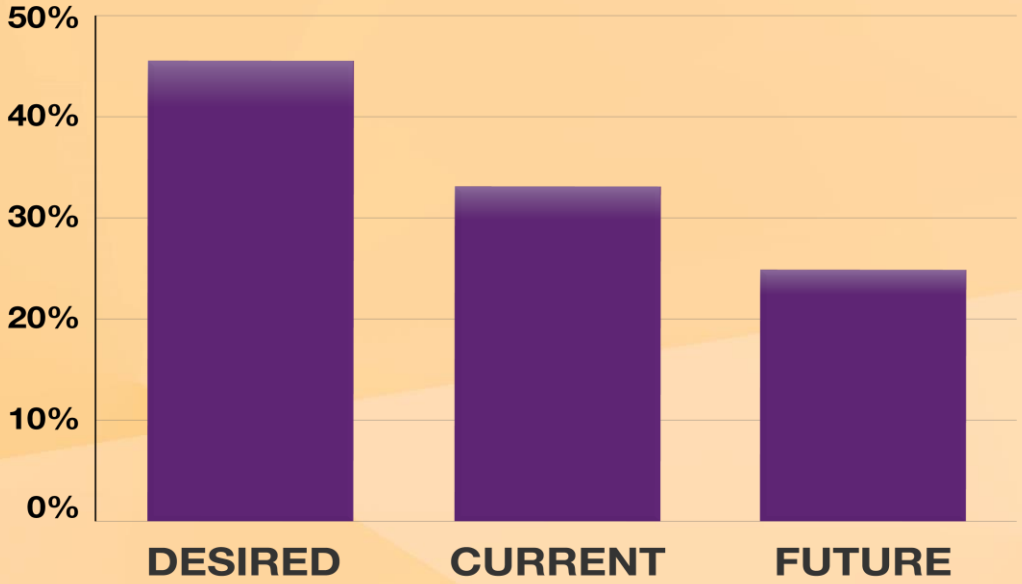
The Problem:

If things stay the same, then they will only get worse

Percentage of Physician Workforce in Primary care



References:
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Colorado Commission on Family Medicine

GME Summit

GME SUMMIT

Seeking a Permanent Solution to the Primary Care Shortage

Welcome &
Rural and Underserved GME Expansion: Two Case Reports from Colorado

Daniel Burke, M.D.
President, Colorado Institute of Family Medicine
Faculty, University of Colorado Family Medicine Residency
Dan.burke@ucdenver.edu

Colorado Commission on Family Medicine

GME Summit

Today's Speakers:

- **Dan Burke, M.D.** Faculty Univ. Colorado Department of Family Medicine
  - **Two brief case reports from Colorado**
- **Tom Told, D.O.** Interim Dean, & Chair of Rural Medicine, Rocky Vista University
  - **The Challenges of Opening a Family Medicine Residency**
- **Jacqueline Thomas** Legislative Health Advisor for Senator Mark Udall
  - **Background on GME reform**

Colorado Commission on Family Medicine

GME Summit

Today's Speakers:

- **Andrew Bazemore, M.D.** Director of the Robert Graham Center
- **Bob Phillips, M.D.** VP of Research at the American Board of Family Medicine
  - **Building the Case for GME Reform**

- **Ted Epperly, M.D.** CEO, Family Medicine Residency of Idaho
  - **The Three Goals of Primary Care Reform: The 40/5/Flow Model**

- **Gina Martin, M.D.** 3rd Year Resident at St. Mary's FMR, Grand Junction
- **Sarah Hemeida, M.D.** 3rd Year Resident at Univ. of Colorado FMR, Denver Health Track
  - **Voices of the Future of Family Medicine**

Chronology of the GME Initiative and the GME Summit

- Colorado Commission on Family Medicine (COFM)
  - **State's 9 Family Med. Residency directors and citizen representatives from each congressional district**
- 2010 COFM Strategic Plan -> GME Initiative
  - **Why is it so difficult (financially) to train Family Doctors**
  - **Grassroots collaboration of health care consumers and family medicine educators chaired by Hon. Kris Mix**
- July 8, 2011: Meeting in Denver
  - **GME Initiative members, health policy experts, congressional staffers, COFM members**
- October 20, 2011: Consensus Statement
- December 21, 2011 Letter from Seven Senators to IOM
  - **Mark Udall, Jeff Bingaman, John Kyl, Tom Udall, Chuck Grassley, Michael Bennet, Mike Crapo**
- March 2013 Publication in Family Medicine
- April 2013 COFM & CIFM Strategic Plan
  - **Need for continued education -> -> GME Summit**

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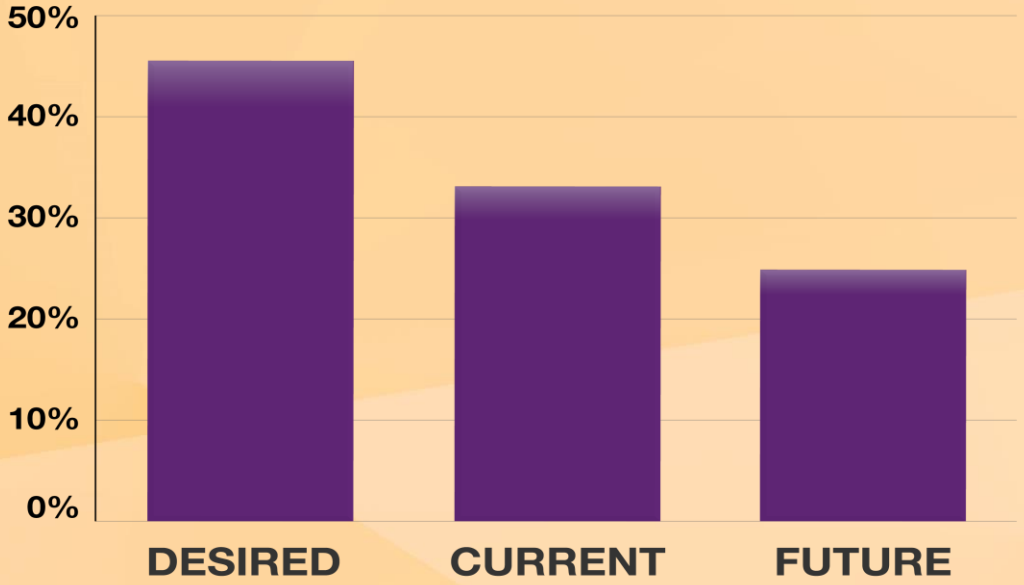

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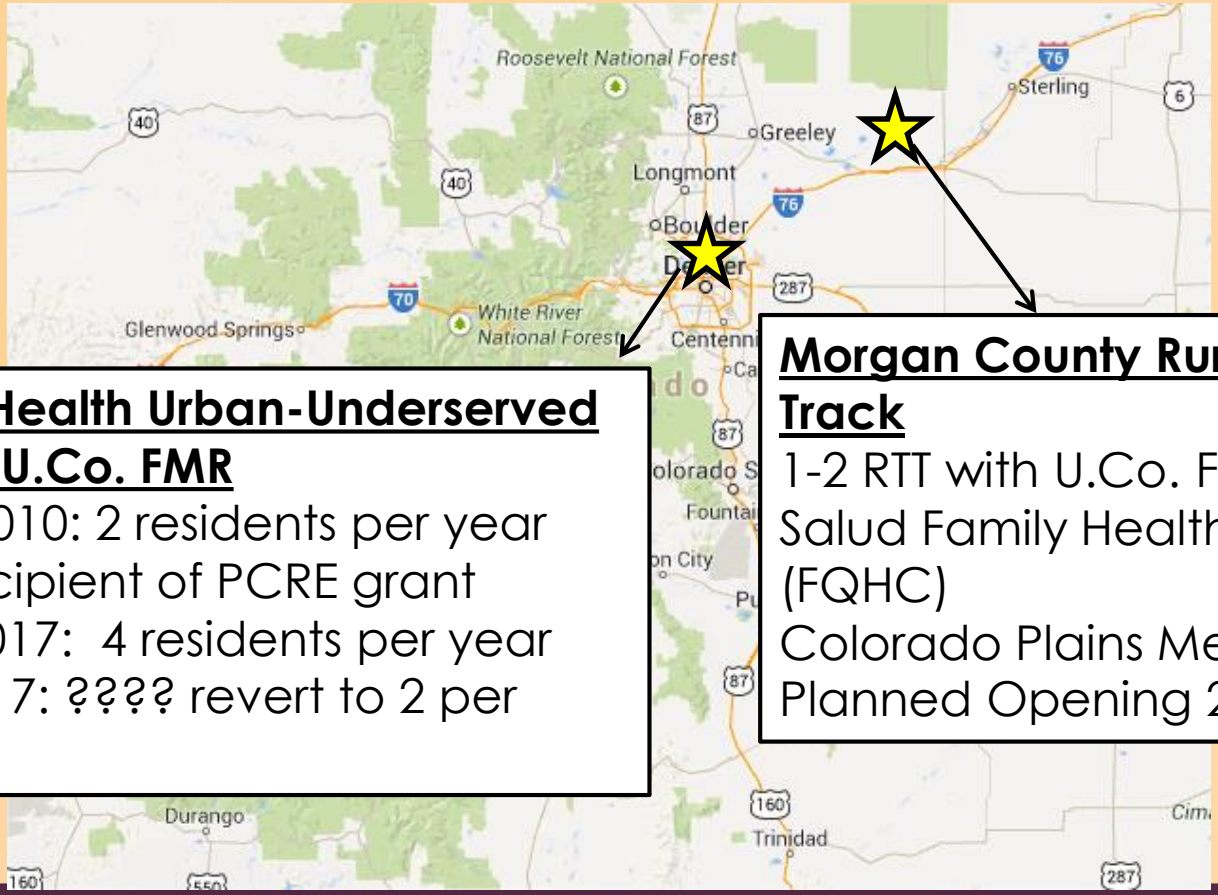
A Tale of Two Cities: Denver and Fort Morgan



Denver Health Urban-Underserved Track of U.Co. FMR

1998 – 2010: 2 residents per year
2010: recipient of PCRE grant
2011 - 2017: 4 residents per year
After 2017: ???? revert to 2 per year

Morgan County Rural Training Track

1-2 RTT with U.Co. FMR
Salud Family Health Center (FQHC)
Colorado Plains Medical Center
Planned Opening 2017

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Denver Health
A GREAT Place to Train Residents

- **Denver Health**
  - Vertically integrated safety net healthcare system
  - FQHC network of 9 primary care clinics
- **Good News:** The Denver Health Urban Underserved Residency Track Works
  - 60% of Grads work in underserved settings
  - 20% in the Denver Health system
- **Good News 2011:** Training Expands with PCRE
- **Bad News:** PCRE Funding Ends after 5 years

Denver Health Track with HRSA Primary Care Residency Expansion

Class Entering 2010

Class Entering 2011

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Denver Health Training Track Uncertain Future

Class Entering 2014
With PCRE




Class Entering 2015
Without PCRE

☺ ☺

☺ ☺

-OR-

😐 😐

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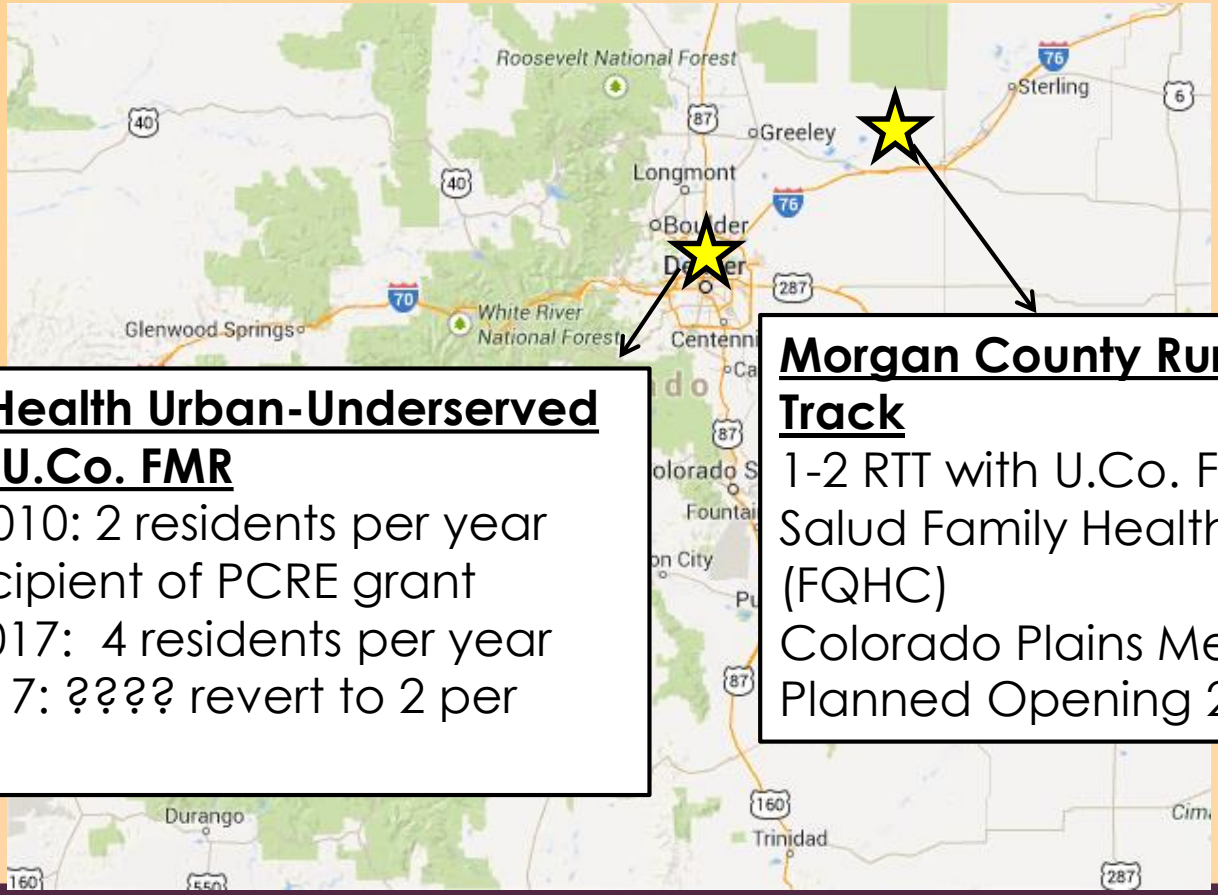
A Tale of Two Cities: Denver and Fort Morgan



