NEW RESIDENCY PROGRAM DEVELOPMENT

CRITICAL CONVERSATIONS
Adapted from Judith Pauwels, MD et al
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<tr>
<th><strong>Conference Title:</strong></th>
<th>2021 SLHS Med Grand Round</th>
<th><strong>Date:</strong></th>
<th>11-05-2021</th>
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<tr>
<td><strong>Moderator(s)/Planning Committee:</strong></td>
<td>C. Douglas Cochran, MD: Nothing to Disclose; Donald Campbell, MD: Nothing to Disclose; Diana Dark, MD: Nothing to Disclose; Greg Hartman, MD: Nothing to Disclose</td>
<td><strong>Moderator(s)/Planning Committee:</strong></td>
<td>Veronica Byers-Harms: Nothing to Disclose; Deborah Mintner, BS: Nothing to Disclose; Peter Greenspan, DO: Nothing to Disclose</td>
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<td><strong>Presenter:</strong></td>
<td>Roger Bush, MD: Nothing to Disclose</td>
<td><strong>Topic:</strong></td>
<td>General Medicine – Narratives, Purposes and Possibilities</td>
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<td><strong>Objectives:</strong></td>
<td>At the completion of this activity, learners will be able to:</td>
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<td>1. Review recent and salient literature addressing the coordination and management of patients with complex disease pathology.</td>
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<td>2. Develop options in the conservative management of patients based on recent and salient literature.</td>
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<td>3. Analyze scientific research from peer-reviewed journal articles.</td>
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This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Missouri State Medical Association through the joint providership of Institute for International Medicine (INMED) and Saint Luke’s Health System. The Institute for International Medicine is accredited by the Missouri State Medical Association to provide continuing medical education for physicians.

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Commercial Support: No commercial support was provided for this event.
Disclosure of ABIM and ABFM Service

- I am a current director of ABIM and ABFM
- To protect the integrity of certification, these boards enforce strict confidentiality and ownership of content
- As such I agree to keep exam information confidential
- As with all ABIM and ABFM candidates having taken certification exams, I signed a Pledge of Honesty to keep exam content confidential
- No exam questions will be disclosed in this presentation
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

- “Core” 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

- **Rural Training Track:**
  - Associated with a core program in a larger community
  - Greater than 50% training in rural location
  - 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 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
Sponsoring Institution

- Sponsors:
  - Hospitals
  - Community Health Centers/FQHCs
  - Teaching Health Centers
  - Others

- For Rural Tracks and rotations:
  - *Must* be affiliated with a core program
Local physicians to lead program

- Program/site director:
  - Critical need for a local “champion”

- Program faculty:
  - Numbers depend on size of program and specialty
Community support

- Local hospitals/health care systems:
  - Support for training mission
  - Adequate size and capabilities for needed training experiences

- Specialty physicians:
  - Support of key specialties for training mission
  - Willingness to teach

- Community engagement:
  - Support from local boards/leaders
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

- **Essential** for FM training programs:
  - Concept: new or existing practice?
  - Location
  - Existing patient population
  - Unmet community needs: enough volume?
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
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 programs

- 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 y; IM 2 y, psych 2 y, gen surg 2+ y

- 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
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.
- FFS/Volume mentality is toxic to GME
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 initiatives
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 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:

- Sometimes mitigated through carefully planned interprofessional education models, and residents teaching medical students
- Training community preceptors is 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
Log in to the portal

https://www.ruralgme.org/
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.

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.

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.

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.

STAGE 5
Maintenance

- Ongoing Efforts

To advance to the next stage:
- Make an organizational decision to proceed with investing significant resources in program development.
- Finalize a draft budget. Complete program design to include curriculum outline and site mapping. Submit a Sponsoring Institution (SI) application & receive initial accreditation.
- Achieve initial program accreditation – requires successful site visit and letter of accreditation from the ACGME.
- Complete contracts and orient first class of residents. Hire all required faculty.

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<th>Goal 1.1</th>
<th>Complete community asset and capacity inventory.</th>
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<td>Goal 1.2</td>
<td>Assemble a local leadership team.</td>
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<td>Goal 1.3</td>
<td>Engage potential financial stakeholders and identify a preliminary governance structure.</td>
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<tr>
<td>Goal 1.4</td>
<td>Make an organizational decision to proceed with investing significant resources in program development.</td>
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Tools and Resources

- Community Engagement
- Program Design & Development
- Financial Planning
- Institutional Sponsorship
- Program Accreditation
- Program Implementation
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”).