Private Groups and programs and the need for the private organizations to be involved. Is there a model we can use?

Summary

- The delivery (output) of graduate medical education involves both public and private organizations.
- Many reports on GME funding only refer to the government streams (Medicare, etc)
- Some reports indicate funding also comes through hospitals, insurance companies
- There is a reference to "sponsoring" institutions or "stakeholders" (they don't distinguish between public and private) that work to help with workforce development and GME.
- An example: The Utah Medical Education Council (created in 1997) is described from their website (http://www.utahmec.org/about-umec.php) as follows in italics.

UMEC is a governor appointed, eight-member board charged to bridge the gap between public/private health care workforce and educational interests.

Our Mission:
To promote healthcare workforce planning, production, and policy through assessment, innovation, and collaboration with stakeholders.

Our Vision:
The Utah Medical Education Council holds assessment, collaboration, and innovation as its core values and focuses on the interdependency of the three to promote healthcare workforce planning, production, and policy based upon the community's healthcare workforce needs.

Core Responsibilities – Health Care Workforce
- *Assess - supply and demand*
- *Advise/develop policy*
- *Seek and disburse Graduate Medical Education (GME) funds*
- *Facilitate training in rural locations*

Products
- *Partnerships - public/private*
- *Reports - health care workforce*
- *Models - workforce and financial*
- *Program(s) expansion - rural and urban*
- *Funds management - privately funded programs expansion, Medicaid GME and rural training site expansion.*

Impact/Accomplishments
• Economic
♦ $3 million annually to expand GME training from public/private partnership□♦ $6 million annually in Medicaid GME funding statewide

• Workforce
♦ Increased the number of interns and residents trained in Utah programs by 38%, about 200 positions, over the past ten years □♦ Increased rural health care workforce and education, including establishment of new rural surgery program; rural family medicine fellowship; and rural rotations in dental, emergency medicine, obstetrics/gynecology, pathology, pediatrics, psychiatry, and surgery□♦ Preserved both child and adult psychiatric training programs□♦ Received the only national GME demonstration project awarded by CMS

Current Areas of Focus
• Retention of Utah trained healthcare workforce
• Facilitate rural training opportunities
• Strengthen public/private partnerships

And, from http://www.utahmec.org/Council_BOD.php: *The Utah Medical Education Council (UMEC) was created in 1997 by H.B.141 out of a need to secure and stabilize the state's supply of health care clinicians. This legislation authorized the UMEC to conduct ongoing health care workforce analyses and to assess Utah's training capacity and graduate medical education (GME) financing policies. In addition, H.B. 141 requires the UMEC to advise the Governor and State Legislature on these issues and to provide policy recommendations for achieving state workforce objectives.□□All individuals on the Council are appointed by the Governor. In an effort to create a representative body, the following entities have been included on the Governor's list of Council members:*

• Dean of the School of Medicine at the University of Utah
• Representatives from each institution sponsoring an accredited clinical education program. Currently, the following institutions are represented:
  Intermountain Healthcare
  St. Mark's Hospital
  University of Utah
• Representatives from the health care insurance industry
• Members of the general public not employed or affiliated with any institution that offers, sponsors, or finances health care or medical

education

Utah Graduate Medical Education Demonstration Project

Utah Medical Education Council

Physician Workforce Projections 1994-2000

- COGME January, 1994 projections for 2000
  - Surplus of 115,000 specialists
  - Deficit of 35,000 generalists
  - Third party payers should explicitly pay for GME
  - GME largely funded by teaching hospitals from patient care
  - Accounting of GME funds remains unclear and are poorly coupled with physician workforce requirements
  - Teaching hospitals increasingly compete with non-teaching hospitals
- COGME January, 2005 projections for 2020
  - Deficit of 96,000 physicians
  - No recommendations of generalist/specialist mix

Utah GME Environment, 1997

- Physician shortage (44th of 50 states)
- Federal GME funding capped
- GME pipeline insufficient for needs
- 442 residents
  - 25 training programs
  - 9 teaching hospitals
  - 4 sponsoring institutions
  - 73 fellows in 26 programs
- No alignment with workforce needs

Utah Medical Education Council

- Quasi-governmental body
- Established 1997
- Broad representation appointed by Governor
  - Sponsoring institutions (3)
  - Insurance industry
  - Public
  - School of Medicine Dean

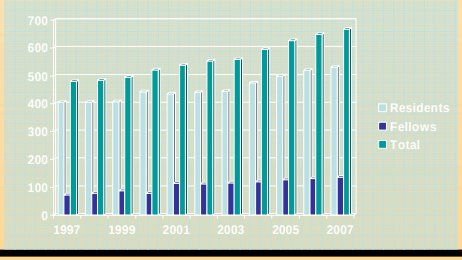
CMS Waiver Goals 2002-2010

- Allocate resources based on workforce needs
- Track workforce needs to determine GME funding priorities
- Establish independent body to coordinate workforce and educational objectives
- Manage residency positions on a statewide basis
- Direct funds to the individual programs with the greatest impact on workforce needs
- Hold each program accountable

Impact of Initial Waiver

- Established a neutral public body
  - Legal safe haven for discussion
  - Promoted collaboration
- Collected workforce and cost data
- Established statewide goals
- Developed methodology for resource distribution to meet the goals
- Aligned program size with state needs
- Expanded number of residents
- Allocated new positions based on needs

GME Growth in Utah 1997-2007



Utah 1997-2007

1997	2007
442 Residents	568 residents (29%)
- 25 programs	- 30 programs
- 9 hospitals	- 9 hospitals
- 4 sponsors	- 3 sponsors
73 fellows in 26 programs	137 fellows in 34 programs (88%)

Funding for Resident Expansion

- Retrospective accounting identified eligible positions under the CMS cap for continued funding
- Refined the Medicaid payment methodology which increased GME payments significantly (in jeopardy)
- Negotiated new position support with two major hospital systems

Workforce Coordination

- Surveyed physician workforce to identify needs in 1998 and 2006 (survey planned for 2009)
- Shortage of all specialties – could not recommend shift in funding between programs
- Developed methodology to distribute new funds based upon workforce needs
- Worked with programs to encourage graduates to practice in Utah
  - Portion of funding at risk
  - Programs could develop own initiatives
  - Annual Accountability
  - Job board
  - Job fair
- Rural training opportunities
  - Stakeholder committee
  - Existing positions

New Rural Training

- Family Medicine
- General Surgery
- Internal Medicine
- Obstetrics and Gynecology
- Pathology
- Pediatrics
- Psychiatry

UMEC Capabilities

- React quickly to program changes
- Annual potential reallocation of funds if contract terms not met
- Unfilled positions revert to UMEC to redirect funds
- Target certain specialties for expansion without decreasing size of existing programs
- Budget neutral
- Minimal impact on Federal payment policies

Results

- Training programs and teaching hospitals now accountable
- Medicaid funds can be used to reimburse their fair share of GME training costs (in jeopardy)
- Links GME funds to workforce objectives

Pending Questions

- Has the UMEC increased trainee retention in Utah?
- Has alignment of funding and needs changed the specialty mix in Utah?
- Has emphasis on rural experiences improved rural physician recruitment?