

Training Physicians for Rural Practice: Capitalizing on Local Expertise to Strengthen Rural Primary Care

Key Points

- The challenge:** Rural America is facing a shortage of primary care physicians. Family medicine training in rural communities has declined along with the number of rural family medicine physician residency sites, called “Rural Training Tracks” (RTTs).
- The opportunity:** RTTs are a successful strategy in postgraduate medical education for rural family physicians. They are well aligned with current efforts to support primary care, with the growth of Community Health Centers and Teaching Health Centers, and a renewed federal emphasis on health workforce planning.
- The solution:** Engage the expertise of RTT program directors, faculty, and staff to discover how existing RTT programs have thrived, understand their threats and opportunities in light of health reform, and provide technical assistance to sustain their success. Veterans of RTT programs are especially qualified to work with rural communities and institutions to expand existing programs and start new ones.
- The strategy:** The Health Resources and Services Administration’s Office of Rural Health Policy has recently established the Rural Training Track Technical Assistance Program to utilize local expertise in sustaining the “1-2” RTT as a national model for training physicians for rural practice.

Rural Primary Care Physicians Are in Short Supply

Family medicine physicians are critical to primary healthcare in rural America. The more rural the location, the more patients rely on family medicine physicians for their care, the most common rural specialty (see Figure 1). Yet many rural areas face persistent shortages of primary care physicians:

- Of the 2,050 rural counties in the U.S., 1,582 (77%) include primary care health professional shortage areas (HPSAs). In 2005, 165 rural (8%) counties lacked a primary care physician.¹
- In 2004, rural Community Health Centers (CHCs) had significantly higher proportions of unfilled positions and more difficulty recruiting family physicians than urban CHCs; more than one-third of rural CHCs spent over 7 months recruiting a family physician.²

Rural access to primary care is threatened as fewer U.S. medical graduates choose family medicine careers:

- The number of U.S. medical school graduates selecting family medicine as a career has declined by half in the last decade.⁴

- The number of first-year post-medical school residency education positions available in family medicine peaked at 3,293 in 1998³ but dropped by 20% to 2,630 in 2010.⁴

Figure 1. Rural Residents Rely More on Family Medicine Physicians

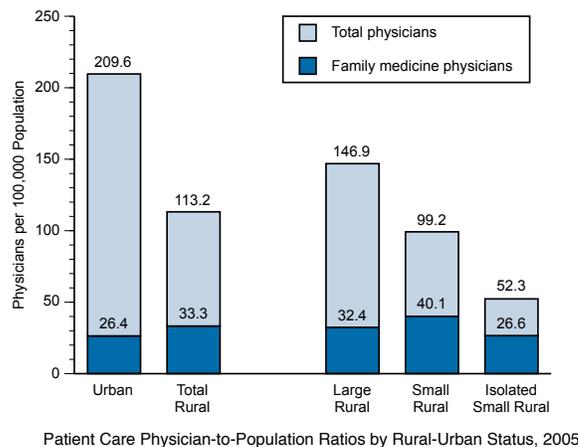
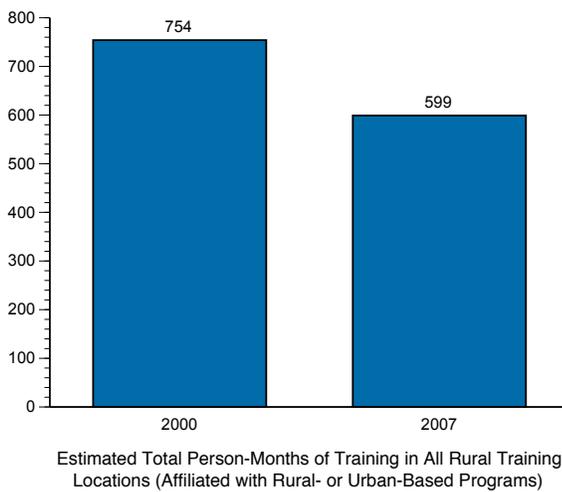


Figure 2. The Amount of Time Family Medicine Residents Spend in Rural Locations Has Declined



- Recruiting residents to rural family medicine programs can be difficult: from 2002 to 2004, rural programs filled 60.1% of their slots through the National Resident Matching Program while urban residencies filled 72.5%.⁵
- Immersion in rural training helps residents acquire the obstetric and surgical expertise required in a rural primary care practice. Yet estimates of the total amount of time that family medicine residents spend in rural training locations show a 21% decline from 2000 to 2007 (Figure 2).⁶

Rural Training Tracks Provide Local Solutions for Strengthening Primary Care

Rural training offers a compelling solution to rural primary care shortages: medical residents who train in rural settings are two to three times more likely to practice in a rural area.⁷⁻¹⁰ This is especially true of residents who participate in rural training tracks (RTTs), spending at least two years in a full-time rural continuity clinic.^{11,12}

RTTs have been very successful in graduating well-prepared physicians to rural practice.¹²⁻¹⁴

RTTs are a greatly underutilized strategy for ensuring an adequate rural primary care physician workforce.

