

# St. Mary's Health Care System

## Graduate Medical Education Feasibility Assessment

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Final Report

January 7, 2008

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## **I. Executive Summary**

## I. Executive Summary

The state of Georgia is confronted by an expected shortage of physicians in the coming years. The development of graduate medical education (GME) programs, which are necessary to train physicians in various medical and surgical specialties upon graduation from medical school, is an essential response to this challenge. Accordingly, in November and December, 2007, a steering committee comprising the senior leadership of Athens Regional Medical Center (ARMC), Northeast Georgia Health System (NGHS), and St. Mary's Health Care System (SMHCS) was assisted by ECG Management Consultants, Inc., in conducting a preliminary feasibility assessment of each hospital's capability to participate in GME. In addition, the hospital chief executive officers (CEOs), through the steering committee, considered the possibilities for a collaborative arrangement among the three institutions and potential academic partner(s) for establishing new GME programs in the region.

The team accomplished the following objectives:

- For each hospital, conducted a preliminary assessment of the organizational feasibility, operational capacity, and cultural viability of participating in GME.
- Determined the desire to explore in more detail a collaborative GME arrangement among the three hospitals.
- Based on this determination, outlined a conceptual framework for a collaborative GME arrangement, comprising principles, objectives, and imperatives for organization, governance, finance, and decision making.

More specifically, the steering committee reached the following conclusions during the process:

**Physician workforce studies completed independently by each hospital are consistent and project shortages emerging in many specialties in the next 10 years.** All three participating hospitals have in recent years independently analyzed future physician supply needs for their institutions. Although their projections differ somewhat in methodology and the time frame analyzed, their conclusions are essentially in agreement about a looming shortage of physicians in the region that is already being experienced in several medical fields of specialty. The physician shortages predicted by these hospitals for the coming decade will affect a combined service area involving multiple counties in a region of Georgia experiencing very rapid population growth. Addressing these shortages, or failing to do so, will have direct implications for healthcare statewide.

**The establishment of GME programs in northeast Georgia would serve to improve concerns regarding physician supply.** Residents graduating from GME programs tend to practice in the service area of the program in which they train. Importantly, the strategy explored in the present study, to create new residency training programs in the region, will not in itself meet the projected physician supply need. However, in addition to creating a cohort of new physicians with strong ties to the Georgia medical community, these new residency programs will: (1) help in recruiting other

physicians to Georgia who seek careers in association with teaching hospitals; (2) provide a training environment for third- and fourth-year medical students in support of medical school expansion; and (3) offer opportunities for other hospitals to participate as consortium members in the development of additional new residency programs in the future.

**The three hospitals individually and collectively can provide a clinical environment conducive to the operation of high-quality GME programs.** Based on a high-level review of clinical volumes and service mix, as well as the educational requirements of various GME programs, each hospital CEO concluded that his individual organization can provide adequate patient care volumes and an appropriate patient mix in support of a robust GME training experience. GME programs of interest to the hospitals have not been finalized, but programs considered included:

- Internal medicine.
- Family medicine.
- Obstetrics and gynecology (OB/GYN).
- Pediatrics.
- General surgery.
- Psychiatry.
- Emergency medicine.

**There is a seemingly supportive medical staff environment and physicians who have expressed interest in serving as faculty to GME programs.** Interviews and meetings with medical staff representatives conducted by ECG, as well as the firsthand knowledge of each hospital's senior leadership team, indicate that there is preliminary interest among selected physicians to serve as faculty. Without high-quality faculty and physician leadership, new GME programs at these institutions would face insurmountable challenges. The university environment of Athens in particular appears to contribute to a general level of support for academics in the physician community. Interviews with representatives of the Medical College of Georgia (MCG), Philadelphia College of Osteopathic Medicine (Suwanee, Georgia, campus), and the University of Georgia indicate support for developing high-quality faculty for the GME programs. Ultimately, physician willingness to serve as faculty to GME programs will depend on program organization, the specific individual requirements for physician teaching effort, the impact of those requirements on the efficiency of physician clinical practice, and the associated financial arrangements for program administration and teaching.

**A medical education consortium model for organizing, governing, managing, and financing GME in the region may represent the best opportunity to meet institutional, regional, and statewide objectives and imperatives.** A view across the country reveals a variety of models and arrangements whereby hospitals and medical schools affiliate and participate in GME. One such model is a medical education consortium through which hospitals and their academic partner(s) formally organize, typically through incorporation, and unite to more effectively manage, operate, and finance GME programs across their institutions. Consortia models tend to promote a community-oriented focus toward GME (as opposed to an institution-centric bias), foster the development of programmatic economies and administrative efficiencies, and enable coordinated planning and financing of the educational enterprise. The project participants identified the major

attributes of a potential consortium model for northeast Georgia, and they believe such a model may best create opportunities to meet institutional, regional, and statewide objectives and imperatives.

**Significant financial hurdles will need to be resolved to promote establishment of GME programs in northeast Georgia and foster their ongoing financial viability.** The costs of GME include resident and faculty wages and benefits, program administration and infrastructure requirements, and the institutional and professional inefficiencies created by medical education. The Medicare program is the principal source of funding and reimbursement for the costs of GME in the United States. In recent years and beginning with the Balanced Budget Act of 1997 (BBA), Congress has generally constrained and reduced financial support for the nation's GME programs through caps and reductions in payments to teaching hospitals. While this situation has created significant pressure on existing teaching hospitals with long-standing GME programs, it presents a unique set of challenges to community hospitals seeking to establish new GME programs and become teaching hospitals. Existing legislation provides a time-limited and financially narrow opportunity for new teaching hospitals to establish eligibility for GME reimbursement, and modeling suggests such reimbursement may be significantly below levels required to adequately support the ongoing and one-time start-up costs of new GME programs. Accordingly, the hospitals and their academic partner(s), the state of Georgia, and the local and regional communities will need to explore creative solutions to identify and secure appropriate funding for GME programs in northeast Georgia.

**Participation in GME is a mission-changing decision for each hospital, requiring deliberative and comprehensive planning, substantial constituency support, and requisite corporate approvals.** While potentially creating a range of tangible and intangible benefits for each hospital, the operation of GME programs has transformational implications that affect clinical service design, care delivery models, medical staff and nursing relations, patient perceptions, and institutional resource utilization. Accordingly, a comprehensive planning effort is required that defines specific programs, resident complements, faculty arrangements, academic affiliations, financial implications, and so forth. Such planning will best be informed through broad participation of each hospital's relevant constituencies, as well as potential academic partners. A comprehensive planning effort will create greater visibility regarding the specific challenges that will require strategic, organizational, operational, financial, and political solutions. Ultimately, the willingness of each hospital to commit to, and the associated level of, participation in GME will be predicated upon the sufficiency of the identified solutions.

\* \* \* \* \*

SMHCS appreciates the opportunity provided by the Georgia Board for Physician Workforce to explore the prospects of establishing GME programs in northeast Georgia through this project. While serious challenges exist, the spirit of collaboration demonstrated among each hospital's leadership teams, as well as the potential for establishing a GME consortium to address the important physician workforce issues that confront our hospital, the region, and the state of Georgia, compels further planning. SMHCS looks forward to continued participation in such efforts.

## **II. Methodology**

## II. Methodology

### A. Steering Committee and Project Participants

To accomplish the project's strategic goals within an aggressive time frame, a steering committee was convened comprising the CEOs and other senior leaders of ARMC, NGHS, and SMHCS, as well as senior leadership from the University of Georgia College of Public Health. Members of the steering committee included:

- Representing ARMC:
  - » Mr. John Drew, President and CEO.
  - » Stephen Lucas, M.D., Chief Medical Officer.
  
- Representing Northeast Georgia Medical Center (NGMC):
  - » Mr. Jim Gardner, President and CEO.
  - » Ms. Tracy Vardeman, Vice President for Strategic Planning.
  
- Representing SMHCS:
  - » Mr. Thomas Fitz, President and CEO.
  - » Mr. Marty Hutson, Chief Financial Officer.
  
- Representing the University of Georgia:
  - » Eric Dahl, Ph.D., Associate Dean, College of Public Health.
  - » Ms. Alison McCullick, Program Coordinator for Health Initiatives.

Broader participation in the project was accomplished through individual interviews with hospital administrative and physician leadership from each institution, as well as leadership from the University of Georgia, MCG, and the Philadelphia College of Osteopathic Medicine (Suwanee, Georgia, campus). In addition, there were several group meetings of members of the medical staffs from each hospital to discuss the project, assess the level of understanding relative to GME, and determine preliminary willingness to consider participation in GME.

### B. Data Review and Interviews

The first phase of the project encompassed a review of data from ARMC, NGHS, and SMHCS. As available, participants provided data pertinent to assessing the feasibility of establishing GME at their institutions, which established a foundation for subsequent project activities. Specific areas of focus included:

- Inpatient and outpatient clinical facilities, including locations, numbers of beds, services provided, and volumes.
- Clinical program strengths.
- Physician need analyses and medical staff development plans.
- Medicare cost reports.
- Planning documents.

Concurrently, individual interviews were conducted with each steering committee member as well as a variety of other individuals recommended by the steering committee. Interview topics included:

- Desire to participate in GME and collaborate on GME.
- Understanding of the implications of participation.
- Impediments to participation.
- Critical issues that must be considered over the course of this preliminary feasibility assessment.

### **C. Steering Committee Meetings**

The steering committee met four times during November and December to conduct this preliminary feasibility assessment and to determine preferred GME arrangements in a collaborative manner. Meeting dates and agendas were:

#### **1. November 17 – Project Initiation**

The first meeting of the steering committee addressed the consulting team’s baseline findings and established a context for future project efforts. Agenda items included:

- Discussion and validation of preliminary interview and data findings.
- A review of the medical education process.
- The process of institutional and program-specific accreditation.
- Sources of financing for medical education.
- Identification of the range of GME organizational models.

#### **2. November 28 – GME Program Attributes**

The second meeting explored the required elements of a successful GME collaboration among the participating institutions. Agenda items included:

- Overview of current GME programs in Georgia.
- Key considerations for institutions sponsoring and/or participating in GME.
- Attributes of successful multiparty affiliations for GME.
- Preliminary identification of desired GME programs.

**3. December 6 – Requirements to Establish New GME Programs in Northeast Georgia**

The third meeting addressed the feasibility of offering the desired GME programs identified in the previous meeting, as well as a potential structure for the GME enterprise. The agenda included:

- Volume assessments for desired GME programs.
- Characteristics and performance of GME consortia.
- Suggested straw man model for a GME consortium in northeast Georgia.

**4. December 14 – Conclusions and Next Steps**

The final meeting revisited and confirmed the desired structure of a GME consortium and explored the issues surrounding funding of such an enterprise. Specific agenda items included:

- Refined straw man model for the Northeast Georgia Graduate Medical Education Consortium (NGMEC).<sup>1</sup>
- Potential state and federal reimbursement opportunities.
- Other funding requirements/opportunities.
- Next steps.

\* \* \* \* \*

APPENDIX A to this report provides a brief list of key attributes of each of the hospitals that may be conducive to the operation of GME programs. APPENDIX B provides excerpted material from steering committee documents.

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<sup>1</sup> Described in detail at the conclusion of this report.

### **III. SMHCS Physician Need Analysis**

### III. SMHCS Physician Need Analysis

#### A. Categories

SMHCS provided the consulting team with a detailed medical staff development plan for its clinical services. The plan was updated in 2007, based on a previous iteration prepared in 2004. The assessment categories included:

- Primary care.
  - » Family practice.
  - » Internal medicine.
  - » OB/GYN.
  - » Pediatrics.
- Medical specialties.
  - » Allergy and immunology.
  - » Cardiology.
  - » Dermatology.
  - » Endocrinology.
  - » Gastroenterology.
  - » Hematology/oncology.
  - » Infectious diseases.
  - » Nephrology.
  - » Neurology.
  - » Pulmonology.
  - » Rheumatology.
- Surgical specialties.
  - » Cardiothoracic.
  - » General.
  - » Neurosurgery.
  - » Ophthalmology.
  - » Orthopaedics.

- » Otolaryngology.
- » Plastic.
- » Urology.
- » Vascular.
- Other specialties.
  - » PM&R.
  - » Psychiatry.

## **B. Methodology**

SMHCS's projections are intentionally conservative, resulting in a potential understatement of the system's needs in 2010. Projections of physician demand in secondary and extended service areas were also reduced based on these areas' typically lower physician-to-population ratios and utilization of physician services. Data sources employed in the projections include:

- Georgia Medical Board.
- St. Mary's medical staff roster.
- SMHCS and ARMC databases.

## **C. Findings**

By 2010, SMHCS projects a need to expand its existing medical staff as follows:

### Primary Care – 93.6 Physicians

The projected physician need increases include:

- 31.4 family practitioners.
- 29.3 internists.
- 20.1 OB/GYNs.
- 12.8 pediatricians.

### Medical Specialties – 34.2 Physicians

The projected physician need increases include:

- 5.5 cardiologists.
- 6.1 dermatologists.
- 3.3 endocrinologists.

- 4.8 gastroenterologists.
- 4.4 hematologist/oncologists.
- 4.3 infectious disease specialists.
- 2.1 neurologists.
- 3.8 pulmonologists.
- 3.2 rheumatologists.

Projected declining physician needs are:

- -1.1 allergist/immunologists.
- -2.2 nephrologists.

*Surgical Specialties – 46.2 Physicians*

The projected physician need increases include:

- 1.9 cardiothoracic surgeons.
- 14.7 general surgeons.
- 9.6 ophthalmologists.
- 10.4 orthopaedic surgeons.
- 7.1 otolaryngologists.
- 0.5 plastic surgeons.
- 2.4 urologists.

Projected declining physician needs are:

- -0.3 neurosurgeons.
- -0.1 vascular surgeons.

*Psychiatry and PM&R – 17.7 Physicians*

The projected physician need increases include:

- 4.0 PM&R specialists.
- 13.7 psychiatrists.