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Morgan County Colorado
A GREAT Place to Train Residents

- **Williams Family Foundation**
- **Colorado Plains Medical Center**
- **Salud Family Health Center**
- **Morgan Community College**

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Morgan County RTT Financial Analysis

- **Expenses**
  - **$386,450** Residents
  - **$263,698** Non-resident personnel
  - **$30,000** Space
  - **$45,800** Other
  - **$725,948** Total expenses $120,991 per resident
- **Income**
  - **$64,075** CPMC DGME only (if no "zero PRA")
  - **$232,638** CU IME + DGME
  - **$67,600** "Excess visit" value Salud FQHC
  - **$364,313** Total Income, $60,719 per resident
- **Net annual shortfall**
  - **$361,636, $60,273 per resident**

MCRTT
Financial Analysis - Detail

Location Matters	Medicare Educational Payment per resident per year
University of Colorado Hospital	$116,319
Colorado Plains Medical Center	$ 16,018
"delta"	$100,301

- **$64,075 CPMC DGME only (if no "zero PRA")**
  - **Industry Standard Joke:**
    - **"Resident walks into a GME-naïve hospital -> -> -> -> -> -> -> PUNCHLINE"**

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GME 12 Point Report Card:

The Top Three

1. Set a goal of at least 40% primary care physician workforce

2. Count primary care accurately

3. Payments directly to training programs

- E.g. THC program

The Problem:

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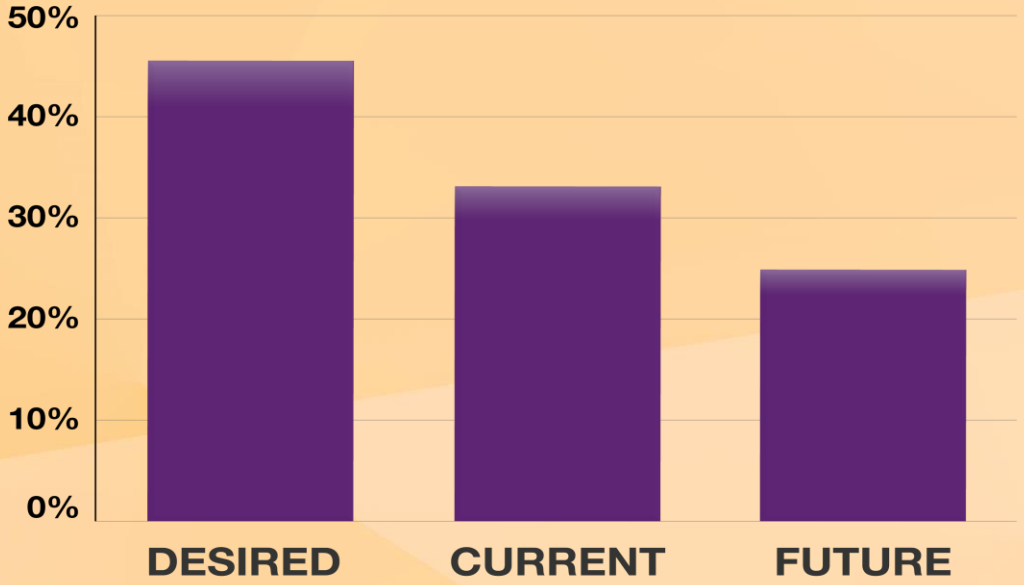

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Making Graduate Medical Education Accountable to the Triple Aim for Health in the United States: Primary Care Matters

Andrew Bazemore MD MPH
Robert Graham Center for Policy Studies
June 2014

Colorado Commission on Family Medicine

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ROBERT GRAHAM CENTER

Policy Studies in Family Medicine and Primary Care

SEARCH

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tools & resources

HealthLandscape

Explore our health data, upload your own, make and print customizable maps that tell stories important to health policy and primary care in your area.

MORE INFORMATION

ROBERT GRAHAM CENTER UPDATE

Review and freely borrow from our annotated slide series on Graham Center analyses, health policy and primary care.

MORE INFORMATION

THEMES

Guiding the work of the Robert Graham Center

- The Value of Primary Care
- Health Access and Equity
- Delivery and Scope of the Medical Home
- Healthcare Quality and Safety

White Paper

The House of Representatives has proposed to use Federal funds to raise Medicaid payments rates for primary care physicians to those of Medicare (Section 1721 of HR 3200). The Graham Center estimated the effects on total gross revenue of the average physician nationally and the total gross revenue of the average family physician in each state. The white paper shows the widely variable but important impact.

Read the report:

Estimated effects of Sec. 1721 of draft bill HR 3200

THE ROBERT GRAHAM CENTER exists to...

Improve individual and population health by enhancing the delivery of primary care.

The Center aims to achieve this mission through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international levels.

WHAT'S NEW

- Primary Care Physicians by State (09/01/2009)
- Decreasing self-perceived health status despite rising health expenditures (09/01/2009) (One-Pagers)
- The effect of facilitation in fostering practice change (06/01/2009) (One-Pagers)
- Effects of proposed primary care incentive payments on average physician Medicare revenue and total Medicare allowed charges (05/01/2009) (Monographs & Books)
- Specialty and geographic distribution of the physician workforce: What influences medical student & resident choices? (03/02/2009) (Monographs & Books)

AMERICAN ACADEMY OF

The World Envisions 'Health for All': Declaration of Alma Ata (1978)

"**Primary care** is essential health care …made *universally accessible to individual and families in the community* through their *full participation* and at a cost that the *community and country can afford*…

It forms an *integral part* of both the country's health system, of which it is the **central function and main focus**.

Global Revisitation to Primary Care as Solution

Colorado Commission on Family Medicine

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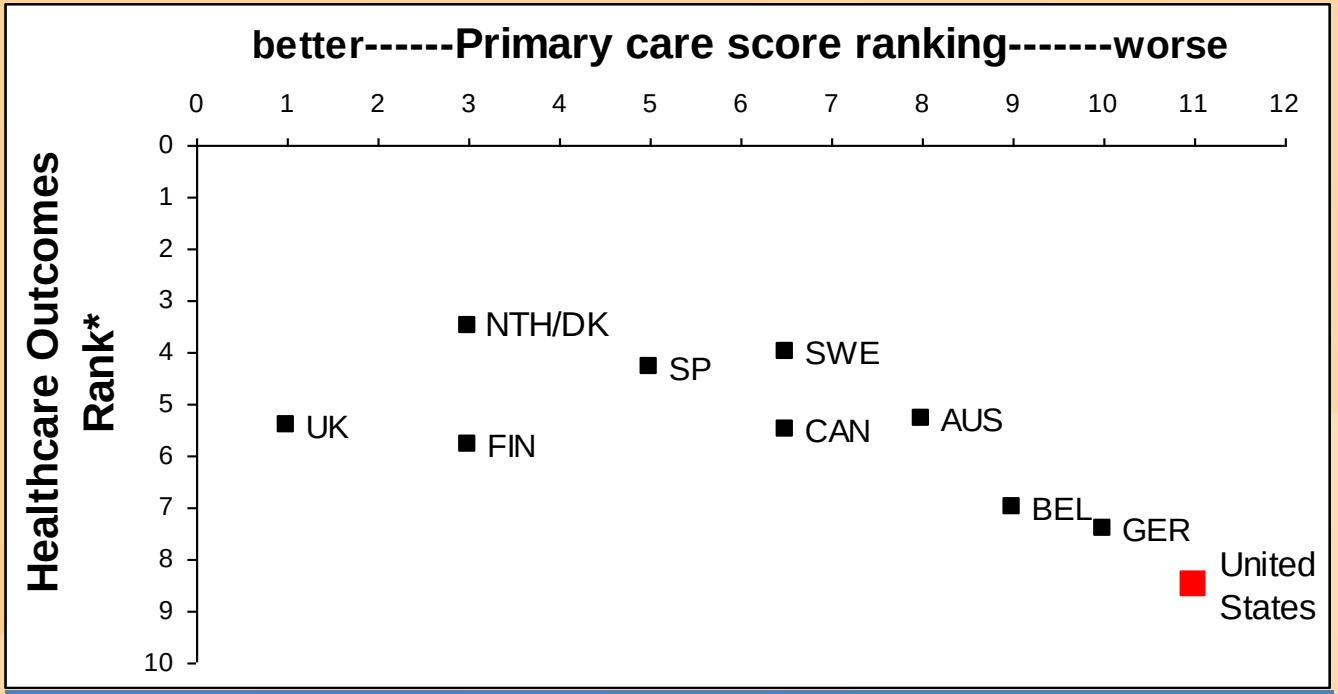
Reality: Primary-Care Score vs Health Outcomes



*Rank based on patient satisfaction, expenditures per person, 14 health indicators, and medications per person in Australia, Belgium, Canada, Denmark, Finland, Germany, Netherlands, Spain, Sweden, United Kingdom, United States

