

## **MiDocs**

(FY2018 Appropriation Act - Public Act 107 of 2017)

**December 1, 2017**

***Sec. 1870. The department shall continue to work with the MiDocs consortium to explore alternative graduate medical education financing sources and mechanisms that expand residency opportunities for primary care training, per approval from CMS. By December 1 of the current fiscal year, the MiDocs consortium shall submit a report presenting a comprehensive funding plan to the senate and house appropriations subcommittees on the department budget and the senate and house fiscal agencies.***



Michigan Department of  
Health & Human Services

RICK SNYDER, GOVERNOR  
NICK LYON, DIRECTOR



*In Partnership with*



*Report for*

*Governor Rick Snyder*  
*and the Michigan Legislature*

*November 2017*

**TABLE OF CONTENT**

Executive Summary.....1-2
Section I. MIDOCs History.....2-6
Section II. Physician Workforce Shortage.....6-11
Section III. Community-based Training Model.....11-12
Section IV. Current GME Funding.....12-14
Section V. Funding Model.....14-16
Section VI. Oversight.....16
Section VII. The Role of AHEC.....16-18
Section VIII. Resident Recruitment & Retention – Incentive Programs.....18-20
Section IX. University RFP Proposals.....21
Section X. Resources & References.....21-23
Appendix 1. Medicare Graduate Medical Education Payments.....24-26
Appendix 2. Creation of an MIDOCs Community-Based GME Payment and Match.....27-31
Appendix 3. GME in Georgia: Growth, Funding and Sustainability.....32-45
Appendix 4. University RFP Proposals.....46
Appendix 4.1. RFP – Central Michigan University.....46-55
Appendix 4.2. RFP – Michigan State University.....56-64
Appendix 4.3. RFP – Wayne State University.....65-74
Appendix 4.4. RFP – Western Michigan University.....75-83

**INTRODUCTION**

**Executive Summary**

It is widely accepted that the funding model for graduate medical education is broken. For the first time, there are now more students graduating from medical school than there are medical residency slots. Here in Michigan, we have substantially increased the number of medical school graduates but have not seen any increase in residency slots. As a result, medical students go to other states for their residencies, where they often reside to practice medicine. In essence, Michigan taxpayers are subsidizing the workforce of other states. Additionally, we have an aging physician workforce, an increasing population, and an even larger increase in the percentage of Michiganders with insurance seeking coverage.

It is also widely accepted that too many citizens of Michigan do not have access to the physicians they need. In rural communities across the state, local physicians have a difficult time finding psychiatrists in their area to refer their patients. In both rural and urban communities, aging family physicians are afraid to retire because they cannot find a younger general practitioner to replace them. As our state continues to battle the Opioid crisis, increased needs for mental health care, and other health care challenges, Michigan needs to develop its own public health policy to address the physician workforce shortage.

In response to the leadership challenge by then state senator John Moolenaar, a group of Medical Schools including Central Michigan University, Michigan State University, Wayne State University, and Western Michigan University, created a consortium (MIDOCs) to address this critical issue. As international leaders in medical education, clinical delivery, and research, the MIDOCs consortium is uniquely positioned to offer a public health focused plan on how to increase health care access for those who need it most.

By 2029, the MIDOCs initiative will create approximately 300 new primary care physicians practicing in underserved communities throughout Michigan from Escanaba to Detroit, and from Benton Harbor to Alpena. For the first time, medical students growing up in Michigan will be able to participate in a program that will help them practice in the community they grew up in. Also for the first time, Michigan will have a program for those medical students who want to commit their career to helping the underserved. No longer will medical students be forced to practice in areas of medicine simply because of their fear of medical school debt. Instead, medical students will be inspired and empowered to choose a career based on impact rather than financial necessity.

Each of the four participating universities have submitted proposals of how they would best utilize resources to create up to 10 new residency slots per year. Suggested specialties include Family Medicine, Pediatrics and Psychiatry. Leaders in Washington and Lansing agree that there is no “one size fits all” approach to increasing access to care, especially in underserved communities. An important aspect of MIDOCs is allowing the expertise at our respective universities and data from local needs assessments to guide our approach. Empowering local stakeholders will ensure community buy-in and create important partnerships as we identify ways to retain trainees in those areas. You will find the detailed proposals from each university in Section X (10) of this document.

The MIDOCs plan is based on the premise that there are existing resources that can be leveraged to solve this problem. For starters, this is the first time that Michigan universities and their medical schools have worked collaboratively to address a statewide public health issue. The universities that are public institutions have a responsibility to help solve this problem. Next, we reached out to the Michigan Primary Care Association, the Michigan Area Health Education Centers, the Michigan State Medical Society, and many other groups, to solicit their input and help in putting this proposal together. This document is the culmination of that work. We also recognize that this document is just the first step in a longer process. We very much look forward to working with the Governor and his administration, and the legislature to put this plan into action. This would be a lasting legacy to ensure that those communities across our great state receive critically important access to high quality physicians.

## **SECTION I. MIDOCs HISTORY**

### **A. How MIDOCs Came About**

Michigan is a state rich in geographic and demographic diversity, including high density urban and low density rural communities. Despite these contrasts, the state is largely uniform in its challenge to provide access to quality health care providers. According to the Health Resources and Services Administration, 75 of Michigan’s 83 counties have at least a partial designation as a primary care health professional shortage area. Both rural and urban areas suffer workforce shortages because of the inadequate distribution of health care professionals. A 2015 report by the Citizens Research Council of Michigan indicated that Michigan will be short more than 1,500 primary care physicians by 2030. As more medical schools graduate more doctors, there is a need to place these physicians in underserved areas and to retain them in the state of Michigan. While the state has experienced a substantial increase in the number of medical school graduates, there has not been a parallel increase in funded Graduate Medical Education slots. This results in more of our medical school graduates going to other states for their residencies and likely staying there to practice.

While Michigan is ranked in the top ten for the number of residency slots, Medicare regulations have capped the number of funded residency slots in the state. This has caused hospitals to freeze its number of residency positions. Furthermore, to increase much needed physicians in underserved communities, Michigan would either need to recruit physicians from out of state or develop a system of its own to increase residency slots. To that end, MIDOCs was created as a Michigan plan of how we can retain new medical school graduates in the state and address our physician workforce problem. From the beginning, MIDOCs was charged by state legislative leaders to develop a plan that would increase the net number of residency slots in the state, be financially transparent & accountable, focus on primary care specialties including general practice pediatrics, family medicine, general practice internal medicine, psychiatry, ob/gyns, and general surgeons, and retain residents to practice in underserved communities after their training. With Medicare GME funding flat, MIDOCs and the state of Michigan would leverage Medicaid funding to finance the new residency slots.

In January 2014 Sen. John Moolenaar (R-Midland), chair of the Department of Community Health Subcommittee, submitted a legislative proposal which called for the Michigan Department of Health and Human Services (MDHHS) to work with the state's Liaison Committee on Medical Education (LCME)-accredited medical schools, or faculty physician groups affiliated with an LCME-accredited Michigan medical school, to create a Graduate Medical Education consortium. This consortium, called MIDOCs, would direct and encourage the development of new Accreditation Council for Graduate Medical Education (ACGME)-accredited residency training positions in primary care and other ambulatory care specialties to address Michigan's looming physician shortage and bring doctors to medically underserved rural and urban communities.

## **B. Legislative Support**

The Michigan legislature recognizes that a stable primary care workforce is essential to the long-term health care goals of the state, and is especially needed in our rural and urban underserved communities. As such, the legislature appropriated \$500,000 in funds to develop an implementation plan and create a legal fiduciary entity to formalize the MIDOCs Consortium. These funds are designated to obtain legal support to establish a 501c(3), if needed, engage consultants, identify leadership, develop a staffing model, including a Medicaid match expert, establish a Board of Directors and develop a full proposal to support a pilot program of 32 new residency slots.

To accomplish the above, \$250,000 has been earmarked for the 4 Consortia members to develop a comprehensive plan to create new residency slots, recommend rotation sites, ensure accreditation standards are met, and develop a data collection and distribution protocol. Each institution received \$50,000 to develop a proposal for their designated program, starting with six (6) to eight (8) residency slots per year or thirty-two (32) total over three years.

Funding would need to be appropriated for Fiscal-Year 2018 in order for the first MIDOC residency class in Academic Year 2019. It is estimated that approximately \$5 million will be needed in general funds each year, with the associated \$10 million Medicaid match (\$15 million total budget). During 3 years, this would fund approximately 90 residents, meaning the program could produce approximately 30 new physicians per year who would practice in underserved urban and rural communities across the state in specialties most in need. Some of these residencies will require a 4 year timeframe, depending on which specialty is funded (e.g. Psychiatry). While most residency programs in Michigan have costs exceeding \$200,000, it is the intent of the legislature and MIDOCs that these residency slots would have average costs closer to \$150,000. Furthermore, indirect and direct costs would be consolidated into one

distribution. MIDOCs consortium members will be required to detail costs for each funded resident. With that said, there are costs variations depending on specialty and training sites, which will be considered during the (to be determined) budget approval process.

### **C. Development of the Consortium**

MIDOCs is a program in partnership with Michigan medical schools and the MDHHS to provide medical resident positions in rural and medically underserved areas across the state. The consortium includes Central Michigan University, Michigan State University, Wayne State University, and Western Michigan University. MIDOCs will utilize the established network of Federally Qualified Health Centers (FQHCs) as placement sites and other ambulatory clinical sites as appropriate. MIDOCs will function under the terms of an agreement reached under the authority of the Urban Cooperation Act, MCL 124.501, et seq. by a consortium of Michigan medical schools. The Michigan Area Health Education Center (AHEC), a statewide network established in 2010 with five regional centers (Detroit, Grand Rapids, Mount Pleasant, Houghton Lake and Marquette), will act as a subcontractor for MIDOCs services including data development and placement services, and will function as a liaison to the FQHC network utilizing the five Michigan AHEC Regional Centers.

As the sponsoring institution and fiduciary, MIDOCs will develop, manage and administer physician-based primary care and other non-hospital based GME programs sponsored by consortium members of the program, monitoring:

- Accreditation Council for Graduate Medical Education (ACGME) status
- Financial accountability
- Clinical quality
- Educational outcomes
- Compliance with guiding principles.
- Coordination of all activities needed for program operations, including the provision of an annual report detailing per resident costs for medical training and administrative overhead as well as clinical quality measures and educational outcomes.
- Physician retention in the state of Michigan in the Health Professional Shortage Areas (HPSAs)

### **D. Mission, Vision, Goals and Guiding Principals**

The mission of MIDOCs is to increase primary care training and educational opportunities to direct, recruit, and retain physicians to practice in rural and underserved areas in Michigan.

The vision of MIDOCs is to increase the public's access to primary care to improve health outcomes of Michigan residents.

The goal of MIDOCs is to improve the health of underserved and vulnerable populations by strengthening the health workforce by connecting and retaining trained providers to communities in need.

**1. Reaching the objectives listed below is critical to the program’s success:**

- a) Retention of graduates in the State of Michigan and HPSAs
- b) Educational outcomes from innovative educational curriculum (e.g., Inter-professional education, telemedicine, population health, public health and community engagement, Patient Centered Medical Home (PCMH))
- c) Financial transparency and accountability of funds.
- d) Clinical outcomes for patient care quality, safety, and equity and cost effectiveness.

**2. Guiding principles for the 2017 MIDOCs Consortium**

- a) Alternative Medicaid GME model is required due to the combination of flat funding for GME programs and the financial limitations on hospitals to prioritize the creation of ambulatory based residency slots.
- b) Michigan based medical schools are an underutilized resource in helping produce the increasing need for primary care physicians.
- c) While hospitals will undoubtedly serve as partners in the training process, the medical schools and their affiliated physician groups will serve as the program leaders.
- d) Residency programs would be required to show detailed cost accounting for individual residents, providing the state with a return on investment for each appropriated dollar to the program. Programs will be required to submit annual audited financial statements.
- e) Program incentives will require students to commit to practicing in the state of Michigan for a designated period following the completion of their residency. Students will receive a yet to be determined incentive for compliance. Further incentives could be awarded for serving in an underserved community, as determined by MDHHS.
- f) Since most primary care residency training is performed outside of the hospital, it is assumed that these programs will cost less than the current statewide average for residency training. Cost will be a factor in determining which programs are funded.
- g) As a result of these programs being medical school based, it is assumed that these programs will incorporate innovative teaching models with special attention to integrated care, the medical home model, and the principles of the “triple aim” of health care reform (cost, quality, and access).

Timeline

2018	<ul style="list-style-type: none"><li>• Medical Schools Create MIDOCs Consortium<ul style="list-style-type: none"><li>○ Urban Cooperation Agreement between Universities &amp; MDHHS</li></ul></li><li>• State Funding Granted in FY19 Budget Process, Class of 2022</li><li>• State Amends Medicaid Plan to Incorporate MIDOCs Funding Plan</li><li>• May to July – MIDOCs Programs Send Plans to ACGME for Accreditation Approval</li><li>• September – MIDOCs Slots Included in Match Program, Recruiting Begins at Med Schools</li></ul>
2019	<ul style="list-style-type: none"><li>• April – First MIDOCs Class Selected (40 Residents)</li><li>• July – First MIDOCs Class Begins Residencies</li></ul>

	<ul style="list-style-type: none"> <li>• January – First Preliminary Report Delivered to Legislature</li> <li>• June – State Funding Granted in FY20 Budget Process, Class of 2023</li> </ul>
2022	<ul style="list-style-type: none"> <li>• Approximately 30 New MIDOCs Physicians Begin Practice in Underserved Communities Across Michigan</li> </ul>

Over a ten-year period, MIDOCs will produce approximately 300 new physicians practicing in underserved communities across Michigan.

## **SECTION II. PHYSICIAN WORKFORCE SHORTAGE**

### **A. Statement of the Problem**

The primary care system in Michigan serves as the first point of contact for the prevention, diagnosis, treatment, and management of all health concerns. An extensive body of literature demonstrates that comprehensive primary health care reduces mortality rates for a multitude of conditions associated with population health disparities, such as heart disease and cancer. Nations that have a strong network of primary care providers have lower health care costs, and better population health.<sup>14</sup>

Consequently, primary care physicians are in high demand in Michigan because of an increase in population growth, an increase in the aging population that needs more medical care in comparison to the younger population, and a greater insured population following the implementation of the Affordable Care Act (ACA).<sup>12</sup> Furthermore, 28% of active physicians in Michigan are 60 years or older, and current medical students are less likely to pursue a career in primary care.<sup>15</sup>

As a result, Michigan faces a primary care physician shortage across the state, with underserved, rural, and elderly communities being particularly vulnerable. A study done in 2013 by the Robert Graham Center indicates that currently Michigan faces a primary care physician workforce shortage of about 400 physicians. In 2025, this number increases to 707, and by 2030 Michigan will be short 862 primary care physicians. However, the latest study done by the U.S. Department of Health and Human Services in 2016, paints a much more alarming picture. In 2025 Michigan will face a workforce shortage of 960 primary care physicians, which is a 36% increase from previous estimates.<sup>13</sup>

### **B. Regional Access & Workforce Needs**

According to estimates, some 1.7 million Michigan residents don't have access to primary care health services.<sup>16</sup> To help identify and steer resources to areas facing critical shortages, the U.S. Department of Health and Human Services (HHS) developed Health Professional Shortage Area (HPSA) designation and Medically Underserved Area and Medically Underserved Population (MUA and MUP) systems.<sup>7</sup>

A HPSA is a geographic area, population group, public or nonprofit private medical facility or other public facility determined to have a shortage of primary health care professionals.<sup>7</sup> A MUA is a service area with a demonstrable shortage of primary healthcare resources relative to the needs of the entire population with the service area.<sup>7</sup> A MUP is a group of persons with a service area facing barriers to healthcare access and having a demonstrable shortage of primary healthcare resources relative to the needs of that specific population group.<sup>7</sup> Average HPSA

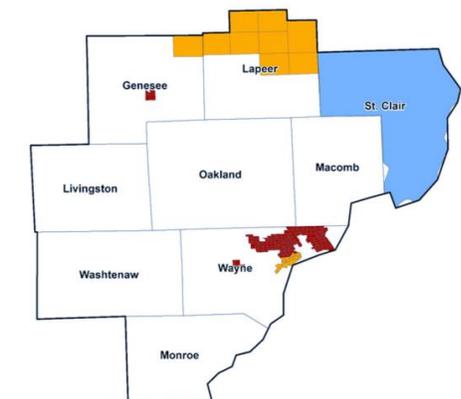
Score for Primary Care, was developed by the National Health Service Corps (NHSC) in determining the priority of assigning primary care clinicians, to a particular region. On a scale of 1-26, with 1 being the lowest need and 26 the highest.<sup>3</sup>

As stated above, 75 out of the 83 counties in Michigan face a primary care workforce shortage. Metrics like HPSA, MUA/P, and average HPSA score for primary care will be used to analyze high need counties in Michigan. Examining the state via the five different MI-AHEC regions of: Southeast, Mid-Central, Northern Lower, Upper Peninsula, and Western Michigan demonstrates where the primary care residency positions created by MIDOCs, can make the most robust impact, and are of greatest need.

## 1. Southeast Michigan Region Access & Workforce Needs

The Southeast Michigan AHEC Region consists of: Genesee, Lapeer, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne County.

**Healthcare Professional Shortage Area (HPSA) – Primary Care, 2016**  
Southeast Michigan AHEC Region



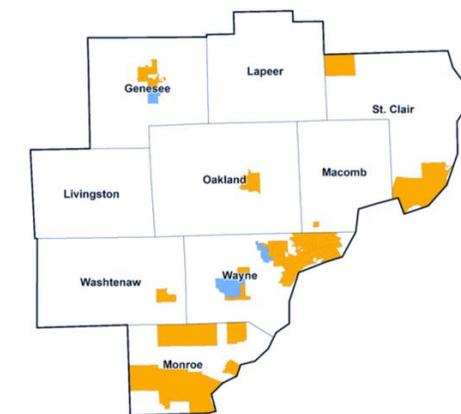
Wayne County has several large high needs geographic primary care HPSAs, along with Genesee County.

Wayne County also has an additional geographic primary care HPSA, along with Genesee and Lapeer County.

Finally, all of St. Clair County has been designated as a population primary care HPSA.

**Designated Area Type**  
■ Geographic Shortage Area  
■ High Needs Geographic Shortage Area  
■ Population Shortage Area

**Medically Underserved Areas and Populations (MUA/P), 2016**  
Southeast Michigan AHEC Region



Monroe, Wayne, and St. Clair County have a large MUA, followed by Genesee, Oakland, and Macomb County.

Meanwhile Wayne and Genesee County have regions with a MUP.

**Designated Area Type**  
■ Medically Underserved Area (MUA)  
■ Medically Underserved Population (MUP)

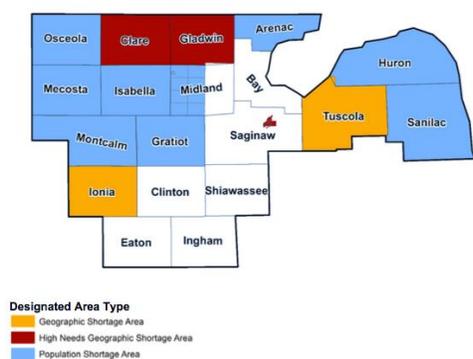
Average HPSA Score for Primary Care in Southeast Michigan AHEC Region

Wayne County has 19 primary care HPSAs that have an average HPSA score of 17, which is the worst in the state (83/83 counties). Next, Genesee County has 4 primary care HPSAs that have an average HPSA score of 14.75, which is the 8<sup>th</sup> worst HPSA score in the state. Monroe County has 1 primary care HPSA, with a HPSA score of 14.

**2. Mid-Central Michigan Region Access & Workforce Needs**

The Mid-Central Michigan AHEC Region consists of: Arenac, Bay, Clare, Clinton, Eaton, Gladwin, Gratiot, Huron, Ingham, Ionia, Isabella, Mecosta, Midland, Montcalm, Osceola, Saginaw, Sanilac, Shiawassee, and Tuscola County.

**Healthcare Professional Shortage Area (HPSA) – Primary Care, 2016**  
Mid-Central Michigan AHEC Region



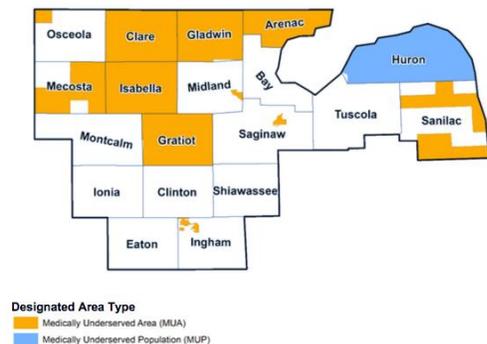
Clare, Gladwin, and Saginaw County are high needs geographic primary care HPSAs, in the Mid-Central Michigan AHEC Region.

Meanwhile, Ionia and Tuscola County are geographic primary care HPSAs.

Finally, Arenac, Osceola, Gratiot, Huron, Mecosta, Midland, Montcalm, and Sanilac have been designated as a population primary care HPSAs.

**Medically Underserved Areas and Populations (MUA/P), 2016**

Mid-Central Michigan AHEC Region



Arenac, Clare, Gladwin, Gratiot, Osceola, Isabella, Mecosta, Midland, Ingham, Saginaw, Sanilac County have been designated as MUAs.

Meanwhile all of Huron County has been classified as a MUP.

Average HPSA Score for Primary Care in Mid-Central Michigan AHEC Region

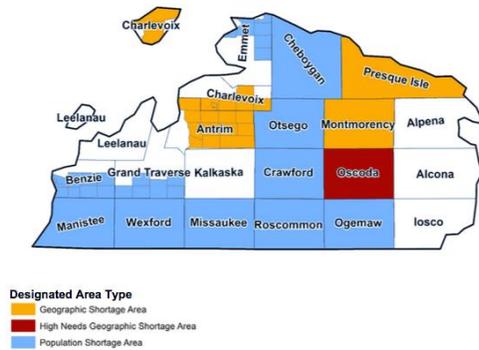
Osceola County has 4 primary care HPSAs that have an average HPSA score of 15.75, which is the third worst in the state (80/83 counties). Next, Isabella Country has 4 primary care HPSAs that have an average HPSA score of 14.25, which is the ninth worst in the state.

