GME Reform:
Why, What and How

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Many prior calls for reform… has GME changed?

yes
• Curriculum based on necessary competencies
• Limits on resident duty hours
• Supervision requirements
• Greater emphasis on ambulatory training

and no
• Predominantly hospital-based
• Time-delimited
• Organized in specialty/disciplinary silos
• Positions offered unconnected to projected need
The Context:
Why GME Reform is Critical

- Changing patient demographics and health care needs
- Rapidly evolving delivery system
- Explosion of technology
- Globalization
- Unsustainable growth in health care costs
- Looming physician shortage
What Stimulates GME Reform?

- recruitment problems
- accreditation hammer
- funding shortfalls
Should GME Reform Occur at the Program, Institutional or National Level?

Yes
## Context: GME at Partners

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residency programs</td>
<td>35</td>
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<tr>
<td>Fellowship programs</td>
<td>203</td>
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<tr>
<td>ACGME-accredited</td>
<td>72</td>
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<tr>
<td>Non-ACGME</td>
<td>131</td>
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<tr>
<td>GME Trainees</td>
<td>2167</td>
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</table>
Central Themes

• Educate a diverse group of physicians as leaders for variety of career paths
• Continue to emphasize scholarship
• Individualize resident/fellow education to enhance career development (aim for clinical excellence with “added value”)
• Expand inter-disciplinary and inter-professional education
• Focus on trainee quality of life
Central Themes, cont.

- Education must be curriculum-driven, with focus on outcomes (competencies)
  - Rooted in the patient care experience
  - “Protected” from other agendas
  - Enhanced by technology
  - Informed by research

- Physician-educators and program leaders must have faculty development opportunities, assessment, recognition and rewards
Medical Education Research Initiative

Education Specialist Role Created

Program Director Curriculum; Expanded Workshops

“PORT” (Partners Office of Resources for Trainees)

Centers of Expertise

Housestaff Lounge; Lactation space

Medical Education Awards
Centers of Expertise

Quality and Safety
Healthcare Administration
Global and Humanitarian Health
Health Policy
Research
Medical Education

Activities include: dinner seminars, research projects, electives, travel grants, faculty mentoring
New: certificate program; fellowships
Next: incorporating interdisciplinary perspectives; endowing the program
Kraft Center Fellowship in Community Health Leadership

- 4 Fellows – open to IM, Peds, IM-Peds, OB, Psych
- Innovative curriculum (health disparities, advocacy, health policy, cultural competence, etc)
- Interdisciplinary learning
- Practice in community health center
- Scholarly community-based project
- Intensive mentoring
- Funded masters degree (in addition to salary)
- Access to loan repayment
- Commitment to practice for specified duration
GME Funding at PHS

- Resident positions funded by hospitals
- Fellow positions funded by varied sources
  - Clinical practice funds
  - Hospital funds
  - Industry gifts (with increasing restrictions, including multi-funder requirement)
  - Other institutions, governments, etc—NO for funding tied to an individual
But...

- Reengineering GME one program or institution at a time has limited impact.
- Regulatory constraints limit the scope of possible changes.
- No vehicle for coordinating or mandating structural system-wide reforms.
The Macy Foundation GME Conferences

- October 2010: Regulation and Finance
- May 2011: Content and Format

Basic premise: GME is a public good, with significant public funding, which must be more accountable to the public.
What is our responsibility in GME?

1. Produce competent physicians
2. Educate the appropriate number and mix of physicians to meet the public’s needs
3. Ensure an efficient educational process
Key Recommendations from 2010 Macy GME Conference

• Reevaluate GME governance and finance via an independent, external review
• Align number and specialty mix of physicians trained with public need
  – Begin with 3000 PGY-1’s added to targeted specialties
• Provide funding and flexibility needed for program innovation
Macy 2011 Recommendations

• Expand public representation and public reporting
• Expand sites and content of training; increase emphasis on inter-professional education
• Improve quality and efficiency:
  – use competency-based approach to GME completion with nationally endorsed, specialty-specific standards (rather than fixed duration);
  – eliminate unnecessary time in GME (e.g. shorter “core” training for subspecialists)
Macy 2011 Recommendations

• Reexamine transitions in medical education
  – Ensure that milestones for GME are met in a flexible but rigorous final year of medical school; allow for earlier graduation where possible
  – Eliminate independent preliminary programs or tracks; re-evaluate “transitional year” programs; incorporate necessary prerequisites into specialty-based residencies
  – Provide period of “monitored independence” within GME
Macy 2011 Recommendations

- Empowered GME leaders should ensure that program design is driven by educational needs and that high-value educational experiences are prioritized.
- Flexibility at the program and individual level should be encouraged to enhance training for varied physician roles.
- Expand research to support evidence-based education; fund and coordinate via a “National Institute of Health Professions Education.”
What is needed to make this happen?

- Faculty development
- Broadly accepted competency standards and assessment tools for evaluating individuals; metrics for reporting program outcomes
- Revision of regulations that restrict innovation and unduly limit flexibility; outcomes-based accreditation
What is needed to make this happen?

• Reduction in administrative work related to all oversight organizations
• Research to support evidence-based education
• A mechanism for coordinated change across the U.S.
• ? A burning platform
How Can an Increase in Physicians Trained through GME be Funded?

• Consider new sources of funding
  – All-payer
  – Private insurers (with GME contribution included in medical loss ration)
  – States, targeting support to address local needs
  – Organizations sponsoring GME (already occurs)

• Free up and reallocate a portion of Medicare GME payments to help fund new positions
Potential Targets for Reallocating Slots to Meet Public Need

- Preliminary and transitional year positions
- Decreased duration of core specialty training, especially for subspecialists
  - Prioritize educationally-rich experiences
- Early graduation for those that achieve competency in less than the usual duration
- More aggressive prioritization of funding for primary board certification (residency>>fellowship)
How can the number of physicians trained in different specialties be aligned with projected need?

- Financial incentives aimed at
  - Individual physicians
    - Physician payment reform
    - Incentive payments for targeted specialties
    - “Self-funding” for subspecialty training
  - Organizations sponsoring GME
    - Federal GME reimbursement prioritized toward shortage specialties
How can the number of physicians trained in different specialties be aligned with projected need? (cont.)

- Regulation of the number of GME positions accredited nationally, by specialty

Limited slots could be allocated according to a variety of metrics, e.g.

- Program quality
- Geography
- Track record of program graduates
Considerations in Addressing Distribution Across Specialties

- Med school experiences, role models, mentoring
- Perceptions about specialty culture, prestige
- Student/Physician choice
- Student debt
- Work-life balance
- Physician reimbursement
- Availability of GME positions