Aligning Graduate Medical Education with Surgical Workforce Needs

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UNC

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FOR HEALTH SERVICES RESEARCH

American College of Surgeons GME Position Paper Under Development

- Cecil G. Sheps Center for Health Services Research collaborating with American College of Surgeons to develop ACS position paper on GME
- ACS developing forward-thinking, data-driven GME position paper to answer question:

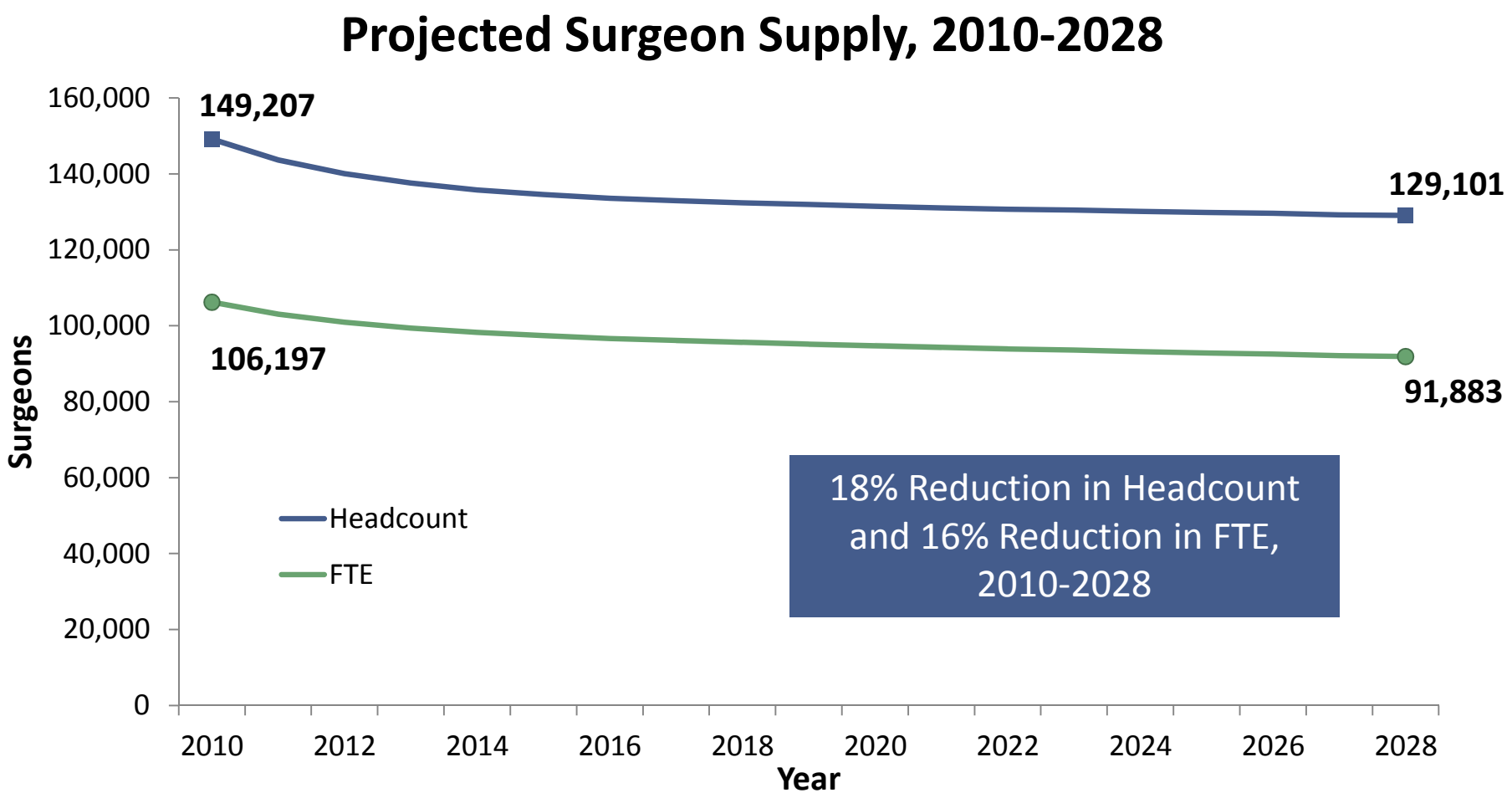
What changes are needed to better align GME policy to meet the surgical health needs of the US population?

