To: Committee on Energy and Commerce

From: GME Initiative: A coalition of family medicine leaders from Midwestern and Western states

Date: January 16, 2015

Re: Input on graduate medical education reform

We appreciate the invitation from the Committee on Energy and Commerce to submit feedback about the Institute of Medicine recommendations regarding graduate medical education (GME) and to share our thoughts about GME reform. We are a coalition of family medicine educators in Midwestern and Western states. Our coalition strongly supports the recommendations in the Institute of Medicine report "Graduate Medical Education that Meets the Nation's Health Needs," released July 29, 2014. We encourage Congressional action to transform the recommendations into law.

In this response to your request for feedback, we begin with evidence showing why GME reform is necessary and our general thoughts about GME financing, governance, and structure, and how it might be improved or restructured. We then respond to the seven specific questions posed in your open letter of December 6, 2014.

Our principal interest is to strengthen the primary care physician workforce to meet the nation's healthcare needs. Data from many sources show unequivocally that an expanded primary care physician workforce is necessary to achieve the triple aim of improved population health, reduced cost, and better health care. To improve health care outcomes and reduce costs, the primary care workforce must be expanded. Based on research in the U.S. and other countries, the proportion of primary care physicians should be increased to at least 40% of physicians. The current U.S. physician workforce is 33% primary care. Yet, alarmingly, the U.S. GME system currently produces primary care physicians at a rate of less than 25% of the total physician workforce. In other words, if nothing is done to change the GME financing, governance, and structure, the problem of an insufficient primary care physician workforce will only get worse.

A review of recent trends suggests that the percentage of primary care physicians produced by our GME system is likely to get even worse. From 2008 to 2012 the overall number of GME trainees has expanded by 7.5%. In spite of the evidence showing that a strong primary care base for this country can decrease costs while improving quality and outcomes, the expansion has been uneven across specialties. As examples, the growth in neurosurgery was 41%, thoracic surgery 21%, neurology 19%, emergency medicine 17%, plastic surgery 17%, and dermatology 10%. Meanwhile, the rate of primary care-related specialties has been below the average: pediatrics 6%, family medicine 5%, internal medicine 5%. Subspecialty care is vitally important to our nation's health. However, we feel that the composition of the American physician workforce is currently out of balance with an insufficient primary care foundation. The trends cited here indicate that this foundation is likely to continue to weaken.

A significant improvement for reforming Medicare GME is to create options for the routing of GME payments. In many instances it would be helpful to make payments directly to programs and sponsoring organizations where primary care training occurs. Examples include direct funding of Teaching Health Centers, educational consortia, and/or residency programs rather than

teaching hospitals. In the current system, hospitals that receive GME payments determine the type of residencies they sponsor. They have not been held accountable for use of GME payments to directly benefit residency programs or to the workforce needs of the country. A significant portion (21%) of teaching hospitals do not produce any primary care physicians. The current GME system incentivizes the growth of sub-specialty residencies. In recent years, the number of sub-specialty residencies, which produce financial income to offset training costs, has grown significantly while primary care residencies have decreased. Given the current system, it is understandable that hospitals would make business decisions that would provide maximal financial benefit. However, these decisions are based on the needs of the institution, not on the health needs of citizens. On a related topic, in the current system, GME payments are based on a hospital's percentage of Medicare patients. However, the percentage of Medicare patients does not correlate with the cost of running a residency program. Consequently, the system puts at a disadvantage, safety net hospitals, many rural hospitals, and other training sites that care for mostly non-elderly patients. The current GME payment system, including the routing of funds and basing payments on the number of Medicare patients in a hospital, is resulting in a smaller primary care physician workforce at a time when the nation needs to expand primary care.

Another important element of the current system, one that is often over looked in efforts to reform GME, is the inaccurate measurement of primary care. Teaching institutions may inflate their number of primary care trainees by reporting the number of medical school graduates entering a primary care specialty, such as internal medicine. However, the majority of students entering internal medicine go on to sub-specialize. The number of physicians entering primary care should be counted five years after graduating from medical school, not at the time of entering residency. The resulting data will accurately reflect whether residencies are truly producing primary care physicians, as opposed to starting in an internal medicine or pediatrics residency and then eventually sub-specializing.

