

Consensus Group Members

Baylor College of Medicine

Texas A&M Health Science Center:
Bryan-College Station, Temple, and
Round Rock

Texas Tech University Health
Sciences Center: Lubbock, Amarillo,
and Odessa; and Paul L. Foster
Medical School in El Paso

The University of Texas System

The University of Texas Health
Science Center at Houston

The University of Texas Health
Science Center at San Antonio; and
Lower Rio Grande Valley Regional
Academic Health Center in Harlingen
and Edinburg

The University of Texas Health
Science Center at Tyler

The University of Texas
M.D. Anderson Cancer Center
at Houston

The University of Texas Medical
Branch at Galveston

The University of Texas Southwestern
Medical Center

University of North Texas Health
Science Center at Ft. Worth

Teaching Hospitals of Texas

Texas Medical Association

CONSENSUS STATEMENT

82nd Texas Legislature



CONSENSUS

Texas' nine medical schools, regional campuses, and other health-related institutions, joined by the state professional associations for physicians and teaching hospitals (listed in the left column), offer this 2011 consensus statement on medical education and physician workforce to members of the 82nd Texas Legislature. This was prepared with consideration for the extraordinary pressures on the state budget at this time and the foreseeable future. In response, each medical school has implemented budgetary reductions as part of a commitment to identify greater efficiencies in educating and training physicians for Texas. These budget cuts come at a time, however, of rapid growth in physician demand, resulting in tough challenges for producing a workforce adequate to meet the state's expanding medical needs.

The primary goal of the consensus statement, unchanged from versions in 2007 and 2009, is as follows:

To inform about the expanding shortage of physicians and corresponding necessity to prepare a physician workforce that meets the medical needs of the state while reflecting the population of Texas.

The health of Texans depends on meeting this goal. A physician shortage negatively impacts access to care, health care costs, and ultimately, the health of Texans.



Physicians Caring for Texans

PHYSICIAN SHORTAGES

Although physician shortages are NOT new to the state, what IS new is a deepening shortage with signs of undersupply in more places, including urban centers and in more specialties. This means that shortages in primary care and many other specialties are now affecting even more Texans. And projections indicate the shortage is likely to grow worse by 2015.

Texas ranks 42nd out of 50 states (and the District of Columbia) in the ratio of patient care physicians per 100,000 peopleⁱ. In addition, Texas ranks LAST among the top five most-populous states behind California, New York, Florida, and Illinois in the number of physicians per 100,000 people.

Texas lags behind the national average for ratios of doctors per 100,000 people in 37 out of 40 major specialty groupingsⁱⁱ. This is despite the fact that Texas is attracting record-high numbers of new physicians. Why? Because the state is adding new Texans at about the same pace as new physicians. In fact, during the past decade, physicians grew at 23.9 percent, barely ahead of the population gain of 22 percentⁱⁱⁱ.

In addition to the state's population growth, other factors are driving up physician demand, including the growing numbers of older Texans and the greater prevalence of health conditions such as heart disease, hypertension, obesity, and diabetes. Although greater efforts are needed to solve the state's physician shortage, these efforts should not result in a lower quality of medical care nor should lower standards be adopted for rural or other physician shortage areas.

GRADUATE MEDICAL EDUCATION (GME)

With the help of Texas legislators, Texas medical schools are doing their part to grow admissions; however, their graduates are not qualified to enter medical practice upon graduation. An additional three to seven years of GME are required in a particular specialty to be qualified for practice. However, medical school and GME growth are not typically linked. Why should this matter? Because physicians who complete both medical school and GME in Texas are three times more likely to remain in the state to practice^{iv}.

When medical graduates have to leave the state for GME due to a shortage of available positions, given the strong correlation between where a physician trains and where he or she enters medical practice, the long-established pattern is that fewer who leave for GME will return to Texas to practice. Further, when they leave for GME and stay away, they take the state's investment of more than \$200,000 in their medical education with them.