Project Overview

Project includes:

- Projection of future supply of surgeons for 12 ACGME surgical specialties
- Cartographic analyses showing geographic distribution of surgery services
- Synthesis of lessons learned from state-based initiatives to expand GME training

Overall Supply of Surgeons Projected to Decline



Source: Fraher E, Knapton A, Sheldon GF, Meyer AA, Ricketts TC. Projecting Surgeon Supply Using a Dynamic Model. *Annals of Surgery.* (in press)

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Declines in Surgical Workforce More Rapid than HRSA's Previous Projections

Relative Change in Physician FTE from 2010-2025

Surgical Specialty	Change in FTE 2010-2025	HRSA Physician Supply Model [1]	Sheps/ACS Model
Surgery	-2,053		0.9
Colorectal Surgery	298		1.28
Pediatric Surgery	97		1.18
Thoracic Surgery	-847	0.86	0.74
Vascular Surgery	145		1.07
Sub-Total Surgery	***-2,359***	***0.97***	***0.91***
Neurosurgery	-72	1.01	0.98
Ob/Gyn.	-3,426	1.09	0.88
Orthopedic	-1,898	1	0.88
Ophthalmology	-2,612	0.98	0.79
Otolaryngology	-888	1.01	0.87
Plastics	-589	0.93	0.87
Urology	-1,502	0.93	0.78
All Surgery	***-13,347***	***1.01***	***0.87***

Source: Fraher E, Knapton A, Sheldon GF, Meyer AA, Ricketts TC. Projecting Surgeon Supply Using a Dynamic Model. *Annals of Surgery.* (in press)

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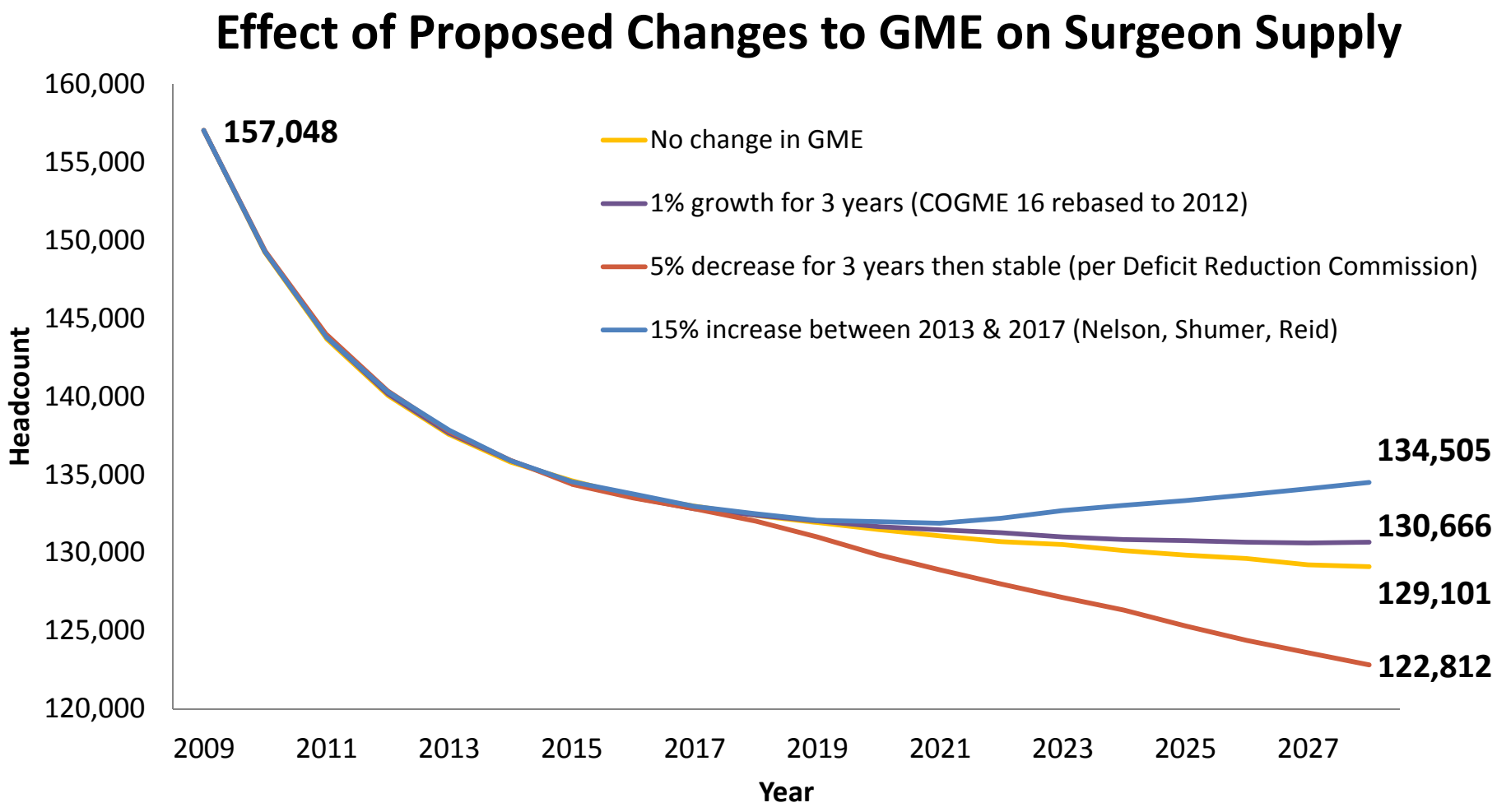
Proposed Changes to GME Will Not Solve Supply Issues



