The GME Initiative and the GME Summit
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Western and Midwestern Family Medicine Leaders for GME Reform

Correcting the physician workforce specialty and geographic mal-distribution will require bold and deliberate legislation.

Why?:
1. We are going in the wrong direction.
   - We want a physician workforce that is 50% primary care
   - We have a physician workforce that is about 32% primary care
   - Current GME production of primary care is about 20%

2. Previous well-intentioned attempts at correction have not gone well:
   - 1997 rural training tracks provision allows creation of new positions above the cap for rural training. BUT from 2000 to 2010 the nation’s active RTTs decreased from 35 to 25 (13 programs closed and 3 new ones opened).
   - 2003 Medicare redistribution 3000 GME positions to improve rural and primary care training. BUT only 3% of those positions were redistributed to rural areas. Hospitals that did receive redistributed positions did increase primary care training by 1585. BUT in the same period they also increased their non-primary care positions by 3,433

3. Current programs from the ACA are running out of time
   - Funds for new primary care training positions under the Teaching Health Centers program (THCs) and the Primary Residency Training Expansion grants (PCRE) were appropriated for only 5 years.

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The GME Initiative

July 2011 - Meeting of Family Medicine leaders and legislative aides from the Colorado delegation

October 2011 – Proceedings form the July meeting distributed

December 2011 – Letter from seven US Senators requesting that the IOM review the issue GME Reform

March 2013 – “A Proposal for Reform of the Structure and Financing of Primary Care Graduate Medical Education” published in Family Medicine

The GME Summit

Spring 2014 – We are planning an educational event in Washington. Timing is to coincide with the release of the IOM report due early 2014

Our Colorado Experience

A Residency Rural Training Track in Alamosa Colorado
- Things Align – The University Family Medicine Residency, The University Hospital, The Rural Hospital (San Luis Valley Medical Center), the Rural FQHC Network (Valley wide Health Services), the local philanthropy (Colorado Health Foundation) are all rowing the boat in the same direction towards an RTT. BUT THEN:
  - A Good thing happened – CEO of Valley Wide (Marguerite Salazar) was chosen to lead region 8 for HHS.
  - A Bad thing happened – The pro forma from our financial consultant showed the residency would run in the red by about $70,000 per year.
  - Result – Not so much alignment. The project is pretty much on hold.

Expansion of our Urban Underserved Track at Denver Health
- PCRE Grant – We were awarded a grant to expand our Denver Health track from 2 residents per year to 4 residents per year. We grew one class at a time. Starting July 2013 we will have our full complement of 12 residents (4 from each class-year). We are attracting truly top notch skilled and dedicate physicians. The Funding for this runs out in 2015. If we don’t secure private salary funding for these positions by July 2013 ten we will not be able to recruit for positions for the class beginning July 2014. We will be decreasing the number of primary care doctors being trained. We will be going in the wrong direction.
  - 65% have not identified funding. T.J. Staff is on faculty with the Denver Health Track. He surveyed PCRE grant recipients in January 2013. Like our situation at Denver Health, 65% of those responding to the survey had not yet identified a funding source to allow them to keeping training the expanded number of positions.