New Jersey Council of Teaching Hospitals
New physicians. New medicine. New ways. For New Jersey.

Hopping the Fence: New Jersey Teaching Hospital CEOs and Medical School Educators Convene to Jump-start New Collaborative Efforts

New Jersey Council of Teaching Hospitals
2012 Leadership Forum
Medical Education: Aligning to Create Value
September 6, 2012 Monroe Township, NJ
Forum Summary

In an all-out effort to get ahead of the coming tsunami in health care reform, the New Jersey Council of Teaching Hospitals convened leaders of the state's teaching hospitals and medical schools to get clarity on the issues and begin hammering out solutions – together.

Hopping the Fence: New Jersey Teaching Hospital CEOs and Medical School Educators Convene to Jump-start New Collaborative Efforts

New Jersey Council of Teaching Hospitals
2012 Leadership Forum
Medical Education: Aligning to Create Value
September 6, 2012 Monroe Township, NJ
Forum Summary

It was "back to school" as the leaders of the state's top medical teaching and training organizations came together on September 6th to dissect the current state of academic medicine, the looming specter of the Affordable Care Act, and the threats and opportunities inherent in new demands and directions in medical education.

The overriding message was that in this new day, courteous colleagues will become connected comrades. Boundaries will evaporate as the once nearly feudal system of health care specialization is forced into cohesion by money, measurement and momentum of patient-led and outcome-based health care.

Ultimately, the quality of graduate medical education (GME) links directly to the quality of the health care delivery system. Innovations and reforms must continually be addressed within both infrastructures to ensure they continue to excel. The GME enterprise depends on society not only for financial support but also for moral support.

-GME Primer, 2012
New Jersey Council of Teaching Hospitals

"We're here today to talk about the issues confronting medical education, the challenges and opportunities that lay ahead, and to put our heads together to create new solutions," said Robert C. Garrett, chair of the New Jersey Council of Teaching Hospitals (NJCTH), the forum sponsor. Some 25 of the nation's and state's leading medical teaching organizations convened to learn not only from the experts, but also from one another. Garrett is also president and chief executive officer of HackensackUMC, one of the state's largest providers of inpatient and outpatient services and training home to about 250 student physicians. (HackensackUMC is affiliated with UMDNJ-New Jersey Medical School).

"It's clear our governor and legislators understand the importance of medical education. They've spent months working to develop a structure that they believe will enhance the viability of medical education in our state," said Garrett, referring to the recent mergers of UMNDJ School of Osteopathic Medicine with Rowan University, and the New Jersey Medical School and the Robert Wood Johnson Medical School, with Rutgers University.

"Just as the Council took a leadership role in identifying and illuminating physician workforce issues, we intend with this forum to focus new interest and energy on the threats and challenges ahead for medical education," he said.

Riding the rails; forming a new posse

Chronicling a summer "listening and learning tour," NJCTH Acting President and Chief Executive Officer Deborah S. Briggs spoke of the echoing plea to bring together those who lead teaching hospitals and those who lead medical schools. "It seems the casual nod in the hallway and boardroom is no longer enough," she explained. "Hospitals and classrooms are being forced closer together under new federal initiatives and accreditation requirements that will eventually lead to a shared triple bottom line on financing, quality results and value to funders."

"What I heard from some CEOs was a desire to partner more closely with deans on future systems strategy," she said. "What I heard from some medical school deans was a desire to partner more closely with CEOs on future education strategies. Surely, each partnership will need to build those bridges internally, but given the transitory nature of health care today, the more we meet certain challenges together, the better off our patients, doctors and organizations will be in the long run." NJCTH was

It's clear our governor and legislators understand the importance of medical education. They've spent months working to develop a structure that they believe will enhance the viability of medical education in our state.

-Robert C. Garrett
New Jersey Council of Teaching Hospitals and HackensackUMC
[in reference to the recent UMDNJ-Rowan University merger]

created 28 years ago to encourage dialogue among teaching institutions and to advance the quality of the state's academic medicine sector."

Navigating through the potholes

"GME has become a dirty word in D.C.," said Briggs. She explained that the folks who hold the Medicare purse-strings are of the overriding opinion that there's too much "me" in GME.

"While they may articulate respect for the professional skills of physicians, they certainly decry the system," she said. "They call it expensive, dysfunctional and far too focused on the needs of the practitioner at the expense of the patient."

She explained that physicians in training must understand the financial implications of their patient management decisions, and their training must include new and efficient models of care so that they will be prepared to practice cost-effective medicine and be responsible stewards of resources while providing high quality patient care.

In fact, a leading critic, George E. Thibault, M.D., CEO of the Josiah Macy Jr. Foundation says, "GME financing is a prime target for federal deficit reduction. Because GME is financed primarily by public dollars (including nearly $10 billion from Medicare), we believe GME needs to be a more accountable, flexible and responsive system if it is to be maintained."

According to a conference summary from a Macy-sponsored gathering (Ensuring an Effective Physician Workforce in the United States, May 2011), "Many prior calls for GME reform have failed to produce meaningful change. Now, however, a convergence of forces makes a more compelling case for accelerating reform." According to the report, those forces include, changing demographics and disease burden of the patient population; transformation of the health care system; and the explosive growth in health care technology coupled with the need to use that technology in ways that are most safe and efficient.

Briggs outlined the current call for changes:

- Harmonize UME, GME and clinical practice;
- Revamp the current model of financing;
- Balance population need with the practice environment to create more emphasis on primary care;

Many prior calls for GME reform have failed to produce meaningful change. Now, however, a convergence of forces makes a more compelling case for accelerating reform.

- Conference Summary, Ensuring an Effective Physician Workforce in the United States, May 2011 Josiah Macy Jr. Foundation

- Add an understanding of the health delivery and payment systems to the student physician curriculum; and
- Target funding on expanding number of primary care providers.

