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Advocacy • Education • Leadership

Primer for Starting Osteopathic Family Medicine Residency Programs

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Forward - A Call to Action: Primer for Starting Osteopathic Family Medicine Residency Programs

Over the past six decades, the profession of osteopathic family medicine has achieved steady growth and established itself as a significant contributor in the United States health care system. More than 10,000 certified osteopathic family physicians apply our distinctive principles and skills each day for the benefit of thousands of patients throughout the country.

With specific regard to the future pipeline, medical school graduates can select from 185 osteopathic family practice residency programs – an increase of ## percent in the past # years alone.

Yet, in recent years, the number of osteopathic graduates entering our residency programs has experienced a slow fade, and we risk losing those unfilled spots to other specialties or their elimination. We know that geography is a primary factor in residency selection, but we do not have an adequate geographic dispersion of our residency programs.

The question is legitimate – why add more programs when the ones we have now are not filling?

Because the perfect storm is forming – more graduates but fewer residency positions available to those graduates. We must provide the appropriate number of residency positions to meet the needs of our future graduates, and we must provide those graduates with geographic options. Furthermore, national health care legislative and regulatory initiatives favor expansion of primary care residencies.

ACOFP Board Task Force on Residency Program Development

To address these demographics and provide a viable future for the profession of osteopathic family medicine, we have established the ACOFP Board Task Force on Residency Program Development.

Its purpose is to develop the Primer that follows so that those interested in developing a new residency can "add water and stir." This Primer is by no means the end of the Task Force's efforts. We anticipate a multi-year initiative for which the Primer is but a tool.

Overall, we seek the involvement of ACOFP state chapters, OPTIs, and the AOA in the collective effort to provide quality, geographically diverse osteopathic family medicine residencies that will attract those who will carry the profession into future decades.

George T. Sawabini, DO, FACOFP *dist*.
2011-2012 ACOFP President

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Chapter 2
What is Family Medicine?

Family practice is the medical specialty that provides continuing and comprehensive health care or both individuals and families. The scope of family practice encompasses all ages, both sexes, each organ system and every disease entity. Osteopathic Family Practice integrates all the sciences of medicine.

The family physician continues to be trained to care for patients of all ages in the family practice center, the emergency department, the hospital, the nursing home, the sports field and the family home. The family physician can manage 90 percent of patients' health problems, accessing consultants as necessary. Although the face of health care as a whole has changed dramatically in the past few years, the need and demand for family physicians by the U.S. population and health care delivery system remain great.

Along with higher initial earnings, starting family physicians are gaining a greater amount of income compared with more established physicians. Most newly graduated family physicians have used this higher income to pay off their student loans more rapidly. Furthermore, many underserved communities offer loan forgiveness programs to attract family physicians. Given the multitude of practice arrangements available, family physicians can expect to achieve a comfortable lifestyle and pay off student loans, and the need and demand for family physicians will provide continued income support.

A philosophical statement on the scope of family practice notes that "the specialty is three-dimensional, combining knowledge and skill with a unique process. The patient-physician relationship is central to this process. ... Knowledge and skills vary among family physicians according to their patients' needs and the ability to incorporate new information into their practices. Above all, the scope of family practice is dynamic, expanding, and evolutionary."

A teacher learns twice. Many family physicians precept and teach. These physicians continually add to and reinforce their own knowledge base. Their participation in the instructional process keeps them current and intellectually refreshed.

Residency training provides future family physicians with integrated inpatient and outpatient learning over a period of three years. Family practice residencies give extensive in-hospital training

in the care of adults and children, maternity care, emergency and critical care, and other inpatient situations. Equally important, family practice residencies have a strong focus on learning in the outpatient setting. Thus, residents have an opportunity to learn by providing continuous care to a population of families.

Family practice residents learn how to comprehensively manage the multiple problems of patients and their families, including health risks and psychosocial problems. They develop meaningful relations with their patients over time, and they also engage in community health experiences. Most programs provide opportunities for family practice residents to do research and to teach medical students and more junior residents. Different residencies provide varying opportunities to develop specific procedural skills, but all provide enough training for residents to develop a high level of technical skill in a broad range of common procedures.

Newer training models, including rural training tracks, provide exceptionally rich clinical experiences with a wide variety of populations of all economic strata and levels of medical need. Learning to address the needs of ethnically and racially diverse patients is considered an important aspect of family medicine training, as is learning to care for the medically underserved.

Although good stewardship of health care resources and cost containment are part of the curriculum of most programs, family practice residency training focuses on providing the skills needed to be the patient's advocate. In addition, newer curricula in managed care are directed at going beyond a strictly clinical role within managed care settings to a role in shaping the future of health care organizations.

Satisfaction with family practice residency training tends to be high. Graduates indicate that their residency did an "excellent" or "good" job of preparing them for practice, especially with regard to coordinating care with community resources, providing preventive care and providing cost-effective care.

Opportunities and challenges for family physicians persist, more than for any other specialty. Family physicians have been (and are still) the most recruited physicians for managed care systems, as well as for rural and inner-city practices. Family physicians are suited for practice in the smallest and largest communities, in partnerships, in single specialty or multispecialty group practices, and in fee-for-service or managed care systems. The challenge is to continue to distribute family physicians in the same percentages as the U.S. population so that every American has access to cost-effective, comprehensive, continuous primary care services.

The family practice specialty has gone a long way toward meeting the nation's health care needs. Indeed, family practice is the only medical specialty in which physicians distribute themselves in the same geographic proportions as the American people. Family physicians will continue to work with other health care providers to ensure that all Americans have access to primary care.

There is a critical need for more investment in and support for primary care research. Important contributions in teaching and research are not limited to full-time faculty positions. As many as 30 percent of community-based family physicians teach medical students in their offices, and an increasing number are participating in practice-based research networks.

In addition, 51 percent of U.S. family physicians include some emergency room care in their practices, with as many as 88 percent providing this type of care in some states. A full-time career in emergency medicine was chosen by 4 percent of physicians who completed family practice residencies in 1969 through 1993. Many managed care organizations consider family physicians to be the specialist of choice because of their breadth of skills, the quality of care provided and their skills in preventive care.

Family physicians with interest and expertise in public policy and administration can find challenging careers at all levels of influence, from the local community to state and federal agencies. For example, family physicians are directors of state health departments, legislators, administrators in managed care organizations and heads of federal bureaus. A family physician, David Satcher, M.D., became Surgeon General of the United States in 1998, and the current acting Surgeon General is Rear Admiral Donald Weaver, M.D. is also a family physician. Regina Benjamin, M.D. scheduled to take office as Surgeon General on October 30,2009 is also a family physician.

Certainly the demand for family physicians has increased dramatically because of the cost-effective care they deliver. Their ability to coordinate care, to take responsibility for patient care, to use resources wisely and to be efficient and comprehensive bodes well for the future. The Barbara Starfield report update in 2006, from the original 1999 report, gives evidence that adults who have a primary care physician have 33% less cost of care, and a 19% less mortality (i.e. are less likely to die prematurely), and this report also indicates that patients who have a primary care physician is consistently associated with improved health outcomes, and in the United States an increase of 1 (one) primary care physician is associated with 1.44 fewer deaths per 10,000. A white paper from the American College of Physicians (ACP) 2008, entitled "How is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?", reveals that by increasing the number of primary care physicians by 1 per 10,000 population was associated with a reduction in overall spending of $684 per Medicare beneficiary, and an increase of 1 specialist per 10,000 population increased spending of $526 per Medicare beneficiary.

It is known that family physicians have great control over their level of satisfaction in their professional lives. Family physicians who include maternity care in their practice and who are in small group practices are generally more satisfied. Physicians whose main value is benevolence (e.g., as contrasted to power) are the most satisfied. As a whole, family physicians report being extremely satisfied with their general professional life, intellectual stimulation, status within the community, clinical competence and long-term relationships with their patients.

Why Choose Family Medicine?

"I chose to become an osteopathic family medicine physician because, to me, a doctor provides COMPLETE care with compassion. As an osteopathic physician, my principles are built on the foundation of compassion for my patients. As an osteopathic family medicine resident, I am provided with training that enables me to provide complete care to my patients. An osteopathic family medicine physician provides complete, compassionate care. As a resident, I provide care to the entire family and am receiving training in the full spectrum of medicine from pediatrics to geriatrics. Each day, I provide complete, compassionate medical care to my patients and caring for my patients brings a smile to my face."
- Ronna D. Compton, DO

Why Choose Family Medicine?

"I love my life as a family medicine resident. Every morning I wake up and get to do something different. I get to practice as a subspecialist in everything. I deliver babies at all hours, do the circumcision, see them later for well checks, perform a colonoscopy, cast a broken limb, fight chronic disease, cheer on the local team with my family and my only limitation is myself. I can't fix everything but I can fix most things, I love doing it and seeing the difference it makes in my patients lives and in mine."
– M. Ross Pieper DO

There are numerous benefits for all the stakeholders in starting a dually accredited family medicine residency.

For the student:

1. Strictly allopathic programs do not teach any OPP.
2. A training slot with a choice of options.
3. Refine and build on osteopathic skills learned in medical school.
4. Student are more apt to apply to the teaching institutions with a family practice program to continue their training.
5. Exposure to diverse patient populations, a wider spectrum, and variety of diagnosis (vs. specialty care).
6. Hands- on to connect personally and therapeutically with the patient.
7. Student will select participation in an institution that has a residency program of their choice, than a hospital that has no teaching service.

For the resident:

1. A training position.
2. Post residency employment in the geographically area.
3. Most educational programs are resident driven.
4. Mutually beneficial learning environment to both the allopathic and osteopathic trainees, the curricula are similar but present more than each alone.
5. Since Osteopathic programs are affiliated with an OPTI in many states, whereby allopathic trainees can attend sessions.
6. A benefit to allopathic residents being exposed to osteopathic thinking.

Why Choose Family Medicine?

" I chose family medicine because it had everything I wanted. A family physician is a geriatrician, a pediatrician, a gynecologist, a surgeon, and a confidant at all times. I look forward to each new day, knowing I will not be bored because medicine is constantly changing, everyday is different, and each patient is unique. I enjoy what I do and it is a privilege caring for my patients".
- Alicia Martin DO

For the hospital:

1. Physicians are available on site all the time (24 hour house coverage by residents.)
2. Financial funding for the institution from Medicare and Medicaid funding.
3. Residency programs are a prerequisite for a fellowship program.
4. An institution with a residency program will foster a learning environment, and will be to apply for research funding.
5. The institution will draw patient from adjacent geographic areas, thereby increasing the revenue to the hospital.

Benefits for the community:

1. Increase the number of primary care physicians in the community, to meet the projected shortage of physicians.
2. Saves money and resources for the community in recruiting efforts.
3. New business setup in the community.
4. Residents are a good cheap and free resource for the community, (outreach programs, nursing home, health department, and immunization clinics.)
5. Residents will become attending physicians when they graduate and settle in the community.
6. Communities may partner with a COM to insure an adequate supply or trainees
7. Physicians in the community would refer preferentially refer patients to an institution that has house staff.
8. All osteopathic physicians are "American trained".
9. There is less cultural adjustment for the trainees and the community. In comparison to foreign medical graduates.
10. Studies indicate lower mortality in hospitals run by family medicine.
11. Value-added emphasis on "the whole person" with a focus on preventative health care.

