

Chapa De Indian Health Residency Program Overview

Glenn Gookin, MD, PhD, FAAFP

Program Director, Sierra Nevada Family Medicine Residency Program

California Area Indian Health Service Program Directors Meeting

May 21, 2024



Dignity Health™
Sierra Nevada Memorial Hospital



CHAPA-DE
INDIAN HEALTH

Disclosures

- Glenn Gookin has no actual or potential conflict of interest in relation to this program/presentation.
- This presentation represents our opinions and experience only and does not represent the formal opinion of Chapa-De Indian Health or Dignity Health



Dignity Health™
Sierra Nevada Memorial Hospital



CHAPA-DE
INDIAN HEALTH

The Why

- Many rural American population groups experience significant health disparities.
- Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, **limited access to healthcare specialists and subspecialists**, and limited job opportunities.
- Healthcare workforce shortages are prevalent throughout rural America.

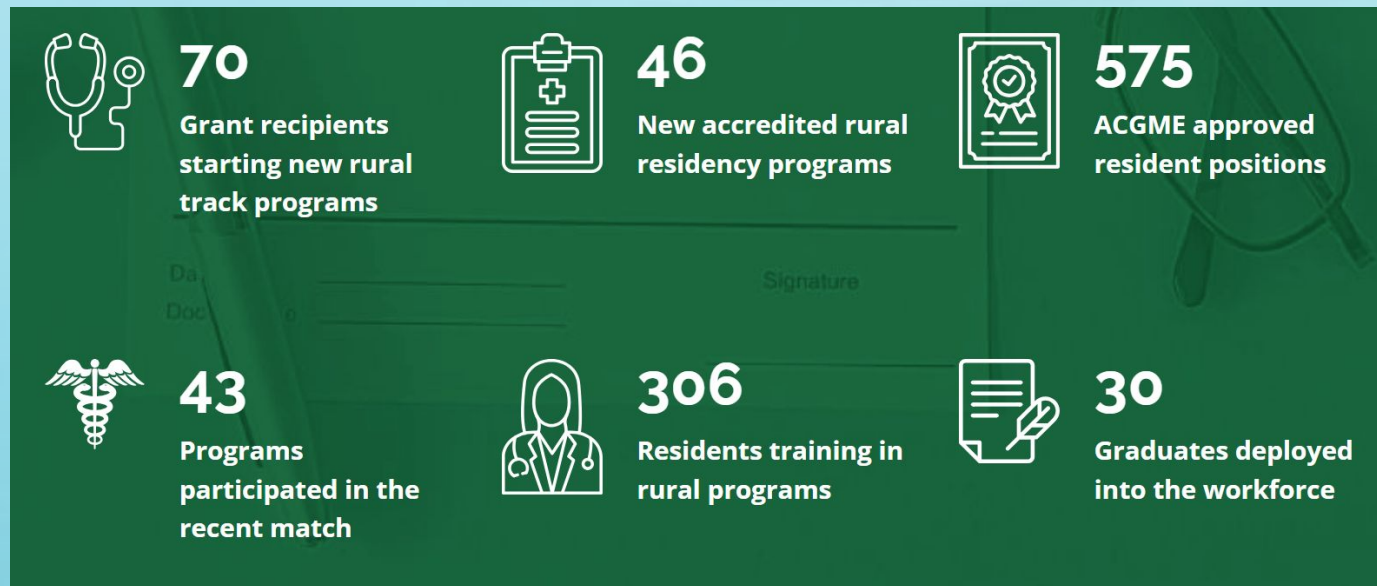
Twice Invisible

- American Indian and Alaskan Natives are an integral and unique part of U.S. society, they continue to be invisible to most Americans due to a lack of data, accurate media images, historical and contemporary awareness about Native peoples in schools, healthcare facilities, professions, military service and daily life.
- Bad data and multiple different definitions of “rural” has lead to confusion among funders, federal agencies and supporters, and a belief that the majority of Native people live in urban areas.
- Unfortunately, these inaccurate statistics continue to shape people’s understanding of rural Native America, rendering it twice invisible.

PLACE BASED EDUCATION

Train your future workforce

- Research has demonstrated that physicians who train in a rural setting are more likely to practice in a rural setting
- To reduce physician shortages in rural and underserved areas a group of declining rural residency program faculty pushed HRSA to support the development of rural residency programs.



Rural Residency Planning & Development Technical Assistance Center (RRPD-TAC)
 Lead PI: Cristy Page

HUBS
 Advisor Pairing & Regional Coordination

CONTENT EXPERTS
 Ad hoc Technical Advisory Resources

KEY PARTNERS
 Network, Consultant, Education & Research Support

KEY STAKEHOLDERS & EXTERNAL PARTNERS
 Assistance and/or Resources

Western Hub
 U Washington
 Lead: Chen



Advisor Specialties

FM	IM	Psy	OB	GS	PM
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Central Hub
 U Wisconsin
 Lead: Spencer



Advisor Specialties

FM	IM	Psy	OB	GS	PM
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Eastern Hub
 UNC-CH
 Lead: Page



Advisor Specialties

FM	IM	Psy	OB	GS	PM
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- Networks**
- RTTC - The RTT Collaborative
 - WWAMI - Residency Network
 - WCRGME - Wisconsin Collaborative for Rural GME

- Consultant Organizations***
- RTTC - The RTT Collaborative
 - RPS - Residency Program Solutions
 - PKF Health - Perry, Krumsiek, & Francazio, LLC

- Education and Research**
- NC AHEC - North Carolina Area Health Education Centers
 - Sheps - Cecil G. Sheps Center for Health Services Research
 - UWSMPH - University of Wisconsin School of Medicine
 - UWSOM - University of Washington School of Medicine

*Consultant Disclaimer: Other consultant organizations may be considered upon approval by HRSA and TAC.