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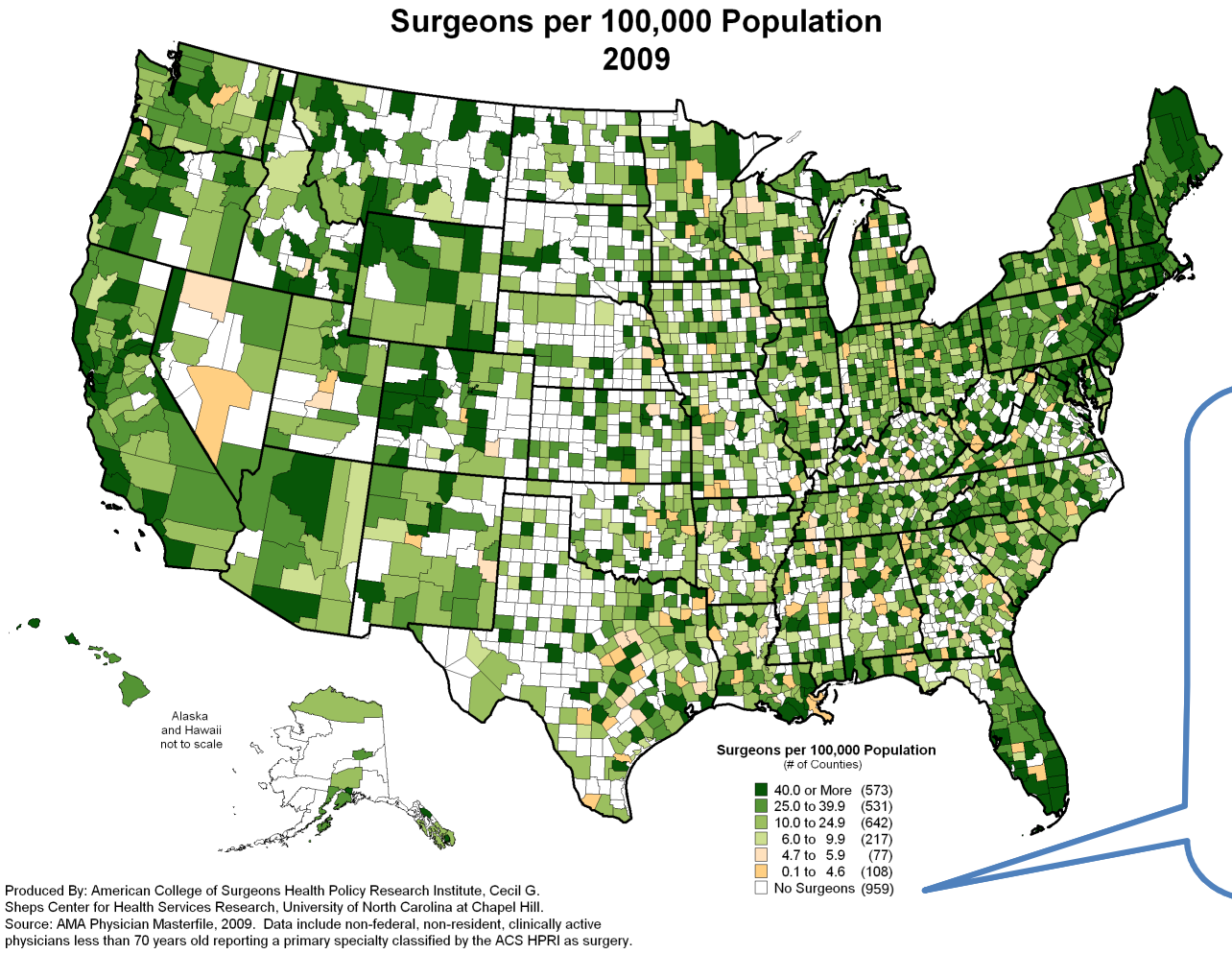
GME Needs to Address Distribution



