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TO: Joint Committee on Finance
Wisconsin State Legislature

FROM: Wisconsin Rural Physician Residency Assistance Program
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DATE: November 30, 2012

SUBJECT: Annual Report of the
Wisconsin Rural Physician Residency Assistance Program

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Executive Summary

This Annual Report to the Wisconsin State Legislature establishes the background, purpose and need recognized by the Joint Finance Committee in establishing funding for the Wisconsin Rural Physician Residency Assistance Program (WRPRAP). It summarizes activities and progress achieved in 2012 toward the long-range goals of creating more Graduate Medical Education (residency) training positions in small community settings to build the future medical workforce in underserved rural areas.

In addition to reporting on mandated questions, it details WRPRAP accomplishments granting awards to programs seeking to enhance residency education quantity or quality; outlines technical assistance offered to grantees and to other stakeholder groups to support their early development in GME; demonstrates expanded outreach to primary care sub-specialties beyond family medicine; and indicates intended future development efforts.

In brief, WRPRAP awarded seven new grants for the 2011-12 fiscal year and one thus far for the 2012-13 fiscal year, with more interest and activity anticipated. Grants were issued in support of development of new rotation sites, fellowship programs and feasibility studies to determine the viability and sustainability of one GME model or another, and in one case, to organize and nurture a coalition of organizations embarking on new GME initiatives. The coalition organized informally as the Wisconsin Collaborative for Rural Graduate Medical Education (WCRGME or "the Collaborative"). Membership consists of WRPRAP grantees and those organizations that have been active in the Collaborative, usually because they are also contemplating future residency training in their communities with WRPRAP support.

The Collaborative is housed at the Rural Wisconsin Health Cooperative (RWHC) in Sauk City. Collaborative members benefit considerably from the expertise and attention of the Manager for Rural GME Development and Support hired by RWHC with WRPRAP funding to guide and mentor each partner through its development process.

WRPRAP has provided technical assistance directly to members of the Collaborative through regular educational workshops about many aspects of GME process, regulations, accreditation, funding, faculty development, etc., and also by contracting for consulting services from national rural residency experts both collectively in common meetings and through individual consultations at their respective sites. The support provided by the Manager and also paid consultants has proved crucial in giving Collaborative members the confidence to believe they have the capacity to succeed as resident training sites in their rural communities.

Outreach efforts have continued to identify organizations, programs and individuals who potentially have the interest and capability to contribute to rural residency training in Wisconsin. WRPRAP has deliberately pursued national networks and connections to those engaged in rural GME in other states to learn and share information, contribute to the national dialogue and raise awareness about the effort that will be needed to create the medical workforce future generations will require, especially among currently underserved populations.

Outreach this year has also extended directly to the full range of physician specialties eligible for WRPRAP funding. While GME development for family medicine physicians – our early focus – is undoubtedly the greatest need in terms of total numbers of physicians needed to eliminate shortages in small communities, it is also important to increase the numbers of other primary care physicians in those communities in order to make adequate care accessible outside large urban centers. Act 190 identifies family medicine, internal medicine, OB/GYN, pediatrics, general surgery and psychiatry specialties as eligible grantees.

In an effort to lay the groundwork for an education pipeline that will supply the current and future medical care needs of rural communities, WRPRAP has entertained proposals for educational innovation for residents through unsolicited RFPs as well as specifically defined grant options. In this way, we have identified potential growth areas that are uniquely suited to the needs and strengths of particular communities.

Background

On July 1, 2010, the state legislature enacted Act 190, and thus established the Wisconsin Rural Physician Residency Assistance Program. The Department of Family Medicine of the University of Wisconsin School of Medicine and Public Health was designated to administer this program which annually provides $750,000 to the planning and implementation of rural Graduate Medical Education (GME) experiences.

Currently, the availability of rural Graduate Medical Education (residency) education experiences in Wisconsin falls far short of the need. The Baraboo Rural Training Track (RTT) residency program sponsored by UW Department of Family Medicine (DFM) is the only remaining RTT of Wisconsin's six programs a decade ago – and it has capacity for only two residents per year. Other RTTs in Wisconsin and elsewhere disappeared primarily for two reasons: 1) financial and logistic barriers and 2) insufficient student interest.

The significant and growing shortage of physicians practicing in rural Wisconsin has been well documented including by the Wisconsin Council on Medical Education & Workforce (WCMEW). Counties designated as totally or partially underserved in primary care constitute fully 79% of all counties (57/72). Of these, 70% are rural. Projections for the next 20 years indicate an increasing deficit without serious intervention. Unaddressed, economic and population health consequences would continue to multiply.