KEY

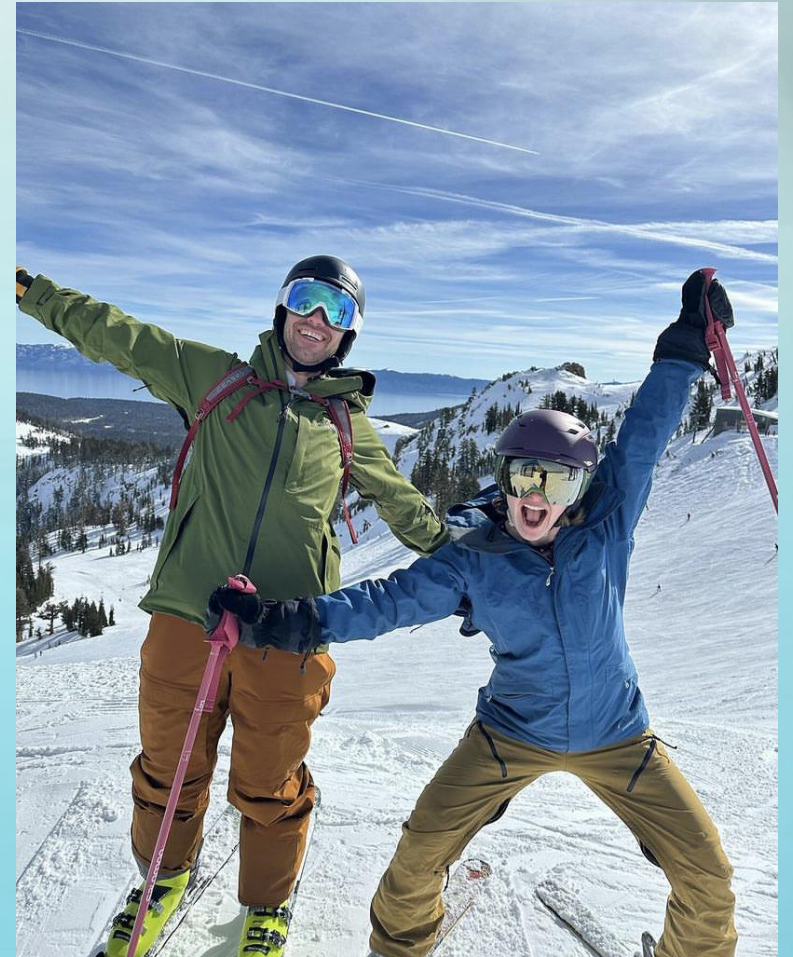
 RRPD-TAC Hub	 RTTC Network
 RRPD Awardees	 WWAMI Network
 Content Expert	 WCRGME Network
	 NC AHEC Network

Family Medicine Residency Program - Chapa-De

- First Cohort of the HRSA Rural Residency Program Development Grants
- Accreditation was received in 2021 as a rural training program (2 residents per year)
- Recruitment was postponed to 2022 due to delays from the pandemic.
- Matched first class 2023, second 2024
- Maintenance of Accreditation Site Visit 3-19-24
- Residents full time at rural clinic, Grass Valley July 2024

Family Medicine Residency Program - Chapa-De

- Sponsoring Institution: Methodist Hospital of Sacramento (PGY-1)
- PGY-2 & PGY-3 are at the rural site Grass Valley Tribal FQHC continuity clinic (Chapa-De Indian Health) and Sierra Nevada Memorial Hospital
- Official Name: Dignity Health Methodist Hospital of Sacramento/Sierra Nevada Memorial Hospital Program



STAGE 1
Exploration



Community Assets

Identify community assets and interested parties.



Leadership

Assemble local leadership and determine program mission.



Sponsorship

Identify an institutional affiliation or sponsorship. Consider financial options and governance structure.

STAGE 2
Design



Initial Educational & Programmatic Design

Identify Program Director (permanent or in development). Consider community assets, educational vision, resources, and accreditation timeline.



Financial Planning

Develop a budget and secure funding. Consider development and sustainability with revenues and expenses.



Sponsoring Institution Application

Find a Designated Institutional Official and organize the GME Committee. Complete application.

STAGE 3
Development



Program Personnel

Appoint residency coordinator. Identify core faculty and other program staff.



Program Planning & Accreditation

Develop curricular plans, goals and objectives; evaluation system and tools; policies and procedures; program letters of agreement; faculty roster. Complete ACGME application and site visit.

STAGE 4
Start-Up



Marketing & Resident Recruitment

Create a website. Register with required systems. Market locally and nationally.



