



## Transforming Graduate Medical Education

### **Basis for Reform**

The Medicare Payment Advisory Commission’s (MedPAC) June, 2008 report recognizes that “patient access to high quality primary care is essential for a well-functioning health care delivery system.”(pg.14). The report recommends that “policy makers should also consider ways to use some of the Medicare subsidies for teaching hospitals to promote primary care. Such efforts in medical training and practice may improve our future supply of primary care clinicians and thus increase beneficiary access to them.” Lastly, the Commission also recognizes that “medical education subsidies could also be used to help pay student loans for clinicians committed to primary care specialties.”

The following policy deals with the middle of the continuum of the primary care pipeline of medical education, graduate medical education, and practice.

### **Role of Medicare in Graduate Medical Education**

- Medicare has a duty, along with other payers, to ensure the production and training of physicians to provide care for the nation.
- Medicaid should continue to allow for funding of graduate medical education. Should other payers continue to be small players in this arena, or remain uninvolved at all, Medicare cannot abdicate its role.
- Payments should cover all the costs of graduate medical education. This would be a change from the current system where the tying of GME payments to patient care has ignored the costs of providing certain types of training such as didactic teaching or supervision.

### **Funding Generation, Allocation and Distribution for Family Medicine GME**

#### *Generation of Funding*

- www.aafp.org
- Identify the GME payments amounts (DME and IME) from the top 10 highest reimbursed hospitals in the nation and develop an average payment rate per resident, based on those amounts.
  - Hospital DME and IME for family medicine, general primary care medicine tracks and general pediatrics primary care tracks should be uncoupled from the hospital and used to directly fund primary care general internal medicine, primary care general pediatrics, and family medicine. These funds should be used to pay the costs of medical education, not be tied to patient care costs. (These training programs can be further recognized as family medicine, primary care internal medicine tracks, primary care pediatric tracks, and not hospitalists. They can be identified using Medicare data as programs or tracks that currently receive the primary care differential payment in the DME payment).
    - Any inflationary adjustments or new money entering the GME system should also go to those primary care programs.

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Rationale:

- As shown by Kerr White's article "The Ecology of Medical Care,"<sup>1</sup> the preponderance of medical care does not occur in the hospital. (Updated by Green, 1991) Because such care is provided in outpatient sites including, among others, physicians' offices, ambulatory care sites, home visits, nursing homes, and clinics, training should occur in these sites and payment should be made for training in these sites.
- Medicare GME currently doesn't pay for training in many appropriate sites and for certain valuable types of training (e.g. care management, working in teams, supervision of nursing students, quality improvement). This needs to change so that GME pays for appropriate sites and types of training.
- Training in new models of care, both in new sites of practice and new forms of training for such care can be expected to be more expensive than current hospital-based training.

*Allocation and Distribution of Funding*

- Use the average payment amount identified above to fund every family medicine residency based on the number of residents within its program. (We mean actual individuals or FTE equivalents, not Medicare "slots," as that would perpetuate a problem for primary care that developed in the counting of slots in 1996 – where non-hospital training time was excluded from the resident/hospital count.)

Rationale:

- This will provide an incentive the development of programs in primary care. Funding can help provide higher stipends to residents, helping encourage higher USMG choice of family medicine training. Such funding will also help programs develop innovative training, infrastructure, and collaborative training with non-physician trainees or faculty.
  - Higher funding would encourage the development of new primary care programs.
  - Emergency situations such as what happened in Louisiana with Hurricane Katrina would be helped by funding programs rather than hospitals because the programs can move locations without loss of funding.
- These new payments to primary care programs should only be paid for training toward achievement of initial board certification. Programs must be accredited or in process of applying for initial accreditation.

Rationale:

    - Federal funding should be used to aide in the increase of primary care physicians only. This would still allow flexibility in duration of training as we do not know what length of training future practice will require, but we do know such funding should only support primary care.
  - Medicare should also consider giving an incentive back to hospitals for every primary care physician they produce.
  - Payments back to primary care programs ought to relate to the costs of training. There should be some geographic regional variation in payment.
  - Address geographic and underserved mal-distribution of primary care physicians by providing incentive payments of GME for training in sites located in Community Health Centers (CHCs), Rural Health Centers (RHCs), and Health Primary Care Shortage Areas (HPSAs). Additional payments should also be used for the development of new training programs and current programs which would change training sites to these areas.

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<sup>1</sup> White, et al. NEJM 1961; 265(18):885-892 "The Ecology of Medical Care."