In a frequently cited report issued by the Wisconsin Hospital Association (WHA) in November 2011 ("100 New Physicians a Year: An Imperative for Wisconsin"), WHA provided data illustrating a current supply deficit of 100 physicians per year. Among the contributing factors are an aging population that will require more care, a bulge of retiring baby boomer physicians likely to find themselves soon on the other end of the stethoscope, the imbalance in the percentage of Wisconsin physicians trained in-state versus out-of-state, and the pending effects of the Affordable Care Act as millions more patients become insured–dramatically increasing the number of primary care physicians needed to serve them.

In the report, Charles Shabino, MD, WHA senior medical advisor, recommended aggressive action to combat the growing shortfall in light of statistics like these: Of the 340 medical students graduated by the state's two medical schools each year, only 36-40% remain in Wisconsin. Of the new physicians needed each year, only about 150 come from the UW School of Medicine and Public Health and the Medical College of Wisconsin, requiring us to import 720 out-of-state physicians each year. As the demand for physicians everywhere grows, Wisconsin's ability to recruit from external sources will be impaired. The need is for an *additional* 100 physicians per year post-residency training to meet existing demand. If not successfully addressed, rural communities and inner city Milwaukee will be the most affected. While

primary care physicians are undersupplied throughout the state, a sizeable percentage of those physicians is needed in rural areas.

Predictive factors for which students will choose to practice in this state include being a Wisconsin native, attending medical school here and completing residency training here. For individuals who fit all three categories, the retention rate for choosing Wisconsin for practice is 86%. For choosing rural practice, having rural origins, a service orientation, and significant time in rural areas during medical and/or residency training are also strongly correlated.

Growing awareness of need among health care organizations and academic institutions provides an opening for serious effort to attract and train rural hospitals, clinics and providers to provide quality graduate medical education (GME/residency) experiences in real life rural settings. This developing awareness is WRPRAP's entrée for organizing and nurturing rural educational development.

Recently, growing interest among residents is also apparent. Application rates for all Wisconsin's family medicine residency programs is up significantly this year, notably for the Baraboo RTT where 28 medical school graduates will be interviewed for two resident slots in the current recruitment process – up from 18 last year. Interviewees were selected from 106 applications from US medical school graduates.

The Wisconsin Academy for Rural Medicine (WARM) is a comprehensive medical education program established in 2007 in the University of Wisconsin School of Medicine and Public Health (UW SMPH) for growing the medical workforce. It enrolls 25 students per year. The Medical College of Wisconsin (MCW) is currently planning to expand campus sites to include rural settings for medical students as well. Together, these combined efforts, while potentially growing the future primary care workforce, will increase the number of medical students seeking new resident slots each year, exacerbating the pressure for venues where new physicians can complete their required residencies.

Required Reporting

Section 36.63 (4) of Act 190 enumerates specific information that is to be reported to the Joint Committee on Finance by December 1:

36.63 (4) (a)

The number of physician residency positions that existed in the 2009–10 fiscal year, and in each fiscal year beginning after the effective date of this paragraph that included a majority of training experience in a rural area.

- 2009-2010: ***53 =*** *5 Baraboo residents + 48 Marshfield residents in the specified specialties*
- 2010-2011: ***54*** *= 6 Baraboo residents + 48 Marshfield residents in the specified specialties*
- *2011-present:* ***61*** = 6 Baraboo residents + 55 Marshfield residents *in the specified specialties*
- *2012-present:* ***62*** *= 6 Baraboo residents + 54 Marshfield residents + 2 Augusta residents in the specified specialties*

36.63 (4) (b)

1. The number of such physician residency positions funded in whole or in part under this section in the previous fiscal year:

- As of 11/30, 2011:
  - 1 rural residency – Wesley Harden, MD, Baraboo

2. The eligibility criteria met by each such residency position and the hospital or clinic with which the position is affiliated:

- All criteria met (population size, distance from metro area, duration of rotation, etc.)
  - Baraboo Family Medicine Associates

3. The medical school attended by the physician filling each such residency position:

- Wesley Harden, MD – University of Texas Medical School in San Antonio

4. The year the Accreditation Council for Graduate Medical Education certified the residency position:

- Start date for Harden: 07/01/2010 *(added to resident roster off-cycle; no additional resident spot required)*
  - Baraboo Program originally certified 07/01/1996; most recent certification: 03/11/2008

5. The reason the residency position had not been funded:

Not Applicable

In interpreting the above data, the following should be noted:

WRPRAP is still in development stage as this is only our second operational year. While the first was devoted predominantly to organizing and infrastructure building, the second has concentrated on creating increased awareness among health care systems, academics, policy makers, potential training sites and trainees, and the public about the urgent need and strategies for producing more rurally trained residents for rural practice. These audiences require specific information about the nature of WRPRAP and the resources it can supply to residents, residency programs and rural hospitals, clinics and providers to collectively address the future supply of medical workers in small communities.

