Community Context in Distributive Rural Med Ed

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dis·tri·bu·tive

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/disˈtribyətiv/

(Adjective)

1. concerned with the supply of goods to stores and other businesses that sell to consumers.

concerned with the way in which things are shared between people.

2. Grammar (of a determiner or pronoun) referring to each individual of a class, not to the class collectively, e.g., each , either .

Rural Medical Education

- Who is trained?
- Where are they trained?

- For what are they trained? What is the training? (Shouldn't this be the same question?)
- How are they trained?

- Why is Rural Medical Education Valuable?

“Start with the end in mind…”

- Intentional education – community context
  - “For what are they trained”
  - http://www.raconline.org/rtt/pdf/policybrief_jan11.pdf
- Socially responsible education – return on investment
- “Train to Remain” evidence in rural med ed
  - http://www.raconline.org/rtt/pdf/rural-family-medicine-training-early-career-outcomes-2013.pdf
- Health Care Transformation and Payment
  - Populations, PCMH, rural community and networks

The Yin-Yang of Med Ed

- The "Day Job" of a medical educator:
  - Making it fit
    - People (HR)
    - Economics
    - Accreditation
- Keeping it real, Keeping it relevant:
  - Residency to reality
    - Developing Competence
    - Developing Confidence

Why Distributive Rural Med Ed?

- Training to remain requires the learner to develop both competence and confidence
- Competence and confidence are situational for the learner/provider and based on the needs and assets of the community
- Rural is uniquely suited to community definitions (e.g. by geography): including medical care delivery; and now payment

Why Distributive Rural Med Ed?

- GME funding and efforts in rural med ed are often local and function well when associated with an anticipated return on investment
- Rural and remote communities have unique and differing healthcare needs within the scope of FM physician training and practice
- The evidence supports it!

Your Role: The Community Preceptor

- How has your practice adapted to the community and patient needs?
  - What are the stresses?
  - What are the adaptive solutions?
  - What is unique and can be uniquely taught?
  - How was the community needs assessment achieved? (How were patient needs identified?)
    - e.g. CAH Community Needs Assesment
    - e.g. Telemedicne, psychiatry, OB, ER services

Your Role: The Rural Program Director

- How does the unique community context of your rural program:
  - Meet accreditation and economic standards?
  - Uniquely distinguish itself in favor of recruitment of *your best* medical students for FM training?
  - Support "Train to Remain" community integration of the resident (and family, if applicable)?
  - Develop community preceptors, leaders and resources to support and develop your program?

Your Role: Distributive Rural Med Ed Planning – Intentional Leadership

- How does your spectrum of unique communities and their networking and contexts…
  - Support programs that meet accreditation and economic standards, matching HR resources and needs?
  - Support variation for learner needs, interests, aptitudes and situations for medical student recruitment and FM resident training?
  - Support "Train to Remain" models in the distribution of training communities and target workforce areas?
  - Support program directors, community preceptors, leaders and resources to assist to develop the program?

Our Role: We're all in this together

- Your – y ("y me factor") = Our
- You are not in this alone!
  - The RTT Collaborative: http://www.rttcollaborative.net/
  - RTT Technical Assistance Program: http://www.raconline.org/rtt/
  - Wisconsin Collaborative for Rural GME (WCRGME)
  - WRPRAP
  - NRHA Rural Medical Educators
  - Many others!

Making it real for WI Communities

- Top Needs in WI Rural FM workforce:
- Top Assets for WI Training Programs in FM GME:
- Next steps:
  - Does a distributive model help match the resources?
  - How does it fit accreditation and economic requirements?
  - How does it recruit medical students? Preceptors?
  - Is there flexibility, diversity and adaptivity?

Changing Times and Planning for the Future

- Rural medical education has always had a unique advantage for scope of training
- The emphasis on community context in rural medical education is aligned with new models of care delivery and payment
- Parts of the “old curriculum” such as “Community Medicine” and “Practice Management” are now core objectives

Review: dis·tri·bu·tive
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Distributive Rural Med Ed is Community Focused, Community Contextual

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Distributive Med Ed recognizes the uniqueness of rural communities and the "diversity of rural" in training, practice and setting

Our Roles in Rural Med Ed

- Community Preceptors are the best experts in defining the educational curriculum which produces competent and confident physicians
- Program Directors (site directors) have the best local view of ascribing the content to fit accreditation and economic return on investment at the community/program level
- Distributive Rural Medical Educators are working together to produce support, evidence and advocacy for a diverse and related field of study

Questions and Contact

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