AAFP family medicine ADVOCACY SUMMIT

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Teaching Health Centers

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Teaching Health Centers History and Promise

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Pipeline Needs

- How many of you are recruiting family physicians for your practice?
- How many of you have all the doctors you need at your site?
- How many of you would like to hire a family physician trained to be efficient and resource sensitive?

Community Health Centers and Family Medicine

Partners in Care

- Co-evolved and emerged from the social justice movement in the 1960s
- Began to expand their participation as primary care education sites in 2010 with Teaching Health Center movement and funding

The emergence of our specialty

- 2011 was the 40th Anniversary of Family Medicine
- Our specialty grew out of a movement to reclaim general practice medicine in an era of increasing specialization and fragmentation of health care delivery which began accelerating after WW2
- Medicine was becoming specialized even at the primary care level
- There was also a growing sense of loss
  - of connection with the patient and their family,
  - of the gift of a continuous relationship between a physician and a patient
  - of someone able to connect and integrate care delivery

What is Family Medicine all about?

- Wholeness – biopsychosocial model
- Physicians trained in breadth and depth of care
- Care across the life span
- Care in the context of family and community

Birth of Family Medicine 1965-66

- Folsom Report: every American should have a personal physician to ensure the integration and continuity of all medical services
- Millis Report: focused on GME – Family Practice should be a board-certified specialty
- Willard Report: Board oversight of FM residency

- ABFP established 1969
- First residency: 1970
- Now 480+ residencies and over 94,000 family physicians practicing – AAFP has around 120,000 total members

Community Health Centers

- 2010 was the 45th Anniversary of the CHC program

- Growing alongside our new specialty was another health care movement, designed to bring care to the impoverished and underserved of the nation

International Roots
South Africa in 1940-50s

- A group of physicians, nurses and community organizers started a “community health center” model to counter the health consequences of apartheid

- They defined their responsibility as:
  - Care of the individual patient
  - The health of entire target populations
  - Merging the fragmented disciplines of medical care, epidemiology and public health

Medical Students Can Drive Change

- Jack Geiger was a visiting medical student in 1957 on an international elective in South Africa and was exposed to this model

- He considered it only as a unique solution to that unique third

Civil Rights Movement

- During the civil rights protests in the south and the voter registration drive in Mississippi in 1964, the Medical Committee For Human Rights brought hundreds of physicians, nurses, psychologists and social workers to Mississippi to assist and protect civil rights workers

- They saw devastating poverty, shocking infant mortality rates and virtually complete lack of access to then-segregated medical care

Birth of the CHC in the US 1965

- Dr. Geiger was in Mississippi with them - he had seen a model that worked
- Proposal was brought to Office Of Economic Opportunity

Happening together:

- 1965 -- first two health centers opened -- in a Boston public housing project and in Bolivar County, Mississippi
- 1965 -- the commissions on generalist health care were convened to seek solutions to shrinking access to primary health care in the country

Community Health Center Growth

- Soon there were four more health centers: Denver, LA, Chicago, South Bronx
- Now over 10,400 CHC sites delivering health care, serving nearly 24 million people annually
- The vast majority of CHC physicians are family physicians
- We provide health care to all, in every sense

CHC and Family Medicine

Children of the 60s
Solutions for Today

- The two systems – one providing the setting and one the workforce – grew up together with similar missions and goals

- The integration of residency training in Community Health Centers has been slow but steady and logical, The recent designation of THCs recognizes that

- As family medicine and CHCs enter their 50's together, we still share the larger overarching goal of healthcare for all

Teaching Health Center

- Movement initially called Educational Health Centers
  - Grew out of strategic planning session in mid 2000's at University of Washington to explore and support this model of training
  - There were some successful residencies in health centers – few, but the model appeared ideal in many ways
- Teaching Health Center funding first was part of ACA for a 5 year pilot beginning 2010
  - Highly successful tho accreditation/ recruiting barriers slowed startup

Our personal success story so far……

- Montana Family Medicine Residency and RiverStone Health Center
- Began as 6-6-6 residency in 1995, expanded with THC funding, now 8-8-8
- Patient access grew from pre-residency base of 7000 visits per year to current over 60,000 visits per year
- 70% of 108 graduates practice in Montana and over 40% have gone to health centers or other safety net sites to practice
- One resident “line” (1-1-1) currently is temporarily internally funded (hoped to

Problems

- Two year appropriation cycle
- Three year Family Medicine residency timeline
  - Plus front end recruiting and match cycle
- ACGME Accreditation requirements state: IV.N.2. the Sponsoring Institution must allow residents/fellows already in an affected ACGME-accredited program(s) to complete their education at the Sponsoring Institution, or assist them in enrolling in (an)other ACGME-accredited program(s) in which they can continue their education. (Core)
- Hard to make a three year commitment to a resident with two years of funding, and to program resources when funding occurs at varying levels

Community Health Centers view

- Conjunction of stressors for health centers
  - THC funding uncertainty
  - Many are AOA programs that need to make accreditation change to ACGME
  - Funding cliff for CHCs coincide with THC funding cycle this year
  - NHSC funding is in same boat – key recruitment advantage for many CHCs
  - Medicaid/ACA uncertainty with potential funding impact on clinical revenues

- CHCs do not have deep pockets – operate generally with tiny margins
- CHC primary funded mission is service not education
- HOWEVER have increasingly embraced education as pipeline started to produce

Attrition already starting

- 741 currently in training at all sites
  - Up from 689 last year
  - BUT – that obscures the decline
- This total number reflects continued growth from newer programs, **however 33 spots** have been **cut** this year across 8 different residencies, and **30 more were cut** the previous year in 6 residencies
  - These programs are NOT taking new resident classes, and are ramping down

The MUST ASK

- Teaching Health Centers funding must continue
  - They expand the number of primary care doctors being trained
  - They train primary care doctors in resource sensitive care
  - They expand access to patients
  - Current funding stops this year Sept 30th
  - CMS funding is capped– there is no other funding option
- Funding must return to the equivalent of the well-researched 2010 level of $150K per resident

Sustained funding will maintain a specific focus on primary care physician education

Sustained funding will help provide access to patients

Sustained funding will continue to produce family physicians for America

Together we will make the world a better place

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