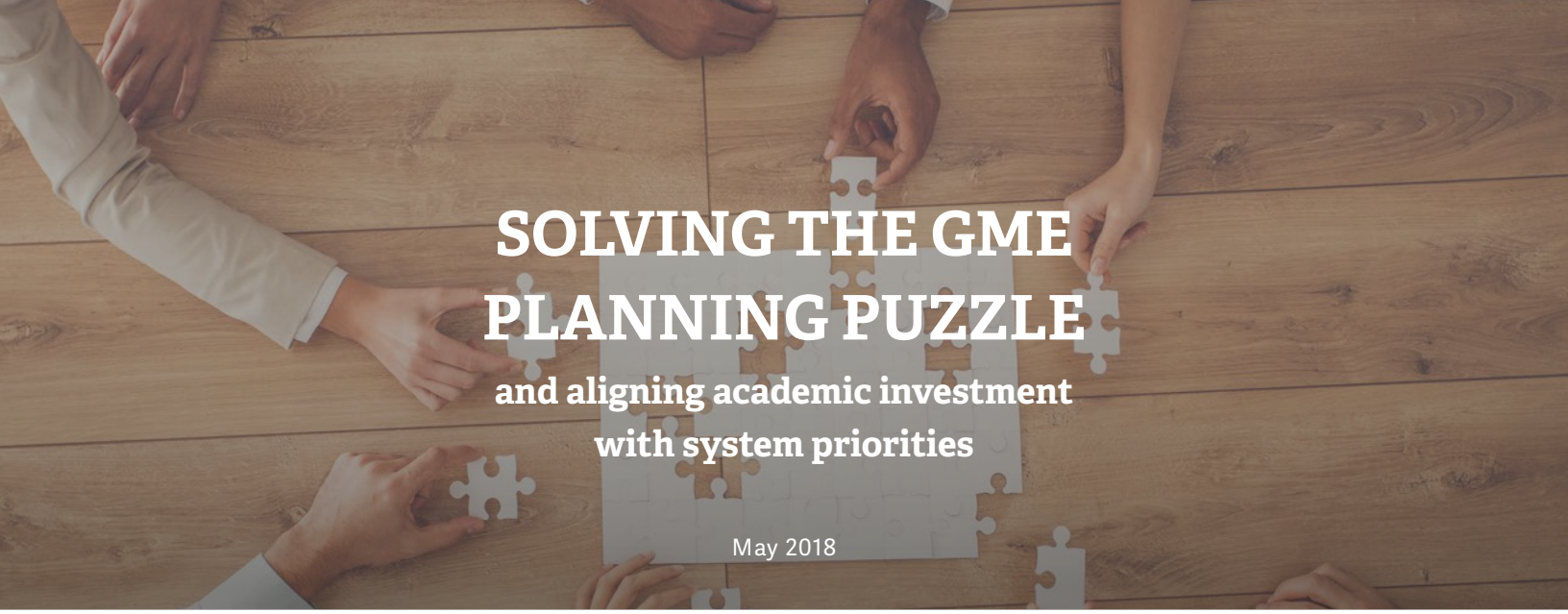

SOLVING THE GME PLANNING PUZZLE

and aligning academic investment with system priorities

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With the average patient care margin for major US teaching hospitals at (3.7)%, a 19% decrease in NIH funding from 1994 to 2016, as well as continued uncertainty about health reform, academic medical centers are increasingly focusing their attention on ensuring hospital expenditures are aligned with the mission and strategy of the organization.[1,2,3] Teaching hospitals across the United States spend an estimated $17 billion annually on graduate medical education (GME) programs. While federal and state funding provides some offsetting revenue, teaching hospitals and academic health systems must make a significant investment in training new physicians each year.