#### **D. Conclusions**

Even a conservative methodology for estimating SMHCS's projected physician needs through 2010 yields significant deficits, which are likely to grow in severity over time. While it will be impossible to meet all of these needs via graduates of regional GME programs, it is equally unlikely that recruitment from other regions and programs alone will lead to an adequate physician supply. Therefore, a development approach involving both recruitment and increased GME opportunities is likely to prove most effective for SMHCS.

#### **IV. Benefits of GME**

## IV. Benefits of GME

### A. Benefits to Communities

Offering high-quality GME programs can serve as a productive source of physicians committed to the communities and states that host their training. The percentage of active Georgia physicians who completed GME training in state is approximately 50 percent, ranking Georgia 14th out of 50 states for retention of physicians after residency and/or fellowship training.<sup>2</sup> This implies a strong disposition on the part of Georgia-trained residents to join hospital staffs and private practices in the state.

The limiting factor for effectiveness of GME as a physician workforce enhancement mechanism in Georgia appears to be the scarcity of such opportunities. According to the 2006 National GME Census,<sup>3</sup> the state ranks 37th out of 50 for the number of physicians enrolled in ACGME-accredited residency and fellowship programs, with a total of 1,942 residents and fellows representing 20.7 training physicians per 100,000 population. While in-state GME opportunities have increased by 4.2 percent over the past decade, this growth is substantially below the national average growth rate of 7.1 percent over the same period,<sup>4</sup> and even further below the anticipated growth in need implied by the AAMC's recent call for a 30 percent increase in medical school enrollment between 2002 and 2012.<sup>5</sup>

Communities hosting vibrant GME programs may enjoy benefits in addition to those related to physician workforce, including an enhanced economy resulting from the increased presence of medical research and practice.

### B. Benefits to Teaching Hospitals

Medical students and residents depend on the participation of hospitals for clinical clerkships and GME training. Hospitals are participants in the country's system of medical education because teaching hospitals derive a number of benefits from medical education programs. For example:

- The presence of high-quality residents fosters recruitment and retention of high-quality physicians who want to practice in a teaching hospital and participate in medical education.
- Graduating residents who subsequently practice in the hospital's service area typically admit and refer to the hospital at which they trained.

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<sup>2</sup> AMA Physician Masterfile, January 2007.

<sup>3</sup> Based on population estimates obtained from the U.S. Census Bureau.

<sup>4</sup> *Journal of the American Medical Association (JAMA)*, September 5, 2007 – Vol. 298, No. 9. Appendix II, Table 4.

<sup>5</sup> AAMC *Statement on the Physician Workforce*, June 2006.

- Teaching hospital status affords the hospital a positive and unique distinction in the marketplace.
- The training programs tend to ensure that the hospital and its medical staff remain up to date with the latest medical advances.
- The educational model may enhance the quality of care delivered at the hospital as a result of the use of patient care teams that include attending physicians, residents, medical students, and others.
- Residents offer a valuable patient care resource to the hospital by, for example, providing evening and weekend coverage of inpatients.
- Coverage provided by residents positively affects hospital/physician relations, since physicians tend to enjoy the support of residents.
- The existence of medical education programs affords the hospital the opportunity to attract selected subspecialist physicians and thereby offer subspecialty care unavailable at the typical nonteaching hospital.
- The presence of full-time faculty physicians may enable the hospital, community physicians, and their patients to participate in important clinical research projects.

The above benefits create significant strategic advantages for teaching hospitals and their physicians, particularly when the medical education programs are aligned with clinical delivery system strategies.

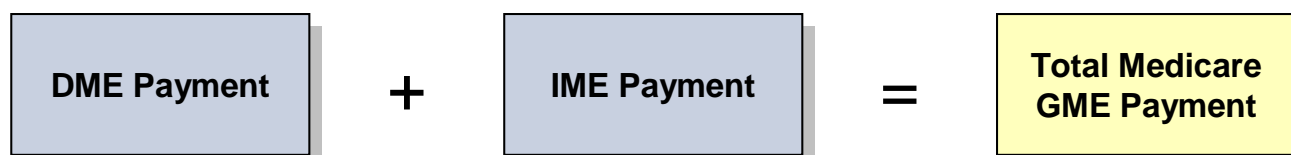
## **V. GME Financing**

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This section provides a brief overview of the reimbursement available to teaching hospitals related to medical education.

### A. Reimbursement for Teaching Hospitals

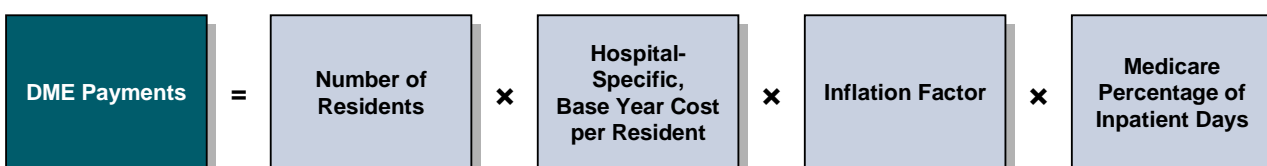
Medicare reimburses teaching hospitals for a portion of the direct and indirect costs of providing GME training through two mechanisms: direct medical education (DME) payments and indirect medical education (IME) payments.



- To recognize the direct GME-related costs incurred by the teaching hospital.
- Medicare's share of direct:
  - » Resident salary and fringe benefits.
  - » Faculty compensation for resident teaching and supervision.
  - » Other direct, allowable costs.
- To recognize the indirect costs of GME programs borne by the teaching hospital due to inefficiencies.
- To compensate teaching hospitals for higher inpatient costs due to patient severity of illness not fully captured by diagnosis related groups (DRGs).

DME payments are intended to cover the direct costs incurred by hospitals that sponsor GME programs. Direct costs include resident salary and benefits, faculty compensation for teaching and supervision of residents, and administrative overhead.

#### DME Payment Calculation

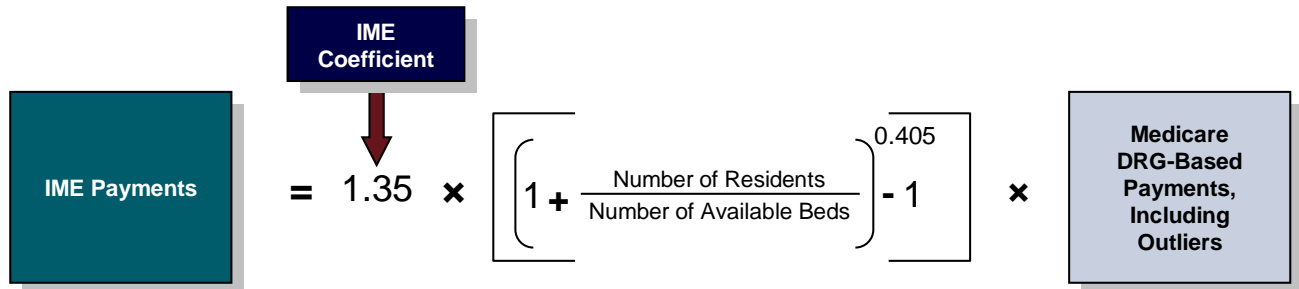


It is noteworthy that in 1997, Congress set limits on the number of reimbursable residents that could be counted for calculating DME payments. This created a financial disincentive for teaching hospitals to increase the number of physicians in training.

IME payments are intended to cover the indirect costs incurred by teaching hospitals. Indirect costs include inefficiencies related to longer lengths of stay, additional use of ancillary services, additional duties imposed on staff, and so forth. Since IME reimbursement is largely determined by a coefficient set by the Centers for Medicare & Medicaid Services (CMS), it is intended to reflect the

percentage by which teaching hospitals' costs of care increase due to the presence of GME programs and is built into hospitals' DRG rates.

### IME Payment Calculation



The 1997 congressional legislation that placed limits on the number of residents that could be counted for calculating DME payments also contained limits on the number of residents that could be counted for calculating IME payments, creating further financial disincentives for GME program growth.

It should be noted that there is often significant confusion regarding the purpose of IME payments. AAMC, in a publication titled *Medicare Payments with an Education Label: Fundamentals and the Future*,<sup>6</sup> may have explained it best:

*“The IME adjustment carries a misleading name because its purpose is broader than GME. It compensates teaching hospitals for their higher inpatient costs due to patient severity of illness not fully captured by the DRG patient classification system. Additionally, there are higher operating costs associated with the presence of GME programs. Indirect costs cannot be specifically quantified; they can only be estimated through statistical analysis.”*

This is supported by the following congressional statement:<sup>7</sup>

*“This adjustment is provided in light of doubts... about the ability of the DRG classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with teaching residents... The adjustment for indirect medical education costs is only a proxy to account for a number of factors that may legitimately increase costs in teaching hospitals.”*

<sup>6</sup> Published by AAMC, Ms. Linda E. Fishman, Associate Vice President, Division of Health Care Affairs, 1996.

<sup>7</sup> House Ways and Means and Senate Finance Committees' reports accompanying Public Law 98–21, March 1983.

Regardless, there has been downward pressure on both DME and IME reimbursement from the federal government in recent years, and while there are calls from some in Congress to stop or even reverse this trend, the federal deficit is likely to continue to exert financial pressure on the Medicare program.

## **B. GME Reimbursement for New Teaching Hospitals**

BBA was the specific legislation that capped the number of resident FTEs a teaching hospital could claim for reimbursement on its Medicare cost report at the hospital's unweighted FTE count for the most recent cost reporting period ending on or before December 31, 1996. For hospitals that did not offer GME programs at the time of the cap, CMS established the following exception:

*“If a hospital had no residents before January 1, 1995, and it establishes one or more new medical residency training programs on or after that date, the hospital's FTE cap will be based on the number of first-year residents participating in its accredited graduate medical education training programs in the third year of receiving payment for direct GME. The hospital's unweighted FTE resident cap will equal the product of the number of first-year residents in that year, and the number of years in which residents are expected to complete that program based on the minimum accredited length for the type of program, as published in the Graduate Medical Education Directory.”<sup>8</sup>*

The above exception would appear to apply to the three hospitals and creates a financial incentive for rapid GME program growth. However, the imperatives for rapid growth will be challenged by the ability to successfully recruit high-quality residents into new programs. Importantly, any GME program growth in the future beyond the 3-year period (i.e., increase in residents in existing programs or the addition of new programs) will be ineligible for reimbursement. As detailed business planning efforts for new GME programs in Georgia commence, it is therefore of the utmost importance to develop strategies that maximize resident enrollment during the first 3 years of operation while balancing the need to provide clinical and didactic education at the highest levels of quality.

## **C. State Funding of GME in Georgia<sup>9</sup>**

DME and IME reimbursement from Medicare often represents the only direct source of financial support for GME programs. However, in some states, the Medicaid program may also provide IME and/or DME reimbursement to teaching hospitals. In states where such reimbursement is available, the magnitude of the Medicaid payments generally pale in comparison to the Medicare payments.

The Georgia state legislature created a commission in the late 1990s to explore options for creating a statewide GME trust fund to support ongoing medical education in Georgia. This activity was

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<sup>8</sup> *Federal Register*, Vol. 62, No. 168, Section 413.86(g).

<sup>9</sup> *State and Managed Care Support in Graduate Medical Education: Innovations and Implications for Federal Policy*. Council on Graduate Medical Education (COGME) Resource Paper, July 2004.

motivated in part by a concurrent decline in federal funding for Georgia Area Health Education Centers (AHECs) and the rural GME programs associated with them.

Georgia's Medicaid program paid a lump sum to MCG through a line-item appropriation beginning in 2000 in order to support core clinical training efforts in all state AHECs. This funding was disbursed through the state university's resident instruction budget via a designated account to support the AHECs. A temporary transfer of funds by the university back to Medicaid enabled Medicaid to access additional federal matching funds to support benefits for Medicaid patients in rural and medically underserved communities. Reportedly, Georgia enjoyed a 1:1 match of state and federal Medicaid dollars, totaling approximately \$1.45 million in aggregate. In 2003, the state contributed an incremental \$300,000 to support initiatives including a new AHEC and the training of additional students in medicine, physician assistant (PA), nurse practitioner (NP), and other health professional training programs. This led to total funding in that year of approximately \$1.8 million.

A 2005 AAMC survey indicated that in the United States, 46 states (including Georgia) and the District of Columbia made both DME and IME payments under their Medicaid fee-for-service (FFS) programs. Fourteen states (excluding Georgia) and the District of Columbia made DME and IME payments explicitly and directly to teaching hospitals under capitated managed care programs – a decline from 17 states doing so in 2002. In 2005, Georgia reported making \$76.2 million in Medicaid DME payments.<sup>10</sup>

In addition, in 2006 the Georgia Statewide AHEC Network received approximately \$3.5 million in state, federal, and local funding to support the needs of students engaged in and/or considering training in the health professions. The state portion of this funding totaled just over \$1.4 million, of which approximately 93 percent originated with the Department of Community Health (DCH).<sup>11</sup> However, it is important to note that this funding supports not only the expenses associated with GME, but also those of undergraduate medical students and students in myriad other health professional training programs.

Until May 2006, all Georgia Medicaid payments for GME were included in each hospital's FFS inpatient case rate. Later in 2006, over 1 million families were transitioned from traditional Medicaid FFS plans to care management organizations (CMOs). While DCH continued to pay the GME payment per case rate for FFS claims submitted during and after this transition, it is expected that FFS claims will decline precipitously over time.<sup>12</sup>

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<sup>10</sup> *Financing Graduate Medical Education: Some Basics*. Presentation by Ms. Karen Fisher of AAMC to Georgia House of Representatives Medical Education Study Committee. August 15, 2007.

<sup>11</sup> *Annual Report of the Area Health Education Centers Program*. Georgia Statewide AHEC Network.

<sup>12</sup> *Care Management Organization: GME Supplemental Payment*. Georgia DCH/Georgia Healthy Families, May 4, 2006.