Why Choose Family Medicine?

"I made the decision to be a family practice doctor prior to starting undergrad classes. I had worked 16 years as a paramedic and enjoyed the excitement and variety involved in emergency medicine. What it didn't offer was continuity of care. When I decided to become a doctor, I knew that I wanted to treat patients from birth to death. I am from a small rural town in Pennsylvania and felt that I would be most comfortable returning to that area to practice medicine. My family practice residency program prepared me to be the country doctor that I am. I see all ages of patients, do a variety of office procedures, take walk-ins and do house calls. I also care for my hospitalized patients. There is never a typical day. Every day is an adventure. I am very happy with my choice to become a rural family practitioner."
- Lisa A. Phelps, DO

"Because I've always had so many interests, family medicine was a great fit for me. No subject is off limits, and you can "specialize" in anything. As a medical student, if you are interested in more than a single subject, even a little, don't rule out a career in Family medicine. Seriously!"
- Sarah James, DO

Why Choose Family Medicine?

"I chose Family Medicine because of the many opportunities and variety of intellectual cases it presents to me everyday of my life. Family Medicine truly exemplifies the teamwork approach to medicine. In residency, I get to interact with and learn from colleagues, specialists, nurses, hospital staff, and patients. The relationships I get to build each day and all the families I get to meet are priceless. The opportunities within Family Medicine are endless. This is truly the area of medicine where you can provide continuity of care (mind, body, spirit) and be the quarterback for the medical home team!"
- Becca R. Rodriguez DO

Benefits for the profession:

1. More training slots.
2. Projected decrease in competition for a training position.
3. The introduction of osteopathic medicine in areas with no exposure to the alternate medical treatments.
4. The more slot s the less the competitiveness, and the guarantee that graduates with find a training position.
5. Osteopathic medicine is more proportionately primary care vs. specialty care.
6. The residents will stay within an osteopathic family training program vs. a strictly allopathic program.

What Makes A Good Residency Program

- Location, Location, Location
- Continuity clinic (number of patients, is it attached to hosp or separate)
- Didactics - quantity (sometimes less is better depending on learning style)
- Technology (website, EMR, online research)
- Flexibility (call schedule, vacation, program director to individual)
- Hospital (university vs. community setting) (size - large vs. small)
- Fellowship/Specialty Track
- Benefits (salary, health insurance, books, CME money)
- People (other residents, attending, support staff)
- Procedural training
- Educational diversity (inpatient/outpatient, specialty care, international)
- OMT
- Autonomy (structured supervision vs. go out and do it!)

Reasons to Choose a Career In Osteopathic Family Medicine

- Osteopathic family medicine gives a physician the ability to practice in any environment from private practice to the operating room.
- FPs can pay off their student loans.
- The breadth of our specialty guarantees that as an OFP, you will not be bored.
- Lifestyle – on your terms.
- Income and demand is on the rise for FPs.
- Ability to do procedures – earn extra income.
- Osteopathic Family Physicians can and do work anywhere.

Chapter 3
Definitions

Parallel Track:
Program Choices Separate M.D. and D.O. Programs
a. Run under one "roof"
b. Separate- -but-equal programs
c. Some shared programming and lectures
d. Each take only their own certification boards.
e. M.D. programs which preserve a specified number of slots for D.O.s
f. D.O.s in ACGME accredited programs may take M.D. Boards
In some instances may obtain a waiver for internship approval and board eligibility on A.O.A. side.
Dually Accredited Residency Programs doesn't matter which program comes first MD or DO
Some or All slots are accredited by both ACGME and A.O.A. D.O. Residents may sit for both boards
Curriculum is the same and meets both standards.

Dual Track: There are many AOA/ACGME dual programs available to you and the number is growing. A dual program will allow DO trainees to sit for either AOA or ABMS boards after completion of their program.

Direct GME Funding

A. Direct Medical Education Reimbursement

This portion of GME payment reimburses hospitals for the "direct" costs of GME such as resident stipends and fringe benefits, some teaching physician salaries, GME administrators like a DME, program directors, and some overhead costs like heat and lights for the GME offices. Hospitals costs for direct GME are calculated on the 1984 "base year". Therefore, whatever costs a hospital had in 1984 are taken and a yearly inflation factor is added. You simply take total GME costs and divide by the number of residents to get a per resident GME cost. This is what "direct" GME reimbursement number. As an added complication, Medicare will only pay GME costs for Medicare patients. It won't pay these costs for patients who have other insurance or Medicaid.
The more Medicare patients, the more reimbursement your hospital will get.

Okay, now that you know this, lets look at how direct GME is actually calculated. We will use Hypothetical General Hospital as our example. This is a hospital with big GME programs. It has total costs of $60,000/resident, based on the 1984 base year and now has 400 residents in various programs:

1. Start with cost/FTE resident. Remember this is calculated based on what costs the hospital was able to demonstrate in 1984 plus inflation. So, for our Hypothetical General Hospital (HGH), we are going to say they were able to claim costs of $60,000/resident. We are also going to say the over the year, 46% of HGH patients were Medicare patients.

2. Calculate total GME costs:

Cost/resident	**X**	**Number of Residents**	**=**	**Total Program Costs**
$60,000	**X**	**400**	**=**	**$24,000,000**

3. Calculate Medicare Share of Costs

Total Program Costs	**X**	**Medicare Utilization Rate**	**=**	**Direct Medical Education Reimbursement**
$24,000,000	**X**	**0.46**	**=**	**$11,040,000**

Thus, HGH received $11,040,000 from Medicare in Direct GME payments. As you can see, whatever your approved per resident costs are, the final payment depends on what the proportion of Medicare patients was in your hospital for that year. This will change to some extent yearly and varies somewhat by hospital,.

Indirect GME Funding

Indirect Medical Education Reimbursement

The Indirect GME reimbursement is the other portion of reimbursement hospitals receive for GME training. This portion is supposed to compensate hospitals for the "added costs" of GME training. It appears that whenever you train residents, medical care is somewhat more expensive. Residents seem to order more lab tests, radiology procedures and so on, there is a tendency for sicker patients to come to your hospital, and in general the intensiveness of services seems to be higher. Now, no one really knows exactly what these "added costs" are, or how much extra they actually do cost. No kidding. The Federal government makes a best guess and uses this to calculate indirect GME costs. This is forwarded to hospitals as an "add on" to each Medicare DRG. Now, to calculate this, you have to use a chart that is keyed to the resident/bed ratio. For increasing numbers of residents, you get more indirect funding, because, presumably, more residents means you have more indirect costs. The actual calculation is too complex to go through in detail, because I don't understand it myself.

The following is all my simple mind can assimilate and should give you some idea of how this works. Lets start with a basic DRG payment to HGH of $10,000 for some hospitalization.

1. **Calculate the resident/bed ratio**
   400 residents/600 beds = 0.6

2. **Use a chart (provided by the Federal Government) to calculate that at this ratio, the add-on to the DRG is 27.59%**

3. **$10,000 X 27.59% = $2,759 in indirect costs**

As you can see, HGH receives and extra $ 2,795 it would not receive if it didn't have a GME program. At HGH each Medicare DRG has an extra 27.95% added for indirect GME costs. Over a year this is significant money to the hospital. The general rule of thumb is that indirect reimbursement is 1 ½ to 2 times directs to a hospital. Hypothetical General Hospital should be getting between $16,560,000 and $22,080,000. As you can see, this is a very significant piece of change for the hospital. It is very important to point out the enabling legislation regards the indirect as for the "added costs of GME to the hospital". It does not go into the GME pot. Hospitals us this funding to increase the bottom-line and support other hospital costs.

<u>Disproportionate Share Adjustment</u>

The third segment of GME funding goes to many, but not all teaching hospitals. The Disproportionate Share Adjustment (DSH) is intended to compensate hospitals that engage in high proportion of uncompensated or poorly compensated care, like Medicaid and charity care. These are usually urban hospitals and of course, most university and affiliated major teaching hospitals are urban. DSH is also an add-on to the DRG and along with the Indirect, is very important to the bottom line of these hospitals, since they provide a large proportion of uncompensated care.

Residents in Ambulatory Settings

You don't just have to be in the hospital to derive GME funding.
Medicare will allow hospitals to claim for direct (DME) and indirect medical education (IME) funding, resident time in "non-hospital settings". In order to qualify, a hospital must "incur all or substantially all of the costs for the training program in the setting" and, the sites must be eligible for DME funding. This means that the hospital must pay stipend and fringe benefit costs travel cost if any for residents and any faculty costs. Outpatient sites eligible for DME funding have traditionally included "freestanding clinics, nursing homes and physician offices".

Training directors should be able to argue more effectively for, and hospitals should be willing to fund more outpatient rotations, as long as they do not impact

on workforce needs on hospital wards. Several things to remember however:

There is a cap on resident numbers for DME and IME. Residents often are in outpatient settings that did not qualify for IME before this regulation was changed in 1997. These rotations were thus excluded from counting toward resident IME numbers. If you continue or add outpatient rotations that that did not qualify for IME previously, the FTE numbers will go up and your hospital may end up over its IME cap. Hospitals are still going to want to cover inpatient units. They may be less willing to rotate residents to outpatient settings because of this.

Volunteer Faculty

(OLD WAY)

The activities through which volunteer faculty members contribute to fulfilling the academic mission of the Residency include but are not limited to: teaching graduate or medical students, interns, residents, postgraduate fellows, or other healthcare professionals, community service activities, generating community support for the Medical School, collaborating in academic and research programs, and participating in various departmental and institutional activities. Volunteer faculty status is available to both clinicians and basic scientists. Appointments to the volunteer faculty do not provide tenure or tenure-earning status. Members of the volunteer faculty are not considered employees, but they are subject to policies on such issues as sexual harassment, health and safety, patent and copyright, professional conduct, credentialing and all other faculty rules and regulations. In most cases, Volunteer Faculty members have titles with a prefix indicating their area of expertise and suffix, indicating Volunteer status. Most clinical preceptors have the title "clinical assistant professor (Volunteer)." Faculty whose academic ranks contain the modifiers "Clinical" and "Volunteer" serve in a volunteer capacity without financial compensation. Appointments to the ranks of clinical instructor through clinical professor must be reserved for physicians and other clinical practitioners who have completed their graduate medical education. In all cases, volunteer clinical faculty members are expected to contribute actively to the educational, research, academic service, and/or patient care programs. Scholarly presentations or publications of research and/or clinical accomplishments are standard for this promotion with two criteria added to the requirements for promotion to clinical associate professor (volunteer). Additional evidence of accomplishments at this level may include: service as a speaker at local, national, or international professional conferences; promotion of relationships with professional medical societies; service as a visiting professor; preparation of books, chapters, or reviews; service on editorial boards, or as officer of a national professional society; awards or honors; appointment to government-review panels or committees; appointment to major committees of state or national professional societies. Members of the Volunteer Faculty are expected to conduct their activities in a professional and collegial manner.

