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# The IOM GME Report: GME Financing Reform, Workforce Needs and the Resistance to Change

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GW Speaker Series

# Topics to be Covered

- The IOM GME report: Key workforce related recommendations
- What's in it for academic medicine?
- What about shortages and the “GME squeeze”?
- Would the IOM recommendations worsen shortages?
- Closing comments

# IOM GME Report: Key Recommendations

1. Maintain the \$10 billion in Medicare GME dollars annually (adjusted for inflation) and establish:
  - An Operational Fund for direct GME costs of existing Medicare GME positions; and
  - A Transformation Fund to support new needed GME expansion and innovations
2. Operational Fund pays a national Per Resident Amount (regionally adjusted) to GME program sponsor
3. 10% to 30% of total funds to Transformation Fund
4. New GME Policy Council in Office of HHS Secretary

# The IOM Recommendations: Many Positives for Academic Medicine

1. Holds GME funding constant adjusted for inflation (vs. decreasing funding)
2. Increases the amount going to **training** (reprograms IME to GME programs)
3. Flows funds to GME sponsor and detaches from Medicare inpatient days
4. Uses a per resident amount (regionally adjusted)
5. Supports expansion of GME positions based on documented need and covers Teaching Health Centers and Children's GME
6. Supports innovation in GME

# Three Key Workforce Questions to Consider in Assessing the IOM Report

- Are we facing a physician shortage?
- Are we facing a GME squeeze?
- Would the IOM GME recommendations worsen shortages?

# Are we Facing a Physician Shortage?

2010 AAMC projections for 2020 - shortage of:

**45,400** primary care physicians

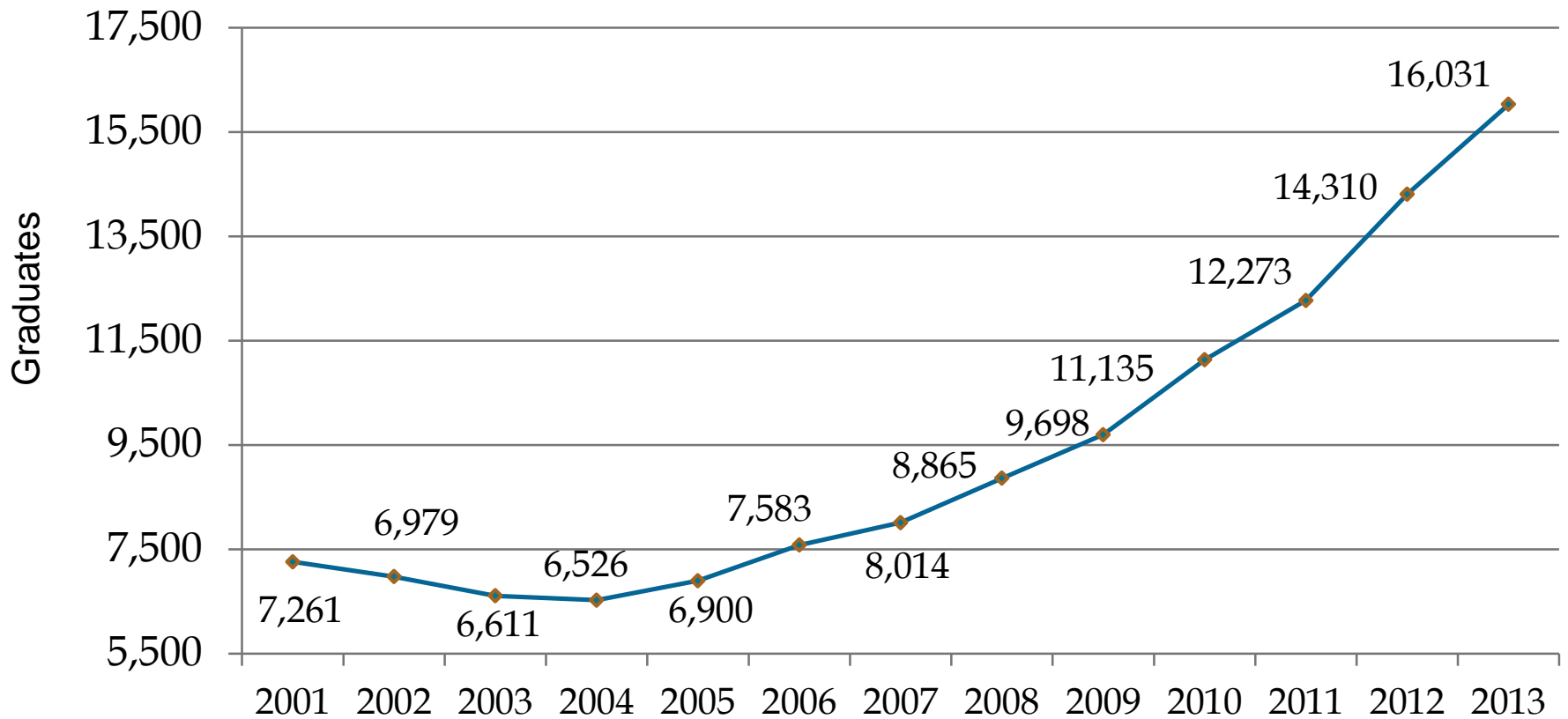
2013 Federal (HRSA) projections for 2020 using updated data and information - shortage of: **6,400** primary care practitioners, less than the shortage in 2010!

