Training Family Physicians for All of Oregon

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September 22, 2017
Disclosures

I own stock in Cascade Comprehensive Care, a public benefit corporation which operates the CCO for Klamath County.
Objectives

• Identify the health care workforce challenges for Oregon and how comprehensive training is needed in family medicine
• Describe the issues in training comprehensively in FM residencies as well as the challenges of staying comprehensive across the span of our own career
• View new dimensions of comprehensiveness through the lens of complexity theory, understanding it in relation to health systems and population health
• Incorporate concepts of comprehensiveness into the individual trajectory of our deepening professional growth
To train Family Physicians for all of Oregon, we need to train them in comprehensive practice and foster an understanding of the paradox of comprehensiveness as we tailor our practices to community needs and focus on higher levels of prioritized care and healing across the span of our careers.
Why I went to medical school:

Maslow’s Hierarchy
“I believe that community - in the fullest sense...is the smallest unit of health and that to speak of the health of an isolated individual is a contradiction in terms.”

- Wendell Berry, Health is Membership
To maintain current rates of utilization, Oregon will need an additional 1,174 primary care physicians by 2030, a 38% increase compared to the state's current (as of 2010) 3,027 PCP workforce.

Oregon Projected Primary Care Physicians Need

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<th>Year</th>
<th>ACA Effect</th>
<th>Aging</th>
<th>Population Growth</th>
<th>Total</th>
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<td>132</td>
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Suggested citation: Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.
Training for Oregon:
Primary Care HPSAs, Graham Center
Primary care HPSAs if Family Physicians were withdrawn

Graham Center, 2002
The challenge of rural

What is different about rural?

• Rural populations tend to be older, poorer and sicker than their urban counterparts

• 20% of the US population lives in rural areas

• Only 10% of physicians live in rural areas

[Sources: National Rural Health Association, Dallas Morning News research]
The challenge of rural
Addressing the maldistribution of family physicians

• What scope of practice do residents experience in training?
• How much time do they spend in different settings across the state?
• Mismatched expectations for scope of practice between some health systems and family medicine graduates
Residency characteristics

• Family Medicine Residency characteristics associated with practice in a HPSA
  • Community Health Center sites
  • Rural sites

• Do residencies that aim to produce rural family physicians provide relevant training?
  • Time spent in rural areas
  • Training for different procedures
More Comprehensive Care Among Family Physicians is Associated with Lower Costs and Fewer Hospitalizations

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2The American Board of Family Medicine, Lexington, Kentucky

ABSTRACT
PURPOSE Comprehensiveness is lauded as 1 of the 5 core virtues of primary care, but its relationship with outcomes is unclear. We measured associations between variations in comprehensiveness of practice among family physicians and healthcare utilization and costs for their Medicare beneficiaries.

METHODS We merged data from 2011 Medicare Part A and B claims files for a complex random sample of family physicians engaged in direct patient care, including 100% of their claimed care of Medicare beneficiaries, with data reported by the same physicians during their participation in Maintenance of Certification for Family Physicians (MGFP) between the years 2007 and 2011. We created a measure of comprehensiveness from mandatory self-reported survey items as part of MGFP examination registration. We compared this measure to another derived from Medicare's Berenson-Eggers Type of Service (BETOS) codes. We then
Competencies for Rural Practice

- Comprehensiveness
- Agency & Courage
- Adaptability
- Abundance in the face of scarcity and limits
- Resilience
- Integrity
- Self-reflection
- Collaboration & Community-responsiveness

Competencies for Rural Practice

• Comprehensiveness

• Agency & Courage: self-efficacy

• Adaptability

• Abundance in the face of scarcity and limits

• Resilience

• Integrity

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Cardinal features of primary care:

- Comprehensiveness
- Continuity
- Coordination
- Accessibility
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= “Addressing a large majority of personal health needs”
  - Institute of Medicine Committee on the Future of Primary Care, 1996.

