Improving Rural Health through Clinical Training at Community Health Centers

Leonard B. Goldstein, DDS, PhD
Assistant Vice President for Clinical Education Development
A.T. Still University
Professor, OMM/OPP ATSU/SOMA
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Health Equity

“When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.”

http://www.cdc.gov/socialdeterminants/Definitions.html
The Challenge

*Projection for physician shortage
*Outlook particularly severe for rural

The SOMA Solution

● Partner with community health centers
● Utilize different educational models
SOMA-Wright Center Partnership

Osteopathic Family Medicine Residency Consortium
Wright Center for Graduate Medical Education

- Based in Scranton, PA
- ~35 years experience in GME- IM program
- Dually accredited FM program
- CHC based
- First round grantee of Teaching Health Center money
- Innovative, evidence based, community oriented primary care
SOMA

- 6 of our campus sites participated
  - Lutheran in NY – 4 slots/year****
  - Unity in D.C. – 6 slots/year
  - HealthSource in OH- 2 slots/year
  - El Rio in AZ- 4 slots/year
  - HealthPoint in WA- 4 slots/year
  - Virginia Garcia in OR- 2 slots/year****

- Total of 22 first year residents started on July 1, 2013.
- First graduating class, June 2016
- Funding reduction => NY & OR did not participate in the match
NACHC, ATSU, & Community Health Centers
ISSUE: ACCESS TO PRIMARY CARE

• Access to primary care is difficult for many people living in rural America\(^1\)
• Growing number of rural residents who gained health insurance under the ACA will exacerbate the access problem\(^2\)
• Newly acquired ACA-insured population is estimated to increase the use of physicians by 7.9\(^3\)
• Who will provide the additional primary care visits needed?

Educational Health Centers
Models for Training in the Community

Health Centers Serve:

• 1 in 7 Medicaid beneficiaries
• 1 in 7 uninsured persons including:
  • 1 in 5 low income, uninsured
• 1 in 3 individuals below poverty
  • 1 in 3 minority individuals below poverty
  • 1 in 3 children below poverty
• 1 in 7 rural Americans

Source: NACHC, 2013. Includes patients of federally-funded health centers, non-federally funded health centers, and expected patient growth for 2013.
Educational Health Centers

Models for Training in the Community

Health Center Patients are Disproportionately Racial/Ethnic Minorities, 2011

Note: Percents may not total 100% due to rounding.
Sources: Based on 2011 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.
Educational Health Centers
Models for Training in the Community

Health Centers Provide a Broad Array of Services

- Medical Care: 72%
- Dental: 13%
- Behavioral Health: 9%
- Enabling Services: 6%
- Vision: 1%

Total = 80 million patient encounters in 2011

Note: Encounters for enabling services include visits to case managers and health educators.
Percent may not total 100% due to rounding.
Source: Federally-funded health centers only. 2011 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.
Educational Health Centers
Models for Training in the Community
Most Health Center Patients are Uninsured or Publicly Insured

- 39% Medicaid / SCHIP
- 36% Uninsured
- 14% Private Insurance
- 8% Medicare
- 2% Other Public Insurance

*"Other public insurance" may include non-Medicaid SCHIP and state-funded insurance programs.
Source: Federally-funded health centers only. 2011 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.
Note: Percentages may not total 100% due to rounding.
The Good News

- 3237 medical students matched to family medicine residency programs, the highest number in the history of family medicine as a specialty
- The 3378 offered positions was 118 more than offered in 2016
- Eighth year of the match rate increasing
The Not-So-Good News

- By 2035, 44,000 primary care physicians (FM, GIM, Peds) will be needed for the population
- Current residency production of primary care physicians will result in a shortage of over 33,000 primary care physicians
- Estimates are that about 1000-1100 additional family medicine graduates would be needed each year to help meet the demand for primary care physicians
Physician Shortage

• The United States will face a shortage of between 40,800 and 104,900 physicians by 2030, according to a new study commissioned by the AAMC. Released March 14, 2017, the study found that the numbers of new primary care physicians and other medical specialists are not keeping pace with the demands of a growing and aging population.
Starting with the end in Mind

Percent of Physicians Retained in State from UME in 2012
- Arizona 43.2% (rank 19/50 states)
- State median 38.7%

Percent of Physicians Retained in State from GME in 2012
- Arizona 48.4% (rank 16/50 states)
- State median 44.9%

Percent of Physicians Retained in State from UME and GME Combined, in 2012
- Arizona 74.2% (rank 12/50 states)
- State median 68.1%

Physicians Needed to Meet US Rate per 100,000, Active primary care physicians in Arizona:
- Current supply: 5151. Rate 77.1
- Target supply: 6042. Rate 90.5
- Physicians needed 891

Take home message- single biggest predictor of where a physician practices is where they trained. And where they trained is often aligned with specialty selection. And people from a certain background more likely to specialize and practice in rural/ underserved communities/ populations. So, lets find the students with the “right” stuff, train them in the rural/ underserved settings, and they will stay and serve these communities
Increased Demand for Physicians

- Growing population of all ages
- Growing population of older people, with more health issues
- Better access to health insurance with the Affordable Care Act
- Renewed emphasis on primary care as part of a cost-effective health care system
Challenges in Rural Workforce Education Programs

- Funding (start-up to ongoing)
- Competing mission demands: Education and Service
- Integration and Culture
- Infrastructure (people, space, housing, technology, etc)
- Buy-in to the educational mission by partners outside of the particular organization
- Academic requirements for hours of instruction, dedicated time of core faculty
- Recruitment
- Meeting all accreditation requirements
Why Teaching Health Centers