"The supply of specialists continues to grow, while the supply of primary care physicians has remained essentially, flat. With the Affordable Care Act expected to usher 650,000 newly insured individuals into New Jersey's system, researchers are predicting a gap of about 1,600 primary care physicians by the year 2020 in New Jersey," she said.

Turning Abraham upside down

It was 1910 when the Carnegie Foundation published educator Abraham Flexner's treatise on medical education that called for a strict system of scientific rigor and established a training framework that is largely adhered to still today.

Well, "NAS" has something to say about that. In a presentation from the Accreditation Council for Graduate Medical Education (ACGME) sources, Briggs explained that implementation of the Next Accreditation System (NAS) began its two-year transition period in July 2012.

That was then and this is now. In 1910, the concerns were the mediocre quality and pronounced profit motive of many medical schools and teachers, inadequate curricula and facilities and a lack of scientific rigor in physician preparation. Over a century later, concerns remain surrounding the numbers and types of physicians, but the predominant concerns are "not enough" and "not connected to one another or to the needs of the population."

The emphasis will change from an "episodic biopsy model" to one that relies on outcomes for which the physicians of tomorrow will be measured.

The goals of the Next Accreditation System are:
- To begin the realization of establishing tangible measures and documented outcomes for every student;
- To free good programs to innovate;
- To assist poor programs to improve;
- To reduce the burden of accreditation; and
- To provide accountability for outcomes to the public.

If accreditation councils and teaching hospitals do not take the lead in outlining reforms, legislators and funders will do so on our behalf. Does anyone think this would be good?"

-Deborah S. Briggs, in presenting the American College of Graduate Medical Education's update on the Next Accreditation System

• • •

It's time to 'do' or 'be done to.'

"If accreditation councils and teaching hospitals do not take the lead in outlining reforms, legislators and funders will do so on our behalf. Does anyone think this would be good?" Briggs asked.

The presentation outlined two components of NAS that will be of particular importance to leaders in academic medicine – both on the academic side and the hospital side:

- Clinical Learning Environment Review (CLER): Institutions will be provided with up to three weeks' notice to prepare for a site visit. The purpose of the review will be to assess the GME learning environment of each sponsoring institution and its participating sites. According to ACGME, "CLER emphasizes the responsibility of the sponsoring institution for the quality and safety of the environment for learning and patient care. The intent of CLER is to generate national data on program and institutional attributes that have a salutary effect on quality and safety in settings where residents learn and on the quality of care rendered after graduation."

- Educational Milestones: The Milestones are observable developmental steps moving from the beginning resident to the expected level of proficiency at graduation from residency, ultimately, the level of expert/master. According to ACGME, "one of the benefits of The Milestones is that they articulate shared understanding of expectations, set aspirational goals of excellence, provide a framework and language for discussions across the continuum, and ultimately track what is most important – the educational outcomes of the residency program."

"No longer will hospital CEOs be able to leave it to the educators," said Briggs. "This is about measuring not just the student, but the entire system."

"One of their goals is to hear from us. This is a period of transformation. ACGME wants to hear what's working and what's not," she said. "There is a tremendous opportunity over the next two years as a state with multiple teaching hospitals to have a voice in this transformation."

• • •

This is a period of transformation. ACGME wants to hear what's working and what's not. There is a tremendous opportunity over the next two years as a state with multiple teaching hospitals to have a voice in this transformation.

-Deborah S. Briggs
New Jersey Council of Teaching Hospitals

• • •

"Yes, this time of transition will bring its share of frustrations, but most knowledgeable observers believe that the end result will be a more resilient system that rewards new solutions," she said.

It's GME, stupid.

"Not only is the health care system transforming as it needs to be, but that the transformation in medical education and health professions education has to be a part of that," explained Stephen C. Shannon, D.O., M.P.H., president of the American Association of Colleges of Osteopathic Medicine (AACOM). Shannon's organization represents 29 colleges in 28 states, more than 20,000 medical students and 32,000 faculty members.

"Given current projections, by 2015, there will be 35 percent more physicians trained yearly at U.S. medical schools than in 2002," said Shannon. His data indicates that the number of M.D. medical school graduates will increase by 22 percent, while the number of students graduating from schools of osteopathic medicine will increase by 102 percent.

"We all know that our medical education system is kind of a hodgepodge of things that have been put together," he said. "It's not put together necessarily in a rationale way. If you were creating a medical education system for the country, you wouldn't create it the way it's currently created."

"This is one of the biggest challenges we have," he stated as his slide blared out: "GRADUATE MEDICAL EDUCATION." "I picked the biggest font I could because this is the headline," he explained.

"We can graduate as many students as we want from medical schools but they're not physicians until they go through a GME system," he said. "Licensure, specialty training, certification – all those things need to continue to happen, but we've got this silo and that's a problem. Even if all the funding was there, it still doesn't fill the gap based on the predicted workforce shortage of physicians."

Can we be the change they want to see?

"The IOM [Institute of Medicine] has seated a panel to look at this. They met for the first time last Tuesday – and they are serious," he said.

• • •

We all know that our medical education system is kind of a hodgepodge of things that have been put together. It's not put together necessarily in a rationale way. If you were creating a medical education system for the country, you wouldn't create it the way it's currently created.

-Stephen Shannon, DO, MPH
Association of American Colleges of Osteopathic Medicine

Shannon outlined their major questions:

- "They wanted to know about the Indirect Medical Education (IME) issue and how we can possibly cut IME or re-direct some of the IME funds to do what they identify is needed for training.

- They wanted to know whether GME was over-funded and they are not getting the value needed or whether the funding that is there needs to be re-directed to get the value they need.

- They wanted to know if programs are being built to train for tomorrow's health care world.

- They wanted to know whether there can be changes in the GME system that can affect the primary care shortage and specifically, why isn't the GME system taking into account other health professions that could address the issue of the primary care shortage? Nurse practitioners, physician's assistants and others are in the mix.

- And, they wanted to know about the current funding system versus community-based training needs."

