Tripp Umbach

Turning Ideas Into Action

Strategies to Advance GME Growth in Medically Underserved Rural and Urban Areas

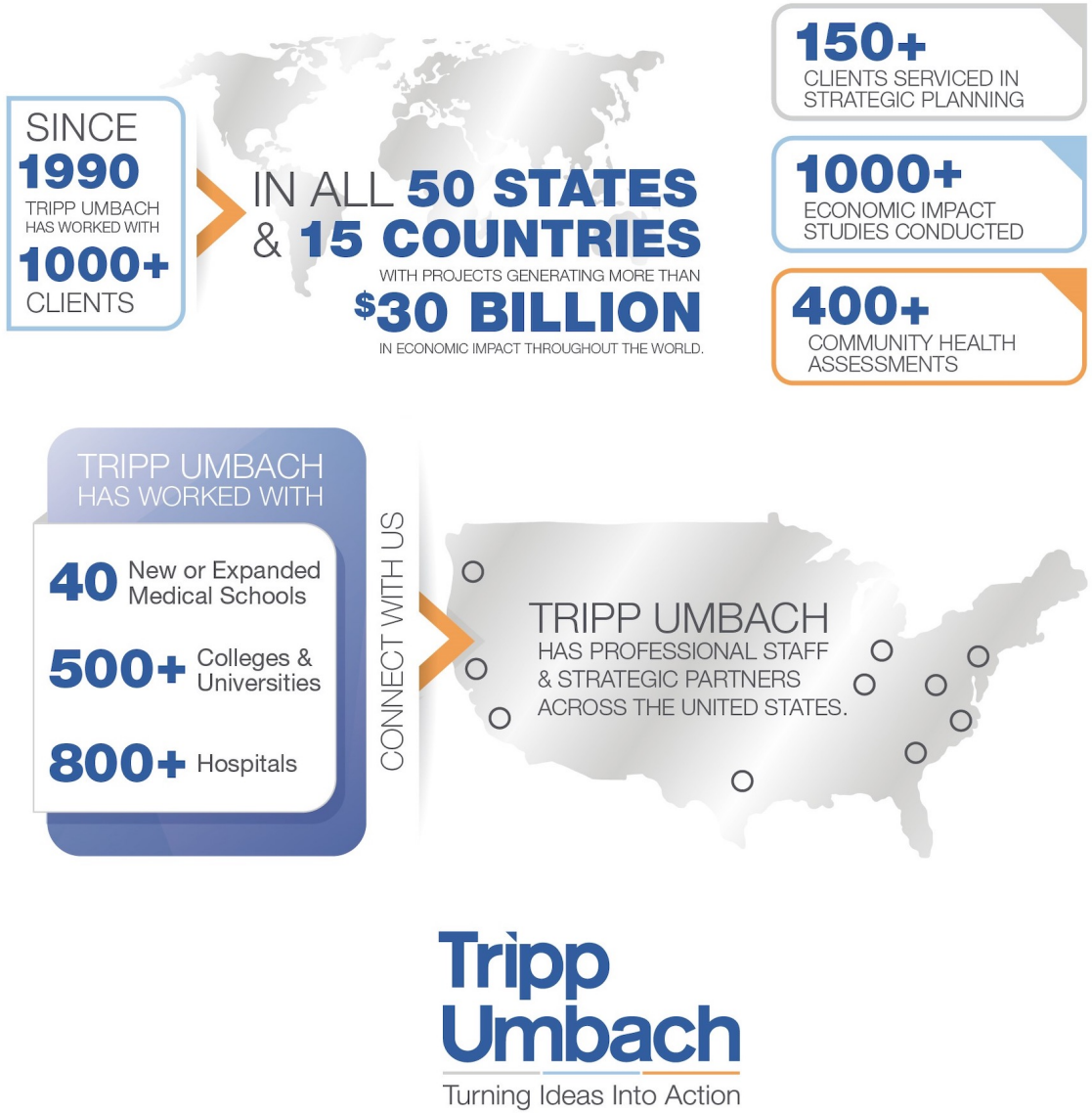
Economic Impact of GME in Medically Underserved and Community-Based Settings

June 20, 2023

About Tripp Umbach

Tripp Umbach Profile

- Tripp Umbach is a private consulting firm founded in 1990.
- Nationally recognized consulting firm that provides comprehensive services ranging from research and strategic planning to economic impact analyses for medical schools, hospitals, non-profit organizations, communities, and corporations throughout the world.
- Tripp Umbach has completed more than 500 Higher Education studies over the past 30 years for clients in North America, Australia, and Europe.
- Tripp Umbach has completed feasibility studies for more than 30 new medical schools and consulting for more than 75 medical schools in the United States as well as medical schools in Canada, Europe, South America, Australia, and Abu Dhabi.



Tripp Umbach

INTRODUCTION

Founder & CEO

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As Founder and President of Tripp Umbach, Paul has consulted with over 1,000 of the nation's most prestigious organizations since 1990.

He pioneered the national "healthy community" movement, completing community assessments and health improvement plans in more than 500 communities.

Leading figure nationally in academic medicine consulting, with extensive experience establishing 30 new medical schools and hundreds of residency positions.

At the Graduate School of Design at Harvard, Paul developed a new field of Economic Design Thinking, using societal impact analysis as a planning tool to bring value to communities worldwide. Paul is a Doctorial Candidate at Vanderbilt University.

The Economic and Social Benefits of GME

Economic & Social Benefits of GME

- Strong Hospitals: Hospitals save $100k+ in recruitment costs for every hired resident – allowing these dollars to be invested in patient care and community health programs.
- Lower Costs: Hospitals with primary care residency programs have lower utilization of ED visits as a result of clinics that residents staff.
- Patient Care Quality: Outpatient services provided by residency programs include school-based programs, screenings, community-based education programs, nursing home support, medical home health care support, ED follow-up, and support for public health departments.

Health Care and Financial Benefits of GME for Hospitals

- Revenue Generation Due to Increase in Physicians and Residents
- Provision of Care by Residents (compensation lower than other care providers)
- Revenue from Quality Outcomes
- Image Enhancement as a “Teaching Facility”
- Workforce Aligned with Culture of Life-Long Learning
- Community-Based Training Sites
- Improve Health Status, Decrease Costs, and Facilitate Interdisciplinary Care

Economic and Social Benefits of GME

More Doctors

Residency programs can lead to the recruitment of additional sub-specialty physicians who train medical students but also provide sub-specialty clinical services only available in the community after the formation of the residency program.

Cost-savings

The typical hospital with a residency program in Internal Medicine saves approximately $3 million yearly in uncompensated care.

Partner Benefits

Academic medical centers benefit from funding associated with primary care access-related research.

Resident Benefits

Residents who remain in the community have a solid working knowledge of the local and regional healthcare environment and are better able to direct care for their patients

Economic and Social Benefits of GME Programs

Each Resident Who Stays and Becomes a Primary Care Physician within an Underserved Area Generates $3.6M Economic Impact on the Region

Each Physician Who Stays in a Community Generates $1.3M in Economic Impact on the Region

Physician Workforce

Each Physician's Practice within the Community on Average Creates an Additional 6-7 Jobs

Each Physician's Practice on Average Generates $300,000 in Regional Tax Revenue

Source: American Medical Association

Residents Drive Medical Education

Residents spend up to 20% of their time on teaching activities, regardless of their department or future career plans.

Residents recognize they have a responsibility to teach medical students and fellow residents.

Residents enjoy teaching and consider it a critical component of their experience and education.

Resident teaching roles are complementary to attending teaching roles (faculty) and that residents conduct more teaching at the bedside.

One-third of resident knowledge could be directly attributed to house staff (resident) teaching.

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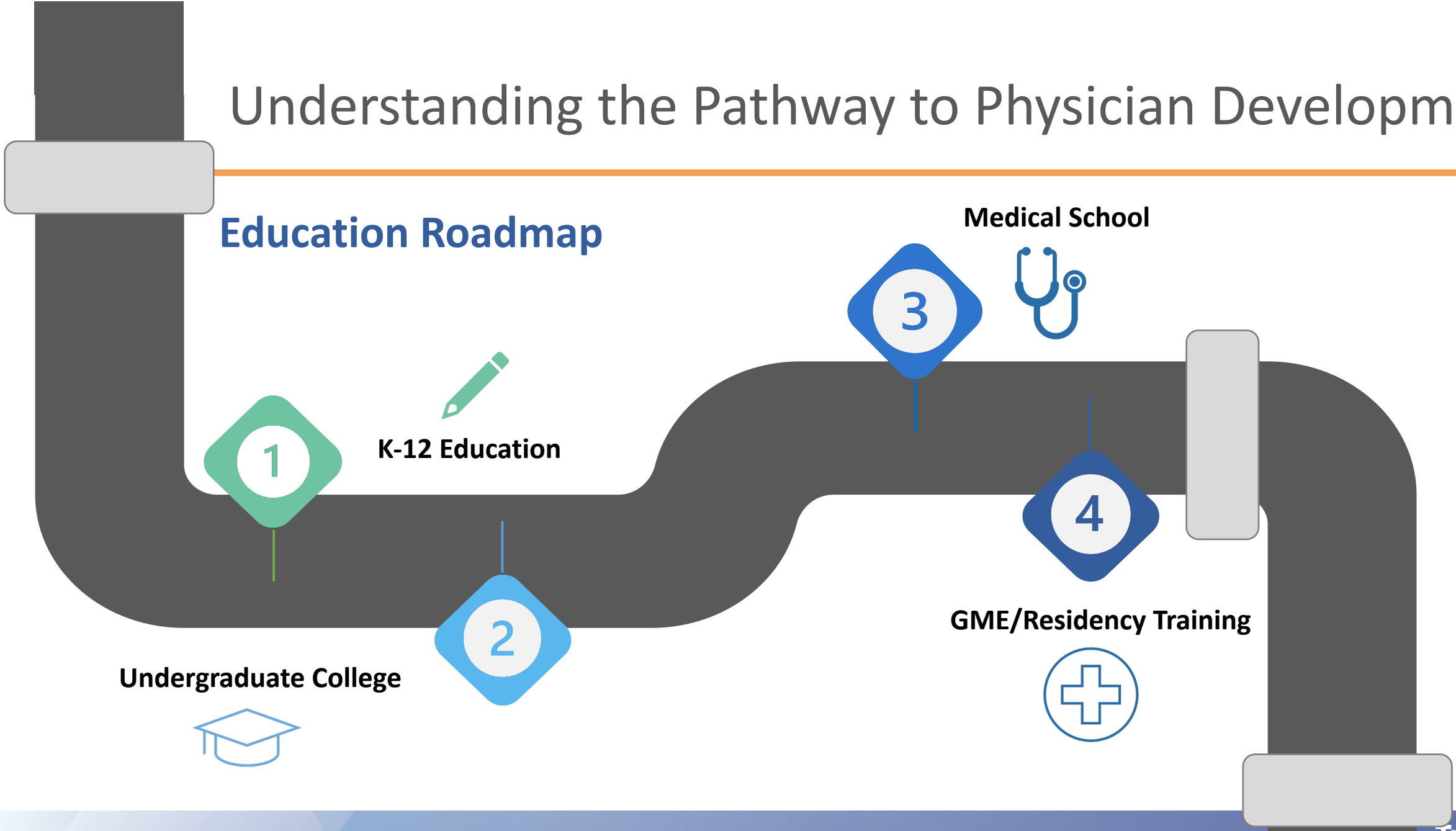
Understanding the Pathway to Physician Development

Education Roadmap



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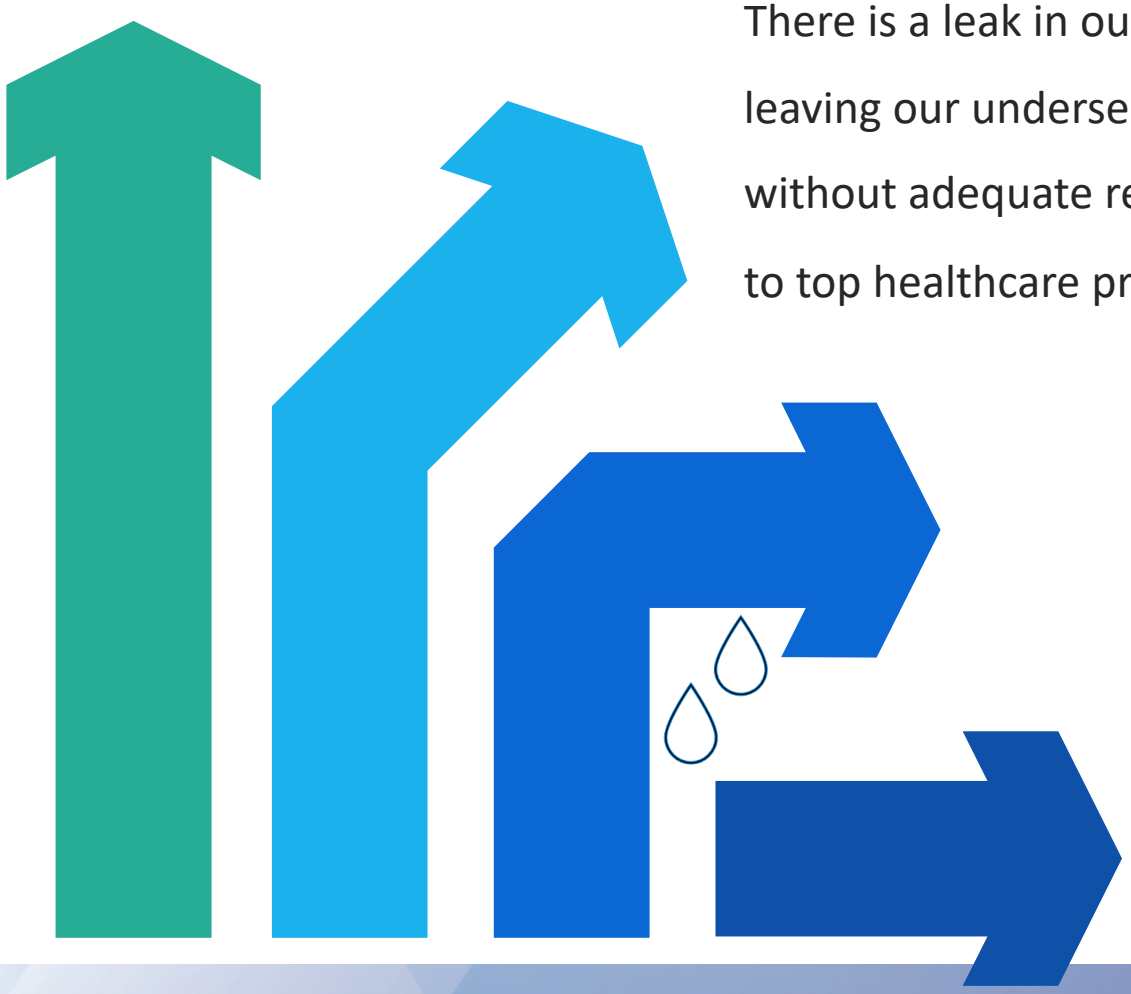
Leaking Pipeline in Underserved Areas



There is a leak in our pipeline process that is leaving our underserved minority communities without adequate representation or a pathway to top healthcare professionals.

Phase 1
K-12 Grades

Phase 2
Undergraduate Education

Phase 3
Medical School

Phase 3+
GME/Residency Training

Key Takeaways

A. Boldly communicate why GME CAN be expanded – this will be new news to most hospitals.

B. Don’t expect established public MD programs and traditional academic medical centers to be your friend as you dive deeper into GME development.

C. CMS is one of many funding sources, and CMS doesn’t give permission only funding.

D. Hospitals in underserved urban areas are often capped or have low per-resident amounts.

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OPEN DIALOGUE

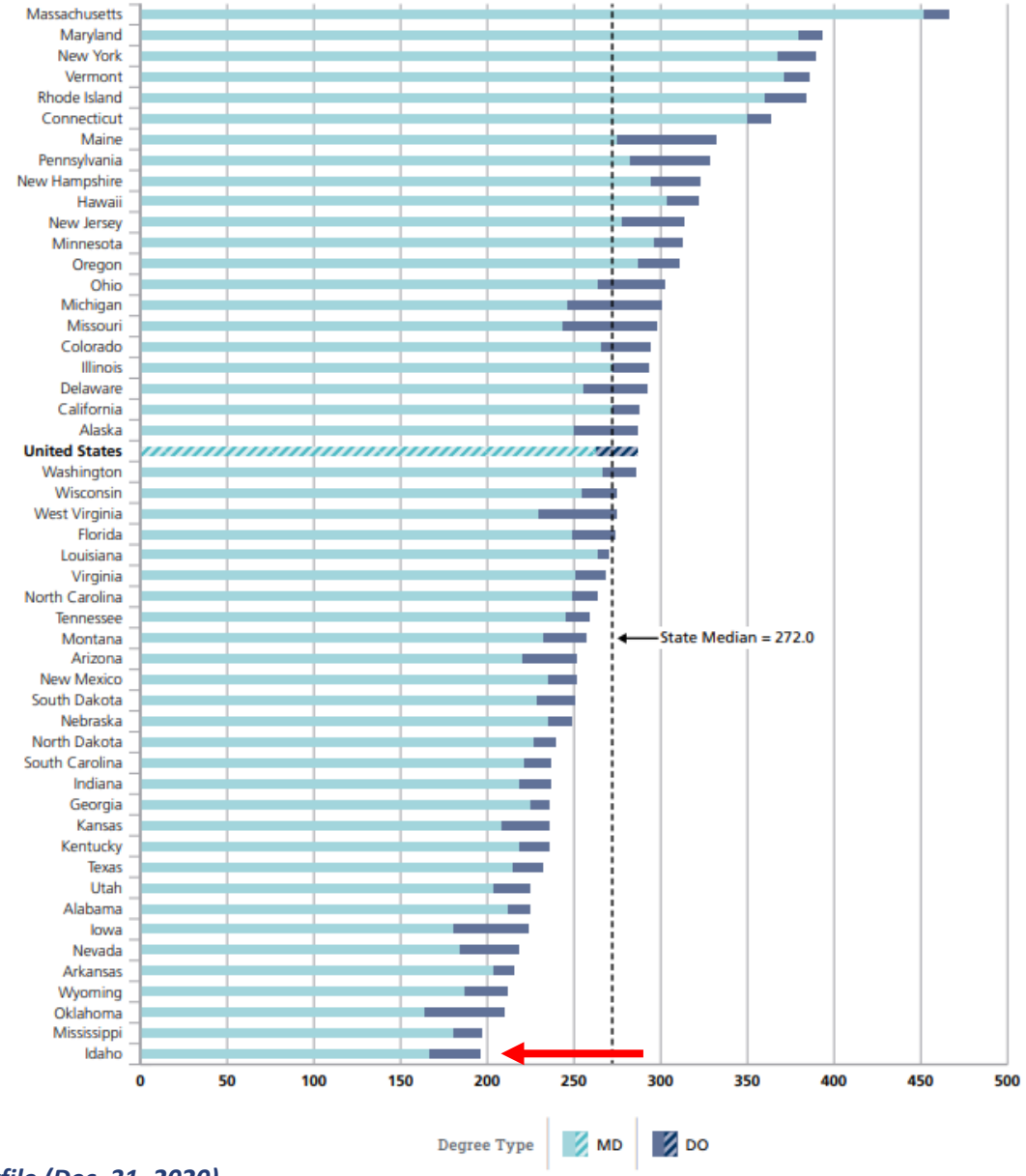
Creating Idaho's Future:
Idaho's Ten Year Graduate Medical Education (GME) Strategic Plan

Assembly of Osteopathic Graduate Medical Educators
American Association of Colleges of Osteopathic Medicine
June 20, 2023

