NEW YORK STATE | Department of Health

New York State Council on Graduate Medical Education

Report of Activities

November 2019

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Recent Past Members

The members and staff of the New York State Council on Graduate Medical Education wish to acknowledge the following recent past members who greatly contributed to the work of the Council during their tenure. Their contributions are reflected in this report and will resonate in future Council deliberations.

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Introduction

New York State (NYS) supports the largest graduate medical education (GME) system in the United States. It is nearly twice the size of California's GME system, which is the nation's second largest. Currently, NY has 16 medical schools, 92 teaching hospitals, nearly 9,100 medical students, and over 17,000 physicians in training. Of the physicians in training, 45 percent are International Medical Graduates. Eighteen international medical schools are approved by NYS to provide long-term clinical clerkship training in New York's teaching hospitals. Medicare and Medicaid reimburse New York's teaching hospitals over $3.2 billion annually for GME expenses. In 2017, NY ranked third in National Institutes of Health (NIH) funding for biomedical research to teaching institutions ($2.4 billion).

Since 1987, the NYS Council on Graduate Medical Education (Council) has advised and assisted the Governor and NYS agencies on the formulation and implementation of statewide policies regarding GME. This report describes (1) the Council and how it functions, (2) challenges and opportunities taken into consideration by the Council in its deliberations, and (3) recent developments in NYS programs that impact the content, supply and distribution of physician training in New York.

NYS Council on Graduate Medical Education (Council)

In 1987, by Executive Order, Governor Mario M. Cuomo created the Council. It was reauthorized by Governor Andrew M. Cuomo in 2011. [1] Its mission is "to provide policy guidance to State policymakers regarding the composition, content, supply and distribution of physician training programs in NYS." [2] The Council is also required to be consulted by the Department on the content of the coursework or training in infection control practices [3] and have the Executive Director or member of the Council participate on the NYS Palliative Care Education and Training Council. [4]

The Council's 19 members, broadly representing health professions, hospitals, and public interests, in addition to the Commissioner of Health and the Chancellor of the Board of Regents (or their representatives) who serve as ex-officio members. All members, with the exception of ex-officio members, are appointed and serve at the pleasure of the Governor for a term of no more than four consecutive years. Council meetings are held in Plenary Sessions that are open to the public, webcast by the Department of Health (DOH) and posted on the Council's website.

Since its beginning, the Council has considered a variety of timely matters, such as the relationship between teaching hospitals and medical schools, diversity in medical training and practice, training opportunities for primary care physicians, and quality in training programs. The Council has championed many causes distinguishing NY as a national leader in medical education, many of which have been adopted at the national level, e.g.:

- a limitation on the hours residents may work,
- the development of residency reform initiatives,
- the use of outcome requirements to transform primary care training sites,
- a requirement for primary care residents to devote a significant portion of their training in continuity of care settings caring for a panel of patients,
- financial support to train residents in ambulatory care settings,
- initiatives to promote diversity in medical education,
- greater transparency in GME funding,
- significant support to train physicians in biomedical research,
- training residents to better care for the developmentally disabled and special needs populations, and
- the development of new residency programs in rural communities.

The Council has been instrumental in developing several key programs administered by the DOH. The Empire Clinical Research Investigator Program (ECRIP) provides funding to teaching hospitals to train physicians in clinical research and to support projects that advance biomedical research. The Council contributed to the establishment of the Rural Residency Program, the

[1] Executive Order # 2, issued by Governor Andrew Cuomo (January 1, 2011).

[2] Executive Order # 98, issued by Governor Mario Cuomo (May 13, 1987).

[3] Public Health Law, Section 239. HIV/HBV/HCV Prevention and Training Act.

[4] Public Health Law, Section 2807-N. Palliative Care Education & Training Act.

Physician Workforce Studies Program, the New York's Area Health Education Center (AHEC) program, and several grant programs such as the Diversity in Medicine Program that promotes diversity in medical education. The Council also recommended the establishment of the Doctors Across New York (DANY) initiative, created in 2008, to help train and place physicians in underserved communities - in a variety of settings and specialties - to care for New York's diverse population. DANY programs now include Physician Practice Support, Physician Loan Repayment and the Ambulatory Care Training Program.

Ensuring Adequate Physician Capacity in New York State

Growing Shortage and Maldistribution of Physicians

The Council is charged to "consider…the number and specialties of physicians needed in New York State". In 2017, the federal Council on Graduate Medical Education (COGME) forecast that by 2025 there would be a shortage of between 67,100 and 94,700 physicians nationwide. The Association of American Medical Colleges (AAMC) has called for a 30 percent increase in medical school enrollment over the next 10 years. Even with an increase in medical school enrollment, the shortage is projected to worsen due to a growing and aging population, the rapid pace of medical advances, an overall improvement in economic status, lifestyle choices, changes in federal health care policies and programs and other trends and developments.

Given the significant number of GME training programs in NY, physician shortages in the state would seem unlikely. However, while NY has an overall physician-to-population ratio that exceeds the national average, in most regions there is a maldistribution of physicians, both in terms of geographic location or the availability of specialty services like primary care, obstetrics, general surgery and child psychiatry. The maldistribution is reflected by New York's 90 Health Professional Shortage Areas (HPSA), which require over 350 primary care physicians to remove this designation and meet minimum patient coverage capacity needs. Each year, over one-half of New York's trainees leave the state after completing their training. NY must reorganize the system to educate and train physicians and to provide incentives that will keep more physician graduates working in the state.

Beginning in 2012, the Council undertook a major project to address New York's physician workforce supply. The Council established a workgroup, led by Dr. Mark Schwartz, to build on the Council's recommendations included in their 8th Report to advance the goal of increasing access to health care services for New Yorkers by sharpening the Council's focus on primary care and other specialties in short supply.

The group aligned its work and its recommendations with the transitions occurring along the education/training continuum -- from undergraduate to GME, GME itself, and then from GME into practice. It focused on how state policies could leverage the transitions between stages to address shortages in certain specialties in medically underserved areas. The goal was to provide incentives and opportunities for students to pursue shortage specialties such as primary care.

Three subgroups, comprised of Council members and consultants from various stakeholder groups, met separately to develop recommendations. The workgroup's efforts closely align with the NYS Health Innovation Plan (SHIP) in that it aimed to align the future workforce within the framework of the advanced primary care model. The SHIP included four recommendations. First, modify medical school admission criteria to prioritize admitting New Yorkers with strong roots in a community who are more likely to stay. Second, increase student exposure to rural and non-hospital settings through support of community rural training sites. Third, increase retention in the state after GME by providing resources to support graduates staying here to practice. Fourth, increase primary care, particularly in underserved areas, by expanding or extending the Medicaid enhancement for primary care.

The workgroup recommended a goal for NYS to increase the percentage of residents that remain to practice in NY after completing their training from 44 to 60 percent over the next 10 years. It also established a set of guiding principles including:

- recognize primary care shortages and shortages in other specialties in some regions across the State;
- align its recommendations with new and emerging practice models;
- focus on physician workforce policy while also considering services by other health care professionals as necessary to provide integrated, team-based primary care;
- explore medical practice and payment reform as needed; and
- understand that initiatives that provide financial assistance can help shape career decision-making.

In developing its recommendations, the workgroup heard presentations by and held discussions with experts on each of the topic areas above.

The Council heard from experts whose organizations are implementing innovative approaches to attract medical students and residents to NYS practices and retain them once their practice begins. Mark Taubman, M.D., Council member, Dean of the University of Rochester School of Medicine and Dentistry, and currently also CEO of the Medical Center and Senior Vice President for Health Sciences, described Rochester's community-wide approach involving providers, insurers and businesses, to addressing the problem of an aging workforce, particularly in primary care. With a goal of doubling the number of students who express early interest in pursuing a career in primary care, students are exposed to practices that provide a positive primary care experience early on in their careers and rotate through a medical home pilot. These efforts resulted in students expressing far more interest in primary care. To further enhance primary care practice, Rochester committed to community-based care management and data coordination in primary care offices and implemented a local loan forgiveness program to attract entry-level primary care physicians.

Many areas underserved throughout the State are in rural communities. Only four percent of residents plan to practice in a rural area after completing training. Lee Goldman, M.D., Dean of the College of Physicians and Surgeons at Columbia University, discussed the Columbia-Bassett partnership to improve physician capacity in rural communities. This program allows medical students to spend up to two and a half years of their clinical experience in the rural environment of Bassett Hospital in Cooperstown. Their belief is that by exposing students to rural settings early in their careers, they are more likely to become grounded in that location. Bassett students create and follow a panel of patients and families over the course of their year, allowing them to experience longitudinal care. The Columbia-Bassett model also recognizes that physicians often have spouses or significant others with similar educational backgrounds and professional aspirations, so the school looks for opportunities where students and faculty can both be placed in the same area.

