



Improving ROI on Graduate Medical Education in North Carolina: Towards a Statewide Solution

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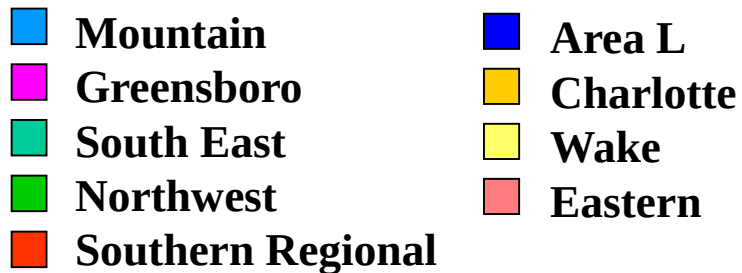
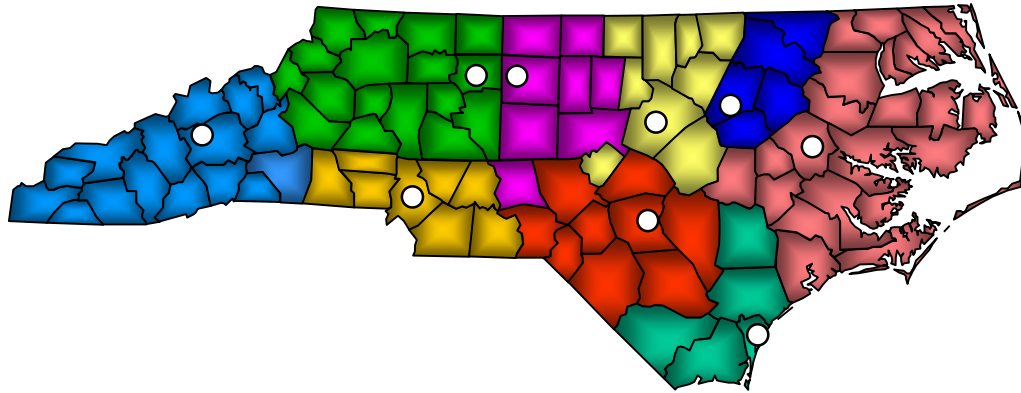


Key Messages

- Prioritize rural GME expansion
- Target the right specialties and settings
- Comprehensive solution
- Collect data to track outcomes
- Pay for Performance for education
- Transparency and public leadership



Why AHEC?

