NEW RESIDENCY PROGRAM DEVELOPMENT

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WWAMI Family Medicine Residency Network

Overview

- GME program models / training options
  - Different specialties
- Critical conversations for communities developing residency training opportunities
- Funding considerations:
  - Starting the program
  - Sustaining the program
- Common challenges

GME Training for Rural Needs

- Primary Care:
  - Family Medicine
  - General Internal Medicine
  - General Pediatrics

- Specialty Care:
  - Psychiatry
  - General Surgery
  - Obstetrics/Gynecology

GME Program Models

- **“Full” training program:**
  - Independently accredited
  - Minimum size:
    - FM: 4 residents/year for 3 years
    - IM: 5 residents/year for 3 years
    - GS: 3 residents/year for 5 years
    - Psych: 3 residents/year for 4 years
  - **Requires sufficient size of community and local health care institutions to support training**

GME Program Models

- **Training track:**
  - Associated with a core program in a larger community
  - Full time at rural location; more senior residents; usually 1-2 years
  - 1-3 residents/year
- **Rural rotation:**
  - Associated with a core program
  - Typically 1-2 months at rural location; can be longer
  - 1 resident at a time

Critical conversations:
What does it take to "grow" a GME program?

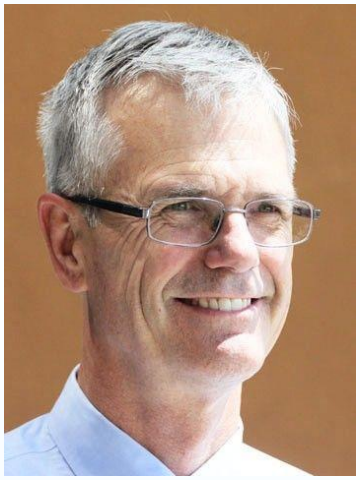
- Program mission
- Sponsoring institution
- Community support
- Training resources
- Attractiveness to applicants
- Financial viability

Program Mission: *the "ROI"*

- New providers for community
- Meeting regional workforce needs
- Meeting local service needs: community access
- Quality improvement
- Recruitment/retention of other local physicians

Envisioning mission

- *Training the future primary care workforce*
  - Knows local institutions and physicians
  - Committed to and skilled in excellent patient care
  - Trained in systems-based practice, team-based care, leadership, and health systems approaches



Dr. Jim Guyer

Billings MT

Dr. Ned Vasquez

Missoula, MT

Sponsoring Institution

- Sponsors:
  - Hospital
  - Community health centers
  - Consortium
- For Rural Tracks and rotations:
  - *Must* be affiliated with a core program

Community support

- Local physicians to lead program
  - Program/site director
  - Program faculty
- Local hospitals/health care systems
- Specialty physicians
- Community engagement

Dick McLandress, MD

Coeur D'Alene ID

An aside: UME/GME

- **Undergraduate medical education (medical students):**
  - Require more supervision
  - Can be used for fewer payment opportunities
  - Active learning optimal but more of a role for “role modeling”
- **Graduate medical education (residents):**
  - Gradually increasing abilities, need for less supervision
  - Can be used for more payment opportunities:
    - Documentation
    - Procedural assistance
  - Can be more active in teaching others and in leadership
  - Critical to use Adult Learning models (*action*)

Teaching resources

- Patient volumes
  - Inpatient
  - Outpatient
  - Diversity
  - Procedures
- Staff support
- Space
- Electronic health record
- Simulation labs
- Observation / videotaping capabilities
- Conference rooms
- Communications
- Electronic resources

Family Medical Center

- Concept
- Location
- Existing patient population
- Unmet community needs

Attractiveness to applicants

- Local/regional "pipeline"
- Current training programs in region
- Match rates and quality
- ***What you will have to offer THEM***

Attractiveness to applicants: *if you build it, will they come?*

- Factors helping:
  - New medical schools and existing school expansions: more students in pipeline
- Factors hurting:
  - Increased medical student debt
  - Challenges facing rural health care delivery systems
- Rural training tracks:
  - Develop local/regional pipeline
  - Recruitment strategies
- Rural rotations
  - Be sensitive to travel/family issues

Attractiveness to applicants:
if you build it, will they come (and stay)?

- Family Medicine:
  - WWAMI region typically higher US graduate match rates than rest of country, and higher post-graduate retention rate locally
- Internal Medicine, General Surgery:
  - Significant post-graduation fellowship rates
- Psychiatry:
  - Challenge with filling with US graduates

What does it take to “grow” a program?

- Program mission
- Sponsoring institution
- Community support
- Family Medical Center base
- Attractiveness to applicants
- ***Financial viability***

Financial Planning

- Funding Projections - Revenues
- Funding Projections – Expenses

Three phases:

- Start-up
- Program build-up
- Mature program/ongoing operations

Funding Projections - Revenues

- Federal:
  - CMS: DME/IME; CAH; other
  - HRSA: Teaching Health Centers
  - VA funding
- State:
  - Medicaid: GME
  - State budget lines
- Patient care services provided
- Hospital / Sponsoring Institution support
- Other (foundations, grants, etc.)