FUNDING GME

Medicare is the single largest funder of GME in the United States, contributing about $11.3 billion per year to teaching hospitals. The Balanced Budget Act of 1997 placed a limit, or "cap," on the number of resident FTEs for which each hospital can claim Medicare GME reimbursement. For most hospitals, new training programs developed after the establishment of the FTE cap receive no additional Medicare reimbursement and must be fully supported by the hospital. The average annual cost of graduate medical training is at least $130,000 per resident, and may be significantly higher for small training programs and sub-specialty fellowships; establishing new GME programs with no offsetting revenue is an enormous financial undertaking for hospitals.[4,5]

STRATEGIZING GME PORTFOLIOS WITHIN YOUR HOSPITAL

As hospitals adjust their clinical offerings and service lines to better meet the needs of the community, align with organizational strategies, and provide training in emerging specialties and competencies, they may find their portfolio of GME programs is out of synch with the new clinical focus and physician pipeline needs. Most hospital GME portfolios have been developed organically over time, with little overarching strategy or integration of GME planning. While early training programs have already been developed in long-standing medical specialties, new training programs for emerging specialties—which could be critical to the future of how healthcare is delivered—may be disproportionately challenged due to funding constraints. Hospitals and health systems need to make strategic decisions about the appropriate mix and size of the GME programs they offer to optimize their GME investment and resolve misalignment with system priorities.

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DEFINING THE VALUE OF GME

To solve the GME portfolio puzzle, organizations must first understand the overall contribution GME makes to an institution, as well as the crucial role it plays in shaping healthcare delivery in the broader community by providing increased access to care, fostering an environment of innovation, and supporting high-quality care. This insight directly informs recommendations and enables organizations to monitor the impact of any adjustments made to their GME portfolios. Furthermore, GME planning can be framed in a way that considers the strategic direction of the hospital or health system and how GME can support or advance those objectives. As shown in figure 1, by anchoring the planning process to a set of guiding principles, organizations can ensure strategic alignment and continued focus on organizational priorities.

PLANNING PROCESS OVERVIEW

An effective planning process should deliver consistent outcomes and be flexible enough to accommodate the inherent variability among GME programs and care delivery models. The planning process is ongoing and must coordinate with recruitment cycles and budget planning timelines; however, it may also be initiated to facilitate decision-making that is necessitated by extenuating circumstances (e.g., funding changes, faculty turnover). At the outset of each planning process, organizations must identify and prioritize existing needs as well as potential opportunities. These goals should be communicated so that outputs from the process are both understood and actionable.

KEY STAKEHOLDERS

GME planning efforts must be coordinated and benefit from the input of the hospital/health system, physician organization, and academic leadership. Recommendations from a diverse group of stakeholders are more likely to incorporate the breadth of system needs and priorities and be understood and accepted if the planning process it initiates is objective, reliable, and transparent to all stakeholders. The existing GME committee at the institution should consistently be engaged to provide oversight of resident educational experiences, academic quality, and the programs' ability to meet accreditation requirements. In addition, program directors and clinical

Figure 1: Planning Framework

and operational leadership should be involved in providing insight, collecting data, and conducting analyses to support and inform decision-making.

EVALUATION AND DECISION SUPPORT

Within the planning process, forward-thinking organizations use a dynamic decision support tool that incorporates both internal and external data to render an objective, comparative assessment of GME programs. Based on the organization's definition of GME value, as well as its identified organizational priorities, a defined set of criteria can be developed and incorporated into the tool to help measure performance within specific areas of focus. Sample performance areas are shown in figure 2.

This evaluation criteria should recognize (1) the value GME provides in enhancing the academic mission and brand of the organization and (2) the contribution residents and fellows make through contributions to patient care.

The output of the decision tool can be used to guide resource allocation; for example, to invest more heavily in highly aligned programs, to address deficiencies, and/or to identify programs that may be considered for contraction or discontinuation. The data-based process is not intended to supplant management expertise; rather, it is a source of objective information that can support deliberations and highlight potential areas of focus for decision makers, as well as provide rationale to support change recommendations.

GME PROGRAM EVALUATIONS AND PLANNING REQUIRE CONTEXT

GME program evaluation and planning does not occur in a vacuum. Organizations must supplement the outputs of the decision support tool with updated information regarding overall market trends and the role of the GME enterprise in the organization and region. Any responses to requests/recommendations related to resizing, adding, or discontinuing programs should be developed with the understanding that action or inaction will likely be dependent on the strategic, operational, and financial circumstances facing the hospital or health system. Those organizations that construct a reliable, objective planning process will be better prepared when making the necessary investment decisions to optimize and sustain their academic mission.

