Medical School Expansion, Primary Care, And Policy: Engaging Primary Care Educators In Evidence-based Advocacy

Andrew Bazemore

Julie Phillips

Amy McGaha

Hope Wittenburg

The Robert Graham Center: Policy Studies in Family Medicine and Primary Care
www.graham-center.org

Need to build Primary Care Capacity Now

- So, with a higher per capita GDP, fewer uninsured and less rural-urban separation, Massachusetts has struggled mightily to guarantee comprehensive primary care access for its population
- Why?

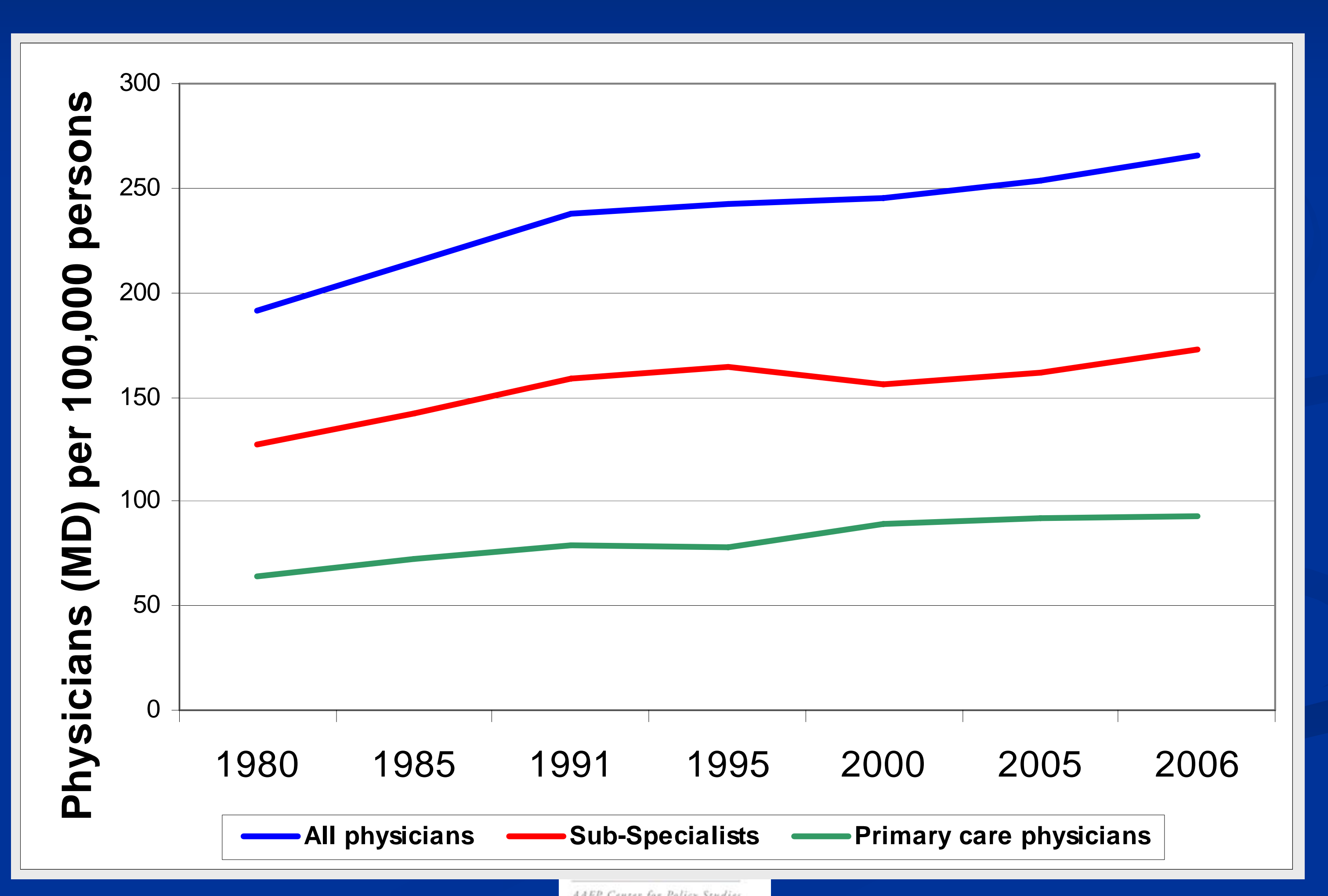
National Trends for Physician Workforce

- National workforce trends
- Updates on School expansion, residency expansion

Primary Care Workforce

- 97,752 family physicians/general practitioners
  - 1 for every 3, 081 persons
- 92,257 general internists
  - 1 per 2,443 adults
- 48,930 general pediatricians
  - 1 for 1,548 children and adolescents
- **238,939 primary care physicians**
  - **1 for every 1,260 persons**

Physician Specialties to Population Ratio 1980-2006 (Physicians per 100,000 persons)



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Is it a Primary Care Shortage?

- Problems:
  - Distribution
    - Still concentrated in desirable areas
    - Relative shortage in underserved and rural areas
    - True for physicians, NPs and Pas
  - Scope
    - Primary care physicians performing non-primary care tasks to remain solvent

What lies ahead: Will there be a Primary Care Shortage?

- What's to come:
  - Substantial decline in US student interest
  - Increased reliance on international students
  - Increased interest in specialization and alternative careers
  - Contraction of training programs
  - Majority of PAs now subspecialize; NPs?
- Current physician expansion effort not promoting primary care

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Erosion of Primary Care Training Capacity

Status check: Family Medicine

Positions

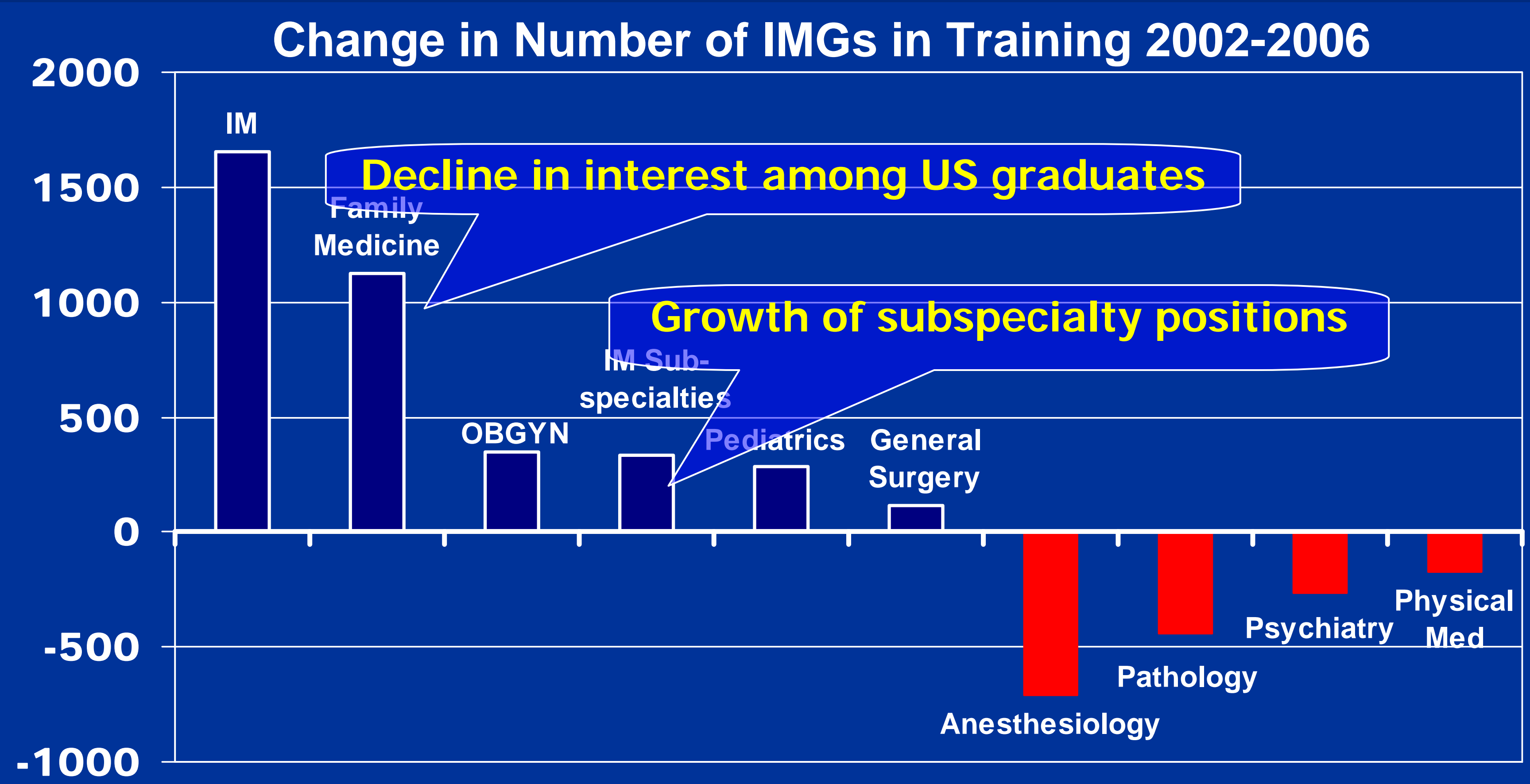
Year	Positions Offered	Filled U.S. Seniors
1997 71.7%	3,262	2,340
1998 66.2%	3,293	2,179
1999 62.0%	3,265	2,024
2000 57.2%	3,206	1,833
2001 49.0%	3,096	1,516
2002 47.4%	2,983	1,413
2003 42.0%	2,940	1,234
2004 41.5%	2,884	1,198
2005 40.7%	2,782	1,132
2006 41.5%	2,727	1,132
2007 42.2%	2,621	1,107
2008 44.2%	2,654	1,172

Positions Offered — Filled U.S. Seniors

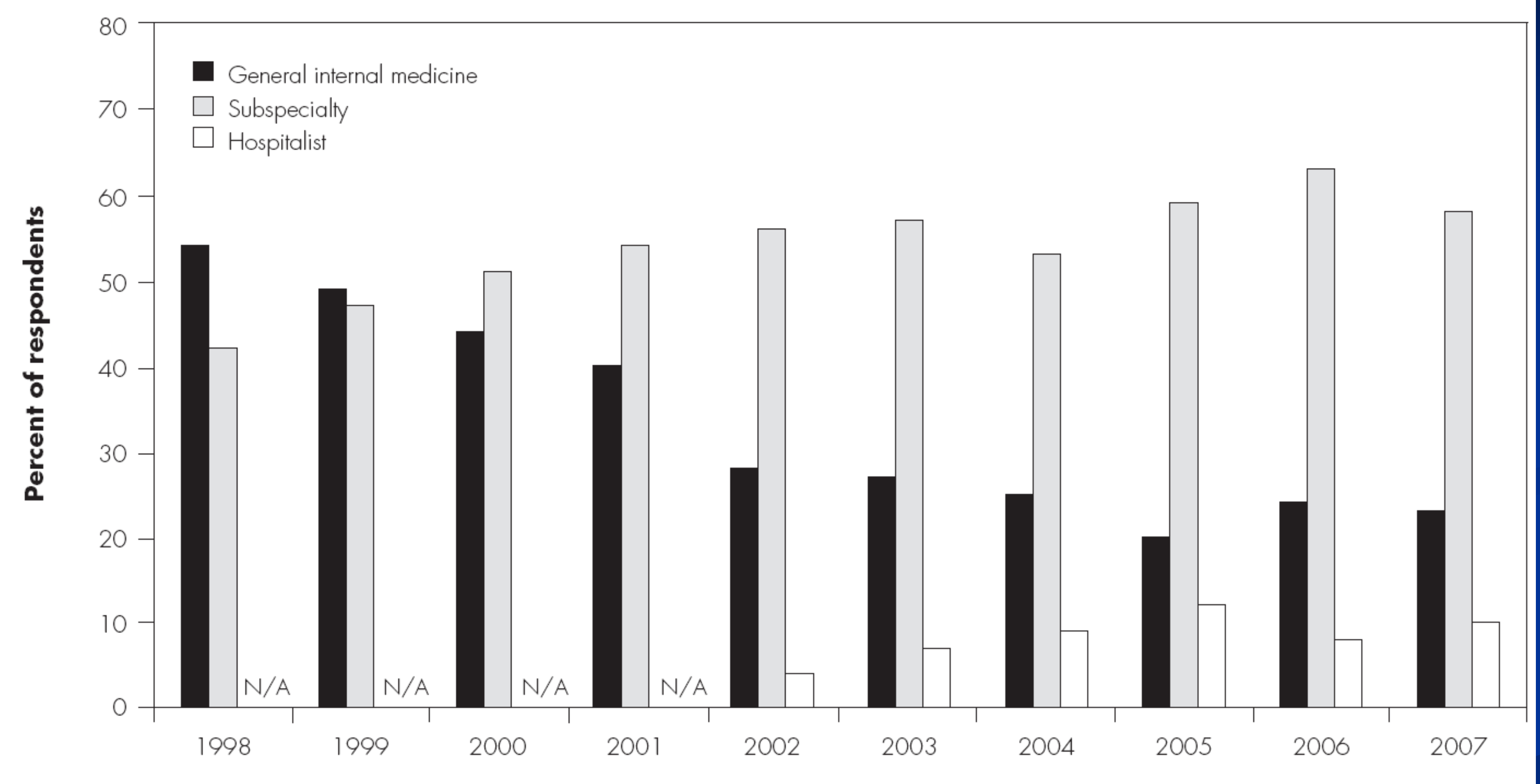
Family Medicine Positions March, 2008

Filled by US Graduates

Reliance on International Medical Graduates



Source: JAMA Medical Education Issues, Ed Salsberg, AAMC



Note: MedPAC June 2008

Source: Bodenheimer, T. 2006. Primary care–Will it survive? *The New England Journal of Medicine* 355:861–864. *Copyright © 2006 Massachusetts Medical Society. All rights reserved.* Updated to include years 2006 and 2007, supplied by Thomas Bodenheimer, who obtained the relevant data from The American College of Physicians.

