

From Crisis to Catalyst: Building Community Coalitions

CAFP Education Conference
February 2010

Peter Broderick, MD, MEd
Valley Consortium for Medical Education

Overview of Discussion

- Review of bit of history about FM training within California
- Present the local events that prompted us to need a community coalition
- Encourage hope for change with a “To Do List” and a “Wish List”

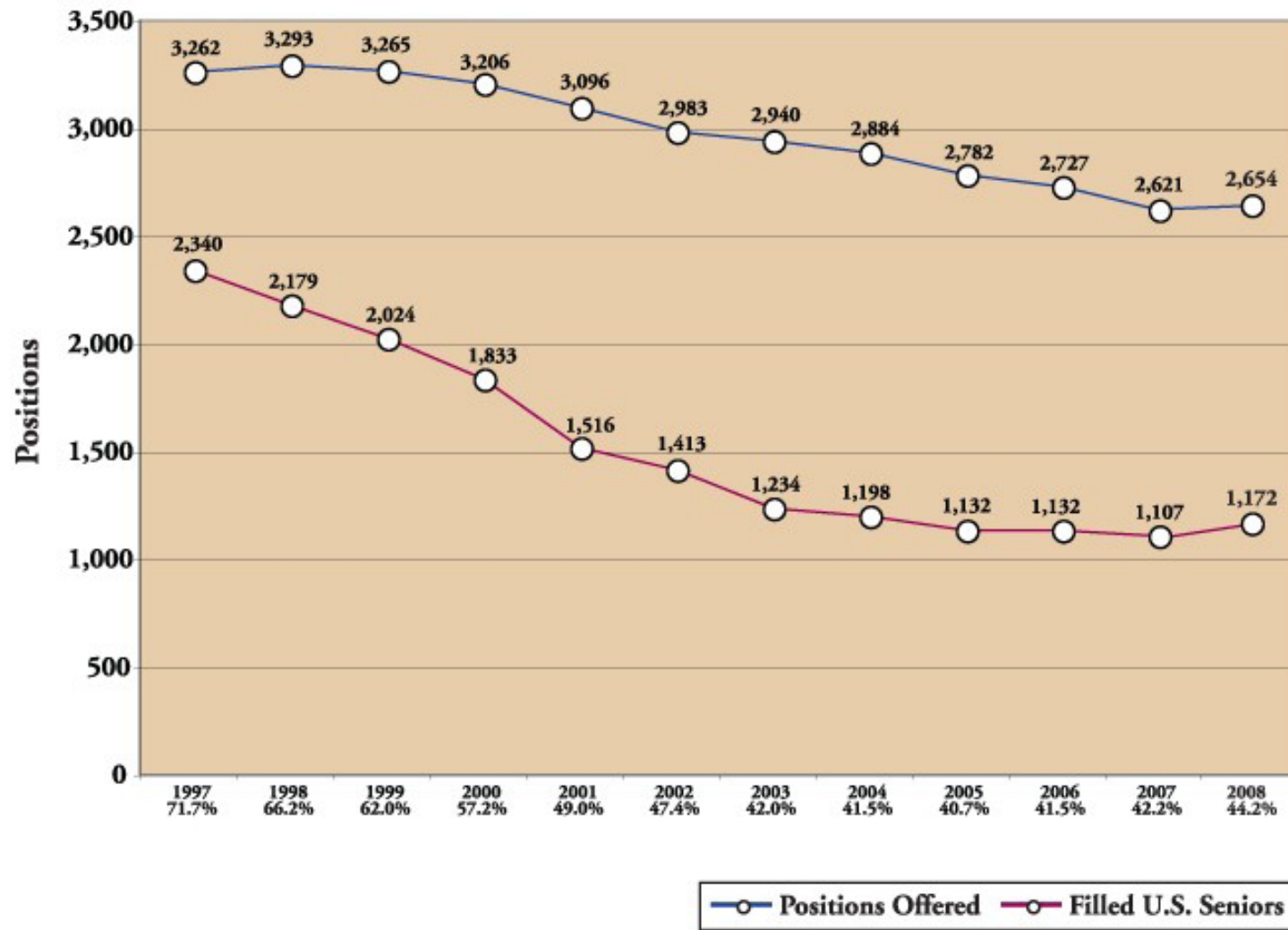


History of Family Medicine training in California

- County Hospital system originated many of the FM residencies.
- Safety-net systems combined indigent need and medical education.
- Disease-burden mal-distribution makes for winners and losers.