Ted Epperly, MD

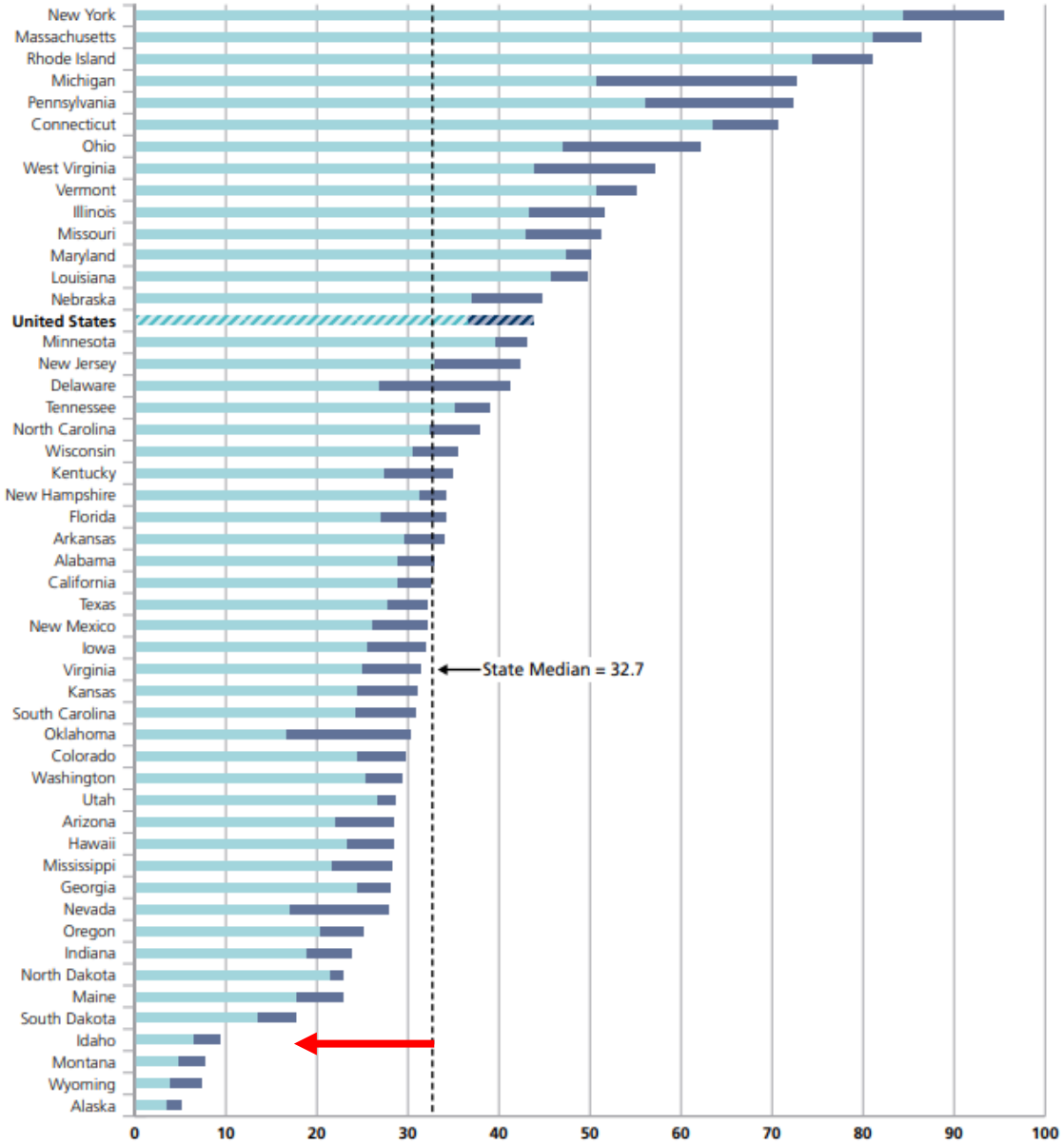
CEO / DIO | Full Circle Idaho (Formally Family Medicine Residency of Idaho)
Past President and Board Chair America | American Academy of Family Physicians
ACGME | Past Board of Directors
COGME |Council Member
Idaho State Board of Education | GME Coordinator

Active Physicians per 100,000 Population 2020



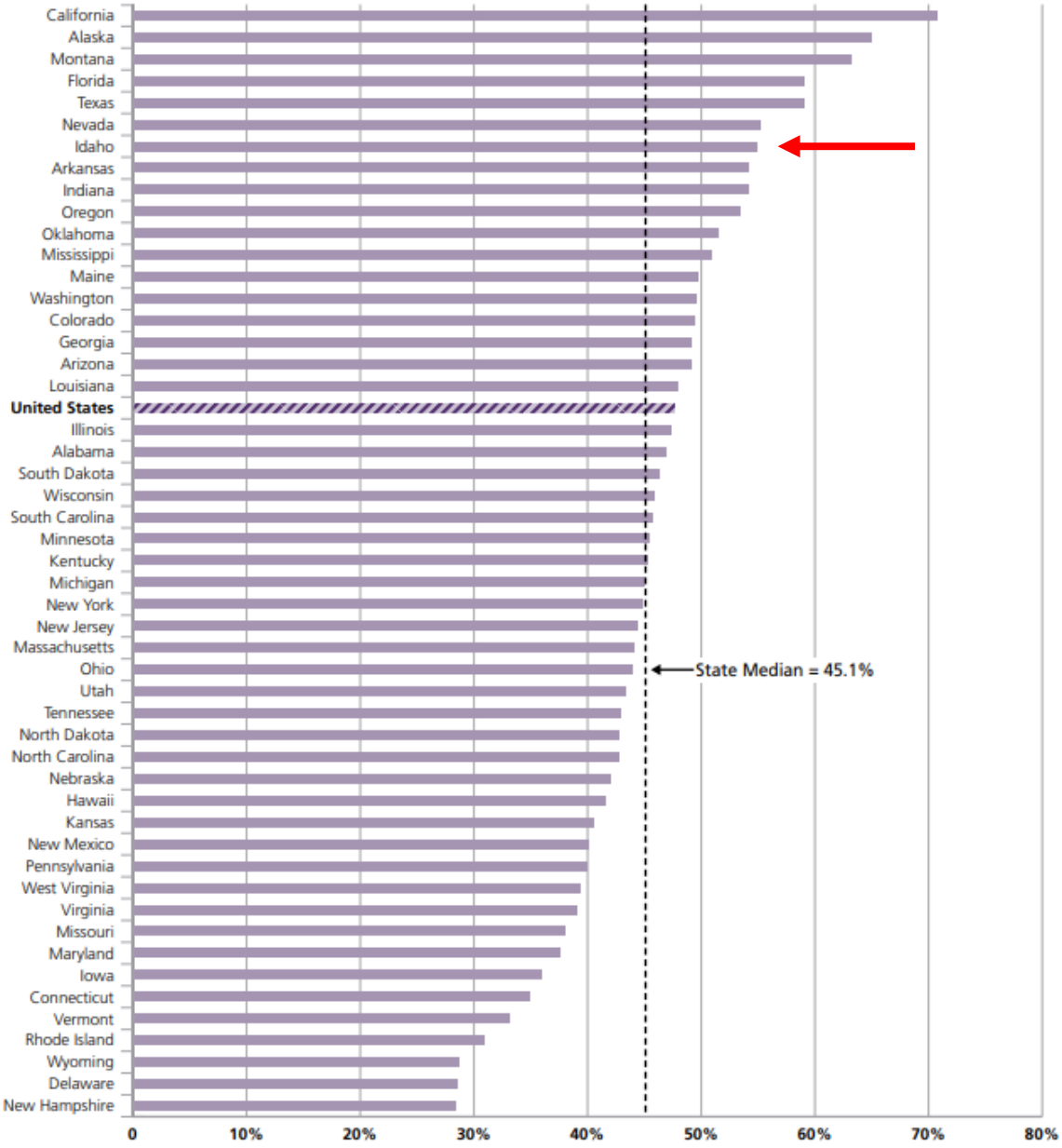
Source: 2021 AMA Physician Masterfile (Dec. 31, 2020).

Residents and Fellows on Duty as of December 31, 2020



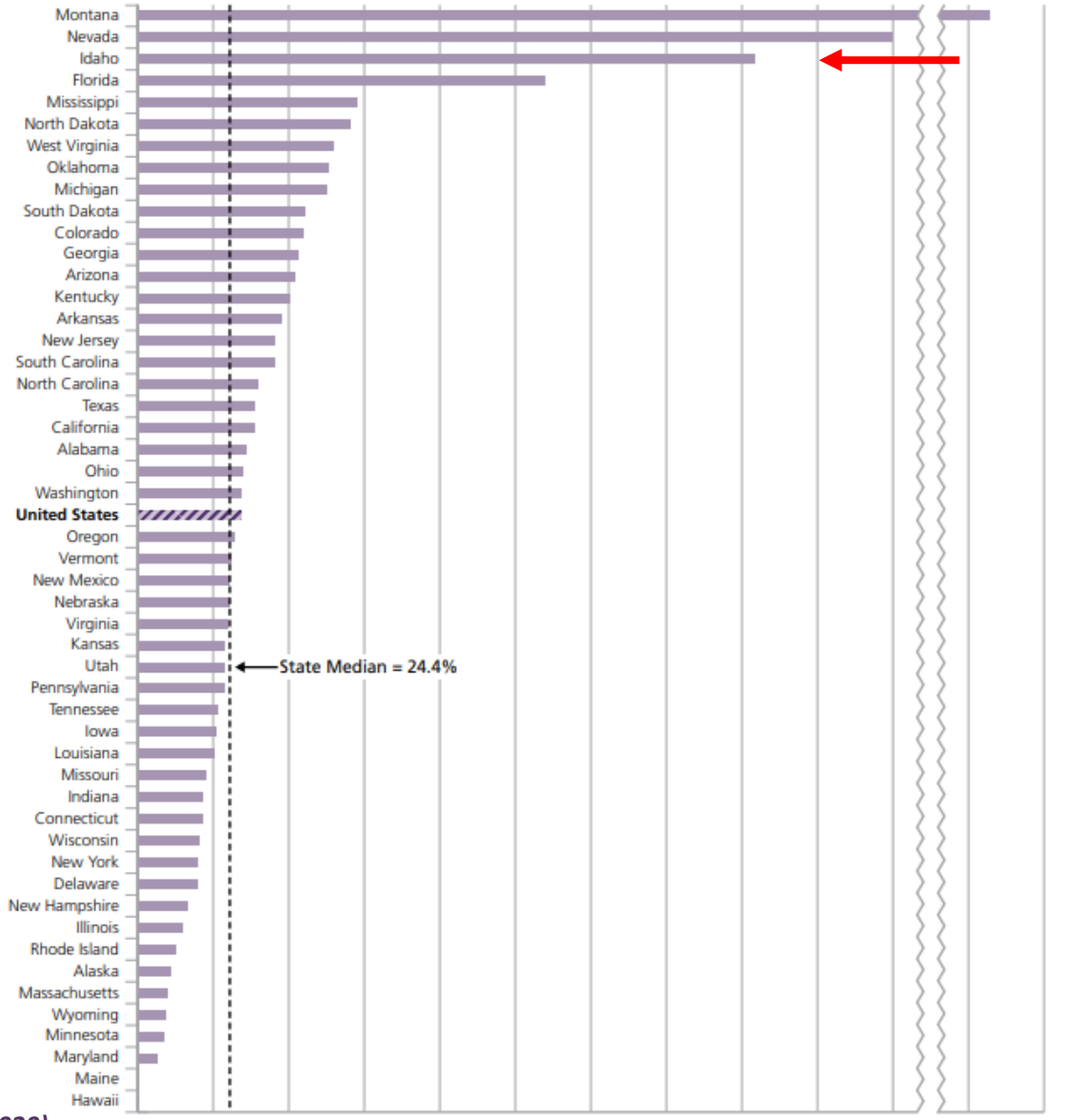
Source: 2021 AMA Physician Masterfile (Dec. 31, 2020).

Percentage of Physicians retained from Graduate Medical Education (GME) 2020



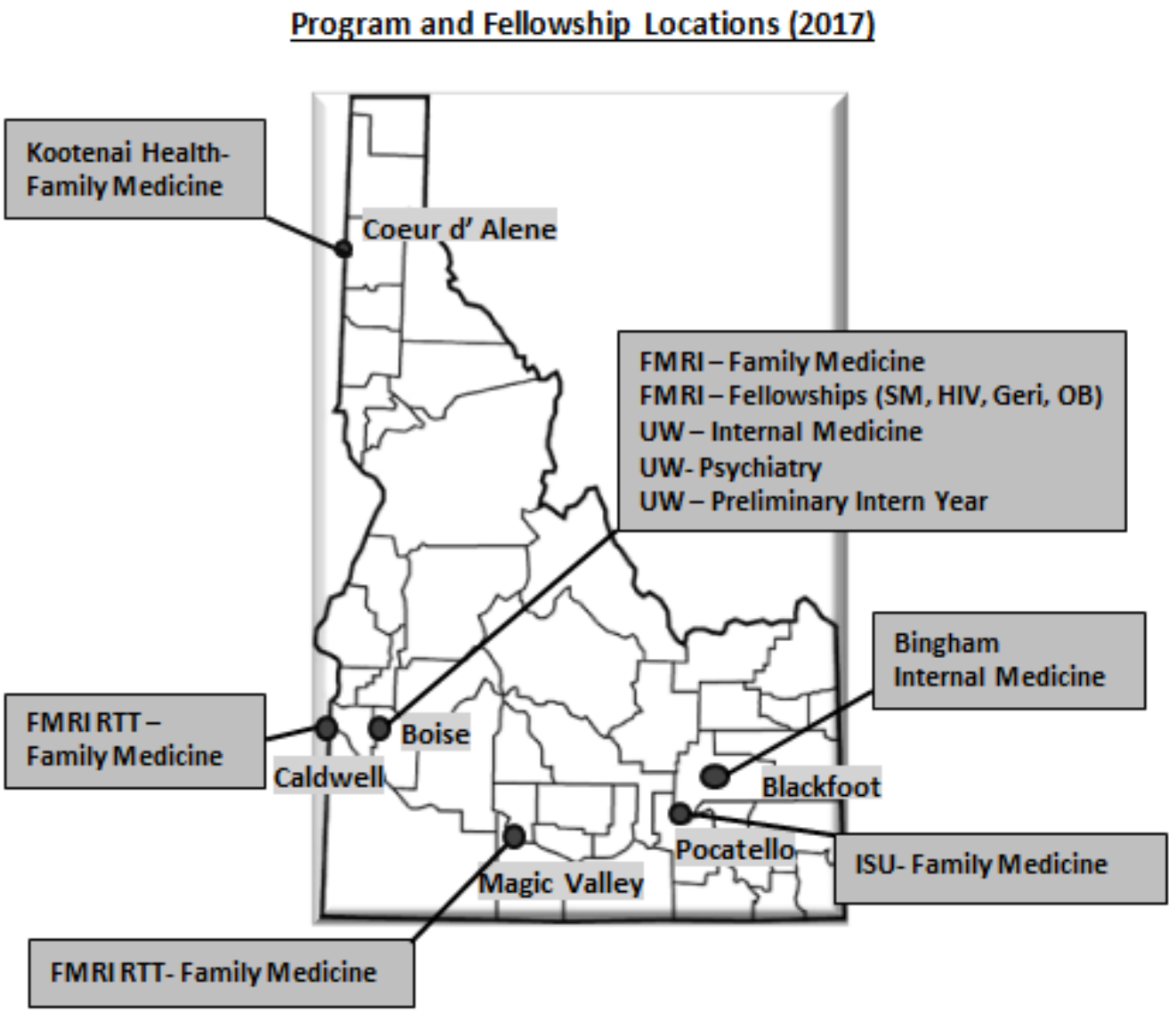
Source: 2021 AMA Physician Masterfile (Dec. 31, 2020).

Percentage Change in Number of Residents and Fellows in ACGME-accredited programs, 2010-2020

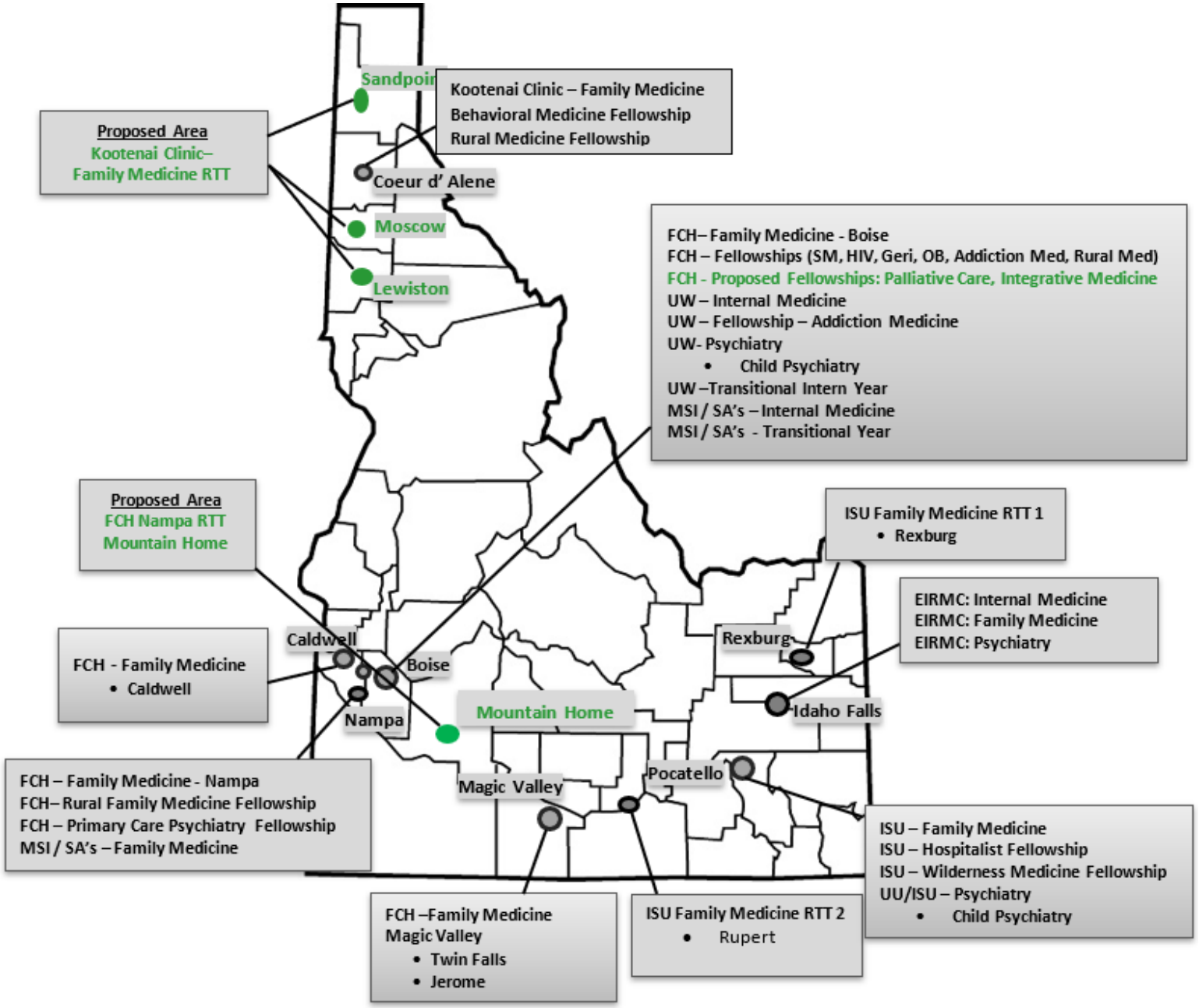


Source: 2021 AMA Physician Masterfile (Dec. 31, 2020).