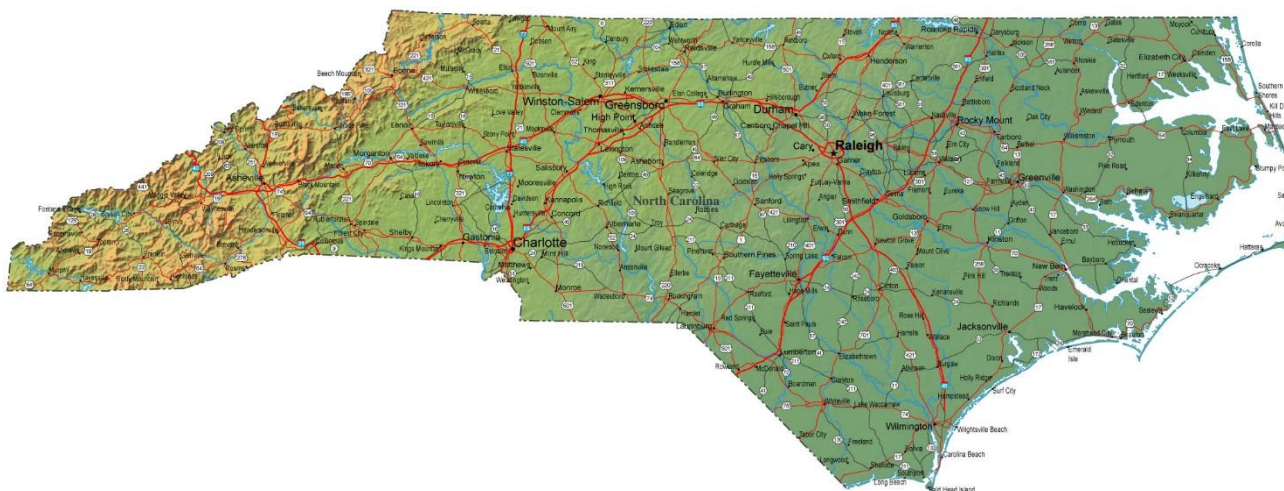


- 19 community based residencies in needed specialties; over 2500 community practitioners who precept students
- work with all academic medical centers and in over 1200 primary practices across the state
- provide >200,000 hours continuing professional education yearly
- work with other providers—NPs, PAs and others

Source: NC AHEC Program



North Carolina



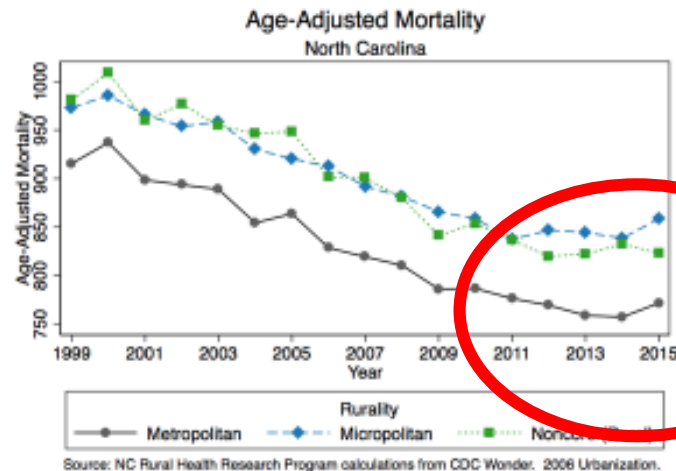
~10,000,000 people: 8th biggest, 36th in health outcomes

Dramatic transformation of both health care and health education over last 5 years



