

# Toward a National Strategic Plan for GME: Stakeholders, Data and Innovative State Approaches

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# Presentation Overview

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- Who are the key GME stakeholders?
- What if we actually used data to allocate GME positions?
- What are states doing to reform GME?
- Q&A

# Funders and collaborators, no conflict of interest to declare

- **Funding:**
  - Grant from the Physicians Foundation
  - Cooperative agreement (U81HP26495) with the National Center for Health Workforce Analysis, Health Resources and Services Administration
- **Collaborators:**
  - Tom Bacon, Mark Holmes, Andy Knapton, Tom Ricketts and Julie Spero
- **Conflict of Interest:**
  - None. I am a health workforce researcher. I do not represent the interests of any profession, medical specialty or organization involved in GME

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# Who are the key GME stakeholders?

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# This work came out of a “rapid response” request from HRSA

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- We were asked to conduct an environmental scan to support COGME’s efforts to develop a National Strategic Plan for GME.
- Specific questions:
  - Who are the major stakeholders in the GME system?
  - What are their roles? Perspectives? Interests?
  - How do/can they influence the system?
  - What are their limitations?
  - How are they connected?

# Stakeholders were grouped by role they play in GME (1)

- Organizations that advise Congress on GME
  - COGME, GAO, MedPAC, National Health Workforce Commission
- Federal agencies with jurisdiction or interest in GME
  - HRSA, CMS, VA, DOD, etc.
- Professional associations with advocacy interest in GME
  - Institutional Advocacy: AAMC, COTH, AACOM, AOA, AMA
  - Specialty Advocacy: Family Medicine, ACP, ACS, CMSS, etc.
- Agencies with regulatory, accreditation or credentialing functions
  - ACGME, ABMS (+ 24 Boards), ECFMG, Joint Commission, etc.

# Stakeholders were grouped by role they play in GME (2)

- Policy community and think tanks interested in GME
  - IOM, National Health Policy Forum, Rand, workforce researchers, etc.
- Entities with an interest in state-level GME reform:
  - State legislatures, Medicaid offices, professional associations, offices of rural health and the National Governors Association
- GME training institutions and their affiliates
  - Academic health centers, health systems, hospitals (with and without GME programs), medical schools, community-based clinics, etc.

# Stakeholders were grouped by role they play in GME (3)

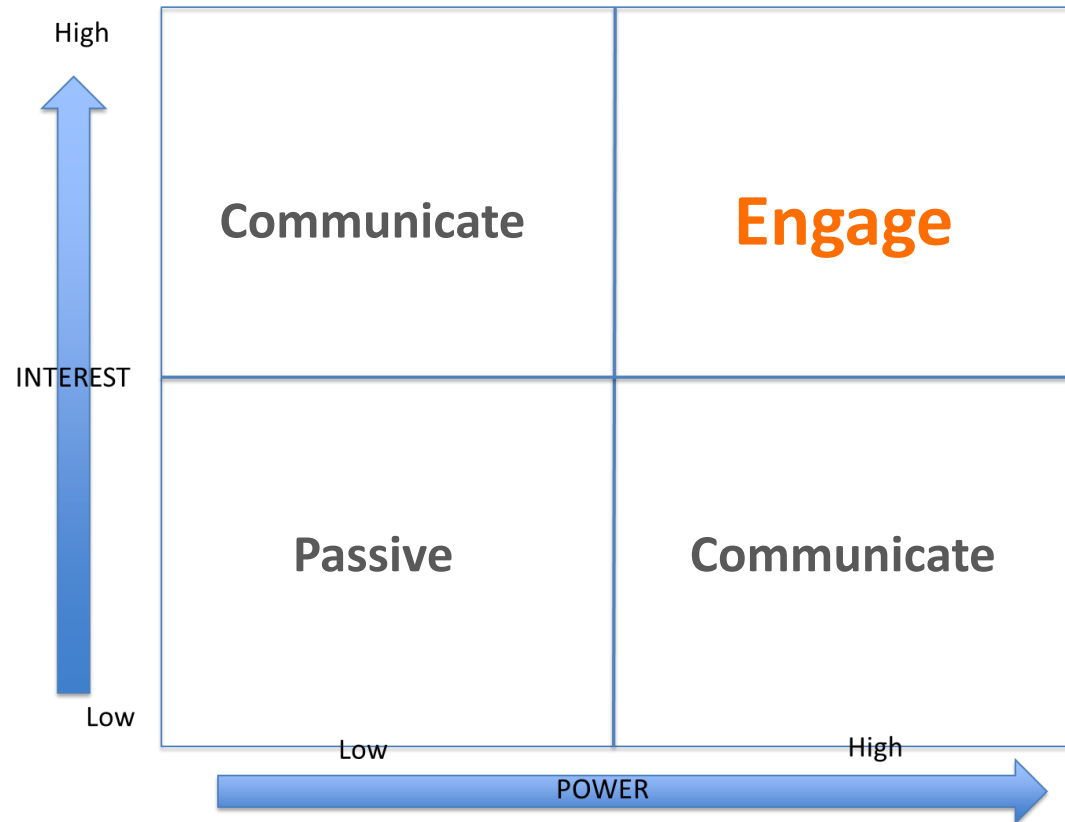
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- Non-governmental payers supporting GME (e.g., third-party payers)
- Administrative structures that support GME
- Private foundations that invest funds in studying GME and convening stakeholder groups (Macy etc.)
- Organizations of students/trainees



