The Residency Program of the Future: How Healthcare Reform is Impacting Medical Training and Graduate Medical Education

Speakers:
Maurice Lemon, MD, Principal, HMA
Margaret Kirkegaard, MD, Principal, HMA
Jeffrey Ring, PhD, Principal, HMA

Moderator:
Annie Melia, HMA Information Services

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Agenda

• Graduate Medical Education and US healthcare
• Health care reform and GME
• Academic health centers (AHC) and GME program responses
• Impact on hospitals – spotlight on the Clinical Learning Environment Review (CLER) program
• Critical issues and actions for key healthcare stakeholders
GME Scope

• GME enterprise:
  – Over 110,000 residents and fellows
  – About 9000 training programs/150 specialties
• 679 Institutions sponsor GME but most residents trained in larger academic medical centers
• Safety net institutions provide a disproportionate amount of GME training
• About ⅓ of practicing physicians in primary care
• About ¼ of residents in primary care training*

*There are varying definitions of which specialties are included in the “primary care” category
GME funding

- **Funding: Federal**
  - Medicare - $9.5 billion yearly
    - $3 billion Direct (DME)
    - $6.5 billion Indirect (IME)
  - Medicaid - $2 billion yearly

  Total cost to the feds = ~$100,000 per resident per year

- **States: Medicaid** $3.78 billion yearly
  - 40 states, varying contributions and expectations

- **Other agencies:** Dept of Defense, Veterans Affairs, National Institute of Health
Key Drivers of Change for the GME Enterprise

• Increased focus on accountability for outcomes from GME funding for specialty choices, practice location and physician competencies
• Movement towards Value-Based Purchasing
• Heightened emphasis on outcomes, especially for safety and quality
• Expansion of Medicaid and transition to Medicaid managed care *
Medicaid 2015: 75 M Enrollees, 75% in Managed Care

Figure 6

Many states are expanding their Medicaid managed care programs.

Number of states with recent or planned managed care expansion activity:

- New Geographic Areas: 8 (FY 2014), 6 (FY 2015)
- New Eligibility Groups: 25 (FY 2014), 19 (FY 2015)
- New Mandatory Enrollment: 6 (FY 2014), 9 (FY 2015)
- Any Managed Care Expansions: 26 (FY 2014), 23 (FY 2015)

SOURCE: KFF Medicaid Managed Care Market Tracker
Other Forces Pressuring GME

- Service vs education dilemma
- The patient empowerment and safety movement – e.g. resident work hours
- Increasing numbers of medical students but flat GME residency position numbers
- Increased focus on provider productivity by payers and medical centers
Provisions in the Affordable Care Act Involving GME

- Physicians trained in primary care
- Non-physician support (e.g. APNs)
- Geographic distribution of physicians
- Workforce planning development
- Physician productivity (through care coordination, medical home and ACOs)
- Medicaid/safety net institution funding
Figure 1 Relationship between percentage of graduates in primary care and number of residents trained in U.S. graduate medical education sponsoring institutions. Data are limited to sponsoring institutions with more than three graduates during 2006–2008. Institutions in Puerto Rico are not included.
Figure 2 Relationship between percentage of graduates practicing in rural areas and number of specialties trained at U.S. graduate medical education sponsoring institutions. Data are limited to sponsoring institutions with more than three graduates during 2006–2008. Institutions in Puerto Rico are not included.
Institute of Medicine Report

• “Graduate Medical Education that Meets the Nation’s Health Needs” – July 2014
• Increase federal oversight of GME policy, reduce Academic Health Center control
• Redirect some funds to support GME performance measures
• Association of American Medical Colleges, American Medical Association and American Hospital Association respond thumbs down
• Debate about physician shortage
“Help! I can’t swim! No immediate danger, but it does worry me.”
Key Challenges Ahead

- Are AHCs “accountable” to address US provider workforce needs?
- How to address imbalances in distribution and types of physicians?
- More physicians vs. physician-substitutes?
- Safety net GME training sites under financial pressure?
- GME and changes in the healthcare setting: 
  - medical homes, team-based care, tech changes, consumer empowerment, the patient safety movement, value-based purchasing?
GME Responses to Change Drivers

• Teaching Health Center
• Delivery System Reform Incentive Program
  Medicaid Waivers
• Patient-Centered Medical Home
  – Delivery system
  – Curriculum framework
The Teaching Health Center

• The Teaching Center (THCGME) was the only provision of ACA specifically directed to GME. Allocated $230 M over 5 years.
• Provides funding outside of the traditional Medicare GME funding streams directly to community-based health centers.
• Additional funding allocated through Medicare Access and CHIP Reauthorization Act of 2015.
• Currently 60 THCGME programs in 24 states are training over 550 residents in primary care, psychiatry and dentistry.
• Survey of 91 recent THC graduates found that 76% were working in underserved areas, compared to only 26% of their peers which is consistent with other studies of training programs in underserved environments.
Delivery System Reform Incentive Program (DSRIP)

- New type of Medicaid supplemental payment approved under Section 1115 waiver authority.
- Support provider-led efforts to change the delivery of care, improve quality of care, and promote population health.
- In FY 2015, a total of $3.6 billion in federal funds is available to implement DSRIP programs in 6 states: CA, TX, MA, NJ, KS, and NY.
- Projects include expanding primary care clinics, building information technology capacity, co-locating behavioral and primary health care providers, and creating patient navigator programs.
DSRIP in TX

• At least 4 providers have applied for DSRIP funding to support expanded GME training, generally in conjunction with additional community focused services.