As representatives of family medicine training programs in the Midwestern and Western states and advocates for family medicine education, we have been acutely aware of the geographical disparities in the amount of GME paid per resident. For example, in recent years, the "per resident amount" paid in many Northeastern states is double the amount paid per resident in most Mid-Western and Western states. The regional differences in GME payments are disproportionate and do not reflect the true cost of training. This unjust payment system is corrected in the IOM recommendations that base GME payments on a national per-resident amount that will include necessary geographic adjustments.

The recommendations put forth in the IOM report successfully address these essential elements for GME reform. Other notable strengths of the IOM recommendations are budget neutrality, creation of a GME Policy Council that will oversee the sufficiency, geographic distribution, and specialty configuration of the physician workforce, and greater accountability and transparency to assure appropriate stewardship of public funds. Additionally, the creation of an innovation fund will allow us to experiment with new training models that will help achieve better community health outcomes at lower costs.

In the next section, we respond to specific questions posed by the Committee.

1. What changes to the GME financing system might be leveraged to improve its efficiency, effectiveness, and stability?

We identify seven changes to improve the GME financing system:

- Options should be created for GME payments to be made directly to the institutions and organizations where training occurs.
  - The current system discourages training at clinics or community-based settings; nearly all GME training occurs in hospitals – including primary care residencies – even though non-hospital settings are where most primary care physicians will spend their careers and where most people seek health care services.
  - The location of GME training is predictive of practice location; we need to support training programs in community-based and rural settings.
- Require accountability in GME financing.
  - GME financing should be tied to meeting the workforce needs of the local population.
  - Currently, CMS allocates GME payments independent of workforce needs.
- Increase the transparency of GME financing.
  - The GME payment system should be much less complex and opaque.
  - Base payments on a per-resident-amount paid to training institutions.
  - Discontinue DME and IME formulas.
  - Reports should help the public understand if GME funding is meeting population healthcare needs.
- Establish a GME Policy Council.
  - The Council can identify physician workforce needs and use that data to inform GME funding; a direct link is needed between GME policy and GME financing.
  - Identify performance measures to monitor program outcomes.
  - Develop strategic policy.
- Correct regional inequities in GME payments.
  - The funding of training positions should be based on a national per-resident amount that reflects realistic program costs.
  - Currently, GME payments are disproportionality higher in specific geographic regions and urban areas.
- Prioritize the medical specialties in greatest need.
  - Fund training positions based on priority disciplines, specifically primary care.
- Fund the proposed "Transformation Fund" described in the IOM report.
  - The structure, organization, and functions of clinical practice have evolved significantly over the past fifty years to accommodate new knowledge and apply new technology. The GME financing scheme established in the 1960's has not kept pace with these changes.
  - The Transformation Fund could significantly hasten the ability of the GME community to adopt currently recognized improvements. An improved workforce composition could be incentivized, along with improved training in team-based care, integration with communities, improved integration between physical health and mental health, and closer ties with public health.
  - The Transformation Fund will allow for improvements in existing programs and provide a structure for subsequent generations to continue the evolution of medical training.

2. There have been many proposals put forward to reform the funding of the GME system in the United States. Are there any proposals or provisions of proposals you support and why?

   We support two recent proposals to reform the GME system. We believe the recommendations in the IOM report address many problems inherent in the current GME system. We also

support proposals to sustain and expand the Teaching Health Center model for training the physician workforce.

Reasons we support the Institute of Medicine recommendations:

- Transparency: Replaces complex payment formulas (IME and DME) with a simpler, more transparent structure (per resident amount).
- Accountability: Creates a link between GME financing and the production of workforce outcomes that meet the nation's healthcare needs.
- GME Policy Council: Establishes one body to develop strategic plan, identify physician workforce priorities, and identify measures to assess outcomes.
- Transformational Fund: Enables the creation of new programs and innovation to better accomplish workforce training into the future.
- Transition period: Allows for a 10-year transition period to make reforms in the GME system; this is necessary to assure that the transition is done in a gradual and intentional manner.
- Prioritizes nation's health care needs.

Reasons we support Teaching Health Center (THC) proposals:

- Training in community-based settings: Most patients receive care in non-hospital settings – this is where we should be training our primary care workforce.
- Physicians practice near their training site: The majority of physicians practice within 100 miles of their residency program; de-centralizing training outside of hospitals will disperse the physician workforce to the areas of greatest need.
- Accountability: The THC proposals require training programs to meet population health priorities, such as producing residents trained in shortage specialties and training physicians in interprofessional and multidisciplinary care teams.
- Transparency: THC proposals also require transparency of expenses and outcomes, such as annual reports showing Medicare GME payments to each sponsoring organization, Medicare GME costs, the number of residents, and their specialties.