Program Infrastructure & Resources

Hire core faculty and other program staff. Ensure faculty development. Complete any construction and start-up purchases. Establish annual budget.



Matriculate

Welcome and orient new residents.

STAGE 5
Maintenance



Ongoing Efforts

Report annually to ACGME and the Sponsoring Institution. Maintain accreditation and financial solvency. Recruit and retain faculty. Track program educational and clinical outcomes. Ensure ongoing performance improvement.

TO ADVANCE TO THE NEXT STAGE:

Make an organizational decision to proceed with investing significant resources in program development.

TO ADVANCE TO THE NEXT STAGE:

Finalize a draft budget. Complete initial program design. Receive Initial Accreditation as a Sponsoring Institution.

TO ADVANCE TO THE NEXT STAGE:

Achieve initial program accreditation – requires successful site visit and letter of accreditation from the ACGME.

TO ADVANCE TO THE NEXT STAGE:

Complete contracts and orient first class of residents. Hire all required faculty.

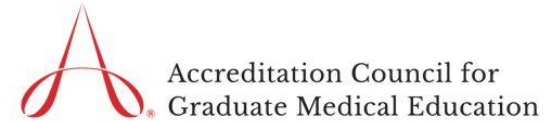


NEVADA COUNTY
Public Health



Physician Knowledge Gaps

- Weekly Primary Care Rounds
- Virtual ICU Rounds
- Connect Inpt and Outpt



Physician Shortages

- Hospital Coordination
- Workforce Development
- Graduate Medical Education



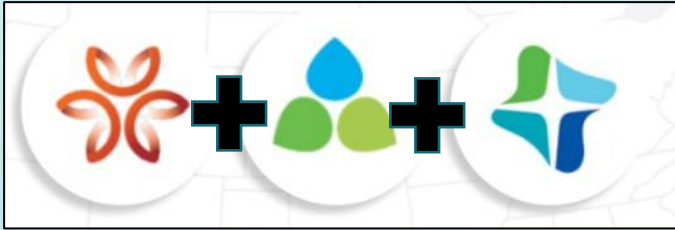
Mission & Values

Mission: The Sierra Nevada Family Medicine Residency Program is dedicated to training well rounded family physicians in underserved rural communities.

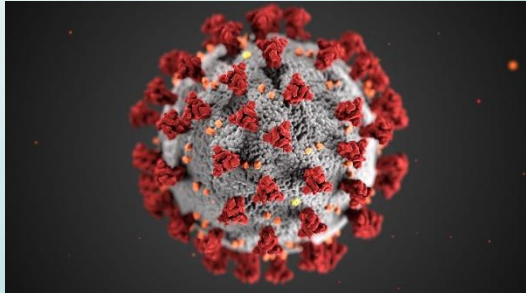
Vision: A Family Medicine training program of excellence that promotes health equity through the placement and retention of physician leaders in rural communities.

Values: We are committed to community based training that compassionately collaborates with patients, harnesses the expertise of our multidisciplinary partnership, and delivers quality care regardless of social status or station.

Challenges



=



Get a tribal health safety net clinic & a sole community hospital to partner and start a family medicine residency training program.

In a rural setting

Easy Right?

