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*President
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Committee on Energy and Commerce
House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representatives Pitts, Green, McMorris Rodgers, Griffith, Pallone, DeGette, Welch and Castor:

Johns Hopkins Medicine (JHM) in Baltimore, Maryland has played a key role in defining graduate medical education in this country, from the creation of the modern residency system in the early 20th century to the implementation of the Aliko Initiative more recently. The Aliko Initiative, initially funded by philanthropy, focuses on providing patient-centered care and coordinating care across the continuum of care delivery sites from hospital to ambulatory sites to home. Dr. Kenneth Ludmerer, author of several books on medical education including Let Me Heal: The Opportunity to Preserve Excellence in American Medicine. New York, NY: Oxford University Press; 2014, has recommended that the Aliko Initiative be adopted by every residency training program in the country. It is important to note that in addition to having important positive effects on patient and physician satisfaction, the Aliko Initiative was found to reduce 30-day readmission for heart failure (see Record, et al. Arch Intern Med 2011; 171: 858-859, *attached*).

The need has never been greater to ensure that graduate medical education prepares young physicians to practice in new health care delivery models and to effectively prevent illness while providing health care to populations of patients in a country with changing demographics. We therefore feel a responsibility and are pleased to have the opportunity to respond to the call by Congress in your December 6, 2014 letter requesting information on graduate medical education in this country. Below, please find our thoughts with respect to the questions you posed.

1. *What changes to the current GME financing system might be leveraged to improve its efficiency, effectiveness, and stability?*

Changes in graduate medical education programs are necessary to better prepare residents for 21st century practice and sustainable financing mechanisms must be developed to support these programs. Residency training must: (1) shift from a treatment of illness paradigm to a model of disease prevention and improving population health. New curricula must help residents develop a better understanding of the social determinants of the health of the population of individuals who reside in the area they serve rather than focus only on the population of patients for whom they care in the hospital or outpatient clinic; (2) emphasize quality and safety; (3) teach residents about transforming the health care delivery system to reduce fragmentation and inefficiencies; (4) focus on high value, cost conscious care; (5) emphasize care coordination and team-based care; and (6) address how health information technology can be used to achieve these other goals.

2. *There have been numerous proposals put forward to reform the funding of the GME system in the United States. Are there any proposals or provisions of proposals you support and why?*

Residents must learn more in ambulatory settings. While providing care in ambulatory settings is often more efficient and less costly than hospital-based care, *training* in these settings may be less efficient and more costly. This is because the hospital provides a nexus of complex patients, faculty, other health care workers, colleagues, conference room, learning space, etc., that cannot be easily duplicated in the ambulatory arena. Faculty supervision per patient requires time and personnel, and efficiency is reduced when trainees are providing care. Changes in funding for GME must support the costs of training wherever it occurs, particularly programs that make the best use of assets/resources available across multiple venues.

JHM recognizes that a number of proposals were introduced during the 113th Congress addressing GME and salutes the efforts of those members to tackle this very complicated issue.

3. *Should federal funding for GME programs ensure training opportunities are available in both rural and urban areas? If so, what sorts of reforms are needed?*

There are significant problems with respect to geographic and specialty maldistribution of physicians in this country. The shortage of primary care physicians and certain specialty physicians, particularly in underserved rural and urban areas, is crystal clear. There are many reasons for this, and a simple solution is unlikely. As the number of physicians has increased in the past several decades, the proportion of generalists and specialists has changed from about a 50-50 split (as it is currently in many other countries) to about a 25 (generalist) – 75 (specialist) split. It is primary care practitioners who take responsibility for coordination of the subspecialty medical, surgical, and community services needed for elderly patients and individuals of all ages with complex medical conditions. Although many factors that maintain the status quo would not be altered by changing GME policy, it is likely that teaching more residents in ambulatory settings, and in primary care settings in particular, will increase their exposure to generalist role models and may thereby favorably affect this maldistribution.

There are at least 3 strategies that can be used to improve the geographic maldistribution of the physician workforce. These include: (1) strategies to make practice in medically underserved areas more attractive, (2) strategies to influence the types of students who enter the pipeline (especially who enter medical school), and (3) strategies that address the experience of physicians-in-training. Only the last of these 3 strategies has the potential to be affected by reforms in federal funding of GME programs.

There are 2 approaches to consider in this context. One of us (Dr. Paul Rothman) has considerable experience with this issue, having come to Johns Hopkins after serving as Dean at the University of Iowa Carver College of Medicine. First, GME programs could be incentivized to provide residents with training opportunities in underserved rural and urban areas; to make it explicit in their mission that their goal is to train physicians for practice in underserved areas; and to train residents in community health centers and/or expose their residents to patient populations that have greater percentages of socioeconomically disadvantaged patients. There is evidence that these approaches increase the likelihood that trainees will practice in medically underserved areas once they enter practice. Second, GME programs could be incentivized to develop and implement curricula in telemedicine. Telemedicine might help provide expert services to patients in rural and

underserved areas, even if physicians don't locate there. Moreover, the greater availability of physicians trained in telemedicine may help keep physicians practicing in rural or underserved areas by providing greater connection to a community of colleagues, thereby lessening the sense of isolation these individuals often report. Related to this is the need for GME programs to focus on training residents to work in teams that include physician assistants and nurse practitioners, since these health professionals play critical roles in the care of individuals in underserved areas.

