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FOR
HEALTH AFFAIRS COMMITTEE

Committee Meeting: 2/13/2013

Board Meeting: 2/14/2013
Austin, Texas

Robert L. Stillwell, Chairman
James D. Dannenbaum, Vice Chairman
Paul L. Foster
Printice L. Gary
Wallace L. Hall, Jr.

	Committee Meeting	Board Meeting	Page
7. **U. T. System: Update on academic developments for the South Texas Medical School**	*3:01 p.m.* **Report/Discussion** *Dr. Shine* *Dean Francisco González-Scarano, M.D., U. T. Health Science Center - San Antonio*	Not on Agenda	**325**
8. **U. T. System: Quarterly report on health matters of interest to the U. T. System, including recognition of the group contracting activities of the U. T. System Supply Chain Alliance**	*3:16 p.m.* **Report/Discussion** *Dr. Shine*	Not on Agenda	**326**
Adjourn	*3:30 p.m.*		

1. U. T. System Board of Regents: Discussion and appropriate action regarding Consent Agenda items, if any, referred for Committee consideration

(The proposed Consent Agenda is at the back of the book.)

2. U. T. System: Approval to amend The University of Texas System Professional Medical Liability Benefit Plan

RECOMMENDATION

The Chancellor concurs in the recommendation of The University of Texas System Professional Medical Liability Benefit Plan (Plan) Management Committee, chaired by the Vice Chancellor and General Counsel and comprised of the Committee Chair, the Executive Vice Chancellor for Health Affairs, and the Executive Vice Chancellor for Business Affairs, that the Plan be amended to provide discretionary authority to the Plan Administrator (Committee Chair) to exceed the current $25,000 limitation on legal fees and expenses for physician and dentist disciplinary matters, up to $35,000 when warranted.

BACKGROUND INFORMATION

Authority for the establishment of a self-insurance program to indemnify U. T. System physicians was granted to the Board of Regents by Senate Bill 391, Acts of the 65th Legislature, effective March 10, 1977 (later codified as *Texas Education Code* Section 59.01 et seq.). The self-insured Plan for professional medical liability was originally approved by the Board of Regents on April 15, 1977. Since the Plan was first approved, it has been amended periodically as needed.

In Fall 2003, a Task Force of physicians and attorneys was appointed and met to discuss tort reform measures that had recently been adopted by the legislature and the impact of these changes on U. T. System physicians and institutions. In anticipation of the effects of the new law, the Task Force overwhelmingly recommended expanding medical liability coverage to also provide legal representation before the Texas State Board of Medical Examiners (now the Texas Medical Board) and the Texas State Board of Dental Examiners. On August 12, 2004, the Board of Regents adopted a Plan amendment to provide coverage for legal representation and expenses in disciplinary, licensing, or similar administrative proceedings up to $25,000 per proceeding and $100,000 per enrollment year, unless other Plan exclusions apply. Fines, penalties, or costs assessed as a result of the proceedings are explicitly excluded from coverage.

Since 2004, the Plan has provided coverage to approximately 427 U. T. System physicians and dentists for defense in disciplinary matters before their respective licensing board based on care rendered in the course and scope of their U. T. employment. The majority of these disciplinary matters resulted favorably for the physician or dentist. Despite efforts to restrain legal fees, cases have arisen recently where the $25,000 per proceeding limitation has been inadequate to cover the informal disciplinary hearing before the licensing board due to the complexity of the case and the legal defense. The proposed Plan amendment, set forth below, would provide the Plan Administrator with discretionary authority to exceed the current $25,000 coverage limitation up to $35,000 when warranted.

THE UNIVERSITY OF TEXAS SYSTEM PROFESSIONAL MEDICAL LIABILITY BENEFIT PLAN

ARTICLE V
COVERAGE OF PARTICIPANTS

Section 3 -- Supplementary Payments

The System will pay from the Fund, in addition to the applicable limit of liability:

...

D. Costs and expenses incurred in connection with the investigation and defense of a disciplinary and licensing action brought against the Participant; however, the Plan will not pay more than $25,000 in costs and expenses on behalf of a Participant for any single proceeding, unless in the discretion of the Plan Administrator or a designee there is a determination of necessity to exceed such limitation on costs and expenses up to $35,000. Furthermore, the Plan will not pay more than $100,000 for costs and expenses on behalf of a Participant for all such proceedings during an annual enrollment period.

3. U. T. Health Science Center - San Antonio: Report on nursing workforce issues, shortages, needs, future education, and pathways

REPORT

Eileen T. Breslin, Ph.D., RN, FAAN, Patty L. Hawken Nursing Endowed Professor and Dean of the School of Nursing at U. T. Health Science Center - San Antonio, will report on nursing workforce issues, shortages, needs, future education, and pathways. A PowerPoint is set forth on the following pages.

Nursing Workforce Issues, Shortages, Needs, Future Education, and Pathways

Dr. Eileen T. Breslin
Dean and Professor, U. T. Health Science Center - San Antonio School of Nursing

U. T. System Board of Regents' Meeting
Health Affairs Committee
February 2013

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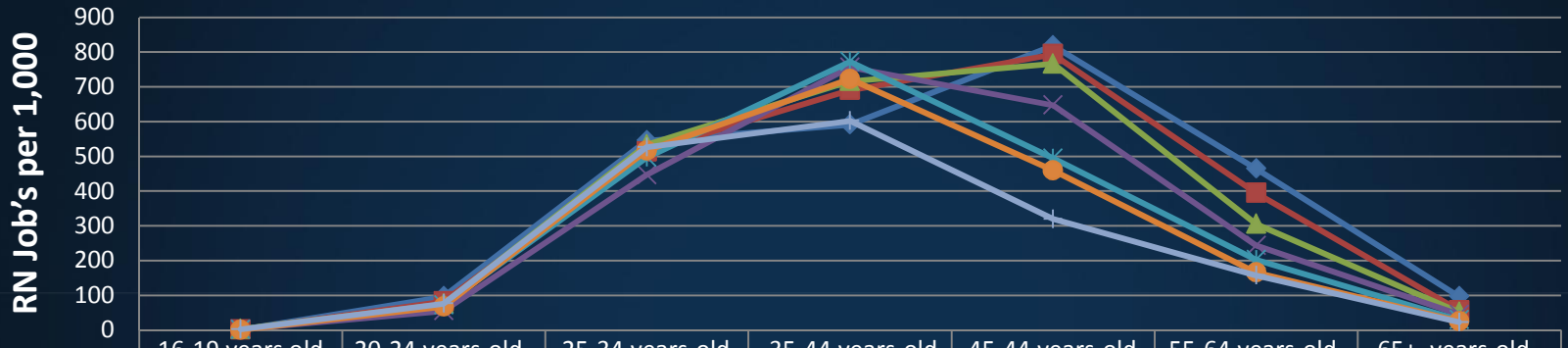
Nursing Workforce Issues

- BLS Projections 2010-2020
  - Registered Nurse (RN) workforce is the top occupation in terms of growth through 2020.
  - Increase in average age of RN's until 2016

- http://www.bls.gov/news.release/ecopro.t06.htm

Workforce Issues



	16-19 years old	20-24 years-old	25-34 years-old	35-44 years-old	45-44 years-old	55-64 years-old	65+ years-old
2009	1	96	545	591	818	464	96
2006	1	82	513	690	793	394	56
2003	3	75	533	716	766	305	51
2000	2	55	446	756	647	243	44
1997	1	72	496	772	494	202	29
1994	0	67	516	722	459	165	25
1991	2	76	526	602	319	157	22

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Workforce Issues (cont.)