The problem is geographic and specialty mal-distribution not a general shortage.

# Why a Future General Physician Shortage is Unlikely

- ✓ The changing health delivery system: driven to improve efficiency and effectiveness (ACOs, bundled payments, patient centered medical homes, demonstrations, etc.)
- ✓ The growing supply of physicians (slow, but growing)
- ✓ The rapidly growing supply and expanded use of NPs, PAs, pharmacists, therapists, nurses, assistants, community health workers and others
- ✓ Technology/EHRs/telehealth/ehealth
- ✓ The flexibility and creativity of health providers (supply and demand are not static/independent)

# Growth in Nurse Practitioner Graduates 2001 - 2013



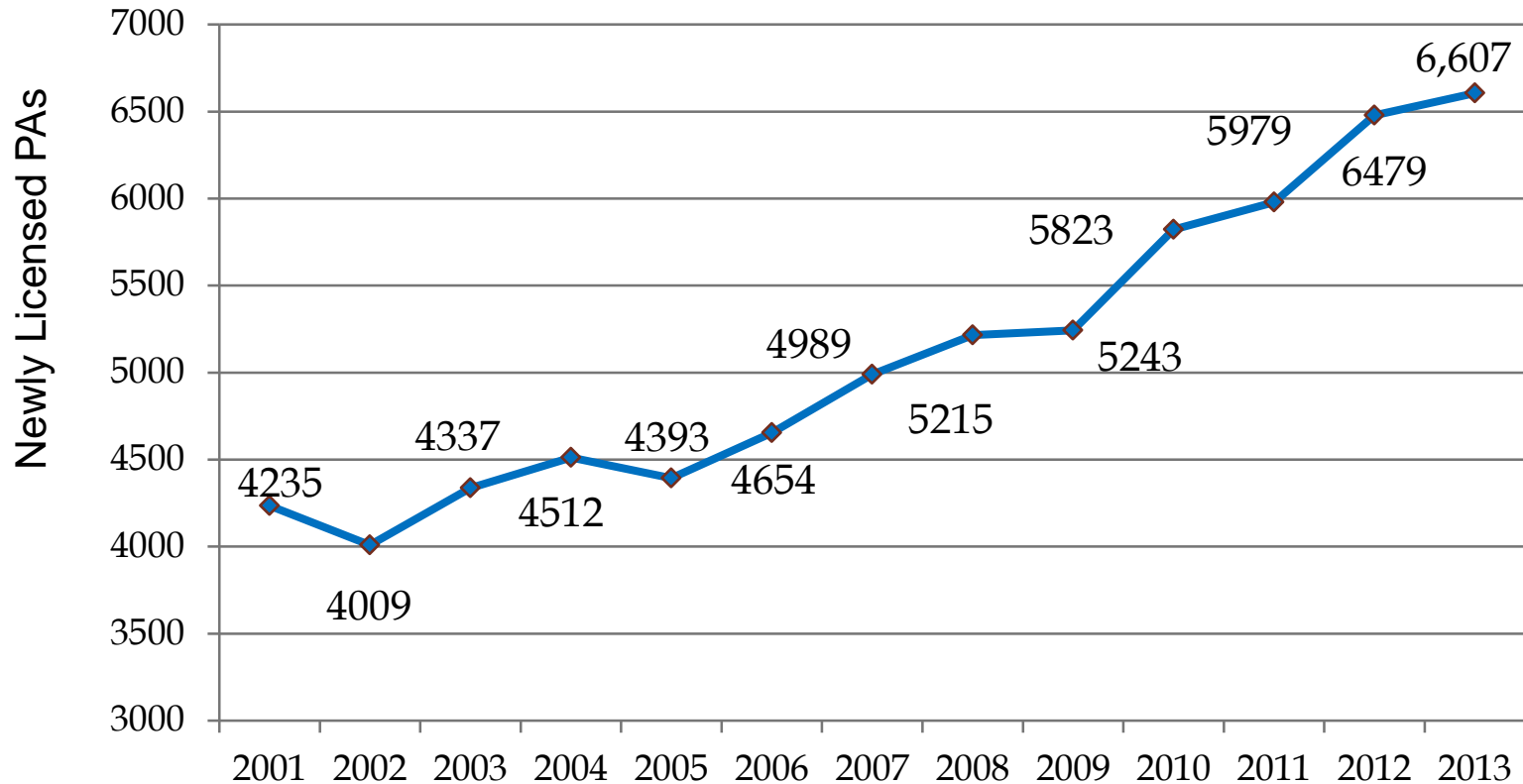
Source: American Association of Colleges of Nursing and National Organization of Nurse Practitioner Faculties Annual Surveys

<sup>1</sup>Counts include master's and post-master's NP and NP/CNS graduates, and Baccalaureate-to-DNP graduates.