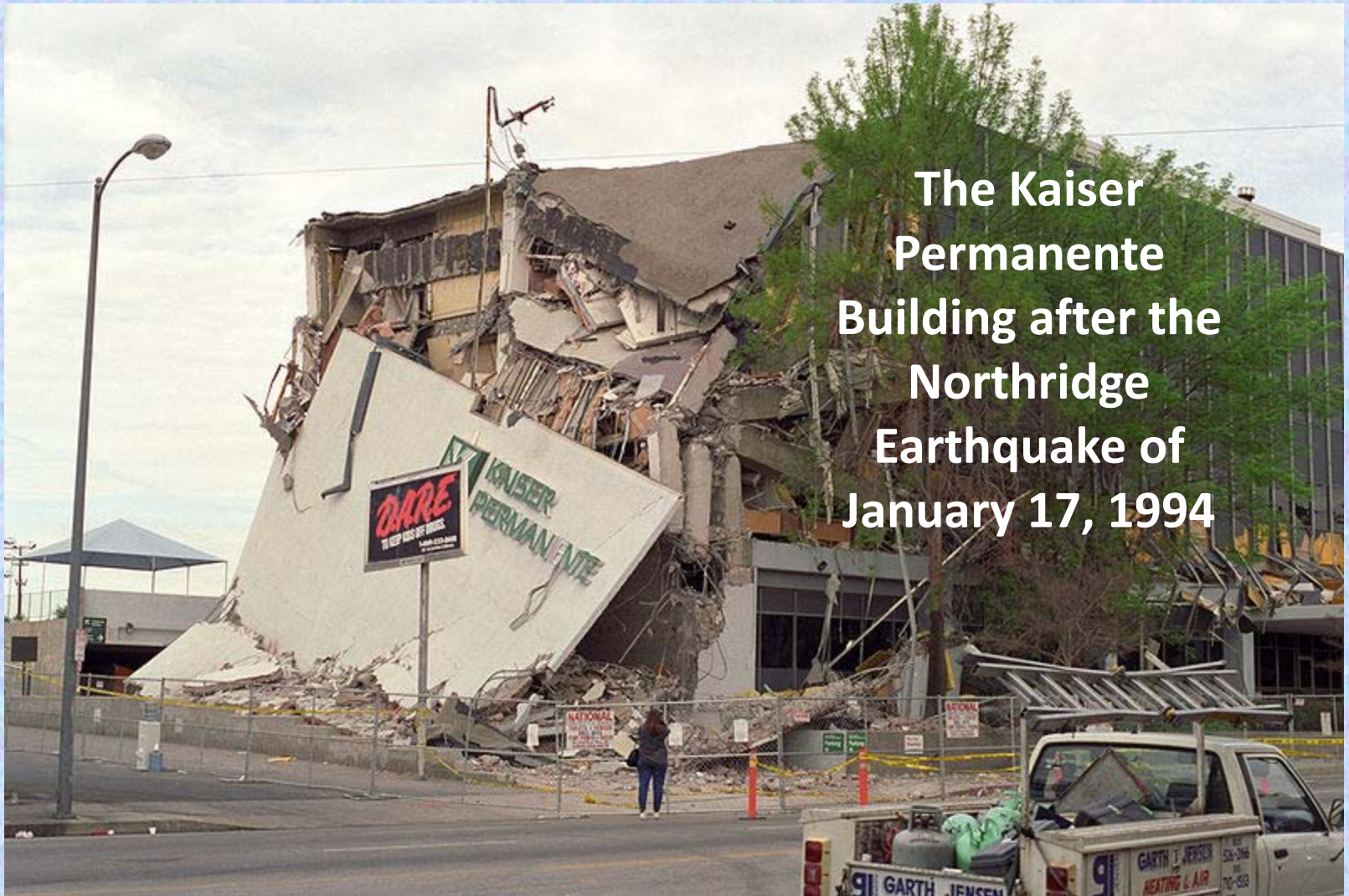


From Crisis to Catalyst



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From Crisis to Catalyst



The Kaiser
Permanente
Building after the
Northridge
Earthquake of
January 17, 1994



Seismic Shift in Health Care

- More than 8,700 were injured including 1,600 that required hospitalization, with total damage range as high as \$25 billion
- Eleven hospitals suffered structural damage and were damaged or unusable after the earthquake
- Senate Bill 1953, which sets a 2008 deadline for implementing seismic standards to ensure that their acute care units and emergency rooms would be in earthquake-proof structures



Well meaning goal, but...