- RN shortage in the U.S. is projected to be between 712 thousand to 1.2 million by 2020

- Juraschek, SP, Zhang, X, Ranganathan,V, Lin, V (2012) United States Registered Nurse Workforce Report Card and Shortage Forecast
- http://www.bls.gov/news.release/ecopro.t06.htm

Average Age of Texas Nurses - 2011

- **Registered Nurses (RNs) -** 46
- **Nurse Practitioners (NPs)** - 48
- **Licensed Vocational Nurses (LVNs)** - 44

Nursing Workforce Status Report

U.S.

Over 3 million licensed Registered Nurses live in the U.S.; an estimated 2.6 million-plus are employed

59% of RN jobs are in hospitals and they comprise the largest single component of hospital staff

23% growth projected in RN employment between 2006 to 2016

Texas Nurses Association (Texas Affiliate of ANA)

Texas

Over 178,612 Registered Nurses in health care settings, making the RN profession the largest health care occupation in the state

Approximately 63% of Texas RNs are employed in hospital inpatient and outpatient departments

Median Texas hospital vacancy rate for RN positions in 2008 increased to 11.1% in metro and non-border regions; 23.8% in rural-border regions

Shortages

- RN shortage to be most intense in the Southern and the Western parts of the U.S.
- Baby boomers comprise 40% of the RN workforce
- 50% of the RNs are within 20 years of retirement

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Shortages (cont.)

- Letter grades were assigned to each state based on projected RN job shortage ratios. Texas was graded as:
  - C- for 2009
  - F for the 2030 (projection)

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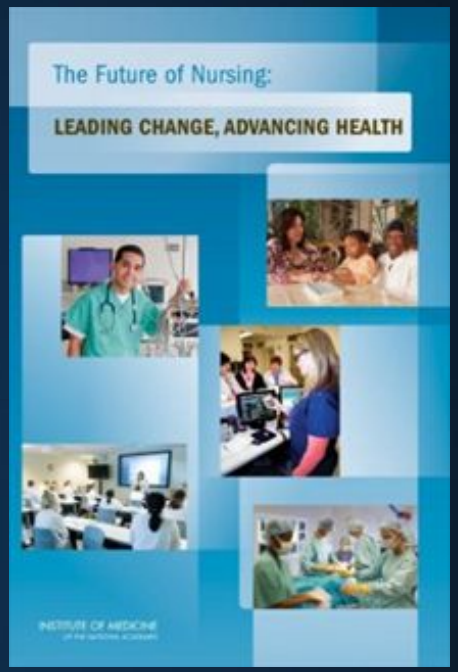
Needs

- 16M individuals projected to gain health insurance coverage by 2016
- Many states are considering options to increase the number and role of primary care providers

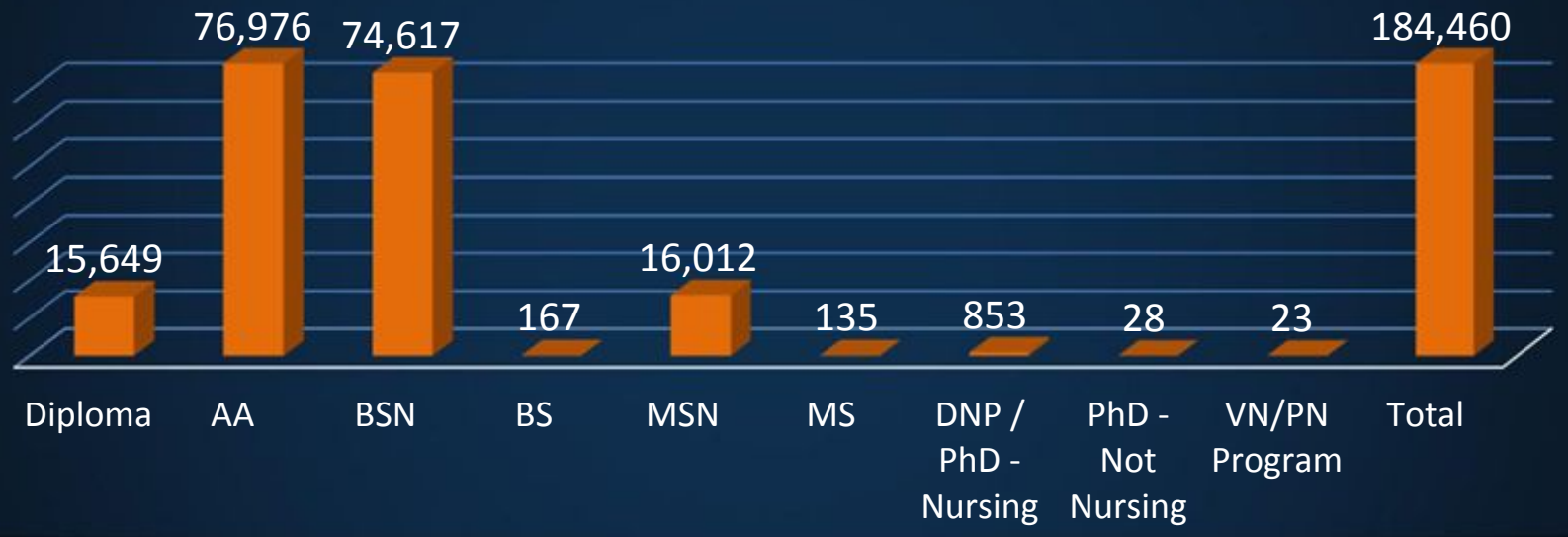
Needs (cont.)

- Chronic conditions
- An aging population
- A more diverse population
- Health disparities
- Limited English proficiency