(NEW WAY)

A Primer on CMS Requirements for Payment of Clinical Faculty Physicians

By Gary L. Knepp, DO

Abstract: Regulations and legislation governing compensation for volunteer faculty teaching in non-hospital Graduate Medical Education sites have been evolving since 1997. The uncertainties surrounding the regulations have presented significant administrative challenges to hospitals and Directors of Medical Education. On May 11, 2007, the Center for Medicare and Medicaid Services published new regulations in the Federal Register. If 90 percent of the program costs as outlined in the new regulations are already being paid, the program is not required to make additional payment to the preceptors. A methodology is described and a spreadsheet provided to help programs calculate their potential financial liability. If payment is required to meet the 90 percent threshold, the payment must be paid within 90 days of the rotation. Formal contracts are not required but specific details must still be documented. For programs that prefer a contract to document the mandatory details, a sample contract is provided.

Introduction

On May 11, 2007, the Centers for Medicare and Medicaid Services (CMS) published its final rule on revising the Medicare policies for training residents in nonhospital settings. The final rule was published in the Federal Register along with regulations establishing 2008 payment rates and policy changes for long term care hospitals.[1] The new rules are well described in the regulations, but procedures and processes to implement the new regulations are left for hospitals to develop.

Many health systems who participate in Graduate Medical Education have historically been implementing only a portion of the new regulations and now find themselves in the position of quickly trying to implement the complete regulations. This is especially true in many osteopathic family medicine residency programs that have traditionally relied on volunteer nonhospital faculty. This document references the new CMS regulations to describe a method to implement the new CMS rules with sample contracts, timelines, worksheets and sample documentation tools. Background is also provided for Directors of Medical Education and Residency Program Directors who need background information to share with their administrative team and institutional Board of Directors who may need education on the clarified CMS regulations. The contents of this document have not been through a formal legal review. Therefore, any hospital who wishes to use the processes and documents herein described should review and modify the documents and processes based on their own internal financial and legal counsel. An excellent fact sheet and summary overview of the new regulations by Margaret J. Hardy, J.D. is also available from the AOA Bureau of Hospitals.[2]

Background

Graduate Medical Education (GME) in the United States receives a significant portion of it's funding from CMS. The payments received from CMS are divided into two categories, Direct Graduate Medical Education (DGME) payments[3] and Indirect Medical Education (IME) payments.[4]

DGME payments were established for hospitals that have approved graduate medical education programs. CMS will provide payments to the hospital to cover the direct costs of employing the interns and residents. These direct costs include intern and resident salaries, benefits, travel and lodging costs, supervising faculty salaries and fringe benefits, allocated overhead costs and other

direct costs.[5] The payments are subject to legislated limits.

IME payments were established to provide hospital compensation for the anticipated higher cost of patient care due to the perceived notion that teaching institutions care for a more complex case mix than non-teaching hospitals. The IME payments also provide compensation for higher costs incurred by interns and residents as they potentially order more diagnostic tests than experienced clinicians do and are less efficient in their patient management skills leading to longer hospital Length of Stays.[6] The calculated IME payment is determined by a defined formula.[4] The formula includes several factors including the number of interns and residents in training, the number of beds in the hospital and a legislatively defined multiplier. The magnitude of the multiplier has gradually decreased over the last several years. This gradual withdrawal of GME funding by decreasing the IME Multiplier has put significant financial pressure on many GME[7] programs.

Most GME programs have at some point in time felt the need to include nonhospital training sites in their clinical education programs. These nonhospital rotations provide training in the skills necessary for competent outpatient management skills. The practice of medicine has shifted, often from third party payor pressure, from inpatient care to aggressive outpatient care. This transition has created a need for high quality outpatient experiences to train interns and residents. As residents and interns are placed in these nonhospital outpatient settings, the hospital often wonders if it can count these rotations for DGME and IME payment. While DGME costs are not difficult to justify, it is not as simple to justify IME costs. IME costs are related to increased utilization expenses within the hospital and therefore CMS initially excluded it for residents training in nonhospital settings. This loss of revenue to GME programs resulted in significant legislative pressure which produced legislation in 1997 as part of the Balanced Budget Act of 1997 (BBA). The BBA legislation provided that DGME and IME payments could be made to an approved medical residency program effective October 1, 1997 for rotations in nonhospital settings if "the hospital incurs all, or substantially all, of the costs for the training program in that setting."[8]

From 1997 to 1999, CMS interpreted "all, or substantially all" to mean resident's salary and benefits. After 1999, the interpretation became "residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct medical graduate medical education."5 Many GME programs assumed that if the supervising physician volunteered their time to teaching there was no cost, therefore the hospital was eligible for DGME and IME as long as they paid the residents salary, benefits and travel costs. CMS however ruled otherwise, essentially stating that except for limited situations someone always bears the cost of the faculty salary and unless the hospital incurs the cost, they cannot claim the resident for DGME and IME payment.

The debate over the payment of volunteer faculty became intense enough within the GME profession to cause Congress to include new legislation in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.9 The legislation gave an exception for 2004 to family practice programs to allow the use of volunteer faculty and directed an OIG study of the issue to be completed with a report due to Congress in one year.10 Details of the implementation of the family medicine moratorium were published in the Federal Register along with commentary on CMS's interpretation of the issue for all other residency programs which essentially stated that all costs including

faculty supervision cost must be paid by the hospital in order to qualify for DGME and IME reimbursement for nonhospital rotations.

On April 4, 2005, after completing its mandated report, CMS issued a policy clarification.[11] It reaffirmed their original interpretation that unless a faculty physician is a "solo practitioner", there is a cost associated with supervising residents and the cost must be borne by the hospital. Rather than giving the clear guidance needed for implementation, the report generated many additional questions such how do GME programs determine and document the time physicians spend in teaching? How do programs determine and document actual physician salaries? How should resident training time be documented? When should the physician be paid? How do you determine if a physician is a "solo practitioner"? In the face of the continued uncertainty many GME programs procrastinated on implementing payments for volunteer faculty.

Following the April 2005 CMS publication, many GME programs and GME affiliated organizations asked for either further legislative or regulatory clarification. CMS finally responded by posting a Proposed Rule in the February 1, 2007 Federal Register with comments due back by March 26, 2007. The Final Rule was published May 11, 2007 in the Federal Register.[12]

Final Rule

The commentary in the Federal Register has provided clarity to the requirements for GME programs training residents in nonhospital sites if they wish to receive DGME and IME reimbursement for those rotations. The requirement remains unchanged in that the hospital must pay "all or substantially all" of the cost of training the residents at the nonhospital site including all faculty supervising physician costs. However, to simplify the administrative overhead to document and comply with the regulations, CMS has introduced several proxies that can be used in place of actual cost data. These proxies are especially helpful in establishing supervising physician costs. A second major change in the regulations is the ability to meet the "all or substantially all" cost requirement by demonstrating that the hospital has paid at least 90 percent of the actual costs.

Implementation

Implementing the new regulations can initially appear to be a daunting task. The regulations and commentary provided in the Federal Register do not flow in a continuous line of logic or topics. The author has grouped together similar topics for consideration when implementing the new regulations. These topics will be given subheadings to help organize the major considerations that a GME program should consider as they develop and/or refine their current processes. The reference notations can be used to reference back to the Federal Register for those who wish to read the complete commentary provided by CMS.

Contracts

Hospitals now have the option of contracting with their supervising faculty physicians supervising at a nonhospital site using a written contract or proceeding without a written agreement.[13]

If a written contract is used, it must be in place prior to the start of the first resident rotation at the start of the academic year. The contract must clearly define all costs involved at the nonhospital site including the compensation for supervisory teaching activities. It should document the hours the

clinic publicly posts as the clinic operating schedule. It should clearly define which physicians (if it is a group practice) are involved in teaching. It should provide a schedule of resident rotations for the year and using that schedule, calculate the supervisory teaching costs.

The specialty of each physic ian should be identified and if multispecialty certified, the specialty of the service for which the physician is being asked to teach should be clearly delineated. The schedule of rotations should also clearly identify for each resident or intern the following: salary and benefits, travel and lodging costs where applicable, and year of training. The contract should specify that the hospital pays all costs. With such a contract, the hospital has up to one year after the cost reporting year to pay the teaching site any required payment.[14] If during the year the rotation schedule changes, the hospital must update the agreement by June 30 of the academic year to reflect any changes in costs based on actual rotations at the nonhospital site.[15]

The second option does not require a contract. The required information the hospital must collect and document remains unchanged, however the imple¬mentation is simpler in that estimated costs do not have to be calculated prior to the rotation start dates. The test for compliance when no contract is used is that the hospital pays the nonhospital site for the costs of the program concurrently. Concurrently is defined as "the end of the third month following the month in which the training occurs."[16] If a hospital elects to use a contract but pays concurrently, then the program is held to the simpler noncontract standards.[17]

Definition of "All or substantially all of the cost"

CMS has redefined the term "all or substantially all of the cost" to have been met "if the hospital incurs at least 90 percent of the costs of training at the site". The total costs which must meet the 90 percent requirement include the sum of the" resident's salaries and fringe benefits (including any travel and lodging where applicable) plus the portion of the teaching physicians costs attributable to direct GME at the nonhospital site".[18] Resident malpractice cost should not be included in the costs. Actual resident salaries and benefits must be used in calculating costs reflective of their actual year in training.[19]

Supervisory Physician Salary

Hospitals can use actual teaching salaries with supporting documentation or they can use the new proxy formula to calculate the supervising physician cost. The major proxy assumptions are that the physicians spends three hours a week teaching.[20] The physician is assumed to earn the median salary reported yearly in the Medical Group Compensation and Financial Survey published by the American Medical Group Association and available at cms.hhs.gov/AcuteInpatientPPS/ 06_dgme.asp#TopofPage.[21] The supervising salary by proxy becomes the physician' salary for their specialty as listed in the survey times three hours divided by the number of hours the physician's clinic is open per week. The assumption further sets limits by assuming the office will be open a minimum of 40 hours so that the maximum supervising cost will never exceed 7.5 percent of the median salary. If the office is open more than 40 hours, the actual hours can be used instead of 40.[22] If a physician is board certified in more than one specialty, the salary to be used is the specialty in which the physician is training the residents. If a physician subspecialty is not listed in the survey the next less specialized salary should be used.[23] If a physician's actual salary can be documented, it can be used in lieu of the salary survey data.[24]

Supervising Physician to Resident Ratio

Even if more than two physicians are supervising a resident at a site, a 1:1 physician to resident ratio is allowed. If one physician teaches two residents, then a 1:2 physician to resident ratio would be allowed. If multiple physicians of different specialties team up to teach a single resident, then an average salary of the physicians would be calculated to establish the cost of teaching at the site.25 It is also acceptable to prorate the teaching salary in situations where the resident is assigned to the nonhospital site on a part-time basis. The commentary acknowledges that half day assignments to a clinic are a common training model.[26]

Calculations

Each program now has the option of demonstrating actual physician costs or using the proxy formula. If the proxy is used, the hospital must document several data elements and then apply them to rules to calculate the supervising costs. The rules actually define an algebraic formula. The total costs (T) include Resident Salary (S) and Benefits (B) plus the Supervising Physician Salary (P). T = S + B + P. Benefits (B) are the sum of Insurance and vacation pay (I), Housing and Travel (H), possible signing bonus (A) and educational expenses (E), therefore B = I + H +A + E. Resident salaries must account for differences in pay based on year of training. Physician pay (P) is equal to 3 hours divided by the number of hours per week their office is open (O) times their AGMA median salary (R), therefore P = (3 / O) * R.