## **VI. Proposed Collaborative Model for GME in Northeast Georgia**

## VI. Proposed Collaborative Model for GME in Northeast Georgia

The optimal structure for achieving the goals and objectives for increasing the Georgia physician workforce is a medical education consortium, typically defined as an organization or arrangement developed to unite the diverse group of stakeholders necessary to reorganize and/or effectively manage medical education. Medical education consortia include two or more separate institutions involved with GME and are formed to reorganize and/or strengthen medical education through shared and joint decision making.

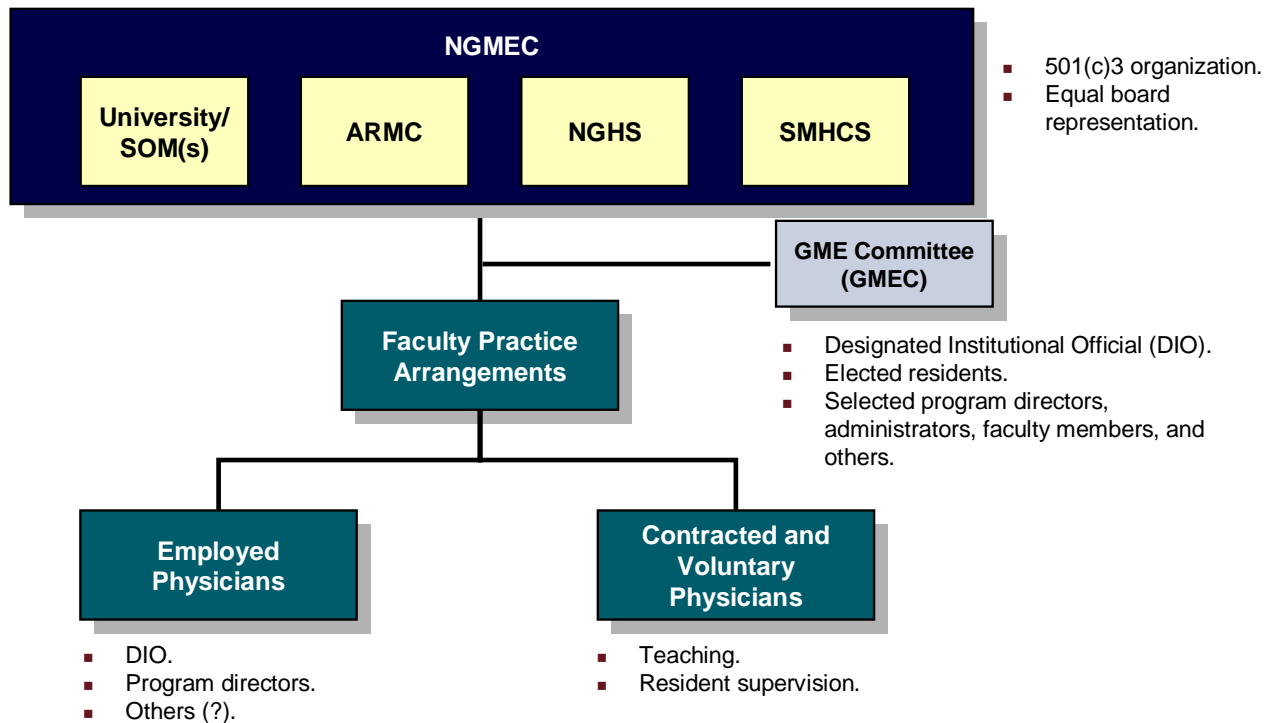
Member organizations of medical education consortia typically report many benefits to their medical education enterprises, including:<sup>13</sup>

- Furthering and protecting the interests of community physicians by providing a forum for addressing workforce and other concerns.
- Improving working relations and dispute resolution by bringing hospital executives, medical school deans, and academic department chairs and clinical service chiefs together on a regular basis.
- Enhancing administrative efficiency by coordinating the oversight of educational quality, program requirements, and accreditation, and by sharing the administrative costs of GME to reduce redundancies and realize economies of scale.
- Coordinating programs' financial arrangements by providing transparency of the sources and uses of education funds, defining equitable resource distributions and contributions, and enabling a longer financial planning horizon through pre-set financial support commitments.

After examining the attributes and performance characteristics of GME consortia models nationally, the steering committee developed a conceptual framework for applying a consortium model to the hospitals as a vehicle for GME program development and operation, illustrating it as NGMEC. NGMEC is envisioned as an incorporated, tax-exempt, 501(c)3 organization, with member organizations including the hospitals and appropriate academic partners (i.e., university and/or schools of medicine [SOMs]).

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<sup>13</sup> Data regarding consortia derive from proprietary ECG surveys and engagements, and from *Graduate Medical Education Consortia: A National Survey*, published in 1996 by AAMC and the Center for Health Professions (CHP) at University of California, San Francisco (UCSF).



The current conceptual framework identifies that once incorporated, NGMEC will seek accreditation as the institutional sponsor of the GME programs.

NGMEC will focus on achieving multiple vital objectives for the state and region, and for its member organizations, which closely reflect the benefits of national consortia models cited above. Specific shared objectives identified by the GME steering committee include:

- Training excellent physicians to practice in Georgia, and particularly in northeast Georgia.
- Providing opportunities to integrate undergraduate medical education (UME) clerkships and GME.
- Ensuring high quality by providing streamlined, efficient oversight of multiple GME programs.
- Contributing to patient care quality.
- Fostering a learning environment across all care sites.

Strong governance is a critical success factor for medical education consortia. Accordingly, NGMEC must define a board of directors, which provides balanced representation for all member organizations, in its corporate bylaws. It is advisable for each organization to include the CEO (or his/her designee), plus a board member/trustee, so that the governing bodies of the various constituent entities remain apprised of current academic medical center (AMC) issues. These governance constructs will not only foster open discussion and a spirit of coordination and collaboration, but also engage senior management and board members in the mission, goals, and challenges of NGMEC.

The shared governance structure should set strategy and policy for the educational enterprise, approve academic budgets, and oversee educational operations. The NGMEC bylaws should specify the governing board's authorities and provide a mechanism for the member organizations to address important considerations. Typical areas addressed by consortium bylaws include:

- Clinical education and affiliation arrangements.
- Arrays of teaching affiliates and program assignments.
- Coordination of the academic budget and designation of the flow of funds.
- Hiring authority for, and locations of, department chairs.
- The roles of full-time faculty and community physicians.
- Coordination of educational administration.

The hospitals have discussed offering a suite of GME programs that would address specific needs within the state and region and serve as core components of a robust GME enterprise. While the composition of the enterprise was not finalized, the preliminary programs and potential sizes discussed include:

<b>GME Program</b>	<b>Minimum Program Size</b>
Emergency Medicine	<ul style="list-style-type: none"> <li>■ 24 residents total.</li> <li>■ 6 residents per training year.</li> </ul>
Family Medicine	<ul style="list-style-type: none"> <li>■ 12 residents total.</li> <li>■ 4 residents per training year.</li> </ul>
Internal Medicine	<ul style="list-style-type: none"> <li>■ 12 residents total.</li> <li>■ 4 residents per training year.</li> </ul>
OB/GYN	<ul style="list-style-type: none"> <li>■ 8 residents total.</li> <li>■ 2 residents per training year.</li> </ul>
Pediatrics	<ul style="list-style-type: none"> <li>■ 12 residents total.</li> <li>■ 4 residents per training year.</li> </ul>
Psychiatry	<ul style="list-style-type: none"> <li>■ 12 residents total.</li> <li>■ 3 residents per training year.</li> </ul>
Surgery	<ul style="list-style-type: none"> <li>■ 10 residents total.</li> <li>■ 2 residents per training year.</li> </ul>
Transitional Year	<ul style="list-style-type: none"> <li>■ 4 residents total.</li> </ul>

GME programs will be overseen by a centralized GMEC, which will address issues of program siting and resident rotations according to each organization's available resources, preferences, and

other factors. ACGME requirements stipulate that GMEC membership must include the DIO,<sup>14</sup> residents nominated by their peers, representative program directors, administrators, faculty members, and others as determined. The GMEC and DIO are jointly responsible for ensuring compliance with ACGME institutional and program-specific requirements.

NGMEC employees (or leased staff) will include:

- GME administrative staff, including program coordinators and secretarial/clerical staff.
- GME program directors (for their protected nonclinical time devoted to program oversight).
- DIO.
- Faculty physicians (for the percentage of time devoted to teaching and other GME-related activities).<sup>15</sup>
- Residents and fellows.

NGMEC will have a shared funding model. Core consortium and administrative costs will be shared equally, while other expenses will be allocated to members based on the number of residents and fellows assigned to their institutions. Any Medicare or Medicaid reimbursement for GME will accrue directly to the recipient institution. Whenever possible, other funds (e.g., state appropriations for GME) will accrue directly to the consortium.

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<sup>14</sup> A DIO is required by ACGME to be appointed by each institution to supervise high-level accreditation and program issues. The DIO is generally a physician or administrator devoting a percentage FTE to these duties.

<sup>15</sup> Selected faculty will be employed by or through the consortium, and others may be under contract.

## Appendix A

## Brief List of Key Hospital Attributes

Provided below is a brief list of key characteristics of each of the hospitals that may be conducive to the coordinated operation of GME programs. The list is by no means exhaustive, but rather is intended to highlight selected key attributes of each institution.

### A. ARMC

ARMC has an existing medical library, an experienced medical librarian, and a learning lab suitable for residents and medical students. In addition:

- There are five critical care units (including surgery, medicine, neurosurgical intensive care, coronary care, and cardiovascular intensive care).
- A 46-bed emergency department (which includes 5 trauma beds) will be completed in summer 2008.
- A 289-seat lecture hall already exists on the campus.
- A midwifery program has been in operation for over 25 years, and the program is now led by a director and obstetrician with prior MCG teaching experience.
- A pediatric unit exists with two pediatric hospitalists, and in the outpatient setting, Athens Regional Physician Services has 14 employed pediatricians.
- There is a Mind Body Institute, which makes available complementary therapies such as acupuncture.

### B. NGHS

- NGHS has more than 24,000 acute care admissions with 557 licensed beds.
  - » Two hospital campuses in Gainesville with over 4,000 annual births and 100,000-plus emergency room visits.
  - » A third hospital campus is planned for southern Hall County to open in 2012–2013.
- NGHS is sponsoring host for the Foothills AHEC that coordinates rural healthcare education and student clinical placements throughout the region.
- NGHS is ranked number one in cardiac care in Georgia (Health Grades) and in the top 6 percent in the nation in oncology for excellence in clinical research and coordination of care (American College of Surgeons Commission on Cancer).
- There are growing hospitalist and intensivist programs in active operation with strong focus on clinical outcomes, and more than 30 primary care physicians and midlevel providers operating Neighborhood Healthcare Centers throughout the northeast Georgia region.

**C. SMHCS**

- SMHCS's recent expansion and modernization project included a family birth center, neonatal ICU, women's imaging center, updated MRI suite, and the expansion of several existing departments and services.
- In 2004, SMHCS became the second hospital in Georgia – the first outside of Savannah – to be certified as a Primary Stroke Center by the Joint Commission, providing leading-edge neuroscience care and operating a neuroscience critical care unit.
- SMHCS has an existing hospitalist program in conjunction with an independent group of board-certified internal medicine physicians, Athens Hospitalists Services.
- SMHCS has a 20-bed unit for rehabilitative medicine as well as an outpatient rehabilitation center.

## Appendix B

# Northeast Georgia GME Feasibility Assessment

## Appendix B

*Excerpted Material from Steering Committee Meetings*

# ECG

MANAGEMENT  
CONSULTANTS

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# Agenda

- I. What is GME?
- II. GME Organizational Models
- III. Current GME Programs in Georgia
- IV. Attributes of Potential GME Programs
- V. Characteristics and Performance of Medical Education Consortia
- VI. Straw Man Model for NGMEC
- VII. Volume Assessments for Potential GME Programs