# Physician Assistant Growth

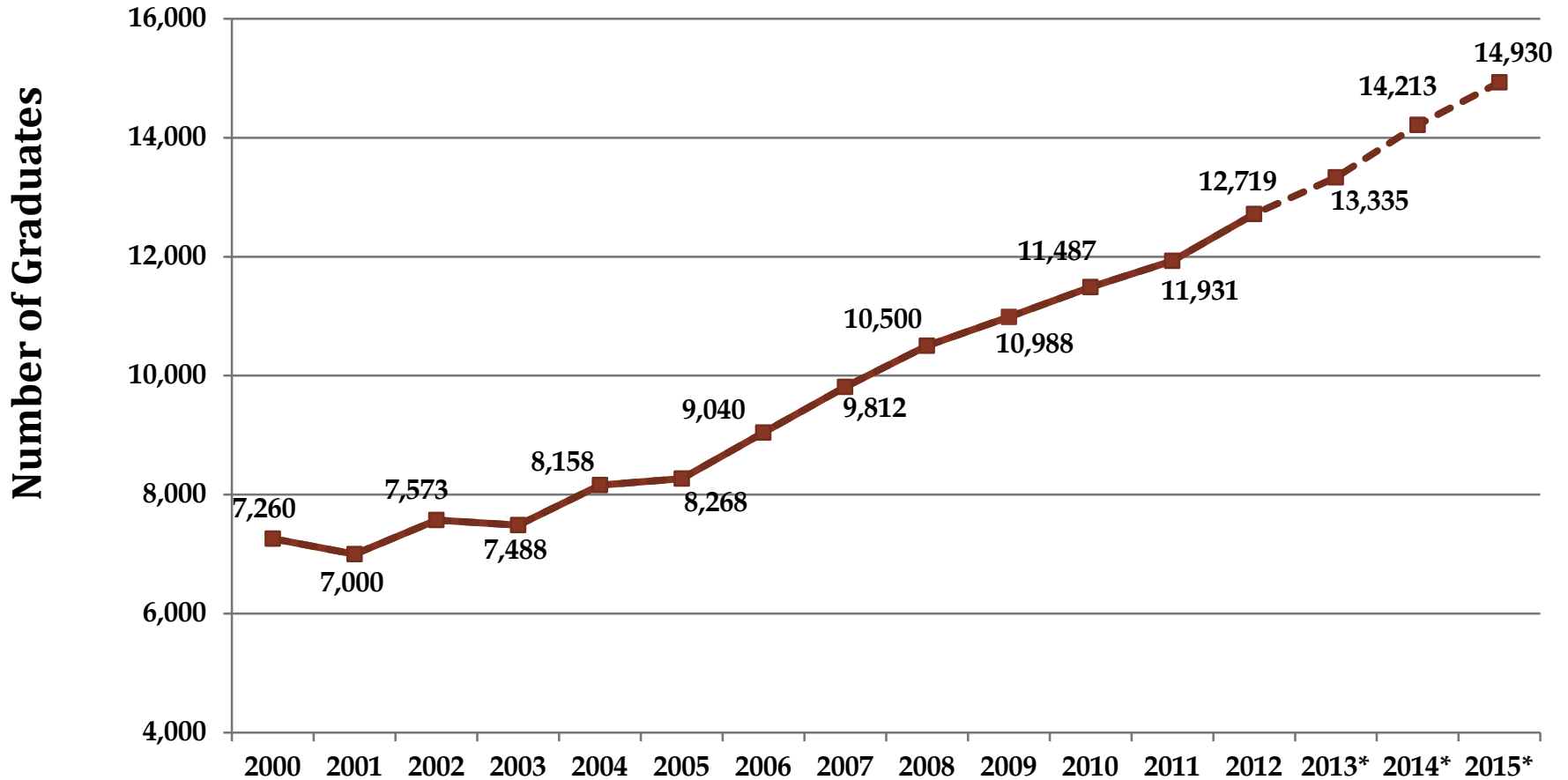
## Newly Certified PAs, 2001 - 2013



Source: National Commission on Certification of Physician Assistants "Certified Physician Assistant Population Trends"; 2013 data from personal communication with NCCPA January 2014

# Pharmacy School Graduation Trends

## 2000 - 2015



\* Graduation projection figure based on enrollment data

Data represent first professional degrees including B.S. Pharmacy, B.Pharm., and Pharm.D.1

Source: AACP 2012 Enrollment Data

# Team for Comprehensive Care

Physicians

Nurse practitioners

Physician assistants

Psychologists

Optometrists

Registered Nurses

Pharmacists

Case Managers

Nutritionists/Dieticians

Physical Therapists

Community Health Workers

...And more

# Importance of Effectively Using Non-Physician Clinicians in Primary Care

Impact of alternative staffing for PCMHs:

- If no delegation: 1 physician for 983 patients = 315,000 PC physicians; *Then significant shortage!*
- If significant delegation: 1 physician for 1,947 pts = 159,000 PC physicians; *Then significant surplus!*

\* “Estimating a Reasonable Patient Panel Size for Primary Care Physicians with Team Based Delegation”, Altschuler, Margolis, Bodenheimer and Grumbach; Annals of Family Medicine, Sept/Oct 2012

# Growing Evidence of Systems Transformation

## *Health Affairs* Workforce Issue, Nov. 2013

- **Primary Care: Proposed Solutions To the Primary Shortage Without Training More Physicians** by Bodenheimer and. Smith
- **Nurse-Managed Health Centers And Patient-Centered Medical Homes Could Mitigate Expected Primary Care Physician Shortage** by Auerbach, et.al.
- **Physician Assistants And Nurse Practitioners Perform Effective Roles on Teams Caring For Medicare Patients With Diabetes** by Everett, et. al.
- **Scope-Of-Practice Laws For Nurse Practitioners Limit Cost Savings That Can Be Achieved In Retail Clinics** by Spetz, et.al.
- **Primary Care Technicians: A Solution To The Primary Care Workforce Gap** by Kellermann,et. al.
- **It Is time to Restructure Health Professions Scope-Of-Practice Regulations To Remove Barriers To Care** by Dower, et.al.

