Financial Implications of Curriculum (and other) Decisions

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Program Directors make decisions about their residency program. This function is key to the successful creation of a program that meets the educations goals and facilitates effective program management. However, Program Directors do not often consider the possible financial implications of the decisions they make for the program. Program directors and faculty will learn how curricular aspects of the residency program has financial implications for the institution, including the size of a program, the type rotations planned, the location of rotations, research and conferences times and the impact of away electives.

Learning Objectives

At the end of this presentation, the learner will:

- Identify curriculum decisions that have financial impact such as elective rotation, supervision models, faculty teaching time, conference attendance requirements.
- Understand how to value those decisions.

Your Program is Expensive

Running a program is expensive, it should be. Many expenses are fixed.

- Salary, benefits, liability insurance
- Accreditation fees, in-training exam
- Program coordinator
- Licenses, background checks, lab coats, scrubs
- Faculty teaching time

When your institutions decide to sponsor your program…they agree to these expenses. These fees are often common across all programs.

Expenses generally that relate to your curriculum generally fall into one of three categories:

- Meets an explicit accreditation requirement: "Residents must spend one month on…"
- Meets an explicit but not defined requirement: "Residents must be trained in…"
- Usual and customary: "all programs do this"

And then:

"Makes my program unique"
"I need this to recruit"
"We've always done it this way"

When making budget decisions, leaning on accreditation requirements can help justify the expense. An accreditation requirement "must", will always

be paid for while "Makes my program unique" might not be as easy to justify.

Block Schedule Issues

Remember that CMS provides funding to your hospital to pay for *their fair share of the training when you residents treat their beneficiaries* (Medicare patients). Rotations where your residents are not treating these beneficiaries are at risk for non-reimbursement.

At risk rotations and activities "in the house"

- Administrative months
- Research experiences: longitudinal versus discrete assignments
- QA/QI/PS months
- Conference locations
- Simulation training

At risk "out" rotations

Out rotations that are served in a hospital generally CANNOT be claimed by your hospital even when you still pay the residents. Out rotations to a physician's office as an example, can be claimed on the Medicare Cost Reports because you are responsible for *substantially all* the resident's expenses.

You can create financial opportunities when residents rotate to another hospital.

- Receiving hospital returns GME money
- Receiving hospital does not return GME money
- Receiving hospital demands money

Justifying "out rotations" requires an understanding of the curriculum imperative:

- Required to meet accreditation standard
  - Your hospital is reimbursed by participating institution
  - No money exchanged
  - Your hospital pays participating institution
- Required to meet curriculum need
  - Your hospital is reimbursed by participating institution
  - No money exchanged
  - Your hospital pays participating institution
- Electives
  - No one is going to pay you for those

What kind of money are we talking about here? How many FTEs per year does your program need to support out rotations?

12 residents/class, 1 away assignment/month for each of 3 years for "non-required" rotations

- 36 months annually = 3 FTE = ~ $300,000 in DME cannot be claimed but expense is incurred
- Over cap? Matters less… At cap? Matters more...
- Assuming one of the rotations is with a private practice faculty who would like to be paid FMV for lost productivity and non-clinical activities related to the resident (such as orientation, evaluation, discussion) ~ $100,000
- 36 months of lost "service" requires 3.5 FTE of replacement staff ~ $300,000

Supervision Models

Direct $$$ > indirect $$ > oversight $

Are your residents working in a "levered" model?

- Do the residents enhance faculty productivity?
- Do the residents erode faculty productivity?
- Do you even know?
- What does your operational scheme look like? Supervision is embedded in your operations.

What is your program's "contribution"? The contribution margin is the amount of money a hospital has to cover its fixed costs after it pays all of its variable expenses. It is also the amount, after covering fixed costs, that contributes to the net operating profit or net operating loss of the hospital.

Some faculty function better with residents? Better off alone? Can you measure your faculty's RVU productivity when they are working in varied models with and without residents?

Resident Assignments

- Poorly skilled junior trainees in high volume areas? Highly skilled residents in high volume areas?
- Senior residents "learning" to supervise? Is this a productive use of their skills and competency?
- Junior residents assigned to decision making bottlenecks?
  Deciding who is admitted?
  Deciding who is discharged?

Duty Hours

How do you determine the resident's clinical schedule?

Duty hour rules?
Patient encounter target? Like 10,000 golf balls?
Something in the name of "wellness"?

What "usual and customary" is?

It is very probable that the PD has control over the resident's schedule. While there are many factors that go into the schedule, from a workforce perspective…how many hours the residents work has a financial impact.

What if....the residents proposed and you agreed to reduce the duty hours by 4 hours/week?

12 residents per class, 3 classes
36 x 4 = 144 hours per week
144 hours per week x 48 weeks =6912 hours/year
If the average resident worked 1728 hours/year

The hours reduction costs 4.0 FTE...and how much does that cost? And conversly, how much could be gained by increasing the resident's hours? Could you eliminate the salary of 4 Advanced Practice Providers?

Other Discretionary Program Expenses

Number of core faculty…in addition to making your scholarly activity "denominator" larger, you may also be spending more money on teaching dollars

Faculty conference attendance: how many do you need?

If you had 200 hours of conference a year and each faculty attend 20 percent of all conference (40 annual hours) and you had 10 core faculty…
400 hours of teaching time to be paid for
400 hours of lost clinical productivity

True for any non-clinical faculty activity: PEC, CCC, recruiting

Decisions Related to Individual Residents

Residents on extended training

Extend a resident by 6 months….that's a $50K decision

Residents on H1B visas

Mandated governmental fees, attorney fees, expedited processing, visa renewals, # of LCA sites

Residents past their Initial Residency Period (IRP)

Set when resident begins training, does not change
DME reimbursed at only 50% if the resident exceeds IRP (all capped at 5 years), IME reimbursed at 100%, exceptions for geriatrics, pediatric neurology, preventative medicine

How many residents do I "need"? Do you have the right provider workforce configuration?

Summary

1. It is expensive to run a residency program
2. Many expenses are fixed and SHOULD be standard across the GME enterprise
3. Program Directors have a lot of program design decisions to make and many of these have financial implications. Review your programs and create opportunities for a better financial performance

Curriculum opportunities	**Changes Needed**
Determine if costly rotations: Required > Needed > Usual > Unique	
Maximize CMS funding: • Match residents with no prior training • Move rotations to hospital with higher PRA • Move rotations to higher % Medicare pts • Move rotations to hospital with DSH	
Consideration of rotations: • Administrative months • Research months – longitudinal? • QA/QI/PS months	
Out of hospital rotations: • How many out rotations do you have? • Receiving hospital returns GME $$ • Receiving hospital does not return GME $$ • Receiving hospital demands money • Away elective	
Supervision models • Rotation increase faculty productivity? • Junior resident bottleneck decision points?	

Faculty decisions • How many core faculty do you need/pay? • How many faculty at resident conference? • How many needed on each committee?	
Right size programs • Workforce needs • Cost of others to replace them • Opportunities to centralize administration	
Increase revenue • Charge medical schools for clerkships • Private industry • Third party foreign support • Rural hospitals support • VA GME slots • Seek redistributed cap slots • Grow new positions in virgin hospitals	