Baraboo Rural Residency Training Track Program
St. Clare Hospital
Baraboo WI

BENEFITS
1. Recruitment – Holds Promise for Addressing Problems of Work Force Distribution
   Dr. Tim Deering
   Dr. Christina Hook
   Dr. Bridget DeLong
   Dr. Stu Hannah
   Dr. Jamie Kling
2. Ease of On Boarding
3. Externships of Future Medical Students
4. Medical Staff Learning Opportunities
5. Students Become Imbedded in the Community

GREATEST STRENGTHS
1. Committed Directors, Coordinators, and Teachers
2. Hospital Support
3. Community willingness to be seen by Learners
Opportunities for Improvement in Training Rural Physicians

1. Need an increase focus on rural practice as an opportunity during medical school.
2. Need for additional rural training sites.
3. Economy of scale of rural training programs.

THREAT

1. Health care reform and the impact it may have on the support of training rural physicians.
2. Students being steered towards urban programs and specialities/subspecialities.

FAMILY MEDICINE RESIDENCY
TRAINING IN A RURAL COMMUNITY

The 1-2 Rural Training Track Concept
James R. Damos, MD
Baraboo, WI
Objectives for next Few Minutes

• Background information on what 1-2 RTT is and why
• Share Baraboo RTT graduate statistics
• Discuss successes and barriers
• Make personal recommendations
• Handouts

1970’s FP TRAINING DIFFERENT

• My training in Family Medicine was different
• FP training had strong rural focus
• 100% of our faculty had had extensive rural practice experience

1970’s FP TRAINING DIFFERENT

• In 1970’s, other specialties took interest in teaching family medicine residents

“You need to know how to do this if you are going to practice rural”
Things have changed

The Amount of Time Family Medicine Residents Spend in Rural Locations Has Declined

Less focus on rural

Estimated Total Person-Months of Training in All Rural Training Locations (Affiliated with Rural- or Urban-Based Programs)

UNFORTUNATE BECAUSE RURAL EDUCATIONAL EXPOSURE = RURAL PLACEMENT

Resident Placement in Rural Sites by Months of Rural Training (Bowman 1988)
THINGS HAVE CHANGED WITH HOSPITAL BASED TRAINING
De-emphasis on primary care

• Specialization in medicine has lead to many super sub-specialty fellowships AND scientific advances
• There is competition for learning in larger hospitals
• Turf disputes amongst specialties
• Rural primary care left behind

Rural Communities Also Left Behind

• Scientific advances have lead to many cures but rural community needs neglected (primary care)

Prestige and financial compensation of being a specialist trumps rural primary care

• Most Internal medicine and pediatric residents sub-specialize instead of going into primary care – even fewer locate rural
• General surgeons are now breast surgeons, GI surgeons, thoracic surgeons etc. – declining numbers locate rural in gen. surgery
• Orthopedists specialize in ankle, knee etc. – declining numbers locate rural
KRYPTONITE HAS HIT RURAL FAMILY MEDICINE EDUCATION

• Even within family medicine training, specialization is beginning to flourish
  • (Prestige, respect);
    – Sports medicine
    – Geriatrics
    – Palliative Care
    – Preventive Cardiology
    – Substance abuse
    – Academic Medicine
    – Integrative Medicine

Family Medicine residencies struggle to get their residents hospital experiences pertinent to rural practice

Rural champion status fading

More grads staying urban
Sub-specializing in Family Med

WITH THIS BACKGROUND, ENTER BARABOO RTT

• First year in a urban medical center
• 24 months in a rural apprenticeship with time away for specialty rotations and other educational events

1-2 RURAL TRAINING TRACKS

• Concept is to train residents in laboratories similar to where they will work in the future
• We feel prolonged rural exposure challenges resident physicians to think differently in an environment without numerous specialists
• Allows resident physician to experience rural living
• Allows resident physician to practice in a community where patients are also neighbors and friends.
UW-BARABOO RTT

- Started in 1996 with our first 2 residents
- Successful community-academic partnership between
  - University of Wisconsin Dept. of Family Medicine-Madison program
  - St. Marys-Dean Venture
  - AHEC
  - St. Clare Hospital
  - Baraboo Medical Associates

DEVELOPMENT TOOK 3 YEARS OF PLANNING

- CRITERIA FOR DEVELOPMENT AFTER ASSEMBLING PLANNING GROUP

A Process for Developing a Rural Training Track
James R. Damos, MD; Louis A. Sanner, MD, MSPH; Carrol Christman, MA; Janet Aronson, MSSW; Sharon Larson, MBA

Special Series: Rural Residency Tracks (Fam Med 1998;30(2):94-9.)