Physician/Pop Ratios 1980-2010

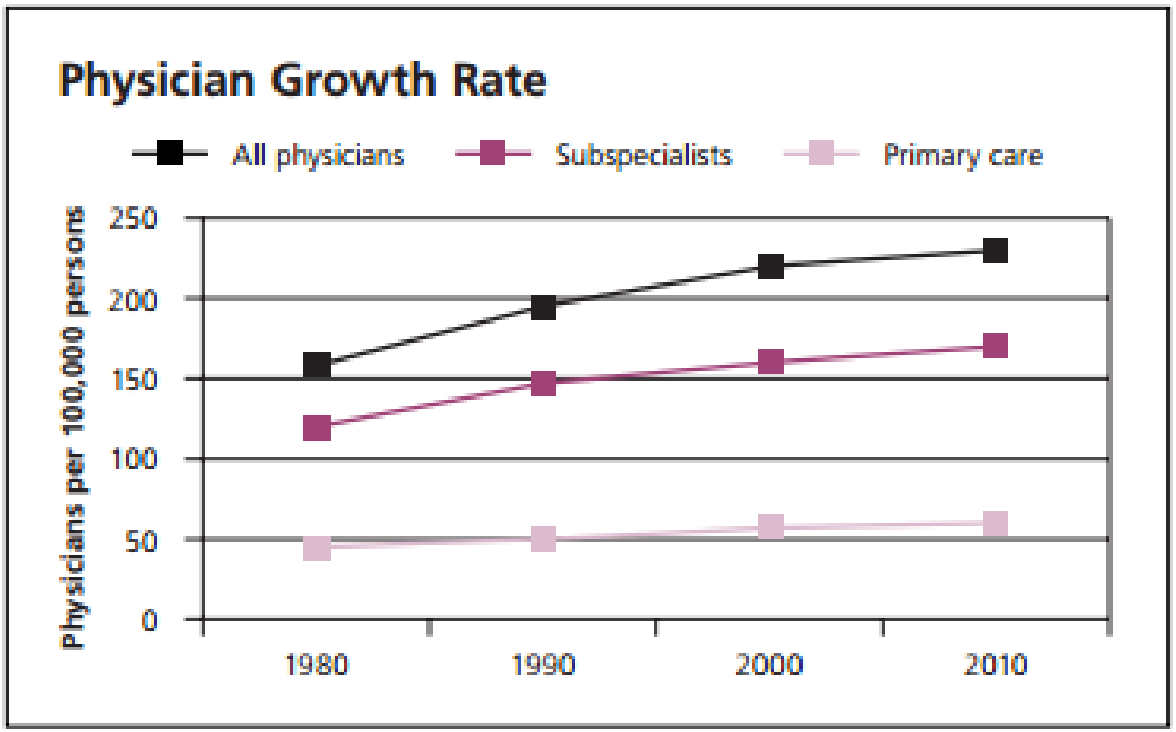
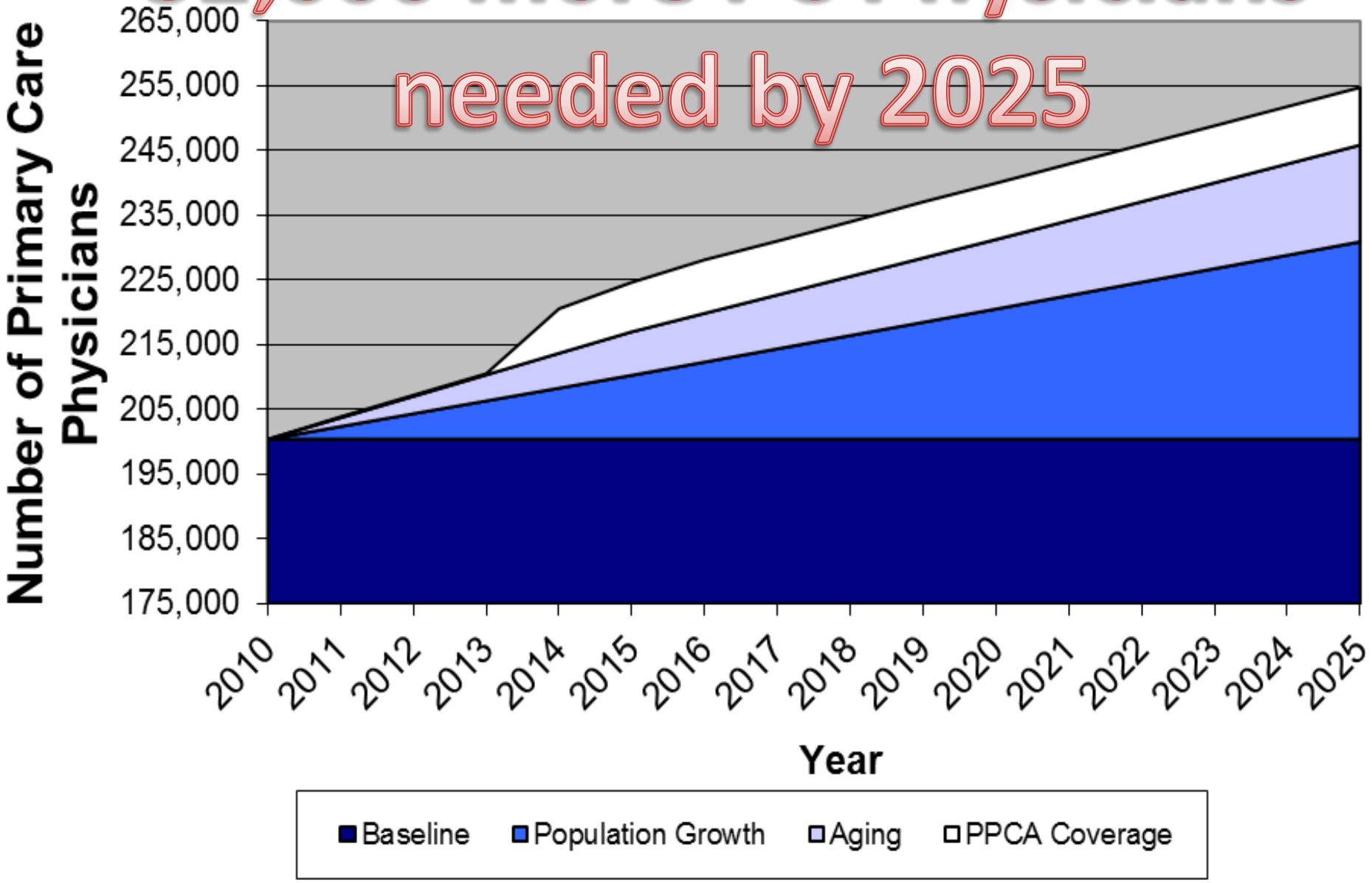
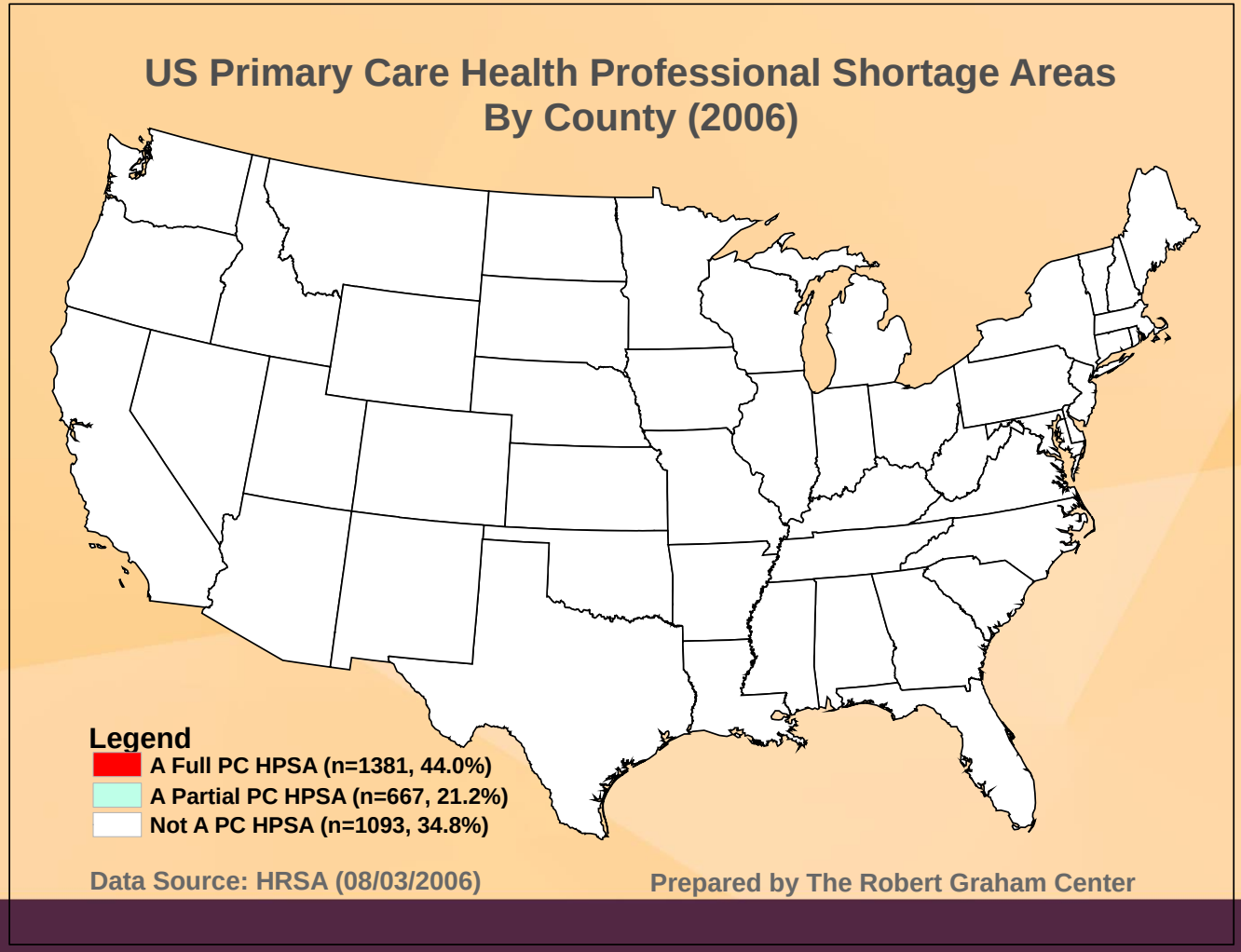


Figure. Physician-to-population ratios have steadily increased every decade since 1980. The rate of growth in the physician workforce has decelerated in the past decade, but still outpaces population growth.

52,000 more PC Physicians needed by 2025



Physician/Pop Ratios 1980-2010



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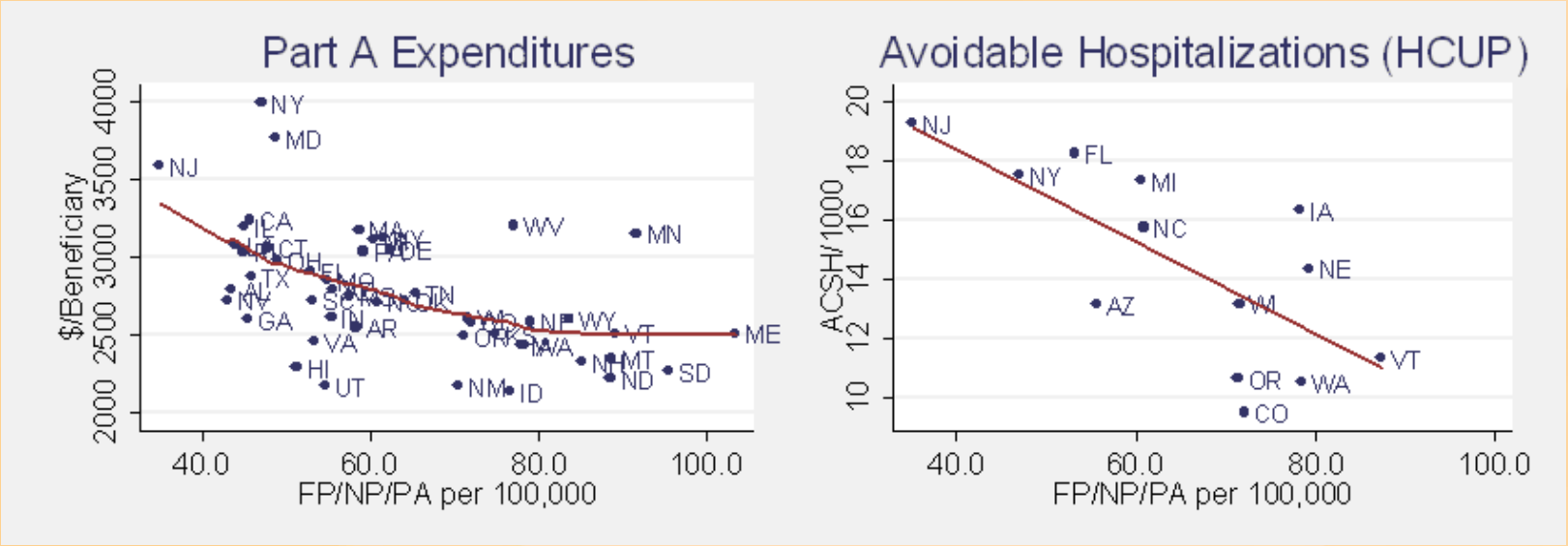
Do Provider/Population Ratios Matter?



Expenditures and Avoidable Hospitalizations seem to drop with increasing PC/population ratios, opposite the trend with Specialty/pop ratios.