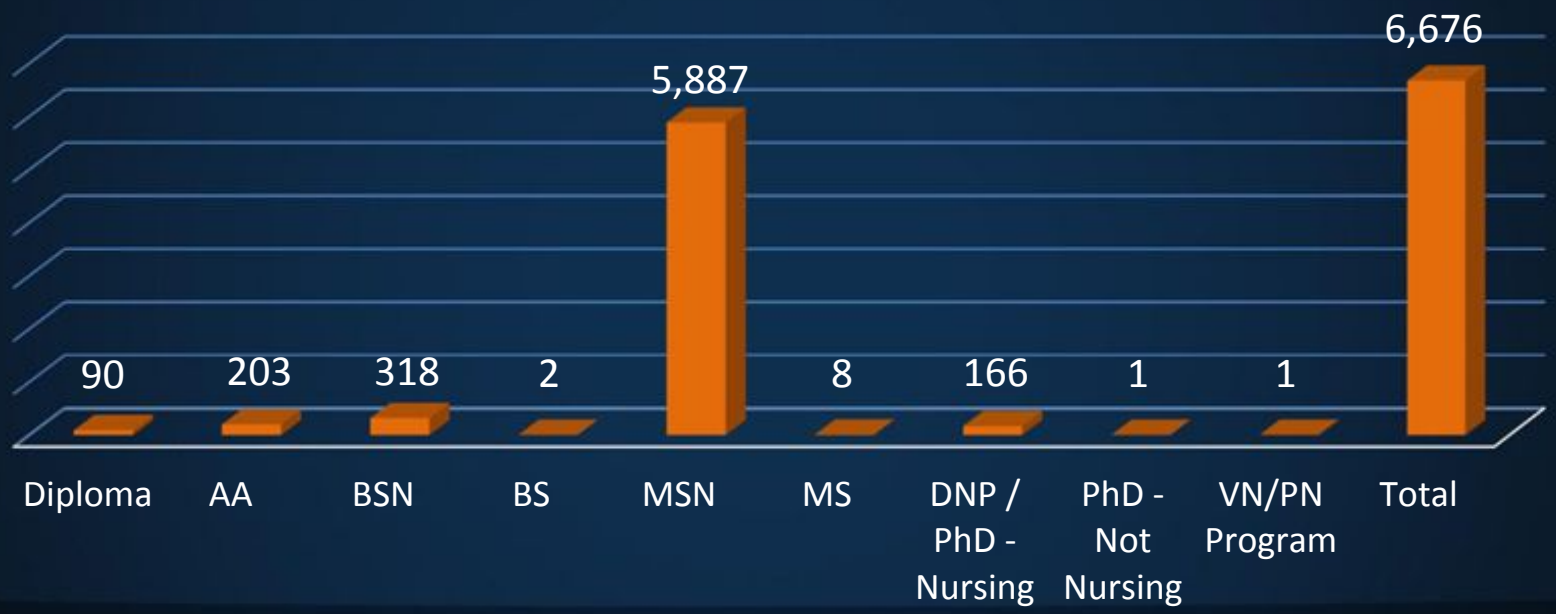
Texas Workforce Education Data

RNs - Highest Degree, 2011



Texas Workforce Education Data (cont.)

NPs - Highest Degree, 2011

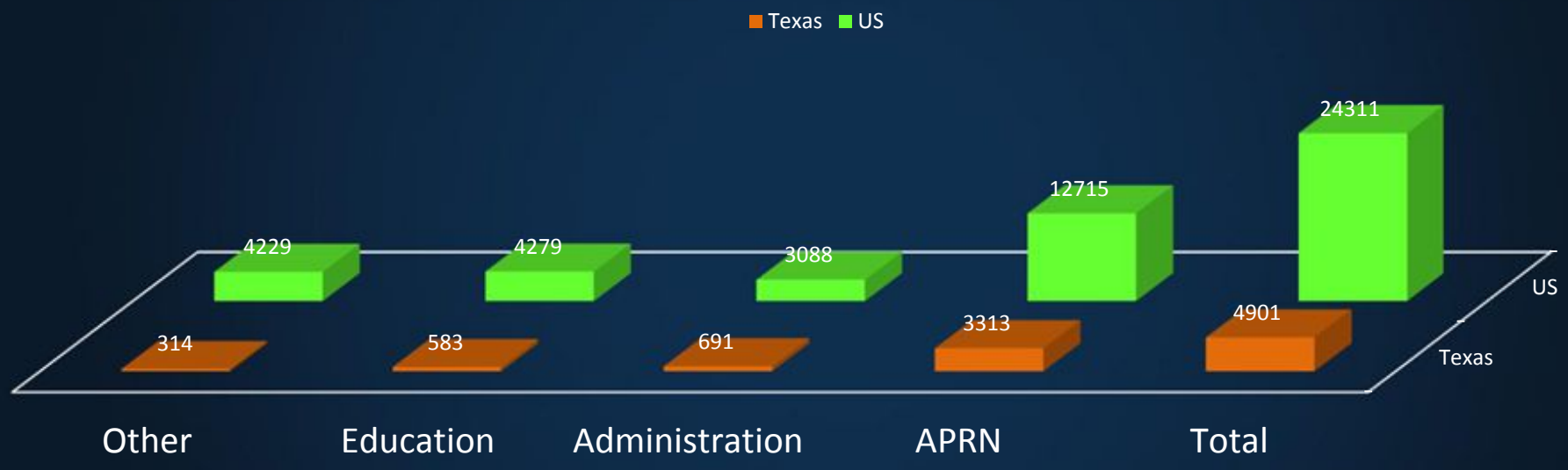


Core Essentials for Nursing Education

1. Liberal education/science
2. Organizational & systems leadership
3. Leadership for quality care & patient safety
4. Scholarship for evidence based practice
5. Information management for patient care technology
6. Health care policy & advocacy
7. Communication & collaboration for improving patient outcomes
8. Clinical prevention & population health
9. Professionalism & professional values

Master's Degree Enrollment

American Association of Colleges of Nursing
ADVANCING HIGHER EDUCATION IN NURSING