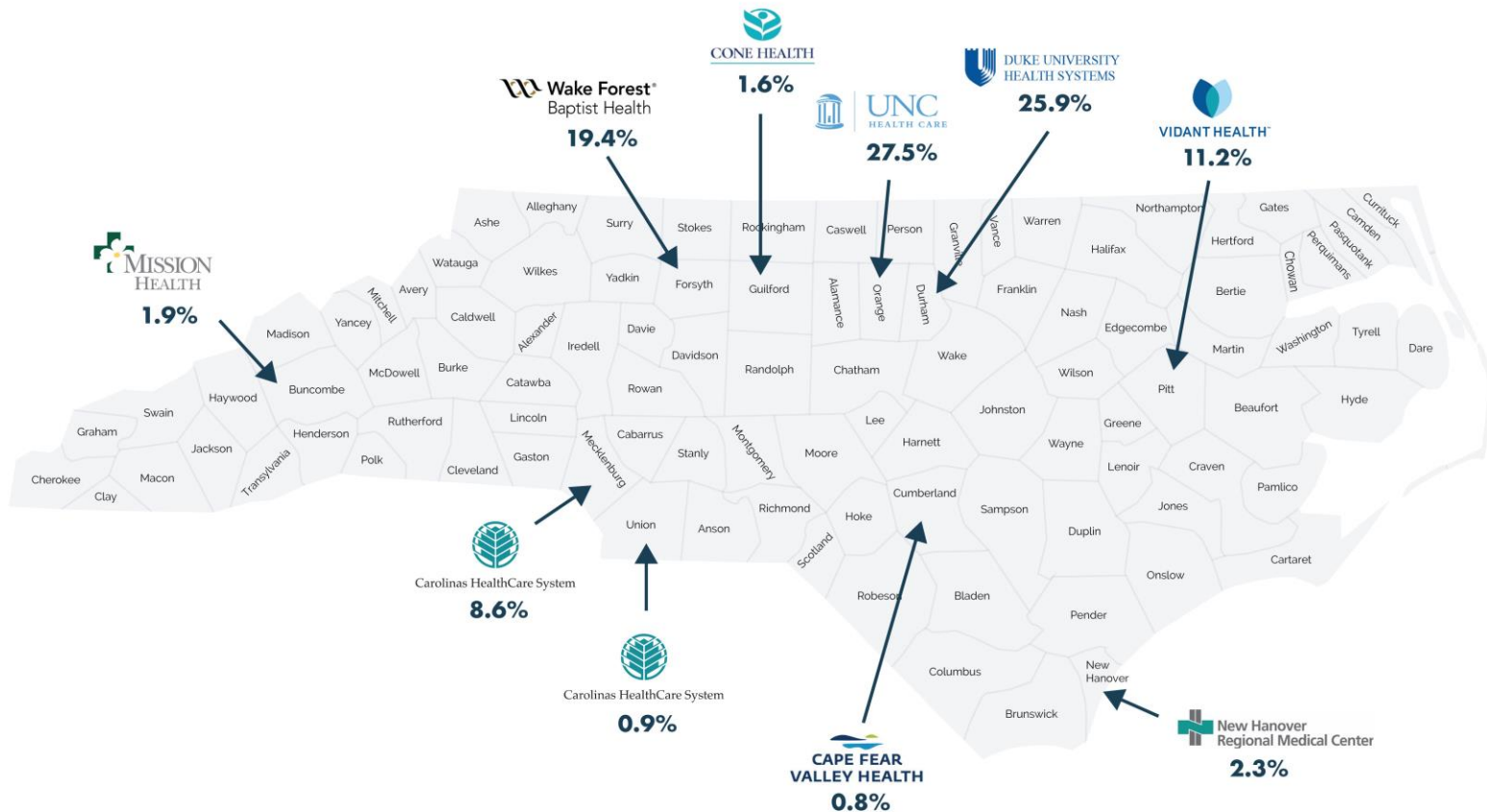
Rural Mortality Has Started to Increase

- Rural areas poorer health on almost every measure
 - Older, poorer, more isolated
 - **Persistently higher mortality**
- Less healthcare infrastructure
 - Fewer docs, smaller hospitals
 - Half of rural hospitals lose money
- 120 rural hospital closures since 2005



Graduate Medical Education in North Carolina

Note: Percentages show the proportion of total North Carolina medical residents by teaching center.