# I. What is GME?

# I. What is GME?

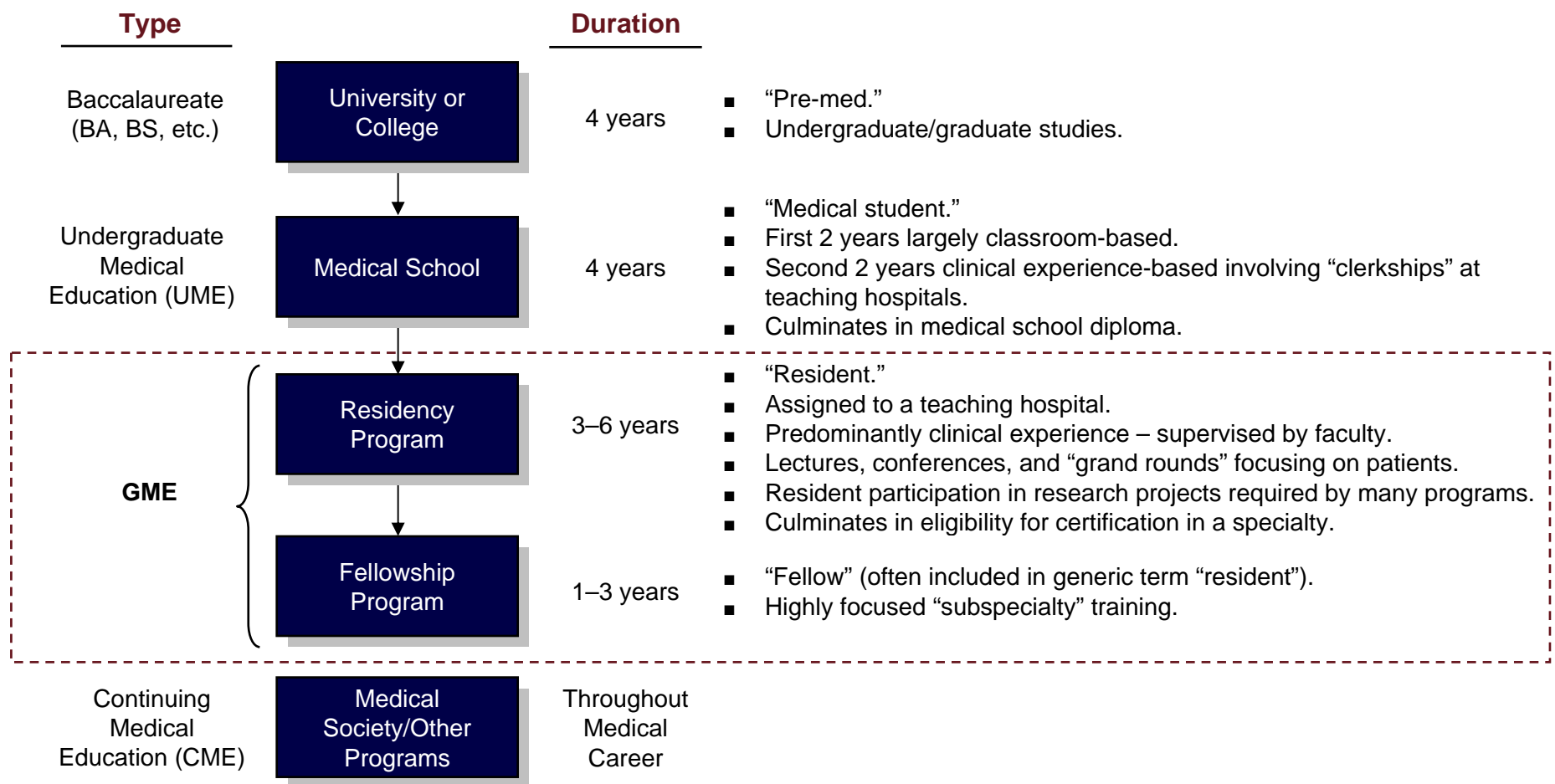
## *Definition*

- **G**raduate **M**edical **E**ducation is the period of didactic and clinical education in a medical specialty after the completion of medical school.
- Prepares physicians to practice medicine independently.
- Includes up to two phases of education:
  - » Residency: 3–6 years' training in core disciplines (e.g., internal medicine, general surgery, OB/GYN, pediatrics, psychiatry, etc.).
  - » Fellowship: 1–3 additional years' additional training in subspecialties (e.g., allergy and immunology, orthopedic surgery, gynecologic oncology, etc.).
- Is a requirement for physician board certification.

# I. What is GME?

## Definition (continued)

*This graphic represents the typical course of medical education in the United States today.*



# I. What is GME?

## *Participants and Perceived Value*

*Medical schools and teaching hospitals participate in GME for a variety of reasons.*

- By definition, GME is clinical training and takes place in hospitals and outpatient provider settings.
- All GME programs must have an academic affiliate.
- GME requires scholarship (research).
- Medical schools look to GME programs as training opportunities for third- and fourth-year medical students (residents generally supervise the students).
- Graduating residents often go on to practice in the region and generally admit and refer to the institution in which they trained.
- Residents provide evening and weekend coverage of inpatients, which might otherwise be difficult for a hospital to arrange.

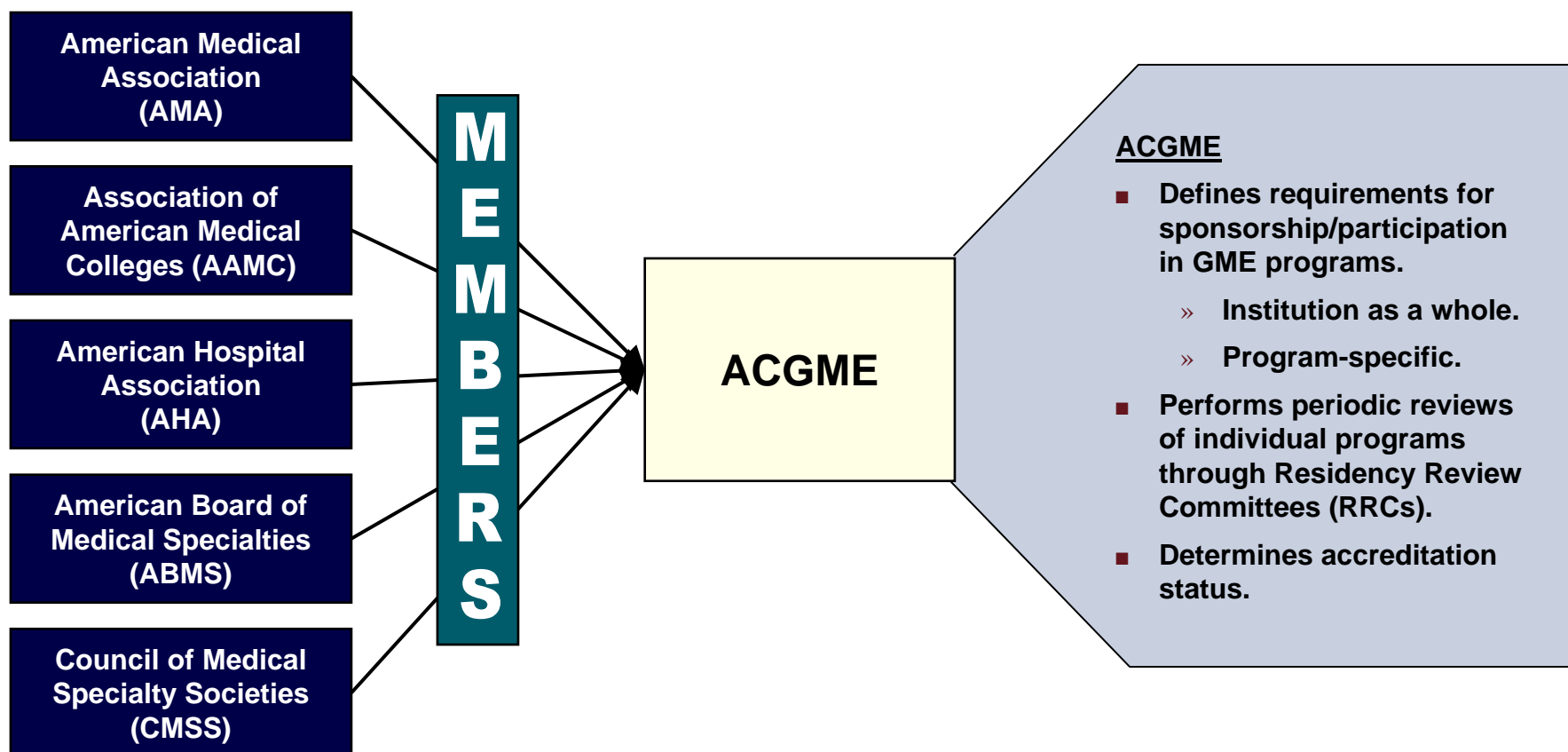
# I. What is GME?

## *Participants and Perceived Value (continued)*

- Coverage provided by residents may positively affect hospital/physician relations, since physicians enjoy the support of residents.
- The educational model may improve the quality of care as a result of the use of patient care teams – attending physicians, residents, and medical students.
- Teaching hospital status may afford a positive and unique distinction in the marketplace.
- Training programs tend to ensure that hospital and medical staffs remain up to date with the latest medical advances.
- Residents may represent a cost-effective resource for providing care to indigent patients in support of an institution's charitable mission.
- The presence of residents may foster the recruitment and retention of high-quality physicians.

# I. What is GME? Accreditation

*Allopathic GME programs are accredited by the Accreditation Council on Graduate Medical Education (ACGME), founded in 1981.1*



<sup>1</sup> Accreditation for osteopathic GME programs is supervised by the American Osteopathic Association (AOA) and is not addressed in this presentation.

# I. What is GME?

## ***Accreditation*** (continued)

- ACGME recognizes three levels of GME participation:
  - » A *sponsoring institution* assumes the ultimate financial and academic responsibility for a GME program.
  - » A *major participating institution* (MPI) hosts residents for a rotation or rotations equal in length to at least 2 months for each training year of the program (i.e., 4 months of a 2-year program, 6 months of a 3-year program, etc.).
  - » A *participating institution* hosts residents for a required educational experience or experiences of at least 1 month in length.
- Sponsoring institutions must undergo two types of accreditation:
  - » *Institutional accreditation* is ACGME's evaluation of an institution's capability to administer successful GME programs, regardless of specialty.
  - » *Program-specific accreditation* is ACGME's evaluation of an institution's ability to support successful GME programs in a specific medical specialty.

# I. What is GME?

## ***Accreditation*** (continued)

- MPIs must be evaluated on a program-specific basis.
- Participating institutions are not evaluated by ACGME.
- ACGME has 28 review committees that accredit programs and institutions.
  - » 26 RRCs, one for each medical specialty.
  - » 1 Institutional Review Committee (IRC), to review institutional compliance with accreditation requirements.
  - » 1 committee tasked with reviewing 1-year “transitional year” programs (general clinical programs, for medical school graduates who have not yet chosen a specialty).

# I. What is GME?

## ***Accreditation*** (continued)

***ACGME requires programs to meet two sets of accreditation criteria: one common to all programs, and one specific to each specialty.***

- Common requirements include:
  - » One program director with accountability for the quality of all aspects of the program.
  - » Adequate faculty to supervise resident education.
  - » An organized didactic program including rounds, lectures, and conferences.
- Specialty-specific requirements include:
  - » 50% nonclinical protected time for the program director to fulfill program responsibilities (psychiatry).
  - » Sponsorship of, or affiliation with, accredited programs in general surgery and internal medicine (anesthesiology).
  - » Minimum of two residents per training year (OB/GYN).

# I. What is GME?

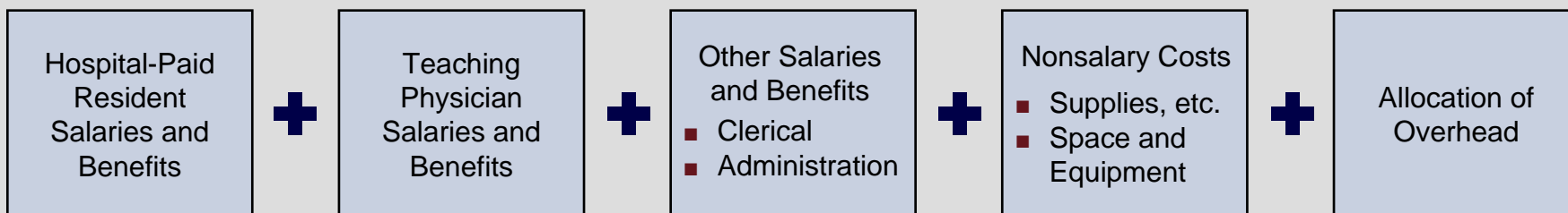
## ***Accreditation*** (continued)

- Frequency of site visits depends on a program's accreditation status.
  - » Every 4 years for fully accredited programs.
  - » More frequently for programs with accreditation concerns, including:
    - Failure to meet institutional accreditation requirements.
    - Administrative turnover.
    - Consistently unfilled residency positions.
    - Insufficient board-exam pass rates by program graduates.
    - Others.

# I. What is GME? *Financing*

## Typical Components of Cost

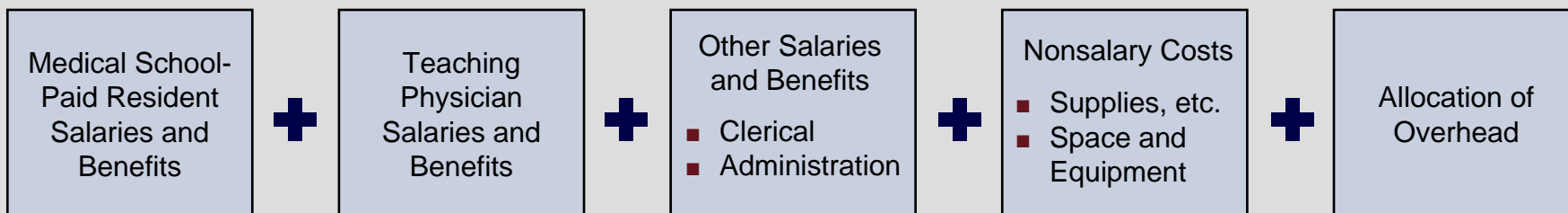
### Hospital:



A financial agreement may exist between the hospital and the medical school.

**Total Per Resident** ➔ \$120,000+

### Medical School:



# I. What is GME?

## ***Financing*** (continued)

- Financial support for GME programs comes from a variety of sources:
  - » Center for Medicare & Medicaid Services (CMS).
  - » Medicaid (in some states, including Georgia).
  - » Professional fees generated by faculty physicians while supervising residents and fellows.
  - » Sponsoring and participating institutions:
    - Medical schools.
    - Teaching hospitals.
- Medicare is generally the largest of these sources.
- However, in 1997 Congress imposed a “cap” on the number of reimbursable residents and fellows per institution, which has led to increasing strain on medical schools and teaching hospitals.

# I. What is GME?

## *Financing* (continued)

**Total Medicare GME payments received by teaching hospitals are composed of direct medical education (DME) and indirect medical education (IME) payments.**

### DME Payment

+

### IME Payment

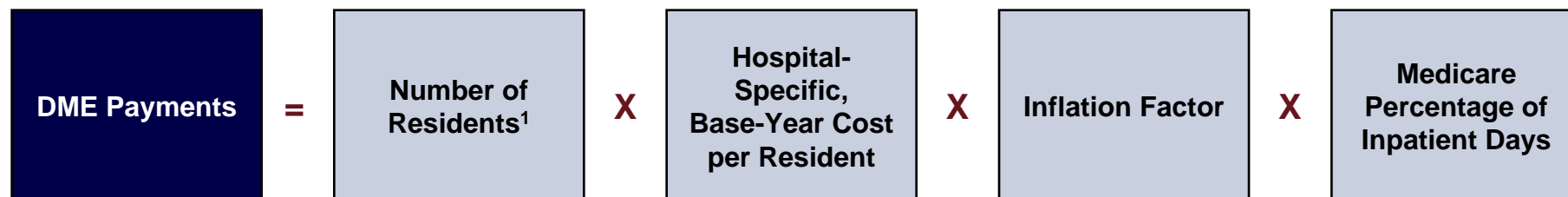
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### Total Medicare GME Payment

- To recognize the direct GME-related costs incurred by the teaching hospital.
  - Medicare's share of direct:
    - » Resident salary and fringe benefits.
    - » Faculty compensation for resident teaching and supervision.
    - » Allocation of hospital overhead.
    - » Other direct allowable costs.
      - Administrative personnel.
      - Office supplies.
      - Teaching materials.
      - Travel.
- To recognize the indirect costs of GME programs borne by the teaching hospital.
  - Related to inefficiencies caused by:
    - » Additional tests ordered by residents.
    - » Additional duties imposed on hospital staff.
    - » So forth.

