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PROTECTING GRADUATE MEDICAL EDUCATION
A ROADMAP FROM IDEA TO A GRASSROOTS MOVEMENT

THE GME INITIATIVE
MEDICAL EDUCATION FOR AMERICA'S HEALTH

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The GME Initiative

2010 — Discussion Began

A handful of Colorado family medicine program directors are frustrated with chronic funding shortages for residencies. GME Initiative is formed.

2011 — Growing Interest

First summit is held in 2011 in Denver, with 30 attendees spanning 10 states. Outcomes: letter to the IOM (7 US Senators), article in Family Medicine.

2012 — Problem Statement

Materials being developed: policy briefs, problem statements, researching the "haves" and "have nots" to highlight disparities.

2013 — Catalyst Nat'l Action

Planning next summit in 2014 in Washington DC to coincide with release of IOM report on GME. Recommendation and education on "forty, five, and flow."

2014 — Policy Recc's

"Forty, five, and flow" education continues, more research on the financing of GME and how the system came to be. IOM report recommendations analyzed.

2015 — Gathering Steam

Third summit held in 2015 in Denver, "GME Summit West," with 96 attendees. Outcomes: three working groups, a policy brief, and a call-to-action video.

2016 — Accelerated Growth

Hired consultant to facilitate group activity, activate work groups, launch website, branding materials, shared resources, increase outreach/ partners.

2017 — Traction/Visibility

Fourth summit held in 2017 in Albuquerque, focus on "States' Initiatives" and the Finance, Governance, and Accountability of GME system. 120 attendees.

2018 — Position/Credibility

Fifth summit held (2018) in Atlanta "Working Meeting, Comprehensive Reform." Planning 2019 Convening in Washington DC, "Building Community Responsive GME."

MEMBERS

- 2010: 1 STATE — 10 MEMBERS
- 2011: 9 STATES — 23 MEMBERS
- 2013: 11 STATES — 30 MEMBERS
- 2015: 22 STATES — 50 MEMBERS
- 2016: 26 STATES — 76 MEMBERS
- 2017: 33 STATES — 120 MEMBERS
- 2018: 35 STATES — 152 MEMBERS

TOOLS

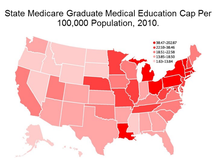
Supportive leadership + Facilitation, Technical experts + Organizing, Active engagement + Coalition building, Resource acquisition + Policy analysis, Consensus/alignment activity + Stakeholder engagement, Outreach and expansion, National relationships + First hire, Resource commitment, Resource allocation, Management/logistics, National presentations + GME reform education, curriculum, Stakeholder analysis, Resource audit/assessment, Literature review + Workplan creation and strategy, Grassroots organizing/advocacy, Collaborative agreements, Communication strategies, Legislative strategies

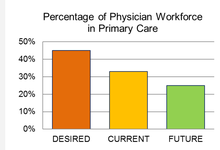
PRODUCTS

- 2010: Investigation on funding issues for family medicine GME.
- 2011: Formation of the GME Initiative.
- 2012: Identification of key workforce issues related to GME system. Workforce goal identified.
- 2013: Continued research/assessment of GME issues. Refinement of problem statement. 2014: GMEI first summit
- 2014: IOM GME report analysis. Opportunity to educate legislative aides and policy makers on GME. Planning for 2015 Summit.
- 2015: GMEI second summit. Creation of legislative report card. Letters to Congress. Educational video. Creation and adoption of work groups.
- 2016: Website, shared resources, branding. Work groups: legislation, state initiatives, comprehensive reform. Funding from partners to support summits and GMEI activity. Report card analysis of relevant legislation.
- 2017: Collection of state GME reform work. Research paper on state GME finance, governance, accountability. State level best practices. Increased partnership and participation. Funding from partners to support summits and GMEI activity.
- 2018: Position paper, comprehensive platform GMEI workplan: education, outreach, advocacy, convening, catalyst. National publications, presentations. Fed legislation introduced to Congress. Invitations to advise and partner on national, federal projects.