- RTTs have shown that a rigorous teaching program can be scaled to a size that fits rural communities.¹⁵ Even many of the RTT trainees from urban backgrounds select rural careers.
- Since 1990, “1-2” RTTs (one year urban, two years of rural training) have placed 75% of their graduates in rural practice.^{12,14}

Rural Training Track Programs Rely on Key Resources for Sustainability

Though successful, RTT programs have room to grow. As of September 2010, RTTs were serving a total of 140 family medicine residents,¹⁶ but these rural training opportunities are neither plentiful nor well distributed across rural America:

- In 2000, 35 RTTs existed, but by 2010 only 25 were in operation.
 - Large expanses of rural America are not served by RTT programs (see Figure 3). For example, while many of its neighboring states have no RTTs, Nebraska is home to 5 programs, or 20% of all RTTs.
- RTTs face three challenges:
1. Financial sustainability.
 2. Human resource sustainability.
 3. Organizational sustainability.

Financial Sustainability

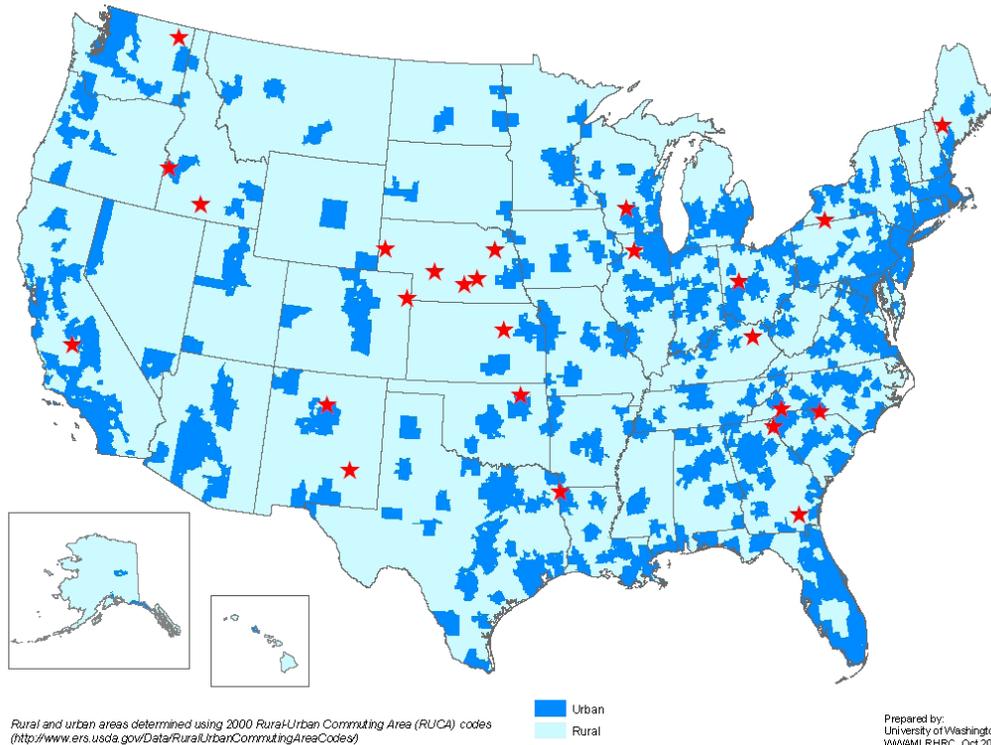
RTTs lack sustainable financing for residency education and faculty support. Many RTTs rely on subsidies from rural hospitals that often cannot afford them. In the last decade, federal law has allowed newer RTTs to receive graduate medical education (GME) funding to train more residents. Some RTTs have encountered barriers to capitalizing on this benefit, but the reasons for this and the extent of the problem need further exploration.

The Rural Assistance Center Rural Training Track Technical Assistance Web Portal

The Rural Training Track (RTT) Technical Assistance Program web portal (<http://www.raconline.org/rtt/>) provides a virtual library of tools, information, and timely access to technical assistance for RTTs and those they serve. On the site, medical students can learn about rural practice and explore opportunities for rural training; RTT program staff can find resources and access technical assistance to help sustain and improve their programs; and rural stakeholders, researchers, and policymakers can learn about RTT programs and access resource and policy considerations related to RTTs.

This RTT Technical Assistance Program is specifically for rural training track family medicine residency programs in the traditional “1-2” format as outlined by the ACGME Residency Review Committee for Family Medicine.¹⁷ These programs receive a waiver of the minimum requirement of four residents per year of training and must be integrated in significant ways with the larger, usually urban, parent program and sponsoring institution. All current RTTs have less than four residents per year and at least 20 months of shared training experiences.