Opportunities in Physician Recruitment Services

Mr. Allen Kram and Ms. Gina Truhe, from HealthQuest, a health system made up of Vassar Brothers Medical Center, Northern Dutchess Hospital, and Putnam Hospital Center, discussed the Upstate New York Physician Recruiters (UNYPR), an organization with approximately 35 members who represent close to 50 hospitals across the state. They meet to discuss issues related to recruitment and retention. They explained that UNYPR regularly recruits physicians in

the greater NY area and are able to access the latest statistics along with hiring trends. They serve as a conduit between the hospitals and physicians that are hired. Their goal is not just to find a doctor to take a job, but rather to pinpoint the best fit for the position in the community. They also have educational sessions that they provide to trainees and are able to offer unbiased education for the residents and fellows about finding jobs in the upstate NY region.

Council Recommendations

Based on the workgroup's deliberations, the Council reviewed and approved recommendations to address New York's health workforce supply. Several of them are provided below and the remaining are included in other chapters of this report. These recommendations have recently been modified since they were originally endorsed by the Council.

- The Department of Health should regularly and systematically measure the physician maldistribution (by specialty, geography and diversity).

- NY should establish awards ($40,000 annually) for residents during training who commit to practicing in a shortage specialty or in medically underserved area. State funding for this award should be shared by a "matching fund" from communities seeking to recruit a physician.

- NYS should commit to consistent funding for Doctors Across New York (DANY) with an annual cycle and a predictable timeline for the application process.

- NYS should partner with regional organizations to create and promote a NYS physician job database for graduating residents that is a user-friendly and up-to-date resource for physician job-applicants.

- NYS should explore ways to ensure that primary care providers are appropriately compensated by all payors for the vital health care services they provide.

- NYS should fund a longitudinal evaluation of strategies to shape the physician workforce.

- In order to continuously improve the efficiency and effectiveness of workforce development programs, NYS should set short and long-term goals and assess program performance on an ongoing basis.

Department of Health Workforce Placement Programs

The Department of Health (DOH) administers several programs to study, monitor, and support physician workforce recruitment and retention, particularly serving patients in underserved communities. Furthermore, and consistent with the Council's recommendation, DOH has launched a performance measurement initiative to evaluate program outcomes using a variety of metrics that vary by program and their goals. The following, and further in the report, provides a summary and current status of each of these programs.

Physician Practice Support (PPS) & Physician Loan Repayment (PLR) Programs

Originally, PPS provided up to $100,000 to physicians who agree to practice in an underserved community for at least two years. PLR provided up to $150,000 in funds for repayment of educational debt for physicians who agree to practice in an underserved community for at least five years. Since 2009, under this structure, the Department has made 637 awards, through October 2018, ensuring that many underserved communities are able to recruit and retain physicians to provide vital health care services

In the 2016-17 State budget, the PPS and the PLR were merged to simplify the programs and make them more efficient. As a result of these changes, and consistent with the Council's recommendations, beginning in 2019 all Cycle V and future awards will be for a maximum of $40,000 per year over a three-year period. Funds can be awarded to: (1) a physician to pay qualified educational debt; (2) a physician to submit the costs of establishing or joining medical practices; or (3) a health care facility to recruit or retain a physician by providing the physician with sign-on bonuses, funds to pay outstanding qualified educational debt, or enhanced compensation. In all cases, 100 percent of the funds ultimately must be distributed to the physician, or the physician's practice. One-half of funding must flow through hospitals. Also, one-third is directed to New York City (NYC) and two-thirds is earmarked for the rest of the State.

The Cycle V Request For Applications (RFA) was released in the Spring 2018 for approximately 75 new awards to begin their three-year service obligation in January 2019. Later in 2018, DOH was awarded federal funding, through the Federal State Loan Repayment Program (SLRP), that allowed DOH to make additional awards. As a result, in October 2018, a total of 100 DANY PLR/PPS Cycle V awards were made. Additionally, and consistent with the Council recommendations, Cycle VI was released in February 2019 and all future cycles will be released approximately at the same time annually on a consistent and predictable schedule. There were 72 Cycle VI awards made in July 2019. **($9.065 million appropriated for PPS and PLR in SFY 2019-20).**

Primary Care Service Corps (PCSC)

The Primary Care Service Corps (PCSC) was created in statute in 2012 and assists non-physician practitioners with repayment of up to $150,000 in educational debt in exchange for up to five years of service in underserved areas. Eligible practitioners -dentists, dental hygienists, nurse practitioners, physician assistants, midwives, clinical psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed mental health counselors must commit to practice in a NYS HPSA in primary care or behavioral health and in an outpatient or other eligible setting. Since the program began, 76 practitioners have received awards under this program. Fifty percent of funding comes from SLRP funds. **($1 million appropriated in SFY 2019-20)**

Physician Workforce Studies

The Physician Studies Program supports a study of the health care workforce in NYS, including its resident physicians. The primary objective of the program is to clearly identify the size and distribution of the NYS health workforce and determine its ability to meet the health care needs of the diverse patient population in NYS. These data are fundamental to the development of health care policies that will shape graduate medical education and the provision of health care

services throughout NYS. The Center for Health Workforce Studies (CHWS) at the University at Albany contracts with the Department on this multi-year study that will assist the Council and the DOH in evaluating and developing strategies to address the physician and health care workforce supply. **($487,000 appropriated in SFY 2019-20)**

In conjunction with the Physician Studies project noted above, CHWS conducts ongoing research and analysis on workforce issue in key health professions in NYS including physicians, residents, nurses, dentists, and workers in local public health departments. This is accomplished through regular professional surveys that are included in license registries, interviews and the annual resident exit survey. Data is published in reports that are distributed to policymakers, educators, health care providers and the public on the health workforce supply and distribution. **($148,000 appropriated in SFY 2019-20)**

Take-a-Look Tour

The Take-a-Look Tour program supports tours run by the Iroquois Health Alliance (IHA), in collaboration with the American College of Physicians (ACP). The tour exposes medical students, residents and other medical professionals from downstate to facilities in upstate New York. Its goal is to increase access to health care services in upstate communities by increasing the number of clinicians practicing in upstate New York. Since 2012, approximately 50 individuals have embarked on three-day tours, visiting health care facilities and upstate communities including Binghamton, Cortland, Ithaca, Oswego, Syracuse, Watertown and Gouverneur. This unique professional experience encourages participants to consider practice opportunities in upstate NY. This program is currently supported through a legislative appropriation. **($150,000 re-appropriated in SFY 2019-20)**

Undergraduate Medical Education

Included in the Council's charge is that it "consider…the relationship of teaching hospitals to medical schools" and the Council has woven policies to support innovation in undergraduate medical education into its deliberations. Several of the topics include fast-track curriculum, admission criteria, rural experiences and dual campus international medical schools.

Outdated Medical School Admission Criteria

The Council discussed the medical school admissions process with experts including Dr. Robert Ostrander, a family physician in upstate NY teaching at the Rural Medical Education program in Syracuse, Ronald Rouse, representing the NYS Academy of Family Physicians and Dr. David Kolva of Upstate Medical University and St. Joseph's Hospital. There is growing support for updating and diversifying the medical school admissions process. The current applicant pool is skewed toward subspecialties and eventually toward practice in affluent urban or suburban settings, in part due to income and lifestyle potential.

A paradigm shift is needed in the medical school admission process to ensure a more diverse medical school student body who will commit to serving in needed specialties and geographic areas. The predictive value of MCAT scores and GPAs in identifying individuals with the potential to be good physicians is being debated. Test scores cannot predict who will become a generalist or who will work in an underserved area.

The Need for New Pathways to an M.D. Degree

Steven B. Abramson, M.D., Vice Dean for Education, Faculty and Academic Affairs at NYU Langone Medical Center, presented NYU's new curriculum which offers more individualized pathways to an M.D. degree. To produce more physician leaders, for example, NYU is striving for 15 to 20 percent of its graduates to earn master's degrees, and they have added several master's programs in addition to the MPH. In addition, they have developed a three-year pathway to the M.D degree and a 3+1 pathway to the M.D./M.P.H. degree as a way to fast-track students into their professions, reduce student debt and provide for more advanced degree options.

Since the accelerated three-year M.D. Pathway Program began in 2013, 91 students have been accepted into the program through 2017. Only eight of these students have returned to the traditional four-year program and all 34 graduates are now in a primary care residency programs (nearly all at NYU). Additionally, NYU has found no differences in exam scores, clerkship honors and election into the national medical honor society (Alpha Omega Alpha) between these accelerated students and traditional four-year students.