**3. Northern Lower Michigan Region Access & Workforce Needs**

The Northern Lower Michigan AHEC Region consists of: Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau,

Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, and Wexford County.

**Healthcare Professional Shortage Area (HPSA) – Primary Care, 2016**  
Northern Lower Michigan AHEC Region

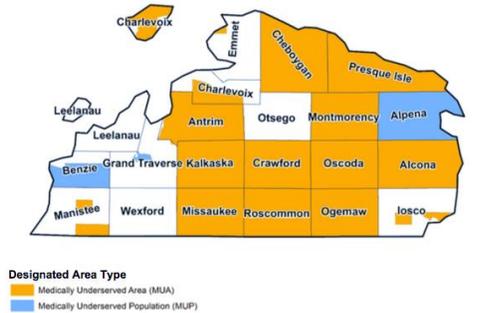


Oscoda County is a high needs geographic primary care HPSA, in the Northern Lower Michigan AHEC Region.

Antrim, Charlevoix, Presque Isle, and Montmorency County are geographic primary care HPSAs.

Finally, Benzie, Cheboygan, Crawford, Emmet, Grand Traverse, Ogemaw, Otsego, Manistee, Missaukee, Roscommon, and Wexford County have been designated as population primary care HPSAs.

**Medically Underserved Areas and Populations (MUA/P), 2016**  
Northern Lower Michigan AHEC Region



Alcona, Antrim, Charlevoix, Cheboygan, Crawford, Emmet, Presque Isle, Iosco, Kalkaska, Ogemaw, Oscoda, Manistee, Montmorency, Missaukee, and Roscommon County have been designated as MUAs.

Alpena, Benzie, and Grand Traverse County are MUPs.

Average HPSA Score for Primary Care in Northern Lower Michigan AHEC Region

Roscommon County has 4 primary care HPSAs that have an average HPSA score of 10. Oscoda County has 2 primary care HPSAs that have an average HPSA score of 9.

**4. Upper Peninsula Michigan Region Access & Workforce Needs**

The Upper Peninsula Michigan AHEC Region consists of: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft County.

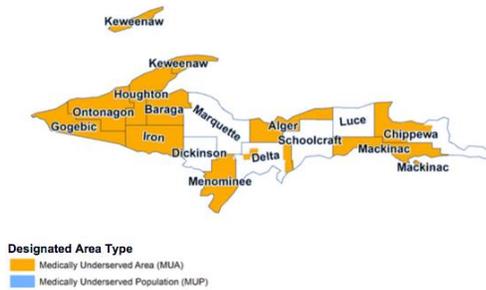
**Healthcare Professional Shortage Area (HPSA) – Primary Care, 2016**  
*Upper Peninsula Michigan AHEC Region*



Mackinac, Marquette, and Menominee County are geographic primary care HPSAs.

Next, Alger, Baraga, Chippewa, Delta, Gogebic, Keweenaw, Luce, Houghton, Ontonagon, Iron, and Schoolcraft have been designated as population primary care HPSAs.

**Medically Underserved Areas and Populations (MUA/P), 2016**  
*Upper Peninsula Michigan AHEC Region*



Alger, Baraga, Chippewa, Delta, Gogebic, Houghton, Iron, Keweenaw, Mackinac, Menominee, and Ontonagon County all have been designated as MUAs.

The Upper Peninsula Michigan AHEC Region, does not have any MUPs.

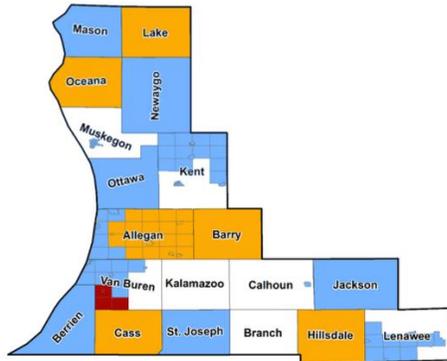
*Average HPSA Score for Primary Care in Upper Peninsula Michigan AHEC Region*

Houghton County has 4 primary care HPSAs that have an average HPSA score of 17, which is the second worst score in the state (82/83 counties). Meanwhile, Dickinson County has 3 primary care HPSAs that have an average HPSA score of 15.6, which is the fourth worst score in that state (79/83 counties).

**5. Western Michigan Region Access & Workforce Needs**

The Western Michigan AHEC Region consists of: Allegan, Barry, Berrien, Calhoun, Cass, Hillsdale, Jackson, Kalamazoo, Kent, Lake, Lenawee, Mason, Muskegon, Newaygo, Oceana, Ottawa, St. Joseph, and Van Buren County.

**Healthcare Professional Shortage Area (HPSA) – Primary Care, 2016**  
 Western Michigan AHEC Region



**Designated Area Type**  
 Geographic Shortage Area  
 High Needs Geographic Shortage Area  
 Population Shortage Area

Van Buren County is a high needs geographic primary care HPSA, in the Western Michigan AHEC Region.

Allegan, Barry, Cass, Lake, Hillsdale, and Oceana County are geographic primary care HPSAs.

Finally, Allegan, Berrien, Kent, Lenawee, Mason, Jackson, Ottawa, Newaygo, St. Joseph, and Van Buren County have been designated as population primary care HPSAs.

**Medically Underserved Areas and Populations (MUA/P), 2016**  
 Western Michigan AHEC Region



**Designated Area Type**  
 Medically Underserved Area (MUA)  
 Medically Underserved Population (MUP)

Allegan, Berrien, Branch, Calhoun, Cass, Hillsdale, Lake, Oceana, Newaygo, St. Joseph and Van Buren County have all been designated as MUAs.

Calhoun, Kalamazoo, and Kent County have all been designated as MUPs.

**Average HPSA Score for Primary Care in Western Michigan AHEC Region**

Muskegon County has 4 primary care HPSAs that have an average HPSA score of 15.5, which is the fifth worst score in the state (78/83 counties). Kent County has 5 primary care HPSAs that have an average HPSA score of 15, which is the sixth worst score in the state (77/83 counties). Cass County has 4 primary care HPSAs that have an average HPSA score of 15, which is the seventh worst score in the state (76/83 counties). Finally, St. Joseph County has 6 primary care HPSAs that have an average HPSA score of 14, which is the tenth worst score in the state (73/83 counties).

**SECTION III. COMMUNITY-BASED TRAINING MODEL**

**A. Theory of Community-Based Training**

**1. Opportunities**

Community hospital based training in urban and other settings offers the following opportunities:

- a) Provides hospitals in other than academic settings the opportunity to train residents and develop faculty for the teaching program.
- b) Residency training programs in community hospitals under the supervision of faculty enhance patient safety and quality patient care with improved outcomes.
- c) Provides a forum for continuing medical education for the attending staff of the community teaching hospital.
- d) Residents provide care for the medically and economic underserved of that teaching hospital's community.
- e) Utilizing a large urban hospital as the base specialty residency working with a smaller urban or rural hospital to create an extended primary care or psychiatry specialty residency community hospitals is a means to have residents training in smaller and/or urban communities.
- f) The opportunity of recruiting physicians to smaller and/or rural hospitals is also greatly enhanced with residents training in their communities. Forty-six (46) % of family medicine residents after graduation from their residency practice within 50 miles of their residency training.

## **2. Examples of Community based Models**

- a) CMS has designed a Rural Training Track (RTT) to accommodate the development of new teaching programs in smaller and/or rural hospitals. The program requires an urban hospital to partner with a rural hospital to create a specialty residency. The carrot that CMS offers the urban hospital is CMS will allow the urban hospital to add to its cap. These programs must be new residencies and approved by ACGME as a new program. There are 24 family medicine programs approved in various States.
- b) There are other urban rural hospital partnerships that have rural rotations so residents can have experience in rural health care.
- c) The Health Resources and Services Administration (HRSA) has provided funding for a concept called The Health Center Graduate Medical Education (THCGME) in which an ambulatory facility can partner with a hospital to develop a specialty primary care residency. In many cases the ambulatory facility is a Federally Qualified Health Care (FQHC) center. The finance mechanism is not Medicare based and the payment does not go to the hospital, it goes to the FQHC or the ambulatory unit. However, this program is at risk because Congress has currently not renewed the funds to sustain the program.

## **SECTION IV. CURRENT GME FUNDING**

### **A. Description of Current GME Process**

#### **1. Residency selection**

Upon graduation from medical school medical students choose a specialty residency (i.e. in a primary care discipline – Family Medicine, Internal Medicine, Pediatrics and/or

Psychiatry) or another specialty (i.e. General Surgery, Obstetrics and Gynecology, Radiology) or a sub specialty such as Orthopedic Surgery, Urology, Otolaryngology, etc.

In today's current primary care residency training, Internal Medicine has few practicing general internists because of the trend for residents to seek sub-specialty fellowships and hospitalists positions upon graduation from their general internal medicine residency.

In pediatric medicine it is not the same as Internal Medicine but there is a trend to sub specialize as well.

There are also other specialties (i.e. General Surgery and Obstetrics and Gynecology) needed in smaller and/or rural hospitals in the State of Michigan. However, we have focused on the family medicine and psychiatry programs as an immediate need.

## **2. The Role of the Medicare Financing Mechanism**

The Current Graduate Medical Education (GME) process is driven by the Medicare financing mechanism and the Accreditation Council for Graduate Medical Education (ACGME) accreditation requirements.

### **3. Financing Mechanism: (See Appendix 1: Medicare Graduate Medical Education Payments)**

Medicare in the Prospective Payment System (PPS) created a payment methodology for GME that is administered by the Centers for Medicare and Medicaid Services (CMS). The Medicare GME payments are:

- a) The Direct Graduate Medical Education expense (DGME)
- b) The Indirect Medical Education Adjustment (IME)
- c) The Capital Pass-through

The DGME is a pass-through payment and is not part of the Diagnostic Related Group (DRG) payment for patient clinical care. It is a payment that is determined by the initial base cost of the residents –the salary, fringe benefits and other perks. However, the hospital does not receive the full DGME because Medicare only pays its “fair share” of costs. The “fair share” of a teaching hospital is based on the hospital's Medicare inpatient volume. If the hospital's inpatient Medicare volume is 50% of the total admissions, the hospital only receives 50% of the DGME.

The IME payment is an add-on payment to the DRG. The IME was created to account for the difference in teaching hospital costs versus non-teaching hospital costs. The increase costs in teaching hospitals, are driven by a higher acuity of care and increased ancillary costs influenced by resident training.

The IME payment is driven by the Medicare inpatient collected revenue of each teaching hospital. The Medicare inpatient care revenue is a factor of both traditional and Medicare contract inpatient revenue.

- a) The Medicare GME payments are only paid to Medicare Acute care hospitals not to physicians, not to clinics and not to medical schools.

- b) Medicare in a 1997 Statute – the Balanced Budget Act – capped all teaching hospitals based on their 1997 Medicare cost reports. As a result teaching hospitals are capped and cannot increase their GME resident positions.
- c) However, they can change how they assign specialty residency positions within their cap. Many teaching hospitals use their resident positions to support sub specialty programs, which drive DRG income by taking away primary care residency positions so as not to exceed their cap.

#### **4. Description of Residency costs**

As noted above, hospitals are paid GME funds by Medicare. However, the funds paid are not based on the cost of the residency. Teaching hospitals do not receive the same funding for residents as do the FQHC/Ambulatory programs funded by HRSA.

- a) In the State of Michigan the cost for the resident’s salary, fringe benefits and perks is approximately \$85,000.00 per resident.
- b) The cost of Faculty to support a Family Medicine and/or Psychiatry program is approximately \$28,000.00 per resident and the cost of administrative support staff, operations cost and depreciation is approximately \$32,000.00 for a total cost of approximately \$145,000.00 per resident. HRSA pays a cost per resident of \$150,000.00.
- c) Faculty payments are not only for family medicine faculty but also for the non-family medicine specialists and sub specialists that are required by ACGME as faculty for the program.

### **SECTION V. FUNDING MODEL (See Appendix 2: Creation of an MIDOCs Community-Based Graduate Medical Education Add-On Payment, and Administrative Match for AHEC Activities)**

#### **A. Creation of an MIDOCs Community-Based Graduate Medical Education Add-On Payment, and Administrative Match for AHEC Activities**

Support for the community-based MIDOCs residencies would be provided through the Medicaid program in order to ensure that funds allocated by the legislature can be matched with federal funds to maximize their impact. MDHHS would establish special GME payments for clinics and other community-based training sites that agree to host the residencies. The host sites would use the GME funding to cover the costs of the residencies (which would consist primarily of payments to the medical schools for the resident time, supervisory services and other programmatic costs). In addition, MDHHS would claim matching funds on costs for certain MIDOCs programmatic activities undertaken through the MI-AHEC.

Using this approach, a legislative appropriation of \$5 million could be matched with federal funds to provide roughly \$15 million in both new Medicaid GME payments to host sites, which could fund approximately 90 new residents over a three-year period (approximately 30 residents in each class), and new administrative support for the MIDOCs programmatic work.

Specifically, the GME funding proposal would include the following elements:

##### **1. Affiliation Agreement with University(ies)**

Each training site would enter into an affiliation agreement with the university/universities sponsoring the particular residency programs from which it receives residents. Under that agreement, the school(s) would establish resident rotations at the site for specified periods of time, provide faculty physicians to supervise the residents as they provide patient care, and be responsible for the educational components of the residency through program directors and related staff.

*a) Host Payment for University Support:*

The clinic host sites would pay the university(ies) for the residents' time (a portion of the salary and benefits paid to the residents by the schools) and the related supervisory services.

*b) Host Payment for AHEC Support*

The host site might also have an agreement with the MI-AHEC to pay for some supporting services, such as resident and preceptor scheduling, data tracking, etc.

*c) Enhanced Medicaid Payments for Host Sites*

MDHHS would establish an enhanced Medicaid reimbursement rate for the host sites. MDHHS would make these payments, using the appropriated state funds as the non-federal share, and the federal government would provide federal match of at least 65 percent.

Most of the host sites will be federally qualified health centers (FQHCs). In the case of FQHCs, federal law requires the state to pay the clinics a minimum payment rate for their services, so this proposal would be an incremental add-on/increase to that mandated rate. The increase could be implemented through an alternative payment methodology that incorporates the GME costs for clinics hosting the new MIDOCs residencies, or by allowing the host clinics' GME training to be considered an expansion of the scope of services to be reimbursed through the current Medicaid payment methodology. Both approaches have been approved by the federal government in other states.

Regardless of the approach adopted, the amount of the payment increase would include the direct costs of the residencies (i.e., the payments to the schools and AHEC where applicable) as well as the indirect costs as a result of engaging in teaching activities (e.g., more tests, reduced productivity, residents learning by doing). MDHHS would develop a transparent methodology for calculating those amounts, with input from the Michigan Primary Care Association and appropriate reporting and oversight mechanisms to ensure accountability.

*d) Federal Approval*

MDHHS would need to obtain federal approval for the new payment methodology (specifically through an amendment to the State Medicaid Plan). While the approval process can be lengthy (often 6 months to a year), there should be sufficient time to work with CMS on an approvable methodology before the residencies begin on July 1, 2019.

In addition, Medicaid administrative matching funds should be available for some of the costs incurred by the universities and/or the MI-AHEC in developing the MIDOCs

initiative, coordinating among the universities, curriculum development, program evaluation, engagement of experts, etc. The matching rate for administrative costs is different than the 65 percent rate available for medical service payments, and generally is 50 percent. MDHHS would need to enter into an agreement with either the AHEC or the universities to facilitate this claiming.

In combination, the proposals outlined above will provide critical support to create training opportunities in community-based settings through the MIDOCs Initiative.

## **SECTION VI. OVERSIGHT**

A vast majority of funding for this program would be contained within the existing Medicaid funding model. Therefore, the state of Michigan would be the primary fiduciary of the program, along with the local FQHC's who incur the costs. The only exception is the administrative functions of the MIDOCs consortium including annual reporting requirements, audited financial statements, quality data, and other duties as assigned by MDHHS.

The best avenue to constitute the MIDOCs "consortium" would be by the participating medical schools entering into a contract using Act 7 of 1967 (the Urban Cooperation Act ("UCA")). The UCA provides that a "public agency of this state may exercise jointly with any other public agency of this state ... any power, privilege or authority that the agencies share in common and that each might exercise separately." MCL 124.504. Using the UCA has the advantage of not needing any new legislative authority and gives all the medical schools broad discretionary authority over what terms and conditions to include in the agreement.

Moreover, Section 7 of the UCA specifically contemplates that "An inter-local agreement may provide for a separate legal entity to administer or execute the agreement which may be a commission, board or council constituted pursuant to the agreement." Stated differently, the UCA allows MIDOCs to become a separate legal entity that can then contract with AHEC to administer the program. This could be accomplished at the outset or done through an amendment to the contract after the pilot program is complete. Section 9 also provides qualified immunity for board members and employees of the new entity. Likewise, because the an agreement reached under the UCA contemplates a joint exercise of authority there is limited risk that the appointment of officials or employees of the participating medical schools would create a conflict of interest or constitute incompatible offices under state law.

Finally, establishing MIDOCs formally under the legislative authority of the UCA provides additional assurance that the necessary amendments to Michigan's Medicaid State Plan to provide the required funding for the program will be approved at the federal level.

## **SECTION VII. THE ROLE OF AHEC**

The Michigan Area Health Education Center (MI-AHEC) is well positioned to provide the MIDOCs initiative with the support necessary to successfully launch and maintain this proposed demonstration project and plan. With five staffed Regional Center offices across the State, MI-AHEC is located in urban and rural sites that include Marquette, Houghton Lake, Mount Pleasant, Grand Rapids and Detroit. Connected by a state-wide data management system, MI-AHEC can track residents, collect both financial and operational data and report on outcomes specified by the MIDOCs plan.

The new 2017-2022 national AHEC objectives align closely with the goals of MIDOCs. Practice Transformation, provider Diversity and needs based Distribution of services are the initiatives for State AHECs around the country. Historical AHEC pillar programs of Continuing Education, Community Based Student Education and Pipeline Programs continue to be a mainstay activity for all AHECs. Graduate Medical Education and increased resident training slots in urban and rural underserved areas across Michigan is the focus of the MIDOCs initiative. Together, the objectives of MI-AHEC and MIDOCs stand ready to help meet the primary care provider needs of Michigan.

Each of the MI-AHEC Regional Centers is hosted by a partner rooted in their community and dedicated to medical education and community health care services: Northern Michigan University and their School of Health and Human Performance, Mid-Michigan Community Health Services a rural based Federally Qualified Health Center (FQHC), Central Michigan University and Mid Central Regional Center, a not-for-profit, Western Michigan University and their College of Health and Human Services and Covenant Community Care, a faith based FQHC in the inner City of Detroit all provide leadership and support to the MI-AHEC effort. In addition, each center has an established Community Advisory Board that meets quarterly, with representation from regional education, health and human service organizations and medical providers such as local FQHCs.

MI-AHEC has a 7 year history of working with state wide organizations and has developed an internal network consisting of 4 Universities with 3 Medical schools and 2 FQHCs each in both the north and south regions of the state. The support relationship to the MIDOCs Consortium, made up of 5 of the state's Medical Schools, is a strong connection developed from the common objective of addressing primary care provider shortages in Michigan.

MI-AHEC recently received letters of support and commitments of collaboration from the Michigan Primary Care Association, Michigan Center for Rural Health, Michigan Health Council, Michigan Primary Care Consortium and the Midwest Inter-professional Practice, Education and Research Center. These organizations help MI-AHEC bring the appropriate state-wide resources to the table to address access issues to health services where workforce shortages exist.

As the Consortium of MIDOCs establishes itself to provide fiduciary functions for its efforts, MI-AHEC can address any administrative and management needs of the consortium. To date, MI-AHEC has assisted the Consortium's Governmental Affairs Departments and Graduate Medical Education Leadership with budgeting and funding distribution, proposal development services and coordination of regular meetings and correspondence. These services will extend to MIDOCs field activity including support to resident placements, assistance with certification of training sites, data collection and outcomes reporting and emphasis on IPE and patient centered models of care. The strength of MI-AHEC is its familiarity with issues of patient care, student education and training and its community relationships developed at the local levels of need.

In addition, because MI-AHEC is primarily supported by HRSA and its host partners, its cost for services is very low. Passing on these savings to the MIDOCs Consortium is a great advantage and long term, can represent a significant savings to the initiative and its state and federal partners. MI-AHEC can provide or coordinate, through a sub contractual relationship with MIDOCs, a variety of management and administrative services. This business arrangement would enable MIDOCs to focus on governance and educational matters while maintaining a very low level of infrastructure costs that would traditionally be passed on to funders of the project.

The role of Michigan AHEC in the MIDOCs proposal and demonstration project strengthens the capacity to meet the plan's objectives. While the Consortium represents the state's best medical schools and graduate medical education efforts, MI-AHEC represents the linkage to underserved communities in both urban and rural underserved areas across the state. Our community and academic connections, established relationships with FQHCs and our focus as a HRSA federally funded initiative, link us to the areas of greatest primary care needs in Michigan.

## **SECTION VIII. RESIDENT RECRUITMENT & RETENTION – INCENTIVE PROGRAMS**

Working in collaboration with MDHHS, HRSA, Michigan Center for Rural Health, Michigan Primary Care Association, Michigan Osteopathic Association, and the Michigan State Medical Society; MIDOCs will develop a comprehensive plan to first recruit medical students into MIDOCs residencies and then retain them in medically underserved communities across Michigan. Residents would receive an annual payment towards their medical school debt for every year of their residency and then each subsequent year they practice within a medically underserved Michigan rural or urban community. MIDOCs would work with MDHHS, the non-profits listed above, and local communities, to design recruit plans specific to each community. It is anticipated that some or all of the incentive monies could be included in the Medicaid funding model described in Section V.