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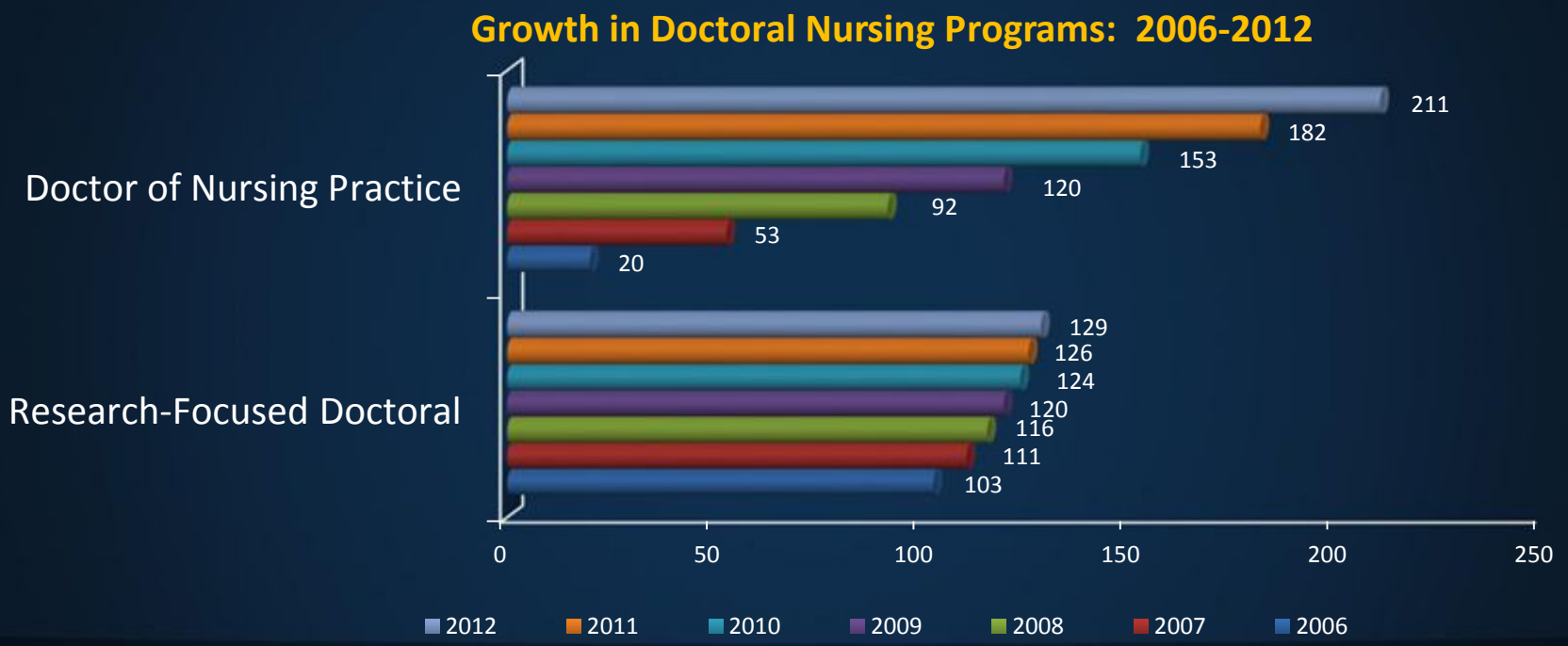
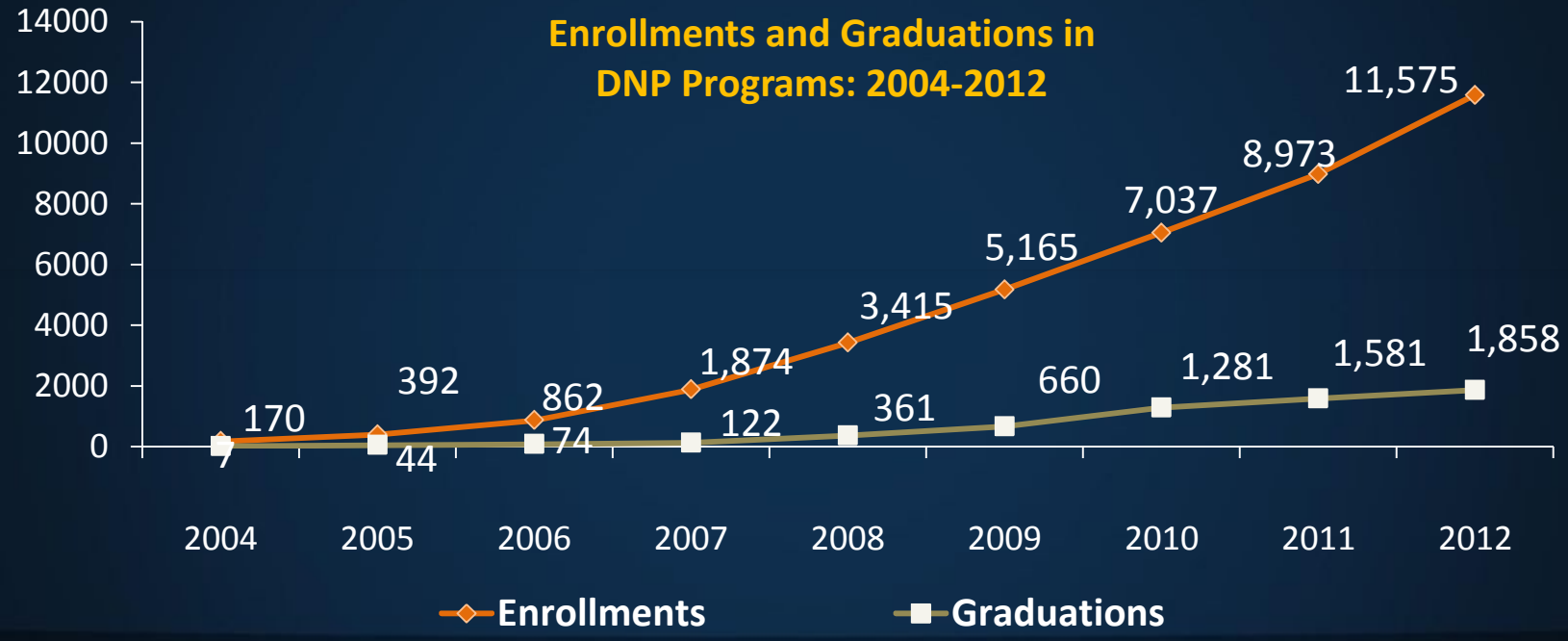
Education Trends

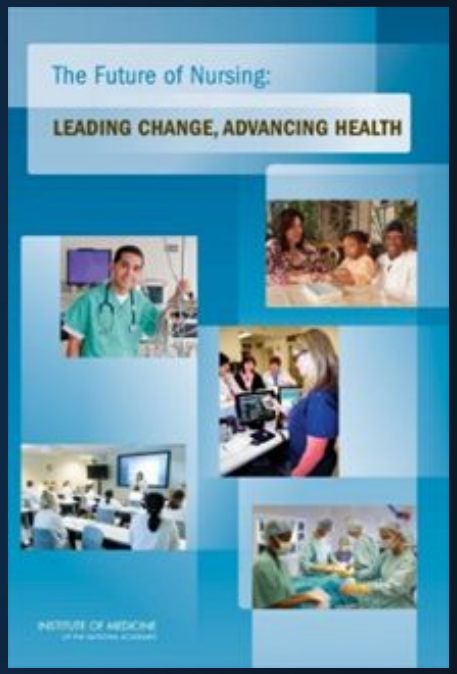


Education Trends (cont.)



Institute of Medicine (IOM) recommendations

1. Practice to the full extent of education and training
2. Achieve higher levels of education and training through an improved system that promotes seamless academic nursing progress
3. Full partnership, with physicians and other health professionals, in redesigning health care in the United States
4. Improved information infrastructure for better data collection



Actions & Response to IOM Report

- The National Governors Association has called for an expanded scope of practice for NPs as a solution to meeting the nation's primary care needs.

4. U. T. System: Progress report and request for approval of $4 million in additional funding from the Available University Fund for the Transformation in Medical Education (TIME) initiative

RECOMMENDATION

The Chancellor concurs in the recommendation of the Executive Vice Chancellor for Health Affairs, the Executive Vice Chancellor for Academic Affairs, and the Executive Vice Chancellor for Business Affairs that the U. T. System Board of Regents approve additional funding of $4 million from the Available University Fund for the Transformation in Medical Education (TIME) initiative.

Executive Vice Chancellor Shine, Executive Vice Chancellor Reyes, and Vice Dean for Academic Affairs Steven A. Lieberman, M.D., at U. T. Medical Branch - Galveston, will give a progress report on the TIME initiative. A PowerPoint presentation, progress report, and partnership summaries may be found on Pages 305 - 315.

BACKGROUND INFORMATION

Funding of $4 million for the TIME initiative over three years was approved by the U. T. System Board of Regents on August 12, 2010. To proceed with full implementation of pilot programs at the general academic institutions and to continue development of the medical school phase of these programs, additional funding of $4 million over three years is requested.

Approximately $1 million would be used for support of initiative-wide efforts, including development of competency assessments and consultation with national and international experts. The $3 million would be awarded following a call for proposals from any partnership of U. T. System institutions that includes at least one general academic and at least one health institution. It is anticipated that all four of the currently funded partnerships (see Page 315) will submit proposals. Submissions from new or modified partnerships will also be accepted. Explicit in the call for proposals will be the expectation that Regents' funding be augmented by local institutional funds.

Funds will be awarded based on demonstrated commitment to developing truly transformative approaches to predoctoral physician education, with emphasis on the following aspects:

- Incorporation of TIME priorities into program design, including
    - The four elements of the TIME model
      A pre-health professions program
      Competency-based education
      Professional identity formation
      Nontraditional topics (both medical and nonmedical)
    - Relevance to 21st century medical practice
    - Innovativeness

  - Reducing time to degrees
  - Reducing student debt

- Commitment of institutional resources (e.g., tuition revenue, formula funding, other) to supplement Board of Regents' funding

Proposals will be evaluated and funds will be awarded by a reconstituted 11-member Steering Committee that will include Dr. Reyes and Dr. Lieberman (Co-Chairs), Dr. Kevin Lemoine (U. T. System Academic Affairs), Ms. Susan Franzen (U. T. System Leadership Institute), Dr. J. Scott Wright (Texas Medical & Dental Schools Application Service), three representatives of the academic institutions, and three representatives of the health institutions (the latter six are yet to be named).