- In California, the finished cost of a fully furnished and equipped new hospital building is about \$1,000 per square foot.
- This translates into about \$ 1 M/hospital bed.



Hospital Closure & Consolidation

- Between 1995-2000, 23 California general acute care hospitals closed, 11 in the Los Angeles area.
- Many of these hospitals host FM Residencies
- San Jose Medical Center (2004) left a vulnerable population and orphaned a residency with 90 days notice



Stanislaus Family Medicine Residency

- We are the major safety-net provider for this community.
- We deliver over 1,300 babies a year, see more than 60,000 patients a year, and admit more than 1,500 hospital patients a year.
- We are one of the oldest residencies in the US, part of the original five UC Davis FM Programs
- Are 232 graduates are all over the country, in rural, suburban, urban and academic settings.



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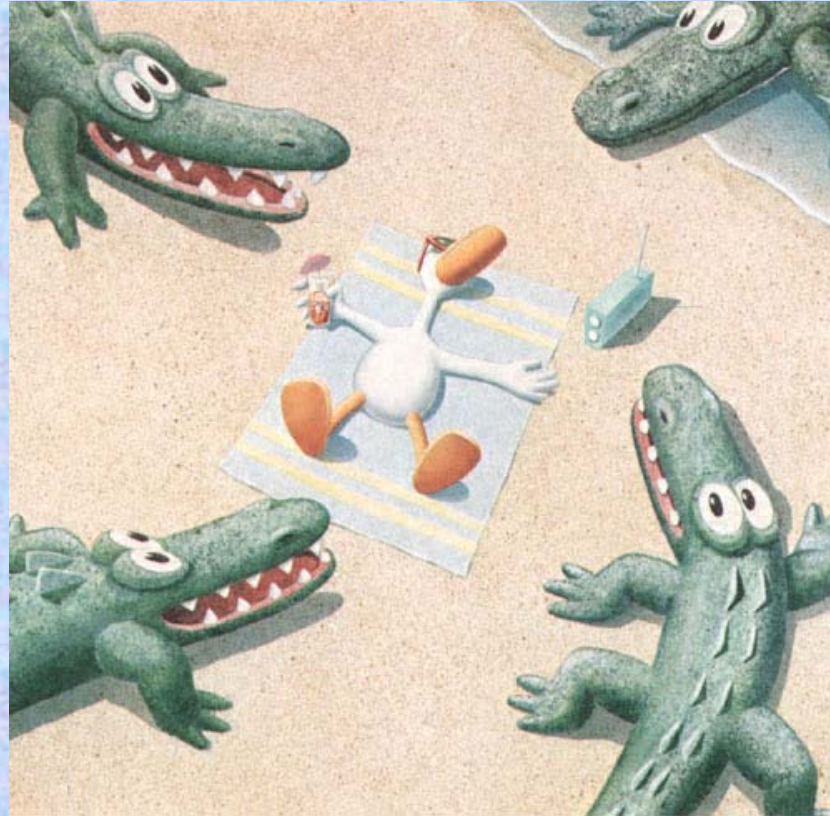
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Wanted:

Family Medicine
Program Director
for exciting job
opportunity

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Local story, universal problem

- Stanislaus Medical Center closes 11/97 and consolidates residency with Doctors Medical Center (TenetHealth)
- Cost of residency equally-shared by County and DMC
- Continues ambulatory, safety-net care for Medical and indigent.
- Increased costs and diminished reimbursement brings system to financial crisis 2005.



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Financial crises are
to consultants what
garbage scows are to
seagulls.



Local Story, Universal Problem

- Beware of outside consultants bearing feeble analyses.
- Sometimes the right thing happens for the wrong reasons.
- Do your homework



Crises are a terrible thing to waste

- In 2005, the community faced possibly losing the residency because of budget crisis.
- We developed the concept of “cost-avoidance” as a principle value for the program.



The problem is revenue,
not expense.

- Residencies are actually very cost-effective solutions to low-margin health care.
- Safety-net providers are gasping for life from under-funded public insurance systems.