3. Should federal funding for GME programs ensure training opportunities are available in both rural and urban areas? If so, what sorts of reforms are needed?

Yes, we strongly support GME reform to ensure the availability of training opportunities in rural areas.

The need for a primary care physician workforce in rural areas is well established:

- About 19% of US population lives in rural areas; only 11% of physicians practice in these areas.
- Less than 3% of medical students expect to practice in rural areas.
- The location of GME training is predictive of future practice location; to place physicians in rural areas, we need training programs in rural areas.

Historically, there has been a clear Congressional intent for there to be expansion of training in both primary care and rural areas. The Balanced Budget Act of 1997 placed a cap on new residency positions supported by Medicare, but the 1999 Balanced Budget Refinement Act allowed for new Rural Training Tracks (RTTs) to be an exception to this cap. In 2003 the Medicare Prescription Drug, Improvement and Modernization Act authorized the redistribution of GME positions with the intent of increasing primary care and rural training. However, attempts to carry out these Congressional intentions have been confounded by the CMS rules that govern GME.

In many Western and Midwestern states, we have encountered numerous obstacles to obtaining Medicare GME funding for new or expanded residency programs in rural areas. Despite a clear need for rural training programs, the interest of rural communities in hosting programs, and motivated local rural physicians who are prepared to teach, several regulations in the current GME payment system reduce the funding or completely prevent funding for rural residency training.

- Examples of Medicare GME payment regulations that reduce or prevent funding for rural GME programs:
    - Reduced GME funding due to low Medicare bed-day ratio: Part of the GME payment is determined by the amount of inpatient Medicare provided by a teaching hospital. Maternity care is an important service that most rural hospitals provide for their community. Moms and newborns seldom qualify for Medicare, so rural hospitals end up with a much lower Medicare bed day ratio than large teaching hospitals. This reduces the GME payment to rural teaching hospitals.
    - No Per Resident Amount (PRA) payment due to prior resident training: If resident physicians have completed rotations at a rural hospital in the past (for example, a family medicine resident gaining rural experience) and the hospital did not pay their salary, benefits and other expenses, and if this expense was not included in the rural hospital's cost report at that time, the PRA is set at zero for all residents at that rural hospital in the future. These rural hospitals were being good citizens and not aware of this little known rule. This CMS rule permanently decreases or eliminates GME payments for any physician trainees in rural hospitals that have had trainees in the past.
    - Sole Community Hospitals are not eligible for Indirect Medical Education payment: Many rural hospitals are designated as Sole Community Hospitals. Most of these hospitals are paid through a different mechanism than the Diagnostic Related Group (DRG) system and therefore are not eligible to receive the IME (Indirect Medical Education) portion of the GME payment, as this is an increase to the DRG payment.
    - Cap on new training positions due to existing or previous rural training track: If an urban residency program currently operates a successful rural training track or has in the past (even if closed long ago), they cannot receive GME payments for opening a second rural training track. A second rural training track is considered a "residency expansion" by CMS and, therefore, is not eligible for Medicare GME funds.
- Policies such as these, and others, are extremely frustrating to states and programs interested in developing new rural primary care training programs. These policies underscore the need to reform the GME system if we want to expand primary care GME to rural and undeserved locations.

Reforms that are needed to ensure training opportunities are available in rural areas:

- Allow Medicare GME payments directly to organizations that sponsor training and where patients go for care (teaching health centers, rural clinics, rural residencies, etc.).
- Fund proposals to maintain and expand THC programs.
- Remove or modify CMS regulations that obstruct the development or expansion of rural residency programs.

4. Is the current finance structure for GME appropriate to meet current and future healthcare workforce needs?

   No, the current GME system does not meet current and future healthcare workforce needs.

5. Should it account for direct and indirect costs as separate payments?

   No, DME and IME as separate payments should be discontinued.

   a. If not, how should it be restructured? Should a per-resident amount be used that follows the resident and not the institution?