"Think about this with no new money – and in fact a reduction in money," he said. "And performance-based measures should be expected."

"They are looking for some guidance on what can be done," he said. "So, we're thinking about how we can provide some helpful leadership to come up with some creative suggestions so we can maintain as much of our system and control of our system as possible."

Shannon indicated that AACOM would be issuing a report in the next few months that speaks to re-engineering and addresses some of the silo issues.

Shannon explained that "if I were CEO or running the GME program, I would be thinking about a few things," including:

- Performance-based measures for GME – not just within your organization, but broadly;
- Team-based care and education and how to help that advance;
- The needs of the community and state beyond the institution;

If I were CEO or running the GME program, I would be thinking about a few things:

- Performance-based measures for GME -- not just within your organization, but broadly;
- Team-based care and education and how to help that advance;
- The needs of the community and state beyond the institution;
- How you can justify and demonstrate value to the external world; and
- What you will do if you have to come up with other funding streams to maintain the system.

-Stephen Shannon, DO, MPH
Association of American Colleges of Osteopathic Medicine

- How you can demonstrate and justify your value to the external world; and

- What you will do if you have to come up with other funding streams to maintain the system.

They're coming after the money.

"What they're talking about in Washington – and they're talking about it a lot – is *accountability,"* said Len Marquez, director of government relations for the Association of American Medical Colleges (AAMC). "At the end of the day, the country is $16 trillion in debt. How can we make the case for value of GME and do more with less?" he said.

"How do we put some paint on the IME dollar and follow that through your system? When we ask our members where does that money go, we don't often get back answers. We do a lot of explaining on the Hill, 'well, this is what happens if that money disappears' as opposed to what that money is actually being used for."

Marquez explained that there is a broad call to reform both UME and GME. "Whether it's COGME [Council on Graduate Medical Education], IOM – and certainly the House and Senate – it's more in the context of how do we get our hands on some of that money to pay for other things?"

"The question isn't how can we re-allocate; it's how can we come up with more funding to do what we need to do?" he said. "The question is how can we do this with less money because we need to cut? We need to find the savings."

"This is important to CEOs because there's a lot of money in the Medicare system," he said. "You're looking at $9.5 billion a year in Medicare support for Direct Medical Education (DME) and IME. There are people who are coming after this money. How can we – in a world of reduced clinical revenue while demanding excellent outcomes – make the case for value in GME, but also potentially do more with less?

"You need to be anticipating demands for accountability in GME," he said.

"AAMC has taken a position that it's difficult to be against transparency; it's difficult to be against accountability," he explained. "There are people on the Hill who are saying you are overpaid with IME."

This is important to CEOs because there's a lot of money in the Medicare system. You're looking at $9.5 billion a year in Medicare support for DME and IME. There are people who are coming after this money.

How can we – in a world of reduced clinical revenue while demanding excellent outcomes make the case for value in GME, but also potentially do more with less?

-Len Marquez
Association of American Medical Colleges

"Nobody's talking about the second part of that conversation – they are focusing on 'hey, you are overpaid and we need to take back some of that money and spend it on something else.'"

Better living through legislation?

"We were able to get a bipartisan bill (H.R. 6352, the Physician Shortage Reduction and Graduate Medical Education Transparency Act) introduced on the House side by Aaron Schock (R-Ill.) and Allyson Schwartz (D-Penn.), said Marquez." The bill would increase the number of residency positions over a five-year period in order to keep annual costs below $10 million. In addition, the bill would direct the General Accounting Office to do a physician workforce study to determine where shortages exist. According to Marquez, it will also require the Department of Health and Human Services to create a report [and rules] that will increase transparency. Marquez explained that the questions would be "how much DME are you getting; how much IME are you getting; but also, how much does it cost?"

"Our figures tell us that it costs about $145,000 a year in DME to train each resident," he explained. "We believe that on the DME side we are being underpaid by about $2 billion per year. We think the actual costs are closer to $5 billion instead of $3 billion. And beyond IME, what are the other costs that are making it so expensive to train residents? It's the cost of research, trauma centers and burn units. Those costs are not necessarily paid for through other payment systems."

How about a system where real winners win?

On an optimistic note, Marquez concluded his remarks with the idea that while we may feel some pain in the process, we are ultimately, building a better system.

"As you are reporting those measures back – once they're developed and the systems are in place for reporting back measures – it's going to lead to better data.

"We'll know what we're doing well and what we're not doing well," he said. "There's a possibility that those who are doing well can earn back more than the 2 percent they put at risk. Unfortunately, that means there

We'll know what we're doing well and what we're not doing well. There's a possibility that those who are doing well can earn back more than the 2 percent they put at risk.

Unfortunately, that means there would also be losers – and hopefully in the end, that drives everyone to improve.

-Len Marquez
Association of American Medical Colleges

would also be losers – and hopefully in the end, that drives everyone to improve."

It's all about how well we treat the patients.

"Let me tell you this: It's all about the patients. It has nothing to do with you. It has nothing to do with me. It has nothing to do with the federal government," said Martin S. Levine, D.O., M.P.H., immediate past president of the American Osteopathic Association (AOA). For Levine, it's all about patient outcomes.

"It's all political and I say that because that's where the crap really happens," he said. Levine recounted an airplane encounter with California Sen. Dianne Feinstein (D-Calif.) where he hoped to make a case for more primary care residency slots in southern California. Her response, according to Levine was, "GME is lucky to be getting the money they are getting." And, he remarked, "There are many others who think just like she does."

Necessity is the mother of invention – and investment.

"When we say we have a shortage of physicians, you know what it is – it's a mal-distribution of physicians," he explained. Levine spoke of new medical schools starting up in Auburn, Ala., Hattiesburg, Miss. and Yakima, Wash. – areas where physician shortages have been identified, thus immediately filling the need for physicians.