The average medical student finishes medical school with \$190,000 in debt.<sup>1</sup> This crippling debt steers graduates to higher paying specialties, where they can make three times as much in salary compared to a primary care physician.<sup>2</sup> Hence, incentives need to be provided to recruit and retain quality primary care physicians to HPSAs and underserved areas. The MIDOCs initiative will look to provide 100% debt relief for prospective physicians who are willing to make a long-term commitment to serve in a state designated underserved community. MIDOCs will first utilize all existing programs listed below and then use new funds to fill any gap. Debt relief will be a very strong tool to help draw new physicians to these underserved communities. It is our understanding from Eyman & Associates that we would be able to use the Medicaid match to leverage new dollars for medical school debt relief.

Below is a brief synopsis of federal and state physician incentive programs already in place, which can be utilized to address the primary care workforce shortage in Michigan.

### **A. Federal Physician Incentive Programs**

#### **1. National Health Services Corps (NHSC) Scholarships**

The NHSC gives 180-205 scholarships every year, out of ~2,300 applications received.<sup>3</sup> Medical students can apply for these scholarships upon matriculation to medical school. The scholarship covers tuition, fees, and offers a living stipend, in return for a commitment to work at least 2 years at an NHSC-approved site, in an underserved area. This pledge begins after a student has completed their residency training. For 1 school year of scholarship support, students must serve 2 years full-time or 4 years part-time in the designated NHSC service area. To obtain full scholarship support for 4 school years, students must serve 4 years full-time or 8 years part-time, in an underserved area.

## **2. NHSC Student Loan Repayment/Loan Forgiveness**

The NHSC also offers a loan repayment/loan forgiveness program. Primary care physicians can receive up to \$50,000 for loan repayment in exchange for a two-year commitment to serve in a designated NHSC underserved area, after residency training. The payment is tax free, and given at the beginning of service to minimize accrued interest on the physician's loans. Physicians can then apply for additional loan repayment assistance after the completion of their initial 2-year service commitment. Preference is given to physicians in areas with high HPSA scores, and those who are likely to stay in the community after their service obligation has been met.

## **3. NHSC Students to Service Program**

Available to fourth year medical students, the NHSC Students to Service program provides up to \$120,000 in loan repayment.<sup>4</sup> In exchange students make a 3-year commitment to practice in an underserved, high HPSA score community, upon completion of residency. The payment is made in four annual instalments. Again, preference is given to those who show previous experience serving in underserved communities, and are likely to stay after their service obligation is met.

## **4. Public Service Loan Forgiveness (PSLF)**

Authorized in 2007 under the College Cost Reduction and Access Act of 2007 (CCRAA), PSLF can also be used to recruit primary care physicians to HPSA areas.<sup>6</sup> If physicians make 10 years' worth of loan repayments, while serving full-time in a HPSA area, any loan balance after that 10 year period is forgiven. However, there has been recent talk of capping this program.

## **5. Medicare HPSA Bonus Payment**

While loan repayment/forgiveness programs show to be the most effective in recruiting and retaining primary care physicians to HPSA areas, other factors like the Medicare HPSA bonus payment can be used in recruitment packages to primary care physicians.<sup>2</sup> Specifically, the Medicare HPSA bonus payment results in a 10 percent bonus payment for physicians who provide services to beneficiaries in a HPSA.<sup>5</sup> This bonus is paid quarterly.

## **B. Michigan Physician Incentive Programs**

### **1. Michigan State Loan Repayment Program (MSLRP)**

The MSLRP was established in 1990 as a federal, state, and local partnership administered by the Michigan Department of Community Health (MDCH).<sup>7</sup> A combination of funding from federal, state, and local sources is combined to provide loan repayment for up to four years, to primary care providers upon completion of residency. In exchange, participants will be required to serve in a HPSA area, working 40 hours a week, with 32 hours of direct patient care, for a minimum of 45 weeks a year. Initial MSLRP loan repayment agreements are for two years, with an annual repayment from \$25,000 to a maximum of \$35,000 per year, for primary care physicians.<sup>8</sup> After the initial 2-year service agreement is completed, physicians can apply for an additional 2-year commitment. Practice sites given preference include Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes, Critical Access Hospitals (CAH) and Certified Rural Health Clinics (RHCs) that have been designated as facility HPSAs.<sup>7</sup>

In 2014, the MSLRP had a total budget of \$1,594,430 (a reduction from \$1,693,000 in 2013).<sup>8</sup> This consisted of a \$569,400 federal program award, \$666,250 in state funds, and \$358,780 in employer contributions.<sup>8</sup> On a year to year basis funding comes 40 percent from federal funds, 40 percent from state funds, and 20 percent from employer contributions. In 2014, 14 primary care physicians received MSLRP assistance (8 MDs & 6 DOs).

## **2. NHSC**

The MDCH collaborates with the federal government in the administration of the NHSC student loan repayment/loan forgiveness and scholarship program, as described above. MDCH is responsible for the review of applications, recommends NHSC site applications and provides technical assistance to sites and providers. In Michigan, there are 489 NHSC approved sites, in HPSA areas.<sup>7</sup> It is important to note that competition is fierce for these programs, due to limited funding.

## **3. Conrad J-1 Visa Waiver Program**

MDCH also runs the State Conrad 30/J-1 Visa Waiver Program, with the intention of improving access to primary health care services, and reducing health disparities in HPSAs and MUAs/MUPs. This federal program allows each state to recommend 30 physicians a year to receive a waiver of J-1 educational visa requirements in exchange for serving in a medically underserved community for 3 years full-time.<sup>7</sup> Priority is given to safety net provider sites that include: county health departments, FQHCs and look-alikes, community mental health centers, free clinics, public and critical access hospitals, and certified rural health clinics.

This program has been vital in maintaining access to healthcare in many rural communities, when other recruitment efforts have failed. Michigan has used all the 30 slots every year between 2001 and 2012, placing 350 providers in HPSA areas.<sup>7</sup>

## **4. Primary Care Provider Incentive Payment Program**

As stated in Section 1801 of Public Act 252 of 2014, the Michigan Department of Health and Human Services (MDHHS) provides an increased payment rate for Medicaid primary care services rendered by primary care providers.<sup>9</sup>

## **5. Physician Signing Bonus**

Less conventional means to recruit a primary care physician to a HPSA, entail a signing bonus. The average signing bonus in 2017 for a primary care physician was \$32,636.<sup>10</sup> Signing bonuses, offer physicians a great way to make a dent in their medical education debt.

## **C. Other State Physician Incentive Programs**

### **1. Georgia (See Appendix 3: *GME in Georgia: Growth, Funding and Sustainability*)**

In addition to providing loan repayment/forgiveness programs and expanding GME funding, Georgia offers a rural provider tax credit program for recruiting and retaining primary care physicians in rural areas.<sup>11</sup> Physicians can receive up to \$5,000 per year in tax credit, for up to 5 years for practicing in a designated high need rural area.

## **SECTION IX. UNIVERSITY RFP PROPOSALS (See Appendix 4)**

The Michigan legislature appropriated \$500,000 to MIDOCs to be used as planning funds. A Request for Proposal (RFP) was issued to Central Michigan University, Michigan State University, Wayne State University, and Western Michigan University, to develop university specific plans to increase primary care based residency slots in the state. Each of those institutions received \$50,000 to develop a plan that would address needs in their particular service areas of the state. Each plan was required to provide:

- Initial needs assessment for planned program expansion (specialty and sites)
- ACGME accreditation status
- Complete a financial proforma, including identification of possible sources of revenue other than from clinical activities, including GME support. Anticipated expenses to support the expanded residency training program
- Proposed mechanism or incentive plan to recruit residents to this program
- Preceptor roles, responsibilities and supervision requirements
- Description of innovative educational curriculum
- Define placement needs to inform AHEC (housing, transportation, other)
- Resident placement plan beyond pilot program
- Physician retention plan (post-graduation from residency program)
- Outline educational outcomes
- Outline clinical outcomes
- Description of utilization of the resources provided by Michigan AHEC and regional centers

These four plans, in total, would create approximately 35 to 40 new residency slots in the first year and would create approximately 400 new primary care physicians in a ten year span. You can review each plan below in the appendix section.

- A. Central Michigan University (4.1)**
- B. Michigan State University (4.2)**
- C. Wayne State University (4.3)**
- D. Western Michigan University (4.4)**

## **SECTION X. RESOURCES AND REFERENCES**

Resources

- A. [AHEC Needs Assessment](#)**
- B. [Michigan Primary Care Health Centers](#)**

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### **Medicare Graduate Medical Education Payments**

The Federal Government through the Medicare Payment System provides two payments to teaching hospitals for their Accreditation Council for Graduate Medical Education (ACGME) Graduate Medical Education (GME) program costs.

The two payments are:

- The Direct Graduate Medical Education expense (DGME) ,and
- The Indirect Medical Education adjustment (IME)

### **Direct Graduate Medical Education (DGME)**

The Medicare DGME payment is a pass-through and not part of the Diagnostic Related Group (DRG) payment for patient clinical care. The DGME payment was created by the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1985. The statute required the Federal Government's Medicare Agency, the Health Care Financing Authority (HCFA) - which today is known as the Center for Medicare and Medicaid Services (CMS) – to audit the 1984-85 GME costs of every teaching hospital in the United States. The audits were conducted over a five year period and in February 1991, HCFA sent a notice of Program Reimbursement (NPR) to all teaching hospitals. The NPR stated the Per Resident Amount (PRA) or the amount of GME costs divided by the resident count for 1984-1985 that HCFA had determined from its audit of the teaching hospital. Note: The DGME cost is hospital specific.

The DGME of a teaching hospital is not the payment that the teaching hospital receives. Medicare only pays its "fair share" of costs. The "fair share" of a teaching hospital is based on the hospital's Medicare inpatient volume. To relate the DGME payment to the resident, the hospital's resident count is divided into the DGME and the payment per resident is determined. Note: The resident count is not the employee count of the hospital. The resident count is determined by the time that the resident actually is in the teaching hospital or in a physician's office if the physician is a faculty member of the teaching hospital and the teaching hospital has a signed agreement with the physician. If the resident rotates out of the parent teaching hospital to another hospital, the parent teaching hospital may not count that time nor receive a DGME payment from Medicare for that resident even though the parent teaching hospital employs the resident and pays the resident a salary with fringe benefits.

The DGME is calculated in the following manner:

- If the PRA of the teaching hospital determined by the HCFA audit is \$1,000,000 and the resident count at that teaching hospital is 20 residents the per resident amount is \$50,000 per resident. The \$50,000 is then multiplied by the teaching hospital's Medicare inpatient utilization. We will assume that this teaching hospital has an inpatient Medicare utilization of 50%.

- Therefore the 50,000 is multiplied by 50% and a resident amount of \$25,000 will be paid to the teaching hospital.

### **The weighted DGME payment**

The DGME payment is also weighted by first board qualification. If a medical student selects a specialty residency for training that has a three year board qualification residency training requirement, Medicare will pay the teaching hospital a full PRA payment. However, if the resident upon completion of the requirements of his/her first board qualification, decides to continue training in another specialty or subspecialty, the teaching hospital will only receive one half (50%) of the Medicare resident payment for the additional training passed the first board qualification.

The resident count of most teaching hospitals has a DGME weighted resident count and an IME resident count. The IME resident count is **not** a weighted count so the IME payment is not reduced as the resident continues his/her specialty or subspecialty residency or fellowship training.

Medicare and its Fiscal Intermediary (FI) determine the resident's first board qualification after the resident completes his/her first year of residency training. Medicare only allows a maximum of five years for a full DGME payment. After five years the teaching hospital would only receive 50% of the residency amount for those residents that train beyond the maximum of five years.

In Addition, if a resident training for first board qualification goes beyond five years of training, Medicare will only pay 50% of the resident payment after five years.

### **The IME Payment**

The IME payment is an add-on payment to the DRG. The IME was created to account for the difference in teaching hospital costs versus non-teaching hospital costs. The increase costs in teaching hospitals, are driven by a higher acuity of care and increased ancillary costs influenced by resident training.

The IME is an algorithm/ formula using a resident to bed ratio as the means to calculate the payment. The IME algorithm/formula is:

$$1.35 \times \left[ \left( 1 + \frac{\text{\# of Res.}}{\text{\# of Beds}} \right)^{0.405} - 1 \right]$$

The front loader 1.35 was originally 2.00 when the IME was created. However, over time the Federal Government has reduced the IME payment and CMS, Medicare's agent continues to lobby Congress to reduce the IME payment.

In the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 promulgated a reallocation of residents rule. If a teaching hospital was not filling all of its resident's positions relative to the cap on the teaching hospital resident count established by the Balanced Budget Act 1997, the teaching hospital would forfeit 75% of the resident count it did not fill for fiscal year 2002. If a teaching hospital added residents to its resident count by the MMA reallocation rule, the teaching hospital only

receives approximately one half of the IME payment for those residents added by the reallocation rule.

The IME payment is driven by the Medicare inpatient collected revenue of each teaching hospital. The Medicare inpatient care revenue is a factor of both traditional and Medicare contract inpatient revenue.

### **Summary of DGME and IME Payments**

The two Medicare payments – DGME and IME are paid by Medicare to teaching hospitals. Medicare DGME and IME payments are **not** paid to physicians, clinics, VA hospitals, medical schools, and other non-hospital facilities. An acute care hospital which has a Medicare number is the only provider eligible for Medicare GME payments. Current Medicare GME payments to teaching hospitals provide a valuable resource to teaching hospitals. The payments offset the cost of resident salaries, fringe benefits, faculty cost, staff costs and GME operating expenses. From the description of the two Medicare GME payments above, the DGME is based on the GME costs even though the DGME does **not** pay for 100% of the GME costs, Medicare pays only its “fair share”. In addition, the DGME is not based on current costs since it was derived from the audit of the teaching hospital’s 1984-1985 teaching costs. Medicare has provided an annual update but it does not keep up with the increase in salaries for residents, faculty costs driven by increases in compensation as well as accreditation agencies requiring additional faculty commitments. However, with the IME payment, which most teaching hospitals recognize as a Medicare payment that is only received if there are GME programs with a resident count, teaching hospital’s can usually cover the GME expenses.

CMS continues to publish rules that seek to reduce the IME payments, as well as rules to change the DGME payment. Competent well trained physicians must be continually recognized as a value to our society and our future health care.

### **Creation of an MIDOCs Community-Based Graduate Medical Education Add-On Payment and Administrative Match for AHEC Activities**

The Medicaid program is a significant source of federal support for graduate medical education (GME), and presents a range of opportunities to leverage the state's funds in support of the initial pilot phase of the MIDOCs residency program, as well as future expansion and innovation.

The most feasible approach to achieving approval and implementation of new Medicaid support for residencies starting July 1, 2019 is to create new Medicaid GME payments for the MI DOCS's community-based clinical training sites. The Michigan Department of Health and Human Services (MDHHS) would establish special graduate medical education (GME) payments for clinics and other community-based training sites that agree to host the residencies. The new GME funding would enable the host sites to cover the costs of the residencies—including payments to the medical schools for the resident time, supervisory services and other programmatic costs. In addition, federal Medicaid matching funds can be claimed for certain administrative activities undertaken to develop, implement and evaluate the MIDOCs initiative.

Using this approach, a legislative appropriation of \$10 million could be matched with federal funds to provide roughly \$30 million in both new Medicaid GME payments to host sites, which could fund 90 new residencies over a three-year period, and new administrative support for a portion of the MIDOCs costs.

#### **A. GME Funding Proposal**

Many of the proposed community-based training sites will be Federally Qualified Health Centers (FQHCs). Therefore, this report considers in detail the options for the creation of new GME payments for FQHCs hosting the new MIDOCs residents. A similar Medicaid GME add-on payment could be adopted for other provider types to the extent that they serve as MIDOCs training sites.<sup>1</sup>

Each provider serving as a training site would enter into an affiliation agreement with the university/universities sponsoring the particular residency programs from which they receive residents. Under that agreement, the school(s) would establish resident rotations at the clinic for specified periods of time, provide faculty physicians to supervise the residents as they provide patient care, and be responsible for the educational components of the residency through program directors and related staff.

The clinic host site would pay the university(ies) for the residents' time (a portion of the salary and benefits paid to the residents by the schools) and the related supervisory services.<sup>2</sup> The host site might also have an agreement with the MI-AHEC for some supporting services, such as resident and preceptor scheduling, data tracking, etc. In addition to the direct costs of these agreements, the health centers would also incur indirect patient care costs as a result of engaging in teaching activities. These indirect costs, which are more difficult to isolate, include the costs of reduced clinical productivity due to the training, an increase in the number of diagnostic tests ordered, the cost of residents learning by doing, etc.<sup>3</sup>

### ***Developing Enhanced Medicaid Payments for Host Sites***

Under federal Medicaid law, MDHHS generally must pay FQHCs a prospectively-set, per-visit rate for their services, based on historic costs for a defined scope of services,<sup>4</sup> or an alternative payment methodology (APM) that results in payments no less than the FQHC would have received under the prospective rate.<sup>5</sup> States implementing the statutory prospective rate must adjust the rate to account for changes in the scope of services provided by the FQHC.

To support the MIDOCs initiative, MDHHS would increase or create an add-on to the per-visit payment rate for health centers that serve as MIDOCs clinical training sites to reflect the additional residency-related costs they incur. The increase could be implemented through an alternative payment methodology that incorporates the GME costs for clinics hosting the new MIDOCs residencies, or by allowing the host clinics' GME training to be considered an expansion of the scope of services to be reimbursed through the current Medicaid payment methodology. MDHHS has already used the APM approach to create supplemental payments for FQHCs providing certain dental services.<sup>6</sup> CMS recently approved the use of an APM to support FQHC GME costs related to training primary care physicians in New Mexico, which could serve as a model for Michigan.<sup>7</sup> CMS also approved expansion of a clinic's scope of services to include GME in California<sup>8</sup> and Texas.<sup>9</sup>

Regardless of the approach adopted, the amount of the payment increase would include the direct costs of the residencies (i.e., the payments to the schools and AHEC where applicable) as well as the indirect costs as a result of engaging in teaching activities (e.g., more tests, reduced productivity, residents learning by doing). MDHHS would develop a transparent methodology for calculating those amounts, with input from the Michigan Primary Care Association, as well as appropriate reporting and oversight mechanisms to ensure accountability.<sup>10</sup> The methodology would likely be limited to Medicaid's share of those costs (e.g., based on the share of FQHC visits that are for Medicaid patients).

### ***Process and Timeline for Development and Approval***

MDHHS would need to seek federal approval of an amendment to the State's Medicaid Plan in order to draw down federal matching funds.<sup>11</sup> The State Plan Amendment (SPA) would clearly define the new GME payment targeted to providers hosting MIDOCs residents. While the approval process can be lengthy (often 6 months to a year),<sup>12</sup> there should be sufficient time to receive approval before the residencies begin.<sup>13</sup>

Implementation of GME payments for FQHCs would require additional procedural steps, which could be undertaken while the SPA is undergoing federal approval. For example, if MDHHS uses the APM approach, it must enter Memoranda of Agreement (MOA) with the affected health centers and receive federal approval of the MOAs.<sup>14</sup> If MDHHS uses the change in scope of service approach, the MIDOCs clinics must request an adjustment to their payment rate from MDHHS at least 90 days in advance. MDHHS will also need to confirm whether they would require health centers to seek approval from the federal Health Resources and Services Administration for a change in the scope of project to include GME before approving a rate adjustment.

### ***Federal Matching Rate***

The usual federal matching rate of 64.78% (for FY2018) would generally apply to the GME payments, as payments for medical services. To the extent the health centers provide services

to individuals made eligible through the Medicaid expansion, the state would receive an enhanced federal matching rate for that portion of the payments (90% beginning in federal fiscal year 2020). Therefore, the actual matching rate for the GME payments is likely to be higher than 64.78%.

### **B. Administrative Matching Funds for AHEC Activities**

Medicaid administrative matching funds also should be available for some of the costs incurred by the universities and/or the MI-AHEC in developing the MIDOCs initiative, coordinating among the universities, curriculum development, program evaluation, engagement of experts, etc.<sup>15</sup> Federal rules define allowable costs for purposes of such administrative claiming.<sup>16</sup>

MDHHS would need to enter into an agreement with either the AHEC or the universities to facilitate this claiming. MDHHS would use a portion of the requested appropriated funds as the non-federal share of the payments for the services under the agreement, to be matched with federal funds. The matching rate for administrative costs is different than the 64.78 percent rate available for medical service payments, and generally would be 50 percent.<sup>17</sup>

### **C. Other Medicaid Payment Opportunities for Future Consideration**

In addition to the proposals above, as the MIDOCs initiative progresses, the state could pursue additional federal Medicaid funding to support it through an incentive program. For example, the state could provide incentive payments to the host sites working with the universities and AHEC to undertake specific workforce development metrics or to meet certain measures, using new managed care authority to direct health plan expenditures through delivery system reform or performance improvement initiatives.<sup>18</sup> The state could also seek approval of a Medicaid demonstration to create payments that directly support the universities in developing and expanding community-based residency programs.<sup>19</sup>

## Example of FQHC Host Site Affiliations and Related GME Activities

## Example Matching of State Funds to Support Enhanced Medicaid Payments to FQHCs Hosting MIDOCs Residents

<sup>1</sup> Notably, Medicaid managed care regulations permit states to make GME payments to providers directly, without having to incorporate the payments into rates paid to managed care plans. 42 C.F.R. §438.60.

<sup>2</sup> The payment to the university would be one part of the affiliation, which would outline the university and FQHC's respective roles and responsibilities for the training.

<sup>3</sup> Such indirect medical education costs are recognized and reimbursed by Medicare.

<sup>4</sup> Soc. Sec Act § 1902(bb)(3)(B).

<sup>5</sup> Soc. Sec Act § 1902(bb)(6). The affected health centers must agree to accept the APM.

<sup>6</sup> MI State Medicaid Plan, Attachment 4.19-B, Page 6c.1; MI SPA 14-006, approved Sep. 14, 2014.

<sup>7</sup> NM State Plan Amendment 16-0002, approved Mar. 2, 2017.

<sup>8</sup> California Code, Welfare and Institutions Code - WIC § 14132.100.

<sup>9</sup> TX Admin. Code §355.8261(a)(7).

