

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).



RESOLUTION: 48(20)
SUBMITTED BY: New York Chapter
SUBJECT: Residency Program Expansion

PURPOSE: Engage the ACGME and other stakeholders to construct objective criteria for new residency accreditation considering workforce needs, competitive advantages and disadvantages, geographic distribution, and demand for physicians.

FISCAL IMPACT: Budgeted task force and staff funds.

1 WHEREAS, Emergency medicine residency is the only pathway to emergency medicine board certification;
2 and

3
4 WHEREAS, In 2011, there were 150 residencies approved by the Accreditation Council for Graduate
5 Medical Education (ACGME) with 1,607 emergency medicine PGY-1 positions offered, while 2018 saw a rise to 220
6 ACGME-approved residencies with 2,278 PGY-1 positions offered; and

7
8 WHEREAS, The change in overall numbers comes both from previously approved American Osteopathic
9 Association residencies along with the proliferation of newly accredited ACGME residencies; and

10
11 WHEREAS, There has not been objective criteria in place for the determination of need for approval of new
12 residencies by the ACGME specifically in terms of an assessment of emergency medicine workforce needs; and

13
14 WHEREAS, Contract management groups and other private entities have begun to build, control, and take
15 over ACGME-accredited residencies without demonstrable commitment to educational needs or emergency medicine
16 workforce stewardship; therefore be it

17
18 RESOLVED, That ACEP engage the Accreditation Council for Graduate Medical Education and other
19 relevant stakeholders to construct objective criteria for new residency accreditation that takes into account emergency
20 medicine workforce needs, competitive advantages and disadvantages, geographical distribution of workforce, and
21 expected shortages and/or excess of emergency physicians to adequately steward needs for newly accredited
22 emergency medicine residency programs.

Background

This resolution calls for ACEP to engage the ACGME and other relevant stakeholders to construct objective criteria for new residency accreditation that takes into account emergency medicine workforce needs, competitive advantages and disadvantages, geographical distribution of workforce, and expected shortages and/or excess of emergency physicians to adequately steward needs for newly accredited emergency medicine residency programs.

ACEP has a long history of supporting the development, expansion, and funding of emergency medicine residency programs as well as studying current and future needs of the emergency medicine workforce.

In November 1987, the Board of Directors adopted the position that there was a shortage of board-certified emergency physicians and the projection for physician supply through the year 2010 would drop by 1.6%. An ACEP task force charged with studying the issue at the time reported that while supply would drop, there would be an increase in demand because of increasing population, need for access to care, an increasingly aging population, and increasing

demand for full time faculty. In 1987 there were 73 emergency medicine residency programs producing approximately 430 graduates a year. The task force recommended that the College explore ways to increase the number of residency training slots within existing programs as well as through the creation of new residency training programs. The task force recommended that the College encourage private and public sources of funding for residencies to address the projected shortage.

The 1998 ACEP workforce study, [A Study of the Workforce in Emergency Medicine](#), found that less than 50% of the necessary emergency medicine physician workforce was able to fully staff U.S. EDs and that the current number of emergency medicine residency programs was not projected to provide a significant increase in the available emergency medicine workforce. A follow-up study, [A Study of the Workforce in Emergency Medicine: 1999](#), was published in *Annals of Emergency Medicine*. In 2001, the Board was asked to accept a report from the Staffing Task Force looking at current use of paramedics and EMTs and their future roles and to, “provide a special analysis of the ability for emergency medicine residency programs being able to meet the educational requirements for residency training while at the same time meeting the training requirements for paraprofessionals who will work in the ED.” The task force surveyed emergency medicine residency directors and residents in June 1999 and found that 66% of residents and 45% of residency director respondents believed that there would be some competition for career positions with non-physician providers.

A [2008 workforce study](#), published in *Annals of Emergency Medicine*, found that while younger physicians were more likely to be emergency medicine trained or emergency medicine board certified, many non-emergency medicine trained/emergency medicine board-certified physicians still provided coverage in EDs and that demand for rural emergency medicine care would likely continue with shortages likely to increase in rural areas.

In July 2009, a Future of Emergency Medicine Summit was convened. The consensus from summit attendees was that there would not be enough emergency medicine residency trained board-certified emergency physicians to meet the needs of all emergency patients in the U.S. for at least the next 20 years. It was noted that midlevel providers would provide some of the care in EDs, particularly where physician shortages exist. Summit participants recommended increasing the number of emergency medicine trainees with a corollary increase in GME funding, improving the geographic distribution of residency trained board certified emergency physician incentives for rural practice, increasing the number and size of emergency medicine programs, including loan forgiveness programs and targeting rural hospitals to host emergency medicine programs. In 2011, representatives from the 2009 meeting reconvened following the enactment of the Patient Protection and Affordable Care Act. The group [published](#) an update to their 2009 report. Regarding physician shortages in emergency medicine, the group recommended that policies to secure funding for additional training positions should be developed and residency training programs should provide increased exposure to rural practice.

