

Cultivating Healthy Governance in Rural Programs

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Healthy governance is important to cultivate in any graduate medical education (GME) program. It is especially important to rural programs called integrated rural training tracks (RTTs) that span geographic distances and accommodate significant differences in health system culture and institutional scale.¹ Collaboration is both their strength and vulnerability, and addressing authority, decision-making, and accountability in healthy ways is key to their sustainability.² The sparse literature that exists focuses on centralized urban settings and lacks relevance to distributed rural programs.^{3,4} For this reason we wish to share our personal expertise in advising rural programs and the wisdom accumulated among a community of rural program directors.

Unique challenges exist for the smaller rural entity in an RTT, for whom crafting an affiliation agreement with a large academic medical center can feel like “dancing with elephants.”⁵ Rural program directors, like their urban colleagues, frequently report to multiple individuals, but in disparate places and cultural settings. Over the past decade there has been a steady trend in rural hospitals affiliating with larger urban health organizations, so that now more than 50% of non-metropolitan hospitals have become part of a larger health care system.⁶ When a residency program’s rural and urban participating institutions are combined under a common central governing body, these institutions must proactively work to ensure a continuing healthy relationship.

Affiliations defined by “interdependence” best serve the joint educational venture represented by an RTT, bringing benefits to both urban and rural hospitals (TABLE). Executing a shared value proposition in designing, developing, and maintaining an RTT requires visionary leadership with an investment mentality and special attention to those benefits that are indirect or delayed.

Principles for Healthy Governance in RTTs

Good governance is participatory, explicit, accountable, effective and efficient, equitable, inclusive, and receptive.³ These general principles, applied in tribal

settings, can be specifically adapted to RTTs.⁷ From our experience in advising developing and existing rural programs, we propose 5 principles of healthy governance particularly key to their sustainability. Urban academic centers and large health systems that strategically share authority and decision-making with rural communities will significantly increase the odds that these GME programs will be sustained, their social mission accomplished, and health improved in rural populations.

Engage the Rural Community as an Equitable Partner From the Start

Engage the rural community in the design, development, and implementation of the program. Frank Lloyd Wright introduced organic architecture more than a century ago, designing houses that perfectly fit the place in which they were built. In the same way, an organic approach to residency design and implementation begins with the assets and capacity of the rural community, then works within the rules of accreditation, finance, and governance to creatively adapt them to local realities rather than imposing a structure that may not fit.⁸

Language is important in reflecting shared ownership and decision-making. The urban program with which an RTT is affiliated is often labeled the “core,” even among its leaders, faculty, and residents. Although almost certainly well-intentioned, this naming structurally defines a relationship that is neither equal nor equitable. Successful residency programs acquire names and identities they can own, establishing community pride and shared responsibility.

Intentionally engage the community in governance. Federally Qualified Health Centers set an excellent example of shared governance in the clinical realm, with boards of directors led by patients, empowering the local community.⁹ A community group advisory to a rural residency can engage local businesses, organizations, schools, even faith-based organizations in addition to health care professionals and patients. In return, the program director can deliberately place faculty and residents on community boards or service clubs.

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TABLE

Potential Benefits of Developing an Integrated Rural Training Track for Rural and Urban Hospitals

Benefits to Rural Hospitals	Benefits to Urban Hospitals
▪ Access to technology (eg, tele-education as a complement to telehealth and/or access to simulation centers for training) ▪ Shared staff recruitment and retention across rural and urban sites ▪ Expanded educational services for professional and administrative staff ▪ Economies of scale in both number of teaching faculty and the provision of faculty development ▪ Shared program costs ▪ Opportunities for group purchasing ▪ Reduced cost of capital	▪ Increased GME funding through the rural track full-time equivalent limitation above the urban hospital's current GME cap and through payment for non-provider settings in the rural community, including critical access hospitals ▪ Improved regional quality of care ▪ More appropriate subspecialty referrals ▪ Access to the educational innovation spawned in a setting of limited resources ▪ Economies of scale in both number of teaching faculty and the provision of faculty development ▪ Additional rotations for urban residents

Cultivate Formal and Informal Individual Relationships

All organizational relationships are fundamentally personal, and fostering these relationships promotes mutual respect and influence.^{3,10} Generative relationships between rural hospital and rural residency leadership lead to program improvement and innovation and impact program longevity. For example, the authors have witnessed rural hospital executives and board members who have long-cultivated relationships with program leadership choose to bear the costs of the residency during times of financial stress because they were individually convinced of the value of the program to the hospital and community.

Explicitly Establish Shared Governance and Mutual Accountability

Purposefully integrate decision-makers from each participating institution's governing body into the fabric of the sponsoring institution (SI). Consider key GME office roles for rural site leaders and look for ways to promote continuity, engaging both faculty and residents from the rural program. Empower rural leadership by implementing a unifying central focal point of organizational decision-making.⁶ Where there are dual or even greater number of reporting relationships, it is important to establish and regularly revisit clear lines of accountability and closed-loop processes so that decisions are revisited after a predetermined period of time.

A transparent and regularly communicated budget process with explicit justification and annual reconciliation is essential not only to planning, but also as a scaffold for critical conversations. GME finance is complicated, and difficult issues are not always immediately apparent. Limited knowledge sharing between rural and urban hospitals and a lack of transparency and shared decision-making have contributed to the demise of some RTTs.² Simply

assuming things are going well until there is clear evidence to the contrary is a formula for failure. When difficulties arise, healthy governance fosters problem-solving and decision-making that is mutually respectful and participatory.

Demonstrate Creativity in Meeting the Requirements of Sponsorship and Accreditation

Be creative in meeting program requirements and sustaining a healthy learning environment across geographically distributed settings. In a variation of the prototypical 1–2 format, RTTs can have a program director in the rural location sharing leadership with an associate program director in the urban place. Consider creating a director of GME learning and working environment physically located at the rural program site who is responsible for ensuring quality and safety across multiple institutions, particularly if the SI has a rural program with multiple sites or programs at multiple locations across a region or state. Share power across institutions through strategic appointments and shared leadership of the Graduate Medical Education Committee (GMEC) among participating institutions.

Develop a Learning Environment Characterized by “Hospitality” Toward the Other

Visit each other deliberately and often. Honor and enhance the rural program voice by encouraging resident-resident and faculty-faculty academic exchanges across locations, inviting rural program educators to engage as faculty in teaching in the urban location and in other specialties, and highlighting the rural program as a standing item on the GMEC agenda. Key decisionmakers from both rural and urban locations should shoulder the burden of travel and regular in-person visits.

Accommodate distance by using videoconference connections. Periodically and regularly hold the

GMEC at the rural site or hold an annual retreat for the GMEC in the rural location. Creating a culture that is inclusive, honoring, and receptive to each other builds mutual respect and trust.

Conclusions

Healthy governance is key to the sustainability of rural residency programs and ultimately important in addressing health disparities and promoting the well-being of rural communities. Good governance requires recognition of unique challenges across both rural and urban settings. Health in the governance of RTTs depends on equitable engagement, generative and trusting relationships, mutual accountability, creativity, and hospitality.

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