25

A Pipeline Is Broken for All

- More recent estimates: NPs in Primary Care settings (40-50%); PAs (33%)
- NP, PA, Family Medicine, General Internal Medicine & Pediatrics are all struggling components of the PC pipeline

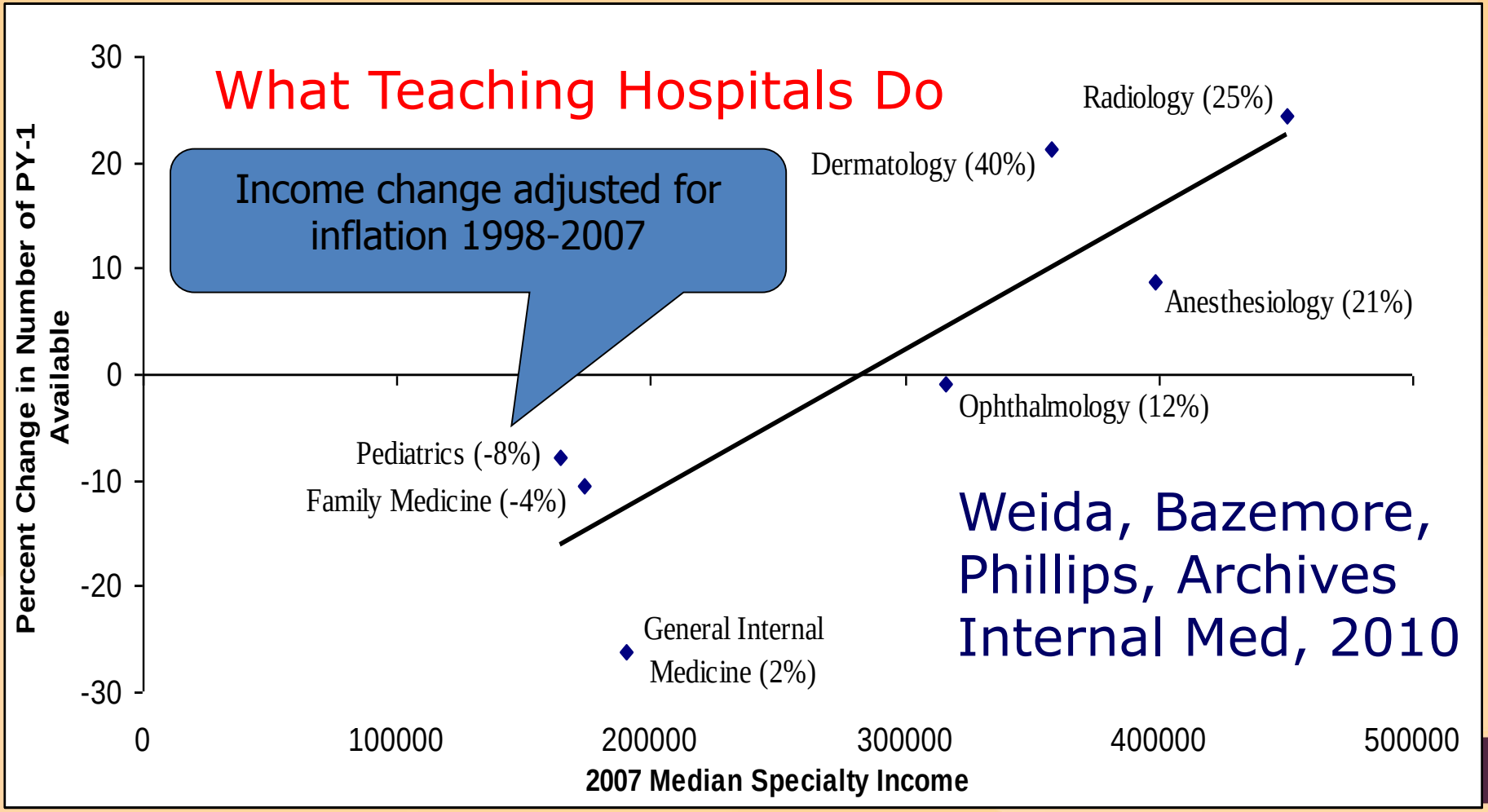
Table. Estimated Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States

Provider type	*Total*	*Number in primary care*
Nurse practitioners	106,073	55,625 (52.4%)
Physician assistants	70,383	30,402 (43.2%)

NOTE: *Data from the 2010 National Provider Identifier file.*

Adapted from Agency for Healthcare Research and Quality. The number of nurse practitioners and physician assistants practicing primary care in the United States. Primary care workforce facts and stats No. 2. October 2011. http://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html. Accessed June 20, 2013.

Market Driven Expansion Fails Primary Care



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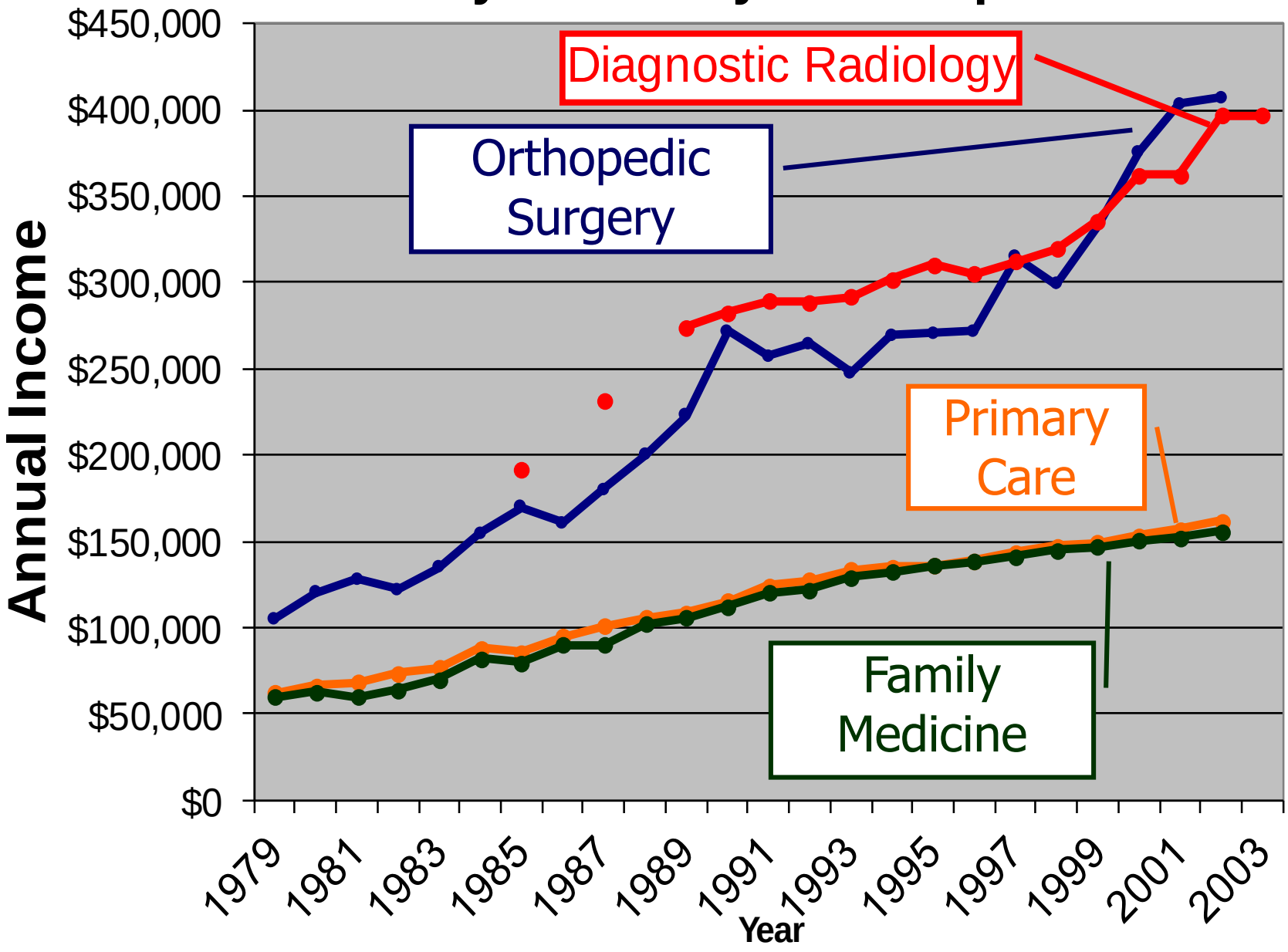
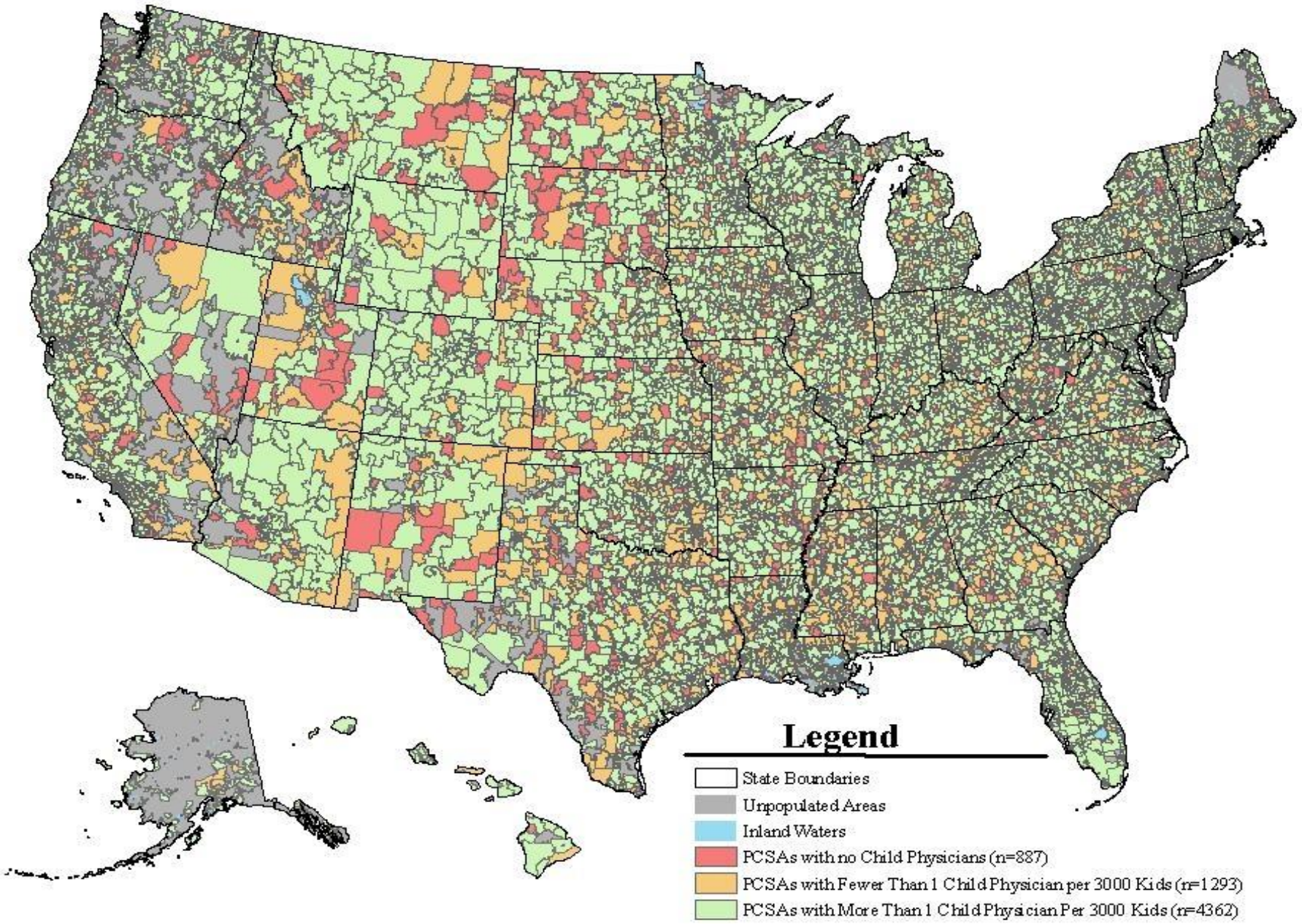
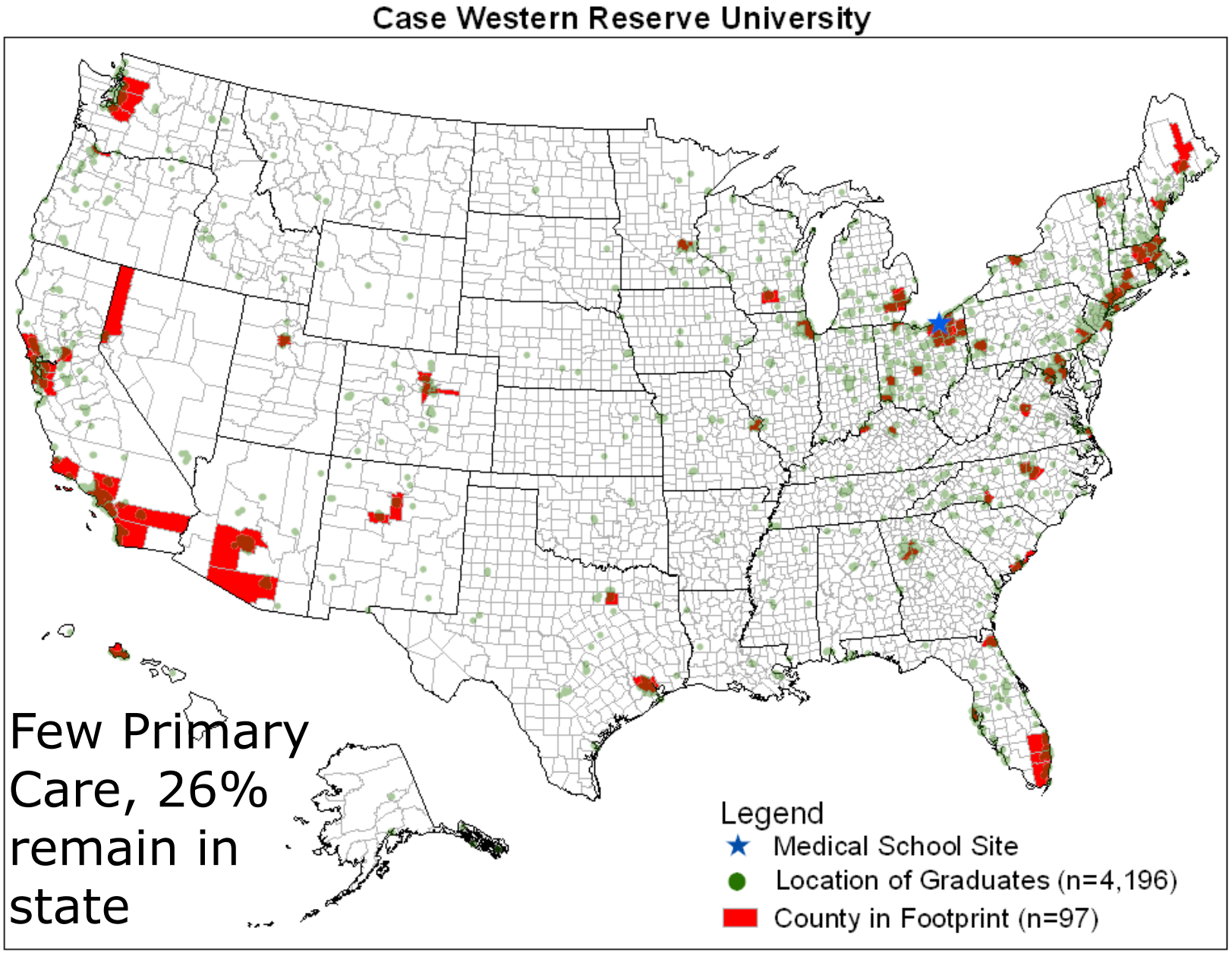
Specialty to Primary Care Physician Payment Gap



