

The Social and Economic Impact of GME

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WIPFLI^{LLP}
CPAs and Consultants
HEALTH CARE PRACTICE

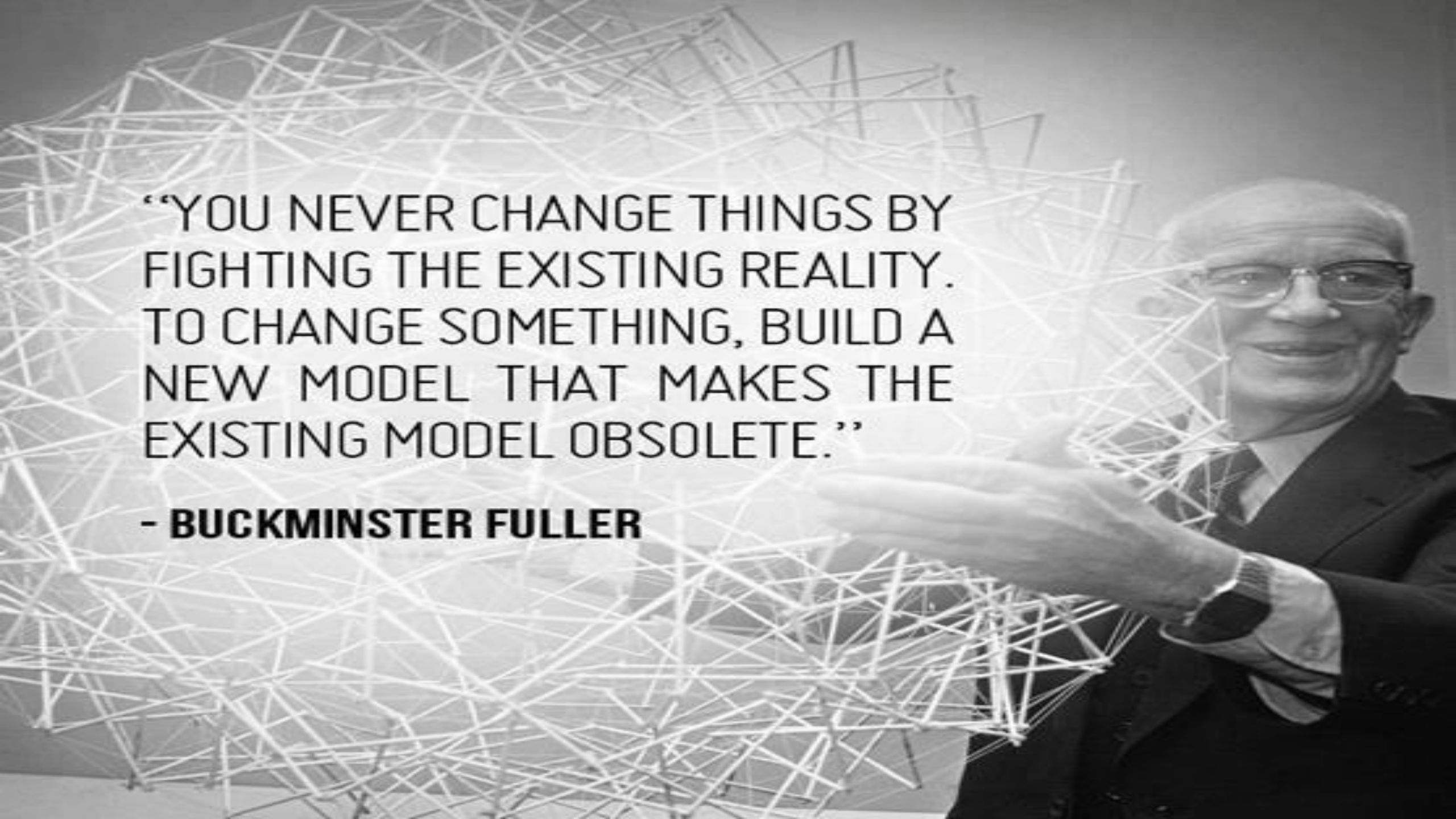


Disclosures

I have nothing to disclose

Objectives for today:

1. Understand how GME is one component of a bigger picture that FQHCs need to help drive through collaborations with local, regional and state entities.
2. Develop a roadmap to facilitate your state in developing it's business plan
3. Understand where workforce and Graduate Medical Education fits in this broader view of state based approaches, fiscal accountability, and population health.



“YOU NEVER CHANGE THINGS BY
FIGHTING THE EXISTING REALITY.
TO CHANGE SOMETHING, BUILD A
NEW MODEL THAT MAKES THE
EXISTING MODEL OBSOLETE.”

