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Family Medicine

Harnessing the Friction to Influence Policy: The Power of Research Questions that Emerge from the Clinic

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Peter Curtis Lecture
UNC School of Medicine Faculty Development Fellowship
June 7, 2024

Collaborators

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- Emily Hawes, PharmD, CPP
- Brianna Lombardi, PhD, MSW
- Tania Jenkins, PhD
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- Haley Simons, BA

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My lens

- Health services researcher
- Direct Carolina Health Workforce Research Center
- Director of Policy for two technical assistance centers developing residency training in underserved communities
- Faculty appointment in Family Medicine; my work is interprofessional and interdisciplinary
- My research: workforce modeling, graduate medical education, team-based models of care, state and federal workforce policy
- Teach and mentor learners from medicine, nursing, social work, and health policy
- I believe in the power of data to shape policy

This presentation in one slide

- Primary care is having its moment on the policy stage
- Taking advantage of the current policy window requires evidence and policy solutions
- Significant untapped potential exists to leverage Family Medicine clinics and training sites as "living laboratories" to inform primary care reform
- How to do this? Translating research into policy requires you to:
  - » Document trends requiring attention of government officials (*Brown 1991*)
  - » Find your voice by using your lived experience from the front-lines, combined with data (quant and qual)
  - » Tell your story to policy makers who often want to hear specific examples
  - » Deploy patience because policy change is incremental

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Primary Care Workforce Shortages. Everywhere.

KFF Health News

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PRIMARY CARE DISRUPTED

Will the Doctor See You Now? The Health System's Changing Landscape

CNN health | Life, But Better | Fitness | Food | Sleep | Mindfulness | Relationsl

Concern grows around US health-care workforce shortage: 'We don't have enough doctors'

SPORTS | BUSINESS | POLITICS | OPINION

Why Is It So Hard to Get a Doctor's Appointment in Philadelphia?

If Philly is one of the greatest medical cities in America, why does it take so long to get a doctor's appointment here — and does it have to be this way?

by CHRISTINE SPEER LEJEUNE • *4/22/2024, 11:00 a.m.*

Months-long waits accessing care leave patients sicker and in anguish

A fourth of Massachusetts doctors plan to leave the field in the next two years, according to a survey.

By Jessica Bartlett Globe Staff,
Updated March 16, 2023, 5:27 a.m.

163

KFF Health News

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The Shrinking Number of Primary Care Physicians Is Reaching a Tipping Point

NIGHTLY NEWS

Primary care doctor shortage worsening across U.S.

SAVE

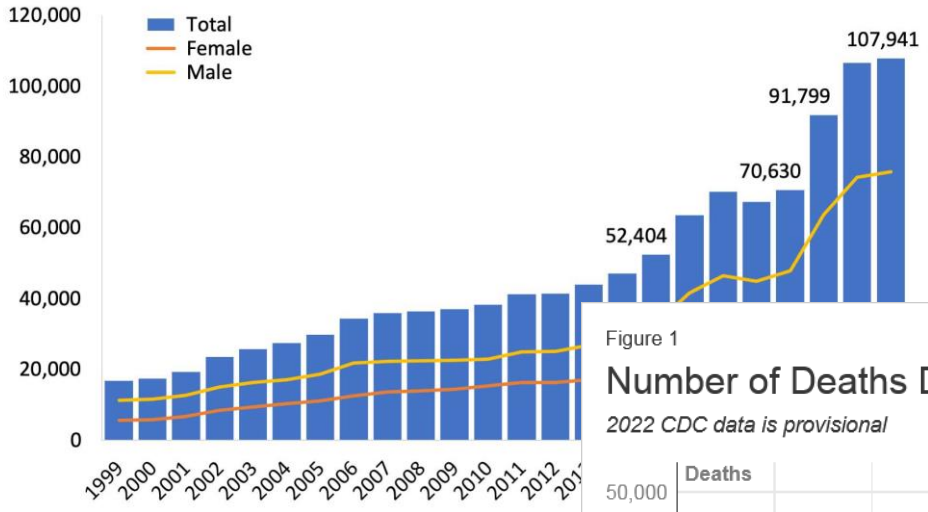
Sept. 26, 2023

PERSPECTIVE

The Shrinking Number of Primary Care Physicians Is Reaching a Tipping Point

Rising Behavioral Health Needs are Spurring Integrated Primary Care/Behavioral Health Models

Figure 1. National Drug Overdose Deaths*, Number Among All Ages, by Sex, 1999-2022

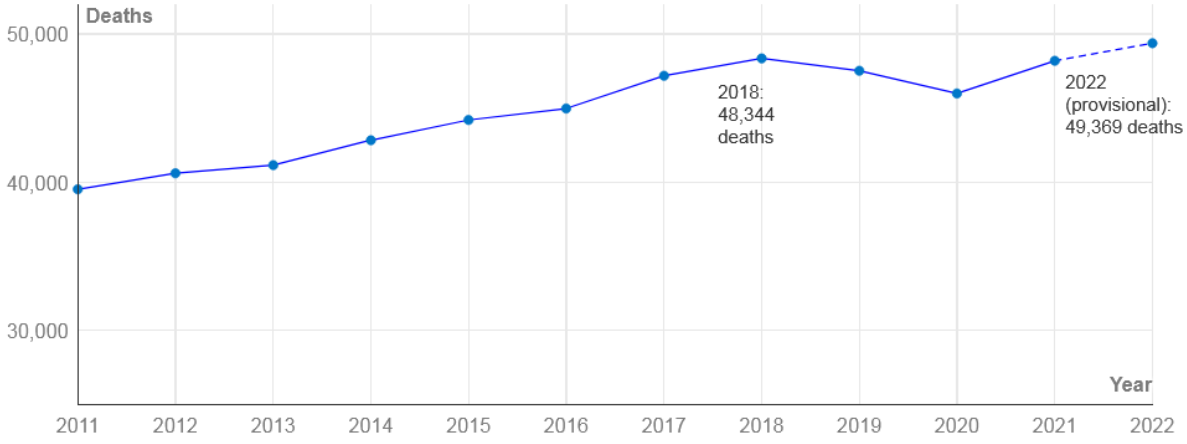


*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suic
poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the Int
Source: Centers for Disease Control and Prevention, National Center for Health Statistics.
WONDER Online Database, released 4/2024.