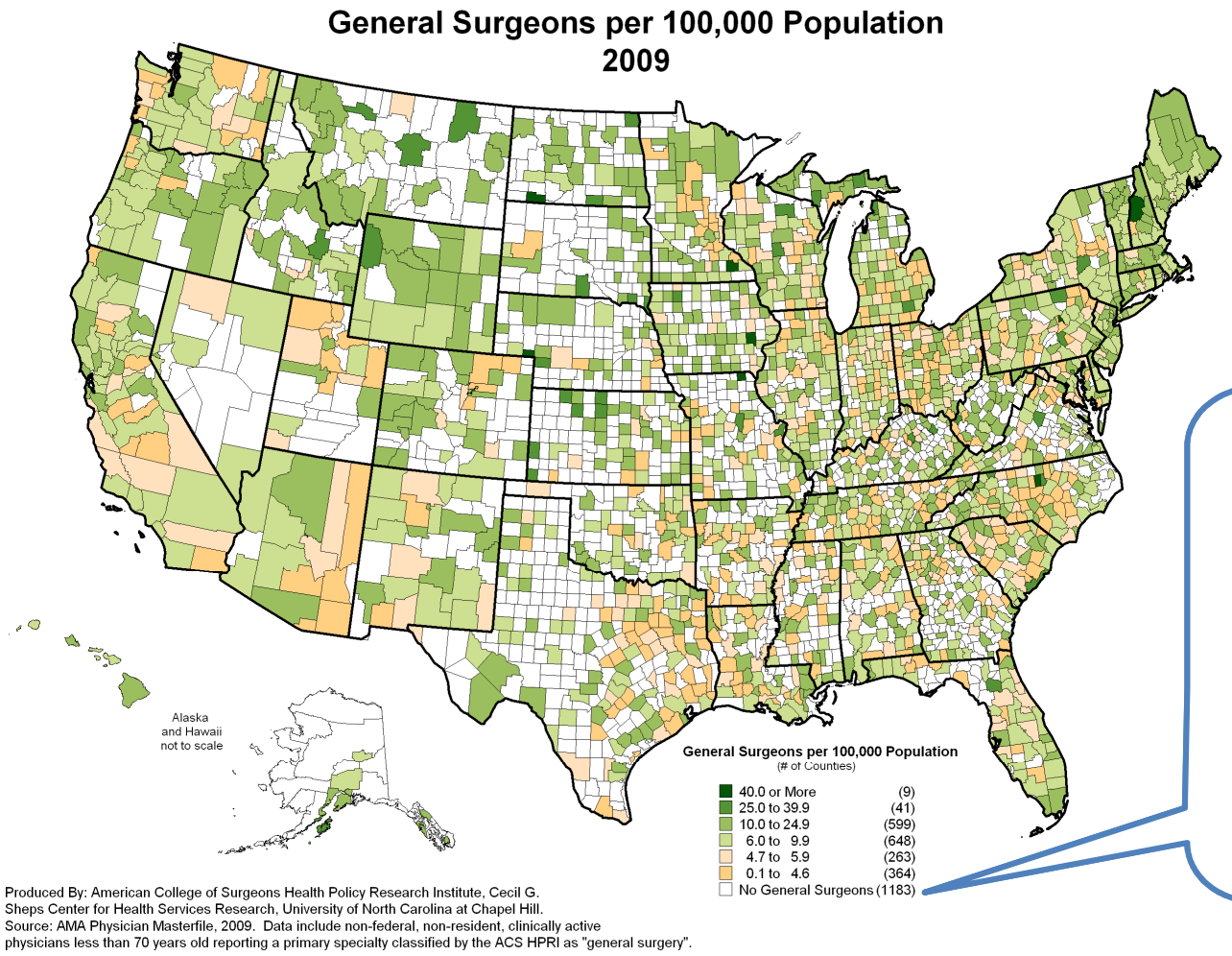
Produced By: American College of Surgeons Health Policy Research Institute, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Source: AMA Physician Masterfile, 2009. Data include non-federal, non-resident, clinically active physicians less than 70 years old reporting a primary specialty classified by the ACS HPRI as surgery.

In 2009:

959 counties did not have a surgeon.

9.7 million people lived in these counties.

