Growing a Rural GME Collaborative: Advocacy, Collaboration & Good Fortune

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1. About RWHC

RWHC is a collaboration of 40 rural hospitals located across the state. Mission of advocacy and shared services in support of keeping local care local.

Big Challenges Not New to Rural WI (1 of 2)

1970s: Federally funded planners proposed massive consolidation of rural hospitals in Wisconsin; that plan was blocked and RWHC’s role as an advocate was born.

1980s: Growth of health plans with closed provider networks were seen as threat; RWHC started a rural based plan and received federal anti-trust protection.

1980-90s: Medicare radically changed how they paid hospitals and 100’s of rural hospitals closed; in response, RWHC and others championed Medicare’s Critical Access Hospital program that provides critical support to most of our members today.
Meeting Big Challenges Not New (2 of 2)

• **1990s:** Growth in the shortage of physicians working in rural Wisconsin led to the Wisconsin Academy of Rural Medicine, RWHC’s Wisconsin Collaborative for Rural Graduate Medical Education and a major rural expansion by the Medical College of Wisconsin.

• **2000s:** The National Institute of Medicine highlighted major gaps in American health care quality—RWHC helps lead call for rural relevant metrics.

• **2010s:** That providers will be paid not for volume but for value has led RWHC to focus on services preparing for the new era of ACOs.

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**RWHC at 10,000 Feet.**

• Founded in 1979; result of outreach from UWHC.

• Non-profit cooperative of 40 rural hospitals; ≈ $3.5 B Total Gross Patient Revenue; ≈ 14,000 (full and part-time) employees.

• 9 PPS & 31 CAH; ≈ 20 independent, 20 affiliated.

• ≈ 70 employees; ≈ 50 FTE.

• RWHC budgets ≈ $12.5 M; 75% from members, 17% non-members, 5% dues & 3% grants.
RWHC Shared Services*

**Professional Services:** Medical Record Coding, Financial & Legal Services, Negotiation with Health Insurers, Workforce Development, Staffing Rehab Services

**Educational:** Professional Roundtables, Leadership Training, Nurse Residency Program & Preceptor Workshops

**Quality Programs:** Credentials Verification & Peer Review Services, Quality Indicators, Quality Improvement Programs

**Technology Services:** Data Center Services, Electronic Medical Records, Financial Consulting

*Partial List

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RWHC Strategic Partners

- Cooperative Network
- La Crosse Medical Health Science Consortium
- Marquette University
- Medical College of WI
- MetaStar, Inc.
- National Cooperative of Health Networks
- National Rural Health Resource Center
- National Rural Health Association
- UW School of Medicine & Public Health
- UW School of Nursing
- UW School of Pharmacy
- WI Area Health Education Centers
- WI Center for Nursing
- WI Collaborative for Healthcare Quality

- WI Council on Workforce Investment
- WI Dept of Health Services
- WI Dept of Workforce Development
- WI Dept Safety & Professional Services
- WI Hospital Association
- WI Health & Ed. Facilities Authority
- WI Healthcare Data Collaborative
- WI Medical Society
- WI Office Rural Health
- WI Primary Care Association
- WI Public Health Association
- WI Rural Health Development Council
- WI Statewide Health Information Network
2. Ongoing Need for Myth Busting

*There is an Ongoing Need for Rural “Myth” Busting*

- Rural residents *don’t care about local care.*
- Rural folks are *naturally healthy, need less.*
- Rural health *care costs less* than urban care.
- Or rural health care is *inordinately expensive.*
- Rural *quality is lower; urban is better.*
- Rural hospitals are just *band-aid stations.*
- Rural hospitals are *poorly managed and governed.*

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**What We Faced in the 1990’s re GME**

- “Rural primary care physicians are ‘local yokals.’”
- “All they do is wipe kids noses in a rural area.”
- “They’re not really doing real medicine in a rural area”
- “No one needs knowledgeable rural physicians—they just transfer the patients to the city anyway”
- “Our medical school only needs students with an interest in specialties and surgery.”
- “It is not a medical school’s job to worry about where their graduates practice.”
2. Advocacy for an “Over Night Success”

- Working for a desired future on behalf of yourself or others.
- It may be in public or private sectors or both, alone or with others.