• University of TX Health Science Center in San Antonio applied for three waivers:
  – Hire two nurse care managers and three MAs for population health
  – Expand FM residency from 13 to 15 trainees annually
  – Recruit 13 CHWs
DSRIP in NY

• The 2013-2014 Hospital Medical Home Program provided awards to 60 hospitals and 118 affiliated residency programs (training more than 5000 residents) to transform outpatient sites into PCMHs and provide high-quality, coordinated care.

• A total of 156 participating outpatient sites (100%) received PCMH recognition. All sites enhanced resident education using PCMH principles through patient empanelment, development of quality dashboards, and transforming resident scheduling and training.
Leveraging State Medicaid Funds

- New Mexico used 1115 waiver to create the New Mexico Primary Care Training Consortium
- Provides increased Medicaid funding per pt visit for FQHCs that expand scope of services to create or expand primary care residency programs
- Anticipated to create 10 new residency slots at 4 locations starting in 2016
Patient-Centered Medical Home and GME

- Many primary care residency programs have achieved PCMH recognition
- GME programs are using PCMH as a teaching framework for developing population health management skills
- Statewide collaboratives to promote PCMH in training programs
  - PA
  - CO
PCMH and GME Challenges

Faculty survey of pediatric residencies assessing barriers to PCMH development:

• Resident schedules (80%)
• Faculty time (69%)
• Lack of expertise (53%)
• Financial support (47%)
Colorado PCMH GME Collaborative

Collaborative effort:
• University of Colorado Department of Family Medicine
• HealthTeamWorks
• Colorado Association of Family Medicine Residencies

Setting:
• All 9 family medicine residency programs in Colorado and 1 Internal Medicine residency program

Outcomes:
• All residency programs have received NCQA PCC-PCMH Level III Recognition
• Developed PCMH e-Learning Modules that have been licensed to the American Board of Family Medicine (http://pcmhelearning.com/)
• All practices have functioning quality improvement teams
Challenges for AHCs in Value-based Payment

• AHCs typically have higher acuity patients with rare disorders
• AHCs more likely to be located in urban environments with significant social determinants of health
• Teaching and research mission make care more costly
• MCOs seeking higher value may exclude AHCs from narrow networks
• AHCs often refer patients back to community care for post acute care making episodic payments difficult to operationalize
Potential Solutions for AHCs

• Disconnect funding for teaching and research from patient care
• Focus medical education and research on providing value; expand translational research
• Leverage specialized skills at AHCs.
• Compensate AHCs for e-referrals, telemedicine, and telephone consultations so that AHCs can support the medical neighborhood
CLER Criteria from the ACGME (2014)

Clinical Learning Environment Review

“Expectations for an optimal clinical learning environment to achieve safe and high quality patient care”

Built on a foundation of continuous quality improvement through feedback
Six CLER Foci

- Patient Safety
- Health Care Quality (including reductions in health disparities)
- Care Transitions
- Supervision
- Duty hours/Fatigue Management and Mitigation
- Professionalism
Health Care Quality

- Faculty proficiency and resident training in quality improvement
- Quality activities and data metrics provided to guide practice
- Resident & faculty education in reducing disparities
- Resident disparity reduction projects
Care Transitions

- Policies and Procedures
- Inter-professional Training
- Resident Communication
- Faculty Assessments
Professionalism

• Policies and Procedures
• Communication
• Role Models
• Monitoring
• Reporting
Future Directions for GME

What GME-related actions should health system stakeholders consider?
Stakeholder Response Options

- **AHCs**
  - Need to rebalance primary care and specialty care training programs
  - Develop infrastructure to successfully work with Medicaid managed care

- **Safety-net providers**
  - Partner with AHCs in new ways (e.g. e-referrals)
  - Participate in expanded primary care training programs

- **MMCOs**
  - Recognize unique value of AHCs in networks
  - Develop innovative contracting strategies to foster new roles for AHCs
Stakeholder Response Options

• States
  – Consider using 1115 and DSRIP Medicaid provisions to address workforce issues
  – Use oversight functions to ensure appropriate inclusion of AHCs in MMCO networks

• Public
  – Support GME accountability as tax dollars well spent
  – Select MCOs with AHC partners for consumers with special medical needs
  – Advocate for separation of research and medical education funding from healthcare services payments
Oh, crap! Was that TODAY?
Q & A

Maurice Lemon, MD, Principal, HMA
mlemon@healthmanagement.com

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mkirkegaard@healthmanagement.com

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jring@healthmanagement.com

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