During a pandemic

Both GME Naïve



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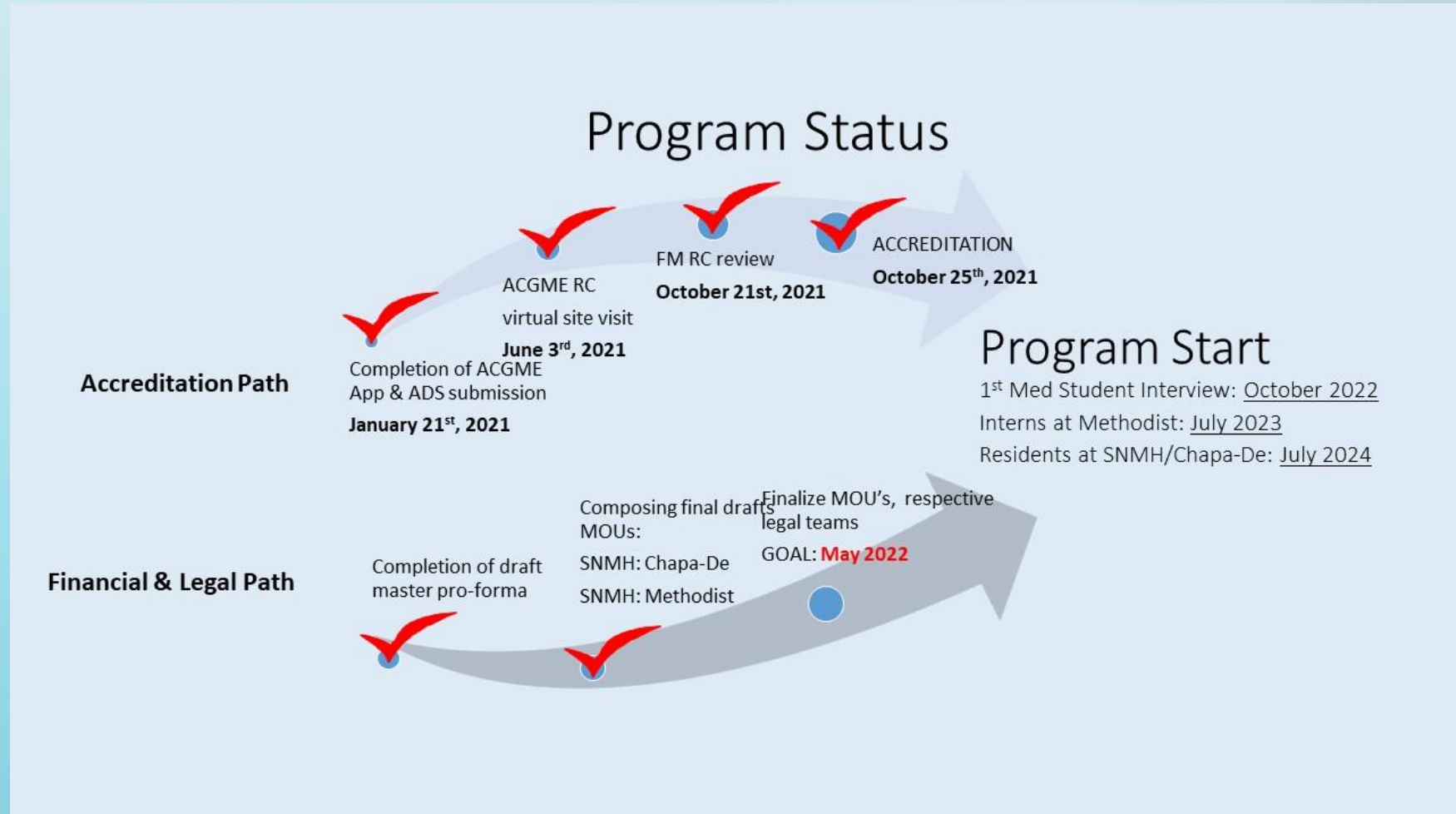
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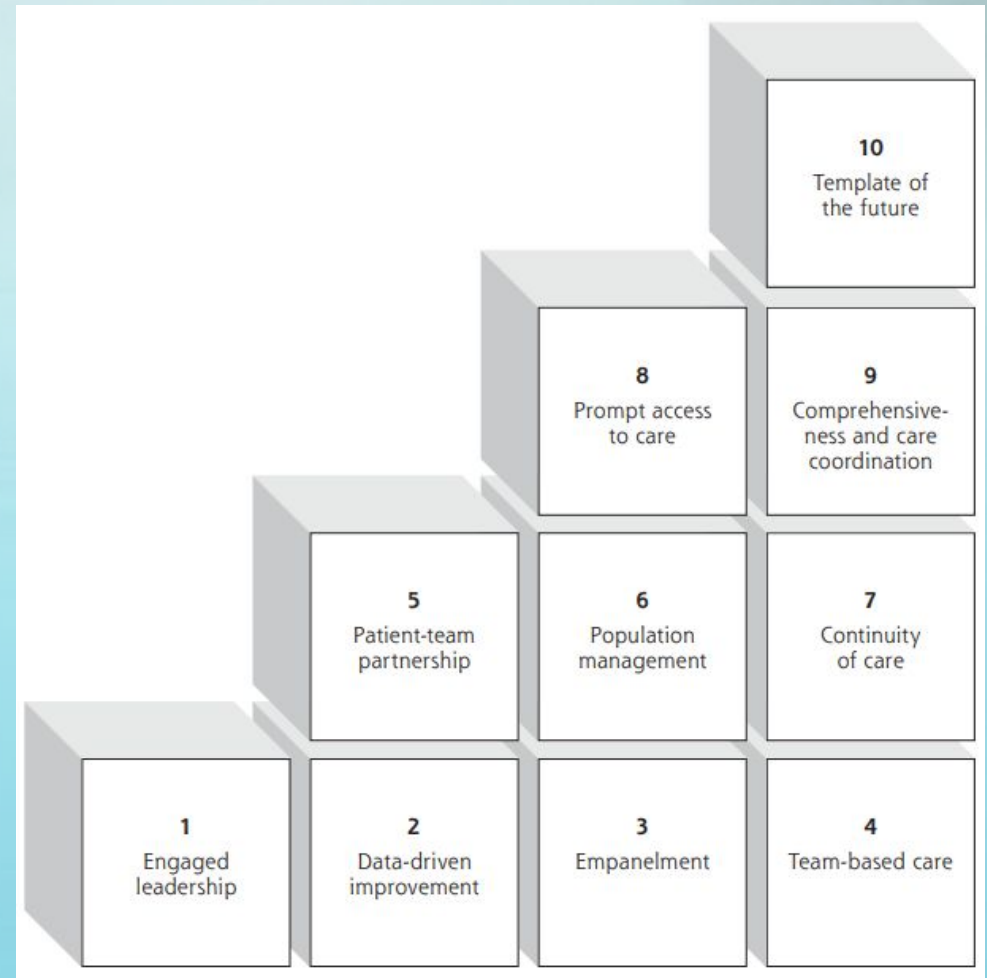
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Overcoming Barriers