Rationale:

- Creating a training site increases physicians that work in underserved areas and enhance careers of for those who want to teach in such areas<sup>2</sup> and increase access to care for currently disenfranchised local populations.
- After the primary care programs are funded, the funding left over for GME purposes would be distributed to hospitals for specialty and subspecialty care.
- To ensure that appropriate hospital training is still available for primary care residency training, hospitals should be mandated as a condition of participation in Medicare to continue relationships with their primary care training programs and to accept new primary care training programs.

Rationale:

- We have concerns that if GME funding for primary care training is withdrawn from the hospital there is not any leverage for primary care programs to negotiate reasonable rates for “buying back” hospital services such as call rooms, library, cafeteria, etc.

### **Development of an appropriately sized and trained Primary Care Workforce**

- Financial incentives for residents, including higher stipends and potentially loan repayment programs, are possible uses of this GME funding to help address imbalance in student specialty choice.
- Raise the percentage of active, full-time practicing primary care physicians in the U.S. from the current 31% to 45%

Rationale:

- Current data from Europe and the U.S.<sup>3</sup> recommend that an appropriate percentage that would reduce costs and increase quality of care is between 45 to 50%.
- This increase in percentage should be phased in over a period of time (to be determined).

Acknowledgement:

- Given the current lack of interest in generalism from Internal Medicine and Pediatrics, to reach the 45-50% figure we expect that the largest increases would probably occur in family medicine.

### **Content and Duration of Family Medicine Training**

#### *Flexibility*

- RRC needs to give programs flexibility to rapidly respond to variations or innovations in local health care markets.
- Residencies need to be more ecologically based (Kerr White’s “The Ecology of Medical Care.” Training must move out of the hospital even more and into multiple and diverse outpatient settings.
- Residency training needs more person (patient) based, less disease-oriented training.
- Length of training may vary. Joint medical school/residency programs should be allowed once again. Some residencies may need to increase to 4 years to accomplish additional training in practice management, quality improvement, HIT skills, and public health training.

#### *Key elements of Training for Family Medicine*

While much of this content would also be applicable to other primary care specialty training programs, we are only discussing family medicine training content here, and will leave it to other specialties to identify their own training content and duration.

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<sup>2</sup> Bowman, Penrod Fam Med 1998; 30(4): 288-92

<sup>3</sup> Starfield B. New paradigms for quality in primary care. Br J Gen Pract 2001; Starfield, B., L. Shi, and J. Macinko. 2005. Contribution of Primary Care to Health Systems and Health. *Milbank Quarterly* 3: 457-502)

1. Consistent competency-based curricula, with a core set of process, skills, and knowledge, must be taught.
2. Competency based education will allow a more consistent graduate to be produced. Special skills must be developed to facilitate practice components of a patient centered medical home. These include, at a minimum, the following concepts:
  - ongoing relationships with a personal physician
  - physician directed medical practice
  - whole person orientation
  - care is coordinated and integrated
  - quality and safety are paramount
  - access is enhanced
  - payment is value driven
3. There will be variability in training across the country as programs try to meet the needs of their communities and regions. To assure that family medicine residents are trained for the practices they will be a part of, each family medicine resident should have curricular flexibility to develop special skills, talents, or mastery of one or two areas germane to family medicine that enable him/her to provide special services to patients in a practice that is organized to provide a competent patient centered medical home.
4. Innovations that encourage efficiencies in time and resources as well as delivery of care and increased quality of care should be encouraged.
5. Strategic thinking should be made part of family medicine residency programs. This skill would position a program appropriately in its community, in its region, and with its sponsoring hospital and educational institutions. To encourage this, every residency program should have the following:
  - A strategic plan that clearly outlines vision/mission, major goals, strategies for achieving them, and evaluation methodologies. A historical/environmental scan should be a key tool in the development of a strategic plan. Knowing historical precedents and rationales in light of today's needs, resources and priorities is key to the vitality and utility of a strategic plan. This plan should be reviewed no less than every two years.
  - Every program should have a core curriculum that is anywhere from 18-24 months in length with a well defined process and content education as outlined below. In addition, every program should have a 12-24 month flexible curriculum that allows for the differentiation of residents in terms of acquiring additional knowledge, skills and attitudes that will enable them to provide specific expertise to a practice and to the patients that practice serves. During this time, refinement and improvement of the core skills and knowledge base will continue.
  - Every program should measure the progress of its residents in a competency-based fashion minimizing time and number requirements.
  - Residents should be able to demonstrate the ability to build and manage a clinical practice.