Levine shared some examples of medical institutions that have taken a creative tack to getting what they need. He spoke of starting the osteopathic family practice program at Christ Hospital in New Jersey some 30 years ago. Additional funds were available because the area was classified as having a physician shortage.

"The investment they made in the beginning has paid off. There are still physicians practicing and sending patients to the hospital," he said.

Isn't it worth it to invest in training the physicians? Levine explained that "the value of a family practitioner in your hospital is $1.2 million per year over the practice life of the physician."

It's all about the patients. It has nothing to do with you. It has nothing to do with me. It has nothing to do with the federal government. It's all about patient outcomes.

-Martin S. Levine, DO, MPH
American Osteopathic Association

According to Levine, 62 percent of New York has a shortage of primary care doctors. "I am sure there are parts of New Jersey that have shortages," he said. "Go to your legislators and say that you want to implement similar recruitment and retention programs in your state. That's the kind of thing you should be spearheading," he said.

Get residents out into the trenches – earlier.

Levine spoke of meetings with other advocates of medical education and explained that he challenges the system by asking, "How do you know that the competencies you are planning to measure are going to translate into better patient outcomes?"

He described the Clinical Assessment Program – a program that has been in place since 1999, where the osteopathic profession has been measuring residents and residencies against national norms, against each other and against patient outcomes.

"What kind of product are you really producing? Well, most of them pass their boards, but is that a real criterion for measurement?" he asked.

"How well are your patients actually treated and how well are your residents' diabetic patients doing? What percent of their diabetics have optimal hemoglobin A-1C, blood pressures and LDL," he asked. "We all know that's the evidence. Are we really measuring it?"

Levine encouraged the audience to bring the schools and the hospitals together in whatever way they can. He spoke of programs in which hospitals linked residents to private practices – especially where physicians are near retirement – so that the hospital could recruit them to remain in that practice and maintain the patient base.

His theme? Innovation. "Do something new. Do something you haven't done before," he said.

He described a program in New Jersey where Aetna is offering capitated payment for a group of Medicare patients. He outlined how his own practice conducts over 1,200 house calls a year and works with five to seven nursing homes. "It is critical to get your residents into these environments, he said."

Right now, what we're doing in New Jersey doesn't seem to be working. Thirty-eight percent stay – not a good number. We need to do more innovative things to get them to want to stay; to help them feel comfortable practicing in the environments you are creating.

-Martin S. Levine, DO, MPH
American Osteopathic Association

"Right now, what we're doing in New Jersey doesn't seem to be working. Thirty-eight percent stay – not a good number," he said. "We need to do more innovative things to get them to want to stay; to help them feel comfortable practicing in the environments you are creating."

"You must demonstrate excellent patient outcomes linked to your training program for all physicians that go to your institution; real patient outcomes. I am not talking about the stuff that you are doing for Joint Commission," he challenged. "Go higher. Get your physicians to participate. Help them do it. Encourage them to do it and get the residents in their offices to see how it's done."

"Get the residents out into the private sector to see what's going on. Team them up in a new way," he said. "The patients love it. They think they're getting better care. You will win in all respects."

Speaking up for change.

Midway through the morning, it was time to turn the tables to audience participation. With handheld electronic devices, participants were polled on a variety of pressing issues.

With an audience composed of 35 percent CEOs or CEO representatives and 65 percent educational leaders, it was helpful to look at the responses as a whole, but also to see the commonalities and differences in thinking between the CEOs and the educators.

For example, when asked what they thought was the greatest threat today to graduate medical education, the split was clear: 46 percent of the CEOs said "cuts to IME funding," while 38 percent of the educators said "not lifting the current resident cap."

When asked what they felt was the most important institutional action that needed to be taken, the CEO response was split: 32 percent said "perform a regional analysis of physician workforce needs" and 27 percent said "work with my team to document actual cost associated with Indirect Medical Education." Educators said "provide resources for faculty to adopt and adapt to new educational requirements and the new outcome measurement system."

When asked what they felt was the most important institutional action that needed to be taken, the CEO response was split:

32 percent said "perform a regional analysis of physician workforce needs" and …

27 percent said "work with my team to document actual cost associated with Indirect Medical Education."

Educators said "provide resources for faculty to adopt and adapt to new educational requirements and the new outcome measurement system."

-Audience response to key questions

Leaders encourage inclusion and innovation.

When asked what was the most important action they could take as an individual leader within the medical education sector, the top response for both CEOs (43 percent) and educators (50 percent) was the same: "encourage innovation and inclusion of residents in the development of new systems such as patient-centered medical homes, accountable care organizations and interdisciplinary teams." The number two response for both was to "develop strong partnerships between teaching hospitals and medical schools."

When asked what they wanted to learn more about, responses were fairly evenly scattered among the following topics:

- Ways to break down the walls between pre-med, med school, residency and practice (28 percent)
- Ways to support the transition to competency-based education (24 percent)
- Increasing the accreditation emphasis on educational outcomes (20 percent)
- Ways to measure my actual IME costs (20 percent)

Finally, when asked what ways NJCTH could assist medical education leaders, the overriding and energetic answer was *"all of the above"* (55 percent). Possibilities listed included:

- Monitoring and reporting on state and federal legislative activity and supporting policy and legislative reforms that are favorable to teaching hospitals and medical schools (20 percent)
- Organizing special interest work groups that can take action on priority issues (10 percent)
- Holding workshops to provide more in-depth information about emerging concerns (5 percent)
- Providing advisories, white papers, and best practices that include information specific to New Jersey's situation (5 percent)
- Continuing to monitor the physician supply situation and encourage new practices that help us recruit needed physicians to the state (5 percent)

What is the most important issue we can tackle together between the medical schools and teaching hospitals?

-Deborah S. Briggs, seeking audience response

• • •

It's time to rumble…and to ruminate.

With all votes counted, it was time to open the floor to response and reaction. Briggs sparked the conversation with this question:

What is the most important issue we can tackle together between the medical schools and teaching hospitals?