<sup>10</sup> It is important to note that federal Medicaid support will likely be approved only for Medicaid's share of the training costs (for example, a portion of the FQHCs total residency-related costs based on the share of the FQHC's total visits that are for Medicaid patients).

<sup>11</sup> The current State Plan provisions related to FQHC reimbursement do not include a GME add-on as part of the APM, and does not list the addition of GME costs as a change in scope requiring an increase in Medicaid payment.

<sup>12</sup> The state must provide 30-days' public notice prior to submitting the state plan amendment (SPA) to CMS. CMS technically has 90 days to approve, but often requests additional information from the state, which tolls the 90-day clock.

<sup>13</sup> CMS has limited discretion and must approve the proposal if it is consistent with Medicaid requirements (which it should be given precedent in other states).

<sup>14</sup> Michigan Medicaid Provider Manual, FQHCs, Sec. 5.8.

<sup>15</sup> See Soc. Sec. Act § 1903(a)(7); 42 CFR § 433.15(b)(7).

<sup>16</sup> See, e.g., CMS Medicaid Administrative Claiming website at <https://www.medicaid.gov/medicaid/financing-and-reimbursement/admin-claiming/index.html>; OMB Circular A-87.

<sup>17</sup> 42 CFR 433.15. Higher matching rates are available for a limited scope of administrative expenditures. See 42 CFR 433.15(b)(1)-(6).

<sup>18</sup> 42 C.F.R. §438.6(c)(ii). Arizona, for example, has received approval to establish a Targeted Investment Program that will require MCOs to make incentive payments to providers that implement pre-approved delivery system reform projects related to the integration of physical and mental health care systems. Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Demonstration, Special Terms and Conditions, 47-55, referencing authority of §438.6.

<sup>19</sup> For example, Tennessee's Medicaid Section 1115 demonstration program includes a GME pool from which the state makes payments to four designated medical universities to support training and retention activities. (TennCareII 1115 Waiver Demonstration, STC 52.) Minnesota created a Medical Education and Research Costs Trust Fund, part of which is designated for annual payment amounts to identified institutions, to support training opportunities in rural areas and increase the number of primary care physicians. (MN 1115 Waiver, STC 23.)

# **GME IN GEORGIA: Growth, Funding, and Sustainability**

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## **Executive Summary of GME Programs in Georgia and Funding Stream Estimates for GME in FY 16:**

### **GENERAL:**

In FY 2016 there were 2,315 residents training in GME programs spread across 14 hospitals. Georgia continues to have an imbalance between the number of students graduating from in state medical/osteopathic schools (approximately 594 in 2012) and the number of available GME 1<sup>st</sup> year training slots (473 in 2012).

### **FINANCING IN FY 16:**

The Board of Regents through the GME Expansion Program, provided **\$4,275,000** to 3 hospitals who were engaged in GME expansion efforts.

The Georgia Board of Physician Workforce provided approximately **\$6,612,493** in Specialty Specific Residency Capitation payments to support **383** residency slots in certain programs (primarily **Primary Care** disciplines.) Through the (general) Residency Capitation program, the GBPW provided payments of \$3,172 per resident for a total of 2,315 residents at 14 hospitals (approximately **\$7,343,180**). (Some federal dollars are drawn down so the total of the above two programs is not strictly reflecting state dollars).

The Georgia Department of Medical Assistance provided approximately **\$100,000,000** in GME payments added to claims from hospitals supporting GME programs based on the Medicaid share of hospital billings; some of these dollars are obtained through the Medicaid match from the federal government so all were not State funds.

### **Medicare payments vary significantly for residency programs based on when the program was established.**

On average, Medicare provides approximately **\$100,000** per resident within the cap allotted to each GME program; programs established before 1997 receive on average almost ½ of the payments provided to new programs. *For example, Augusta University receives \$23,000 per resident in direct GME funding from Medicare; new programs will receive approximately \$45,000 per resident. When indirect and direct GME payments from Medicare are totaled, Augusta University receives approximately \$80,000 per resident while new programs will receive approximately \$135,000 per resident from this funding source.*

### **FAST FACTS:**

Since FY 13, Georgia has invested over **\$17 million** to develop new GME slots in 9 hospitals in the state who had not previously sponsored GME programs. Existing GME programs already established at 10 teaching hospitals were not eligible for these funds to expand their existing programs.

Georgia's goal was to open 400 new GME slots across the state, with a focus on **Primary Care**. If all projected programs open the planned residencies, Georgia will have an estimated **581** new slots by 2025.

As new programs come on line, many are or will be eligible for state Residency Capitation funding and Specialty Specific Residency Capitation; the projected shortfall for the GBPW to provide the latter in FY 18 is **\$761,651**.

Funding for GME sustainability in Georgia is provided by Medicaid, GBPW, and Medicare. The Veteran's Administration also supports some residency slots in Augusta and Atlanta. The Board of Regents has administered the GME Expansion funds through the GREAT Committee.

***The complexity of GME funding is made more challenging by the difficulty of obtaining pertinent data and the lack of public transparency concerning funding from certain sources.***

## **GME IN GEORGIA: Growth, Funding, and Sustainability**

### **BACKGROUND:**

Between 1990 and 2010, Georgia's population grew from 6.4 to 9.7 million- a 77% growth. Comparatively the U.S. population grew 36%. New England states consistently *lost* population during this time of population growth nationally, and most dramatically in the South. New England, which includes all states with a greater than 50 GME residents/100,000 population ratio has a physician to population rate of 350/100,000. Georgia, which is capped by the Balanced Budget Act of 1997 at 20.8 GME residents/100,000 population has a physician to population rate of 200/100,000.

***It can take 11-16 years post high school to educate and train a new physician.*** In the United States, students training to be physicians spend approximately four years pursuing an undergraduate degree, followed by four years of medical school. Upon graduation from medical school, they receive their MD/DO degrees and license. Following medical school is the period most commonly called Graduate Medical Education (GME) or ***residency*** training. During this period, students see and treat patients under the supervision of more seasoned physicians. This training usually takes place in hospitals. On average, physicians spend four years in graduate training, although the length of training in highly specialized fields is several years longer and some primary care disciplines require only three years of residency training.

Residency programs are strictly regulated by state and federal governments and the Accreditation Council for Graduate Medical Education (ACGME). Each one is unique in many ways, but all fall under the same mandates.

## **GROWTH OF GME IN GEORGIA**

### **GME HOSPITALS AND SLOTS IN GEORGIA CIRCA 2010**

During the mid-2000's, Georgia was committed to understanding its physician supply and its educational resources in place to meet shortages predicted on the horizon. This was done through review of its medical education programs (medical school enrollment) and its GME slots available across the state. It became clear that while the medical schools were expanding, the GME programs were not, resulting in a negative position of graduating more medical students than could be trained in the state. Compounding this problem were data indicating Georgia medical school graduates were not choosing Georgia residency programs for their training, thus significantly reducing their retention in the state (particularly in primary care disciplines.) **In 2010-2011, the state had 10 teaching hospitals with a total of 2,166 GME slots and graduated approximately 575 residents a year. Of the 747 first year GME slots in the state, approximately 15.8% (106) were filled by graduates of Georgia medical schools.**

### **GEORGIA'S GME EXPANSION INITIATIVE**

Circa 2009, at the direction of Governor Nathan Deal, and in cooperation with the Georgia General Assembly, the University System of Georgia (USG) began a concerted effort to expand new graduate medical education programs at hospitals ***without established GME programs*** in the state to address an impending physician shortage that could cripple the state's health-care system.

The Governor created a GME advisory committee to guide the Board of Regent’s implementation of the GME expansion plan. Through the creation of the GME Regents Evaluation and Assessment Team (GREAT Committee), the USG devised a template for distribution of funds to potential GME hospitals; created an application process; developed eligibility criteria including a required 1:1 funding match of hospital and state funds; and established a requirement that all programs must secure ACGME accreditation – although dual accreditation is permitted. The GREAT Committee focused on the following:

- Developing opportunities for USG and Georgia hospitals to work together to create 400+ new residency positions;
- Narrowing the gap between the number of medical school graduates in the state and the number of 1st year GME positions available in state;
- Increasing the number of residents in Georgia to more appropriately reflect the southeastern per capita rate of residents to population; and
- Focusing on Primary Care programs and General Surgery, particularly in rural parts of Georgia.

For a new teaching hospital, GME start-up costs are estimated to be \$2 - \$8 million depending on the number of residency programs (disciplines), number of faculty to recruit, etc. Through the GME expansion program, the state committed to bearing up to 50% of these costs at each hospital; there are no ceilings or limits on the funding that an eligible hospital can receive. State GME expansion funds continue until the first resident reports for duty. (Medicare GME payments to the hospital begin on the first day a resident is on duty.)

The initiative has been successful in securing ongoing budgetary commitment from state leaders. Funding began with a \$1.2 million state appropriation in FY13 and has continued to flow. To date, **\$17,161,925** has been provided to fund GME expansions. While it is difficult to obtain the specific data about expenditures of the expansion funds, the following summarizes the best approximate numbers **encumbered** for each fiscal year. Where noted, funding include special funding from the legislature for specific hospitals through the Georgia Board for Physician Workforce.

<b>TABLE 1: GME Expansion funding recipients, as encumbered, FY 13-FY 16</b>					
<b>Institution</b>	<b>FY 13</b>	<b>FY 14</b>	<b>FY 15</b>	<b>FY 16</b>	<b>Total</b>
<b>Athens Regional</b>	\$620,000	\$631,000	\$900,000	-0-	\$2,151,000
<b>Gwinnett Medical</b>	\$280,000 <b>\$150,000*</b>	\$350,000 <b>\$150,000*</b>	\$350,000 <b>\$150,000</b>	\$375,000	\$1,355,000 <b>\$450,000*</b>
<b>St. Mary’s</b>	\$250,000	\$300,000	\$325,000	-0-	\$875,000
<b>South Georgia</b>	\$50,000 <b>\$523,000*</b>	\$694,000	-0-	-0-	\$744,000 <b>\$523,000*</b>
<b>Wellstar</b>		\$500,000	\$1,400,000	\$2,000,000	\$3,900,000
<b>Tanner</b>		\$400,000	\$700,000	-0-	\$1,100,000
<b>Redmond Regional</b>		\$400,000	\$800,000	-0-	\$1,200,000
<b>NE Georgia</b>				\$1,900,000	\$1,900,000
<b>University</b>			\$800,000	-0-	\$800,000
<b>Total Expansion Funds</b>	<b>\$1,200,000</b>	<b>\$3,275,000</b>	<b>\$5,275,000</b>	<b>\$4,275,000</b>	<b>\$14,025,000</b>
<b>Total Special Funds *</b>	<b>\$673,000</b>	<b>\$150,000</b>	<b>\$150,000</b>	-0-	<b>\$973,000</b>

The USG has a total of **nine partners** to date to establish new GME programs: WellStar Health System in Marietta, Gwinnett Medical Center, St. Mary’s Health Care System in Athens, Athens Regional Medical Center, Tanner Health System in Carrollton, Redmond Regional Medical Center in Rome, University Hospital in Augusta, Northeast Georgia Medical Center in Gainesville, and the South Georgia Medical Education Consortium.

**GEORGIA GME EXPANSION PROGRESS TO DATE**

The Governor and the legislature have remained steadfast in the commitment of funds and personnel to achieve this goal. Between FY 13 and FY 17, with approximately **\$17,161,925 in state appropriations**, the GME Expansion program has demonstrated success. **To date, with several programs still in development, the state is on track to open 581 new residency slots by FY 25.** Ninety-seven of these slots were already open and accepting students in FY 17. Table 2 reflects the projected growth in GME slots by discipline in the state.

**Table 2: Georgia New Residency Slots Projected, per year, FY 15- FY 25**

Discipline	FY15 14-15	FY16 15-16	FY17 16-17	FY18 17-18	FY19 18-19	FY20 19-20	FY21 20-21	FY22 21-22	FY23 22-23	FY24 23-24	FY25 24-25
Internal Medicine		16	66	119	157	184	209	234	234	234	234
Family Medicine	5	10	21	31	56	83	106	114	114	114	114
OB/GYN				4	8	16	24	32	40	44	48
General Surgery					4	16	28	40	52	60	60
Emergency Medicine					8	16	29	34	39	39	39
Psychiatry						4	8	17	26	31	36
Transitional Year			10	32	40	40	50	50	50	50	50
<b>TOTAL</b>	<b>5</b>	<b>26</b>	<b>97</b>	<b>186</b>	<b>273</b>	<b>359</b>	<b>454</b>	<b>521</b>	<b>555</b>	<b>572</b>	<b>581</b>

Clearly the process and mechanisms established to identify potential new hospitals and the provision of expert technical and financial assistance to these hospitals has been successful. **However, the opening of new slots and addressment of the GME imbalance was only part of the initiative. The enduring strategy was to create these new slots to strengthen the pipeline of physicians receiving their education and training in state, and then choosing to establish their practice in Georgia.** According to data from the Georgia Board for Physician Workforce, if a medical student is from Georgia, attends a Georgia medical school, and then trains in a Georgia GME program, there is approximately a **79-82%** chance of retaining this provider in the state. If an individual only does the GME training in the state, there is only a **49%** retention rate.

**While Georgia is not on track to meet the national ratio of medical school graduates to available GME slots in the state, we will have met and surpassed the regional ratio by 2025, meeting the goals of the GME Expansion Project.**

## GME FUNDING IN GEORGIA

### 1. **FEDERAL (MEDICARE) FUNDING OF GME IN GEORGIA**

**Medicare funding in General:** Before the Medicare program was created, GME was funded directly by hospitals. Residents were provided with a small cash stipend, room, board, and laundry and other services. Hospitals would directly and indirectly recover some of these costs through insurance billing. The current system of GME funding began in 1965, when the Medicare program was created. Congress included payments to hospitals for GME funding in Medicare because it recognized a need for trained physicians and other health care professionals to provide health care to the nation, and acknowledged that educational activities in a hospital enhance the quality of patient care. GME encompasses both medical/osteopathic training as well as dental residents. The latter are funded at the same level as medical/osteopathic residents. There is only one dental residency program in Georgia and that is at Augusta University.

Medicare pays hospitals for GME through two payment streams – Direct GME payments and the Indirect Medical Education Adjustment. *Direct GME* payments compensate a teaching hospital for overhead costs related to GME, such as salaries and fringe benefits for residents, teaching physicians and GME administrative staff. The *Indirect Medical Education Adjustment* compensates teaching hospitals for higher operating costs associated with the presence of a residency program such as more complicated cases, additional tests ordered by residents as part of the learning process and reduced patient care productivity by all staff members. Payments are calculated based on the percentage of charges that are attributed to Medicare patients, among other adjusters. There are approximately 115,000 physicians currently in residency programs nationally. **Federal support translates roughly to about \$100,000 per resident per year.**

The impact of the Balanced Budget Act of 1997 effectively **froze** the GME payments at 1997 levels for all existing residency programs and created a “cap” on the number of funded GME slots. The Act established limits on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments. **For most hospitals, the limits were the number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996. Any residency slots added in established programs after this date were not eligible for Medicare reimbursement- as they were considered “over the cap”. Many established residency programs/hospitals continued to add slots to provide the workforce needed in their area even though the hospital or health system had to fund these slots themselves.** Most if not all of these existing GME programs support training above their Medicare cap, and have done so at their own expense. Many of these programs have significant numbers above the cap- up to 100 or more residents in some sites.

After 1997, few **new** teaching hospitals created new residency programs, largely due to the cost associated with standing up a wholly new program. However, if they were successful in opening new programs then their Medicare direct GME payments would be based on current cost reports. **This translates to a significant variance in GME Medicare reimbursement available to teaching hospitals**

**based on when the residency program was established, with older programs being reimbursed at a significantly lower rates.** In Georgia, the GME Expansion initiative chose to focus on standing up wholly new programs and did not invest in expansions at existing programs or in addressing the funding shortfalls created at the hospitals who were providing training to residents above their Medicare “cap”.

**EXAMPLE: Impact of Balanced Budget Act of 1997 on Georgia’s Medicare GME funding rates:** Augusta University’s long established residency programs (both medical and dental) are capped at the 1996 cost report amount of **\$23,000/** resident in direct GME financing for a maximum of 327 residents (although AU self-funds an additional 68 GME slots over its cap). **Most of the residency programs in the state which predate the state’s GME Expansion program would be paid at or around this same capped rate.** Newly opened residency programs in the state (through the GME Expansion program) will receive direct GME financing based on 2016 cost reports (or later), or an estimated **\$45,000/resident**. If indirect GME funding is included, then Augusta University (and similar programs in the state) receives a total direct and indirect Medicare GME payment/resident of approximately **\$80,000**. The **new** programs in Georgia will receive an estimated combined IDGME/DGME payment of **\$135,000+** per resident from Medicare.

According to the AAMC, residents typically work between 40-80 hours per week, at a median salary nationwide of \$52,200. In the South the average salary is \$51,000. Georgia’s average resident salary is \$51,000. This equates to an overall payment of under \$13/hour for residents.

## **2. STATE FUNDING OF GME IN GEORGIA**

There are two agencies which currently provide **sustainability** funding for GME in the state, (this excludes the Board of Regents GME Expansion program as it funds start-up costs but does not provide ongoing support). These are the Georgia Department of Medical Assistance (Medicaid) and the Georgia Board for Physician Workforce (GBPW).

**Medicaid- general:** Although there are no federal requirements that state Medicaid programs contribute to GME, it remains the second largest funder of these programs nationally. With no requirement for states to provide for GME, recent economic instability and budget constraints have led to a significant reduction in the number of states making Medicaid payments to GME programs. In 2015, forty-two states (down from 47 in 2012) were providing an estimated total of \$4.26 billion in GME support, representing 6.6 percent of the program’s inpatient hospital expenditures. Three additional states have indicated they may consider ending Medicaid GME funding within the next few years. According to the American Association of Medical Colleges in 2016, Medicaid programs in 32 of the 42 states made GME payments with the expectation of producing more physicians, (up from 22 states in 2012).

### **Georgia Department of Medical Assistance (Medicaid)**

Georgia’s Medicaid program provides GME payments directly to teaching programs and implicitly through capitation rates of Managed Care Organizations. A Medicare methodology is used for payment of indirect costs. Direct GME costs are reimbursed from a separate pool of funds based on the 2011 Medicare cost report. An important note to this is that Georgia **assumes** MCOs are distributing GME

payments to teaching hospitals, but unlike many other states who recognize and include GME payments in capitation rates to MCOs, it does not **require** them to distribute these funds to the hospitals.

States differ in which health professions are eligible for Medicaid GME payments. Georgia only provides payments for medical residents while other states include graduate nurses and other professions. As reported to the AAMC in 2015, Georgia provided **\$46.6** million in direct GME payments (amount for indirect GME payments was not submitted) for **FY 15**. This number includes only payments for direct GME costs under both fee for service and managed care; payments for indirect GME costs were not provided. This could account for the difference in Medicaid GME funding captured in the AAMC's 2013 survey of state Medicaid programs which reported that Georgia spent **\$100.9** million in 2012 for GME payments. It is logical to assume that Georgia's actual total GME payments in FY 15 were closer to the \$100 million level.

Prior to July 1, 2015, Georgia Medicaid reimbursed GME through a hospital specific add-on payment based on GME program costs and the Medicaid charges as a percentage of hospital charges. This was included in the payment (remit) received for each patient seen in the hospital. After July 1, 2015, Georgia Medicaid changed its reimbursement for GME by utilizing a stand-alone pool of funds. Each hospital receives its percent share of the pool based on its GME costs, based on prior year GME cost.

Another significant change effective July 1, 2015 was that payments are delivered quarterly rather than being paid on each claim. Georgia Medicaid is in the process of changing the way it calculates GME funding for FY 17 but the new methodology has not yet been found.

### **Georgia Board for Physician Workforce (GBPW)**

The GBPW is perhaps the most important funder to sustain existing and new residency programs in Georgia. It operates two critical programs that offer direct support to GME in the state. These are *Residency Capitation* and *Specialty Specific Residency Capitation*. **Table 3** presents a detailed report of the expenditures in these two programs.

**Residency Capitation:** Circa 1984, the GBPW was authorized to initiate a resident capitation program for all residents at any teaching hospital then operating residency programs in the state. The law provided for up to \$10,000/resident and did not exclude any disciplines from eligibility. Funding level was to be determined by the legislature's appropriation for this program. The law (31-7-95) further stipulated that **no new hospitals** could be added to receive these funds without specific legislative action. Currently, this program provides \$3,172 per resident for 2,315 residents training at 14 hospitals. Hospitals creating new slots with GME Expansion funds are not eligible for this funding without specific legislative action, which has not occurred nor been mentioned at this time.

**Specialty Specific Residency Capitation:** In the 1980's the legislature took a new route for supporting GME by creating special residency capitation for family medicine, general internal medicine, emergency medicine, and psychiatry slots. This was followed by additional funding for select pediatric slots in Macon and Savannah (MSM was later added). Later Commissioners at DCH added preventive medicine slots at Emory and MSM and 6 OB/GYN slots in Macon and Savannah. These residencies receive different

levels of capitation, and not all slots are capitated. Some of these primary care slots are eligible for the Medicaid match, which provides approximately \$2 per every \$1 of state funds expended.

