CoNGR* and StING*

Relating State and National GME Reform Efforts

*Comprehensive National GME Reform(CoNGR)
*State Initiatives on GME (StING)

2017 GMEI States Initiative Summit

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Goal: *To cultivate enthusiasm for **Comprehensive** GME reform*

- Objectives
  - Why does comprehensive reform need to be so comprehensive?
    - Anencephaly
  - Roadmap to a transformed GME system
    - The four phases of a twelve step program
  - The relationship of state and regional advancements to comprehensive reform
    - Provide help for all four phases of the transformation

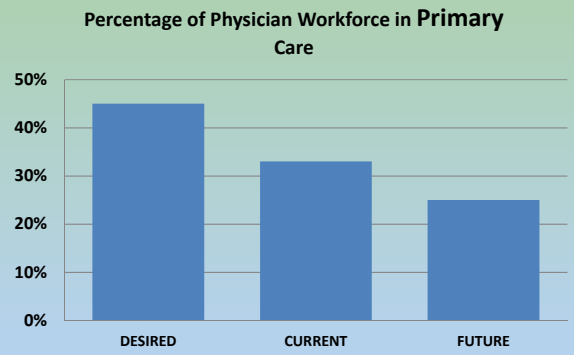
Goal of Comprehensive Reform:

• *A sustainable and well supported GME system that is responsive to the ever-changing needs that America has of its healthcare workforce.*

• *This system would include key features outlined in the 2014 IOM report on GME including an effective Policy Council and an ability to continually innovate, transform and evolve.*

The Problem: *Specialty Maldistribution*

"If things stay the same, then they will only get worse"



References:
1. Council on Graduate Medical Education. Advancing primary care. Rockville, MD: Council on Grad Med Educ, 2010.
2. Chen C, et al. Toward GME Accountability: Measuring the Outcomes of GME Institutions. Acad Med. 2013;88(9):1267–1280.

Growth by Specialty 2008 - 2012

Specialty	2008	2012	Change from 2008	Percent change from 2008
All (ACGME)	109,482	117,717	8,235	**7.5%**
Neurosurgery	857	1,212	355	41%
Thoracic Surgery	228	276	48	21%
Neurology	1,795	2,139	344	19%
Pulmonary/critical care	1,518	1,771	253	17%
Emergency Medicine	4,763	5,590	827	17%
Plastic Surgery	665	777	112	17%
Dermatology	1,123	1,240	117	10%
Family Med	***9,561***	***10,060***	***499***	***5%***

The Problems With GME

- Opaque
  - Very difficult to follow where the money goes
- Confusing
  - Is my program eligible? For how much?
- Lack of Accountability
  - Once eligible, no strings attached
- Anencephalic
  - Congressional intent goes awry

Anencephalic:
Congress Cannot Control the Outcomes

- 1997 RTT Exception to the cap
  - "Gotcha" Rules
  - Morgan County Rural Training Track
    - University Hospital $116,000 PRPY
    - Rural Hospital - $Zero
- 2003 Prescription Drug, Improvement and Medicare Modernization Act
  - Created more specialist than Primary Care

The "Gotcha" Rules for RTTs

- 1. Lower Medicare Bed-day ratio
- 2. Sole Community Hospital
- 3. Previous residency training activity
- 4. Previous Attempted RTT
- 5. Current sponsor of another RTT

Medicare Prescription Drug, Improvement and Modernization Act of 2003

- Redistributed 3000 positions from hospitals that were under the cap
- Intention for these slots: Increase primary care and rural training
- Look back from 2008
  - For hospitals receiving new positions
    - Primary care positions increase 1586
    - Specialty positions increased 3433
    - Only 12 positions were rural
- Published 2013

Medicare Prescription Drug, Improvement and Modernization Act of 2003

- Overestimate of primary care production
  - Included IM, Peds and ObGyn
- "78 of the hospitals that received positions proceeded to reduce their primary care positions."
- "48 of these increased non-primary care positions"

Is the relationship between Congress and GME *Anencephalic?*

- Anencephaly
- Locked in syndrome
- Athetosis
- Temporal disconnect between Brain commands and responses
  - Command in 2003
  - Report in 2013

- ***Point is:*** **the current "system" is incapable of addressing workforce needs.**

Roadmap to a Reformed System

• *A sustainable and well supported GME system that is responsive to the ever-changing needs that America has of its healthcare workforce.*

• *This system would include key features outlined in the 2014 IOM report on GME including an effective Policy Council and an ability to continually innovate, transform and evolve.*

IOM Recommendations

- 1. Maintain Current level of support For GME
- 2. Create a GME **Policy Center in HHS**
- 3. Divide funding into two Funds
  - Operational fund 90%
  - **Transformational Fund 10%**
- 4. Modernize payment methodology
  - Single PRA across the country (with cost of living adjustments)
- 5. Continue Medicaid GME funding – but instill some clarity

4 Phases of a 12 Step work plan

- Governance
  - Create on-going political and stakeholder support with skilled public servants to manage it.
- Political
  - Write and pass a bipartisan bill
- Stakeholder Consensus
  - Perhaps a Delphi Process
- From Grassroots to Mainstream
  - Widening rings of stakeholder participation

Political Phase

- Have versus Have Not States
- Increased funding or not
- Traditional power sources – are they in flux?
- We'll need health aides to write bills in both houses

Consensus Phase: What is the Universe of Stakeholders?

- Energy and Commerce Committee 2014
  - 108 Potential Collaborators
  - J. Harwood, JGME Dec. 2015:
    - 27 of 108 responses analyzed
    - Themes:
      - Change funding to allow diversified experiences
      - Eliminate caps
      - Change to improve geographic and specialty distribution
      - About 50 other suggestions

Grassroots to Mainstream Phase

Immediate Tasks:

- Capacity Building
- Messaging
- Growing the circles
- 2018 GME Initiative Summit

CoNGR and StING

Relating States and National Reform

- States as laboratories
- Regional Needs Vary, Regional Solutions Vary
  - Comprehensive can't mean "one size fits all"
- Content expertise
- Political Connectivity

Next Steps

Today's CoNGR Meeting 1 - 3

- 12 step work plan – more details
- Next steps
  - 2018 summit
  - Capacity analysis
  - Growing circles of interest
  - Message(s) – creating and communicating
- More granular work plan for 2017