Programs Specialties and Locations in Idaho (2017)



Program and Fellowship Locations (2030)



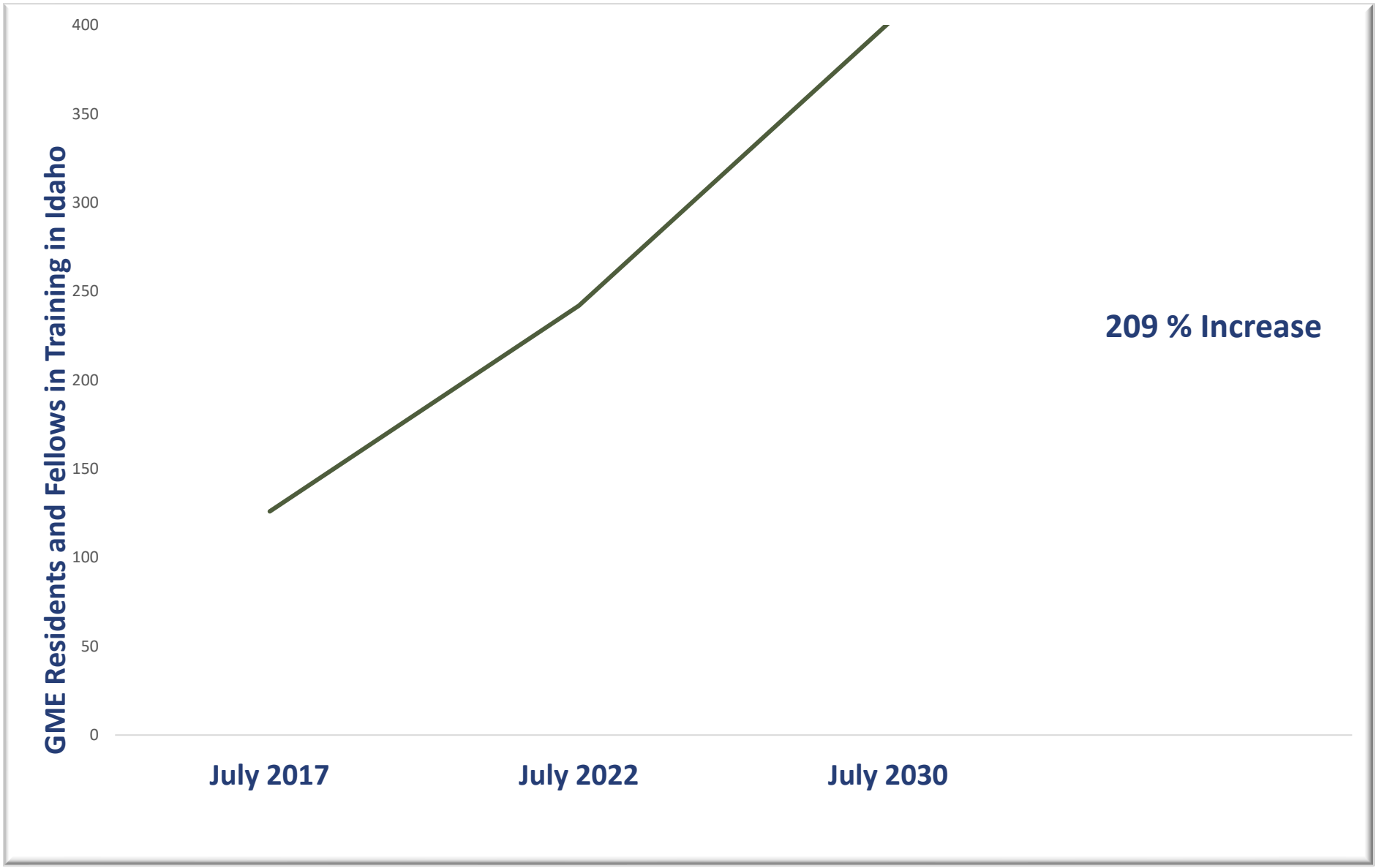
Current and New Program Growth

Program Types	2017	2022	2030
Family Medicine	5 Programs • FCH -Boise • FCH – RTT Caldwell • FCH – RTT – Magic Valley • ISU – Pocatello • Kootenai – Coeur d' Alene	8 Programs • FCH Boise • FCH Caldwell • FCH Magic Valley • FCH Nampa • ISU Pocatello • ISU Pocatello – RTT #1 (Rexburg) • Kootenai Coeur d' Alene • EIRMC Idaho Falls	12 Programs • FCH Boise • FCH Caldwell • FCH Magic Valley • FCH Nampa • FCH Nampa RTT • ISU Pocatello • ISU Pocatello – RTT #1 (Rexburg) • ISU Pocatello RTT #2 (Rupert) • Kootenai Coeur d' Alene • Kootenai Coeur d'Alene – RTT (TBD) • EIRMC Idaho Falls • MSI/SA's Nampa
Internal Medicine	2 Programs • UW- Boise • RVU – Bingham - Blackfoot	2 Programs • UW- Boise • EIRMC – Idaho Falls	3 Programs • UW- Boise • EIRMC – Idaho Falls • MSI / SA's - Boise
Psychiatry	1 Program • UW – Boise -Psychiatry	3 Programs • UW – Boise– Psychiatry • ISU/UU – Pocatello • EIRMC – Idaho Falls *	3 Programs • UW – Boise– Psychiatry • ISU/UU – Pocatello • EIRMC – Idaho Falls
Transitional Year Internship	1 Program • UW- Boise	1 Program • UW – Boise	2 Programs • UW – Boise • MSI/SA's - Boise
Pediatrics			1 Program • FCH – Pediatrics Residency of Idaho - Boise
Emergency Medicine			1 Program • TBD
General Surgery			1 Program • TBD
Neurology			1 Program • TBD
Total	9 Programs	13 Programs *EIRMC Psychiatry begins funding in FY 2024	21 Programs (Possibility of 24)

Ten Year Strategic GME Growth Plan for Idaho

Institution	Residents/Fellows in Training as of July 1, 2017	Resident / Fellows in Training on July 1, 2022	Residents / Fellows in Training in July 1, 2030	Number of Residents Graduating from All Program classes/year in 2017	Number of Residents / Fellows Graduating from all Program/class/yr in FY 22	Number of Residents Graduating from All program classes/year in 2030
FCH (FM, Peds)	52	77	107	20	28	43
ISU (FM)	21	27	37	7	8	14
Kootenai/CdA (FM)	18	20	31	6	6	11
UW (IM/ Preliminary /Chiefs)	31	38	45	13	16	21
UW Psychiatry	4	16	26	0	4	8
EIRMC (IM, FM, Psychiatry)	0	52	64	0	16	20
UU/ISU (Psychiatry)	0	12	18	0	0	6
UU Neurology	0	0	4	0	0	2
MSI/SA's	0	0	56	0	0	24
	126	242	389	46	78	149
		93% Increase	61% Increase		70% Increase	91% Increase
		209% Increase			239% Increase	

Graduate Medical Education Resident and Fellow Growth from 2017 - 2030



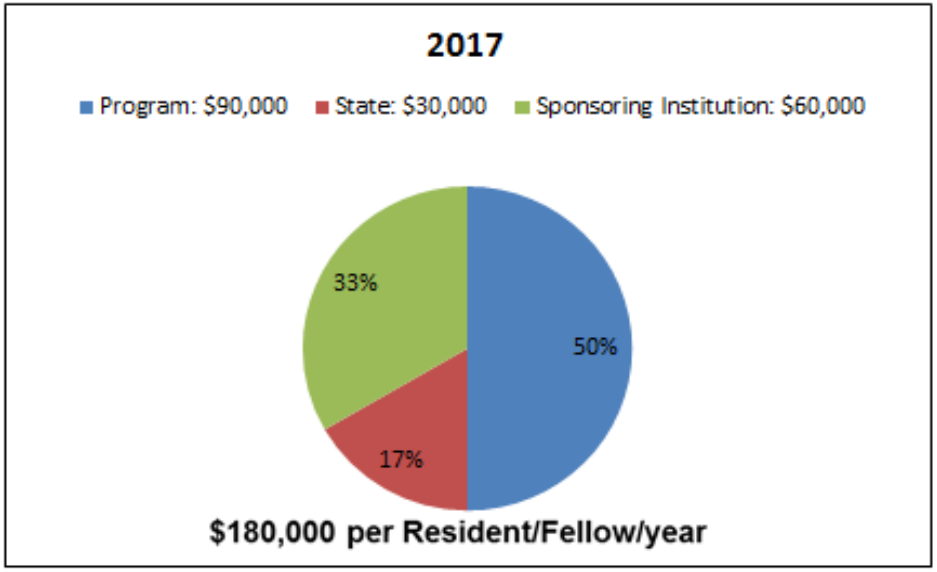
Number of Medical Students in Medical Schools with Close Connections to Idaho

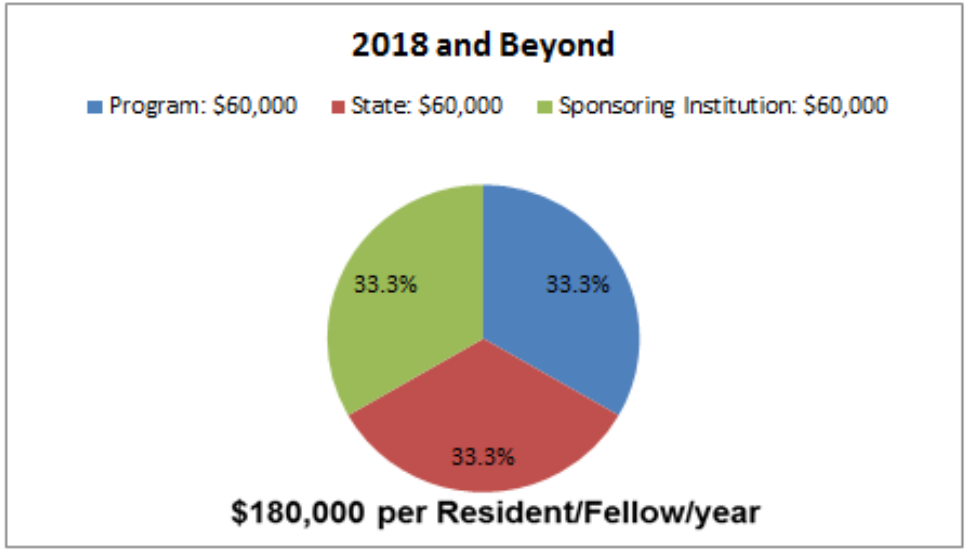
Name of School	Year of First Class	Medical School Class Size	Guaranteed Idaho Positions
University of Washington School of Medicine	1946	270/year	40
University of Utah School of Medicine	1935	125/year	10
Pacific Northwest University of Osteopathic Medicine	2008	135/year	0
Washington State University Elson Floyd College of Medicine	2017	80/year	0
Idaho College of Osteopathic Medicine	2018	160/year	Preferred status for admission
		750/year	

Application for State Legislative Budget Request through the Idaho GME Committee

1. Why is this program needed?
2. How will this program benefit your community / region?
3. Name of program:
4. Program Director's name:
5. Who will be the Sponsoring Institution?
6. Who will be the Designated Institutional Official?
7. Date of ACGME approval or pending approval:
8. How many faculty are you in need of? How will you get them?
9. Description of program infrastructure:
10. Description of financial plan for sustainability:
11. Description of space:
12. Please provide a timeline for development:

Resident Funding Per Year by Institution

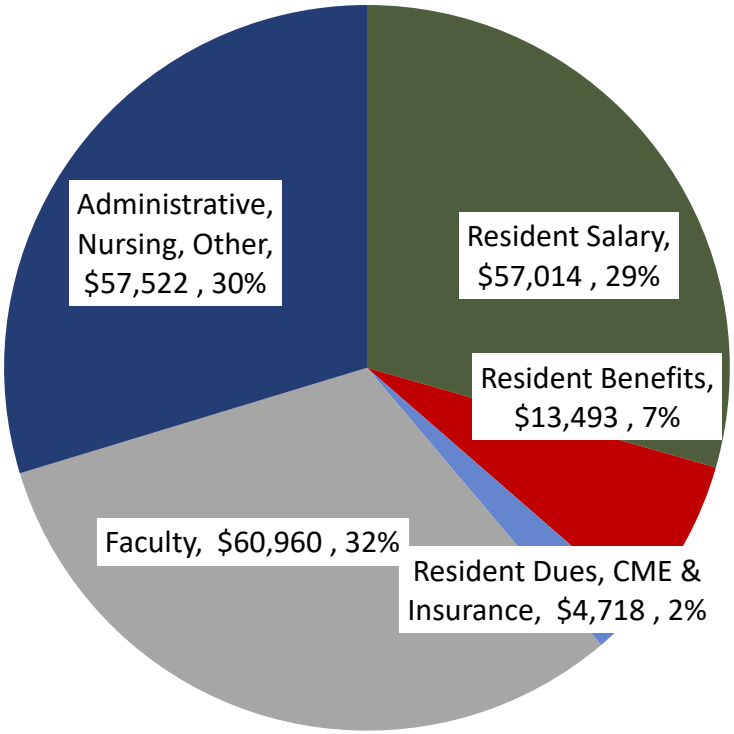




- **NEJM** | 2016 – Regenstein, et al
  - $244,730
- **Family Medicine University of Washington** | 2018 – Pauwels, et al
  - $179,353
- **FCH** ***(Formally FMRI)*** | 2017
  - $194,000

Cost of a Resident

FY17: $194K



Current Funding Estimates (2023)

- **GWU – HRSA THC-GME Advisory Group**

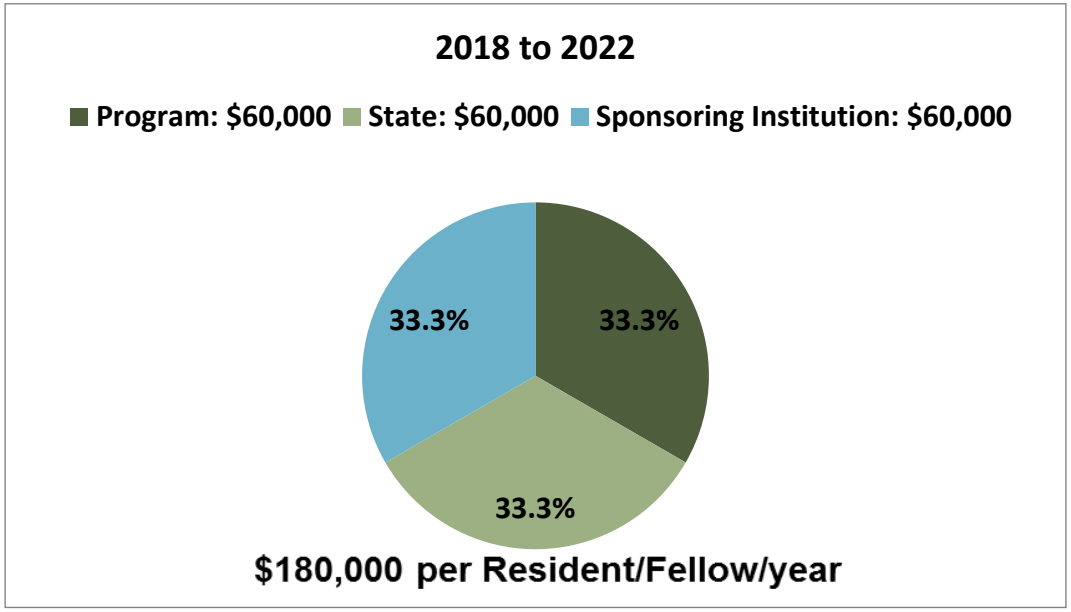
Regenstein / Pauwells / Epperly et al

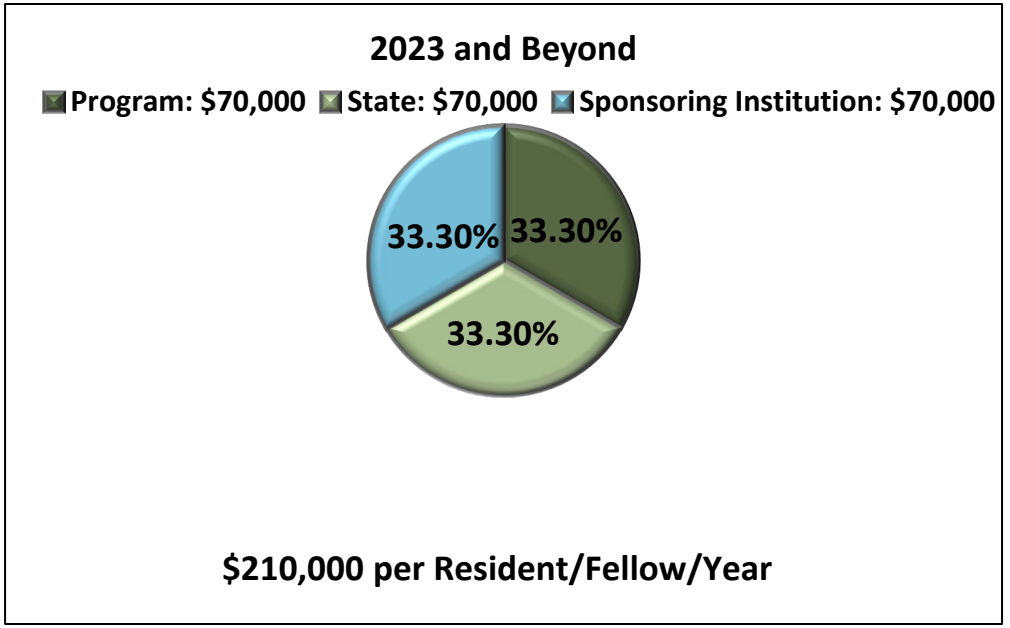
  - $209,623

- **THC-GME (2011) - $150K**
  - $207K General Inflation
  - $211K MCI

- **Full Circle Health**
  - $279,000

Resident Funding Per Year by Institution





Twelve Year Growth in Graduate Medical Education Programs, Residents and Fellows, and Cost to State of Idaho

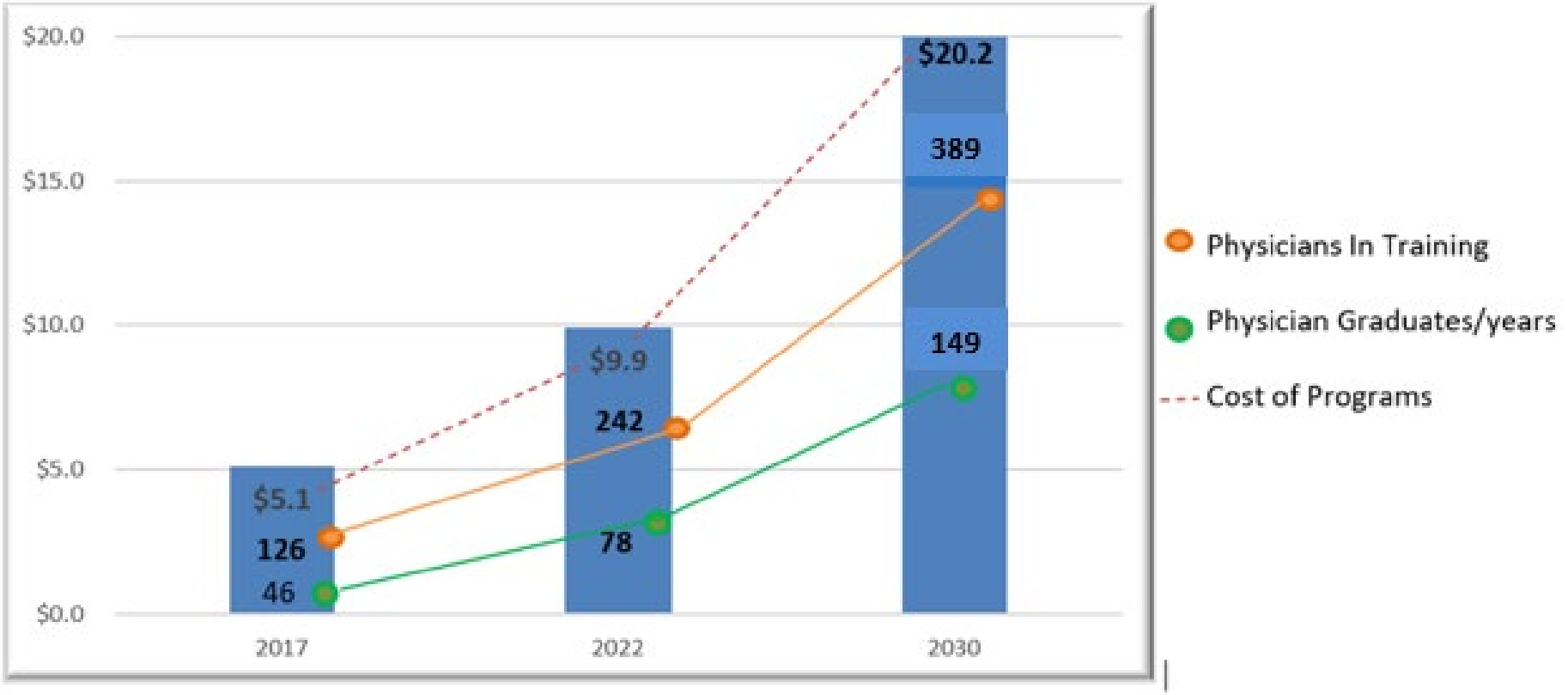
	2017	2022	2030
GME Residency Programs	9	13	21 (Possibly 24)
GME Fellowship Programs	4	10	16
Residents and Fellows Training in Idaho/year	126	243	389
Number of Graduates Each Year from Idaho's GME Programs	46	78	149
GME Residents per 100,000 citizens in Idaho	6.7 (National Average is 28.1)	13.8	20.0 (Assuming Idaho's Population grows to 2 million People by 2030)
Cost of GME and Additional Healthcare Programs in Idaho	$5,138,700 per year	$11,157,000 per year	$20,200,000 per year

The state's investment in additional healthcare providers is matched 2-to1 by the programs and sponsors. Each physician will generate $1.9 Million per year in economic impact and 12 jobs —total impact to Idaho will be $1.9 Billion and 12,000 new jobs—and quality healthcare for citizens throughout Idaho.
Return on investment (ROI) 9.5 to 1

Idaho GME Program Dashboard and Metrics

Program	First Graduating Class	100% Fill Rate Intern Class	ACGME Accreditation	Graduates Practicing in Idaho as Measured by Rolling 5-year Average ≥50% - Fam Med ≥40% - Int Med ≥30% - Psych ≥30% - Emerg Med ≥30% - Surgery	Graduates in continued fellowship training outside of Idaho	≥30% of Graduates in Idaho Serve in Rural or Underserved Areas by Rolling 5-year Average		≥80% Board Certification Pass Rate for Graduates as Measured by Rolling 5-year Average
						Rural	Urban Underserved	
Full Circle – Boise	1976	100%	Yes	31 of 56 / 55%		5 of 31 / 16%	20 of 31 / 65%	45 of 45 / 100%
Full Circle – Fellowships	1999	100%	Yes	12 of 19 / 63%		1 of 12 / 8%	9 of 12 / 75%	19 of 19 / 100%
Full Circle – Caldwell RTT	1998	100%	Yes	10 of 14 / 71%		3 of 9 / 33%	5 of 9 / 56%	14 of 14 / 100%
Full Circle – Magic Valley RTT	2012	100%	Yes	7 of 10 / 70%		3 of 6 / 50%	3 of 6 / 50%	10 of 10 / 100%
Full Circle – Nampa	2022	100%	Yes	5 of 6 / 83% (1 year of data)		2 of 6 / 33% (1 year of data)	2 of 6 / 33% (1 year of data)	6 of 6 / 100% (1 year of data)
ISU – Pocatello	1994	100%	Yes	19 of 35 / 54%		8 of 19 / 42%	9 of 19 / 47%	35 of 35 / 100%
ISU – Rexburg RTT	2022	100%	Yes	1 of 1 / 100% (1 year of data)		0 of 1 / 100% (1 year of data)	1 of 1 / 0% (1 year of data)	1 of 1 / 100% (1 year of data)
Kootenai Family Medicine	2017	100%	Yes	23 of 30 / 77%		5 of 23 / 22%	11 of 23 /48%	30 of 30 / 100%
Boise Internal Medicine/Fellowship	2014	100%	Yes	23 of 41 / 52%		1 of 23 / 4%	5 of 23 / 15%	31 of 38 / 82%
Western Idaho Psychiatry	2010	100%	Yes	14 of 18 / 77%		0 of 18 / 0%	14 of 14 / 100%	14 of 15 / 93%
EIRMC Internal Medicine	2021	100%	Yes	6 of 19 / 32% (2 years of data)		1 of 6 / 17% (2 years of data)	1 of 6 / 17% (2 years of data)	5 of 7 / 71% (1 year of data)
EIRMC Family Medicine	2023	100%	Yes	NA		NA	NA	NA
EIRMC Psychiatry	2026	100%	Yes / Initial	NA		NA	NA	NA
U of U/ISU Psychiatry	2024	100%	Yes	NA		NA	NA	NA

Ten Year GME Growth and Additional Providers Trained



The Idaho Ten Year GME Plan provides a once in a generation opportunity that will serve multiple generations of people!