<b>Table 3: Specialty Specific Residency Capitation and (general) Residency Capitation Funding Levels through the GBPW, 2016</b>			
<b>SPECIALTY SPECIFIC RESIDENCY CAPITATION PAYMENTS</b>			
<b>Residency Type</b>	<b># of Slots funded</b>	<b>Capitation Amount per slot</b>	<b>Total</b>
<b>Family Medicine</b>	240	\$18,755	\$4,501,200
<b>Internal Medicine</b>	65	\$15,000	\$975,000
<b>Pediatrics</b>	50	\$15,591	\$779,550
<b>OB/GYN</b>	14	\$15,333	\$214,662
<b>General Surgery</b>	4	\$15,502	\$62,008
<b>Emergency Medicine</b>	Under Development	\$14,500	-0-
<b>Psychiatry</b>	Under Development	\$14,500	-0-
<b>Preventive Medicine</b>	10	\$8,073	\$80,073
<b>TOTAL</b>	<b>383</b>		<b>\$6,612,493</b>
<b>(GENERAL) RESIDENCY CAPITATION PAYMENTS</b>			
<b>Hospitals specified in 31-7-95</b>	<b>2,315</b>	<b>\$3,172</b>	<b>\$7,343,180</b>

### **GME SUSTAINABILITY IN GEORGIA**

Long term sustainability of GME programs in Georgia is a critical priority. Responding to a lack of federal funding solutions, federal funding discrepancies described previously, and the increasingly critical need for physicians, Georgia has chosen to invest over \$17 million dollars to date to expand its GME programs. But opening programs is not enough. ***These programs were also intended to extend GME training opportunities outside of the metropolitan area of Atlanta and North Georgia, to target expansion of primary care, and to retain the graduates in the state for practice upon completion of training.***

The GBPW offers the logical place to insure continued funding stability for Georgia’s GME programs. As new slots are opened via the GME Expansion program, then funds must be transferred to the GBPW to provide resident capitation and specialty specific resident capitation to the eligible programs for sustainability. If this does not occur then two negative consequences occur. First, if the existing funds are simply divided by a greater denominator, then every program will be “cut.” And as older programs are already receiving significantly lower federal GME payments, their cuts will be more critical. Second, if the new programs are not provided with capitation funding, then the business plan on which they were predicated will have fatal flaws in their future funding projections and future sustainability.

If all projected expansion slots funded by the state reach fruition, there will be a substantial increase in slots across the state. **Table 4** demonstrates this projected growth, by specialty, through FY 2025.

This is a problem for FY 18. The GBPW will be short approximately **\$761,650** to fully fund the existing and new slots coming on line in fiscal year 2018. A choice must be made to fund every program at a lower level or to **exclude** new programs if the funding is not increased.

Additionally, if the projections hold true, the state will have grown from having GME programs at 10 teaching hospitals to having GME programs at 19 hospitals. **Table 5** provides the projected growth in slots and in hospitals participating in GME.

Specialty	Total of PGY 1 positions, 2010-2011	Total PGY 1 positions projected, 2024-2025
Family Medicine	81	188
Internal Med.	138	214
Pediatrics	55	55
OB/GYN	25	37
General Surg.	47	59
Other Specialties	401	473
<b>Total</b>	<b>747</b>	<b>1,026</b>

Teaching Site	Total # Residency slots, 2010-2011	Total # of Residency slots, Projected, 2024-2025
Emory	1159	1159
AU / MCG	449	449
Morehouse	140	140
Memorial (Savannah)	123	123
MCCG (Macon)	109	109
Atlanta Med. Center	81	81
The Medical Center (Columbus)	53	53
Floyd Medical Center	30	30
Phoebe Putney	16	16
Satilla Regional	6	6
<b>Total, 2010-2011</b>	<b>2,166</b>	<b>2,166</b>
Athens Regional Medical Center		108
St. Mary's Hospital		30
Gwinnett Medical Center		58
South GA Consortium		9
Redmond Regional		40
Tanner Medical Center		46
Wellstar		123
University Hospital (Augusta)		12
Northeast GA Medical Center		155
<b>Total, New, 2024-2025</b>		<b>581</b>
<b>TOTAL- ALL- 2024-2025</b>		<b>2,747</b>
<b>GBPW: Spotlight on Graduate Medical Education, February 2011; Board of Regents, GREAT Committee, 2016</b>		
*These projections do not include those proposed by Coliseum Medical Center in Macon as these are not being funded through the GME Expansion program but through private funds. Projected numbers of new slots at Coliseum are 400.		

## SUMMARY THOUGHTS:

1. To sustain Georgia's GME programs- ***Existing, New, and Projected***- there must be a solid funding road map developed and followed to insure sufficient funding for capitation programs from the state. Commitments to funding must be re-evaluated and affirmed.
2. Efforts to insure that the residency programs- ***Existing, New, and Projected***- actually **recruit** students most likely to practice in the state upon completion of training must become a priority. ***Aggressive marketing and recruitment for all of Georgia's GME programs, including development of incentives directed towards graduates of Georgia medical schools choosing Georgia residency programs, and robust Loan Repayment programs through the GBPW to secure providers in our most underserved areas post residency training.***
3. As the GME Expansion program ends, equal commitments must be made to insuring the ongoing sustainability of newly opening GME programs in the state and planned transfer of funds from the BOR to the GBPW to sustain GME investments in the state.
4. Possible limitations or constraints on any additional new teaching hospitals could be considered, perhaps limiting further expansion opportunities or innovative partnership strategies to serve certain geographic locations such as in South Georgia.
5. Future expansions should include utilization of the established GME programs and the long history they have of providing 50+ years of training in the state. Most of these programs, located in Atlanta, Augusta, Savannah, and Macon are already bearing the costs of supporting residency slots over the federal CMS cap. With assistance, they could potentially create innovative programs to expand slots dedicated to meeting geographic and /or discipline specific workforce needs. This could happen much more rapidly than what is necessary to stand up a totally new program from scratch.
6. Data about GME funding in Georgia needs to be streamlined and appropriate sources identified to collect and report annual information. The difficulty of obtaining data for this report underscores the lack of public transparency available about this crucial issue. A mock spreadsheet is provided at the end of this document as an example of the minimum data that is recommended to be routinely reported to the legislature through a designated agency.
7. Continued monitoring of the ratio of graduates of in state medical/osteopathic schools and the number of PGY1 GME training slots should be made. Ideally, there should be a 1:1 match to create a better balance in our undergraduate and graduate medical education pipeline.

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## **Interviews and Consultations were held with the following individuals to obtain data reported herein:**

Angela Ashmore Bryant, *Reimbursement Supervisor/Finance*, Augusta University Health

LaSharn Hughes, Executive Director, Georgia Board for Physician Workforce

Shelley Nuss, MD, Dean, MCG-UGA Medical Partnership

Cherri Tucker, (Retired), Georgia Board for Physician Workforce

Summary Tables:

<b>Table 1: Georgia's Residency Positions by Teaching Institution, 2010-2011</b>			
<b>Teaching Site</b>	<b>Total # Residency slots</b>	<b>Total # of Filled Slots</b>	<b>Total Graduates / 2010</b>
Emory	1159	1094	323
AU / MCG	449	421	111
Morehouse	140	129	33
Memorial (Savannah)	123	117	35
MCCG (Macon)	109	107	30
Atlanta Med. Center	81	79	19
The Medical Center (Columbus)	53	47	11
Floyd Medical Center	30	30	7
Phoebe Putney	16	16	4
Satilla Regional	6	6	2
<b>Total</b>	<b>2,166</b>	<b>2,046</b>	<b>575</b>
<b>GBPW: Spotlight on Graduate Medical Education, February 2011</b>			

<b>Table 2: Georgia's Primary Care Residency Programs filled by Georgia Medical Student graduates , 2010-2011</b>			
<b>Specialty</b>	<b>Total of PGY 1 positions</b>	<b># of PGY 1 positions filled / GA med stud.</b>	<b>% of PGY 1 positions filled by GA med. Stud</b>
Family Medicine	81	9	11.1%
Internal Med.	138	19	13.8%
Pediatrics	55	21	38.2%
OB/GYN	25	6	24.0%
General Surg.	47	11	23.4%
Other Specialties	401	52	13.0%
<b>Total</b>	<b>747</b>	<b>106</b>	<b>15.8%</b>
<b>GBPW: Spotlight on Graduate Medical Education, February 2011</b>			

Example Data Items to be routinely collected and reported: GME

HOSPITAL and DATE Residencies began	RESIDENTS		Federal CMS/ Medicare Funding for GME					State Funding for GME				NOTES
	# TOTAL RESIDENTS	# TOTAL PGY 1	CMS CAP	TOTAL SLOTS OVER CAP	DIRECT GME	INDIRECT GME	TOTAL CMS PAYMENTS/ Resident	STATE MEDICAID	GBPW RESIDENT CAPITATION	GBPW Specialty Resident Capitation	BOR GRANT FUNDS / EXPANSION	
<i>Example:</i> Augusta University	510		327	68	\$23,000	\$57,000	\$80,000				-0-	94 VA slots; 21 military slots

**Name of Institution:**

Central Michigan University College of Medicine/CMU Medical Education Partners

**Residency Programs:** Family Medicine & Psychiatry

**Designated Institutional Official (DIO):**

Mary Jo Wagner, MD ([mj.wagner@cmich.edu](mailto:mj.wagner@cmich.edu))

Contact Information: 1000 Houghton Ave

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## **Overview**

The Central Michigan University College of Medicine (CMED), CMU Medical Education Partners (CMEP) and its hospital partners have identified the priority needs for physician providers in the Mid-Central AHEC region. The Saginaw-based Graduate Medical Education (GME) programs have provided both faculty and training physicians for the region for 70 years. With the new Undergraduate Medical Education (UME) program, the longitudinal physician training supports the goals of the MIDOCs with the College mission and vision emphasis on “training diverse, culturally competent physicians focused on improving access to high quality health care in Michigan with an emphasis on rural and medically underserved regions.... to facilitate the transformation of health care in Central and Northern Michigan.” We have worked closely with our Mid-Central Area Health Education Center (AHEC), covering 19 counties and covers a large swath through the Mid Michigan region from counties in the thumb to Osceola County on the west side.

Our initial needs assessment for planned program expansion would include two residency programs, Family Medicine and Psychiatry. The local community needs assessment done by the hospitals indicates an immediate need for primary care physicians and psychiatrists. Our needs mirror the country’s as family physicians and psychiatrists are the most commonly recruited physicians nationally according to a physician-staffing firm. (U.S. Psychiatrist Shortage Intensifies, Bruce Japsen, Forbes, June 6, 2017.

<https://www.forbes.com/sites/brucejapsen/2017/06/06/psychiatrist-shortage-intensifies/#1e936e8d5d96> )

## **Family Medicine positions**

As one of the first Family Medicine programs in the country, the CMEP community-based Family Medicine program has always provided training for physicians to stay in the community and surrounding rural region. We would like to expand the existing fully accredited program of 6 residents each year to 4-6 more residents per year over 3 years (a total of 10-12 residents per class) with the primary continuity clinic site for this second group at our regional Federally Qualified Health Center (FQHC), Great Lakes Bay Health Centers (GLBHC). This is the second largest FQHC in Michigan, with 26 locations primarily serving the Mid-Central AHEC region caring for nearly 50,000 patients. The CMEP Family Medicine residents currently rotate for a limited time in an urban underserved clinic, but we would like to pursue the opportunities to provide care in rural sites throughout the AHEC region. We are in discussion with several of our critical access hospitals to provide rotations for this group of residents, with consideration of the opportunity to develop a classic rural track if the MIDOCs program demonstrates success.

The needs assessment included data from several sources. We reviewed the Michigan Health Improvement Alliance (MiHIA) data from counties that nearly mirror the Mid-Central AHEC region. This data indicates that 12 of 14 counties in our MiHIA region have a lower rate of Primary Care Providers than the rate for the State of Michigan. (See attached map.) The trend over time shows eight of our counties demonstrate either no change (1) or worsening (7) in

their provider rate including two that are getting significantly worse (Bay and Ogemaw), while only six are improving with only one improving significantly (Midland County.)

The Health Professions Shortage Area (HPSA) score for Saginaw primary medical care is 15 for geographic designation, and ratio of 16 for a geographic designation with unusually high needs. From data gathered by the Michigan AHEC, the GME training sites in Saginaw are within 30 minutes in most directions of a large expanse of the state of Michigan that makes up the primary care designated geographic and physician shortage areas.

Finally, we reviewed the Community Health Status indicators by the Centers for Disease Control (CDC) that show the ranking of individual counties in clinical care available for comparison in the County Health Rankings. The ranking is based the following measures: uninsured, primary care physicians, mental health providers, dentists, preventable hospital stays, diabetic monitoring, and mammography screening.

<http://www.countyhealthrankings.org/using-the-rankings-data/exploring-the-data#peer> Our region has two of the top counties in the state, Clinton and Midland, but also has seven of the bottom counties.

### **Psychiatry positions**

The other area of severe need for GME training in our AHEC is in psychiatry. We would plan for the expansion of our new residency program to increase by two residents over four years (for a total of six residents per year) that will allow psychiatry residents to train in Saginaw, Isabella, Gratiot, and Midland counties. If funding is available, we are also exploring new fellowship programs in Child/Adolescent (C/A) psychiatry (three positions for two years) and Geriatric psychiatry (one position for one year). The needs for these specialists are critical - review of the practitioner data indicates that there are only three currently boarded-certified C/A psychiatrists and two currently boarded-certified geriatric psychiatrists in the entire AHEC physician shortage region. From AHEC data, the GME training sites are within the designated mental health geographic and physician shortage areas.

Data from MiHIA shows that 13 of the 14 counties in the AHEC fall below the state of Michigan rate for mental health providers. The exception is Tuscola County with its Caro Regional Mental Health Center – a long-term care state psychiatric hospital that provides primarily residential patients from southeastern Michigan. The critical shortage of psychiatrists in the rest of these counties has led to an increase in mental health issues throughout the region.

The HPSA score for Saginaw County in mental health is 16 for geographic designation, and ratio of 17 for a geographic designation with unusually high needs. The percentage of Saginaw County residents reporting as having poor mental health days increased by nearly two-thirds (9.4% - 15.4%) between the 2008-2015 reporting periods. The percentage of Saginaw County residents reporting as having poor mental health days (15.4%) exceeds that of the entire state (12.2%). The percentage of Saginaw County residents reporting ever being told they were depressed (24.4%) also exceeds that of the entire state (20.5%). Youth Substance Use/Abuse was

identified as a concern for Social, Emotional, and Behavioral Health for Saginaw County and most significantly with alcohol abuse, is much higher than the Michigan average.

There are several opportunities for collaboration to provide training for our psychiatry residents. Health Source Saginaw includes inpatient behavioral health services for 33 child/adolescents, 16 geropsych patients and 60 adults in addition to the 6 beds in the chemical dependency treatment center. Mount Pleasant Community Mental Health provides out patient services in the Central Michigan Community Mental Health District.

Integrated behavioral health care has been defined as “the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population” (Peek, et al, 2013). <https://integrationacademy.ahrq.gov/resources/ibhc-measures-atlas/what-integrated-behavioral-health-care-ibhc> Increased adult psychiatry residents and C/A fellowship would allow the GME program to implant psychiatry residents and fellows in the pediatric and family medicine clinics as well as provide telepsychiatry consultation to the entire AHEC region.

Finally, national data indicates the severity of need for psychiatrists - The National Council for Behavioral Health produced the report “The Psychiatric Shortage: Causes and Solutions” through The National Council Medical Director Institute. One of the primary solutions recommended is to address the workforce crisis. (Pages 15-20 provide graphical representation of the shortages in both chart and map format.) <https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage-National-Council-.pdf>

## **Recruitment**

Recruitment of the CMED students begins at the time they arrive on our Saginaw campus. We have established a welcome event for students and residents, an introduction to our community event (with local business leaders in attendance), we are working on a very low rate Country Club membership for students and residents, and a process of regularly distributing concert and sporting event tickets. We have created a new position of physician recruiter and retention specialist who will act as a student and resident recruiter. We have recently been granted 300k that will be used for any CMU student who matriculates in our residency program for loan repayment (10k per matriculated resident). Specific funds for student and resident support include:

- i. Michael Jeffers Memorial Fund Award - \$10,000 for CMED students who match in Saginaw residency programs
- ii. Dow endowment
- iii. Saginaw Enrichment Fund at the CMU College of Medicine – can be used to incentivize students and residents to remain in the region after graduating

### **Preceptor and Faculty roles**

One key aspect of the MIDOCS program is the opportunity to bring more faculty physicians to the community with a focus on innovative training to the programs. Based on the Accreditation Council of Graduate Medical Education (ACGME) requirements for residency training, an additional core faculty member will be needed for each group of additional residents. To assure patient safety while allowing direct patient experience of the physicians in training, there is a requirement for supervision from the faculty physicians. The time needed for this activity should be supported financially. The financial Performa includes an allocation for the time faculty cannot be caring for patients while providing the educational milieu for training.

With the involvement of the less traditional faculty, additional funds could provide an academic stipend to rural supervising physicians for time spent in education of the residents away from traditional patient care activities. Consideration of financial support will be needed to provide faculty development and administrative/educational time for faculty physicians who are not currently in the residency program from the underserved area.

### **Innovative educational curriculum**

With the new medical school in our region, the faculty have been focused on creating new innovative educational activities. The school has a commitment to distance learning and the new residency positions can take advantage of the information technology already in place to connect residents who are on rural rotations. Through the connections we have with our rural faculty, we will develop didactic educational sessions with a rural focus to highlight topics needed for practice in locations without a large local medical support system. Our programs already emphasize training for resident comfort with independent practice and highlight the use of technology for support and medical consultation. With an institutional focus on experiential educational workshops, topics critical to the underserved patient population will be taught to all residents, including disparities of care and population health research. The residency programs will increase their emphasis for all residents on opportunities for rural electives. Though the careers of the MIDOCs track residents will be studied carefully over time, the inclusion of all residents in these opportunities will likely increase the career choices of the group as a whole.

### **AHEC support**

The Mid Central AHEC will provide several critical support services for the MIDOCs program. The responsibilities will include the following:

- a. Both short term and long term Housing identified and secured for electives in rural sites
- b. Liaison and assistance with scheduling between rural clinic preceptors, residents and GME program in rural sites.
- c. Identify and serve as point of contact with rural FQHCs in Arenac and Isabella counties for rural site rotation development and preceptor identification.

- d. Liaison with rural hospitals supporting new resident rotations including credentialing, scheduling and assuring completion of rotation assignments.
- e. Mid Central AHEC responsible for data tracking all new residency positions in this region and reporting to GME program, state and HRSA.
- f. Mid Central AHEC can provide CME, CNE and CEU educational programs as appropriate for residents and/or preceptors that support and advance rural rotations and MIDOCs Program objectives.
- g. The Mid Central AHEC is knowledgeable in Interprofessional Education (IPE) roles and development at rural practice sites and can incorporate these experiences into rural resident rotations.

### **Resident placement plan beyond pilot program**

If this program were successful, then we would consider trying to establish a rural training track for the family medicine program. This option is unlikely for our psychiatry residency program given the current lack of appropriate training support in our rural regions.

<https://members.aamc.org/eweb/upload/Rural%20Training%20Track%20Programs%20-%20A%20Guide%20to%20the%20Medicare%20Requirements.pdf>

### **Physician retention plan**

The training hospitals in Saginaw already work closely with the referral hospitals to provide clinicians in offices throughout our AHEC region. We will continue to increase rural health provider recruitment with federal and local loan repayment programs and other recruitment initiatives.

### **Educational Outcomes**

The educational outcomes for the residents in the MIDOCs program must obviously start with the well-defined competencies and milestones of the respective ACGME residency programs. Over time, rural specific competencies should be developed as nicely delineated by the National Rural Health Association and the American Academy of Family Physicians:

*Rural residency programs and medical educators, in addition to specific content particularly relevant to rural practice, should elaborate, teach, and measure general competencies in rural medicine including:*

1. *Adaptability – how to shape one’s skill set to the needs of the rural community*
2. *Improvisation – how to deliver quality care within the resources and skills you have available in the moment*
3. *Life-long learning – how to continually acquire additional knowledge and skills as needed*
4. *Collaboration – how to get help from others and work together*
5. *Endurance – how to sustain oneself and others in rural practice and lifestyle*

6. *Resilience – how to continue to re-energize your practice in the context of changing personal and community needs*  
<http://www.aafp.org/about/policies/all/rural-practice.html>

### **Clinical Outcomes**

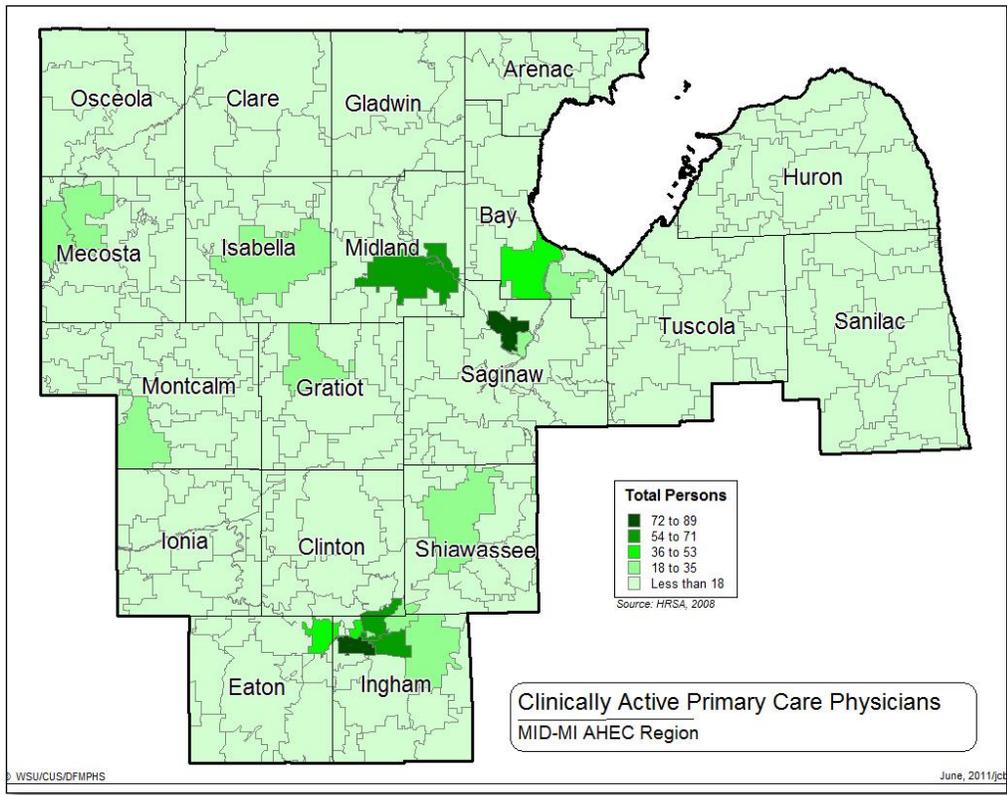
The clinical outcomes of this training program will only be able to touch upon the long-term goal of a sustainable program. First, we would hope to increase the health monitoring data including a decrease in preventable hospital stays, and an increase in diabetic monitoring and mammography screening. Improvement in psychiatric services can be measured by a decrease in the reported rate of depression and youth alcohol use/abuse as well. In the short-term nature of support for one residency class, our goals would be to have 35% of our graduating residents practice in either Saginaw or the underserved region in our AHEC (current average over past 10 years is 18% for each.) Research of other rural track programs includes the Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) regional medical education success – 35% were practicing predominantly in the rural area – twice the rate of most FM residency graduates. (Patterson DG, Schmitz D, Longenecker R, Andrilla CHA. Family medicine Rural Training Track residencies: 2008-2015 graduate outcomes. Seattle, WA: WWAMI Rural Health Research Center, University of Washington. Feb 2016.