The CMS test of meeting "substantially all" is 90 percent of the total costs. If the resident salary (S) and benefits (B) (which the hospital will have paid the resident to meet contractual pay requirements with the resident) is greater than 90 percent of the total cost (T), then the hospital has meet the 90 percent requirement.[27] Therefore the minimal pay (Z) required to the physician can be defined by the equation:

Z = .9 (T) – (S + B)
By substitution since T = P + S + B (see discussion above):
Z = .9(P + S + B) – (S + B)
Z = .9P + .9S + .9B – 1.0S – 1.0B
Z= .9P - .1S - .1B

If Z is negative, then no payment is required by CMS regulations for the physician.

The calculations lend themselves to an Excel Spreadsheet Model to collect the required data and process the necessary calculations. Since prorating is allowed, the process lends itself to a monthly or every four week calculation. Appendix B is a sample spreadsheet which collects the necessary data and calculates the pay for a half-day supervision session. This data then populates the fields in the spread¬sheet in Appendix C which gathers the resident work hours and calculates the physicians pay for a given month and tracks the yearly payments to the physician.

Conclusion

The CMS regulations for resident training in nonhospital sites have removed a significant amount of uncertainty for the payment of volunteer supervising physicians. Essentially it clarifies that it is not allowed except in a couple of unique scenarios for solo physician or cost sharing group

practices. Formal contracts (download an example for reference) are no longer required as long as required payments are made concurrently. Programs may still want to use a contract such as the example in Appendix A to define other parameters of the supervising program, clarify salary expectations with the supervising faculty and ensure compliance with accreditation standards but the written agreement is not mandatory for CMS.

Even physician payment may not be necessary as long as the 90 percent test is met. Programs however may want to consider using the methodology to calculate an equitable payment for their supervising physician in all their resident rotations whether hospital or nonhospital based as the methodology has a consistency that can apply to all specialties and a variety of clinical situations. It would appear that the only time no payment is required is if a physician has extended office hours that lowers the office multiplier, or if resident salary and benefits are higher than industry averages. As one analyzes the formula, three observations materialize. Required physician pay decreases as resident salary and benefits increase, therefore less pay is required for upper-class residents. This may fit an intuitive model in that typically upper-class residents require less supervision than interns. The second observation is that as physicians extend their office hours, their required pay decreases. Finally CMS allows the assumption of a 1:1 ratio of supervising physician to resident ratio. They will also allow a 1:2 or lower ratio if the physician is supervising more than one resident. The effect of this allowance is to lower the physician's salary (Z) as (P) remains constant but (S) and (B) increase. (Remember Z = .9P - .1S -.1B). This seems counterintuitive and in fairness to the supervising physician, the spreadsheet model assumes a ratio of 1:1. GME programs who wish to use the spreadsheet in these situations and pay the minimum CMS required salary may wish to edit the spreadsheet.

All GME programs are encouraged to implement the above changes as quickly as possible to avoid risking DGME and IME funding for nonhospital training sites. For those of us who believe there is such a thing a as a true Volunteer, the only long-term relief appears to be continued legislative efforts to rewrite the definition of "volunteer"!

Fellowship/Plus-1 Programs: A fellowship is a formal, full-time training period in a designated medical specialty with a focus that is beyond the requirements for eligibility for first Board certification in the respective core discipline.

CAQs vs special emphasis: Completion of an AOA approved fellowship may constitute eligibility for a Certificate of Added Qualification (CAQ) or Certificate of Special Qualification (CSQ).

Internship: An OGME-1 training year is an educational program requiring extensive participation in patient care. The OGME-1 traditional internship exposes graduates to core disciplines including Internal Medicine, Family Practice, General Surgery, Obstetrics/Gynecology, Pediatrics and Emergency Medicine. Alternatives to the traditional internship structure were approved by the AOA Board of Trustees and House of Delegates in 2006 (Resolution 19 [A/2006]—Restructuring of the Osteopathic Internship) and were implemented effective July 1, 2008. Many specialties now offer a first year of residency in a new structure that includes a combination of broad- based curriculum and specialty training in the residency. Three OGME-1 training options have been approved by the AOA. Specialty college affiliates who develop and review specialty specific curriculum and standards, considered and selected from these options.

A description of the OGME 1 training year options and a listing of specialties by option, can be found within the OGME 1 Training Year Options (PDF format) document.

Residency: Residency programs build upon the broad-based osteopathic medical education and OGME-1 training programs that expose DOs to the major clinical fields of medicine and surgery. A residency is defined as a formal, full-time training period in a designated medical specialty of not less than one year in an osteopathic facility approved by the AOA. The program provides advanced and concentrated training in a designated specialty. In the new restructured format, many specialties are combining a broad based curriculum with specialty training so that the OGME-1 year provides a combination of the traditional core rotations and specialty training.
A certificate is awarded upon completion of an AOA-approved residency program. Residency training is undertaken with the intention of becoming board certified in a particular osteopathic specialty. Osteopathic students, interns and residents can find information about internship and residency programs through the Opportunities Web site.

Approved Training Positions:
http://www.acofp.org/ResidencyDirectory/

TIVRA (Trainee Information Verification and Registration Audit)
The AOA division of postdoctoral training launched the TIVRA system in September 2003 to replace the previous paper-based protocol for osteopathic internship and residency programs, all of which were required by the AOA to (1) submit signed intern and resident contracts to the AOA; (2) verify the status of all osteopathic medical interns, residents, and fellows who have completed training in the previous academic year; and (3) update AOA records with any program changes. Without this vital information from osteopathic internship and residency programs, the AOA is unable to finalize the certification process for osteopathic trainees. One additional advantage of the new system over the old paper-based system is that TIVRA allows the AOA to track the educational progression of osteopathic trainees from the moment they enter an internship or residency program.

Strong, accurate, and verifiable OGME data is critical to the osteopathic medical community, which relies on the regular and accurate reporting of this information. The AOA's division of postdoctoral training provides statistics—based directly on TIVRA data—that are used by the Association for the following purposes:

- to define the osteopathic medical profession in terms of potential workforce strength,
- to document trends in the various medical specialties,
- to record internship and residency program "fill rates,"
- to allow the Association to anticipate future shortages of OGME programs, and
- to report on OGME positions funded through the Center for Medicare and Medicaid Services (CMS).

Finally, because it is not in the purview of the AOA to track allopathic training data for COM graduates, the OGME data available to the division of postdoctoral training allows the Association to make more accurate assumptions about the number of physicians who have opted to receive their residency training through programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Chapter 4
Osteopathic Organizations, Responsibilities & Staff Contacts

AOA: As the only accrediting agency for osteopathic medical education, the AOA is responsible for developing and enforcing postdoctoral training requirements, policies and procedures in order to ensure the highest quality programs. See: https://www.do-online.org/pdf/sir_postdoctrainproced.pdf

ACOFP: Postdoctoral Training
The ACOFP through its Committee on Education and Evaluation (CEE) reviews and evaluates Postdoctoral Training Programs as well as the Residents. The ACOFP CEE assists Directors of Medical Education, Program Directors, and other individuals concerned with Osteopathic Family Practice and Manipulative Treatment residency training programs and provide the highest quality of osteopathic graduate medical education for residents in its osteopathic institutions.

Access the current Basic Standards for Residency Training in Osteopathic Family Medicine & Manipulative Treatment and the related basic standards at http://www.osteopathic.org/inside-aoa/accreditation/postdoctoral-training-approval/postdoctoral-training-standards/Pages/family-medicine.aspx

AOBFP: The AOBFP is one of 18 certifying Boards of the American Osteopathic Association (AOA) and is regulated by its Bureau of Osteopathic Specialists to administer examinations resulting in certification awarded by the American Osteopathic Association. The examinations offered by the AOBFP include primary certification in family practice, certification of added qualifications (CAQ) examinations in osteopathic geriatrics in family medicine and sports medicine, recertification in family practice and CAQ recertification in addiction medicine, osteopathic geriatrics in family medicine and sports medicine.

The residency pathway requires that your AOA-approved training must be approved as complete by the American College of Osteopathic Family Physicians (ACOFP) before your final scores are released by the AOBFP and before presentation to the AOA with a recommendation for certification. That approval requires submission to the ACOFP of residency paperwork. The ACOFP may be contacted at (800) 323-0794, (847) 952-5100 or at www.acofp.org (under 'residents' selection) for details.
The American Osteopathic Conjoint Sports Medicine Education and Evaluation Committee may

be accessed at www.aosmcee.org for details on the approval of sports medicine fellowship training.

All completed applications and supporting documents, with the exception of those in sports medicine and undersea/hyperbaric medicine, should be sent no later than the postmark deadline date to -

American Osteopathic Board of Family Physicians
330 E. Alqonquin Rd., Suite 6
Arlington Heights, IL 60005

Three weeks should be allowed for verification and processing of materials. It is highly suggested that materials be sent via certified mail with return receipt requested or priority mail with delivery confirmation to allow for confirmation of delivery with post office.

ACGME: Residents who have or will be completing an allopathic training program must apply for and obtain program approval thru the American Osteopathic Association and the American College of Osteopathic Family Physicians (ACOFP) prior to the application postmark deadline date in order to qualify for examination. The approval of residency paperwork by ACOFP for training approval may take place thereafter. Scores other than a pass/fail designation as well as recommendation for certification by the American Osteopathic Association will be withheld until the paperwork is approved by the American College of Osteopathic Family Physicians (ACOFP).

The successful completion of the examination, the review and approval of the residency paperwork and the awarding of certification must be accomplished within six years from the date of approval of the training program.

The AOA and the Accreditation Council for Graduate Medical Education's (ACGME) Role in Approving and Accrediting Residency Programs

The AOA approves internships and residency programs. The ACGME accredits residency programs, but basically it is the same process for each accrediting organization. Accreditation is a credential that shows that a program substantially complies with the AOA or ACGME's GME standards. To develop and refine these standards and to review accredited programs for continued compliance, the AOA and ACGME rely on the views of industry professionals in the different medical specialties: the AOA works with 18 specialty colleges while the ACGME works with 26.

