# SOUTHWEST ALABAMA MEDICAL EDUCATION CONSORTIUM, INC.

## FINAL REPORT

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## **OVERVIEW**

## **Purpose:**

The purpose of the Southwest Alabama Medical Education Consortium (SAMEC) is to create an organization to operate a medical residency program focused on rural physician training. If successful, this program would also serve as a national model to address physician placement in other rural and underserved areas.

#### **Mission:**

The mission of the Consortium is to facilitate the placement of medical residents into community-based rural facilities or in urban, under served areas. This mission would be realized by the operational model of the Consortium such that greater emphasis is placed on identifying medical residents with an interest in locating to a rural area and also by exposing those residents to a rural setting and practice of medicine.

#### **Identification of Need:**

There is an unmet need for health care providers in the First Congressional District: Mobile, Baldwin, Washington, Monroe, and Escambia. Rural communities rely on various physician recruiting strategies to address their specific physician requirements. Fees of \$25,000 are often paid to recruiting agents to help locate, recruit and place physicians in local practice settings. The physicians placed by recruiting agents are often from other areas of the country or in many cases, foreign medical graduates. Many physicians thus recruited offer only short term solutions to the continuing physician shortage in rural areas. Experience indicates that it is more unlikely that physicians recruited from different cultural backgrounds whether it be regional or national, will remain in specific rural practice settings for prolonged periods. It is common for J-1 visa physicians (foreign physicians attending American residency programs) to serve two years in a qualified under served area, only to relocate at the first opportunity to a metropolitan practice. In order to remain in this country post residency completion, these foreign medical graduates must serve at least two years in an under served area. Following this brief period of service, they are free to relocate and to seek citizenship through the normal processes. Non J-1 physicians have no particular incentive to locate to rural areas and it is oftentimes difficult to convince potential physician candidates and their families that a rural practice is a viable alternative. Obstacles encountered may be as diverse as quality of education, entertainment opportunities, shopping and perceived lack of cultural events. These obstacles are compounded by biases within the traditional medical education system in that urban medical centers have little focus toward rural practice and placement but rather toward general medical educational goals and objectives. Existing data indicate that there is a greater tendency for medical students completing traditional programs such as the program offered at USA to migrate toward

urban areas as opposed to rural areas. This tendency mimics the general trend within society as a whole.

The Consortium has been successful in developing a rural medical resident tract. The traditional program at the University of South Alabama and their mission haven not been harmed but enhanced. The additional residency positions (slots) allocated to the Consortium has increased the total number of residency positions available within the First Congressional District and the state as a whole. These additional slots are above and beyond the number of positions (slots) that are currently available at USA. Residents associated with the Consortium are required to participate in a 1-2 program such that after the first year of academic/didactic experience at Springhill, year 2 and 3 will be conducted at a rural site under the direct supervision and academic control of the Consortium. It is the responsibility of the Consortium to insure that the resident receives appropriate academic and practical experience at the rural site. Residents will work directly with local physicians and will rotate through the various medical areas such as obstetrics, surgery, emergency medicine, etc. The resident will also return to Springhill for specific or enhanced medical educational experience.

The mission is to train primary care physicians to practice in medically under served areas of Alabama, rural and urban.

## **Operational Premise:**

It is the premise of the Consortium that the establishment of a separate program that partners with Springhill but that has a rural focus will enhance the probability of placement of primary care physicians in the rural are. The concept for this program has been developed over the past several years through the efforts of numerous individuals within the medical education establishment.

#### **Background:**

The idea to address rural communities' needs for additional physicians originated several years ago through conversations with several individuals including Dr. Wil Baker, former Professor of Behavioral Science at the University of South Alabama School of Medicine, Dean for Continuing Medical Education and currently Project Director for the Alabama Southern Rural Access Program sponsored by The Robert Wood Johnson Foundation, Max McLaughlin, MD, Family Practice, Mobile, Tom Yancey, MD, Family Practice, Fairhope, Bert Eichold, MD, Mobile County Public Health Director, Dick Esham, MD, former Professor and Chair, Division Primary Care Internal Medicine, Bill Curreri, MD, surgeon and national surgical education provider, and Mr. Bob Koewing, former Administrator, Department of Family Practice, University of South Alabama Medical School.