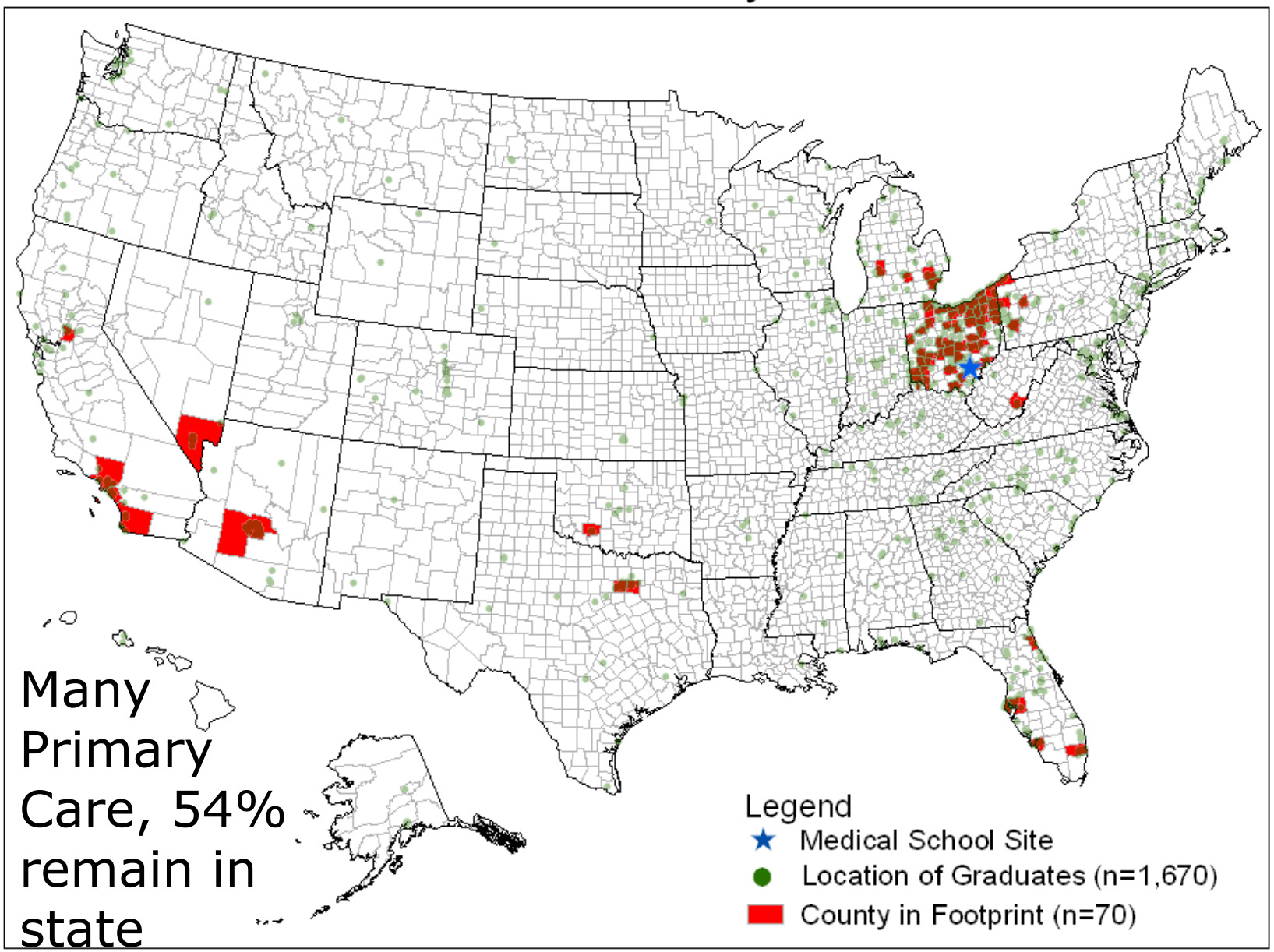
Variation in Local Supply of All Child Physicians



…Where You Train Matters



WHERE DO THE DOCTORS I TRAIN PRACTICE?


Ohio University
Many Primary Care, 54% remain in state
Legend
Medical School Site
Location of Graduates (n=1,670)
County in Footprint (n=70)

Social Mission Defined

The social mission of medical education is the contribution of a medical school in its mission, programs, and the performance of its graduates to addressing the critical and unmet health problems of the society in which it exists.

Best/Worst Primary Care Production

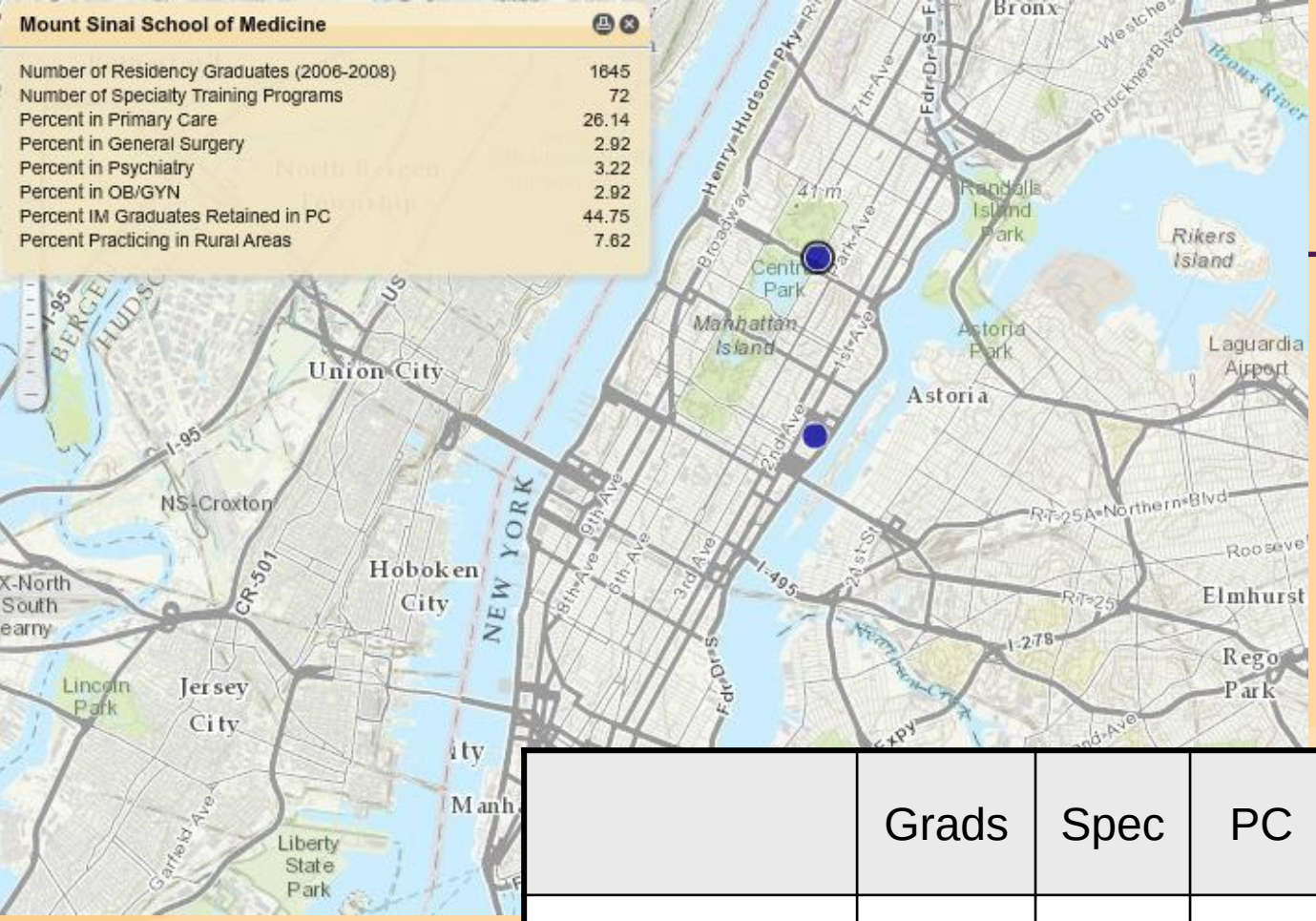
	State	Grads	Spec	PC	% PC
1. Univ Nevada SOM	NY	239	11	**129**	**54%**
2. Bronx-Lebanon	NY	286	12	**143**	**50%**
3. KP South. California	CA	286	16	**140**	**49%**
4. Brooklyn Hosp Center	NY	227	9	**109**	**48%**
5. James H Quillen COM	TN	240	12	**113**	**47%**
157. Vanderbilt	TN	793	59	**67**	**8.5%**
158. Stanford	CA	781	70	**65**	**8.3%**
159. Brigham and Women's	MA	893	45	**69**	**7.7%**
160. Mass General	MA	848	44	**55**	**6.5%**
161. Wash Univ	MO	1048	72	**66**	**6.4%**

* Limited to programs with more than 200 graduates between 2006-2008

Best/Worst Rural production

	State	Grads	Spec	**Rural**	**% Rural**
1. Univ Puerto Rico	PR	343	29	**74**	**61%**
2. Geisinger Health System	PA	220	21	**57**	**46%**
3. Mary Hitchcock Mem Hosp	NH	361	37	**80**	**44%**
4. Univ of Kansas	KS	233	11	**46**	**30%**
5. James H Quillen COM	TN	240	12	**40**	**29%**
157. New York Presbyterian	NY	1,599	70	**7**	**1.4%**
158. St. Luke's-Roosevelt	NY	529	29	**3**	**1.3%**
159. Cedars-Sinai	CA	325	27	**2**	**1.2%**
160. UCLA Medical Center	CA	458	33	**2**	**0.8%**
161. Boston Children's	MA	423	29	**0**	**0%**

* Limited to programs with more than 200 graduates between 2006-2008 and physicians in direct patient care



	Grads	Spec	PC	% PC	Rural	% Rural
Mount Sinai	1,645	72	430	26%	51	7.6%
New York Presbyterian	1,599	70	137	8.6%	7	1.4%

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Bleak Outlook for Primary Care and Rural

Overall GME Primary Care Production	**25.2%****
Primary Care Physician Workforce*	32%
COGME Primary Care Workforce Recommendation*	40%

* COGME 20th Report

** overestimate due to inclusion of hospitalists

Overall GME Rural Production	**4.8%**
Rural Physician Workforce*	11.4%
Rural U.S. Population*	19.2%

* Fordyce et al. 2005 Physician Supply and Distribution in Rural Areas of the United States

