Commentary: The Modesto Story: Back to the Future?
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Abstract

In this issue of Academic Medicine, Broderick and Nocella describe the creative use of an educational consortium model to bring community providers together to solve the fiscal crisis faced by the local family medicine residency program, which was sponsored by a single-program sponsoring (hospital) institution. The authors of this commentary explore the specific adaptation of the educational consortium model to the previously single-program-sponsor setting, provide current numbers of accredited residency programs sponsored by educational consortia and other institutions, and speculate on the consortium model’s potential to enhance community engagement and support for graduate medical education (GME) in the various settings in which GME is conducted in the United States.

Editor’s Note: This is a commentary on Broderick PW, Nocella K. Developing a community-based graduate medical education consortium for residency sponsorship: One community’s experience. Acad Med. 2012;87:1096–1100.

For the purposes of residency program accreditation in the United States, the Accreditation Council for Graduate Medical Education (ACGME) defines the term consortium as “an association of two or more organizations, hospitals, or institutions that have come together to pursue common objectives,”1 including graduate medical education (GME). This relatively broad definition is intentionally permissive in order to facilitate creative solutions to local GME sponsorship challenges. Although educational consortia were the topic of considerable discussion in the 1990s, little has been written about them since the 1996 national study by Cox and Dower2 and the 1997 report by the Council on Graduate Medical Education.3 In this issue of Academic Medicine, Broderick and Nocella4 describe a California community’s recent use of the consortium model to address the challenges the community faced when its ACGME-accredited family medicine residency program’s sponsoring institution was confronted with a significant fiscal crisis that called into question the survival of the sponsor and the program.

In similar circumstances, when sponsoring institutions have faced significant fiscal challenges or closure due to insolvency, residency programs have been closed, residents have been placed in other programs, and communities have lost programs’ faculty and future graduates. Indeed, this occurs with sufficient frequency for the ACGME to have in place policies and procedures5 that govern the actions of the failing sponsor, the receiving programs, and the ACGME. Thus, the actions of the participants in the situation in Modesto, California, are both important and laudatory and offer a broader series of lessons for the GME community in the United States.

The Modesto Story

As Broderick and Nocella4 relate, the precipitating crisis was a fiscal challenge specifically related to a residency sponsorship transfer in 1997 and the related GME funding decisions, which ultimately resulted in the loss of GME funding opportunities for the sponsor in 2008. In other words, the residency lost its Medicare funding, and it was ordered by the Centers for Medicare and Medicaid Services (CMS) to repay millions of dollars in past GME funding. As we noted above, on the basis of other programs’ experiences in similar situations, the typical progression of events would have resulted in the community losing its family medicine residency program.

A residency program fills several important roles in its community. It often serves as a source of civic pride and of physicians to rejuvenate the regional practitioner base. The program often provides its sponsor with an academic focus that stimulates clinical innovation and excellence as well as loyalty among practitioners in the region. Finally, it often serves as a significant infrastructure to support the provision of care for the local uninsured and underinsured populations. Indeed, in this case, before the program’s transfer to a community hospital in 1997, the Modesto family medicine residency program had originally been sponsored by the county hospital, where access to such care was provided.

Rather than accept the pending closure of the program as the final event, the community mobilized. The county, the community health centers, local hospitals, physician groups, and other interested parties began the difficult discussions that all potential educational consortia must have. Although not directly stated, the residency program director appears to have played a pivotal role in convening these discussions. Each potential consortium member provided seed funding for the exploration of legal, contractual, financial, and other elements required to create the consortium infrastructure. The organizers recognized and explored the potential for funding...
through a Health Resources and Services Administration (HRSA) Teaching Health Center grant for primary care by engaging the county’s health services agency and community health centers as consortium leaders. Their collective efforts were successful, and their new, community-based GME consortium was accredited by ACGME, funded by HRSA, and recognized for funding by CMS based on provisions contained in the Balanced Budget Act of 1997. Through a Health Resources and Services Administration (HRSA) Teaching Health Center grant for primary care by engaging the county’s health services agency and community health centers as consortium leaders. Their collective efforts were successful, and their new, community-based GME consortium was accredited by ACGME, funded by HRSA, and recognized for funding by CMS based on provisions contained in the Balanced Budget Act of 1997.7

Lessons From the Modesto Story

Aside from the laudable achievement of ensuring that family medicine residency training continued in the community, what other benefits resulted from this community’s efforts? We believe this collaboration will have benefits that extend far beyond the short-term funding of the program. Engaging the community in the problem-solving effort stimulated many within the community to rediscover the residency program’s value to the community. The community’s subsequent sponsorship of the new residency program validated the proposition that its GME program is a “public good” for this community.