These specialty colleges have review committees that update standards for residency training in their specialties and review previously accredited programs against those standards. The process for updating standards includes obtaining suggestions from interested parties and the public at large. For AOA standards, the AOA reviews recommended changes and present them to the Program and Trainee Review Committee and the Council on Postdoctoral Training for approval. The AOA Bureau of Osteopathic Education then reviews the new standards and policy before sending them to the AOA Board of Trustees for final approval.

AOA-Approved Residencies vs. ACGME Residencies: An ACGME residency will not give you training in osteopathic principles and practices that you will need to learn in order to practice as an osteopathic physician. Taking an AOA-approved residency will provide exposure to osteopathic

medical practices. Yes, you will receive adequate medical training in an ACGME-approved residency, but if you want to be a certified DO, you'll have to be trained in an AOA-approved program. So what happens if you go through all the trouble of finding an AOA-approved internship and then can't fund a residency to match, or you decide to go to an ACGME residency instead? The AOA recommends that you consider funding and board eligibility.

ABMS: Resolution No. 56, passed by the AOA Board of Trustees in July 2004, allows for examination eligibility for those holding ABMS primary certification in good standing and who completed residency training at least five (5) years prior to submitting an application for eligibility. This resolution was later modified to include ABMS-certified osteopathic physicians who participated in a clinical pathway to achieve ABMS certification.

The AOA Certification Office must be contacted to obtain an application for eligibility and further requirements. They may be reached at (800)621-1773.

OPTIs: An OPTI is a community-based training consortium comprised of at least one COCA-accredited college of osteopathic medicine and one AOA HFAP-accredited hospital. All AOA approved programs must be affiliated with an OPTI. Osteopathic Postdoctoral Training Institution (OPTI)

Recognizing the need for a new system to structure and accredit osteopathic graduate medical education, the American Osteopathic Association established the Osteopathic Postdoctoral Training Institution (OPTI) in 1995.

Each OPTI is a community-based training consortium comprised of at least one college of osteopathic medicine and one hospital. Other hospitals and ambulatory care facilities may also partner within an OPTI. Community-based healthcare facilities such as ambulatory care clinics, rehabilitation centers and surgicenters may now have the resources and support necessary to provide physician training with an OPTI's assistance.

OPTIs are recognized for providing a comprehensive, seamless model of education for physician training-from colleges of osteopathic medicine through graduate medical education programs and beyond. An OPTI adds value to medical training by assuring the osteopathic concepts of holism, wellness and prevention, caring for the patient's individual health needs, environment and ability to access quality health care.

OPTI Contacts & Locations

http://www.osteopathic.org/inside-aoa/Education/opti-clearinghouse/Documents/opti-partner-list.pdf

Chapter 5
The Business of Starting an Osteopathic Family Medicine Residency

The most recent statistics released as of March 2011 state that by 2010 the United States will be short approximately 100,000 physicians, with the percentage being split almost 50/50 between primary care and medical subspecialty. With that knowledge it is important that the ACOFP be on the leading edge of initiating new residencies throughout the United States, but especially in areas that have physician shortages, and that are in proximity to the new Osteopathic Medical Schools that have been instituted within the last decade.

In 1997, the U.S. Government studies indicated that in the next decade there would be a "glut" of physicians and therefore enacted legislation that would limit the amount of residency slots that would be available for training based on a hospitals complement of residencies beginning with the 1996-1997 budgetary year. Since that time there has been essentially no shift in the number of residency positions available within the United States. The Act essentially fixed the number of ACGME slots at 25,000 for each PGY one class. Slots have moved around and been reestablished at different hospitals but no "new" slots have opened. There has been a marginal increase in first year slots in that some hospitals have self funded, as well as some slots have been added in "rural" areas.

With that said, a hospital can open new residency positions (either DO or MD) within a "virgin" hospital, i.e. a hospital that has had no residency positions paid for by CMS since the 1996-1997 year of the cap. The residency positions come from programs that were not able to fill their programs and therefore the slots are "redistributed" to hospitals that have not previously had post-doctoral training (since 1997).

Within the Osteopathic profession, there is a great need to increase post-doctoral programs due to multiple reasons. The allopathic profession is increasing there class size on average by 10% to meet the physician shortage predicted, and by 2017-18 will consume over 21,000 of the 25,000 slots (currently they graduate approximately 17,000) into PGY one programs. There is also the additional consequence of opening multiple Colleges of Osteopathic Medicine within the profession, resulting

in over 6,000 graduates by the year 2017-2018. As one can see with both the increase of U.S trained allopathic physicians, and well as the continuation of IMG applying to programs, there will be a shortage of GME training spots for Osteopathic graduates in the coming years. COCA (the accrediting agency for COM's) is in the beginning stages of requiring COM's to have a certain percentage of GME slots for each graduating class, placing more emphasis on developing new OGME slots.

The unfortunate side to much of this discussion is that the Health Care Act recently passed by Congress (2010) did not address GME funding, and most educators do not feel the either MEDPAC or CMS intends to push for additional training spots. Their belief is that there are an adequate amount of training spots available at the present time, and that the mounting problem is a misdistribution of physicians, more than a shortage of physicians.

How to Approach Hospitals

For those beginning discussions with hospitals regarding starting new Family Medicine Residencies, there needs to be a basic understanding of the business aspect of starting a program. Following will be a discussion of payments as well as a general time line-though this is more dependent on hospital resources than a true chronological time line.

It is important to have initial discussions with the administrative staff of a hospital, but in conjunction there must be dialogue with the medical staff. If either one of these two entities is against a residency program, the odds of ever seeing a program begin are remote. Most hospital administrations and staff see the need for GME, but there may be a few exceptions where one group is hesitant, and it is here that a broad based knowledge of a hospital's needs is important to the individual or group trying to begin a program. The best plan is one that allows the administration and staff to see the benefits of having residents for multiple reasons, one that does not begin and end with profitability.

Hospitals know that the lifeblood of a hospital is the continual addition of new physicians, and there is cost to a hospital for using either internal or external search firms, so most administrations are open to GME programs as long as their staff is in agreement. The hospital staff at times may feel threatened by the addition of new physicians that a residency produces, but once they realize that they can be part of the training, as well as hiring of those physicians, there is less concern in this area. Residents can also lower cost for administration, in that a resident can work 80 hours per week, without overtime. Many times that will help offset paying one or two NP's or PA's per resident.

There is also the patient satisfaction that increases with having a house staff, in that patients perceive that are receiving better quality of care with additional physicians participating in their health care. Residents also keep medical staffs sharper, in that there is a renewed emphasis on staying current with medical literature and practices. Residents on call may also allow time away from the hospital for some physician specialties.

Finally, there is the monetary gain to hospitals for both GME dollars, and the monies that a residency can generate in both increased patient numbers, as well as procedures that can be performed with the addition of a house staff.

One must realize that there is a start up cost for residencies and this can vary from a one to two hundred thousand on up, depending on the number of residents, the type of residencies, and the expected addition of multiple specialties, if the hospital is considering adding programs. Most, if not all, of the start up cost can be built into the pro-forma of a new residency, with the hospital recouping the monies through CMS payments, though this can take 12-16 months after a program takes its initial residents, due to the time of CMS payments (remember that payments are based on Medicare Bed utilization-to be discussed later).

Timeline for Starting a New Program

Many may view a time line as being a chronological progression line, that needs to be followed, but in actuality, the time line is dependent on multiple factors, that are not necessarily time sensitive.
The important aspects within a time line of starting a residency are the (1) approval of administration and staff, (2) the availability of the administration to use existing funds for the program, until CMS payments begin, (3)the availability of proper space in the hospital for a residency: (a) call rooms, (b) conference rooms, (c) clinic space for a residency clinic, (d) parking utilization, (e) library space. Once these parameters are in place the time line will essentially be dependent on completing the proper paperwork, for all the necessary AOA entities including the ACOFP, COPT, PTRC, and the inspection process.
In general it is best to plan on 24-month plan to complete all of the required work, though it can be done within 18 months, if one maintains a tight schedule!

What Types of Hospitals are Best Suited?

There are over 500 community hospitals within the United States (hospitals of 150-250+ beds) that have the potential to make ideal Family Medicine training programs. When one looks at programs, there needs to be adequate inpatient volume for both IM and surgery, but this can be achieved in hospitals with 100+ beds often as easily as in larger hospitals. There may be times to send residents out to other hospitals for additional training. It is best if this is done with an affiliated hospital so that the resident can still count on the cost report for the primary institution
Per the Medicare Statutes Patient Protection and Affordable Care Act-2010, hospitals can count the resident time in Non Provider setting if they incur cost of residents' salaries and fringe benefits. Hospitals can also count resident time in certain non-patient care activities (including didactic conferences and seminars.

Regarding redistribution of residency slots, rural hospitals (less than 250 beds) are exempt, and hospitals not filling will be at risk to lose 65% of unfilled slots

Medicare Graduate Medical Education Payments

The Federal Government through the Medicare Payment System provides two payments to teaching hospitals for their Accreditation Council for Graduate Medical Education (ACGME) Graduate Medical Education (GME) program costs.
The two payments are:

- The Direct Graduate Medical Education expense (DGME) ,and
- The Indirect Medical Education adjustment (IME)

DGME

The Medicare DGME payment is a pass-through and not part of the Diagnostic Related Group (DRG) payment for patient clinical care. The DGME payment was created by the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1985. The statute required the Federal Government's Medicare Agency, the Health Care Financing Authority (HCFA) - which today is known as the Center for Medicare and Medicaid Services (CMS) – to audit the 1984-85 GME costs of every teaching hospital in the United States. The audits were conducted over a five-year period and in February 1991, HCFA sent a notice of Program Reimbursement (NPR) to all teaching hospitals. The NPR stated the Per Resident Amount (PRA) or the amount of GME costs divided by the resident count for 1984-1985 that HCFA had determined from its audit of the teaching hospital. Note: The DGME cost is hospital specific.

The DGME of a teaching hospital is not the payment that the teaching hospital receives. Medicare only pays its "fair share" of costs. The "fair share" of a teaching hospital is based on the hospital's Medicare inpatient volume. To relate the DGME payment to the resident, the hospitals resident count is divided into the DGME and the payment per resident is determined. Note: The resident count is not the employee count of the hospital. The resident count is determined by the time that the resident actually is in the teaching hospital or in a physician's office if the physician is a faculty member of the teaching hospital and the teaching hospital has a signed agreement with the physician.

If the resident rotates out of the parent teaching hospital to another hospital, the parent teaching hospital may not count that time nor receive a DGME payment from Medicare for that resident even though the parent teaching hospital employs the resident and pays the resident a salary with fringe benefits.

The DGME is calculated in the following manner:

- If the PRA of the teaching hospital determined by the HCFA audit is $1,000,000 and the resident count at that teaching hospital is 20 residents the per resident amount is $50,000 per resident. The $50,000 is then multiplied by the teaching hospital's Medicare inpatient utilization. We will assume that this teaching hospital has an inpatient Medicare utilization of 50%.
- Therefore the 50,000 is multiplied by 50% and a resident amount of $25,000 will be paid to the teaching hospital.

