48th STFM Annual Spring Conference

Leadership to Create Change

Using the Institute of Medicine's Report on Graduate Medical Education as a Case Study to Communicate Key Policy Issues

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Disclosures

- No conflicts of interest to disclose

Objectives

- List two recommendations from the IOM GME report and how the implementation of those recommendations would affect family medicine residency education.
- List two ways that faculty and learners can get involved with advocacy efforts.
- Demonstrate competency in creating a clear, concise message that can be delivered in a number of settings including the office of an elected official, as well as to deans and hospital leaders.

Agenda

- 1) **Workforce Overview (15 minutes); 3:30**
- 2) **IOM Report Overview (15 minutes); 3:45**
- 3) **Advocacy Introduction (15 minutes); 4:00**
- 4) **Preparing for a Mock Visit (25 minutes); 4:15**
- 5) **Performing a Mock Visit (20 minutes); 4:40**

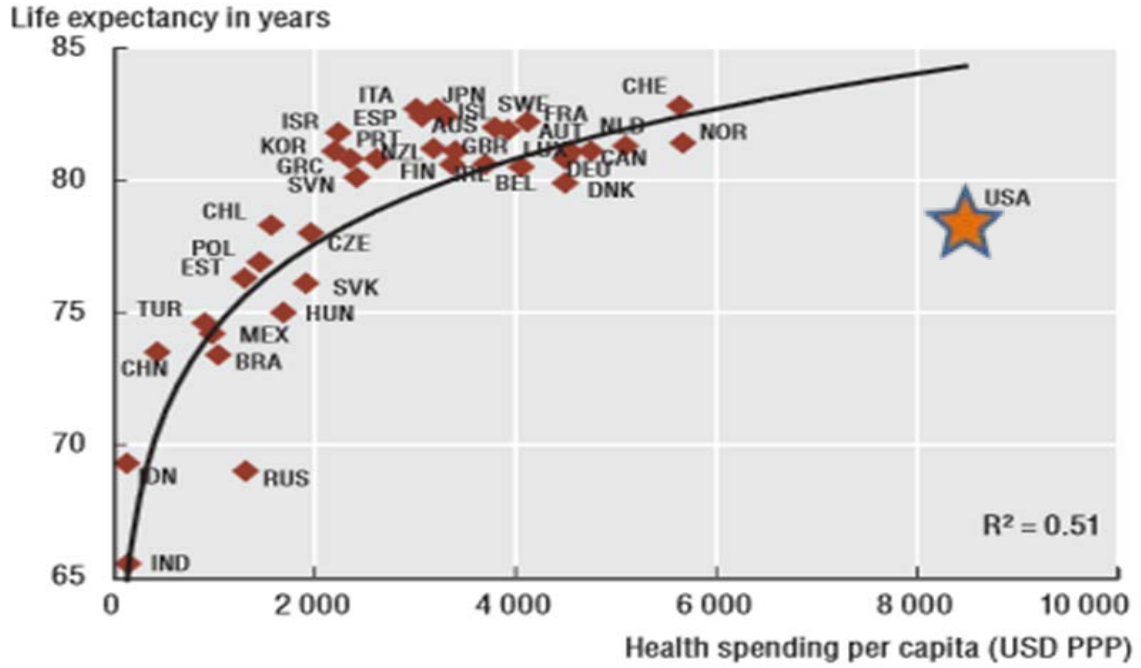
The Robert Graham Center

- Improve individual and population health by enhancing the delivery of primary care
- Generation or synthesis of evidence that brings family medicine and primary care perspective to health policy deliberations

Workforce Overview

Cost of Care and Life Expectancy

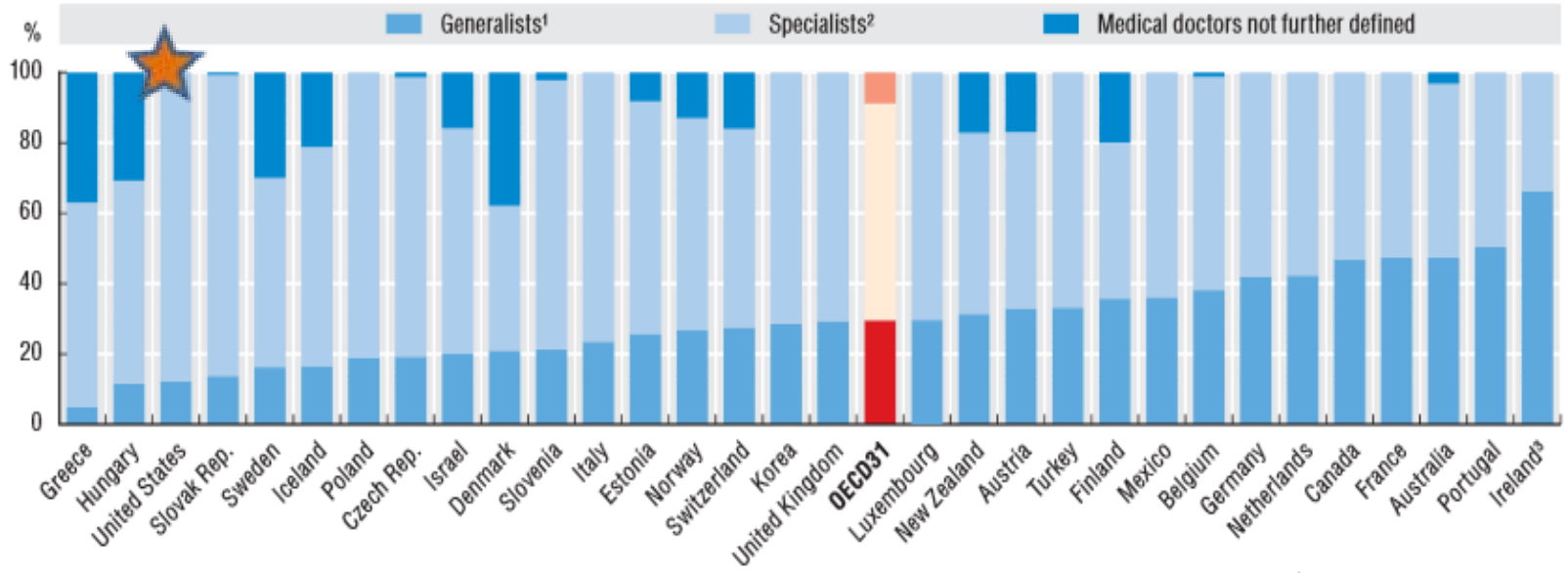
1.1.3. Life expectancy at birth and health spending per capita, 2011 (or nearest year)



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en; World Bank for non-OECD countries.