Substantial progress has been achieved in making WRPRAP more visible to relevant potential partners and prospective residents through persistent outreach to these groups. However, while efforts to produce significantly more physicians per year should be an immediate priority to address the growing gap between need and supply each year, it should also be noted that producing a fully trained licensed family medicine practitioner takes three years post medical school – and much longer for some other physicians supported by WRPRAP.

Additionally, creating a new RTT is also a commitment of at least three years of development with numerous issues to address – financial, regulatory, accreditation, faculty recruitment – to name a few, before being ready to accept residents for training. Given that WRPRAP is also in early stages of its development, we are pleased that outreach this year has so far resulted in eight individual grants to various parts of the state, ranging from $32,000 - $150,000 and spanning projects from early development feasibility projects to long-range infrastructure building to considerable technical assistance. (See below.)

We are especially pleased to report all 60 residency program directors and education staff of eligible specialties throughout the state, as well as partner institutions and clinics, have received multiple opportunities for gathering information about funding options and invitations to apply for funding. Where interest has been expressed, one-to-one meetings between program leadership and WRPRAP staff have been conducted to answer specific questions and explore context specific options.

Budget

36.63 (3)

Annually by December 1, the department shall submit a plan for increasing the number of physician residency programs that include a majority of training experience in a rural area to the Wisconsin Council on Medical Education and Workforce Rural Wisconsin Health Cooperative, the Wisconsin Hospital Association, the Wisconsin Medical Society, the UW School of Medicine and Public Health, and the Medical School of Wisconsin). The plan shall include a detailed proposed budget for expending the moneys appropriated to the board under s. 20.285 (1) (qe) and demonstrate that the moneys do not supplant existing funding. The department shall consider comments made by the organizations in formulating its final budget.

For the period of December 01, 2011 through November 30, 2012, the Wisconsin Rural Physician Residency Assistance Program has spent approximately $235,570 salary and benefits, and $474,944 in financial assistance to grantees. Beyond dedicated financial assistance funds, WRPRAP's other budget expenses have been minimal.

- Please refer below for further budget detail:

Expenses	Salaries	Fringe Benefits	Services & Supplies	New Program Development	**TOTAL**
Calendar Year 2012*	$182,226.26	$53,345,20	27,512.00	$474,944.00	$773,026**

*Actual expenses through November 2012 and anticipated December 2012 expenses
**Includes pending award to be paid in December of $32,262

WRPRAP Accomplishments – 12/01/2011-12/01/2012

As previously reported, WRPRAP has so far awarded grants to eight* organizations since the first of the year. A total of $474,944* ranging from $35,000 feasibility study grants to $150,000 education development grants has been awarded to Aurora Health (Milwaukee and multiple rural partners), Baraboo RTT, Calumet Medical Center (Chilton), Community Health Network (Berlin), Grant Regional Health Center (Lancaster), Monroe Clinic (Monroe), and Upland Hills Health Center (Dodgeville). "Feasibility study" here implies a guided exploration of what is required to develop a particular type of residency education program and an assessment of the capacity of the site in question to successfully pursue which types. Formation of the WCRGME Collaborative among these grantees is a major step in advancing development individually and collectively among them.

WRPRAP's first year was largely devoted to program design, development and creating infrastructure to pursue our goals, and we also issued four grants in support of rural rotations, educational software and subsidizing a resident in a rural setting. Access to funding applications is available through the WRPRPAP website (www.fammed.wisc.edu/rural/applications-funding) and also by responding to solicited or unsolicited proposals.

Our second year has allowed us to pursue development in substantial ways, by organizing a coalition of this year's grantees as well as other active participants. In addition to current grantees, the Collaborative includes organizations that intend to pursue WRPRAP funding to support educational programs, (e.g., collaborating with rural sites to develop training venues for residency program rotations at those sites). Also represented are communities that are at an earlier decision-making stage regarding a future role in graduate medical education (GME).