      The per-resident amount should not follow the resident, but should be paid to the program or sponsoring organization. Sponsoring organizations require stable, predictable funding to maintain the infrastructure for a residency program, such as hiring faculty and administrative staff. If the per-resident amount follows residents, it will de-stabilize the programs. We agree with the IOM report recommendation that the PRA should be made in one payment to organizations sponsoring GME programs and that the PRA payment should be based on a national per-resident amount.

   b. Does the financing structure impact the availability of specialty and primary care designations currently? Should it moving forward?

      Yes, the current GME financing structure impacts the availability of specialty and primary care designations. The structure allows teaching institutions to start and/or expand sub-specialty programs because they are financially viable whereas primary care programs are at a disadvantage and are not expanding because the market does not provide sufficient patient care revenue to offset their costs. Residencies offered by hospitals have become more specialized at the expense of primary care. Between 2002 and 2007, hospitals opened 7,754 more new training positions, 88.3% of which were in specialty care despite the GME cap. The current GME financing structure is preventing the nation from educating a primary care workforce that will meet the triple aim.

6. Does the current system incentivize high-quality training programs? If not, what programs should Congress consider to improve program training, accountability, and quality?

   In broad terms, the financing of GME has been the responsibility of CMS while the assurance of the quality of training has been the responsibility of the private sector, specifically the Accreditation Council on Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). Both of these organizations have been very responsive to recent calls for increased accountability for the quality of physician training. Both the ACGME and the ABMS have been hard at work since 2000 when they defined and agreed upon the six general competencies that all physicians need to attain during their training. The ACGME continues to advance their work on quality training through the milestones project and the ABMS promotes lifelong learning for physicians through ongoing expansion of their Maintenance of Certification programs.

   While the efforts of the ACGME, ABMS and other medical and hospital organizations to ensure a high quality physician workforce are laudable, it is beyond the purview of these organizations to be accountable for the overall specialty composition and geographic distribution of the physician workforce. There is significant opportunity in reforming the GME system for the federal government to incentivize quality and accountability specifically geared towards the health care needs of the American public.

   With regard to this question, we identify two major deficiencies in the current system. First, the CMS GME system lacks a standard definition of quality other than ACGME accreditation. Second, the system lacks accountability. The current Medicare GME funding is formula-driven

without accountability for national health care needs or priorities. Moreover, the current system offers little, if any, incentives to improve the quality or efficiency of physician training. These deficits point out the need to define the standards of quality and to require transparency of outcomes for each program.

The GME system should reward performance by establishing performance-based payment methods. It should phase out the linkage between hospital Medicare patient volume and GME payment.

Examples of quality measures and standards of accountability for GME programs:

- Percent of residents training in shortage specialties
- Placement of graduates that match local population health priorities
- Evidence of training in interprofessional and multidisciplinary care teams
- Periodic reports on Medicare GME payments, including
  - Payments to each hospital
  - GME costs of each hospital
  - Number of FTE residents
  - Specialties of residencies

Establishment of a GME Advisory Council, with the proposed Transformation Fund, is vital to establish standards of quality and accountability. A central body is needed to identify national physician workforce goals, establish outcomes for GME programs that match the workforce needs, and monitor the performance of each teaching institutions with the ability to incentivize progress.

7. Is the current system of residency slots appropriately meeting the nation's healthcare needs? If not, please describe any problems and potential solutions necessary to address these problems.

   We are more concerned about the specialty composition and geographic distribution of training slots than about the total number of slots. As reflected in the IOM report, research findings are not clear regarding the total number of training positions needed now and in the coming years. It is difficult to distinguish the training interests of special groups from the appropriate healthcare workforce to meet the needs of the U.S. population.

   However, it is clear that the proportion of primary care vs. sub-specialty physicians is not meeting the needs of the country. A comparison with other developed countries shows that the U.S. has a significantly lower primary care physician base, poorer health outcomes, and higher healthcare costs. Ample research shows that the presence of primary care physicians accomplishes the triple aim of healthier communities, a better health care experience, and lower costs.

   Potential solutions to increase the production of the primary care workforce:

   - Base the number of training slots on healthcare needs of the population, not the financial interests of the teaching hospital.
   - Require accountability of teaching institutions: require data to determine whether the GME productivity meets the health care needs of the local and national population.
   - Make GME payments directly to the institutions and organizations where training occurs and where most people receive their health care, including community-based and rural settings.

