Recreating the Country Doctor

Critical Access Hospital Fellowship

— By Robert J. Johnson, MD —

Remedy Medical Services
Abstract

Rural healthcare in America is in serious trouble! Manpower shortages and a decrease of Disproportionate Share Hospital payments are two of the top reasons. The "critical access hospital" designation by the federal government has tried to address some of these issues by creating a category of hospitals based on need, size, and location for which reimbursement for services may be enhanced. The criteria required to comply with standards to be a certified critical access facility are well defined by the federal government and for many clinics and hospitals attaining this status, cash flow has improved.

Even so, the number of critical access hospitals that are closing has increased in recent years. Contributing factors include aging, poor and shrinking populations, high uninsured rates and a payer mix dominated by Medicare and Medicaid, local economic challenges, aging facilities, outdated delivery systems and poor business planning and implementation.

According to The North Carolina Rural Health Research Program (NC RHPR), between 2005 and 2009, 42 rural hospitals closed and from 2010 to 2016, 72 more hospitals closed. More than half of the hospitals that closed since 2010 were in the south. Twenty-five percent of the 1,332 certified critical access hospitals in America are projected to close in the next decade. This loss of healthcare access for rural residents will increase the already widening gap for services in rural communities versus urban centers. The death rates for rural residents from heart disease, cancer, diabetes and lower respiratory diseases are higher than those of urban centers primarily due to lack of healthcare access and preventative medicine, which is directly related to the availability of physicians and healthcare providers. The doctor shortage in America is more a matter of distribution than of strict numbers; nonetheless studies show that overall rural areas will be short 45,000 doctors by 2020.

The practice of rural medicine has also changed. In the past, local hospitals and established physicians would recruit a doctor who either bought into an already operating private practice or opened their own office to see patients, subsequently admitting patients to the hospital and utilizing hospital ancillary services. The doctor supported the hospital through their admission of patients and was an important part of the growth and sustainability of the hospital. Not only did the doctor see his or her patients in their own clinic but they admitted and rounded on patients they placed in the hospital. Often hospital admissions were the sole discretion of the doctor.

Today things are very different. Brick-and-mortar private practices are almost extinct; most doctors are employees of the hospital and the practice of medicine has morphed into sub-specialties of clinic (primary provider) and hospitalist. Another cog in this wheel is that in days past, physicians in a community provided emergency room coverage as part of their practice routine; this is now the realm of doctors who specialize in emergency medicine. The divergence of these three forms of medical practice from what used to be one provider-based model has created an even greater need for physicians in rural communities and what we now refer to as hospital or clinic-based medicine.

Many doctors working in clinics do so because they do not want the added stress and responsibility of treating hospitalized patients, while hospitalists – those physicians who admit and care for in-hospital patients – do not have the time to serve both the clinic and the hospital. Both of these practices are themselves a form of subspecialty and it is impractical to expect one provider to do both jobs simply because of the volume and acuity of patients involved. Add to this milieu the leg of emergency medicine and you can see that hospitals are faced with an impossible dilemma. Recruiting board-certified
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emergency physicians to rural communities is almost impossible for many reasons, including salary expectations, better career opportunities in urban centers, and the dearth of available boarded providers.

Primary care doctors such as internists and especially family physicians have taken up the slack of this need and have become the mainstay of rural emergency medicine. They have also become the default hospitalist in areas where clinic physicians are in short supply. The practice of rural medicine is in and of itself a sub-specialty, as most rural doctors must be prepared to provide care without readily available specialties such as cardiology, pulmonology and gastroenterology. They have to be able to distinguish between what is practical in this rural setting and what needs to be referred to a higher level of care. The need to wear many hats and be able to provide healthcare in a setting of limited resources has created its own specialty.

So what is the answer? Enter the Critical Access Fellowship, a program designed to train physicians in a post-doctoral setting to be the in-hospital physician dedicated to practicing in rural communities and educated specifically to the care of patients in a rural culture. This is NOT the "country doctor." The designation of Critical Access Physician would be a hybrid of hospitalist and emergency medicine, with the knowledge and training needed to oversee associate providers and practice medicine in the small hospital setting. The training would include rotations in hospital medicine, emergency medicine, OB, radiology and rural health.

The implementation of such a specialty within the rural hospital setting would release the clinic physician from overload and improve recruitment and retention of primary physicians in this setting. The expectation would be a one-year postdoctoral fellowship, paid for by hospitals looking to recruit such a doctor for their facilities. The doctor would be paid a reasonable salary for their fellowship and do at least some rotations in the facility in which they would practice. The necessary arrangement would require a doctor to sign an employment contract with the sponsoring hospital or clinic.

Educational Setting

The training of fellows in a critical access program would require affiliation with designated teaching institutions capable of providing rotations in the key elements of Critical Access Medicine (CAM). Rotations would also include electives in subspecialties such as anesthesia, cardiology and intensive care medicine, to name a few. At least four to six weeks of rotation would be done at the sponsoring facility’s hospital where the fellow has contracted to be on staff.