Grant Awards

Award recipients include:

Program	Grant Type/Purpose	Award Amount
Aurora Health Care* (Milwaukee & Rural Partners) 2012-13	Feasibility Study Determine whether to develop RTT or standalone Rural Residency	$32,262
Baraboo Rural Training Track* (Baraboo) 2011-12	Education Development Grant Phase I redesign of women's health curriculum	$35,000
Calumet Medical Center/Fox Valley* (Chilton/Appleton) 2011-12	Development of rotation sites for Fox Valley Family Medicine Residency (4 resident rotations/year in any of 6 specialties)	$35,000

Community Health Network* (Berlin) 2011/12	Feasibility Study Determine potential as community-based RTT in CAH setting	$34,970
Grant Regional Health Center* (Lancaster) 2011-12	Feasibility Study Determine capacity as rural rotation site in CAH setting (3 specialty areas)	$34,974
Monroe Clinic* (Monroe) 2011/12	Unsolicited RFP Develop 4th Year Rural Fellowship for family medicine physicians in emergency medicine or hospitalist specialties	$150,000
Upland Hills Health Center* (Dodgeville) 2011/12	Feasibility Study Determine capacity as RTT with four potential partners	$35,000
Wisconsin Rural Health Cooperative* (Sauk City) 2011-12	Education Development Grant Organize cooperative effort among rural health care institutions & providers; provide infrastructure and technical support for them	$150,000
		$507,206

*Attestations by each program that funding requested from WRPRAP would not supplant existing funding for the same purpose were confirmed in writing by each grantee in the application process that resulted in their respective awards.

Outreach

WRPRAP has pursued a strategy of building communication channels through identification of likely audiences, e.g., academic residency in any of the funding-eligible specialties; record as a current or previous host of residents or medical students; or hospital or clinic located in a rural area that meets the Act 190 definition of "rural." Considerable effort has been devoted to collecting contact and role information on residency programs and communities interested in or connected to underserved populations. This information has been used to approach individuals associated with these programs and communities via email, phone, newsletters, "push" marketing to these audiences, personal invitations, and connections through professional meetings or colleagues.

The groups that can benefit from WRPRAP resources or technical assistance are narrowly defined. Therefore, our outreach must be targeted – and also patient. There is a long learning curve between interest/desire to provide clinical training for residents, understanding the many complexities of the regulated GME system and finally, becoming an efficient and educationally sound learning environment for residents. Program directors of residency programs, hospital administrators, physician advocates and willing clinical faculty are all key players needed for the development of new or expanded residency training in small communities. Long-term coaching as well as start-up funding is needed in many cases.

To capitalize on interest and to accommodate the busy schedules of practitioners, WRPRAP staff has often traveled to academic or clinical sites to introduce the opportunities WRPRAP can provide to clinicians or academic faculty. As the Wisconsin Collaborative for Rural Graduate Medical Education begins to take root, relationships among disparate groups are developing and word of mouth is bringing new interest to WRPRAP.

Expansion of Effort

Individual contacts with program directors across the state, across specialties and across health systems are beginning to pay off. Recent conversations with academics in Pediatrics, General Surgery and Psychiatry hold promise for duplicating some of the progress already achieved in Family Medicine. Inquiries and responses from representatives of a number of the major health systems in Wisconsin are also encouraging.

Mindful of the widespread need across the country for better medical access and quality of care among the underserved, especially rural populations, WRPRAP has also cultivated connections with national leaders in rural GME development. This allows us to take advantage of others' successful strategies and to share ours.

Technical Assistance

Recognizing the need for unique training for those who will practice in rural settings and actually being able to deliver quality experiences is a complex process that requires coordinated efforts of clinical staff, hospital and clinic administration along with community and educational program support. This is one of the reasons WRPRAP is prepared for sustaining growth.

We have provided **workshops** to introduce prospective grantees to GME, and to the advantages and challenges of bringing resident training to rural community settings. We have invited participants to examine whether and how being part of a **collaborative** would facilitate their efforts to create GME in

their facilities, and have provided regular group meeting opportunities and individual site consultations to members of the Collaborative both via video conference and in person.

WRPRAP engaged national consultants with expertise in rural GME to provide instruction, **consultation**, and individual **coaching** to Collaborative members to inspire confidence and competence to take on GME. In three separate visits between July and September this summer, two highly respected experts helped to motivate action and commitment among Collaborative members. Their efforts produced observable advances in development progress. Their further involvement will help to build infrastructure and to sustain development over time.