8. Is there a role for states to play in defining our nation's healthcare workforce?

Yes, states can play an important role in the GME system. States can better identify the specific health care needs of local populations and target the types of providers needed to address those needs. For example, states with a higher rural population may have need for a larger, diverse rural workforce. A GME Advisory Council will need to work closely with states to identify training needs.

However, we do not endorse a system in which it left entirely to the states to address their workforce needs on their own. The mechanism of support for GME varies from state to state, but it usually is routed through the state's Medicaid system. In times of economic downturn states must often cut their Medicaid budgets. Training programs that rely on Medicaid funding are therefore at greater jeopardy of instability than those with relatively secure CMS funding. It would strike us as inherently unfair if a system developed in which the federal GME system, through the guarantees of CMS, underwrite the current sub-specialty dominated GME system, while states are left to address the primary care deficits and geographic mal-distributions on their own.

In closing, the current Medicare GME financing system does not encourage the production of the physician workforce that the nation needs. Under current statute, Medicare provides funding to teaching hospitals regardless of local, regional, or national workforce needs or the social accountability of the training programs. The IOM recommendations, if transformed into law, will result in a GME system that is responsive to national health needs, based on targeted outcomes, and founded on a strong primary care physician workforce.

Our interests and perspectives are grounded in the health care needs of the nation's citizens. We advocate for a GME system to produce the physician workforce that will result in a healthier population, a better healthcare experience, at a lower cost. We need to increase the primary care physician workforce in order to balance the ratio of primary care and specialty physicians. We urge you to keep your eye on the target of healthier populations. We speak based on evidence and a desire for healthier citizens. If nothing changes with the GME system, the problem of an insufficient primary care physician workforce will only get worse.

This letter is endorsed by the professional organizations listed below. Our recommendations do not necessarily conform to policies of all the organizations with which individual members are associated.

GME Initiative

The GME Initiative is a coalition of family medicine educators, practitioners, and leaders in Western and Midwestern states that support GME reform.

Chris Baumert, M.D., Montana Family Medicine Residency Program
Daniel Burke, M.D., University of Colorado
Byron Crouse, M.D., University of Wisconsin
Ardis Davis, M.S.W., University of Washington
Ted Epperly, M.D., Idaho Family Medicine Residency Programs
Larry Green, M.D., University of Colorado
Sarah Hemeida, M.D., University of Colorado
Cheryl Lovell, Ph.D., Rocky Vista University, Colorado
Gina Martin, M.D., Family Physician, Delta, Colorado
Kim Marvel, Ph.D., Colorado Commission on Family Medicine

Tom Norris, M.D., University of Washington
Robert Phillips, M.D., M.S.P.H., American Board of Family Medicine
Frank Reed, M.D., Montana Family Medicine Program
Larry Severidt, M.D., Broadlawns Family Medicine Residency, Des Moines, Iowa
Tim Size, Wisconsin Rural Health Cooperative
Tom Told, D.O., Rocky Vista University College of Osteopathic Medicine, Colorado
Michael Tuggy, M.D., Swedish Family Med. Residency Program, Seattle, Washington
Ned Vasquez, M.D., Montana Family Medicine Residency Program
Kent Voorhees, M.D., University of Colorado

Colorado Commission on Family Medicine (COFM)
Founded in 1977 by state statute, the Commission supports the education of family physicians in order to improve access to health care, especially in rural and underserved areas of Colorado. The Commission is composed of 19 members that include governor-appointed citizens from the state's congressional districts, the directors of the state's nine family medicine residency programs, the deans of the medical and osteopathic schools, and a representative from the Colorado Academy of Family Physicians.