Physician Primary Care to Specialty Ratios in OECD Nations

3.2.3. Generalists and specialists as a share of all doctors, 2011 (or nearest year)



1. Generalists include general practitioners/family doctors and other generalist (non-specialist) medical practitioners.
2. Specialists include paediatricians, obstetricians/gynaecologists, psychiatrists, medical, surgical and other specialists.
3. In Ireland, most generalists are not GPs ("family doctors"), but rather non-specialist doctors working in hospitals or other settings.

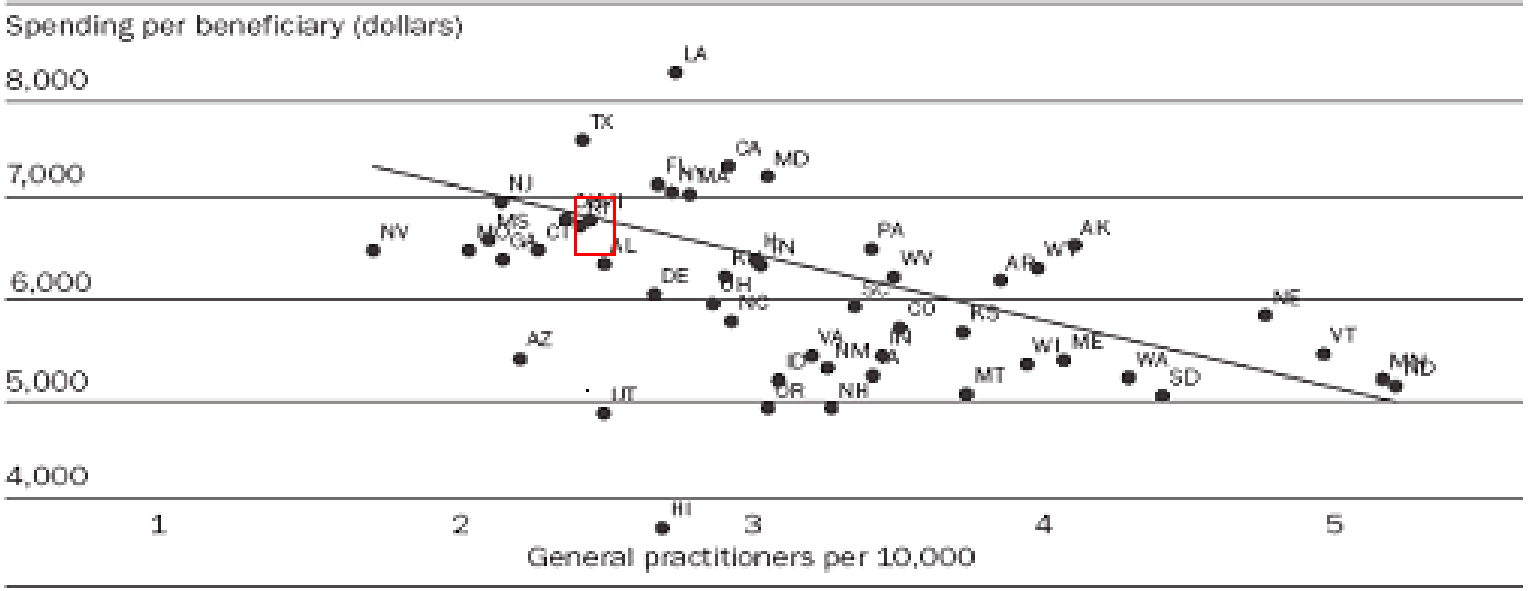
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

Physician Workforce by the Numbers

Primary Care	Total (%)
Family Medicine	**83,815 (38.9%)**
General Internal Medicine	74,105 (34.4%)
General Pediatrics	46,215 (21.5%)
General Practice	7,541 (3.5%)
Geriatrics	3,527 (1.6%)
Total	**215,206** (100%)
All Physicians	
Primary Care	**215,206 (32.9%)**
Subspecialist	438,034 (67.1%)
Total	653,240 (100%)

(Source : American Medical Association (AMA) Physician Masterfile, 2013)

Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

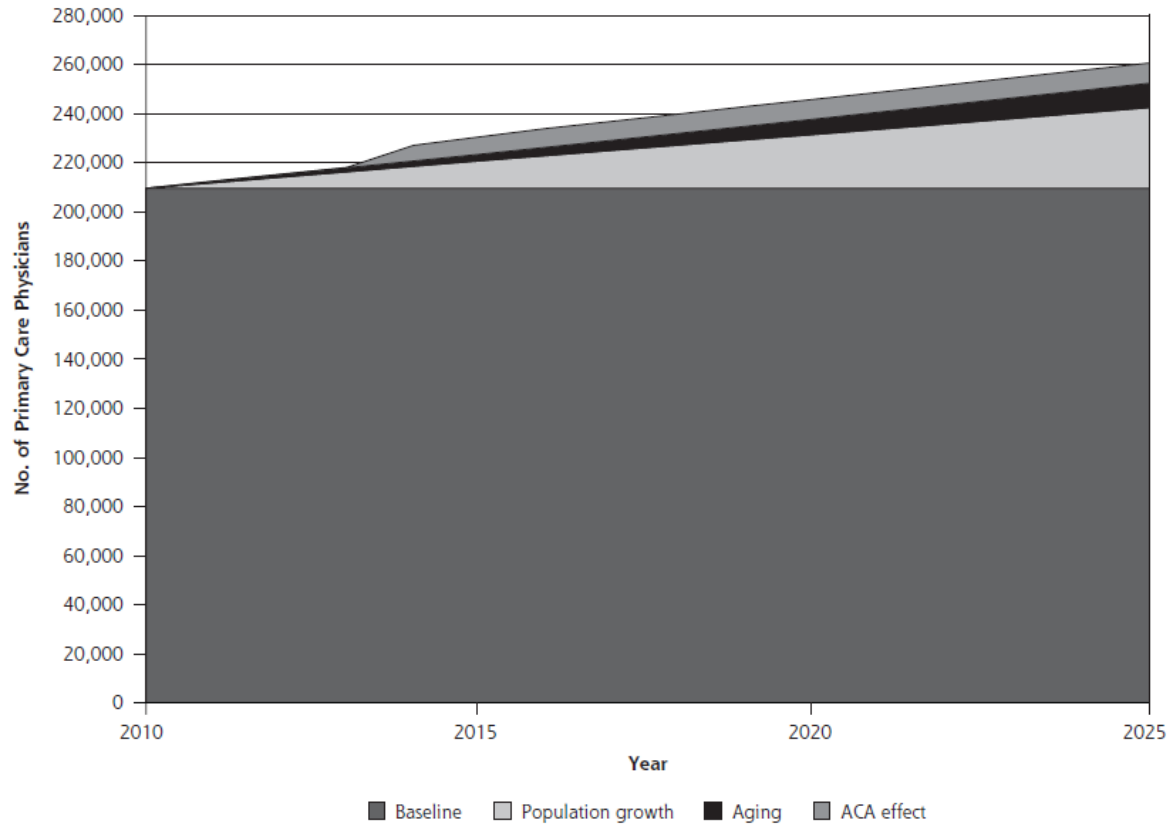
Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Affairs. 2004 April 7. W4: 184-197.