- Perhaps our most challenging and defining characteristic
Defining Comprehensiveness

- Attaining and maintaining skills to meet the majority of personal health needs of patients and community
- Scope of practice
- Low referral rates
- Breadth of roles in practice and community
Our most challenging and defining characteristic

• Breadth of knowledge and skills
• Needed to build relationships across time and illness
• Allows understanding of context and impact of individual health on wider health issues
  • Population health, social determinants of health

• Is it a characteristic of the provider? The practice?
• Is it context dependent?
What aspects of comprehensiveness matter most?

• Hospital care?
• Maternity care?
• Broad ambulatory scope?

• Bazemore article
• Referral pattern article
How does comprehensiveness change over time and context?

• Does it matter more to residents and new physicians than more experienced physicians?
Dimensions of Comprehensiveness

• Scope of practice lists change over time
  • New skills are added
    • Addiction medicine, medication-assisted therapy
    • Point of care ultrasound
    • Data-driven quality improvement

• Skills required change
  • Practice management/Patient-centered medical home
• COPC/Population health
  • Addressing social determinants of health

• Characteristics of provider, team, practice
• Perhaps it is not enough to promote comprehensive training during residency.
• We need to understand the characteristics of physicians who maintain a broad scope and comprehensive practice throughout their career?
• Or what systems and settings foster comprehensiveness over time?
The paradox of comprehensiveness in context

• Being community-responsive is core to our role as family physicians
• Comprehensiveness is defined as meeting the majority of the health care needs for our patients and practice

• When we tailor our practice and skills to the community and population we serve, some loss of breadth is likely to occur in all but the most frontier rural sites.
Complexity theory and Comprehensiveness

• Sturmberg described the history of complexity theory as applied to Family Medicine
  • Helpful to think about complex adaptive systems as applied to
    • Relationships with patients
    • People as they relate to health and illness
    • Providers working in multi-dimensional systems, addressing healing
    • Understanding our discipline, leading change

The Holarchy of Healthcare

Building on the work of Ken Wilber and others, Stange has described a holarchy of health care.
Much like Maslow’s Hierarchy

The components relate to each other as nested hierarchies
As residents we are particularly interested in mastering fundamentals and multimorbidity.
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Over time we move into personalized and prioritized care
Breakthrough moments of fostering healing occur more often.
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Does Abiding = Equanimity?
ACGME anecdote
Older physicians often list interpersonal continuity with a cohort of long term patients as the most rewarding aspect of their practices, but medical students are attracted to the breadth.

Perhaps we are describing our developmental shift from fundamentals into prioritized and personalized care.
The Holarchy of Healthcare

Like with Maslow, moving into a higher level still includes the lower levels.

We hope that our physician leaders are still active in practice, so that they have deep knowledge with which to balance individual and system needs.
Applying this model to comprehensiveness

• Perhaps increased meaning found in the higher levels is responsible for the ways that physicians tailor their practice to community needs.

• Prioritizing care means meeting systemic needs and potentially shifting away from others.

• We want generalists approaching systems issues based on breadth of knowledge of patients and communities.

• We want our residents being comprehensive in systems issues and healing and not just fundamental care.
Paradox of Comprehensiveness in Context and across professional development
Rediscovering Comprehensiveness

• As we or our colleagues move into addressing systemic issues or find unique areas of transcendence and healing with our patients, we must gently remind ourselves to stay connected to comprehensive practice in the most fundamental ways

• This requires self-reflection
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• To train Family Physicians for all of Oregon, we need to train them in comprehensive practice and foster an understanding of the paradox of comprehensiveness as we tailor our practices to community needs and focus on higher levels of prioritized care and healing across the span of our careers.
• Please consider the ways that you have embraced comprehensiveness in your practice.
• Reflect on what has drawn you away from comprehensiveness.
• How can you maintain comprehensiveness in its fullest forms?
• How can you help students and residents foster the self-efficacy needed to practice comprehensively?
• How can you help new physicians develop awareness of the tension they will face as they tailor practice and address community health systems?