# We used stakeholder map to plot each organization's level of interest and power in GME

- Stakeholder maps used to identify organizations that should be focus of engagement
- Traditionally, this means focusing efforts on organizations that fall in upper right quadrant

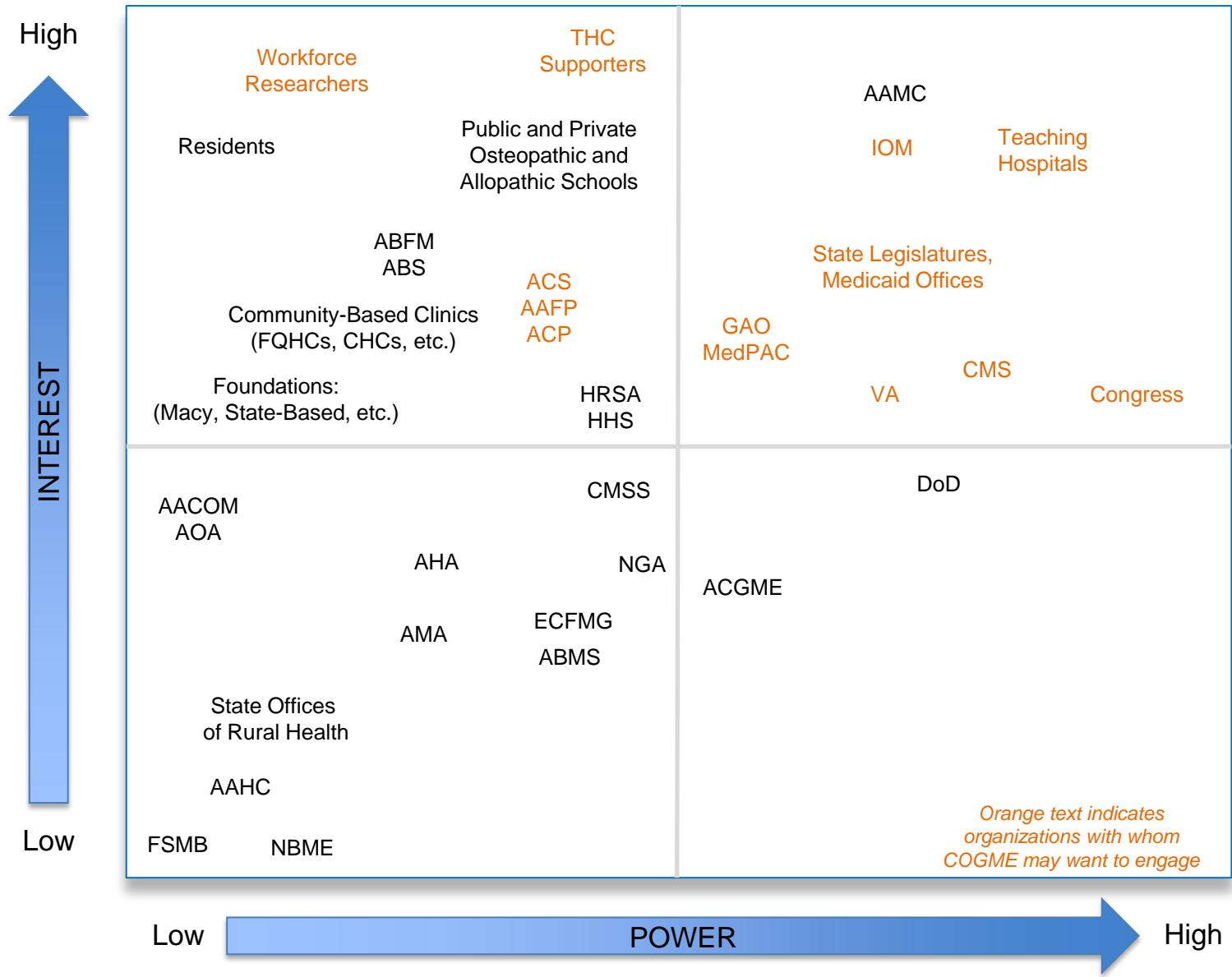


# But we adapted the approach...

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- We thought COGME might want to engage organizations in other quadrants whose mission/role are in support of:
  - Aligning GME system with population health needs
  - Maximizing efficiencies presently lacking in the system
  - Adding transparency and accountability to GME funding
  - Integrating workforce predictions into GME planning

# We ended up with a picture that looked like this



# Caveats

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- Rapid response analysis was done quickly
- Used materials available on websites, not comprehensive
- Subjective, based on our judgment and expertise
- Starting point for further discussions

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**So...**  
**what if we actually  
used workforce data to  
allocate GME positions?**

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# Congressional GME proposals

- Congressional proposals set goal of expanding GME by 3,000 new PGY1 slots for five years – a total of 15,000 new residency positions
- The Resident Physician Shortage Reduction Act of 2015 (S.1148) and companion bill in the House (H.R. 2124) suggest the National Health Workforce Commission identify shortage specialties using a 2008 HRSA workforce model
- Two problems: Commission not funded and those projections are out of date

# GAO involvement in GME

- Another bill, Training Tomorrow's Doctors Today Act (H.R. 1201) requires the General Accounting Office (GAO) to identify physician shortage specialties
