



*DELAWARE HEALTH
AND SOCIAL SERVICES*

Division of Public Health

Review of Feasible Strategies: Expanding Primary Care Workforce in Underserved Delaware through Graduate Medical Education Programming.

Spring-Summer 2013

Prepared for the Delaware Division of Public Health

December 2013
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President



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EXECUTIVE SUMMARY:

From April to September 2013 a committee of key stakeholders representing health service delivery organizations, academic medicine, health policy, public and private sector organizations met to review feasibility for expanding the Delaware primary care workforce in underserved areas of Delaware through graduate medical education activities. There was much impetus for this effort. Environmentally, stakeholders have heightened sensitivity to the need to ready Delaware's health system to meet the service demands created by health reform as well as the general demands of rapidly changing population demography. Initial focus in this effort was placed on the use of graduate medical education programming as a means to potentially expand the net number of providers being trained in, and ultimately practicing in, Delaware. New opportunities created by the Affordable Care Act, specifically those within its Title III to fund the development of new community-based teaching programs, provided a focal point for discussion. Ultimately, a model for workforce development was created that enjoys broad stakeholder support and addresses federal funding requirements, should federal funds for its implementation be pursued. Most importantly, the model creates a customized and innovative Delaware strategy for cultivating primary care workforce.

The Consortium model was determined as the most feasible structure to centralize multi-stakeholder planning, design, and oversight of new and enhanced graduate medical education programs for primary care development. Moreover, the centralized Consortium model, by design, provides an infrastructure for multi-disciplinary and interdisciplinary health professional training programs in Delaware and a framework for the development of additional health workforce training programs.

This report describes Delaware assets on which to build, a vision, start-up costs, and core operational priorities for the establishment of a formally organized Health Workforce Development Consortium. As Delaware's government, academic and health industry leaders continue to prepare for health reform, a consensus has clearly emerged that Delaware, the First State, should also position itself as a "Learning State." The ideas presented in this paper lay groundwork for beginning that transformation while creating a dynamic health workforce for the future.

BACKGROUND:

In 2012, Delaware Health and Social Services' (DHSS) Division of Public Health (DPH) received federal funds (American Recovery and Reinvestment Act (ARRA)) to assess the feasibility of establishing new residency programs and/or residency rotations for National Health Service Corps Scholars and residents to gain exposure to underserved communities in both rural and urban areas. A committee explored the programmatic approaches that could be used to stimulate primary care providers' interest to practice in Delaware's underserved communities. The feasibility process was anticipated to give structure to, at minimum, a refreshed review of a pilot project conducted in the 1990s by the Delaware Health Care Commission (DHCC), the "Downstate Residency Rotation Pilot Project."

Also during 2012, using a multi-stakeholder planning process, the DHCC led the development of comprehensive recommendations intended to strengthen Delaware's health professional workforce. One recommendation from that global body of work approved in January 2013 was to ***"complete an analysis of graduate medical education processes that could support broader geographic exposure of statewide Delaware practice opportunities."***

Cultivating a robust health professional workforce in southern Delaware and other underserved areas has unique challenges. There are no medical school(s) in Delaware, and residency programs/teaching hospitals are located only in New Castle County. Additionally, there is the documented association between the location of an individual's graduate medical education experience(s) and their ultimate decision about more permanent practice location.

The two agencies, DPH and the DHCC, joined forces to utilize the ARRA-funded feasibility assessment opportunity as a mechanism to leverage the stakeholder momentum generated by the Workforce process and delve further into one specific recommendation (identified above). Concurrent to this joint activity, DHSS and the DHCC initiated the development of a State Innovation Model. The Plan is being finalized now for anticipated submission to the Centers for Medicare and Medicaid Innovations (CMMI) in Spring 2014 for test funding consideration. The Model focuses on payment reform, health information technology, population health, transforming service delivery systems (including care coordination, the use of team-based care and more) and workforce; all to achieve the "Triple Aim" espoused throughout the industry. A multi-stakeholder, multi-factorial planning process was used. The process and recommendations resulting from this ARRA-funded project were used to further augment the DHCC's Workforce recommendations from January 2013, and ultimately to construct the Workforce-related aspect of the State Innovation Model.

While this project began with a relatively focused area of review, it ultimately broadened to recommend a health professions workforce development infrastructure with primary care

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graduate medical education activities serving as the initial building block for new program and policy development.

WORK PROCESS AND ASSETS:

DPH's director appointed DPH's medical director to chair the activity. DHCC officials were briefed on the scope of the funded project. Together, an internal management team formed and identified an administrative framework for a path forward to leverage the funded project for a broader examination of provider workforce development needs. DPH secured professional services to support the completion of the assessment process including, but not limited to, stakeholder engagement, literature review, information gathering, documentation, and communication.

