Complexities & Progress in Graduate Medical Education

NHPF Meeting on GME

Atul Grover, M.D., Ph.D., FACP, FCCP
Chief Public Policy Officer, AAMC
September 6, 2013
Key Principles of Accountability Measures in GME

Three domains to consider:

- Workforce
- Trainee competence
- Training environment
Projected Supply and Demand, Physicians, 2008-2020

(ALL SPECIALTIES)
Family Medicine, Internal Medicine, Pediatrics are 50% of 1st year residency positions.
MedPAC Recommendations

• Achieve “performance-based” incentive program for Medicare GME payments to foster greater accountability
  - Practice-based learning & improvement, interpersonal/communication skills, professionalism, & systems-based practice (e.g., integration of community-based care w/ hospital care)

• Place at risk all IME payments above the “empirically justified amount” (~50%) and use “to fund the new performance-based GME program”
H.R. 1201, Training Tomorrow’s Doctors Today Act (Schock/Schwartz)

- IME performance program—up to 2% of IME at risk, in line with other VBP programs
- Directs HHS Secretary to develop measures of pt care priorities consistent with MedPAC; and to report on GME costs/payments (transparency)

  - Training provided in E/M or cognitive services;
  - Training across a variety of settings and systems;
  - Coordination of patient care across various settings;
  - The use of HIT;
  - Relevant cost and value of diagnostic and treatment options;
  - Inter-professional & multidisciplinary care teams;
  - Methods for identifying system errors & implementing system solutions.
Key Principles of Accountability Measures in GME (cont’d)

✓ Be reliable and valid—most not yet tested

✓ As appropriate, begin with reporting, then process measures, then outcomes

✓ Not create an undue burden of measurement (integrate with existing outcome measurements, e.g. accreditation, quality and safety reporting, payment, etc.)

✓ Encourage and incentivize further advances in GME outcomes measurement

✓ Link to payment cautiously
Medicare GME Payments

1. Direct Graduate Medical Education (DGME) Payments—*Resident Training*
   - Partially “reimburse[s] teaching hospitals for Medicare’s share of the costs of salaries and fringe benefits paid to residents, interns, and teaching faculty, and certain overhead costs relating to teaching activities.” *U.S. Congress, 1999*

2. Indirect Medical Education (IME) Payments—*Patient Care*
   - Percentage add-on reimbursement to the basic per-case (MS-DRG) payment paid to teaching hospitals

*Medicare DGME and IME support capped since 1996*
Medicare Covers 21% of Direct Teaching Costs (DGME)

- $12.2B Total DGME Costs
  - $3.2B Medicare DGME Payments
  - $9B DGME Cost Absorbed by Teaching Hospitals
  - Medicare PRA Underpayment ($2.6B)

- There are ~110,000 trainees.
- The average DGME cost per trainee was $143,000.
- Medicare based its reimbursement on a $101,000 PRA.

Source: HCRIS 9/30/2012 Release
IME is a Patient Care Payment with An “Education” Label

Created because of concerns about the inability of Medicare coding to “account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents”

(House Ways & Means Committee Rept., No. 98-25, March 4, 1983 and Senate Finance Committee Rept., No. 98-23, March 11, 1983 [emphasis added]).

“to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals.”

U.S. Congress, 1999
EXAMPLE: Level I Trauma Center Requirements (>80% in COTH)

Clinical Service Costs Alone:

• *Minimum* 1200 trauma admissions annually
• 24/7 in-hospital trauma surgeon and anesthesiologist
• 24/7 *immediate access* to complete operating room team (team *cannot* be dedicated to other functions in the hospital)
• 24/7 in-hospital surgical ICU physician
• 24/7 in-hospital radiology staff
• 24/7 in-hospital clinical lab services
• 24/7 access *within 15 minutes* to a board certified: cardiac surgeon; hand surgeon; neurosurgeon; orthopedic surgeon; microvascular/replant surgeon; OB/GYN surgeon; eye surgeon; oral/maxillofacial surgeon; plastic surgeon; thoracic surgeon; critical care physician; radiologist
Level I Trauma Center Requirements

Examples: Education and Research Requirements are Mandatory

• Maintain a trauma fellowship and/or trauma-focused residency training programs in related specialties
• Offer educational programs for providers not affiliated with the trauma center
• Maintain a trauma registry
• Conduct research that investigates issues related to trauma, trauma care, and trauma prevention
My hospital, the Brigham and Women’s Hospital, received thirty-one victims, twenty-eight of them with significant injuries. Seven arrived nearly at once, starting at 3:08 P.M. All required emergency surgery. The first to go to surgery—a patient in shock, hemorrhaging profusely, with inadequate breathing and a near-completely severed leg—was resuscitated and on an operating table by 3:25 P.M., just thirty-five minutes after the blast. The rest followed, one after the other, spaced by just minutes. Twelve patients in all would undergo surgery—mostly vascular and orthopedic procedures—before the evening was done.