Kim Marvel, PhD

Kim Marvel, PhD, Executive Director

John Gardner, citizen representative, state congressional district 4
Chandra Hartman, M.D., Director, Rose Family Medicine Residency Program
Jim Helgoth, citizen representative, state congressional district 2
Freddie Jaquez, citizen representative, state congressional district 3
Richard Krugman, M.D., Dean, University of Colorado School of Medicine
Donna Marshall, citizen representative, state congressional district 7
Linda Montgomery, M.D., Director, Univ. of Colo. Family Medicine Residency Program
Blaine Olsen, M.D., Director, St. Joseph Family Medicine Residency Program
Doris Ralston, citizen representative, state congressional district 5
David Smith, M.D., Director North Colorado Family Medicine Residency Program
Thomas Staff, M.D., Asso. Dir., Denver Health Family Medicine Residency Program
Lynn Strange, M.D., Director, Southern Colorado Family Medicine Residency Program
Sherman Straw, M.D., Director, St. Mary Family Medicine Residency Program
Tom Told, D.O., Dean, Rocky Vista University College of Osteopathic Medicine
Sharry Veres, M.D., Director, St. Anthony Family Medicine Residency Program
Kent Voorhees, M.D., Vice-Chair Education, CU Department of Family Medicine
Brian Watson, citizen representative, state congressional district 6
Bradford Winslow, M.D., Director, Swedish Family Medicine Residency Program
Janell Wozniak, M.D., Director, Fort Collins Family Medicine Residency Program

Colorado Association of Family Medicine Residencies (CAFMR)

The Association is composed of the directors of the state's nine family medicine residency programs who collaborate to assure the best possible training within the state's residency programs.

Janell Wozniak, MD, Chair

Chandra Hartman, M.D., Director, Rose Family Medicine Residency Program
Linda Montgomery, M.D., Director, Univ. of Colo. Family Med. Residency Program
Blaine Olsen, M.D., Director, St. Joseph Family Medicine Residency Program
David Smith, M.D., Director North Colorado Family Medicine Residency Program
Thomas Staff, M.D., Asso. Dir., Denver Health Family Medicine Residency Program
Lynn Strange, M.D., Director, Southern Colo. Family Medicine Residency Program
Sherman Straw, M.D., Director, St. Mary Family Medicine Residency Program
Sharry Veres, M.D., Director, St. Anthony Family Medicine Residency Program
Kent Voorhees, M.D., Colorado Academy of Family Physicians
Bradford Winslow, M.D., Director, Swedish Family Medicine Residency Program

Colorado Institute of Family Medicine (CIFM)

The Institute is composed of community and business leaders as well as family medicine educators who obtain external funding and develop initiatives to strengthen family medicine residency training in Colorado.

Dan Burke, MD, Chair

Austin Bailey, M.D. Frank DeGruy, M.D.
Kevin Hougen Jean Jones
David Smith, M.D. Tom Told, D.O
William Wright, M.D.

Mesa County (Colorado) Medical Society

Frederic Walker, IV, MD, President

Montana Academy of Family Physicians (MAFP)
As the representative of family medicine and family physicians in Montana, the Montana Academy of Family Physicians promotes family medicine, provides education for family physicians, and is the guiding force for quality primary care in Montana.

Janice Gomersall, M.D., President

Legislative Committee members:

Chris Baumert, M.D.	John B. Miller, M.D.
Heidi Duncan, M.D.	Dennis Salisbury, M.D.
Jonathan Griffin, M.D.	Larry Severa, M.D.
Robert Stenger, M.D.	John Williams, M.D.

Montana GME Council
The Montana Graduate Medical Education Council was created in 2011 to increase the physician workforce in Montana by developing an infrastructure to support Residency Graduate Medical Education (GME).

Jay Erickson, MD, Chairman

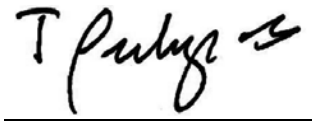
Roger Bush, MD
Joyce Dombrouski
Kristin Juliar
Barry Kenfield
Bob Marsalli
Ned Vasquez, MD
Pat Wilson

Montana Chapter—American College of Physicians
Jay Larson, MD, Governor
Pamela Hiebert, MD, Governor-Elect

FAMILY MEDICINE RESIDENCY NETWORK
UNIVERSITY of WASHINGTON

WWAMI Network (Washington, Wyoming, Alaska, Montana, Idaho)

The University of Washington Family Medicine Residency Network (WWAMI Network) is a group of family medicine residency programs related to each other by geography and university affiliation. The WWAMI Network is one of the largest residency networks in the United States, and now comprises over 20 residency programs in Washington, Alaska, Montana, Idaho and Wyoming. The Network exists to promote excellence in family medicine residency education, to provide academic leadership, and to respond to societal needs for family physicians.