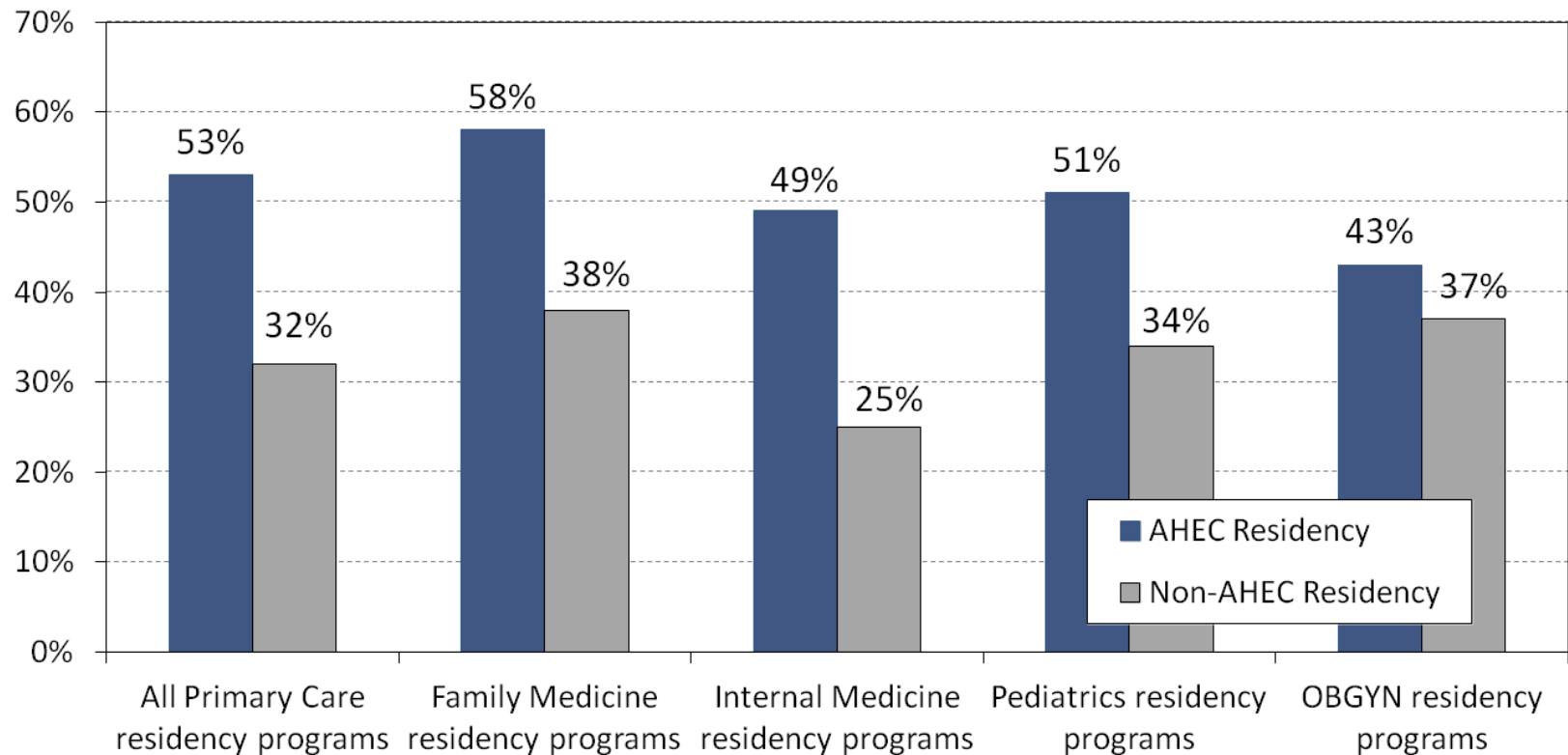


Our Health Workforce Strategy



Outcomes of Community Based Residencies

**Former North Carolina Residents Practicing in NC by
Primary Care Residency Specialty, 2011**



Source: NC Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the American Medical Association Masterfile, 2011. "Active" includes federal, as well as non-patient care activities such as teaching, research, administration, etc.



North Carolina Institute of Medicine Needed Specialties



- Family Medicine
- General Medicine, General Pediatrics
- General Surgery
- Community Based Psychiatry
- Value Based Care will need more primary care



What Physician Workforce Do We Need?

- Primary Care and related disciplines needed to:
 - move care out of hospitals
 - improve quality and cost-effectiveness
- What we are getting is not what we need
- We need quantity and especially distribution