OUTCOMES

BARABOO GRADS – 1999-2011

- 18 Graduates of Baraboo through 2011
- 15 have entered rural practice (83%)
- 10 have remained in rural practice in Wisconsin (55%)
- 14 Baraboo grads are practicing maternity care in rural areas (77%)
- 4 Baraboo grads are performing Cesarean Sections in rural communities (22%)
- 5 grads have stayed in town (27%)
NATIONAL DATA ON RTTS IS SIMILAR TO BARABOO
• 76% of RTT graduates are practicing in rural America
• 65% are providing obstetrical services
• Half are performing cesarean sections Thomas C. Rosenthal M.D. et al
• Graduate surveys state well trained
• Residents report they have learned procedures pertinent to rural practice

NATIONAL RTT’S IN DEVELOPMENT
Rexburg, ID
Weimar, TX
Farmington, NM
Tuscaloosa, AL
Silver City, NM
Alamosa, CO
Hood River, OR
Olympia, WA
New RTTs are not limited by the current cap in Medicare GME payment (BBRA 1999)

DOES TRAINING IN A RURAL COMMUNITY HURT RESIDENT EDUCATION?
• Baraboo grads improve all 3 years on in-training exams that we monitor
• 100% of Baraboo grads have passed their AAFP board exams
• Graduate surveys tell us they feel well trained for rural practice
• National data tells us they do more procedures pertinent to rural practice

HAS THE RESIDENCY HELPED THE COMMUNITY?
• Residency Community care program - a win - win program
  – Residents care for uninsured and underinsured from Sauk County
HAS THE RESIDENCY HELPED THE COMMUNITY?

- In addition to adding 5 RTT grads to Baraboo area, other physicians have moved to Baraboo since RTT opened in 1996 (Hard to recruit prior to 1996)
  - 1996-2010 physicians locating in Baraboo
    - Dr. Cheryl Gehin (Family Medicine)
    - Dr. Jennifer Orkfritz (Internal Medicine)
    - Dr. James Damos (Family Medicine)
    - Dr. Eric Hamburg (Internal Medicine/Critical Care)
    - Dr. Kristin Wells—General Surgery
    - Dr. Dave Jarvis (Family Medicine)
    - Dr. Tom Stark (Family Medicine)
    - Dr. Amy Delong (Family Medicine)
    - Dr. Kansas Dubray (Med-Peds)
    - Dr. Chris Dale (Orthopedics)

Majority teach in the residency

Interacting with Residents keeps our Doctors sharp

- Sharing call with residents and medical students
- Precepting in clinic
- Sharing hospital patients
- Doing obstetric deliveries with residents
- Faculty doing academic activities
  - Several Baraboo physicians—certified instructors in the Advanced Life Support in Obstetrics (ALSO) Course
  - Several Baraboo physicians—Neonatal Resuscitation Instructors
  - Publications in Medical Journals

BARRIERS TO RTT TRAINING

- Baraboo is the only surviving RTT in Wisconsin
  - Prairie du Chien—closed
    - Lacrosse-Mayo program
  - Antigo—closed
    - UW-Wausau
  - Menomonie—closed
    - UW-Eau Claire
  - Black River Falls—closed
    - Lacrosse-Mayo program
  - Mauston—closed
    - Lacrosse-Mayo program
  - Baraboo—still open
    - UW-Madison

REASONS FOR CLOSING EXPRESSED BY PROGRAM DIRECTORS

1. Few applicants interested
2. Academic—community partnerships fell apart or never developed fully
3. Financial support lacking
4. Too much paperwork and documentation required by regulatory agencies
5. Lack of urban-based physician or support staff champions
PERSONAL RECOMMENDATIONS FOR RESIDENCY TRAINING IN WISCONSIN

• Support what you have already in Baraboo. The Madison-Baraboo RTT has been successful.
• Develop similar programs in Peds, IM, General surgery,
• Centralize the administrative documentation for all RTTs by having a traveling administrative staff to write and document for the regulatory agencies.

