Family Medicine Updates

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP
From the Association of Departments of Family Medicine

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"THE GME INITIATIVE" AND GME IN STATES

Family medicine struggles to fund graduate medical education (GME) due to antiquated Medicare rules that fund hospitals for GME. Medicare GME funding inadequately covers family medicine residencies, is inequitable with variation across the United States, and does not fill gaps in the cost of training.[1] Program leaders need to identify funding streams which include state initiatives, and learn to advocate for options to create sustainable residency infrastructures to produce needed workforce in their states. Having answers to key questions about state GME funding and collaborative partnership opportunities, and sharing best practices to advance these efforts will support advocates at state levels to optimize opportunities for meeting state and regional workforce needs.

The GME Initiative (GMEI) (http://www.gmeinitiative.org) is a grassroots, volunteer group of roughly 150 members representing approximately 35 states and is comprised of health care learners, educators, advocates, and leaders who are passionate about reforming GME through payment reform, partnerships, state initiatives, legislation, advocacy, and education at the state, regional, and national level. Beginning with a policy brief calling for GME Reform,[2] a GME Summit was held in 2015 (http://www.gmeinitiative.org/november-2015-summit/x0i4v). A key recommendation from this summit was to create a workgroup focused on state-based GME reform initiatives. The goal of the GMEI's State Initiatives Workgroup is to track state initiatives, educate others about state GME activities, look at the finance, accountability, and governance of GME reform, and to host conference(s) on behalf of the GMEI. The first GMEI summit focusing on States was held January 2017 in Albuquerque New Mexico. (http://www.gmeinitiative.org/2017summitmaterials). Thirty-three states were represented at the Summit; since then more states have joined the GME Initiative and work of the States' Workgroup.

In general, states that do support GME do it through Medicaid, through state general funds, taxes, special fees, or some combination of these. To better understand specific sources and availability of funds to support GME at the state level, the GMEI States' Workgroup has developed a template for gathering key information across states. Key areas addressed in this template are: (1) state-specific goals for GME; (2) total annual amount of non-CMS federal dollars; 3) sources of funding—where does the money come from?; (4) strategies (legislative, financial) to expand GME within a state; (5) governance and accountability structures to ensure oversight over finances; and (6) barriers and challenges.

With pilot information from 9 states, the GMEI is beginning to learn about common strategies and common barriers/challenges. A key strategy for any GME activity is to engage stakeholders and legislators to educate them about what GME is and how targeted GME efforts support state workforce needs over time. A number of states are engaged in specific efforts targeting rural areas and often involve a coalition of multiple stakeholders (state Academy of Family Physicians, state medical association, state hospital association, medical school, and others). Barriers and challenges we are learning about include too many disparate stakeholders, administrative burdens related to oversight of funds, continual need to educate and reeducate legislators about what GME is and how long it takes to produce a physician workforce, and Medicare GME cap limits which prevent residency program expansion, especially in underserved areas.

Whatever the strategy or policy in play within a given state, what the GME States' Workgroup strives to do is to "connect the dots" between the intent of a particular policy or strategy and the reality on the ground. An overriding inherent challenge in any state-supported GME effort is the time-limited nature of state funding. This is diametrically opposed to the hard-wired funding through Medicare from CMS which continues to flow with no accountability tied to those funds. State GME efforts require constant attention to data to demonstrate accountability while at the same time constant attention to ensuring that stakeholders continue to see the value.

There is much more to learn about GME at the state level. In a recent survey of Association of Departments of Family Medicine, more than one-half (54%) of the Departments are reportedly involved in formal regional or statewide efforts to address family physician workforce needs and workforce planning. What we have found through the GME Initiative is

that there is much to be gained by learning from each other. For more information about the GME Initiative, and how one can join, contact Mannat Singh at mannat.singh@gmail.com.