The Rural Advocacy Agenda is Multifaceted

- Federal and market places reform that works for rural.
- Fair Medicare and Medicaid payments to rural providers.
- Federal and State regulations that recognize rural realities.
- Retain property tax exemption for nonprofit hospitals.
- Solve growing shortage of rural physicians and providers.
- Bring rural voice to regional provider networks & payers.
- Bring a rural voice into the quality improvement movement.
- Continue push for workplace and community wellness.
- Strong link between economic development and rural health.
Milestones Pre WCRGME (1 of 4)

1990: WI had 6 rural residency training tracks (by 2003, only 1.)
1993: The Governor’s Rural Health Development Council’s study on primary care workforce and encouraged Wisconsin’s two medical schools to further engage in primary care and rural health.
1996: Baraboo RTT accepts first residents.
2000: The Wisconsin Partnership Fund was created at the then University of Wisconsin School of Medicine (UWSM) with half of the proceeds from the for-profit conversion of Blue Cross & Blue Shield of Wisconsin. Funds subsequently help fund expansion into rural and primary care issues.

Milestones Pre WCRGME (2 of 4)

2000: Due to internal and external advocacy, the Dean of the UWSM created the position of Associate Dean for Rural and Community Health.
2001: Byron Crouse moves from Duluth to become the first Associate Dean for Rural and Community Health at the UWSM.
2002: Steve Brenton returns to Wisconsin as head of the Wisconsin Hospital Association (WHA); future physician workforce. Long neglected at WHA, becomes a priority.
2004: “Who Will Care For Our Patients?: Wisconsin Takes Action to Fight a Growing Physician Shortage,” seminal report by the Wisconsin Hospital Association and Wisconsin Medical Society.
Milestones Pre WCRGME (3 of 4)

2004: RWHC received a planning grant from the Wisconsin Partnership Fund for the “Wisconsin Academy for Rural Medicine (WARM). Application developed with the University of Wisconsin Medical School, Southwest and Northern Area Health Education Centers and St. Clare Hospital & Health Services in Baraboo.

2005-2007: WARM received additional grants leading to its implementation. Rural GME highlighted as critical next step.

2006: UWSM name/purpose changed to University of Wisconsin School of Medicine Public Health (UWSMPH) with critical support provided by rural communities in face of fierce opposition from certain quarters.

Milestones Pre WCRGME (4 of 4)

2008: The UWSMPH starts receiving $400,000 in annual funding from the state of Wisconsin to support WARM.

2009: The State, in collaboration with the WHA and RWHC gained approval from CMS for a hospital assessment that captured an additional $300 million in Medicaid funding.

2010: Wisconsin Act 190 provides an annual $750,000 to fund Wisconsin Rural Physician Residency Assistance Program (WRPRAP) at the UWSMPH.

2012: WRPRAP funds RWHC’s proposal for the Wisconsin Rural GME Collaborative.
Your Advocacy Behaviors Matter

- **Be Brief**
- Be Accurate - **NEVER false** or misleading info
- **Personalize** Your Message - cite examples
- Be **Prepared** - know your issue
- Be Aware Every Issue Has **Two Sides** - there are voters on other side
- Be **Courteous**/Don’t Threaten
- Be Patient - long process; be in for **long haul**

Wisconsin Hospital Association’s Grass Roots Handbook

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Three Prong Advocacy Strategy

**Make your best case**: Develop concise, credible, persuasive, fiscally responsible, but emotive arguments.

**Make friends and form alliances**: Find elected champions, develop agency contacts, form alliances with a diverse set of groups.

**Make it happen**: Use some or all of your advocacy tools – government relations, grassroots and media advocacy.

National Rural Health Association
4. Collaboration Lessons Learned

Caveat:
Collaboration needed both within and between organizations and sectors.

Collaboratives Address Diverse Rural Issues
- EHR Networks (RWHC)
- Health Plan Contracting Networks (RWHC)
- Baby Friendly Hospitals (RWHC)
- Immunization Consortiums (SWIC)
- GME Collaboratives (WCRGME)
- Rural Telestroke Networks (Illinois)
- Advanced Directive Campaigns (La Crosse, WI)
- CMS’s “Partnership for Patients” with an emphasis on Care Transitions (WHA)
- Community Collaboratives (New Roadmaps Prize)
A Checklist for Successful Collaborating

- Host organization ready?
- The right partners involved?
- Shared vision unifies partners?
- Partners aware what is expected?
- Partners know partnership goals and objectives?
- People to do the work have been identified, staffed and made accountable?
- “Best practices have been researched and shared?
- Assets residing within the partnership have been mapped?
- Partnership encourages participation in and sustainability of its work?
- Partnership actively recruits new members?
- Defined governance model?
- Leadership is effective?
- Communication/outreach plan?
- Financial needs known and addressed?
- Work evaluated/revised?
- Partnership knows challenges that it faces?