Particularly for General Surgery



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Source: AMA Physician Masterfile, 2009. Data include non-federal, non-resident, clinically active physicians less than 70 years old reporting a primary specialty classified by the ACS HPRI as "general surgery".

In 2009:

1,183 counties did not have a general surgeon.

15 million people lived in these counties.

National GME Policy Can Learn From State Policy "Laboratories"

Project Aims

Synthesize lessons learned from state-based initiatives to expand GME training, including innovations and pitfalls in:

- Assessing health workforce required to meet population health needs
- Identify governance structures to allocate GME positions between specialties, geographies and training sites
- Identify various funding models, including all-payer systems

Timeline

January 1, 2012 to December 31, 2012

Need for Surgical Voice Now in GME,
One That is Collaborative With Other Specialties

- Most policy efforts aimed at primary care, fewer on general surgery
- Yet General Surgery faces same issues as Primary Care: increasing specialization, erosion scope of practice, "branding issues", diminished attractiveness to medical students, need for enhanced community-based training

"A mutually beneficial political synergy with family medicine, especially as seen in inner city or very rural practices could occur."

Polk et al. "A Proposal for Enhancing the General Surgical Workforce and Access to Surgical Care." *Annals of Surgery*. 255(4):611-617. April 2012

Recent Recommendations from Conference on GS Workforce Shortfalls

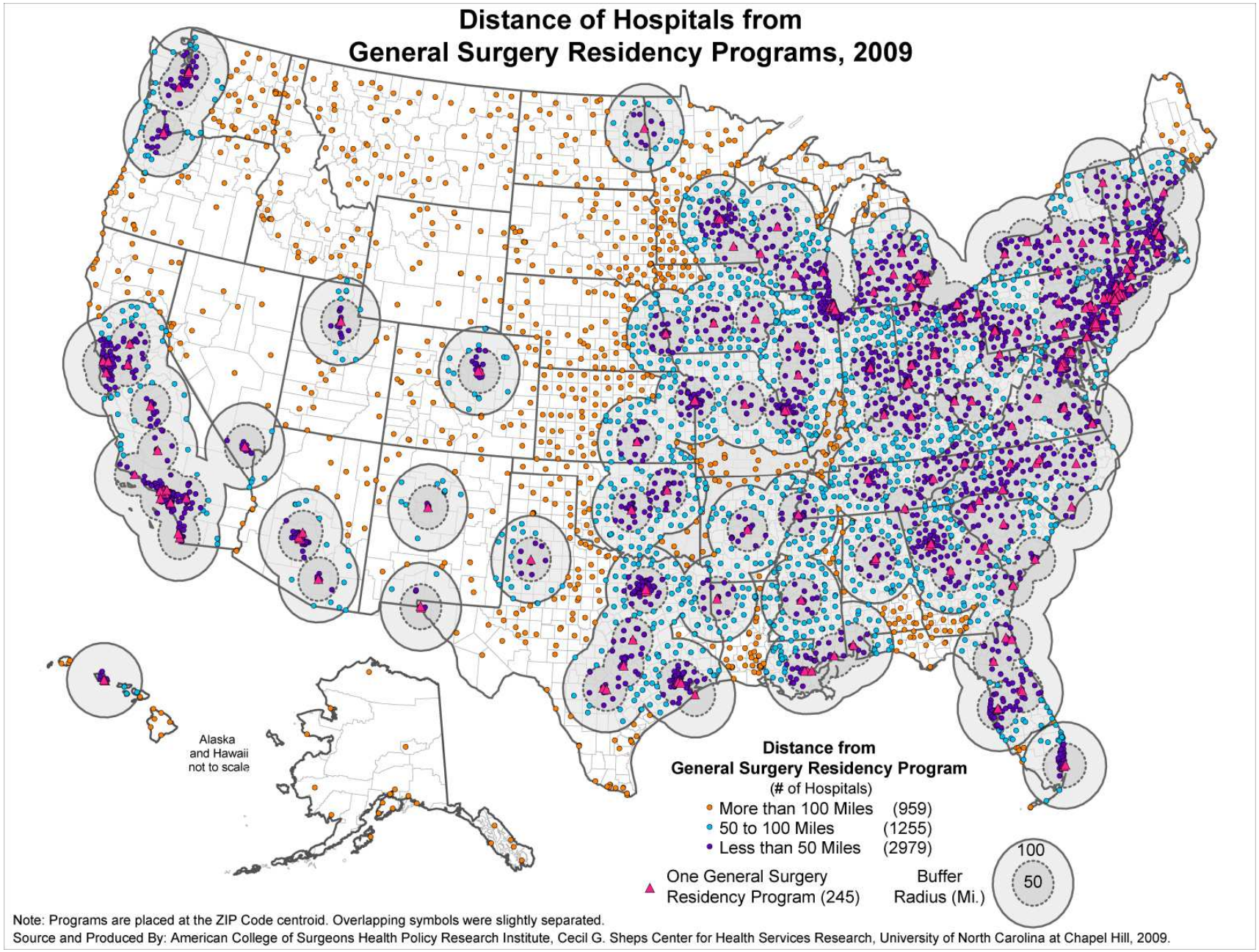
- Increase size of accredited surgery residencies
- Increase flexibility and breadth in general surgery training
- Enhance links with community-based hospitals
- Seek loan forgiveness for general surgeons
- Select resident candidates (in part) based on commitment to General Surgery