International Medical Schools and Clinical Clerkship Education

The Council has been involved with clinical clerkship education throughout its existence and international medical graduates (IMGs) have been an integral part of the U.S. medical workforce since the late 1940s. There are two streams of IMGs who enter residency training and practice in the US. One category are IMGs who are not US citizens and the other category is comprised of U.S. citizens who attend an international medical school (USIMG). In 2014, 33 percent of the

physician workforce in NYS were IMGs[5]. In 2016, 43 percent of residents who completed training in NYS were IMGs, including 29 percent who are U.S. citizens and permanent residents who graduated from an international medical school[i]. Many IMGs accept residency positions in "hard-to-fill" specialties and in hospitals located in neighborhoods that provide health care to underserved populations. Many US IMGs attend dual campus schools that have patterned their curriculum after the U.S. system, which includes two years of basic medical sciences and two years of clinical clerkships training. Clinical clerkship training and experience generally occurs during the 3rd and 4th years of medical education through core and elective rotations in teaching hospitals and other institutions. Dual campus medical schools often provide such clinical clerkship training in U.S. institutions including many in NY teaching hospitals. Due to an anticipated increase in demand for physicians in the U.S., dual campus international medical schools have expanded their enrollment and clinical clerkship training in NY hospitals.

Since 1981, SED regulations require international medical schools that provide over 12-weeks of clinical clerkship education in a country other than where the school is located to obtain approval from the NYS Board of Regents to train their students in hospitals in NYS. Additionally, DOH regulations prevent graduates from such dual campus international medical schools from participating in a residency training program unless such school is approved by the Board of Regents.

In 2011, the Board of Regents, adopted regulations to create an Advisory Committee on Long-Term Clinical Clerkships in order to develop standards and a process to review and approve international medical schools that seek to place students in long-term clinical clerkships in hospitals located in NYS. The Advisory Committee currently includes Council Member Mark Taubman, M.D., the Council's Executive Director (who serves as an alternate), Heather Dacus, D.O., representing the DOH and others representing the Board of Regents, the State Education Department, the State Board for Medicine, international medical schools, and medical schools and teaching hospitals located in NYS.

Through the work of the Advisory Committee, the Board of Regents approved such standards and process in regulations in 2012 and has subsequently approved 18 international medical schools for long-term clinical clerkship training in NYS. All of these schools must meet educational requirements comparable to Liaison Committee on Medical Education (LCME) standards. These requirements include a team of reviewers who visit the medical school. Schools are approved for up to seven years and all approved schools must submit annual reports to SED with updated data and progress to address any deficiencies identified by the Board of Regents at the time of their approval. The Advisory Committee meets twice annually to review new or revised applications, annual reports, standards and other matters pertaining to their charge. Recently, the Advisory Committee has discussed also including site visits to teaching hospitals where these students are participating in clinical clerkship training.

Council Recommendations

[5] Armstrong, D.P. and Forte, G.J. *New York Physician Workforce Profile, 2014 Edition*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. April, 2015

- Medical schools in NYS should give additional weight in the application process to students originating from medically underserved areas of NY who commit to a career in a shortage specialty or who intend to practice in a medically underserved area.

- DOH should host a conference series of all NY medical school deans and other educators to promote strategies for addressing the physician maldistribution in NYS.

- NYS should examine private sector initiatives that develop modifications to traditional medical education curricula that help place students and physicians in needed specialties and communities.

- NYS should encourage international medical schools to provide information regarding NY regulations relating to the 12-week limitation to all U.S. student applicants.

It should also be noted that the State Health Innovation Plan (SHIP) workforce section also included a proposal that medical schools in NYS should modify their medical school admission criteria to prioritize admitting New Yorkers with strong roots in a community who are more likely to stay.

Diversity in Medical Education

The Council is charged to "consider…efforts to increase the number of minority physicians in training in NY and to increase and improve the training of physicians who will serve as medical residents, and subsequently as practitioners, in underserved areas of the State". This is appropriate as NYS has an ethnically and culturally diverse population. There are an estimated 200 languages spoken in the State, and one-third of the residents are from Under-represented in Medicine (URM) population groups which generally include Black or African American, Hispanic or Latino, and American Indian and Alaskan Native populations. However, the diversity of the physician population does not reflect the diversity of the State URM population. While individuals from URM population groups, make up 38 percent of the population in NYS, they account for only 9.5 percent of practicing physicians. Increasing the number of URM physicians is vital for the health of all residents.

Physicians from URM backgrounds are more likely to work in primary care or obstetrics/gynecology (39 percent) compared to all other physicians (27 percent). Additionally, URM physicians are more likely to work in downstate NY (82 percent vs. 69 percent) and in urban areas (94 percent vs. 91 percent) compared to all other physicians. URMs are more likely to practice in hospitals and clinics, to report a primary care specialty and to serve Medicaid patients. In NYC, URMs are more likely to practice in Health Professional Shortage Areas. URMs also report more difficulty in finding a satisfactory practice position compared to all physicians and are burdened by more educational debt. In addition, the need to increase the diversity in medicine pipeline is especially acute in light of an impending physician shortage nationally and in NYS.

National data finds that ethnic minorities have more negative health care experiences and are more vulnerable to health care disparities than are whites. For example, a Commonwealth Fund survey showed that "nearly one of six African American (15 percent), one of seven Hispanics (13 percent), and one in ten of Asian Americans (11 percent) feel they would receive better health care if they were of a different race or ethnicity compared to one percent of whites.

Council Recommendation

- NYS should test the impact of a pilot program that provides full scholarships for students from disadvantaged backgrounds who commit to a career in a shortage specialty or to practice in a medically underserved area.

Department of Health Diversity in Medicine Programs

DOH administers several pipeline programs to expand the pool of geographically, educationally and economically disadvantaged students in medicine and other health related fields. Programs are conducted statewide in collaboration with high schools, undergraduate colleges, medical schools and residency programs. These initiatives support academic enrichment programs, health professions orientation, summer research programs, admission and recruitment counseling, master's programs, tutoring and mentoring, post-baccalaureate programs and faculty development. The goal of these programs is to provide students interested in careers in health and medicine, with an educational opportunity that many of them would not have due to cultural, educational and financial barriers.

AMSNY Diversity in Medicine Program

The Associated Medical Schools of New York (AMSNY) participates with the DOH in the administration of several programs that provide educational opportunity to students interested in health and medicine who face cultural, educational, and financial barriers. Seven projects seek to increase the numbers of such students that enter medicine and the health professions. This program was created in statute in 2008 and incorporates the Post-Baccalaureate program at the State University of New York (SUNY)University at Buffalo (UB) , that began in 1991, to provide a one-year post baccalaureate education to students in preparation to enter medical school.

From 1991 - 2018, 482 students were enrolled in the UB program and among the first 22 cohorts (1991 – 2013):

- 93% (349) matriculated into medical school
- 85% (296) who matriculated into medical school, successfully graduated. Among these, 61% (179) entered in a NYS residency program and 7% (140) matched into a primary care residency program.

($1.244 million appropriated in SFY 2019-20)

AMSNY Diversity Scholarship Program

Consistent with the Council recommendation, the AMSNY Diversity Scholarship Program supports scholarships to medical students from economically and geographically disadvantaged backgrounds in exchange for a two-year service obligation in an underserved area after the students complete residency training. Awards of approximately $40,000 annually (that represents the full cost of SUNY medical school tuition) are limited to medical students attending schools in NYS. Since the program began, three students have graduated from medical school and are enrolled into residency training programs. **($500,000 appropriated in SFY 2019-20)**

The Gateway to Higher Education

The Gateway to Higher Education Program intends to increase the number of historically economically and geographically disadvantaged students to prepare to enter high-level professional careers, specifically in medicine, science, mathematics and engineering. Gateway has partnerships with summer medical pipeline programs at Hofstra University, Long Island Jewish Medical Center, Lenox Hill Hospital and CUNY School of Medicine. Gateway also has a formal collaboration with the Summer STEM Institute at the Grove School of Engineering and Gateway participants will start medical rotations at Harlem Hospital in summer 2018. Since its inception, 7,782 students have completed the program. Among these program graduates, 97.6% have graduated from high school and 92% have been admitted into four-year colleges or universities. **($83,000 appropriated in SFY 2018-19)**

Upstate Scholars Program

The Upstate Scholars Program supports the education of students from economically and geographically disadvantaged backgrounds in an effort to increase the numbers of such students who enter medicine and the health professions. The goal is to increase access to

health care services in underserved communities by increasing the number of clinicians from similar backgrounds. **($15,000 appropriated in SFY 2019-20)**

GME Training Initiatives

The Council is charged to consider: (a) "graduate medical education programs including the composition, supply and distribution of residency programs, subspecialty programs and fellowship training'; (b) "policies and programs to increase the training of primary care physicians and the training of physicians in non-hospital settings"; and (c) "promotion of high quality residency and training programs". As a result, the Council's deliberations have included presentations and extensive discussion on initiatives in teaching hospitals, federal and state programs, and national priorities.

Determining the Structure and Content of Residency Programs of the Future

Thomas J. Nasca, M.D., President and Chief Executive Officer, Accreditation Council for Graduate Medical Education (ACGME), discussed what will drive the structure and content of residency programs in the future – new competencies, physicians who aspire to mastery, and a national evaluation tool to track outcomes. The ACGME has, over the years, updated its standards to support these new competencies and focus accreditation on outcomes.