Demonstrate your Clinics Strengths

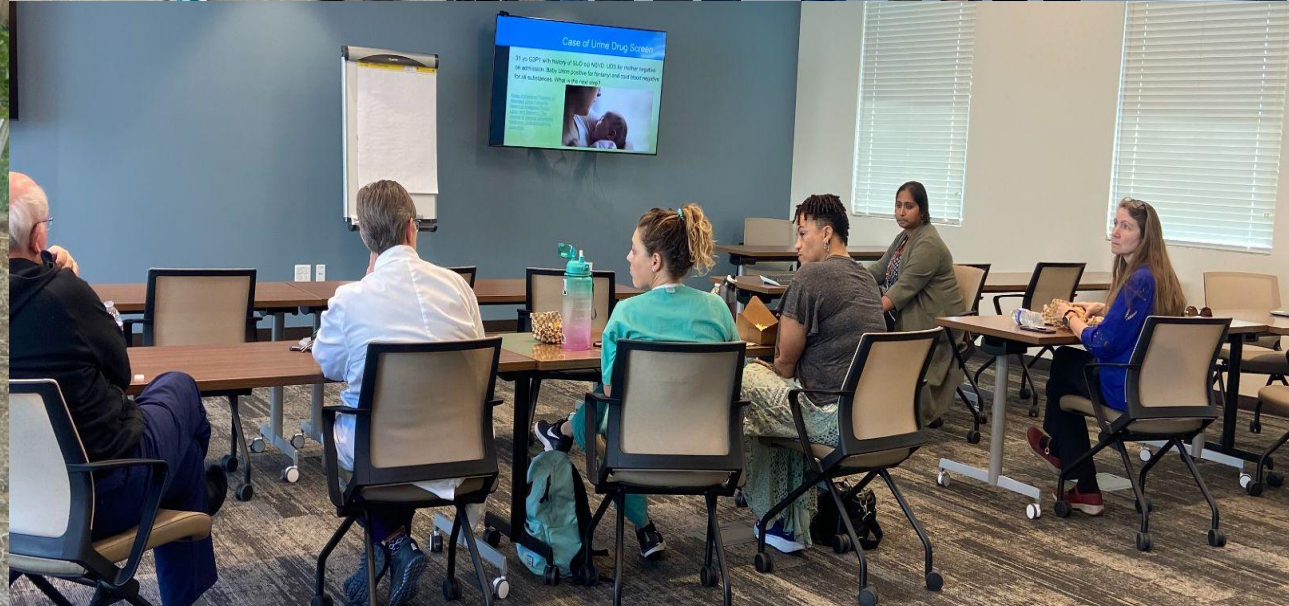
- Bodenheimer et. al described a conceptual model that guides practice improvement.
- “10 building blocks of high-performing primary care.”
- Synthesis of a team at UCSF and their thinking from a decade of observing and experiencing improvement work in primary care.