Funding Issues & Strategies in Family Medicine Residencies

**CAFP Education Conference
2006**

Peter Broderick, MD, MEd
Stanislaus Family Medicine
Residency



Valley Consortium for
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From Crisis to Catalyst

- **August 2008**
 - Notification of CMS review
- **October 2008**
 - County delegation visit to CMS
- **November 2008**
 - General election ceased activity/communication
- **February 2009**
 - CMS demand for recoupment of \$19 million GME payment
- **March 2009**
 - County BOS vote support for residency
 - Public awareness with media attention



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AAFP Joins California Academy in Supporting Residency Program Under 'Assault' by CMS

By Barbara Bein
4/1/2009

The AAFP is going to bat for the Stanislaus Family Medicine Residency Program at Doctors Medical Center of Modesto, Calif., after CMS decided to stop supporting the residency with funds for graduate medical education and demanded repayment of more than \$19 million in Medicare payments to the facility. CMS has given no regulatory justification for its actions, which could increase health care costs and hurt patients' access to care, says the Academy.

Calling CMS' decisions an "assault" on the residency program, the Academy says in a sharply worded letter to CMS Acting Administrator Charlene Frizzera that even though the federal agency can't point to any regulations to justify its actions or to any misuse of funds, "CMS staff are demanding nothing less than



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FOR IMMEDIATE RELEASE: March 25, 2009

CMA Seeks to Reinstate Residency Program for Primary Care

Contact:
Amber Pasricha Beck
(916) 551-2551

Sacramento – The California Medical Association has asked the federal government to restore funding for the Stanislaus Family Medicine Residency Program so it can continue to train much-needed primary care physicians in the San Joaquin Valley.

The Centers for Medicare and Medicaid Services (CMS) has ceased funding the program for failing to meet certain federal criteria, but CMA believes the program is too important to shut down and is urging authorities to reconsider.

The federal action runs counter to President Obama's goal to enhance primary care and prevention – a key element of his health reform plan – and it comes as California faces a shortage of primary care physicians that is particularly acute where the Stanislaus Family Medicine program is based.

The San Joaquin Valley has 24 percent fewer primary care physicians than the state average. (Source: Central Valley Health Policy Institute, California State University, Fresno). Of the 223 physicians who have graduated from the program since 1975-70 have remained in the county to

Modesto, CA
Clear, 63°
HI/Low: 76° / 50°
Extended forecast



OPINION _ LETTERS TO THE EDITOR

Tuesday, Mar. 31, 2009

Save residency program

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Our community is lucky to be home to the Stanislaus Family Residency Program.

The Hippocratic oath includes the ideal of teaching the next generation of physicians. I have learned much from my almost 20 years of practice in Modesto, and I continue to learn from the residency.

...among physicians represent the best and the brightest... going to pursue their careers...

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Kübler-Ross Response To Crisis

- “You gotta be kidding...?”
- “ Can you believe this $\beta^*I!\$h1\&t...!$!”
- “Can’t we just talk about this...?”
- “I think you really can kill us...”
- “We’ve got nothing to lose...”



From Crisis to Catalyst

There's nothing like threatened extinction to help you focus your attention.



Don't get mad, get active.



Getting the story right

- Have your points succinct
- Control the release
- Go big, Go loud
- Tie the bad news to a plan



Getting the right people to worry

- Pre-release the news to inform reactions
- Make the news relevant to the audience
- Build a coalition of victims
- Mobilize networks of influence



Keeping calm in the midst of the storm

- Present the challenge with “Can Do” and “Will Do” attitude.
- Troop morale depends on committed leadership.
- Stay healthy, feel lonely.



Getting the facts right

- Get a “10-second Elevator Speech” ready.
- Repeat the succinct plan over and over
- Chant “Failure is not an option.” to everyone.



Showing a vision

- Find compelling examples of solutions
- Paint the picture from the perspective of the viewer.
- Release all ideas, if they are good, they will return.
- Don't be attached to how it should be.



Consortiums Benchmarked

- Santa Rosa GME Consortium
- Heart of Texas GME Consortium
- Morton Plant Meese Residency Program
- SE Michigan Center for Medical Education
- Des Moines Area Consortium for Medical Education
- Grand Rapids Medical Education and Research Center



Consortium Findings

- “You’ve seen one consortium, you’ve seen one consortium” (D. Pieper, January, 2009)
- Can make the case for efficiency by pooling the GME from each hospital.
- Keep the number of institutions small. Focus on a meeting of the minds, not the money
- Of the 6 studied:
 - 1 never became a consortium
 - 3 are solely Family Medicine
 - 4 have some form of GME “pass through”
- Board size ranges from 11-18 members



Building a common purpose

- Once a vision merges into a plan, re-iterate why each stakeholder is doing this.
- Remind everyone of the 'Failure Alternative'.
- Allow time for people to 'ripen' with decisions.