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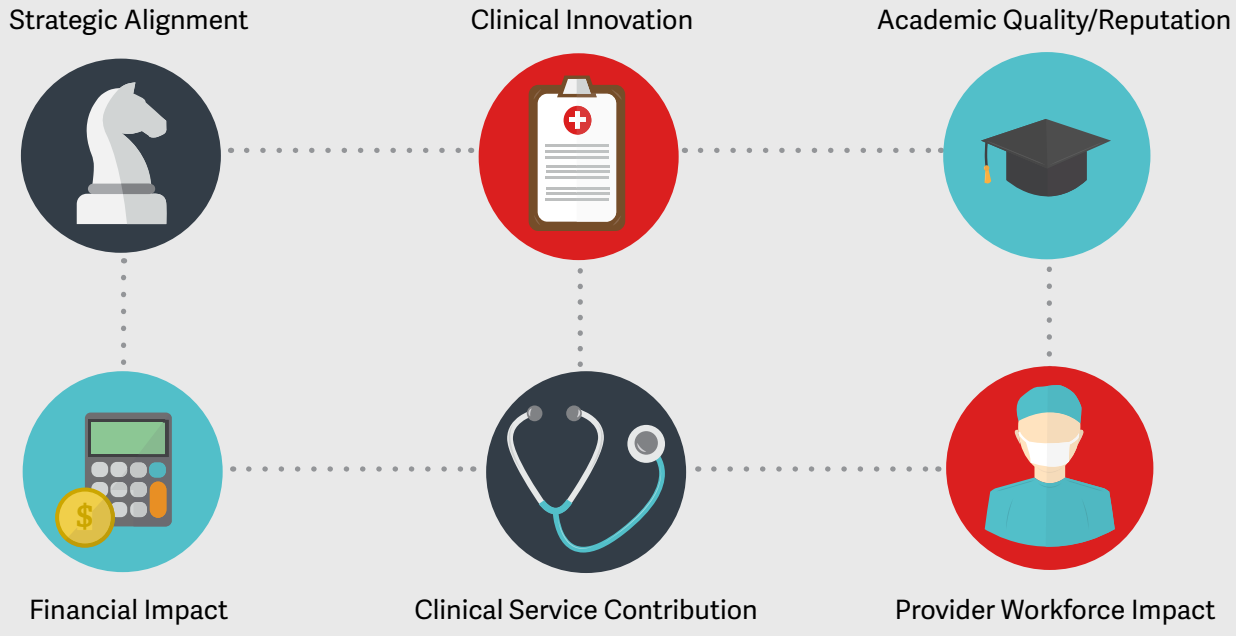
1. AAMC, 2017 TEACHING HOSPITAL CHARACTERISTICS, HTTPS://WWW.AAMC.ORG/DOWNLOAD/478668/DATA/2017TEACHINGHOSPITALCHARACTERISTICS.PDF.
2. Congressional Research Service, NIH Funding: FY1994–FY2016.
3. NIH funding increased slightly from 2016 to 2017 but remains significantly below prior funding levels.
4. A.F. Steinmann, "Threats to Graduate Medical Education Funding and the Need for a Rational Approach: A Statement from the Alliance for Academic Internal Medicine" (Annals of Internal Medicine, Vol. 155, No. 7, Oct. 4, 2011, 461–464).
5. R. Ben-Ari, R.J. Robbins, S. Pindiprolu, A. Goldman, and P.E. Parsons, "The Costs of Training Internal Medicine Residents in the United States" (American Journal of Medicine, Vol. 127, No. 10, Oct. 2014, 1017–1023).

Figure 2: Areas of GME Program Performance



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ECG is a national healthcare consulting firm that has worked exclusively in the healthcare provider sector for more than 40 years serving AMCs, hospitals and health systems, children's hospitals, and physician organizations. Since our founding, ECG has maintained a dedicated practice of professionals exclusively devoted to working in the subsector of academic healthcare. Our clients include the leading medical schools and teaching hospitals, as well as related academic and nonacademic physician organizations. We help a wide array of AMCs, ranging from small, community-based medical schools typically with three separate component entities to large, fully integrated, single-CEO AMCs. We have experts within our Academic Healthcare practice who subspecialize in each mission of the AMC, including medical education (undergraduate and graduate), research, and the clinical enterprise.

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