- **BUCKMINSTER FULLER**

GME – The Existing Reality



Let's Become Obsolete

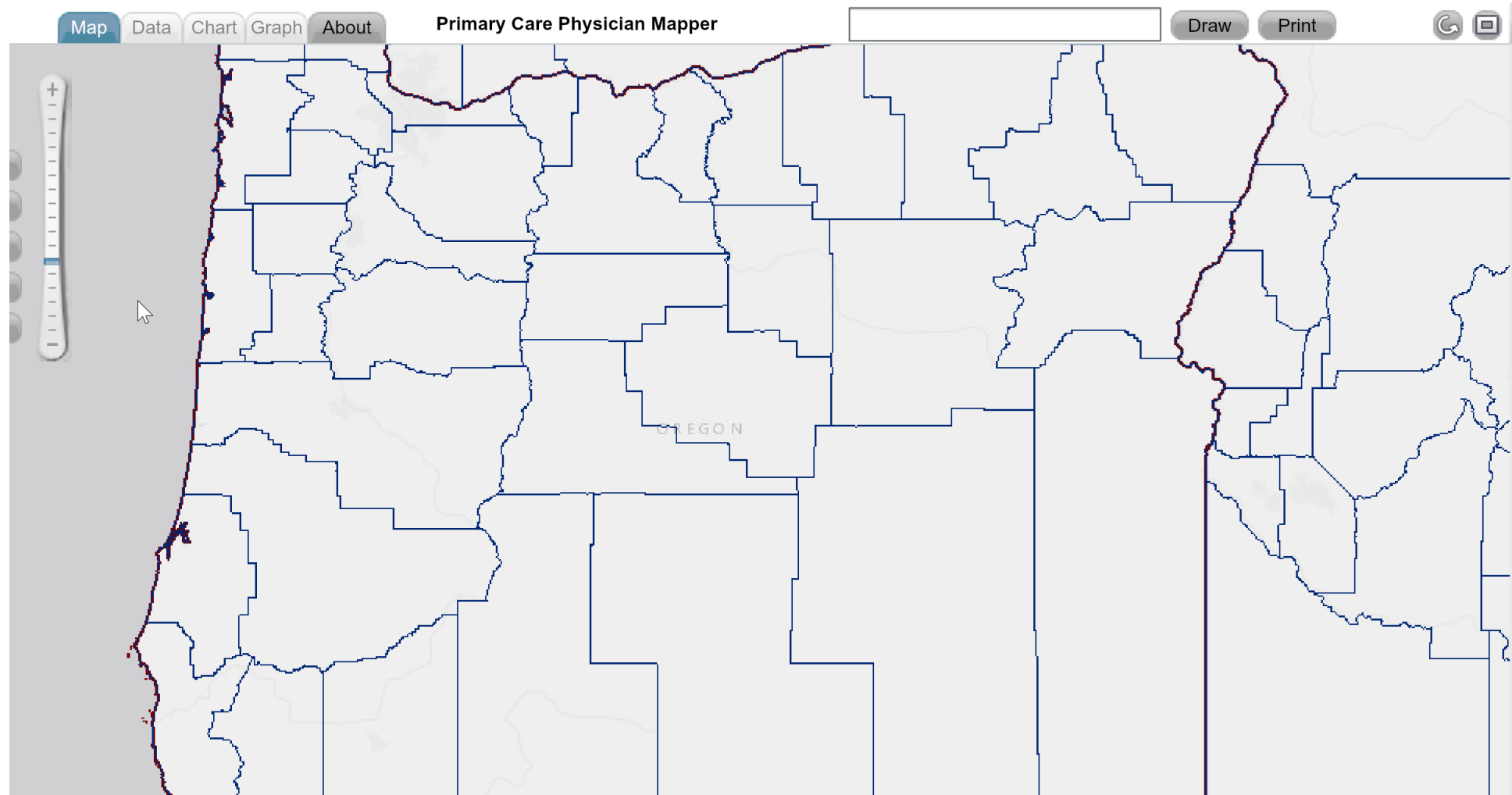


What is the PROBLEM we are trying to solve??????

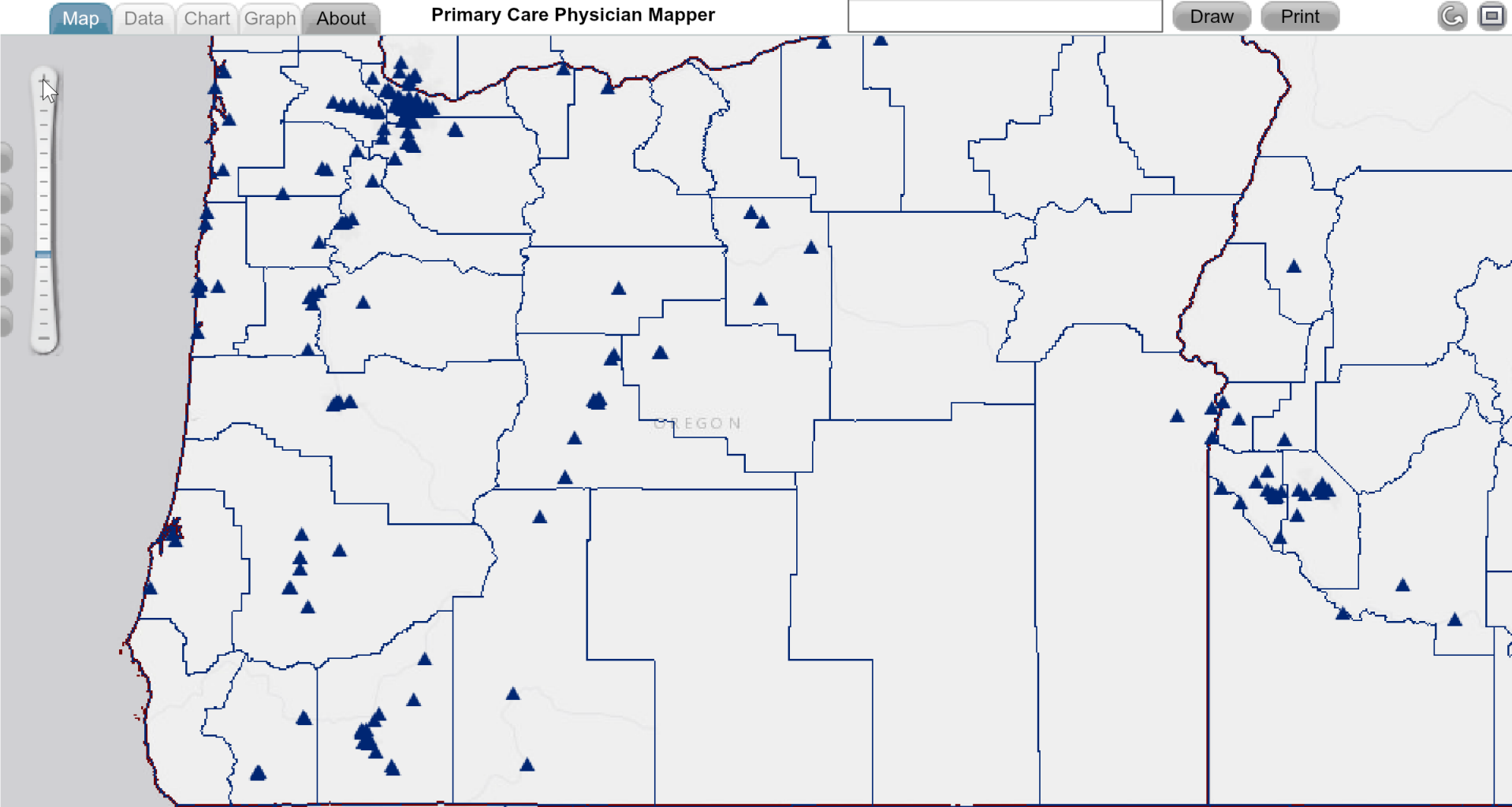
- Workforce shortage?
- Or turn it upside down?
- And develop ***business plans*** to address the issues?



