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Graduate Medical Education in the Context of the Nation's Healthcare Workforce

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Overview

- GME
  - IOM report on GME released last July
  - Brief History/Context
- Workforce
  - Growing question as to accountability to the American public for meeting the nation's workforce needs

Why is GME Important?

EDUCATION AND SERVICE

What is GME?

- Graduate medical education (GME) refers to the period of training following medical school necessary to become a licensed physician provider
- Ranges from 3 – 8 years
- Hospital-based
- Medicare is the largest payer

Why is GME important?

- It determines the nation's output of physicians
- It trains the next generation of physicians
- It is in the public's interests

Brief history of GME - 1

- Concept of “house physician,” “intern,” and “resident” began with the rise of early academic teaching hospitals around the end of the 19th century (led by Johns Hopkins)
- The idea was to train unsalaried clinician scientists to advance teaching and research
- As medicine developed in the 20th century, these positions became uniquely necessary for hospitals to function in order to provide services to patients

Brief history of GME - 2

- As a result, unlike medical schools which are based in universities, GME is based in teaching hospitals
- Led by the medical specialty boards, residency review committees (RRCs) in each specialty accredited programs based on standards set by these boards
- An annual “Match” coordinates the selection of residents

Relatively recent GME milestones

- 1983 Medicare introduced the prospective payment system and made the distinction between DME and IME
- 1997 the Balanced Budget Act reduced payments over 5 years and capped the number of positions supported by Medicare at 1996 levels

What is happening with GME now?

IOM REPORT AND RESPONSE

State of affairs today for GME

- xxx,xxx positions at x,xxx teaching hospitals
  - Just under 100,000 are supported by Medicare
- Federal GME funding is about $16 billion dollars/year
  - Medicare pays about $9.5 billion
    - $3 billion for direct medical education to pay the salaries of residents and supervising physicians (DME)
    - $6.5 billion to subsidize the higher costs that hospitals incur for training programs (IME)
  - Medicaid spending is about $2 billion
  - Veterans Health Administration and HRSA $4 billion
- States support GME around $4 billion from Medicaid

Quick Summary of IOM Report - 1

1. Maintain current Medicare support
2. Build a GME policy and financing infrastructure
   - Create a GME Policy Council at HHS
   - Establish a GME Center at CMS
3. Create a single Medicare GME fund
   - Operational fund for approved positions
   - Transformation fund for initiatives and new positions

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Quick Summary of IOM Report - 2

4. Modernize Medicare GME payment methodology
   - Replace IME and DME with one payment
   - Set a national per-resident amount
   - Redirect GME funds to the sponsoring organizations
   - Implement performance-based payments
5. Maintain Medicaid GME at state's discretion

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Landscape responses

- How are others responding and why that matters (/is short sighted)

AAHC Response to IOM

- GME reform must be considered in the context of national health workforce policy
  - Not in isolation
- National health workforce policy must be driven by what makes sense for the future of health care
  - Not what is desirable for a particular discipline or industry

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What will Impact GME in the future?

WORK FORCE, PAYMENT, DELIVERY

Factors that are generally overlooked in the GME discussion

- Impact of the professions outside of medicine
- The new physics of patient care
- Effect of machines
- The evolving payment system

"Simply adding more doctors to the current mix is not a thoughtful solution to workforce challenges."[1]

1. From Pizzo et al. The Future of Graduate Medical Education: Is There a Path Forward? Forthcoming chapter in *The Transformation of Academic Health Centers*, Elsevier, May 2015

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Some concerns

- Mismatch between the health needs of the population and specialty make-up of the physician workforce
- Persistent geographic maldistribution of physicians
- Insufficient diversity of the physician population
- Gap between new physician's knowledge and skills and the competencies required
- Lack of fiscal transparency

The future workforce - people

- Luddite horse video here

Machines in the workforce

- How many and what types of humans will they replace?
- How will they change the roles of physicians and other care providers?

The new "physics" of patient care

$$E = mc^3$$

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The "New Physics" of Patient Care

- c^1 = Care is moving from a *fixed setting* to *wherever* the patient may be
- c^2 = Care by teams
- c^3 = Care by large data sets

Some other features of the new physics of patient care

- *Real-time* continuous monitoring of patients
- *Big clinical data sets*: how to manage and operationalize them
- The Pandora's Box of technology and new entrepreneurial income streams
- Patient empowerment
  - Shifting from provider control to "crowd control"

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The evolving payment system
Impact on trainees

"The most important factor affecting residency training is the quality of patient care that house officers observe."

- Kenneth Ludmerer in *let me HEAL,* Oxford University Press, 2015

We know that payment models impact physician incentives and care delivery models

The problem of paying healthcare providers

"There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary."[1]

1. Robinson JC. Theory and Practice in the Design of Physician Payment Incentives. Milbank Q 2001;79 (2)

Short and long term models

- Short-term: Some kind of Blended/Hybrid model
  - PMPM with FFS carve outs
  - Shared savings (for ACOs)
  - Partial capitation
- Long-term: more *at-risk* for populations
- What does this mean for trainees?

Bottom line:

We need to think *differently* about the health care workforce

- In regards to workforce projections
- In regards to resident education

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New model for GME is needed

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So where do we go next?

AAHC Plans

- Serve as a convener to develop relevant questions and foster debate
  - Bring all relevant stakeholders to the table to talk about solutions
  - While we can't get Congress to pass a Bill tomorrow, we can start to put the pieces together to eventually bring about necessary reform
- Continue to support funding for the National Health Workforce Commission (or some equivalent)

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Comments and thoughts?