Governor's Task Force on Graduate Medical Education

Mitchell D. Forman, D.O., FACR, FACOI, MACP
Dean & Professor, Touro University Nevada COM
President, Nevada State Medical Association

What could we do in the way of Consortium Model Residencies?

- **Consortium – partnership**
  - **Shared resources**
  - **Variety of models**
- **It may not be necessary to reinvent the wheel. Look to the successes and challenges of states, cities and communities comparable to Nevada, Clark County, etc., who have addressed the issue of GME through shared resources and partnerships (Consortium models)**
- **During HEALS meetings it became apparent that Valley Hospital's orthopedic residents spend part of their training in a hospital in California. That same experience could occur at UMC. Valley Hospital would save the cost of their residents traveling to CA & UMC would have the patient care benefit of Valley's orthopedic residents. This is an example of a Consortium relationship. Liability issues need to be determined**
- **In a multihospital system, e.g., Universal Health Services – network of 5 acute care hospitals. Valley Hospital Medical Center has a robust GME program with residency & fellowship programs. Several of the UHS hospitals have the capacity to start GME programs that could include residencies with other specialties. Residents can rotate between UHS hospital GME programs on a 1:1 basis so that each of the hospitals retains the CMS reimbursement for their residents. This can include different specialties**
- **Osteopathic Post-Graduate Training Institutes (OPTI) – these are community – based training consortiums comprised of at least one college of osteopathic medicine (COM) and one hospital and may include additional hospitals and ambulatory training facilities. By building medical education partnerships, OPTIs enhance educational quality, facilitate sharing of educational resources, provide faculty development, foster cooperative training programs, support community based medical education, encourage clinical research, and create strong linkages among medical schools,**

teaching hospitals and ambulatory training facilities. Shared costs may save significant amounts of money. There are many examples of this:

- **Nova Southeastern University COM**

- **Arizona COM, Florida Atlantic University College of Medicine (not osteopathic)**
- **Valley Family Medicine Residency Consortium in Modesto CA**
    - **Faced with a funding crisis that threatened a single-sponsor family medicine residency program critical to a county-wide health system, health care organizations located in the CA community formed a nonprofit, corporate GME consortium to sponsor a new residency program that can allow multiple stakeholders to assume a model of shared ownership that reflects alignment of pooled community resources for the mutual benefit of physician workforce development**
- **South Georgia Medical Education & Research Consortium - national studies show that the combination of undergraduate medical education (UME) and graduate medical education (GME) in the same region has the greatest impact on future workforce. While the value of hospital contributions to medical education from volunteered time and resources can be measured in the millions of dollars, the true impact of these efforts is measured by the number of young people form South Georgia who completed some or all of their training in the region and remained in South Georgia communities to practice.**
- **Grand Rapids Medical Education Partners – is an education consortium of area hospitals and Michigan State University College of Human Medicine. It is Michigan's 2nd largest GME center & consists of a variety of hospital systems**
- **Teaching Health Center Models of Primary Care**
    - **Urban areas – identify larger primary care providers, e.g., HealthCare Partners of Nevada – multiple clinics providing primary care. Can be a model of Family Medicine GME. Funding of GME through the clinics with revenue from resident services, particularly 2nd & 3rd year residents and saving recruitment costs. Some of the training may involve hospital rotations**
    - **Rural areas – smaller community hospitals and clinics can form collaborative partnerships to support Primary Care GME. Shared funding would cut costs and provide recruitment opportunities for these communities**
- **VA Hospital & local acute care hospitals that may not have the capacity to start robust GME programs – sharing residents through a consortium model of GME. The VA hospital and clinic system is growing rapidly and will need healthcare manpower to support its growth. The challenges are the unique finances associated with the VA system**