- In August of 2015, 27 members of the House Ways and Means/Energy and Commerce Committees asked GAO to evaluate the current structure of the nation's federally funded GME programs and provide recommendations for improvements

# The problem

- Even if Workforce Commission, HRSA, or GAO had accurate and current data on physician workforce shortages, they would need a methodology to translate data into recommendations about how to allocate new positions by state and by specialty
- The purpose of our study was to outline a methodology for using workforce projections to make decisions about GME investments
- We test the methodology using the case example of 3,000 new PGY1 slots for 5 years



# What our study does and does not intend to do

- The methodology draws on shortage/surplus data from our workforce projection model—The FutureDocs Forecasting Tool\*—but any rigorous projection model could be used
- The goal of study was not to evaluate whether the proposed expansion is appropriate but to:
  - outline a methodology for using workforce data to allocate the 3,000 PGY1 positions by state and specialty
  - assess how well the methodology performed

# Workforce models are data hungry

## Supply Model

- 2012 and 2013 Physician Masterfile (AMA)
- 2012 and 2013 GMETrack Data (AAMC) on residents in training
- MGMA data on # of encounters per FTE
- North Carolina licensure data on FTEs by sex, age and specialty
- AHRF and peer reviewed literature for NP/PA numbers and growth rates

## Demand model

- MEPS: visits by age, sex, race, state, etc. .
- US Census: age/sex/race/ethnicity profiles estimates, poverty estimates, small area insurance estimates
- County Health Rankings
- Behavioral Risk Factor Surveillance System
- Proximity One: population forecasts