Tony Pedroza, MD, President

WWAMI Legislative Committee Members

Chris Baumert, M.D., Montana Family Medicine Residency
Amy Carrasco, M.D., Kadlec Family Medicine Residency
Freddy Chen, M.D., Univ. Washington W Family Medicine Residency Network
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Harold Johnston, M.D., Alaska Family Medicine Residency
Barry Kenfield, M.D., Family Medicine Residency of Western Montana
Russell Maier, M.D., Central Washington Family Medicine
Judy Pauwels, M.D., Univ. Washington Family Medicine Residency Network
Beth Robitaille, M.D., University of Wyoming Family Medicine Residency, Casper
David Schmitz, M.D., Family Medicine Residency of Idaho Rural Training Tracks
Barbara Schneeman, M.D., Montana Family Medicine Residency
Nancy Stevens, M.D., Univ. Washington Family Medicine Residency Network
Michael Tuggy, M.D., Swedish Family Medicine, First Hill, Seattle
Ned Vasquez, M.D., Family Medicine Residency of Western Montana

WWAMI Executive Committee Members

David Ruiz, MD, Director, Family Medicine of Southwest WA
Kerry Watrin, MD, Director, Tacoma Family Medicine

NORTHWEST REGIONAL PRIMARY CARE ASSOCIATION
Alaska · Oregon · Idaho · Washington

Northwest Regional Primary Care Association (NWRPCA)

Northwest Regional Primary Care Association (NWRPCA) is a not-for-profit 501 (c) 3 member association of community and migrant health centers, working to ensure equal access to primary and preventive health care and to develop healthy communities in the Northwest. Funded in part by the Health Resources and Services Administration/HHS, NWRPCA leverages regional power and resources to strengthen health centers in Alaska, Idaho, Oregon and Washington.

Bruce Gray, Executive Director

NWRPCA has over 80 Federally Qualified Health Center members from the four states of the northwest.

Rural Wisconsin Health Cooperative (RWHC)
RWHC is a member-owned network of 39 rural community hospitals (both CAHs and PPS) with a vision that Wisconsin communities will be the healthiest in America. Founded in 1979, RWHC is one of the earliest and considered one of the most successful models for collaboration among health providers in the country, providing a wide range of programs and services to members and non-members alike.

Tim Size, Executive Director

Network hospitals:

Antigo, Langlade Memorial Hospital
Ashland, Memorial Medical Center
Baldwin, Baldwin Area Medical Center
Baraboo, St. Clare Hospital & Health Services
Berlin, Community Health Network
Black River Falls, Black River Memorial Hospital
Boscobel, Gundersen Boscobel Area Hospital and Clinics
Chippewa Falls, St Joseph's Hospital
Columbus, Columbus Community Hospital
Cumberland, Cumberland Healthcare
Darlington, Memorial Hospital of Lafayette County
Dodgeville, Upland Hills Health Inc.
Edgerton, Edgerton Hospital & Health Services
Fort Atkinson, Fort HealthCare
Friendship, Moundview Memorial Hospital and Clinics
Hillsboro, Gundersen St. Joseph's Hospital & Clinics
Ladysmith, Rusk County Memorial Hospital
Lancaster, Grant Regional Health Center
Mauston, Mile Bluff Medical Center
Medford, Aspirus Medford Hospital & Clinics
Monroe, Monroe Clinic
Neillsville, Memorial Medical Center
Oconto, Bellin Health Hospital
Oconto Falls, HSHS St. Clare Memorial Hospital
Platteville, Southwest Health Center

Portage, Divine Savior Healthcare
Prairie du Chien, Crossing Rivers Health
Prairie du Sac, Sauk Prairie Healthcare
Reedsburg, Reedsburg Area Medical Center
Richland Center, The Richland Hospital
Shawano, Shawano Medical Center
Sparta, Franciscan Healthcare in Sparta
Spooner, Spooner Health System
St. Croix Falls, St. Croix Regional Medical Center
Stoughton, Stoughton Hospital
Sturgeon Bay, Ministry Door County Medical Center
Tomah, Tomah Memorial Hospital
Viroqua, Vernon Memorial Healthcare
Whitehall, Gundersen Tri-County Hospital & Clinics

Wisconsin Collaborative for Rural Graduate Medical Education (WCRGME)
Established in 2012, the Wisconsin Collaborative for Rural Graduate Medical Education (WCRGME) is an expanding group of over twenty-five healthcare and academic organizations whose mission is to address the rural shortage of primary care physicians through the expansion of rural graduate medical education.

Kara Traxler, Director