[http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/02/RTT\\_Grad\\_Outcomes\\_PB\\_2016.pdf](http://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/02/RTT_Grad_Outcomes_PB_2016.pdf) )

Similarly, a focus on rural health training by programs in Wisconsin increased the settlement of resident graduates in the underserved and rural regions. (What works for health: Policies and Programs to improve Wisconsin's Health

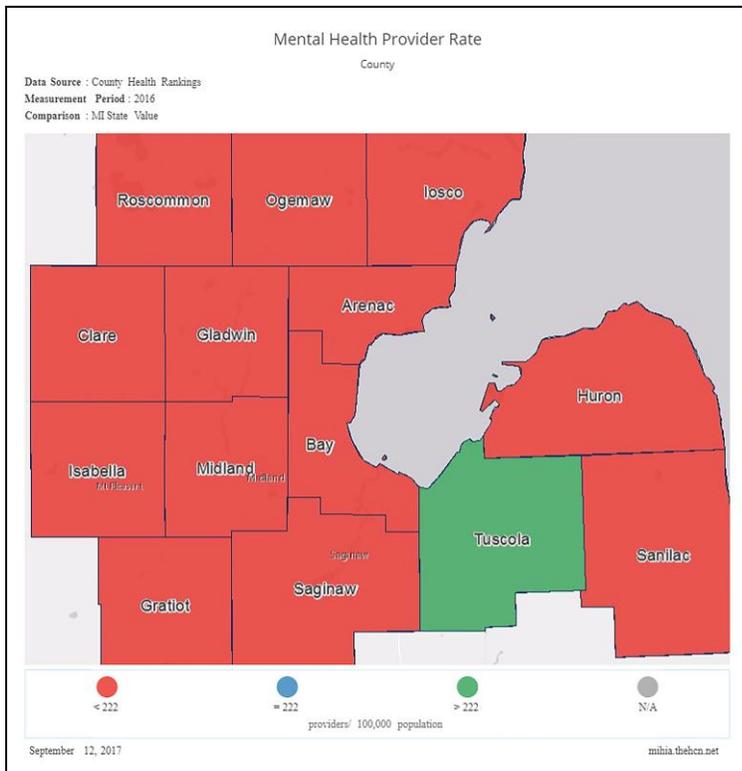
<http://whatworksforhealth.wisc.edu/program.php?t1=22&t2=16&t3=111&id=362> )

We would utilize the resources provided by Michigan AHEC and regional centers extensively. The AHEC will be the community liaison for rural resident with support organizations and rural community resources. They will help the program link with local champions to support physician training in general and provide local mentors for the residents. The Mid Central AHEC will provide application assistance and eligibility support for residents and connections to apply for NHSC Loan Repayment programs and Michigan State Loan repayment program. This will assist with the financial support needed by medical graduates to assure they will not have any economic concerns that will preclude interested practitioners from practicing in rural Michigan. In addition, the Mid Central AHEC will pursue resident recruitment and placement in rural FQHCs beyond pilot program and develop a retention plan with rural sites to improve workforce development in medically underserved areas.



Primary Care shortage in Mid Michigan AHEC region

Psychiatry shortage area in Mid Michigan MiHIA data



**Resident  
2017-18**

	<b>PGY-1</b>	<b>PGY-2</b>	<b>PGY-3</b>	<b>Average</b>
Salary *	49,954.26	51,719.45	53,447.36	51,707
Fringes:				
Health insurance	13,159	13,159	13,159	13,159
Fica	3,822	3,957	4,089	3,956
Pension	1,998	2,069	2,138	2,068
Other	2,783	2,783	2,783	2,783
Lab Coats/Uniform	120	60	60	80
Meals	0	0	0	0
Supplies	250	250	250	250
Educational Supplies	40	40	40	40
Residency Management	193	193	193	193
Travel/ conference	135	135	1,040	437
Required training (ATLS, ACLS...)	1,390	465	420	758
Licensing requirements	235	170	170	192
Membership Dues	860	490	490	613
Educational reimbursement	1,275	1,500	1,500	1,425
Total fringes and educational expenses	26,260	25,270	26,332	25,954
Total direct resident costs (above)	76,214	76,990	79,779	77,661
Malpractice Ins	0	3,567	3,567	2,378
Additional academic FTE costs	73,786	75,262	76,767	75,272
<b>Total Per Resident Cost</b>	<b>150,000</b>	<b>155,819</b>	<b>160,113</b>	<b>155,311</b>
Additional AHEC expense	75,000	75,000	75,000	75,000

\* Resident salary increase has averaged 1.5% per year.

October 2, 2017

To Whom It May Concern,

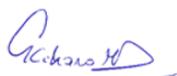
Central Michigan University College of Medicine – Medical Education Partners is enthusiastic to support the Request for Proposal regarding the MIDOCs consortium. This consortium will strengthen the connection to medically underserved populations.

The goal of MIDOCs is to improve the health of underserved and vulnerable populations by strengthening the health workforce by connecting and retaining trained providers to communities in need. Reaching the objectives listed below is critical to the program's success:

- 1) Retention of graduates in the State of Michigan and HPSAs
- 2) Educational outcomes from innovative educational curriculum (e.g., Interprofessional education, telemedicine, population health, public health and community engagement, Patient Centered Medical Home (PCMH))
- 3) Financial transparency and accountability of funds.
- 4) Clinical outcomes for patient care quality, safety, equity and cost effectiveness.

Central Michigan University College of Medicine – Medical Education Partners is eager to fully support the Request for Proposal of MIDOCs and its initiatives.

Sincerely,



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George Kikano, MD, Dean  
Central Michigan University College of Medicine



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Mary Jo Wagner, MD, DIO



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Sethu Reddy, MD, Medicine Discipline Chair



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John Blebea, MD, Surgical Discipline Chair

**MIDOCs Consortium 2017 Proposal  
Residency Expansion Programs**

**Submitted by**



**Randy Pearson, MD, DIO, Assistant Dean for GME  
Michigan State University College of Human Medicine**

1200 E. Michigan Ave., Suite 245  
Lansing Michigan 48912  
(517) 364-5777  
pearson@msu.edu

## MIDOC's Request for Proposal

### Michigan State University College of Human Medicine

Michigan State University College of Human Medicine has prepared this Request for Proposal (RFP) for the MIDOC's Consortium to improve access to quality health providers especially Primary Care Providers (PCP) including Psychiatrists in the State of Michigan. The purpose of the proposal would be to create residency-training positions in rural and underserved communities in Northern Lower Michigan and the Upper Peninsula. Adding resident training to these communities would increase the possibility of retaining PCP's and Psychiatrists in these communities. We would also focus on the cost to provide quality care as well as the access for the patients in the community.

#### Initial Needs Assessment

We have reviewed a number of references to determine need for the PCP's and Psychiatry in the State of Michigan focusing on Traverse City and northern Michigan and the Upper Peninsula for Psychiatry, and we focused on and Alpena, Petoskey/Emmet County and Ludington for PCP's.

The Psychiatry references are:

- The HRSA Mental Health Professional Shortage Area Map
- Munson Medical Center 2016 Community Health Needs Assessment
- UP/Marquette Community Health Needs Assessment
- The Michigan Physician Profile
- The Michigan Physician Supply and Demand
- The Michigan Rural Health Profile

The Mental Health Shortage Area Map - We note that the vast majority of the service areas of both Munson Hospital in Traverse City and the UP Health System Marquette are mental health shortage areas with most surrounding counties for both health systems documenting < 1 psychiatrist per 30,000. Notably, in the Upper Peninsula, every county but one is a mental health professional shortage area.

This need is recognized by the community as evidenced by the [Munson Medical Center 2016 Community Health Needs Assessment](#), which identified substance abuse and mental health issues as top needs recognized by both community members and providers in the service area. This need is even more apparent in the Upper Peninsula, where [the community health needs assessment](#) prioritized substance abuse and mental health issues as two of the top three priorities for the region.

In addition to the above documented information, we have received anecdotal information from the Director of GME at Pine Rest Christian Mental Health and Pine Rest's Traverse City Program Director as to the out-patient services at Pine Rest's Traverse City clinic. Their report was that out-patient clinics are currently booked through mid-December 2017 and Pine Rest is always recruiting Psychiatrists for that region.

In the UP, Stuart K. Johnson, DO, Community Assistant Dean for the MSU UP Regional Campus in Marquette, indicates that there are only 5 to 6 FTE Psychiatrists in the entire UP, referrals for outpatient psychiatry are often longer than a year, and inpatient Psych is always at capacity. Many patients are transferred downstate or to Green Bay to receive in-patient services because of this acute shortage.

The PCP references are:

- [The HRSA Primary Care Health Professional Shortage Area Map](#)
- [The 2015 Northern Michigan Community Health Assessment](#)
- [The District Health Department #10 Community Health Assessment](#)
- [MAFP HPSA/MUC map with current residency program overlay](#)
- [Family Medicine Graduate Proximity to Their Site of Training: Policy Options for Improving the Distribution of Primary Care Access; Fagan et.al; Fam Med 2015;47\(2\):124-30.](#)

The [Northern Michigan Community Health Assessment 2015](#), developed in collaboration with three hospitals across an 8-county region in Northern Michigan, identified access to primary care as its main priority with 69% of community members and health care providers identifying this as a top factor for the region. Five of the eight counties in the tip of the Mitt region serviced by McLaren Northern Michigan and Mid-Michigan-Alpena hospitals have primary care provider to population ratios ranging from 15-67, which is considerably below the state rate of 80:100,000. These are some of the counties that would be served by establishing family medicine residency clinics in Emmet and Alpena counties, both from a clinical perspective and from a recruitment and physician workforce perspective.

[District Health Department #10](#) Community Health Assessment mirrored that of Northern Michigan, with every county in the district identifying access to health care as the primary need for the region. These are the counties that would be served by a primary care residency program at Spectrum Health Ludington Hospital in Mason County\*. In addition, every county in this region is a PCP [health professional shortage area](#).

Forty-six percent of family medicine residents practice within 50 miles of their residency training program. For this reason, we have also attached to this RFP **attachment 1** that depicts a map the MAFP group created that shows the HPSA's and Medically Underserved Communities (MUC), with an overlay of Michigan's current Family Medicine Residency programs with 50-mile radius indicators. This map confirms the need for residency programs in the Alpena, Petoskey\*, and Ludington\* communities, in order to best meet the primary care physician workforce needs of the state.

## **ACGME Status – List of Proposed Programs**

### The Psychiatry Programs

- 1) The Psychiatry residency we intend to develop in northern Michigan will be based in Traverse City at Munson Health System. This program will be overseen by the Pine Rest Christian Mental Health residency program based in Grand Rapids. This program is an approved ACGME program; they will seek ACGME approval to expand their program by two slots for this rural track psychiatry program in northern Michigan.

- 2) The Psychiatry residency we intend to develop for the Upper Peninsula will be based in Marquette at the Duke Lifepoint UP Health System. This program will be overseen by the MSUCHM psychiatry residency program in East Lansing. This is currently an approved ACGME program; they will seek approval from ACGME for a 2-slot expansion for this rural track psychiatry program in the Upper Peninsula.

### The PCP Programs

- 3) The Family Medicine (FM) residency we intend to develop for the Alpena region will be based at MidMichigan Health Alpena hospital, which currently services a seven county area of Northeast Michigan. This program will be a 1-2 Rural Training Track program, which will utilize the MSU-CHM Affiliated Midland Residency program for portions of the residents' early training; residents will transfer to the Alpena community for years two and three of residency. This is an approved model of family medicine residency training used in other areas of the US but not currently developed in Michigan. The Midland Residency program is an approved ACGME program; they would seek ACGME approval for a 2-slot expansion for a rural track to MidMichigan Health Alpena.
- 4) The FM program we intend to develop for the Petoskey/Emmet County region will be based at McLaren Northern Michigan hospital, a rural regional referral center for a 22-county area which encompasses the northern lower peninsula and eastern upper peninsula of Michigan. This program will be a 1-2 Rural Training Track program, which will utilize the MSU-CHM affiliated McLaren Flint FM program. The McLaren Flint FM program is an approved ACGME program; they will seek approval for a 2-slot expansion for a rural track to McLaren Northern Michigan serving Petoskey and Emmet County.\*
- 5) The FM program we intend to develop for the Ludington region will be based at Spectrum Hospital-Ludington in Mason county. This hospital system serves 5 counties, which make up one of the most underserved regions of Michigan's lower peninsula. This program will be a 1-2 Rural Training Track program, which will utilize the MSU-CHM affiliated Spectrum Health FM residency in Grand Rapids, which is currently applying for ACGME approval. This program will seek approval for a 2-slot expansion for a rural track to Spectrum Health Ludington hospital to serve this region.\*

\*Programs #4 & #5 are additional slots should funding be available.

### **Financial Proforma for the residency programs**

The residency programs in Psych and FM currently have a cost per resident that is on average for salary and fringe benefits of \$83,500.00 per resident. In addition, the on average cost for faculty, departmental expenses, operational depreciation and other is on average \$65,000.00 or a total cost per resident of \$148,500.00. Since the residency programs are at or above their cap, we do not anticipate the possibility of being able to claim Medicare GME payments. We also do not anticipate any the extended residencies. **See Attachment 2.**

### **Proposed mechanism or incentive plan to recruit residents to this program**

All the communities that MSUCHM is proposing to add residents currently have MSUCHM medical students training at the facility. These students are involved in MSU-CHM's rural medical student training programs, and tend to be students who have sought out these rural opportunities due to ties to the specific regions or interest in rural health. We intend to recruit from this cadre of medical students.

In addition, MSU-CHM's The Integrated Program (TIP) offers several benefits for both the medical students and FM residency programs. The TIP program is for MSUCHM students who;

- Currently are in their third year of medical school and are interested in a career in family medicine
- Are looking for additional training and experience in leadership, scholarship or community outreach/public health
- Have a strong interest in the participating communities where we have CHM Family Medicine residencies and would like to do their residency in one of these programs
- Are looking for an experience to ease the transition to residency and that allows them to participate in residency experiences as fourth year students
- Would benefit from a \$20,000 commitment by the residencies to them.

This has been a successful recruitment program for other MSU-CHM affiliated residency programs. We intend to work with hospital partners and residency programs to expand the TIP program for these expansion sites.

We will also work with the Michigan Loan Repayment Program, the National Health Service Corps Loan Repayment Program, and the resident to facilitate payment of up to \$200,000.00 in tax-free funds to repay the educational debt incurred by the resident, if they agree to practice post-residency in one of Michigan's underserved communities.

### **Preceptor roles, responsibilities and supervision requirements**

The residency program director of the existing residency programs will be responsible to assign the site director at the rural site and to write the rotation curriculum with its goals and objectives including the supervision and evaluation component as prescribed by the ACGME specialty residency Review Committee (RC).

### **Description of innovative educational curriculum**

The rural track program integrated into an existing residency will be the method to create this opportunity. This is certainly an innovative curriculum for the State of Michigan. It is the means to create meaningful and longitudinal training opportunities to a rural region for residents, which increases the likelihood they would stay in the area for practice upon graduation. We note that this rural type of curriculum has been used successfully in other states to educate residents and to better distribute the physician workforce to rural regions of states.

In addition, having learners and residents in a region will improve the quality of care for rural residents for several reasons. Initially regions will benefit from increased access to care due to the ability to access the residency ambulatory clinics, which historically in other regions have

provided an enhanced level of care for a region's most indigent and underserved patients. In addition, current physicians will assume teaching roles, which will help the medical staff remain up to date with current treatments and guidelines. Finally, these regions will benefit from the added ability to recruit medical staff interested in academic medicine and residency instruction, both specialists and primary care faculty.

### **Define Placement needs to inform AHEC (housing, transportation, other)**

We envision AHEC helping in several ways. Students interested in the program may need temporary housing for interviews, recruitment, and audition rotations. Rural residents may need temporary housing for individual rotations, either in the rural community or if they need to return to the urban site for specific training. Residents also may need transportation assistance, for interviews, audition rotations, or necessary experiences. We also believe AHEC could help with recruitment through their pipeline programs and potential for in-state and national networking.

### **Resident Placement plan beyond pilot program**

The intent of the project will be to establish an extension of an approved ACGME residency to recruit medical students who are interested in practicing in the rural and/or underserved area. In addition in offering the incentives noted above, our hope is that the resident upon graduation will stay to practice his/her specialty in the area. MSUCHM has been very successful in having medical school students who train in rural communities return to those communities following residency. Having a residency option in those rural areas will only improve upon that success. The hope is that these extension programs will precede future full residency programs in these communities for FM and Psych; however, because of reimbursement issues there may be a need for subsidization of those programs long term to make them successful.

### **Physician retention plan (post-graduation from residency program)**

In order to assist the community and the resident in maintaining the practice in the rural community, we will continue to assist the resident in his/her continuing medical education utilizing the MSUCHM CME resources. MSUCHM has also had success working with hospital partners to establish post-residency contracts, including loan repayment and incentive programs, to recruit former trainees back to these rural regions. We also understand the importance of integrating rural students and residents within the rural training communities; we plan to also continue to work with local partners to assist the physician and communities in this endeavor.

### **Outline Educational Outcomes**

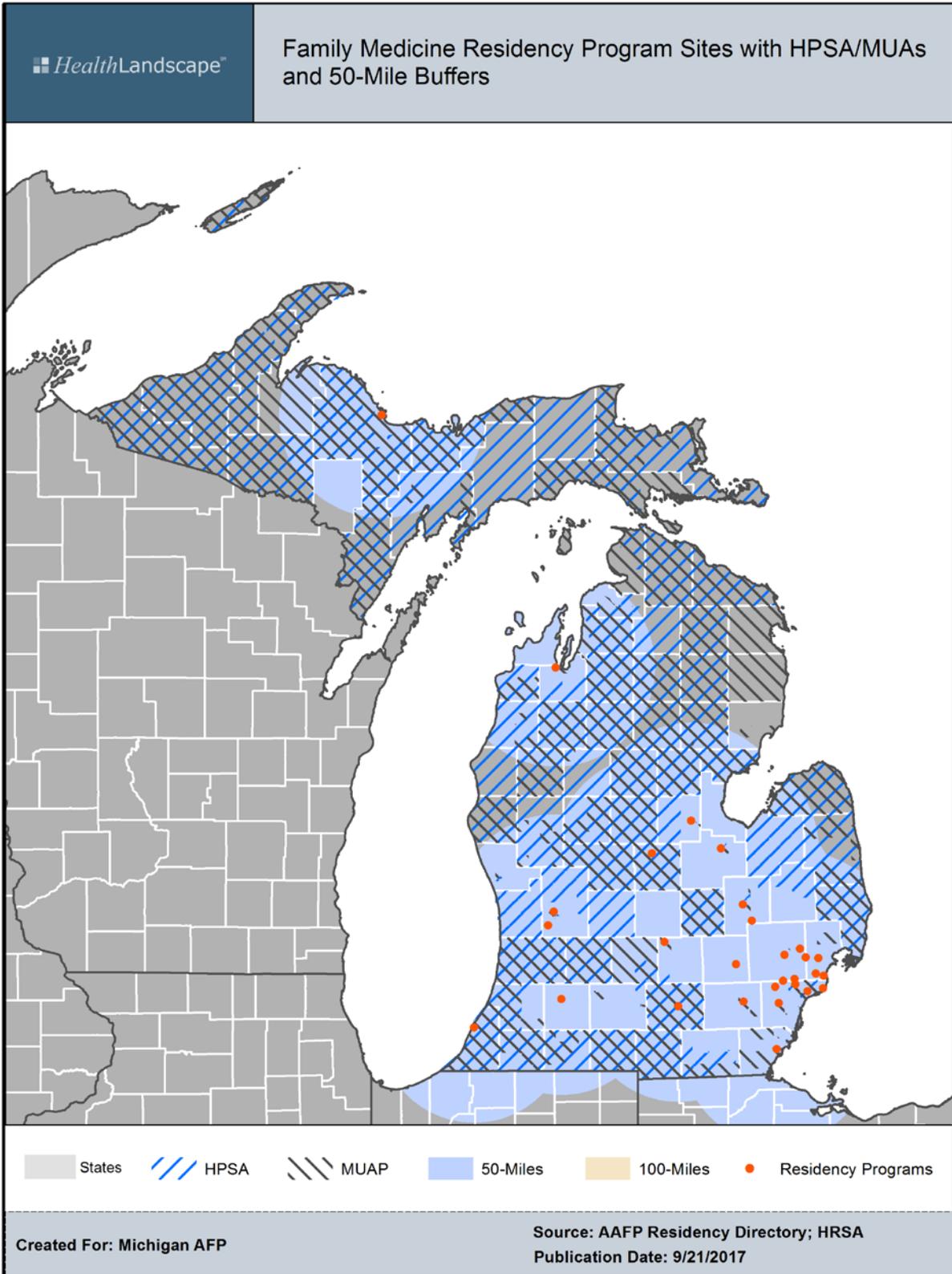
We anticipate that the resident will seek and pass board certification as well as work closely with the community in providing quality care to the citizens striving for a bond with the community social agencies to highlight specific community need. The opportunity to work closely with the community will be an outcome of the rural track program.