Stakeholder engagement was completed on a targeted basis to engage senior leadership from key categorical organizations. These organizations discussed larger-scale opportunities for primary care workforce development that could be realized through a consensus process on training and education. Individual outreach was conducted with senior management officials and physician leadership from each Delaware teaching hospital program and each "downstate/rural" community hospital system. A presentation about the launch of the project was completed to the Delaware Institute for Medical Education and Research (DIMER). DIMER enjoys leadership from academic institutions, hospitals, state officials, and physicians who have since the 1970s created strategies to support medical education activities in Delaware, given the absence of a state medical school. (Many of the targeted stakeholders for this project also participate in DIMER.) Outreach was also completed to the individuals and organizations that participated in the DHCC Workforce process. A multi-stakeholder committee consisting of approximately 30 senior level officials was ultimately formed and a six month planning process was formally launched in April 2013. The Committee met at least monthly with ad hoc subgroups meeting on a more frequent basis throughout the project period. **See Committee listing Appendix 1.**

Key observations and common beliefs were identified through the stakeholder engagement process and were used to frame the formal launch of the project:

- 1. There is a critical need in Delaware to increase the primary care workforce, particularly in underserved and downstate areas of the state.** This Delaware need already exists on a net population to provider basis, evidenced by Health Professional Shortage Area and Medically Underserved Area federal designations throughout the state. This need will be amplified in the short term with full implementation of the Affordable Care Act and in the longer term with forecasted state demographic trends associated with the aging of the population.

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2. There are numerous assets in Delaware to undergird primary care workforce development. Delaware enjoys numerous established programs and resources on which to build and derive additional benefits. These randomly include, but are not limited to:

- The Delaware Institute for Medical Education and Research (DIMER) and the Delaware Institute for Dental Education and Research (DIDER) that each have forged significant, innovative, strategic partnerships with nationally renowned academic institutions;
- Venerable teaching hospital systems and their continued innovation;
- Federally qualified health centers that have statewide penetration to medically serve at least 30,000 Delawareans and that each have established on-site training and precepting partnerships with health systems and local colleges;
- The Delaware Health Sciences Alliance which enables partner organizations to collaborate and conduct cutting-edge biomedical research, to improve the health of Delawareans through access to services in the state and region, and to educate the next generation of health care professionals;
- Established pathways for medical student clerkships and electives in southern Delaware through the various activities of community hospitals, their medical staff and physician networks, and in affiliation with their respective institutional academic partners;
- Incentive programs such as the State Loan Repayment Program and the National Health Service Corps Program; and
- A customary spirit of shared problem solving across public and private sectors, and more!

3. There is national impetus and new tools to support primary care workforce development. New service delivery models, such as the Patient Centered Medical Home, which are cornerstone to the tenets of the Affordable Care Act, rely upon the provision of primary care as the central core component of multi-disciplinary, inter-disciplinary, team-based care. There is a national dialogue emerging from academic institutions about the need for additional primary care physicians as well as additional training slots for medical school graduates. In an August 2013 *New York Times* article, the American Association of Medical Colleges forecasted a shortage of 90,000 primary care physicians over the next decade. A recent perspective piece in the *New England Journal of Medicine* discusses how although more people are attending and graduating from medical school, there are not enough residency slots to train them. One of the key factors in the growth of medical school graduates is an increase in the number of

medical schools (16 new ones since 2002). The article notes how federal funding is a key factor limiting graduate medical education (GME) positions. According to the article, efforts have been made by medical societies to persuade Congress to increase the number of GME positions available, but Congress has yet to act. The article says unless there is a sizable increase in the number of training positions, the physician shortage will only worsen.¹ The Council on Graduate Medical Education, in its “Twenty-First Report” issued in August 2013, echoed these sentiments and requested Congress to authorize the development of new programs and additional “all-payer” funding streams beyond the Centers for Medicaid and Medicare (CMS) to foster new capacity for graduate medical education.

There are new grant programs borne of the Affordable Care Act, administered by agencies within the federal Department of Health and Human Services, to support the development of new training programs, e.g. the “Teaching Health Center Graduate Medical Education Program” (THCGME) which through the Health Resources and Services Administration (HRSA) establishes new community-based training programs via Title III of the Affordable Care Act. (The technical requirements of the grant program hold some flexibility; however they require thoughtful consideration and specific planning to meet eligibility. See below.) States are individually creating strategies to attract medical school students and retain them in their state for training pursuant to their graduation. For example, a Texas legislator in their last legislative session introduced a bill to appropriate \$16 million to create new State-supported residency slots, planning grants for new residency development, and incentives for medical students to enter the discipline of primary care.

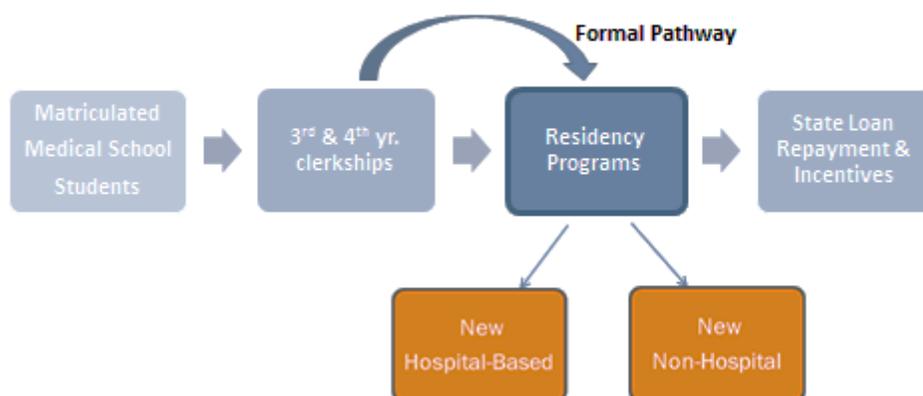
¹ John K. Iglehart New England Journal of Medicine 2013; 369:297-299 July 25, 2013 DOI: 10.1056/NEJMp1306445

