

Graduate Medical Education in the US: Lessons Learned from State Initiatives

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Why Study States?

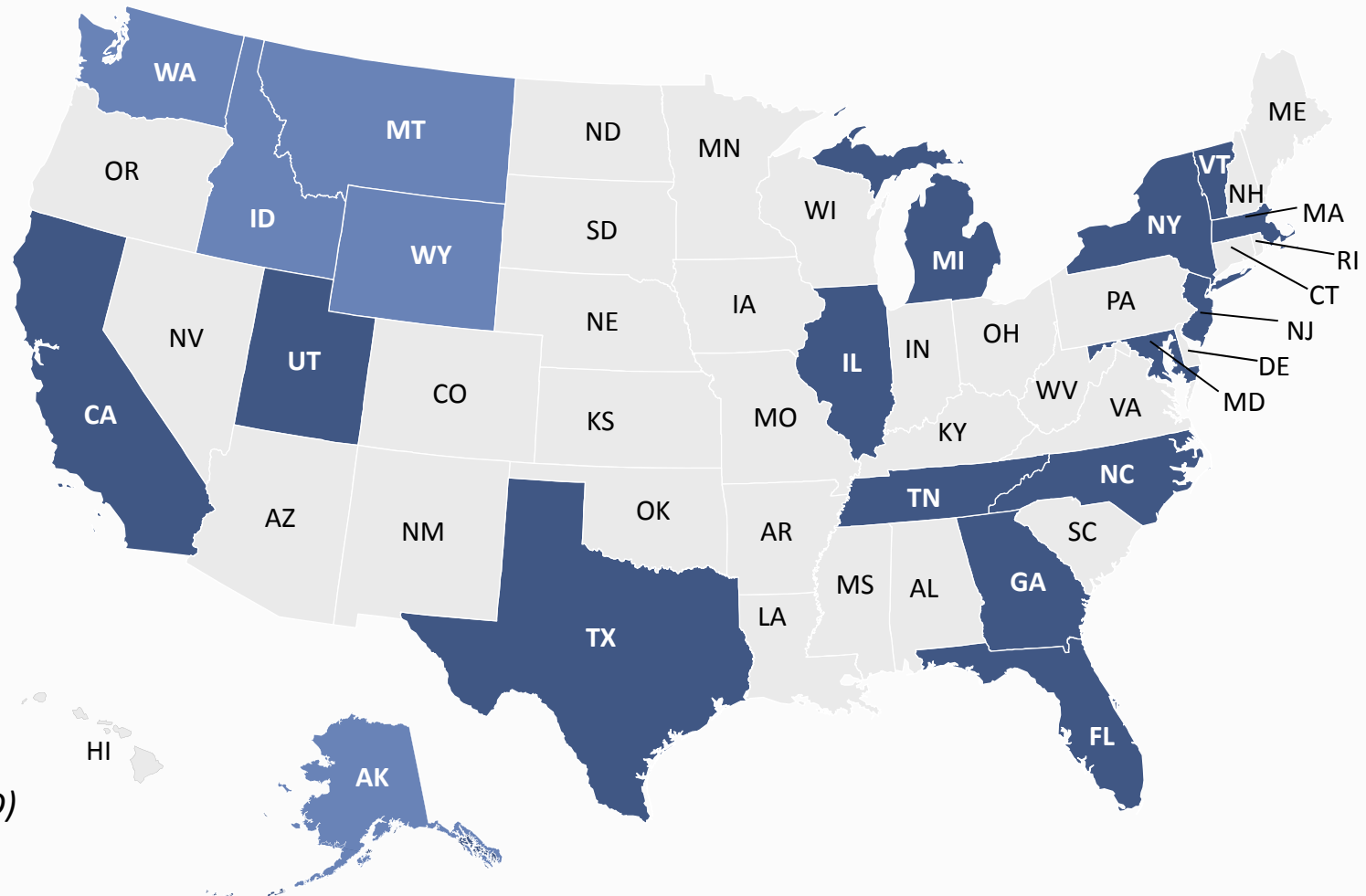
- Most discussion has been national, our study examines state initiatives
- In absence of substantive federal policy change, states are “policy laboratories” for GME innovation
- We sought to:
 - understand successes and failures of state innovations
 - identify innovative ideas about how to reform GME policy, governance and financing

Methods: Sample

- **Timeframe:**
March 1 and June 28, 2013
- **Purposive sampling strategy:**
17 states, 45 participants, 2-4 interviews/state.
- States selected for balance of census regions, high/low urban, non-elderly, uninsured, residents per capita and physician per capita
- **Snowballing sampling to identify interviewees:**
deans, assistant deans, GME program directors, physician workforce experts, and stakeholders

States in Our Sample

California
Florida
Georgia
Illinois
Maryland
Massachusetts
Michigan
New Jersey
North Carolina
New York
Tennessee
Texas
Utah
Vermont
WWAMI
(WA, WY, AK, MT, ID)