He also discussed the need for more primary care and outpatient-based training programs. That perspective was shared by Mack Lipkin, M.D, Professor, Department of Medicine, NYU Langone Medical Center. Dr. Lipkin noted that our graduate medical education system needs to train physicians how to provide services in both institutional and non-institutional settings, to be consistent with changes in health care delivery. The Council heard from other experts whose organizations have developed training programs to achieve those goals.

Lawrence Smith, M.D., Dean, Hofstra North Shore-LIJ School of Medicine, described a curriculum that is completely integrated, with heavy emphasis on very sophisticated science learned in the context of problem-based learning with real patients. Hofstra's clerkships have a mix of longitudinal and focused experiences.

Lia Logio, M.D., who at the time was the Vice Chair for Education, Department of Medicine, Weill Cornell Medical College, highlighted some of the changes in the Weill Cornell Internal Medicine Residency Program. Those changes included: integrating inpatient and outpatient training, embedding patient safety and quality improvement in the resident training program, adding a new curriculum for vulnerable populations that sends residents to resource-poor environments and underserved areas, incorporating the concept of value in health care, and creating a minority house staff committee.

Dr. Brenda Matti-Orozco, Chief, Division of Geriatric Medicine St. Luke's Roosevelt Hospital Center**,** now known as Mount Sinai St. Luke's and Mount Sinai West Hospitals, discussed the development and implementation of medical home transformation for residency clinics at the hospital. Their residents and clinics began moving out of the hospital into community-based sites, increasing the number of clinic sessions for residents.

As part of the Hospital-Medical Home Demonstration Program, resident education and training focus on team-based care including care integration, transitions of care, inpatient safety, and quality of care. Time is dedicated for residents to learn how these relate to the patient centered

medical home. Lastly, they implemented a Transitions of Care Collaborative - which is a learning collaborative for outpatient faculty, inpatient faculty, and residents. The Collaborative consists of many workgroups that join efforts to not only improve outcomes, but to transform the way that health care is delivered in both inpatient and outpatient settings.

Anu Ashok, Associate Vice President, GME and Physician Workforce Policy, and Carla Nelson, Assistant Vice President, Ambulatory Care and Population Health, of the Greater New York Hospital Association (GNYHA) discussed a new grant program that focuses on educating residents on social determinants of health, increasing residents' awareness of community resources and activities of community-based organizations and getting residents involved in Delivery System Reform Incentive Program (DSRIP) program activities. The program involves 13 hospitals, including 15 Family Medicine, Pediatrics and Internal Medicine residency programs that were matched with 15 community-based organizations (CBOs). The training includes on-site training at the CBOs, hands on learning activities for the residents, and opportunities for the residents to interact with CBO clients. The hospitals and residency program intend to sustain the program.

The GNYHA also administers the Teaching Clinic Redesign Project, which is aimed at the unique challenges that hospital-sponsored clinics face when serving as both patient care settings and teaching settings. The goals were to complement efforts around participation in the NYS Hospital Medical Home Demonstration program and the milestones associated with that program.

Workgroups consisting of ambulatory practice directors and residency program leadership developed a teaching clinic toolkit that focus on empowerment and care coordination. They then conducted a learning collaborative on teaching redesign strategies, redesigning resident schedules, and continuing care measures and offered a matching program for consulting services to address at least one area of redesign indicated in the toolkit.

Council Recommendation

- Medical schools and teaching hospitals in NYS should establish primary care and Medically Underserved Area Practice tracks to promote these career paths, with a State grant program to promote educational innovation and infrastructure development.

Department of Health Graduate Medical Education (GME) Programs

DANY Ambulatory Care Training Program

The Ambulatory Care Training Program is specifically designed to incentivize sponsoring institutions to provide clinical training to residents in freestanding diagnostic and treatment centers. Although most physicians practice medicine in outpatient settings, such as private practices, most residency training occurs in hospital settings. This program ensures that resident training reflects current practice trends and adequately addresses patient health care needs.

The program was created in statute and requires that grantees train residents with the option to train medical students. Funding is awarded only to accredited sponsoring institutions (medical

schools, teaching hospitals or D&TCs) that have the responsibility to educate residents. The first cycle ran from 2012 through 2016 and included 13 institutions training residents and medical students in 29 sites. Awards for the second cycle, that will run from 2018 through 2021, were announced in November 2017. Currently, eight institutions train residents and medical students in approximately 25 to 30 community health centers and physician practices. Nearly all of these sites are located in underserved communities. **($1.8 million in SFY 2018-2019)**

Empire Clinical Research Investigator Program (ECRIP)

The Empire Clinical Research Investigator Program (ECRIP) was created by the Council in 2000 to promote training of physicians in clinical research in order to advance biomedical research in NYS. Earlier research found that NYS slipped from first to third nationally in its share of NIH funding and was not producing the necessary clinical researchers to remain highly competitive with other states.[6] [7] While NY still ranks third nationally in NIH funding since ECRIP was created, it has narrowed the gap in the total number of awards between itself and second ranked Massachusetts. The program supports the Governor Cuomo's commitment to develop a life sciences research cluster.

ECRIP provides both Individual physician research awards as well as larger Center awards to teaching hospitals that meet program requirements. Individual awards promote the development of clinician researchers by funding physician ECRIP fellows to train in clinical research under a classic paradigm of one-on-one mentoring. Sponsor/mentors must have been a Principal Investigator (PI), Co-PI or Co-Investigator of a federal research or Patient-Centered Outcomes Research Institute (PCORI) grant within three years of the abstract deadline. These awards provide one two-year award made per teaching hospital at $75,000 per year. Institutions are encouraged to train two fellows at the same time in a team-based collaborative training model using additional in-kind or other grant funds.

Center awards are also two-year awards promoting the development of clinician researchers while providing seed funding for new center grants. The awards require teaching hospitals to form research teams around themes, such as "improved therapies for type 2 diabetes" that represent a strategically important growth area for the institution. Each research team must be led by a director who will sponsor/mentor one project and coordinate the research team's activities. The director must be or have been a PI or Co-PI of a federal research or PCORI grant within two years of the abstract deadline. For every $100,000 annually in State funding, the institution will be required to train at least one ECRIP fellow and also commit at least $100,000 per year in real (not in-kind) matching funds. Inter-institutional collaborations (with shared funding) involving other NY teaching hospitals and other NY entities are encouraged. Center fellows are also expected to work in a collaborative team-based training model.

ECRIP is an open and flexible program, allowing teaching hospitals to hire physicians in all subject areas of clinical research to perform patient-oriented, epidemiologic, behavioral, outcome measured, health services and translational research. ECRIP is also used by teaching hospitals to leverage additional and substantial research funding from other sources,

[6] Sturman L.S., Sorin M.D., Larkins E, Cavanagh, K.A, DeBuono, B.A. *Losing Ground: NIH Funding to NYS Researchers.* Bulletin. New York Academy of Medicine. 1997; 74 (1): 6-14.

[7] Sturman, L.S., Sorin, M.D., Hannum R.J. *Opportunities Lost: NIH research Funding to New York's Medical Schools.* Journal of Urban Health: Bulletin. New York Academy of Medicine. 2000; 77 (1): 86-95.

e.g. NIH, pharmaceutical companies and foundations to continue the research. Funding for research generates a substantial return on investment. According to a 2010 study prepared by Tripp Umbach for the Associated Medical Schools of New York (2010, The Impact of Medical Education on the State of New York), for every dollar in Federal and State research funding invested in NY medical schools, NYS receives a return of $7.50.

Since the program began, 635 awards totaling over $129 million, including required matching funds, has been awarded to teaching institutions, including academic health institutions and community teaching organizations that has resulted in approximately 815 physicians trained in ECRIP projects. Sample data that the Department collected in a survey to the teaching institutions from the first eight years of the program showed that 73% of ECRIP fellows have continued in research and 81% of those fellows have remained in NYS.

More recently, data obtained from three hospitals demonstrates significant success with ECRIP in terms of increasing the number physicians in research and obtaining federal grant funding. Montefiore Medical Center reported that since 2002, it has trained 48 ECRIP fellows who have secured appropriately $55 million in grant funding, mostly from NIH. Columbia University College of Physicians and Surgeons reported that a 2013 ECRIP Center project funded at $600,000 over two years resulted in five published journal articles and $16 million secured in grant funding. Another 2013 ECRIP Center project also funded at $600,000 over a two-year period at New York Presbyterian Hospital resulted in 29 published journal articles and 30 abstracts. This project successfully secured $13 million in grant funding through 13 separate grants. **($3.445 million appropriated in SFY 2019-20)**

State Innovation Model (SIM) Rural Residency Program

In December 2014, the DOH was awarded a $99.9 million State Innovation Models (SIM) grant by the Centers for Medicare and Medicaid Innovation (CMMI) to implement the State Health Innovation Plan (SHIP). NY developed the SHIP and the SIM grant application with the support of numerous stakeholders. The state's official project period for the grant began February 1, 2015 and will continue for five years. NY was one of eleven states to receive such an award.