A VISION:

There are many assets on which Delaware can build. There is broad awareness of the need for new infrastructure and policy to facilitate workforce development in support of the full implementation of health reform as well as Delaware’s changing population. Delaware stakeholders agree that there is significant opportunity to create an energized new “Learning State” environment in Delaware, and new pathways to nurture health professional interest -- and ultimately commitment -- to practice in locations throughout the state. Ultimately, it is the vision of key stakeholders that a pipeline of aligned education and training requirements, service obligations, and financial incentives be created to strengthen Delaware’s physician workforce. The gradation of color in the Exhibit 1.1 below demonstrates the baseline existence of key elements of the pipeline, with the boldest color used on the segment of the pipeline that needs the most immediate work to fulfill the broader vision.

Exhibit 1.1

Vision: A Delaware “Pipeline”



FINDINGS AND PRIORITIES:

Two initial sub-groups were formed to focus respectively on “**New Programs**” and “**Enhancement of Existing Programs.**”

The charge of the “New Programs” group was to complete an exploration of strategies for expanding the number and types of “net new” primary care residency programs in Delaware.

The “**New Programs**” group considered two main vehicles for program development:

- 1) The HRSA Teaching Health Center Graduate Medical Education Program; and/or
- 2) The development of “net new”* hospital based programs (with direct graduate medical education funding support derived from the federal government via the Centers for Medicaid and Medicare Services (CMS)).

*Private sector hospitals in Delaware that do not currently have any federally approved graduate medical education slots (and that could be considered as “net-new” hospitals) include but are not limited to: the Rockford Center, Meadowood Hospital, Bayhealth Medical Center, Beebe Medical Center, and Nanticoke Health Services.

The sub-group reviewed in detail the Teaching Health Center Graduate Medical Education Program (THCGME) grant opportunity and the mechanisms available under that program to submit a competitive, eligible, application. Briefings were completed with other THCGME funded programs (including Oklahoma), federal project officers from HRSA, the National Association of Community Health Centers, and the ACGME. Key aspects of the THCGME program that influenced the planning process are contained in Exhibit 1.2, which follows on page 11.

The charge of the “**Enhancements to Existing Programs**” sub-group was to explore best-practice models for leveraging the interest created via medical student’s field experiences in underserved/downstate Delaware areas back to an established Delaware residency program(s) where they would be guaranteed to have continued teaching experiences in that original underserved/downstate environment. Through the creation of specialized curricular design, residents in existing programs could opt into “Tracks” that would provide outbound, diversified training experiences throughout underserved areas of the state. “Tracks” are more longitudinal than time-bound “rotations,” and there are numerous models that have been applied throughout the country.

Findings emerged independently from each sub-group, and through subsequent full Committee review, synthesized into a set of overarching priorities which are detailed below and predicated on two core agreements for future planning process:

- 1) **It should not be self-limiting to the creation of just one particular type of new residency program (THC or “net-new hospital based”).** It was recognized that surmountable challenges exist in both scenarios and that either approach used singly may not be a robust enough, “Delaware” solution. A simple but important priority of continuing to nurture planning dialogue about **both** types of programs within a multi-stakeholder forum was identified.
- 2) **It should focus simultaneously on the enhancement of existing programs AND the development of new residency programs.** It was agreed that while enhancements of existing programs may stimulate increased interest in the array of geographic settings, and population subsets, in Delaware, they alone do not create new provider capacity.

For New Programs:

-  **PRIORITY: Use of the “Consortium model” for THCGME application does evoke specific requirements; however, that approach is viewed as being a favorable multi-stakeholder engagement mechanism to create systemic workforce development solutions larger than that which could be realized by a single organization (federally qualified health center) applicant. Use of the Consortium model was determined a “no-fail” approach of building readiness for new programs regardless of whether the THCGME funding source is ultimately pursued.**
-  **PRIORITY: Any new program should be accredited for both allopathic and osteopathic training.** At this writing, accreditation from the American College of Graduate Medical Education effectively supports residency training of students graduated from both allopathic and osteopathic medical schools. It was recognized that accreditation could be pursued singularly from the American Osteopathic Association, perhaps using one of its regional Osteopathic Postdoctoral Training Institutions (OPTI). Although OPTI was the effective pathway used for the start-up of other HRSA-funded Teaching Health Center programs, it was determined that for Delaware’s purposes, a more global accreditation such as ACGME, at onset, is a priority. (Efforts to unify the ACGME and AOA accreditation processes are underway but are not expected to affect the principle priority of creating accredited training for both allopathic and osteopathic medical students.)