Figure 1

Number of Deaths Due to Suicide, 2011 to 2022

2022 CDC data is provisional



NOTE: Analysis of CDC WONDER underlying cause of death data, 2011 to 2022. Provisional data used for 2022 is not yet final and may represent incomplete data for that year that is subject to change. Suicide deaths are identified using the following codes: X72-X74, U03, X60-X71, X75-X84, and Y87.0) It is possible that some suicides may be classified under other categories.

SOURCE: KFF analysis of CDC WONDER data, 2011 to 2022 • PNG

KFF

Children's Physical and Mental Health Needs are Rising

- Mental health conditions for children were rising before the COVID-19 pandemic *(Gandour 2021)* and have increased over the last 3 years, resulting in what the US Surgeon General has called a "mental health pandemic for youth."
- Rates of obesity, hypertension, and type 2 diabetes continue to climb *(CDC)*
- Teen vaping and firearm morbidity and mortality have increased significantly *(Cooper 2022; Goldstick et al 2022)*

Image 1

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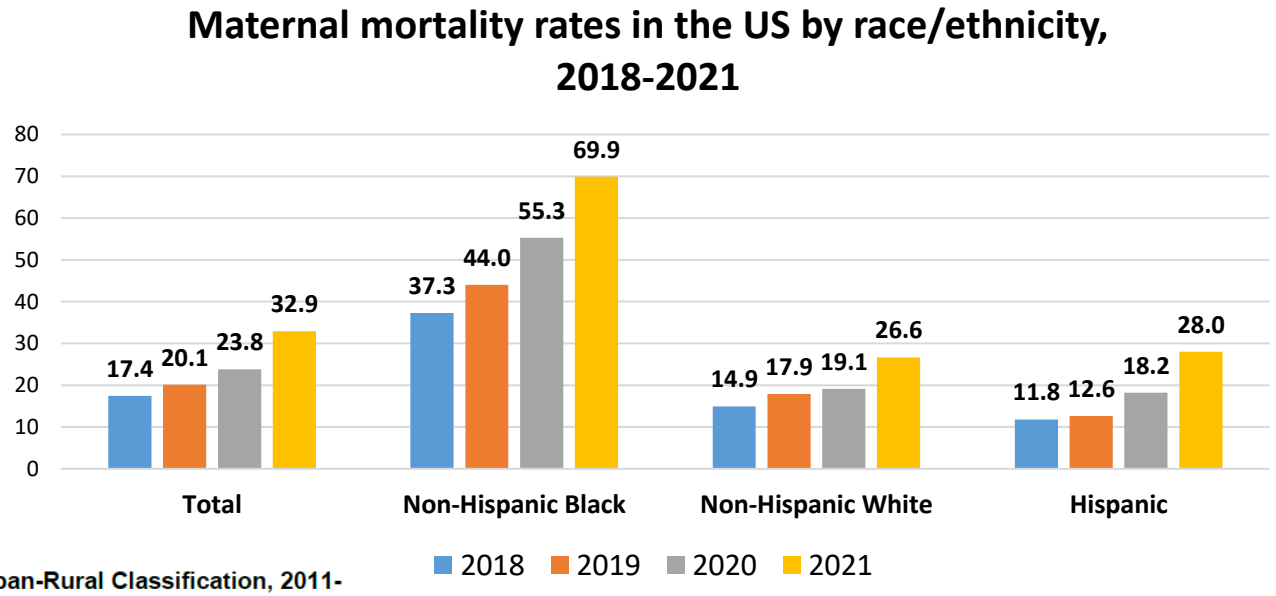
Nation Faces a Maternal Care Crisis, Particularly among Minoritized and Rural Populations

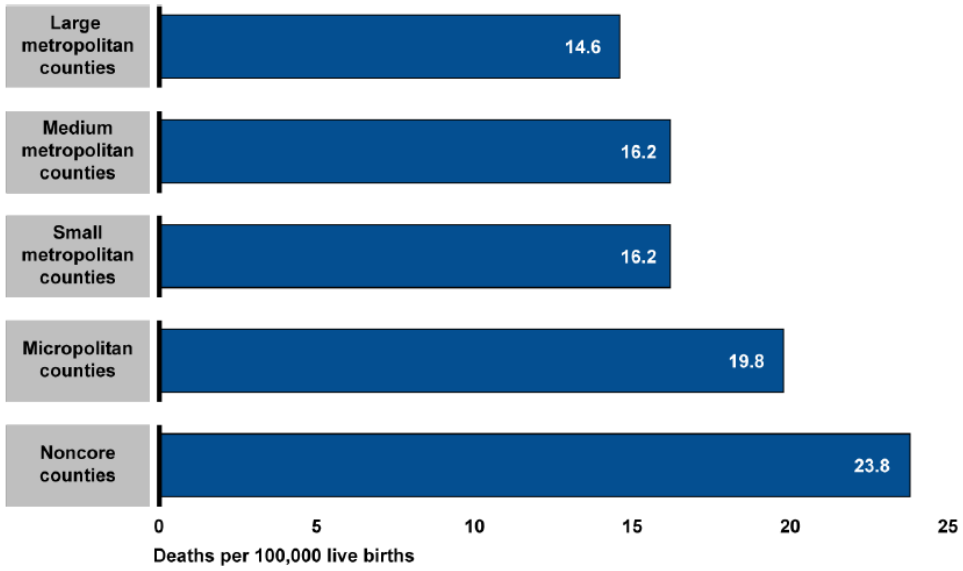


[1]Statistically significant increase from previous year ($p < 0.05$).