Summary of Idaho's Journey to Transform Healthcare and GME

- Complicated
- Not been easy but is vitally important
- Starts with a vision, communication, a team, support, resources and plan
- Persistence
- Right thing to do!

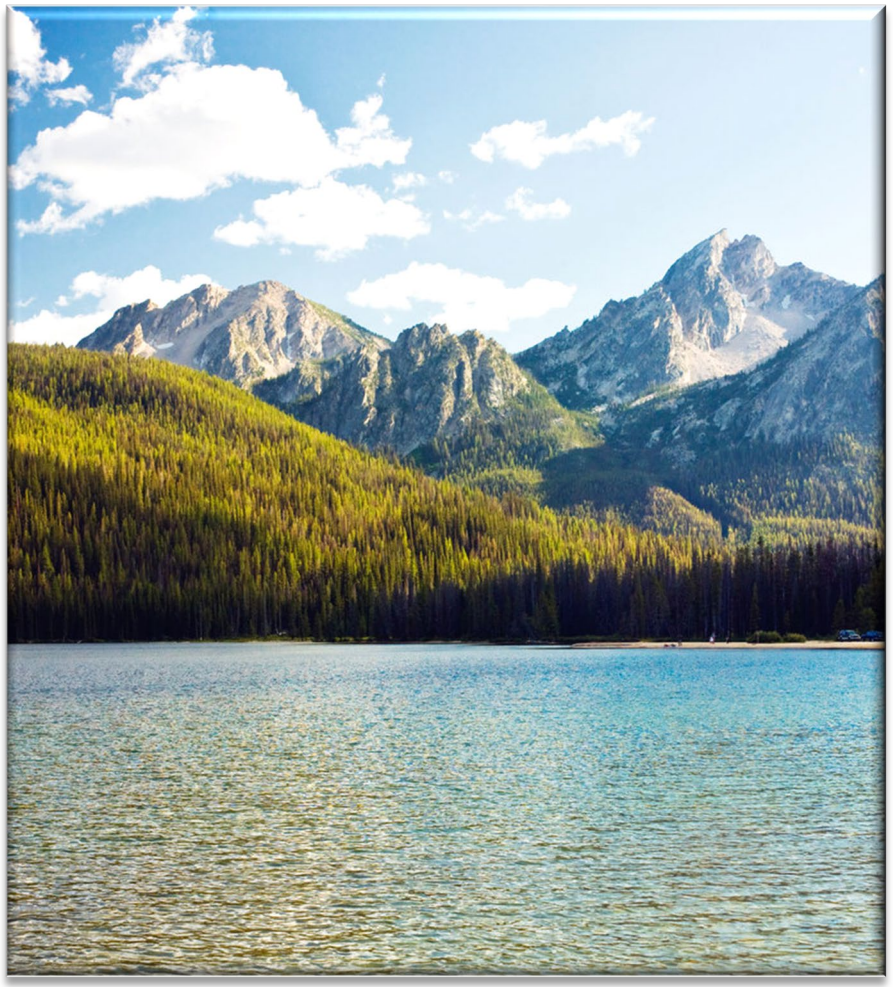
- Idaho GME Council/Committee
  - GME Coordinator
  - Oversees 10 Year Strategic Plan
  - 10-15 Members (Guests as needed)
  - Program Directors/Medical Schools/Hospitals/ IMA/IHA/IAFP/IDHW/Others
  - Housed in Idaho State Board of Education
  - Modifies/Innovates/Collaborates/Adjusts

Successes of the Ten Year Plan

- Common Vision
- Speak with One Voice
- Teamwork
- Advocacy

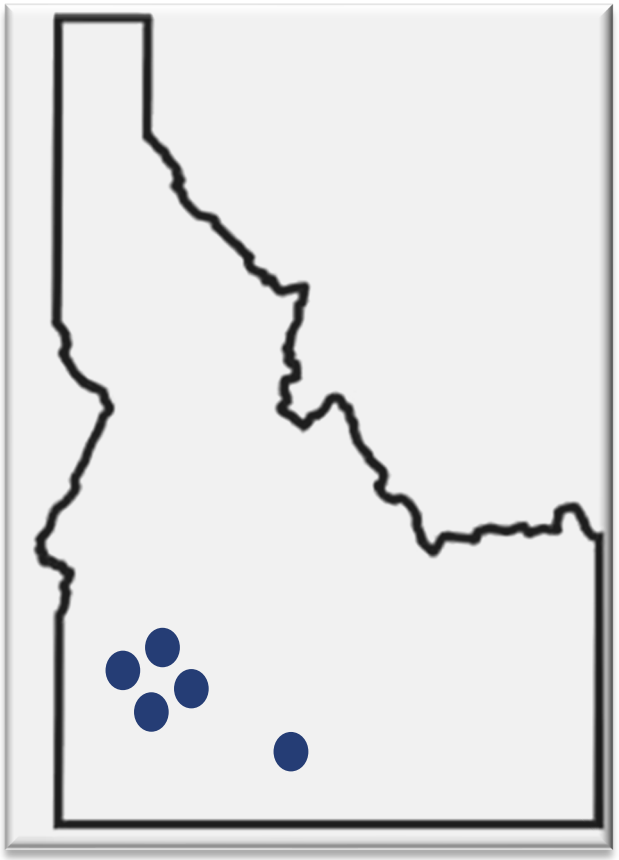
Challenges to the Ten Year Plan

- Pandemic
- Governors 3% Budget Cap
- Rogue Elements
- Politics



Full Circle Health Story

- 1974- 501c3
- 4/4/4 – Family Medicine
- 2007 – FQHC- LA
- 2011 – Teaching Health Center (HRSA)
- 2013 – FQHC
- 2023:
  - 4 Family Medicine Residencies (24-24-24)
  - 1 Pediatrics Residency (4-4-4)
  - 7 Fellowships
- $56M/Budget; $2.5M Margin (4.5%)



Full Circle Health

THC-GME / FQHC

- Governing Board
- Sliding Fee
- 4 Services (Primary Care, Behavioral Health, Pharmacy, Dental)
- Not all Eggs in One Basket
  - 24/91 R/F's THCGME (26%)
- Positive Margin – Medicaid / Medicare

"If you want to go fast, go alone. If you want to go far, go together".

AFRICAN PROVERB

“NEVER, NEVER, NEVER, GIVE UP.”

Winston Churchill

Questions

State and Local Approaches for Expanding GME Opportunities

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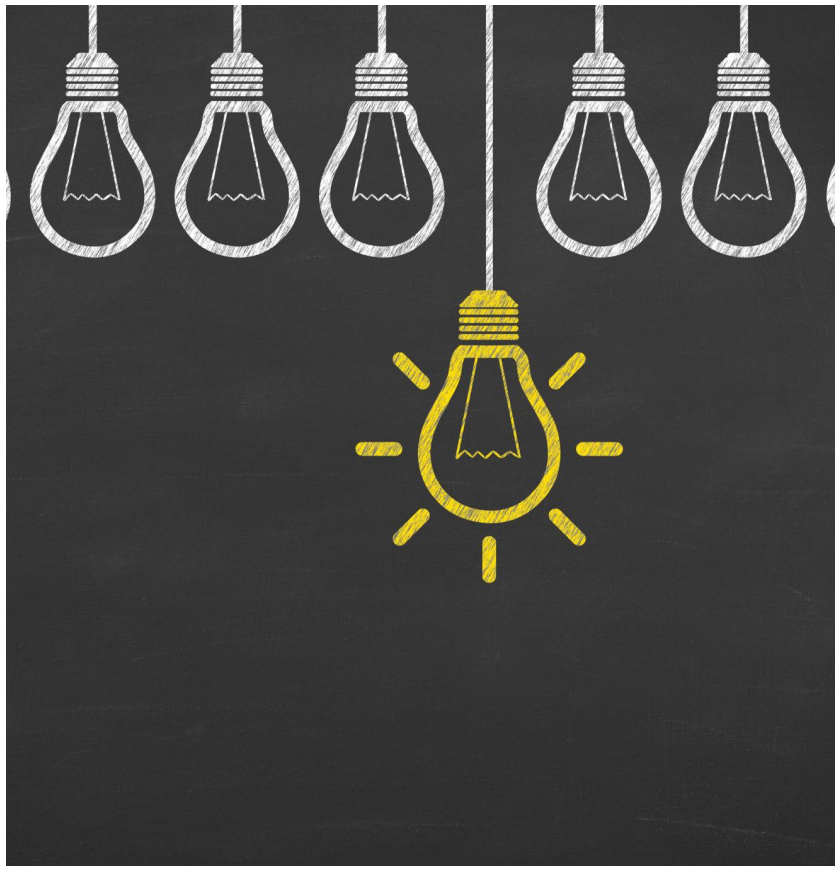
GME Program Development Priorities

Alleviate dramatic shortages in Primary Care, Psychiatry and other physician specialties through non-traditional residency Growth and Development options

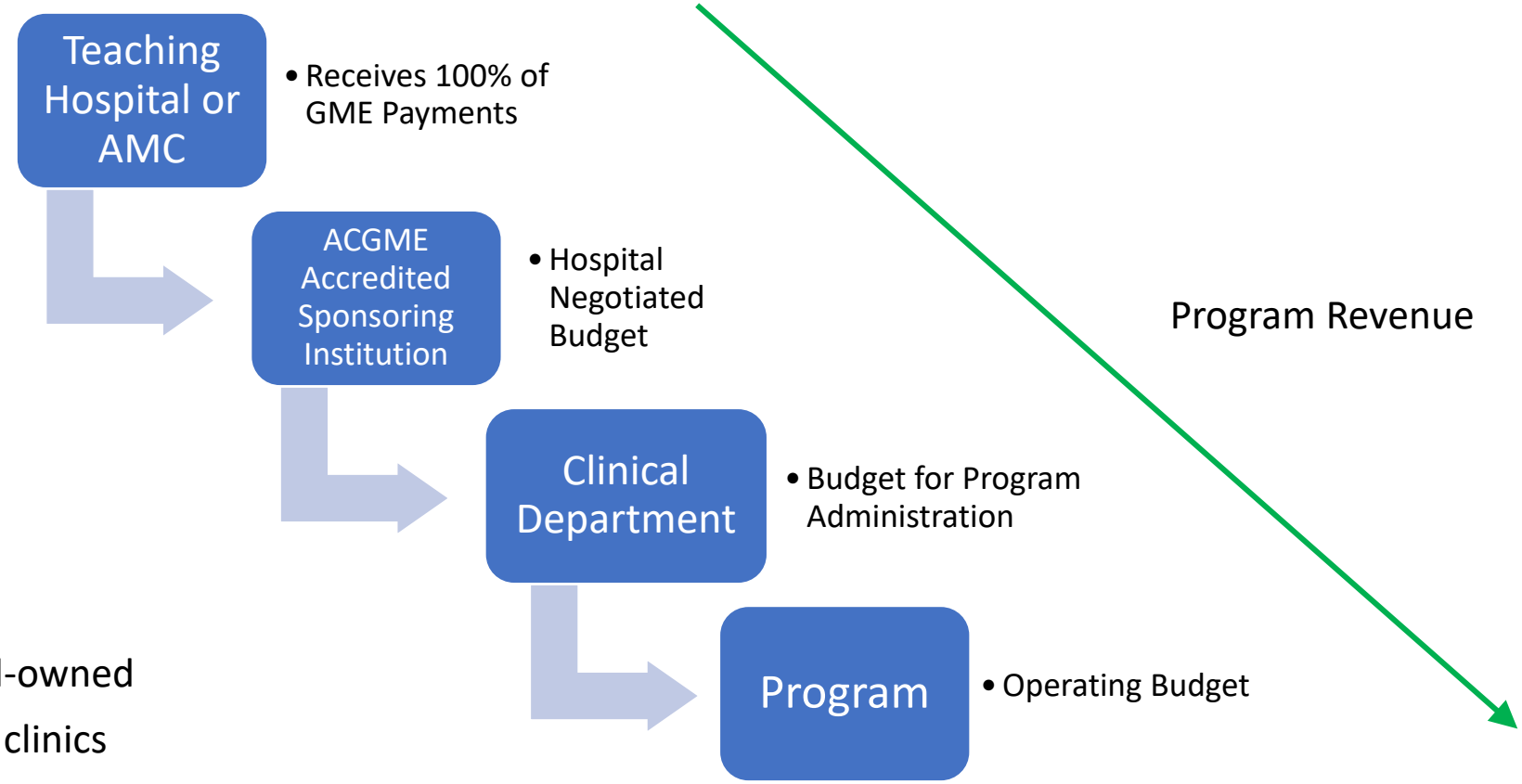
Session Objectives:

- Review Traditional Structure of Hospital-Based GME Programs
- Review Changes in Federal Policy Supporting GME Growth and Development
  - HRSA Grant Funds Supporting Decentralized GME Programs
  - Development and Technical Assistance Availability
    - RRPD -- RuralGME.org
    - THC -- THCGME.org
  - Medicare Improvements in GME Financing
  - Teaching Health Center Funding
- Review newer models of program development and collaboration created by Medicaid
- Understand Options -- State Programs for Program Development and GME Financing



Traditional GME Payment Flow -- Internal Hierarchical Hospital-Centric Processes

GME Specialties designed to Support Hospital-Specific ROI



All or a vast majority of training incurs within the hospital and hospital-owned or contracted continuity clinics

Where traditional model NEW GME Development Might Work Financially

- Medicare examples:
  - Urban Hospitals that have not Exceeded “Cap” – Medicare allowed maximum residency positions
  - Urban Hospitals that have obtained positions from other hospitals under Medicare prescribed circumstances
  - Hospitals that are “never claimers” or “GME naïve” hospitals
- Medicaid Existing Regulations – State Plan
  - May or may not follow Medicare rules
  - May allow GME growth with no “Cap”
  - May allow inter-governmental transfers to finance state share of GME costs
  - May or may not be sufficient to finance a program without Medicare $
  - Know your current Medicaid GME environment

Medicaid can help beyond GME payments -- New Mexico Experience

- New Mexico Primary Care Training Consortium – 2013 + Legislative Support
  - Appropriation Only -- Technical Assistance for GME Development
- Legislation Introduced by Burrell College of Osteopathic Medicine
  - House Bill 480 – Reps Gallegos and Small – 2019
  - Initially Modeled after Texas legislation when introduced
  - Multiple Amendments and Negotiation with key stakeholders
  - Final Bill Passed – GME Expansion Grant Program
    - Allows funds for GME development
    - Creates GME Expansion Review Board
      - Develops State Strategic Plan with Budget targets for New Primary Care Positions
      - Family Medicine, Peds, IM and Psychiatry

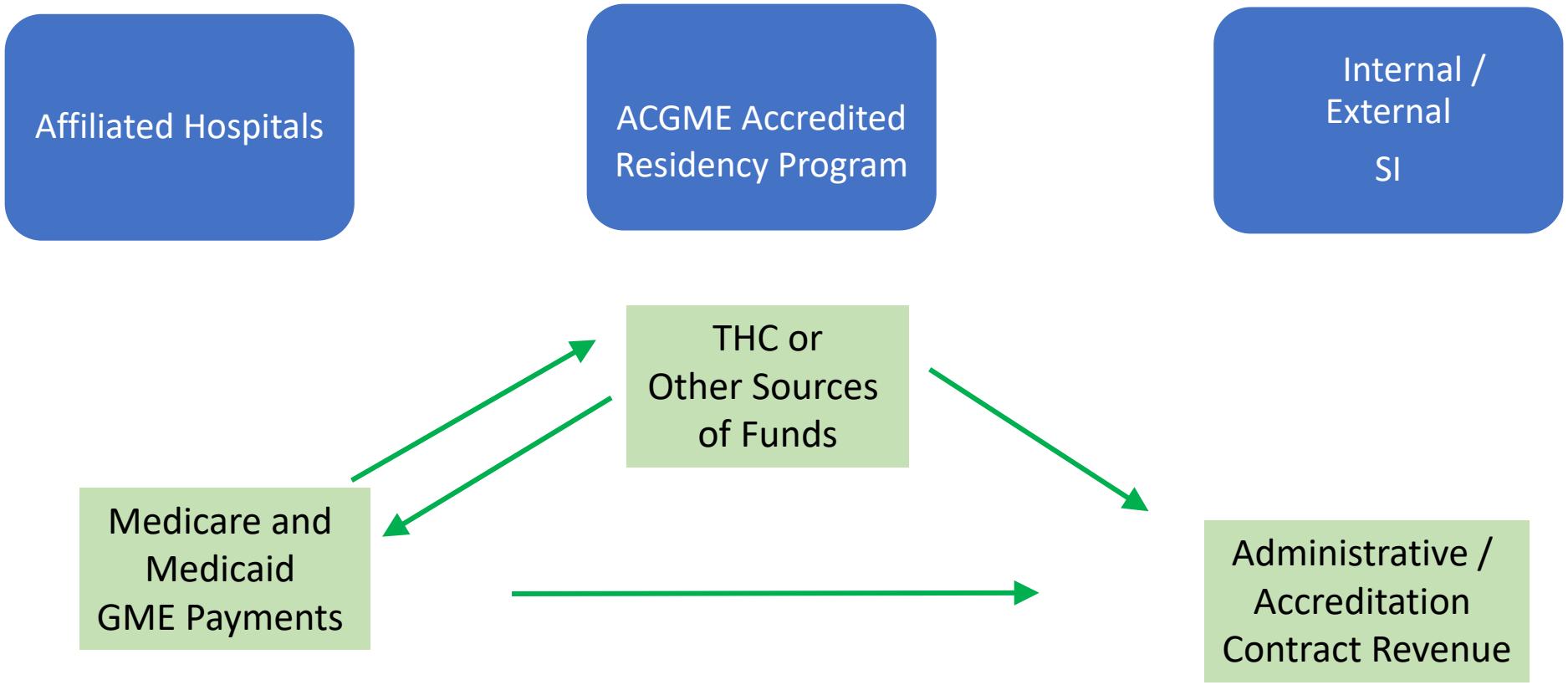
New Mexico
Using Regulations to Finance New GME Approaches

- State (Medicaid) Plan Amendments (PLA) effective July 1, 2020
  - Expands Indirect Graduate Medical Education (IME) payments to all DRG Hospitals
    - Previously limited to UNM
  - FQHCs and RHCs added to Direct GME payment eligibility
  - Categorizes payments into Primary Care and “Other” specialties
    - Primary Care = FM, Peds, IM and Psych
  - All historic resident positions (before 7/1/20) paid $50,000 per year (20% increase)
  - All New PC Positions $100,000 per year
  - All New Other Positions $50,000
  - Subject to CMS inflation rates

Federal Programs and Medicaid Spur
NEW GME Relationships

CMS allows Medicare payments to urban hospitals that support rural residency programs

New Models of Program Financing



Principles of New Program Model Engagement

Early identification of Core Partners

Thank You

Charlie Alfero
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If you're thinking about starting a residency program, Get Help!

