Association of Academic Health Centers
Leading institutions that serve society

GME Regional Roundtable Series: Overview and Summary

September 2015

Association of Academic Health Centers
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Overview

7 Round table sessions across the US:

- ***Southeast*** at Emory University in Atlanta
- ***Northeast*** at the University of Pennsylvania in Philadelphia
- ***Mid-Atlantic*** at AAHC offices in DC
- ***Mid-West*** in Chicago alongside our SAFO meeting
- ***South Central*** at UT Southwestern Medical Center in Dallas
- ***Mountain West*** at the University of Utah in Salt Lake City
- ***Western*** at Stanford University in Palo Alto

Over 100 participants across all regions and covering most states.

Participants

Members in these States:

AL, AK, AZ, CA, CO, DC, FL, GA, IA, IL, LA, MD, MO, NE, NJ, NM, NY, OH, OK, RI, TN, TX, UT, VA, WA, WV, WI

Other organizations:

AHA
AMA
AACN
ACGME
AAMC
Kaiser Permanente
GME Initiative
Georgia Board for Physician Workforce
Intermountain Health
Utah Medical Education Council
National Institutes of Health
New Jersey Hospital Association
Texas Medical Association (TEXMED)

FORMAT/AGENDA

Consistent execution: Opening remarks, materials, format and set up by AAHC were kept constant for each session.

Agenda – two questions:

- What are the top 2 issues specific to your institution, region or state of the current GME program?

- Does the current GME program support the training of residents for meeting future healthcare needs?

DISCUSSION HIGHLIGHTS

- Discussion was free flowing, thoughtful and open – through lunch and without interruptions.

- Every session lasted the entire time (3 hours). Average # of participants for each session: 18

- Participants specifically noted their appreciation for:
  1. The opportunity to come together with their peers for the discussion
  2. AAHC coming to them in their region for the meeting
  3. The encouragement and inspiration by the discussion and possibilities for change
  4. The AAHC serving as the neutral convener with no pre-formed agenda or position

FINDINGS: 8 SUBSTANTIVE AREAS

1. ORGANIZATIONAL CONFLICT

- The organizational and cultural conflict between the hospital and the medical school was found to be consistently significant in all but one region.
- The conflict comes primarily from two main drivers:
  - The missions of the organizations do not align (bottom line vs. teaching residents)
  - Funding distribution – hospital gets GME funding, but medical school does not and is responsible for training the residents
- Surprisingly this was recognized to be the case even in situations where the same institution owns both.

Bottom line: *the overall funding of GME may need to be changed in order to adequately address this, however certain best practices can be shared (e.g., cross board membership)*

FINDINGS: 8 SUBSTANTIVE AREAS cont'd

2. PRIVATE SECTOR INFLUENCE

- We were surprised by the lack of knowledge about and/or coordination with private sector developments in health care delivery among participants, even in highly innovative regions (e.g., Silicon Valley).
- There was consensus that academic health center programs were not producing the right 'product' for the marketplace, and that the private sector could be consulted to determine gaps and possibly filling some of them (e.g., certain technology training).
- There was also widespread recognition that if the participants did not make themselves aware of what was happening 'around them,' they would be 'passed by.'

Bottom line: *academic health centers cannot ignore the private sector market developments around them and need to find a way to learn from the private sector to enhance their GME programs*

FINDINGS: 8 SUBSTANTIVE AREAS cont'd

3. MENTAL HEALTH/WELLNESS

- Mental health issues were identified across the board as a growing and urgent area of concern, and there is a critical need for more wellness programs within the AHCs.
- Participants in all regions described the heightened urgency of the mental health needs of the population at large, and *especially for our own residents and faculty*.

Bottom line: *the level of concern and need here is clear and comprehensive*

FINDINGS: 8 SUBSTANTIVE AREAS cont'd

4. REVISIONS TO PROGRAM STRUCTURE

- There is a recognized need for flexibility in GME programs which does not exist today due to ACGME and other requirements, and to produce a better-suited 'product' for the market.
- Such flexibility would enable residents to have a focused curriculum in their subject area, rather than a 'one size fits all' residency.
- This would presumably lower debt levels, shorter length of program, more efficient use of resources including faculty time.
- A revised curriculum should also include ambulatory training, and curriculum in 'non-traditional' areas such as use of technology, professionalism, leadership, data analytics, etc.
- Ideally this would include a coordinated curriculum across UME, GME and CME.

Bottom line: *participants recognized that they stand in their own way on this one, and are overwhelmingly interested in making such changes; these changes could help to solve problems identified in other areas.*

FINDINGS: 8 SUBSTANTIVE AREAS cont'd

5. NEEDS OF RURAL / UNDERSERVED

- Given membership in AAHC, these issues are relevant to ALL members in ALL regions
- Rural vs. 'frontier' vs. underserved populations – challenges are similar across all
- There is a recognized need to provide and retain physicians in these areas, but also to provide and retain the RIGHT physicians for these areas
- Technology can help here, some regulation needs adjustment to keep pace
- Partnerships are critical

Bottom line: these issues are widespread and impact <u>all</u> of our membership; they need to be addressed by us somehow

FINDINGS: 8 SUBSTANTIVE AREAS cont'd

6. PARTNERSHIPS / INTER-PROFESSIONAL TRAINING

- Partnerships were seen by participants as a vehicle for solving a number of the issues raised, but were also viewed as challenging and often difficult.
- Similarly, there was consensus that inter-professional training was effective and necessary, given the move toward team-based medical care; however, this was also seen as challenging and difficult for a variety of reasons.

Bottom line: *some institutions are doing this well, and a sharing of best practices could serve our members well here. Academic health centers are in the best position to address inter-professional training.*

FINDINGS: 8 SUBSTANTIVE AREAS cont'd

7. WORKFORCE

- There was unanimous agreement that this was a **foundational issue** – the lack of a comprehensive and accurate workforce analysis is necessary for a successful GME strategy.
- The appropriate **methodology** (how to measure, what metrics to use) and **scope** (national, regional, local or sub-local) were debated.

Bottom line: *analysis is inadequate for what is needed; no clear consensus on methodology or scope*

FINDINGS: 8 SUBSTANTIVE AREAS cont'd

8. CURRENT GME FUNDING STRUCTURE

- Though this issue was intentionally not a focus of the discussion, it was clear from the sessions that all participants believe that the funding mechanism is broken.
- There was consensus that reworking this to better fit today's health care marketplace, the roles of AHCs vis-à-vis the hospitals in the residency programs, changing health care delivery systems and developing patient needs could eliminate a number of the issues raised, but that it would be extremely difficult to do.

Bottom line: *updating the funding mechanism to the needs of today is very much needed but will be very difficult to achieve*

FINDINGS: DISRUPTIVE IDEAS

The sessions produced a number of provocative and paradigm-changing ideas, such as:

- Create self-sustaining clinical settings without residents, and then layer residents on top of the program, ensuring sustainability and allowing flexibility.
- Redirect funding to medical schools who would then provide a 5 year, tuition-free program, including 2 years of residency training as part of the 5 years and guarantee each resident a slot; each school would become known for its teaching area of specialty
- Remove residents from hospitals entirely and train them in entirely ambulatory training centers
- Abandon primary care training entirely – let other healthcare professionals provide first level care, and focus on physicians providing higher level care and specialties (may be already trending in some states)

FURTHER QUESTIONS OR INPUT

Contact Kristen Verderame at kverderame@aahcdc.org

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