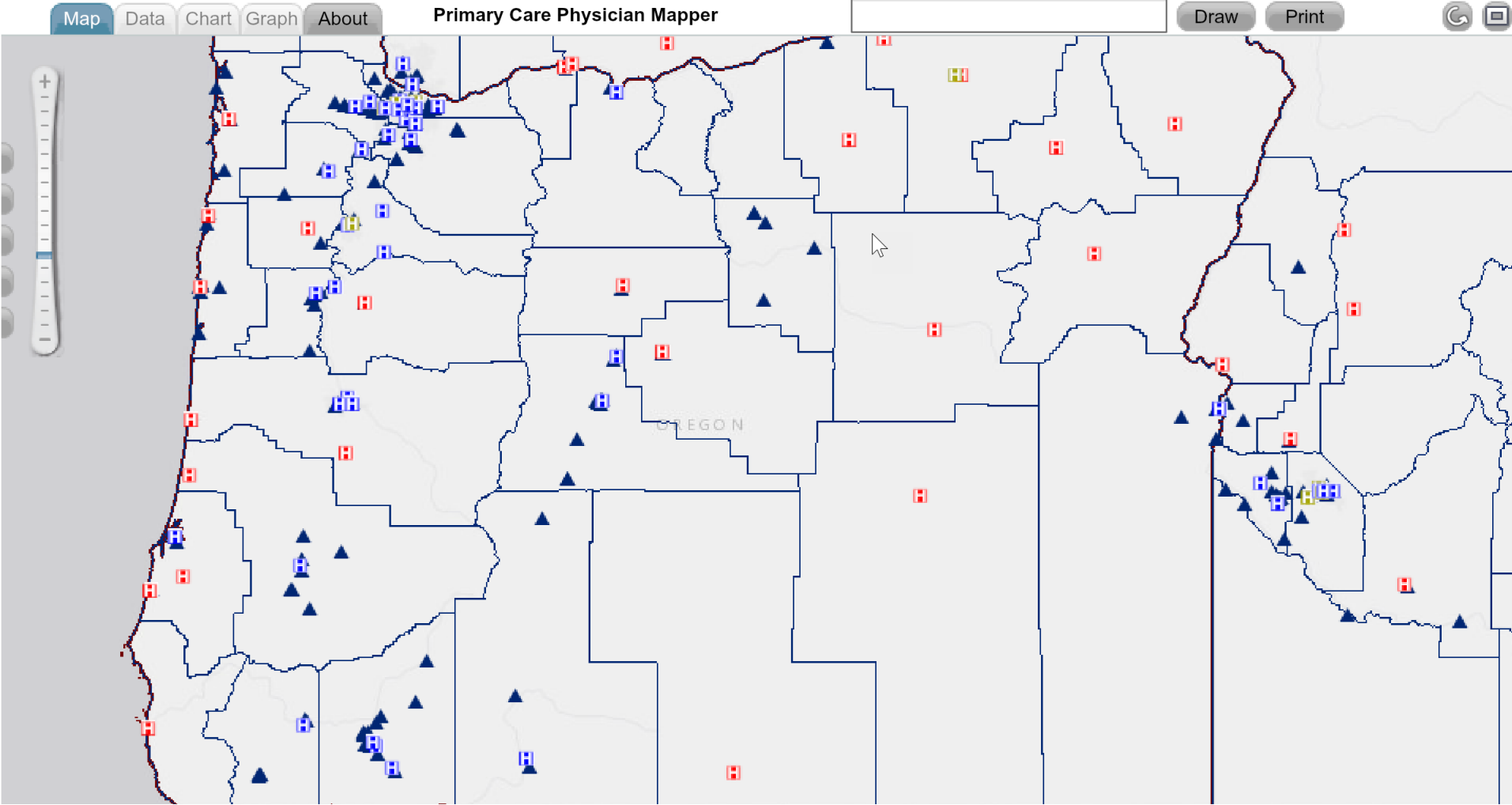
Let's Play....The State of Oregon



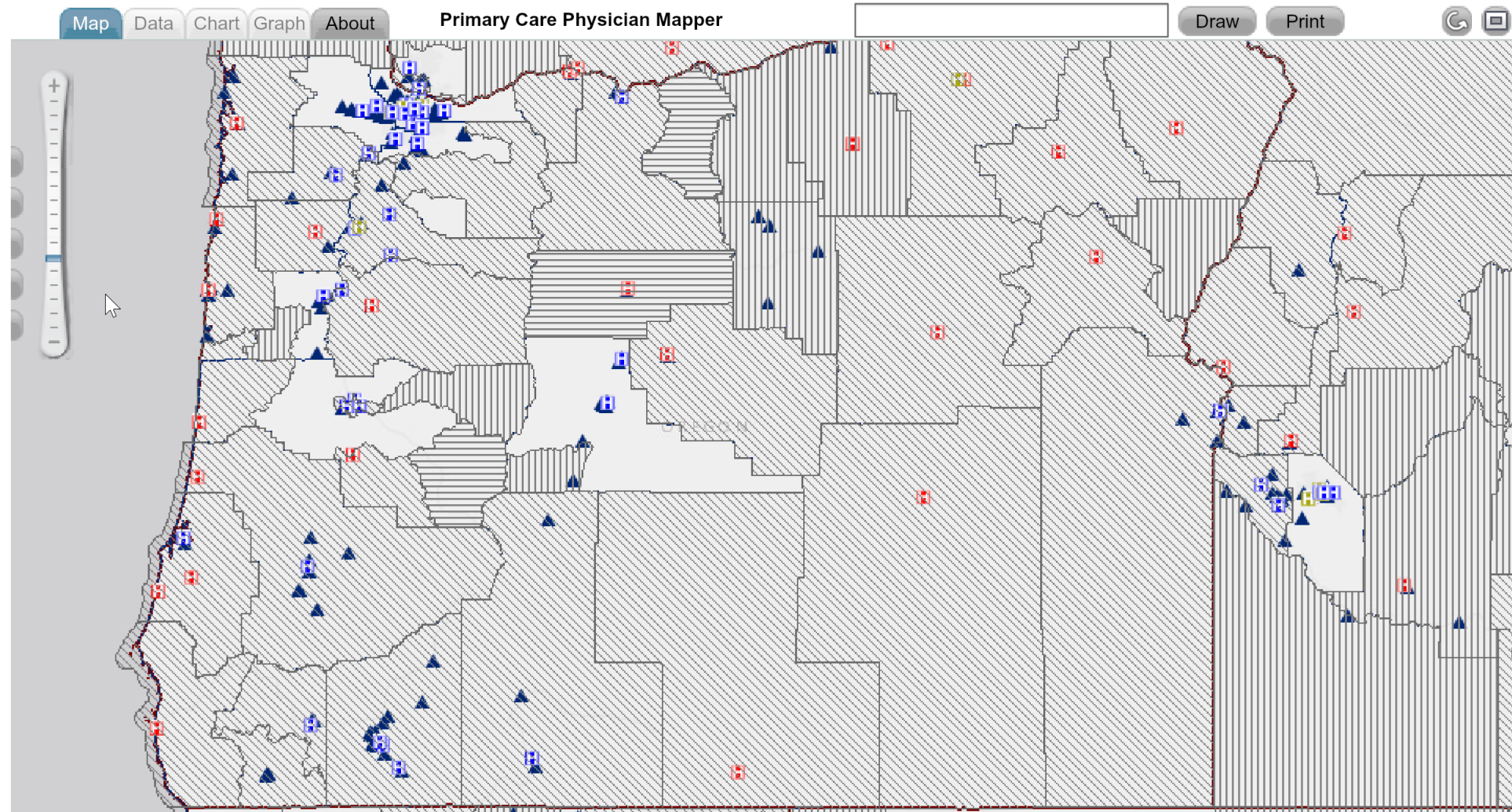
FQHC Distribution



Now add hospitals.....