Per Resident Amount (PRA) 2007

CT:	$142,217
CO:	$68,155
ID:	$64,248
MT:	$108,859
NH:	$146,299
NM:	$43,532
NY:	$128,707
WA:	$88,765





The information about the problem with the system is available, but the messages are fragmented and disparate.

How do we bring these reports, advocacy efforts, policy recommendations, and advocates together to create an opportunity for reform?

Whose role is it to do so?


SPECIAL ARTICLES

A Proposal for Reform of the Structure and Financing of Primary Care Graduate Medical Education

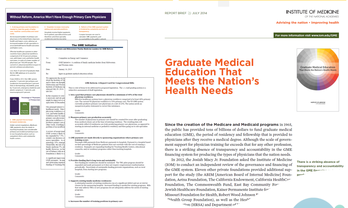
Kenton I. Voorhees, MD; Antonio Prado-Gutierrez, MPH, MS; Ted Epperly, MD; Daniel Derksen, MD

Category One – The Individual

- Not prepared for 21st century practice
  - Team Based Care
  - Outpatient care
  - Care Coordination
  - Quality Improvement
  - Diverse and Aging Population
- Realm of ACGME, Specialty Societies (e.g. STFM)?

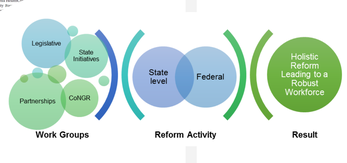
Category Two – The Workforce

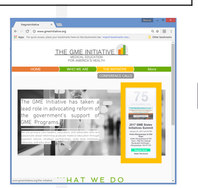
- Specialty Maldistribution
- Geographic Maldistribution of training
- Geographic Maldistribution of graduates
- Role of Governance and Finance
- Realm of Whom?
  - HRSA, CoGME, MedPAc AAMC,NAM?
  - ***The GME Initiative and CoNGR***



"Forty, Five, and Flow…Plus"

Finance	
	Maintain current amount of Medicare GME funding while modernizing (or reforming) it *+#11 (GME caps should be lifted as needed to permit training an adequate number of primary care physicians including internal medicine specialists, and physicians in other specialties facing shortages, including internal medicine, pediatrics, and many internal medicine subspecialties)* *+#4 (All payers should be required to contribute to a financing pool to support residencies that meet the nation's policy goals related to the supply, specialty mix, and training sites.)*
	Replace IME/DME with one per resident payment (PRP) with geographic cost of living adjustments
	Redirect Medicare GME payments so they are distributed directly to GME sponsoring organizations *+#5 GME funding should follow trainees into all training settings, rather than being linked to the location of service relative to the sponsoring institutions.*
	Money going to primary care positions needs to stay in primary care (can't be reassigned).
Governance/Accountability	
	Create a GME Policy Center in HHS *+#7 Establish a GME Center within CMS to manage GME operations (funding, transformation fund, collect data, responsive to GME Policy Council)*
	Mandate states show same transparency at the level required of Medicare
Specialty Composition and Geographic Distribution	
	Goal: 40% primary care (with primary care counted accurately, 5 years post medical school)
Transformation and Innovation	
	GME Transformation Fund: pilot alternative payments, develop and evaluate innovations, validate appropriate performance measures.
	Promote alternate mechanisms





Program: **Expedition CoNGR: Comprehensive National GME Reform to address physician specialty and geographic maldistributions**

Goal: **A National GME system that produces the physician workforce needed for the health of Americans and has features of transparency, accountability and the ability to respond to an evolving healthcare system.**

