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AAHC Report: Regional Roundtable Series on Graduate Medical Education (GME) Reform

Background

After the release of the IOM report on GME in July 2014, many of our members urged AAHC to convene a meeting to discuss the Association's role, if any, given the IOM's recommendations. A discussion about this was held at AAHC's annual meeting in Chicago in September 2014, and the attendees made it clear that AAHC would make an important contribution by serving as a convener on the topic—and should do so with the larger perspective of the healthcare workforce and the changing healthcare delivery system in mind. A regional approach to this effort was chosen because it seemed the best way to gain knowledge that is specific to various parts of the country, as well as to limit the discussion groups to manageable sizes.

It is important to note that throughout this process AAHC has not taken a position on GME reform per se. However, we recognize that any reforms to the GME system must be considered as part of a national health strategy that considers all aspects of patient care, including not only the education of physicians, but also the other health professions that will play an increasingly important role in care delivery in the 21st century. In addition, changes in the healthcare market, including both vertical and horizontal consolidation of healthcare providers, an increasingly hybridized payment model, and the accelerating development of health-related discoveries and technologies, will bring substantive changes to all aspects of the healthcare delivery system. As a result, we continue to believe it is important to encourage debate and discussion, and to learn from the views and experiences of our members and other important stakeholders around the country, so that those considering reform of the current system may be better informed.

Format

The sessions consisted of seven round table discussions in various parts of the country with groups averaging around 18 participants. The set-up, materials, and opening remarks for all of the sessions were intentionally kept constant so as not to bias the direction of any discussion. Each discussion was, however, free-flowing, thoughtful, and open, and lasted for the full three-hour period allotted.

The agenda was intentionally limited to the same two specific items for each session: (1) Participants were invited to identify their top two GME-related issues or concerns with respect to their institution, state and/or region; and (2) Participants were asked to discuss whether their current GME program was adequate for training physicians to meet their area's future healthcare needs. Specifically excluded as initial discussion topics were the geographic redistribution of GME funds from Medicare, whether there is or is not a physician shortage, and increased opportunities and/or need for additional GME funding. Although

these topics clearly came up in the various roundtables, we intentionally made them not to be the focus of the discussions so as to prevent them from serving as a distraction in order to achieve deeper clarity on the issue as a whole.

The seven regional sessions and hosts were:

- Southeast, Emory University in Atlanta
- Northeast, the University of Pennsylvania in Philadelphia
- Mid-Atlantic, AAHC offices in Washington, DC
- Mid-West, Chicago concurrent with our Senior Administrators/Fiscal Officers (SAFO) meeting
- South Central, the University of Texas Southwestern Medical Center in Dallas
- Mountain West, the University of Utah in Salt Lake City
- Western, Stanford University in Palo Alto

Participants

In each of the regional GME Roundtables, we invited existing AAHC members based in that region, as well as prospective members, associations involved with the GME issue, and other local/regional stakeholders. In addition to AAHC members, participants included associations, such as the Association of American Medical Schools (AAMC), the American Association of Colleges of Nursing (AACN), the American Hospital Association (AHA), and the American Medical Association (AMA); accreditation bodies, such as the Accreditation Council for Graduate Medical Education (ACGME); local/regional experts, such as the new Jersey Hospital Association, the Georgia Board for Physician Workforce, the Utah Medical Education Council, and The GME Initiative (otherwise known as Western and Midwestern Family Medicine Leaders for GME Reform); other organizations with GME interests, such as the National Institutes of Health (NIH) and the Uniformed Services University of the Health Sciences; and hospital, insurance, and provider systems, such as Intermountain Health Care and Kaiser Permanente. Overall, we had more than 100 participants join the discussions, with representatives covering more than 30 states.

Response

The response to the roundtable sessions was overwhelming. Participants, without exception, expressed their gratitude for the opportunity to come together with their peers to discuss this important issue and participated generously and enthusiastically in the discussions. The regional approach with sessions organized by and including local subject-matter experts was greatly appreciated, and AAHC was complimented for taking the lead in a neutral and unbiased manner and including such a wide array of stakeholders in the process.

Themes

There were a number of themes that emerged from the discussions, as well as region-specific areas of concern. The main themes are summarized below.