The intent and goal of the Plan is to identify and stimulate the spread of promising innovations in health care delivery and financing that result in optimal health outcomes for all New Yorkers. Multi-payer support of these initiatives is key to long-term success, as is the input and recommendations of key stakeholders throughout the state.

The Plan will pave the way for the state to support innovations in health care delivery, to implement strategies to spread those innovations more broadly throughout New York.

The ultimate goal of SIM in NYS is to increase adoption of value-based payment arrangements that improve access to care, quality of care, and affordability of care for all New Yorkers. To accomplish this goal, DOH/Health Research, Inc. (HRI) adopted a model approach that targets critical areas such as Health Information Technology, population health, access, workforce development, and integrated care. Robust development in these areas supports the long-term sustainability of the SIM project, as well as activities after the project period and funding from CMMI has expired.

An adequate supply of physicians is critical to support the Advanced Primary Care (APC) model, but rural communities particularly experience shortages in primary care physicians.

Although NYS trains more residents than any other state, there are very few residency programs located in rural communities. As a result, one of the workforce components of the SIM is an initiative to create residency training programs in rural communities. Such programs provide an excellent source of newly trained physicians who will have experience caring for patients in rural communities and a direct understanding of the social, cultural, and educational environment of rural areas.

The SIM's Rural Residency Program provides funding over 2 1/2 years to create five new or restructured primary care medical residency programs in rural areas of NYS. Once operational, these rural residency training programs will help alleviate regional and primary care workforce shortages and prepare physicians to deliver quality services in a networked, team-based, value-driven, primary care focused model.

The short-term key outcome of this initiative is to have five residency programs accredited by the Accreditation Council on Graduate Medical Education (ACGME) by the end of the grant period. Funding would be used to develop the curriculum, hire program personnel, utilize consultant services, and pay for accreditation costs. All SIM funds would end when residents have begun training in the rural settings.

It is expected that each of the grantees will form partnerships with community-based organizations, sustain the program with Medicare, Medicaid and other GME funding when residents are enrolled, and aggressively work towards retaining graduating residents in rural communities to practice in the APC model.

The five rural residency program grantees presented to the Council and provided a status on their planning progress to create new residency programs in rural communities. Arnot Ogden Medical Center and Champlain Valley Physicians' Hospital have already begun to train residents in July 2018, Cayuga Medical Center begun to train in July 2019, and Mary Imogene Bassett Hospital and Samaritan Medical Center in 2020 or later. When fully implemented, these five residency programs (four family medicine and one internal medicine) intend to train approximately 60 residents in up to 35 new rural sites.

Area Health Education Centers (AHEC)

AHEC provides funding to support the regional and local AHEC system. Their mission is to enhance the quality of and access to health care services, improve health care outcomes and address health workforce needs of medically underserved communities and populations. This is accomplished by creating partnerships between the institutions that train health professionals and the communities most in need.

AHEC is a workforce development initiative established in 1998 to address the drastic specialty shortages and serious lack of diversity in the NYS health care workforce. AHEC works with health care institutions, practicing professionals, and educators at all levels to promote careers in health care, especially with underserved populations. There are nine AHECs based in communities across the State (Buffalo, Bronx, Brooklyn, Canton, Cortland, Glens Falls, Highland, NYC and Warsaw).

AHEC encourages service in various underserved medical specialties and regions within the State, but it also increases the diversity within the health care field by assisting students from underrepresented and disadvantaged backgrounds to pursue health care careers. These

objectives are essential to the stabilization of the health care workforce. In 2016-17, AHEC trained approximately 26,000 students and professionals throughout the State, using community-based training, continuing education, distance learning and web-based programs. Since 2000, AHEC has provided:

- 240,000 students with knowledge on health careers
- 37,000 students with education and training in their local community
- 190,000 health care workers with skills through educational programs

($1.6 million appropriated in SFY 2019-20)

Hospital Medical Home (HMH) Demonstration Project

The Hospital Medical Home (HMH) initiative was a Partnership Plan CMS 1115 Waiver from through the Quality Demonstration Program. Approximately $250 million in funding was awarded through NYS to 65 hospitals to transform their primary care training sites to National Committee for Quality Assurance (NCQA) Recognized Patient-Centered Medical Homes (PCMHs) at 2011 Level 2 or 3 standards. The funds were also used to implement patient safety and quality improvement projects in the ambulatory training and inpatient settings, and extend or enhance the resident and patient continuity experience. The purpose of this demonstration was to improve the coordination, continuity, and quality of care for individuals receiving primary care in hospital outpatient departments operated by teaching hospitals, as well as other primary care settings used by teaching hospitals to train resident physicians. This demonstration was meant to be instrumental in influencing the next generation of practitioners in the important concepts of patient-centered medical homes.

The goals of the demonstration were:

- Provide better care of chronic disease.
- Increase preventive screenings and immunizations.
- Increase access to care for acute conditions.
- Improve health for individual Medicaid members seen in training clinics.
- Improve performance on population health.
- Decreased potentially preventable readmissions for certain defined high-risk populations
- Have primary care training sites achieve PCMH Level 2 or 3 2011 NCQA recognition.
- Train the future primary care work force in new models of primary care and encourage adoption of advanced primary care models such as PCMH.

Participating entities that serve as training sites for primary care residents were required to transform their sites to high level patient-centered medical homes and obtain National Committee on Quality Assurance (NCQA) Patient Centered Medical Home Level II or Level III Recognition at their 2011 standards; develop and report on five clinical performance metrics; restructure operations to enhance patients´ continuity of care experience and extend the ambulatory training experience for residents; implement one of four care integration initiatives; and implement two of six quality and safety improvement projects.

The awards to hospitals ranged from just over $120,000 to $21 million (averaging $3.9 million) per hospital and participating affiliated outpatient sites. Allocation of demonstration funds, as per terms and conditions, was based on 80 percent total Medicaid visits and 20 percent number of residents with an additional 25 percent weight for community-based sites.

Awards were distributed in five payments over a two-year period and contingent on the successful completion of defined milestones. Awardees initially encompassed 65 teaching hospitals throughout the state and ended with 60 participants - 28 in NYC and 32 throughout the rest of the state. There were 119 residency training programs: 48 Internal Medicine; 34 Pediatrics; 33 Family Medicine; and 4 Internal Medicine/Pediatrics. There were also 156 outpatient primary care residency training clinics. Together these clinics trained approximately 5,000 primary care residents and serve approximately 1 million Medicaid members.

The HMH Initiative demonstrated the feasibility and value of transforming residency training clinics into patient-centered medical homes; increasing resident continuity and exposure to the outpatient setting, which also increases access and continuity for patients, and focusing on care integration in the areas of transitions of care, integration of behavioral health into primary care, specialty access and improved cultural competence. Additionally, HMH has shown that residents can and should be involved in quality and safety in the inpatient setting, where they spend much of their training and may work after graduation.

Federal Teaching Health Centers Graduate Medical Education Grant Program

The Patient and Protection Affordable Care Act, enacted in 2010, amended the Public Health Service Act to allow the Secretary of the U.S. Department of Health and Human Services (HHS) to provide grants to eligible Teaching Health Centers (THCs) to establish new or expand existing accredited primary care residency programs in family medicine, internal medicine, pediatrics, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, general and pediatric dentistry, and geriatrics.

THCs include federally qualified health centers (FQHCs), community mental health centers, rural health clinics, and health centers operated by the Indian Health Service. Nationally, 60 teaching health centers train 732 residents in 27 states and the District of Columbia. Annual funding originally provided in the amount of $150,000 per resident, was reduced in 2015 to $95,000 per resident, and increased to $157,000 per resident in March 2018. In addition, $10 million annually was also provided in March 2018 for additional positions. All funds are provided directly to THCs and are necessary to support the training of residents in community health centers that are ineligible for Medicare and Medicaid Graduate Medical Education funding, which is limited to teaching hospitals. Nationally, 60 teaching health centers train 732 residents in 27 states and the District of Columbia.

There are four centers in NYS that train a total of 68 residents annually under this program. They are the Sunset Park Health Council in Brooklyn, the Long Island FQHC, Inc., and two sites operated by the Institute for Family Health sites, one in Harlem and one in mid-Hudson. Nationally, data from the American Association of Teaching Health Centers show:

- 82% of THC graduates remain in primary care practice;
- 55% of THC graduates went on to practice in underserved communities; and
- 36% of THC graduates become primary care providers in non-profit, community health centers working with underserved communities.

Federal GME Funding

Assessing the Future of GME Stability, Funding and Content

The Council discussed the future of GME with experts including George E. Thibault, M.D., President, Josiah Macy, Jr. Foundation, and Barbara Ross-Lee, D.O., now former Vice President for Health Sciences and Medical Affairs at the New York Institute of Technology and a former member of the Council who was one of the 21 members of the Institute of Medicine's (IOM) Committee on the Governance and Financing of Graduate Medical Education. Their input demonstrated the complex issues surrounding GME.