Funding: Rural training tracks

- Federal:
  - CMS: SCH and CAH payments
- State
- Patient care services provided
- Hospital / Sponsoring Institution support
- ***Paying for the first years of training***
- Ability of core program to "break even"
  - FM 1 yr; psych 2 yr, gen surg 2+ yr
- Complex CMS *and* accreditation rules

Funding: Rural rotations

- Federal:
  - CMS: CAH
- State
- Patient care services provided
- Hospital / Sponsoring Institution support

- *Paying for resident training*
- Ability of core program to “break even”
  - They may “lose” GME there
- Complex CMS and accreditation rules

Funding Projections - Expenses

- **Faculty compensation and benefits**
- Resident salaries, benefits and support
- Program operational staff
- FMC costs
  - Staff
  - Fixed and operational expenses

- Educational support
- Accreditation costs
- Insurances (malpractice)
- Faculty and resident recruitment

Roughly $150,000/resident/year…

Thinking about program financing:

- Finances are NOT why a community starts a program, nor the only factor in the decision to do so.
- However, they ARE a critical factor in determining the viability of developing and sustaining a successful program.
- GME training is not cheap, and it depends upon government sources of funding to make it affordable for communities.

Critical conversations…

- What is the mission?
- To what extent are the needed resources (both non-financial and financial) available?
- To what extent are the key participants ready and willing to commit?
- *Opportunity to create the health system of the future that will effectively and efficiently produce the best patient outcomes, with providers who are thriving (the "Quadruple Aim").*

Challenge #1: *funding*

- CMS rules
  - Caps
  - "Zero" PRA
  - CAH/SCH issues
  - ***BIGGEST ISSUE FOR MOST PROGRAMS***
- Medicaid funding
- State funding

Opportunities to address:

- New funding streams; Medicaid GME federal matches
- GME Initiative Group
- Many congressional bills in the pipeline
- State support inititatives

Challenge #2:
faculty recruitment and retention

- Few physicians in a community may be interested in teaching
- Faculty recruitment:
  - Differential pay scales with community physicians
  - May be MORE work than community colleagues
- Faculty development
  - Teaching skills
- Faculty retention

Challenge #3: *teaching resources*

Availability of and competition for teaching resources, and limited sites that are able to support resident training programs:

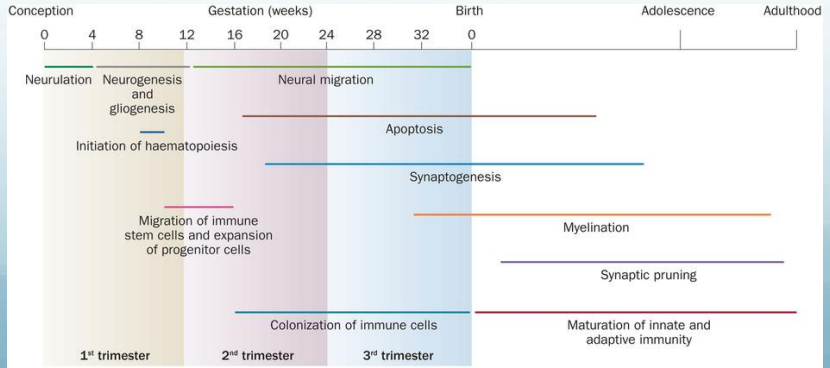
- Size of hospital (beds, occupancy/utilization)
- Number of procedures done locally
- Ability of community to provide specialty services