External funding will also be pursued through a newly-announced American Medical Association initiative as well as through private foundations.

Transformation in Medical Education (TIME)

Steven A. Lieberman, M.D.
Vice Dean for Academic Affairs
U. T. Medical Branch - Galveston School of Medicine

U. T. System Board of Regents' Meeting
Health Affairs Committee
February 2013

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TIME Initiative: Mission and Strategies

- *Mission*: The U. T. System TIME initiative is a student-centered, clinically-focused program designed to increase the effectiveness of medical education while shortening its duration.
- *Strategy #1 (short-term)*: Participating U. T. System academic and health campuses will partner to develop, implement, and assess pilot programs of innovative and integrated medical education with the goal of generalizability and scalability across the U. T. System and beyond.
- *Strategy #2 (mid-term)*: Participating campuses will work collaboratively to assess outcomes and identify best practices across the pilot programs to create a shared model for medical education to be expanded within schools, across partnerships, and outside the U. T. System.

Competency-based Medical Education (CBME) in the TIME Initiative

Competency domains	Traditional	TIME [General Academic Institutions (GAI) phase]
Targeted Sciences	Chemistry, Biology, Physics	Human biology (including foundations of biomedical sciences)
Clinical skills	—	Medical history & physical exam
Evidence-based medicine	—	Basics of searching & analysis of research
Health care system	—	Basic concepts of delivery and financing
Ethics	—	Basic principles
Professional maturation	"Osmosis"	Intentional professional identity formation

Competency-based Medical Education (CBME) in the TIME Initiative (cont.)

- Transition milestones-generalizability
- Graduation milestones-collaborating in national milestone project [Association of American Medical Colleges (AAMC)]
- Assessing competence-collaborating with national CBME assessment effort (Georgia Regents' University + AAMC)
- Measuring (CBME)-beginning to explore approaches with the Texas Higher Education Coordinating Board

Professional Identity Formation in Medicine

- Task force work completed - 95 page report
- Thorough elaboration of concepts
- Identification of approaches to development and assessment
- Developing a Web-based resource for broad utility

Pre-Health Professions Programs (PHPP) & Nontraditional Topics

- Partnership & campus-specific approaches/solutions
  - Each campus has unique values, culture, mission
  - PHPP: Different health care profession students on each campus
  - Nontraditional topics: Some will incorporate health care into core requirements

Admissions & Timeline

- Two partnerships enrolled college freshmen in 2012
  - SHAPE: UTAUS + UTHSCH & UTSWMC
  - PACT: UTD + UTSWMC
- Two will launch in 2013
  - A-PRIME: UTB, UTEP, UTPA+UTMB, UTHSCH
  - FAME: UTSA + UTHSCSA
- Transition to medical campuses in 2015 & 2016
- Medical School graduation in 2018–2020

Projected Student Savings

- Total academic cost savings (BS + MD): $16,766–$20,744
  - Estimates based on Fall 2012 tuition + fees
  - Assumes 3-year medical school curriculum
- Percent savings: 19–23%
- Pilot programs: 140 students/year
- Total savings per cohort: $2,542,494

TRANSFORMATION IN MEDICAL EDUCATION (TIME)

PROGRESS REPORT
January 2013

1. Mission statement and initial strategies were formally adopted:

   Mission: The University of Texas System TIME initiative is a student-centered, clinically focused program designed to increase the effectiveness of medical education while shortening its duration.

   Strategy #1 (short-term): Participating U. T. System academic and health campuses will partner to develop, implement, and assess pilot programs of innovative and integrated medical education with the goal of generalizability and scalability across the U. T. System and beyond.

   Strategy #2 (mid-term): Participating campuses will work collaboratively to assess outcomes and identify best practices across the pilot programs to create a shared model for medical education to be expanded within schools, across partnerships, and outside the U. T. System.

2. Competency-based milestones spanning all six domains of competence used in residency education were adopted for the transition from the academic to health institutions. These common transition milestones will assure compatibility across the initial partnerships and generalizability of the TIME model beyond the pilot phase. These milestones specify that *at the beginning of medical school* students will be able to:

   - apply principles of foundational and biomedical sciences to patient problems
   - perform a medical history and physical exam
   - search the medical literature for articles relevant to patient problems
   - explain basic principles of patient safety and quality improvement
   - describe health care delivery and financing in the United States
   - apply fundamental principles of medical ethics to patient-centered dilemmas
   - describe the roles of various health care professionals and demonstrate teamwork

   With regard to medical school graduation milestones, TIME is participating with multiple organizations to contribute to the development of national standards for competency-based medical education. These efforts will help to inform the development of TIME medical school graduation milestones.

3. A task force on professional identity formation, with members from eight campuses and multiple disciplines, has completed its charge. The group identified six domains of physician identity, elaborated specific objectives, identified curriculum activities, and outlined assessment strategies. This model and the identified resources provide a common foundation for partnerships to design and evaluate a variety of approaches to promoting students' professional growth.

4. Pre-health professions programs for students interested in a variety of health-related fields are being developed by each campus. Best practices will be identified as experience accumulates.

5. Curriculum redesign is proceeding, with each campus developing a variety of approaches to increase efficiency (e.g., course combinations & reductions) while updating instructional approaches and expanding medically-relevant topics as detailed in the competency-based transition milestones. Campuses are mapping competencies to modules and courses to assure their inclusion and to promote tracking. A number of "proofs of concept"—most developed specifically for the TIME initiative (marked with an asterisk below) and others developed in parallel but likely to be useful in TIME—have been implemented:

- Biochemistry, cell biology, and molecular biology modules for college freshmen (UTB)*
- Medical ethics for college freshmen (UTAUS)*
- Multi-institution online courses (UTEP, UTPA)*
- United States health care system and health economics for college freshmen (UTD & UTAUS)*
- Clinical skills instruction by non-physician teaching associates (UTMB & UTHSCH)
- Computer-based simulation of patient interaction dynamics (UTD)
- Piloting courses developed and taught collaboratively by academic institutions and health institutions faculty members (UTD/UTSWMC, UTSA/UTHSCSA)*
- Case-based and problem-based learning for college freshmen (UTB)*
- Numerous additional innovations are planned, but not yet implemented.*

6. Admissions approaches are being collaboratively developed within each partnership. Highlights include:
   - The PACT partnership (UTD/UTSWMC) admitted a cohort of 21 students in fall 2012 (ahead of schedule). This included admission to medical school, conditioned upon maintaining academic and professional standards.
   - The SHAPE partnership (UTAUS/UTHSCH/UTSWMC) accepted 54 students into its initial pre-health professions program in 2012 (also ahead of schedule). Medical school admissions for this group will occur in spring of the sophomore year.
   - Group interactions during the SHAPE professional identity formation course at UTAUS allowed the identification of personal characteristics—both desirable and undesirable (e.g., immaturity)—in students. This information will be incorporated into provisional medical school admission decisions.

7. Timeline: All partnerships are on or ahead of schedule. The initial student cohorts matriculated in 2012 and a second set of cohorts will matriculate in 2013, with transition to medical school in 2015 and 2016, and graduation from medical school in 2018 and 2019.