Competent physicians need to have the knowledge, skills, and attitudes to meet current and future patient needs, and to work effectively in an evolving health care system. The system must have an efficient process of producing physicians at a time when the cost of health care, which includes the cost of training physicians, is of great concern. There is concern about whether the content of training appropriately includes subject matter that is going to be relevant to the current and future practice of medicine, such as patient safety, quality improvement, and the cost of care and how it can be improved.

The IOM's Committee on Governance and Financing of GME was charged with assessing current regulations, financing, content, governance, and organization of U.S. GME and recommending how to modify GME to produce a physician workforce for the 21st century.

Key findings of the Committee include: forecast of future physician shortages vary and are historically unreliable, increasing the number of physicians will not resolve important workforce issues, increasing the number of GME slots is not dependent on additional Medicare funds, newly trained physicians lack the skills needed for future care delivery, Medicare GME payments are based on rigid, statutory formulas, the financial impact of sponsoring residency programs is poorly understood and there is a lack of transparency.

The Committee's recommendations included: that Medicare GME funding should be maintained, adjusted for inflation and gradually move to a performance-based system; phase out the current payment system; create a resource policy council within Health and Human Services; establish a GME center in CMS; create a GME operational fund and a transformational fund; and modernize the Medicare GME payment methodology.

Dr. Ross-Lee's presentation also discussed physician shortages, particularly in the South and Northwest and a surplus of physicians in the Northeast. She added that very little reliable data related to the workforce exist and that the Teaching Health Center Program was a wonderful model but not part of a sustainable system. (see Appendix A for a related NYS Department of Health response to Congressional questions relating to this report)

Council Recommendation

- NYS should actively encourage federal officials to allow hospitals that provided limited training experiences in the past to establish new GME reimbursement rates when such hospitals create new residency programs.

Integrated Care

The Council recognized the importance of integrating medical health care with behavioral health care, which is commonly referred to as integrated care, and devoted several presentations on this critically important topic. The Council discussed the challenges to integrating medical and behavioral health, and some initiatives intended to address them, with experts including Harold Pincus, M.D., Professor and Vice Chair, Department of Psychiatry, Columbia University, College of Physicians and Surgeons; Lisa Ullman, Director, Center for Health Care Policy and Resource Development, NYS Department of Health, Ann Sullivan, M.D., Commissioner of the NYS Office of Mental Health, and Anu Ashok, Associate Vice President, Graduate Medical Education and Physician Workforce Policy. Government Affairs, Communications, and Public Policy.

Challenges to Integrated Care

Two types of patients seek care from today's system: patients seeking primary care who also suffer from co-morbid behavioral health conditions such as depression or anxiety, and patients who experience severe and persistent behavioral health conditions such as schizophrenia and bipolar disorder. Both types of patients have had difficulty in receiving appropriate care for all of their conditions in a comprehensive, coordinated way. This is in part due to the fact thatgeneral health and mental health providers operated in silos.

Other challenges to linking behavioral health and general medical care include: ambiguity of accountability in regard to patient outcomes, lack of attention to the longitudinal aspects of care in terms of risk factor identification and prevention, and lack of sustainable payment models to support integrated care.

However, recent efforts have emerged to integrate primary care, mental health, and substance use disorder services. These include: (1) addition of behavioral health services into a primary care setting; (2) addition of primary care services into behavioral health clinics; and (3) the collaborative care model. The NYS Office of Mental Health and DOH are modifying regulations and policies to make it easier to integrate primary care and behavioral health services. In addition, the agencies are working together to support telehealth such as telepsychiatry to address the shortage of child psychiatrists, provide education for work and peer support, ensure communication between mental health and primary care providers, and improve prevention.

Two other initiatives are focused on improving care integration and capacity building. The GNYHA, through its workgroup on integrating primary care and behavioral health, developed a framework to better instruct primary care residents on diagnosing mental health conditions in the primary care setting. The resulting report addressed the following: key concepts for faculty wanting to teach these concepts, different roles of the collaborative care team members, how to diagnose depression and anxiety, and patient engagement techniques.

The Doctors Across New York Psychiatrist Loan Repayment Program was initiated in 2016 to help combat a severe shortage of psychiatrists working in NYS Office of Mental Health (OMH) facilities. The program seeks to increase access to mental health care services in underserved communities. It provides loan repayment to psychiatrists in OMH facilities who agree to work in such facilities for five years. Currently, 14 psychiatrists are enrolled in the program. **($3 million appropriated in SFY 2019-20)**

Council Recommendation

- GME programs should be encouraged to train residents to treat patients using the integrated care model.

Department of Health Initiatives that Impact Physicians

The Council has been fortunate to have leaders within the Department of Health periodically share their perspective and discuss important health care issues that impact medical education and residency training. Each of the topics addressed below have been critically important to physicians and residents in NYS.

Also, in addition to the Council's charge outlined in the Executive Order, the Council also has statutory responsibilities in relation to infection control training and palliative care education. Its role in these areas is provided below.

Department of Health Leadership

Howard Zucker, M.D., J.D., L.L.M., who at the time was the First Deputy Commissioner of Health and is currently NYS Commissioner of Health, posed the following questions for the Council to consider: How do you get more people involved in the issues of not just public health, but public health within city, state, or the federal government? How do you get doctors more interested in this field? Given that GME fellowships are often three years long, is there a way during that third year to offer fellows the opportunity to do research or to get involved in issues of public health or to spend some time within the federal or state government?

Dr. Zucker expressed concern about GME related to the changes that have been taking place over the last five to ten years in health care. He suggested there is a need for efficiency in GME. The whole concept of education for interns and residents is so important and central to the profession as a whole. His presentation also focused on the need to ensure that we continue to do what has been so successful in training doctors for so many generations.

Since Dr. Zucker's comments to the Council, some examples of efficiencies in GME and medical education that have been implemented (and described in this report) include: renewed support to train residents in community health centers and other ambulatory care sites, the creation and development of new residency programs in rural communities, continued annual support for physician and workforce development programs, prescriber education in opioid abuse (later described), efforts in integrated care, and the accelerated three-year M.D. pathway program.

Departmental Initiatives

Nirav R. Shah, M.D., M.P.H., who at the time was NYS Commissioner of Health, highlighted several new initiatives for the Department of Health. He first discussed the Maximizing Essential Tools for Research Innovation and Excellence (METRIX) website, the Department's open government platform. This website enables DOH to share data assets with the public and external stakeholders. He noted that there are almost two dozen totally unique datasets available. The Department is investing in a new platform called 'Socrata" that will allow users to get application programming interfaces for developers. The Department will continue to add datasets and enable direct links into the data, and real-time updates for reports. Dr. Shah said the Department is modeling their work after the federal government's healthdata.gov initiative.

Dr. Shah also announced the creation of the Office of Patient Safety and Quality that will enable the Department to be more proactive in quality and safety issues, and guide policies and regulations for the State to meet future health care needs. Dr. Shah also provided an update on the implementation of the all-payer database (APD) that builds on top of the existing State-wide Planning and Research Cooperative System (SPARCS). SPARCS provides all the demographic data concerning hospital discharges, emergency department visits, ambulatory surgery and clinic visits. He said the Department has received funding from the Federal government to build the APD which will draw claims data from Medicare, Medicaid and private payers.

Dr. Shah said NY received federal approval to launch an initiative to improve the quality, continuity and coordination of primary care that Medicaid patients receive in hospital outpatient departments operated by teaching hospitals and other primary care training settings. Up to $250 million was provided to teaching hospitals, with the ultimate goal being to have all sites certified as NCQA level two or three patient centered medical homes (see additional information on the Hospital Medical Home Demonstration Project earlier in this report).

Vision for Health Care in New York State

At a later meeting, Dr. Nirav R. Shah commended the Council for its commitment to medical education and helping NYS meet the highest standards of care in the nation. He said NY has the largest, most diverse and prestigious medical education system in the country. As Commissioner, he spent considerable time focusing on the need to transform New York's public health and health care systems and explore ways to invest our dollars creatively and strategically. His vision for health care in NY is to bring an evidence-based, data-driven approach to the 21st century challenges of our health care system. He stressed a need to integrate a public health perspective into health care delivery and how we approach illness and disease. This system will be patient-centered, aligning incentives and reimbursement for wellness, integrate networks with communities, rapidly deploy best practices, and make prevention integral to primary care. Dr. Shah said we must strengthen our primary care system to engage individuals and provide programs, treatments, information, and care in an effective and comprehensive way to reach people where they live, work and play and make them partners working towards good health.