In 2018, a workgroup of the ACEP Board of Directors was appointed to discuss trends in emergency medicine, such as future workforce needs, the role of physician assistants and nurse practitioners, consolidation of the employment market, and other concerns. It was determined that two task forces would be appointed: Emergency PA/NP Utilization Task Force and Emergency Medicine Workforce Task Force. The Emergency PA/NP Task Force included representation from all stakeholders in the provision of care of emergency patients. Their primary objective was to recommend the scope of practice for physician assistants (PAs) and nurse practitioners (NPs) in the ED, considering such factors as membership growth, education, training and experience, patient acuity, employment models, and the utilization of adjuncts such as telemedicine and other forms of oversight. Their final report was provided to the Board of Directors in April 2020. The primary objective of the multi-organizational Emergency Medicine Workforce Task Force is to assess the current and future emergency medicine workforce with assistance from an outside expert to review the literature and existing data on current and projected emergency medicine workforce needs. The task force launched in November of 2018. A final report is expected from the outside consultant in December 2020. The task force will then continue its work incorporating the consultant’s report and recent publications. Their final report is expected in June 2021.

A recent [2020 study](#) in *Annals of Emergency Medicine* examined changes in the current U.S. emergency medicine workforce compared to 2008. While the study found an overall increase in physicians since 2008 (up by 9,774), of the 48,835 clinically active emergency physicians, 19% were neither emergency medicine trained nor emergency medicine board certified. Those 19% non-emergency medicine trained, or emergency medicine board-certified

physicians were more likely to be men and international medical graduates. They were also older and more likely to be in rural areas. While the density of emergency physicians has increased overall since 2008 (14.9 per 100,000 U.S. population), the increase is not reflected evenly between urban, large rural, and small rural (1.4, -0.4, -3.7 respectively). The study noted the continued need for effective delivery of care in rural and underserved areas. The study suggests that it is likely that as this group of physicians retire, and as urban areas continue to see increases in newly trained emergency medicine physicians, rural areas are likely to experience further shortages.

According to the [ACGME](#), in 2018-19 there were a total of 7,940 emergency medicine residents in a total of 247 programs (63 of which had initial accreditation). Since the single-accreditation system, emergency medicine is one of the top four specialties with the highest 5-year increase in total number of programs. From 2014-15 to 2018-19, emergency medicine saw a 47.9% increase in programs. The number of active residents from 2014-15 to 2018-19 has increased by 33.6% from 5,941 to 7,940. Across specialties, approximately half of sponsoring institutions with ACGME-accredited programs are General/Teaching Hospitals (47.7%) and the next largest group is Academic Medical Centers/Medical Schools (15%). Academic Medical Centers/Medical Schools account for 9.7% more programs than general/teaching hospitals and have almost the same number of residents (ACGME Databook). It should be noted that the Residency Review Committee of the ACGME is obligated to accredit any residency that meets its criteria and will not be influenced by concern about an excess or deficit of physicians in that specialty.

GME funding for training programs is complex. GME funds are comprised of federal, state, and private monies. The federal government remains the largest funder of GME, covering approximately [86% of training costs](#). In 2018, the [Congressional Budget Office](#) estimated that approximately \$15 billion in Medicare and Medicaid was spent on GME. Private funds are difficult to quantify but as the Institute of Medicine noted in their 2014 [report](#), “may be significant.” The report also notes that while nationally, private funding might represent a small fraction of overall GME funding, for some programs it might be a significant support. The ACGME published a position paper in 2011, [Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME](#), (an update to their 2002 guidance) outlining principles for sponsoring institutions and programs using industry GME funds. [Some](#) have cited changes in accreditation regulations over the years (reduced work hours for residents, increased supervision requirements, etc.) as driving up the cost of training. With increased costs and capped funding from federal sources, some institutions have turned to private funding, through industry or philanthropy, to cover the costs of training. Other institutions have embraced training programs as a way to recoup some operating costs, solve physician shortages, and increase productivity. In the case of one [study](#), they found that eliminating GME programs would have a negative impact on their hospital’s bottom line. In the case of Hahnemann University Hospital, owned at the time by a private equity firm, while in bankruptcy proceedings attempted to auction off its residency positions even though this move was seen as illegal by CMS. ACEP sent a letter to the ACGME on November 18, 2019, informing them of ACEP’s opposition to the sale of Hahnemann’s GME slots and any further commoditization of GME slots.

Residency training programs and graduates are frequently faced with a changing funding landscape, evolving accreditation standards, shifting patient population needs, and challenges with the distribution of its workforce.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted funds for task force study on workforce issues and staff time.

Prior Council Action

Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted. Directed ACEP to support CMS in opposing the sale of GME slots and oppose any sale or other commoditization of GME slots.