“The Collaboration Primer” by Gretchen Williams Torres and Frances Margolin

Tip #1: Partnership Proposals Must Be Authentic

- Good grants are good “business” plans.
- They start with an idea about which there is passion and that you all would do with your own organizations money, if you had it.
- There needs to be a clear “public purpose” for the requested use of public/foundation funds.
- If successful, real value added–justifying the funder’s investment and reviewers time.
- Bold/Innovative is good and characteristic of funded grant. But reviewers as a whole can be conservative.
Tip #2: Not Every Group Is a Partnership

- A partnership has a written agreement that defines its purpose, member roles and responsibilities.
- A partnership works according to an explicit strategic plan that includes accountability.
- A partnership is not dominated by one entity.

Tip #3: It’s About Social Entrepreneurship

- Network development is an entrepreneurial activity and as such success is not certain.
- The odds can be increased if all participants understand that networks are businesses, albeit typically “non-profit.”
- A key responsibility is to NOT become a small business startup that fails after running through its initial capital (aka grant).
- Sustainability is too often thought of as just one of those annoying questions one has to answer about “life after the grant.”
Tip #4: Communication is Core Competency

- Everyone Participates, No One Person Dominates
- Listen As An Ally–Work To Understand Before Evaluating
- An Individual’s Silence Will Be Interpreted As Agreement

RWHC Meeting Guidelines from Tercon, Inc.

Tip #5: Strategy is Both Art & Science

Strategy is both the art and science of employing the political, economic and psychological forces of a group to afford the maximum support to adopted policies.”
Tip #6: Balanced Portfolio

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**Green:** “High Value - Low Risk” **Do it!**

**Red (Orange):** “Low Value - High Risk” **Non-starter.**

**Yellow:** “Low Value - Low Risk” **maybe helpful in short run** and “High Value - High Risk” **maybe needed for longterm.**

Tip #7: Seeking the Win-Win is Necessary

“Try Saying:
‘Yes, if …’ rather than
‘No, because…’”

*Anne Woodbury,
Chief Health Advocate
for Newt Gingrich’s
Center for Health Transformation*
TS “Last” Words: Follow Your Passion (1 of 2)

RWHC Eye On Health

“Yes, I'm a generalist. I chose primary care over being a partialist.”

TS “Last” Words: Vision Matters (2 of 2)

RWHC Eye On Health

“I knew I was going to take the wrong train, so I left early.” (Yogi Berra)
6. Birth of the WI Collaborative for Rural GME

- Rural hospital administrators and Family Medicine Residencies invited to initial meeting to gauge interest in a collaborative and in developing an RTT.
- Topics covered included:
  - Need for expanded GME, specifically rural
  - How the Baraboo RTT was formed and its experience
  - GME funding basics
  - Steps to accreditation

Initial WCRGME Grant

- Proposed partnership structure
  - RWHC as overarching sponsor and administrator
  - 3-5 Rural Hospitals
  - Baraboo RTT
  - UWFM
  - WRPRAP
  - Future RTT’s and sponsoring institutions
Long-Term Goals Stated in Grant

- Hire Manager
- Identify, develop, and support new RTT’s or expansions
- Assist local RTT coordinators with:
  - Best practice resources
  - Accreditation training & support
  - Recruitment
  - Faculty development
- Consider other specialties, i.e. general surgery
Long-Term Goals Added

- Broadened RTT expansion to include rural rotation and fellowship development
- Started marketing WCRGME opportunities through conferences, website, newsletter, and presentations
- Data collection from members to gauge growth and from residencies for needs assessment

Initial Grant Budget

- Staff
- Consulting
- Equipment
- Supplies
- Travel
- Recruiting
- Indirect

Total: $149,900
WCRGME Mission

Addressing the primary care physician shortage by providing vision, leadership, development, and support of rural graduate medical education in Wisconsin.

Active Collaborative Sites
... and growing!