Towards a Statewide Solution



GME Expansion Collaborative

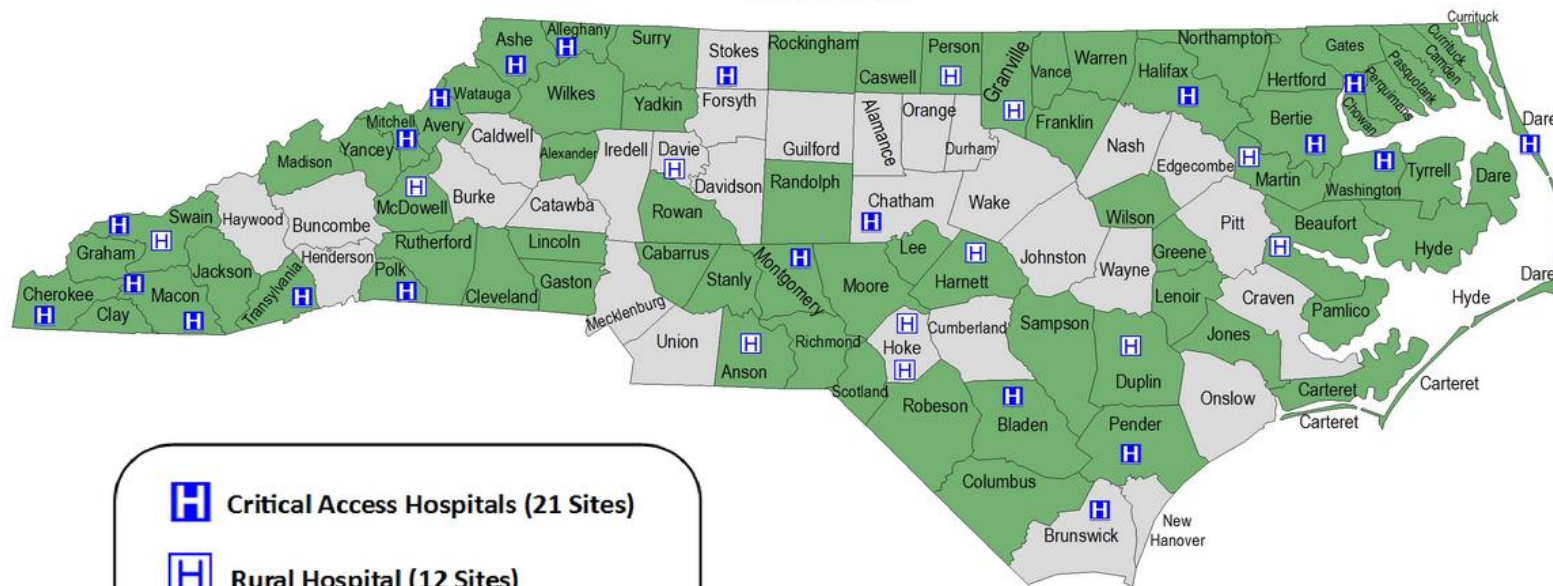
April-December 2016

- NC Healthcare Association
- NC Medical Society
- NC AHEC
- NC Academy of Family Physicians
- NC Pediatric Society
- NC Psychiatry Association
- NC Community Health Centers



Focus on Rural Communities

Office of Rural Health
Critical Access and Rural Hospitals
SFY 2016



 Critical Access Hospitals (21 Sites)

 Rural Hospital (12 Sites)

 Rural County (70 Counties)