# I. What is GME? *Medicare Financing*

*DME reimbursement is determined via the following formula. Critical factors include number of residents and the hospital's cost structure and percentage of Medicare inpatient days.*

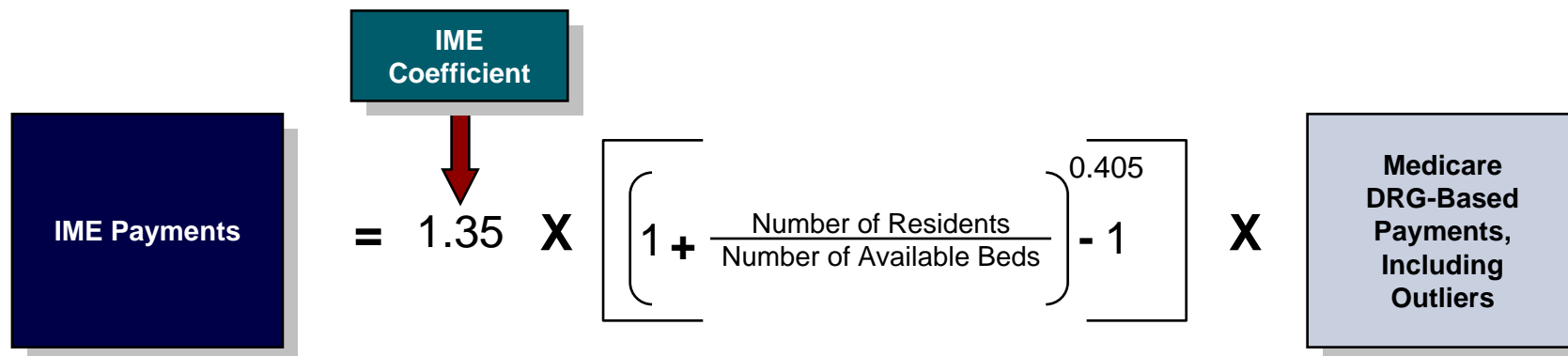


*The actual number of residents is claimed on a hospital's Medicare cost report and payments are made periodically by CMS.*

# I. What is GME?

## Medicare Financing (continued)

*IME reimbursement is largely determined by a coefficient set by CMS, reflecting the percentage by which teaching hospitals' costs of care increased in the presence of GME programs.*



*IME payments are built into hospitals' DRG rates.*

# I. What is GME?

## *Trends*

*Demand for UME is increasing rapidly.*

- In 2006, AAMC called for 30% growth in U.S. medical school enrollments by 2015 to prevent a significant physician shortage nationwide.
- The following means were recommended:
  - » Increasing class sizes in existing medical schools.
  - » Establishing new medical schools.
- Substantial enrollment increases were reported in medical school classes matriculating in 2006, including:
  - » 28 schools with an increase of 5% or more students over 2005.
  - » 9 schools with an increase of 10% or more students over 2005.
- In January 2007, however, AAMC predicted only a 17% increase in total U.S. medical school enrollment by 2012.

# I. What is GME?

## *Trends (continued)*

***New schools of medicine (SOMs) are in various stages of development nationwide, particularly in areas with historical physician shortages.***

- Some of these schools include:
  - » Florida International University, Miami, Florida (first class expected to matriculate in fall 2009).
  - » University of Central Florida, Orlando, Florida (fall 2009).
  - » Virginia Tech/Carilion, Roanoke, Virginia (fall 2009 or fall 2010).
  - » Touro College, Florham Park, New Jersey (Date TBD).
  - » Medical Education Development Consortium, Scranton, Pennsylvania (fall 2009).
  - » Branch campus of the University of Arizona, Phoenix, Arizona (fall 2007).

# I. What is GME?

## *Trends (continued)*

***Increased medical school enrollment and graduation rates will require a corresponding increase in available residency and fellowship positions – with no additional support from Medicare planned.***

- An increase in GME positions will be achieved by:
  - » Increasing the resident complement in existing GME programs.
  - » Expanding the number of GME programs offered by already-participating institutions.
  - » New or renewed participation in GME by institutions currently not offering GME programs.
- AAMC has called for a 30 percent increase in the cap of GME positions supported by Medicare to support this expansion of resident training.
- As Congress has not responded to this call with new legislation, AMCs will likely face the burden of funding their additional GME positions without support from Medicare.

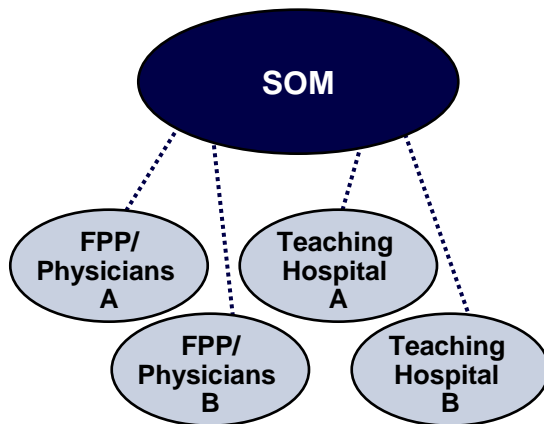
## **II. GME Organizational Models**

## II. GME Organizational Models

*There are three typologies that may describe structures for the governance, organization, financing, and management of GME.*

### Multiple Affiliation Agreements

SOM maintains a number of academic affiliation arrangements with teaching hospitals and/or faculty physicians to provide clinical education.



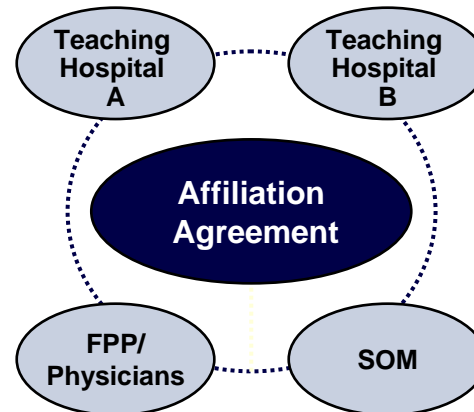
#### **Example:**

- University of North Dakota
- University of Nevada

..... Affiliation and/or buy-sell arrangements.

### Multiparty Affiliation Agreements

Academic affiliation agreement among multiple components of the AMC.

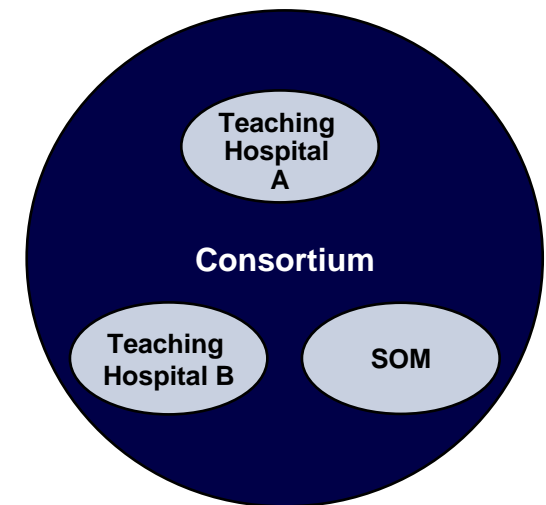


#### **Example:**

- Southern Illinois University

### Medical Education Consortium

Multiparty structure designed to organize, manage, and finance clinical education.



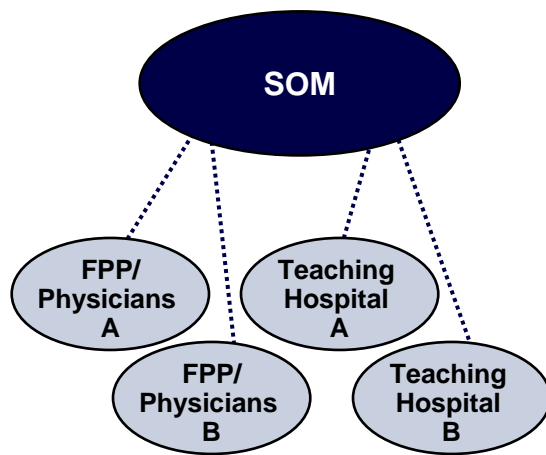
#### **Example:**

- Michigan State University

## II. GME Organizational Models *(continued)*

***SOM maintains a number of academic affiliation arrangements with teaching hospitals and/or faculty physicians to provide clinical education.***

### Multiple Affiliation Arrangements



..... Affiliation and/or buy-sell arrangements.

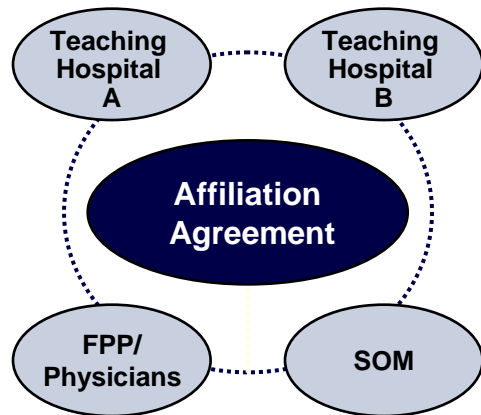
### Key Attributes

- The SOM generally maintains a number of academic affiliation arrangements with teaching hospitals and/or faculty physicians to provide clinical education. These physicians can be full-time or community-based.
- This arrangement:
  - » Presents a number of challenges for community-based medical schools, given the number of organizational participants.
  - » Can lead to interorganizational and administrative complexities.
  - » Can disenfranchise certain entities if a perception exists that there is an imbalance among the contractual provisions contained in the different affiliation agreements.
  - » May result in a lack of collaborative spirit among AMC components vis-à-vis the educational mission.

## II. GME Organizational Models *(continued)*

### ***Academic affiliation agreement among multiple components of the AMC.***

#### Multiparty Affiliation Agreements



..... Affiliation and/or buy-sell arrangements.

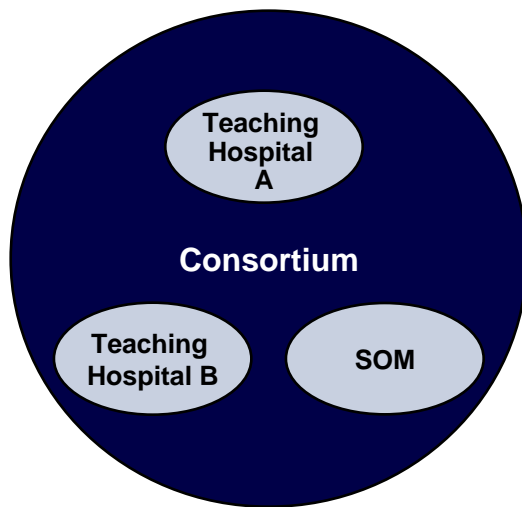
#### Key Attributes

- A single, multiparty academic affiliation agreement among multiple components of the AMC. (Example: a medical school and two or more teaching hospitals enter into a multiparty agreement.)
- Eliminates some of the complexities of the multiple affiliation agreements model, since the multiparty contractual provisions are known to all parties.
- An advisory council is often developed to coordinate educational strategy and operations and to foster collaboration around the educational mission.

## II. GME Organizational Models *(continued)*

*Multiparty structure designed to organize, manage, and finance clinical education.*

### Medical Education Consortium



### Key Attributes

- A formalized, multiparty structure designed specifically to organize, manage, and finance clinical education. (Typically, consortia are formalized through incorporation.)
- Enables constituent organizations to:
  - » Collaborate on GME activities.
  - » Cooperate on educational affairs while competing in the healthcare marketplace.
  - » Enhance the quality of GME.
  - » Improve the diversity and geographic distribution of the physician workforce.
  - » Coordinate the financing of GME.
  - » Foster efficient and effective administrative infrastructure.

## II. GME Organizational Models *(continued)*

*Determining the preferred model is dependent upon a variety of considerations.*

- Scope of the GME programs.
- Number of participants.
- Roles of various participants.
- Desire for collaboration.
- Objectives for participating in GME.
- Others.

## II. GME Organizational Models *(continued)*

*In addition, there are a variety of other key considerations that will affect GME.*

- Clinical education affiliation arrangements.
- Array of teaching affiliates and program assignments.
- Coordination of the academic budget and designation of the flow of funds.

## II. GME Organizational Models

### *Other Key Considerations*

#### Clinical Education/Affiliation Arrangements

- The AMC must ensure that the clinical education/affiliation arrangements are strategically designed to:
  - » Achieve interorganizational goals.
  - » Foster the financial performance necessary to sustain the academic enterprise (GME programs).
  - » Consider the history of the AMC and the parties involved.
  - » Address political, economic, social, and other concerns unique to its own context.

## II. GME Organizational Models

### *Other Key Considerations (continued)*

#### Array of Teaching Affiliates and Program Assignments

- A mechanism is required to collaboratively determine a strategy for meeting the educational mission/objectives of the AMC as needs change and the service lines of various teaching hospitals/affiliates prosper or fail. This process should include:
  - » Review of program evaluations.
  - » Discussion of program strengths and weaknesses of affiliates.
  - » A mechanism for decision making regarding program assignments. Because most community-based AMCs want to provide access to care in underserved areas, the governing body should ensure that multiple teaching hospital affiliates, strategically located across the state, participate in the AMC.<sup>1</sup>

<sup>1</sup> Most community-based medical schools have several teaching affiliates. Of the community-based medical schools surveyed by ECG, the number of teaching affiliates ranged from 3 to 16.