8. External consultation and feedback from a nationally-recognized leader in education has continued.

9. Momentum of the initiative continues to grow:
   - Increasing numbers of faculty members are becoming involved on each campus.
   - Semiannual workshops for faculty from all campuses have had steadily increasing attendance.
   - Faculty development activities to promote new approaches to instruction and assessment have occurred at semiannual workshops and are being planned on campuses to increase availability and impact.
   - Interest among students and parents in TIME programs has been strong.

TRANSFORMATION IN MEDICAL EDUCATION (TIME)

A multi-institutional initiative within The University of Texas System

Mission: The U. T. System TIME initiative is a student-centered, clinically focused program designed to increase the effectiveness of medical education while shortening its duration.

Ten U. T. System institutions—six academic and four health institutions—are collaborating to transform the century-old American model of physician education. All four U. T. System medical schools are partnering with one or more undergraduate academic institutions to develop curricula incorporating four principle elements: a '**pre-health professions program**' for students to work interprofessionally while learning traditional, non-traditional, and clinical subjects and while demonstrating teamwork and professionalism; (2) **competency-based education,** in which advancement and degree completion is based on demonstrated ability to apply knowledge and perform clinical skills; (3) **professional identity formation** that complements competency-based education and promotes maturation through intentional experiences, reflection, and mentoring; and (4) education in **non-traditional fields**, both medically-related (e.g., clinical safety, quality improvement) and non-medical (e.g., philosophy, economics, systems thinking). Four partnerships are developing compatible pilot programs:

SHAPE: **UT-Southwestern, Houston, Austin Professional Education (UTSWMC—UTHSCH—UTAUS)** SHAPE is an accelerated medical education program developed as a partnership between UTSWMC, UTHSCH, and UTAUS medical campuses. Each year 50-60 UTAUS freshmen enter the pre-health professions program in which they demonstrate learning about science (taught in renovated courses), medical ethics, clinical skills, and the United States health care system. Application for early admission to a partnering medical school will occur in spring of their second year, and students will complete their undergraduate experience in three years. The two medical school partners are collaborating on professional identity formation activities and early clinical experiences at UTAUS and will host summer professional development opportunities on their campuses. The first cohort matriculated in fall 2012.

PACT: **Partnership in Advancing Clinical Transition (UTD—UTSWMS)** The overall goal of the PACT pilot program is to achieve better integration of undergraduate and medical studies in preparation for careers in health care. This highly interactive curriculum—including early clinical skills training and professional identity formation under faculty from UTSWMC—is fostered by the proximity of the two campuses. Students will transition to the medical school in the fourth year, maintaining ties to UTD from which electives in humanities, health care policy, and other topics will continue to broaden their perspectives as health care professionals. The first cohort matriculated in fall 2012.

FAME: **Facilitated Acceptance to Medical Education (UTSA—UTHSCSA)** The goal of the FAME Program is to graduate physicians who have acquired exceptional knowledge of the sciences basic to medical practice as well as professional skills and a keen understanding of the social, cultural, and behavioral aspects of health care. In addition to a new medical school curriculum, the students will participate in a variety of new courses which are being jointly developed and taught by UTSA and UTHSCSA faculty. These courses include content that focuses on clinically-related topics. In the capstone "GATEWAY" courses, students will learn many aspects of patient care, incorporating a multidisciplinary approach that emphasizes the importance of communication, leadership, health economics, and social and cultural aspects of patient care. The first cohort will matriculate in fall 2013.

A-PRIME: **Accelerated Professional, Relevant, Integrated Medical Education (UTB—UTEP—UTPA—UTMB—UTHSCH)** The A-PRIME TIME partnership is developing a multi-institutional model of physician education that is innovative in its approach to increasing educational effectiveness and promoting professionalism of its graduates. Student on three undergraduate campuses will learn in novel settings in the pre-health professions program and apply for early admission to medical school in the spring of their second year. Medical school curricula will also be transformed in recognition of the advanced training of A-PRIME students and the evolving needs of medical practice in the 21st century. The first cohort will matriculate in fall 2013.

5. U. T. System: Discussion on graduate medical education - issues and opportunities

REPORT/DISCUSSION

Executive Vice Chancellor Shine will discuss graduate medical education (GME) - issues and opportunities. (See background information on GME on the following pages.)

Graduate Medical Education

What is GME?
Graduate medical education (GME), or residency training, is the post-medical school training of doctors. Medical school graduates must complete one year of training to be licensed and most complete full residency programs (3 to 7 years) in order to become board certified. Certification is important for participation in health plan networks and hospital admitting privileges.

GME programs are partnerships between health related institutions (HRI), which provide faculty to supervise residents, and clinical facilities, usually hospitals, where residents care for patients. Residents cannot bill for services they provide. The Texas Higher Education Coordinating Board (THECB) has estimated the annual cost of training a resident at $150,000. These costs include: residents' stipends, benefits, and malpractice insurance; faculty time; program administration; and higher medical costs due to less efficient delivery of care (more tests and faculty see fewer patients when supervising residents).

Why does GME matter?
Although medical residents cannot bill for services, they play a critical role in providing patient care, particularly to indigent patients. Texas leads the United States with the highest rate of uninsured—25% compared to a 15% national average—and the uninsured receive a significant amount of health care through the state's teaching hospitals.

Physicians tend to practice where they do their residency and 80% of Texas medical school graduates who complete residency in Texas remain here to practice (3rd in the nation). Texas graduates who complete a residency elsewhere return to Texas to practice about 60% of the time (2nd in the nation).

How is GME funded?
GME is financed through a combination of federal, state, and local/institutional funding—Medicare being the largest source overall. The Medicare payments go to hospitals as partial compensation for salaries for a limited number of residents and for the higher patient care costs incurred by teaching hospitals (due to less efficient care delivery patients at teaching hospitals being relatively sicker than patients at other hospitals). Medicare limits the number of residents for which hospitals generate Medicare GME payments. Of the approximately 6,100 filled residency positions (not including military programs) in Texas, approximately 2,300 positions are above the Medicare cap and not supported by this critical GME funding source.

State General Revenue (GR) funding for GME is appropriated to a number of programs but overall this funding has decreased by 48% since 2002-03: the GME Formula, created in 2005 reimburses HRI for less than 30% of the estimated costs of supervising residents (and equals about 3% of the total estimated cost of a resident); funds trusteed to the THECB provide minimal support for certain types of residency programs (and have been cut by 89% since 2002-03); a few GME-related Special Items to HRI which have been reduced the last two biennia; and effective FY 2009 the state reinstituted Medicaid GME only for state-owned hospitals (no GR is provided).