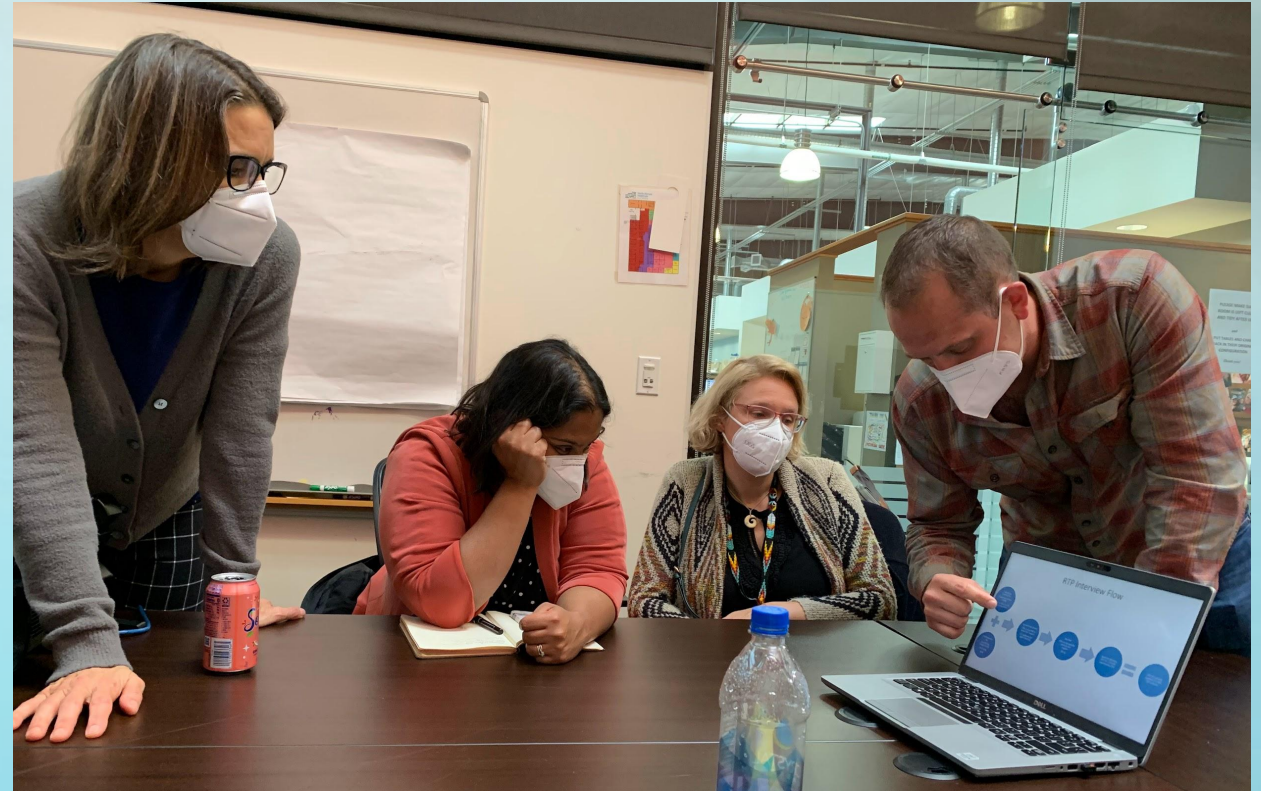


GET PEOPLE TOGETHER AND SHOW THEM



Meetings

- Make sure you clearly understand your clinics org chart
- Set regular meetings with:
 - Nursing/ medical assistant lead
 - Call center leads
 - Medical Director
 - IT/Facilities
 - Others (?)



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~~Pipeline~~ Pathway model for the Rural Training Program

Outreach to Medical Students

- Recruitment of local medical students interested in rural health
- Matriculate medical students with local and underserved and rural connections

UCD Tribal PRIME LC

- Inter-professional partnerships
- Telehealth experience
- Job Placement in rural and underserved communities

FM OB Fellowship

- Train one family medicine-obstetric fellow per year at the current residency site
- Expand the program's faculty to include additional family medicine OB Fellowship-trained faculty members

UC Davis Tribal Health Program in Medical Education (PRIME)

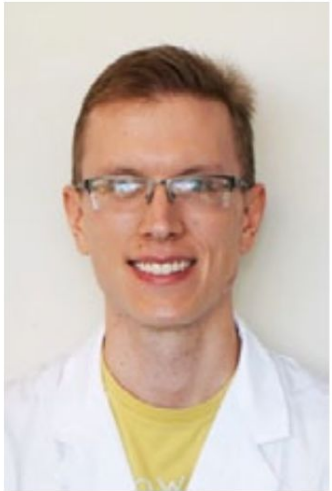
- Program within UC Davis School of Medicine
- Focus is training physicians to practice medicine in California's tribal communities - both rural and urban
- Tribal Health PRIME students:
 - Complete the standard medical school curriculum, AND;
 - Have specialized coursework, scholarly project, unique clinical experiences, and mentorship from physicians and tribal leaders dedicated to California's tribal communities

UCD THP Student Qualities

- Significant ties to AI/AN communities
 - Tribal descendance is preferred
 - Also be available to applicants without tribal affiliation who have significant connection with AI/AN communities and culture
- Are passionate about addressing AI/AN healthcare disparities
- Wish to serve California tribes and other AI/AN communities

Tribal Health PRIME Current Students

Class of 2026 (2nd years)



Justin
RehwaldtTH



Hanna
PoseyTH



Alyssa
FowldsTH

Class of 2027 (1st years)



From left: Jen Tashjian, Temerity Bauer, Savannah Lukkes,
Drew Ramos, and Ashley Martinez