- ✚ **PRIORITY:** While initial focus of this planning project is on primary care workforce development, it is envisioned that any mechanism(s) for new program development that results should apply to other disciplines of medicine; e.g. mental/behavioral health, oral health, or other critically needed medical specialties.

- ✚ **PRIORITY:** Any new training opportunities, whether enhancements to existing programs or new programs, should integrate inter-disciplinary training opportunities; e.g. nurse practitioners, physician assistants, behavioral health providers, and more.

For Enhancements to Existing Programs:

- ✚ **PRIORITY:** New residency program “Tracks” are of interest and should be considered as one aspect of a broader strategy to address the goal of building workforce. New “tracks” may stimulate additional interest and/or further cultivate the interest created from a third or fourth year medical student’s earlier exposure to Delaware. However, they do not add new employees in that they work within existing program caps on GME teaching slots. Adding a new “track” could make existing residency programs even more attractive, and could support the success of any emerging new residency programs by creating favorable “word of mouth” amongst medical students and resident physicians. It was determined that, since it is going to take time to develop infrastructure for net new program development, new “track” development could begin and serve as a stepping stone towards simultaneous new residency program development.

- ✚ **PRIORITY:** Creating a broader “Underserved/Community Health Track” may enjoy greater success than a “Rural Track.” In this regard, the new “track” may be broader in nature, offering experiences in several aspects of community health to appeal to today’s more “mission-driven” health professional. For instance, a “Community Health Track” could include teaching experiences that highlight the diversity of Delaware’s population and topography (e.g., rural medicine, inner city medicine, services to persons experiencing homelessness, farmworker/migrant service, services to those with HIV/AIDS, and service to multi-cultural populations).

- ✚ **PRIORITY:** Advocacy for financial support of two (2) existing, but unfunded, psychiatric residency slots at the current psychiatric residency program within the Delaware Psychiatric Center

Exhibit 1.2

Teaching Health Center Graduate Medical Education Program CFDA#93.530

Key Technical Considerations

- To participate in the HRSA Teaching Health Center Program, a **new** residency program must be created.
- New residency programs are expected to demonstrate innovation and teaching in quality improvement process, health outcomes, team-based/patient-centered care, and use of electronic health records and data.
- The new residency program must be centrally administered by a health center, or a “Consortium,” either of which must be the official sponsoring institution for American College of Graduate Medical Education (ACGME) accreditation.
- ACGME defines “Consortium” in its glossary in the following manner: *“Two or more organizations or institutions that have come together to pursue common objectives (e.g., GME). A Consortium may serve as a “sponsoring institution” for GME programs if it is formally established as an ongoing institutional entity with a documented commitment to GME.”*
- The Consortium must be a formal LLC or 501c3 entity.
- The ACGME requires that a program’s sponsoring institution hire the program director. The application that is submitted to the ACGME Review Committee requires that the Program Director be identified and his/her curriculum vitae included as a component of the application. The ACGME accreditation process for Family Medicine programs requires a site visit at which time the application is reviewed in full with the Program Director and the sponsoring institution’s “Designated Institutional Officer.”
- The application process can take 7-10 months, and longer based on completion of the site visit.
- Application to the HRSA THC program requires, at minimum, proof of application for accreditation of the new residency program.
- The HRSA THCGME program is currently authorized through July 2015. In 2012, the HRSA allocation of funds available per resident in an approved THCGME program was \$150,000. HRSA funded resident time/expense cannot under any circumstance be billed to CMS. In other words, the HRSA funded resident fulfilling training at a current teaching hospital site cannot have any portion of his/her time/service billed to CMS as a GME expense.

RECOMMENDATION(S):

A “**Delaware Health Professions Consortium**” should be established to provide a multi-stakeholder mechanism for planning, implementing, and monitoring health professions workforce development. The Consortium will be a formally incorporated 501c3 or LLC structure. It is to provide a centralized framework for leadership, innovation, program development, and the continuous incubation of new and/or enhanced program development whether those programs are centrally administered or led by an individual organization from within the Consortium. **Specifically, for programs that the Consortium itself designs and implements** (in contrast to programs created by one of the Consortium’s members), the Consortium will complete the following core functions:

- Centralized Administration
- Accreditation by the indicated accrediting body; e.g. the ACGME/AOA
- Faculty Development
- Fund Solicitation/Management

Over time, the Consortium will incubate the development of a variety of health professions training programs, all needed to supply the diverse levels and types of health providers required in the emerging new healthcare system. At its inception, however, the Consortium’s first critical building block will be medical education programs, specifically primary care (family medicine). New and/or enhanced residency programs are required to increase the primary care workforce in Delaware. Through innovative design, they will provide interdisciplinary and community-based training opportunities in diverse settings and regions throughout Delaware. Current GME programs may be enhanced to include special tracks in new geographic areas of the state and/or new community health/special population experiences. The availability of new experiences within current programs is expected to stimulate broad interest among existing resident physicians. These physicians will generate communication within their peer networks, cultivating interest and filling slots in any **new** residency program.