State General Revenue (GR) for Graduate Medical Education

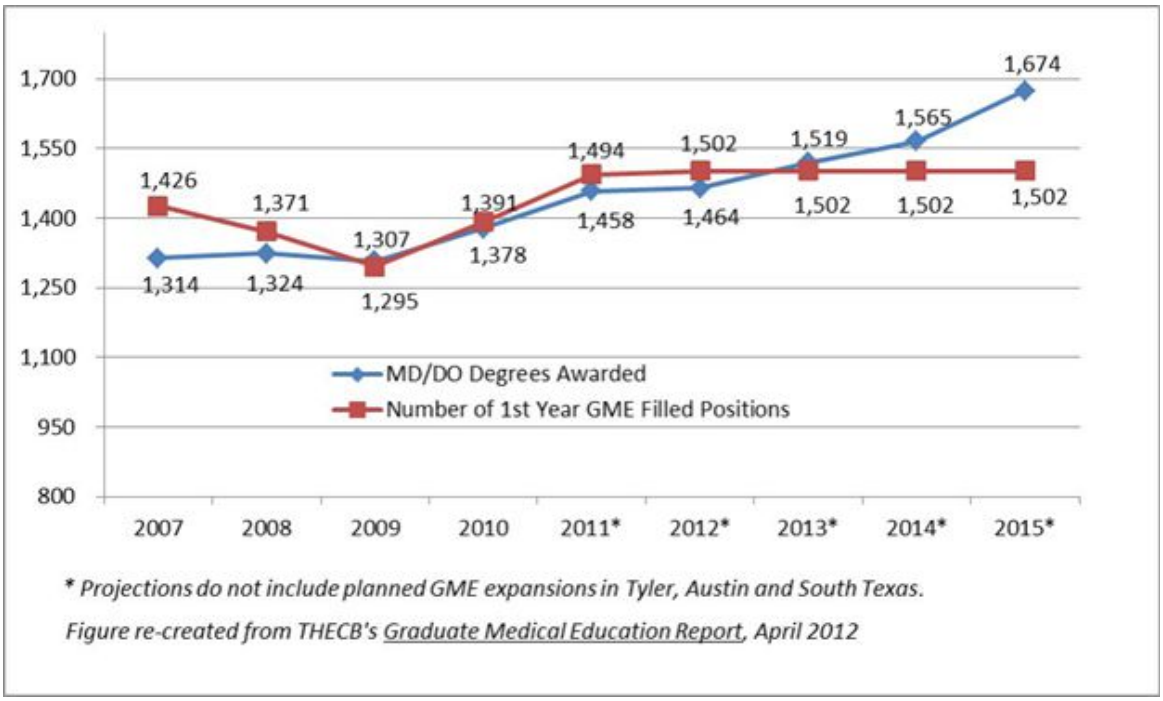
	2002-03 Biennium *(in millions)*	2010-11 Biennium *(in millions)*	2012-13 Biennium *(in millions)*	Change 2002-03 to 2012-13
Texas Health and Human Services Commission				
Medicaid GME (estimated GR)	$67.5	$0.0	$0.0	-100%
Medicaid GME (estimated Federal $)	$101.7	$17.5	TBD	
Article III Health-Related Institutions *				
GME Formula (GR)	$0.0	$79.1	$56.9	
Texas Higher Education Coordinating Board**				
Family Practice Residency Program (GR)	$20.6	$21.2	$5.6	-72.8%
Primary Care Residency Program (GR)	$5.9	$5.0	$0.0	-100%
GME Program (GR)	$15.2	$0.6	$0.0	-100%
Resident Physicians Compensation Program (GR)	$8.1	$0.0	$0.0	-100%
Family Practice Pilot Projects (GR)	$2.0	$0.0	$0.0	-100%
Sub-Total, THECB Programs	*$51.7*	*$26.8*	*$5.6*	*-89.2%*
TOTAL, GENERAL REVENUE (GR)	*$119.2*	*$105.9*	*$62.5*	*-47.6%*

** Does not include Special Item appropriations to health institutions for residency related programs.*
*** Data from THECB, July 2012 report of GME Programs.*

Why more GME slots are needed?

Texas ranks 46th in the nation in active patient care physicians per 100,000 population and 47th in the nation in active primary care physicians. With Texas' fast growing population, these ratios will only decline without continued expansion of the health care workforce. Texas public medical schools have made a concerted effort to expand class sizes and medical school applications continue to increase (by 5% each of the last three years), ensuring a high quality pool of candidates. Texas schools are an incredible bargain—a Texan would pay just over $16,000 tuition and fees per year, compared to the nearly $27,000 an in-state student would pay nationally. A Texan enrolled as a nonresident at a public medical school in another state would pay an average tuition and fees of nearly $52,000.

While the number of GME slots have increased—total GME slots at public health institutions have increased 32% since 2003—the increases have not kept pace with the increase in medical school graduates in Texas. THECB has predicted that Texas medical school graduates in 2014 will outnumber first year GME positions available in Texas. This means some Texas graduates will have to leave Texas to find a GME position in his/her chosen area of practice.



** Projections do not include planned GME expansions in Tyler, Austin and South Texas.*

Figure re-created from THECB's Graduate Medical Education Report, April 2012

6. U. T. System: Discussion on the economic impact medical schools have in Texas

REPORT/DISCUSSION

Executive Vice Chancellor Shine and the presidents from the six health institutions will lead a panel discussion on the economic impact medical schools have in Texas. Benchmark data from the Association of American Medical Colleges (AAMC) may be found on the following pages.

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

The Economic Impact of AAMC-Member Medical Schools and Teaching Hospitals

2012

Conducted for the AAMC by Tripp Umbach

December 2012

Association of
American Medical Colleges

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AAMC

Table 1
Summary of Economic, Employment, and Government Revenue Impact For AAMC Members, 2011

States	Rank	Total Economic Impact	Total Employment Impact	Total Government Revenue Impact
New York	1	$74,151,538,606	430,743	$4,819,032,979
California	2	$49,201,512,761	264,046	$2,921,073,540
Pennsylvania	3	$47,033,121,373	272,640	$2,882,702,406
Massachusetts	4	$38,760,110,682	195,154	$2,234,308,702
Texas	5	$35,825,649,773	228,513	$1,327,689,312
Ohio	6	$32,314,079,590	209,047	$1,884,550,734
Illinois	7	$28,732,944,479	155,233	$1,478,370,705
Florida	8	$24,490,233,642	166,676	$1,211,629,554
Michigan	9	$23,051,327,122	133,120	$1,585,794,455
North Carolina	10	$17,330,838,088	120,578	$942,220,251
New Jersey	11	$15,413,836,889	94,961	$1,001,558,411
Maryland	12	$14,611,835,125	81,944	$861,726,043
Missouri	13	$12,442,654,552	78,390	$605,050,899
Georgia	14	$12,359,469,277	83,483	$554,084,789
Tennessee	15	$11,959,611,610	74,553	$543,903,310
Connecticut	16	$11,768,111,887	65,915	$724,790,589
Minnesota	17	$10,276,917,979	65,208	$734,519,205
Virginia	18	$9,794,616,363	63,145	$441,567,020
Arizona	19	$9,783,041,405	51,897	$489,246,458
Wisconsin	20	$9,619,603,739	44,244	$639,287,761
Indiana	21	$9,030,962,138	55,456	$569,725,984
South Carolina	22	$8,251,462,603	38,242	$448,599,521
Louisiana	23	$7,593,762,705	42,602	$383,823,662
District of Columbia	24	$7,320,921,118	49,290	$1,041,793,206
Washington	25	$5,745,608,783	34,474	$309,279,038
All Other States		$60,429,232,449	389,881	$3,666,397,182
U.S. Total		**$587,293,004,740**	**3,489,435**	$34,302,725,713

Note: Tables include the 24 individual states and the District of Columbia in which AAMC members' impact is highest, plus an "all other states" total, which reflects the impact of the remaining 22 states where AAMC members are located.