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Student Interest

General Internal Medicine	2.0%
Med/Peds	2.7%
Family Medicine	4.9%
General Pediatrics	11.7%
Total:	21.3%

K. E. Hauer et al. Choices Regarding Internal Medicine Factors Associated With Medical Students' Career *JAMA*. 2008;300(10):1154-1164

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Primary care losing ground: GME

- Between 2002 and 2007
  - Residency positions grew +7.9%
  - Subspecialty positions grew +24.7%
  - Primary care positions grew +2.3%
  - Family Medicine positions fell -2.8%
    - **However…the estimated number of graduates going on to practice primary care fell 15%** (from 28.1% to 23.8%)

E. Salsberg et al. US Residency Training Be[...]d After the 1997 Balanced Budget Act. *JAMA.* 2008;[...]4-1180.

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Medical Student Debt, Primary Care Career Choice, and Service

Background

- Medical student debt is very high
  - Out of proportion to other professions
  - Growing faster than physician income
  - Mean: more than $130,000
  - One in four 2008 U.S. medical school graduates will have more than $200,000 in educational debt
- No clear relationship between debt and specialty choice in studies to date

Hypotheses:

- students with high debt will be…
  - Less likely to choose primary care specialties
  - Less likely to serve in Federally Qualified Community Health Center or rural locations
  - More likely to serve in National Health Service Corps
- Effect of debt would be stronger as debt levels increased

Results: Debt and Primary Care

	Public School			Private School		
	Mean Debt	Median Debt	Percent with Debt	Mean Debt	Median Debt	Percent with Debt
Primary Care	$70,000	$64,000	79%	$100,000	$92,000	78%
Family Medicine	$70,000	$64,000	80%	$99,000	$90,000	79%
Other	$61,000	$54,000	77%	$86,000	$73,000	76%

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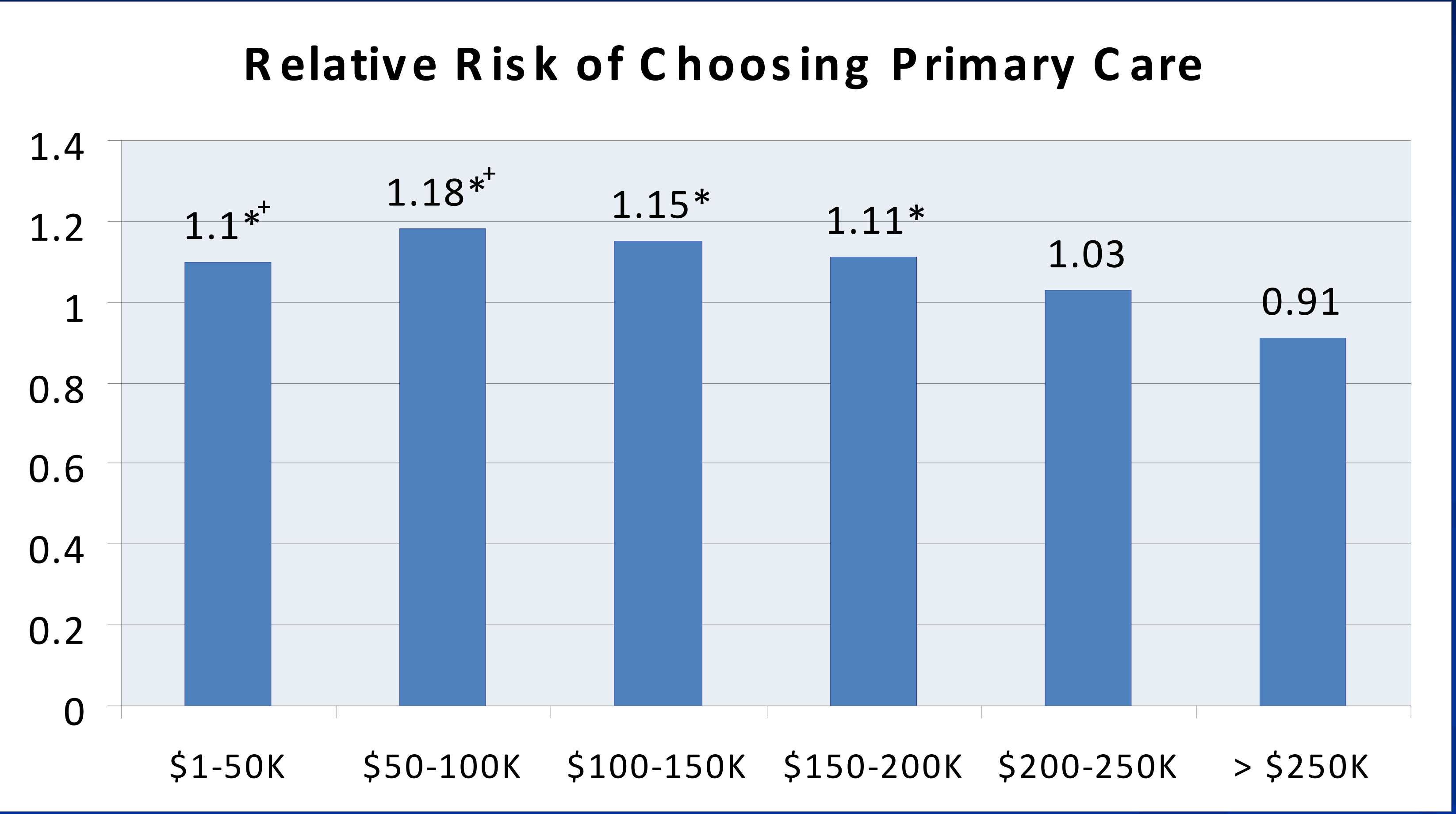
Results: Debt and Primary Care



Reference variable: no educational debt

*statistically significant differe[illegible] ference

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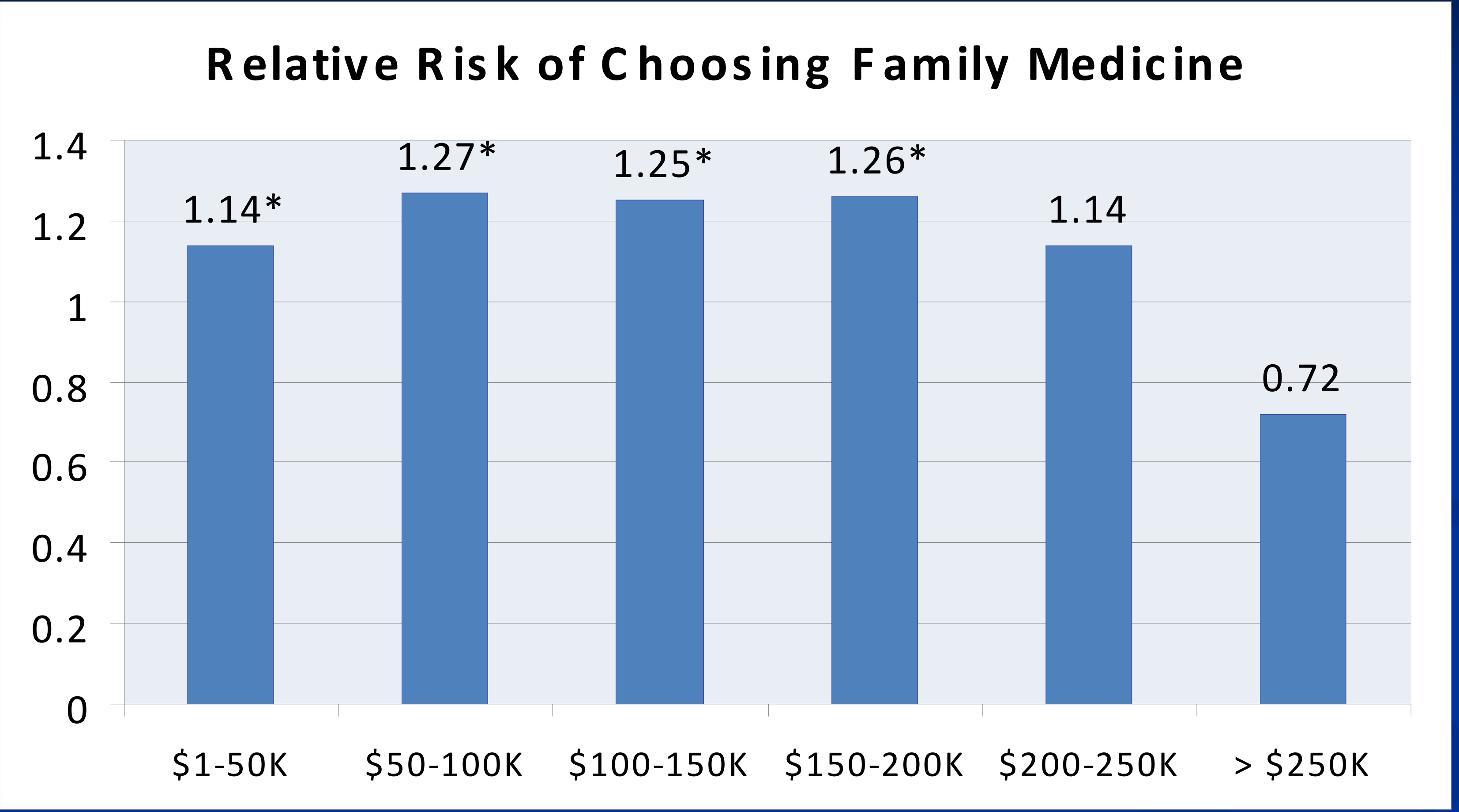
Results: Debt and Family Medicine



Reference variable: no educational debt

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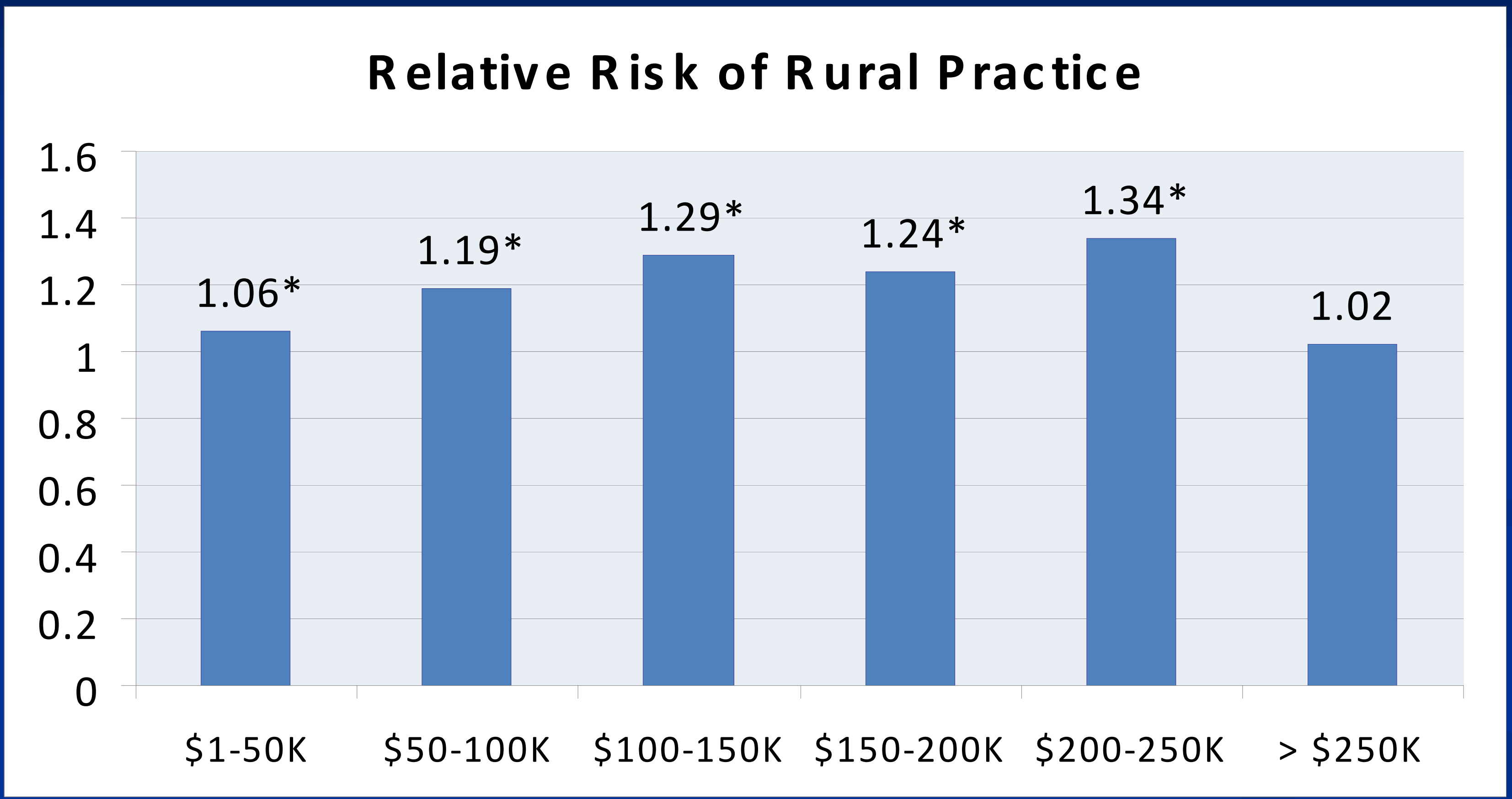
Results: Debt and Other Outcomes