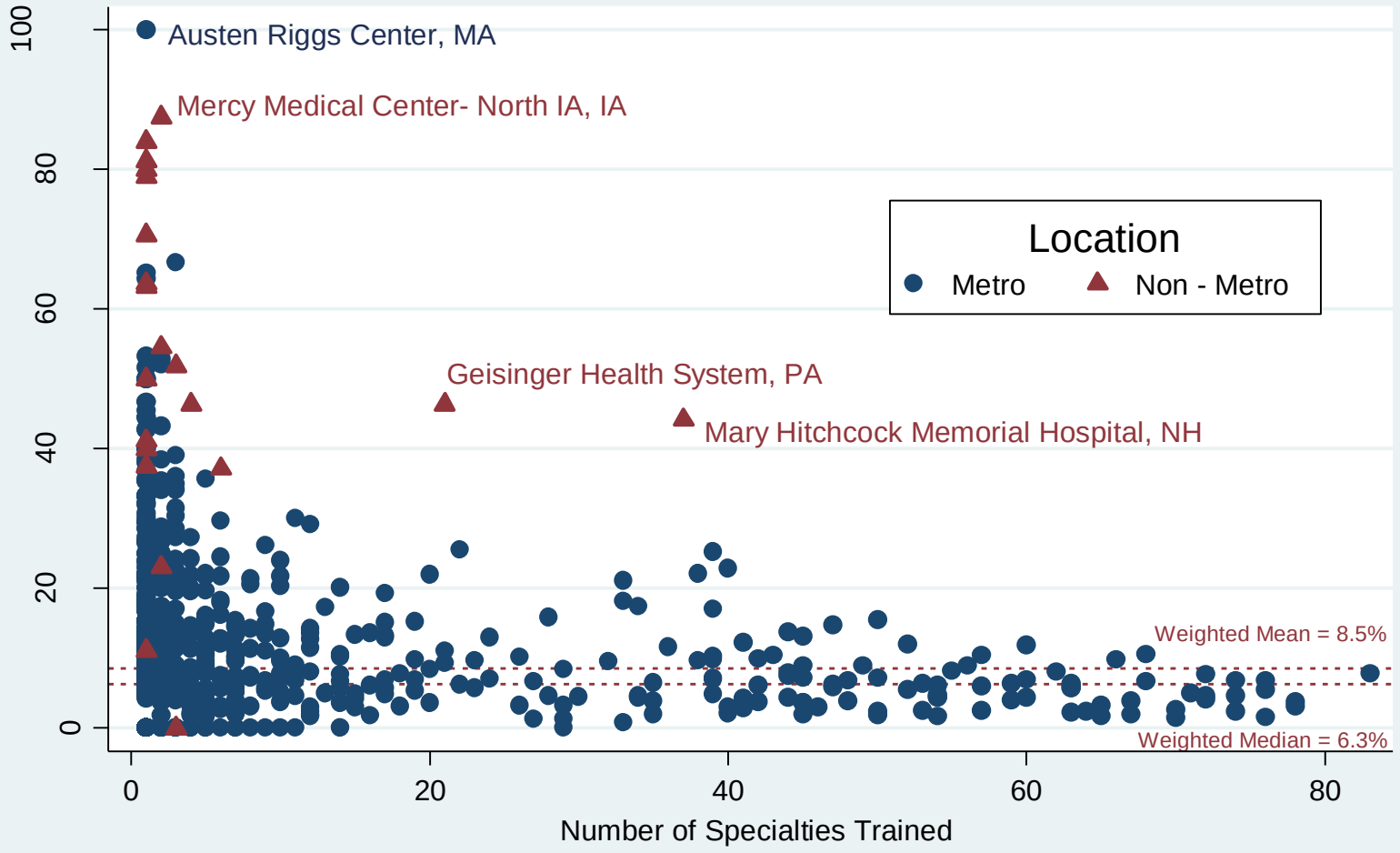
Training and Cost of Care

Unadjusted

	Practice HRR Average Spending Per Beneficiary (# Physicians)			
Training HRR Average Spending Per Beneficiary		Low	Average	High
	Low	**$6,751**	$7,009	$7,846
	Average	$6,332	**$7,760**	$8,589
	High	$8,043	$8,299	**$9,398**

	Practice HRR Average Spending Per Beneficiary (# Physicians)			
Training HRR Average Spending Per Beneficiary		Low	Average	High
	Low	**$6,918**	$7,215	$7,470
	Average	$6,715	**$7,664**	$8,213
	High	$7,904	$7,974	**$8,451**

Rural Outcome Relative to Number of Specialties Trained



* Limited to Sponsoring Institutions with more than 3 graduates between 2006-2008.

** Puerto Rico institutions are excluded as PR is not included in the rural-urban continuum code designation

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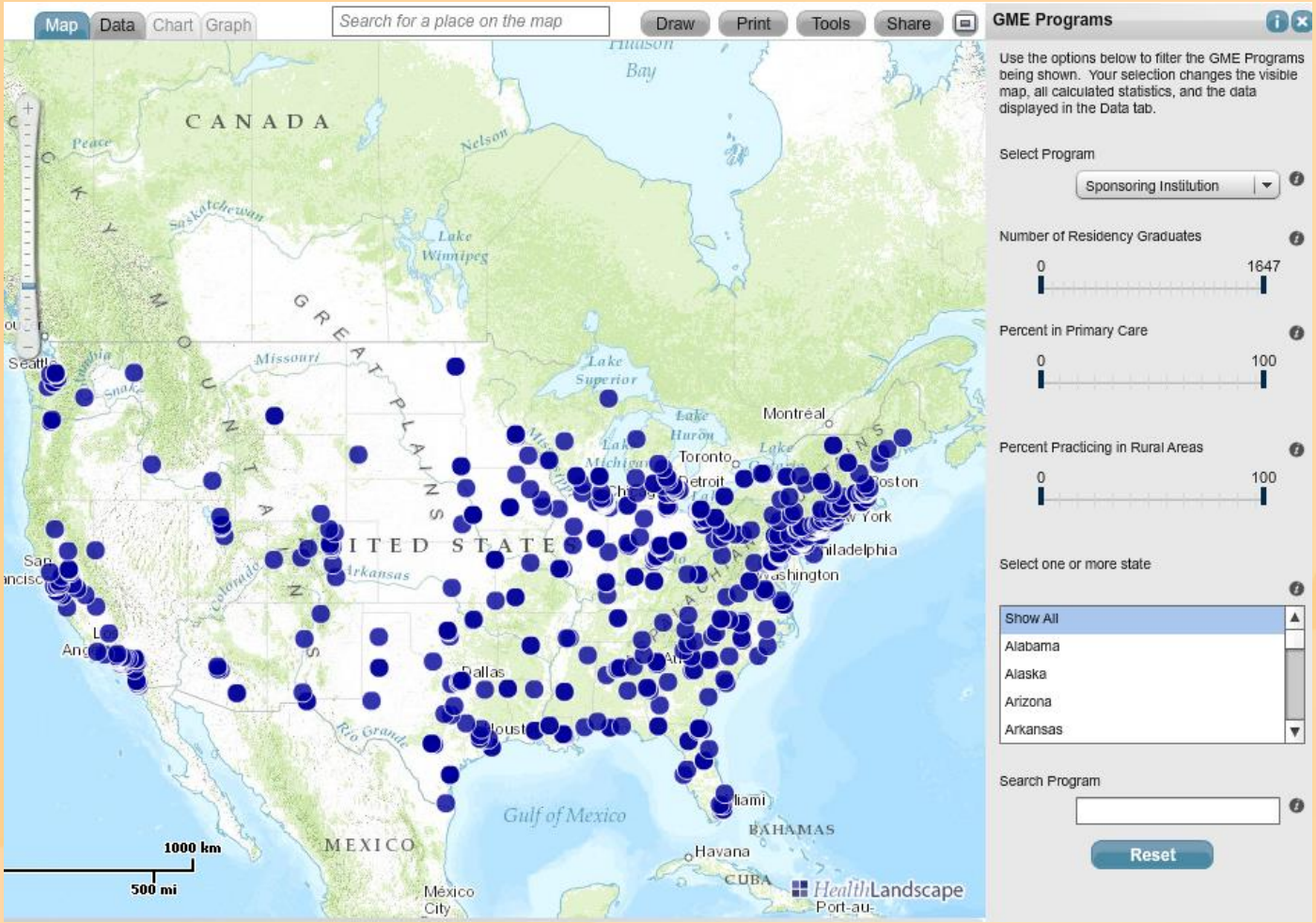

www.graham-center.org/gmemapper

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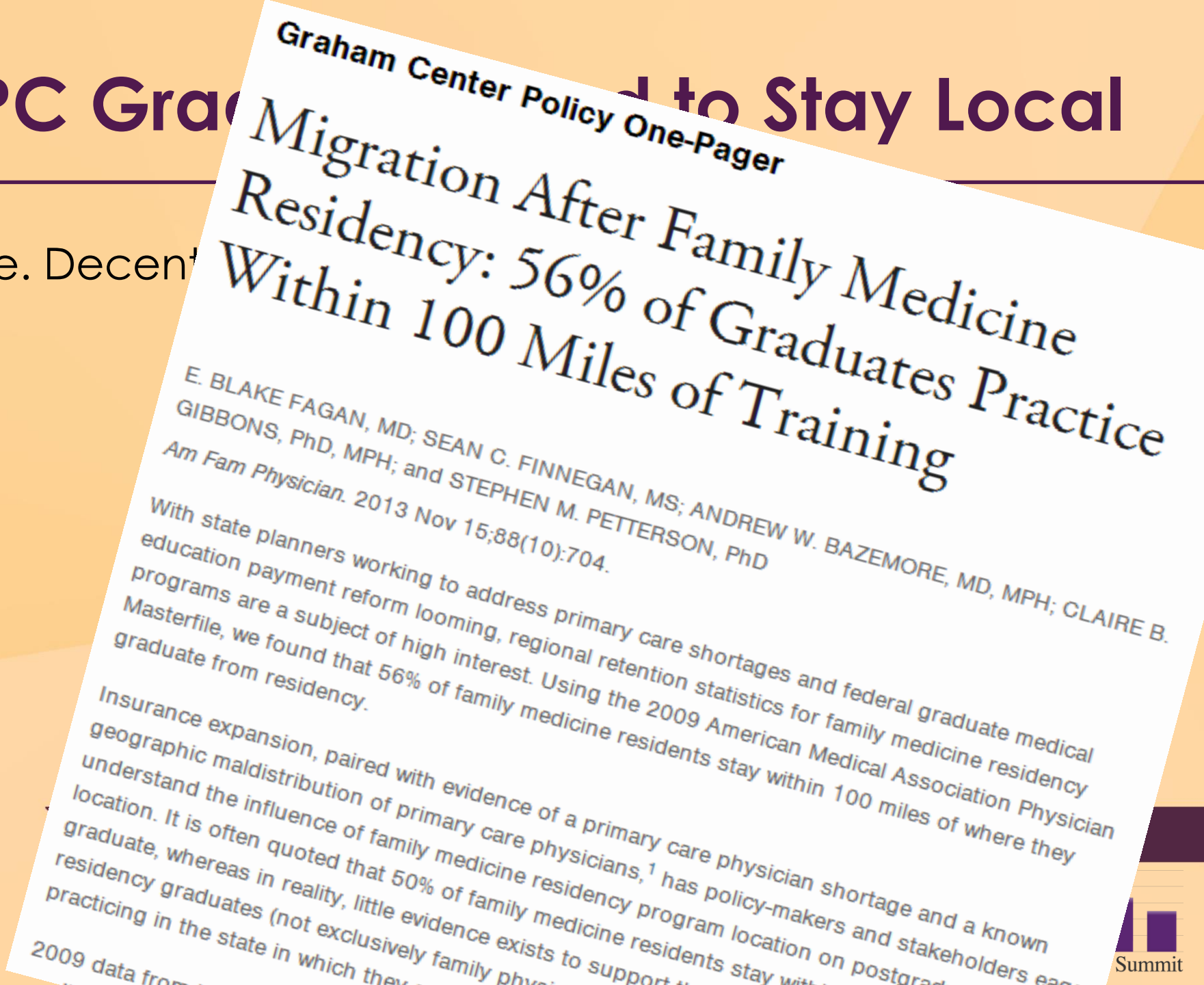
PC Gra[illegible]d to Stay Local

i.e. Decent[illegible]



Graham Center Policy One-Pager

Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training

E. BLAKE FAGAN, MD; SEAN C. FINNEGAN, MS; ANDREW W. BAZEMORE, MD, MPH; CLAIRE B. GIBBONS, PhD, MPH; and STEPHEN M. PETTERSON, PhD

Am Fam Physician. 2013 Nov 15;88(10):704.