- Resources
  - https://portal.ruralgme.org/
    - University of North Carolina – National Technical Assistance Contractor
  - https://newmexicoresidencies.org/
    - New Mexico Primary Care Training Consortium

  www.nmlegis.gov
    - HB480 2019 Session
  - https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education
    - US Department of Health and Human Services
    - Links to other DHHS GME and Workforce Programs
  - https://www.acgme.org/about/overview/
    - Overview of the Accreditation Council for Graduate Medical Education

How to Identify GME Naïve Hospitals

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June 20, 2023

Conflicts

- Sole member of Falcon Ridge Consulting, LLC that assists hospitals and Colleges of Osteopathic Medicine in developing GME financial projections

Hospital A - A good candidate for GME?

- ✓ Part of system actively engaged in GME
- ✓ 238 Licensed beds
- ✓ 141 Average daily census
- ✓ Medical staff interested
- ✓ CEO interested
- ✓ 2021 Operating margin = 2.7%
- ✓ 2021 Excess margin = 5.7%
- ✓ Positive margins during the pandemic

Hospital B - A good candidate for GME?

- ✓ Independent hospital
- ✓ 238 licensed beds
- ✓ 118 Average daily census
- ✓ Engaged medical staff and administration
- ✓ 2021 Operating margin = 10.6%
- ✓ 2021 Excess margin = 26.2%
- ✓ Positive margins during the pandemic

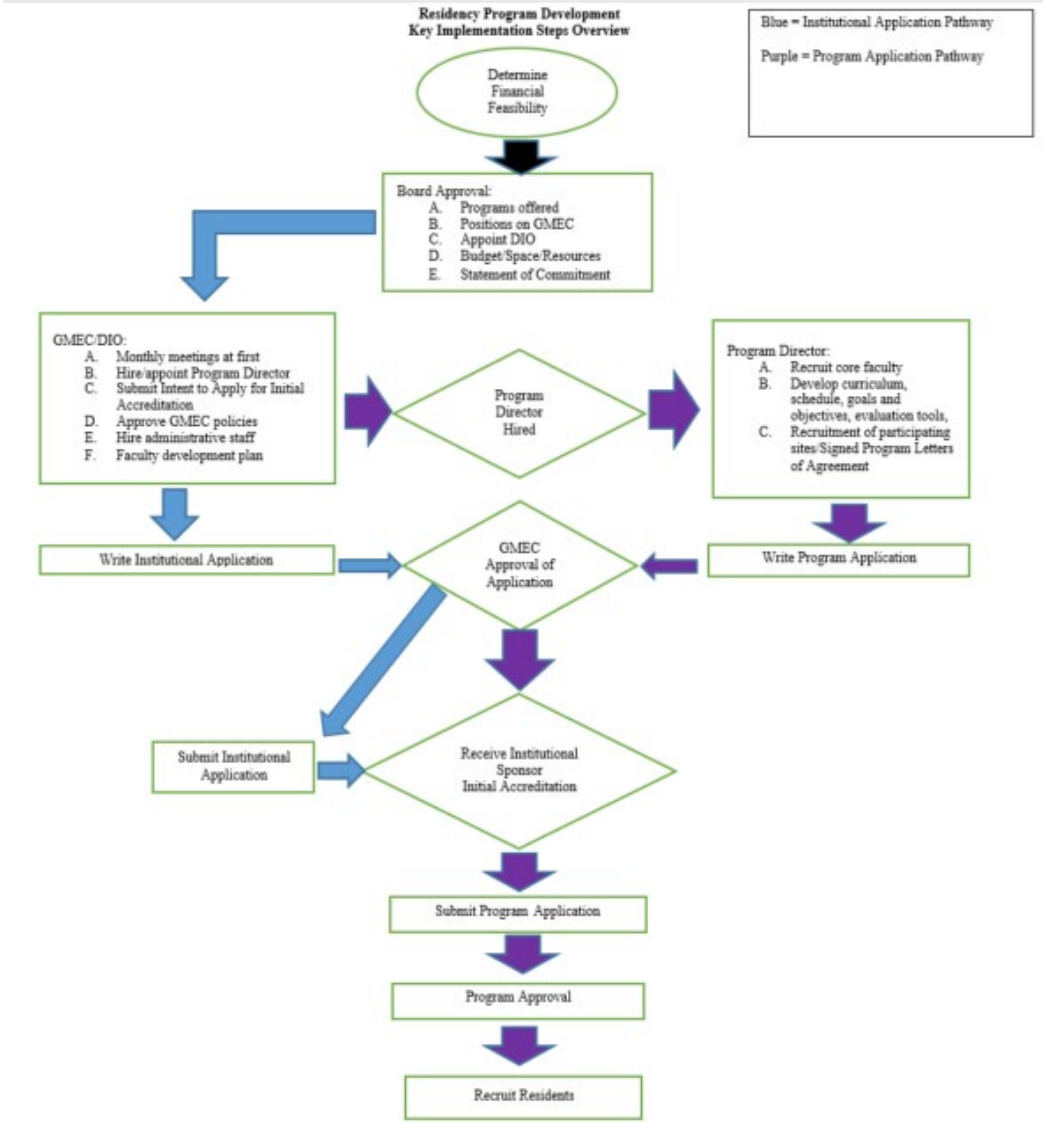
Presentation objective:

- Provide a process to identify acute care hospitals that can potentially support new GME based on :
  - I. Clinical volumes
  - II. Medicare funding (is the hospital naïve?)
    - A. Teaching Status
  - III. Recognize other potentially limiting factors
    - A. Critical Access Hospitals
    - B. Sole Community Hospitals
    - C. Medicare Dependent Hospitals
    - D. Financial condition
    - E. Consolidated Medicare Provider Numbers

Why would you want to know this stuff?

1. Focus efforts where most likely to be successful.
    a) Spend resources wisely to achieve GME strategic plan
2. Know a few things before you go
    a) Need to know if GME might be viable option now are in the future

GME is a Process




✓ Consistency with Mission/Vision
✓ Leadership buy-in
✓ Medical staff support
✓ Financial viability

Information Sources:

- Accreditation Council for Graduate Medical Education
  - Sponsoring Institution search
  - Program search
- Subscription services
  - Cost reports
  - Identifying types of hospitals/other info
- Hospital Websites and Community Needs Assessments
- Departments of Health (sometimes)
- Rural GME Analyzer tool https://portal.ruralgme.org/login.

I. Volume indicators to consider:

- Average Daily Census
  - Total acute care patient days/365
    - Higher the better
  - Potential sources
    - Subscription services
    - Departments of health in some states
    - Hospital annual reports
- Service line volumes often difficult to obtain

Average Daily Census Rule of Thumb

- 0.3 – 0.4 residents per ADC
  - ADC = 100
    - Hospital could possibly support 30 to 40 trainees

- Recommendation: If you recommend a number of residents
    - Start low and grow

Process overview:

1. Identify hospitals of interest
2. Determine current teaching status
3. Identify rural teaching hospitals
4. Identify Sole Community Hospitals (SCH)
5. Identify Critical Access Hospitals (CAH)
6. Identify Medicare Dependent Hospitals (MDH)
7. Is the hospital (items 3, 4,5) an exception to general rules

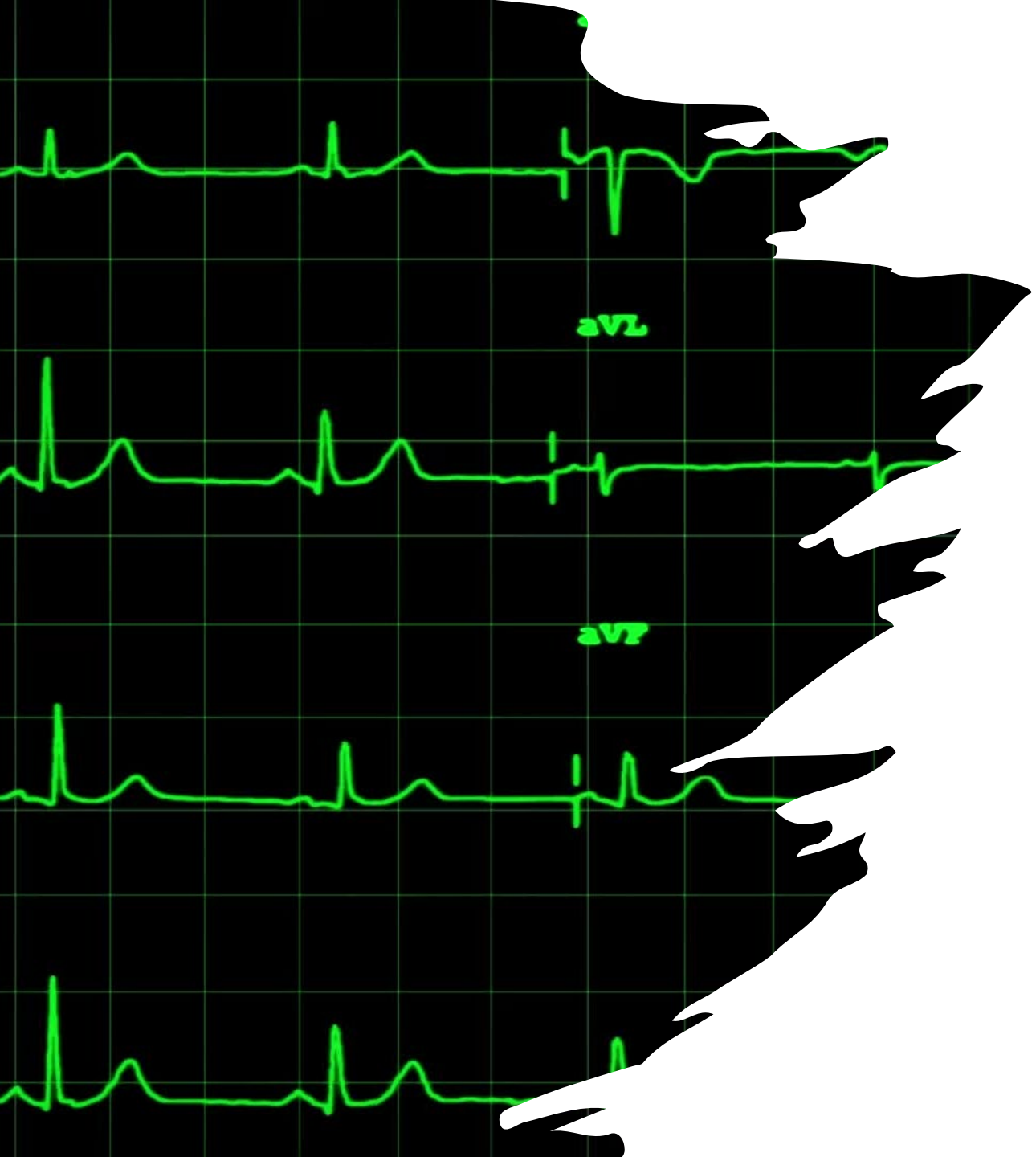
II. What do we mean by GME naïve?

- Hospital does not have an established cap
  - Residents have not rotated through facility
- CARES Act of 2023
  - Hospital can reestablish cap and per resident amount
    - If never claimed more than 3.0 residents
    - Less than 1.0 prior to 1996
  - Must establish new caps and PRA before 12/26/2025

Current Teaching Status

- ACGME search
  - List of programs by sponsor
    - https://apps.acgme.org/ads/Public/Reports/Report/2.
- Worksheet E, Part A, Line 5

4	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment Calculation for Hospitals	86.42	
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)	45.96	



Past teaching?

- Review Worksheet E, Part A, for every cost report going back to 1996/1997
  - <3.0 = naïve through 12/26/2025
  - >3.0 = not naïve
- WARNING: Ultimately up to the hospital to determine if they are eligible
  - Advise hospital to verify with fiscal intermediary

But is the hospital rural as defined by Medicare?

- Many definitions of rural
- Only one matters for GME
  - Reported on cost report Worksheet S-2, Part 1, Line 26

THAT's a 2

2=rural

Most recent cost report

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2

Am I rural?

Located within an Urban Area.

- Urban Area Name: Virginia Beach--Norfolk, VA Urban Area

Hospitals with Medicare rural designation:

- Cap can be increased for new programs

III. Recognize other potentially limiting factors

A. Critical Access Hospitals
B. Sole Community Hospitals
C. Medicare Dependent Hospitals
D. Financial condition
E. Consolidated provider numbers

A. Critical Access Hospital (CAH)

Located in a rural area

No more than 25 acute care beds

Average length of stay less than 4 days

Must furnish emergency care 24 hours a day, seven days a week

Located more than 35 miles from similar facility

15 miles in mountainous areas

Reimbursed 101% of reasonable costs

CAH unlikely to support a GME program

- Low patient volumes
- Lack of specialties
- Distance
- Cannot receive GME or IME payments
  - BUT
- Potentially a partner for Rural Training Track
- About 15 teaching CAHs nationally out of 1,361

CAH easily identified:
Fourth digit from right of Medicare Provider Number = 1
38**1**319

B. Sole Community Hospital (SCH)

At least 35 miles away from similar hospital

Between 25 and 35 miles

(Exceptions based on market share and bed size)

Between 15 – 25 miles if inaccessible for 30 days due to weather

Travel time to nearest hospital is at least 45 minutes

Receive additional payments due to importance to community

The potential issue with SCH’s

- Receive Direct Graduate Medical Education payments
- Not eligible to receive Indirect Medical Education reimbursement based on the Medicare Inpatient Prospective Payment System(Part A)
- IME payments can represent about 66% of Medicare GME payments

Perhaps not an issue: Hospital-specific or Federal Rate?

- Hospitals reimbursed the federal rate eligible for IME payments
- How do I determine what rate they are paid?
  - Medicare Cost Report: Worksheet E, Part A, Lines 47 and 48
    - If Line 47 > Line 48 = Federal Rate
    - If Line 47 < Line 48 = Hospital-Specific Rate

Two SCH's

47	Subtotal (see instructions)	9,859,291
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	10,399,780

Line 47 – 48 is negative = Hospital Specific Rate, not eligible for IPPS IME payments

47	Subtotal (see instructions)	26,182,955
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	20,648,695

Line 47 – 48 is positive = Federal Rate, eligible for IPPS IME payments. Facility has 38 residents

Another SCH twist:

- SCH's can receive IME reimbursement for Medicare Managed Care payments (Part C).
  - Worksheet E, Part A, Line 3

Hospital-specific rate hospital in previous example

- $19,174,071 (68% of Medicare Collections) reported in Line 3
- Might be sufficient depending on:
  - Per Resident Amount
  - Resident-to-Bed ratio

1	DRG amounts other than outlier payments	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,166,140
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,734,508
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	
2	Outlier payments for discharges (see instructions)	
2.01	Outlier reconciliation amount	
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	7,123
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	100,185
3	Managed care simulated payments	19,174,071
4	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment Calculation for Hospitals	96.02

If Line 3 not reported

- Add Lines 1, 1.01 and 1.02 from Worksheet E, Part A
- Divide by IPPS discharges
  - Worksheet S-3, Part 1, Column 13, Line 1
- Equal payment per IPPS discharge
- Multiply by Managed Care Discharges
  - Worksheet S-3, Part 1, Column 13, Line 2

From the example:

- IPPS payments = $8,900,648
- IPPS discharges = 1,093
- IPPS payment per discharge = $8,143
- Managed Care discharges = 2,111
- Payment X discharges = $17,174,071
- Line 3 actual = $19,174,071
- A conservative estimate but can go the other way. Will need to obtain the actual from the hospital to project accurately.

C. Medicare Dependent Hospitals (MDH)

- Approximately 170
- Reduced IME payments of 25%
- Similar implication as SCH
- Worksheet S-2, Part 1, Line 37

D. Financial condition

- If available, consider the hospital's operating and total margins
  - Hospital's losing money may be reluctant to consider GME

E. Consolidated provider numbers

- A hospital may not have residents and look like a GME fit

However,

- Operate under the same Medicare Provider Number as a teaching hospital
  - Cap is shared

Hospital A

- ✓ Sole Community Hospital
  - ✓ Value of SCH = $5.5 million
- ✓ Rural
- ✓ No prior cap
- ✓ Medicare Managed Care Payments 25% of total Medicare payments

Hospital B - A good candidate for GME?

- ✓ Sole Community Hospital
  - ✓ Value of SCH = $500,000
- ✓ Rural
- ✓ Prior caps <3.0
- ✓ Medicare Managed Care Payments 25% of total Medicare payments

Hospital B – IM program opening 2024

Things to remember

- The information is out there
- Determine current and past teaching status
- If teaching, is the hospital rural
- Check on other statuses (CAH, SCH, MDH)
- For SCH and MDH, don’t give up – evaluate
- If questionable, seek outside expertise
- Consider hospitals financial condition
- Look out for changes in the law


Questions
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Medicare GME payments for new residencies– the basics

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With much assistance from
Alan Douglass, MD FAAFP

Educational Objectives

- We presume you are… trying to start or expand a residency or fellowship! You could be one or more of these:
  - Already are (or partner with) an established teaching hospital
  - Are considering hospital partners that may be GME-naïve
  - Already have or are or want to be a GME Sponsoring Institution
  - Are considering community partners (e.g. an FQHC) for GME program development
  - Want to expand an existing residency/fellowship
  - Want to start a new residency/fellowship
- We presume (today) that you know very little about how the Medicare GME payment system works

Educational Objectives

- Today we will present the basics about:
  - Medicare DGME and IME payments
  - Hospital “types” that influence Medicare GME payments
  - Brief mention of Medicaid GME
- Future webinars in July and September

The Big Picture

The Big Picture

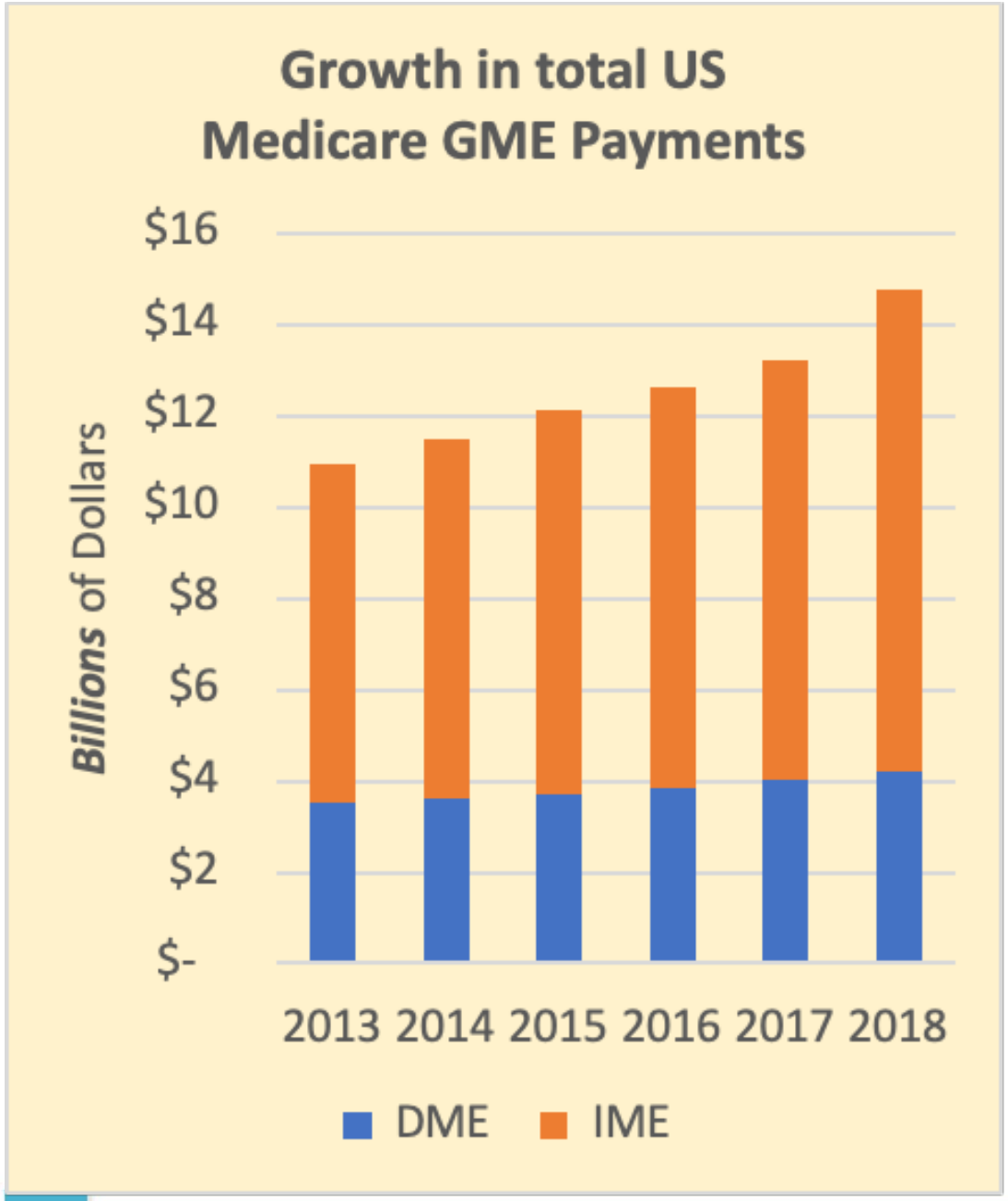
- Cost of academic/administration for ***any specialty*** medical residency * program is $140,000 to $220,000 per FTE resident per year. The variability is mostly due to how residency associated clinical operations are included in the GME budget.
- Academic/admininstrative costs include Residents' salaries, Faculty "non-billable" time, GME staff, associated benefits, GME space, travel/CME, housing, food, etc.
- Mostly covered by Medicare GME plus Medicaid (in some states) GME payments.
- This usually does NOT include the revenues and cost of GME-associated clinical operations – e.g. what the clinical operation would cost and produce in revenue if there were no residents.
- GME-associated clinical operations may be a net financial negative or positive depending on specialty, payer mix, etc.