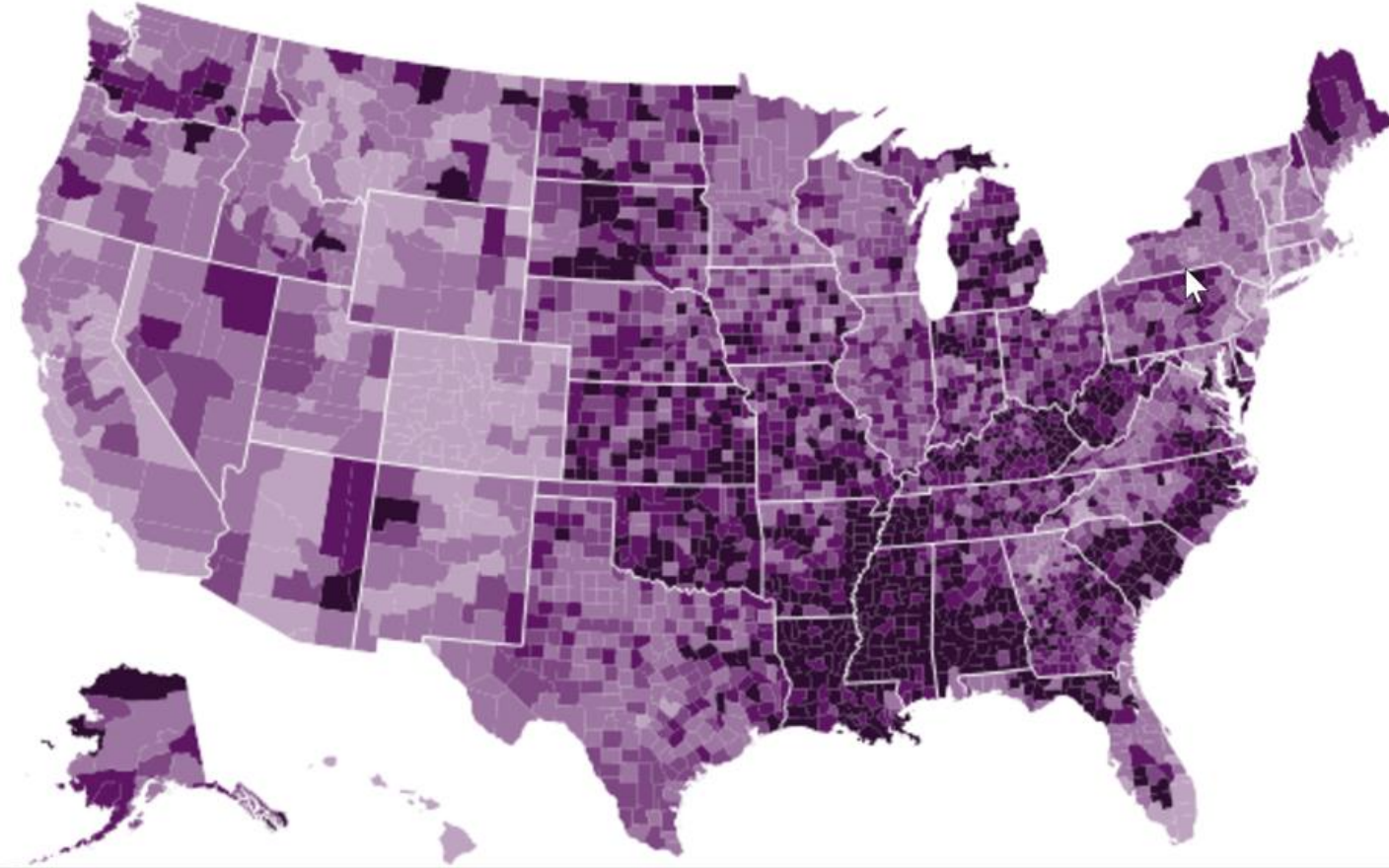
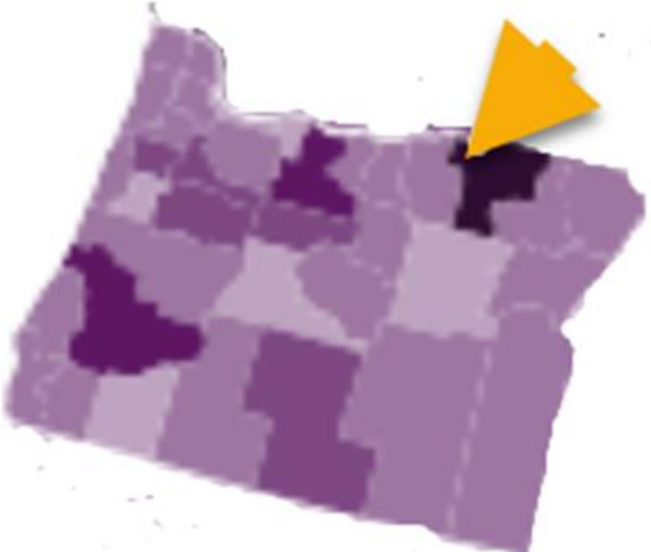
And HPSAs



Lots of pretty pictures.....but what is it telling us???

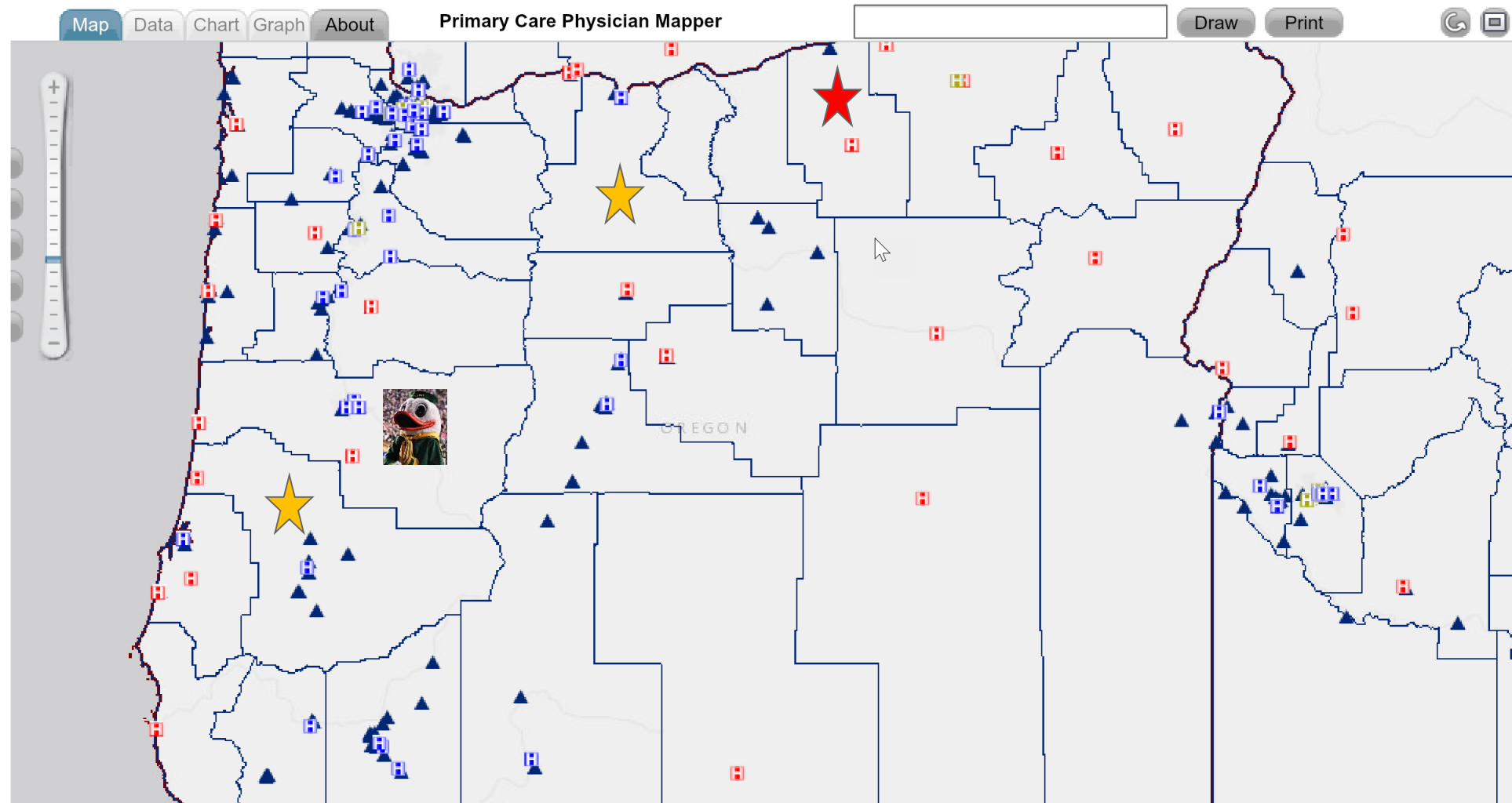
Now let's look at some health data

Percent of adults that report a BMI ≥ 30



More pretty pictures.....but what is it telling us???