NOTE: Race groups are single race.

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Figure 3: Pregnancy-Related Mortality Ratios by Urban-Rural Classification, 2011-2016



Source: 2021 April. Maternal Mortality and Morbidity. Additional Efforts Needed to Assess Program Data for Rural and Underserved Areas. United States Government Accountability Office. https://www.gao.gov/assets/gao-21-283.pdf

Primary Care is Having Its Moment and Family Medicine is At The Nexus!

FEBRUARY 22, 2023

REPORT

The Health of US Primary Care: A Baseline Scorecard Tracking

Press Releases

CMS Finalizes Physician Payment Rule that Advances Health Equity

Nov 02, 2023 | Billing & payments, Physicians

Defining the State Role in Primary Care Reform

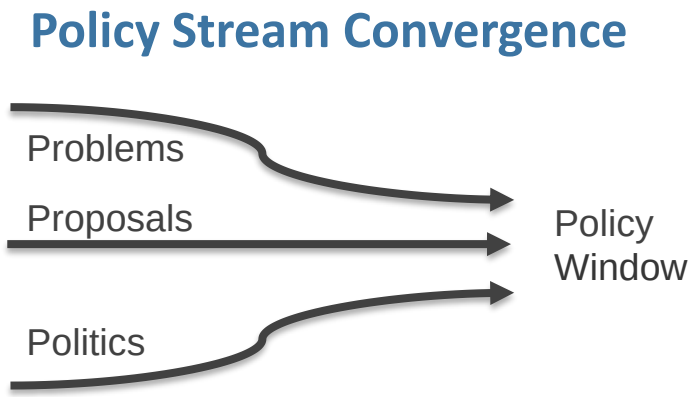
Making Care Primary (MCP) Model

On June 8, 2023, the Centers for Medicare & Medicaid Services (CMS) announced a new voluntary primary care model – the Making Care Primary (MCP) Model – that will be tested in eight states. Launching July 1, 2024, the 10.5-year model will improve care management and care coordination, equip primary care clinicians with tools to form partnerships with health care specialists, and leverage community-based connections to address patients' health needs as well as their health-related social needs (HRSNs) such a housing and nutrition. CMS is working with State Medicaid Agencies in eight states – Colorado, North Carolina, New Jersey, New Mexico, New York, Minnesota, Massachusetts and Washington – to engage in fu

The Nation's Primary Care Crisis Has Created a Policy Window for Action

- Kingdon (1995) describes how an "idea whose time has come" can move forward when a policy window is open
- A policy window opens when three separate streams converge:
  - **Problem Stream**-data and evidence emerge indicating severity of a problem
  - **The Policy Stream**-actors **(that's you!)** invested in problem assemble data and propose solutions
  - **The Politics Stream**-public mood, politics, or changes in administration support action

The policy window for primary care reform is open



Kingdon, John W., and Eric Stano. *Agendas, alternatives, and public policies*. Vol. 45. Boston: Little, Brown, 1984.

Taking advantage of that policy window requires documenting trends requiring attention of government officials*

Example of Documentation

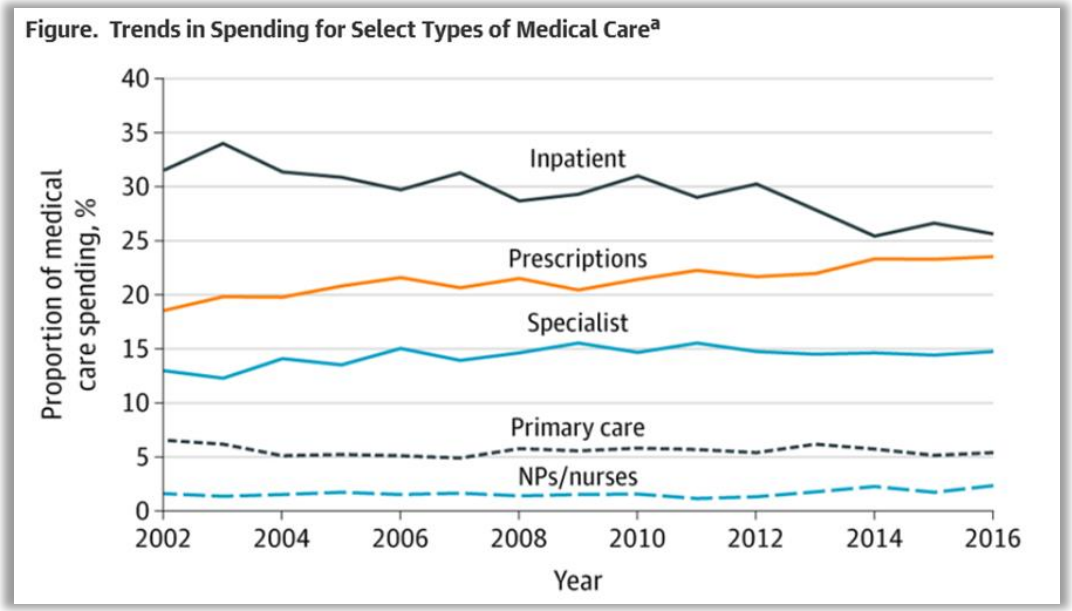
The Milbank Memorial Fund Primary Care Scorecard tracks trends in:

1. Financing
2. Access
3. Workforce
4. Training
5. Research

Jabbaour Y, Jetty A, Byun H, Siddiqi A, Petterson S, Park J. February 27, 2024. https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/introduction-access-to-primary-care-is-worsening/

*Brown LD. 1991. "Knowledge and Power: Health Services Research as a Political Resource" In Health services Research: Key to Health Policy, edited by Eli Ginzberg, 20-45, Cambridge MA: Harvard University Press

1. Financing: US systemically underinvests in primary care and efforts to reform payment models are underway



Martin S, Phillips RL, Petterson S, Levin Z, Bazemore AW. Primary Care Spending in the United States, 2002-2016. JAMA Intern Med. 2020;180(7):1019–1020. doi:10.1001/jamainternmed.2020.1360

Invited Commentary

February 18, 2019

The Future of Primary Care in the United States Depends on Payment Reform

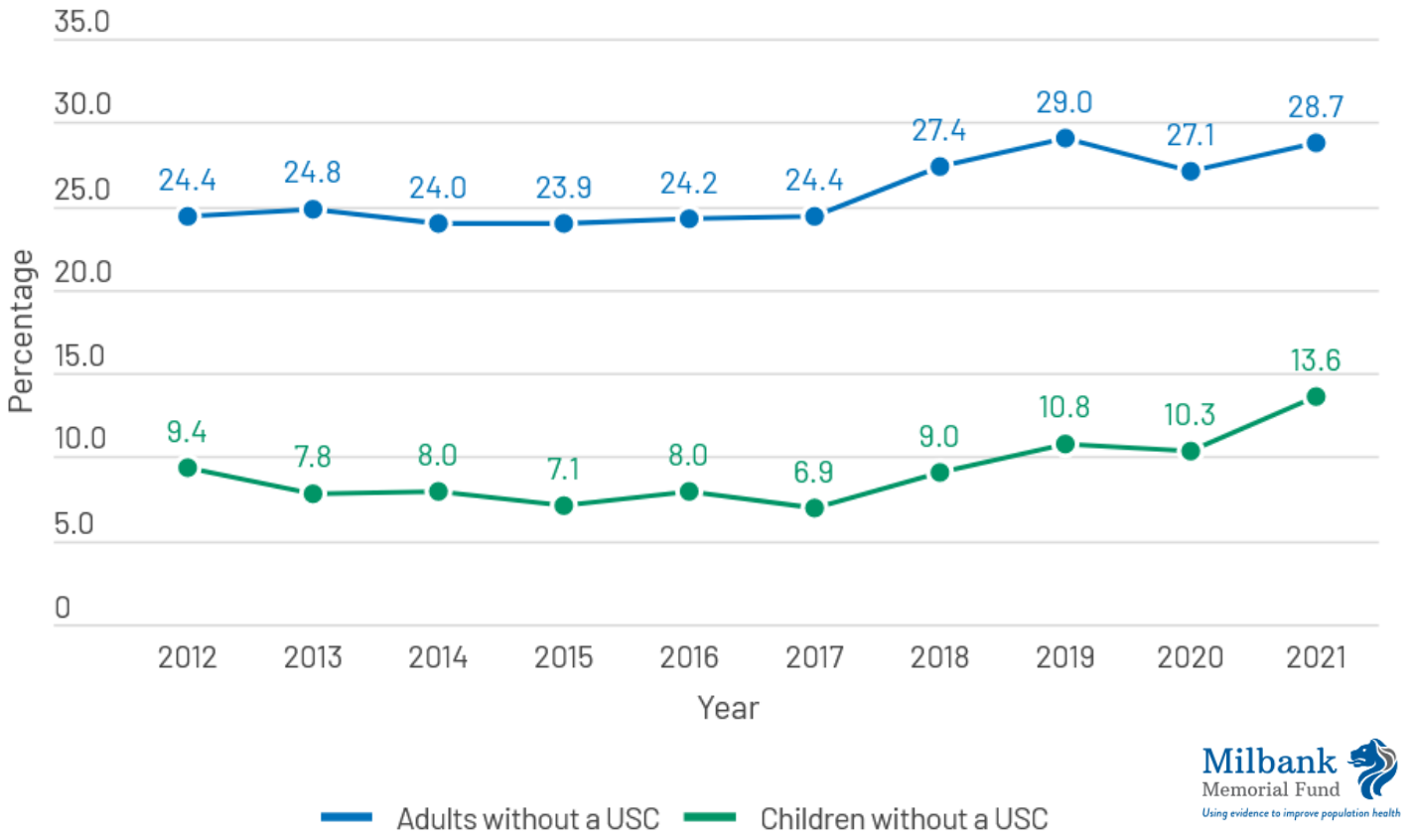
Sondra Zabar, MD[1]; Andrew Wallach, MD[1,2]; Adina Kalet, MD, MPH[1]