* "**Residents**" in this presentation ***includes fellows*** from accredited fellowships. "GME trainees" would be a better term but is not used in most CMS and ACGME publications.

Total Medicare GME Funding

FY18 Graham Center	aggregate all US IPPS hospitals			median $ per FTE resident claimed
	total	cap FTEs	claimed FTEs	
DGME	$ 4,204,871,956	95,259	117,325	$ 41,673
IME	$ 10,549,069,009	90,813	105,686	$ 97,058
total GME	$ 14,753,940,975			$ 144,083

Note that the country as a whole has claims > caps so many hospitals are not getting Medicare GME $ from all their trainees

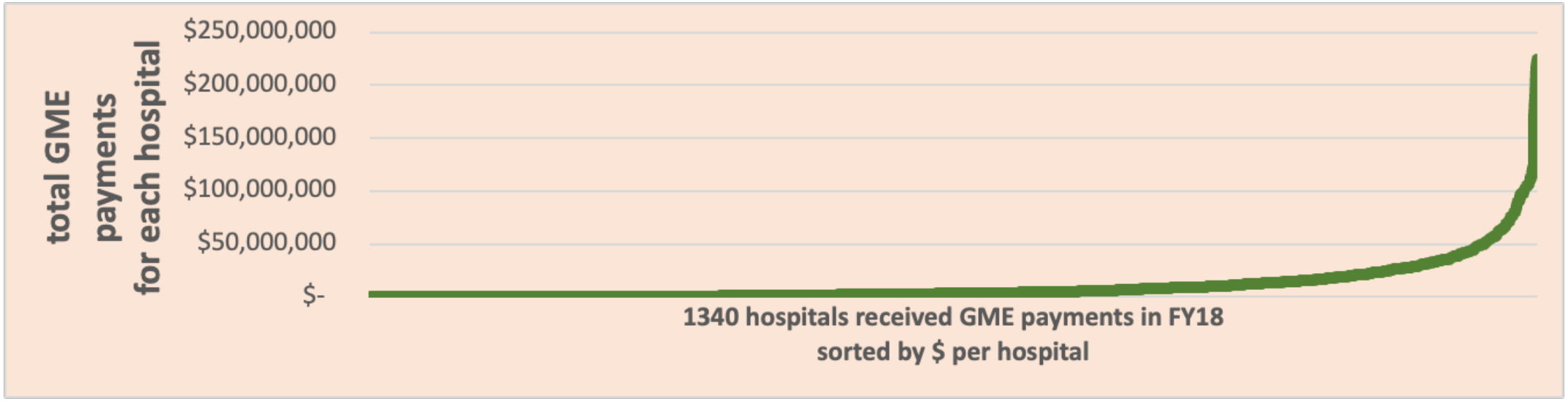


Total Medicare GME payments keep growing

- Increased 40% 2013-2018
- Will grow even faster over next 5 years given growth in number of urban “Rural Referral Centers”

<- Graham Center data

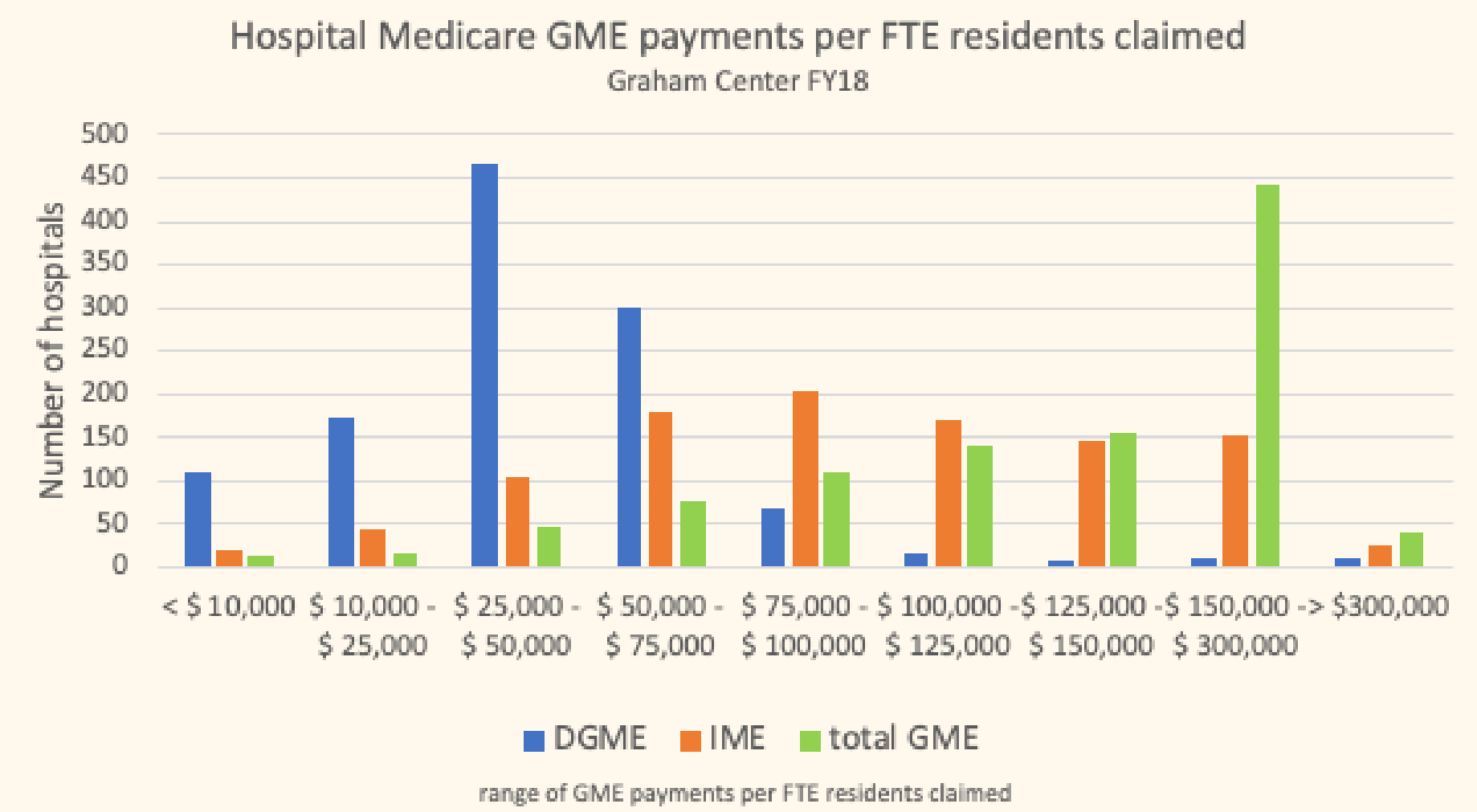
Distribution of total Medicare GME payments *per hospital*



40% of hospitals receive 2% of total GME payments

8% of hospitals receive 50% of total GME payments

Wide range of Medicare GME payments *per Resident*



Different Hospitals- Different Rules

- IPPS (Inpatient Prospective Payment System) hospital is the most common type
  - Paid by Medicare using the Diagnostic Related Groups (DRG) coding system
  - Can receive DGME and IME
  - ***The rest of this talk presumes the "hospital" is an IPPS hospital***
- Subtypes of IPPS hospitals (e.g. Sole Community Hospitals, Medicare Dependent Hospitals, Rural Referral Centers, others)
  - Can receive DGME and IME but rules are different (see July 12 webinar)

More Different Hospitals- more Different Rules

- Inpatient Psychiatric Facilities (IPF), Inpatient Rehabilitation Facilities (IRF) and distinct Psychiatric and Rehab units in IPPS hospitals follow IPPS DME rules but their “indirect” GME payments follow ***very*** different formulas.
- Children’s Hospitals – which tend to have very little Medicare covered patients – receive GME payments from a HRSA (not CMS) grant program that has a fixed annual budget for the country and requires ongoing congressional approval.
- VA , Department of Defense and Indian Health Service hospitals receive GME related payments by a separate mechanism
- Critical Access Hospitals and Rural Emergency Hospitals are ***NOT*** IPPS hospitals
  - DGME and IME are usually not involved in Federal support (if they receive any) for residency education – but time residents spend there can be claimed by a GME partner IPPS hospital that is paying for residents’ salary and benefits.

DGME
for IPPS hospitals

What Is DGME?

- Direct GME (DGME) is *theoretically* the amount Medicare pays the hospital for Medicare's share of the direct cost of operating the residency
  - Resident salaries and benefits
  - Faculty teaching time
  - Program administration
  - Other typical educational costs (space, laundry, etc.)

DGME Calculation Simplified

DGME =

(Claimable Resident FTE x Per Resident Amount) x Medicare Share

DGME Calculation- Resident FTEs

Accredited FTE

Currently enrolled FTE

Worked FTE at your Institution

Cap FTE

CAPS

- Set for ”old” teaching hospitals’ FTE counts in 1997 by BBA
- Post-1997 GME-naïve hospitals that start claiming residents from “New” GME programs set their own CAPS over first 5 years.
  - Rural hospitals can continue to add to caps with new GME programs
- IME and DGME capped separately
  - “Old” (pre 1998) hospitals have IME caps lower than DGME caps because of old counting rules
  - “New” hospitals’ FTE caps DGME=IME in general
- Redistribution of unused cap slots – 2006 and 2010 so far
- CAA 2021- 200 new CAP positions nationally in each of next 5 years

DGME Calculation- PRA

- Per Resident Amount (PRA) established ***specific to each hospital*** on base GME year compared to regional average or other more local average.
  - Example: $41,484 per FTE resident 1984
- VERY important to get this right for the base year. See July webinar.
- PRA is updated for inflation (CPI-U) each subsequent year with different adjustments for primary care (PC) residents vs. others (NPC)
  - Example: $102,875 PC; $100,956 NPC 2017
- Note that the PRA is NOT what a hospital is paid per resident. It is always discounted by Medicare's share of care each year.

Census Region Average PRAs

region	states	Dec-1998	Oct-2022
	CPI-U ->	163.9	298.01
New England	CT, ME, MA, NH, RI, VT	$ 69,696	$ 126,724
Mid Atlantic	NJ, NY, PA, PR	$ 92,567	$ 168,309
S Atlantic	DE, DC, FL, GA, MD, NC, SC, VA, WV	$ 62,513	$ 113,664
EN Central	IL,IN, MI, OH, WI	$ 67,120	$ 122,040
ES Central	AL, KY, MS, TN	$ 59,619	$ 108,402
WN Central	IA, KS, MN, MO, NE, ND, SD	$ 70,212	$ 127,662
WS Central	AR, LA, OK, TX	$ 55,240	$ 100,440
Mountain	AZ, CO, ID, MT, NV, NM, UT, WY	$ 60,697	$ 110,362
Pacific	AK, CA, HI, OR, WA	$ 68,652	$ 124,826

DGME Calculation- DGME Cost

- Total claimable FTE residents (up to CAP) sorted by Primary Care (PC) and Non-primary Care (NPC) discounted by 50% for any beyond initial eligibility period (3 years for FM)
  - Example
    - $102,875 *55 PC FTE = $5,658,125
    - $100,956 *165 NPC FTE = $16,657,740
    - Aggregate total DGME “cost” = $22,315,865

DGME Calculation- Medicare Share

- Determining **Medicare's share** of total DGME based on proportion of inpatient days
  - Example: Medicare inpatient days = 52,560
  - Total Inpatient Days = 175,200
    - Includes OB inpatient days but NOT "Observation" days
  - Medicare's share = 52,560/175,200 = 30%
  - $22,315,865 *30% = **$6,694,760**

IME
for IPPS hospitals

What Is IME?

- Calculated percent added to each and ***every*** DRG payment. Residents need ***not*** be involved in care for every DRG
- Hospitals with more residents per bed get a higher percent added to their DRGs (0 to over 40%)
- Hospitals can recover full credit for IME associated with Medicare Advantage plans
- IME typically double DGME with wide variation

The Theory of IME

- IME payments were originally intended to cover teaching hospital's "excess costs of care":
  - Residents' inefficiency (more tests, longer LOS, longer OR time)
  - Sicker patients
  - "More advanced technology" at teaching hospitals

The Reality Of IME

- ***Care*** by Residents is probably NOT more expensive
- IME makes up for the insufficiency of DGME payments and the absence of medical education support by other payers
- IME supports the expensive and underfunded indigent care system in many localities
  - Examples- New York City and Boston
  - 1/5 of teaching hospitals receive 2/3 of IME payments

IME Calculation (really) Simplified

%DRG Add-on = FTE Residents x a crazy calculation (!)
Hospital Beds

IME calculation- Residents and Beds

- 1. Count “IME” Residents (up to IME cap)
  - Example: 200 FTE residents countable for IME (vs. 240 for DGME)
- 2. Count staffed beds
  - Exclude: well baby beds, psych/rehab beds, custodial care beds, ambulatory surgery beds
  - Include: Med/Surg beds, Newborn ICU, L&D
  - Special Rules: Observation and swing beds
  - Example: 600 beds

IME calculation- IRB

- 3. Calculate Intern Resident Bed ratio (IRB)
  - Example: 200 Residents / 600 beds = 0.30 IRB
    - Note that IRB increases lag for one year:
      - IRB used in formula is the smaller of current year's IRB vs prior year's IRB
      - Somewhat delays "advantage" of decreasing number of beds (thus higher IRB) in terms of boosting IME payments
      - Hospitals that add a new residency use a different IRB comparison method for IRBs in the residency's first year.

IME calculation- Formula Multiplier

- 4. Find the “formula multiplier” for the year
  - Pre 1997 was 1.89 corresponding (roughly) to 7.7% add-on per 0.1 IRB
  - Since 2007 is 1.35 for a 5.5% per 0.1 IRB added on to every DRG payment

IME calculation- The Crazy Calculation!

$$\%addon = multiplier * [((1 + IRB) \uparrow 0.405) - 1]$$

- Excel: =mult*(POWER((1+IRB),0.405)-1)
- Example = 1.35*(POWER((1+0.3),0.405)-1) = 15.1%
- The 15.1% for the example hospital will be applied to all Medicare DRG payments including the “DRG equivalent” calculated for Medicare Advantage

IME calculation- % Add-on

- The % add-on is then added on to EVERY DRG the hospital claims from Medicare for that year
- It does NOT matter if Residents were involved in any of this DRG billed care

Example hospital gets…

- Total DRG (including capitated Medicare) claims for were $94,000,000
- Multiply by 15.1%
- = $14,194,000 in IME payments
- Plus $6,694,760 in DGME payments
- = $20,888,760 total
- ~ $104,000 per FTE resident = financial trouble!

IPPS Hospitals
specific data matters!

Key data about your partner IPPS hospital(s) determine their access to Medicare GME funding

whether they can receive Medicare DGME and/or IME at all for new or expanded GME progtrams and how much they will get:

1. hospital **provider TYPE** (“regular” IPPS, RRC, SCH, MDH, etc.)
2. **GME history** (GME-naïve, not GME-naïve but able to reset PRA and/or cap… or not)
3. Historically high vs low **PRA** and **Caps**
4. **rural/urban location/classification**
5. Is planned GME program a **Rural Track Program** or not

You can find out all this hospital-specific data via publicly available sources

- Get a **ruralgme.org** login (free to anyone)
- At top of page is the “Hospital Analyzer” and you can look up any IPPS or CAH in the US (as of 2022) and get a report.
  - Links in the report to a glossary with succinct descriptions about all report elements
- **Graham Center** data shows PRAs, Payment amounts for DGME and IME and caps vs claimed number of FTE residents
  - Last Graham Center update was FY18
- Much of this data summarized in a “hospital type and data lookup” in the ruralgme.org toolbox

Ruralgme.org tools

Contact Us
info@ruralgme.org

Home | Get Started | Programs | Toolbox | Hospital Analyzer

RuralGME.org

Get Started

Click here to view the recommended

Toolbox

Click here to view tools and resources

Search

hospital type

Section

Financial Planning

Type

All

Specialty

All

Financial Planning | Specialty: Not Specialty Specific | Type: Resource 0 0
Collection Or Website

Step by Step Guide to Hospital Type and Status Lookup

A step-by-step guide for looking at the "Type" and "Status" of the hospitals you work with.

Financial Planning | Specialty: Not Specialty Specific | Type: Resource 0 0
Collection Or Website

Hospital Type & Data Lookup File

Excel file that can be utilized to look up hospital type related to CMS Rule Changes, DME and IME FTE caps and $ claimed, and CAA section 131 HCRIS status (whether or not GME has been claimed) (version updated Jan 2023)

Hospital Analyzer example:

This hospital

- is located in a county designated as **Metro** (defined by OMB's CBSA standards (2020)). For CMS Medicare GME purposes, onl resident training in non-metro counties will count towards the requirement for RTP funding of at least 50 percent in non-metr counties.
- is classified as **Rural** by CMS. This may affect the hospital's ability to get new Medicare GME funding depending on its categor described below.
- is considered **Non-Rural** according to the Federal Office of Rural Health Policy (FORHP). Training in a FORHP-designate rural place will count towards the requirement for RRPD grant application of at least 50 percent in a "rural" place but won't cour towards Medicare RTP funding requirements for rural training location unless the place is ***also*** not in a metro-CBSA.

A hospital may fall into multiple categories below - e.g. be both an RRC and a SCH or an Category A in a Lugar County.

Hospital in category?	**Category**	**Implications for GME.** Further details are provided in on the Rural GME Analyzer website.
	Critical Access Hospital (CAH)	NOT an IPPS hospital. Time residents spend in a CAH can be claimed by a residency partner IPPS hospital (if it meets nonprovider setting requirements) which often is more financially advantageous than direct expense claims by the CAH. The status of the partner IPPS hospital will matter when considering that option. Click for more detail.
	Sole Comunity Hospital (SCH)	A special type of IPPS hospital. Special rules apply that limit IME payments. Click for more detail.
	Medicare Dependent Hospital (MDH)	A special type of IPPS hospital. Special rules apply that limit IME payments. Click for more detail.
	Rural Comunity Hospital (RCH) Demonstration	A special type of IPPS hospital. Special rules apply that limit IME payments. Click for more detail.
Yes	Rural Referral Center (RRC)	A special type of IPPS hospital. Special rules apply that allow new GME programs to qualify for new Medicare GME payments. Click for more detail.
	IPPS hospital that is a Never Claimer	There is no evidence this hospital ever claimed GME expenses on a Medicare cost report. Thus, this hospital is likely a GME-naïve hospital that can get Medicare GME payments when the hospital first starts resident rotations. Click for more detail.
	Category A	This IPPS Hospital has a low cap and may also have a low Per Resident Amount (PRA) suppressing their DGME payments. Category A and B hospitals may be able to reset their PRA and could add to that cap with a new GME program. Click for more detail.
	Category B	
Yes	Established Teaching Hospital	This hospital has a cap high enough that it is not eligible for Category A or B reset opportunity. Their cap can't generally be increased unless it has a CMS classification and/or location or participates in a new RTP residency. Click for more detail.
	Indian Health Service (IHS) Hospital	Special considerations apply for IHS hospitals. Click for more detail.
	Lugar County	Hospitals in Lugar counties (all are classified as locations) have the option of reclassi-fying as to get a better wage rate. However, this can limit GME funding qualification. Click for more detail.