And is it statistically significant anyway?

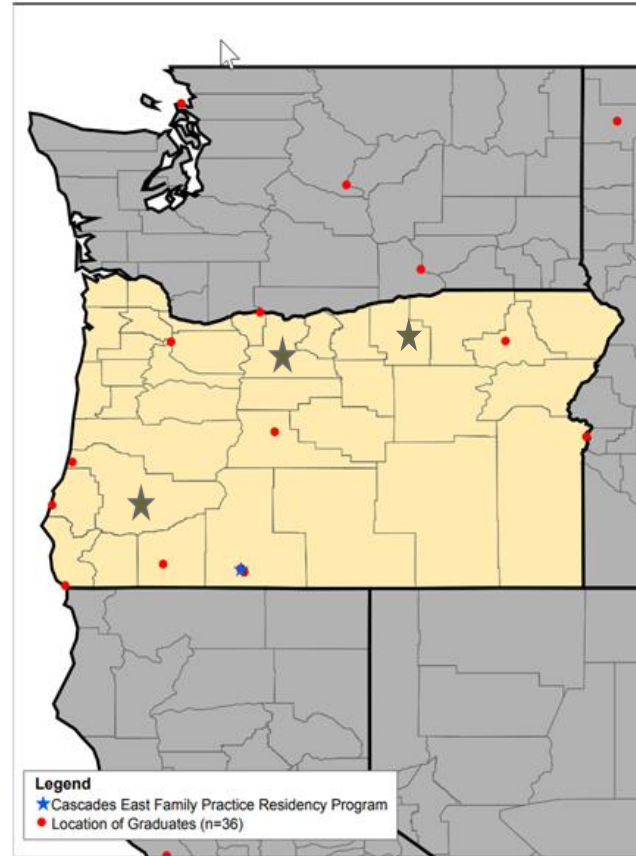


What if we add residency program data?

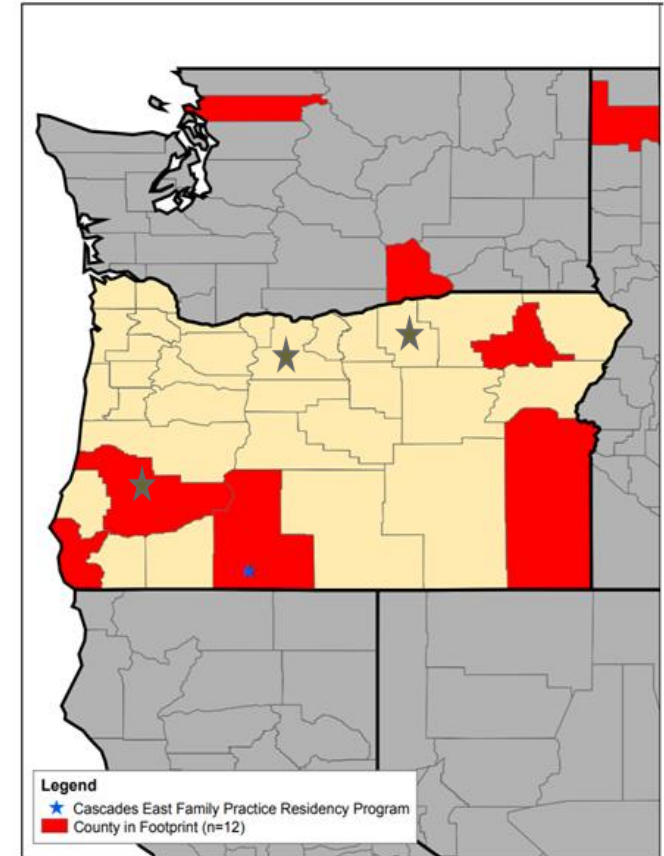
Warning....This data is OLD

CASCADES EAST FAMILY PRACTICE RESIDENCY PROGRAM FACT SHEET

Practice Locations



Footprint



PROVIDENCE MILWAUKIE HOSPITAL FAMILY PRACTICE RESIDENCY PROGRAM FACT SHEET

Practice Locations

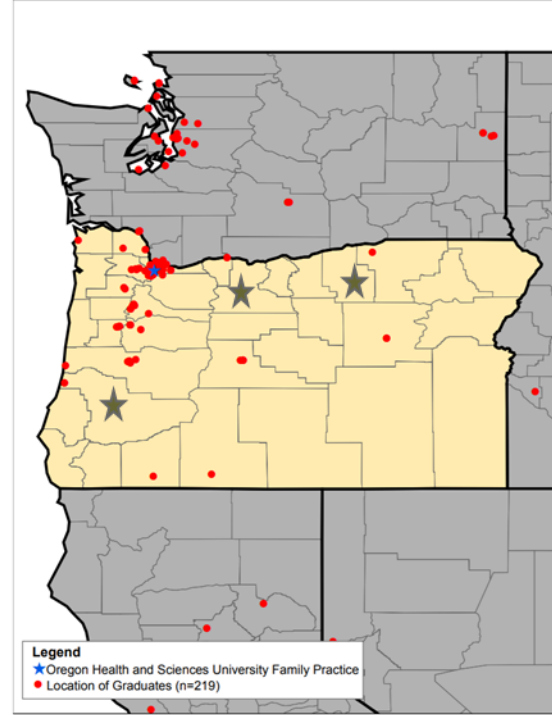


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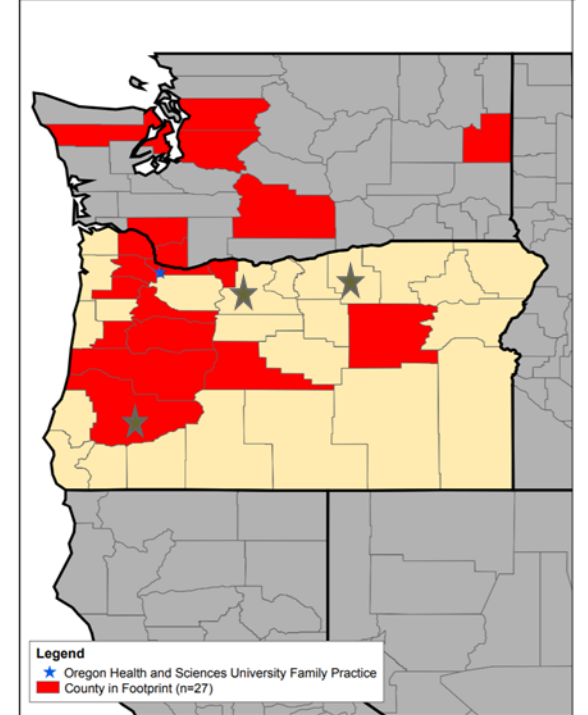


OHSU Family Medicine Residency Program

Practice Locations



Footprint



We start to see a story emerge.....