» Author Affiliations | Article Information

JAMA Intern Med. 2019;179(4):515-516. doi:10.1001/jamainternmed.2018.7623

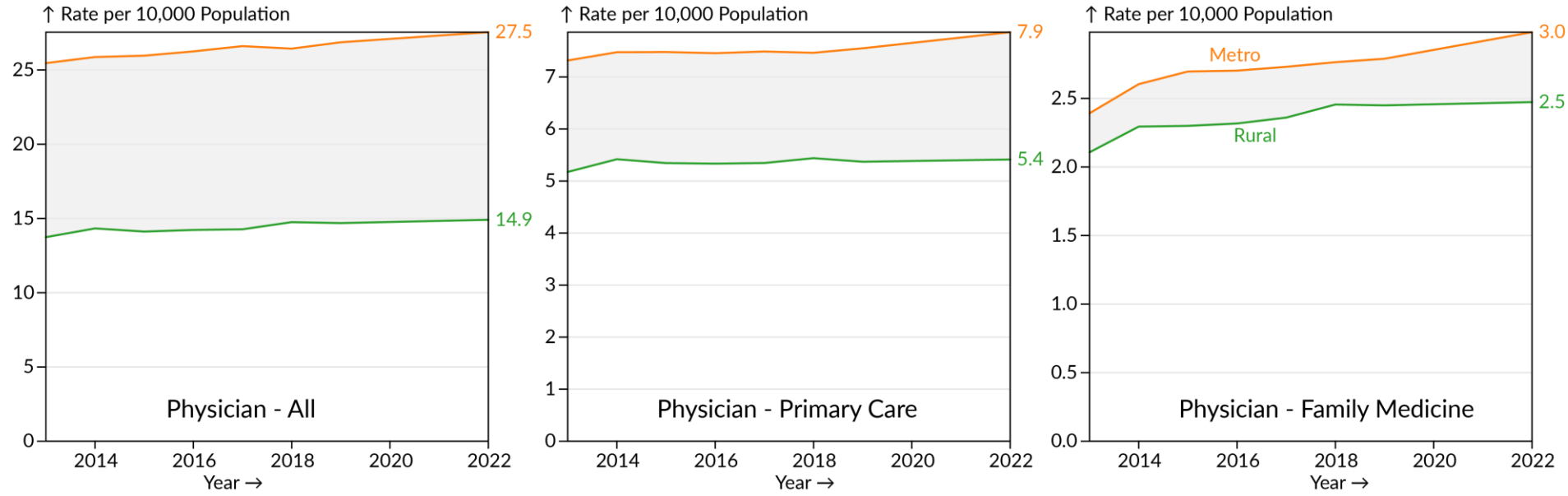
2. Access: The Percent of the US Population without Access to Primary Care is Increasing

Figure 1. The Percentage of the US Population Without a Usual Source of Care Is Rising (2012–2021)



Introduction: Access to Primary Care is Worsening. 2024 February. Report. Milbank Memorial Fund. https://infogram.com/2024-scorecard-figure-1-1hnp27e3vw3gn4g

3. Workforce: Here in North Carolina, Gap in Physician Supply between Rural and Metro Counties is Growing



Largest gap between metro and rural is for all physicians. Smallest gap is for Family Medicine

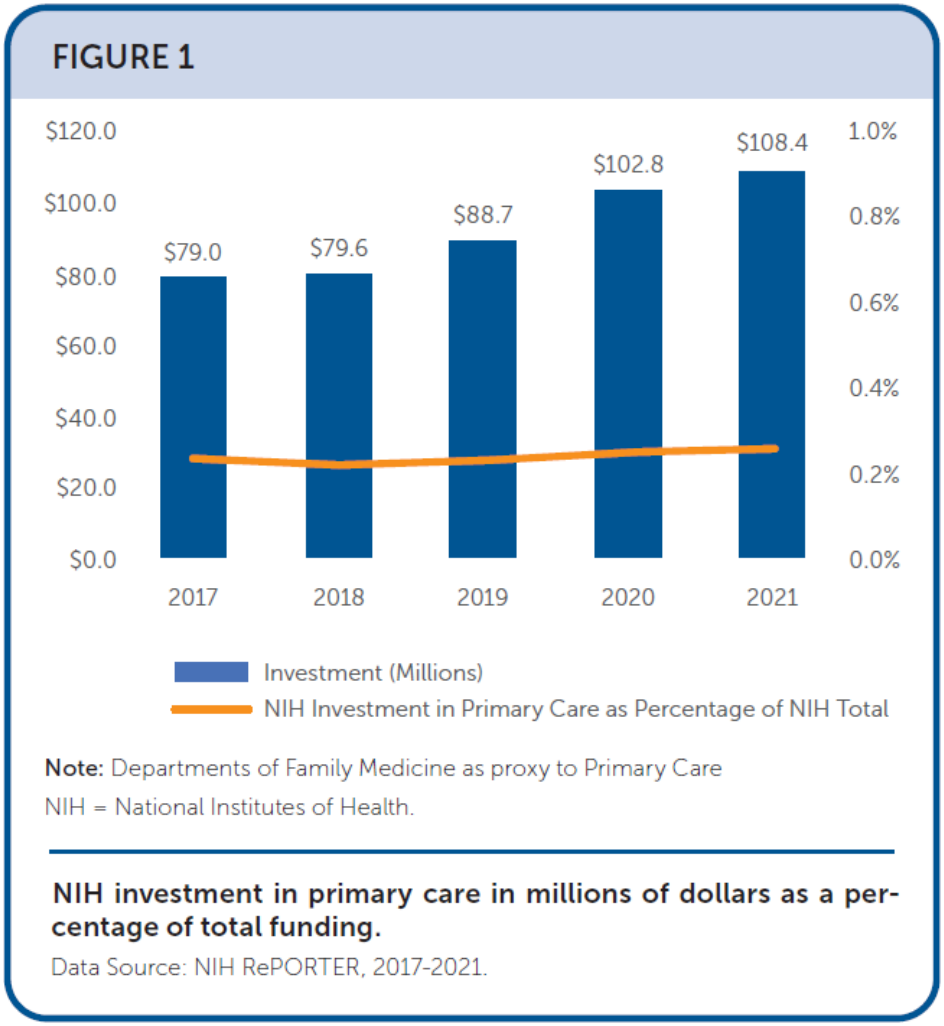
North Carolina Health Professions Data System. Program on Health Workforce Research and Policy. Cecil G. Sheps Center for Health Services Research. University of North Carolina at Chapel Hill. https://nchealthworkforce.unc.edu/