Responses ranged from the practical to the aspirational. Among the responses were:

- *Steve Littleson, CEO, Jersey Shore University Medical Center:* "There's an opportunity for us to create a case for the graduate medical education money we get. It's at risk, but we have an opportunity, partnering with the schools to create the measures to prove that we earn the money we get and that we don't just spend it. I think the age-old arguments of needing that money because we have historically spent it are getting old and now we need to turn that into an argument that we earn it by demonstrating the outcomes and value that I think the schools can help us create."

- *Barbara Schindler, M.D., vice dean, Drexel University School of Medicine:* "Particularly around the discussion of the need for more primary care physicians, I was most struck with the importance of aligning the educational priorities between the academic medical centers and the hospital systems and really helping practicing physicians understand that while there is some financial cost associated with their taking residents and students in as trainees, I think that until we move the model out of the hospitals into the primary care setting, we're still going to struggle mightily with trying to encourage both residents and medical students to go into primary care and we need to make sure those priorities get aligned."

- *Mary L. Voytas, D.D.S., designated institutional officer, Mountainside Hospital, HackensackUMC:* "I think we need strong organized systems for outpatient care for our residency programs that we can then feed the students into that system and I think that's essential because most of the care is going to be outpatient, not inpatient."

• • •

I think one of the things that is going to be really important is that we are able to assess the success or non-success of the training of the residents. How are we going to be able to do that? And it's not just board certification because most physicians do pass the boards.

There must be some other way of doing it – population health improvement is certainly one, but that's going to take some time.

- Gary Horan
Trinitas Hospital

• • •

- *Gary Horan, CEO, Trinitas Hospital:* "I think one of the things that is going to be really important is that we are able to assess the success or non-success of the training of the residents. How are we going to be able to do that? And it's not just board certification because most physicians do pass the boards. There must be some other way of doing it – population health improvement is certainly one, but that's going to take some time. So I think there assessment of success or non-success – there needs to be mechanisms in place for that."

- *Robert C. Garrett, CEO, HackensackUMC:* "I was struck by the answer that the group gave collectively about the role of the New Jersey Council of Teaching Hospitals by the 'all of the above' response. When you think about the issues that were identified this morning, we really do need an organization that can coordinate efforts whether it be about saving dollars that are at risk for direct GME or IME; to specifically coordinate with medical schools on the physician shortage issue; developing those outcomes and measures that we are all going to be held accountable for; or just in terms of curriculum changes that need to be made given the new environment we are in, whether it be ACOs, population health management, etc. I was struck by the 'all of the above response' that indicates to me that there is still a great need for organizations like the New Jersey Council of Teaching Hospitals."

- *Maria Ciminelli, M.D., family medicine program director, Centrastate Medical Center*: "What struck me this morning – being an educator in a community hospital with just one residency program – the physician shortage is a big problem, yes. One of the biggest issues for my residents that graduate – and keeping them in New Jersey especially – is their economic burden coming out of medical school. They tell me they can find lots of opportunities outside of New Jersey for better pay and for more payback in terms of their medical education. I wonder if the alliance with the hospitals, with the medical schools, with lobbying, with some of the political parties here in New Jersey, can help us to improve the opportunities for our graduates in the state of New Jersey."

- *Thomas Cavalieri, D.O., dean, UMDNJ School of Osteopathic Medicine:* "The partnership between the hospital and the medical school is critical – to address two very important issues: cost and innovation in medical education. The cost, because as we all know while we're

• • •

So we need to make a better case that in fact, the dollars we are getting for medical education – graduate medical and undergraduate together – are insufficient to really address the physician training needs for the future.

We need to need to be accountable and demonstrate that more dollars are needed.

-Thomas Cavalieri, DO, UMDNJ School of Osteopathic Medicine

• • •

saying we need more and more physicians, the funding for medical education is threatened. Quite frankly, we talk about GME and UME, there's a lot of overlap between the two. The medical schools rely heavily on the hospitals for training, so the GME dollars and the dollars that support the medical school in some way get pooled. So we need to make a better case that in fact, the dollars we are getting for medical education – graduate medical and undergraduate together – are insufficient to really address the physician training needs for the future. We need to be accountable and demonstrate that more dollars are needed.

And the issue with innovation in medical education is true. As we talk more about ACOs, prevention and the medical home – and also issues of population health - the medical schools and hospitals really need to work together for innovation in education."

- *Martin Levine, D.O., immediate past president, American Osteopathic Association:* "One of the schools in Florida put together a new residency program in psychiatry that is completely funded by the Corrections Department of the State of Florida. So when you think of that, think of partners outside of the room, think outside the box; outside of whom we've been discussing. The opportunities are there."

- *Thomas McGinley, Jr., M.D., family medicine program director, St. Luke's Warren Hospital:* "It's obvious there is going to be no further allocation of resources in this infrastructure from our government. From the perspective of a community hospital in Warren County — in an area of need – there are a lot of people out there in the trenches, training physicians for areas of need, who are frankly, quite innovative. From that perspective, the collaboration with hospitals and medical schools would be helpful to us because I have lots of ideas, having done this for 20 years in the trenches, that I think any of you would be surprised. I just don't have the funding resources, so it's going to be tighter for folks like me. I don't have the knowledge or wherewithal for funding, so those collaborations with people outside of academic medical centers, you might find surprisingly innovative – and we could use your assistance in making some of these ideas a reality."

- *Suresh Raina, M.D., vice-president of medical affairs and chief medical officer, Palisades Medical Center:* "Health care has been notorious for

• • •

Health care has been notorious for creating a product and then trying to find a market for it, instead of the other way around.

What we haven't identified is what do they need to know when they are out in the practice?

We need to go backward and define what we need different specialists to do when they finish and then tailor our programs to that product.