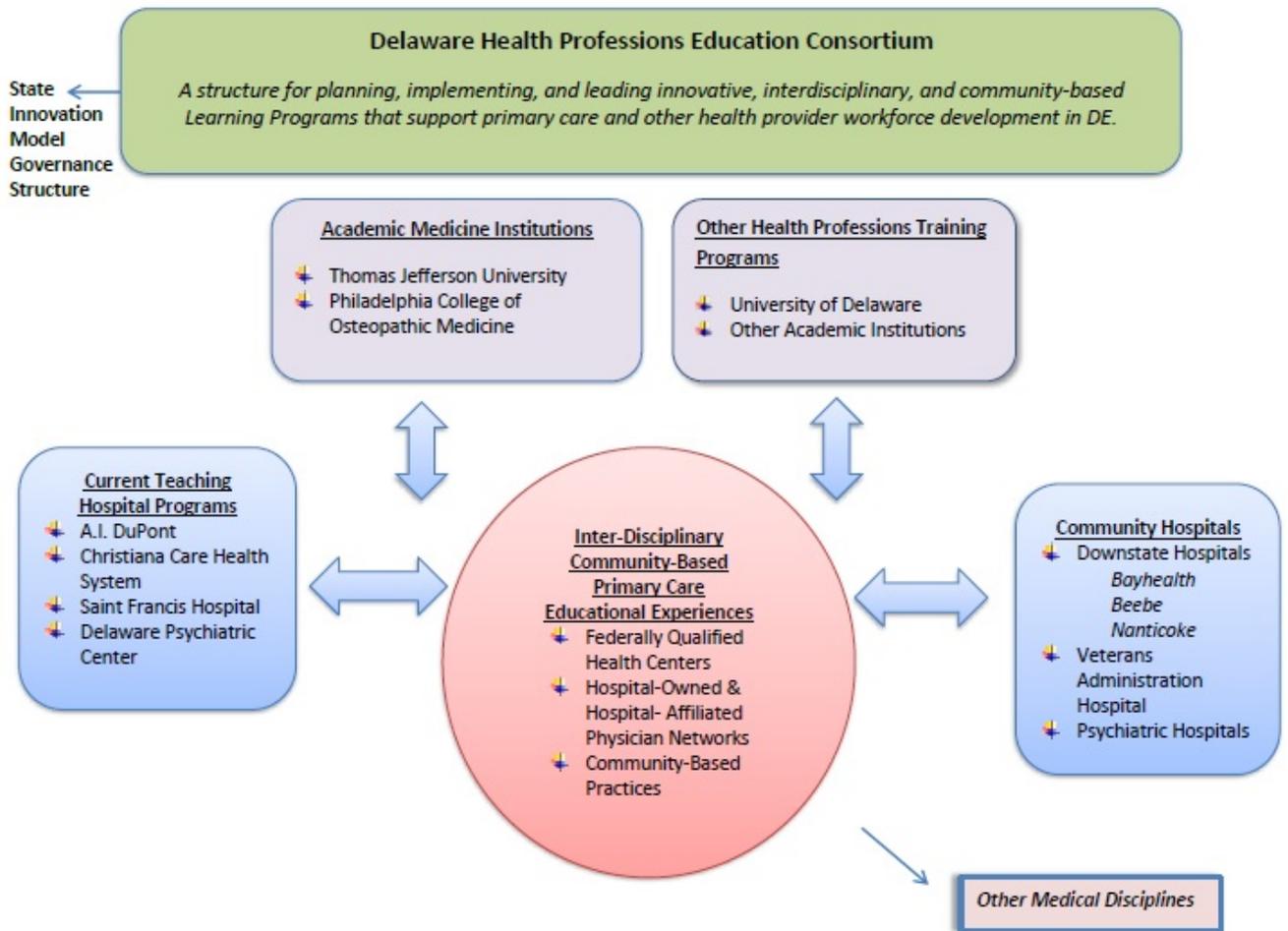
The Consortium will foster the development of innovative primary care teaching programs that provide interdisciplinary training opportunities, support the principles of “team-based” care, and foster new service delivery models such as:

- Patient-Centered Care;
- Mental/Behavioral Health Service integration; and
- Integrated Use of Health Information Technology (for clinical care and distance learning).

Finally, the Consortium will provide leadership to the creation of process and policy to develop a formal pipeline of aligned requirements and incentives for individuals who are pursuing a

primary care medical career, completing training in Delaware, and ultimately practicing in Delaware. See proposed Consortium Structure [Exhibit 1.3](#).