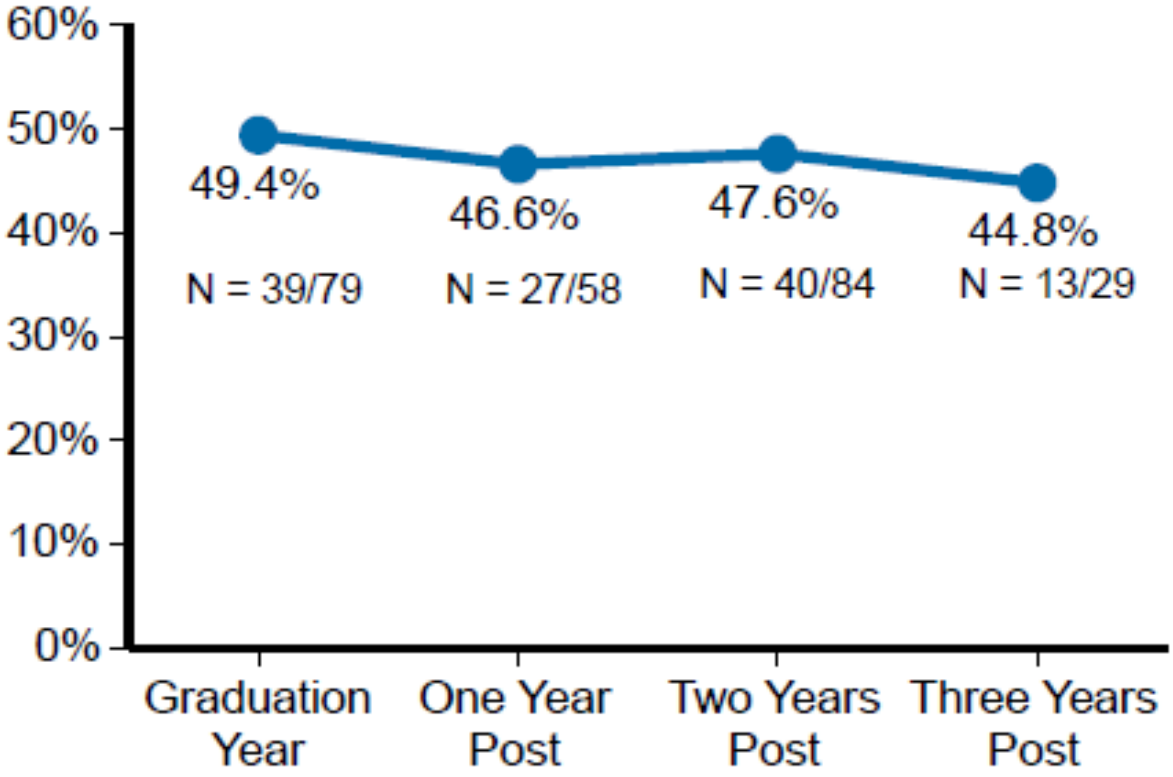
With state planners working to address primary care shortages and federal graduate medical education payment reform looming, regional retention statistics for family medicine residency programs are a subject of high interest. Using the 2009 American Medical Association Physician Masterfile, we found that 56% of family medicine residents stay within 100 miles of where they graduate from residency.

Insurance expansion, paired with evidence of a primary care physician shortage and a known geographic maldistribution of primary care physicians,[1] has policy-makers and stakeholders eag[illegible] understand the influence of family medicine residency program location on postgrad[illegible] location. It is often quoted that 50% of family medicine residents stay within 100 miles of graduate, whereas in reality, little evidence exists to support th[illegible] residency graduates (not exclusively family physi[illegible] practicing in the state in which they

2009 data from

Summit

Figure 2. Family Medicine Rural Training Track Residency Graduates, 2007-08 to 2010-11: Proportion Practicing in Rural Areas



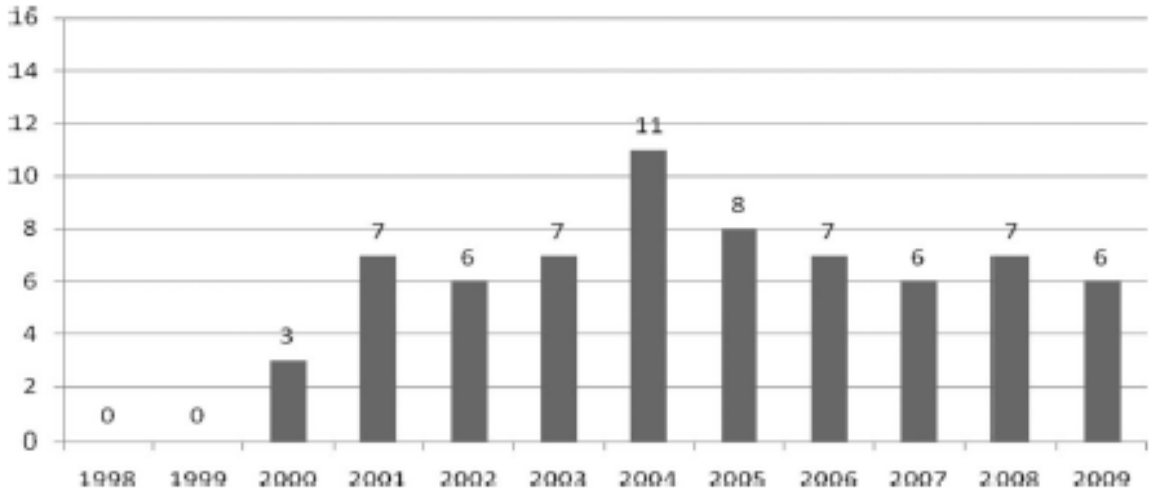
Data sources: graduates identified by 18 RTT programs, AMA Masterfile, Robert Graham Center; rural as defined by Rural-Urban Commuting Areas.

Increasing Graduate Medical Education (GME) in Critical Access Hospitals (CAH) Could Enhance Physician Recruitment and Retention in Rural America

Imam M. Xierali, PhD, Sarah A. Sweeney, BS, Robert L. Phillips, Jr., MD, MSPH, Andrew W. Bazemore, MD, MPH, and Stephen M. Petterson, PhD

Critical Access Hospitals (CAHs) are essential to a functinoning health care safety net and are a potential partner of rural Graduate Medical Education (GME) which is associated with greater likelihood of service in rural and underserved areas. Currently very little Medicare funding supports GME in the CAH setting, highlighting a missed opportunity to improve access to care in rural America. (J Am Board Fam Med 2012;25:7–8.)

Figure 1. Number of Critical Access Hospitals reporting intern and resident full-time equivalents.

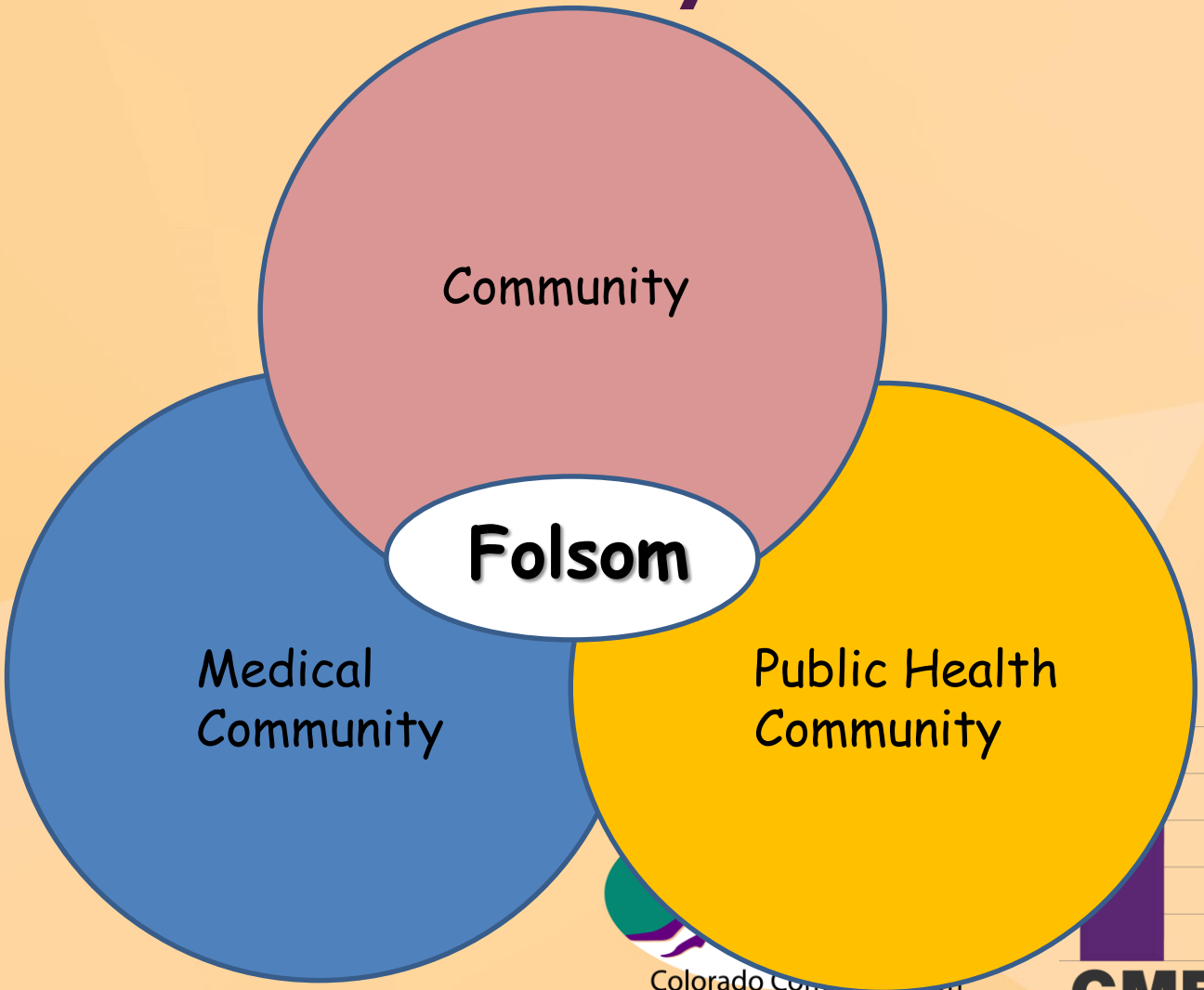


If They Train in the Safety Net: They Provide Care in the Safety Net

- **Trained in a Rural Health Clinic:**
  - **Later worked in a RHC, FQHC, or CAH** **38.3%**
- **Trained in a Federally Qualified Health Center:**
  - **Later worked in a RHC, FQHC, or CAH** **31.2%**
- **Trained in a Critical Access Hospital:**
  - **Later worked in a RHC, FQHC, or CAH** **53.5%**

Phillips RL, Petterson S, Bazemore A. Do Residents Who Train in Safety Net Settings Return for Practice? Ac Med. 2013; 88(12):1934-1940

We need to train Primary Care in Teams that view Health as a 'Community Affair':



Family Medicine

GME Summit

Final Thoughts

- Current GME system serves the market well
- But fails to be accountable to population need and aims
- Our Triple Aim requires a rethinking of training and how we fund it

Final Thoughts

- GME outputs are measurable, and inputs capable of achieving them increasingly known
- Decentralized Training is essential, but we'll only achieve our goals if we also hold our high volume training centers accountable for their outputs

Thank you

abazemore@aafp.org
202-331-3360

www.graham-center.org

www.healthlandscape.org

www.medschoolmapper.org

Colorado Commission on Family Medicine

GME Summit

Strategies for Making Graduate Medical Education Accountable That Don't Require Legislation (but Offer Ideas for Legislation!)

Bob Phillips, MD MSPH
American Board of Family Medicine
June 20, 2014

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Medicare Demonstration Authority

- Medicare has exercised this authority in the past:
  - GME slot reductions in BBA97
  - Utah Medical Education Council (Medicare Waiver)
- Medicare (CMMI) could do training trials
  - Pay for GME differently to test outcomes in different models, different locations
- CMMI could be more open to state-based demonstrations…or create (substantial) incentives for them

Medicaid Authority

- **Purposefulness:** States could be much more purposeful about how they spend nearly $5 billion in Medicaid GME funding—doesn't have to mimic Medicare
- **Accountability**: States could pilot accountability measures and direct funds very differently than Medicare
- **Waivers:** At least 3 states have negotiated Medicaid waivers with GME-specific provisions (Texas!)
- **Expansion:** New Mexico specifically increased Medicaid GME for primary care and received nearly 3:1 match

Community Benefit

- ACA has new requirements for tax-exempt hospital community health needs assessment, investment and evaluation
- Many tax=exempt hospitals already report GME $$ as "community benefit"
- When is it a benefit, when is it simply pass-through money?
- If it is a benefit, then it should produce what the community needs

The chart below outlines the Johns Hopkins Health System's Community Benefit Activities for Fiscal Year 2012.

Fiscal Year 2012 Community Benefit Activites	The Johns Hopkins Hospital	Johns Hopkins Bayview Medical Center	Howard County General Hospital	Suburban Hospital	Sibley Memorial Hospital	All Children's Hospital
Charity Care at Cost	$36,281,442	$23,651,335	$6,011,731	$4,699,607	$3,232,573	$3,797,110
Unreimbursed Medicaid	–	–	–	–	$2,915,541	$14,260,986
Community Health Improvement Services and Community Benefit Operations	$29,354,147	$8,754,633	$12,204,601	$7,762,025	$782,517	$1,535,682
Health Professions Education	$106,236,515	$22,892,530	$793,728	$4,942,629	$668,026	$4,425,115
Subsidized Health Services	–	–	–	–	$3,872,574	$3,919,030
Research	$75,000	$38,003	$136,700	–	$1,091,405	–
Cash and In-Kind Contributions to Community Groups	$1,067,957	$795,024	$877,987	$1,217,870	$14,200	–
Community Building Activities	$3,747,468	$3,050,843	$327,101	$938,362	–	$788,235
Total Community Benefits and Charity Care	**$176,762,529**	**$59,182,368**	**$20,351,848**	**$19,560,493**	**$12,576,836**	**$28,726,158**

Serving the

An Overview of Community Benefits in Fiscal Year 2012

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Hazards of Change

Rolling out a new curriculum could cause some uncomfortable moments.