Compared with the last study, which was completed in 2009, it is interesting to note that 24 of the 25 states in Table 1 remain unchanged. The top 25 individual states remain, with the exception of Alabama, which has been replaced by Washington, at number 25. Also, some states, such as California, Florida, Connecticut, Arizona, and Louisiana have moved up in the list, while others have moved back.

Introduction

Goals of the Economic Impact Study of AAMC Members

In 1995, the AAMC identified a need to provide benchmark data to continue to assess the status of its members' current economic impact on states' economies, employment, and government revenue. Specifically, Tripp Umbach was commissioned to perform research that:

- Measures the direct economic impact on individual states' and the nation's economy as a result of the education, research, and clinical services of AAMC-member medical schools and teaching hospitals.
- Measures the direct and indirect employment generated in the United States as a result of AAMC-member medical schools and teaching hospitals.
- Measures government revenues that are generated by the presence and operations of AAMC-member medical schools and teaching hospitals. (Medical schools and hospitals that are public and not-for-profit indirectly generate government revenue through income taxes paid by staff, employed physicians, and medical residents; sales tax revenues paid by businesses providing goods and services to medical schools and hospitals; corporate net income taxes paid by businesses providing goods and services to medical schools and hospitals; and other selective business taxes such as gross receipts taxes, public utility realty taxes, insurance premium taxes, motor vehicle taxes, and financial institutions taxes.)
- Measures the economic impact of publicly funded research, which has a significant effect on the state and local economy. In 2009, this impact was $44.9 billion.[4]

Methodology Employed in the Economic Impact Study

This report analyzes AAMC-member impact on the national economy. AAMC members employ individuals in their home states, and therefore, generate personal income for state residents. Businesses operating within each state in the wholesale, retail, service, and manufacturing sectors benefit from the direct expenditures of AAMC-member institutions and their staff on goods and services. In addition, businesses in each state are recipients of spending by hospital patients, patients' visitors, medical students, and their visitors.

All of these "direct" expenditures are recirculated in the economy, as recipients of the first-round of income "re-spend" a portion of this income with other businesses and individuals within each state. This re-spending is often termed the "multiplier" or "indirect" effect. Tripp Umbach's research has determined a medical school/teaching hospital business volume multiplier effect of 2.3. Therefore, for every dollar directly spent by a medical school or teaching hospital, an additional $1.30 is indirectly generated for a total impact of $2.30. The methodology used for this study measures the effect of both direct and indirect business volume, employment, and government revenue impacts for states containing an AAMC member.

[4] "Economic Impact of Public Research Funding Received by AAMC Member Institutions," conducted for the AAMC by Tripp Umbach, 2010.

7. U. T. System: Update on academic developments for the South Texas Medical School

REPORT

Executive Vice Chancellor Shine and Francisco González-Scarano, M.D., Dean of the School of Medicine at U. T. Health Science Center - San Antonio, will provide an update on academic developments for the South Texas Medical School. This will include the status of the search for a "Founding Dean," a new initiative in diabetes research, education and patient care, thoughts about curriculum content, and other related matters.

8. U. T. System: Quarterly report on health matters of interest to the U. T. System, including recognition of the group contracting activities of the U. T. System Supply Chain Alliance

REPORT

Executive Vice Chancellor Shine will report on health matters of interest to the U. T. System, including recognition of the group contracting activities of the U. T. System Supply Chain Alliance.

The Supply Chain Alliance proposal is set forth on the following pages. This proposal will be submitted for a breakout session at the Association of American Medical Colleges (AAMC) conference to be held in May 2013. The AAMC conference is the annual joint meeting of the Medical Colleges' business officers and strategic planning officers.

SUPPLY CHAIN ALLIANCE

THE UNIVERSITY of TEXAS SYSTEM

Creating Value Through Collaboration

Title:

Leading Change: How to drive value beyond traditional group purchasing organizations

Short Description:

This session will offer insights into the blueprint of how The University of Texas System formed a contracting cooperative that generated millions of dollars in savings for re-investment into its institutions' missions. Highlights include the initiative's governance structure, business model, sourcing methodology, and future impact on operating margins.

Submission Text:

Burning Platform:

Storm clouds were gathering several years ago. The deficit for Texas was enormous, mandated reductions were looming, research sponsors had shrinking budgets, and health care reform was imminent with significant financial uncertainties. In response, U. T. System health institutions collaboratively launched a strategic initiative to leverage their collective purchasing power on commonly purchased equipment, services, and supplies. This initiative resulted in the development of an entity (the "Alliance") that has benefited from the shared governance of chief business officers, active participation by chief procurement officers, and an exclusively dedicated team of sourcing professionals monitored by agreed-upon performance measures.

Mature Collaborative Initiative:

The Alliance uses a proven strategic sourcing methodology that emphasizes a disciplined, rigorous, data driven, compliant, and total cost of ownership approach, which in a competitive marketplace creates winners and losers. Since 2008, the Alliance has implemented over 40 preferred supplier agreements with contract savings exceeding $85 million. Several agreements cover predictable items (e.g., office supplies, computers); however, there are unique, opportunistic agreements benefiting the research community and revenue cycle operations. The average savings when comparing old price to new price and improving service levels for all agreements exceeds 15%.

There is now over $140 million of annual spending in these agreements of which over $20 million is with Historically Underutilized Businesses (HUBs). Within the first two years of operations, the Alliance became a cash positive activity under a proven and sustainable business model.

Recently, the Alliance published the second Strategic Plan that focuses on sourcing collaboration, marketing and outreach, HUBs, business intelligence, and people. Notably the new five-year Strategic Plan emphasizes a longer term view, expanded governance to include the U. T. System academic institutions, and programmatic themes versus the initial three-year Strategic Plan, which was heavily focused on core operational activities necessary for this "start-up business" to be successful.

SUPPLY CHAIN ALLIANCE
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Creating Value Through Collaboration

Sustainment:

Embedded in the new Strategic Plan are several opportunities to explore and significant challenges to tackle. One opportunity is a new strategic relationship between the Alliance and a large healthcare group purchasing organization. This collaborative approach to combine expertise and systematically evaluate broad and diverse categories (e.g., facilities, medical supplies) of spending will result in cost savings and other efficiencies. One ongoing challenge has been the resistance to change suppliers. This resistance has been mitigated by requiring written justification for non-participation in an Alliance contract and further by establishing cost-saving targets with the engagement of the chief business officers at each U. T. System institution. Regardless, a strategic communication plan to diverse stakeholders in a decentralized environment is necessary.

Learning Objectives:

Session attendees will experience the U. T. System journey of collaborative contracting that has saved millions of dollars. Specific objectives include:

- Learn how U. T. System deployed a robust governance structure
- Understand the Alliance strategic sourcing methodology and business model
- Appreciate Alliance unique agreements and downstream benefits
- Learn critical success factors, key lessons learned, sustainable strategies and future opportunities

Collectively, this information provides a blueprint on how to establish a regional contracting cooperative that augments current activities.

Respectfully submitted by:

Richard St. Onge
Associate Vice Chancellor for Shared Services

John Joshua
Director of the Alliance

Note:
The University of Texas System Supply Chain Alliance adopted this logo and tagline early in our journey. The Alliance logo combines the idea of a chain and collaboration. The chain visualizes people holding hands, sharing information, and trusting each other. The three figures symbolizes that the Alliance is about groups of people coming together. The logo colors represent the diversity in our membership. The tagline reinforces that collaboration results in enhanced value.

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