A. Organizational Conflict

The organizational conflict inherent in the current design of GME programs between the teaching hospitals that are the recipients of Medicare GME funding and the medical schools that are responsible for the teaching and accreditation of the programs was seen throughout the roundtables as a key inhibitor of future adaption for most GME programs to meet future needs. Participants referred to a clear lack of alignment in organizational missions, lack of transparency in approaches, and disparate yet overlapping areas of responsibility.

Surprisingly, this organizational conflict was recognized to be the case even in situations where the same institution owns both a medical school and teaching hospital, as there are significant cultural differences among them. Discussion points in this area included the following:

- The most divisive issue in this regard was felt to be the cognitive dissonance arising from a structure whereby the academic (medical school) component is dependent upon the funding which is provided directly to the hospitals, and yet they have little or no control over (or even visibility into) how the monies are spent.
- In most instances, there is no overall strategic approach that rectifies this disparity. An effort to place representatives from academia on the hospital boards is a small but useful step in this direction.
- Because of their differing missions, the hospitals and training programs are often acting at cross-purposes. For example, hospitals may build new facilities and add new resident positions to attract more patients without fully involving the GME leaders who will be tasked to service them. The question as to whether which 'state of the art' facilities are really necessary for training residents is rarely discussed, with the result that the GME program is forced to figure out a way to 'make it work' operationally and financially.
- With respect to the Clinical Learning Environment Reviews (CLER) conducted by the ACGME, the academic side is often not directly included while their programs are reviewed and assessed. Better integration would be helpful.
- These organizational conflicts are exacerbated by a lack of sustainability in funding from outside sources (e.g., states). Often when hospitals do step in to bridge the gap, they get burned when the (state or other) funding is pulled back.
- It is anticipated that these conflicts will also be exacerbated by increased demand from the Affordable Care Act (ACA), and by the differing and often conflicting policies that continue to be presented in the current market environment (e.g., demand for increased clinical productivity on medical school faculty, push for short hospital stays by payers, funding based on number of beds filled, etc.).
- Interestingly – and perhaps puzzlingly – as noted earlier, these issues often exist even in cases where the hospital and academic institutions share the same ownership.

The Bottom line: the overall funding of GME may need to be changed in order to adequately address the organizational conflict described above; however, there are some best practices that can be shared (e.g., cross-board membership) in the interim.

[B. Private Sector Influence/Education](#)

Throughout the sessions, we heard that market forces were driving a lot of the changes in the healthcare system. Yet the participants in our sessions seemed to be largely unfamiliar and/or disconnected with their private sector 'competitors,' private sector 'end users' of the GME 'product', or entrepreneurial activity being done in areas of healthcare that will impact any GME training program for tomorrow's physicians (this was true even in areas of the country located near some of the hotbeds of innovative activity, such as

Silicon Valley). Discussion points in this area included the following:

- Participants indicated a strong interest and desire to learn from the private sector and private sector delivery models (e.g., entrepreneurs such as 'Uber docs', startups, venture capitalists).
- There was a recognition that academic health centers should better monitor their 'customers' and respond to how they want to see care delivered (e.g., one participant described a study where patients preferred a 'robot doc' in certain situations).
- In addition, there was a recognition that the private sector could be very helpful in filling some of the recognized training gaps where current medical programs do not have appropriate expertise or time to provide additional training (e.g., leadership, technology, business, local government organizations, schools of public health, etc.).
- It was suggested that the current definition of 'inter-professional' healthcare delivery is too narrow and should include professionals from a wider range of disciplines as part of patient-serving teams.
- There was also widespread recognition that if the participants did not make themselves aware of what was happening 'around them,' they run a risk of being 'passed by.'

The Bottom line: academic health centers cannot ignore the private sector market developments around them and need to find a way to learn from the private sector to enhance their GME programs.

C. Mental Health/Wellness

Another overwhelming area of concern expressed by participants in all regions of the country was the mental health and well-being of residents, faculty, and the patient population writ large. Mental health issues were identified consistently across the board in our discussions as a growing and urgent area of concern, and there is a critical need for more wellness programs within academic health centers. Residents were recognized as having a significantly increased need for mental health resources in recent years due to various factors, such as limited time off and increased external pressures (cost of living, child care, debt burdens). In addition to serious concerns about the trainees, the impact on faculty, such as burnout and disengagement due to increased responsibilities with fewer resources (including time given productivity requirements), threatened job satisfaction and increased stress. Wellness programs were recognized as an absolutely critical (and currently lacking) component of GME programs for the faculty and residents, as well as increased mental health training to address the patient population's greater needs in this area.