Examples from "Hospital Type and Data Lookup File"

Name	URGEO	URSPA	Beds	Calculated Residents (Beds x IRB)	Provider type (Impact 2023)	Graham Center FY18 calc DME$/FTE resident	Graham Center FY18 calc IME$/FTE resident	2021 CAA section 131 HCRIS status
St Vincent's East	LURBAN	LURBAN	241	10.9	IPPS	$ 85,930	$ 116,867	Not Cat A or B
Helen Keller Memorial Hospital	OURBAN	OURBAN	172	0	IPPS			Never Claimer
Huntsville Hospital	OURBAN	RURAL	908	54.8	RRC	$ 40,782	$ 107,813	Not Cat A or B
Vaughan Regional Medical Cent	RURAL	RURAL	109	11.7	SCH/RRC	$ 39,931	$ 62,441	Not Cat A or B

- "LURBAN" (Large Urban) and "OURBAN" (Other Urban) are both Urban and there is no GME relevant distinction between the terms
- "URGEO" is physical **location**. URBAN means in a metro-CBSA. RURAL is anything outside a metro-CBSA
- "URSPA" is **classification**. *Many* urban hospitals have reclassified as "RURAL" but are still in an urban location. A *few* rural hospitals have reclassified as "URBAN" but are still in a rural location
- "Not Cat A or B" means this is an established teaching hospital that can't reset their PRA or Cap. See "hospital analyzer" glossary for more details

What if the Medicare GME funding options for my hospital(s) are inadequate?

- Medicaid GME!
  - Different in every state. Some states have lots and some have none. A changing system - generally now putting ***more*** $ into GME than in years past.
  - Know your Medicaid environment and ***potential*** (participate in state improvements!)
    - Identify Medicaid Staff involved in GME payments
    - Understand your PCA, State AFP, or other program advocates' positions on Medicaid GME
  - Funds that flow through Medicaid get matched by the federal government so that each dollar the state puts in is at ***least*** doubled. See https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier
- THCGME funding.
  - A HRSA administered program that directly funds eligible Community Health Centers (FQHCs, etc.) for GME at ~$160,000 per FTE resident per year
  - A competitive grant program… currently in a precarious funding position requiring Congressional action to reauthorize.

June 12 webinar agenda…

- A more in-depth discussion of hospital types and GME funding options.
  - We can discuss specific hospitals using publicly available data
  - Let us know if you want us to discuss ***your*** hospital(s)
- The special opportunities for GME-naïve hospitals – AND the substantial long-term financial risks if residents or fellows start rotations there without informed advanced planning.
- Section 126 of CAA 2021 that will add 200 slots/yr x 5 years via annual application process
- Some topics may be added in response to this presentation

September webinar agenda…

- All things rural… Rural Track Programs, etc.
- Status update (if any) for the THCGME program and details for qualification
- HRSA funding for ***developing*** rural and THC residencies
- GME in the VA
- Some topics may be added in response to the June 20 and July 12 presentations

Questions and Discussion

AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Creating New Rural Psychiatry Residencies

Carlyle H. Chan, M.D.

Professor of Psychiatry

Medical College of Wisconsin

HRSA TAC Psychiatry Content Expert

Conflicts of Interest

- I have no financial conflicts to declare pertaining to this talk.
- I was a Psychiatry Program Director for almost 18 years.
- I have helped start two rural psychiatry residencies in Wisconsin.

Objectives

Attendees will:

1. Comprehend the unique training requirements for a Psychiatry Residency
2. Recognize the issues in establishing a new psychiatric program from feasibility to development
3. Identify challenges in maintaining accreditation

Psychiatry Training Requirements

Minimum Timed Requirements

Primary Care

4 months


Neurology
2 months

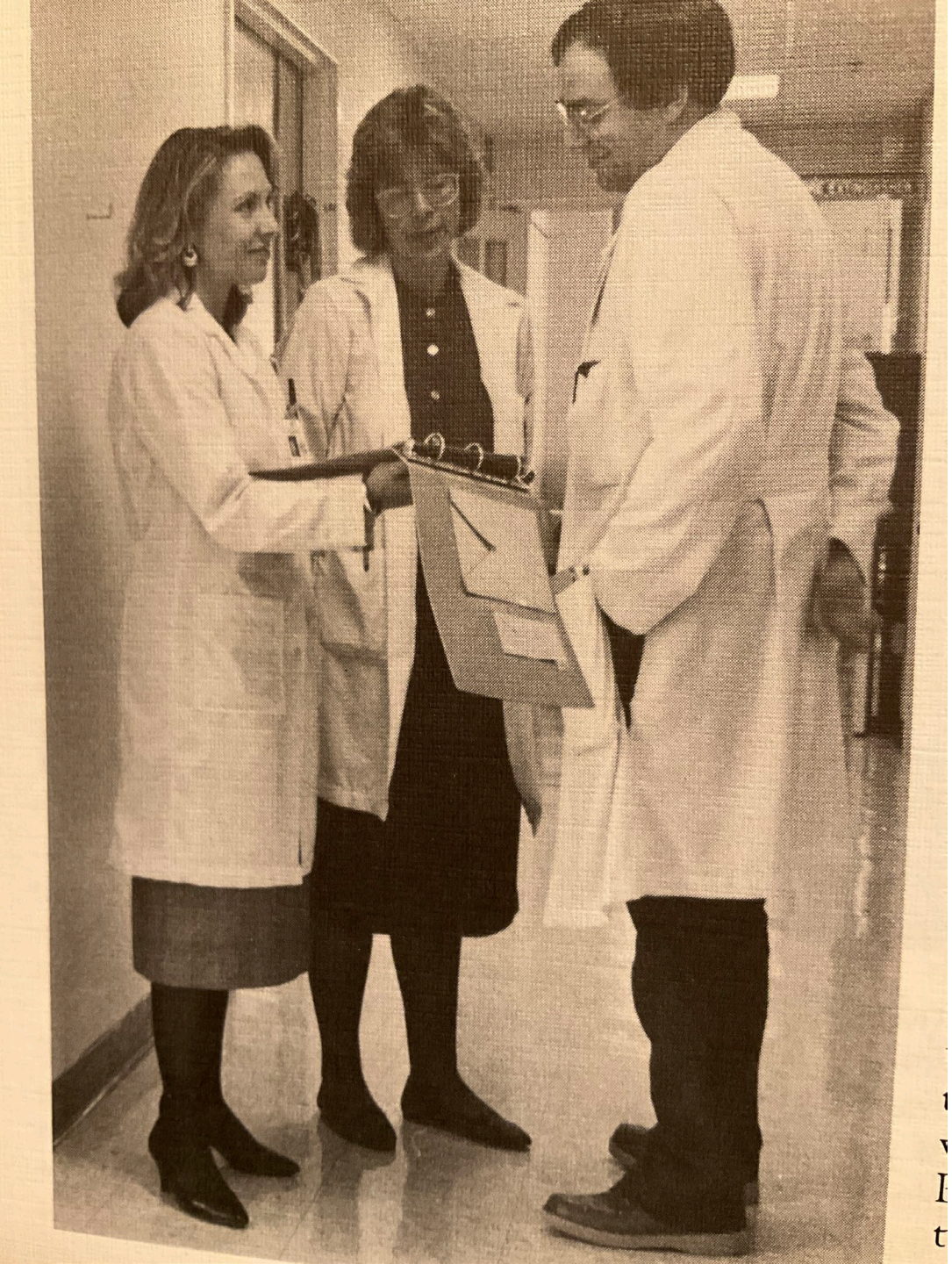
Inpatient Psychiatry

6 months

Photo: NIMH

Outpatient Psychiatry

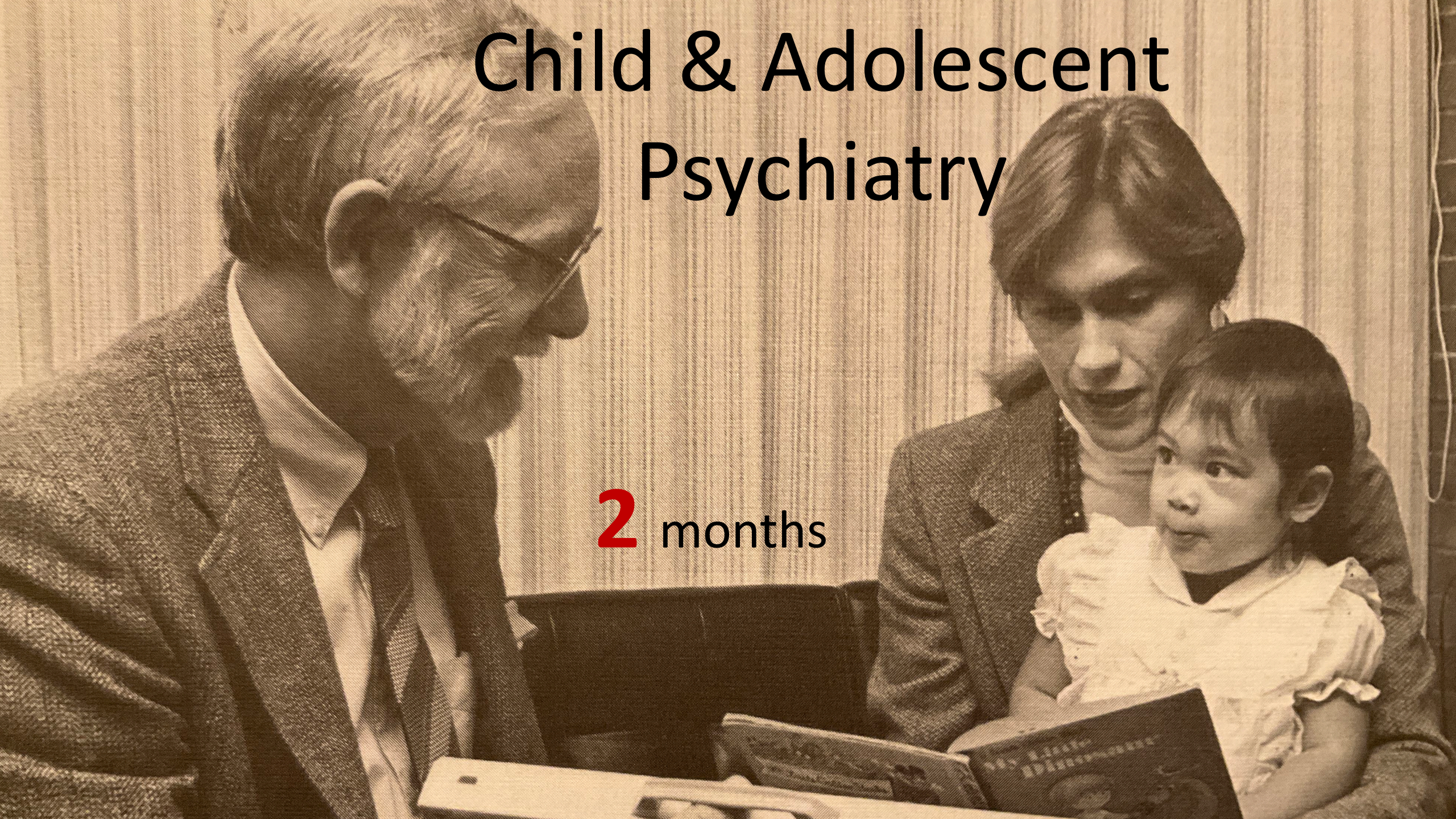
12 months



Consultation Liaison Psychiatry

2 months

Child & Adolescent Psychiatry



2 months

Geriatric Psychiatry

1 month


Addiction
Psychiatry
1 month
Photo: R Bero

Non-Timed Requirements

- Forensic Psychiatry
- Community Psychiatry
- Emergency Psychiatry

It takes a village…

Didactics

- Psychiatric Diagnosis, Interviewing
- Psychopharmacology & Somatic Therapies
- Psychotherapies
- CL; Child; Gero; Addiction;
- Research/Critical Appraisal
- Ethics

Residency Development Issues

- ROI/Pipeline
- 4-year Residency versus Rural Training Track
- Relationship to an academic department
- Potential Affiliates/Stipend Support
- Program Director

Residency Development Issues cont’d

- Faculty
- Travel Times
- Finances, Development & Ongoing
- Committees

Accreditation


COURTESY PHONE CENTER

Maintaining Accreditation

- Faculty Relocations, Retirements, Recruitment
- Scholarship
- Faculty Development
- Core Faculty
- Administration Changes in Affiliates


If you build it, will they come?

Circa 1987: **880**

Circa 2000: **440**

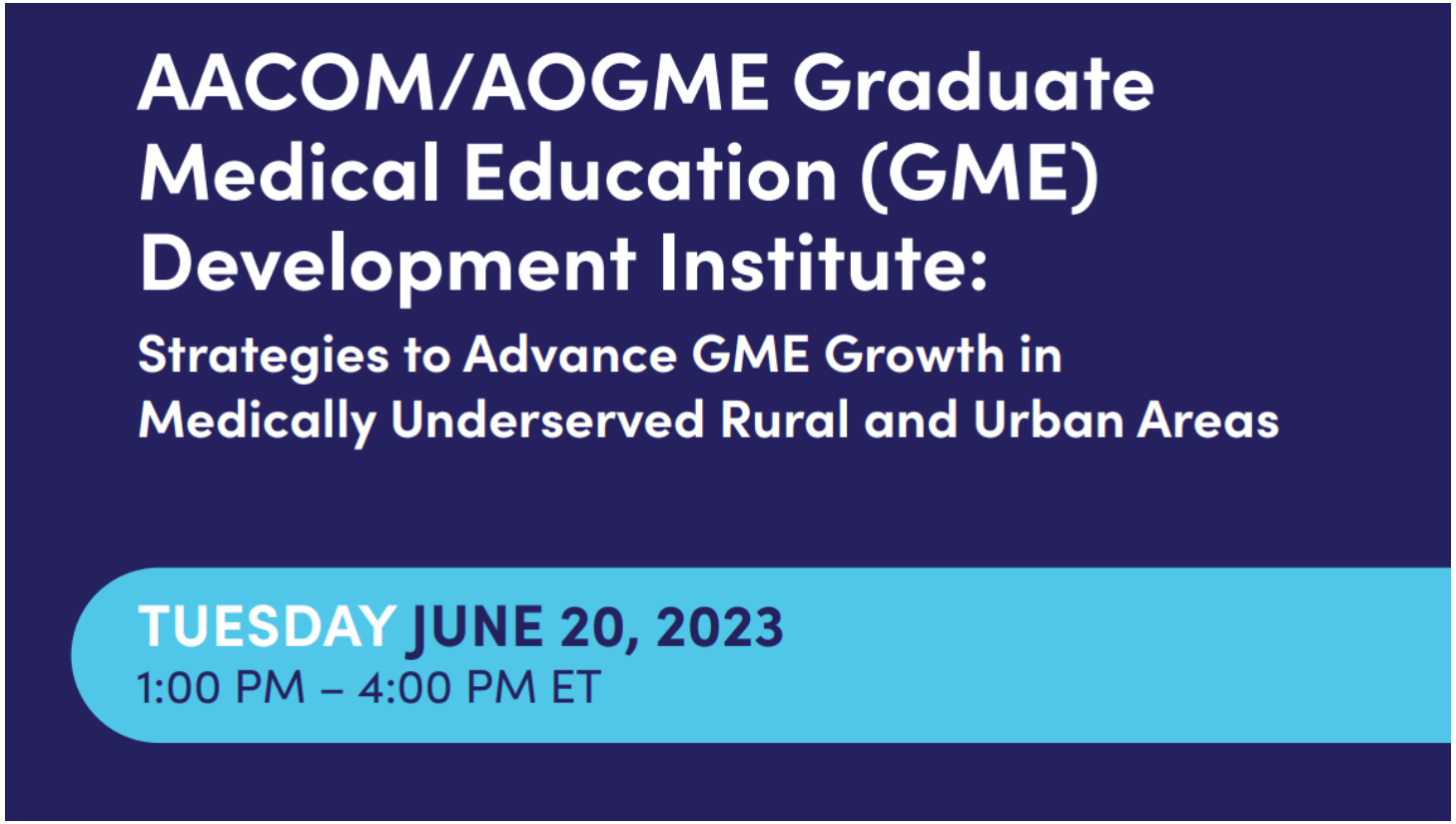
2023: **1746**

Unmatched: **100-150**

Comments, Questions?

kalilak

Consortia Models to Support GME Development and Growth



Thomas Mohr, MS DO FAOGME

Dean and Professor of Internal Medicine

Sam Houston State University College of Osteopathic Medicine

Disclosure

- The presenter has no interest or potential conflict(s) of interest in relation to this presentation.
- The content of this presentation does not relate to any product of a commercial interest. Therefore, there are no relevant financial relationships to disclose.

History of the OPTI

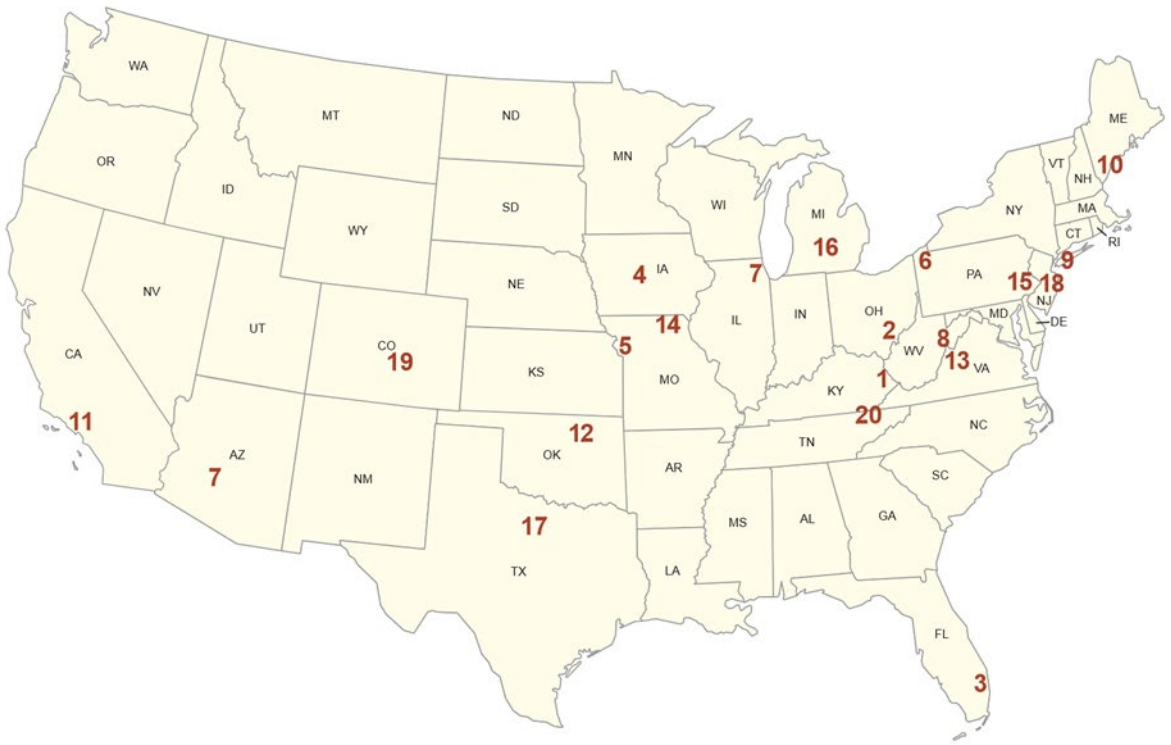
- Osteopathic Postgraduate Training Institution (OPTI)
  - AOA Established accreditation process in 1995
  - Community-based training consortium including at least one COM and at least one hospital with GME program(s)
    - Every AOA residency and all COMs had to be in an OPTI
    - Very similar to ACGME accreditation as institutional sponsor
      - Inspections, reports, standards
      - BUT – larger annual fee (over $30,000 per OPTI)

Purpose of the OPTI

By building medical education partnerships, OPTIs enhance educational quality, facilitate sharing of educational resources, provide faculty development, foster cooperative training programs, support community-based medical education, encourage clinical research, and create strong linkages among medical schools, teaching hospitals and ambulatory training facilities.