- 8 to 23 Organizations
- 8 to 25 Rotations
- 77 to 161 Weeks on Rotation
- 2 Developing RTT’s
- 2 Fellowships
7. Development & Support Services Offered

- Bimonthly Meetings
- General GME Information and Presentations
- Initial Site Assessments
- Recommend Consultants as Needed
- Help with GME Funding Questions
- Administrative & Accreditation Assistance
- Best Practice Resources
- Faculty Development Conferences
- Grant Writing & Review
- Rural Education Coordinators Training & Committee
- Marketing rural GME Opportunities at Regional & National Conferences
- Developing Statewide Rural GME Website & Directory

8. “Typical” Rural GME Development Paths

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<th>DEVELOPMENT PHASE</th>
<th>FELLOWSHIP PROGRAM</th>
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<td>Assembly Core Team</td>
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<td>Identify Initial Champions</td>
<td>Commitment from Preceptors</td>
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<td>Apply for Grants</td>
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<td>Write Program Information Form (PIF)</td>
<td>Curriculum Development</td>
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<td>Complete Agreements</td>
<td>Submit for Accreditation (if applicable)</td>
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<td>Submit PIF</td>
<td>Faculty &amp; Staff Development</td>
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<td>Faculty &amp; Staff Development</td>
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<td>Site Visit</td>
<td>Accept Fellow</td>
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<td>Market Residency</td>
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INITIAL PHASE

- Education & Initial Assessment
- Identify Initial Champions
- Apply for Grants
- Education & In-Depth Assessment
- Choose GME Path(s)

DEVELOPMENT PHASE

- Assembly Core Team
- Commitment from Preceptors
- Identify, Sponsoring Institution
- Budget
- Proforma
- Board Approval
- Write Program Information Form (PIF)
- Complete Agreements
- Submit PIF
- Curriculum Development
- Faculty & Staff Development
- Site Visit
- Market Residency
- Interview Applicants
- Accept Residents
INITIAL PHASE

Education & Initial Assessment

- GME 101
- Identifying Opportunities
- Potential Benefits & Challenges
- Gauging Interest Level
- Past Medical Education Experience

INITIAL PHASE

Identify Initial Champions

- Administrative
- Physician

Apply for Early Development Grant

- WRPRAP
INITIAL PHASE

Education & In-Depth Assessment

- Education of potential preceptors/faculty and other support staff (Admin, Nursing, IT, Credentialing, etc.)
- How residents affect the physician schedule, production and patient access
- Benefits and challenges of training residents

INITIAL PHASE

In-Depth Assessment

- Organization’s Educational Experience
- Physician Champion and Other Physician Interest
- Organizational Support & Readiness
- Patient Volume & Demographics
- Curricular Capacity
- Partners/Sponsoring Institution
- Facilities
- Funding
- Community Support
- Often Involves Consultants
Choosing A GME Path

- Rural Rotation Site
- Rural Fellowship Program
- Integrated Rural Training Track (IRTT) Residency Program
- Rural Training Track (RTT) Residency Program

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Email: timsize@rwhc.com  World Wide Web Site: www.rwhc.com  Tweet: www.twitter.com/RWHC  Page 23
9. Case Studies

Hospital A

- CAH in town of less than 4000
- Many communities & hospitals within the region
- About 30 miles from city of 70,000+
- Larger city home to FM residency
- Experience with medical students

Hospital B

- CAH in town of less than 4000
- Only hospital in its county
- About 1 ½ hours from major metropolitan city
- 30 miles from larger city across state lines
- No current relationship with residency
- Limited experience with medical students
Hospital C

- PPS in town of about 10,000
- About 45 minutes from major metropolitan city
- Currently hosts many medical student and resident rotations
- High level of administrative support

10. WCRGME Lessons Learned

- It takes time to educate the organization
- Funding & sustainability #1 questions
- Faculty development needed for rural preceptors
- Organizations with clearly identified administrative and physician champions develop fastest
- Small rotation sites in need of administrative and marketing help
- Collaborative has an important role of accountability partner and cheerleader
Tim’s Suggested Resources

- RWHC Web: www.RWHC.com
- Free RWHC Eye on Health e-newsletter; email office@rwhc.com with “subscribe” on subject line.
- Wisconsin Office of Rural Health: http://WORH.org
- County Health Rankings & Roadmaps www.countyhealthrankings.org
- Nation Rural Health Resource Center www.ruralcenter.org
- Rural Assistance Center at www.raonline.org/ is an incredible federally supported information resource.
- Tim Size, RWHC Executive Director timsize@RWHC.com

Kara’s Suggested Resources

- Rural Training Track Technical Assistance Program www.raonline.org/rtt/
- Accreditation Council for Graduate Medical Education http://acgme.org/acgmeweb/
- Wisconsin Rural Physician Residency Assistance Program www.fammed.wisc.edu/wi-rural-physician-program
- Kara Traxler, Director Rural GME Development & Support ktraxler@RWHC.com