In an effort to help achieve this objective, Dr. Shah cited the creation of the Office of Primary Care, which later became the Office of Primary Care and Health Systems Management (OPCHSM), that will be responsible for meeting federal health reform implementation milestones, expanding and improving New York's safety net, and focusing on workforce development. Dr. Shah said the Department's support for the Council's work will now reside under this Office and their input and expertise will play an important role in helping the Department achieve its health care goals. He said the move will benefit the Council's efforts to strengthen primary care and responsibilities in other areas, including GME financing and the Empire Clinical Research Investigator Program. He also emphasized that the Council's work to expand diversity in medicine, support training at ambulatory care sites, and oversee the Doctors Across New York programs, all that will continue to be a priority.

Physician Profile and the Office of Professional Medical Conduct

Keith W. Servis, who at the time was Deputy Director, Office of Primary Care and Health Systems Management and Director, Office of Professional Medical Conduct, with the NYS

Department of Health, discussed with the Council the Office of Professional Medical Conduct, its roles and responsibilities, how it operates, and the various individuals that work within it. Mr. Servis shared the categories of misconduct and how each category is defined and investigated. He noted that under NYS Education Law, there are 50 definitions for misconduct.

Mr. Servis shared opportunities that exist to educate medical students on the medical misconduct framework and process works in NYS. He stressed the importance of imparting in medical students an understanding of the expectations of them once they begin to practice, and how they can avoid having complaints alleging misconduct and other charges filed against them. He said that all health care professionals who identify what they believe to be misconduct are required to report to the Office of Professional Medical Conduct.

Mr. Servis also discussed the Physician Profile Requirement as outlines in Public Health Law 2995-a, which dictates timeframe requirements for the creation and updating of a Physician Profile. He noted the type of information that must be provided by a physician to their profile, including hospital privileges, out-of-state actions, practice or hospital privilege restrictions, and criminal convictions among other information.

Mr. Servis clarified that physicians receive reminder letters periodically that their profiles must be update or that their registrations must be renewed. He said that the goal of these letters is to work with physicians to ensure that updates are made, and to avoid progressing to an investigative and potentially prosecutorial phase.

Implementation of I-STOP & Role for Residents

Terrence J. O'Leary, who was at the time was the Director of the Bureau of Narcotic Enforcement (BNE) in the NYS Department of Health, delivered a presentation on the I-STOP Law, a joint Governor/Attorney General initiative that includes five separate components. The first part is I-STOP, the "Internet System to Track Over-Prescribing". DOH has shifted to mandatory electronic prescribing so that it updates the Prescription Monitoring Program (PMP). Within 24 hours of a patient receiving a drug, pharmacies must report it to BNE. In the future, additional data will be shared with practitioners and other parties who are currently not allowed under statute. Before practitioners prescribe a Schedule II, III, or IV controlled substance, they must access the online PMP Registry and make a determination whether or not to dispense or to prescribe a controlled substance.

Mr. O'Leary said that the second part of the law is e-Prescribing. DOH adopted regulations on allowing e-prescribing of controlled substances in NYS, which will be mandatory. The third component involved changes to the Controlled Substance Schedule. Hydrocodone is now a schedule II drug, and tramadol is now a schedule IV drug.

Mr. O'Leary added that the fourth component is the creation of a Work Group comprised of practitioners, pharmacists, consumer advocates, and law enforcement agencies that will create messages for practitioners, pharmacists, and the public about controlled substances in order to inform and change behavior. The Work Group is working on recommendations for CME and continuing education for pharmacists on pain management issues and addiction, creating a public awareness campaign, and helping with the implementation of I-STOP.

The last component is the Safe Disposal program. The DEA recently proposed regulations which will allow pharmacies to take back controlled substances. The State Police have found

that when individuals use drop boxes, they get the drugs out of the house and dispose of them in an environmentally friendly way. The DOH website has a map showing where drop boxes are located. One pain management specialist recently told Mr. O'Leary that she gives these maps to all her patients when she prescribes so that they know what to do with unused medication.

The Medicaid Redesign Team and Delivery System Reform Incentive Program

Greg Allen, Director of the Division of Program Development and Management at the NYS Department of Health, gave a presentation on the DSRIP. His presentation focused on how delivery system transformation will pivot our health care delivery system from one that has been largely responsive to the existing incentives to one that is value-based. These fee-based incentives have contributed to a lack of coordinated care, hyper-focus on inpatient care and overutilization of emergency care. The new goal is to create a set of incentives around patient and population health and utilizing primary care as a key strategy. Through the integration of primary care with other needed specialty care, such as behavioral health, the goal of DSRIP is to achieve a reduction of overall hospitalizations by 25 percent.

Mr. Allen stated that DSRIP would help insurers rethink payment for primary care services by creating higher value for ambulatory and community supports that work to keep people healthy and out of the hospital. Provider systems could be created to tie dollars to population outcomes rather than a specific service.

The presentation also focused on workforce funding in DSRIP, which is intended to help the State create workforce opportunities with Performing Provider Systems through a comprehensive strategy to achieve DSRIP goals. While some of the strategies will be local, others, such as the availability of primary care and psychiatry, may be statewide.

Prescriber Education in Opioid Abuse

David Flashover, R. Ph., from the Bureau of Narcotic Enforcement (BNE) in the NYS Department of Health presented on prescriber education in opioid abuse. He began with legislation that was passed in June 2016. This four-part law included mandatory opioid prescriber education, insurance coverage provisions, regulation for the prescription of opioids for acute pain, and a handout that pharmacies must distribute with all controlled substances. Mr. Flashover discussed the mandatory opioid prescriber education, an attestation that course completion will be required for all prescribers and the methods through which this attestation shall be completed.

Mr. Flashover then discussed new regulations regarding opioid prescription for acute pain, including a 7-day supply limit for all initial opioid medication prescriptions for acute pain. He also discussed a new handout, developed by NYS, that pharmacies will be required to distribute with all dispensed controlled substances. Finally, he briefly mentioned a new insurance coverage provision relating to coverage for inpatient care or medication.

Sepsis Awareness and Education

The Department of Health is required, pursuant to Section 239 of the Public Health Law, to consult the Council when it periodically revises the content of its coursework or training on infection control practices. The Department has been working with various parties on a new Sepsis Awareness and Education Element for the Infection Control Training Syllabus and

consulted the Council before the Element was widely distributed to NYS-approved course providers for incorporation into all courses by July 1, 2018. Ernest J. Clement, M.S.N., R.N., C.I.C. from the Bureau of Healthcare Associated Infections in NYS Department of Health, and several of his colleagues, presented the new Element to the Syllabus, that was mandated in law. One repeated concern raised by the Council was that there is redundancy and a lack of coordination in such training for health care providers.

Hospice and Palliative Care

The NYS Palliative Care Education and Training Council was created by Public Health Law, Section 2807-n in 2007. Members of the Council are to include the Executive Director or a member of the NYS Council on Graduate Medical Education. The Council's Executive Director served on this body for several years and Council member Jody Kaban, M.D. was appointed to this Council in 2018. The Palliative Care Council was established as an expert panel in palliative medicine, education and training, and as per a 2014 amendment to the Public Health Law, is charged with examining and making recommendations to the Departments Health and Education and the Legislature with regard to the need, approaches and resources to provide for palliative care education and training in state certified schools of nursing and social work, as well as in practice settings at the health care provider facility or agency level. The Council's most recent recommendations can be found at the NYS Department of Health's web site at: https://health.ny.gov/professionals/palliative_care/docs/pcetc_recommendations.pdf.

Consistent with the work of the Palliative Care Council, the Council on Graduate Medical Education had an opportunity to get an update on hospice care in NY and nationally. Carla Braveman, B.S.N., R.N., M.Ed., C.H.C.E., CEO and President of the Hospice and Palliative Care Association of NYS provided a brief history of hospice and the benefits it offers to the patients, family and friends involved in the care and support offered by hospice. She said that the model provides quality, compassionate care in a team-oriented approach that includes:

- Expert medical care - hospice and community physicians
- Pain management and symptom control
- Emotional and spiritual support
- Assistance with activities of daily living
- Tailored to the patient's needs and wishes

The premise of hospice is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so. The goal is not to cure but for physician comfort and spiritual healing. Hospice also fulfills the quadruple aim of better care, lower costs, healthier people and improving the work life of our health care providers.

In addition to providing quality services, hospice has proven to provide substantial savings. The average cost savings for Medicare patients in $2,309. Other studies have shown up to a $9,000 cost savings with hospice.

Ms. Braveman said that while nationally, 49 percent of Medicare decedents are in hospice care at the time of death, only 30 percent are on hospice in NYS. This ranks NY at 48th, among all states, in Medicare decedents hospice utilization. She said that there needs to be more: invested in the academic mission; targeted physician and provider education; resources

devoted to a public campaign; demographically targeted education; and diversity among hospice staff.

Conclusion

In the future, the Council will continue to deliberate on issues pertaining to its charge, advise the Department of Health and State leaders on matters concerning medical education and training and provide policy and program recommendations to the Governor and State agencies. The primary focus will continue to remain on addressing New York's physician supply, offering reforms in Graduate Medical Education and ensuring that the health workforce is prepared to care for NY's diverse population.