Costs Across Health Care Services Continuum

Services	Total Expenses (in millions)	(%)
Primary care, office based	74,575	5.93%
Specialist, office based	155,297	12.35%
Non-physician, office based	85,981	6.84%
Outpatient	114,746	9.13%
Emergency room	52,139	4.15%
Prescriptions	296,760	23.60%
Home Health	52,365	4.17%
Dental	61,147	4.86%
Inpatient	339,571	27.01%
Vision	14,161	1.13%
Other	10,506	0.84%
Total	1,257,248	100.00%

(Source : Medical Expenditure Panel Survey (MEPS), 2011)

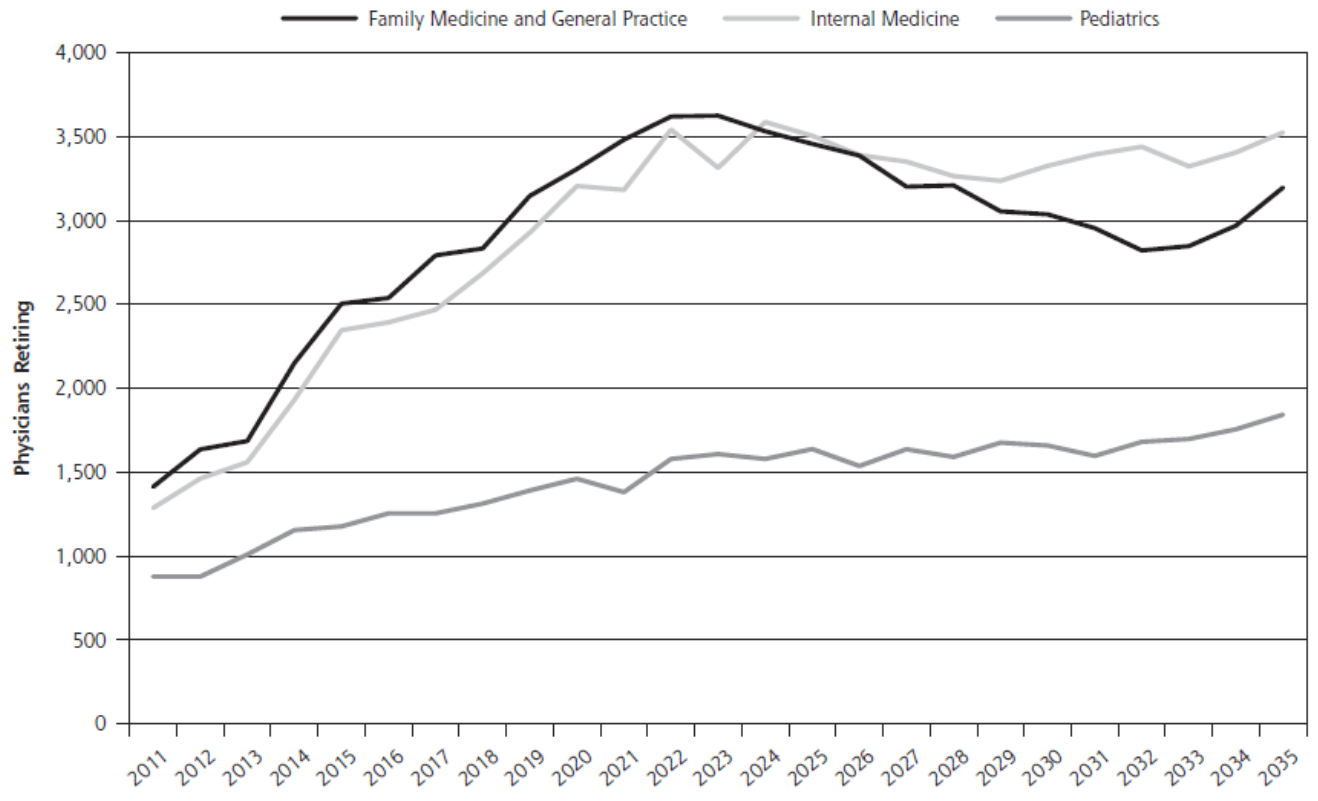
Figure 2. Growing need for primary care physicians, 2010-2025.



ACA = Affordable Care Act.

Projecting US Primary Care Physician Workforce Needs: 2010-2025

Figure 1. Annual projected number of retiring physicians, by specialty type (2011-2035).



[a] Includes physicians trained in medicine-pediatrics.

Estimating the Residency Expansion Required to Avoid Projected Primary Care Physician Shortages by 2035

Table 2. Projected Primary Care Workforce Shortages

Year	Need		Supply		Shortage	Additional Residents per Year
	Overall: Population Growth, Aging, and Insurance	Population Growth Only	Cumulative Production	Cumulative Retirement		
2015	228,547	228,547	8,049	5,819	–2,230	
2020	241,291	237,460	48,294	39,519	3,968	2,196
2025	253,630	246,358	88,539	80,669	17,213	2,710
2030	264,015	254,938	128,784	119,756	26,440	1,773
2035	272,887	262,897	169,029	157,971	33,283	1,700

Primary Care Specialty	2015 New Primary Care Physicians
Family medicine	3,768
General internal medicine	2,412
Pediatrics	1,869
Total	8,049

Primary care residency production will need to increase by 21% in order to avoid a shortage.

