Family Medicine Updates

From the Association of Family Medicine Residency Directors

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A PRESCRIPTION TO ADVOCATE FOR GRADUATE MEDICAL EDUCATION REFORM

Training the next generation of physicians in a system wrought with funding disparities has left many residency program directors wondering if there is hope for change—and what role they might play in bringing about change.

The current state of graduate medical education (GME) financing is based on outdated statutory formulas that are focused on cost-based reimbursements in the hospital setting. The consequences of this imbalanced funding are significant: the formula impacts access to care, contributes to physician workforce shortages, and ultimately fails to meet the health care needs in the United States.

Between 1998 and 2008, there was an increase in the number of residency slots in specialties known for competitive incomes and appealing lifestyles (radiology, ophthalmology, anesthesia, and dermatology) and a decrease in primary care slots (family medicine, pediatrics, and internal medicine). Despite the increasing need for primary care physicians across the country, research indicates that hospitals largely favor higher revenue-generating specialty training, as there is a direct correlation between specialty income and GME slots offered.[1]

In response to the failures of the Centers for Medicare and Medicaid Services (CMS) to meet the health care needs of the public, the Institute of Medicine (IOM) issued a report calling for dramatic changes in GME funding and governance.[2] Specifically, the report recommends providing funding directly to sponsoring institutions, thereby promoting more training at community-based sites. In addition, the report supports the creation of an oversight council to track performance outcomes and lead policy development.

Shortly after the IOM report was released, the American Academy of Family Physicians (AAFP) also took a stand emphasizing the need to expand primary care GME by instilling accountability in a budget-neutral manner. The AAFP proposed that CMS limit direct graduate medical education and indirect medical education payments to the training of first-certificate residency programs. They also proposed that CMS require all sponsoring institutions and teaching hospitals seeking new Medicare and/or Medicaid-financed GME positions meet minimum primary care training thresholds as a condition of their expansion. This change could fund an additional 7,000 new residency training spots with a minimum of 50% going to primary care specialties. In addition, AAFP's proposal would require hospitals and sponsoring institutions to demonstrate a commitment to primary care through the establishment of thresholds and maintenance of effort requirements applicable to all institutions currently receiving GME financing. This is to ensure that institutions truly support training the primary care physicians this country needs.

These collective GME refinancing recommendations would result in positive changes for the future of family medicine training. We anticipate a more robust workforce in a variety of geographic and practice settings. The larger impact would be shifting the focus of health care away from acute illness and toward population health and preventative care. The medical organizations that represent teaching hospitals are opposed to these changes, however.

As family physicians, we must start educating our colleagues in other specialties on why the current system is unsustainable and harmful to patients and physicians alike, emphasizing that better health outcomes occur when primary care is available and affordable. Second, we must collaborate with other primary care specialties in order to speak to the value of primary care with a unified voice. Program directors carry a strong influence in their communities. Our call to action: Contact your representatives and ask them to sponsor or support a bill that includes the AAFP's proposal for GME reform. Use the AAFP's resources (http://www.aafp.org/advocacy/informed/workforce/gme.html) to educate your legislators on this very important topic. Encourage your residents, faculty, and patients to do the same. Change comes when we speak with one voice on an issue that affects every American. It's time to fix this broken system.

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From the North American Primary Care Research Group

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PBRNS DISCUSS UTILIZING BIG DATA FOR RESEARCH AND WITHIN A LEARNING HEALTH SYSTEM

The 2014 NAPCRG Practice-based Research Network Conference had record-breaking attendance, with 218 attendees representing multiple disciplines, including physicians, researchers, pharmacists, dentists, chiropractors, social workers, registered nurses, dentists, and dieticians. Participants at the June 30–July 1, 2014, meeting in Bethesda, Maryland heard from both US and Canadian researchers. The theme of the meeting was "big data" with 3 plenary talks—"The Promise of Big Data," "Pitfalls and Realities of Working with Big Data," and "Advice for How PBRNs Can Use Big Data for Creating a Learning Health System." These plenaries focused on the aggregation of various datasets (eg, clinical, pharmacy, claims, patient surveys) to address questions about clinical care, patient-centered research, and population health. Audio recordings of these 3 presentations are available on the NAPCRG website, http://www.napcrg.org.

New awards were given to the top oral presentations and posters from the 67 that were presented. The Best of Innovations in PBRN Methodology Oral Presentation went to Lyndee Knox and Vanessa Nguyen for their presentation, "Using a Tablet and Smart-Phone Based Survey and Health Education System to Collect Information from Low Literacy and Non-English Speaking Patients and Create the Wait Room of the Future: Research and Clinical Applications for PBRNs." The winner for the Best of Research & Scientific Oral Presentation was awarded to the session, "Findings From the Demonstration of the Health Literacy Universal Precautions Toolkit," presented by Natabhona M. Mabachi and colleagues. The winning poster for Best of Innovations in PBRN Methodology went to Jonathan Tobin and colleagues for, "PBRN Networks Conduct the Full Spectrum of Translational Research Studies of CA-MRSA Treatment and Recurrence in Community Health Centers." The Best of Research & Scientific poster award went to the Wisconsin Research and Education Network (WREN) for, "Back to the Future, With a Twist: Utilizing a PBRN for Real-Time Influenza Surveillance."

Participants presented workshops, forums, and panel discussions that covered a variety of PBRN infrastructure and methodology topics, including:

- The Ends are Determined by the Means: An International Perspective on PBRN Structure
- Identifying Core Competencies for Primary Care Practice Facilitators
- Community/Academic Research Partnerships: A Workplan Approach
- PBRN Organization and Governance to Promote Practice, Clinician, Researcher, and Patient Engagement
- Scoring Projects to Plan Resources and Recover Costs (SPPRC) for PBRN Research
- Describing the Intersection Between Evaluation Research and Quality Improvement
- Advancing Primary Care Research and Practice through Improved Measurement
- Hybrids, Chimeras, or New Species? Emerging Models of PBRNs
- Overview of the PBRN Research Good Practices Toolkit
- Methods of Evaluating Practice Transformation
- Powering Up: Lessons Learned from Project Collaborations Across Multiple PBRN Networks

Session summaries are available in the post-conference newsletter.

At the meeting, the PBRN community celebrated its 15-year anniversary of working with the Association for Healthcare Research and Quality (AHRQ), as it has grown from about a dozen PBRNs in 1999 to more than 123 registered US Primary Care PBRNs. A highlight of the meeting was presenting the Pioneer in PBRN Research Award to James Mold, MD, MPH. Dr Mold was acknowledged for his deep respect and admiration for primary care physicians and his recognition that without the dedication and scientific orientation of practicing clinicians, our PBRN world would not be possible. Notable accomplishments include the promotion of employing Practice Enhancement Assistants who assist clinics with best practices research to explore questions that are pertinent to real-world practices and learn from exemplars in clinical care.

The evaluations reflected the value of networking and hearing from other PBRNs. Join us for the 2015 NAPCRG PBRN Conference at the Hyatt Bethesda, (Maryland) on June 29–30, 2015. The theme of this year's conference is Engagement. The call for submissions is now open.

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