Students with any level of debt were

- More likely to practice in a Federally Qualified Health Center or Rural Health Center
  - Effect disappears after controlling for obligating scholarships
- Equally likely to practice in a Health Professions Shortage Area or Medically Underserved Area
- More likely to practice in a rural area
- Much more likely to practice in National Health Service Corps
  - Scholarship recipients tend to have low levels of debt
  - Physicians accepting loan repayment tend to have high debt

Results: Debt and Rural Practice



Reference variable: no educational debt
*statistically significant differe[illegible]ference

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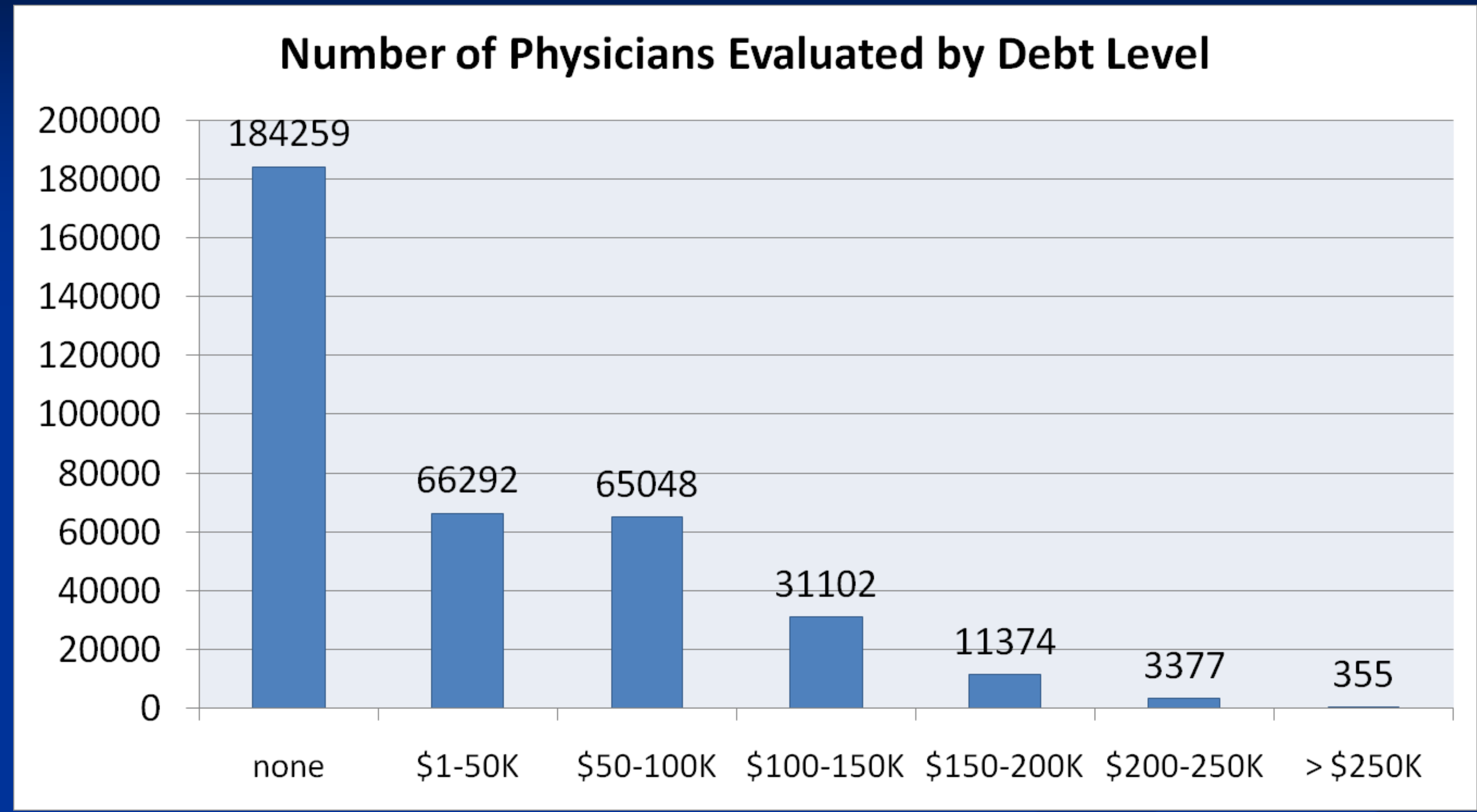
Students who choose primary care, family medicine, and rural practice have **more debt. Why?**

- Parents' income strongest predictor of medical school debt
- Students from lower income families more likely to choose primary care and family medicine
- Not able to control for socioeconomic status in this study
- Positive effect of debt on primary care disappears above $200K – especially among public school students
- Positive effect of debt on rural practice disappears above $250K

Our subjects' debt levels are lower than today.



Reference variable: no educational debt

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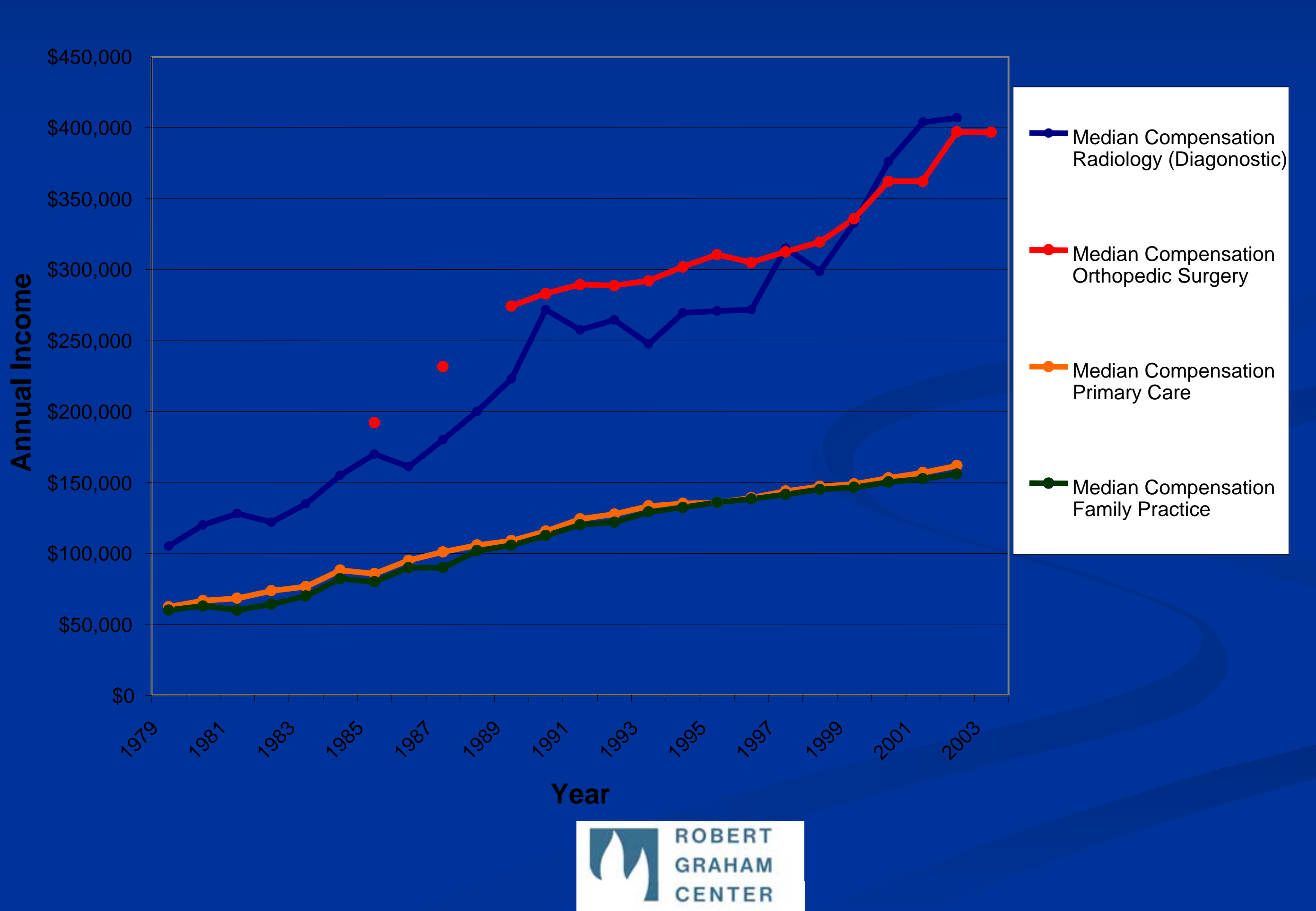
All debt effects were small compared to effect of the **Physician Payment Gap**.



Effect of Physician Payment Gap on Relative Risk of the Outcome

	Relative risk
primary care	0.46
Family Medicine	0.54
FQHC or RHC practice	0.7
rural	0.81
HPSA or MUA	1.12

All differences are statistically significant

Conclusions

- Debt up to $200-250,000 has a modest positive effect of likelihood of choosing family medicine, primary care, or rural practice.
- This effect may be related to socioeconomic status, which could not be measured.
- Effect of very high debt needs more study.
- Effect of physician payment gap on specialty choices is much more powerful.

Question: Is the effect of debt just due to scholarship obligations?

- Answer: Partly.
- Having debt has an independent positive effect on the likelihood of choosing family medicine or primary care, and practicing in a rural area, regardless of obligating scholarships.
- The effect of debt on practicing in a Rural Health Center or Federally Qualified Health Center disappears after controlling for obligating scholarships.

