Reshaping Rural Internal Medicine Training

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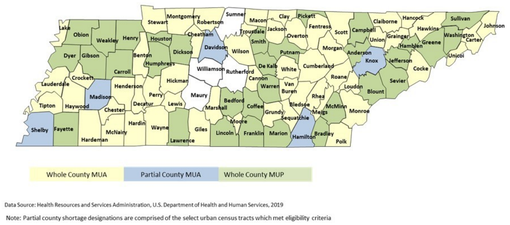
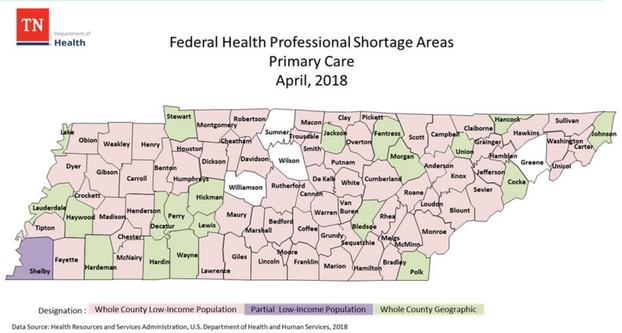
Addressing the Need

- 20% of our US population is rural, cared for by 9% of physicians-mostly family doctors.
- Internal medicine GME training follows a pattern of what has been termed structural urbanism, a form of structural bias.
- Internal medicine is increasingly characterized by an urban focus that may predispose trainees for urban practice, potentially worsening rural workforce gaps and health outcomes.



- General Internists wishing to practice rurally endure additional barriers to appropriate training and infrastructure:
- Rural patients are older, poorer, less educated, and have more multiple chronic diseases than urban dwellers. *Table 1-3.*

Goal of Approach



Henry County Tennessee is a designated primary care Health Professional Shortage Area (HPSA) *Figure 1*. The geographic area includes West TN counties designated as medically underserved populations (MUP) with whole county low-income designations *Figure 2*.

Health statistics for the target patient population indicate disparities relative to the state and/or nation among: adult obesity, diabetes, hypertension, adult mental health, and lower overall health rankings *Table 1-3*.

	County	State	Top U.S. Performers
Life Expectancy[15]	74.3	76.0	81.1
Premature Age-Adjusted Mortality (YPLL)[15]	530	450	270
Infant Mortality per 1,000 in one year[15]	-*	7	4
Diabetes Prevalence[15]	18%	13%	7%
Injury Deaths per 100,000[9]	119	92	58

Advancing OGME

1. Develop rural internal medicine residency curriculum
2. Train faculty and staff to teach, support and administer the curriculum
3. Establish new partnerships and work with existing partners to support residency program development
4. Meet all requirements for ACGME accreditation in internal medicine and apply for osteopathic recognition;
5. Recruit a cohort of residents by the end of grant funding to begin training in academic year 2023-2024;
6. Track residents' career outcomes after graduation for at least 5 years; and evaluate the program to determine extent to which objectives were met.

	County	State	Top U.S. Performers
Adult Smoking[12]	27%	21%	14%
Physical Inactivity[12]	34%	27%	20%
Drug Overdose Deaths per 100,000[12]	27	28	10
Excessive Drinking[12]	16%	17%	13%
Poor or Fair Health[12]	24%	21%	12%
Teen Births per 1,000 females aged 15-19[12]	39	29	13
Obese Adults >age 20 BMI >30[12]	34%	33%	26%
Alcohol Impaired Driving Deaths[12]	38%	25%	11%
Poor Mental Health Days reported in the last 30 days[12]	5.7	5.2	3.4

Results

- Our group analyzed gaps in funding as well as potential barriers to accreditation
- Communication with State Legislature the need with support including in state budget
- ACGME 2019 framework is more adopted to encourage GME in rural and underserved areas

	County	State	Top U.S. Performers
Primary Care Physicians[14]	1,470:1	1,400:1	1,030:1
Mental Health Providers[14]	530:1	630:1	290:1
Preventable Hospital Stays Related to Ambulatory-Care per 100,000 Medicare Enrollees[14]	5,099	4,915	2,761
Flu Vaccinations[14]	53%	50%	53%
Access to Dentists per 100,000[14]	1,900:1	1,800:1	1,240:1
Mammography screening: Medicare Enrollees ages 65-74 that received annual screening[14]	42%	41%	50%

Conclusions/Implications

- Tennessee State Annual Budget to include $5.5 million increase allocated for rural residency training for this program and others like it. *(TN S.B. 0298)*
- Initial American College of Graduate Medical Education (ACGME) Sponsoring Institution Accreditation
- Ongoing Pursuit of Program and Osteopathic Accreditation

TN $5.5 million

References

1. What Does the Evidence Tell Us?: A Review of Rural Health Research Center Literature, 2000-2010. April 2011. 2. Hempel S, Maggard Gibbons M, Ulloa JG, Macqueen I, Miake-Lye I, Beroes J, Shekelle P. Rural Healthcare Workforce: A Systematic Review. VA ESP Project #05-226; 2015. 3. Patterson DG, Schmitz D, Longenecker R, Andrilla CHA. Family medicine Rural Training Track residencies: 2008-2015 graduate outcomes. Seattle, WA: WWAMI Rural Health Research Center, University of Washington. Feb 2016. 4. Competence Revisited 2018; innovation (e.g. archives of The RTT Collaborative Annual Meeting: Family Medicine Program