- A story that isn't "But I want a residency program because we need doctors"
- A story that doesn't proliferate too many of the wrong kinds of doctors in the wrong communities
- But instead a story of "we have certain health issues in the following regions of our state, so what can we do with growing our physician workforce to address those issues?"
- And remember.....
 - Some of the data is old
 - None of the analysis has been done in such a way that it is not statistically significant
 - This is solely being done to provide a fictional example of what we can do to turn things upside down.

So the story continues.....

- The State of Oregon develops a GME Consortium Strategy
- And it sees it's work as critical to achieving the "Triple Aim"....or what we now refer to as the "Quadruple Aim"
- Which is right in line with the conversation on the role of states and Accountability in GME

ACGME NEWS AND VIEWS

States Can Transform Their Health Care Workforce

PAUL H. ROCKEY, MD, MPH
RICHARD E. RIESELBACH, MD, MACP
KATHERINE NEUHAUSEN, MD, MPH
THOMAS J. NASCA, MD, MACP
ROBERT L. PHILLIPS, MD, MSPH
DAVID N. SUNDWALL, MD
INGRID PHILIBERT, PHD, MBA
NICHOLAS A. YAGHMOUR, MPP

Abstract

The United States faces the simultaneous challenges of improving health care access and balancing the specialty and geographic distribution of physicians. A 2014 Institute of Medicine report recommended significant changes in Medicare graduate medical education (GME) funding, to incentivize innovation and increase accountability for meeting national physician workforce needs. Annually, nearly \$4 billion of Medicaid funds support GME, with limited accountability for

outcomes. Directing these funds toward states' greatest health care workforce needs could address health care access and physician maldistribution issues and make the funding for resident education more accountable. Under the proposed approach, states would use Medicaid funds, in conjunction with Medicare GME funds, to expand existing GME programs and establish new primary care and specialty programs that focus on their population's unmet health care needs.


“Enhancing patient experience, improving population health, and reducing costs”and now improving the worklife of providers

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From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD¹ and Christine Sinsky, MD^{2,3}

 Author Affiliations

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Abstract

The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely accepted as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.

So states have a role and we need GME accountability

- States role
 - Not just funding!
 - Partner
 - ~ In securing funding
 - ~ In securing and analyzing data
 - ~ In identifying and monetizing priorities
 - ~ In making the model obsolete
 - GME Accountability
 - ~ National Conversation
 - ~ Cost, quality and outcomes!!!!
 - ~ We can't do it
 - It's too hard
 - We don't have the data
- No longer an option!!!!

Which leads us to developing a business plan

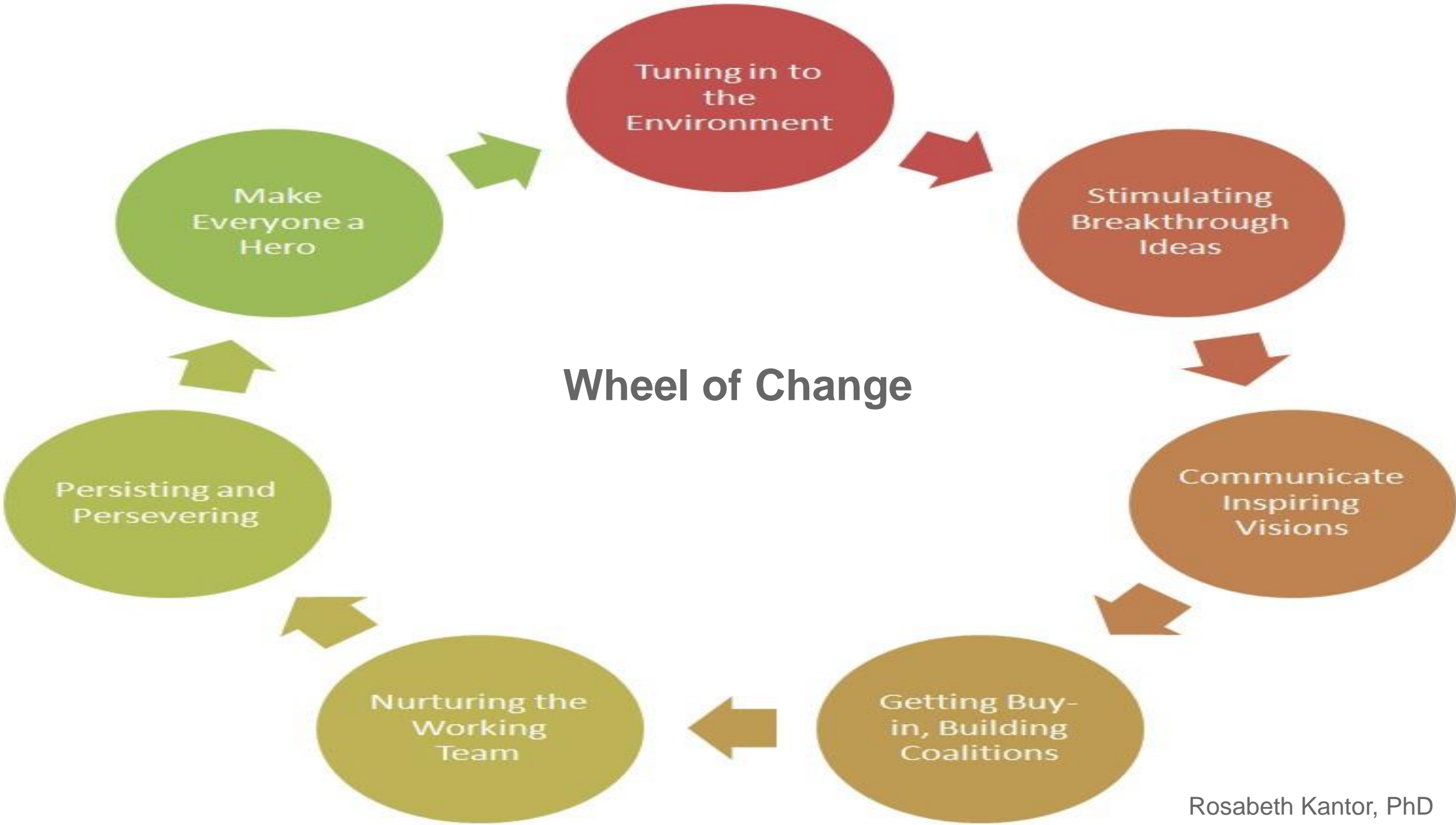
This is where YOU get into action!!!