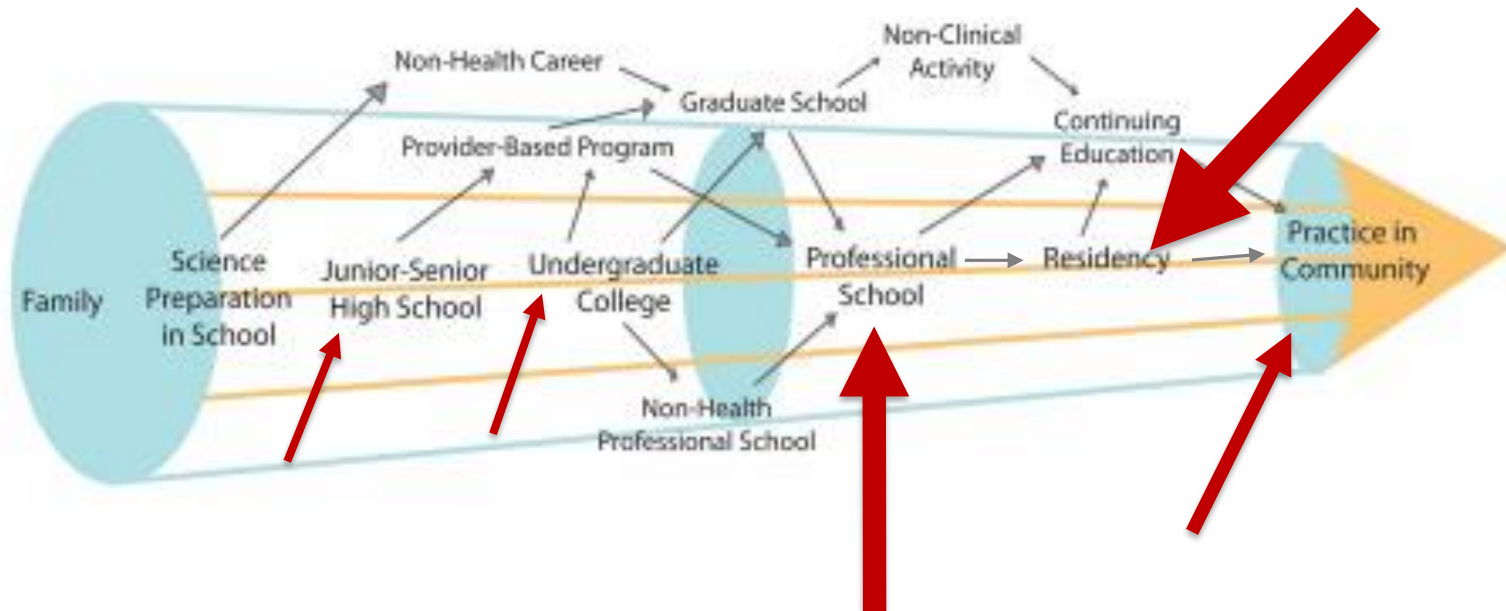
 Urban County (30 Counties)



Rural Health
HEALTH AND HUMAN SERVICES



When in the Pipeline Should We Intervene?



Rural Residency Expansion

- More likely to practice in NC and in rural areas
- Provide care directly
- Provides jobs in communities; support other healthcare training
- Can pull down Federal GME dollars



Needed Specialties

- Primary Care
 - Family Medicine
 - General Internal Medicine
 - General Pediatrics
- General Surgery
- Community Psychiatry



Target the Right Communities

- Clinical leaders who are excellent and committed: quality attracts quality
- Medical community with sufficient size to teach what is necessary—and which wants to improve care and educate future physicians
- GME Naïve
- **A Request for Proposals Process**



Support Excellence in Residencies

- Faculty Development
- Linkage with academic medical center
- Shared support with other community residencies
- ACGME Experience



Think Before and After Residency

- Admitting the right medical students
- Rural community clinical experiences/support for community precepting
- Office of Rural Health support for rural recruitment and loan repayment
- NC AHEC support of graduates' rural practices and quality improvement

