

Rethinking Measures of Success in Family Medicine Training

Thomas L. Stern, MD, FAAFP Memorial Lecture
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FAMILY PHYSICIANS

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Thomas L. Stern, MD, FAAFP



- 1920-2011
- Enhance Quality in Residency Education.
- Founded Residency Program Solutions (RPS) 40 years ago.

Typical Measures of Success

- Fill rate in the MATCH
- Caliber of residents/faculty
- Board pass rate/scores/state licensure
- ACGME RRC Accreditation
- Family Medicine Board certification pass rates
- Graduate achievements
- Publications/Research
- Operated within budget
- Grads practicing in a 30 mile radius

What my grads said...

- Couldn't do what I trained them to do in residency – team-based care; comprehensive, coordinated care
- Lost the joy of being a family physician
- Wouldn't recommend their children become family docs
- Left family practice to do other things

Change is disturbing when it is done to us.

Change is exhilarating when it is done by us.

Rosabeth Kantor
Harvard Business School

A journey to model change and payment reform

- Regional PCMH advocacy...care delivery model change
- HB 198 design – PCMH expansion – training/scholarships/curriculum
- Governor John Kasich – PCMH expansion desire
- Appointment - Director, Ohio Department of Health
- Funding – HB 198 – Training, Scholarships, Curriculum
- Ohio Patient-Centered Primary Care Collab.(OPCPCC)
- CPCi and SIM grants –statewide PCMH and payment reform plan
- Ohio Primary Care Workforce Initiative(OPCWI)

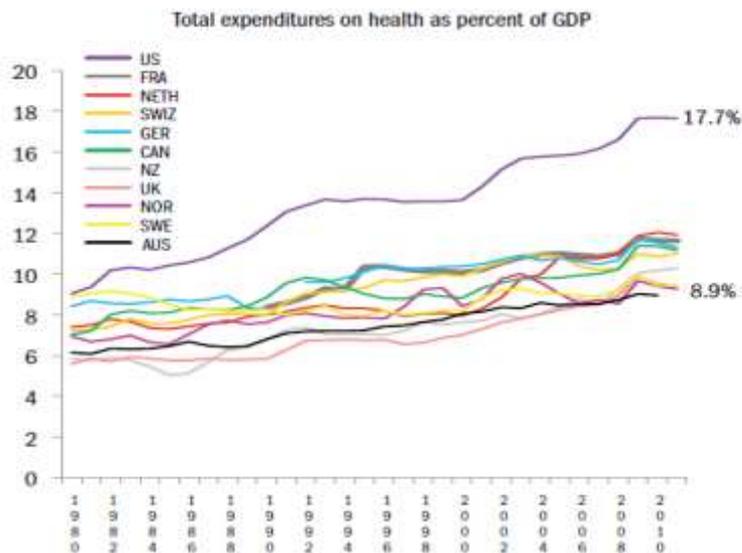
On the way to PCMH expansion...

- Public Health's contribution to Total Health
- Population Health as a necessary focus
- The critical role of Social Determinants of Health
- Importance of Behavioral Health integration
- The absence of a culture of health in our communities

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,568

Notes: * Includes Sex. ** Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2012; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).

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The Commonwealth Fund, 2013

IOM Report – Integration of Public Health and Primary Care (March 2012)

A shared goal of population health improvement

Community engagement in defining and addressing population health needs

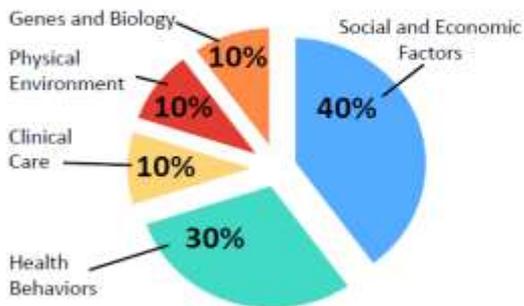
Aligning leadership to reduce fragmentation, clarify roles, develop incentives, and manage change

Develop a shared infrastructure to ensure sustainability

Sharing and collaborative use of data and analysis

Expand the Understanding of What Creates Health

Determinants of Health

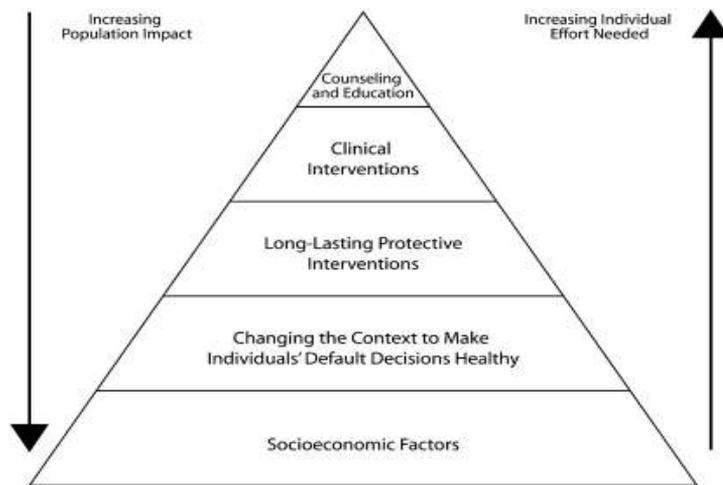


Necessary conditions for health (WHO)

- Peace
- Shelter
- Education
- Food
- Income
- Stable eco-system
- Sustainable resources
- Mobility
- Health Care
- Social justice and equity

Determinants of Health Model based on framework developed by Dahlgren, G. and Whitehead, P. (1991) *Social Determinants of Health: The Solid Facts*. Copenhagen: World Health Organization. http://www.who.int/dahlg_whitehead





Tom Frieden, MD The Health Triangle

Building a Culture of Health in America

-Robert Wood Johnson Foundation -

- Calls for us, as a nation, to strive together to build a Culture of Health enabling all in our diverse society to lead healthier lives, now and for generations to come.