Exhibit 1.3. Consortium Structure



Revised 09/25/13

Roles of Stakeholders within the Consortium (Corresponding to the Diagram)

What: Ambulatory Community Health Educational Experiences

Who: Federally Qualified Health Centers, Hospital-Owned and Affiliated Physician Networks, and Community-Based Practices

Core Function: Serve as integral locations/settings for Core Primary Care Training

- Provide facilities for direct, outpatient, primary care learning experiences.
- Provide daily operating environment for resident physician training including direct patient service opportunity, preceptors, and more.
- Provide clinical and executive leadership input to define learning requirements pertinent to the geography or population(s) being served.
- Input to training design considerations about interface with the following patient populations:
 - Chronic Disease Populations: Diabetes, CV, Cancer
 - Farmworker/Migrant Populations
 - HIV Populations
 - Homeless Populations - rural
 - Homeless Populations - urban
 - Inner City/Urban Populations
 - Latino and Other Emerging Populations
 - Rural Populations

What: Community Hospitals

Who: Community hospitals which do not currently conduct organizationally specific, formal GME training programs. At the time of this writing, these community hospitals by definition include five specific sites: Bayhealth, Beebe, Nanticoke and three private sector psychiatric hospitals. The role of “Community Hospitals” in the Consortium model is two-fold:

1) Operations for Consortium developed new teaching program

- Sites for Inpatient Rotations
- Leadership Liaison to medical staff and other medical disciplines who are needed as community-based preceptors to support the teaching program.

- Leadership Liaison to medical staff and other medical disciplines needed to assist the implementation of enhanced program design components within current teaching programs (e.g., a new track, a new rotation, a new required elective).

2) Potentially structural in that these community hospitals could determine interest in their own, organizationally specific, new GME program.

What: Current Teaching Programs

Who: AI DuPont Hospital for Children, Christiana Care Health System, St. Francis Hospital, Delaware Psychiatric Center

Core Functions:

- Provide direct training of core required curricular content and other Consortium identified topics to fulfill the accreditation requirement of “protected didactic time.” This may be accomplished by:
 - Direct provision of training in established resident physician training forums, and/or
 - The use of technology and distance learning modalities

It is envisioned that current teaching programs could provide technical assistance to assist in the design and structure of new didactic training modules at facilities that have not, heretofore, conducted didactic training but which have the infrastructure and expertise to do so.

- Above leveraging current teaching program’s didactic training infrastructure (supported by the use of technology and distance learning modalities); it is additionally envisioned that current teaching programs will be a valuable source of input and technical expertise on:
 - New program design and operations,
 - Resident physician performance review,
 - The construct and requirements of other precepted experiences to assure well-rounded training content inclusive of other medical disciplines, other health professionals, and other health service delivery settings; and
 - The requirements of faculty development.
 -

What: Academic Medicine Institutions and Other Health Professions Training Programs

Who: Thomas Jefferson University, Philadelphia College of Osteopathic Medicine, University of Delaware, and other Academic Institutions representing additional to be determined types of health professionals who will be jointly/concurrently trained with physicians in the new program (e.g., nurse practitioners, physician assistants, etc.)

Core Functions:

To provide guidance on academic requirements, curricular design considerations, and the overarching totality of academic rigors of newly designed programs including but not limited to:

- Technical assistance with ACGME/AOA, and other accreditation processes.
- Marketing new programs to medical students and potential resident physicians who would be interested in Delaware clerkships and residency training.

Estimated Start-Up Costs for the Delaware Health Professions Education Consortium

Assumptions:

- 1) Start-up costs are necessary to establish a leadership infrastructure (the Consortium) which, among other functions, is capable of qualifying as a “Sponsoring Institution” to meet ACGME/AOA requirements for new primary care residency program development.
- 2) The future operating costs of any training program created by the Consortium are not included at this time. Moreover, as new programs are created it is possible that the Consortium structure would also need to adapt.
- 3) Members of the Consortium will continue to be involved in development of program(s) in which they will experience the indirect costs of senior management’s time in meetings and local travel that are **not** quantified in this document.
- 4) The Consortium will be a formal 501c3 or LLC entity, yet as depicted in the Exhibit 1.3 chart, it will, in a yet to be determined manner, connect to new governance and leadership structure(s) established within the State Innovation Model.
- 5) Costs have been forecasted to err higher than lower.
- 6) Costs are estimated for a one-year planning period with unspecified start/end date.

Personnel/Fringe:

Consortium Director

\$175,000

A full-time family medicine physician with experience in academic training programs will, at Consortium start-up, serve a dual role of providing leadership to the Consortium and the development of new programs. It is anticipated that two types of programs may develop under the tutelage of the Consortium:

- 1) New multi-stakeholder program(s) that utilize multiple members of the Consortium in functional roles; and
- 2) Consortium-incubated programs that emerge as specific new programs at Consortium member sites (e.g., a net new hospital-based residency program).

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In either of the above scenarios, Consortium physician leadership is required to oversee a coordinated approach to faculty development at statewide organizations that will be functionally involved in the operation of a Consortium program. The technical design/development of a new academic training program will meet ACGME/AOA requirements for accreditation of a new family medicine program. The ACGME accreditation process requires an identified program director for any proposed program application, and requires that program director to be an integral contributor at the required ACGME site visit. Further, the Program Director is to have decision-making latitude in the resident’s daily learning environment(s) (ACGME Section II.D.2.b.), which in this envisioned program will utilize multiple organization’s sites for learning/training (hence the need to have a centralized leader encouraging faculty development at multiple sites.) As the Consortium matures and the new program is implemented, it is envisioned that this position would split into two: 1) Consortium Director and 2) Program Director (for the Consortium’s program(s)).