The Weighted DGME Payment

The DGME payment is also weighted by first board qualification. If a medial student selects a specialty residency for training that has a three year board qualification residency training requirement, Medicare will pay the teaching hospital a full PRA payment. However, if the resident upon completion of the requirements of his/her first board qualification, decides to continue training in another specialty or subspecialty, the teaching hospital will only receive one half (50%) of the Medicare resident payment for the additional training passed the first board qualification.

The resident count of most teaching hospitals has a DGME weighted resident count and an IME resident count. The IME resident count is not a weighted count so the IME payment is not reduced as the resident continues his/her specialty or subspecialty residency or fellowship training.

Medicare and its Fiscal Intermediary (FI) determine the resident's first board qualification after the resident completes his/her first year of residency training. Medicare only allows a maximum of five years for a full DGME payment. After five years the teaching hospital would only receive 50% of the residency amount for those residents that train beyond the maximum of five years. In Addition, if a resident training for first board qualification goes beyond five years of training, Medicare will only pay 50% of the resident payment after five years.

The IME Payment

The IME payment is an add-on payment to the DRG. The IME was created to account for the difference in teaching hospital costs versus non-teaching hospital costs. The increase costs in teaching hospitals, are driven by a higher acuity of care and increased ancillary costs influenced by resident training.

The IME is an algorithm/ formula using a resident to bed ratio as the means to calculate the payment. The IME algorithm/formula is:

$$1.35 \times [(1 + \frac{\text{\# of Res.}}{\text{\# of Beds}})^{0.405}] - 1$$

The front loader 1.35 was originally 2.00 when the IME was created. However, over time the Federal Government has reduced the IME payment and CMS, Medicare's agent continues to lobby Congress to reduce the IME payment.

In the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 promulgated a reallocation of residents rule. If a teaching hospital was not filling all of its resident's positions relative to the cap on the teaching hospital resident count established by the Balanced Budget Act 1997, the teaching hospital would forfeit 75% of the resident count it did not fill for fiscal year 2002. If a teaching hospital added residents to its resident count by the MMA reallocation rule, the teaching hospital only receives approximately one half of the IME payment for those residents added by the reallocation rule.

The IME payment is driven by the Medicare inpatient collected revenue of each teaching hospital. The Medicare inpatient care revenue is a factor of both traditional and Medicare contract inpatient revenue.

Summary of DGME and IME Payments

The two Medicare payments – DGME and IME are paid by Medicare to teaching hospitals. Medicare DGME and IME payments are not paid to physicians, clinics, VA hospitals, medical schools, and other non-hospital facilities. An acute care hospital which has a Medicare number is the only provider eligible for Medicare GME payments.

Current Medicare GME payments to teaching hospitals provide a valuable resource to teaching hospitals. The payments offset the cost of resident salaries, fringe benefits, faculty cost, staff costs and GME operating expenses. From the description of the two Medicare GME payments above, the DGME is based on the GME costs even though the DGME does not pay for 100% of the GME costs, Medicare pays only its "fair share". In addition, the DGME is not based on current costs since

it was derived from the audit of the teaching hospital's 1984-1985 teaching costs. Medicare has provided an annual update but it does not keep up with the increase in salaries for residents, faculty costs driven by increases in compensation as well as accreditation agencies requiring additional faculty commitments. However, with the IME payment, which most teaching hospitals recognize as a Medicare payment that is only received if there are GME programs with a resident count, teaching hospital's can usually cover the GME expenses.

One additional and important rule for teaching time is that Medicare will not pay a Part A payment if the facility is also billing for a Part B payment.

CMS continues to publish rules that seek to reduce the IME payments, as well as rules to change the DGME payment. Competent well-trained physicians must be continually recognized as a value to our society and our future health care.

Primer for Starting Osteopathic Family Medicine Residency Programs

Chapter 6
SPGH Division GME Financials

ST. PETERSBURG GENERAL HOSPITAL
HOSPITAL COID # 30901
Division Medical Education Financials
For the Period Ending February 2009

Hospital Operations	Pr Yr	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	2009 YTD Total
Governmental Funding														
Medicare GME Funding	227,727	41,633	36,854											78,487
Medicare IME Funding	317,044	76,618	67,800											144,418
Managed Medicare GME Funding	0	0	0											0
Managed Medicare IME Funding	0	0	0											0
Medicaid CHEP Funding (Mcaid days only)	1,085,647	230,826	240,312											471,138
Med Ed Reimbursement from VA	0	0	0											0
Cost Report Settlements (Med Ed only)	0	0	0											0
Total Funding	1,630,418	349,077	344,966	0	0	0	0	0	0	0	0	0	0	694,043
Operating Expenses														
Salaries/Wages	559,406	93,581	87,123											180,704
Contract Labor	1,250	0	0											0
Employee Benefits (Sal * 24.5%)	137,054	22,927	21,345	0	0	0	0	0	0	0	0	0	0	44,272
Supplies	31,356	883	484											1,367
Professional Fees	213,053	12,167	27,598											39,765
Contract Services	718	0	0											0
Repairs & Maintenance	9,651	0	0											0
Rents & Leases	0	0	0											0
Postage & Transportation	950	20	781											801
Travel & Entertainment	11,587	0	0											0
Dues & Subscriptions	19,071	5,565	2,464											8,029
Other	8,772	3,145	944											4,089
Malpractice	181,406	28,354	28,342											56,696
Total Direct Dept Operating Exp	1,174,274	166,642	169,081	0	0	0	0	0	0	0	0	0	0	335,723
Incr in Pt Care Costs (IME Reimb * 80%)	253,635	61,294	54,240	0	0	0	0	0	0	0	0	0	0	115,534
Hospital Operating Expenses	1,427,910	227,937	223,321	0	0	0	0	0	0	0	0	0	0	451,258
Hospital Operatimng Profit (Loss)	202,508	121,140	121,645	0	0	0	0	0	0	0	0	0	0	242,785
Clinic Operations	(347,585)	(25,492)	(29,324)											(54,816)
Net GME Operations	(145,077)	95,648	92,321	0	0	0	0	0	0	0	0	0	0	187,969
Est # of FTE Residents for Cost Rpt (exhibits)	16.42	16.42	16.42											
GME Cap	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-
IME Cap	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-

Chapter 7
The Accreditation Process

Compliance with AOA Basic Standards for Osteopathic Family Medicine Residencies
Residency training programs in Osteopathic Family Practice and Manipulative Treatment are designed to provide the osteopathic physician with advanced and concentrated training in the specialty of osteopathic family practice. These programs must be designed to meet the needs of the osteopathic medical school graduate desiring to be certified in Osteopathic Family Medicine and Manipulative Treatment. The osteopathic concept of health care emphasizes that the human body is a unit in which structure and function are mutually and reciprocally interdependent; that the body, through a complex equilibrium system, tends to be self-regulatory and self healing; that adequate function of body systems depends upon the unimpeded flow of blood and nerve impulses; that the musculoskeletal elements comprise a body system, whose importance far exceeds that of providing framework support; and that there are somatic components of disease that are not only manifestations of, but are also important contributing and/or maintaining factors in the diseased area as well as areas distant from the diseased part. Disease prevention is the cornerstone of osteopathic family practice and shall be given major emphasis throughout the curriculum.

The ACOFP Committee on Education & Evaluation will evaluate each program at regular intervals. At the time of this evaluation, it will be determined the degree of compliance with these basic standards. One measure of quality shall be the performance of residents on the certifying examination of the American Board of Osteopathic Family Physicians.

New programs must adhere to the standards of residency training as put forth by the ACOFP Committee on Education & Evaluation from the inception of the program. Directors of new programs can use the basic standards as the template to insure the new program has the resources available to be successful.

The Accreditation Process:

Recognition:
The Bureau of Professional Education (BPE) of the American Osteopathic Association (AOA) is the sole accrediting agency for osteopathic medical education recognized by federal and state authorities. All osteopathic postdoctoral training is ultimately approved by the AOA.

Benefits of Approval from the AOA and ACOFP:
Program approval signifies that the residency program has met or exceeded the ACOFP and AOA standards for education quality with respect to all required components, including: organization and administration; faculty; curriculum; instruction and evaluation; resident relations, and facilities. The AOA/ACOFP Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment are included as Appendix A, and will be referred to throughout this handbook.

Completion of a residency training program approved by AOA and ACOFP is a prerequisite for certification by the AOA through the American Osteopathic Board of Family Physicians (AOBFP).

Chapter 8
The Inspection Process for Osteopathic Family Medicine Residencies

Approval Process:
ACOFP Committee on Education & Evaluation identifies an inspector from a list of eligible inspectors. The name of the inspector is provided to AOA, which notifies the site and schedules an inspection. Following the inspection, the ACOFP CEE reviews the inspector's recommendations. The ACOFP recommends a term of approval to the AOA Program and Trainee Review Council (PTRC), based on the deficiencies found during the inspection.

Terms of Approval:
Recommendations from the CEE for continuing program approval always specify the number of years before another inspection is necessary. Excellent programs may be approved with up to five (5) years before the next inspection. Programs, which meet most standards but have some deficiencies or appear to be in transition, are recommended for approval with re-inspection within two (2) to five (5) years. Programs, which meet most standards but are not in compliance with one or more major standards, may be approved with re-inspection within one (1) year (probationary status), with a requirement that they immediately correct any deficiencies. Such programs are informed of the specific deficiencies, with reference to AOA/ACOFP Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment. Unless specifically waived by the PTRC, programs approved with re-inspection within one (1) year are required to have a "mandatory consultation" (site visit by a consultant who will advise them regarding program improvement) within this year, to help them with program improvement. This consultant will work with the institution and program director to develop strategies for correcting deficiencies. This consultant will also submit a written report on the visit to the ACOFP and AOA Division of Postdoctoral Training.

Programs on probationary status are not permitted to contract with or recruit new residents until the program receives a recommendation for approval with re-inspection in two (2) years or more (although such programs may continue to contract with residents already in training). Furthermore, failure to correct deficiencies will result in denial of program approval. Institutions, which are unable to correct deficiencies, may choose to voluntarily terminate their programs.

If programs are recommended for deferral, denial, or probation, the program has the right to appeal the decision.

Responsibilities of Site Inspector before the Visit:
When a potential Site Inspector is asked to inspect a program, his or her first responsibility is to determine whether there is a conflict of interest in conducting this inspection, as discussed previously. The Site Inspector must be prepared to make either a positive or negative report based on findings at the institution, without any real or apparent influence from personal relationships with the institution or program faculty.

After a Site Inspector has been assigned by ACOFP, the AOA staff sends a letter to both the Site Inspector and the residency program director at the institution being inspected to confirm the name of the inspector and to ensure that preparations are made for the inspection.

The letter from the AOA to the program director includes:
1. A list of documents to be available at time of the visit (Part I-A: On-Site Review of Documents) and
2. A set of self-study questions to be answered prior to the visit (Part I-B: On-Site Review of Responses to Self-Study Questions).