An American Culture of Health is one in which...

- Good health flourishes across geographic, demographic and social sectors
- Attaining the best health possible is valued
- Individuals and families have the means and the opportunity to make choices that lead to the healthiest lives possible
- Business, government, individuals and organizations work together to build healthy communities and lifestyles.

An American Culture of Health is one in which...

- Everyone has access to affordable, quality health care because it is essential to maintain, or reclaim, health
- No one is excluded
- Healthcare is efficient and equitable
- The economy is less burdened by excessive and unwarranted health care spending
- Keeping everyone as healthy as possible guides public and private decision-making
- Americans understand that we are all in this together

Health is Community



"...the community in the fullest sense is the smallest unit of health...to speak of the health of an isolated individual is a contradiction in terms."

Wendell Berry in Health is Membership

Strengthening Community Capacity Embedding Healthcare in the Community



Accountable Communities of Health



Family Medicine Fundamental Principle

To evaluate and manage every patient in the context of their family, and every family in the context of their community.

Abraham Flexner

1910 Flexner Report

“...the physician’s function is fast becoming social and preventive, rather than individual and curative...(do) not to forget that directly or indirectly, disease has been found to depend largely on unpropitious environment...a bad water supply, defective drainage, impure food, unfavorable occupational surroundings...(these) are matters for “social regulation,” and doctors have the duty to promote social conditions that conduce to physical well-being.”



IOM Vital Signs 4/28/15

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BOX
Core Measure Set with Related Priority Measures

- | | | |
|---|--|--|
| <p>1. Life expectancy
Infant mortality
Maternal mortality
Violence and injury mortality</p> <p>2. Well-being
Multiple chronic conditions
Depression</p> <p>3. Overweight and obesity
Activity levels
Healthy eating patterns</p> <p>4. Addictive behavior
Tobacco use
Drug dependence/illicit use
Alcohol dependence/misuse</p> <p>5. Unintended pregnancy
Contraceptive use</p> <p>6. Healthy communities
Childhood poverty rate
Childhood asthma
Air quality index
Drinking water quality index</p> | <p>7. Preventive services
Influenza immunization
Colorectal cancer screening
Breast cancer screening</p> <p>8. Care access
Usual source of care
Delay of needed care</p> <p>9. Patient safety
Wrong-site surgery
Pressure ulcers
Medication reconciliation</p> <p>10. Evidence-based care
Cardiovascular risk reduction
Hypertension control
Diabetes control composite
Heart attack therapy protocol
Stroke therapy protocol
Unnecessary care composite</p> | <p>11. Care match with patient goals
Patient experience
Shared decision making
End-of-life/advanced care planning</p> <p>12. Personal spending burden
Health care-related bankruptcies</p> <p>13. Population spending burden
Total cost of care
Health care spending growth</p> <p>14. Individual engagement
Involvement in health initiatives</p> <p>15. Community engagement
Availability of healthy food
Walkability
Community health benefit agenda</p> |
|---|--|--|

IOM Vital Signs 4/28/15

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Better, Smarter, Healthier : HHS Sets Clear Goals and Timeline

HHS Secretary Sylvia Burwell on Jan. 26, 2015 –
Timeline to shift payments from volume to value...

FFS Medicare payments to providers for Medicare services will be increasingly tied to quality or value through alternative payment models (ACOs, bundled payments, etc)... (Currently about 20% in 2015)

30% by 2016

50% by 2018

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Succeeding in Value-Based Payment Reform

As we move to value-based payment reform, we can't achieve our targeted health goals unless we more effectively address issues BOTH inside and outside our medical practices that will prevent us from improving the health of the population we are serving!

To What End are we Training our Learners?

- Traditional Quality Measures – Cancer screening, acute and chronic disease management, prevention, access, decrease ER utilization rates, decrease avoidable hosp., attain PCMH status, etc.
- Community Health Measures – smoking rates, dental caries, suicide, substance abuse, mortality rates, obesity rates, employment, education attainment, food security, safety, housing, injury prevention, etc.

Training to Population Health Goals

- Integrate Public Health into training – pre-doc and GME
- Teach to population health measures – tobacco use, substance abuse, infant mortality, obesity, etc
- Educate on Social Determinants of Health – nutrition, activity level, education, employment, safety, housing
- Understand the components of Total Health, and the part healthcare plays in its achievement – necessary, but not sufficient

Your Role as an Educator

- Inspire learners about the role they can play in leading change, both inside the practice and in the community
- Make your residencies Continuously Learning Organizations
- Connect with your communities in new ways
- Use Public Health data to drive your mission and goals – become relevant to your communities

“If you want to build a ship, don’t drum up people together to collect wood and don’t assign them tasks and work, but rather teach them to long for the endless immensity of the sea.”

Antoine de Saint-Exupery

Ohio's Federally Qualified Health Centers
& FQHC Look-Alikes



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