4. Training: Too few physicians are being trained in community settings, where most primary care takes places

- Only 2% of ~$16 billion of annual Medicare funding for GME goes to rural areas (GAO 2021)
- Family physicians who train in rural residencies are at least twice as likely to practice in rural areas (Russell et al 2022)
- Most Medicare GME dollars go to hospitals (CRS 2023)
- Just 3.5% of all residency training occurs in safety-net clinics where high percentage of underserved patients seek care (GAO 2021, Blanchard 2016)

Hawes E, Rains J, Chen C, Fraher E. Training the Primary Care Workforce to Deliver Team-Based Care in Underserved Areas: The Teaching Health Center Program. The Milbank Memorial Fund. June 2023.

5. Research: Funding for Primary Care Research is less than 1% of federal investments



Source: Huffstetler A, Byun H, Jabbarpour Y. Family Medicine Research Is Not a Federal Priority. Am Fam Physician. 2023 Dec;108(6):Online. PMID: 38215411.
Notes: Federal investment includes spending from the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the Food and Drug Administration. Funding given to family medicine departments was used as a proxy for funding to primary care.

Image 2

Significant untapped potential exists to leverage Family Medicine clinics and training sites as laboratories to build research capacity that can inform policy change

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Dr. Curtis Recognized This Untapped Potential in His 2003 Paper Comparing Outcomes of Family Medicine, Internal Medicine and Pediatric Fellows

Faculty Development

Building Capacity for Research in Family Medicine: Is the Blueprint Faulty?

Peter Curtis, MD; Perry Dickinson, MD; John Steiner, MD, MPH; Bruce Lanphear, MD, MPH; Kieu Vu

Background and Objectives: *This study compared the training programs and career paths of family medicine graduates in the National Research Service Award (NRSA) Program for Research in Primary Medical Care with general internal medicine and general pediatric peers.* Methods: *We mailed a survey to NRSA fellows graduating from 23 programs nationally between 1988–1997. Personal characteristics, fellowship experience, current professional activities, and academic productivity were compared among primary care disciplines.* Results: *Of 215 NRSA participants, 146 (68%) completed the survey. Of the 131 primary care respondents, 25% were family physicians. During the fellowship, family physician trainees spent significantly less time in hands-on research activity (32%±12%) than internists and pediatricians (39%±17%). Family physician graduates also had less post-fellowship*

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Curtis P, Dickinson P, Steiner J, Lanphear B, Vu K. Building capacity for research in family medicine: is the blueprint faulty? Fam Med. 2003 Feb;35(2):124-30.

Recent Work Echoes Dr. Curtis' Findings

- Newton (2024) measured amount of family medicine-affiliated scholarship published from 2018-2022 in 12 high impact journals
- Of the 5,170 peer-reviewed articles on primary care payment and delivery system reform
  - 497 (8.7%) included at least one author affiliated with a department of family medicine
  - 229 (4%) had a first author from a department of family medicine
  - Just 19 (0.3%) had a senior family medicine author

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Newton H, Helton M, Fraher E. Family Medicine's Role in Generating Evidence to Inform Primary Care Payment Reform and New Care Delivery Models. In press at the Journal of the American Board of Family Medicine

Family Medicine researchers have low participation in scholarship relative to size of the specialty and number of patient visits they provide

All primary care payment and delivery system reform articles, 2018-2022

		Any Department of Family Medicine Authors		Any Department of Internal Medicine Authors		Any Department of Pediatrics Authors	
Year	N Articles	N	%	N	%	N	%
2018	1,225	104	8.5%	209	17.1%	104	8.5%
2019	1,242	95	7.6%	260	20.9%	109	8.8%
2020	1,318	104	7.9%	231	17.5%	109	8.3%
2021	1,282	106	8.3%	252	19.7%	105	8.2%
2022	1,145	100	8.7%	245	21.4%	77	6.7%
Total	6,212	509	8.2%	1,197	19.3%	504	8.1%

Newton H, Helton M, Fraher E. Family Medicine's Role in Generating Evidence to Inform Primary Care Payment Reform and New Care Delivery Models. In press at the Journal of the American Board of Family Medicine.

Half of physician office visits are for primary care and family physicians comprise 40% of primary care workforce, yet less than 10% of impactful payment and delivery reform scholarship is authored by family medicine researchers

Where do YOU go from here? What's Your Passion?

How will you:

- Document trends requiring attention of government officials?
- Find your voice and passion by using your lived experience from the front-lines?
- Tell your story to policy makers who often want to hear specific examples?

