

Innovations in Graduate Medical Education Workgroup

Workgroup Charge

Purpose: The Innovation in Graduate Medical Education (IGME) Workgroup is needed to oversee the development of a five-year plan to advance innovations in medical education. As part of the agreement with CMS, the state of Maryland has committed itself to convening the medical schools and schools of health professionals within the state to:

“[D]evelop a five-year plan that will serve as a blueprint for improvement elements necessary to sustain health transformation initiatives in Maryland and which will be generalizable to other schools across the United States.”

Context: The new All-Payer Demonstration Waiver in Maryland establishes global budgets and aggressive quality and safety targets that fundamentally alter the financial incentives facing hospitals by aligning them with the triple aim. In order to be successful in the long term, physicians and other health professionals must be trained to both thrive and lead in this new environment. A report detailing recommendations on changes to graduate medical education are due to CMS by January 1, 2016. A proposed work plan is being drafted in advance of identifying and convening the IGME Workgroup in early 2015.

This work is part of a broader set of activities designed to implement successfully the new All-Payer Demonstration Waiver. Beginning in late 2013, in advance of the new All-Payer Model’s approval, the HSCRC (The Commission) convened an Advisory Council to develop Guiding Principles for implementation of the new globally budgeted all-payer model. The Advisory Council put forth a Final Report on January 31, 2014, shortly after approval of the new All-Payer Model. Subsequently, the Commission convened four Workgroups -- Payment Models, Physician Alignment & Engagement, Performance Measurement, and Data & Infrastructure. Given the nature of the task at hand, however, this IGME Workgroup must be convened and led by interests broader than just the HSCRC to include the Department of Health and Mental Hygiene and the two schools of Medicine.

In order to provide a common understanding of the issues, a brief proposed Statement of Problem is appended at the end of this document and includes some initial guiding principles.

Proposed Framework: Working with The Commission and DHMH, the IGME Workgroup will provide a forum for education, discussion and debate among stakeholders, to facilitate decision-making related to innovations in graduate medical education.

Membership: The membership base of the IGME Workgroup should balance the need to gain input from a wide variety of stakeholders, yet support an effective working relationship among its members. Appointments to the Workgroup will be made by March 1, 2015. Membership may not be designated to a substitute representative.

Consensus: The Workgroup should seek to find consensus on key issues. When consensus cannot be achieved, their report to DHMH and the Commission should reflect the different perspectives that were provided. The Workgroup is not a decision-making organization, and therefore, will not be expected to vote on implementation activities.

Leadership and Staff: The Workgroup should be co-chaired by key stakeholders. Staff or consulting experts will be designated to facilitate the meetings of the Workgroup. Experts will also be designated to support the deliberations of the group as needed. These lead staff will actively participate in the HSCRC project management team and provide routine updates to ensure coordination (e.g., with The Commission and among the groups).

Transparency (Public Meetings and Materials): The Workgroup will convene three to five meetings, from approximately March through November 2015. Meeting dates and materials will be posted on-line on the DHMH website. Meeting agendas should include presentations from knowledgeable individuals and experts on policy or methodological issues. The Workgroup may choose to convene a summit on the topic to solicit broad input to the plan.

Project Management Team – The HSCRC staff will establish a project management team and will engage project management resources. The lead staff for the Workgroup will actively participate in this team to coordinate the activities. The project management team will develop a management plan to be shared with DHMH and the Commission.

Timeline and Initial Work Plan – Understanding that the State is forming this team in response to the specific requirement included in the agreement with CMS, the Workgroup needs to form and begin its work immediately as a final report and recommendations are due to CMS by December 30, 2015.

1. The initial meeting of the Workgroup should be held by mid-March 2015, with the goal of completing their work (facilitating several additional meetings and preparation of Final Report) by November 30, 2015.
2. Since this Workgroup is being formed by the HSCRC in their role as catalyst and convener, it is not a policy-making body.
3. Specific issues the Workgroup may wish to consider include:
 - Current Status and Gap Analysis
 - Development of Guiding Principles
 - Assessment of Regulatory Guard Rails
 - Financial Considerations
 - Timeline & Implementation Plan
4. It is not intended that the Workgroup efforts include undergraduate medical education (medical school) or physician workforce.

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Statement of Problem

The financing of graduate medical education (GME) is currently based on an outdated model tied to hospital admissions and inpatient cost. The majority of patient care now occurs outside of the hospital and going forward, payment will be tied to the totality of health for a population, not just to revenue generated from episodic medical care delivery.

Although most current graduates will enter a health care environment in which most of the care they provide will take place in settings outside the hospital, GME continues to be hospital-based, leaving residents not fully prepared for independent practice after residency training. In part, this is because hospital-based training is convenient: the hospital is a setting in which patients, learners (e.g., residents), teachers (e.g., physicians in practice), and facilities (e.g., lecture halls, conference rooms) co-exist. Much of GME occurs in tertiary care referral centers, which allow learners concentrated access to the breadth and depth of disease pathology that is often not available in community-based settings. In addition, GME remains hospital-based in part because of the current GME funding model. There has not been widespread interest in incorporating training in cost conscious care or population health in residency training.

A new model of GME in Maryland, and a new funding model to support it, should accomplish at least four things:

1. **It should be focused on the Triple Aim.** GME under the new Maryland waiver must address the importance of improving value by improving the patient experience of care (including quality and satisfaction), improving patient health outcomes, and reducing the per capita cost of health care. GME training must include measures of *resident-specific quality of care* and must include curricula on high quality, safe, *cost conscious care*. This is important given the change from a hospital revenue model to a population-based or “total patient revenue” payment model.
2. **It should include specific curricula that address population health.** The goal of this training should ultimately be improving the health of a community, reducing hospitalizations and decreasing inappropriate volume given the change from a per-admission payment system to one that is based on overall per capita expenditures for hospital services and population health outcomes. This new paradigm will require an even greater reliance on team-based care, and as such, will require that physicians in training develop the skills and insight into what it takes to be effective team members and leaders.
3. **It should be funded in an equitable and efficient manner.** Funding should follow where the training is going, whereby the model will take into consideration that as GME shifts from hospital to ambulatory, and even community settings, teaching hospitals will incur considerable costs that will need to be offset by non-resident health care providers (e.g., hospitalists, nurse practitioners, physician assistants) to provide care for hospital inpatients. For this reason, the model would ideally incorporate mechanisms for reduced expenses or incentivized reductions in inpatient care.

4. It should augment what is good about residency training today. In the efforts to improve medical training in the ways outlined above, we must be sure that changes in GME payment policy preserve the best of the current system that provides critical support to teaching hospitals. This support allows teaching hospitals to participate in training highly skilled physicians who are in demand world-wide, and supports innovation, research, and discovery that should allow us to bring the best care to all Americans in a safe and affordable manner. Innovations in financing and training contemplated through the demonstration waiver should recognize that efforts to reduce hospitalizations, enhance ambulatory and community care and improve the health of the population must involve trainees in specialty and subspecialty fields as well as those in primary care.