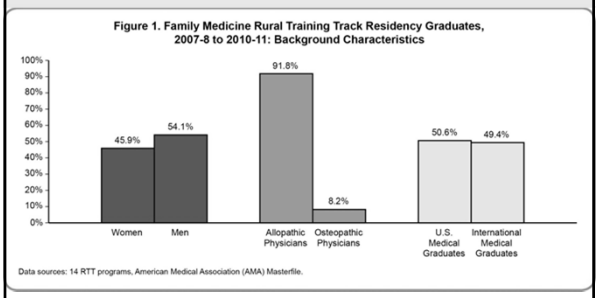
Program characteristics

Characteristics of RTTs reporting

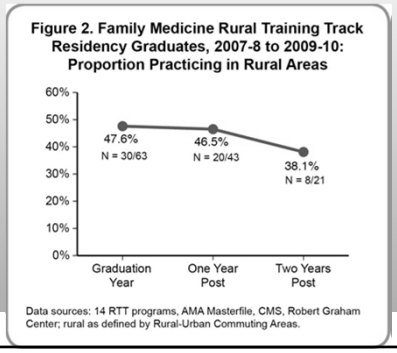
- Longevity: diverse, mean =14 years
- Sponsoring institutions:
  - 9 (64%) academic medical centers
  - 9 in rural areas, 5 in urban areas
- Rural block rotations: 23-35, mean = 27
- Continuity clinics:
  - Majority RHCs or FQHC Look-Alikes in PGY-2/3
- Rural hospitals:
  - At least half CAHs in PGY-2, 36% in PGY-3

Early-career outcomes of graduates, 2007-8 through 2010-11

Graduate backgrounds (n = 85)

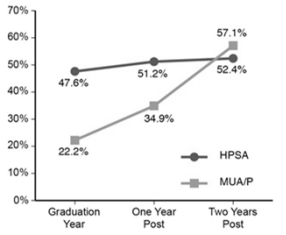


Half or more* practice in rural areas at graduation



High proportions of graduates provide service to designated shortage areas

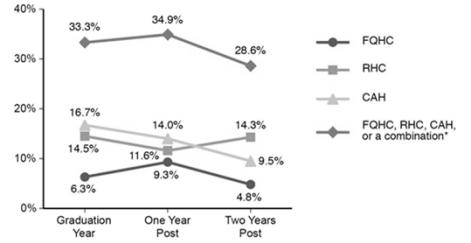
Figure 3. Family Medicine Rural Training Track Residency Graduates, 2007-8 to 2009-10: Proportion Serving HPSAs and MUA/Ps



Data sources: 14 RTT programs, AMA Masterfile, CMS, Robert Graham Center.

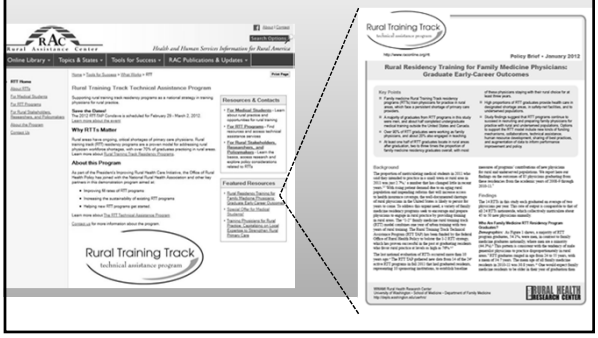
One third practice in safety net facilities at graduation

Figure 4. Family Medicine Rural Training Track Residency Graduates, 2007-8 to 2009-10: Proportion Practicing in FQHCs, RHCs, and CAHs



* Some practice in more than one facility type.
Data sources: 14 RTT programs, AMA Masterfile, CMS, Robert Graham Center.

Policy brief available: http://www.raconline.org/rtt



Acknowledgements

- Thanks to all RTT personnel who provided information!
- ….and thanks to Montana Wright (FMRI) for working with RTTs to collect the information.
- Funding: Office of Rural Health Policy, US Health Resources and Services Administration (HRSA)

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http://depts.washington.edu/uwrhrc/

http://depts.washington.edu/uwchws/

Rural Training Track
technical assistance program

RURAL HEALTH RESEARCH CENTER

Adaptability – a Rural Competency!