Image 3

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Tom Bodenheimer's Work Provides Master Class on Drawing on Clinical Expertise, Assembling Data and Bringing Voice to Primary Care Challenges and Solutions

Revitalizing Primary Care, Part 1: Root Causes of Primary Care's Problems

Thomas Bodenheimer, MD, MPH

Department of Family and Community Medicine, University of California, San Francisco, San Francisco, California

ABSTRACT

This 2-part essay offers a discussion of the health of primary care in the United States. Part 1 argues that the root causes of primary care's problems are (1) the low percent of national health expenditures dedicated to primary care (primary care spending) and (2) overly large patient panels that clinicians without a team are unable to manage, leading to widespread burnout and poor patient access.

Information used in this essay comes from my personal clinical and policy experience bolstered by summaries of evidence. The analysis leans heavily on my visits to dozens of practices and interviews with hundreds of clinicians, practice leaders, and practice staff.

Revitalizing Primary Care, Part 2: Hopes for the Future

Thomas Bodenheimer, MD, MPH

Department of Family and Community Medicine, University of California, San Francisco, San Francisco, California

ABSTRACT

Part 1 of this essay argued that the root causes of primary care's problems lie in (1) the low percent of national health expenditures dedicated to primary care and (2) overly large patient panels that clinicians without a team are unable to manage, leading to widespread burnout and poor patient access. Part 2 explores policies and practice changes that could solve or mitigate these primary care problems.

Other researchers have harnessed friction on issues such as behavioral health integration and social needs screening to generate evidence and propose solutions

Applying Lessons From Behavioral Health Integration to Social Care Integration in Primary Care

Theresa J. Hoeft, PhD[1]
Danielle Hessler, PhD[2]
Damon Francis, MD[3]
Laura M. Gottlieb, MD, MPH[2]

[1]Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington

[2]Department of Family and Community Medicine, University of California San Francisco, San Francisco, California

[3]Health Leads, Oakland, California

ABSTRACT

Interest and incentives are increasing around strategies whereby the health care sector can better identify and address patients' social and economic needs in the context of primary care delivery. This interest is likely to accelerate during the economic recession following the COVID-19 pandemic. Yet effective and sustainable strategies for integrating social care practices (eg, patient-facing social risk screening and activities to address identified needs) have not been clearly established. Lessons learned from more than 2 decades of research on behavioral health integration could be applied to efforts to integrate social care into primary care. In this article, we synthesize learnings from primary care and behavioral health care integration, and translate them into organizing principles with the goal of advancing social care integration practices to improve the health of both patients and communities.

Ann Fam Med 2021;19:356-361. https://doi.org/10.1370/afm.2688.

Implementation of Health-Related Social Needs Screening at Michigan Health Centers: A Qualitative Study

Margaret Greenwood-Ericksen, MD, MSc[4]
Melissa DeJonckheere, PhD[2,3]
Faiyaz Syed, MD[4]
Nashia Choudhury, MPH[5]
Alicia J. Cohen, MD, MSc[2,6,7]
Renuka Tipirneni, MD, MSc[3,8]

ABSTRACT

PURPOSE Federally qualified health centers (FQHCs) are leaders in screening for and addressing patient's health-related social needs but variation exists in screening practices. This variation is relatively unexplored, particularly the influences of organizational and state policies. We employed a qualitative descriptive approach to study social needs screening practices at Michigan FQHCs to characterize screening processes and identify drivers of variation in screening implementation.

METHODS Site visits and semistructured interviews were conducted from October

Connecting People With Multimorbidity to Interprofessional Teams Using Telemedicine

Pauline Pariser, MD[1,2,3]
Thuy-Nga (Tia) Pham, MD[1,4]
Judith B. Brown, PhD[5]
Moira Stewart, PhD[5]
Jocelyn Charles, MD, MScCH[1,2,6]

[1]Department of Family and Community Medicine, University of Toronto, Toronto, Ontario, Canada

[2]Toronto-Central Local Health Integration Network Toronto, Toronto, Ontario, Canada

[3]University Health Network, Toronto,

ABSTRACT

PURPOSE Most models for managing chronic disease focus on single diseases. Managing patients with multimorbidity is an increasing challenge in family medicine. We evaluated the feasibility of a novel approach to caring for patients with multimorbidity, performing a case study of TIP—Telemedicine IMPACT (Interprofessional Model of Practice for Aging and Complex Treatments) Plus—a 1-time interprofessional consultation with primary care physicians (PCPs) and their patients in Toronto, Canada.

METHODS We assessed feasibility of the TIP model from the number of referrals from PCPs and emergency departments in Toronto, Canada; the intervention cost; and the satisfaction of patients, PCPs, and team members with the new model. One patient and PCP story highlights the model's impact. We also performed thematic analysis of written feedback.

Other examples include models for better harnessing technology, EHRs and the workforce

Primary Care Practices' Abilities And Challenges In Using Electronic Health Record Data For Quality Improvement

Deborah J. Cohen, David A. Dorr, Kyle Knierim, C. Annette DuBard, Jennifer R. Hemler, Jennifer D. Hall, Miguel Marino, Leif I. Solberg, K. John McConnell, Len M. Nichols, ... See all authors

One Year of Family Physicians' Observations on Working with Medical Scribes

Amelia Sattler, MD, Tracy Rydel, MD, Cathina Nguyen, RN, MPH, and Steven Lin, MD

Purpose: **The immense clerical burden felt by physicians is one of the leading causes of burnout. Scribes are increasingly being used to help alleviate this burden, yet few published studies investigate how scribes affect physicians' daily work, attitudes and behaviors, and relationships with patients and the workplace.**

Stories from the Front-Lines Are Powerful. Policy Makers Want to Understand Lived Experience of Frontline Primary Care Physicians

EDITORIAL

We ask too much of primary care doctors. 26.7 hours a day, to be exact.