4. *Is the current financing structure for GME appropriate to meet current and future healthcare workforce needs?*

Direct Medical Education (DME) payments should cover costs incurred to directly support residents' salaries and fringe benefits, as well as to pay for teaching faculty and overhead in the venues/settings where training takes place. Freestanding children's hospitals should not be excluded from the DME payment mechanism.

Indirect Medical Education (IME) payments should be considered/evaluated in a way that is consistent with their actual purpose. Although IME is said to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care, IME is primarily intended to compensate teaching hospitals for providing special services and treatments that are only available at those facilities. The designation IME is a misnomer, since these fees are not tied to medical education *per se* but to patient care. Patients with more complex, multisystem illness and those who require highly specialized care would continue to come in greater numbers to medical centers that offer state-of-the-art research, facilities, specialists, and procedures not offered elsewhere *whether or not residents were there*. These medical centers, including the country's free-standing children's hospitals, require additional funds to compensate for the provision of highly technical procedures, provision of complex care, and round-the-clock staffing or they would close. Residents and clinical fellows should have opportunities to learn and train in this environment, but they should not be relied on as the primary medical providers in these settings.

Teaching hospitals should use IME payments in a transparent way to prepare residents for 21st century practice. A portion of IME payments should be used to develop the infrastructure to provide more training in ambulatory sites; to modify curricula to meet the evolving needs of society (as discussed above); and to incorporate the principles of the Alike Initiative (also discussed above).

If federal policymakers want to ensure that GME continues to be responsive to the needs of society, it should be in a broad context that strengthens the ability of institutions like JHM to train the next generation of health care professionals and clinician-scientists. For example, we recently launched The Urban Health residency program: a combined internal medicine-pediatrics training program and an internal medicine primary care track, both of which train residents to care for vulnerable populations in an urban environment. This program, currently funded by a HRSA grant that will end this coming year, develops leaders in primary care who can serve as system level change agents as well as provide patient-centered care. It is important to note that projected physician shortages in the United States will total more than 120,000 FTEs by 2025. While this shortage is expected to significantly affect the supply of primary care physicians, it must be noted that given the changing demographics in our society (with a doubling of the population over age 65 expected by 2030) there are also significant and growing shortages in specialties like geriatric medicine and rheumatology.

5. *Does the current system incentivize high-quality training programs? If not, what reforms should Congress consider to improve program training, accountability, and quality?*

Federal GME payment policy must evolve to support 21st century training programs.

Teaching hospitals and others are innovating to train physicians for the future, but federal payment policies do not adequately support these efforts. Indeed, federal payment policies and broader health system reforms aim to reduce the share of health care dollars going to inpatient settings and, thus, may hinder teaching hospitals' efforts.

Research-intensive academic medical centers like Johns Hopkins play a special role in our nation's health care system. We are concerned that certain changes to GME may erode the base of support for the critical role we play and limit our ability to provide innovative training for future leaders in population health as well as in medical and surgical subspecialties. It is equally important to both enhance our nation's capacity for preventive and primary care AND to maintain the creativity and innovative energy of the medical and surgical subspecialists who have enlightened medical care and advanced cures.

6. *Is the current system of residency training slots appropriately meeting the nation's healthcare needs? If not, please describe any problems and potential solutions necessary to address these problems.*

Congress needs to address head-on the physician workforce challenges arising from an aging population and improved access to care through implementation of the Affordable Care Act. The number of federally-supported GME positions is capped at the same number it was nearly 20 years ago despite significant changes in the size and demographics of the population of our country, with most of the growth occurring in "high utilizers" (i.e. elderly patients with multiple comorbidities). **This suggests that the number of funded GME positions should be increased.**

7. *Is there a role for states to play in defining our nation's healthcare workforce?*

All payers should explicitly contribute to the funding of medical education. Everyone benefits from the supply of well-trained physicians and therefore it makes sense that everyone should explicitly contribute to assuring that supply for future generations. At Johns Hopkins, we have had the benefit of operating under an all-payer hospital rate setting system in Maryland since 1977. The Health Services Cost Review Commission (HSCRC) – the agency that oversees that program – includes the reasonable costs of medical education in the rates that all public and private insurers must pay. Under a recently established new all-payer demonstration, we are working with the HSCRC and other stakeholders in developing for CMS a plan for medical education appropriate to sustain the new global budget model.

We believe the federal government (and all payers) are indispensable partners in training the next generation of physicians and other caregivers for our evolving health care delivery system. Changes in GME payment policy must preserve the best of the current system that provides critical support to teaching hospitals, trains highly skilled physicians who are in demand world-wide, and supports new approaches that will allow us to bring the best care to all Americans in a safe and affordable manner.

We and our colleagues at Johns Hopkins Medicine would welcome the opportunity to have you and your staff visit our hospital to see first-hand some of the innovative programs we have referenced herein and meet with the dedicated faculty, staff and young physicians working on the front lines of academic medicine.

Please do not hesitate to contact us to arrange a visit or if you have any questions.

Sincerely,



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Ronald R. Peterson
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Enclosure