Macy Report: Return on Investment

Bob Phillips MD MSPH

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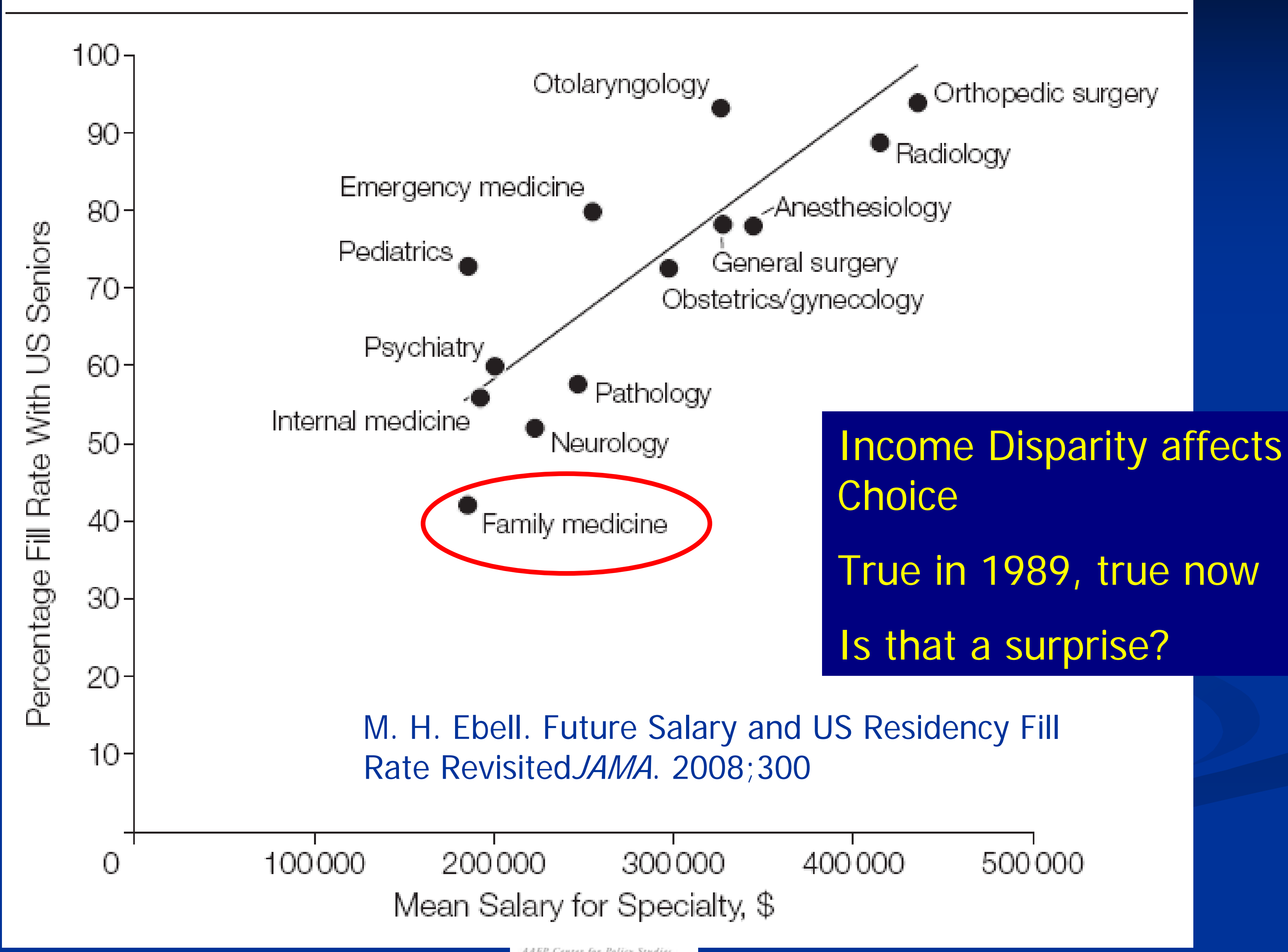
Figure. Percentage of Positions Filled With US Seniors vs Mean Overall Income By Specialty
Percentage Fill Rate With US Seniors
Mean Salary for Specialty, $
0
10
20
30
40
50
60
70
80
90
100
100000
200000
300000
400000
500000
Otolaryngology
Orthopedic surgery
Radiology
Emergency medicine
Anesthesiology
Pediatrics
General surgery
Obstetrics/gynecology
Psychiatry
Pathology
Internal medicine
Neurology
Family medicine
Income Disparity affects Choice
True in 1989, true now
Is that a surprise?
M. H. Ebell. Future Salary and US Residency Fill Rate Revisited JAMA. 2008;300
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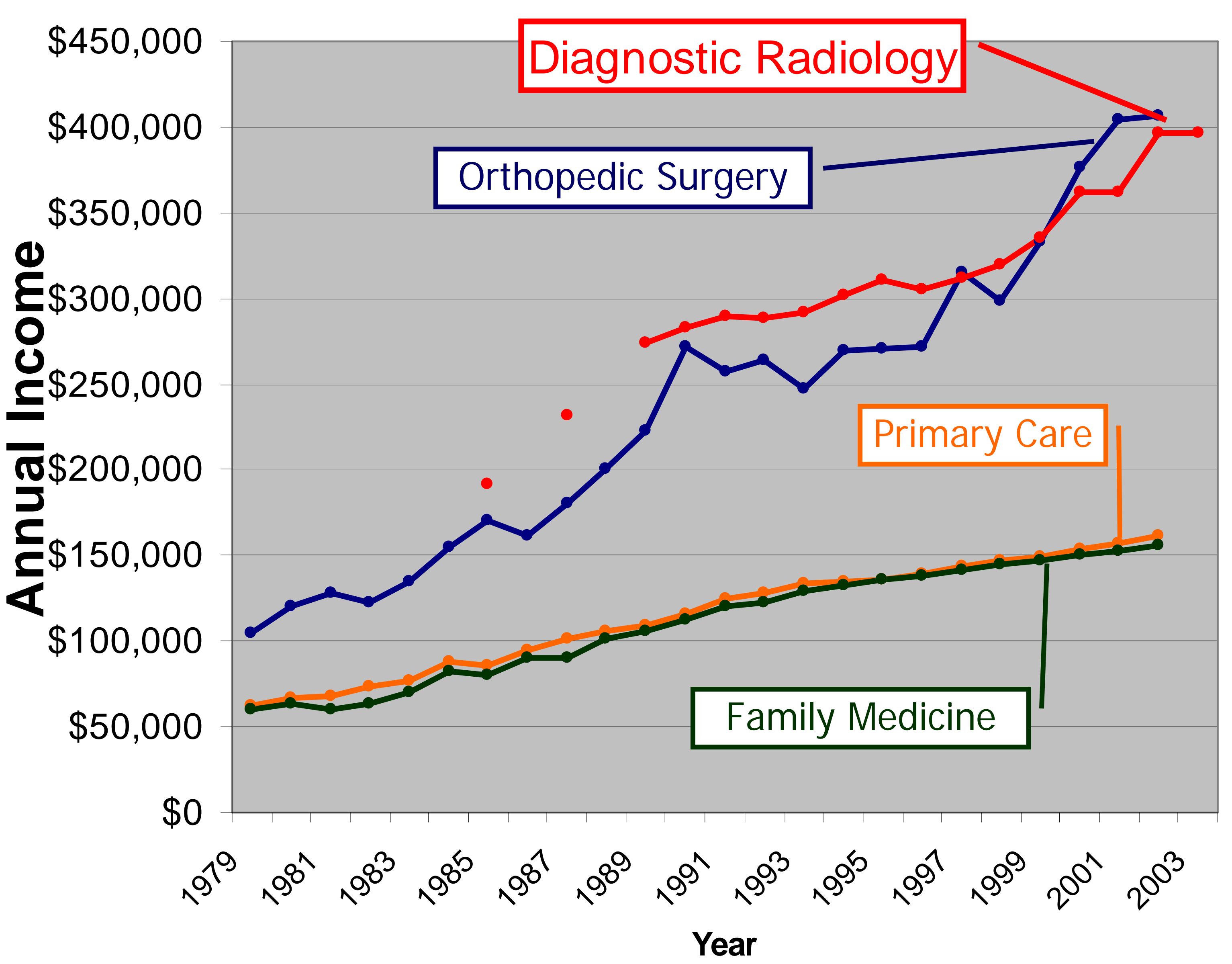
Progress of the Physician Payment Gap
Diagnostic Radiology
Orthopedic Surgery
Primary Care
Family Medicine
Annual Income
$450,000
$400,000
$350,000
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$0
1979
1981
1983
1985
1987
1989
1991
1993
1995
1997
1999
2001
2003
Year

Unintended Consequences of Resource Based-Relative Value Scale Reimbursement [1]

"Medicine's generalist base is disappearing as a consequence of the reimbursement system crafted to save it – the RBRVS"

[1] Goodson JD. Unintended Consequences of Resource Based-Relative Value Scale Reimbursement. JAMA. 2007:298:19:2308-10

Market doesn't absolve Schools

- Income gap – 0.5 odds of choosing Primary Care
- Preliminary results Macy Foundation Study:
  - Rural birth – 2.5 x odds of rural practice
    2 x odds of Family medicine
  - Public Medical School
    2 x odds of FM and Rural
  - National Health Service Corps
    4 x odds of being in an FQHC
  - Interest in Serving Underserved
    3 x odds of being in an FQHC 4
    x odds of Rural Health Center
  - Inner City, Rural and Primary Care Clerkships and Electives Matter

Factors Affecting Medical Student a... ...nt Career Choices. Graham Center 2009. Funded by th... ...acy Jr. Foundation

Medical Schools can <u>choose and train</u> students to produce

- More Primary Care
- More Rural Access
- More Access for Underserved

Despite the Market

STFM, AFMAA & Advocacy on behalf of the primary care pipeline

Hope Wittenburg

Director of Government Relations, STFM

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Also working for you - AFMAA

- Advocating educational issues on a federal level
- Coalition of
  - STFM
  - NAPCRG
  - ADFM
  - AFMRD
- Staff of 1.5
- Advocacy Power rests in the membership

RGC & AFMAA

- Collaborating to expand both group's mission to advance primary care through policy change
- Information that enhances grassroots advocacy is a shared goal

The Role of the AAFP Medical Education Division

Amy McGaha, MD

Assistant Director, Medical Education

AAFP

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Entry of US Medical School Graduates Into Family Medicine Residencies: 2007–2008 and 3-year Summary

Amy L. McGaha, MD; Gordon T. Schmittling, MS;
Ashley D. DeVilbiss; Perry A. Pugno, MD, MPH, CPE

This is the 27th report prepared by the American Academy of Family Physicians (AAFP) on the percentage of each US medical school's graduates entering family medicine residency programs. Approximately 8.3% of the 16,300 graduates of US medical schools between July 2006 and June 2007 were first-year family medicine residents in 2007, compared with 8.5% in 2006 and 8.4% in 2005. Medical school graduates from publicly funded medical schools were more likely to be first-year family medicine residents in October 2007 than were residents from privately funded schools, 10.0% compared with 5.6%. The West North Central and the Mountain regions reported the highest percentage of medical school graduates who were first-year residents in family medicine programs in October 2007 at 12.2% and 11.9%, respectively; the New England and Middle Atlantic regions reported the lowest percentages at 5.5% and 4.7%, respectively. Nearly half of the medical school graduates (46.5%) entering a family medicine residency program as first-year residents in October 2007 entered a program in the same state where they graduated from medical school. The percentages for each medical school have varied substantially from year to year since the AAFP began reporting this information. This article reports the average percentage for each medical school for the last 3 years. Also reported are the number and percentage of graduates from colleges of osteopathic medicine who entered Accreditation Council for Graduate Medical Education-accredited family medicine residency programs, based on estimates provided by the American Association of Colleges of Osteopathic Medicine.

(Fam Med 2008;40(8):551-62.)

Graham Center tools & resources for medical education advocacy

Andrew Bazemore

Assistant Director

Robert Graham Center

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Visits to family physicians constitute more than 22 percent of all outpatient patient visits -- 250 million visits annually -- but family physicians receive just 0.22 percent of NIH research dollars. Family medicine's substantial clinical presence means family physicians should be instrumental in helping to bridge the chasm between medical knowledge and actual clinical care toward improved population health. So what's the problem with research translation?

Read the full report:
Off the Roadmap? Family Medicine's Grant Funding and Committee Representation at NIH

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The Center aims to achieve this mission through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international leve

WHAT'S NEW

- Characterizing breast symptoms in family practice
  November 2008
  (Articles)
- Changing patient health-risk behavior requires new investment in primary care
  October 2008
  (One-Pagers)
- Navigating general practice. The use of geographic information systems
  October 2008
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Primary Care Forum

What the Federal Government Should Do to Revitalize the Primary Care Infrastructure in the United States

- Thurs., Jan. 29, 2009, at 7:30 a.m.
- For more information, please contact us at policy@aafp.org

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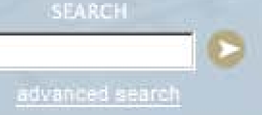
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How can the Graham Center help?

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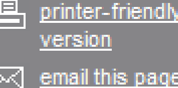
- Ensuring access to a modern, Medical Home: The role for a primary care extension program in health reform
- The Family Physician as Economic Stimulus
- Family medicine's grant funding and committee representation at NIH

Ensuring access to a modern, Medical Home: The role for a primary care extension program in health reform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As momentum builds for health reform legislation in the 111th Congress, calls to rebuild the crumbling primary care infrastructure in the United States are reaching receptive ears, with public and private advisory groups including the Medicare Payment Advisory Commission and the National Business Group on Health recommending increased payments for primary care. New investment in primary care is necessary, but not sufficient to create modernized, high performing primary care medical homes unless joined to a strategy for disseminating and implementing innovations and best practices. As the family medicine TransforMED program and other efforts in practice improvement have found, to successfully redesign practices requires knowledge transfer, performance feedback, facilitation, and HIT support provided by individuals with whom practices have established trusting relationships over time. The farming community learned these principles a century ago. Primary care practices are very much like the small farms of that era which were geographically dispersed, poorly resourced for change, and inefficient in adopting new techniques or technology, but vital to the nation's well being. Practicing physicians need something akin to the agricultural extension agent which was so transformative for farming.

Health reform legislation should include establishment of a nationwide Primary Care Cooperative Extension Service, modeled after the US Department of Agriculture's Cooperative State Research, Education, and Extension Service which so successfully accelerated farm transformation. Similar to the USDA program, a new Primary Care Extension Program would establish partnerships between community-based primary care clinicians and university-based centers of excellence to facilitate practice redesign, adoption of team-based care models, shared care management resources, workforce development, and other activities. County-based health extension organizations would support primary care clinicians in the same manner that the agricultural model assists family farmers, providing infrastructure for local learning communities and practice transformation. Successful progenitors of primary care extension programs exist in several states and demonstrate the promise of taking a Primary Care Extension Program to scale nationwide.

For more information:

- Ensuring Access to a Modern, Medical Home: The Role for a Primary Care Extension Program in Health Reform
- Primary Care Extension Agent Concept Diagram [1-page PDF; About PDFs]
- The Oklahoma Physicians Resource/Research Network (OKPRN)
- The Center for Excellence in Primary Care, the University of California, San Francisco
- Community Care of North Carolina
- The New Mexico Health Extension Regional Offices (HEROs)
- TransforMED
- Improving Primary Care: Strategies and Tools for a Better Practice

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One-pagers, publications, monographs

The Patient Centered Medical Home

History, Seven Core Features, Evidence and Transformational Chang

ROBERT GRAHA

The Medical Home: Growing evidence to support a new approach to primary care.

Thomas C. Rosenthal MD
University at Buffalo
Department of Family Medicine

Journal of the American Board of Family Medicine

"The better the primary care, the greater the cost savings, the better the health outcomes, and the greater the reduction in health and health care disparities". 1

Data Tables, Annotated Slides, and Maps

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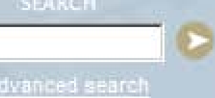

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What the Federal Government Should Do to Revitalize the Primary Care Infrastructure in the United States

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The Robert Graham Center Update

A compendium of slides for public use that includes original and adapted analyses and commentary from the staff of the Robert Graham Center.