BY DEAN/CEO EDWARD D. MILLER, M.D.

I've been mulling over a crucial question: What should a 21st-century medical school education look like?

Barton Childs, the pediatrician who 50 years ago helped pioneer the whole field of medical genetics here, once commented that "it's easier to move a graveyard than to bring revisions to medical thinking." I wouldn't go that far, but as we get ready to introduce a new medical school curriculum called "Genes to Society," it's clear that a lot rides on the answer to my question.

The fact is, a curriculu

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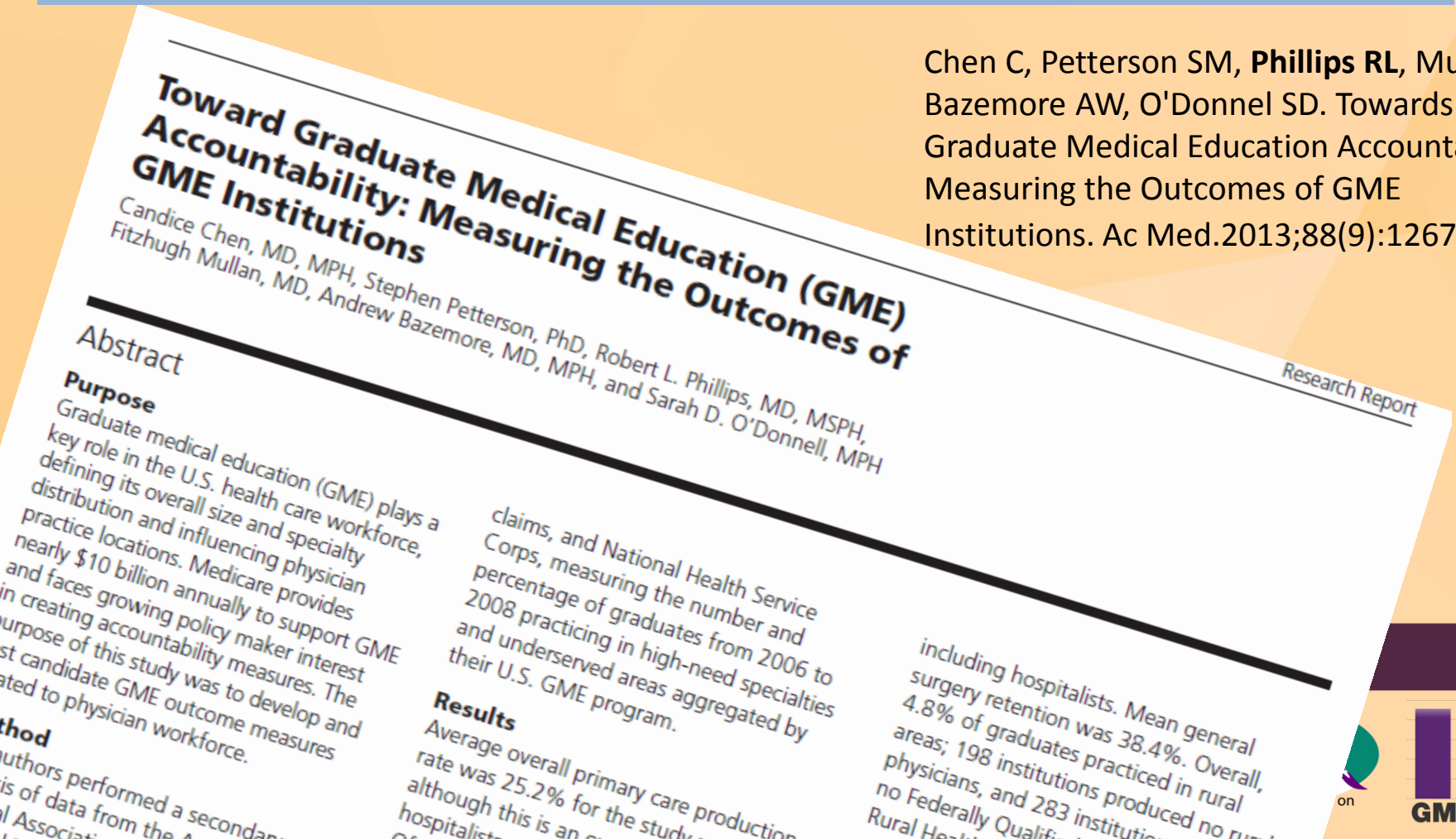
Of the 161 teaching hospitals with more than 200 residency graduates 2006-2008, Johns Hopkins ranked 151 for primary care



Research Report

Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions

Candice Chen, MD, MPH, Stephen Petterson, PhD, Robert L. Phillips, MD, MSPH, Fitzhugh Mullan, MD, Andrew Bazemore, MD, MPH, and Sarah D. O'Donnell, MPH

Abstract

Purpose

Graduate medical education (GME) plays a key role in the U.S. health care workforce, defining its overall size and specialty distribution and influencing physician practice locations. Medicare provides nearly $10 billion annually to support GME and faces growing policy maker interest in creating accountability measures. The urpose of this study was to develop and st candidate GME outcome measures ated to physician workforce.

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uthors performed a secondar is of data from the A l Association

claims, and National Health Service Corps, measuring the number and percentage of graduates from 2006 to 2008 practicing in high-need specialties and underserved areas aggregated by their U.S. GME program.

Results

Average overall primary care production rate was 25.2% for the study although this is an hospitalist

including hospitalists. Mean general surgery retention was 38.4%. Overall, 4.8% of graduates practiced in rural areas; 198 institutions produced no physicians, and 283 institution no Federally Qualifi Rural Hea

Chen C, Petterson SM, **Phillips RL**, Mullan F, Bazemore AW, O'Donnel SD. Towards Graduate Medical Education Accountability: Measuring the Outcomes of GME Institutions. Ac Med.2013;88(9):1267-80.

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Residency Outcomes

Johns Hopkins University School of Medicine	
Number of Residency Graduates (2006-2008)	1148
Number of Specialty Training Programs	76
Percent in Primary Care	8.97
Percent in General Surgery	1.66
Percent in Psychiatry	2.44
Percent in OB/GYN	2.26
Percent IM Graduates Retained in PC	20.55
Percent Practicing in Rural Areas	1.49

http://www.graham-center.org/online/graham/home/tools-resources/gme-mapper.html

Johns Hopkins Hospital	
Number of Residency Graduates (2006-2008)	848
Number of Specialty Training Programs	70
Percent in Primary Care	4.60
Percent in General Surgery	0.00
Percent in Psychiatry	0.00
Percent in OB/GYN	0.00
Percent IM Graduates Retained in PC	100.00
Percent Practicing in Rural Areas	1.45

What Should We Get for $15B?

- Primary care is key to achieving the Triple Aim
- US health is underachieving at great expense
- Will get worse with insurance expansion, aging
- Where and how we train physicians matters
  - Can drive costs up and reduce access (now)
  - Can drive costs down and increase access (needed)
- Some hospitals and models doing well!
- Medicare and Medicaid opportunities exist now
- ACA community benefit is another lever

The Three Goals of Primary Care GME Reform: The 40/5/Flow Model

GME Summit: Seeking a Permanent Solution to the Primary Care Shortage

June 20, 2014

Ted Epperly, MD, FAAFP

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Past President and Past Chairman of the Board | American Academy of Family Physicians
Co-Chair, Center on Care Delivery and Integration | Patient Centered Primary Care Collaborative
Board Member | Accreditation Council for Graduate Medical Education
President | The Rural Training Track Collaborative

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Major Problems Facing United States Healthcare System

- Inadequate healthcare coverage
- Lack of usual source of care
- Lack of timely access to high-quality primary care
- Too much secondary, tertiary, and quaternary healthcare
- High-cost system
- Large healthcare disparity gaps
- Wrong focus (disease v. health)
- Wrong team on the field (subspecialists v. primary sare)

Commonwealth Fund

1. Some type of health insurance coverage.
2. A usual source of care.

- The Commonwealth Fund
- www.commonwealthfund.org

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So what are we going to do to fix these problems?

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40/5/Flow Model

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The 40/5/Flow Model

1. We want the future workforce of the US to be **at least 40%** primary care physicians (Family Medicine, General Internal Medicine, General Pediatrics, and Geriatrics) to allow high-quality, timely access to all US citizens in all settings (urban, suburban, rural, frontier). These physicians provide first contact, comprehensive, continuing, and coordinated care in the context of family and community
2. We want the calculation that all medical/osteopathic schools perform to determine this minimum of 40% production to be done **five years after graduation** from these schools. Federal funding/NIH grants to US medical/ osteopathic schools could be formula weighted on this 40/5/Flow Model to ensure accountability.
3. Enhanced GME money must **FLOW** directly to where these primary care physicians are being trained.

Six Additional Waypoints to Success

- GME Reform should be done in a **budget neutral** fashion.
- **Minimum of $100K Direct Medical Education (DME) Payment** per resident, per year for all residents in all primary care training programs that demonstrate that at least 40% of their graduates are practicing in primary care areas five years after medical school (two years after their residency programs are over).
- **No** GME funding for **fellowship training except** in needed fellowship areas, (e.g., geriatrics, palliative care, some pediatric sub-specialties).
- **All payer system** developed where private insurance companies contribute along with Medicare and Medicaid to GME in the US. Combined pool of money should preferentially fund primary care training first, general surgery, and psychiatry next, and then all others after this in a prioritized manner.
- Fund the **Work Force Advisory Committee** from savings on stopping fellowship GME and listen to their recommendations.
- Listen to the Council on Graduate Medical Education (**COGME**) and their recommendations.

What Does the U.S. Healthcare System Get By Doing This?

- **Rebalancing** of our healthcare system workforce.
- **Accountability** to our communities, states, and nation of timely access to a usual source of care in all locations.
- **Better** prevention, wellness, and chronic disease management.
- **Seeing** the right people, in the right places, for the right reasons.
- Having a national **strategy** with national **metrics** to guide us and keep us on track.
- Achieving the **Triple Aim** of better health, better healthcare, and lower costs.

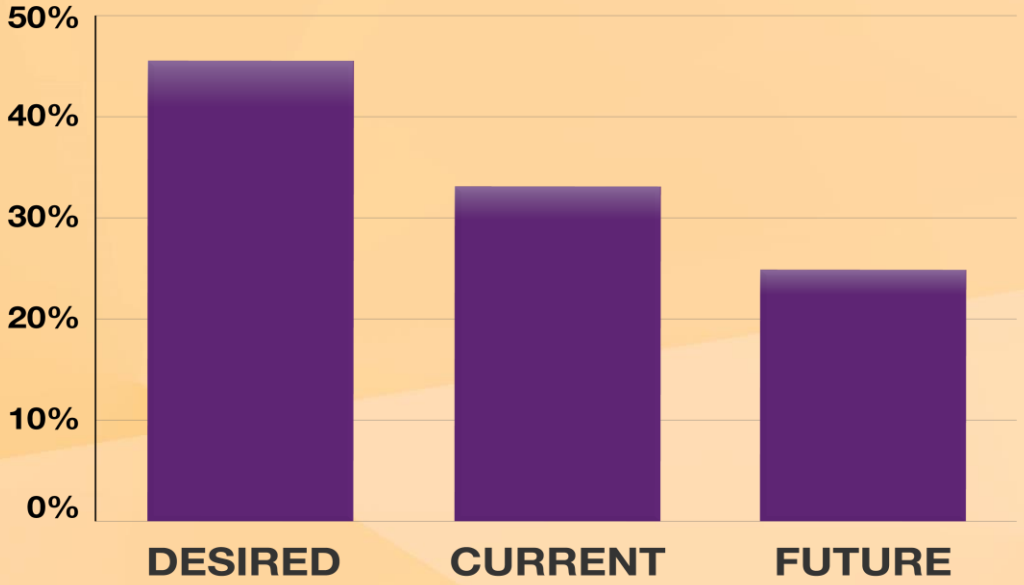
Summary Points 40/5/Flow Model of Primary Care GME Reform

1. At least forty percent of all U.S. MD/DO graduates → Primary Care.
2. Measurement of Primary Care done five years after graduation from MD/DO schools.
3. GME money flows directly to the primary care residencies in a prioritized and budget neutral fashion.

The Problem:

If things stay the same, then they will only get worse

Percentage of Physician Workforce in Primary care



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1. Council on Graduate Medical Education. Advancing primary care. Rockville, MD: Council on Grad Med Educ, 2010.
2. Chen C, et al. Toward GME Accountability: Measuring the Outcomes of GME Institutions. Acad Med. 2013;88(9):1267–1280.

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