# Are we facing a GME Squeeze?

# What Does the 2014 Data Show?

- There were:
  - 22,300 seniors** (MD + DO)  
For **30,459 PGY-1 positions** (ACGME, AOA, military)
- There were 1.54 first year positions in NRMP for every US MD senior, a record high
- **6,355 IMGs** were matched through the NRMP;

Of 17,374 US MD seniors in NRMP, 366 (**2%**) didn't Get an ACGME position (includes SOAP)

# The GME Squeeze is Limited & There will be Plenty of Slots for US Grads

- Based on current enrollment plans of MD and DO schools, there will be about 28,000 graduates in 2021;
- Assuming a continuation of the 1% annual growth in GME PGY-1 positions since 1997, there would be more than 32,000 PGY-1 positions in 2021;
- Leaving plenty of PGY-1 positions for US MD and DO graduates. Depending on assumptions, there would still be slots for all US MDs and DOs and between 3,600 and 4,500 PGY-1 positions for IMGs in 2021;
- US med students need good counseling; not scare tactics.



# Rapidly Increasing GME Slots Will Further Promote the Use of IMGs

- Adding a few thousand PGY1 slots does not guarantee slots for US MDs
- Facilitating more IMGs is contrary to the *WHO Global Code of Practice on the International Recruitment of Health Personnel* which was signed by the US and 182 other countries
- Medicine is an outlier in its dependence on foreign grads 25% vs. 5 – 8 % for most health professions
- The main beneficiary is likely to be for-profit Caribbean schools

# Would the IOM Recommendations Worsen Shortages? NO

- IOM approach would provide \$1 to \$3 billion per year for needed GME expansion and innovation
- Expansion targeted to high need areas and specialties as identified by new GME Policy Council
- Targeted expansion far more likely to meet workforce needs than general increase in GME funding (and more likely to be politically acceptable in tight budget times)
- Targeting will be facilitated by advances in projection modeling (i.e. UNC Shep's Center Forecasting Tool)

# Why the Opposition?

## What they said\*:

- “...the IOM’s proposal to *radically overhaul* graduate medical education (GME) and make *major cuts* to patient care would *threaten* the world’s best training programs for health professionals and *jeopardize* patients, particularly those who are the most medically vulnerable.”
- “...proposed *wholesale dismantling* of our nation’s graduate medical education system will have significant negative impact on the future of health care...”
- “By *drastically cutting support to teaching hospitals*, the IOM recommendations *will worsen these projected shortages...*” [My italics]

\* AAMC Press Release

# Why the Opposition?

## What they may have meant:

- The proposal would reprogram IME which provides about \$3.5 B per year to hospitals (mostly to do important things but with no accountability or links to performance)
- The report does not call for new dollars for general GME expansion
- The proposal would allow dollars to sponsors who are not hospitals
- The proposal would use a PRA eliminating the great disparities and some hospitals will see a loss in dollars (although many more would see an increase).

# Closing Comments

- The current GME financing system is outdated, inequitable, has unintended consequences, and is unsustainable
- The IOM GME committee recommendations provide a rational and reasonable framework for financing GME and meeting future workforce needs
- There is a need for targeted investments in GME to address specific geographic/specialty needs and to support educational innovations
- The IOM recommendations would **not** destroy GME; they would strengthen the “E” in GME
- It is time for constructive dialogue not narrow protectionism; we need all of the key players around the table

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