The Robert Graham Center Update -- PDF Version
(47-page PDF file; About PDFs)

The Robert Graham Center Update -- Powerpoint Version
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July 2008

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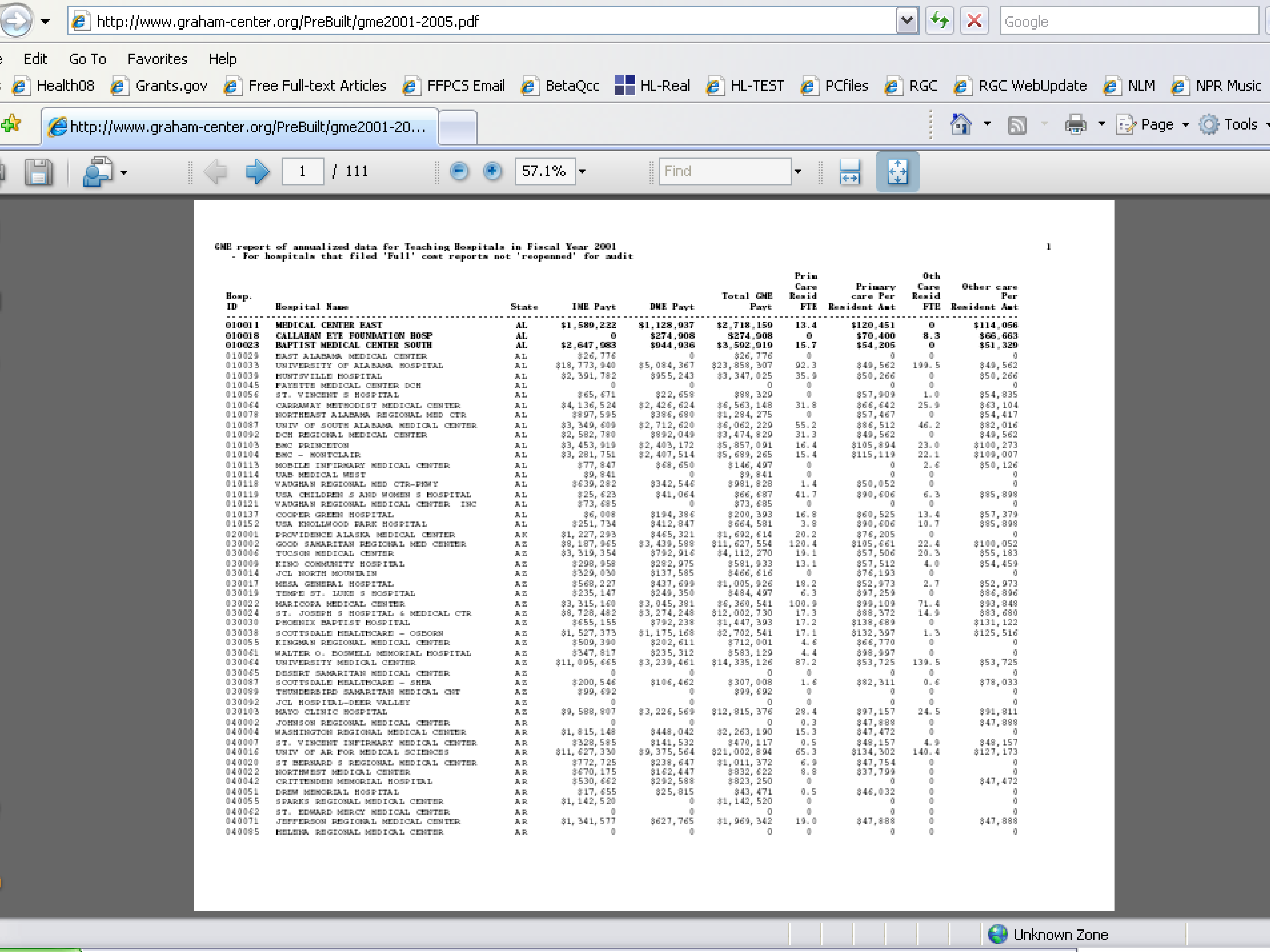
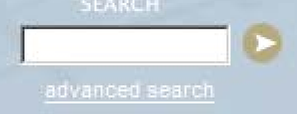


GME report of annualized data for Teaching Hospitals in Fiscal Year 2001
- For hospitals that filed 'Full' cost reports not 'reopenned' for audit

Hosp. ID	Hospital Name	State	IME Payt	DME Payt	Total GME Payt	Prim Care Resid FTE	Primary care Per Resident Amt	Oth Care Resid FTE	Other care Per Resident Amt
010011	**MEDICAL CENTER EAST**	**AL**	**$1,589,222**	**$1,128,937**	**$2,718,159**	**13.4**	**$120,451**	**0**	**$114,056**
010018	**CALLAHAN EYE FOUNDATION HOSP**	**AL**	**0**	**$274,908**	**$274,908**	**0**	**$70,400**	**8.3**	**$66,663**
010023	**BAPTIST MEDICAL CENTER SOUTH**	**AL**	**$2,647,983**	**$944,936**	**$3,592,919**	**15.7**	**$54,205**	**0**	**$51,329**
010029	EAST ALABAMA MEDICAL CENTER	AL	$26,776	0	$26,776	0	0	0	0
010033	UNIVERSITY OF ALABAMA HOSPITAL	AL	$18,773,940	$5,084,367	$23,858,307	92.3	$49,562	199.5	$49,562
010039	HUNTSVILLE HOSPITAL	AL	$2,391,782	$955,243	$3,347,025	35.9	$50,266	0	$50,266
010045	FAYETTE MEDICAL CENTER DCH	AL	0	0	0	0	0	0	0
010056	ST. VINCENT S HOSPITAL	AL	$65,671	$22,658	$88,329	0	$57,909	1.0	$54,835
010064	CARRAWAY METHODIST MEDICAL CENTER	AL	$4,136,524	$2,426,624	$6,563,148	31.8	$66,642	25.9	$63,104
010078	NORTHEAST ALABAMA REGIONAL MED CTR	AL	$897,595	$386,680	$1,284,275	0	$57,467	0	$54,417
010087	UNIV OF SOUTH ALABAMA MEDICAL CENTER	AL	$3,349,609	$2,712,620	$6,062,229	55.2	$86,512	46.2	$82,016
010092	DCH REGIONAL MEDICAL CENTER	AL	$2,582,780	$892,049	$3,474,829	31.3	$49,562	0	$49,562
010103	BMC PRINCETON	AL	$3,453,919	$2,403,172	$5,857,091	16.4	$105,894	23.0	$100,273
010104	BMC - MONTCLAIR	AL	$3,281,751	$2,407,514	$5,689,265	15.4	$115,119	22.1	$109,007
010113	MOBILE INFIRMARY MEDICAL CENTER	AL	$77,847	$68,650	$146,497	0	0	2.6	$50,126
010114	UAB MEDICAL WEST	AL	$9,841	0	$9,841	0	0	0	0
010118	VAUGHAN REGIONAL MED CTR-PKWY	AL	$639,282	$342,546	$981,828	1.4	$50,052	0	0
010119	USA CHILDREN S AND WOMEN S HOSPITAL	AL	$25,623	$41,064	$66,687	41.7	$90,606	6.3	$85,898
010121	VAUGHAN REGIONAL MEDICAL CENTER INC	AL	$73,685	0	$73,685	0	0	0	0
010137	COOPER GREEN HOSPITAL	AL	$6,008	$194,386	$200,393	16.8	$60,525	13.4	$57,379
010152	USA KNOLLWOOD PARK HOSPITAL	AL	$251,734	$412,847	$664,581	3.8	$90,606	10.7	$85,898
020001	PROVIDENCE ALASKA MEDICAL CENTER	AK	$1,227,293	$465,321	$1,692,614	20.2	$76,205	0	0
030002	GOOD SAMARITAN REGIONAL MED CENTER	AZ	$8,187,965	$3,439,588	$11,627,554	120.4	$105,661	22.4	$100,052
030006	TUCSON MEDICAL CENTER	AZ	$3,319,354	$792,916	$4,112,270	19.1	$57,506	20.3	$55,183
030009	KINO COMMUNITY HOSPITAL	AZ	$298,958	$282,975	$581,933	13.1	$57,512	4.0	$54,459
030014	JCL NORTH MOUNTAIN	AZ	$329,030	$137,585	$466,616	0	$76,193	0	0
030017	MESA GENERAL HOSPITAL	AZ	$568,227	$437,699	$1,005,926	18.2	$52,973	2.7	$52,973
030019	TEMPE ST. LUKE S HOSPITAL	AZ	$235,147	$249,350	$484,497	6.3	$97,259	0	$86,896
030022	MARICOPA MEDICAL CENTER	AZ	$3,315,160	$3,045,381	$6,360,541	100.9	$99,109	71.4	$93,848
030024	ST. JOSEPH S HOSPITAL & MEDICAL CTR	AZ	$8,728,482	$3,274,248	$12,002,730	17.3	$88,372	14.9	$83,680
030030	PHOENIX BAPTIST HOSPITAL	AZ	$655,155	$792,238	$1,447,393	17.2	$138,689	0	$131,122
030038	SCOTTSDALE HEALTHCARE - OSBORN	AZ	$1,527,373	$1,175,168	$2,702,541	17.1	$132,397	1.3	$125,516
030055	KINGMAN REGIONAL MEDICAL CENTER	AZ	$509,390	$202,611	$712,001	4.6	$66,770	0	0
030061	WALTER O. BOSWELL MEMORIAL HOSPITAL	AZ	$347,817	$235,312	$583,129	4.4	$98,997	0	0
030064	UNIVERSITY MEDICAL CENTER	AZ	$11,095,665	$3,239,461	$14,335,126	87.2	$53,725	139.5	$53,725
030065	DESERT SAMARITAN MEDICAL CENTER	AZ	0	0	0	0	0	0	0
030087	SCOTTSDALE HEALTHCARE - SHEA	AZ	$200,546	$106,462	$307,008	1.6	$82,311	0.6	$78,033
030089	THUNDERBIRD SAMARITAN MEDICAL CNT	AZ	$99,692	0	$99,692	0	0	0	0
030092	JCL HOSPITAL-DEER VALLEY	AZ	0	0	0	0	0	0	0
030103	MAYO CLINIC HOSPITAL	AZ	$9,588,807	$3,226,569	$12,815,376	28.4	$97,157	24.5	$91,811
040002	JOHNSON REGIONAL MEDICAL CENTER	AR	0	0	0	0.3	$47,888	0	$47,888
040004	WASHINGTON REGIONAL MEDICAL CENTER	AR	$1,815,148	$448,042	$2,263,190	15.3	$47,472	0	0
040007	ST. VINCENT INFIRMARY MEDICAL CENTER	AR	$328,585	$141,532	$470,117	0.5	$48,157	4.9	$48,157
040016	UNIV OF AR FOR MEDICAL SCIENCES	AR	$11,627,330	$9,375,564	$21,002,894	65.3	$134,302	140.4	$127,173
040020	ST BERNARD S REGIONAL MEDICAL CENTER	AR	$772,725	$238,647	$1,011,372	6.9	$47,754	0	0
040022	NORTHWEST MEDICAL CENTER	AR	$670,175	$162,447	$832,622	8.8	$37,799	0	0
040042	CRITTENDEN MEMORIAL HOSPITAL	AR	$530,662	$292,588	$823,250	0	0	0	$47,472
040051	DREW MEMORIAL HOSPITAL	AR	$17,655	$25,815	$43,471	0.5	$46,032	0	0
040055	SPARKS REGIONAL MEDICAL CENTER	AR	$1,142,520	0	$1,142,520	0	0	0	0
040062	ST. EDWARD MERCY MEDICAL CENTER	AR	0	0	0	0	0	0	0
040071	JEFFERSON REGIONAL MEDICAL CENTER	AR	$1,341,577	$627,765	$1,969,342	19.0	$47,888	0	$47,888
040085	HELENA REGIONAL MEDICAL CENTER	AR	0	0	0	0	0	0	0



Maps

Maps offer an excellent way to communicate complex information. Academy members told us that our initial maps opened doors with policy-makers, who found them visually compelling conversation synopses of difficult issues. We have responded to these comments, and are pleased to offer here our latest in a series of map collections. We believe these maps will be valuable resources for members and advocates at the local level as well as at the national level. These include the theoretical impact of removing family physicians from the country, and the graduate 'footprint' of residency programs on their communities.

If you wish to create your own customized maps, please visit HealthLandscape.org

Family Medicine Residency Footprint Maps

Closing Family Medicine Residency Programs Footprint Maps

Primary Care Health Professional Shortage Area Maps

Primary Care Health Professional Shortage Area Maps After Withdrawal of Family Physicians