# Assumptions

- GME expansion begins in 2016 to meet forecast shortages in 2026
- We assume:
  - New slots are filled
  - States have the capacity to train in specialties allocated to them
  - New training slots do not affect health services use
- First group of new residents complete training (on average) in 2021 and provide 5 years of additional supply until 2026

# Methods

- Use model to identify number of visits we will be short in 2026 for 19 types of health care services in 50 states
- Translate shortage visits into FTEs needed by specialty using “plasticity matrix” (see Holmes et al 2013)
- Convert FTEs to headcounts needed to meet shortages
- Apply 3,000 new PGY1 slots each year for 5 years to meet shortages (total of 15,000 new positions)
- Fill from the “bottom up”. New GME positions go to states and types of health care services facing most significant shortages until all 15,000 new positions have been allocated

# Results

- After expansion, 77.4% of demand for visits in 2026 across all types of health care services in all states was met
- “Filling from bottom” approach meant that states:
  - facing most significant shortages were brought up to a level of meeting 77.4% of demand
  - that were already meeting demand above 77.4% did not receive any new positions

# How were slots allocated by specialty?

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- Expected findings:
  - Largest GME expansions in “first certificate” programs— Family Medicine, Internal Medicine, General Surgery, Psychiatry, etc.
  - Large expansions in cardiology
- Unexpected findings:
  - Relatively small GME expansion in geriatrics
  - Relatively large GME expansions in pediatric surgical and non-surgical specialties

# Why the unexpected findings?

- Plasticity matrix that matches demand for visits with type of provider needed is based on current, national patterns of how visits are distributed across specialties:
  - Currently, small number of geriatricians providing care for elderly relative to internists
  - Specialists are providing “generalist” care
- As delivery models change, plasticity matrix could be adapted to model the effect of shifting care from:
  - Specialists to generalists
  - Physicians to physician assistants and nurse practitioners
  - Inpatient to outpatient settings
- Plasticity matrix could also be adapted to reflect local labor markets

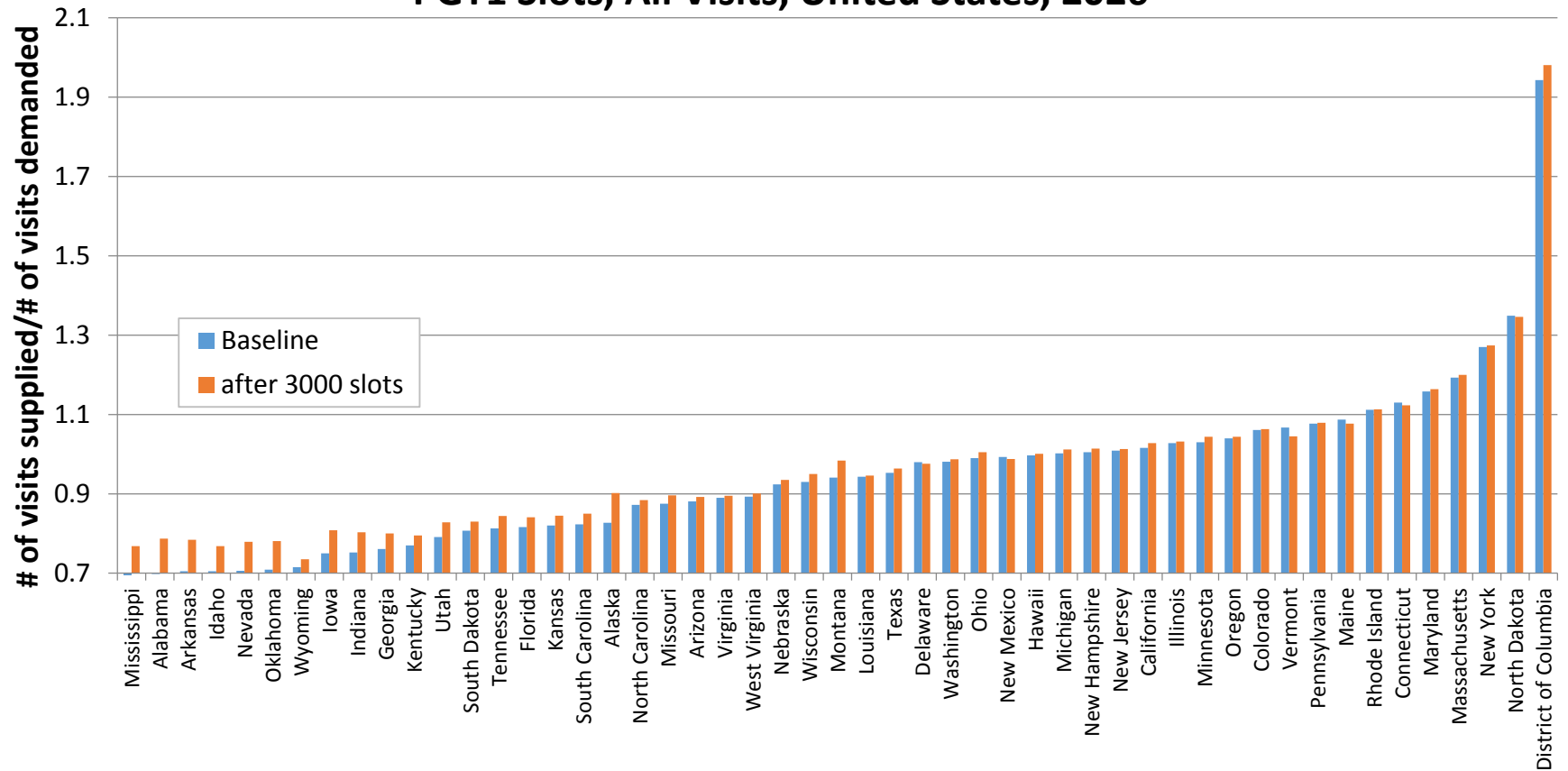
# How were new GME positions allocated by state?