Administrator **\$100,000**
 Seasoned professional who administratively leads the Consortium, develops and maintains key relationships across sectors and disciplines, complies with various program requirements, completes fundraising and marketing, and manages Consortium business operations. Fulfills ACGME’s “Designated Institutional Officer” requirement-(ACGME Section II.F.).

Administrative Assistant/Educational Coordinator **\$45,000**
 Staff to support the development of the new program, complete follow-up on details associated with statewide faculty development activities, provide administrative support for accreditation application development, and to complete general administrative duties of document preparation, meeting support, communications, and logistics. As the Consortium matures, these duties are anticipated to split over two employees.

Fringe **\$96,000**
 30% of salaries

Supplies:

Meeting Costs **\$1,000**
 Bi-monthly face-to-face and frequent teleconferences of the Consortium

Travel **\$20,000**
 Local mileage (for Consortium Director and Administrator) to statewide meetings and program sites for faculty development activities and program development planning.
 Out-of-state travel to promote the program.

Educational Outreach/Marketing **\$25,000**
 Development of promotional materials, exhibit materials, website, fees to participate in trade shows and recruitment fairs. Costs associated with a public relations approach to program promotion to stakeholder organizations (medical schools) and medical students.

Professional Services:

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Legal Fees

\$7,500

Consultation services for final business model; LLC or 501c3

Faculty Physician Fees

\$450,000

Three faculty physicians are required to meet ACGME requirements for a Faculty to Resident ratio of 1:6 (ACGME Section II.B.2) (assuming an 18 slot program which was discussed at the June 2013 meeting). Also, review of the ACGME requirements indicates that there must be a faculty physician with admitting privileges at the hospital at which patients served by residents in the new program are admitted. Given our priority to engage all three downstate hospitals, it is presumed that **at minimum** one (1) faculty physician with admitting privileges to each southern Delaware community hospital system will be required for the continued planning of a new program. These costs are factored under “Professional Services” as contract fees in contrast to “Personnel/Fringe,” assuming that individuals may be readily available from hospital systems to provide an incremental level of FTE, and that this remuneration offsets some of the hospitals’ losses in time/expense in the planning process. \$75,000 is arbitrarily approximated for faculty at each of the three southern Delaware hospital organizations that do not currently operate Graduate Medical Education training programs. **Additionally**, \$75,000 per site is budgeted for each of three community health center organizations whose organizations will be critical to the discharge of a new Consortium designed program, and who may not at this writing employ clinical leadership specific to overseeing a teaching environment. The \$75,000 is a budgetary placeholder that recognizes that organizations involved in the planning and implementation of a new Consortium-designed program will have direct and indirect costs as they shift their respective environments to training/teaching sites, and as they actively coordinate with the Consortium Director and faculty development activities discussed above. (Six @ \$75,000). (It should be noted that the faculty preceptors at Consortium-developed program sites will represent an ongoing operational program cost separate from the spirit of intent of this cost item.)

Other:

Corporate/Non-Profit Filing Fees

\$1,000

Administrative filing fees

Overhead

\$138,075

15% of direct costs (\$920,500) are estimated to cover overhead costs of space, utility, and miscellaneous support .

TOTAL

\$1,058,575

Notes About Estimated Start Up Costs and Sustainability:

The Consortium Start-Up costs are, at this writing, associated directly with only the roll-out of the first building block of medical education activities. Over time, the Consortium infrastructure is anticipated to provide leadership to additional yet undetermined health profession modules, thus spreading its overhead across multiple focused cost centers.

The Consortium will complete fund development and provide fiduciary responsibility for programs created under its auspices. Funds from grants, the private sector, and State and

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federal sources are expected to be required to support the totality of this infrastructure. As indicated earlier, several federal Department of Health and Human Services grant programs initially suggest opportunity as related but diversified funding streams (e.g., the Teaching Health Center Graduate Medical Education Program, and the Area Health Education Center Program).

It should be noted that the Consortium represents a centralized mechanism for workforce analysis, strategy development, program implementation, and policy support. This structure may provide a centralized leadership infrastructure and cost savings for other health education mission-related commissions, boards, and entities.

Next Steps

- ✚ Coordinate with DHCC officials to incorporate indicated elements of this report into narrative progress reports and grant opportunities associated with the State Innovation Model, its test phase, and indicated timelines between now and Spring 2014.
- ✚ Continue to utilize the multi-stakeholder committee that came together for the planning process to implement the next phase of readiness activities. Identify an administrative process for sharing completion of program development tasks by milestone time periods. Explore proprietary project management tools such as “Smart Sheets.”
- ✚ Implement the use of small ad hoc committees as often as indicated. Re-establish the “pipeline priority.”
- ✚ Create a white paper document that can be used for the continued cultivation of executive level buy-in at key stakeholder organizations. The white paper will include a financial order of magnitude about the operational costs of any new residency program created.
- ✚ Create a Committee-approved timeline of critical milestones including, but not limited to, the following key topics:
 - Finalization of the governance/leadership mechanism and the type of formal entity (LLC or 501c3) best to facilitate long-range planning activities.
 - Finalization of a staff funding, recruitment, and orientation strategy.
 - Strategy Development for stakeholder and policymaker buy-in.
 - Technical review and creation of a sub-timeline for program development in concise conjunction with ACGME (and HRSA).