Polk HC Jr, Bland KI, Ellison EC, Grosfeld J. Trunkey DD, Stain SC, Townsend CM. "A Proposal for Enhancing the General Surgical Workforce and Access to Surgical Care." *Annals of Surgery*. 255(4):611-617. April 2012.

Why Not Train General Surgeons and Family Physicians Together in Critical Access Hospitals?

In 2009:	# of Hospitals	Total Population
Within 50 Miles of a GS Res Program	2,979	240,210,154
More than 50 Miles from a GS Res Program	2,214	66,414,114
Within 100 Miles of a GS Res Program	4,234	282,378,993
More than 100 Miles from a GS Res Program	959	24,245,275

Sources: OSCAR Provider of Services File, 2nd quarter, 2009; "Claritas" 2009 (zip code population).
Note: Hospitals include Short-Term General, CAH, Children's, and "other" (typically Federal).
Population calculated for zip codes whose centroids are within 50 and 100 miles of a GS Res Program.



Map courtesy of Tom Ricketts, Randy Randolph, Katie Gaul and Elizabeth Kasper, Cecil G. Sheps Center for Health Services Research.

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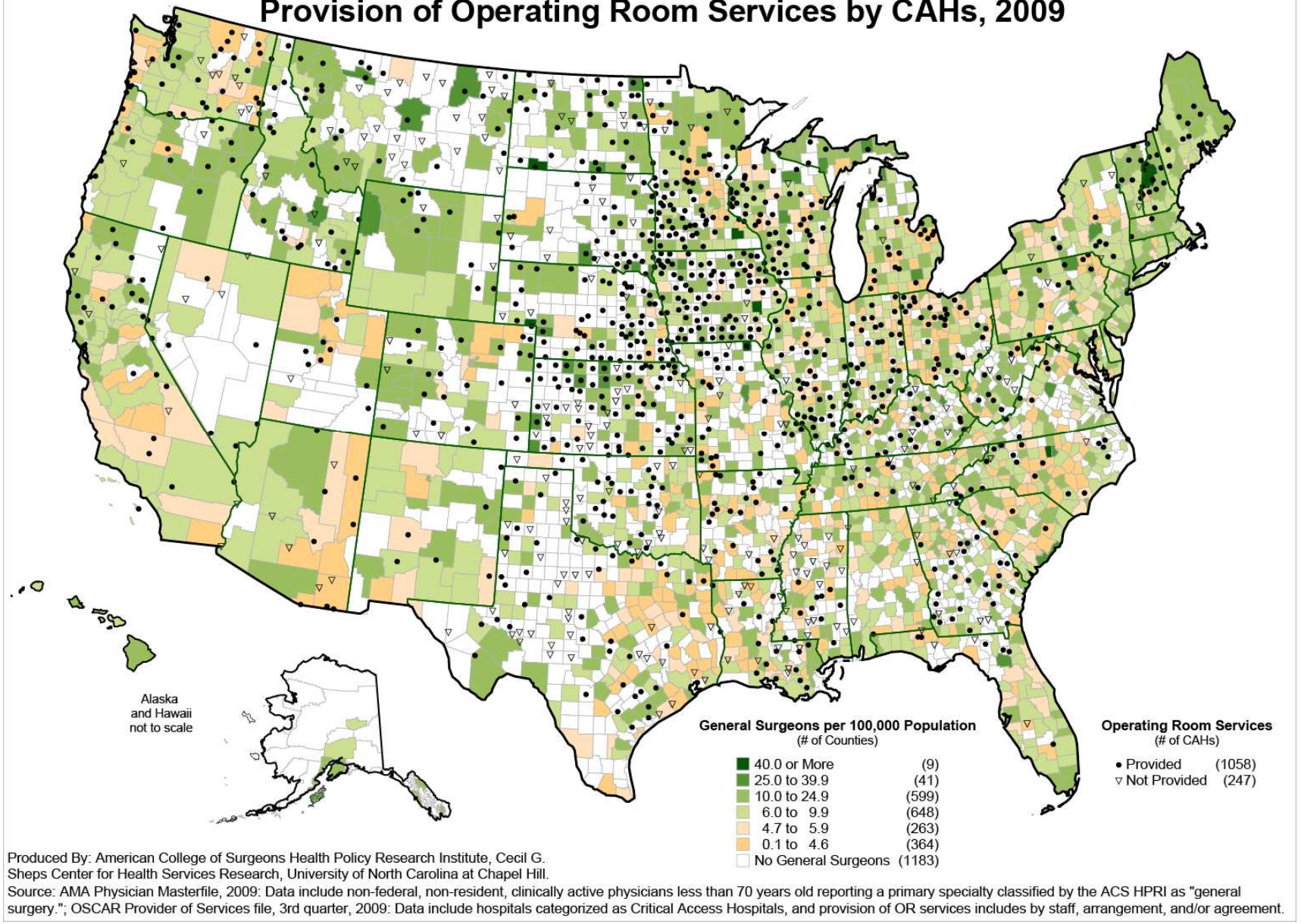
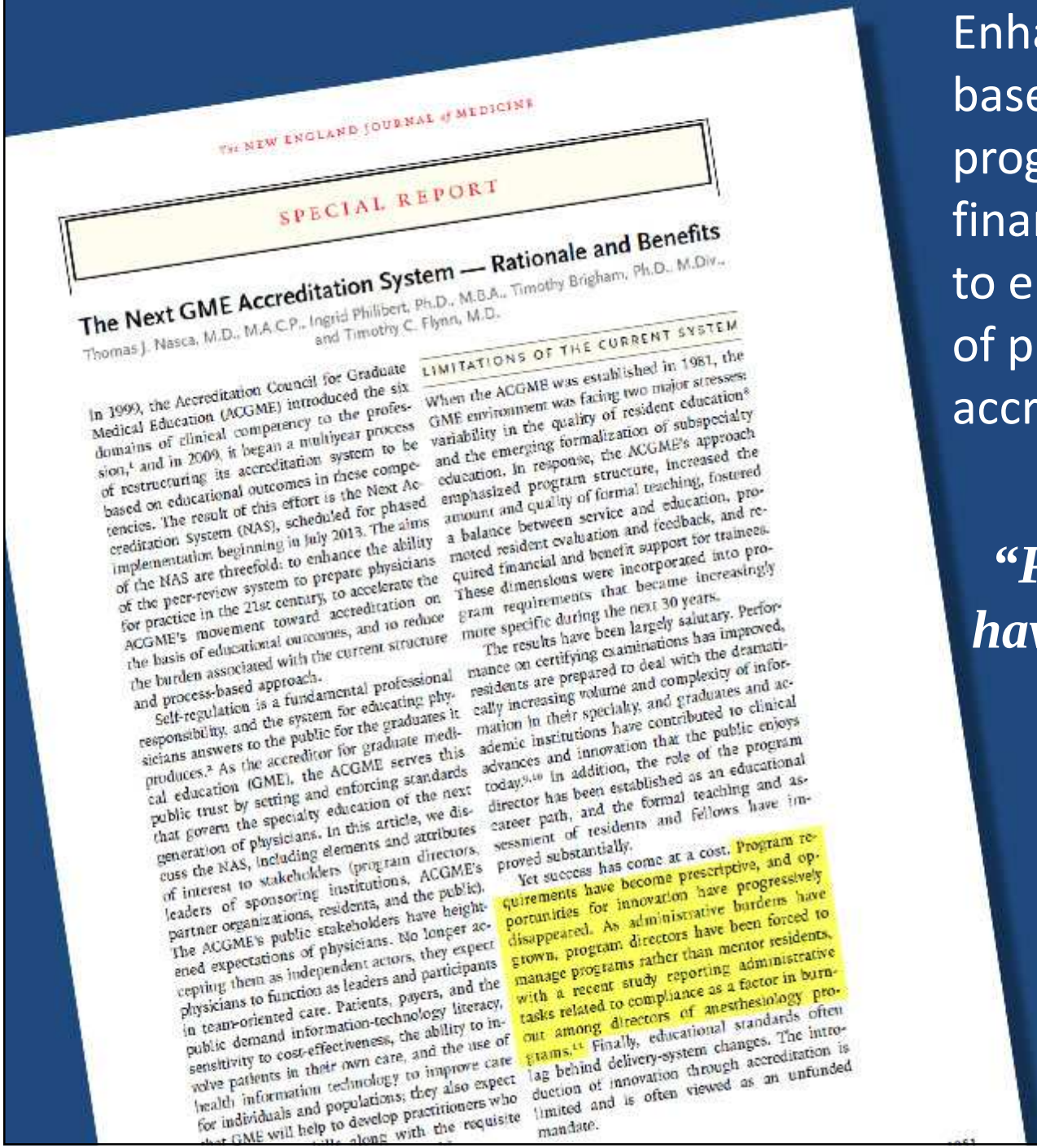
General Surgeons per 100,000 Population and Provision of Operating Room Services by CAHs, 2009