The Bottom line: the level of concern and need here is clear and comprehensive.

D. Revisions to Program/Accreditation Structure

A large part of every session centered on the need for revisions to the current structure of GME programs and the accreditation programs that incentivize and drive the structure of these programs. The overwhelming consensus view was that medical schools need much more flexibility to properly train the physicians of the future. One area of flexibility

discussed many times was the ability of medical schools to customize or tailor programs to the chosen specialties of the residents. This was a reaction to the recognition that academic health centers are not producing a 'product' that is necessarily a good fit for the 'marketplace;' that resident/faculty needs are often not met; and that the outdated 'one size fits all' model produces significant inefficiencies. Discussion points in this area included the following:

- The GME 'product' should be based more on patient needs than on "irrelevant" metrics and school rankings, and it should be able to change over time (during the physician's career) to meet the changing needs of patients and patient population. This applies to all stages: recruitment, assessment, and graduation requirements. The 'marketplace' (patients, private sector employers) needs to be consulted when determining the standards for success and the types and measures that are appropriate for recruitment/assessment.
- The lack of flexibility in current programs comes in large part from traditional accreditation approaches that need to be updated. This lack of flexibility prevents innovation in the programs because it limits the time for curriculum based on anything other than the 'basics'—such as disruptive technologies, professionalism, leadership, quality, safety, mentoring, complex billing systems, data analytics, technologic developments, and entrepreneurship.
- There was a recognition that not all GME training had to come from within the medical school and/or medical community, but could also be obtained and provided by other professionals or partnerships.
- If academic health centers were able to tailor programs to the both medical students' and residents' areas of interest (and accreditation schemes would permit), the length of time of medical education (including GME), as well as the cost, might be significantly reduced. For example, research-oriented physicians' training or residents with specific specialty interests could have a more tailored and efficient training experience. Possibly more of the 'foundational education' could be provided in medical school, and training programs in certain areas could proactively span the physicians entire career spectrum to include seamless medical school, residency and fellowship training, and continuing medical education activities that take place during the physician's practice career.
- In addition, spreading the education curriculum across this entire continuum offers enhanced flexibility, more adaptability over the course of physicians' careers, and increased ability to adjust focus based on changing patient/population needs.
- There was a recognition that programs as they are currently organized struggle to keep pace with technology, whether it be the learning style of the current resident generation ("digital natives"), the training of faculty in new products, discoveries, techniques, or the technology-dependent nature of future medical practice (e.g., robotics, data analytics).
- Along those lines, data and data analytics were seen as key components of training programs for future physicians. The increased capturing of data across the healthcare field will require physicians who are well-versed in gathering, filtering, analyzing, and utilizing data—skills that are not currently sufficiently emphasized in medical schools.

The Bottom line: participants recognized that they stand in their own way on this one and are overwhelmingly interested in making such changes; these changes could help solve problems identified in other areas.

E. Rural/Underserved

The difficulties with providing healthcare to rural and underserved areas was also a consistent theme throughout our discussions in every region. It was apparent from the discussion and the scope of AAHC membership that these issues are relevant to ALL members in ALL regions. Discussion points in this area included the following:

- There is a need for training in the environments in which physicians will practice (rural, mostly ambulatory) rather than simply in the clinical/hospital environment.
- There is a recognized need for a diverse workforce to better match the population served in the rural and/or underserved communities. There is currently a significant disparity in many areas of the country in this regard.
- There is an overall shortage of physicians, residents to serve, and teaching faculty in these areas, due to the lower salaries and inability to repay tuition debts, lack of opportunities for their families (schools, services), professional isolationism, and other reasons.
- It was recognized that it is much more difficult to meet general ACGME standards while providing training in rural/underserved communities, which serves either as a deterrent to such programs or an investment that cannot be recouped.
- Funding needs to match and support whatever model is chosen (current model does not facilitate training outside of clinical/hospital).
- Many of our members expressed that their needs go beyond what some would consider 'rural', and are in fact better defined as 'frontier.' Any actions taken will need to recognize these differences.
- All of the sessions noted the importance of partnerships in this area, as well as the difficulties in establishing and maintaining those partnerships.
- Some of the areas of greatest need within these communities are general surgery, psychiatry, and treatment of chronic illnesses relating to obesity and smoking.
- Technology, including telemedicine, were seen as possible solutions in this area; however, it was emphasized that the current funding, reimbursement, and regulatory schemes do not currently support the use of technology in many instances.