Appendix

Multi-Stakeholder Committee

○ DIMER

Sherman Townsend, Chairman
INSERT MAILING ADDRESS FOR DIMER

○ Medical Schools

Philadelphia College of Osteopathic Medicine

4170 City Avenue
Philadelphia, PA 19131

Kenneth J. Veit, D.O., MBA
SVP for Academic Affairs, Provost and Dean

Joseph M. Kaczmarczyk, DO, MPH
Assistant Dean of Clinical Education
Professor and Vice Chair, OB/GYN

David Kuo, D.O.
Assistant Dean of Graduate Medical Education, PCOM
Program Director, PCOM/Mercy Suburban Hospital Family Medicine Residency

Thomas Jefferson University Hospital

901 Walnut Street, 601E
Philadelphia, PA 19107

David L. Paskin, M.D.
Professor of Surgery
Vice Dean Graduate Medical Education and Affiliations, Jefferson Medical College
Designated Institutional Official

Janice P. Burke, PhD, OTR/L, FAOTA
Dean, Jefferson School of Health Professions
Chair & Professor, Department of Occupational Therapy

○ Residency Programs

(AI DuPont Hospital for Children, Christiana Care Health System and St Francis Hospital)

A. I. Dupont Hospital for Children

1600 Rockland Road, P.O. Box 269
Wilmington, DE 19899

Steven M. Selbst, MD
Vice-Chair for Education
Director, Pediatric Residency Program

David I. Rappaport, MD, FAAP
Assoc Program Director, Pediatric Residency

Review of Feasible Strategies: Expanding Primary Care Workforce in Underserved Delaware through Graduate Medical Education Programming. Spring-Summer 2013

December 2013

Delaware Health and Social Services, Division of Public Health

Christiana Care Health Services

Christiana Care Health System
4755 Ogletown-Stanton Road
Newark, DE 19718

Michael P. Rosenthal, MD
Chairman, Department of Family and Community Medicine

Lisa Maxwell, MD
Program Director, Family Practice Residency Program

Brian M. Aboff, MD, FACP
Director, Internal Medicine Residency Program

Matthew Burday, MD
Faculty, Internal Medicine Residency Program

Neil Jasani, MD, MBA, FACEP
Vice President, Academic Affairs, DIO

Saint Francis Hospital

P.O. Box 2500
Seventh and Clayton Streets
Wilmington, DE 19805

Brian McDonough, MD, FAAFP, CPE, Chairman
Department of Family Medicine, Saint Francis Hospital

Robert Monteleone, MD
Program Director
St. Francis Family Medicine Residency

o Downstate Hospitals

Bayhealth Medical Center

640 South State Street
Dover, DE 19901

Gary Siegelman, MD
Chief Medical Officer

Eric J. Gloss, DO, VPMA
Vice President, Medical Affairs

Joshua Hunter
Manager, Department of Physician Recruitment

Beebe Medical Center

424 Savannah Road
Lewes, DE 19958

Jeffrey E. Hawtof MD, FAAFP
VP of Medical Operations and Informatics

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Delaware Health and Social Services, Division of Public Health

Marilyn Hill
Director, Physician Services

Nanticoke Memorial Hospital

801 Middleford Road
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Thomas E. Brown
Chief Operations Officer

Joseph Kim, DO
President, Nanticoke Health Services Medical Staff

Delaware Healthcare Association

1280 South Governors Avenue
Dover, DE 19904-4802

Suzanne Raab-Long
Vice President

Lisa Shieffert
Director of Health Policy

○ **Federally Qualified Health Centers**

Henrietta Johnson Medical Center

601 New Castle Avenue
Wilmington, DE 19801

Rosa Rivera, CEO

Teshina Williams, MD
Chief Medical Officer

La Red Health Center

21444 Carmean Way
Georgetown, DE 19947

Brian Olson, CEO

Fabricio Alarcon, MD
Chief Medical Officer

Kay Malone
Chief Operations Officer

Westside Family Healthcare

1802 W 4th Street
Wilmington, DE 19805

Lolita Lopez, CEO

Sarah Noonan-Davis
Deputy Director

Tom Stephens, MD
Chief Medical Officer

Theresa Cheek
Legal Counsel and HR Director

○ **Delaware Health Care Commission**

Delaware Health Care Commission
Margaret O'Neill Building
410 Federal Street, Suite 7
Dover, De. 19901

Jill Rogers, Executive Director

Bettina Riveros, Chairperson

○ **Delaware Health and Social Services**

Gerard Galluci, MD, Medical Director

Delaware Division of Public Health

Karyl T. Rattay, MD, MS, Division Director
Awele N. Maduka-Ezeh, MD, MPH, Medical Director
Judith Chaconas, Section Chief, Office of Health Planning and Resources Management
Katherine Collison, Director, Primary Care Office and State Office of Rural Health

○ **Other Health Advocates including Colleges, Physicians, and Community**

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