Staff

WRPRAP staff has remained constant this year except that Program Assistant Paul Howl has recently departed to accept a full-time position. With his departure on November 9th, we are now seeking a replacement.

Program Director, Byron Crouse, MD
Dr. Crouse's depth of knowledge and experience in rural medicine and his position as director of the Wisconsin Academy of Rural Medicine (WARM - the UW School of Medicine and Public Health's medical school program designed to prepare students for rural practice) are valuable to WRPRAP. His vision and these experiences as well as his leadership roles with the SMPH and national rural health organizations make him uniquely qualified to provide leadership and direction for this vital effort to build the medical workforce in rural Wisconsin. (Contact: 608-265-6727; bjcrouse@wisc.edu)

Program Coordinator, Wilda Nilsestuen, MS
This position provides day-to-day management of the program, considerable outreach to potential and awarded grantees and promotion of network building among graduate medical education providers in the state. Ms. Nilsestuen has considerable experience in program planning, leading professional development programs, and in Wisconsin-based rural development in areas such as immigrant integration, rural health care and community sustainability. (Contact: 608-262-2764; wilda.nilsestuen@fammed.wisc.edu)

Program Assistant, Paul Howl, BS
Mr. Howl served the program between October 2011 and November 2012 and provided a broad range of administrative assistance, especially budget monitoring, website development, and database development.

Future Plans

WRPRAP will continue to grow awareness of both the need for a medical workforce that will serve the state's changing demographics and the role WRPRAP can play in contributing to solutions for achieving and maintaining that workforce. We will seek to strengthen collaboration for rural-focused GME efforts at WRPRAP supported locations and specialty education. We will explore possibilities for launching partnerships like the WCRGME Collaborative or other kinds of coalitions among different partners in other regions of the state.

We expect a second round of requests from those who received feasibility study grants this year and from those with implementation grants whose original award specified they could seek continued funding if they fulfilled first year obligations of their grant.

We will continue to draw upon the national and regional conversation on rural GME development by participating in leadership/strategic meetings at the state (e.g., Rural Primary Care Summit) and national levels (Annual RTT Conclave) to bring best practices to Wisconsin.

Conclusion

In a report* published in September 2012, the National Center for Rural Health Works demonstrated the economic impact of a primary care physician on a rural community with statistics showing that a single primary care physician creates annually 23 jobs, $1 million in wages, salaries and benefits and generates $1.8 million in annual revenues to that community. A general surgeon's impact is even greater: 26 jobs, $1.4 million in wages, salaries and benefits and $2.7 million in total revenues annually for the local economy. It is clear from these and other statistics that the benefit to rural communities of adequate health care infrastructure is economic as well as vital to public health and social well-being.

Today's physician shortage in rural Wisconsin will continue to intensify without specific strategies and deliberate actions to address it. The funding WRPRPAP provides is a direct response to this need as residency experience in rural locations is a proven factor in predicting who ultimately will choose to practice in rural Wisconsin.

In the course of supporting new rural residency training or sustaining or enhancing existing rural residency programs, WRPRRAP is fulfilling its mission but also promoting new partnerships and building collaboration across organizations, systems, specialties and locales in the long-term interest of the health of Wisconsin's rural population and communities.

*Summarized from "Economic Impact of Rural Health Care" by Gerald A. Doeksen, Cheryl F. St. Clair, and Fred C. Eilrich at the National Center for Rural Health Works, September 2012. Complete policy brief at ***http://ow.ly/eqSye***.

Attachment A: Advisory Committee

Program Staff and Advisory Committee

Staff

Byron Crouse, MD, Program Director

Wilda Nilsestuen, MS, Program Coordinator

TBD, Program Assistant

Advisory Committee

Tim Bartholow, MD, Senior Vice President of Member Services, Wisconsin Medical Society

Mark Belknap, MD, (Ashland) Former President, Wisconsin Medical Society

Mark Deyo-Svendsen, MD, (Menomonie) Family Physician, Red Cedar Medical Center

Valerie Gilchrist, MD, (Madison) Chair, Department of Family Medicine,
University of Wisconsin School of Medicine and Public Health

Joseph Kilsdonk, Au.D. (Marshfield) Administrator, Division of Education, Marshfield Clinic

Bill Schwab, MD, (Madison) Vice Chair of Education, Department of Family Medicine,
University of Wisconsin School of Medicine and Public Health

Charles Shabino, MD, (Wausau) Senior Medical Advisor, Wisconsin Hospital Association

Tim Size, (Sauk City) Executive Director, Rural Wisconsin Health Cooperative