- Findings suggest expanding GME in states with:
  - Poor health outcomes and high health care utilization (Arkansas, Mississippi and Alabama)
  - Large, growing populations (Texas and California)
  - Aging populations (Florida)
  - Low resident/population numbers (Idaho, Wyoming, Montana, Alaska and Nevada)
- 5 states (Connecticut, Delaware, New Hampshire, Rhode Island and Vermont) and the District of Columbia received no new GME slots because they are already well supplied



# Even though you train residents in one state, they don't "stick"

Shortage/Surplus Ratio Before and After Allocating 15,000 New PGY1 Slots, All Visits, United States, 2026



# Conclusions—data are great but need “GMENAC-like” panels to interpret results

- Methodology produced results that generally smell right
- Important contribution to field because there are calls to better link data to GME investments but no methodology for doing so
- Some unexpected findings—we suggest need for expert advisors who know specialties and states

# Experts needed to consider “reality” of model’s recommendations for GME allocations

- Workforce models will allocate new positions to address specialties that have an “anemic” pipeline (ID, thoracic surgery).
  - If you open new position, will it fill?
- Models will try to address geographic maldistribution. Some specialties are “clustered” (ped sub specialties)
- Models are based on current service delivery patterns. Instead of expanding ped specialty positions, could encourage shift of work from specialists to generalists
- Experts also need to consider:
  - Do states have capacity to develop quality training program if allocated new slots?
  - Can Medicare caps be adjusted to allow for new slots?



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# **What are states doing to reform GME?**

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# New Sheps Center Study: Medicaid GME Innovations in States

- Interviews with 10 states reforming Medicaid GME. Interviews focused on:
  - **Payment**: Has there been a change in the payment mechanism?
  - **Transparency**: Are they tracking how Medicaid GME dollars are spent? Do dollars flow to hospital or directly to teaching program?
  - **Accountability**: Is state targeting Medicaid funds toward residency programs in specific specialties or in particular geographic areas?
  - **Innovation**: Are they shifting funds to community-based programs, non-physician providers, or other innovations?
- Results available Fall 2016