Ardis Davis, Chair, GMEI States' Workgroup, Washington State
Mannat Singh, Director, GME Initiative, Colorado State

References

1. Pauwels J, Weidner A. The cost of family medicine residency training: impacts of federal and state funding. *Fam Med*. 2018;50(2):123-127.
2. Voorhees KI, Prado-Gutierrez A, Epperly T, Dirkson D. A proposal for reform of the structure and financing of primary care graduate medical education. *Fam Med*. 2013;45(3):164-170.

AFMRD Association of Family Medicine Residency Directors

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OPIOID PRESCRIBING: A GENERATIONAL PERSPECTIVE

As our nation grapples with an epidemic that fractures families and wreaks havoc in communities, an aspect of the opioid crisis often goes unspoken. How has this complex patient care dilemma affected family medicine education? Can there be a teachable moment in our past to improve our future? The AFMRD leadership shares 2 stories, one from a faculty physician teaching for over a decade and one from a resident physician in the middle of training.

Faculty Physician

Fresh out of residency in 2004, trained in the era of "pain is the fifth vital sign" and the upswell of OxyContin prescribing that began in the mid to late 90s, I felt overwhelmed by the number of my patients suffering from chronic pain and unprepared to help them. A woman with bipolar disorder had compartment syndrome in her right arm after a suicidal ingestion that left her unconscious in her car for 18 hours. The muscle atrophy and scars from fasciotomy were impressive, resulting in a combination of severe neuropathy and hyperalgesia that were impossible to heal, and it was with consultation that I prescribed her fentanyl patches and later methadone for pain. The guidelines at the time purported that patients receiving opioids for pain relief did not become addicted and that doses should be titrated to pain relief without a ceiling. Medicine has no pain-relieving options more immediately effective than opioids, and I remember the discomfort of first realizing I have the power to dispense or withhold them based on my own judgment of someone else's suffering, and first experiencing the anger and fear this can generate in patients. It is much clearer today than it was then, that a policy of unlimited dose escalation for chronic non-cancer pain is a recipe for dependence, addiction, overdose, potential diversion, and little to no benefit. The drawing of rigid lines, however, can disregard the situations where these powerful medications can provide significant improvements in function and quality of life. I see doctors coming out of training today, immersed in the crisis of opioid addiction, and fearful of offering even very small prescriptions of opioids or of taking on the challenge of connecting with patients who have been dependent on them for decades. The laws and regulations that now limit my prescribing are based on better science, and I try not to resent them as I fill out prior authorization paperwork to allow my patients access to pain medication when I believe they do need it. We are all constantly looking for that balance between compassion and caution, between guidelines and individualized medicine.

Resident Physician

She has a deep vein thrombosis (DVT). It is the first textbook DVT I have seen in my short career, but she won't go to the hospital. She is here today for her 50 MME of codeine and morphine. I have never met her before. She is angry at me because I don't want to prescribe her monthly prescription unless she goes to the hospital; I worry her narcotics are concealing her life-threatening pain. I feel helpless; I feel like a drug dealer. I do not feel that I am helping her and I don't know how to help her. The surge of frustration rises; I want to quit. I alternate rapidly between disgust and pity and confusion. The laws are mounting and the insurance coverage is tightening against my choices, but I have not started ANY of my patients on regular controlled substances. I am drowning in evidence against chronic opiates for these diagnoses but cannot follow any of the recommendations without losing these patients or putting them through withdrawal and suffering. I have walked into a trap of addiction and these patients will desperately and persistently strategize ways to maintain access to my prescribing habits. When I start my clinic day, I look up all new patients on the state controlled substance database. I scan for other acute pain complaints to make sure I am prepared for the demands of my opioid-seeking patients. I avoid starting new patients on these high-risk medications unless there is a very clear clinical need. I seek alternative therapies, though most patients cannot afford acupuncture, talk therapy, or topical analgesics. I set appropriate expectations for pain management, but this is not helpful for the patients I inherited. What I am lacking is the ability to safely treat opioid dependence. I don't know how to help them, so I sustain them.

Two stories, two generations, one emotion: frustration. As resident education moves forward, family medicine must be a part of the solution to this epidemic. Resident physicians are an untapped resource