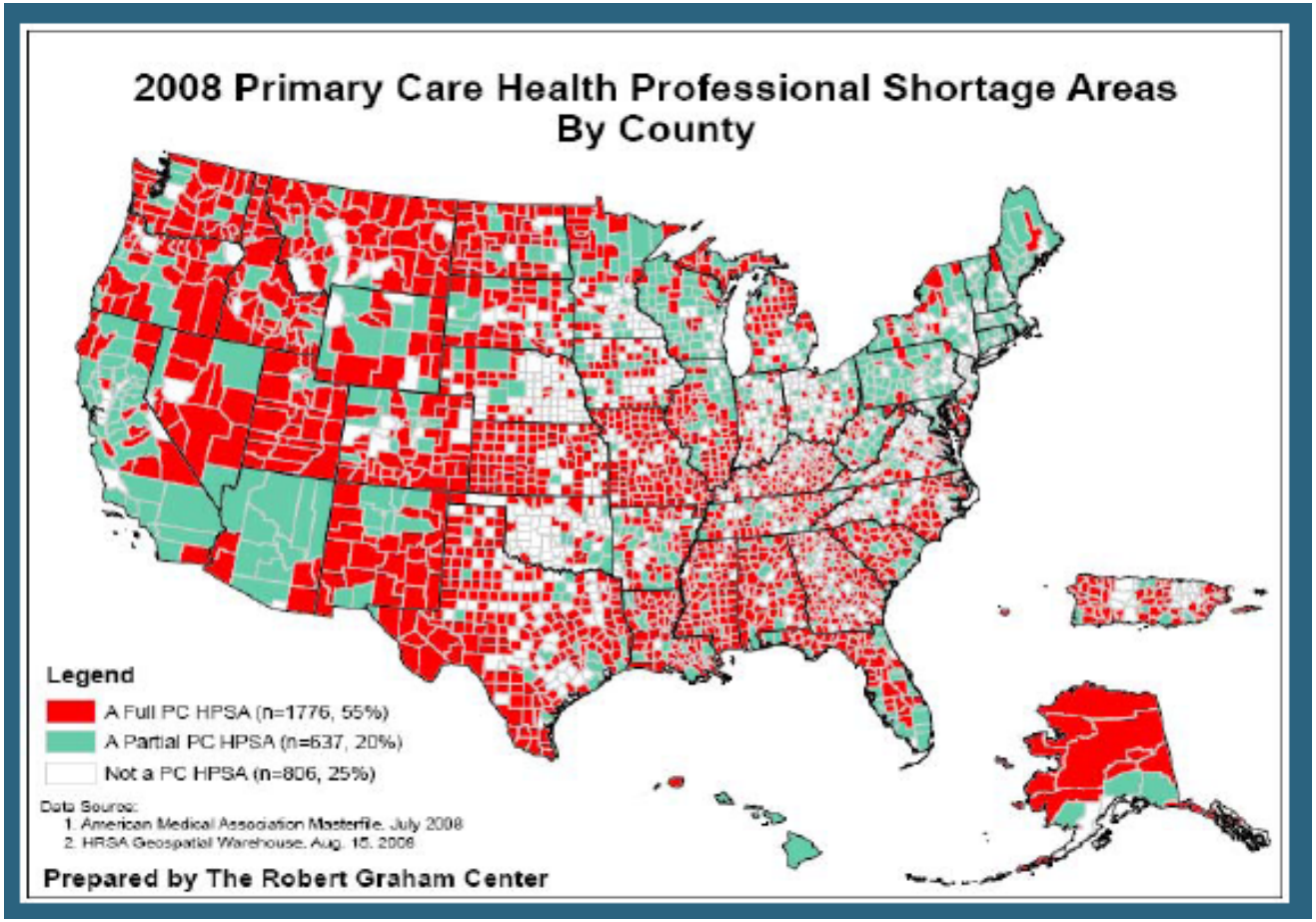
Table 4. Impact of Retirement Age and Population per Primary Care Physician Changes on Shortage Projections for 2035

Variable	Additional Residents Needed No. (% Change)	Projected Physician Shortage by 2035 No. (% Change)
Baseline	1,700	33,283
Retirement age		
64 y	2,427 (43)	38,622 (16)
68 y	1,057 (–38)	26,835 (–19)
Population per physician		
10% decrease	3,064 (80)	60,561 (82)
10% increase	336 (–80)	6,004 (–82)

COUNCIL ON GRADUATE MEDICAL EDUCATION

Tenth Report

Geographic maldistribution of health care providers and service is one of the most persistent characteristics of the American health care system. Even


2008 Primary Care Health Professional Shortage Areas
By County
Legend
A Full PC HPSA (n=1776, 55%)
A Partial PC HPSA (n=637, 20%)
Not a PC HPSA (n=806, 25%)
Data Source:
1. American Medical Association Masterfile, July 2008
2. HRSA Geospatial Warehouse, Aug. 15, 2008
Prepared by The Robert Graham Center

World Health Organization

Social Accountability

Education		Research		Community Service

Boelen C, Heck J. *Defining and Measuring the Social Accountability of Medical Schools*. Geneva: Division of Development of Human Resources for Health, World Health Organization; 1995. Document WHO/HRH/95.5.

Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training

E. BLAKE FAGAN, MD; SEAN C. FINNEGAN, MS; ANDREW W. BAZEMORE, MD, MPH; CLAIRE B. GIBBONS, PhD, MPH; and STEPHEN M. PETTERSON, PhD

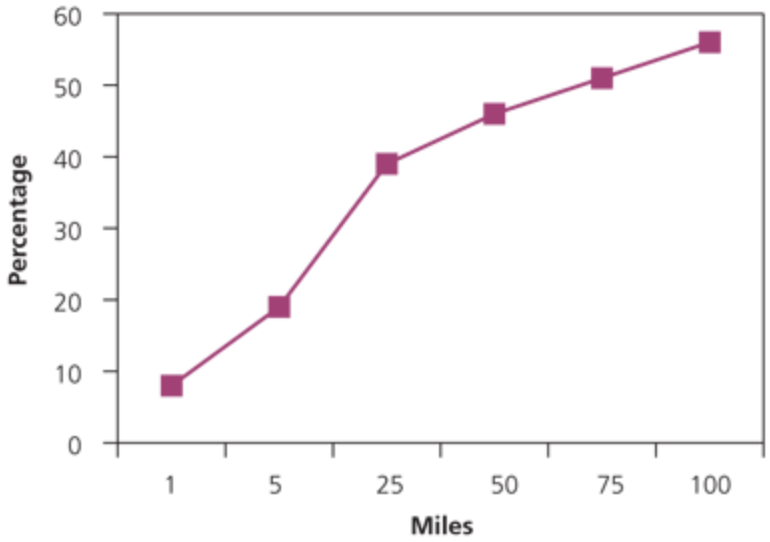


Figure.

Percentage of family medicine graduates who practice within 100 miles of their residency training site.

Data from the 2009 American Medical Association Physician Masterfile.

Does Graduate Medical Education Also Follow Green?