### **Outline Clinical Outcomes**

As noted above we anticipate that the curriculum with its goals and objectives will specify the expectations of the program including its expected clinical outcomes. Some of the expectations will be: understanding the community health needs, focusing patient care on those risks noted in the community health needs, improve access, quality and patient safety.

**Describe how you would utilize the resources provided by the Michigan AHEC and regional centers.**

As noted above, the regional centers of the AHEC will be asked to collaborate with us regarding options available for housing, transportation assistance, recruitment of candidates for the residency programs, and housing for interviews and audition rotations. We also may ask AHEC to provide resources for spousal or partner support for residents (such as social support networks), in order to maximize our potential for recruitment of these families to the region.



**MICHIGAN STATE**  
UNIVERSITY

October 2, 2017

Caryn M. Volpe, Program Manager  
*In support of the MI DOCS initiative*  
Michigan Area Health Education Center  
Wayne State University School of Medicine

Dear Caryn:

I am writing in support of the attached proposal for expansion of Psychiatry and Family Medicine residency programs across northern Michigan and the Upper Peninsula in conjunction with our hospital partners across the state through the MI DOCS Initiative.

There is a dramatic shortage of access to psychiatry and primary care health professionals in northern Michigan and the Upper Peninsula and it is a well-known fact that the majority of residents nationwide stay and practice within their disciplines within a 50-mile radius of where they do their residency. There are currently only three residencies in Michigan north of US 10. MSU College of Human Medicine is proud that all three are affiliated residencies in Family Medicine, but is concerned that we need to train more Family Medicine residents and Psychiatry residents in those regions of the state where there is such need for access.



**College of  
Human Medicine**

**Office of the Dean**

15 Michigan Street NE  
Suite 450  
Grand Rapids, MI 49503

616-233-1678  
Fax: 616-234-2625  
humanmedicine.msu.edu

Thank you for shepherding this process on behalf of MI DOCS and we look forward to working with you to seek funding from the state of Michigan for this unique initiative.

Sincerely,

Norman J. Beauchamp, Jr. MD, MHS  
Dean

Wayne State University School of Medicine

MI DOCs Proposal

Cover Page

September 30, 2017

Name of Institution:

Wayne State University School of Medicine

Primary Care Residency Programs:

- 1) Family Medicine
- 2) Preventive Medicine

Designated Institutional Official (DIO):

Tsveti Markova, MD  
Wayne State University School of Medicine  
Graduate Medical Education Office  
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Troy, MI 48083  
860-581-5900  
[tmarkova@med.wayne.edu](mailto:tmarkova@med.wayne.edu)

Family Medicine Residency Program Director:

Pierre Morris, MD  
Wayne State University School of Medicine  
Family Medicine Residency Program/Crittenton  
1101 W. University Drive, 2-South  
Rochester, MI 48307  
248-601-4900  
[pmorris@med.wayne.edu](mailto:pmorris@med.wayne.edu)

Preventive Medicine Residency Program Director:

TBN

## MI DOCs Narrative

### Wayne State University School of Medicine

September 27, 2017

#### Introduction

Through the MI DOCs program, the Wayne State University School of Medicine (WSU SOM) proposes to increase its **Family Medicine Residency Program by creating an urban track with four positions per year and initiate a new Preventive Medicine Residency Program for two residents per year**. MI DOCs residents will provide ambulatory health care services at community health center (CHC) site(s) and other facilities that provide services to **underserved populations in Detroit**.

**The WSU SOM Family Medicine Residency program** began in 2008 and is based at Ascension Crittenton Hospital in Rochester, Michigan. The educational program employs an innovative integrated Family Medicine Curriculum based on the Patient-Centered Medical Home (PCMH) model. Integrated Family Medicine Rotations are tailored to provide learning experiences that prepare the family physician of the future to operate as the coordinator of care in both a preventive and therapeutic manner. The residency program provides a unique longitudinal experience throughout the three years of training integrating the Family Medicine Center practice with other essential learning domains, including Sports Medicine, Care of the Elderly, Systems-Based Practice Building, Human Behavior and Mental Health and Community Medicine.

The program is accredited by the ACGME and currently, 18 residents (six per year) are enrolled in the program. Residents complete ambulatory practice program requirements at the Family Medicine Practice (FMP) at Crittenton. Under the MI DOCs program, WSU SOM will increase its Family Medicine Residency Program by four positions per year (10 total per year) and establish an urban track. The four new Family Medicine resident positions per year as part of the MI DOCs program will be selected through a separate match process so that the unique needs of the patient population to be served and challenges and demands of the positions can be successfully met. They will practice in a Federally-Qualified Health Center (FQHC) in Detroit, which will serve as their FMP.

**The WSU SOM Preventive Medicine Residency Program** will be a new program created through MI DOCs and will include two residents per year. The program will meet all ACGME program requirements for graduate medical education in Preventive Medicine. The program will train physicians for specialization in general preventive medicine and public health. This 24-month program will be designed to prepare physicians for leadership roles in academic preventive medicine, clinical preventive medicine, health-care management, clinical epidemiology and public health at the federal, state or local level. The Preventive Medicine residents will practice at a CHC and will provide some of the care for Michigan's incarcerated population through an agreement with the Michigan Department of Corrections (MDOC). MDOC is in the process of redesigning key health services contracts, reorganizing management structure, and improving contract management to create a culture of quality.

The MI DOCs residency programs will build on the WSU School of Medicine's commitment to Urban Clinical Excellence. The new positions will improve access to quality health care for underserved populations in Detroit and in Michigan's correctional facilities, while exposing residents to opportunities, challenges and benefits of practicing in an underserved urban area. The framework supports a healthcare workforce of a high-quality, high-value health care delivery system. In addition, it will increase the likelihood of recruitment for continued practice in this environment following graduation.

#### Needs Assessment

*General Information.* The US Census Bureau provides many demographic estimates and social statistics that help demonstrate the some of the ongoing needs of Detroit residents compared to Michigan as a whole. Several examples are provided in Table 1.

Table 1: Detroit and Michigan Demographics and Social Statistics

Measure	Detroit	Michigan
% Below Poverty Level	40	16
% Uninsured (<age 65)	11.4	6.5
% residents with a disability (<age 65)	16	10.5
Median income	\$25,980	\$51,084
% unemployed	20.6	7.2

(US Census, 2015 American Community Survey 1-Year Estimates)

As of September 2017, 87,692 Detroit residents were enrolled in the Healthy Michigan Plan. (Michigan Department of Health and Human Services, Healthy Michigan Plan) Healthy Michigan Plan participants, with some limited exceptions, must enroll in a Medicaid Health Plan that pays for their care. Any Federally-Qualified Health Center (FQHC) partner that will be the site for the MI DOCs residents will accept patients covered by the Healthy Michigan Plan, thus the WSU MI DOCs residents are highly likely to provide clinical services to Healthy Michigan Plan enrollees.

*Measures of Health Status in Detroit:* The 500 Cities Project—Local Data for Better Health—provides high quality small area estimates for behavioral risk factors that influence health status, for health outcomes, and the use of clinical preventive services. The data show that the City of Detroit has poorer age-adjusted prevalence for 23 of the 28 health measures compared to Michigan and the United States as a whole. (Centers for Disease Control and Prevention, 2016). See Table 2 for details.

Table 2: Selected Measures of Health Status among Detroit residents, Michigan residents and the US population

Measure	Detroit Prevalence*	Michigan Prevalence*	US Prevalence*
Obesity among adults >=18 years	45.2	30.5	28.7
High blood pressure among adults aged >=18 years	46.3	32.0	30.2
Diagnosed diabetes among adults aged >=18 years	17.6	9.1	9.4
Mental health not good for >=14 days among adults aged >=18 years	17.2	13.2	11.5
Physical health not good for >=14 days among adults aged >=18 years	18.3	11.9	11.6
Current lack of health insurance among adults aged 18-64 years	25.5	13.1	14.9
Up to date on a core set of clinical preventive services (flu shot past year pneumococcal shot ever, colorectal cancer screening) among men aged >=65 years	24.5	34.2	32.9
Up to date on a core set of clinical preventive services (same as men plus mammogram past 2 years) among women aged >=65 years	21.2	32.1	30.7

\*Age Adjusted

In brief, the health status of residents in Detroit is worse than the state and nation as a whole and health needs continue to persist. Augmenting the physician workforce in Detroit through the MI DOCs program would help meet these needs in the near term and may prove to be an essential part of a long term solution for expanding the healthcare workforce in Detroit, building a high quality healthcare system and in improving health status of Detroit residents.

### **FQHC Partnership**

WSU SOM will partner with **Community Health & Social Services Center (CHASS)**. CHASS operates two health clinics, both of which are located within the city limits of Detroit. The main clinic site in Southwest Detroit provides an array of health services including Family Medicine services and is recognized by the National Council on Quality Assurance as a Patient-Centered Medical Home (PCMH), a model of care that shows evidence of favorable effects on all three triple aim outcomes. (Peikes, Zutshi, Genevro, Parchman, & Meyers, 2012). Both CHASS clinic sites are all located in HRSA-designated Mental Health and Dental Health Professional Shortage Areas (HPSA), and in HRSA-designated Medically Underserved Area (MUA) or

Medically Underserved Population (MUP) area. Additionally, the Southwest Detroit site is located in a HRSA-designated Primary Care HPSA (Health Resources and Services Administration Data Warehouse).

CHASS served 11,477 patients in 2016. Approximately 21 percent of patients were under 18 years of age, 74 percent were adults (age 18-64) and five percent were age 65 and over. 97 percent of patients were a racial or ethnic minority; 75 percent were black and nearly 80 percent were of Hispanic/Latino ethnicity. Over 60 percent of patients are best served in a language other than English. For the percentage of patients with known income, 86 percent are at or below 100% of poverty and 99.7 percent are at or below 200% of poverty. Nearly 28 percent of patients are insured by Medicaid/CHIP and over 60 percent are uninsured.

CHASS provides exceptional patient care, particularly in Chronic Disease Management. It ranked in the top quartile in 2015 among health centers nationally in lipid therapy for Coronary Artery Disease and in the second quartile for use of appropriate medications for asthma. In 2016 it ranked in the top quartile for Hemoglobin A1c control for diabetes and in the second quartile for controlling high blood pressure.

CHASS is a community partner of the Henry Ford Health System in Detroit and its medical providers are affiliated with the Henry Ford Medical Group.

### **WSU MI DOCs Program Foundations**

The WSU MI DOCs program is organized around four themes:

- Educational Innovation: Population and Public Health
- Community Engagement and Leadership
- Interprofessional Education, and
- Health Care Equity and Cultural Competence.

These themes are recognized current priorities across medical education, population/community health and health care workforce development and are integral components of a high quality health system. Several program components overlap across themes and thus function as an interconnected web that reinforce overall project goals.

### **Educational Innovation: Population and Public Health**

The MI DOCs-funded residents will attend lectures and fulfill the inpatient components of the WSU Family Medicine program curriculum and will fulfill ambulatory, longitudinal and elective rotations at CHASS and/or other facilities that serve underserved populations. Opportunities for additional community-based educational experiences will be developed through partnerships with other community health and social service agencies. The existing, extensive network of WSU SOM and FM Department relationships with community health and social service agencies will be leveraged to include innovative learning and service opportunities for WSU MI DOCs residents.

Due to their deep level of interest in public and population health, the program and faculty will encourage MI DOCs residents to pursue specialized training in public health sciences. One such opportunity is the **Wayne State University Bridge Graduate Certificate Program in Public Health Practice (BGC-PHP)**. The Certificate program requirements include 13 credit hours of core public health courses and 2-3 credits of electives. The course of study is designed to develop capacity to apply public health theory and practice in analyzing community health. It provides a valuable foundation in core public health theory and practice including epidemiology, biostatistics, principles of environmental health and the social basis of healthcare. Graduates of the BGC-PHP will learn to:

- Apply evidence-based knowledge from biostatistics, epidemiology, and environmental health to understand and improve the health of the public.
- Use appropriate research and analytical strategies to address public health issues.

- Communicate public health findings verbally and in writing to professional and community audiences using a variety of media and methodologies.

In accordance with ACGME Preventive Medicine Program requirements, MI DOCs Preventive Medicine residents will be required to have or earn a **Master of Public Health (MPH) degree**. Tuition for MI DOCs residents will be waived for BGC-PHP and MPH coursework completed at WSU.

### **Community Engagement and Leadership**

Recruitment strategies for WSU MI Docs residents are expected to result in candidates with leadership qualities and demonstrated commitment to community engagement. The Michigan AHEC Scholars and other WSU SOM community experiences will be vehicles for development of the MI DOCs residents in community engagement and leadership skills.

**The Michigan AHEC Scholars Program.** The Michigan AHEC scholars program is a new initiative that will recruit approximately 75-125 scholars per year across the five Michigan AHEC regions. The program will recruit health professional students from several disciplines from underserved rural and urban communities in Michigan to help build capacity within communities to improve population health. The WSU MI DOCs residents will be encouraged to apply. The program will require a minimum of 40 hours of didactic (e.g. understanding quality, exploring the community needs assessment) and experiential learning per year for the two-year period of the program through workshops and virtual learning at Safety Net Delivery System (SNDS) sites. The Regional Centers will provide a stipend that will assist students with travel and housing. The Michigan AHEC scholars' programs will be interprofessional with the following learning objectives:

- To expose students to the integration of public health and population health principles within the primary care practice of SNDSs;
- To expose students to public health practical skills with a focus on social determinants of health and well-being;
- To identify and track a public health or quality measure of interest;
- To provide students with a clinical immersion experience that allows them to participate in the development and implementation of public health initiatives, provide clinical care services, and integrate concepts of public health and quality within primary care SNDSs.

### **Interprofessional Education**

The healthcare settings for MI DOCs residents will provide optimal care integration among residents and other health professionals. CHASS and MDOC facilities both employ a wide range of health and social services providers due to the fact that they both serve high needs populations. CHASS operates as a **Patient-Centered Medical Home (PCMH)**, a model of care that shows evidence of favorable effects on all three triple aim outcomes. (Peikes et al., 2012) CHASS and MDOC facilities will provide opportunities for MI DOCs residents to work collaboratively with psychiatrists, psychologists, social workers, substance abuse counselors, nurses, and dentists for improved patient outcomes and coordinated care.

All residents in the WSU FM program are required to participate in two academic projects during their tenure. One of the academic projects must be a **Quality Improvement (QI) project**. The FM residents, as well as the Preventive Medicine residents funded through this program will be required to participate in a QI project that aims to evaluate and improve some aspect of ambulatory care at CHASS and the MDOC facilities. The QI project will be planned, implemented and evaluated with participation from members of the **interprofessional team**.

### **Health Care Equity and Cultural Competency**

Because the MI DOCs program has similar goals as the federal Teaching Health Center (THC) GME program, MI DOCs program residents are expected to be similar to THC GME program residents in terms of demographics and career interests. A recent study found that teaching health centers attract residents from rural and/or disadvantaged backgrounds who seem to be more inclined to practice in underserved areas than those from more urban and economically advantaged roots. (Talib et al., 2017)

The WSU GME Office and FM program require or make available several educational experiences related to health care equity and cultural competency. For example, all incoming residents must complete cultural competency training as part of the onboarding process. A **health disparities problem-based learning** case that included reviewing Community Health Needs Assessment was added to the curriculum and a resident-led health disparities task force is under development. Thus, MI DOCs residents will bring their interests and commitment to health care equity and cultural competency to the program where it will be nurtured and developed at the CHASS, hospital, and MDOC settings and supported by the residency programs through educational initiatives and program requirements.

## **Supervision and Evaluation**

Program faculty as well as several community-based clinical faculty currently provide supervision and evaluate FM residents. MI DOCs residents will be supervised and evaluated by community settings-based clinical faculty using the same evaluation forms and processes used for Crittenton-based residents. The MI DOCs programs will be evaluated as required under the terms of the grant looking at educational, financial and patient care categories. The programs will also undergo a comprehensive review as part of the Annual Program Evaluation, required by the ACGME and WSU GME Office.

## **Recruitment and Retention**

**Recruitment:** Recruitment efforts for MI DOCs positions will focus on medical school graduates with diverse backgrounds, including graduates from underserved urban areas. WSU SOM graduates and graduates from other medical schools in Michigan will be prioritized. Demonstrated interest and experience in community health, population health, and working with underserved populations will be a specific requirement.

Currently the WSU residency programs actively recruit WSU SOM graduates to continue their training at a WSU residency program. WSU SOM graduates will be targeted for the MI DOCs positions because WSU SOM has a strong record of student involvement in community experiences, participates in the Michigan Area Health Education Center Scholars Program and is developing a Primary Care and Public Health Track.

***SOM Primary Care and Public Health Track.*** In accordance with major efforts at curricular change, the development of specialized professional development tracks for senior students is planned. One such track is the Primary Care and Public Health Track. This track will be built on the existing strong Family Medicine clinical experiences, service learning opportunities, and the MD/MPH dual degree program established through the recent completion of the Bridges to Equity HRSA grant. The student experience will include coursework, service learning (through the Student-Run Free Clinic in Detroit's most uninsured zip code), and professional development designed on a model that includes the four pillars of clinical care, mentorship and leadership, teaching, and scholarship. During their third year, students will be placed in urban clinical environments in collaboration with the AHEC and develop a scholarly project. Fourth year students will complete the Public Health Elective and also have the opportunity to obtain the Bridge Graduate Certificate in Public Health Practice (BGC-PHP). As described, multiple existing elements will be aligned to provide medical students with an opportunity to develop expertise in primary care and public health which could be leveraged for competitiveness and further specialized residency training.

***SOM Family Medicine Interest Group.*** Student involvement in community experiences at WSU SOM is prioritized, expansive and well-demonstrated. For example, the American Academy of Family Physicians named the Family Medicine Interest Group (FMIG) a 2017 Program of Excellence Award winner for their outstanding activities in generating interest in Family Medicine and community service. The School of Medicine received the Program of Excellence Award in 2012 and 2013 as well. The FMIG will be a powerful pipeline for MI DOCs residents to be active in community experiences organized by the medical school and intimately involved in community activities associated with CHASS, including leadership roles.

In summary, the Primary Care and Public Health track medical students, AHEC Scholars and FMIG medical students, as well as current MD/MPH dual degree program medical students will serve as pipelines to the MI

DOCs residency positions. MI DOCs and its recruitment plan will foster deep and lasting ties to the Detroit community through medical school and residency and result in a pool of diverse, well-prepared primary care physicians committed to practicing in underserved urban environments.

**Retention:** Research has shown that family medicine resident physicians who train in health center settings are nearly three times as likely to practice in underserved settings after graduation when compared to residents who did not train in health centers.(Morris, Johnson, Kim, & Chen, 2008. It is anticipated that graduates of the MI DOCs residency programs will be more likely to remain in Michigan due to the strong ties they will develop in the community and as a result of the recruiting process and priorities planned for the MI DOCs program. Significant associations exist between financial factors (e.g., debt or incentives) and underserved or rural practice, independent of preexisting trainee characteristics. (Goodfellow et al., 2016) Financial incentives for graduating residents of the WSU MI DOCs programs to accept employment at an FQHC in Detroit or in other underserved areas in Michigan and in the MDOC will be provided. Such incentives may include loan forgiveness/deferral, a signing bonus, stipends for conferences and travel, housing assistance, educational funds and other incentives.

## **Summary**

The WSU MI DOCs residency programs will provide funding for four Family Medicine residents in an urban track and two Preventive Medicine residents each year as part of WSU SOM commitment to Urban Clinical Excellence. The residents will provide health services under a Patient-Centered Medical Home (PCMH) model to underserved populations in Detroit at an FQHC(s) and the MDOC population. The programs will be multidimensional and interdisciplinary: They will include training in the biopsychosocial model of health care; cultural competency; social determinants of health and health disparities; behavioral sciences integration; and psychological and social needs of patients.

Multiple research studies show that a diverse health care workforce is associated with better access to and quality of care for disadvantaged populations, greater patient choice and satisfaction, and better educational experiences for students in health professions (Cooper et al. 2003; Health Resources and Services Administration 2006; Institute of Medicine 2004; Komaromy et al. 1996; Mertz and Grumbach 2001; Moy and Bartman 1995). Factors that increase the likelihood of students choosing careers in primary care and caring for underserved populations include being from a rural hometown and being an ethnic or racial minority (Brooks et al. 2002; Phillips et al. 2009). Recruitment efforts will focus on candidates from diverse backgrounds with demonstrated commitment to underserved populations. While many physicians drawn to careers in family medicine desire to practice in underserved areas, the presence of the WSU MI DOCs residents is expected to influence and encourage other residents in the FM program (and in other programs at Crittenton) to serve and ultimately practice in underserved areas.

Training family physicians in CHCs meets the health workforce needs of the underserved, enhances the recruitment of family physicians to CHCs, and prepares family physicians similarly to their non-CHC trained counterparts.(Morris et al., 2008) Taken as a whole, the MI DOCS program components paired with existing and planned WSU programs such as the Public Health Certificate program and the Primary Care and Population Health Track will provide a pool of medical school graduates not only interested in residency programs in an urban setting serving an underserved population, but likely to practice as primary care providers in urban communities in Michigan following the completion of their residency.