# Limited federal action but significant state interest in exploring new ways to leverage Medicaid investments in GME(1)

- **South Carolina**: Proposal to redirect 15% of state Medicaid funds to support GME in underserved/rural areas. GME Advisory Council recommended but not yet created
- **Georgia**: Proposal to create GME funding pool that is independent from claims-based reimbursement. Will pay same amount for GME training by specialty, regardless of which teaching hospital.
- **North Carolina**: DHHS submitted plan to NC legislature to redirect \$30 million in state Medicaid GME appropriations removed by Session Law 2015-241 Section 12-23H.(a) toward a significant, purposeful expansion of GME in underserved areas and specialties needed to meet the health care needs of the state's population

# Limited federal action but significant state interest in exploring new ways to leverage Medicaid investments in GME(2)

- **New Mexico**: using 1115 Waiver to provide increased Medicaid funding to FQHCs to cover costs of residency expansion. All expansions are in primary care which includes family medicine, behavioral health and oral health
- **Nevada**: State appropriation of \$5 million in FY15-16 and \$5 million in FY16-17 for new residency positions. Focus on primary care and behavioral health, but may expand approved specialties later. Governor-appointed GME Task Force will determine criteria for allocating the funds, but will include appropriateness of specialty and success of site in retaining grads in the state
- **Michigan**: Requesting funds to support more rotations of residents to rural and underserved sites, but no money appropriated yet.

# Need for GME governance

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- Many states are creating some type of oversight body to assure new dollars are targeted to meet needs of state
- Some governance bodies are appointed by the Governor (NV), others by legislature (VA)
- Most are advisory and bring together groups of teaching hospitals and other stakeholders to advise on the use of new monies



# Additional resources

See our paper,

## **“GME in the United States: A Review of State Initiatives”**

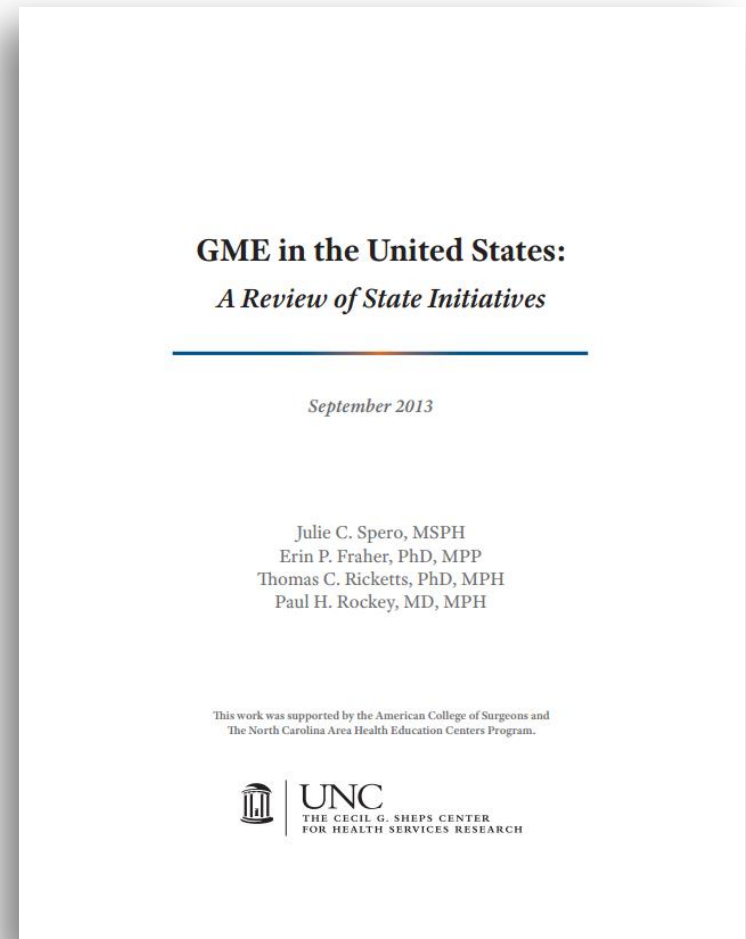
And our state reports on UME  
and GME:

### **GME fact sheet**

[http://www.shepscenter.unc.edu/hp/  
publications/GME\\_Mar2013.pdf](http://www.shepscenter.unc.edu/hp/publications/GME_Mar2013.pdf)

### **UME fact sheet**

[http://www.shepscenter.unc.edu/hp/  
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