Nicholas A. Weida, BA
Robert L. Phillips Jr, MD, MSPH
Andrew W. Bazemore, MD, MPH

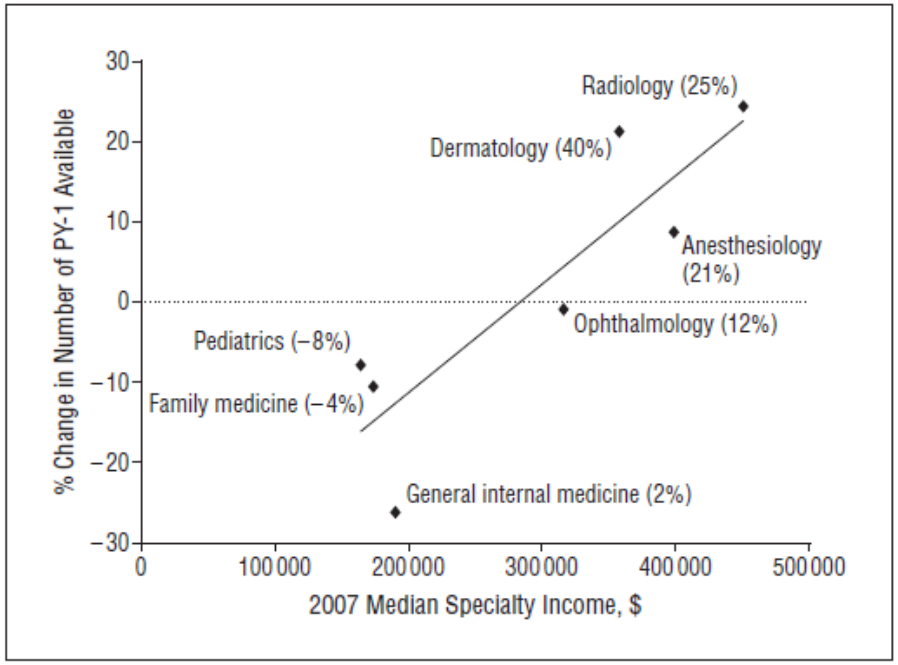


Figure. Percentage change in number of year 1 residency positions (PY-1) offered from 1998 to 2008 vs 2007 income by specialty. Percentages in parentheses are percentage growth in specialty income adjusted for inflation between 1998 and 2007.

Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions

Candice Chen, MD, MPH, Stephen Petterson, PhD, Robert L. Phillips, MD, MSPH, Fitzhugh Mullan, MD, Andrew Bazemore, MD, MPH, and Sarah D. O'Donnell, MPH

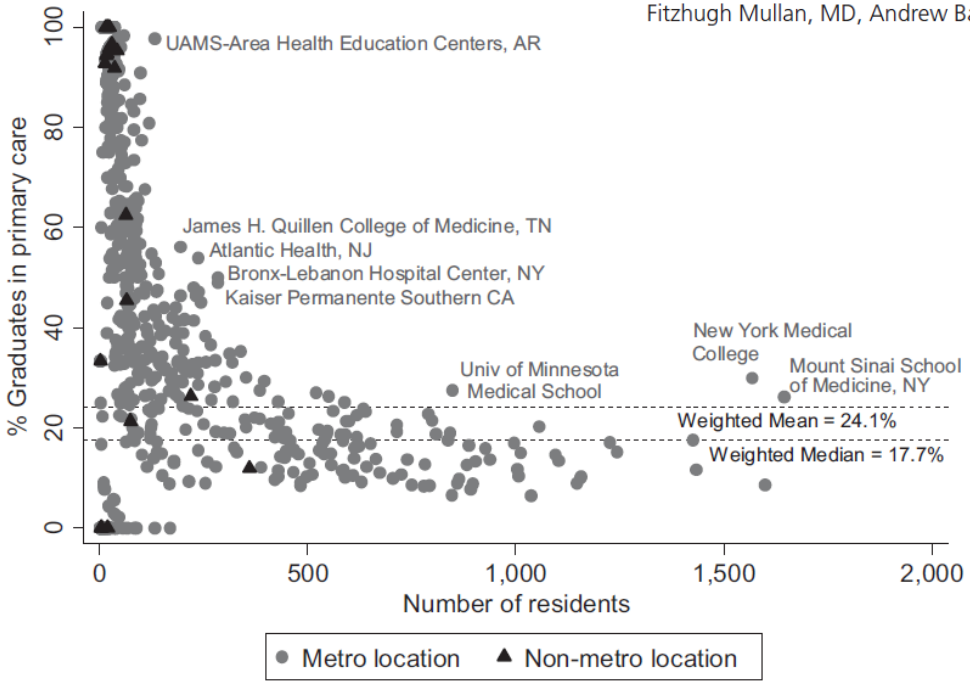


Figure 1 Relationship between percentage of graduates in primary care and number of residents trained in U.S. graduate medical education sponsoring institutions. Data are limited to sponsoring institutions with more than three graduates during 2006–2008. Institutions in Puerto Rico are not included.

Affordable Care Act

- Accountable Care Organizations
  - CMS: by 2018, 50% of payments towards models that reward quality and cost savings
- Community Health Needs Assessment
- Teaching Health Centers

Table 2

Association Between CHC Training and Working in an Underserved Area

Underserved Types	*CHC-trained Physicians* (%)*	*Non CHC-trained Physicians (%)*	*Bivariate Association P Value***	*Multivariate Association OR (95%CI)****
Working underserved****	63.9	37.3	<.001	2.7 (1.6, 4.7)
Community health centers	28.3	7	.001	3.4 (1.6, 6.7)
Indian Health Service	9.7	3.8	.018	2.5 (.9, 5.9)
Medically undeserved area	20.8	9	.001	2.4 (1.2, 4.5)
Migrant health clinic	8.3	3.3	.029	2.4 (.93, 6.3)
Rural health clinic	18.1	6.4	<.001	2.4 (1.2, 5)
Health profession shortage area	6.9	7.8	.79	.9 (.36, 2.5)
National Health Service Corps commitment	4.2	3.9	.92	.81 (.23, 2.8)

CHC—community health center

* The data in the CHC and non-CHC-trained physicians represent the percent of physician working in each of the underserved categories.
** *P* value calculated using chi-square analysis
*** OR=odds ratio and 95% confidence intervals from multivariate logistic regression controlling for gender, FTE, and year from graduation.
**** Working underserved indicates physicians working in at least one of the seven categories of underserved clinics at least 50% time.

Morris CG, Johnson B, Kim S, Chen F. Training family physicians in community health centers: A health workforce solution. Fam Med 2008; 40(4): 271-6.

