



Health care reform, provider education and a federal regulatory quirk

Presentation to the Oregon Health Fund Board Committee on Federal Laws

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Consensus on the problem

- Provider shortages
- Regional mal-distribution
- Increasingly affecting everyday life
 - Can't find physicians, weeks to wait for appointments, long travel times to specialists...
- Today's presentation focuses on physicians, but action needed for all



The impact of shortages on reform efforts

- Meaningful health care reform depends on a robust provider workforce
- The concept of a “medical home” is ineffective with provider shortages
- Health care reform must find ways to fund the size/quality of provider workforce needed for success
- Federal law creates an opportunity

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The Massachusetts example

- “*In Massachusetts, Universal Coverage Strains Care*” – New York Times, April 5, 2008
- 340,000 new uninsured people gained coverage
- No corresponding increase in providers
- Cites doubling of wait time to 3 months for general physical

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Physician supply is declining

- Flat med school graduation (no increase in educational capacity)
- Aging physician workforce (retirement)
 - Nearly half of Oregon’s physicians are 50+ years
 - 22% will retire within 5 years
- Shifting lifestyle expectations
- Malpractice insurance costs
- *Capped residency training opportunities*

Source: Oregon Office of Health Policy and Research, 2006, AAMC, OBME

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Oregon fundamentals are strong

- OHSU’s primary care, family medicine programs ranked second in the nation
- Physician retention rates are high ~ 50% remain
- Our grads buck national trends – still selecting primary care
- The “ingredients” are present
- Time to “cook” them by partnering for expanded education capacity

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Federal law “capped” residency training slots

- 1996 Balanced Budget Act “capped” post-MD training positions
 - For all existing programs
 - No opportunity to expand at OHSU
 - OHSU has 676 post-MD training positions
- The QUIRK: the law allowed for *new* training programs
- *And* federal law provides funding for new training programs

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The GME challenge and the opportunity

- Challenge: Smaller, regional hospitals lack administration, curriculum, accreditation support
- Opportunity: The Graduate Medical Education Consortium
- Three essential steps
- But first, some data

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OHSU School of Medicine graduate data

- 120 medical student graduates per year
 - About 5,000 applications per year
 - 7% (350) of applicant pool is Oregonian
 - Current class is 70% Oregonians
- 200 GME trainees complete their training each year

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Recent data show high percentage of OHSU grads remain in Oregon

- 52% of OHSU medical students stay in Oregon
 - Average nationwide is 40%
 - OHSU ranks 15th in nation
- 56% of OHSU GME trainees stay in Oregon
 - Average nationwide is 45%
 - OHSU ranks 10th in nation
- Tend to settle close to where they train

Source: OHSU alumni questionnaires, AAMC

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Oregon workforce relies on physician imports

- Despite very good retention, OHSU output is inadequate to meet demand
- Of the total number of licensed physicians in Oregon, 32% did all or part of their training at OHSU
- As national shortages worsen, Oregon will be competing for imported physicians

Source: OBME, 2006

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Changing our future

- Increase the “supply” of physicians opting to practice in Oregon
- Improve their geographic distribution
- HOW?
 - Create opportunities, advantages to stay in Oregon
 - Leverage resources
 - Enhance regional partnerships
- Oregon Medicine (ORMED) Collaborative

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Our strengths: ORMED

- Oregon Medicine Collaborative (ORMED)
- Unique partnership
 - OHSU
 - Oregon's higher education institutions
 - Regional health care systems
- Unique opportunity to build out regional capacity
- Enormous ancillary benefits to Oregon
 - Enhanced regional science programs
 - Academic presence in rural communities

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The ORMED solution

- A three-step proposal:
 - Step 1: Regionalize and expand clerkships
 - Step 2: Increase class size (Medical Honors)
 - Step 3: Provide graduate training sites (*The GME Consortium*)
- Each step is essential

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Step 1. Regionalize and expand clerkships

- Clinical clerkships are integral to OHSU unique medical curriculum
- Students introduced to state's providers
 - Encourages future practice in underserved areas
 - Enhances community partnerships
- Now, too few sites
- Training, accreditation, housing needed



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Step 1: Regionalize and expand clerkships

- We cannot maintain or grow class size without new clinical sites
- Regional sites at Bend, Eugene already established for 120 students
- We are at risk of losing ground already gained! Funding is urgently required



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We are at risk of losing ground already gained!