-Suresh Raina, MD
Palisades Medical Center

creating a product and then trying to find a market for it, instead of the other way around. Right now, we recognize within certain broad categories what the needs are going to be in the future. We need primary care physicians. No question of it. We also need general surgeons. We need OB/GYNs. We need pediatricians. What we haven't identified is what do they need to know when they are out in the practice? We need to go backward and define what we need different specialists to do when they finish and then tailor our programs to that product."

- *Susan Hutter, operations manager-academic affairs, HackensackUMC:* "As a non-CEO and a non-physician, I can tell you as a person who deals with residents and medical schools on a daily basis that they need to be part of this equation. They really do not have any idea of the costs we incur as a hospital. They don't even know anything except what they owe in loans. They need to see that they are an equal partner with us in their education and they're required to help us to continue to educate future physicians by participating and staying in the state. It's our responsibility to teach them that."

- *David Skillinge, D.O., vice president, designated institutional officer, Hunterdon Medical Center:* "Coming from a rural county – being a small program – where a consortium could help us is to be able to have a collective group to talk to the medical schools in our catchment area. Medical schools need to place their students in rotations. The academic centers are larger and they are the more obvious. If we could be a collaborative group, we could say let's get students out to the hospitals. We know that if we get students in our hospitals, they will most likely stay for our residencies; they will most likely stay in the local community. Right now each one of us in small hospitals is trying to market ourselves to each different medical school to try to get rotations and get students. Is there a smarter and more efficient way to do that as a collaborative group?"

  "More importantly, it would be nice on the medical school level if we could profile students and find out the ones early on who may be interested in family medicine and then partner them up with residencies in community hospitals and hospitals throughout the consortium that may be the best fit for them."

There are a lot of ways we can collaborate in new and innovative ways to deliver care. One of the areas I've been interested in for a long time is more of a multi-disciplinary approach to patient care. I think there are a lot of silos that exist out there between physicians, nurses, other care givers. There's a lot to be said for new models of care where you can integrate them.

- John Lloyd
Meridian Health

• • •

- *John Lloyd, CEO, Meridian Health:* "There are a lot of ways we can collaborate in new and innovative ways to deliver care. One of the areas I've been interested in for a long time is more of a multi-disciplinary approach to patient care. I think there are a lot of silos that exist out there between physicians, nurses, other care givers. There's a lot to be said for new models of care where you can integrate them; where nurses and physicians can work in simulation labs together; where PharmDs – who have been very successful in working with physicians – can be part of a team. In the end with the shortage of primary care physicians, mid-level practitioners, nurse practitioners, PAs and others, the PharmDs become essential to delivering coordinated care."

- *Ihor Sawczuk, M.D., executive vice president, chief medical officer, chief academic officer, HackensackUMC:* "It really has come to my attention is that the word 'team' is very important. What we need to do is change the way we train physicians from the beginning. As you all know, physicians are Type-A personalities… We train them to be individuals. They have to make decisions on their own, independently. We need to change that. We need the medical schools to teach the future physicians to be team players. They need to work with the nursing staff. They need to work with the ancillary health professionals. They need to work with each other. What I am saying is culture needs to evolve and change. Otherwise, everything we do is very difficult."

- *Antoinette Spevetz, M.D., designated institutional officer, Cooper University Hospital:* "How *do* we actually redesign the system so that some of the service needs that the hospitals depend upon from the residents get met by someone to allow the residents to get out of that typical environment; get out in the community; and do some different things that we are talking about. I think that's a huge challenge. We can think outside of the box. We know we need to do it differently, but the "how" is difficult. The residents deliver a lot of care, so redistributing that is difficult. Also getting administration and board to understand medical education; but to really understand what we do, what needs to be done and that there is cost associated with it."

- *Stephen C. Shannon, D.O., president, AACOM:* "As an outsider and an observer of the work here – and hearing the dialogue – it's very impressive. One role that the Council of Teaching Hospitals could

• • •

As an outsider and an observer of the work here – and hearing the dialogue – it's very impressive.

One role that the Council of Teaching Hospitals could help with is helping tie inter-professional education with practice transformation.

This is something this group potentially could lead – or very much be part of guiding changes in the state – and become a model.

-Stephen C. Shannon, DO
Association of American Colleges of Osteopathic Medicine

• • •

help with is helping tie inter-professional education with practice transformation. This is something this group potentially could lead – or very much be part of guiding changes in the state – and become a model. And if you tie that together with thinking not just about the patients you serve and the communities in which you exist, but also the health of the larger community – tying education and prevention and the health of the population; especially if you think not just in terms of innovation relative to quality, but also think about the larger environment where we are facing real challenges – both the clinical issues we'll all facing and the funding that's going to be available: How *can* we do innovative changes in the way education occurs, care is occurring? And to what extent does this group provide the appropriate place for that kind of dialogue and collaboration."

A conversation with the UMDNJ deans.

While the grounds beneath the traditional structure of medical education shake, rattle and roll, New Jersey faces a seismic change with the merger of its state-funded medical institutions.

Heather Howard, director of New Jersey's State Health Reform Assistance Network at Princeton University and former commissioner of New Jersey's Department of Health and Senior Services, explained briefly that Rutgers, Camden and Rowan are forming a joint board to create and oversee a College of Life Sciences. Rutgers is absorbing six of UMDNJ's seven schools. Rowan will be taking over the seventh, the School of Osteopathic Medicine in Stratford. Rowan will gain a state designation as a research institution that will allow it to create doctoral programs in biomedical engineering and pharmacology.

"This is a historic opportunity to enhance medical education in New Jersey and a unique chance to hear from the folks who are on the front lines," she said. Panelists were Dean Thomas Cavalieri , D.O., of UMDNJ-School of Osteopathic Medicine (SOM) and Dean Paul Katz. M.D., of Cooper Medical School at Rowan University.

"Well, the ink isn't even dry yet," said Cavalieri. "It's early in the process. This will be a lot of work, but we're up to it." He explained that three steering committees have been established. One, to oversee the movement of the UMDNJ schools into Rutgers University (except for the School of

• • •

We're off to a very good start. "We're trying to make a brand for our medical school – not in the advertising sense.