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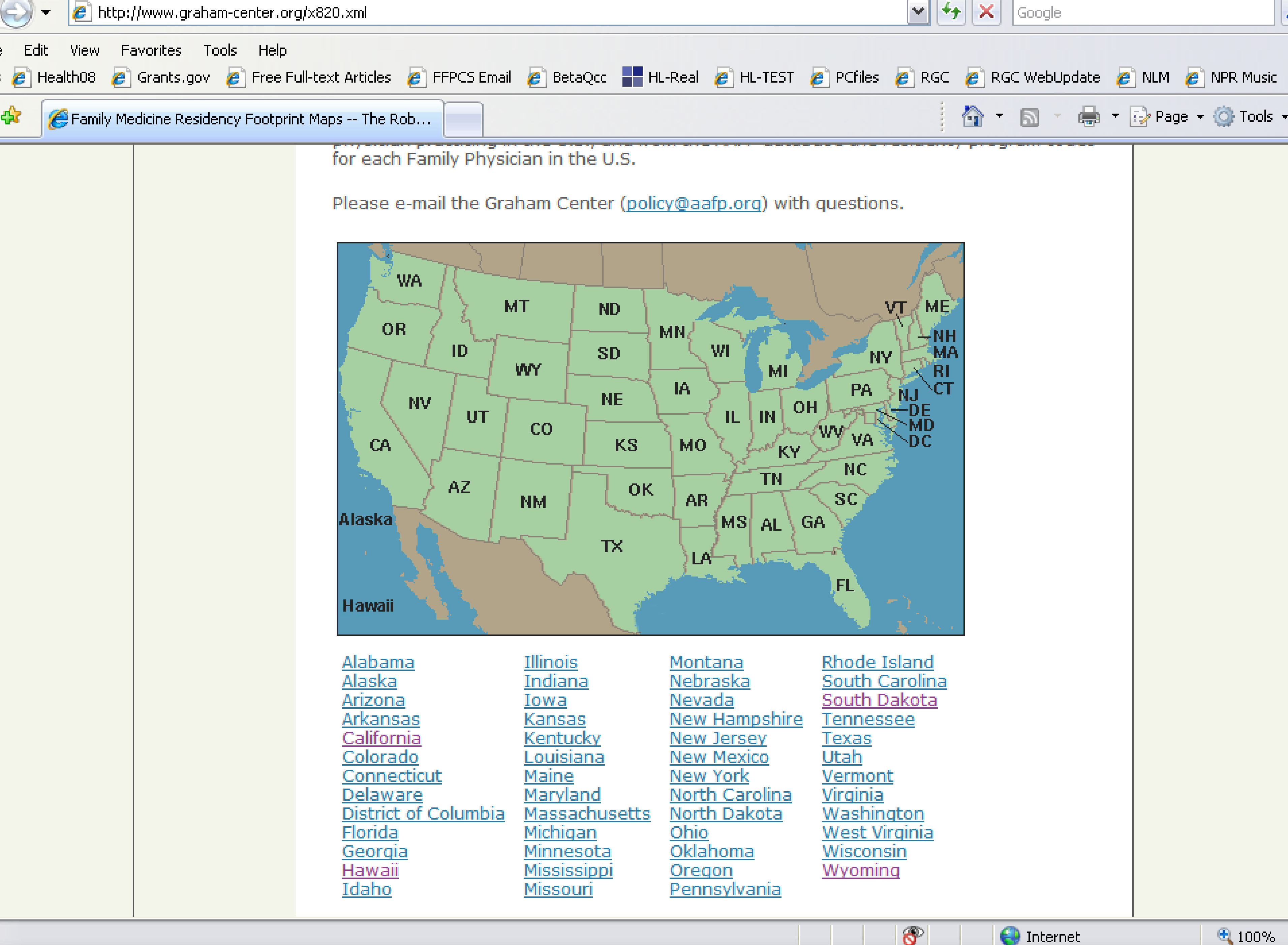
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Family Medicine Residency Footprint Maps -- The Rob...
Page Tools
for each Family Physician in the U.S.
Please e-mail the Graham Center (policy@aafp.org) with questions.
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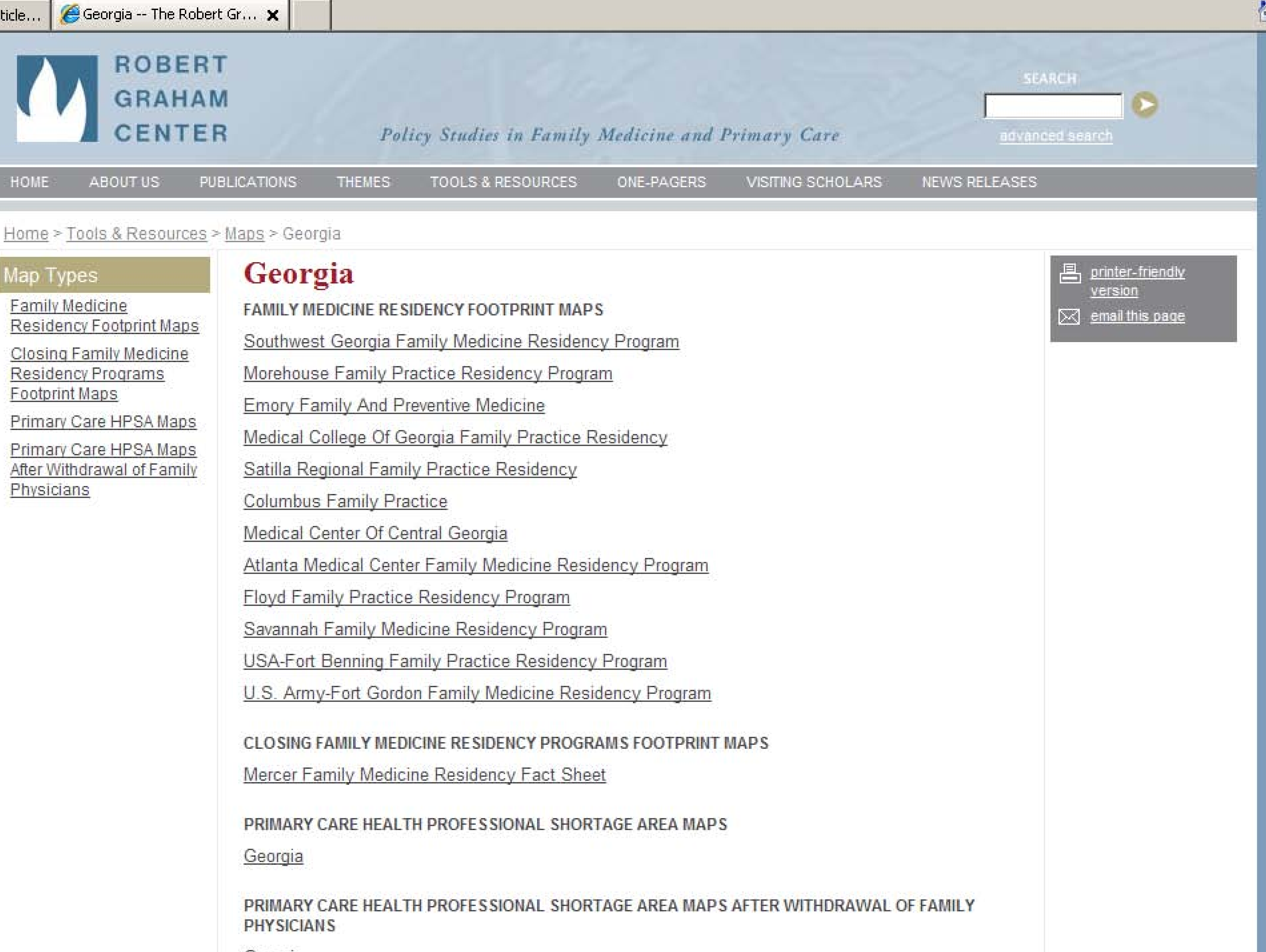

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Closing Family Medicine Residency Programs Footprint Maps
Primary Care HPSA Maps
Primary Care HPSA Maps After Withdrawal of Family Physicians
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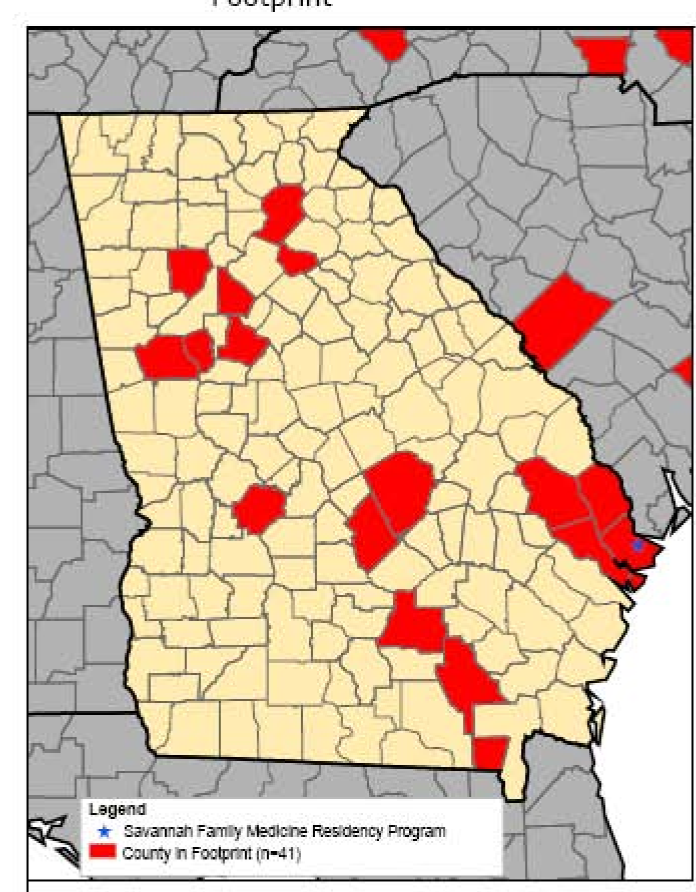
Georgia
FAMILY MEDICINE RESIDENCY FOOTPRINT MAPS
Southwest Georgia Family Medicine Residency Program
Morehouse Family Practice Residency Program
Emory Family And Preventive Medicine
Medical College Of Georgia Family Practice Residency
Satilla Regional Family Practice Residency
Columbus Family Practice
Medical Center Of Central Georgia
Atlanta Medical Center Family Medicine Residency Program
Floyd Family Practice Residency Program
Savannah Family Medicine Residency Program
USA-Fort Benning Family Practice Residency Program
U.S. Army-Fort Gordon Family Medicine Residency Program
CLOSING FAMILY MEDICINE RESIDENCY PROGRAMS FOOTPRINT MAPS
Mercer Family Medicine Residency Fact Sheet
PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREA MAPS
Georgia
PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREA MAPS AFTER WITHDRAWAL OF FAMILY PHYSICIANS

SAVANNAH FAMILY MEDICINE RESIDENCY PROGRAM FACT SHEET

Practice Locations

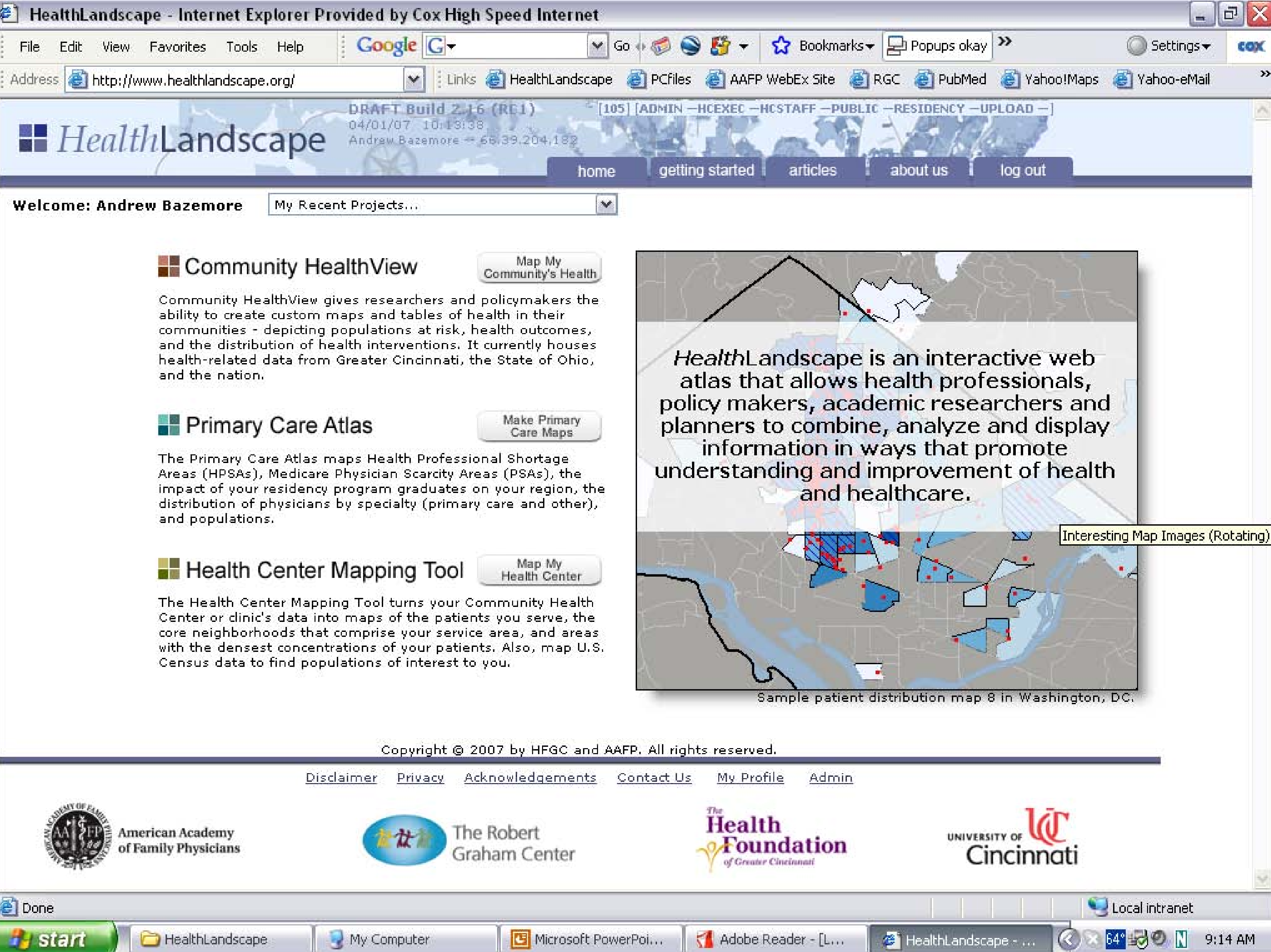
Legend
★ Savannah Family Medicine Residency Program
● Location of Graduates (n=96)