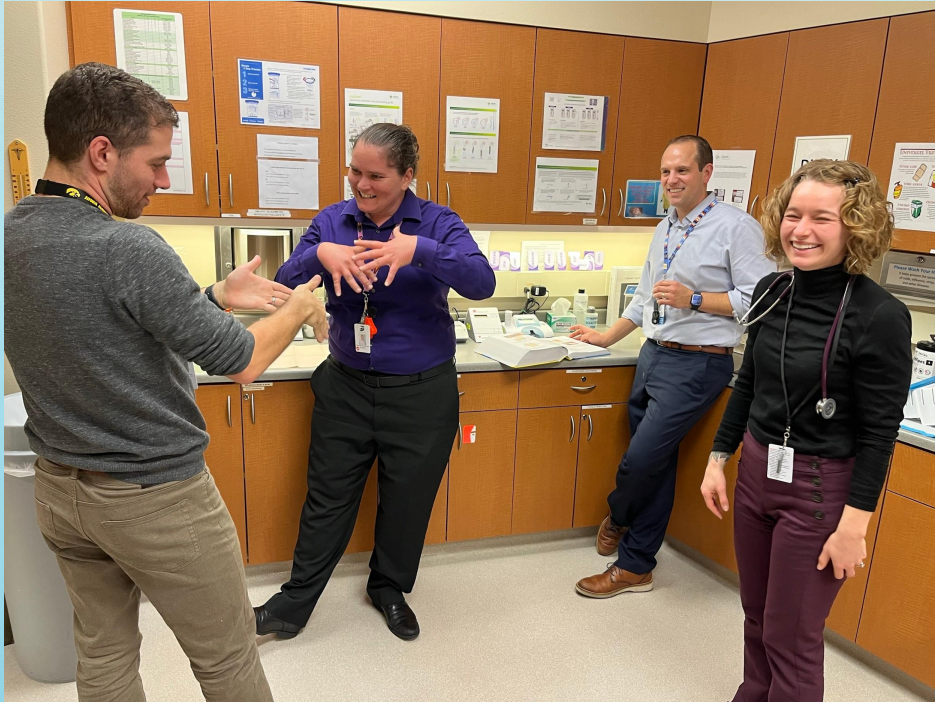
Savannah Lukkes, Class of 2027

Tribal Affiliation: Cheyenne River Sioux
Tribe

Hometown: Rapid City, SD



Staff Engagement



Glenn Gookin, MD PhD
Residency Program Director

Julie Garchow, MD
Residency Program Assoc Director

Introducing Resident Physicians at Chapa-De

Chapa-De is excited to have resident physicians at our health center. A resident is someone who has completed college and medical school. They have received their Doctor of Medicine degree (MD or DO). They are now completing direct training in their chosen specialty. The residents at Chapa-De will become family medicine doctors.

Family medicine residents must complete three years of firsthand training. Then they can become licensed board-certified doctors. An experienced doctor supervises residents. This doctor is certified by the American Board of Family Medicine. There are great benefits to receiving care from a resident. Residents have the most up to date medical knowledge. Patients also benefit from the experience of the supervising doctor.

During your visit, a resident will do a detailed exam. They will also ask questions about symptoms and your medical history. The resident will then talk to their supervising doctor. The supervisor will ask questions and offer guidance. Then the resident will decide on a diagnosis and care plan. This process is called precepting. Precepting makes sure patients are getting the best possible care. It also ensures the resident is prepared to work on their own in the future.

Our residents work extremely hard to give you the best care possible. They are proud to be serving Chapa-De patients. We hope you will welcome them as your future doctor.



What is a Resident Physician?

Program Director: Dr. Glenn Gookin, MD, PhD, FAAFP

Associate Program Director: Dr. Julie Garchow, MD

Patient Engagement and Preparation



Frequently Asked Questions – Residency Program

Is a Resident a doctor?

A resident has completed college and medical school. They have received their Doctor of Medicine degree (MD or DO). Now they are completing firsthand training in their chosen specialty. This will allow them to become a board-certified family medicine doctor.

Do Residents give good quality care?

Yes. Patients often like having visits with residents because they see fewer patients per day. This way they can spend more time with each patient. They also just completed medical school and have the most up to date medical knowledge. Residents also work closely with an experienced Supervising Physician. Patients will receive exceptional care.

Will my visit be with the Resident and the Supervising Physician?

Your visit will be with our Resident. They will do a detailed exam and ask questions about symptoms and your medical history. The resident will then talk to their supervising doctor. The supervisor will ask questions and offer guidance. Then the resident will talk with you about a diagnosis and care plan.

Is the Resident my new doctor?

They may be. Some Chapa-De patients in Grass Valley will be assigned to our Residents for their ongoing care. Others may see a Resident if their usual provider is not available.

Who can answer further questions?

- Our Residents
- Glenn Gookin, MD PhD - Residency Program Director
- Julie Garchow, MD - Residency Program Assoc Director



Meet Our Residents



Nick Sparr, MD

Nick Sparr graduated from the University of Iowa Roy J. and Lucille A.

Carver College of Medicine. He has worked as a nursing assistant in an adult inpatient psychiatry unit and spent twelve years working in phlebotomy. He also spent time working as a manager at a lab. He is passionate about community health and helping with local organizations.

Dr. Sparr is from Beaverton, Oregon. His personal interests include downhill skiing in places like Mt. Hood, Crested Butte, and Arapahoe Basin. He also enjoys woodworking and shade tree mechanics.



Kelty White, MD

Kelty White graduated from the University of Nevada, Reno

School of Medicine. Prior to medical school, she earned her bachelor's degree in biology with Magna Cum Laude honors. She has focused on women's health, rural medicine, and "gut" health. She spent ten years working in the service industry before and during medical school. She also worked for two years as a certified nursing assistant.

Dr. White is from Truckee. Her personal hobbies are skiing, mountain biking, climbing, partner acrobatics, construction/trade work, gardening, and spending time with her dogs.

Capital Improvement

- 2 patient rooms per resident physician
- Procedure room
- Precepting space
- Meeting room
- Telehealth facilities
- Lactation room
- Access to food
- ADA accessible

Conclusion

- Embracing graduate medical education can be a viable solution for physician workforce development to serve tribal communities
- Early preparation is key. Have regular meetings with lots of face time.
- Accept that no clinic will be perfect or perfectly capable of satisfying every ACGME requirement from day 1. Plan for the future while focusing on success every day.
- Maintain ongoing communication with clinic management.
- Don't forget the ideal clinic that you set out to be – aim high!