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted. Directed ACEP to address workforce shortages and lobby for the removal of barriers to increasing the number of residency slots available in emergency medicine. Also directed ACEP to investigate broadening access to ACGME or AOA accredited emergency medicine residency programs to physicians who have previously trained in another specialty.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for the inclusion of EM in the National Health Services Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organization to encourage the development and promotion of rural emergency medicine clerkships/rotations at medical schools and residency programs.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted. Directed ACEP to work with other emergency medicine organizations to use existing workforce data to identify current and future needs for board certified emergency physicians, recommend strategies based on the projected need to ensure appropriate numbers of emergency medicine residency graduates meet the need, and advocate to eliminate barriers to creating adequate numbers of emergency medicine residency positions and achieving optimal funding for those positions.

Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted. Directed ACEP to work with appropriate organizations and agencies to develop strategies to implement protections for resident physicians to complete their training in the event of residency program closures.

Resolution 31(96) Cooperative Training Programs in Emergency Medicine and Family Medicine not adopted. Called for ACEP to study the Canadian model of family physicians and generalists in emergency medicine and consider the implications for emergency care in the US. Additionally, work with other organizations to facilitate the development of combined residency training programs in family medicine and emergency medicine as well as a joint specialty certification by ABEM and ABFP.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted. Directed ACEP to continue long-range planning for projecting emergency physician needs based on patient visits and physician attrition and continue to work toward preservation of adequate numbers of residency positions in emergency medicine, and to continue intensive lobbying efforts to preserve funding for adequate numbers of residency positions in emergency medicine.

Resolution 28(92) Emergency Medicine Residency Training Pilot Program not adopted. The resolution called on ACEP to facilitate, develop, and pilot a model training program in emergency medicine designed to allow practicing emergency physicians who completed training in other specialties to meet the requirements of the RRC-EM and become eligible for the ABEM exam. The pilot programs would be completed in a timely manner, through part-time and independent work, while in practice.

Amended Substitute Resolution 45(91) Emergency Medicine Residencies adopted. Directed the College to work with all appropriate organizations and agencies to obtain increased funding for emergency medicine residency programs.

Substitute Resolution 43(91) Development of New Residency Programs adopted. The resolution directed ACEP to strongly encourage the Residency Review Committee for Emergency Medicine to consistently apply existing special requirements used in reviewing prospective emergency medicine residency programs and meet with the ACGME to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted. Directed ACEP to promote the expansion of existing and the development of additional emergency medicine programs, particularly in those areas of emergency physician shortage.

Amended Substitute Resolution 41(88) Development of Emergency Medicine Residency Programs adopted. Directed ACEP to work with other organizations to continue to provide support, guidance, information, and other appropriate materials for individuals and institutions interested in developing emergency medicine residency programs.

Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted. Directed ACEP to encourage development of new models for funding graduate medical education.

Prior Board Action

June 2020, filed the report of the Emergency PA/NP Utilization Task Force.

Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted.

September 2018, approved appointing the Emergency PA/NP Utilization Task Force to consider the evolution of the role and scope of practice of physician assistants and nurse practitioners in the emergency department.

June 2018, approved the revised policy statement “[Resident Training for Practice in Non-Urban/Underserved Areas](#),” reaffirmed April 2012 and October 2006; originally approved in June 2000.

June 2018, reaffirmed the policy statement “[Emergency Medicine Training, Competency, and Professional Practice Principles](#),” reaffirmed April 2012; revised and approved January 2006; originally approved November 2001.

June 2018, approved the revised policy statement “[Financing of Graduate Medical Education in Emergency Medicine](#),” revised and approved October 2012, reaffirmed September 2005; originally approved September 1999.

February 2018, reaffirmed the policy statement “[Emergency Medicine Workforce](#),” reaffirmed April 2012 and June 2006; revised and approved September 1999 with the current title; originally approved November 1987 titled “Manpower.”

November 2017, approved the revised policy statement “[Workforce Diversity in Health Care Settings](#),” reaffirmed June 2013 and October 2007; originally approved October 2001.

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted.

Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted.

Amended Substitute Resolution 45(91) Emergency Medicine Residencies adopted.

Amended Substitute Resolution 43(91) Development of New Residency Programs. The Board amended the substitute resolution adopted by the Council. The amended substitute resolution adopted by the Board directed ACEP to meet with the Residency Review Committee for Emergency Medicine (RRC-EM) to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted.

Amended Substitute Resolution 41(88) Development of Emergency Medicine Residency Programs adopted.

Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted.

November 1987, adopted the position that, based on current and projected numbers of graduates from emergency medicine residency training programs, there will be a significant shortage of appropriately trained and certified emergency physicians. Additionally directed that a task force be appointed to develop strategies to meet the shortage.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director