This kind of orchestration happened all across the city. Massachusetts General Hospital also received thirty-one victims—at least four of whom required amputations. Boston Medical Center received twenty-three victims. Beth Israel Deaconess Medical Center handled twenty-one. Boston Children’s Hospital took in seven children, ages two to twelve.
University of Colorado Hospital Inpatient Admissions
By Patient Residence Zip Code

Discharge % (N)
- Top 50% (12,440)
- 50 - 70% (5,075)
- 70 - 80% (2,539)
- 80 - 90% (2,410)
- 90 - 98% (2,128)

Date Covered: 12/01/2011 - 11/30/2012
Note: 2% of inpatient admissions were from foreign or unmatched zipcode areas.
“Risking” 50% of IME Payments

- Decreasing highly specialized “loss leaders”
  - Burn units, Sickle cell, Geriatric clinics, Inpatient psych beds
- Reduce residency training positions
- Reduce subspecialty fellowships
- Reduce research capacity
- Decrease access to transfers from surrounding community hospitals seeking specialized service
- Reduced investments in new care models
Role of AAMC in GME Accountability

• Convene stakeholders to develop recommended measures that would achieve desired policy outcomes

• Evaluate/test options for redirecting a portion of federal GME funding to incentivize the outcomes defined by this process

• Ensure that GME incentives are combined with measures to ensure workforce size/skills to meet needs of public

• Work with policy makers to prevent unintended consequences
Competency Based Medical Education (CBME)

• “How do we improve medical education to provide better care for patients?”
  – Common taxonomy for domains of competence and specific competencies
    ✓ Milestones
    ✓ Entrustable professional activities
    ✓ Integrated approach to assessment of competencies

## The Paradigm Shift

<table>
<thead>
<tr>
<th>Variable</th>
<th>Structure/Process</th>
<th>Competency-based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Driving Force for Curriculum</strong></td>
<td>Content &amp; Knowledge Acquisition</td>
<td>Outcomes &amp; Knowledge Application</td>
</tr>
<tr>
<td><strong>Driving Force for Process</strong></td>
<td>Teacher</td>
<td>Learner(s)</td>
</tr>
<tr>
<td><strong>Path of Learning</strong></td>
<td>Hierarchy</td>
<td>No Hierarchy</td>
</tr>
<tr>
<td><strong>Responsibility For Learning</strong></td>
<td>Teacher</td>
<td>Student and Teacher</td>
</tr>
</tbody>
</table>
Interprofessional Collaboration

Core Competencies for Interprofessional Collaborative Practice

Sponsored by the Interprofessional Education Collaborative

Report of an Expert Panel

*IPEC sponsors:
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Dental Education Association
Association of American Medical Colleges
Association of Schools of Public Health
AAMC Physician Workforce Policy Recommendations

1. “The number of federally supported GME training positions should be increased by at least 4,000 new positions a year to meet the needs of a growing, aging population and to accommodate the additional graduates from accredited medical schools. The medical education community will be accountable and transparent throughout the expansion.”

Goal: Address less than half of expected physician shortage through increased training capacity
2. “Current and future targeting of funding for new residency positions should be planned with clear attention to population growth, regional and state-specific needs, and evolving changes in delivery systems. Today, approximately half (2,000) of these additional positions should be targeted to primary care and generalist disciplines; the remainder should be distributed across the dozens of the approximately 140 other specialties that an aging nation relies upon. Attempts to increase physicians in targeted specialties by reducing training of other specialists will impede access to care.”
3. “In addition to expanding support for GME, policy makers should leverage clinical reimbursement and other mechanisms to affect geographic distribution of physicians and influence specialty composition.”

4. “The federal government should continue to invest in delivery system research and evidence-based innovations in health care delivery.”

Need more efficient health care delivery models and increased physician training positions