Informal discussion within this group let to Dr. Dick Esham submitting a proposal to the Alabama Southern Rural Access Program advocating fundamental change within the medical educational establishment. The presentation of this concept to the Alabama Southern Rural Access Program stimulated continued interest within the First Congressional District for development of this concept. Through the efforts of Dr. Wil Baker and the Alabama Southern Rural Access Program, formal meetings were held to

discuss the feasibility of pursuing fundamental change as set forth by Dr. Esham pertaining to the establishment of a rural focused medical education program.

## **Start up Funding:**

Following an initial set of meetings with various participants within the region, it was proposed that the current participants in the discussion (stakeholders) would be asked to fund a preliminary assessment for the concept. The initial group of stakeholders contributed \$65,000 to serve as the catalyst for this review. The group contacted with Dr. Ken Dean to conduct an analysis of need within the region and to determine the viability of a project of this nature. He also helped identify challenges associated with an endeavor of this magnitude and served as facilitator of the group during this consulting tenure.

Following Mr. Dean's report, the services of an individual or firm were considered to move the discussions to the next level. Whereas Mr. Dean served as facilitator and gathered consensus among the stakeholder group, the details associated with such a venture had not been explored. The Consortium was fortunate to have an opportunity to discuss a more detailed and comprehensive approach to the establishment of the Consortium with Ms. Renee Pruitt of The Pruitt Group. Ms. Pruitt had recently moved to Pensacola and had extensive experience with medical residency programs in Texas and in fact had been associated with a program similar to the Consortium model which was envisioned. Her expertise on the subject of rural medical education program and development and her experience with securing grant funding would serve the Consortium well toward moving the concept forward. Ms. Pruitt subsequently conducted interviews with the representatives of each stakeholder group and developed a plan and time line to facilitate continued progress with the development of the consortium.

Ms. Pruitt pursued various funding alternatives and was successful in applying for receiving a grant from the US Department of Energy for approximately \$100,000. Assistance with this grant process was provided by United States Representative Sonny Callahan. Funds from this grant are currently available to the Consortium to reimburse services purchased in the development of the Consortium model.

The above referenced funding represented initial start up and development costs. Dollars secured to date would allow for some further development of the Consortium Model.

The next phase of Consortium development required additional funding of approximately \$300,000. These funds were needed to hire an Executive Director of the Consortium Program, clerical assistance, office space and equipment, etc.

The challenge to the Consortium is to secure funding for the time prior to receiving RCC certification and thus eligibility for federal payments. Federal funding can be received now since the program has been certified. An alternative to RRC certification through the American Medical Association is certification by the American Osteopathic Association which is what this program received on January 1, 2004. Certification through this program was timelier and will allow for federal reimbursement sooner.

Thus, the estimated total dollars required for this start up phase is \$1 million. SAMEC has begun the program with one resident in July 2004 at a cost of less than \$200,000.

AOA certification was achieved in order to receive federal funding. RRC certification will follow and will allow for dual medical residency participants with MD and DO trained physicians.

## **Operational Funding:**

Following certification, rural facilities that participate with the Consortium will be reimbursed by CMV. Health care and educational facilities that care for Medicare patients are reimbursed according to established criteria. Reimbursement received through federal funding mechanisms is being applied to fund residents' salaries, academic and administrative positions and other costs incurred by hospitals and physicians. The Consortium will be responsible for contracting with the various parties involved with the rural medical education program.

The range of reimbursement per resident varies from one region of the country to another but in general the reimbursement ranges between \$60,000 and \$172,000 per resident per year within Alabama. In order to fund the program, between 12 and 16 total residents will be required. Given this level of participation, the program will be self-sustaining and will create a viable model for other rural areas.

January 1, 2004, the Consortium was certified by the AOA for 8 slots per year. The first resident began July 1, 2004. The program will go to the Match in December 2004. The first resident, Greg Stevens, is now employed by the Consortium and is in a rotating internship at Springhill Hospital, Mobile, Alabama.