## II. GME Organizational Models

### *Other Key Considerations (continued)*

Any GME model must address important considerations, which may include:

- Clinical education/affiliation arrangements.
- Array of teaching affiliates and program assignments.
- Coordination of the academic budget and designation of the flow of funds.
- Hiring authority for, and locations of, department chairs.
- Role of full-time faculty and community physicians.
- Coordination of educational administration.

## II. GME Organizational Models

### *Other Key Considerations (continued)*

#### Coordination of the Academic Budget and Designation of the Flow of Funds

- The hospitals and SOM should define a strategy and a process to ensure appropriate and adequate financing of the academic enterprise.
  - » An academic budget that consolidates the sources and uses of funds related to the clinical education activities of all AMC component organizations can be an effective means for managing the financial requirements and expenditures of the academic enterprise.
  - » The academic budget will be financed with funds provided by the medical school and its affiliated teaching hospitals.
  - » The magnitude of those funds should be determined by a documented objective methodology or formula. Such an approach will provide a predictable source of funds to finance the teaching programs.
  - » It is essential that the financing of clinical education be fair and equitable, based on objective criteria that reflect the costs, efforts, and fiscal realities of the constituent organizations.

## II. GME Organizational Models

### *Other Key Considerations (continued)*

*Common sources of financial support from AMCs' organizational components:*

#### SOM and University

- Revenues are generated from university tuition and fees, research grants and contracts, federal and state appropriations, negotiated payments from the practice plan and hospital, and endowments.
- These revenues provide support for teaching, research, infrastructure, or other uses as allocated by SOM leadership.

#### FPP

- Revenues are generated from provision of services to patients and hospitals.
- These revenues may provide support for clinical faculty compensation, shared support staff, equipment and facilities, faculty time in research and teaching, and other expenses related to the academic enterprise.

## II. GME Organizational Models

### *Other Key Considerations (continued)*

#### All Hospitals

- Revenues for all hospitals are primarily generated from clinical patient care activities.
- These revenues are used for all clinical hospital operations and facilities, faculty salaries for medical administrative duties and selected patient care activities, and resident stipends and fringe benefits.

#### Some Hospitals

- Revenues for some hospitals are generated from charitable contributions, research grants and contracts, and federal and state appropriations.
- These revenues are used for faculty salaries for GME and research, office space, administrative support, fund-raising support, operation of educational clinics, and education and research overhead.

## II. GME Organizational Models

### *Other Key Considerations (continued)*

*Funding arrangements and magnitude of financial support provided by hospitals varies greatly based on a number of factors.*

- Corporate structure/interorganizational relationship(s).
- Size and scope of the teaching and research programs.
- Relative mission focus of the teaching hospital.
- Physician complement/employment arrangements.
- Historical funding arrangements.
- Financial constraints.
- Market considerations.
- Other factors.

## II. GME Organizational Models

### *Other Key Considerations (continued)*

#### Hiring Authority for, and Locations of, Department Chairs

- The management of an AMC is distributed among the chairs of the various medical school basic science and clinical departments.
- Clinical chairs are:
  - » Typically hired by the dean, often in collaboration with affiliated hospitals.
  - » Generally assigned a practice location within one or more major teaching affiliates.
- Clinical chairs may not be distributed across all teaching hospitals when great distances separate certain teaching hospitals from the medical school campus.
- The location of the chairs is important to teaching hospitals, since the location of a chair may enhance the hospital's ability to recruit physicians for that department.
- In an AMC with multiple affiliates that are proximate to the medical school, the distribution of chairs among these affiliates does carry significance. The dean should carefully consider the impact of such decisions and strive to maintain a balanced complement of chairs across proximate affiliates.

## II. GME Organizational Models

### *Other Key Considerations (continued)*

#### Role of Full-Time Faculty and Community Physicians

- Community-based AMCs may rely on both full-time and voluntary/community physicians to supervise residents.
- Constituents of the AMC (different hospitals) may have varied strategies and interests vis-à-vis the physician enterprise.
- Principles must be created and a process developed to arrive at constructs for faculty arrangements that recognize:
  - » Educational requirements.
  - » Medical staff realities of the teaching hospitals.
  - » Political, historical, and cultural realities.

## II. GME Organizational Models

### *Other Key Considerations (continued)*

#### Coordination of Educational Administration

- GME administration is typically handled and paid for by the sponsoring organization of a residency program:
  - » SOM.
  - » Teaching hospital.
  - » Medical education consortium.
  - » Other.

## **III. Current GME Programs in Georgia**

### III. Current GME Programs in Georgia

- ECG has analyzed the range of GME programs currently available in Georgia as an integral part of this feasibility assessment.
- A summary of our analyses is presented in grid format as EXHIBIT I.
- These analyses focus on residency programs in the following core and primary care disciplines:
  - » Emergency medicine.
  - » Family medicine.
  - » Internal medicine.
  - » Obstetrics and gynecology (OB/GYN).
  - » Pediatrics.
  - » Psychiatry.
  - » Surgery.
  - » Transitional year.<sup>1</sup>

<sup>1</sup> A 1-year program designed to prepare new medical graduates for further residency education in multiple clinical disciplines.

**NORTHEAST GEORGIA  
GME FEASIBILITY ASSESSMENT**

Sponsoring Institution(s)	Approximate Miles from UGA College of Public Health	Medical School Affiliation(s)	Core and Primary Care GME Programs Offered	Participating Institutions
Atlanta Medical Center	73	Medical College of Georgia (MCG).	Family medicine (18 positions, 18 residents).	<ul style="list-style-type: none"> <li>■ Atlanta Medical Center.</li> <li>■ Children’s Healthcare of Atlanta.</li> </ul>
			Internal medicine (30 positions, 28 residents).	Atlanta Medical Center.
			OB/GYN (12 positions, 9 residents).	Atlanta Medical Center.
			Surgery (16 positions, 16 residents).	<ul style="list-style-type: none"> <li>■ Atlanta Medical Center.</li> <li>■ Piedmont Fayette Hospital.</li> <li>■ Children’s Healthcare of Atlanta.</li> <li>■ Emory University Hospital.</li> </ul>
Dwight David Eisenhower Army Medical Center, Fort Gordon	99	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ Uniformed Services University of the Health Sciences, Edward F. Hebert School of Medicine, Bethesda, Maryland.</li> </ul>	Family medicine (30 positions, 18 residents).	<ul style="list-style-type: none"> <li>■ Dwight David Eisenhower.</li> <li>■ Womack Army Medical Center.</li> <li>■ MCG.</li> <li>■ Winn Army Community Hospital.</li> <li>■ University Hospital.</li> </ul>
			Internal medicine (24 positions, 15 residents).	<ul style="list-style-type: none"> <li>■ Dwight David Eisenhower Army Medical Center.</li> <li>■ Veterans Affairs Medical Center (VAMC) (Augusta).</li> </ul>
			Surgery (18 positions, 16 residents).	<ul style="list-style-type: none"> <li>■ Dwight David Eisenhower Army Medical Center.</li> <li>■ Womack Army Medical Center.</li> <li>■ MCG.</li> <li>■ Doctor’s Hospital of Augusta.</li> <li>■ Martin Army Community Hospital.</li> <li>■ Grady Health System.</li> </ul>
			Transitional year (10 positions, 7 residents).	<ul style="list-style-type: none"> <li>■ Dwight David Eisenhower Army Medical Center.</li> <li>■ Memorial Health – University Medical Center.</li> </ul>

NORTHEAST GEORGIA  
**GME FEASIBILITY ASSESSMENT**

Sponsoring Institution(s)	Approximate Miles from UGA College of Public Health	Medical School Affiliation(s)	Core and Primary Care GME Programs Offered	Participating Institutions
Emory University SOM	67	Emory University SOM.	Emergency medicine (54 positions, 53 residents).	<ul style="list-style-type: none"> <li>■ Grady Health System.</li> <li>■ Emory University Hospital.</li> <li>■ Crawford Long Hospital of Emory University.</li> <li>■ Children's Healthcare of Atlanta at Egleston.</li> </ul>
			Family medicine (30 positions, 24 residents).	<ul style="list-style-type: none"> <li>■ Grady Health System.</li> <li>■ Emory Johns Creek Hospital.</li> <li>■ VAMC (Atlanta).</li> <li>■ Crawford Long Hospital of Emory University.</li> <li>■ Children's Healthcare of Atlanta at Egleston.</li> </ul>
			Internal medicine (177 positions, 171 residents).	<ul style="list-style-type: none"> <li>■ VAMC (Atlanta).</li> <li>■ Grady Health System.</li> <li>■ Emory University Hospital.</li> <li>■ Crawford Long Hospital of Emory University.</li> <li>■ Wesley Woods Geriatric Hospital.</li> </ul>
			OB/GYN (37 positions, 36 residents).	<ul style="list-style-type: none"> <li>■ Grady Health System.</li> <li>■ Crawford Long Hospital of Emory University.</li> <li>■ VAMC (Atlanta).</li> <li>■ Emory University Hospital.</li> <li>■ Piedmont Hospital.</li> </ul>
			Pediatrics (55 positions, 54 residents).	<ul style="list-style-type: none"> <li>■ Children's Healthcare of Atlanta at Egleston.</li> <li>■ Grady Health System.</li> </ul>

**NORTHEAST GEORGIA  
GME FEASIBILITY ASSESSMENT**

Sponsoring Institution(s)	Approximate Miles from UGA College of Public Health	Medical School Affiliation(s)	Core and Primary Care GME Programs Offered	Participating Institutions
			Psychiatry (50 positions, 48 residents).	<ul style="list-style-type: none"> <li>■ Emory University Hospital.</li> <li>■ VAMC (Atlanta).</li> <li>■ Grady Health System.</li> <li>■ Wesley Woods Geriatric Hospital.</li> </ul>
			Surgery (70 positions, 53 residents).	<ul style="list-style-type: none"> <li>■ VAMC (Atlanta).</li> <li>■ Grady Health System.</li> <li>■ Emory University Hospital.</li> <li>■ Crawford Long Hospital of Emory University.</li> <li>■ Piedmont Hospital.</li> <li>■ Children's Healthcare of Atlanta at Egleston.</li> </ul>
			Transitional year (24 positions, 24 residents).	<ul style="list-style-type: none"> <li>■ Grady Health System.</li> <li>■ Emory University Hospital.</li> <li>■ VAMC (Atlanta).</li> <li>■ Crawford Long Hospital of Emory University.</li> </ul>
Floyd Medical Center, Rome	137	<ul style="list-style-type: none"> <li>■ Emory University SOM.</li> <li>■ MCG.</li> <li>■ Mercer University SOM, Macon.</li> </ul>	Family medicine (21 positions, 21 residents).	Floyd Medical Center.
Martin Army Community Hospital, Fort Benning	187	<ul style="list-style-type: none"> <li>■ Pikeville College School of Osteopathic Medicine, Pikeville, Kentucky</li> <li>■ Uniformed Services University of the Health Sciences, Edward F. Hebert School of Medicine, Bethesda, Maryland</li> </ul>	Family medicine (21 positions, 24 residents).	<ul style="list-style-type: none"> <li>■ Martin Army Community Hospital.</li> <li>■ The Medical Center, Inc.</li> </ul>

**NORTHEAST GEORGIA  
GME FEASIBILITY ASSESSMENT**

<b>Sponsoring Institution(s)</b>	<b>Approximate Miles from UGA College of Public Health</b>	<b>Medical School Affiliation(s)</b>	<b>Core and Primary Care GME Programs Offered</b>	<b>Participating Institutions</b>
Medical Center of Central Georgia, Macon	92	Mercer University SOM.	Family medicine (24 positions, 21 residents).	Medical Center of Central Georgia.
			Internal medicine (24 positions, 25 residents).	<ul style="list-style-type: none"> <li>■ Medical Center of Central Georgia.</li> <li>■ Central Georgia Rehabilitation Hospital.</li> </ul>
			OB/GYN (12 positions, 13 residents).	Medical Center of Central Georgia.
			Pediatrics (18 positions, 18 residents).	<ul style="list-style-type: none"> <li>■ Medical Center of Central Georgia.</li> <li>■ Children's Healthcare of Atlanta at Scottish Rite.</li> <li>■ Emory University Hospital.</li> </ul>
			Surgery (20 positions, 16 residents).	<ul style="list-style-type: none"> <li>■ Medical Center of Central Georgia.</li> <li>■ Piedmont Hospital.</li> </ul>
MCG	105	MCG.	Emergency medicine (27 positions, 27 residents).	MCG.
			Family medicine (24 positions, 25 residents).	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ Winn Army Community Hospital.</li> <li>■ VAMC (Augusta).</li> <li>■ University Hospital.</li> <li>■ Dwight David Eisenhower Army Medical Center.</li> </ul>
			Family medicine, Satilla Regional Medical Center (6 positions, 4 residents – rural track program of MCG).	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ Satilla Regional Medical Center.</li> </ul>
			Internal medicine (63 positions, 55 residents).	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ VAMC (Augusta).</li> </ul>
			OB/GYN (16 positions, 16 residents).	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ University Hospital.</li> </ul>
			Pediatrics (36 positions, 35 residents).	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ Aiken Regional Medical Center.</li> </ul>