§Footprint



Graduate Practice Characteristics:96 Graduates

Practicing in Georgia	Graduates Practicing in HPSA's*	Graduates Practicing in Georgia HPSA's	Graduates Practicing in Rural Areas	Graduates Practicing in Rural Georgia
45 (47%)	24 (25%)	5 (5%)	17 (18%)	8 (8%)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Welcome: Andrew Bazemore
My Recent Projects...
Community HealthView
Map My Community's Health
Community HealthView gives researchers and policymakers the ability to create custom maps and tables of health in their communities - depicting populations at risk, health outcomes, and the distribution of health interventions. It currently houses health-related data from Greater Cincinnati, the State of Ohio, and the nation.
Primary Care Atlas
Make Primary Care Maps
The Primary Care Atlas maps Health Professional Shortage Areas (HPSAs), Medicare Physician Scarcity Areas (PSAs), the impact of your residency program graduates on your region, the distribution of physicians by specialty (primary care and other), and populations.
Health Center Mapping Tool
Map My Health Center
The Health Center Mapping Tool turns your Community Health Center or clinic's data into maps of the patients you serve, the core neighborhoods that comprise your service area, and areas with the densest concentrations of your patients. Also, map U.S. Census data to find populations of interest to you.
HealthLandscape is an interactive web atlas that allows health professionals, policy makers, academic researchers and planners to combine, analyze and display information in ways that promote understanding and improvement of health and healthcare.
Interesting Map Images (Rotating)
Sample patient distribution map 8 in Washington, DC.
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The Robert Graham Center
The Health Foundation of Greater Cincinnati
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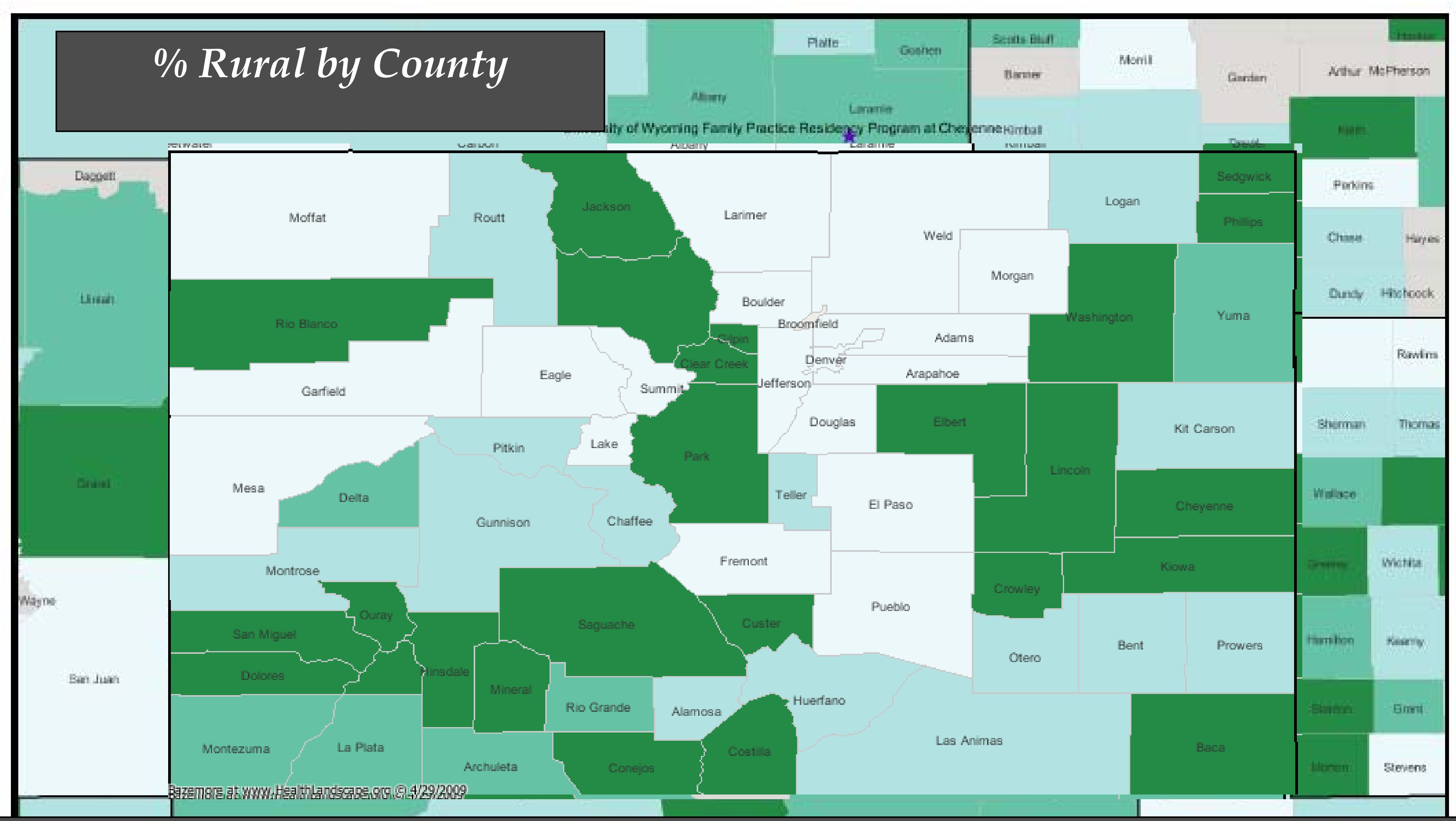
Primary Care to Population Ratios by County, Colorado



Maps provide a way to explore variation in Colorado's physician distribution (Physician per 10,000) – Specialty by Specialty (PC then ALL then FM)

Colorado Me... West Coast)

COUNTY	GRADUATES	STATE
Denver	775	Colorado
Arapahoe	370	Colorado
Jefferson	263	Colorado
Boulder	180	Colorado
Maricopa	152	Arizona
El Paso	151	Colorado
Larimer	116	Colorado
Los Angeles	97	California
Douglas	93	Colorado
Mesa	89	Colorado
King	86	Washington
San Diego	86	California
Bernalillo	79	New Mexico
Pueblo	71	Colorado
Adams	68	Colorado
Weld	65	Colorado
Salt Lake	54	Utah

...sity of Colorado School
...he Footprint (70%)

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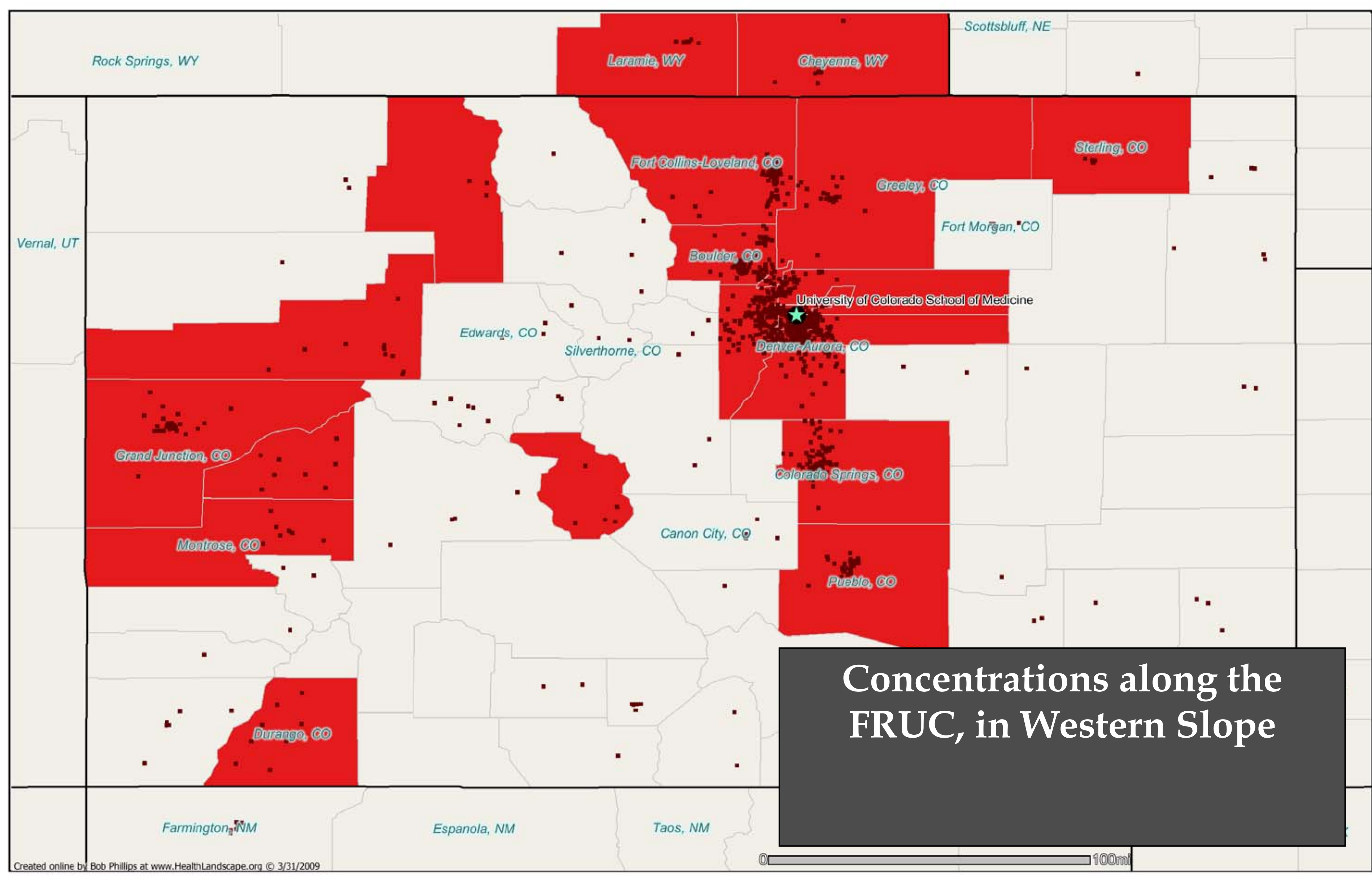
University of Colorado School of Medicine Graduate "Footprint"

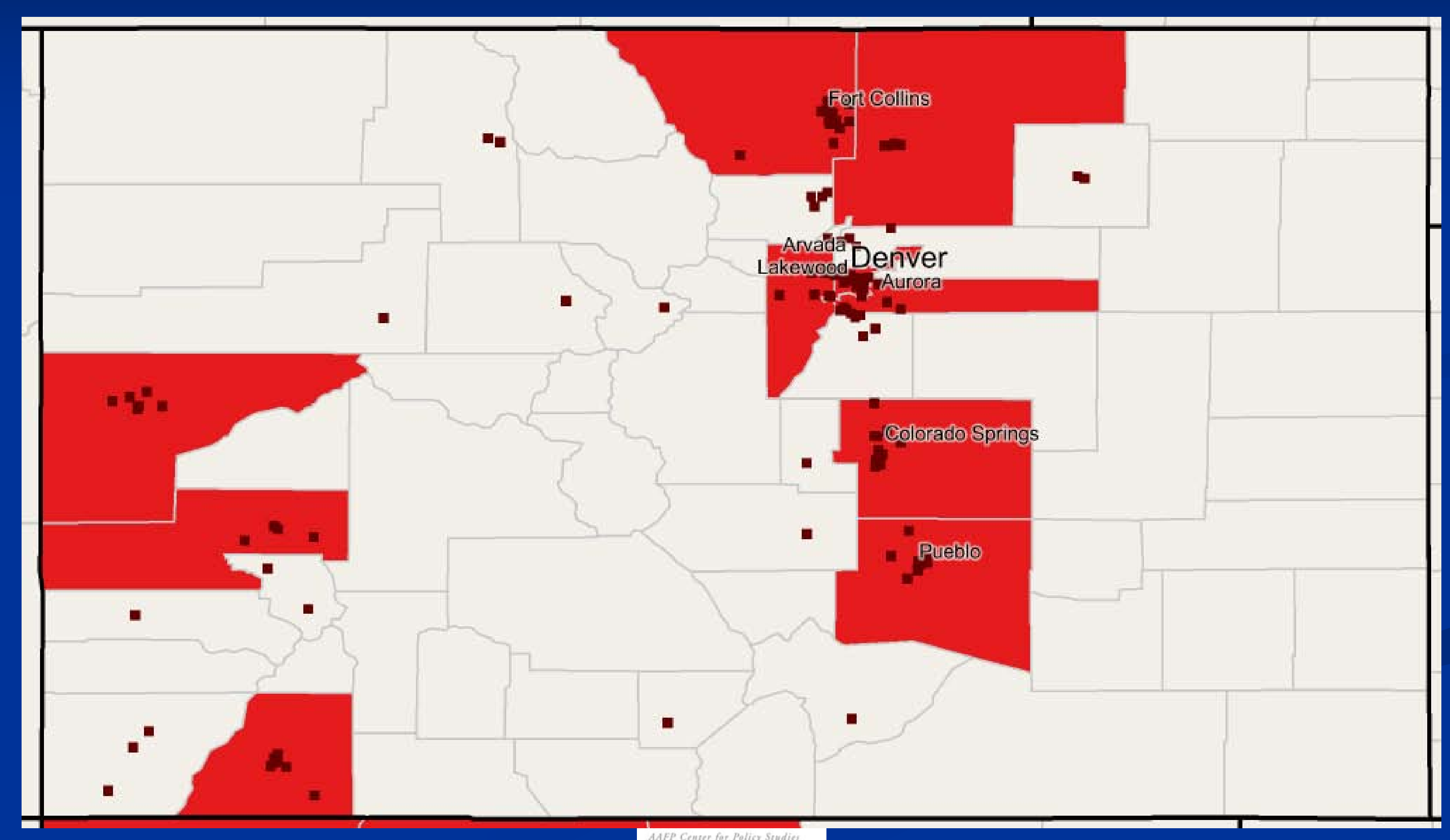


Other Schools with Footprint in Colorado (collaborators?)

