New Program Development in the Pacific Northwest: Opportunities and Challenges

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Conversations

- Current status of region
- Opportunities
- Barriers
- Mechanisms
- Legislative initiatives
Current status of region

■ Why care about regional GME?
  – Physician retirement
  – Physician retention, especially in rural areas
  – Medical school development and expansions that need GME positions
  – Projected workforce needs to meet patient care demands

■ Greater retention of graduates in local region with GME; greatest with both UME and GME
Current and emerging family medicine programs and RTTs in Washington
Current and emerging family medicine programs and RTTs in other WWAMI states
Regional Family Medicine Programs

- **Core Programs** (independently accredited)
  - *Existing:* 20 (1 AK, 3 ID, 2 MT, 12 WA, 2 WY)
  - *New since 2014:* 4 (WA)
  - *Developing:* 3 (1 ID, 2 WA)

- **AOA Programs converting to ACGME accreditation** (independently accredited): 5 (WA)

- **Rural Training Tracks** (linked to a Core Program)
  - *Existing:* 4 (2 ID, 2 WA)
  - *New since 2014:* 3 (WA)
  - *Developing:* 5 (1 ID, 3 WA, 1 WY)
Opportunities in GME

- Creating the workforce of the future
  - Underpinning the health system essential to serving our populations
  - Providing for rural and underserved populations
  - Enhancing diversity
Opportunities in GME

- Developing the leaders of the future
- Enhancing the quality and safety of patient care
Opportunities in GME

- Delivering on the “quadruple aim”:
  - Enhancing the patient experience
  - Improving population health
  - Reducing the costs of medical care
  - Improving physician satisfaction: addressing burnout and wellness
Program Mission: the “ROI”

- New providers for community
- Meeting regional workforce needs
- Meeting local service needs: community access
- Recruitment/retention of other local physicians
Challenges in GME

- Finances: the “return on investment”
- Competition for teaching resources: “learners per square inch”
- Resources needed to assure quality training
- Faculty recruitment and retention
- The ability to recruit quality resident applicants
Challenges: Finances

- The “return on investment”: value/cost
- Cost: expenses in excess of revenues
- Definitions of “cost” in discussing GME finance
- “The Number”
FINANCES: program stages

■ Start-up: before residents are present
  - No federal funding
  - No patient care revenues

■ First two years of having residents (immature program)
  - More expensive because of fixed overhead and limited patient care revenues

■ Mature program
FINANCES: Expenses

- **COMPENSATION: SALARIES/BENEFITS**
  - Faculty
  - "Core" and “the village”
  - Residents
  - Program operations staff
  - Clinical staff, additional needs

- **Space/operations**
- Fixed and operational expenses
- Educational support
- Information technology
- Accreditation
- Insurances (malpractice)
- Faculty and resident recruitment
FINANCES: Revenues

- Federal (Medicare, Medicaid)
- State
- Patient Care Revenues
- Sponsor support
- Other
FINANCES - Revenues

- Federal:
  - CMS: DME/IME; CAH; other
  - HRSA: Teaching Health Center (also Peds)
  - VA funding
- State:
  - Medicaid: GME
  - State budget lines
- Patient care services provided
- Hospital / Sponsoring Institution support
- Other (foundations, grants, etc.)
Challenges: Revenues

- What about CMS monies?
- The problem with rural
- The “have-not” states
- CMS caps, “gotcha” rules
- Medicaid...
- Start-ups
Challenges in GME

- Finances: the “return on investment”
- Resources needed to assure quality training
- Competition for teaching resources: “learners per square inch”
- Faculty recruitment and retention
- The ability to recruit quality resident applicants
What resources are needed to support a GME program?

- Sponsoring institution
- Community support
- Training resources:
  - Faculty in core specialty
  - Faculty in other specialties
  - Hospital volumes and breadth of services
  - Outpatient services
Challenges: Resources

- Availability of and competition for teaching resources, and limited sites that are able to support resident training programs:
  - Size of hospital (beds, occupancy/utilization)
  - Number of procedures done locally
  - Ability of community to provide specialty services
  - Capacity of outpatient resources (physicians; space; patient demand)
Challenges in GME

- Finances: the “return on investment”
- Resources needed to assure quality training
- Competition for teaching resources: “learners per square inch”
- Faculty recruitment and retention
- The ability to recruit quality resident applicants
Faculty recruitment and retention

- Limited number of physicians in a community may be available and/or interested in teaching
- Faculty recruitment:
  - Differential pay scales with community physicians
  - May be MORE work than community colleagues
- Faculty development
  - Teaching and program administration skills
- Faculty retention:
  - Burnout/wellness
  - Personal needs
Challenges in GME

- Finances: the “return on investment”
- Resources needed to assure quality training
- Competition for teaching resources: “learners per square inch”
- Faculty recruitment and retention
- The ability to recruit quality resident applicants
Attractiveness to applicants:
*if you build it, will they come?*

- **Factors helping:**
  - *New medical schools and existing school expansions: more students in pipeline*

- **Factors hurting:**
  - *Increased medical student debt*
  - *Challenges facing rural health care delivery systems*

- **Rural training tracks:**
  - *Develop local/regional pipeline*
  - *Recruitment strategies*
  - *Rural rotations*
  - *Be sensitive to travel/family issues*
Mechanisms for developing positions

- Expansion of existing programs
  - Locally
  - Additional sites
- Development of new programs
  - Core
  - Rural tracks
  - Fellowships
- No new positions, but rural focus: rotations
STEPS IN BUILDING PROGRAMS

■ Initial mission

■ Assessment of local resources:
  - Hospital
  - Family medicine community
  - Clinic sites
  - Patient care volumes and experiences