Funding

The key element in this program is that critical access hospitals themselves would be the primary financial supporter of the individual fellow by providing salary, insurance coverage and other benefits on par with other providers affiliated with that institution.

The goal of the CAM fellowship is to parcel out truly interested candidates who may need additional training to meet the qualifications of a critical access provider, but could not or would not sacrifice their current income potential to take on an additional year of training. In other words, it is expected that critical access fellowships would pay on a par with salary expectations for the candidate in the open market. The candidate and sponsoring hospital would agree to compensation based on a contract with an extended term of practice with the sponsoring facility beyond the initial fellowship. By offering a compensation package that is significantly more than the standard salary expectations for a fellowship, we hope to create a larger pool of physician candidates.
This pool could also include physicians in training and practicing physicians looking to transition into this type of practice but needing to update their skills for such a demanding practice. The negotiations could also include other benefits such as student loan forgiveness.

Other funding can come from federal government programs for post-graduate education, private and commercial scholarships, the different boards of medical education (e.g. AAFP) and local and state education programs.

Candidates applying to the program would also have to be amenable to agreements with the sponsoring facility and be willing to meet the requirements of employment by the facility, which might include relocation, multiple year contracts and repayment of costs for failure to meet contracted issues.

The good news is that the fellowship candidate and the sponsoring hospital will always move forward on the grounds of mutual agreement and support.

The cost of promoting the fellowship and providing the proper instructional setting, including qualified instructors and training facilities, would be carried by the teaching institution offering the program. The location of the program could be anywhere such a qualified teaching facility exists and the sponsoring hospital could be located in any state in America. This could create a large pool of fellowship candidates as well as a pool of sponsoring facilities.

Who is eligible to be accepted into the fellowship program?

The guidelines for admission to the program would be established by a board, which would oversee the screening of acceptable candidates. The minimum criteria would be a medical degree (MD or DO) from a qualified medical school and to have completed a minimum two-year postgraduate residency program. The purpose of the fellowship program is to be attractive to new graduates as well as physicians who may wish to transition from their current status of practice but may lack experience or training in the nuances of CAM.

By expanding eligibility to those who are not BE or BC, we hope to cast a larger net and create a bigger pool of potential candidates. It is our hope that healthcare facilities and medical boards of education will embrace this concept of training in order to achieve these goals.

Conclusion

It is the goal of this paper to propose a viable alternative to the loss of critical access hospitals in America by creating a new category of medical specialists who would be trained to meet the challenges of rural health and who would be willing and interested in undertaking additional training to become board certified in this new class of providers.

The hope is that by casting a wide net and offering on-par financial compensation to the candidate in return for a commitment to a sponsoring program, both the fellowship candidate and sponsor will benefit from long-term stability and mutual support. Since no candidate can be admitted into the program without first signing on to an agreement with a sponsor hospital, the potential for candidate drop out or failure is minimized. Additionally, because the candidate can expect reasonable financial return, the position of the fellowship would be that much more viable and attractive.

The program wishes to promote interest from new post-graduate candidates, J-1 Visa candidates, and physicians seeking transitions from their current practice. The properly trained fellow will have a full understanding of how critical access hospitals operate. By employing
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this knowledge, the physician will improve patient care and increase the utilization of the supporting hospital. All rural hospitals may benefit from this program as a tool for recruitment and retention of emergency room physicians.

By designing a program that produces a hybrid physician who can take on responsibilities that would otherwise require hiring “specialists” in two or more categories of medicine, the fellowship program would save money for the sponsoring hospital. Furthermore, by creating provider teams that include associate providers trained to work under the direction of a supervising physician, the hospital can use such extenders to reduce the number of physicians needed to offer in-house patient care.

The creation of a new specialty in medicine is complicated and it takes significant time to properly design and implement such a program, which may add to the expense of providing healthcare downstream. The fellowship hopes to reduce ramp-up time to establish such a program by partnering with hospitals in need, thereby answering urgent questions of cost for salaries and benefits. By further partnering with teaching institutions we hope to promote this new specialty and in doing so improve the outcomes of critical access hospitals’ recruitment and retention of dedicated physicians. This will eliminate the revolving door of doctors who only temporarily “fix” the problem and replace them with doctors trained to meet this growing need.

Proposed Curriculum for Critical Access Fellowship Candidate

**Mandatory**

<table>
<thead>
<tr>
<th>Course</th>
<th>Duration</th>
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<tbody>
<tr>
<td>Emergency Medicine</td>
<td>12 weeks</td>
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<tr>
<td>Internal or In-Hospital Medicine</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Ob/Gyn with Emphasis on Delivery</td>
<td>6 weeks</td>
</tr>
<tr>
<td>ICU</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Sponsoring Facility</td>
<td>4 weeks</td>
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**Electives** (minimum 2 week rotations)

- Anesthesia
- Pediatrics
- Trauma ER
- Orthopedics
- Radiology
- Surgery

16 weeks

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