**NORTHEAST GEORGIA  
GME FEASIBILITY ASSESSMENT**

Sponsoring Institution(s)	Approximate Miles from UGA College of Public Health	Medical School Affiliation(s)	Core and Primary Care GME Programs Offered	Participating Institutions
			Psychiatry (24 positions, 20 residents).	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ VAMC (Augusta).</li> </ul>
			Surgery (28 positions, 27 residents).	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ VAMC (Augusta).</li> </ul>
Memorial Health – University Medical Center, Savannah	233	Mercer University SOM, Macon	Family medicine (18 positions, 20 residents).	Memorial Health – University Medical Center.
			Internal medicine (35 positions, 34 residents).	Memorial Health – University Medical Center.
			OB/GYN (16 positions, 14 residents).	Memorial Health – University Medical Center.
			Pediatrics (18 positions, 19 residents).	Memorial Health – University Medical Center.
			Surgery (15 positions, 15 residents).	<ul style="list-style-type: none"> <li>■ Memorial Health – University Medical Center.</li> <li>■ MUSC Medical Center.</li> </ul>
Morehouse SOM	76	Morehouse SOM.	Family medicine (15 positions, 14 residents).	<ul style="list-style-type: none"> <li>■ Grady Health System.</li> <li>■ Tenet-South Fulton Medical Center.</li> <li>■ Children’s Healthcare of Atlanta.</li> <li>■ Veterans Affairs Medical Center (Atlanta).</li> </ul>
			Internal medicine (49 positions, 48 residents).	<ul style="list-style-type: none"> <li>■ Grady Health System.</li> <li>■ Tenet-South Fulton Medical Center.</li> <li>■ Central Alabama Veterans Healthcare System.</li> </ul>
			OB/GYN (12 positions, 12 residents).	<ul style="list-style-type: none"> <li>■ Grady Health System.</li> <li>■ Tenet-South Fulton Medical Center.</li> </ul>
			Pediatrics (18 positions, 20 residents).	<ul style="list-style-type: none"> <li>■ Grady Health System.</li> <li>■ Dekalb Medical Center.</li> <li>■ Children’s Healthcare of Atlanta at Scottish Rite.</li> <li>■ Children’s Healthcare of Atlanta at Egleston.</li> </ul>

**NORTHEAST GEORGIA  
GME FEASIBILITY ASSESSMENT**

Sponsoring Institution(s)	Approximate Miles from UGA College of Public Health	Medical School Affiliation(s)	Core and Primary Care GME Programs Offered	Participating Institutions
			Psychiatry (16 positions, 16 residents).	<ul style="list-style-type: none"> <li>■ Central Alabama Veterans Healthcare System.</li> <li>■ Grady Health System.</li> <li>■ Georgia Regional Hospital at Atlanta.</li> <li>■ Inner Harbour Hospitals, Ltd.</li> </ul>
			Surgery (22 positions, 20 residents).	<ul style="list-style-type: none"> <li>■ Grady Health System.</li> <li>■ Children’s Healthcare of Atlanta at Scottish Rite.</li> <li>■ Tenet-South Fulton Medical Center.</li> <li>■ The Medical Center, Inc.</li> </ul>
Phoebe Putney Memorial Hospital, Albany	197	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ Mercer University SOM.</li> </ul>	Family medicine (15 positions, 15 residents).	Phoebe Putney Memorial Hospital.
The Medical Center, Inc., Columbus	180	<ul style="list-style-type: none"> <li>■ MCG.</li> <li>■ Mercer University SOM.</li> <li>■ Morehouse SOM.</li> <li>■ Nova Southeastern University College of Osteopathic Medicine.</li> </ul>	Family medicine (36 positions, 32 residents).	<ul style="list-style-type: none"> <li>■ The Medical Center, Inc.</li> <li>■ Martin Army Community Hospital.</li> </ul>
			Transitional year (5 positions, 5 residents).	The Medical Center, Inc.

### III. Current GME Programs in Georgia *(continued)*

- Results of our analyses include:
  - » Most sponsoring institutions in Georgia offer GME programs:
    - » In five or fewer disciplines.
    - » Focused on primary care, with family medicine particularly prevalent.
    - » With relatively few residents, often close to ACGME minimum requirements.
  - » Exceptions include:
    - » Major AMCs (e.g., Emory, MCG).
    - » Metropolitan institutions (e.g., Memorial Health – University Medical Center, Savannah).
  - » The closest GME programs to northeast Georgia are in the Atlanta area (e.g., Emory, Morehouse, Atlanta Medical Center).

### III. Current GME Programs in Georgia *(continued)*

- Results of our analyses include:
  - » Some programs offer rotations in clinical sites remote from the sponsoring institution:
    - » Medical Center of Central Georgia (Macon) offers rotations at Children's Healthcare of Atlanta – Scottish Rite, 84 miles away.
    - » Morehouse SOM offers rotations at Central Alabama Veterans Healthcare System (Montgomery), 160 miles away.
  - » Only two programs exist in emergency medicine:
    - » Emory.
    - » MCG.

## **IV. Attributes of Potential GME Programs**

## IV. Attributes of Potential GME Programs

*Community hospitals commencing participation in GME often display similar program offerings and numbers of residents.*

- The size of new GME programs at community hospitals is usually:
  - » Sufficient to provide consistent resident presence on participating services.
  - » Equal to or slightly greater than ACGME minimum requirements (e.g., two residents per training year for OB/GYN and surgery; three residents per training year for psychiatry; six per training year for emergency medicine).
- GME programs initially offered by community hospitals typically:
  - » Focus on primary care and “core” disciplines required for third-year medical student clerkships (e.g., internal medicine, family medicine, pediatrics).
  - » Expand to surgical and/or subspecialty programs after several years.

## IV. Attributes of Potential GME Programs *(continued)*

- ECG has performed a preliminary high-level assessment of the potential for successful programs in northeast Georgia in the following disciplines:
  - » Emergency medicine.
  - » Family medicine.
  - » Internal medicine.
  - » OB/GYN.
  - » Pediatrics.
  - » Psychiatry.
  - » Surgery.

## IV. Attributes of Potential GME Programs *(continued)*

- These disciplines were selected according to the following criteria:
  - » “Core” status in medical school curricula.
  - » Physician needs identified in northeast Georgia.
- Other subspecialty programs of interest may be developed in conjunction with these core programs, including:
  - » Cardiology.
  - » Gastroenterology.
  - » Orthopaedic surgery.
  - » Neurosurgery.
  - » Others.

## IV. Attributes of Potential GME Programs *(continued)*

- In many cases, ACGME's RRCs require sponsoring institutions to demonstrate specific attributes that will support a robust residency experience, including:
  - » Sufficient clinical volumes.
    - Overall volumes.
    - Selected procedures.
    - Patient diversity (diagnosis, acuity, age, gender, cultural/socioeconomic background, etc.).
  - » Composition and diversity of the patient population (age, gender, cultural/socioeconomic background, etc.).
  - » Facilities and services available to residents (e.g., call rooms, library, lounges, 24-hour food service, etc.).
  - » Availability of high-quality program faculty and leadership.
  - » Numerous others.

## IV. Attributes of Potential GME Programs *(continued)*

- RRC requirements of primary importance to institutions that are considering sponsoring new GME programs include:
  - » Number of residents in each program.
  - » Other residency and/or fellowship programs operating at the institution.
- The following slide presents this information for programs in each discipline analyzed in Section III of this document.

## IV. Attributes of Potential GME Programs *(continued)*

GME Program	ACGME Minimum Program Size	Additional Required Programs
Emergency Medicine	24 residents total. 6 residents per training year.	Other major specialties. <sup>1</sup>
Family Medicine	12 residents total. 4 residents per training year.	None. <sup>2</sup>
Internal Medicine	12 residents total. 4 residents per training year.	None. <sup>3</sup>
OB/GYN	8 residents total. 2 residents per training year.	At least two of the following: family medicine, internal medicine, pediatrics, surgery.
Pediatrics	12 residents total. 4 residents per training year.	None. <sup>4</sup>
Psychiatry	12 residents total. 3 residents per training year.	None. <sup>4</sup>
Surgery	10 residents total. <sup>5</sup> 2 residents per training year.	At least one of the following: family medicine, internal medicine, pediatrics.
Transitional Year	4 residents total. <sup>6</sup>	At least two other ACGME-accredited programs. <sup>7</sup>

<sup>1</sup> Includes core programs such as internal medicine, pediatrics, and surgery. No minimum number of programs is set.

<sup>2</sup> Requires a dedicated Family Medicine Center for resident training.

<sup>3</sup> Subspecialty programs (including cardiology, gastroenterology, rheumatology, and others) require the presence of an internal medicine program.

<sup>4</sup> While not required by the RRC, most sponsors of these programs also offer at least one additional primary care program (e.g, internal medicine, family medicine).

<sup>5</sup> Value reflects the minimum size of surgical programs observed at ECG clients. The surgery RRC does not designate a minimum number of residents. It is important to note that most program directors report a preference for larger resident complements, due to coverage and educational quality issues.

<sup>6</sup> One-year program.

<sup>7</sup> Disciplines are not specified by the RRC.

## IV. Attributes of Potential GME Programs *(continued)*

*It is difficult to accurately determine the costs to teaching hospitals associated with offering medical student clerkships and resident rotations.*

- The primary data on these costs are derived from studies of independent (nonuniversity) teaching hospitals performed by the Association for Hospital Medical Education (AHME) in 1992 and 2000.<sup>1</sup>
- The primary findings of these studies were:
  - » Very few (if any) revenue streams are associated with medical student clerkships.
  - » Therefore, most teaching hospitals have made minimal effort to formally quantify the costs associated with clerkships.
  - » Hospitals appear to absorb the cost of clerkships by allocating full-time employed faculty physicians' time for teaching activities that do not result in professional fees.

<sup>1</sup> O'Sullivan, Patricia S., Ethel Weinberg, and Stephen M. Sadowski. "Changes in Clinical Clerkship Teaching Since 1992." *AHME News*, Winter 2005.

## IV. Attributes of Potential GME Programs *(continued)*

*Medical student teaching and supervision duties, traditionally assigned to residents, are increasingly performed by full-time faculty physicians.*

- Average daily teaching and supervision hours received by clerks declined significantly between 1992 and 2000 (from 6.6 to 5.2).
- However, the amount and percentage of teaching and supervision shifted substantially from residents to faculty physicians over the same period:
  - » Faculty physicians provided 2.1 hours per day of medical student teaching and supervision (31.9% of all hours) in 1992. In 2000, faculty physicians provided 2.6 hours per day (50% of all hours).
  - » Residents provided 2.8 hours per day of medical student teaching and supervision in 1992 (42.4% of all hours). In 2000, residents provided 1.4 hours per day (26.9% of all hours).

## IV. Attributes of Potential GME Programs *(continued)*

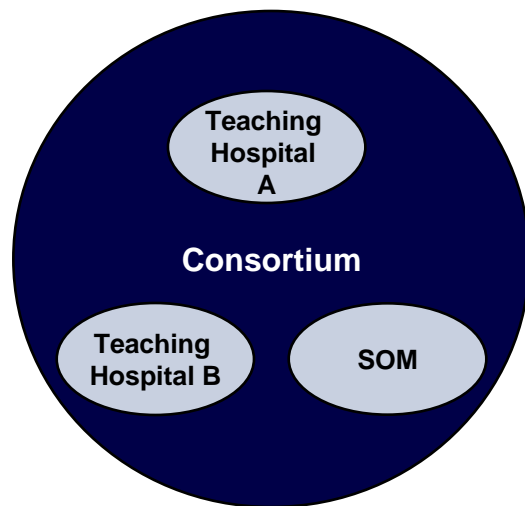
- The drivers of the shift of medical student teaching away from residents and towards faculty include:
  - » ACGME's limit of total resident work hours to 80 per week, leaving residents with less time to devote to medical students.
  - » Higher patient acuity that requires residents' undivided attention to clinical care.
  - » Hospital and faculty perception of higher quality and reduced liability risk associated with faculty supervision of medical students.
- These trends have important implications for hospitals that are considering initiating or expanding a commitment to medical education:
  - » An increase in necessary faculty FTEs unsubsidized by CMS and/or professional fee revenues.
  - » Increased teaching duties for the medical staff, who may demand financial compensation from the hospital.
  - » Others.

# **V. Characteristics and Performance of Medical Education Consortia**

# V. Characteristics and Performance of Medical Education Consortia

*A consortium is a multiparty structure designed to organize, manage, and finance clinical education.*

## Medical Education Consortium



## Key Attributes

- An organization or arrangement developed to unite the diverse group of stakeholders necessary to reorganize and/or effectively manage medical education. (Typically, consortia are formalized through incorporation.)
- Enables constituent organizations to:
  - » Collaborate on GME activities.
  - » Cooperate on educational affairs while competing in the healthcare marketplace.
  - » Enhance the quality of GME.
  - » Improve the diversity and geographic distribution of the physician workforce.
  - » Coordinate the financing of GME.
  - » Foster efficient and effective administrative infrastructure.

## V. Characteristics and Performance of Medical Education Consortia *(continued)*

*Organizations consider developing or participating in a medical education consortium to achieve a plethora of objectives.*

- Improve working relations and dispute resolution by bringing together, on a regular basis:
  - » Hospital executives.
  - » Medical school deans.
  - » Academic department chairs/clinical service chiefs.
- Further/protect the interests of community physicians.
- Enhance administrative efficiency.
  - » Provide coordinated oversight of educational quality, program requirements, and accreditation.
  - » Share the administrative costs of GME, reduce redundancies, and realize economies of scale.

## V. Characteristics and Performance of Medical Education Consortia *(continued)*

- Coordinate financial arrangements for program support.
  - » Provide transparency of the sources and uses of education funds.
  - » Provide for an equitable distribution/contribution of resources.
  - » Enable a longer financial planning horizon through pre-set financial support commitments.
- Provide a forum to address physician workforce issues, as needed.
- Address issues relevant to community physicians.

## V. Characteristics and Performance of Medical Education Consortia *(continued)*

*Medical education consortia have been studied in detail.*

- In 2002, ECG conducted a survey of 10 consortia across the nation to determine key attributes and perceptions of success.
- In addition, the Council on Graduate Medical Education (COGME) developed a report based on a 1996 survey conducted by:
  - » AAMC.
  - » The Center for Health Professions (CHP) at the University of California, San Francisco (UCSF).