From an educational perspective, compared with the previous program, the consortium-sponsored residency program appears to offer trainees many more educational opportunities, all of which were brought about through enhanced community involvement born of crisis. Engagement of the community health centers, more than one local hospital, and other ambulatory training sites provided opportunities to diversify training locations and to broaden the residents’ exposure to a breadth of socioeconomically and culturally diverse populations. The resultant clinical training experience has a much higher potential to realize the goals for diversification of educational settings and for resident competency outcomes set by the public and the profession over the past few years. Finally, it should be noted that no accreditation standards needed to be waived in order to create this salutary educational environment.

A Portent of the Future?

This exciting story serves as both an instructional example and as a harbinger of the future, especially for single-program sponsors. Recent proposals have called for reduction of Medicare GME reimbursement by 33% to 50% or more, so all teaching hospitals will be faced with significant financial pressures and difficult decisions regarding continuation of residency programs. According to a study that we at the ACGME conducted in August 2011, the response to this fiscal pressure will be to reduce or eliminate GME programs and positions. The most noticeable effects may perhaps be felt by single-program sponsors, which constitute nearly 38% of institutional sponsors, and by sponsors with fewer than 10 programs, which comprise an additional 34% (Table 1). Thus, 72% of sponsors of GME programs are institutions that sponsor fewer than 10 residency or fellowship programs. Although the residents and fellows enrolled in these programs represent a small percentage (16.4%) of the entire cohort in the United States, smaller sponsors are often located in rural or suburban areas, whereas large sponsors (10 or more programs) are often based in large, urban areas. The smaller programs are essential in providing practitioners to more-rural districts of the United States and in fulfilling the profession’s promise to provide practitioners to the entire population, not just to individuals living in urban areas proximate to our largest academic medical centers. The loss of these smaller programs would surely undermine the public’s perception of the profession’s contribution to their future health and the breadth of future political commitments to GME funding.

GME is the final phase of fulfillment of medicine’s commitment to educate the next generation of physicians as a part of the profession’s responsibility as a public trust.11–13 However, recognition of the intrinsic link between GME and the core principles of physician professionalism—which reflect this commitment to meet the public need—appears to have been lost in much of today’s political dialogue. This loss acts as a barrier as the profession

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<th>Programs per sponsor institution</th>
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* Data source: Accreditation Council for Graduate Medical Education Accreditation Data System.

† Data provided for all sponsors include data for the consortia subset.
seeks to sustain federal and other funding for GME. Such funding is often viewed as an (unnecessary) subsidy to teaching hospitals that serves the interests of the profession rather than as an essential element of society’s cooperation with the profession’s efforts to prepare the next generation of physicians who will serve the best interests of the public.

Physicians in training, many of whom are burdened with more than $180,000 in educational debt, cannot be expected to provide humanistic “service while learning” to the neediest populations for three to seven years beyond medical school without receiving adequate compensation to support themselves and their families. GME funding that is at least sufficient to support residents’ living expenses is an essential component of our ability as a profession to fulfill our collective promise to society.

A Happy Ending? The Future Is up to All of Us

The Modesto story, in which a community took charge of a residency program’s future, may provide us a chart for navigating the unpredictable seas we may encounter over the next few years. It demonstrates how creative and committed individuals can marshal community resources to solve the vexing problem of funding. When given the opportunity, communities may choose to engage in the challenge of creating locally sustainable models of GME rather than permitting loss of their residency programs. By no means are we suggesting that educational consortia are the solution for all residency programs in all settings—they are but one of the tools available to us to master this challenge. The Modesto example should compel us as educators to proactively get off the sidelines and into the community to stir and enhance support for the local GME effort. In short, we are called to leadership not only as residency program leaders but also as physicians committed to caring for a community. We are reminded that, as program directors and institutional sponsors, we are leaders of a community resource, not just an institutional or departmental resource. The experience in Modesto demonstrates that competing organizations can come together to form new relationships around the shared goal of producing the next generation of physicians. It also demonstrates that new sites of care and education can be created to meet the educational needs of residents as well as the clinical care needs of the population they serve. And, perhaps, it demonstrates how to educate community leaders and members that GME is, indeed, a social good that requires public support ... one community at a time.

Funding/Support: None.

Other disclosures: None.

Ethical approval: Not applicable.

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