The program director is required to send the responses to the questions to the AOA and to the program inspector at least thirty (30) days prior to the inspection. If the materials are not received in advance, this may be interpreted as non-compliance and could put the program in jeopardy. If the Site Inspector has not received required materials by two (2) weeks before the date of the inspection, the Site Inspector should contact the program director directly to discuss.

The AOA/ACOFP will send a formal notice naming the inspector who will visit a particular program; the Site Inspector will contact the program director to arrange an inspection date.
In preliminary telephone conversations with the program director, the inspector should address the following points:

1. Date of the inspection (often must be coordinated with one or two other inspections in the same region, to be conducted in the same general time period.) Generally speaking, the site visit should be conducted on a weekday, which is not a holiday, on a date when the institution's Director of Medical Education (DME) and program faculty will be available to meet with the Site Inspector, and when the program residents are on-site and available for interview. Other schedules (as, involving a weekend day) may be negotiated if mutually agreeable to the Site Inspector and program director, if necessary personnel are available.

2. Supplemental materials to be sent in advance, if any, including a map to the institution and name and phone number of a local hotel, if necessary.

3. Characteristics of the room in which the Site Inspector will be working (a board room or private conference room is most desirable). The room should be able to accommodate all required materials and allow privacy for interviews.

4. Documents to be available at the institution at the time of inspection.

5. Expectations for the agenda for the visit. (See Part Five: Collecting Information during the Site Visit of this document).

6. Specific individuals whom the Site Inspector wishes to interview, including the DME and the residents in the program.

7. Number and type of charts to be pulled for the day of inspection.

Travel Arrangements:
The Site Inspector usually makes his or her own travel arrangements. The Site Inspector should carefully follow the AOA policies regarding reimbursement, which accompany the letter confirming appointment as inspector for a particular program.

Visit Preparation:
1. Review the materials received from the program director.
2. Review the report of the previous site inspection. Note any deficiencies from the previous inspection.
3. Re-read the current "Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment."

Chapter 9
Participating in the Match

Residency programs must participate in the Osteopathic match in order to obtain residents to fill their program. This chapter will provide you the steps and necessary resources for new programs to register for the match, interview students for positions, and match residents into the program. It will also cover what to do if positions remain unfilled after the match and further resources for the program.

Objectives:
- Overview of the Match: Make it Work for Your Program
- Create a Desirable Website
- Roll Out the Red Carpet to Applicants
- Fill Your Program: Rank More Applicants than Spots

What the Match Accomplishes
The match is an effective and fair means of implementing a standardized acceptance date. It allows recruiters and applicants to evaluate each other fully before offers are made, eliminating premature decisions based on incomplete information. All offers, acceptances or rejections occur at the same time eliminating adverse situations such as applicants hoarding multiple offers, applicants reneging on a prior acceptance, and recruiters overfilling the number of positions available.

What the Match Does Not Do
The match will not affect the number or quality of applicants or applications for positions, the number of applicants selected for interview, or the recruiters' ability to evaluate applicants. A Matching Program will not reduce the flexibility or freedom of choice applicants and recruiters have in the selection process, and will not remove the control recruiters currently have in selecting applicants. Matches are based strictly on the preference lists submitted by both recruiters and applicants.

Registering for the Match
National Matching Services Inc. administers the Match on behalf of the AOA. Registration on their website requires information on the program as well as approval from the AOA. The AOA Match closes in January of each year, so in order to increase the likelihood that the proposed program will be able to participate in the AOA Match for the academic year in which you intend the program to begin, we strongly recommend submitting your application by July of the year prior. This is because in order to participate, the proposed program will need approval by the AOA Program and Trainee Review Council (PTRC) no later than the November of the year preceding the intended start date. Once approved, the program will then become available on the match site as well as the Electronic Residency Application Service (ERAS) site for students to send their application (covered in a later section of this chapter).

Opportunities Database
The AOA Opportunities database lists all internship and residency positions available through the web site www.opportunities.osteopathic.org. Students utilize this website often for information on programs that they may wish to apply to for residency. Most of the supplied information is entirely up to the program to change. However, some information is considered to be AOA Primary Source Verified and cannot be changed including Hospital Name, Program Name, Program ID Number, Specialty, Years of Continuing Approval, Number of Approved Positions, DME information and Program Director information. To change any of this information, an official letter must be sent to the AOA's Postdoctoral Division for further research and review. Logging on to the program section of the site and editing desired information can change all other information.

ACOFP Website
The ACOFP database lists all the osteopathic family medicine programs in the country at http://www.acofp.org/ResidencyDirectory. Students can access this database to look for programs once they have settled on Family Medicine as a specialty. It lists program information, program data, program benefits and contact information. This information is provided by the programs and the ACOFP database, and can be changed or amended at any time.

Program Websites
Websites highlighting specific information for each program is encouraged. Although many students will not have the elective time to visit and rotate at each site they are considering for residency, they will have the time to search your program website. Other than providing the basic information that can be found on the AOA or ACOFP websites, you want to be sure your website includes information on range of cultural, athletic, and entertainment options. Be sure to include several photos and graphics of the training sites and surrounding area. Applicants also look for program guidelines and information on current residents (after acceptance of the first class).

ERAS
The Electronic Residency Application Service (ERAS) allows students to apply directly to programs they are interested in. ERAS is a separate and distinct service from the Match. Residency programs are able to download the materials for each student who applies to their program from the ERAS website including photo, CV, Letters of Recommendation, Personal Statement, Dean's

Letter, COMLEX scores and Academic Transcript. Based on this information, programs may then decide which residents they would like to interview for residency positions.

Interviewing
Interviews are conducted according to schedules announced by individual training institution. Programs are responsible for setting up their own interview schedule and contacting applicants to schedule them. It is advisable for programs to interview more students than openings. All interviews must be completed prior to the submission of Rank Order Lists for the Match.

Realize that first impressions are lasting impressions. The interview is the beginning of the candidate's relationship with the program. Be sure you introduce yourself to the candidate briefly so that the candidate knows who is talking to him. If it is a panel, be sure to introduce everyone. Giving candidates business cards can help later when the candidates are trying to write thank you notes to their interviewees. All interviewers should read the candidate's curriculum vitae before the interview. It is rude to read it after the candidate sits in front of you.

Be sure to roll out the red carpet for your interviewees. Helping to arrange and pay for part of an applicants travel accommodations, especially those who are coming from a distance can help ease the financial burden of applications. Taking applicants to a lunch or dinner also helps to promote your program and makes the applicant feel important. It's important to realize that many of the allopathic and a few osteopathic programs do this already, and in order to compete with them and fill your spots you too will need to make applicants feel as if they are your top choice.

Ranking
After all interviews are completed, each student submits a Rank Order List where the student lists the desired programs, in numerical order of the student's preference. Each program submits a Rank Order List, numbering the desirable students, in order of the program's preference and also indicates the number of positions the program has available. It is important to note that no matter what the applicants state during their interview, list more applicants than spots in order to assure that your program matches as many residents as possible. It is important to know that anyone you put on your list could potentially become your resident, so only rank applicants you would like to work with in the future.

Students and institutions may express their interest in each other and may discuss their expected rankings of each other. Institutions may inform their most preferred applicants that they are in a favored position, and students may similarly inform their most preferred programs. Although institutions or students may volunteer how they plan to rank each other, they must not request such information. Volunteered information must be limited to "very likely", "likely", or "unlikely" to be ranked in a preferred position.

Matching
The Match then places individuals into positions based entirely on the preferences stated in the Rank Order Lists. Each applicant's Rank Order List is traversed "downwards", from most preferred program to least preferred, until the first program is reached at which the applicant can be tentatively matched, or until the applicant's list of choices is exhausted. Each program accepts

applicants "upwards" on its Rank Order List, continually removing less preferred matches in favor of more preferred applicants, until the program is matched to the most preferred applicants who wish to be matched to the program.

Students and institutions must not make any verbal or written commitments or contracts for appointment prior to the release of the Match results. Any such verbal or written commitments are non-binding and have no effect on the Match. Institutions violating Match rules by requesting ranking information from students, or by requiring students to make verbal or written commitments or contracts before the release of the Match results may be sanctioned by the AOA and prohibited from recruiting in the subsequent Match.

After the Match
If spots in the residency program remain unfilled, a list is compiled for students who were not successful in matching to a program. Students may then review the list of openings and contact programs to express interest in their residency openings. The Scramble takes place from 12:00 p.m. ET on Tuesday until 12:00 p.m. ET on Thursday during Match Week. During this period, residency applicants who did not match to a position may use ERAS to send applications to a maximum of thirty programs to which they've never applied, as well as fifteen applications to programs where they applied previously. These materials may be obtained from the ERAS site by programs that have not filled all of their residency openings.

Resources

www.natmatch.com

www.opportunities.osteopathic.org

www.do-online.org

Chapter 10
Marketing Your New Program to Osteopathic Medical Students

The success of a residency program is dependent on the recruitment of medical students as applicants to the program. As medical students begin researching residency programs, they consider not only training provided by the program, but also the caliber of residents composing the program. Therefore, it is important that a residency program actively recruits quality students to apply as residents. Residents that possess a strong passion for family medicine and their residency program often actively recruit future residents to the program.

This chapter will provide you with ideas and resources for marketing your new program to osteopathic medical students. Here are a few suggestions:

ACOFP Student Chapters at the Osteopathic Medical Schools
If you are searching for osteopathic medical students that are passionate about family medicine, you can be certain that you will find these students serving as members and officers of ACOFP student chapters at the osteopathic medical schools. By visiting these students at a chapter meeting or activity, you will expose your program to many students that are in the active process of choosing a residency program. As program director, you may attend a chapter meeting to speak to the students or (if you have a class of residents) offer for a few of your residents to attend a meeting and serve on a "resident panel" allowing the students to have a question/answer session with the residents. Students are intrigued by the life of a resident and are very curious about residency. By providing residents at a student meeting, you have a direct avenue to market your program to students. Many programs choose to provide dinner or lunch to the students at the meeting. To plan for you or your residents to visit a student chapter, contact Tobi Kelmer (tobik@acofp.org) at the ACOFP national office.

Website
The ACOFP has conducted many surveys of students and found that students obtain the largest amount of information about individual residency programs directly from the program's website. Therefore, it is vital that your program has an attractive and current website. Students appreciate interactive websites with photos and detailed information. In order to assist programs with the development of effective websites, the ACOFP has an Osteopathic Residency Finder tool at www.acofp.org.

ACOFP Convention Residency Fair
The ACOFP Student Association hosts a residency fair annually at the ACOFP spring convention. Many ACOFP student members (including all chapter student officers) attend the convention and residency fair. This fair is an excellent recruitment opportunity for your program. To make a reservation for your program, please contact Tobi Kelmer (tobik@acofp.org) at the ACOFP national office.