## V. Characteristics and Performance of Medical Education Consortia *(continued)*

### *Consortia surveyed by ECG are as follows:*

- Michigan State University/Flint Area Medical Education.
- Michigan State University/Grand Rapids Medical Education and Research Center.
- Michigan State University/Kalamazoo Center for Medical Studies.
- Michigan State University/Saginaw Cooperative Hospitals, Inc.<sup>1</sup>
- Michigan State University/Upper Peninsula Health Education Corporation.
- Southwest Virginia Graduate Medical Education Consortium.
- Wayne State University/Oakland Health Education Program (OHEP) Medical Education Consortium.<sup>2</sup>
- University of Arizona/Phoenix Area Medical Education Consortium.<sup>3</sup>
- University of Kansas/Graduate Medical Education Consortium.<sup>4</sup>
- Wright State University/Dayton Area Medical Education Consortium.

<sup>1</sup> Now operating as Synergy Medical Education Alliance.

<sup>2</sup> Now operating as Southeast Michigan Center for Medical Education.

<sup>3</sup> Now operating as Arizona Medical Education Consortium.

<sup>4</sup> Now operating as Wichita Center for Graduate Medical Education.

# V. Characteristics and Performance of Medical Education Consortia *(continued)*

## ***ACGME Minimum Program Sizes and Other Required Programs***

<b>GME Program</b>	<b>ACGME Minimum Program Size</b>	<b>Additional Required Programs</b>
Emergency Medicine	<ul style="list-style-type: none"> <li>■ 24 residents total.</li> <li>■ 6 residents per training year.</li> </ul>	Other major specialties. <sup>1</sup>
Family Medicine	<ul style="list-style-type: none"> <li>■ 12 residents total.</li> <li>■ 4 residents per training year.</li> </ul>	None. <sup>2</sup>
Internal Medicine	<ul style="list-style-type: none"> <li>■ 12 residents total.</li> <li>■ 4 residents per training year.</li> </ul>	None. <sup>3</sup>
OB/GYN	<ul style="list-style-type: none"> <li>■ 8 residents total.</li> <li>■ 2 residents per training year.</li> </ul>	At least two of the following: family medicine, internal medicine, pediatrics, surgery.
Pediatrics	<ul style="list-style-type: none"> <li>■ 12 residents total.</li> <li>■ 4 residents per training year.</li> </ul>	None. <sup>4</sup>
Psychiatry	<ul style="list-style-type: none"> <li>■ 12 residents total.</li> <li>■ 3 residents per training year.</li> </ul>	None. <sup>4</sup>
Surgery	<ul style="list-style-type: none"> <li>■ 10 residents total.<sup>5</sup></li> <li>■ 2 residents per training year.</li> </ul>	At least one of the following: family medicine, internal medicine, pediatrics.

<sup>1</sup> Includes core programs such as internal medicine, pediatrics, and surgery. No minimum number of programs is set.

<sup>2</sup> Requires a dedicated family medicine center for resident training.

<sup>3</sup> Subspecialty programs (including cardiology, gastroenterology, rheumatology, and others) require the presence of an internal medicine program.

<sup>4</sup> While not required by the RRC, most sponsors of these programs also offer at least one additional primary care program (e.g., internal medicine, family medicine).

<sup>5</sup> Value reflects the minimum size of surgical programs observed at ECG clients. The surgery RRC does not designate a minimum number of residents. It is important to note that most program directors report a preference for larger resident complements, due to coverage and educational quality issues.

## V. Characteristics and Performance of Medical Education Consortia *(continued)*

*ECG identified many shared characteristics among consortia.*

- All consortia surveyed were tax-exempt, 501(c)3 organizations.
- All member organizations of these consortia were:
  - » Universities.
  - » Medical centers.
- Ambulatory training sites were not accorded membership status.

## V. Characteristics and Performance of Medical Education Consortia *(continued)*

- Most consortia operated within a community-based AMC, in the following arrangements:
  - » Six were affiliated with community-based SOMs.
  - » Two were affiliated with community-based campuses of traditional SOMs.
  - » Two were anomalies in terms of:
    - Limited ties to an AMC.
    - Objectives.
    - Operations.
- Almost all consortia provided for equal representation of member organizations on their boards of trustees.
- The consortium organizations' scopes of authority varied substantially.

## V. Characteristics and Performance of Medical Education Consortia *(continued)*

- Proxies indicating a high degree of authority relative to GME programs on the part of a consortium include:
  - » Program sponsorship.
  - » Program oversight via a centralized GME committee (GMEC).
- Only three consortia sponsored residency programs, while roughly half operated a centralized GMEC.
- Organization size varied significantly across consortia:
  - » FTE counts between 2 and 400 (some consortia employed their residents and fellows).
  - » Budgets from \$400,000 to \$30 million.
- All but one surveyed consortium had a shared funding model, including:
  - » Equal split of expenses.
  - » Expenses split based on number of residents and fellows.
- Some organizations declined to share arrangements.

# V. Characteristics and Performance of Medical Education Consortia *(continued)*

**Percentages of consortia identifying success in selected objectives are as follows:**

## Improved Working Relations

Achievements – Improved Working Relations	
<b>Internal Relations</b>	
Among teaching hospitals.	95%
Between medical schools and hospitals.	90%
<b>External Relations</b>	
Between community physicians and teaching hospitals.	53%
Between community physicians and medical schools.	67%
GME program sponsors/payors.	72%
Regulatory agencies.	43%
Managed care organizations.	15%

## Improved Organizational Efficiency

Achievements – Improved Organizational Efficiency	
Coordination of salaries (and benefits).	84% (79%)
Resident recruitment.	68%
Resident supervision.	68%
Resident evaluation.	74%
Supervising faculty evaluation.	65%
Training program evaluation.	90%
Coordination of UME and GME.	80%
Training site development.	74%
Accounting of GME funds.	80%
Costs of GME program administration.	60%

## V. Characteristics and Performance of Medical Education Consortia *(continued)*

*In the ECG survey, the following were reported as barriers/failures of selected consortia:*

- Limited scope of operations/authority.
  - » Lack of *real* authority.
  - » Unwillingness of member organizations to more fully integrate education programs and administration.
- Ongoing financial negotiations, owing to a lack of an objective methodology and/or ability to resolve real or perceived inequities.
- Counterproductive behaviors among/between teaching hospitals.
- Board composition/attendance.
- Legal issues from employing residents (e.g., named in malpractice suits; contesting unemployment filings).

## V. Characteristics and Performance of Medical Education Consortia *(continued)*

*In the ECG survey, effective governance is the key element of successful consortia.*

- A shared governance structure should set the strategy and policy for the educational enterprise, approve academic budgets, and oversee educational operations.
- Consortia must define a board of directors in their corporate bylaws.
- The shared governance arrangements should provide balanced representation for all major parties/members.
- It is advisable for each organization to include the CEO (or his/her designee), plus a board member/trustee, so that the governing bodies of the various constituent entities remain apprised of current AMC issues/matters.
- These governance constructs not only foster open discussion and a spirit of coordination and collaboration, but also engage senior management and board members in the mission, goals, and challenges of the academic enterprise.

## **VI. Straw Man Model for NGMEC**

## VI. Straw Man Model for NGMEC

### *Primary Objectives*

- Training excellent physicians to practice in Georgia, and particularly in northeast Georgia.
- Providing opportunities to integrate UME clerkships and GME.
- Promoting high quality by ensuring streamlined, efficient oversight of multiple GME programs.
- Contributing to patient care quality.
- Fostering a learning environment across all care sites.
- Others.

## VI. Straw Man Model for NGMEC *(continued)*

### *Consortium Incorporation and Membership*

- The Northeast Georgia Graduate Medical Education Consortium (NGMEC) will be incorporated as a tax-exempt, 501(c)3 organization.
- Member organizations will be:
  - » Athens Regional Medical Center (ARMC).
  - » Northeast Georgia Health System (NGHS).
  - » St. Mary's Health Care System (SMHCS).
  - » University/SOM(s).
- NGMEC will seek accreditation as the institutional sponsor of the GME programs.

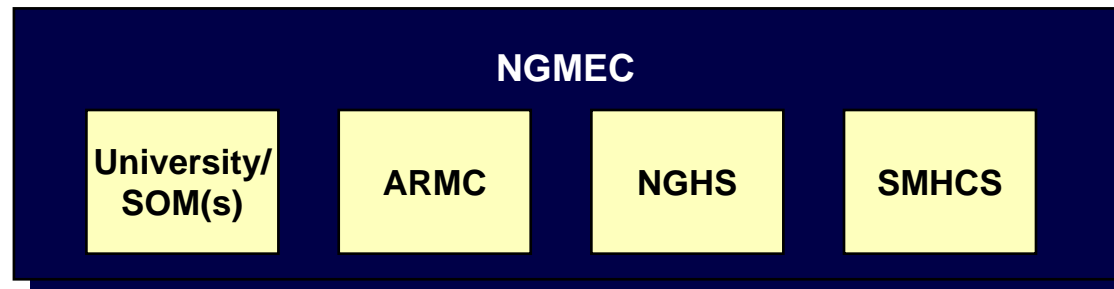
## VI. Straw Man Model for NGMEC *(continued)*

### *Consortium Bylaws*

- NGMEC bylaws will provide a mechanism for the member organizations to address important considerations, which may include:
  - » Clinical education/affiliation arrangements.
  - » Array of teaching affiliates and program assignments.
  - » Coordination of the academic budget and designation of the flow of funds.
  - » Hiring authority for, and locations of, department chairs.
  - » Role of full-time faculty and community physicians.
  - » Coordination of educational administration.

## VI. Straw Man Model for NGMEC *(continued)*

### Organizational Structure for NGMEC



- 501(c)3 organization.
- Equal board representation.

#### GMEC

- DIO.
- Elected residents.
- Selected program directors, administrators, faculty members, and others.

#### Faculty Practice Arrangements

#### Employed Physicians

- DIO.
- Program directors.
- Others (?).

#### Contracted and Voluntary Physicians

- Teaching.
- Resident supervision.

## VI. Straw Man Model for NGMEC *(continued)*

### *Employee and Staffing Arrangements*

- NGMEC employees (or leased staff) will include:
  - » GME administrative staff.
    - Program coordinators.
    - Secretarial/clerical staff.
  - » GME program directors (for the percentage of protected nonclinical time they devote to program oversight).
  - » DIO.
    - Required by ACGME to supervise high-level accreditation and program issues.
    - Generally a physician or administrator devoting a percentage FTE.
  - » Faculty physicians (for the percentage of time devoted to teaching and other GME-related activities).
- Residents and fellows will be employed by the consortium.
- Selected faculty will be employed by or through the consortium, and others may be under contract.

## VI. Straw Man Model for NGMEC *(continued)*

### *Funding Arrangements*

- The consortium will have a shared funding model.
  - » Core consortium and administrative costs will be shared equally.
  - » Other expenses will be allocated to members based on the number of residents and fellows.
- Any Medicare or Medicaid reimbursement for GME will accrue directly to the recipient institution.
- Whenever possible, other funds (e.g., state appropriations for GME) will accrue directly to the consortium.

## **VII. Volume Assessments for Potential GME Programs**

## VII. Volume Assessments for Potential GME Programs

### *Internal Medicine*

- ACGME minimum program size:
  - » 4 residents per training year.
  - » 12 residents total.
- ACGME patient volume requirements:<sup>1</sup>
  - » Minimum 210 admissions per year to medical teaching services for each first-year resident.
  - » Minimum 3 continuity clinic patients per half-day session for each first-year resident.
- Reported discharges in 2006 by hospital:
  - » ARMC: 21,100.
  - » NGHS: 26,047.
  - » SMHCS: 9,822.

<sup>1</sup> More senior residents are expected to treat progressively larger numbers of patients.

## VII. Volume Assessments for Potential GME Programs *(continued)*

### *Surgery*

- ACGME minimum program size:
  - » 2 residents per training year.
  - » 10 residents total.
- ACGME patient volume requirements:
  - » 500 to 1,000 aggregate major cases per resident.
  - » 1,000 to 2,000 annual major cases.
- Major case volumes by hospital were not reported.
- Nevertheless, procedure volume data suggest sufficient major cases to sustain a residency program.

## VII. Volume Assessments for Potential GME Programs *(continued)*

### OB/GYN

- ACGME minimum program size:
  - » 2 residents per training year.
  - » 8 residents total.
- ACGME patient volume requirements:
  - » No specific volumes are identified by the OB/GYN RRC.
- Reported births by hospital in 2006:
  - » ARMC: 2,529.
  - » NGHS: 4,087.
  - » SMHCS: 1,397 (including 130 neonatal admits).

## VII. Volume Assessments for Potential GME Programs *(continued)*

### *Emergency Medicine*

- ACGME minimum program size:
  - » 6 residents per training year.
  - » 24 residents total.
- ACGME patient volume requirements:
  - » Minimum 30,000 ED visits annually at each site where residents rotate for 4 months or longer.
- Reported ED visits in 2006:
  - » ARMC: 59,762.
  - » NGHS: 99,456.
  - » SMHCS: 36,737.

## VII. Volume Assessments for Potential GME Programs *(continued)*

### *Pediatrics*

- ACGME minimum program size:
  - » 4 residents per training year.
  - » 12 residents total.
- ACGME patient volume requirements:<sup>1</sup>
  - » Each first-year resident should have direct responsibility for a minimum of five inpatients daily (on average).
  - » Each first-year resident should see a minimum of three continuity clinic patients weekly (on average).
- Pediatric volumes by hospital were not reported.

<sup>1</sup> More senior residents are expected to treat progressively larger numbers of patients.

## VII. Volume Assessments for Potential GME Programs *(continued)*

### *Family Medicine*

- ACGME minimum program size:
  - » 4 residents per training year.
  - » 12 residents total.
- ACGME patient volume requirements:
  - » Minimum 1,650 documented patient visits per resident.
  - » 19,800 annual patient visits for a 12-resident program.
- Reported outpatient visits in 2006:
  - » ARMC: 256,725.
  - » NGHS: 249,342.
  - » SMHCS: 115,691.

## VII. Volume Assessments for Potential GME Programs *(continued)*

### *Psychiatry*

- ACGME minimum program size:
  - » 3 residents per training year.
  - » 12 residents total.
- ACGME patient volume requirements:
  - » Each resident must have major responsibility for a significant number of patients with acute and chronic psychiatric illnesses.
- Psychiatry volumes by hospital were not reported.