Why is GME growing slower than medical school admissions? Largely because medical schools and teaching hospitals have limited funding to support GME. While Medicare provides the largest amount of direct GME funding to teaching hospitals, Congress capped these funds at 1996 levels, yes, 1996 levels! This means new GME slots are generally not eligible for Medicare funding and must be funded by other sources. Texas has another disadvantage due to deep cuts to state Medicaid GME funding after 2005^v. Texas teaching hospitals appreciate the extension of Medicaid support for GME to state-owned hospitals, but reductions in Medicaid funding for these and other teaching hospitals will reduce their ability to fund new or even existing physician training positions. Hospitals remain the most significant source of GME financial support.

STATE GME FORMULA FUNDING

For the past five years, Texas legislators have offered some support to medical schools for a portion of faculty costs or the development of new slots. Although important, this funding was limited in 2010-11 to \$6,700 per resident per year, less than half of the \$18,000 in estimated annual faculty costs per resident. Further, this does not cover stipends for residents or other related costs at teaching hospitals that add an estimated \$100,000+ for the hospital-related costs of training a resident.

The lack of adequate GME funding prevents the state from growing the needed numbers of GME training positions. As noted, GME training is a long process and requires funding for the full duration of the training period, three to seven years, depending on the specialty, in order to qualify a physician for practice.

PRIORITY ISSUES FOR TEXAS

- ✓ **Produce more homegrown physicians by preserving adequate state formula funding for both medical school enrollments and GME positions in response to the state's expanding physician demand.**
- ✓ **Maintain state GME formula funding at the highest per-resident levels possible. In addition, restore Medicaid GME funding that was discontinued in 2003 (40-percent state/60-percent federal matching dollars) for needed GME growth.**
- ✓ **Align the state's GME capacity with increases in medical school enrollments to achieve the Texas Higher Education Coordinating Board's goal of having a ratio of at least 1.1-to-1 for entry-level GME positions in relation to the number of graduates at Texas medical schools.**

- ✓ **Maintain adequate support for the State Physician Education Loan Repayment Program as a highly effective tool for addressing physician shortages around the state.**
- ✓ **Preserve state support for the state's Joint Admission Medical Program (JAMP) as an effective and nationally recognized program for promoting diversity among the state's physician workforce.**

GOOD STEWARDSHIP OF STATE DOLLARS BY TEXAS MEDICAL SCHOOLS AND TEACHING HOSPITALS

Texas medical schools and teaching hospitals recognize the shared responsibility for good stewardship and accountability for state dollars. Each has identified greater efficiencies in educating and training new physicians during the current budget crisis, without lowering quality. As evidence of this, every Texas medical education institution has implemented spending cuts. Further, each has implemented greater educational and operational efficiencies, as highlighted below.

Baylor College of Medicine at Houston

Baylor College of Medicine, the UTHealth medical and dental schools, and The UT M.D. Anderson Cancer Center save costs by collaborating on faculty development programs. These include workshops to improve teaching skills, a two-year Educational Scholars Program, and collaboration with the University of Houston to provide a Masters of Education program focused on the teaching of doctors, dentists, nurses, and other health professionals.

Texas A&M Health Science Center at Bryan-College Station, Temple, and Round Rock

In a partnership with A&M system schools, Texas A&M HSC College of Medicine is addressing areas of health care shortage in the state with the Partnership for Primary Care program. Exceptional students from rural and underserved areas are selected during their senior year of high school for support and enrichment during their undergraduate studies and are assured acceptance to the College of Medicine for continued academic excellence.

Texas Tech University Health Sciences Center at Lubbock, Amarillo, and Odessa/Midland, and Paul L. Foster Medical School, El Paso

TTUHSC offers a combined medical school and family medicine GME training program, approved by the Liaison Committee on Medical Education^{vi}, that produces family physicians in a shorter period of time — six rather than seven years — while maintaining rigorous academic standards and lowering medical school debt by 50 percent.

The University of Texas System

An Energy Use Task Force works with institutions to review energy use and target reductions. Cooperative contracting and purchasing efforts include: Supply Chain Alliance, whereby all six UT health institutions created a strategic sourcing alliance; a shared journal collection with non-UT institutions, which resulted in the Texas Digital Library; and system-wide software licenses and various shared services initiatives that have resulted in cost savings, have enhanced efficiency through standardization, and have helped identify best practices.