PERSONAL RECOMMENDATIONS FOR RESIDENCY TRAINING IN WISCONSIN

• Need more academic physician residency champions at the University
• National work with Residency Review Commission (RRC) and Accreditation Council on Graduate Medical Education (ACGME) is needed to educate them on rural shortages and success of Rural education in rural placement

NATIONAL CONTACTS

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• Mark Doescher MD, MSPH, Director, WWAMI Rural Health Research Center mdoescher@u.washington.edu
• Rural Assistance Center - RTT Technical Assistance Portal www.raonline.org/rtt
Rural Rotations

Definition
Content-Specific Experiences
General Experiences

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http://www.fammed.wisc.edu/wi-rural-physician-program

Rural Rotations – Act 190

- “at least 8 weeks of training experience in a hospital that is located in a rural area or in a clinic staffed by physicians who admit patients to a hospital located in a rural area”
- “Rural” = population less than 20,000 and at least 15 miles away from a community larger than 20,000
- Any Wisconsin residency program in family medicine, general surgery, internal medicine, obstetrics, pediatrics, psychiatry
What is a Rotation?

- Supervised experience that meets a curriculum requirement or is an approved elective
- Duration is determined by national residency accreditation requirements and individual residency policies
- May be at a single site or multiple sites
- May include time at the home program for didactics, continuity clinics, and/or call coverage consistent with specialty requirements and program needs

Regulatory Requirements for Supervision and Billing

- **Supervision** – must meet ACGME standards for education and CMS requirements for billing
  - Education: “Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring the development of the skills, knowledge, and attitudes in the resident required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.”
    - [http://www.acgme.org/acWebsite/home/home.asp](http://www.acgme.org/acWebsite/home/home.asp)
  - Billing: Supervising physician must see every patient and document her/his involvement in the critical or key portions of service

- **Duty Hours** – must meet ACGME standards
  - [http://www.acgme.org/acWebsite/dutyHours/dh_index.asp](http://www.acgme.org/acWebsite/dutyHours/dh_index.asp)

Example: Madison Family Medicine Residency

“Content – Specific Rotations”

- A core residency requirement can be met in whole or in part by clinical time in a rural area
- Duration of rotation at a site is determined by curriculum requirements, site availability, quality of experience, and resident preference
- Resident clinical responsibility is determined by year in training, resident skill set, preceptor comfort, and patient preference
- Residents must be supervised and evaluated
- Residents must attend weekly didactic conferences and see patients at their continuity clinics
**Example: Madison FM Residency**

**“Content –Specific Rotations”**

- Current Rotations and Sites:
  - **Dermatology** (Fort Atkinson)
  - **Emergency Medicine** (Baraboo, Columbus, Portage, Monroe, Sauk Prairie)
  - **ENT** (Portage, Reedsburg)
  - **Gynecology** (Fort Atkinson, Portage, Sauk Prairie)
  - **Orthopedics** (Monroe)
  - **Sports Medicine** (Spring Green)
  - **Surgery** (Baraboo, Fort Atkinson, Sauk Prairie)

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**Example:**

Madison Family Medicine Residency

**“Specialty-Specific Rural Rotation”**

- 40 years of history with this “general experience” model in FM resident education
- Required for second year residents
- Residents collectively become a “partner” in the practice at a “continuity” rural site, or may go to an alternative site
- The breadth of Family Medicine is provided at the clinic and in the hospital, including the ER
- Residents must be supervised and evaluated

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**Example: Madison FM Residency**

**“Specialty-Specific Rural Rotation”**

- **Richland Center -- continuous site since 1981:**
  - 8 residents/year X 6 week rotations = 48 weeks of coverage at that site
  - Exam rooms and nursing staff allocated for resident
  - On call (including ER coverage) in rotation with other physicians in the group
  - Apartment is maintained for residents
  - Residents return to Madison one day/week for their continuity clinic
Example: Madison FM Residency
“Specialty-Specific Rural Rotation”

- Alternative sites -- may address resident-specific populations of interest or geographic preferences
  - 6 week rotation
  - May or may not include call/hospital coverage
  - Space and staff must be available to support resident practice
  - Lodging is provided
  - Residents return to Madison one day/week for their continuity clinic

Example: Madison FM Residency
“Specialty-Specific Rural Rotation”

- Alternative sites (recent years):
  - Keshena/Shawano (Menominee Tribal Center)
  - Wild Rose/Wautoma (Migrant Health Clinic)
  - Lake Mills
  - Dodgeville/Mineral Point
  - Sauk Prairie
  - Viroqua
  - Mercer

The Richland Center Rural Rotation Experience –
A Preceptor’s Perspective

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