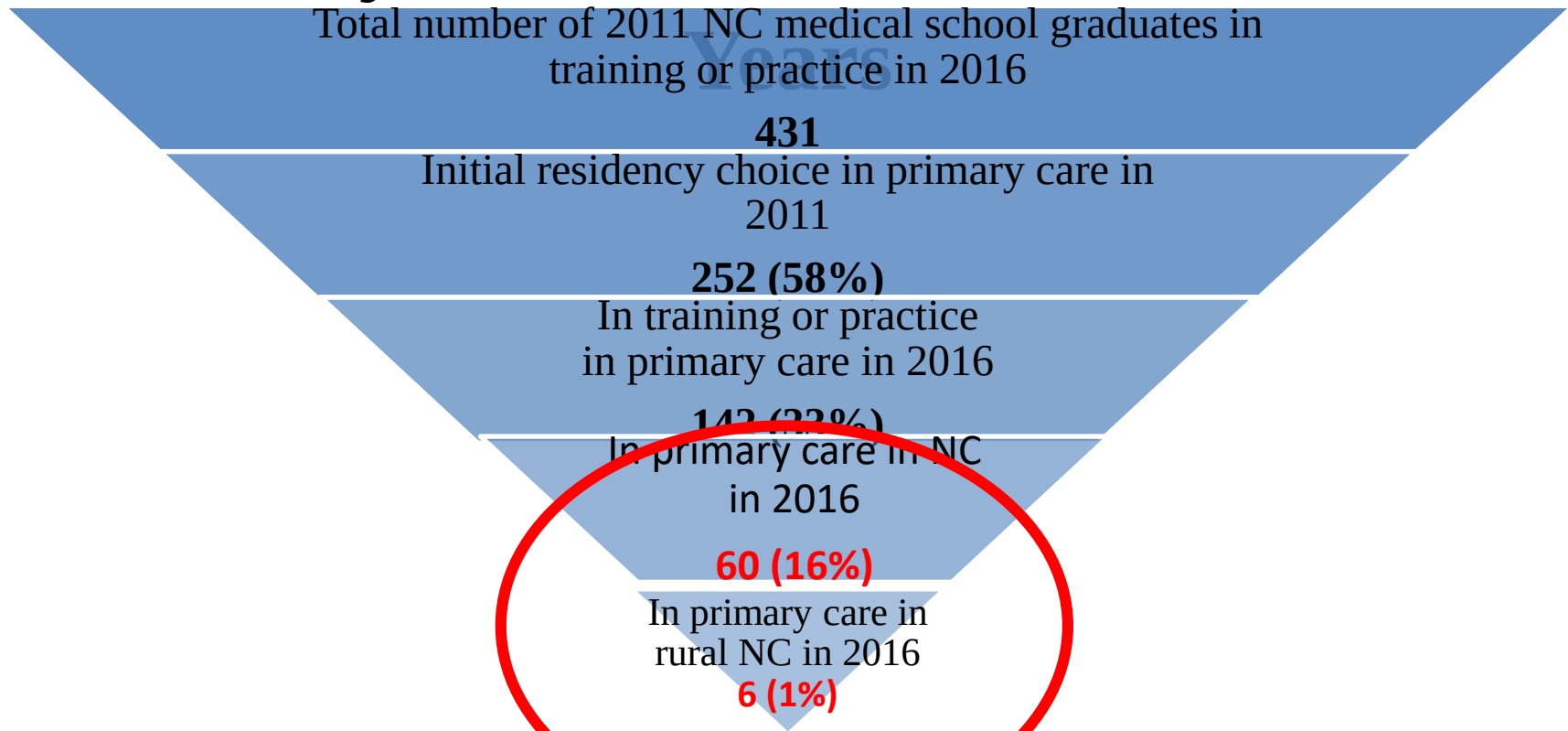


How will this be funded?

- HRSA and Philanthropies led the effort, now funds running out.
- Carolinas, Cone, New Hanover, UNC and Vidant have funded expansions in needed specialties
- Medicaid GME/Medicaid 1115 waiver; anchor in something other than hospital admissions!
- New GME dollars for GME naïve hospitals



Towards Accountability for Outcomes Primary Care in NC Rural Areas in 5



Produced by the Program on Health Workforce Research and Policy, Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Source: North Carolina Health Professions Data System with data derived from the Association of American Medical Colleges, and the NC Medical Board, 2016.
Rural source: US Census Bureau and Office of Management and Budget, July 2015. "Core Based Statistical Area" (CBSA) is the OMB's collective term for Metropolitan and Micropolitan Statistical areas. Here, nonmetropolitan counties include micropolitan and counties outside of CBSAs.



Data

- Require annual submission of information on graduates to the state/Sheps
- Sheps needs to clean the data, collect data from the North Carolina Medical Board, the AMA and the AAMC.
- Support the cleaning and analysis



Tracking Outcomes

- AHEC, Sheps, DIOs from 11 hospitals, test measurement of GME outcomes
- Initial learnings:
 - Account for fellowships
 - Lots of variation from year to year—need rolling averages
 - Large differences in residency outplacement work
- We are asking residencies to add to their mission.



A GME State Board

Paying for GME Outcomes

- Create a Public-Private partnership, with representation from all partners, including communities and practicing clinicians, convened by the state
- Review data and set policy annually
- Pay for long term outcomes



Questions?