We're actually trying to take advantage of our location.

Our big focus is going to be on urban health. Our big focus is going to be service to the community.

- Paul Katz, MD
Cooper Medical School at Rowan University," she said.

Osteopathic Medicine and University Hospital; another, to oversee the separation of University Hospital as a state hospital into a nonprofit hospital that will be managed by an independent management firm; and the third, to oversee the movement of the School of Osteopathic Medicine into Rowan.

"In addition, there are 13 integration teams, designed to address common issues such as clinical research HR, legal, etc. They are just getting formed. Their charge is to identify each of the tasks that need to be done and provide a timeline," he explained.

In the midst of change is fertile ground to try new approaches.

"We're off to a very good start," said Katz. "We're trying to make a brand for our medical school – not in the advertising sense. We're actually trying to take advantage of our location. Our big focus is going to be on urban health. Our big focus is going to be service to the community. "

"We believe that one of the metrics by which we should be judged is not on just how our medical school does or some of the outcomes we heard about today, but how the city of Camden does," he explained.

"We need to make sure that our students pay it forward," said Katz. "We want them to pay back to the people who participated in their education. We want them to be good citizens so we require that they perform 40 hours of volunteer service outside of health care.

"There's some pretty distressing data on how poorly physicians do in voting in national elections," said Katz. "Physicians vote less than the general public, but perhaps worst of all, physicians vote appreciably less than lawyers."

Cavalieri explained his approach to growing the medical school numbers. "We just launched our largest class ever, moving over the years from 100 to 162. We did this for a reason," he explained. "Part of it was to be part of the solution within the state of New Jersey." UMDNJ-SOM performs better than the state average for keeping physicians in the area. "A little better than 50 percent of our graduates stay in the state – and better than about 50 percent stay in primary care," he said.

"Our goal is to grow quality physicians that are likely to stay in New Jersey," he said. Cavalieri explained that his organization is actively

Our goal is to grow quality physicians that are likely to stay in New Jersey.

-Thomas Cavalieri, DO, UMDNJ School of Osteopathic Medicine

participating with community hospitals to launch new family medicine programs.

"Partnering with hospitals that historically haven't been in the milieu of medical education is a positive," he said. "They are still eligible to start new GME programs and get CMS [Centers for Medicare and Medicaid Services] funding—that was very much the case with South Jersey Healthcare in Cumberland County, and is also the case with Southern Ocean Medical Center, where a discussion of a family medicine program is on the table."

According to Katz, one of the concerns "is how poor a job we do at the undergraduate and graduate level of preparing our students to practice."

"They go out into the world unarmed to understand the realities of health care. They know a lot more about exotic diseases than they do about payer mix," he said. "We need to do a better job. Here's where an alignment with our health system and hospitals is important. On the hospital side I know you struggle with getting your physicians to understand the cost of care. It needs to start with residency. They need to understand those financial issues that challenge all of your financial successes."

"Our focus has been on early clinical experiences; our focus has been on small group learning," said Katz. "Our focus has been on problem-solving and critical thinking. One of our competencies is learning and working in teams. We already have our students working with pharmacy students in Philadelphia."

Matthew Wieczkowski, chief administrative officer and executive vice president of St. Peter's University Hospital, described a program in which his organization partners with Rutgers to offer a mini-MBA program to all employees. "Our residents signed up in record numbers for the course on strategic planning," he said.

As in most discussions about health care these days, the final words were about costs.

"We're all talking about all the dollars that they are looking for us to take out of the system," said William McDonald, president and chief executive officer of St. Joseph's Regional Medical Center. "Where's the money coming from to put all this together at a time when the state won't give

They go out into the world unarmed to understand the realities of health care. They know a lot more about exotic diseases than they do about payer mix. We need to do a better job. They need to understand those financial issues that challenge all of your financial successes.

- Paul Katz, MD
Cooper Medical School at Rowan University

any more dollars for graduate medical education; the feds aren't matching anything anymore. This endeavor is going to cost a lot of money. Who's paying for all that, given we're all looking at great reductions?"

"There's no good place to go anymore for money," said Katz. "One of the things we are trying to do as a start-up is trying to be very frugal. A couple of things have to happen. What we're doing is working to be parsimonious. The days of standing alone instead of partnering are going by the by-and-by. It's up to us to assume that for the foreseeable future, these will be the good ole days. We need to think about how we are going to change what we do because I don't think the external forces are going to meet the needs that we currently have."

What's next?

"If today's event is any indication, there's no lack of commitment, interest or receptivity to change among New Jersey's academic medical institutions," said Deborah S. Briggs, acting president and CEO of the New Jersey Council of Teaching Hospitals (NJCTH).

"I am certainly proud to be among such passionate leaders," said Robert C. Garrett, NJCTH chair and president and CEO of HackensackUMC. "In the world of teaching hospitals and medical schools, New Jersey leaders have a rich tradition of being ahead of the curve. Given what I heard today – and what I've been hearing for some time – there is no lack of energy around the idea of working together to keep our sector strong in a way that continues to provide the finest in medical care to those we serve."

"With all the challenges on the table, lesser hearts and minds might retreat," he said. "Not here. We'll continue to use our assets and share our resources for the good of the people of New Jersey. Our hospitals, medical schools, research centers, trauma centers, burn units and children's hospitals have always been on the leading edge. We will embrace the challenges together – and continue to advance. "

In light of the priorities, ideas and concerns expressed at the 2012 Leadership Forum, the New Jersey Council of Teaching Hospitals will maintain an active agenda, working to further develop and take action on the following:

The days of standing alone instead of partnering are going by the by-and-by. It's up to us to assume that for the foreseeable future, these will be the good ole days.

We need to think about how we are going to change what we do because I don't think the external forces are going to meet the needs that we currently have."