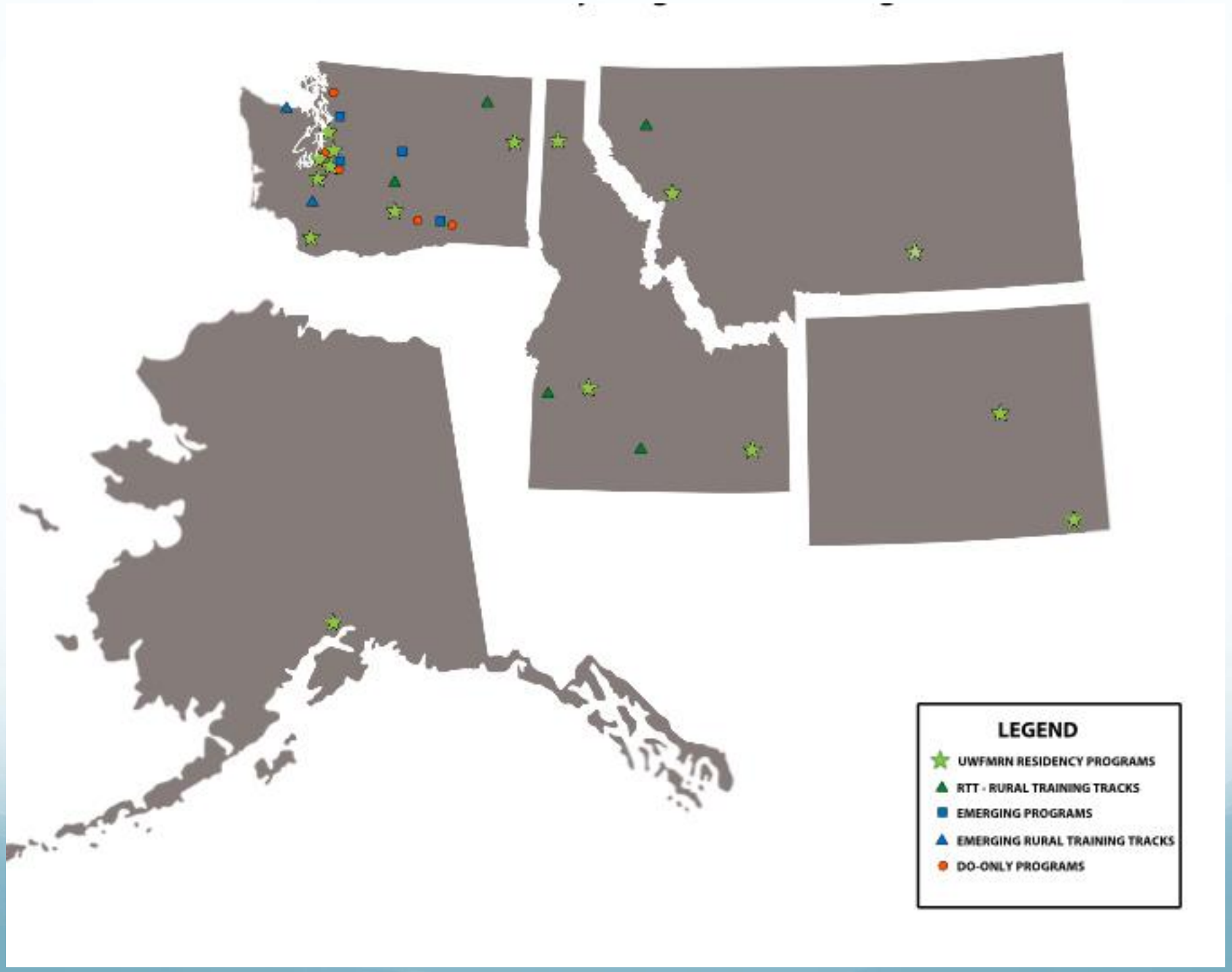
Opportunities to address:

- Can be sometimes mitigated through careful planning around interprofessional education models, and also using residents to teach medical students
- Training of community preceptors critical to their success and confidence as teachers

Timelines

- Sponsoring Institution Accreditation: about one year
- Planning a program: one-two years
- Program accreditation: one year
- Year prior, resident recruiting: one year
- *And then the fun begins!* First graduate 3-5 years later




LEGEND
UWFMRN RESIDENCY PROGRAMS
RTT - RURAL TRAINING TRACKS
EMERGING PROGRAMS
EMERGING RURAL TRAINING TRACKS
DO-ONLY PROGRAMS

Regional family medicine expansion

- New programs:
  - SeaMar CHC Everett (6-6-6): 2017
  - Richland/Kadlec (6-6-6): 2015
  - Community Health Tacoma (6-6-6): 2014
  - Coeur D'Alene, ID (6-6-6): 2014
  - Missoula/Kalispell, MT (10-10-10): 2013
  - East Pierce, Puyallup (6-6-6): 2012
- Program THC expansions and RTTs:
  - Boise, ID (THC)
  - Spokane, WA (THC)
  - Billings, MT (THC)
  - Yakima/Ellensburg, WA (THC/RTT)
  - Chehalis/Centralia, WA (RTT)

Regional family medicine potential

- AOA program “conversions”: Grandview, Kennewick, Mount Vernon, Puyallup Tribe, Health Point CHC Renton
- New programs:
  - Harrison’s Medical Center, Bremerton
  - ? others
- New Rural Training Tracks:
  - Port Angeles
  - Walla Walla
  - Pullman
  - Aberdeen
  - Chelan
  - Others…

Psychiatry (4 years)

- Current:
  - UW Seattle
  - UW/Idaho “2+2” track: 2 yr Seattle, 2 yr Idaho, 3 residents/year expanding to 4/yr
  - UW rural rotations: Anchorage, Fairbanks, Billings)
  - Fellowships:
    - ACGME-accredited: Child/Adolescent; Addiction; Geriatric; Psychosomatic
    - Non-accredited**: Integrated Care (new, plan 5/year)**
  - Spokane: 3 residents/yr for 4 yr
- Potential?

Other specialties

- General surgery:
  - UW Seattle
  - Prior rural rotations not successful
  - Other states: one-year rural rotation; small programs
- Pediatrics:
  - CHMC Seattle
  - Alaska rural track; rural rotations
- Obstetrics/gynecology:
  - Rural rotations

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