• Meeting patient care demands (access)
• Economic impact
• Job creation
• Increased Quality
• Solid model for rural and frontier care
• Resources for Population Health
• Attraction of faculty and residents with “the right stuff”
• High quality community-based training
• Health workforce solution
• Nexus of innovation
• Simple, its our future workforce… “Growing our Own”
GME Operational and Financial Models

Traditional GME Model
- Teaching Hospital/Academic Health Center (inpatient)
  Residency Program (continuity clinic)
- Community Training Site

THC Model
- Teaching Health Center
  Residency
  CHC
- Community Training Sites
- Hospital/AHC
- Medicare GME $
Things to consider when moving from Contemplation to Action

- Shared mission
- Affiliation agreements
- Financial
- Responsibilities and Control
- Legal issues
- Standards and accreditation
Educational Health Centers
Models for Training in the Community

THE TRIPLE AIM

• Improve the health of the community
• Improve the patient experience
• Bend the cost curve
Educational Health Centers
Models for Training in the Community

Habit 1: Be Proactive

Habit 2: Begin with the End in Mind

*The Seven Habits of Highly Effective People*
Stephen R. Covey
COGME Draft 21st Report

The Council on Graduate Medical Education (COGME) believes that GME needs to improve the value that the public receives for its investment in GME.

Recommendation 2: GME funding should be prioritized to accelerate physician workforce alignment with population and health delivery needs.

Recommendation 5: The clinical learning environments and curricula for undergraduate and graduate medical education training requirements should be revised to prepare a physician workforce capable of providing patient-centered, safe, and effective care.
Educational Health Centers
Models for Training in the Community

Educational Health Center: The term “Educational Health Center” (EHC) shall be used to describe those community health centers or CHC sites that have demonstrated commitment to primary care workforce development and that incorporate, at a minimum, the following four (4) characteristics in their primary care workforce development system.
Educational Health Centers
Models for Training in the Community

1) Governance commitment to primary care workforce development.

2) Provider training element

3) Multi-disciplinary staff training element

4) Commitment to inter-professional training
Educational Health Centers
Models for Training in the Community

A.T. Still University

Arizona School of Dentistry and Oral Health
School of Osteopathic Medicine
Arizona

Arizona School of Health Sciences
ATSU Mission

“A.T. Still University of Health Sciences serves as a learning-centered university dedicated to preparing highly competent professionals through innovative academic programs with a commitment to continue its osteopathic heritage and focus on whole person healthcare, scholarship, community health, interprofessional education, diversity, and underserved populations.”
By the Numbers

6: Six CHC-located Family Medicine Residencies in an ATSU/Wright Center Consortium;

Working to establish an additional six
By the Numbers

200: Approximately two-hundred Health centers playing some role in preparing ATSU healers.

320: Three-Hundred-Twenty students whose education is in-bedded in a CHC Community Campus (every year).
By the Numbers

900: Nine-Hundred *Hometown Scholar* ATSU Applicants, with proven compassion, endorsed by CHCs.

1,000: Over one-thousand ATSU graduates working in a Health Center.
By the Numbers

1,300: Thirteen-hundred potential community healers counseled or mentored by Health Center leaders.

1,500: Approximately one-thousand-five-hundred formal CHC shadowing or clinical rotations per year.
By the Numbers

3.8M: Three-point-eight-Million underserved patients per year (est.) to be served by current ATSU Students & Graduates.

450M: Four-Hundred-Fifty-Million visits (est.) with underserved patients over a lifetime of service by current ATSU students/graduates.
Strategic Planning

- **Clinical:** Re-designing the Delivery System for Population Health;
- **Education:** Re-defining the Teaching Model to Prepare Trainees for the Changing Healthcare Landscape;
- **Research:** Organizing Research for the greatest Success and Impact; and,
- **Community:** Explicitly Linking Community to our Missions.
Rural Communities Face the Greatest Shortages of Primary Care Physicians

Primary Care Physicians Per 100,000 Population, 2005

- Urban: 71
- Large Rural: 61
- Small Rural: 59
- Isolated Small Rural: 36

Source: Rural Health Research Center at the University of Washington Policy Brief: The Crisis in Rural Primary Care, April 2009
OUR MANDATE: INTENTIONAL TEACHING

The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates. The great teacher inspires.

William Arthur Ward
We Are Amongst the Largest Trainers in the Nation ...

Proportion of CHCs Teaching

87%

* NACHC Survey 2007

Our Mandate: Intentional Teaching
Yet We Bear the Brunt …

... of the Nation’s Provider Shortages ...
Our Mandate: Intentional Teaching

... Our Communities Have Borne the Burden of Training Physicians ...

... While Wealthy Communities Have Realized the Benefit of Their Practice ...

Our Mandate: Intentional Teaching
We require thousands of additional providers each year, plus....

Our providers need skills and passions unique to our populations and missions....

Our Mandate: Intentional Teaching
THC Opportunities and Challenges…
Thinking to the Future

• New program using a unique Community Health Center structure as the Sponsoring Institution. New models require new thinking, especially financial.
• Innovative teaching program, with a wide variety of regional educational sites. Family Medicine is the only specialty that distributes itself like the population, so why not structure programs accordingly.
• The requirements of graduate medical education are specific and can be challenging to understand for people who are not academic medical professionals. Like everything that is highly regulated (and political), it can seem complicated and arduous to take on this new endeavor.
• “Every system is perfectly designed to get the results it gets”. This is both an indictment on the past, and an harbinger of things to come (hopefully)
A call to action- what you can do?

- Advocate
  - AHEC
  - Medicaid Waiver
  - THC reauthorization and funding
- Development of CHC Educational Culture and Mission
- Forge Academic-Community Partnerships
- Increase Educational Opportunities and Capacity within CHC’s
Questions?

Thank You!

lgoldstein@atsu.edu