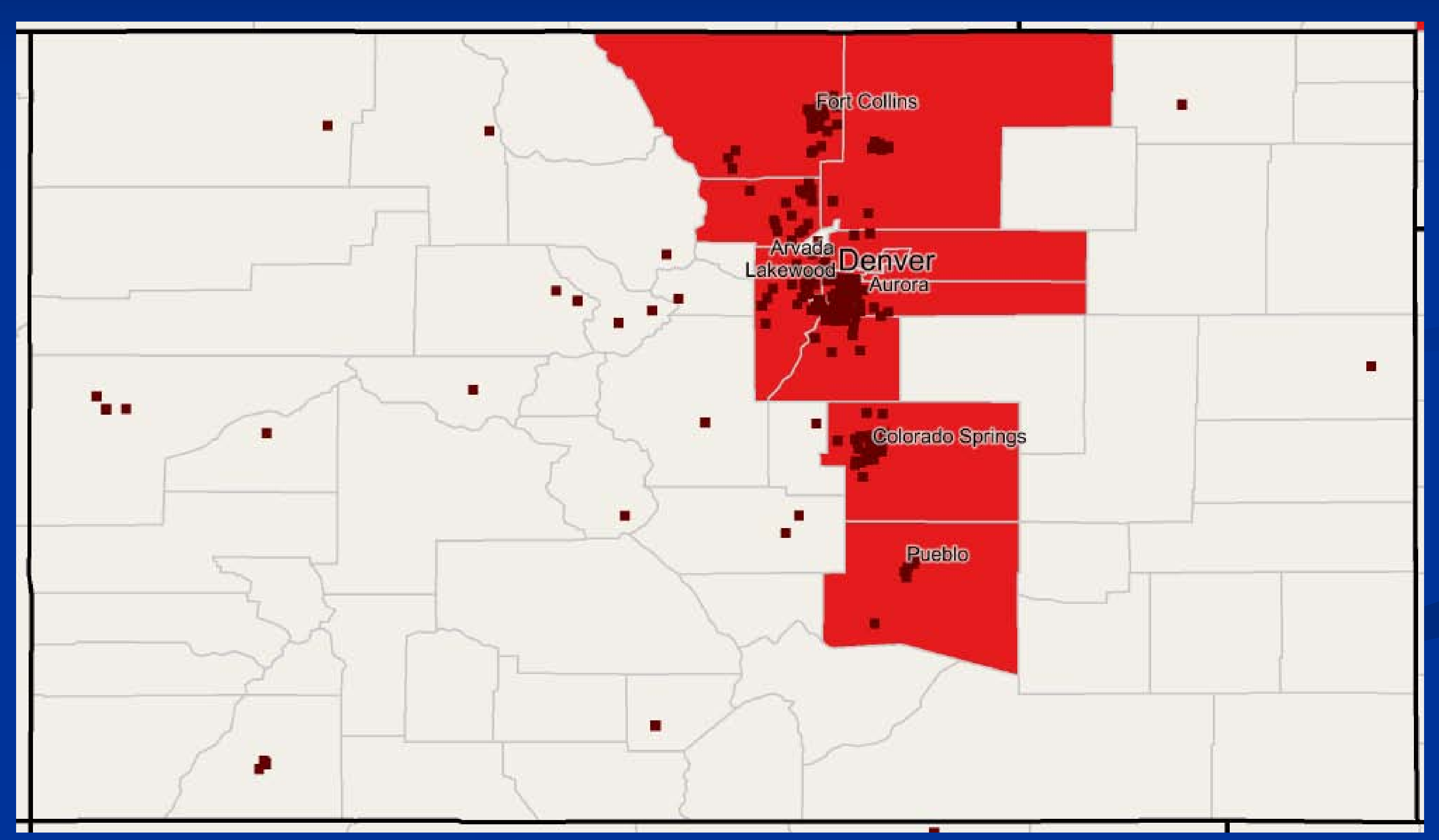
- Nebraska
- New Mexico

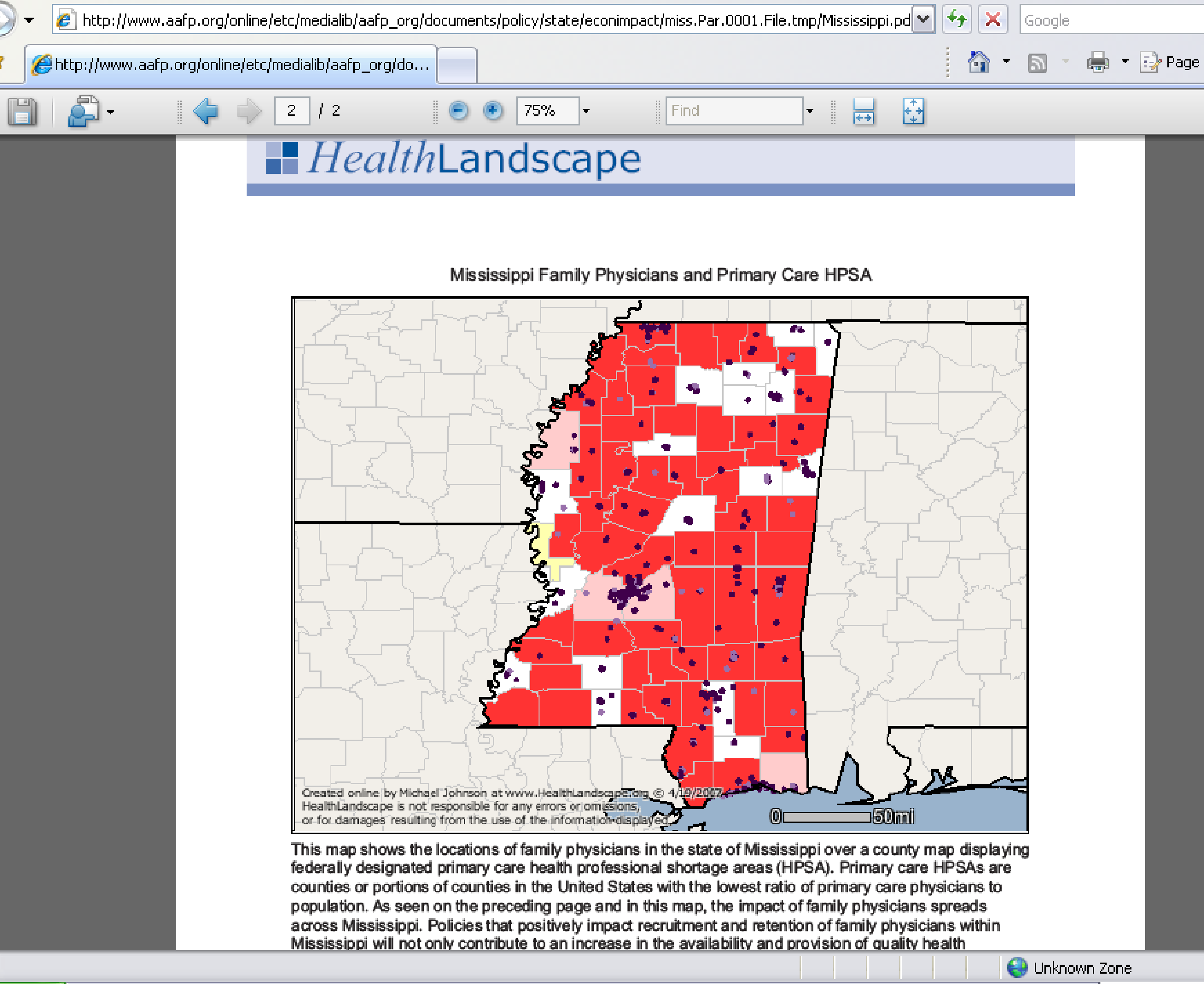
State	Access Ranking	Net Donation, 91-01	Supply/Demand, 91-01	PC-Net
AK	36	-570	0	-253
AL	31	-506	0.825877495	66
AR	42	-401	0.781352236	-109
AZ	33	-3420	0.250328803	-801
CA	44	-15398	0.44776387	-2910
CO	35	-2921	0.319272897	-673
CT	7	-1633	0.543599776	593
DC	13	3425	3.663297045	1562
DE	19	-686	0	-76
FL	40	-7333	0.413078278	-2998
GA	37	-2750	0.589429681	-1287
HI	1	-553	0.519548219	-35
NE	13	1174	1.839170836	113
NM	50	-631	0.547020818	-291

University of New Mexico



University of Nebraska





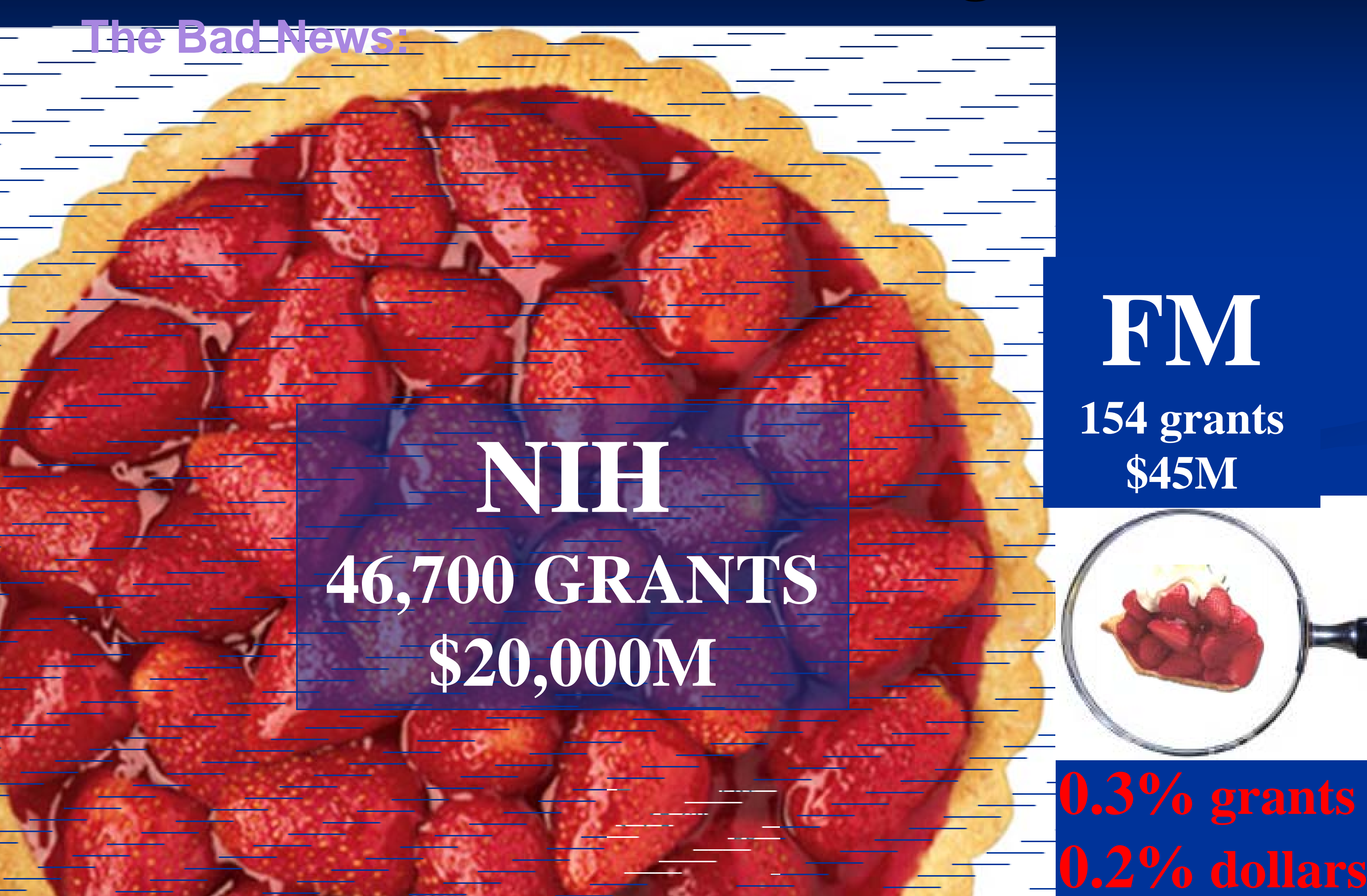
HealthLandscape

Mississippi Family Physicians and Primary Care HPSA

This map shows the locations of family physicians in the state of Mississippi over a county map displaying federally designated primary care health professional shortage areas (HPSA). Primary care HPSAs are counties or portions of counties in the United States with the lowest ratio of primary care physicians to population. As seen on the preceding page and in this map, the impact of family physicians spreads across Mississippi. Policies that positively impact recruitment and retention of family physicians within Mississippi will not only contribute to an increase in the availability and provision of quality health

Other recent work that may be of interest

A. Grant Funding



B. Committee Membership

The Bad News:

The Policy Journal of the Health Sphere

Health Affairs, 28, no. 2 (2009): 567-577
doi: 10.1377/hlthaff.28.2.567
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DataWatch

Usual Source Of Care: An Important Source Of Variation In Health Care Spending

Robert L. Phillips, Martey S. Dodoo, Larry A. Green, George E. Fryer, Andrew W. Bazemore, Kristin I. McCoy and Stephen M. Petterson

Health care spending varies in unexplained ways, and physicians' behavior is thought to explain much of the variation. We studied the spending effects of having different usual sources of care, focusing on variations associated with the type of facility or physician specialty. Based on analyses of data from the 2001-2004 Medical Expenditure Panel Surveys, we found significant differences in annual spending, especially for adults. Use of and spending for subspecialists were similar to those for general internists, and both were significantly higher th those for family physicians. Variation in spending might be the result of training differences among primary care specialties.

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AFMAA Advocacy

- Means:
  - Policy development by volunteer leaders
  - Professional lobbyist
  - Grassroots contacts and relationships
- Methods:
  - Communication of policy-relevant data to key policy makers
- Advocacy Power rests in the membership – NOT the professional lobbyist

Making the most of your data

- Local Data brings the message home to policymakers.
  - Turning data into a compelling picture allows a story to be told in a common language.
  - It supplies a high-impact communication that allows for a common vision.
  - A common vision between policy maker and constituent garners support for action.

Questions & Discussion