Figure 3. U.S. Rural Training Tracks in Family Medicine, October 2010



Human Resource Sustainability

Like other rural family medicine residency programs, RTTs face challenges in recruiting and retaining residents. Possible solutions include:

- Developing a seamless resident recruitment pipeline by creating direct linkages between RTTs and medical schools.
- Assisting RTTs and their rural communities with effective marketing strategies to attract residents.

In addition to difficulty recruiting and retaining residents, RTTs may face staffing challenges. Because RTTs are small, they are vulnerable to disruption when faculty members and program directors depart, retire, or experience burnout. RTTs also rely on volunteer specialist teaching faculty, who also are often in limited supply. Strategies to address these staffing challenges include:

- Providing incentives for faculty recruitment and retention to help alleviate burnout and delay retirement.
- Compensating specialist physicians to broadly train family medicine residents at RTT programs. Even modest compensation may entice busy specialists to engage in resident training activities.

Organizational Sustainability

To secure institutional recognition and support, RTTs need champions in both their urban sponsoring institution and their rural settings. Without effective champions, small RTTs may lack visibility and institutional commitment. Many leaders from the generation that established RTTs in the 1990s are poised to retire or reduce their practices. This poses a widespread challenge to programs that will need to recruit and transition to new leadership.¹⁵ Organizational interventions to strengthen RTTs include:

- Offering RTTs technical assistance on effective succession planning to help them recruit and mentor new program leaders.
- Providing RTTs with models of successful publicity campaigns. Promoting program successes in local communities and in sponsoring institutions can help RTTs make the case for continued support.

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New Opportunities Hold Potential for Expanding the Impact of Rural Training Tracks

Despite challenges, RTTs offer a highly successful strategy for ensuring an adequate rural primary care workforce through rural postgraduate medical education. RTTs are well aligned with current efforts in community-based medical education (such as expansion of CHCs and initiation of Teaching Health Centers), and a renewed emphasis on health workforce planning. Recent healthcare legislation, including Patient Protection and Affordable Care Act (ACA), and new resources from the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) offer opportunities to revitalize and expand RTTs:

- The newly established National Health Care Workforce Commission is charged with advancing evidence-based workforce planning. This offers potential for recognizing the success of RTTs in public policy.
- Increased Medicare or Medicaid reimbursement for clinical services furnished by RTT resident physicians and faculty can enhance many RTTs' ability to serve their communities. For example, HHS recently broadened the eligibility requirements for a 10% primary care bonus payment under the Medicare Primary Care Incentive Program. This change allows more rural family physicians to qualify for this incentive. Experts estimate that 80% of family medicine physicians now qualify.¹⁸
- Primary Care Residency Expansion: This five-year grant program has allowed expansion of family medicine residency positions, including some RTTs.
- New rules for reallocation of unused GME training slots give priority to urban hospitals with rural training tracks.¹⁹ Many RTTs, however, currently operate in hospitals that receive no GME funding, making them ineligible for this expansion.
- The impact of expanding rural training via GME payment to Teaching Health Centers is unknown. Few current RTTs are located in a Federally Qualified Health Center, Rural Health Clinic, or other entity that might qualify as a Teaching Health Center. While this new mechanism for funding residency training may enable the establishment of new RTTs, existing programs could disappear.
- New National Health Service Corps Loan Repayment Program requirements permit recipients to repay their loans through part-time clinical service. This change may support RTT faculty recruitment and retention in eligible locations by allowing participants to combine teaching and clinical work in exchange for this valuable incentive.

RTT Technical Assistance Program

HRSA's Office of Rural Health Policy has recently established the Rural Training Track Technical Assistance Program in response to the President's Improving Rural Health Care Initiative to improve recruitment and retention of healthcare providers in rural areas. The RTT Technical Assistance Program is a pilot intervention aimed at existing RTTs, communities, providers, educational institutions, and others who care about strengthening rural primary care and sustaining the "1-2" RTT as a national physician training strategy. Veterans of RTT programs are especially qualified to work with rural communities and institutions to expand existing programs, champion the successes of this model, and assist with starting new programs. By engaging the expertise of RTT program directors, faculty, and staff around the nation, this program provides an opportunity to share information about the factors that have helped existing RTT programs to thrive, better understand their threats, and provide technical assistance to help support success and expansion of all RTTs.

RTTs are a greatly underutilized strategy for ensuring an adequate rural primary care physician workforce. With large areas of the U.S. not served by RTTs, the implementation of health reform offers a ripe opportunity for scaling up this successful model of rural physician residency training.

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For More Information

Web site: <http://www.raconline.org/rtt/>

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Notes

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