- Paul Katz, MD
Cooper Medical School at Rowan University

- "Pitch a larger tent" to accommodate both CEOs of teaching hospitals and deans of medical schools so they can address common concerns with the goal of solidifying partnerships and gaining strength through stronger integration and coordination between medical schools and teaching hospitals.

- Gain a stronger understanding of the concept of team-building within the health and medical professions and assist members with best practices, tools and process to help strengthen teamwork among professional disciplines, inside partnering organizations and between sector organizations.

- Establish an internal team of experts who will partner with Association of American Medical Colleges and other academic medical institutions to arrive at a formula and methodology to identify the true cost of Indirect Medical Education.

- Establish the Center for Physician Workforce Studies and Solutions to continue the research on New Jersey's physician workforce issues, establish the Office of Recruitment and secure funding to support innovative retention programs.

- Launch the Family Medicine Innovation Center in fall 2012 to bring together 16 family medicine program stakeholder groups and identify top priorities to be addressed in 2012 and 2013.

• • •

References

Cook, M, Irby, D.M., Sullivan, W. & Ludmerer. (2006, September 28). American medical education 100 years after the Flexner Report. The New England Journal of Medicine, Vol. 355 (13), 1339-1344. www.nejm.org

Josiah Macy Jr. Foundation (2011, May). Conference summary: Ensuring an effective physician workforce for the United States: Recommendations for reforming medical education to meet the needs of the public. www.macyfoundation.org

Health Affairs and the Robert Wood Johnson Foundation. (2012, August 16). Graduate medical education. A debate continues over the size and scope of federal subsidies to support residency training of the nation's physicians. *Health Policy Brief.* www.healthaffairs.org

http://www.youtube.com/watch?v=AdqwC4qIu7c&feature=player_detailpage Healthcare education: Did you know? A compelling video of the realities of education in the health care industry today.

Jain, S.H., Goyal, R., Fox, S. & Shrank, W.H. (2012, June). Bowling alone, healing together: The role of social capital in delivery reform. *The American Journal of Managed Care,* Vol. 18 (6), www.ajmc.com.

Nasca, T.J., Philbert, I., Brigham, T. & Flynn, T.C. (2012, February 22). The Next GME Accreditation System – Rationale and Benefits. *New England Journal of Medicine.* www.nejm.org

New Jersey Council of Teaching Hospitals. (2012, September 4). Early Analysis: 2012 New Jersey Resident Exit Survey. New Jersey stands to lose $511 million in future revenue as doctors leave state. www.njcth.org

New Jersey Council of Teaching Hospitals. (2010). The Economic Impact of Physician Shortages in New Jersey.

New Jersey Council of Teaching Hospitals. (2012). Quantifying Success: Demonstrating how GME Funding Impacts Physician Workforce Supply.

New Jersey Council of Teaching Hospitals. (2012). 2012: The Medical Education Landscape in New Jersey (Infographic).

Rye, Brian, CFA. (2012, February 28). Assessing the impact of potential cuts in Medicare doctor-training subsidies. *Bloomberg Government Study.* www.bgov.com

• • •

Participants
NJCTH 2010 Leadership Forum
Medical Education: Aligning to Create Value

Martin Levine, DO, MPH
American Osteopathic Association

Stephen Shannon, DO, MPH
Association of American Colleges of Osteopathic Medicine

Leonard Marquez
Association of American Medical Colleges

Victoria Liedel, MD
AtlantiCare Regional Medical Center

Maria Ciminelli, MD
Centrastate Medical Center

Paul Katz, MD
Cooper Medical School of Rowan University

Antoinette Spevetz, MD
Cooper University Hospital

Barbara Schindler, MD
Drexel University School of Medicine

George Kendall, Esq
Drinker Biddle Reath, LLP

Robert C. Garrett
Hackensack University Hospital

Ihor Sawczuk, MD
Hackensack University Hospital

Douglas Finefrock, DO
Hackensack University Hospital

Susan Hutter
Hackensack University Hospital

David Skillinge, DO
Hunterdon Medical Center

Steven G. Littleson
Jersey Shore University Medical Center

Robin Winter, MD
JFK Edison

Carmen Ciervo, DO, FACOFP
Kennedy University Hospital

John Lloyd, FACHE
Meridian Health

John Fromhold, BA, MBA, FACHE
Mountainside Hospital, HackensackUMC

Mary L. Voytus, DDS, FAAHD
Mountainside Hospital, HackensackUMC

Alan Lieber
Overlook Medical Center

Suresh Raina, MD
Palisades Medical Center

Heather Howard, JD
Princeton University

Matthew J. Wieczkowski
Saint Peter's University Hospital

Mahendra Solanki, MS, MPH
Saint Peter's University Hospital

William McDonald
St. Joseph's Regional Medical Center

Thomas McGinley, Jr., MD, FAAP
St. Luke's Warren Hospital

Gary Horan
Trinitas Medical Center

Thomas Cavalieri, DO
UMDNJ - School of Osteopathic Medicine

The New Jersey Council of Teaching Hospitals (NJCTH) serves as a voice and central catalyst, magnifying the distinct assets of the state's medical education organizations and providing information, opportunities and resources that support their delivery of the finest physicians, research and patient care in the nation.

NJCTH: Five Pillars of Success

- NJCTH will be the authoritative source of information on medical e4ducation and physician workforce issues;
- NJCTH will be the acknowledged authority on issue that have an impact on academic medical centers, teaching hospitals and the medical education system at large;
- NJCTH will be a strong advocate for public policies that enhance medical education, training, research and clinical innovation;
- NJCTH will be the leader in advancing these issues with state and federal officials; and
- NJCTH will be an indispensable resource for medical education stakeholders.

NJCTH
New Jersey Council of Teaching Hospitals
New physicians. New medicine. New ways. For New Jersey.

154 W. State Steet, Trenton, New Jersey 08608 www.njcth.org 609.656.9614