ACADEMIC CONSULTING ADVISORS

# GME GRADUATE MEDICAL EDUCATION

## WHY PURSUE GME?

In the wake of changing market pressures and healthcare delivery needs, many systems have begun to embrace graduate medical education (GME) to address some of their most significant organizational challenges. Developing primary care teaching programs in select community hospitals helps to fill the physician resource gap in historically underserved communities by creating a pipeline of physician talent essential for fostering healthy communities. Community-based hospitals and large health systems are not always considered traditional training grounds for graduate medical education; however, many for-profit health systems are beginning to prioritize GME to address some of their most significant organizational challenges.

### CULTURE

Hospital systems can use their GME programs to align the organization's core values, such as improved patient safety. Programs create lifelong learners and instill an environment of inquiry. Residents tend to practice in the community where they received training, bringing with them the ability to shape the culture of the community in a way that they have been taught in t raining.

### PRIMARY CARE

Community hospitals are ideal hosts for primary care training programs because they provide a diverse panel of patients which residents are required to manage during residency. Each resident must have 1650 patient encounters; this volume will substantially increase the underserved population in the community who will have access to healthcare.

### ECONOMICS

GME reimbursement may provide vital support to the teaching mission. It is essential, however, that the program be structured appropriately to ensure it receives the maximum federal and state funding. In doing so, the program's start-up and ongoing operating costs can be most efficiently managed.

### RECRUITING

Statistics show physicians tend to stay active and live in the state where they completed their most recent GME program, and retention rates were highest among physicians who completed both UME and GME in the same state.

### QUALITY

Studies have shown that GME will drive the adoption of evidence-based practices and use of standardized order sets based on best practices. This has contributed to a reduction in hospital readmission rates.

### PRODUCTIVITY

A precepting primary care physician can supervise up to four residents at any given time. With the appropriate supervision ratios and predictive scheduling, GME can enhance productivity in the delivery of clinical care.

# CUSTOM PROGRAM DEVELOPMENT

Each facility, community, and/or marketplace will face a unique set of circumstances that will affect its ability to host and train learners effectively. Individual markets will need to assess the value of GME based on their respective strategies.

### MARKET NEEDS

Communities with underserved populations will likely be the beneficiary of the required resident continuity clinic training. Hospitals with physician shortages should consider this investment to support their strategic planning.

### SERVICE LINE EXPANSION

Where certain specialty services can be supported, select fellowships can be established. This includes service line development and expansion.

### STRATEGIC PARTNERSHIPS

Forming partnerships (ie. with a medical school, private physician groups, and/or FQHCs) to support the teaching experience can forge stronger community relationships and result in greater collaboration in the provision of care to meet strategic initiatives.

### PHYSICIAN SUPPORT

The interaction between community physicians and residents, coupled with a new economic arrangement between the physicians and the hospital, can enhance clinical throughput for both groups. Physician buy-in for new program development is essential.

### PHYSICAL SPACE

New programs will require dedicated space for resident team rooms, didactic classrooms, and simulation areas. This space may be determined by the program's specialty RRC and the number of residents. Resident call rooms can represent a challenge to many hospitals, as they must be nearby patient care rooms.

### CAPITAL INVESTMENT

Dedicated space requirements may require capital investment for re-modeling or even acquisitions. The timing of such investments must be considered when deciding on the timing of program start-up and to optimize reimbursement.

# CONCLUSION

As the demand for primary care physicians continues to grow, alternative models and approaches should be explored. Since large health systems have a significant presence in nonurban geographies where large academic organizations historically do not deliver care, there is an opportunity for novel, expanded primary care models. These hospitals are ideally suited for primary care training, given their patient mix and relationships with local physician groups. Additionally, new teaching hospitals in these communities can support care for the under-served while training residents in the locations where they are likely to practice. Residents who train in community-based settings are more likely to embrace traditional private practice models when entering practice, generating greater throughput and meeting medical group metrics.