Medical School Hospital Days
Each year, medical schools host a series of "hospital days" at the school. These days are reserved for residency programs to visit the school, host booths, and speak directly to medical students. Many students attend to learn about residency programs. This is an excellent opportunity for residents and residency program representatives to interact with students. In order to obtain additional information, contact individual schools.

Medical Student Rotations
When residents are surveyed on reasons they chose their specific program, many residents report that they were directly influenced by their experience during a student rotation at the program and by their interactions with residents/attendings at the program. It is important that your program actively invites students to visit and complete a rotation within the program. Many fourth year medical students choose to complete fourth year elective rotations at residency programs of interest to them. In order to insure that students are aware of rotations provided by your program, contact the clinical coordinator at the medical schools to have your program listed on the rotation directory. When you or individuals within your program meet students interested in your program, invite them to complete a rotation. Many ACOFP student members also utilize the ACOFP preceptorship directory to locate preceptors for elective rotations. You may contact the ACOFP national office to have your preceptors/program listed in this directory.

Chapter 11
Starting Ambulatory-Based Osteopathic Family Medicine Residency Programs

Preface: Continuity of care is an essential component of residency training. The ACOFP requires the institution to provide a minimum of one osteopathic family practice ambulatory training site for providing this care. Multiple sites may be utilized as long as each site meets the requirements set forth in the Basic Standards. The goal of this chapter is to review the requirements for the Ambulatory Continuity of Care Experience and to provide information on potential opportunities to support the financial success of the experience.

Basic Standard Requirements for the Ambulatory Site
Site: Each site must have a waiting area, examination rooms, resident's office, laboratory and a business office. The site needs to be capable of providing: OMM, minor surgery, blood sugar, throat culture or rapid strep screen, urinalysis, office microscopy, EKG, spirometry, and screening audiometry. The site needs to provide online access to reference texts. The economic aspect of the site must be self contained and patterned after a private practice. It should be capable of setting appointments, providing billing functions, and generating resident specific economic data.

Medical Records: Medical records should be provided for quality assurance and a quality improvement process must be utilized. Medical records need to include: a system for documenting OMM and treatments, a mechanism to identify each patient's primary care physician, chronic medication list, problem lists, health maintenance flow sheets, and chronic disease management flow sheets.

Staffing: Faculty must be available in appropriate numbers to ensure that residents always have readily available on site supervision. The present CMS guidelines for faculty over site of residents providing patient care is 1 faculty member to 4 residents (Note: the faculty member may not be engaged in patient visits or other clinical activities during this time). ACOFP requires each program to have 2 full time faculty members in the program and 1 full time faculty member for each 6 residents in the program. Ancillary support staff must also be available to ensure efficient patient care.

Goals of the Continuity of Care Training: The ambulatory experience must provide residents with their own patient panel that includes a variety of patients in terms of age, gender and ethnicity. The resident must be responsible, under supervision, for the health care needs of their assigned panel of patients. As the skill and proficiency of the resident improves, an increasing daily patient load is expected. The three year continuity of care experience must include at least 1,650 patient visits, with a minimum of 150 occurring in the OGME-1 year. The goal of this experience is to train residents to be both productive and efficient in a primary care setting and at a minimum must include:

- Appropriate utilization of osteopathic principles and manipulative treatment
- Diagnose and manage medical and surgical conditions
- Perform office procedures
- Incorporate preventative measures
- Provide patient education
- Provide counseling
- Coordinate care
- Manage consultations
- Maintain medical records

Making the Ambulatory Experience Financially Viable

It is important to recognize that there are many ways to create an Ambulatory Site that fulfills the Basic Standard requirements set forth by the ACOFP. It is encouraged that the granting institution considers multiple strategies when selecting a model for the Ambulatory Site of residency training experience. The ACOFP does not endorse a specific model and the following information should be considered a resource for creating a financially viable ambulatory experience and not an endorsement by the ACOFP.

There are a variety of obstacles that residency programs face in attempting to operate a financially viable ambulatory experience. Many programs serve sensitive populations of patients where the adequacy of the payer mix negatively impacts the financial viability of the ambulatory site. Additionally, residents in training are not as efficient in the practice of medicine as seasoned physicians. The combination of these 2 variables challenges the financial viability of many programs.

On March 18th, 2010 the House Democratic Leadership released the text of the Reconciliation Act of 2010, which makes changes to H.R. 3590, the Senate-passed Patient Protection and Affordable Care Act. Taken together, the Reconciliation Act and H.R. 3590 are considered the health care reform package. There are numerous provisions in health reform that could impact family medicine residency programs both directly and indirectly. While a description of all of these provisions is beyond the scope of this chapter some key provisions that relate to the ambulatory training experience of residents should be recognized:

- *Teaching Health Centers: Acknowledges the growing role of Federally Qualified Health* Centers (FQHC's) in teaching the next generation of primary care providers by authorizing and funding new programs for health center-based residencies. Authorizes a new Title VII grant program for the development of residency programs at FQHC's and establishes a new Title III program that would provide payments to community-based entities that operate teaching programs. Directly appropriates $230 million over 5 years for the Title III payments. Visit: www.nachc.org for more information.

- *Creating Collaborative Relationships between Institutions with Family Medicine* Residencies and FQHC's: Provide access to federal grants to support the costs of otherwise uncompensated comprehensive primary and preventative health care delivered to underserved populations. Provides access to reimbursement under the Prospective Payment System (PPS) or other state approved alternate payment methodology (which is predicated on a cost-based reimbursement methodology) for Medicaid and CHIP services and cost-based reimbursements for services provided under Medicare. Provides access to federal grants for capital improvements and operational expenses. Provides access to Federal Tort Claims Act (FTCA) coverage, in lieu of purchasing malpractice coverage. In addition to these benefits, health reform allocates an additional $11 billion to FQHC's over the next 5 years ($1.5 billion is allocated for capital projects). Visit www.dhhs.gov, www.nachc.org, or www.healthreform.gov for more information.

Chapter 12
Guidelines for Preparation of Rural Residents in Osteopathic Family Practice and Manipulative Treatment

GUIDELINES FOR PREPARATION OF RURAL RESIDENTS IN OSTEOPATHIC FAMILY PRACTICE AND MANIPULATIVE TREATMENT

American College of Osteopathic Family Physicians

ACOFP, 9/2002
ACOFP, Revised, 11/2002
ACOFP, Revised, 2/2003

Guidelines for Preparation of Rural Residents in Osteopathic Family Practice and Manipulative Treatment

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ARTICLE I

The American College of Osteopathic Family Physicians encourages the training of physicians competent to enter rural (i.e., non-metropolitan) practice with the following statement of convictions:

A. The country has a continuing and increasingly pressing need for rural physicians.

B. The specialty best suited to serve the rural populace is Family Practice.

C. A disproportionate number of family physicians currently in rural practice are D.O.s.

D. Rural practice demands a different level of ability than does that of the urban environ.

E. Both the physician and the rural community are best served by a training program tailored to rural needs.

F. Family Practice residents seeking training in anticipation of rural practice should have the assurance of the ACOFP that those programs advertising rural tracks do indeed provide adequate training.

ARTICLE II

Training of rural residents in accordance with these stipulations is best conducted as follows:

A. Any accredited ACOFP residency program could offer a rural training track to one or several residents of the program. Of course, if capacity and resources permitted, a given program could be entirely rural (i.e. all the residents of that program).

B. Prior to its recruitment of students, the program would need to undergo additional review to insure that the curricular elements were, in fact, present. Reviews would be through the submission of program documentation. Based on this documentation inspection may be required. All programs must be accredited by the American Osteopathic Association (AOA), not be in probationary status, and meet the Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment.

C. Upon completion of such additional review, the program would receive an official designation from ACOFP as a rural training site. No additional certification would be provided to a resident completing the training.

ARTICLE III

THE CURRICULUM

Curricular additions fall into two (2) primary categories: clinical skills with emphasis on procedures, and psychosocial/leadership experience. Rural sites will have widely varying capabilities. It is not the purpose of the curricular enhancement suggestion to be so stringent that some sites would be excluded. Much, if not most, of the added procedural exposure would likely be accomplished at large tertiary centers where the volume would provide ample experience.

ARTICLE IV

RURAL EXPOSURE

The first year of training will remain a hospital based, rotating internship-like experience as it is currently. During years two (OGME-2) and three (OGME-3) the resident must spend time in the rural setting. The definition of rural shall remain that designated by the federal government. The duration of this exposure shall be sufficient to meet all the curricular elements of a rural residency training experience. However, if all curricular elements can be met, the entire two years could be accomplished in the rural setting.

The primary emphasis of this exposure is to develop an appreciation for the delivery and management (funding, training, staffing, reimbursement) of rural healthcare systems, including:

A. Behavioral skills related to lifestyle issues of the physician and physician's family.

B. Exposure to the social issues of rural practice: after hours call, relationships with colleagues and distant consultants, E.D. coverage, resource utilization, community leadership, confidentiality.

C. Experience in leading, managing, and team membership, in rural health resources: mental health facilities, pastoral counseling, county health departments, public health responsibilities, etc.

D. Delivery of medical care collaboratively and interactively with nurse practitioners, physician assistants, social workers, physical therapists, home health nurses and hospice workers.

E. Funding, Training, Staffing and Reimbursements.

ARTICLE V

CURRICULAR AUGMENTATION

PEDIATRICS: Experience must be provided for neonatal resuscitation, stabilization, and requirements for transport. To be prepared to accomplish this the resident must gain experience in resuscitation procedures: intubation, veni- and arterial puncture, lumbar puncture, and umbilical catheter placement.

WOMEN'S HEALTH: Additional experience in obstetrics is needed to include high-risk emergency care. Obstetrical procedures should include ultrasonography, outlet forceps, vacuum extraction. Experience in gynecologic procedures is also needed: D & C, colposcopy, cervical and endometrial biopsy.

OCCUPATIONAL MEDICINE: Experience in the basics of Occupational Medicine emphasizing the work types seen in rural practice.

TRAUMA & EMERGENCY CARE: Experience must be provided in diagnosis and management of common Emergency Department cases to include major trauma. Program must assure familiarity with commonly employed procedures including paracentesis, thoracentesis, chest tube placement, pericardiocentesis, emergency tracheostomy, etc. The ability to interpret acute condition plain radiographs is needed. Opportunities for certification in ACLS, ATLS, ALSO, PALS, and NRP should be provided.

CRITICAL CARE: Additional exposure to the management of critical care patients including stabilization and transport should be provided.

ORTHOPEDICS & SPORTS MEDICINE: Experience should be provided for athletic training, the role of the team physician, fracture management (closed reduction, splinting, advanced casting), reduction of dislocations, and distant consultation/coordination with orthopedic surgeons.

SURGERY: Special emphasis of rural practice procedures including enhanced experience as a first assistant, in conscious sedation, endoscopic procedures and office procedural skills.

GERIATRICS: Exposure to the discipline as experienced in a rural setting.

BEHAVIORAL & MENTAL HEALTH: Exposure to rural mental health systems, experience should be provided in the diagnosis and management of acute psychiatric emergencies.