University of Wyoming
Family Practice Residency Study

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Wyoming Department of Health
Commit to your health.
Footnote 2 to Section 167 of SEA 19 (2016 Budget Bill) required the Department of Health to conduct “...a comprehensive review of the state medical residency programs including the services provided; past, present and future revenue streams; alternative service delivery options; and alternative organizational structures...”
Legislative Requirements

- Not a new topic. Studies have been conducted throughout the history of the residencies:
  - 1960-64: WICHE studies
  - 1972: Wyoming Medical Society study
  - 1974: Dr. Joseph Report (foundational)
  - 1983: UW report
  - 1985: Legislative report
  - 1988: Internal UW report
  - 2005: Legislative report
  - 2009: UW report
Study Scope

This study focuses on the big picture:

(1) What is the **core purpose** of the residency programs? Is this purpose still valid?

(2) **How** are the programs meeting this purpose?

(3) What **alternatives** does the State have in achieving the same outcomes?
Study Scope

Part I: Background

◆ The medical education pipeline
◆ Graduate medical education and funding
◆ The core purpose of the UW Family Practice Residencies

Part II: Operations review

◆ Services delivered
◆ Inputs / Outputs
◆ Efficiencies and outcomes

Part III: Alternatives

◆ Considerations
◆ Options
Medical education overview

- ~52,000 US medical school applicants
- ~20,000 US medical school admissions
- ~18,000 US medical school graduates
- ~17,000 international and other graduates
- ~28,000 residency slots
- ~25,000 newly licensed physicians

Freshman, Sophomore, Junior, Senior, M1, M2, M3, M4, PGY1, PGY2, PGY3, Fellowship

"the Match"
Physician supply, 1950 - 2010

M.D.s per 100,000 people

Year


Non-federal MD supply (United States)

"physician shortage"

"physician surplus"
Residency History

UW Family Medicine Residencies established at peak of “physician shortage” crisis.

◆ Frustration with previous efforts towards medical education in 1950s-1960s (e.g. WICHE)

◆ Options ranging from est. comprehensive system to contracting out.

◆ “Hybrid” model recommended by Medical Education Planning committee in Joseph Report.
  ● Full spectrum of education in-State, integrated with community providers.
  ● Contract out necessary rotations at medical centers.
Residency History


- Appropriation in Governor’s office due to UW faculty resistance.
- Larger medical education system voted down in 1978, but pieces of the vision (e.g. Creighton contracts, WWAMI) gradually implemented later.

- Unclear why residency program was not established in hospital to begin with.
Core Purpose

➔ Increase the number of family medicine physicians in Wyoming

➔ Improve distribution across counties

➔ Provide indigent care to uninsured
## Costs and Revenue

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<th>Casper</th>
<th>Cheyenne</th>
<th>Total</th>
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<tbody>
<tr>
<td>Revenue</td>
<td>$3,581,079.30</td>
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<td>$5,435,840.48</td>
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<td>100-series</td>
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<td>SGF Subsidy</td>
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<tr>
<td>SGF Subsidy (%)</td>
<td>56%</td>
<td>73%</td>
<td>64%</td>
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</table>
Efficiencies

More efficient at training doctors
  ○ Average cost per graduate - $407K
  ○ National average est. $420K - $540K
  ○ Quality of program improving, but is below average.

Less efficient at providing primary care
  ○ Marginal cost per FQHC visit - $142
  ○ National/State average - $105
Outcomes

Retention is poor

- Est. 23% of future “doctor-years” in Wyoming.
- 1970 - 2006 in-State retention of 27% is third-lowest in nation (MT - 54%, UT - 53%, ID - 51%, CO - 51%)
- Cost per physician retained in-State: $1.77M (65% of which is SGF)
- Over 30 years, this investment represents annual SGF cost of $51-71K per graduate.
Retention

Note that retention is higher for Casper.
Outcomes

UW residencies have contributed up to 40% of total family medicine physicians in Wyoming.
Disparities in physician supply across counties have grown
Alternatives

Is the **core purpose** of the residency programs still valid?
Alternatives

Is the **core purpose** of the residency still valid? Should the State continue to pay for **increasing the number** and **improving the distribution** of health care providers in Wyoming?

**N**

Should the State continue to pay for **increased access to primary care services**?

**N**

- **Option H**: Revert SGF

**Y**

- **Option G**: Indigent primary care program

**Y**

- **Option F**: Recruitment / loan repayment contracts

**Y**

Is there value to specifically "building" doctors (i.e., through a residency) vs. "buying" other providers?

**N**
Alternatives

Is a **Wyoming hospital** willing to administer the residency programs?

- **N**
  - Are other non-State entities interested in operating the residency program?
    - **N**
    - Should the State **scale back** the residency programs?
      - **N**
      - **Y**
        - **Option C**: Close Cheyenne, consolidate Casper
    - **Y**
      - **Option D**: Other entity administration
  - **Y**
    - **Option E**: Hospital administration of residency

- **Y**
  - **Option F**
Alternatives

Should the State **expand** the residency programs?

- **Y**: Option B: Residency expansion potential
- **N**: Option A: Look for operational efficiencies
Questions?

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