■ Hiring of program director and administrative support

■ Development of program and curriculum, faculty planning

■ Financial pro formas and approval by all institutions

■ Applications for institutional and program accreditations
Identifying Potential for New Programs

- Evaluating communities and hospitals in the region for resource availability
- Developing local “champions”
- Support from local, regional, and national experts in accreditation and financing
- The key role of state and regional leadership
GME Training for Rural Needs

- **Primary Care:**
  - Family Medicine
  - General Internal Medicine
- **General Pediatrics**
- **Specialty Care:**
  - Psychiatry
  - General Surgery
  - Obstetrics/Gynecology
GME Program Models

- “Core” training program: Independently accredited

Minimum size:
- Family medicine: 4 residents/year for 3 years
- Internal medicine: 5 residents/year for 3 years
- Pediatrics: 4 residents/year for 3 years
- General surgery: 3 residents/year for 5 years
- Psychiatry: 3 residents/year for 4 years
- Ob/Gyn: 3 residents/year for 4 years
GME Program Models

- **Training track:** Associated with a core program in a larger community
  - **Models:**
    - Full time at rural location; more senior residents; usually 1-2 years
    - Intermittent time at rural location in blocks throughout training

- **Rural rotation:**
  - Associated with a core program
  - *Typically 1-2 months at rural location*
Timelines

- Sponsoring Institution accreditation: one year
- Planning a program: one-two years
- Program accreditation: one year
- Year prior, resident recruiting: one year
- *And then the fun begins!* First graduate 3-5 years later
What contributes to success?

- Commitment to the mission
- Local community support (core specialty; hospital; specialists)
- Adequacy of local resources for resident training (patient volumes; spectrum)
- Sufficient “Return on Investment” (value of program relative to cost)
What has led to failures?

- Commitment to the mission
- Local community support (core specialty; hospital; specialists)
- Adequacy of local resources for resident training (patient volumes; spectrum)
- Sufficient “Return on Investment” (value of program relative to cost)
GME FUNDING INITIATIVES

The future of GME funding at the federal and state levels
GME funding, federal and state

- Federal (Medicare and Medicaid)
  - Existing
  - Opportunities
  - Threats
- State
  - What other states are doing
  - Our state
GME funding, federal

- Federal (Medicare and Medicaid)
  - CMS DGME and IME
  - Medicaid

- Veterans Administration

- HRSA: Teaching Health Center funds
Medicaid funding for GME programs

- Medicaid funding is a major source of funding for GME programs
  - *Directly:*
  - Medicaid payments for GME
  - Patient care revenues for caring for patients who are insured through Medicaid
  - *Indirectly:*
  - Funding from sponsoring organizations including hospitals and Federally-Qualified Health Centers serving Medicaid patients
  - *Note: federal match for state GME funding*
WWAMI THC funds

■ Washington:
  - Ellensburg RTT (all 2 residents/year)
  - Spokane family medicine (3) and internal medicine (3)
  - Yakima Valley FarmWorkers, Grandview (2)
  - Puyallup Tribal Health Authority, Tacoma (all 4)
  - HealthPoint Community Clinic, Auburn (all 4)
  - Community HealthCare, Tacoma (all 6)

■ Montana:
  - Billings family medicine program (2)

■ Idaho:
  - Family Medicine Residency of Idaho family medicine program in Boise (2)
GME funding, federal

- Federal (Medicare and Medicaid)
  - **Opportunities:**
  - CMS GME Reform
  - Expansion of VA GME positions
  - Expansion of HRSA THC positions
  - CMS “rule fixes”
GME funding, federal

- Federal (Medicare and Medicaid)
  - **Threats:**
  - Decrease in CMS funding of GME (18 of 20 programs)
  - Loss of HRSA THC funds (6 programs, 24 positions yearly)
  - Loss of Medicaid GME funding sources
  - Decrease in funding of Medicaid itself
Medicaid funding for GME programs

- Potential impacts of Medicaid cuts:
  - *Directly:*
    - Cuts to direct Medicaid GME funding
    - Patients who are no longer insured through Medicaid become uninsured patients
  - *Indirectly:*
    - Hospitals who lose Medicaid funding streams would face significant losses in operating margins
  - *Rural hospitals are at particular risk*
GME funding: state initiatives

- Almost all states are allocating monies to support GME.
- What funding sources are used:
  - *Medicaid GME*
  - 2015: 42 states made Medicaid GME payments
  - *General state funds*
  - *Other assessments: tobacco taxes, hospital/insurance assessments, other grants*
GME funding: state initiatives

- How funding is directed:
  - Support for existing programs
  - Per-resident amounts
  - Direct program support
  - New program development
  - General GME positions
  - Targeted: primary care; rural/underserved
GME funding: future legislative directions

- Federal/Medicare:
  - Continued GME funding of programs
  - Consideration of Institute of Medicine GME Reform recommendations
  - Short-term CMS “fixes”:
    - “Rotator” bill (inadvertent setting of PRA and small caps)
    - Rules to better support funding of rural education
  - HRSA: Teaching Health Center reauthorization

- Federal/Medicaid:
  - Critical need to maintain Medicaid support to the states
GME funding: future legislative directions

- State approaches to address specific state concerns:
  - *Maldistribution of physicians by specialty, geography*
- Funding rural rotations
- Loan payback for rural positions
  - *Creating GME slots to match medical school expansions*
- Providing seed money for new programs or expanded programs
  - *Supporting ongoing successes:*
- Assuring ongoing support of existing programs
Opportunity to create the health system of the future that will effectively and efficiently produce the best patient outcomes, with providers who are thriving (the “Quadruple Aim”)

Needs for thoughtful workforce planning, and GME financing reform to help our states and rural regions in particular