- Support for the distributive model of medical education
- Allow GME growth into smaller communities and hospitals

OPTIs Prior to the Single Accreditation System



1. Appalachian Osteopathic Postgraduate Training Institute Consortium Inc (A-OPTIC Inc), Pikeville, Kentucky
2. Centers for Osteopathic Research and Education (CORE), Athens, Ohio
3. Nova Southeastern University College of Osteopathic Medicine Consortium for Excellence in Medical Education (CEME), Fort Lauderdale, Florida
4. Health Education and Residency Training Network (HEARTland), Des Moines, Iowa
5. Kansas City University of Medicine and Biosciences College of Osteopathic Medicine Educational Consortium (KCUMB-COMEC), Missouri
6. Lake Erie Consortium for Osteopathic Medical Training (LECOMT), Erie, Pennsylvania
7. Midwestern University/OPTI (MWU/OPTI), Downers Grove, Illinois, and Glendale, Arizona
8. Mountain State OPTI (MSOPTI), Lewisburg, West Virginia
9. New York Colleges of Osteopathic Medicine Educational Consortium (NYCOMEC), Old Westbury
10. Northeast Osteopathic Medical Education Network (NEOMEN), Biddeford, Maine
11. OPTI—West Educational Consortium, Pomona, California
12. Osteopathic Medical Education Consortium of Oklahoma (OMECO), Tulsa
13. Osteopathic Medical Network of Excellence in Education (OMNEE), Blacksburg, Virginia
14. Still OPTI, Kirksville, Missouri
15. Philadelphia College of Osteopathic Medicine (PCOM) MEDNet, Pennsylvania
16. Statewide Campus System/Michigan State University College of Osteopathic Medicine (SCS/MSUCOM OPTI), East Lansing
17. Texas OPTI, Fort Worth
18. Rowan School of Osteopathic Medicine OPTI of New Jersey (RowanSOM OPTI), Stratford
19. Rocky Mountain OPTI (RM OPTI), Parker, Colorado
20. Tennessee Osteopathic Medical Education Consortium (TOMEC), Harrogate

What Happened to the OPTIs?

Some eventually disappeared as programs ended their AOA accreditation or became their own sponsoring institution.

Swedish Medical Center
Englewood, Colorado

Hospital was already Accredited

Peak Vista Community Health Centers
Colorado Springs, Colorado

Joined other OPTI as SI

Idaho Physicians Clinic/Bingham Memorial and Davis Hospital
Blackfoot, Idaho

Became its own SI then Closed

RVU/Colorado Dermatology Institute
Colorado Springs, Colorado

Program Closed

Parkview Medical Center
Pueblo, Colorado

Hospital is new ACGME SI

RVU/Sky Ridge Medical Center
Lone Tree, Colorado

Hospital is new ACGME SI

University of Wyoming
Casper, Wyoming

Was Dually Accredited

St. Mary Corwin Hospital
Pueblo, Colorado

Was Dually Accredited

University of Wyoming
Cheyenne, Wyoming

Was Dually Accredited

Some OPTI's Still Exist

- MSUCOM Statewide Campus System (ONMM Residency)
- OPTI West (10 programs)
- Midwestern University GME Consortium (10 programs)
- NYIT COM (1 FM Program)
- NOVA Southeastern COM (3 programs)
- And others…..

ACGME Newly Accredited Sponsors (22-23)

Regional Network or Consortium

Sponsor Number / Name	State
[018082] Franklin Primary Health Center	Alabama
[030173] Creighton University School of Medicine	Arizona
[030200] El Rio Health	Arizona
[050570] DOC 1 Health	California
[050517] Oroville Hospital	California
[059699] Providence St. Mary Medical Center	California
[059620] Sharp Grossmont Hospital	California
[050510] Stanford Health Care Tri-Valley	California
[070092] Denver Community Health Services, Inc.	Colorado
[119598] HCA Florida Orange Park Hospital	Florida
[110541] Jessie Trice Community Health System, Inc.	Florida
[120169] CareConnect Health Inc.	Georgia
[160044] Roseland Community Hospital	Illinois
[179578] Marion Health	Indiana
[208067] Lake Cumberland Regional Hospital	Kentucky
[200077] Lewis County Primary Care Center, Inc	Kentucky

Sponsor Number / Name	State
[210063] DePaul Community Health Centers - New Orleans	Louisiana
[218092] North Oaks Medical Center, LLC	Louisiana
[218038] Ochsner Lafayette General Medical Center	Louisiana
[230054] CCI Health Services	Maryland
[240044] Mass General Brigham	Massachusetts
[320017] White Mountains Medical Education Consortium, Inc	New Hampshire
[349999] Covenant Health Hobbs Hospital	New Mexico
[358181] Community Healthcare Network	New York
[350245] Syracuse Community Health Center, Inc.	New York
[389999] Dermatologists of Central States (DOCS)	Ohio
[380234] Mercy Health - Lorain Hospital	Ohio
[389587] Mercy Health Fairfield Hospital	Ohio
[410190] Butler Memorial Hospital	Pennsylvania
[410133] Corry Memorial Hospital	Pennsylvania
[410261] Delaware Valley Community Health, Inc.	Pennsylvania

Sponsor Number / Name	State
[428066] Ashford Hospital	Puerto Rico
[450082] Medical University of South Carolina Regional Network	South Carolina
[479525] Christ Community Health Services	Tennessee
[470116] Methodist Medical Center of Oak Ridge	Tennessee
[480689] Prime South GME Consortium	Texas
[480526] Project Vida Health Center	Texas
[480601] Rio Grande Valley Graduate Medical Education Consortium	Texas
[480609] South Texas Health System GME Consortium	Texas
[518037] Augusta Health, Inc	Virginia
[569518] Sixteenth Street Community Health Center	Wisconsin

ACGME Newly Accredited Sponsors (22-23)

Community Health Centers or FQHCs

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Only about 50% are traditional hospitals and medical centers!

Why the change from hospital to CHCs?

- Many hospitals are capped for CMS federal funding
  - May have already started their own residency programs in the past
  - May want to focus on higher revenue generating residencies
- Community Health Centers may be eligible for HRSA funding
  - Already have infrastructure and focus for outpatient primary care
  - Hospitals need to CHCs for outpatient care and uncompensated care
  - Many CHCs have multiple locations and plenty of patients
  - Desperate need for physician providers

Challenges of Starting GME at CHCs

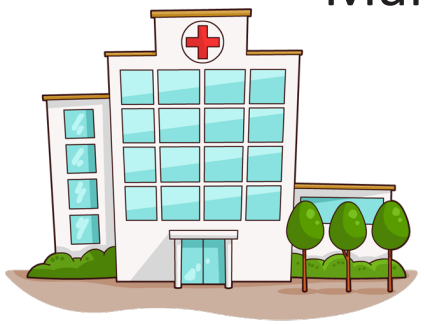
- Lack of educational infrastructure in place
  - DIO, office staff, accreditation, facilities, library, software
- Lack of educational/curricular expertise
  - Experienced educators, curriculum design, well-being, patient safety, etc.
- Lack of resources for start-up and operational expenses
  - Consultants, Pro-formas, capital expenditures, grants management
- Difficulty supervising research or quality improvement projects
- Required in-patient rotations at partner hospital

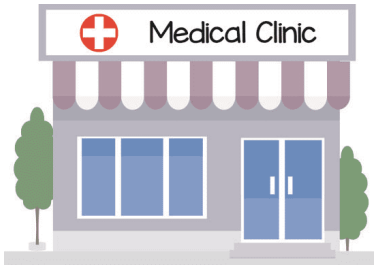
GME Consortium Model

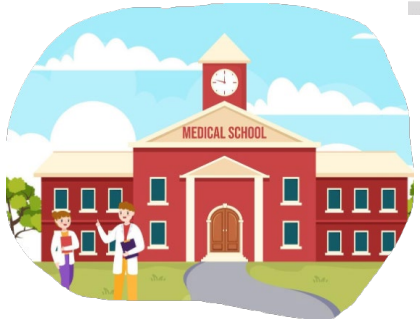
- The “Neo-OPTI”
  - Multiple clinical partners under the sponsorship of the consortium
  - Ideally at least one medical school, hospital, and community health center
  - The consortium provides infrastructure and expertise
    - Allows the site to focus on patient care and hands-on training

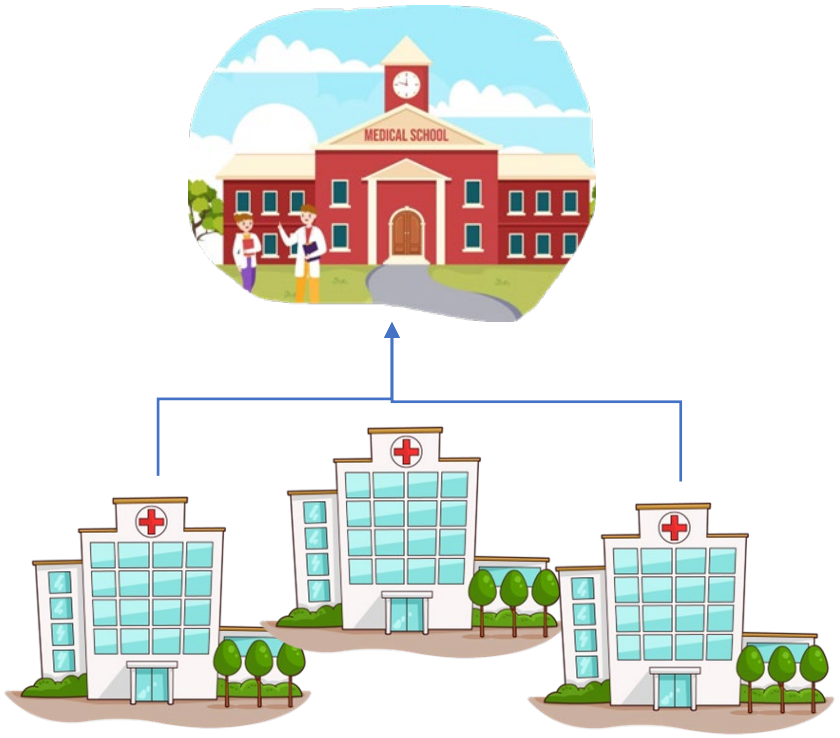
Many options to design the perfect fit

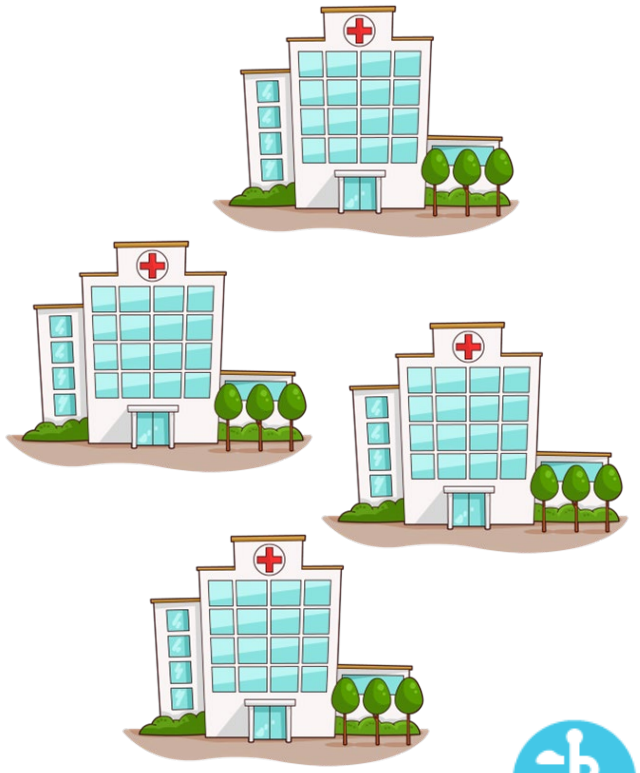
- “Seen one consortium, you’ve seen one consortium”
  - Many ways to set up a consortium











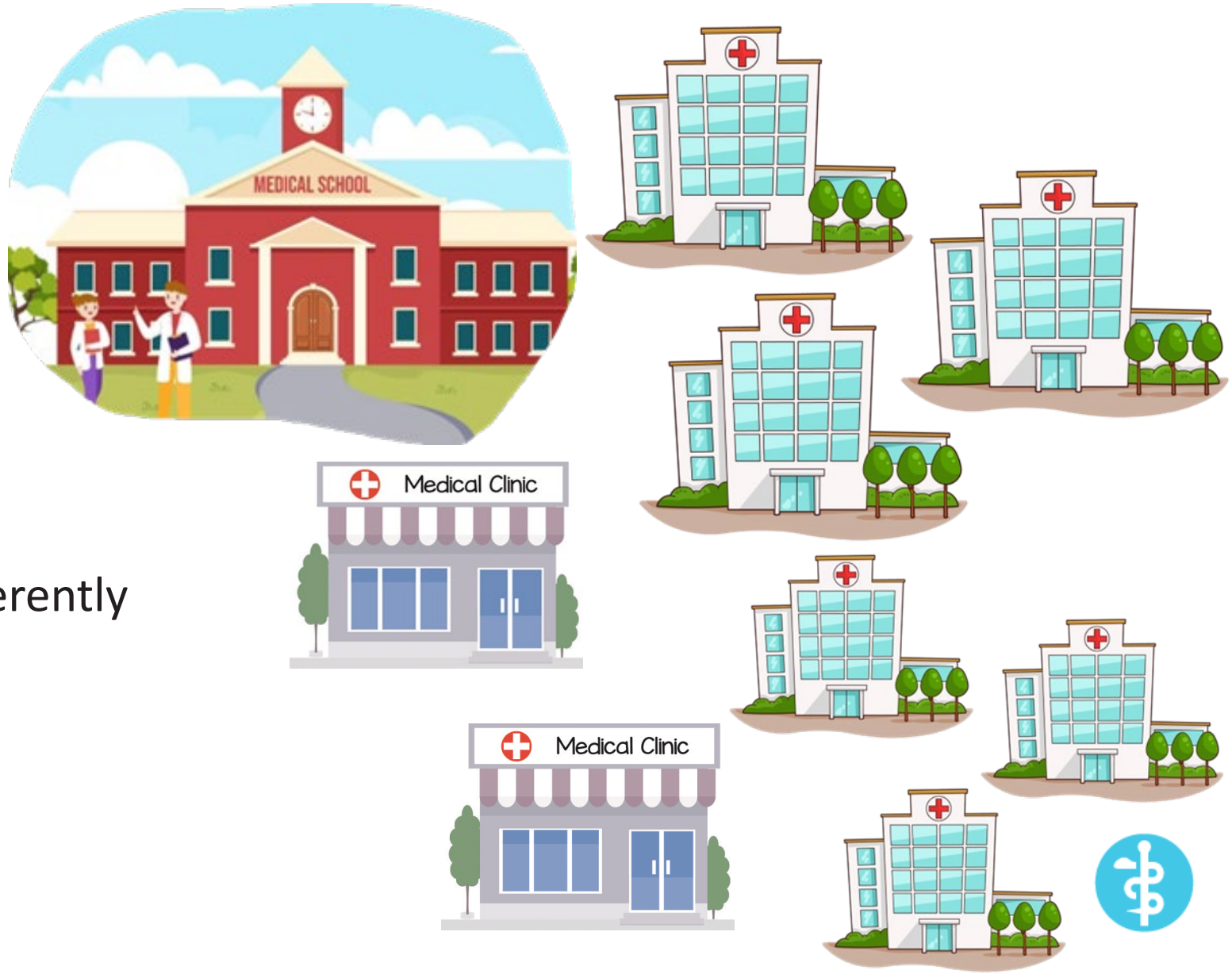
UNIVERSITY OF THE INCARNATE WORD
SCHOOL *of* OSTEOPATHIC MEDICINE

Texas Institute for Graduate Medical Education and Research

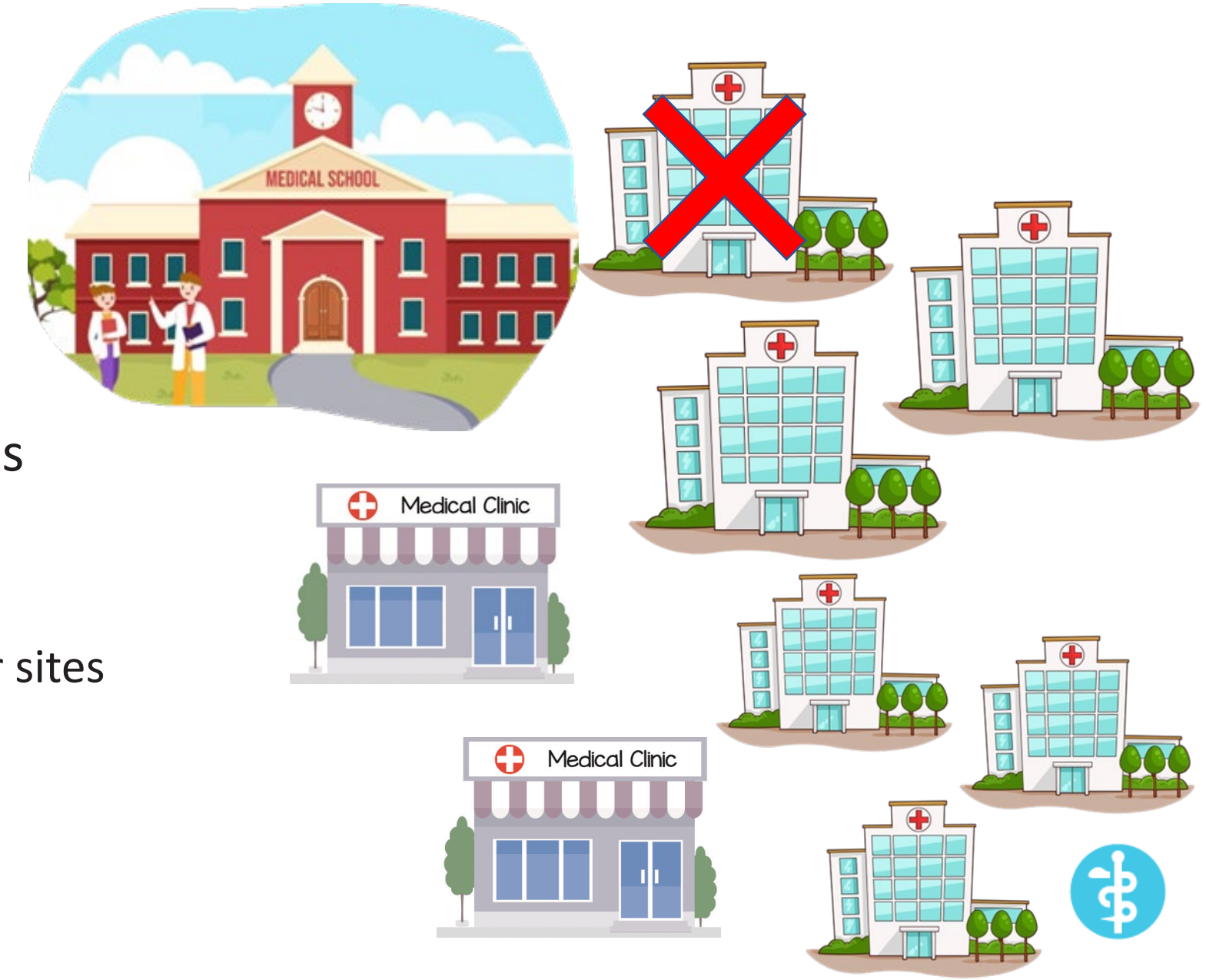
- Established by UIWSOM in 2015 as 501(c)3 nonprofit
- UIW is sole corporate member of the Board
- UIW manages financial accounts
- ACGME Initial Accreditation as Institutional Sponsor

TIGMER Model

- 1 COM
- 2 FQHCs
- 3 major hospital sites
- 3 minor hospital sites
- 7 Residency Programs
  - Each program funded differently
  - State, federal, VACAA, philanthropy funding



TIGMER Model



- Options to share resources
- Nightmare scenario
  - Hospital closes
  - May be able to utilize other sites

Sam Houston State University COM

- SHSU-COM accredited as ACGME Institutional Sponsor
  - Planned 4/4/4 FM program at Rural Health Center in Huntsville, Texas
  - Perfect for HRSA grant funding, BUT:
    - Medical Schools and Hospitals are NOT eligible
    - Must be FQHC, RHC, or CMHC
    - Or a GME consortium
  - COM wrote grant, RHC submitted grant
    - Funded for $5.7M over 4 years
    - RHC then contracted with COM to manage grant and run the program

Sam Houston Regional Education Consortium (SHREC)

- Plan to apply for 2 additional HRSA grants for rural primary care programs next cycle, so developing consortium in advance
  - HRSA requires a ‘legally binding agreement’
  - Does not need to be a 501c3
    - But this can provide benefits, especially if COM or hospital is ‘for-profit’
  - Setting up a ‘Consortium Agreement’ between COM and each member
    - Agreement to allow SHREC to serve as the accredited sponsoring institution
    - To submit for grants and to manage the grants for the programs
    - Defines representation on a Board and the GMEC
    - Financial details are left for a separate agreement
  - Then request transfer of Huntsville program from SHSU-COM to SHREC

Summary

- Benefits
  - Shared resources and expertise
  - Eligibility for THCGME grants
  - Links the COM to the programs
  - Supports rural and community-based programs
  - Fits the mold of osteopathic clinical education and the mission of many COMs in the nation.
  - Provides an opportunity to improve access in places with great need
- Concerns
  - Members can always leave
  - Have to balance competition
  - May have difficulty with traditional CMS payment structure
  - Requires multiple agreements
  - Greater responsibility on the COM for resources, finances, faculty, and expertise

Questions?


HUNTSVILLE


SAM HOUSTON STATE UNIVERSITY
COLLEGE OF OSTEOPATHIC MEDICINE