And FQHCs have the ability, relationships and history to be the facilitators and drivers of this work.

What's in a business plan???

- VC and Angels
- ROI, ROI and ROI
- **The TEAM** – that's key to their investment
- **The Business Model**
 - ~ Objectives
- **Financing Requirements**
 - ~ Exit Strategy / ROI
- **Market Opportunity**
 - ~ Market Size
 - ~ Customer Requirements
- **Purpose**
 - ~ Mission / Vision
 - ~ Objectives / Goals
 - ~ Values
- **Strategy**
 - ~ Revenue Model / Revenue Sources
 - ~ Purchase Options
 - ~ Sales Channels
 - ~ **Strategic Alliances**

Wheel of Change



Approach

- COLLABORATION
 - PCA, Hospital Association, Medical Associations, and any other entity that has a dog in the fight
- Data of “what’s so”
- Early, tangible, and relevant successes
- 1115 waivers and state plan amendments....while we can
- Other creative state solutions
- Pre/Post economic impact study
- Pre/Post population health and cost data

Together, as PARTNERS, write a business plan that a VC would fund

- Who are the partners? How can the VC be SURE that this will not fall apart?
 - ~ Trust
 - ~ Defined roles and responsibilities
 - ~ In the for profit world, we define “ownership”. Each entity must have something big at risk and it must be delineated in the legal agreements.
- What are your objectives and SMART goals?
- What will you achieve, by quarter?
- Who is your market and how will you reach them? Quarter by quarter.
- What is your business model? And will a residency program be part of it?
- Who are you accountable to? And more importantly, what happens if you miss a quarterly goal?

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 - ~ Sales Channels
 - ~ Strategic Alliances

ROI

- Economic Impact commitments
- Quality commitments
- Health outcome commitments
- Retention commitments
- Cost of care commitments

Playing with economic impact



Sample GME

You have a funding total of \$ 600,000 and have entered \$ 600,000 in spending.

This scenario was created: 10/18/2017

Economic Impact Report

<i>Total economic impact</i>	\$ 816,000
<i>Ratio of economic impact to total spending</i>	1.36

** Ratios show the dollars returned to a community per dollar invested.*

The assumptions

Project Information

Organization	Test org	
Purpose	Economic Impact of New Family Medicine Program	
Year of Project	2019	
State Served	California	
Area served	Part of State, Using Standard Multipliers	
Population served	180,883	
Grant type	Other	
Funding	HRSA	\$ 0
	Other Sources	\$ 600,000
	Total	\$ 600,000
Total spending	\$ 600,000	

Back to Oregon.....

Highlights: Oregon's Projected Primary Care Physician Demand

Additional PCPs Required by 2030

1,174

Or, **38%** of current workforce, due to an aging, growing and increasingly insured population.

Current Primary Care
Physician Workforce

3,027

The state's PCP ratio
of 1254:1 is lower
than the national
average of 1463:1.

Potential Solutions –

Bolster the Primary Care Pipeline

- ❖ Physician reimbursement reform
- ❖ Dedicated funding for primary care Graduate Medical Education (GME)
- ❖ Increased funding for primary care training (Title VII, Section 747)
- ❖ Medical school student debt relief

Once 1,174 providers were created, conservatively there would be an annual \$957,984,000.00 economic impact. That should look good in any business plan.

But there's more!

Original Investigation


Spending Patterns in Region of Residency Training and Subsequent Expenditures for Care Provided by Practicing Physicians for Medicare Beneficiaries

Candice Chen, MD, MPH; Stephen Petterson, PhD; Robert Phillips, MD, MSPH;
Andrew Bazemore, MD, MPH; Fitzhugh Mullan, MD

IMPORTANCE Graduate medical education training may imprint young physicians with skills and experiences, but few studies have evaluated imprinting on physician spending patterns.

OBJECTIVE To examine the relationship between spending patterns in the region of a physician's graduate medical education training and subsequent mean Medicare spending per beneficiary.

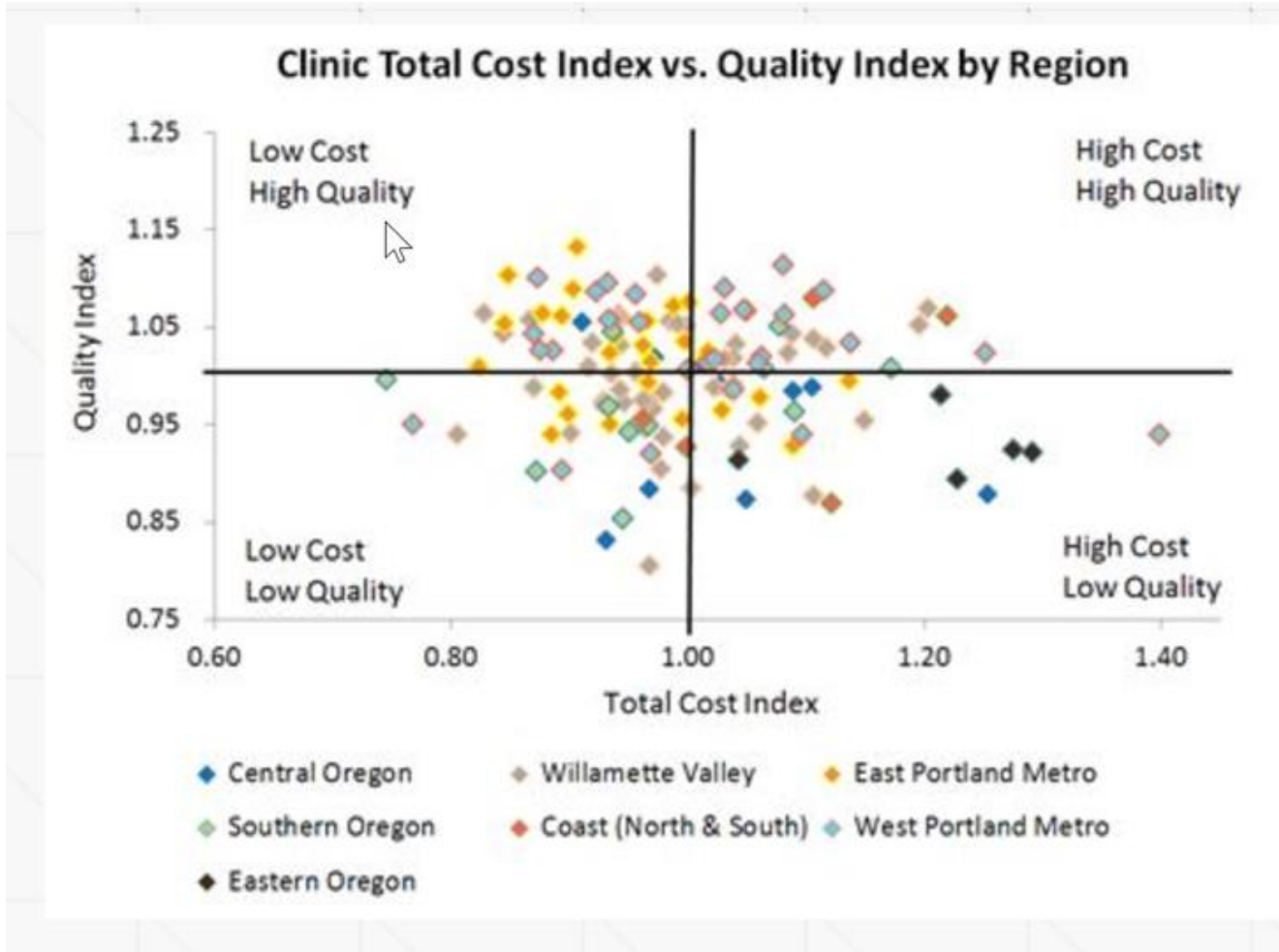
DESIGN, SETTING, AND PARTICIPANTS Secondary multilevel multivariable analysis of 2011 Medicare claims data (Part A hospital and Part B physician) for a random, nationally representative sample of family medicine and internal medicine physicians completing residency between 1992 and 2010 with Medicare patient panels of 40 or more patients (2851