Appendix A – Congressional Letter and Department of Health response

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

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2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
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December 6, 2014

OPEN LETTER REQUESTING INFORMATION ON GRADUATE MEDICAL EDUCATION

Federal contributions – primarily under Medicare financing – have been the principal source of funds for graduate medical education (GME) in this country, and no other profession enjoys a comparable level and type of government support. However, concerns about the sustainability and efficiency of the GME program persist. Earlier this year, the Institute of Medicine (IOM) released a report examining and making recommendations for sweeping changes to our nation's financing, governance, and program design for graduate medical education. As Congress prepares to review the IOM recommendations, we believe additional input is needed.

Given the importance of graduate medical education, we would like your thoughts on GME financing, federal program governance and structure, and how it might be improved or restructured to better meet the country's health professional needs in both the short and long terms. Specific questions for which we seek input include:

1. What changes to the current GME financing system might be leveraged to improve its efficiency, effectiveness, and stability?

2. There have been numerous proposals put forward to reform the funding of the GME system in the United States. Are there any proposals or provisions of proposals you support and why?

3. Should federal funding for GME programs ensure training opportunities are available in both rural and urban areas? If so, what sorts of reforms are needed?

4. Is the current financing structure for GME appropriate to meet current and future healthcare workforce needs?
    i. Should it account for direct and indirect costs as separate payments?
        a. If not, how should it be restructured? Should a per-resident amount be used that follows the resident and not the institution?
        b. If so, are there improvements to the current formulas or structure that would increase the availability of additional training slots and be responsive to current and future workforce needs?

ii. Does the financing structure impact the availability of specialty and primary care designations currently? Should it moving forward?

5. Does the current system incentivize high-quality training programs? If not, what reforms should Congress consider to improve program training, accountability, and quality?

6. Is the current system of residency slots appropriately meeting the nation's healthcare needs? If not, please describe any problems and potential solutions necessary to address these problems?

7. Is there a role for states to play in defining our nation's healthcare workforce?

The committee requests your feedback no later than Friday, January 16. For further information, please contact Katie Novaria or Robert Horne with the Majority staff at (202) 225-2927 or Tiffany Guarascio with Ranking Member Pallone at (202) 225-4671.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

Frank Pallone Jr.
Ranking Member
Subcommittee on Health

Gene Green
Member

Diana DeGette
Member

Cathy McMorris Rodgers
Member

Peter Welch
Member

H. Morgan Griffith
Member

Kathy Castor
Member

RESPONSE TO THE CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
OPEN LETTER REQUESTING INFORMATION ON
GRADUATE MEDICAL EDUCATION

The Institute of Medicine's (IOM) Committee on the Governance and Financing of Graduate Medical Education (GME) report primarily focuses on Medicare and other federal GME funding. This report makes recommendations to Congress regarding federal programs and support, but does not provide significant guidance to the states. The only recommendation concerning Medicaid GME funding (that is under the shared jurisdiction with the states) is that there should be greater transparency and accountability for these funds similar to what they recommend for Medicare GME funding.

The New York State Department of Health (NYSDOH) applauds the IOM Committee's focus on this complex and inter-connected health care issue. The NYSDOH hopes that as the Subcommittee on Health reviews this report and develops appropriate federal legislative proposals, that it considers the significant contributions that current GME programs make to train the nation's physician workforce. Any actions considered by the Subcommittee should continue to support existing GME programs, especially in New York State, and build upon this critical system to expand GME funding to address the increasing physician workforce needs.

Key facts regarding New York's GME system include:

<u>Background</u>

- New York is a national and international leader in Graduate Medical Education
- New York trains over 16,500 residents (15 percent of the nation's residents) in over 80 teaching hospitals that are affiliated with 16 medical schools and other sponsoring institutions
- New York's training programs contribute to a highly-trained physician workforce throughout the nation, as over ½ the physicians trained in New York practice in other parts of the country
- New York is preparing the nation's future primary care physician workforce; more than 6,000 residents are training in primary care specialties
- Nearly 1/2 of residents in New York are graduates of international medical schools
- Over 1/3 of the nation's Medicaid GME funding is spent in New York State
- Annually over $3.2 billion is reimbursed to teaching hospitals in New York State for GME through the Medicare and Medicaid Programs
- GME funding is critical to the operations of hospitals and health care institutions in New York State
- Care provided by the residents trained in institutions in New York State is vital to our health care delivery system

The NYSDOH offers the following responses to the Subcommittee's Open Letter of December 6, 2014:

Question #1: New York's Medicaid program provides periodic updates to GME support through rebasing inpatient reimbursement rates. Such rebasing includes: utilizing current resident counts; updating for any new residency programs; and utilizing current data from the Institutional Cost Report (ICR). The Medicare and other federal programs should consider New York's model to improve its efficiency, effectiveness and stability. In addition, a Transformation Fund, as proposed by the IOM Committee, should be developed to evaluate innovative GME programs and validate appropriate GME-performance measures. However, such a fund should be developed with new rather than redirected GME resources, to avoid a disruptive adverse impact on training.

Question #2: Implement a national GME Trust Fund utilizing support from all payers to support GME. Such a trust fund would more equitably distribute the cost of GME among all payers rather than concentrate support mostly from governmental payers.

Question #3: The NYSDOH strongly supports continued federal funding to support GME programs in both rural and urban areas. Physician workforce shortfalls are greatest in many rural and underserved urban communities. However, since most GME programs in New York State are located in urban areas, additional federal support should be made available for new residency programs in New York's rural communities. In order to ensure that there is an adequate supply of primary care physicians in rural communities, New York State was awarded federal funding through the State Innovation Model (SIM) application to the Center for Medicare and Medicaid Innovation (CMMI) to create new residency programs in rural communities. These grant funds will help rural communities establish new accredited residency training programs. Ongoing, stable additional federal funds should be made available to replicate this model and sustain these new residency programs in rural communities in New York and other states.

Question #4: With the exception to our comments in questions 3 and 7, the current financing structure for GME is appropriate to meet current and future healthcare workforce needs in New York State. The NYSDOH supports expanded funding for residencies in ambulatory settings. However, a redirection of existing funding as proposed in IOM Recommendation # 4, could potentially destabilize hospital operations in New York, even phased-in over a 10-year period. This recommendation may penalize teaching hospitals in New York that have provided quality education and leadership for decades and even centuries in many institutions through a redistribution of funds to facilities in other parts of the country in addition to other non-hospital sponsoring institutions in New York.

In addition, the IOM report does not specifically recommend the continuation of the federal Teaching Health Center (GME) Program authorized in the Affordable Care Act. In 2014, 4 centers were funded by this program in New York State, training 66 residents at a cost of $9.9 million or $150,000 per resident. The 4 centers are: Sunset Park Health

Council in Brooklyn, Long Island FQHC, and 2 Institute for Family Health sites (Harlem and mid-Hudson). Losing this funding would decrease access to care in communities that already face access challenges. Congress should continue to fund this important program at current levels in order to adequately compensate federally qualified health centers (FQHCs) that are training residents in underserved communities.

Question #5: The NYSDOH believes that the current system, which is built upon a public-private accreditation system to oversee the quality of residency training programs, should be retained. The Accreditation Council for Graduate Medical Education (ACGME) is undergoing significant changes to move toward a more outcomes-based system. These ACGME initiatives focus on the production of a physician workforce that is better prepared to work in an evolving health care delivery system. When fully implemented, the ACGME improvements will ensure an effective evaluation program.

Question #6: See responses to questions 3 and 7.

Question #7: There is certainly a role for states in defining our nation's healthcare workforce. In fact, states should play a primary role, as they have the best knowledge of their local and regional healthcare systems. As the leader in medical education in the country and internationally for decades, New York State has developed programs and policies to address the health care workforce. These include: substantial support for GME through the Medicaid program; the development of the nation's first standard to address working hour limits and supervision of residents; the creation and operation of a statewide GME Council; programs to support the training of primary care physicians; initiatives to provide transparency and accountability in GME funding and programs; a federally-funded demonstration program to train residents in patient-centered medical homes through performance-based GME financing; funding to train in free-standing community-based sites; the development of innovative loan repayment and practice support programs to incentivize physicians to work in underserved communities; support for diversity in medicine initiatives all along the academic pipeline; a federally-funded pilot to recruit and retain physicians in needed areas; and the collection and reporting of data on the physician/resident workforce.

The IOM report provides very limited input on the physician workforce supply that is critically important in many areas of New York and many other states. In response to the call from many to increase the number of residency positions, the IOM Committee felt that "Simply increasing the numbers of physicians is unlikely to resolve workforce shortages in the regions of the country where shortages are most acute, and also unlikely to ensure a sufficient number of providers in all specialties and care settings." The NYSDOH has demonstrated through its various programs that physician workforce shortages can be effectively addressed, and believes that increasing residency slots in targeted sectors, e.g., rural and other underserved communities (see response to question # 3 above) and specialties, such as psychiatry, general surgery and several others, can improve our ability to increase access to high quality care.