The University of Texas Health Science Center at Houston

The retention of students and residents is critical to maintaining educational efficiencies. The Medical School recently created 10 areas of concentration, including primary care and patient quality and safety, which allow students to choose a specialty of interest early in career development and nurture seamlessly into residency programs.

The Center for Healthcare Quality and Safety was created to link efforts with our hospital teaching partners on clinical effectiveness and patient safety. The goal is to train residents on health care quality and safety in order to promote patient safety, improve efficiency with our hospital partners, and cut costs. This is especially important as education is reassessed in response to new reductions in resident duty hours and the impact this will have on education, service, and cost.

The University of Texas Health Science Center at San Antonio

A continued partnership with the University Health System is improving the resident cohort and attracting students to underserved areas such as primary care. A primary care strategic plan under development emphasizes the importance of training physicians in the relevant specialties. In addition, the Regional Academic Health Center in Harlingen is increasing the number of residency slots in core specialties by expanding its relationships with local hospitals.

The University of Texas Health Science Center at Tyler

UTHSC at Tyler is developing an expanded residency training program with Good Shepherd Medical Center in Longview; a new internal medicine GME program will begin in 2012 with 18 residency slots each year, for a total of 54 GME positions over three years.

The University of Texas M.D. Anderson Cancer Center at Houston

M.D. Anderson established an Institute for Health Care Excellence and has become a UT System leader in Clinical Safety and Effectiveness training for faculty and staff. These programs are proven to increase the effectiveness and safety of patient care and reduce costs. M.D. Anderson also has created a GME Core Curriculum course, available both live and online, to eliminate duplication of core competency training among its 50+ GME programs and to increase GME training efficiency.

The Cancer Center also is increasing efficiency by extending its expertise to community physicians and mid-level providers through a new Professional Oncology Education (POE) website that provides both entry-level and advanced online education on aspects of cancer biology, cancer care, communication skills for patient care, care of survivors, and other cancer-related topics. Training and development of M.D. Anderson's own faculty and staff also is enhanced through its online Education Center and other education and training resources maintained on its webpages. An office of Institutional Research supports efforts across the institution to continually improve the effectiveness of programs by providing expertise in designing, conducting, and analyzing surveys of improvements and outcomes.

The University of Texas Medical Branch at Galveston

UTMB has implemented a robust performance measurement for all operations including education, health care, research, and administration. The university has instituted patient safety and quality initiatives in all aspects of its health care; established a detailed system for allocating faculty funds based on the teaching of students; and reengineered emergency department processes to increase timeliness, access, and efficiency. UTMB has implemented a robust electronic medical records system as well as extensive administrative efficiencies in areas such as group purchasing and energy conservation.

The University of Texas Southwestern Medical Center

Initiatives from UT Southwestern to date include: implementation of long-term fixed-price utility contracts and improved computer vendor contracts; replacement of leased space with owned space; reductions in classified staff in Administration and Physical Plant Services; and significant reductions in travel and communications budgets. Continued use of these initiatives, combined with savings realized through delayed hiring in Administration and Physical Plant departments, will yield additional efficiencies and related savings.

University of North Texas Health Science Center at Ft. Worth

UNTHSC has realized significant savings by expanding the use of ambulatory training sites and the use of community faculty in rural and urban underserved communities throughout the state. This has allowed reinvestment of state salary savings into educational technologies to accommodate student growth.

ⁱ American Medical Association, "Physician Characteristics and Distribution in the US, 2011."

ⁱⁱ Texas Medical Association analysis of 2007 physician workforce data published by the American Medical Association.

ⁱⁱⁱ TMA calculations using data for 2000-09 provided by Health Professions Resource Center, DSHS.

^{iv} TMA surveys of graduating medical students.

^v Since 2005, only five state-owned teaching hospitals have received Medicaid GME funding, at the exclusion of the other teaching hospitals.

^{vi} The national accrediting body for allopathic medical schools.