Produced By: American College of Surgeons Health Policy Research Institute, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Source: AMA Physician Masterfile, 2009: Data include non-federal, non-resident, clinically active physicians less than 70 years old reporting a primary specialty classified by the ACS HPRI as "general surgery."; OSCAR Provider of Services file, 3rd quarter, 2009: Data include hospitals categorized as Critical Access Hospitals, and provision of OR services includes by staff, arrangement, and/or agreement.

Map courtesy of Tom Ricketts, Randy Randolph and Katie Gaul, Cecil G. Sheps Center for Health Services Research.



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL REPORT

The Next GME Accreditation System — Rationale and Benefits

Thomas J. Nasca, M.D., M.A.C.P., Ingrid Philibert, Ph.D., M.B.A., Timothy Brigham, Ph.D., M.Div., and Timothy C. Flynn, M.D.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) introduced the six domains of clinical competency to the profession,[1] and in 2009, it began a multiyear process of restructuring its accreditation system to be based on educational outcomes in these competencies. The result of this effort is the Next Accreditation System (NAS), scheduled for phased implementation beginning in July 2013. The aims of the NAS are threefold: to enhance the ability of the peer-review system to prepare physicians for practice in the 21st century, to accelerate the ACGME's movement toward accreditation on the basis of educational outcomes, and to reduce the burden associated with the current structure and process-based approach.

Self-regulation is a fundamental professional responsibility, and the system for educating physicians answers to the public for the graduates it produces.[2] As the accreditor for graduate medical education (GME), the ACGME serves this public trust by setting and enforcing standards that govern the specialty education of the next generation of physicians. In this article, we discuss the NAS, including elements and attributes of interest to stakeholders (program directors, leaders of sponsoring institutions, ACGME's partner organizations, residents, and the public). The ACGME's public stakeholders have heightened expectations of physicians. No longer accepting them as independent actors, they expect physicians to function as leaders and participants in team-oriented care. Patients, payers, and the public demand information-technology literacy, sensitivity to cost-effectiveness, the ability to involve patients in their own care, and the use of health information technology to improve care for individuals and populations; they also expect that GME will help to develop practitioners who [illegible] along with the requisite

LIMITATIONS OF THE CURRENT SYSTEM

When the ACGME was established in 1981, the GME environment was facing two major stresses: variability in the quality of resident education[3] and the emerging formalization of subspecialty education. In response, the ACGME's approach emphasized program structure, increased the amount and quality of formal teaching, fostered a balance between service and education, promoted resident evaluation and feedback, and required financial and benefit support for trainees. These dimensions were incorporated into program requirements that became increasingly more specific during the next 30 years.

The results have been largely salutary. Performance on certifying examinations has improved, residents are prepared to deal with the dramatically increasing volume and complexity of information in their specialty, and graduates and academic institutions have contributed to clinical advances and innovation that the public enjoys today.[9,10] In addition, the role of the program director has been established as an educational career path, and the formal teaching and assessment of residents and fellows have improved substantially.

Yet success has come at a cost. Program requirements have become prescriptive, and opportunities for innovation have progressively disappeared. As administrative burdens have grown, program directors have been forced to manage programs rather than mentor residents, with a recent study reporting administrative tasks related to compliance as a factor in burnout among directors of anesthesiology programs.[11] Finally, educational standards often lag behind delivery-system changes. The introduction of innovation through accreditation is limited and is often viewed as an unfunded mandate.

Enhancing community-based surgery training programs difficult due to financial constraints, need to ensure volume/breadth of procedures and accreditation challenges

"Program requirements have become prescriptive, and opportunities for innovation have progressively disappeared"

Nasca et al., NEJM, 2012

Questions? Comments!

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