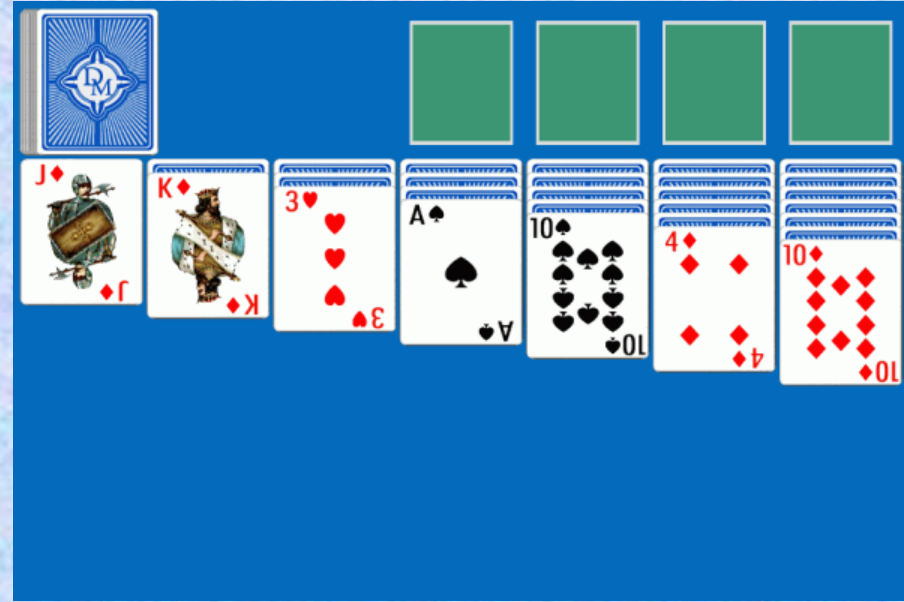


Lawyers, Guns and Money

- Get ready to spend money (to save money)
- Get your power focused
- Why have one lawyer when you can have three at thrice the cost?



Sometimes the card
you need is just
buried



- Be ready to call it a day if you just can't win
- Distance and detachment will help you see reality
- Remember what was today's problem can be tomorrow's fortune



From Crisis to Catalyst

Stanislaus



4/14/2009

Jerry Vasilius, PhD
Executive Director, RRC Family Medicine
ACGME
Suite 2000
515 North State Street
Chicago, IL 60654

Dear Jerry,

I am writing the RRC-FM Committee to alert you to a serious situation facing the continuation of the Stanislaus Family Medicine Residency in Modesto, CA. I am asking that you discuss this matter with the RRC-FM Committee and the Review Committee and the ACGME, but also

As you are aware, the Stanislaus Family Medicine Residency has been fully accredited since 1975, and for nearly 30 years Stanislaus Medical Center was a part of the county health system. When this hospital closed in 1997, we relocated the in-patient training portion of our program to the other participating institutions, Doctors Medical Center. During our 2000 RRC site visit, our residency sponsor stated that Stanislaus Health Services was a high quality program, we did not request a New Program designation from ACGME. When the Centers for Medicare and Medicaid (CMS) reviewed our residency in 1999, they reclassified our program as a New Program, and incidentally reduced our Per Resident Amount substantially.

Subsequently, we continued with full accreditation and continuous GME funding until 2008, when CMS rescinded its original determination of our status, stating that the transaction did not follow the BBA 97 guidelines. In January 2009, they determined that we no longer qualified for GME funding to our major participating institution, Doctors Medical Center, and retroactively recouped over the past 10 years GME funding from 2000-2007 Cost Reports.

While this action has been a significant harm to our local community and county government, who bear half the cost of the program, the more serious aspect of CMS's determination concerns the future of the program in Stanislaus County. While in the past, published guidelines, they are suggesting that the present program must close for one year, replacing faculty, residents and program directors, and open as a new program in order to qualify for GME funding going forward.