Methods: Data Analysis

- **Questions:**
data, financing, governance, and accountability
- **Literature review** of peer reviewed and grey literature
- **Qualitative analysis**
 - Interview notes sent to interviewees to review/modify
 - Directed content analysis to identify themes, patterns, & relationships
 - Iterative, consensus approach between two investigators

Lesson #1: States More Concerned with Maldistribution than Shortages

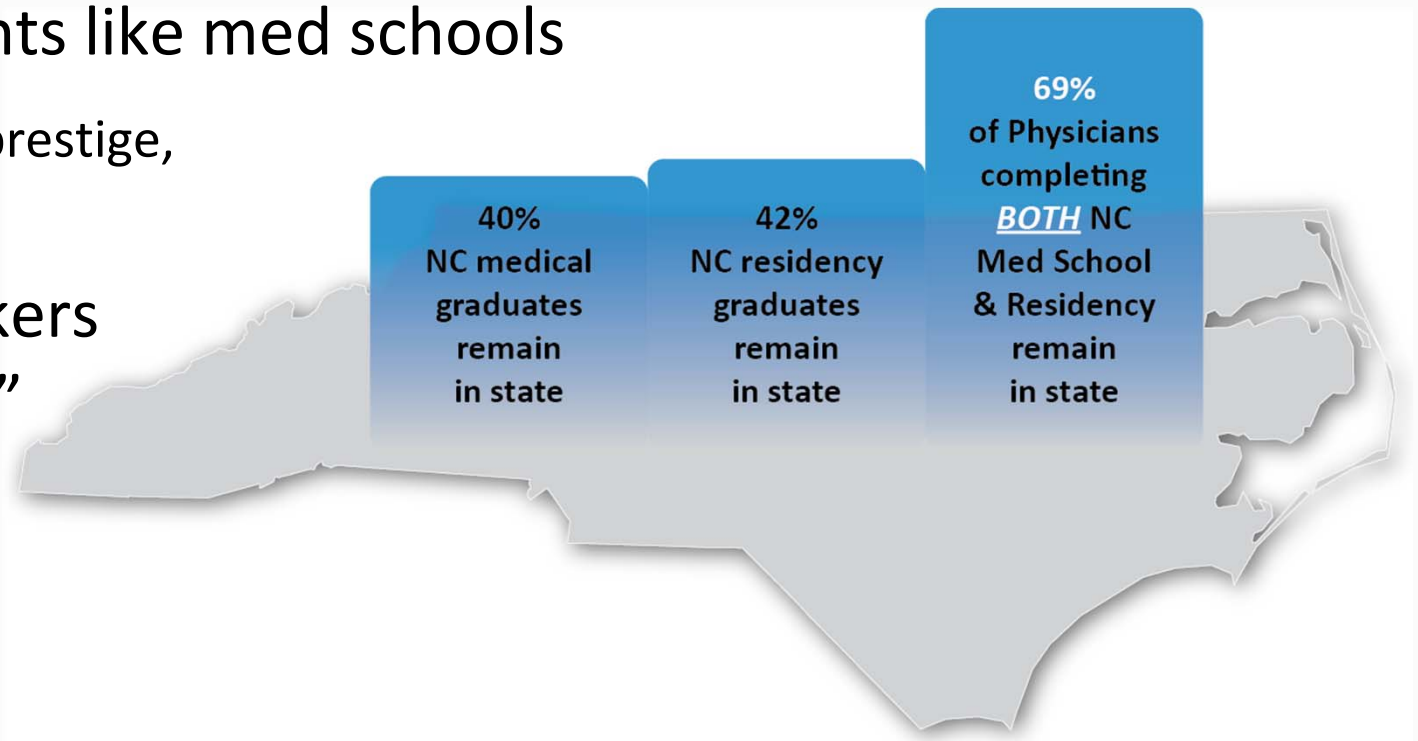
- Concerns about supply of:
 - Primary Care Physicians
 - General Surgeons
 - Psychiatrists
 - Pediatric Subspecialists
- Bigger concern:
 - Maldistribution by geography, specialty and setting

Lesson #2: More and Better Workforce Data Does Not Result in Evidence-Based GME Policy

- Few states have robust data systems to monitor workforce needs
- When they do, evidence generally isn't used to shape GME policy (NC, FL, TX)
- Data used as rationale to open new training programs, not to close programs