The GME Initiative

Inputs	Activities	Outputs	Outcomes – Impact: Short	Outcomes – Impact: Medium	Outcomes – Impact: Long
- The GME Initiative *Support of Colorado Family Medicine Organizations including a group of governor appointed citizens, Farley Center, Graham Center, Communication with AAFP, Content expertise, Representation from diverse stakeholders, Organizational expertise, track record of success -expertise recognized by Senator Gardner* **- Supporting organizations** **-Body of knowledge from Health Resource Research(*1)**	**Education** *- Development and presentation of a curriculum to increase content expertise in the byzantine workings of the US GME system* **Advocacy** **Convening** **Create a platform that represents a vision for the GME System that the GME Initiative believes should exist**	**Education** *- democratization of the empowerment of a broad stakeholder group to be effective communicators on issues related to GME -Empowerment of the educated to become educators of others* **Advocacy** *-Publication of a Position Paper describing a Platform developed through deliberation and consensus -Networking -Broadening stakeholder involvement* **Convening** *-engage the various interest groups and stakeholders involved in GME to develop a consensus that can be carried to congress*	**A broad-based stakeholder group that can effectively advocate for a reformed GME system that is responsive to the nations need for an effective physician workforce. The following characteristics make it effective;** *-broad based – comprised of not only of people who work directly in GME and Healthcare, but also constituents who are affected by its activities -Authoritative due to its content expertise -viewed has ultimately having the health of the nation's individuals at the heart of its intentions rather than the interests of narrow interest groups*	**Passage of Legislation that will create a responsive GME system Which includes;** *-A Policy Center -A Transformation Fund -An ability to produce a physician workforce with a strong primary care foundation* **A broadly based, engaged and empowered stakeholder group that is able to;** *-Critically appraise the performance of the GME policy Center and CMS' GME Center -Sustain critical dialogue to keep the GME system responsive and continuously improving*	**Healthier individuals and populations** *- resulting from a health system with a stronger primary care foundation* **A Workforce that supports the Quadruple Aim** *-Healthier patients and populations -A better experience with the healthcare system with resource more appropriately distributed with a better balance between community and hospital resources -Lower cost resulting from a better balanced and more equitably distributed system -a physician workforce that feels better supported* **A GME System that can monitor itself and continually** *- Well-resourced policy center that can monitor changes in the healthcare system and respond with innovations and shifts in resources in an effective and timely manner*

WORKING MEETING OUTCOMES	GME Reform Curriculum, Planning Activities Drafts (Work Plan, Strategic Plan, Advocacy Plan), RAP-GME Support, GMEI Defined Roles, Platform/Position Paper
GMEI Role: Catalyst for Change	(A) Educators/Facilitators (B) Advocates (C) Converners (D) Data Stewards
Platform Elements	(1) Finance and Payment, (2) Governance and Accountability (3) Specialty Composition and Geographic Distribution (4) Transformation and Innovation

Senate Bill 289: Rural Physician Production Workforce Act

Also known as "RAP-GME"

The Current Challenge. Rural America is experiencing a physician workforce crisis. Research shows the greatest indicator of where a physician will practice is the location of their residency training. Most family medicine residency programs are located in urban areas - we need to train more physicians in rural areas. Current CMS policies for GME funding obstruct the development of rural residencies, preventing the expansion of a successful training model for rural practice.

The Concept. A direct per resident payment (PRP) to an accredited residency program's sponsoring institution for weeks spent training in a rural location, unadjusted for Medicare or Medicaid patient ratios, inclusive of all training time (not just patient care), irrespective of specialty.

Key Features

- Fixed Per Resident Payment
- Pays for rural time with two different thresholds (8 weeks, or >50%)
- Will be built into Medicare GME system
- All kinds of hospitals eligible, all specialties
- Broad rural definition, stable over time
- Hospital choice, no triggers for cap or PRA

Budget allocations/limits. Maximum national expected financial impact is likely small relative to current system.

Political Context. Senator interest in rural GME funding legislation, approached GMEI to develop a proposal to increase rural workforce production. Bill was introduced in 2018 as S. 3014, and has been reintroduced in 2019 as S. 289.