Understandably, this position is untenable in the face of the severe harm that would result in the closure of the county safety-net system. We have very strong political support for a resolution that would allow us to proceed with the Stanislaus program upon closure of the former program, leaving uninterrupted the care of patients and critical training of family physicians in our community.

“Again, as I've mentioned in the past, the Review Committee/ACGME as conditions under which new program numbers are assigned: when a program changes its configuration so significantly (e.g., like a program changing all of its inpatient experiences) a new application is warranted and a new program number is given.”

“Given that the assignment of a new number is a serious matter that involves not only the Review Committee and the ACGME, but also CMS, please send me the requested information so that the magnitude of the changes being proposed are clear.”

**Jerry Vasilius, PhD
Executive Director
RRCs for Family Medicine and Pediatrics**

Email: 4/27/09



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Medicare IPPS 2010

...rather than relying solely on the accrediting body's characterization of whether a program is new, we continue to believe it is appropriate that CMS require a hospital to evaluate whether a particular program is a newly established one for Medicare GME purposes by considering whether a program was initially accredited "for the first time," and is not a program that existed previously at another hospital.

CMS-1406-P

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dividing a hospital's allowable direct costs of GME for a base period by its number of residents in the base period. For base periods for non-hospital sites, the base period reporting period beginning in FY 1984 (that is, the period between October 1, 1983, through September 30, 1994). Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents

working in all areas of the hospital complex (and nonhospital sites, when applicable), and in hospitals, Medicare base period patient days. The base period PRA is adjusted annually for inflation.

Section 1886(b)(4)(B) of the Act sets the limit on the number of allopathic and osteopathic FTE residents that a hospital may include in its FTE resident count for

purposes of calculating direct GME payments. For most hospitals, the limit, or cap, is the unweighted number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996.

2. Clarification of Definition of New Medical Residency Training Program. For purposes of determining direct GME and IME payments, the Medicare statute

establishes a cap on the number of allopathic and osteopathic FTE residents a hospital may count, which for inpatient hospitals is based on the number of allopathic and osteopathic FTE residents the hospital was training in its most recent cost reporting

period ending on or before December 31, 1996. Section 1886(b)(4)(B) of the Act requires that the cap be based on the number of FTE residents in the case of medical residency programs that are established on or after January 1, 1995. This

statutory provision is also made applicable for purposes of the IME adjustment under the

most recent cost reporting period ending on or before December 31, 1996.

2. Clarification of Definition of New Medical Residency Training Program

For purposes of determining direct GME and IME payments, the Medicare statute

Medicare IPPS 2010

In evaluating whether a program is truly new, as opposed to an existing program that is relocated to a new site, it is important to consider not only the characterization by the accrediting body, but also supporting factors such as (but not limited to) whether there are new program directors and/or new teaching staff, and/or whether there are only new residents training in the program(s) at the different site.

2. Clarification of Definition of New Medical Residency Training Program

For purposes of determining direct GME and IME payments, the Medicare statute

Medicare IPPS 2010

This section is intended to address all GME programs that were previously accredited at one operating entity, and that entity ceases to operate the program, but the program is then opened and operated at another entity and is accredited as a new program at the second entity. Such a program would not be treated as new at the second entity.

2. Clarification of Definition of New Medical Residency Training Program

For purposes of determining direct GME and IME payments, the Medicare statute

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Friday, Jan. 29, 2010

Stanislaus County doctor residency gets the go-ahead

Accreditation key for survival of county medical training program

By Ken Carlson
kcarlson@modbee.com

Stanislaus County's revamped physician training program has received full start training physicians under a new banner in July.

Each week, the Accreditation Council for Graduate Medical Education at

What's the rest of the story?



From Crisis to Catalyst



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What can happen

- Communities can coalesce around critical patient-care/medical education services
- Money can be spent to save spending more money
- A common external threat can unite discordant relationships around a common resistance
- The success of partnership inspires consideration of other joint-ventures



What should happen

- GME funding should be unbundled from Medicare
- California should have more direct State GME
- GME payment mechanisms should be standardized and paid directly to training organizations
- There should be national Physician Workforce planning that sustains training balance
- FQHCs and GME should become fully aligned



What to do

- Get data on what you cost and what it would cost stakeholders if you weren't around
- Build coalitions of concerned supporters
- Work toward a larger community engagement with Graduate Medical Education
- Consider the consortium model of sponsorship
- Look for a good crisis to ride