Thank You



Glenn Gookin, MD, PhD, FAAFP
ggookin@chapa-de.org

Learning Environment

- I.D.1.k) Each FMP site must participate in ongoing performance improvement, and demonstrate use of outcome data by assessing the following: clinical quality for preventive care and chronic disease; demographics; health inequities; patient satisfaction; patient safety; continuity with a patient panel; referral and diagnostic utilization rates; and financial performance. (Core)
- I.D.1.k).(1) Each FMP should measure and report this data to the FMP care teams and appropriate preceptors at **least semi-annually**. (Detail)

FMP

- IV.C.1.d) Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Detail)
- IV.C.1.d).(1) This should include integration of multiple non-physician professionals (e.g., behavioral health specialists, certified nurse midwives, clinical nurse specialists, lab technicians, nurse practitioners, pharmacists, physician assistants) to augment education, as well as interprofessional team clinical services. (Detail)

Empanelment

“Empanelment is the act of assigning each patient to a primary care provider who, with support from a care team, assumes responsibility for coordinating comprehensive services for his/her panel of patients.”

~Safety Net Medical Home Initiative. Brownlee B, Van Borkulo N.

Empanelment: Establishing Patient-Provider Relationships

Empanelment

- IV.C.3.c).(5).(b) Each resident's panel of continuity patients must be of sufficient size and diversity to ensure adequate education, as well as patient access and continuity of care. (Core)
- IV.C.3.c).(5).(b).(i) Programs must ensure that each graduate has completed a **minimum of 1,000 hours dedicated to caring for FMP patients.** (Core)

Empanelment

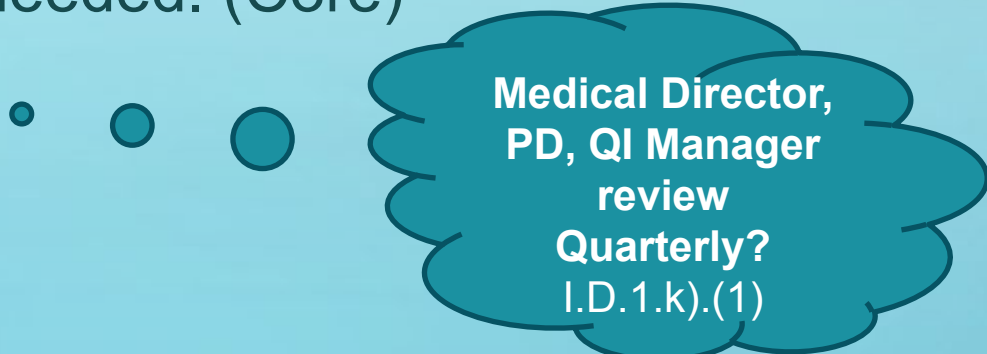
- I.D.1.c).(1) Each FMP must organize patients into **panels that link each patient to an identifiable resident and team.** (Core)
- IV.C.3.c).(5) **Residents must be primarily responsible for a panel of continuity patients,** integrating each patient's care across all settings, including the home, long-term care facilities, the FMP site, specialty care facilities, and inpatient care facilities. (Core)

Empanelment

- IV.C.3.c).(5).(b).(ii) Annual **patient-sided continuity** should be at least **30 percent** at the end of the **PGY-2** and **40 percent** at the end of the **PGY-3**.
(Detail)
- IV.C.3.c).(5).(b).(iii) Annual **resident-sided continuity** should be at least **30 percent** at the end of the **PGY-2** and **40 percent** at the end of the **PGY-3**.
(Detail)

Empanelment

- IV.C.3.c).(5).(b).(iv) Panels must include a minimum of 10 percent pediatric patients (younger than 18 years of age). (Core)
- IV.C.3.c).(5).(b).(v) Panels must include a minimum of 10 percent older adult patients (older than 65 years of age). (Core)
- IV.C.3.c).(5).(b).(vi) Panel size and composition for each resident must be regularly assessed and rebalanced as needed. (Core)



**Medical Director,
PD, QI Manager
review
Quarterly?
I.D.1.k).(1)**

Empanelment

- Have a clear plan when you approach your clinic manager/nursing lead. Address any obstacles to residents being assigned as PCP.
- Determine panel size by PGY.
- Are residents clearly identified for as PCPs in the chart?
- Is it easy for staff/schedulers to tell who the patient is assigned to?
- How are resident teams associated with the panel assignment? How are these identified?
- Who is allowed to change panel assignments?
- Do schedulers have directives for scheduling follow-ups to preserve empanelment? Are resident schedules built out ahead of time?
- Does your EMR contain prebuilt identifiers that can be used to track patient empanelment?

Billing

- GC modifier for Medicare/private carriers (unless primary care exception in which case GE modifier used).
- Bill under preceptor's NPI.
- When billing based on time, only time spent by supervising physician may be included.
- Preceptor must document presence and level of involvement in care, reference resident documentation. Resident should also document preceptor involvement.
- Useful to have method for tracking resident-seen patients to ensure proper coding (many EMRs have this built in).
- No additional billing/coding adjustments for FQHCs.
- Missing attestations and delayed preceptor sign-offs are most prevalent issues when all other requirements are met.

Patient Advisory Council



- I.D.1.h) Each FMP must have members of the community, in addition to clinical leaders, serve on an advisory committee to assess and address health needs of the community.(Core)
- I.D.1.h).(1) The advisory committee should have demographic diversity and lived experiences representative of the community. (Detail)