Looming shortage

+

Push for social accountability

+

Affordable Care Act

=

An opportunity for primary care to push for GME reform

IOM Report Overview

IOM GME Report - 2014

- Current context of GME funding & oversight
- IOM Report Background
- Report Recommendations
- Policy Implications of the Report

Current Context of GME

- Since Medicare creation in 1965 billions of dollars fund graduate medical education (GME), far exceeding other professions.
- Lack of transparency and accountability for the GME investment, $15 billion annually
- Call for assessment to optimize public investment of GME to assure training the type of physicians the nation needs

IOM Report Background

- Medicare provides almost $10 Billion of the total $15 Billion GME annual budget
- Statutes and regulations governing GME financing date to 1965 at a time when physician training was almost exclusively in hospitals
- Emphasis in health care and physician training has shifted, yet current GME payment has not
- There is no central health workforce (including GME) planning or implementation oversight

Report Recommendations

- Significant changes to GME financing and governance
- Address current workforce deficiencies
- Better shape the future physician workforce
- Specific funding recommendations
- Modernize payment system
- Ensure program oversight and accountability

Maintain current federal GME funding

- Modernize GME payment
- Base payment on performance
- Enhance accountability and oversight
- Incentivize innovation

Build a GME Policy and Financing Infrastructure

- 2a: GME Policy Council in DHHS
  - create GME strategic plan, implementation and monitoring
  - Policies and collaboration among federal and other stakeholders
- 2b: GME Center in CMS
  - Management of operations
  - Oversee demonstrations
  - Collect and report data re transparency/distribution of GME funds

Create a GME Fund with Two Subsidiary Funds

- 3a: GME Operational Fund
  - Distributes support for residency training positions
- 3b: GME Transformational Fund
  - Finance initiatives to develop and evaluate innovative GME programs, performance measures, pilot alternative payment methods

Modernize GME Payment Methodology

- Replace the two payment programs of indirect and direct GME payment programs with a single national “per-resident amount” (PRA)
- Redirect funding so that GME funds go directly to sponsoring organizations
- Implement performance based payments

Medicaid GME

- Funding should remain at states' discretion
- Same level of accountability and transparency should be required in Medicaid GME as proposed for Medicare GME

Policy Implications of Report

- Implementation of the IOM GME report recommendations requires legislative action
- Call for accountability of GME investments
- Lack of stakeholder consensus on the nation's workforce needs and what should be supported
- There are potential winners and losers in either maintaining the status quo or implementing some or all of the Report recommendations

Advocacy Overview

Advocacy Goals for Today

Demonstrate competency in creating a clear, concise message that can be delivered in a number of settings.

- Why advocate – what is advocacy?
- What does an Advocacy Campaign Entail?
- Skill development
- How to get started; Opportunities for advocacy
- Tools for You

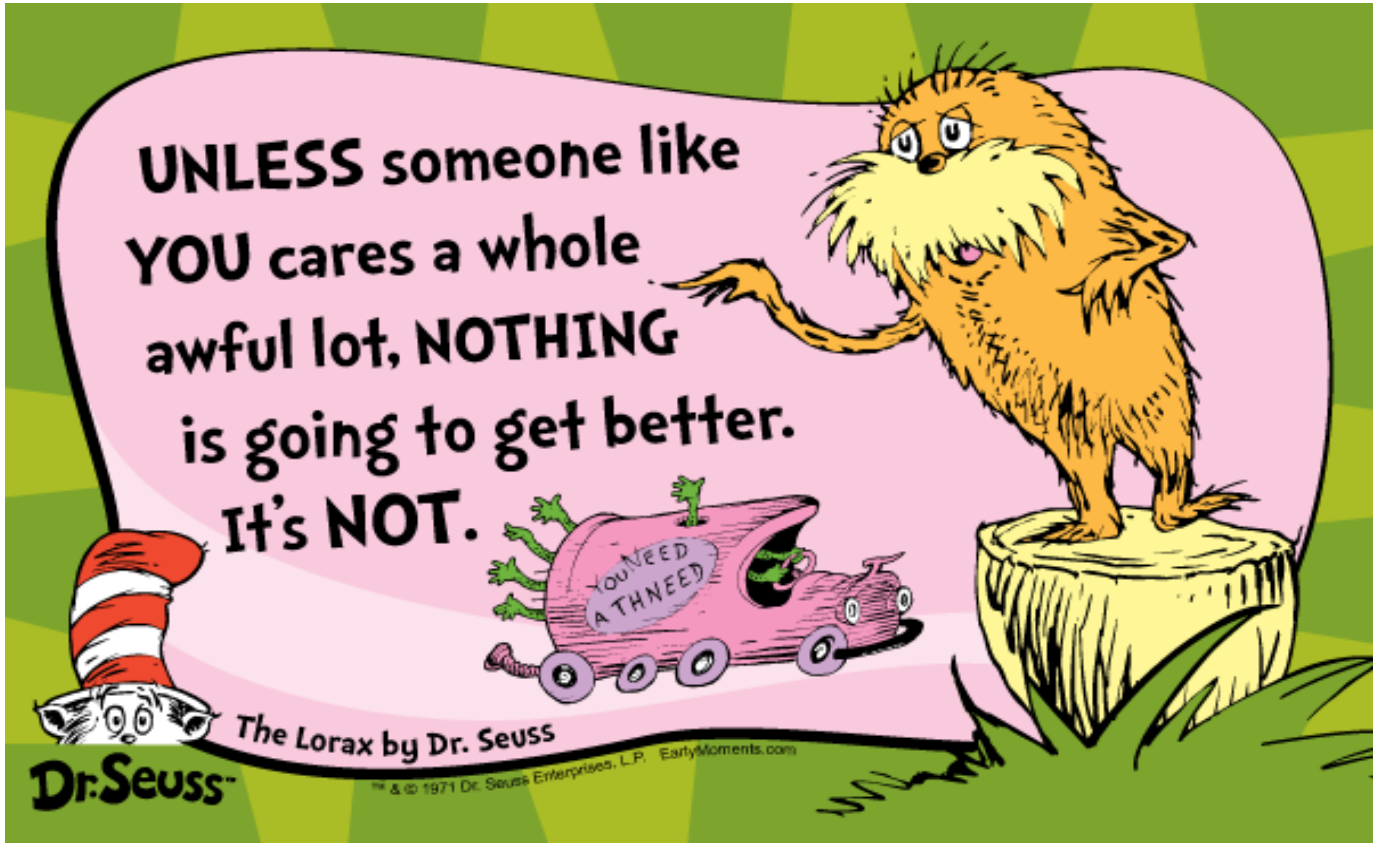
What is Advocacy?

- Trying to solve a problem by moving others to your point of view.
- Working to make change happen
- Political process – Big P-Politics and little p politics
- Using one's influence - not to coerce, but to change minds

How Many of You…?

- Consider yourself as advocates?
- What type? Patients, systems, hospitals, etc.?
- Have been involved at the local government level?
- At the State level?
- Federal Level?
- Think lobbying is a dirty word?

What Do You Care About?



What your peers say about advocacy

How to Get Started?

- Pick an issue, a cause, a problem
- Pick something that matters to you
- Start Small – look local
- You are not alone – find like minded individuals/allies
- Tools and help are available

Today your issue/cause: Graduate Medical Education Reform/Funding

- Federal support for Teaching Health Centers
- State support for Medicaid funding of residency positions
- Hospital Leadership support for family medicine training positions

Working Toward an Advocacy Goal

How to Develop an Advocacy Goal

- What change do we want to bring about?