The Bottom line: these issues are widespread and impact all of our membership.

F. Partnerships and Interprofessional Training

There was a consensus that many problems with current GME programs identified in the sessions could be addressed and/or minimized through partnerships and/or greater inclusion of more interprofessional training. Such interprofessional partnerships were viewed as being critical for addressing limitations in the current programs, such as the need for training primary care and other physicians in the communities in which they will

practice (e.g., community hospitals, clinics, ambulatory, or rural environments).

Interprofessional training was also seen as essential for addressing the holistic needs of patient care and for producing the best results in many areas of specialty. There were a number of shared challenges raised in both areas, which is the reason we group these together into one theme—such as differing missions of the institutions or participants, stovepipe attitudes, inadvertent caps (limits to numbers of trainees), complexities in managing programs (ensuring quality while having little control), inability for current funding mechanisms to support this kind of training, and difficulty in finding staff or facilities. In the end, participants agreed that academic health centers were in the best position to identify and implement best practices in these areas, given their diversified inter-disciplinary coverage and, in some cases, multi-facility structures and systems.

The Bottom line: some institutions are doing this well, and a sharing of best practices could serve our members well here. Academic health centers are in the best position to make improvements in inter-professional training.

G. Workforce

The theme of workforce planning underpinned every roundtable session. There was unanimous agreement that this was a foundational issue—the need for comprehensive and accurate workforce analyses was felt to be essential for a successful GME strategy—and that strategic workforce planning was not being done at a sufficient level (or, in many cases, not at all). The appropriate methodology (how to measure, what metrics to use) and scope (national, regional, local, or sub-local) were debated. Discussion points in this area included the following:

- There is a compelling need to develop workforce analyses that focus on all healthcare providers, not just physicians.
- In this context, there is a need to determine the right distribution of physicians and specialties, and it was recognized in every region that this cannot be done without a workforce analysis and/or strategy.
- There is a need for good data/tracking/metrics of post-graduates in particular (e.g., are they practicing in areas they trained?). Participants agreed that having the right data and doing the right analysis of the data is critical for determining a workforce strategy that will meet the needs/changing needs of patients.
- Many questioned what level of analysis and planning is appropriate—national, regional, local, or sub-local.
- Appropriate workforce planning and analysis could support the need for GME programs to be able to be flexible over time and be more adaptable as patient/population needs change over time; would also support elasticity in physician careers.
- There is a need to take into account diversity that better matches the demographics of patient populations; an appropriate workforce analysis could help GME better meet this need proactively.
- Without workforce planning, market forces become the driver of physician training, which is what is happening today. However, workforce planning could enable

population health/patient needs to be more of the driver, which all agreed was more appropriate.

- There was a consensus of support for funding the National Health Care Workforce Commission.
- There was a recognition that accreditation programs could be fashioned in such a way as to promote and support workforce needs in line with a comprehensive strategy.

The Bottom line: current analyses are inadequate for what is needed; no clear consensus on methodology or scope for these analyses has yet emerged.

H. Current GME Funding Structure

Though the current GME funding mechanism was intentionally not a focus of the discussion, it was clear from the sessions that all participants believe that it is essentially broken. There was a strong consensus that reworking the funding mechanism for GME could ameliorate a number of the issues raised, and, if designed properly, could facilitate GME programs to better fit today's healthcare marketplace, enhance the roles of academic health centers vis-à-vis the hospitals in the residency programs, and support the changing healthcare delivery systems to support patient needs. However, there was also consensus that any change to the funding mechanism would be extremely difficult.

The Bottom line: updating the funding mechanism to the needs of today is very much needed but will be very difficult to achieve.

Next Steps

AAHC intends to follow up in a variety of ways to capitalize on the information obtained from the GME Roundtable series and the positive stakeholder engagement developed throughout the process. In addition to meeting with policy-makers in Washington, including Congressional staff, to educate them about the themes and issues that emerged from the process, we will collect and disseminate best practices in a number of the areas of concern across our membership. In the course of the discussions, we uncovered a number of examples where members and other stakeholders are solving some of the issues raised in creative and notable ways, and we will undertake further analysis with regard to these case studies to develop additional best practice examples. Last but not least, we will look for opportunities in which we can continue to serve as a neutral facilitator to further support positive progress on these important issues.

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