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Creative Variations: Structures

- Varying degrees of integration: 4 -15 months in the urban place, in block or occurring longitudinally over 3 years
- Hub and spoke – Continuity clinic only (Eau Claire/Augusta, WI; Galveston/ Weimar, TX; Terre Haute/Clay City, IN; Lewiston/Rumford, ME; UMKC – Primary Care Expansion)
- Advanced skill level options and selective pathways ("Integrated Residency" option, Columbia, MO)

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Creative Variations: Structures

- Medical School and Residency integration (TRUST program in Montana); now the "All In" exception for Rural Scholars Programs
- Teaching Health Centers (e.g. Boise, ID)
- Universally accepted definition of an integrated rural training track, across specialties
- Transition to practice (4th year, or some portion thereof)

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Creative Variations: Taxonomy

- Location; specifically, the number of rural months and their measure of rurality
- Capacity (residency positions per year of graduate training)
- Scope of training (very program specific)
- Outcomes (percentage into rural practice)

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Creative Variations: Taxonomy

	Rural location and rurality (Rural defined as a Rural Urban Commuting Area code of 4 or greater)	Capacity (residency positions per year)	Outcomes
1-2 RTT (separate accreditation)	21 to 31 months; often RUCA codes of 5 or higher	1-4	75% to rural practice
Rurally located	31 or more months; gene lly RUCA 4 (micropolitan)	4 - 6	[Has not been measured]
Hub-and-spoke (IRTT)	Longitudinal; variable rur ity for the rural component, but at l st 4 months	4 or more	[Has not been measured]
Rurally focused urban	Urban location with limited rural rotations or electives of less than 4 months and variable rurality	Usually more tha 4	50% or greater

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Creative Variations: Faculty Development

- Rural Medical Educators Conclave – Since 2006, visits to a particular rural program
- Peer consultation – a pilot through ORHP since 2008, integrated into the RTT Technical Assistance Program
- RTT Conclave – Since 2011, an annual meeting of RTT program and site directors, by invitation only
- NIPDD-R – First class of 3 in 2011-2012, funding for up to 6 for 2012-2013

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Creative Variations: Accreditation

- Meeting with James Martin MD, RRC-FM Chair in May of 2011; ongoing conversations
- Meeting with the GME leadership of the American Osteopathic Association in October of 2011, ongoing conversations
- Next Accreditation System – Rural Version; mutually accepted ACGME and AOA standards, outcome-focused and aligned with the Milestone Project, not necessarily specialty-specific

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Creative Variations: Funding

- Traditional funding – CMS Regional Rural Coordinators
- AAFP and House Bill 3667 – GME funding reform
- Critical Access Hospitals – Putnam, Schmitz, NRHA Fellows
- Teaching Health Center Consortia – FQHCs, RHCs, other

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Creative Variations: Funding

- State initiatives
  - Florida, a legislative mandate and grant
  - Oklahoma, a legislated funding stream
  - Wisconsin, a hospital association-driven line item
- Alliances with State Offices of Rural Health
- Foundations
  - Ohio University, Ohio Heritage Foundations grant
- Justification through community benefit (e.g. Community APGAR, economic impact analyses)

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RTT Campus Collaborative - 501(c)(3)

- **"**The purpose of this organization is to sustain medical education in rural places."
- Initially focused upon establishing and growing a board directed, sustainable network organization, extending in time and scope the efforts of the RTT Technical Assistance Program
- Eventually expanded to include specialties other than family medicine, osteopathic and allopathic; even other health professions

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Questions?

The best way to predict the future is to create it!

Abraham Lincoln/Peter Drucker

The best way to create the future is to: Act. Learn. Build. Repeat.

Paul Brown

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Resources

- RTT Technical Assistance Program - Policy Briefs, and other downloadable items: www.raconline.org/rtt/
- Train Docs Rural - Student site and links to a student blog and facebook page: www.traindocsrural.org
- PDW site for an updated download of this presentation
- RTT Collaborative – Google Group

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