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Wayne State University School of Medicine  
MiDOCS  
Graduate Medical Education Expenses

Resident Costs

	Year One	Year Two	Year Three
<b>Salaries &amp; Wages</b>			
1 Residents-4	\$ 203,416	\$ 425,369	\$ 660,771
2 Preventive Medicine Residents-2	\$ 101,708	\$ 212,685	\$ 219,065
Resident Fringe Benefits (33.2%)	\$ 101,301	\$ 216,938	\$ 307,943
<b>Total Resident Salaries &amp; Benefits</b>	<b>\$ 406,425</b>	<b>\$ 854,992</b>	<b>\$ 1,187,779</b>

Direct Resident Costs

3 AAFP Resident Membership	\$ 200	\$ 400	\$ 600
4 Educational Allowance	\$ 6,000	\$ 15,000	\$ 23,000
5 Computer Equipment-Residents	\$ 4,800	\$ 4,800	\$ 4,800
6 In-Training Exam	\$ 200	\$ 400	\$ 600
Resident Lab Coats	\$ 1,000	\$ 1,000	\$ 1,000
7 Admin Office Expenses	\$ 5,000	\$ 5,000	\$ 5,000
8 Educational Resources	\$ 2,100	\$ 4,200	\$ 5,600
9 Retention Bonus		\$ 10,000	\$ 30,000
10 Resident & Faculty Recruitment	\$ 10,000	\$ 10,000	\$ 10,000
11 Resident Research and Scholarship	\$ 5,000	\$ 5,000	\$ 5,000
12 MPH Certificate Tuition		\$ 84,000	\$ 112,000
13 MPH Degree Tuition	\$ 36,000	\$ 72,000	\$ 72,000
14 Professional Liability & eCW licensing for Residents	\$ 140,000	\$ 420,000	\$ 560,000
15 GME office expense	\$ 30,000	\$ 60,000	\$ 80,000
Program Coordinator .25 FTE	\$ 8,800	\$ 8,800	\$ 8,800
Staff Fringe Benefits	\$ 2,904	\$ 2,904	\$ 2,904
<b>Total Administrative Costs</b>	<b>\$ 252,004</b>	<b>\$ 703,504</b>	<b>\$ 921,304</b>

<b>Total Resident Costs</b>	<b>\$ 658,429</b>	<b>\$ 1,558,496</b>	<b>\$ 2,109,083</b>
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Teaching Costs

FQHC Site Director Academic Stipend	\$ 25,000	\$ 25,000	\$ 25,000
Teaching Faculty Salary .6 FTE	\$ 150,000	\$ 150,000	\$ 150,000
MPH Certificate Coordinator .2FTE	\$ 10,000	\$ 20,000	\$ 20,000
Faculty Fringe Benefits	\$ 49,500	\$ 51,000	\$ 52,500
MPH Coor Fringe Benefits	\$ 3,300	\$ 6,800	\$ 7,000
16 Research Assistance	\$ 10,000	\$ 10,000	\$ 10,000
17 Faculty Development (CME/Res Scholarly presentations)	\$ 10,000	\$ 10,000	\$ 10,000
18 Teaching by Non-Hospital Site Physicians	\$ 57,600	\$ 115,200	\$ 153,600
19 Professional Liability Insurance	\$ 5,000	\$ 5,000	\$ 5,000
<b>Total Teaching Cost</b>	<b>\$ 320,400</b>	<b>\$ 393,000</b>	<b>\$ 433,100</b>

20 Covered by Wayne State University	\$ (36,000)	\$ (156,000)	\$ (184,000)
<b>Total Resident Cost plus Teaching Cost</b>	<b>\$ 942,829</b>	<b>\$ 1,795,496</b>	<b>\$ 2,358,183</b>
<b>Per resident amount</b>	<b>\$ 157,138</b>	<b>\$ 149,625</b>	<b>\$ 147,386</b>

- 1 Family Medicine Residents -Year 1 (4PGY1), Year 2 (4PGY1 & 4 PGY2), Year 3 (4-PGY1 & 4-PGY2 & 4-PGY3)
- 2 Preventive Medicine Residents - Year 1 (2 PGY1), Year 2 (2PGY1 & 2 PGY2), Year 3 (2PGY1 & 2 PGY2)
- 3 AAFP Membership dues - \$50/resident Family Medicine only
- 4 Educational expenses PGY1=1000, PGY2=1500, PGY3=2000 (dues, conference attendance, educational materials,etc)
- 5 I pads or Tablets for PGY 1 residents \$800/resident
- 6 In Training Exam Fees - \$50/resident per year Family Medicine only
- 7 Administrative Office expense - computers, copier, misc supplies
- 8 Educational Resources - Simulation Center, Procedure lab
- 9 Retention Bonus - \$5,000/resident graduating residents only
- 10 Resident recruitment - Annual recruitment fairs & travel for residents
- 11 Resident research and scholarship - expense to present at regional & national conferences
- 12 MPH Certificate requirement - tuition & fees (\$14,000/resident split into two years)
- 13 MPH Degree requirement - tuition & fees (\$36,000/resident split into two years)
- 14 FQHC Expense - professional liability and E H R Licensing - \$35,000/resident (6-Year 1, 12-Year 2, 18-year 3)
- 15 GME office Expense - \$5,000/resident
- 16 Research Assistance - .6 FTE
- 17 Professional Development - annual required courses & resident scholarly presentations
- 18 Teaching by Non-Hospital site physicians - preceptors on required ambulatory rotations (\$800/rotation)
- 19 Professional Liability Insurance for faculty
- 20 Covered by Wayne State University - Tuition and fees for MPH Certificate & Degree



School of Medicine

September 30, 2017

Caryn Volpe, Project Manager  
Michigan Area Health Education Center

Dear Ms. Volpe:

We write this letter in support of the Wayne State University School of Medicine MI DOCs proposal. For nearly 150 years, the Wayne State School of Medicine has prepared students to be health care leaders and advocates who go on to change the world. Our dedication to urban clinical excellence and contribution to Detroit's revitalization is unwavering. Our community service roots run deep, and our focus on a healthier world grows ever stronger. Through social responsiveness and a continuous focus on innovation in education, research and clinical care, the Wayne State School of Medicine will continue to graduate a diverse group of physicians and biomedical scientists who will transform the promise of equal health for all into a reality.

The MI DOCs program is in complete alignment with the Wayne State University School of Medicine Vision, Mission and Commitment will build on our commitment to urban clinical excellence. The additional six primary care residents made possible through MI DOCs will improve access to quality health care for underserved populations in Detroit and in Michigan's correctional facilities, while exposing residents to opportunities, challenges and benefits of practicing in an underserved urban area. Through this exposure, we are confident that a large proportion of MI DOCs family medicine and preventive medicine residents will go on to practice as primary care providers in urban communities in Michigan following the completion of their residency.

The Wayne State University School of Medicine community applauds the State of Michigan for supporting healthcare workforce development initiatives such as MI DOCs that are necessary to achieve a high-quality, high-value health care delivery system in the State of Michigan and in the City of Detroit. We look forward to our continued partnership in serving the needs of our communities.

Sincerely,

Jack D. Sobel, MD  
Dean  
School of Medicine  
Wayne State University

Tsveti Markova, MD  
Chair, Department of Family Medicine & Public Health Sciences  
Associate Dean for GME and Designated Institutional Official  
School of Medicine  
Wayne State University



## PLAN NARRATIVE

### Initial needs assessment for planned program expansion (specialty and sites)

The Kalamazoo area and the State of Michigan face a substantial shortage of primary care physicians. Kalamazoo County and its immediately contiguous catchment area counties (Allegan, Berry, Calhoun, Branch, St. Joseph, Cass and Van Buren counties) contain Medically Underserved Areas (MUA) and Medically Underserved Populations (MUP). These counties also contain areas defined as HPSA-Primary Care Geographic Shortage Areas, High Needs Geographic Shortages Areas and Population Shortage Areas. As just one example of these shortages: between our medical school and local partner organizations, we currently are actively recruiting over two dozen primary care physician faculty members, without much success.

Many of the primary care physicians currently practicing in the Kalamazoo region are graduates of our residency programs, mirroring the tendency of physicians to practice close to the site of their graduate medical education. Studies show that a powerful influencer of eventual practice setting is the location of the physician's GME program. Indeed, data from our own institution reveals that among our 2015 primary care residency graduates, 44% chose to practice within a 150-mile radius of Kalamazoo. Accordingly, expanding the size of our existing primary care residency programs can be expected to help impact Michigan's physician shortages.

The MIDOCs RFP requests that MIDOCs Consortium members propose expansions of up to six residents per year. However, we are also requested to outline any additional potential expansion capacity. Indeed, we do have such additional, MI DOCs-compliant capacity:

First, we should point out that Residency Review Committees typically approve complement expansions for 1-2 resident slots per year. It is unlikely that an RRC would approve a very large residency complement (six or more residents per year in a single residency) without substantial justification. Accordingly, like most other MIDOCs Consortium members, we will need to propose options that include residency slots from more than one specialty. Thus:

**For the Western Michigan University Homer Stryker M.D. School of Medicine (WMed), our proposed expansion includes four positions from Family Medicine and two from Pediatrics, for a total of six positions.**

However, as noted above, we at WMed do have substantial capacity and capability to incorporate a larger number of MIDOCs-compliant residency positions. Beyond the six slots noted, above, WMed could **immediately** expand **two slots in Psychiatry and two slots in Internal Medicine.**

Thus, if a hypothetical ten additional WMed slots per year were funded in the MIDOCs Pilot Program, WMed could in total accommodate:

- Family Medicine – 4 slots
- Pediatrics – 2 slots
- Psychiatry- 2 slots

- Internal Medicine – 2 slots

The remainder of our Proposal below will assume six additional WMed slots per year, for a total complement expansion of 18 residents over three years.

### **ACGME Accreditation Status**

The WMed residency programs in Family Medicine and Pediatrics are both well-established and have been fully accredited for many years. Both programs currently enjoy Continued Accreditation with the ACGME, with neither citations nor concerns.

Similarly, at the institutional level, WMed has long held Continued Accreditation status with the ACGME, with neither citations nor concerns.

Our Family Medicine residency program has additionally received Osteopathic Recognition status from the ACGME.

Our Family Medicine program currently enters 8 residents each year, for a total complement of 24. Our Pediatrics program also currently enters 8 residents each year, for a total complement of 24. These residency programs have historically had an excellent track record of filling in the NRMP Match with high quality residents.

As part of at the MIDOCs Pilot Program initiative, we propose to expand the FM residency to 12 residents per year (for a total complement of 36 over three years), and expand the Pediatrics residency program to 10 residents per year (for a total complete for 30 over three years).

Like all MIDOCs Consortium members, these additional residency slots at WMed will be new slots, and will thus require RRC approval for an expansion in complement. However, we do not anticipate any obstacles to that approval, as our programs and institution have the educational and clinical resources to support such a proposed expansion.

### **Complete a financial proforma, including identification of possible sources of revenue other than from clinical activities, including GME support.**

Please find attached our proposed budget for the program as an Excel spreadsheet (“WMed MIDOCs Budget”). Budgetary assumptions are outlined on “Sheet 2” of the spreadsheet.

The RFP acknowledges that MIDOCs institutions’ per capita costs average greater than \$200,000 per resident, yet requests that we limit our costs in the MIDOCs Pilot Program closer to \$150,000. Accordingly, there will be inevitable, implicit in-kind contributions.

Thus, our projected per resident budget is \$157,345. We have no other currently identified sources of revenue.

### **Proposed Mechanism or Incentive Plan to Recruit Residents to this Program**

One of the challenges facing the medical education community, and one that MIDOCs will face, is the ongoing difficulty in attracting medical students to primary care specialties.

We propose several mechanisms to recruit residents to our MIDOCs programs at WMed:

*Complementary Housing for Medical Student Electives:* We have long observed that one of the best predictors of matching prospective residents into our programs is whether the student completed a 4th year "audition" elective at our institution. To encourage such audition electives, we will offer complementary housing to visiting students who do electives with us. This will help offset the major expense involved with doing a medical student elective rotation in our MIDOCs residencies.

*Preference in Residency Recruiting:* We will give preference in our interviewing and NRMP match processes to favor applicants that are predicted to stay in Michigan, and especially to enter practice in underserved urban or rural settings. These would include Michigan citizens and residents, applicants with established Michigan roots and those with a background or established intent to practice in underserved urban and rural environments.

*Pipeline Programs:* WMed has a number of Pipeline programs to attract local, urban, underrepresented URM students to the profession of medicine and apply to our medical school. WMed Pipeline programs currently exist at the elementary school, middle school, high school and undergraduate levels, and are just now maturing. We will attempt to capitalize upon them to attract students and applicants to our MIDOCs specialty programs.

*Osteopathic Recognition:* Our WMed Family Medicine residency program was one of the first in the nation to achieve Osteopathic Recognition by the ACGME. Our osteopathic track is open to both DO's and MD's, and a number of our MD residents have chosen to participate. We have a very large and well-established osteopathic medical school in Michigan (MSU/COM), which has a large number of Michigan residents who enter primary care specialties. It is anticipated that our Osteopathic Recognition designation will help attract such applicants to the MIDOCs program.

Two of our other programs (Internal Medicine and Medicine/Pediatrics) also have ACGME Osteopathic Recognition. If our experience with these three programs proves to be the positive recruiting tool we expect, we anticipate seeking ACGME Osteopathic Recognition status for other potential WMed MIDOCs residencies, including Pediatrics.

### **Preceptor Roles, Responsibilities and Supervision Requirements**

All of our residency programs have well-established policies and procedures which explicitly outline the roles and responsibilities of preceptors, and their supervision requirements. These are reviewed and approved annually by our GMEC, and are fully RRC and ACGME-compliant at all times. These roles and responsibilities are applied equally to all residents in all programs, and will be to all MIDOCs residents, as well.

These policies and procedures are too lengthy to be included in this brief Proposal. However, suffice it to say that all our residents have immediate access to senior level residents and faculty level physicians at all times for both supervision and instruction.

### **Description of Innovative Educational Curriculum**

The clinical environment at WMed already has the requisite faculty and residency support infrastructure to support a large number of very successful residency programs. The

Institutional Sponsor (WMed) provides strong central GME Office and GMEC support to our programs, and is very supportive of the MIDOCs project. All partners in the Consortium project will substantially benefit from the collaborative arrangement between MIDOCs and our institutions.

Innovative aspects of our proposed curricula will include:

*Leverage:* Our residency programs already meet most of the requirements for the MIDOCs program. Our participation in the MIDOCs program will enable us to achieve complete “MIDOCs compliance” for ALL the residents in the program, not simply the newly approved MIDOCs slots. Thus, we do not anticipate having a separate “MIDOCs track”. Indeed, the entire residency programs will benefit from the MIDOCs initiative, and the anticipated benefits and outcomes of the MIDOCs program will be leveraged over many more residents than just those specifically funded.

*FQHC Settings:* Our residency programs already work closely with our local FQHC’s here in the Kalamazoo area, and the MIDOCs initiative will enable us to strengthen those curricular ties and exposure even more. For instance, our Family Medicine residency is already 100% FQHC-based (at the Family Health Center in Kalamazoo, a comprehensive FQHC). The MIDOCs initiative will enable residents to devote an even larger proportion of their curriculum to the care of this urban, underserved, FQHC population.

*Outpatient Care:* In both our Family Medicine and Pediatrics programs, the additional MIDOCs residents will permit all our residents to spend more curricular time in the outpatient setting, while still providing adequate staffing for educationally necessary in-patient services.

As an example, our proposal will allow our Family Medicine residents to decrease their time spent on our inpatient Family Medicine Service by approximately one third. This freed up time will be allotted to outpatient care, all of which will be spent in an FQHC setting. Similar benefits will be seen in our Pediatrics residency.

*Interprofessional Education and the Patient-Centered Medical Home:* All our residency Clinics, including our FQHC, have already received Patient-Centered Medical Home designation. We are also fortunate that WMed is the current recipient of a PACER grant (“*Professionals Accelerating Clinical and Educational Redesign*”) from the Josiah Macy Jr. Foundation. The objectives of the PACER program are primary care residency faculty development and curricular enhancement in the areas of interpersonal education / practice, and advancing the principles of the Patient-Centered Medical Home. Our residency programs have already substantially benefited from the PACER initiative, and these benefits will accelerate in the coming years. The MIDOCs program represents an ideal alignment of objectives between the PACER and MIDOCs programs. This provides both WMed and MIDOCs substantial leverage in these areas, increasing the amount of interprofessional education and collaboration in our Clinics, our FQHC’s and other educational environments.

The Family Health Center in Kalamazoo is a comprehensive, one-stop FQHC that offers a wide spectrum of health care services, such as dentistry, behavioral services, PT, OT, counseling, pharmacy and social work. MIDOCs residents will work with and learn side-by-side these interprofessional providers. Our residents are already integrated into the FQHC’s operations and committee structure, working to improve care in this

interprofessional environment.

*Public Health, Community Engagement and Population Health:* WMed is fortunate that the Medical Director of both the Kalamazoo County and neighboring Calhoun County Departments of Public Health (William Nettleton MD) is a medical school employee and one of the core faculty members of our Family Medicine residency. We will leverage this unique relationship to expand our existing curricular offerings in public health, community engagement and population health for both our Family Medicine and Pediatrics residencies.

*Rural Health:* Like many of the MIDOCs Consortium members, our residencies currently serve largely urban, underserved Michigan citizens. However, we propose to develop Rural Health Tracks for both our residencies, to complement these existing urban experiences. These Rural Health Tracks will provide extensive rotations and other curricular experiences in underserved rural settings. This will help recruit residency applicants from rural settings, and increase the likelihood that residents will eventually practice in underserved rural settings.

*Osteopathic Recognition:* As noted above, our Family Medicine residency program is unusual in that, although it is an ACGME program, it has “Osteopathic Recognition” via the ACGME. Michigan is fortunate to have a very large osteopathic medical school (MSU/COM), which has a high proportion of Michigan residents as students, students who are more likely to enter primary care fields. Osteopathic Recognition status is anticipated to attract COM graduates, who will then be more likely to stay in Michigan to practice.

### **Define placement needs to inform AHEC (housing, transportation, other)**

As noted above, we propose to develop a Rural Health Track for our residencies. We will engage the resources of MI-AHEC, the other MIDOCs Consortium members, and the statewide system of FQHC’s to identify appropriate rural educational settings for our MIDOCs residents. It is anticipated that housing, transportation and other resources will be needed in this regard.

### **Resident placement plan beyond pilot program and Physician retention plan (post-graduation from residency program)**

WMed and our FQHC (Family Health Center) already cooperate in aggressive Physician Recruitment and Retention Plans for both retaining our residency graduates to work in our underserved areas, and recruit physicians from outside our institution. These Plans include competitive compensation, excellent benefits, sign-on bonuses and educational loan repayment. We acknowledge that additional financial incentives, outside the scope of our currently proposed budget, may augment these efforts even more.

### **Outline educational outcomes**

The MIDOCs Consortium is an exciting project, one that has many potential education outcomes. Some of the initial educational outcomes that can help to measure the impact of the program will include:

- Successfully recruiting medical school graduates into our MIDOCs programs
- Successfully graduating MIDOCs physicians from residency

- The percentage of MIDOCs residency graduates retained in Michigan to practice
- Percentage of MIDOCs residency graduates who practice in identified Michigan underserved areas
- First time specialty board pass rates of MIDOCs residency graduates

### **Outline clinical outcomes**

Short-term clinical outcomes may include:

- Decreased Michigan Health Professional Shortages Areas in Primary Care
- Decreased Michigan Health Professional Shortage Areas in Mental Health
- Increased number of clinically active primary care physicians in Michigan HPSA's

Long-term clinical outcomes may include:

- Decreased infant mortality rates in impacted geographic areas
- Decreased cardiovascular morbidity and mortality in affected geographic areas

### **Describe how you would utilize the resources provided by Michigan AHEC and regional centers**

As noted above, we plan to develop and implement Rural Health Tracks for our MIDOCs residencies, to enable our residents to gain additional exposure to rural practice and rural settings, both to provide service to those populations during residency, and to practice in such settings after graduation.

We will leverage our relationships within MI-AHEC, the MIDOCs Consortium members and the statewide network of FQHC's to identify appropriate rural rotation and practice settings, and more immediate resources related to the Rural Health Track, including room, board and travel expenses.

### **Summary:**

In conclusion, the Western Michigan University Homer Stryker M.D. School of Medicine is delighted for the opportunity to participate in the MIDOCs Pilot Program. Our proposal includes the following unique features:

- Residents from two different specialties: Family Medicine and Pediatrics. We believe that training additional primary care pediatric physicians will be a legislatively attractive and unique value-added contribution to the overall MIDOCs portfolio.
- Rather than establish dedicated MIDOCs "tracks" within our residencies, we will convert our entire residencies to comply with MIDOCs objectives - substantially leveraging Michigan's MIDOCs investment.
- We already have very strong educational relationships with our local FQHC. MIDOCs will enable us to strengthen those relationships even more.
- Osteopathic Recognition of our allopathic residencies.
- Support to both urban and rural underserved areas.
- The ability to leverage the exiting resources of other grants (i.e., PACER).
- Substantial capacity for additional MIDOCs slots, above and beyond this Pilot Program.

We look forward to the opportunity to work with you on the exciting project!



September 20, 2017

Caryn M. Volpe, Program Manager  
Michigan Area Health Education Center  
Wayne State University School of Medicine  
Office of the Dean  
[cvolpe@med.wayne.edu](mailto:cvolpe@med.wayne.edu)

**RE: WMed Participation in MI DOCs**

Dear Ms. Volpe:

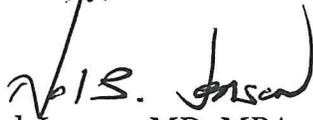
This letter is to indicate our enthusiastic support of Western Michigan University Homer Stryker M.D. School of Medicine's participation in the MI DOCs Consortium Pilot Program.

As you know, federal limitations on funded residency positions have hampered institutions' ability to meet the expanding need for primary care physicians in the workforce. This is especially true here in Michigan, in both urban and rural settings. The MI DOCs Consortium represents an innovative approach to address this problem.

Our primary care WMed residency programs are ideal settings for the MI DOCS Pilot Program. We already have strong working relationships with our FQHC's, including for training with our residency programs. All our WMed Clinics are certified by The Joint Commission as a Primary Care Medical Home, and the medical school's primary care clinics - family medicine, internal medicine, medicine-pediatrics, and pediatrics - are recognized by Patient-Centered Medical Home designation by the National Committee for Quality Assurance (NCQA) and by Blue Cross Blue Shield of Michigan.

We at WMed have the institutional resources, existing GME infrastructure, and administrative support needed to ensure the success of this important and exciting project. You have our support with the highest level of enthusiasm!

Sincerely,



Hal Jenson, MD, MBA  
Founding Dean



Lisa Graves, MD  
Professor & Interim Chair  
Department of Family and Community Medicine



Dilip Patel, MD, MBA, MPH  
Professor & Chairman  
Department of Pediatrics and Adolescent Medicine



David Overton, MD, MBA  
Associate Dean for Graduate Medical Education  
Designated Institutional Official