  What's going wrong? What evidence is there? What needs to change? Change How? What's the alternative to propose?

- Who can make the change?

  Who has the power? Who are your allies? Your opponents?

- How can you activate them to make your change?

  How will you get them to agree your change is important? How will you get them to want to be the one to solve your problem? How do you negate the power of your opponents?

One Example of a Cause and Campaign - THCs

Teaching Health Centers –

- What Change was needed?
  - Resident Training in real world, underserved and community settings
  - Good training for Residents
  - Good pipeline for community health centers
- Who Can Make the Change?
  - Congress needed to allow resources (payment) through Medicare (or appropriations)
- How to Activate them to Make the Change
  - Advocacy Campaign

Skill Development

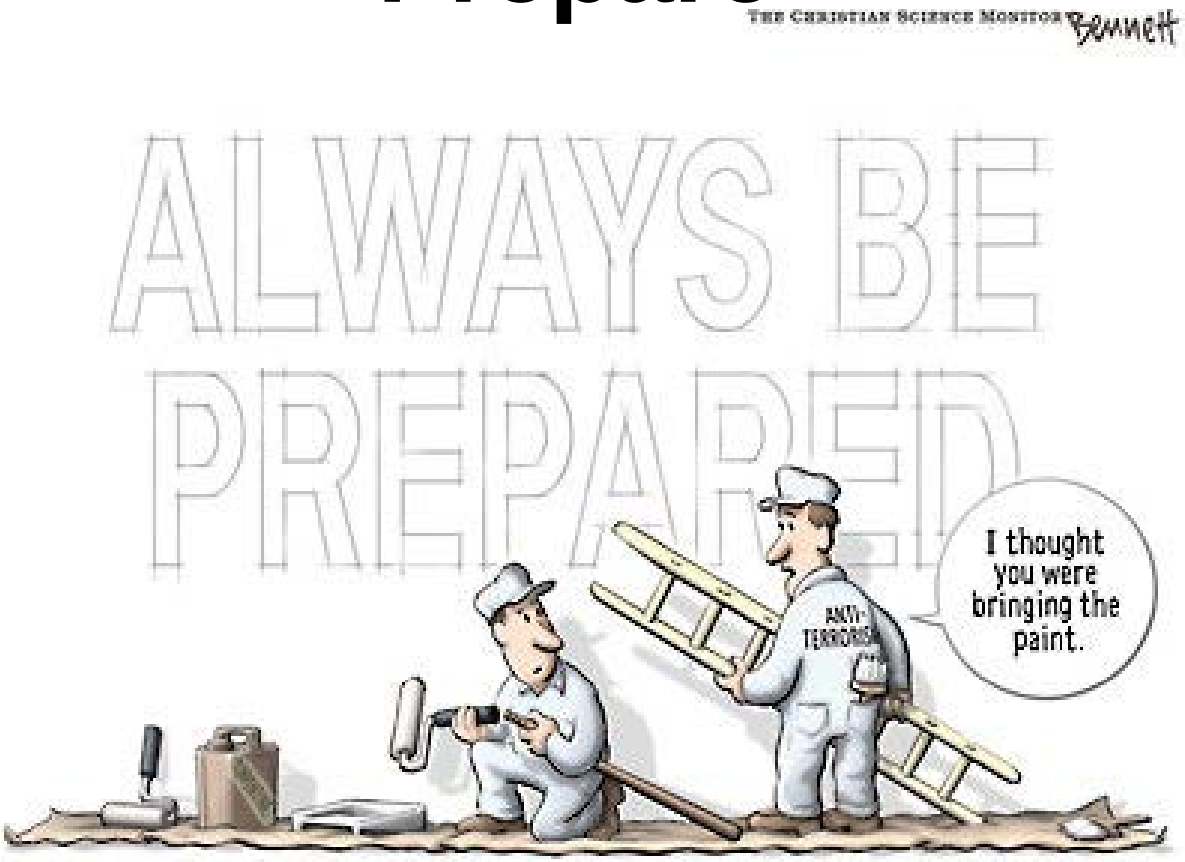
Why FM educators can be great advocates!

- Education: Learners vs. Teachers
- Information = Advocacy
- Use your teaching skills

The First Visit

- First time is the hardest
- Loss of power and control
- Knowledge is power - black box revealed

Prepare


THE CHRISTIAN SCIENCE MONITOR Bennett
ALWAYS BE PREPARED
I thought you were bringing the paint.
ANTI-TERRORIST

Prepare

- **Know Your Legislator or Hospital Leader**
  - ✓ Politics
  - ✓ Committees
  - ✓ Track Record
- **Know Your Ask**
  - ✓ Review Issues
  - ✓ Know your Talking Points
  - ✓ Have Material Ready (Leave-Behinds)
- **Be Prepared for "Chaos"**
  - ✓ Young Staff
  - ✓ Opposition of competing interests
  - ✓ Limited Time – Long Lines

Engage

Do's:

- ✓ Thank Member/Leader
- ✓ Stay on Message
- ✓ Listen
- ✓ Make the Ask
- ✓ Follow Up

Don'ts

- ✓ Don't Be Late
- ✓ Don't Argue
- ✓ Don't Have to Be Expert
- ✓ Limit your Ask – What's your top priority?

Maintain

Skill Needed: It's the Relationship, Stupid

Exchange of ideas

Building trust

Identifying needs

Expertise

Sharing concerns

Maintain the Relationship

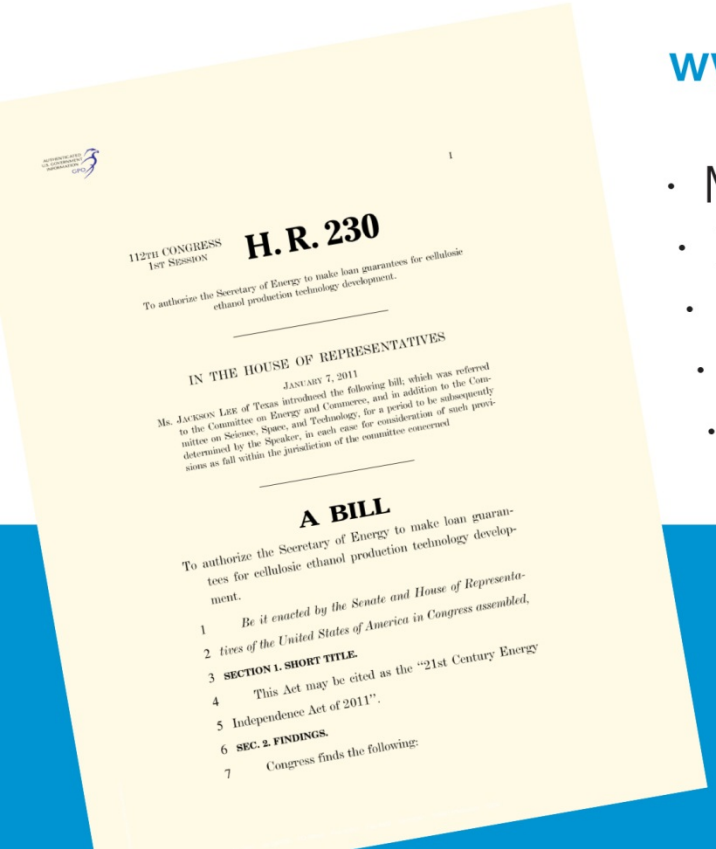
- It's a long haul
- Advocacy takes time and continued effort
- What can you do for "them?"