- Immediate Goal: Retain sites in Bend, Eugene
- Next year: Growth to Medford, Corvallis
 - Accommodate new students from Medical Honors program
- \$1.2 - \$1.5 million annual operating costs for all sites

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Step 2: Increase the class size (Medical Honors)

- 25% of US medical schools offer combined undergrad/MD programs
- Program design by U of O, OSU, PSU (*in progress*)
- Design will play to strengths, goals of each institution
 - Accreditation by OHSU
 - Preferential Oregonian acceptance

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Step 2: Increase the class size (Medical Honors)

- Shortened time frame increases output
- Less student debt (average now is \$155k)
- Rapid scale-up once established
- Needed clinical clerkships in place (Step 1)
- “Marquis” program for undergrad institutions
 - Enhances science programs
 - Keeps our best students IN OREGON
- Estimate of funding needed in progress

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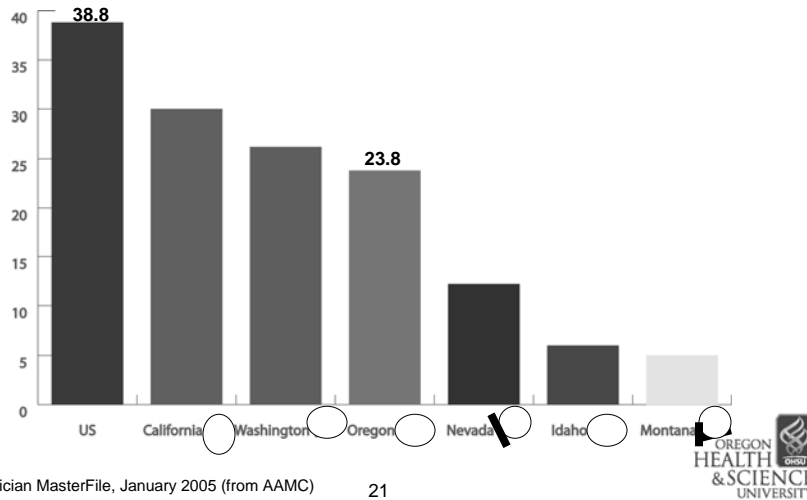
Step 3: Provide graduate training sites (The GME Consortium)

- As we grow number of graduates, must retain them in state
- *Train them in the communities where they are needed*
- Take advantage of opportunity presented by federal laws
- The GME Consortium: a framework for regional hospitals to establish training programs
 - OHSU manages/supports regional partners
 - OHSU is accrediting body

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Residents and fellows (GME) in training per 100,000 (2005)



AMA Physician MasterFile, January 2005 (from AAMC)

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Step 3: Provide graduate training sites (The GME Consortium)

- Complex federal regulations
- The 1996 regulatory “quirk” ensures underserved, regional focus
- Entails start-up costs (\$400,000)
- But eventually, self-supporting from federal funds
- First steps:
 - Statewide needs assessment
 - Coordinate regional hospitals
 - Develop implementation/federal funding strategy

Step 3: Provide graduate training sites (The GME Consortium)

- High potential to address mal-distribution
- Case study: two OHSU family practice sites
- Since 1996
 - Klamath Falls: 81% (22 of 27) of the half retained in Oregon practice in rural/frontier regions
 - Portland: 18% (10 of 56) of the half retained in Oregon now practice in rural/frontier regions

Rural = a geographic area (county) 10 or more miles from a population center of 30,000;
Frontier = a geographic area (county) with a population density of 6/sq mi or less (Office of Rural Health).

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Additional thoughts on primary care

- ORMED proposals provide framework to encourage new primary care in underserved areas
- Could be enhanced by other payer reforms:
 - Allow all providers to serve to the full extent of training
 - Focus on primary care teams
- Increase state support for a lower in-state tuition structure for Oregonian students at OHSU
- Tort reform/malpractice insurance

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Additional thoughts on primary care

- Loan forgiveness for “X” years in primary care?
- Rural areas paying student tuition?
- Important but neither ensures long-term commitments to rural/underserved areas
- Best solution: *Train them in the communities where they are needed*
- ORMED does that

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What can you do?

- Health care reform must include aggressive investment in provider education
- Without clear support for provider education, health care reform will trade one access challenge for another
- Support ORMED initiatives
 - Increase educational capacity
 - Provide framework for primary care providers to stay in Oregon

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