COMMUNITY-BASED TRAINING PROGRAMS

Challenges for Development and Sustainability

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OVERVIEW OF KEY ISSUES

- Start-up challenges for developing programs
- DME/IME calculations and their impacts
- Primary care expansion and CMS GME “cap” regulations
- Interactions with other GME funding: THC and PCRE grant programs
- Sustainability threats for community-based primary care programs
Demand for Primary Care / Family Medicine Programs

- Need for developing primary care workforce.
- Family medicine only community-based specialty.
  - Single-program sponsors; many rural, CHCs.
- Many communities evaluating starting their own programs to meet the needs of their region.
  - Residents often stay near where they are trained.
- Services provided by programs are key to the safety net for their communities.

References: 1, 2.
START-UP CHALLENGES FOR DEVELOPING PROGRAMS

- **Financing:**
  - Start-up costs: estimated $1 million over 2-3 years
  - Ongoing operational deficits / insecurity
    - Estimated $150K / resident / year

- **Community support:**
  - Sponsoring institution
  - Physician community

- **Availability of faculty**

- **Family Medical Center development**

- **Accreditation process**

  *References: 3,4.*
Primary care residency data from WWAMI Network:

- Federal GME provides on average 41.8% of total program revenues
- IME comprised approx 2/3 of total federal GME
- Issues of 1996 base “per resident amount” determination; regional variation
- 83% of programs are “over cap”
- Even with GME, average program net cost to sponsoring institution of $27,260 per resident

Limitations of prior cap reallocations.

Reference: 5.
“Non-virgin” hospitals: cap established in 1996.
- No exceptions for primary care expansion.

“Virgin” hospitals: 5-year window to establish a new cap.
- Larger hospitals hesitating to get started.
- Some already committed to 3-year window.

Concerns by “virgin” hospitals of accepting rotating residents.
- References: 6,7.
Teaching Health Center grants:
- Grant program, sponsoring institution within Community Health Center
- Hospitals used for inpatient rotations can claim GME revenues
- “Cap” issues apply
- No clear extension beyond initial 5-year funding

Primary Care Resident Expansion grants:
- “Cap” issues apply
- No clear extension beyond initial 5-year funding

Reference: 8.
Current GME reimbursement does not offset the total net cost of primary care training.
- “Medicare” share

Threat to IME funding threatens most primary care programs.

DME not always clearly directed to programs.

Non-protection of primary care positions in multi-specialty institutions that are over cap.

Need for outcome accountability: practice in primary care; diversity of workforce; location.

References: 9,10,11.
SUSTAINABILITY OF PRIMARY CARE PROGRAMS

- Other revenue sources also at risk:
  - Patient care reimbursement.
  - Safety net / payer mix.
  - State financing.
  - Medicaid GME.

- Stability of long-term funding is critical both to current training programs, and to starting new programs.
SUMMARY POINTS

- Start-up challenges for developing programs.
  - Particular need for stability for future planning.
- DME/IME calculations and their impacts.
  - Redefinition, simplification, and accountability for outcomes for DME and IME.
- Primary care expansion, PCRE/THC grants, and CMS GME “cap” regulations.
  - Need for exemptions for primary care expansion and protection of existing positions.
- Sustainability of primary care programs.
  - Direct funding to programs.
  - Fundamental restructure of health system structure and payment models.


6. Federal Register. Teaching Hospitals: Change in Program Growth from 3 Years to 5 Years. 8/31/12; 77 FR 53146-53424.