 [Supplem
jama.com](#)

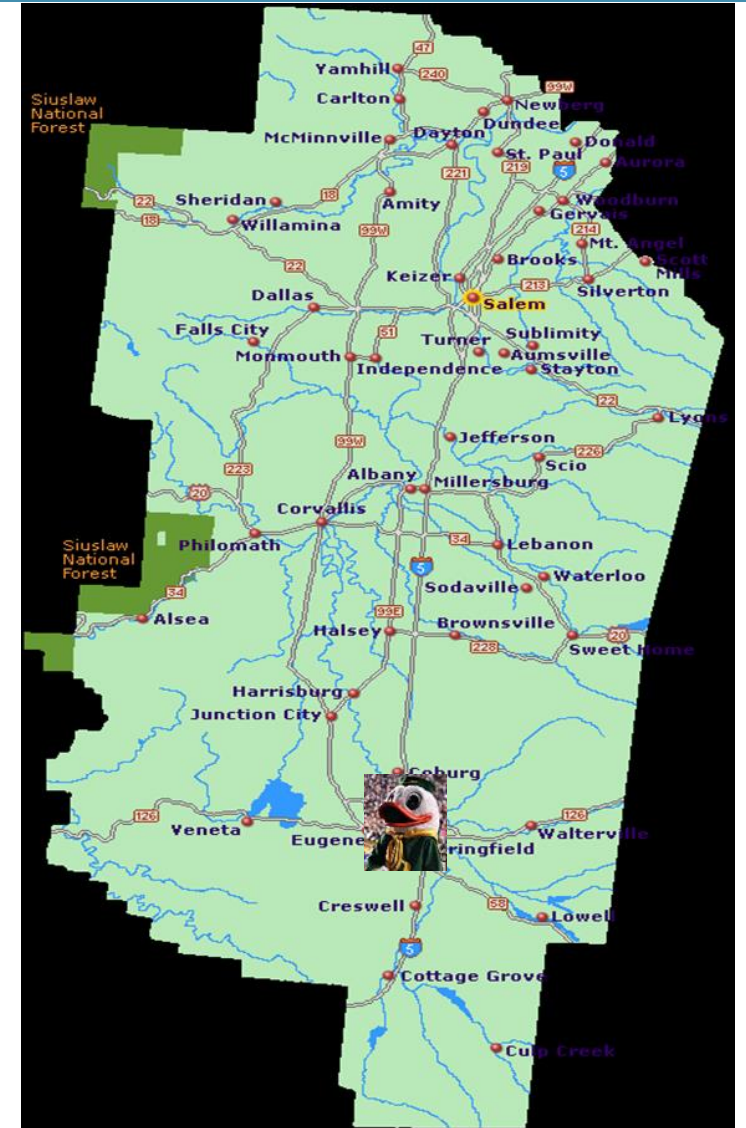
What if.....

- Since physicians who are trained in “high spending regions” have a mean spending per beneficiary per year \$1,926 higher than those trained in low-spending regions (Chen, C. et al, 2014)
- What if states were to prioritize GME funding that is obtained through 1115 waivers, state plan amendments, general fund dollars, philanthropy, or other sources to programs in areas that are in low cost, high quality regions? Or reward those residency programs with lower cost of care but high quality by providing increased training dollars?

In Oregon.....



<http://q-corp.org/our-work/costofcare>



But there is no Family Medicine residency program there.

Imagine what the ROI statement might look like in the Executive Summary.

“By the end of the 5th year of funding, we will achieve \$_____ in positive economic impact, the health outcomes of ___ and ___ will each be improved by ___% in X community, the quality metrics of ____, ____, and ____ will improve by ____, we will add to our Family Medicine physician workforce by training and retaining ___ Family Physicians, and our regional cost of care will decrease by ____%. Our funding will be evaluated quarterly with increases based on achieving specific cost, quality, financial, population health workforce, and community partnership metrics, as mutually defined in Section __”.

Business Plan "Exit Strategy": There never needs to be one

- Family Medicine – Community Medicine and Health Services Management Required Rotations
- Also have elective tracks



MAPS, DATA & TOOLS
Interactive Maps
Maps
Data Tables
Tools
Community Oriented Primary Care (COPC) Curriculum
Population Health Curriculum

Population Health Curriculum

Purpose

The Robert Graham Center, HealthLandscape, American Board of Family Medicine, and Community Health Center, Inc. collaborated to develop this curriculum aimed to introduce health care professionals to population health concepts and tools. Resources include slides and note sets, three case studies with sample data, and a performance improvement activity.

Funding

This project was funded by the Health Resources and Services Administration. The work was guided by an advisory committee composed of providers, policy makers, and researchers with experience in state and national public health funding, population health education, rural practice, and public health research.

Additional Information

Population Health Curriculum

Activities and Modules

- [Module 1 - Introduction to Population Health](#) (54 page PPTX): This module introduces population health terms, concepts, and resources. Contains 51 slides.
- [Module 2 - Geographic and Data Concepts Important for Population Health](#) (38 page PPTX): This module describes key geospatial terms and concepts that will be referenced in the case studies. Contains 37 slides.
- [Case Study 1 - Exploring Community](#) (13 page PDF): This case study introduces the user to online mapping tools. The user also makes observations about the community served by his/her clinic.
- [Case Study 2 - Mapping Clinical Data and Linking to Community Resources](#) (10 page PDF): This case study reviews the tasks of mapping clinical data and connecting patients to community resources. A [file](#) (41 KB XLSX) with synthetic data is included.
- [Case Study 3 - Engaging Community](#) (9 page PDF): This case study follows a real-world community partnership and reviews how population health tools can be used to inform community-level interventions. Prior to completing this case study, the user should read the [pre-reading document](#) (7 page PDF). A [file](#) (10 KB XLSX) with synthetic data is also included.

Performance Improvement Activity

- [Population Health Performance Improvement Activity](#) (7 page PDF): This performance improvement activity (PIA) walks the user through a quality improvement activity that connects pre-diabetics with community [Diabetes Prevention Programs](#) (453 KB XLSX). The document describes activities for both practicing and non-practicing physicians. A [sample spreadsheet](#) (10 KB XLSX) for generating lists of prediabetics is also included.

Are you ready to make the model obsolete?

Who is ready to give this a try?

Questions?

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