What's Next

How do you go from this quick presentation to becoming a strong advocate?

NEW Advocacy Modules

STFM's FREE Advocacy online modules have been completely revised and updated for 2015 with new modules, more interaction, video interviews with fellow family medicine advocates, animated slides, and a running time of under 45 minutes.



112TH CONGRESS
1ST SESSION

H. R. 230

To authorize the Secretary of Energy to make loan guarantees for cellulosic ethanol production technology development.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 7, 2011

Ms. JACKSON LEE of Texas introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Science, Space, and Technology, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To authorize the Secretary of Energy to make loan guarantees for cellulosic ethanol production technology development.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "21st Century Energy Independence Act of 2011".

SEC. 2. FINDINGS.

Congress finds the following:

www.stfm.org/OnlineEd/AdvocacyCourse

- Module 1: *Getting Started in Advocacy*
- Module 2: *Prepare and Make Contact*
- Module 3: *The One-Pager*
- Module 4: *The Visit*
- Module 5: *Maintaining the Relationship*

STFM
SOCIETY OF TEACHERS OF FAMILY MEDICINE

Family Medicine Congressional Conference

Washington, DC – May 12-13, 2015

- Make an impact in our nation's capital
- Converge with other family medicine advocates from across the country
- Learn more about issues at the federal level, as well as what you can do to help family medicine's legislative priorities.

- The first day will provide an opportunity to hear from a variety of experts.
- Put what you learn into practice on the second day by meeting with your legislators on Capitol Hill.
- Leave the conference with tools that will help you continue advocating on behalf of family medicine.

Join the CAFM Advocacy Network (CAN)

With support from the Council of Academic Family Medicine (CAFM) government relations staff, you'll:

- Get to know your legislators' backgrounds, issue priorities, and committee assignments
- Contact and meet with legislators in their district office and/or Washington, DC
- Respond to action alerts
- Report your advocacy efforts
- Goal: at least one rep every residency, department

Tools to Help You

- STFM.ORG/advocacy – one pagers, talking points, etc.
- STFM Government Relations Staff: hwittenberg@stfm.org; llivingston@stfm.org

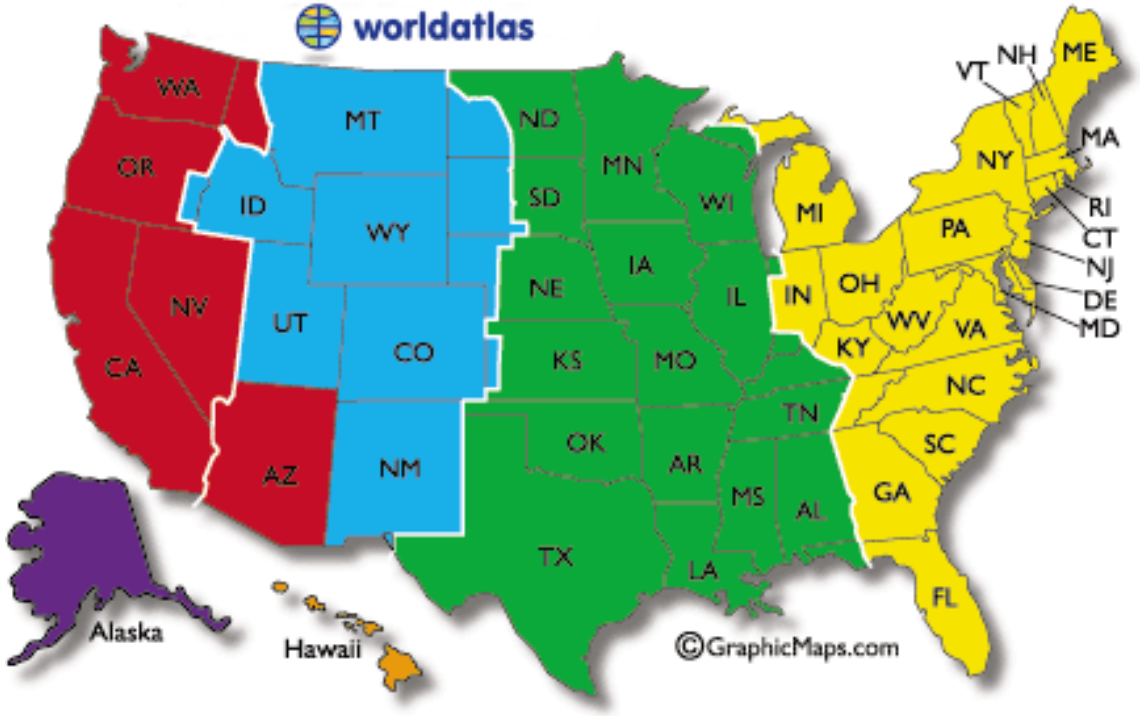
- Family Medicine Congressional Conference
- FREE online Advocacy course
- CAFM Advocacy Network

Putting it into Practice

Prepare for Mock Visits

Prepare for Mock Visits: 25 minutes

- Three large groups of 16
- Within each large group, 4 groups of 4
- One person will be the person with whom you are meeting
  - This person can still participate in preparation
  - Read the feedback form for additional background information
- Select one of the three scenarios:
  - Teaching Health Centers
  - State Medicaid
  - Hospital expansion of GME



Group 1: Yellow states / Kathleen

Group 2: Green and Blue states / Winston

Group 3: Red, Purple, and Orange states / Hope

Prepare for Mock Visits: 25 minutes

- Reminders:
  - Introduce yourselves
  - Communicate your ask
  - Support it with personal stories or anecdotes

Mock Visits

Mock Visits: 20 minutes

- Introduce yourselves
- Objective:
  - Communicate your ask
  - Support your ask with anecdotes

- Person with whom you are meeting
  - Complete the feedback form
  - Leave 5 minutes for giving feedback to the group

Please evaluate this session at:
stfm.org/sessionevaluation