Lesson #3: Legislators Would Rather Open New Med Schools than Expand GME

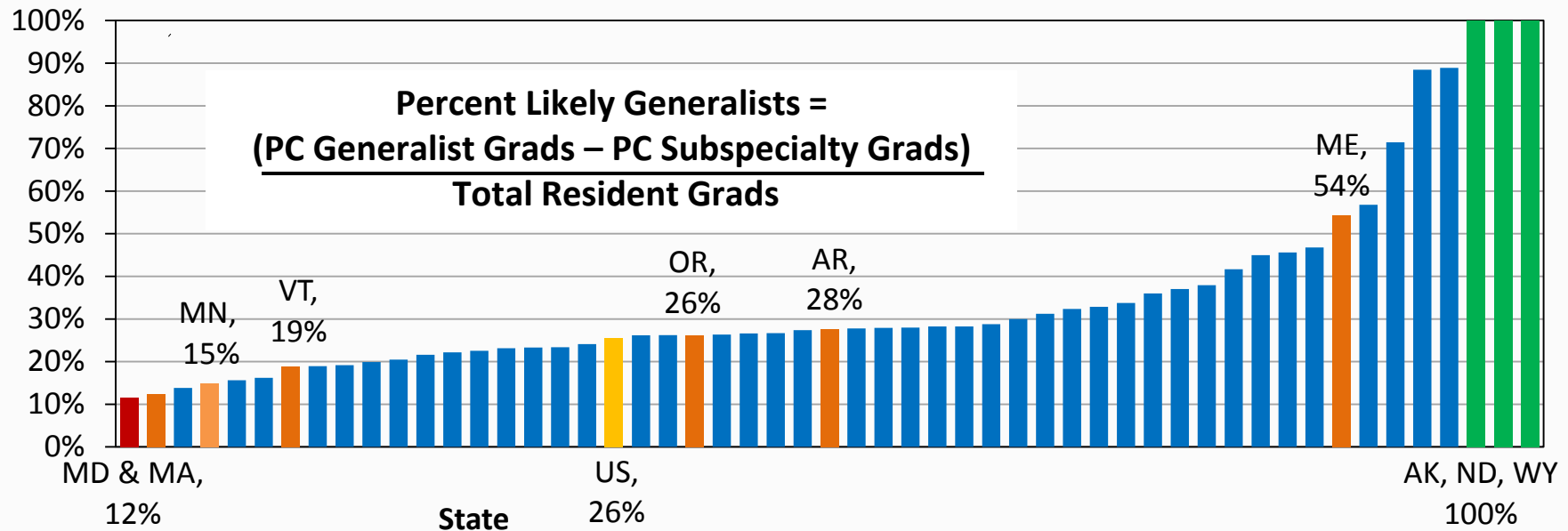
- Perception: US faces shortage and new medical schools are the solution
- Constituents like med schools
 - income, prestige, & jobs
- Policy makers don't "get" GME



Lesson #4: It's Complicated

- GME training pathways not well understood
- In most states, pouring more generalists in front end not likely to result in more generalists out back end

Percent of 2011 GME graduates likely to be generalists



Lesson #5: Medicaid Underutilized as Tool to Shape GME Policy

- Medicaid attractive because feds contribute 50-77% match depending on state income
- Medicaid GME \$ treated in same “hands-off” way as Medicare GME \$
- Teaching hospitals drive GME training decisions, even with public funds
- Medicaid GME & DSH payments hard to separate



Lesson #6:

More Funding is Not the Answer

- All-payer systems appealing to increase GME funds
 - Maryland: GME funds not targeted at specialty or geographic imbalances
- Third party payers not likely to contribute if they don't see value proposition
- State funds are vulnerable and subject to legislative whim

Lesson #7: GME Governance Structures Needed but Lacking

- Individual teaching hospitals oversee GME decisions
- Result: lack of information and coordination
- Need for state (legislated?) governance board
- GME governance board needed *at minimum* as forum to:
 - use data to identify workforce needs
 - discuss individual institution expansion plans
 - educate legislators about role GME plays in getting return on investments in UME

Lesson #8: Some Models Exist for GME Governance Bodies

- Minimalist role could be expanded to have decision-making and funding authority
- Bring diverse (and competing!) stakeholders together
- Utah
 - CMS waiver until 2010 - Utah Medical Education Council
 - Reviewed and prioritized funding based on needed specialties
- Georgia
 - GME start-up funds \$-to-\$ match at virgin hospitals
 - GREAT reviewing applications for virgin hospital funds
 - 50% new positions in high need specialties

Lesson #9: Accountability is Critical But Hard to Implement

- Virtually no accountability for Medicare GME funds*
- No states in our sample tracked accountability of public funds. Few states have data or analytic capacity
- Need to track trainees 10 years out since specialization is long process
- Teaching hospitals focus on GME expansion for service lines and will resist accountability until tied to funding
- Teaching Health Centers: good model, uncertain future

Lesson #10: Keep Your Eye on These States

- Massachusetts-Special Commission on GME
- Georgia- Virgin hospital initiative and the Southwest Georgia Medical Education & Research Consortium
- Montana-Graduate Medical Education Council

Addendum: What's Happening in South Carolina?

- Medicaid Audit led to review of GME
 - Assess state GME landscape via taskforce
 - Found no accountability for Medicaid GME funds
- Proposed:
 - Repurpose 15% of current Medicaid GME funds to expand training in rural areas
 - Create permanent GME Advisory Council
 - Develop data collection system to track outcomes
 - Explore new financing methods (ex. waivers, matching funds)

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

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**Access the
report at**

www.shepscenter.unc.edu/wp-content/uploads/2013/09/GMEstateReview_Sept2013.pdf

Questions?

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