Primary care is in crisis. Doctors need better pay and more administrative help to ease their paperwork burden.

By The Editorial Board Updated May 20, 2024, 4:00 a.m.

Overworked and Undervalued: Unmasking Primary Care Physicians' Dissatisfaction in 10 High-Income Countries

Findings from the 2022 International Health Policy Survey

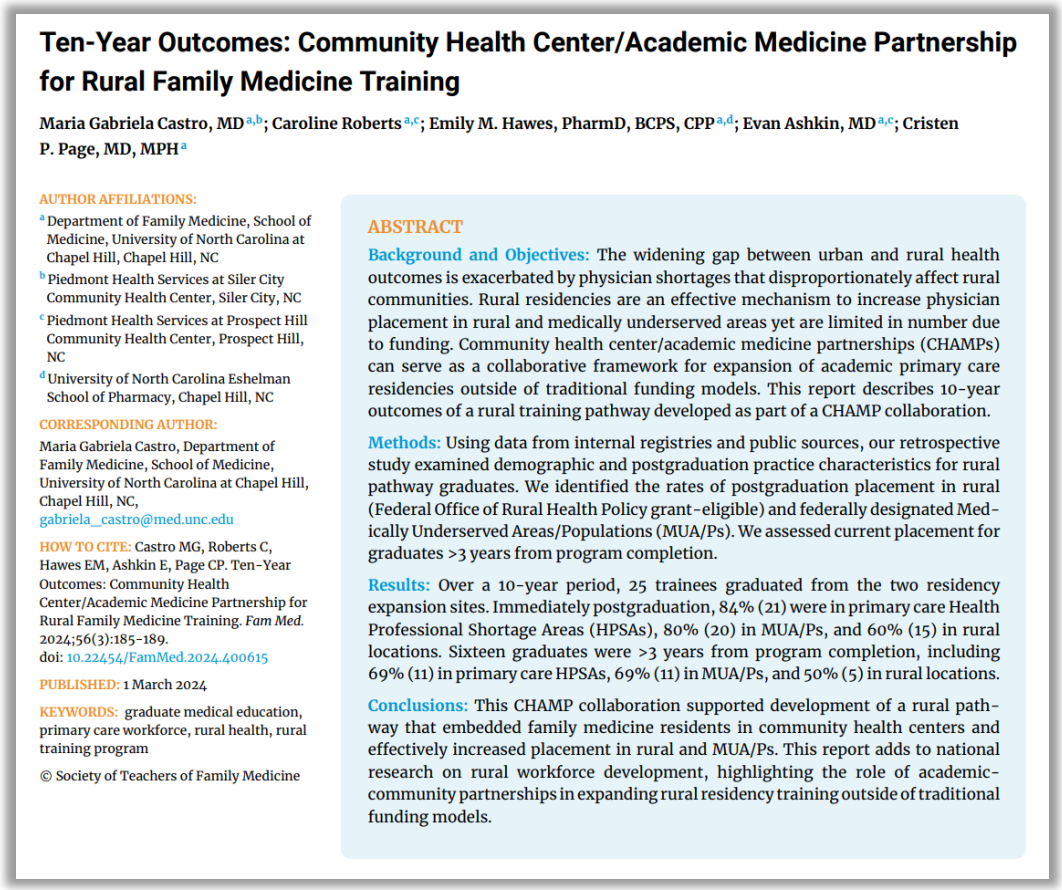
Physicians As Shock Absorbers

Fig. 1. Dynamic socioecological analytic framework of physician burnout.

Institutional	Professional	Societal/System
• Centralized decision-making • Unresponsive leadership • Lack of flexibility in scheduling to accommodate life events (e.g. sickness, pregnancy) • Not feeling valued by institution • Productivity pressures	The organization of training • Mismatched expectations • Balance of service and learning • "A world of judgment" "Superhero norm" • Push bodily needs aside • Don't show 'weakness'	• Social inequalities in health add complexity to visits • Consumerism and patient satisfaction • Systemic racism • Corporatization of healthcare • Documentation requirements • Electronic health record erases line between work and home

Jenkins TM. Physicians as shock absorbers: The system of structural factors driving burnout and dissatisfaction in medicine. Soc Sci Med. 2023 Nov;337:116311. doi: 10.1016/j.socscimed.2023.116311. Epub 2023 Oct 13. PMID: 37857243.

Single Site Studies Can Be Powerful: Tell Your Story with Data and Document Outcomes



Ten-Year Outcomes: Community Health Center/Academic Medicine Partnership for Rural Family Medicine Training

Maria Gabriela Castro, MD[a,b]; Caroline Roberts[a,c]; Emily M. Hawes, PharmD, BCPS, CPP[a,d]; Evan Ashkin, MD[a,c]; Cristen P. Page, MD, MPH[a]

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doi: 10.22454/FamMed.2024.400615

PUBLISHED: 1 March 2024

KEYWORDS: graduate medical education, primary care workforce, rural health, rural training program

ABSTRACT

Background and Objectives: The widening gap between urban and rural health outcomes is exacerbated by physician shortages that disproportionately affect rural communities. Rural residencies are an effective mechanism to increase physician placement in rural and medically underserved areas yet are limited in number due to funding. Community health center/academic medicine partnerships (CHAMPs) can serve as a collaborative framework for expansion of academic primary care residencies outside of traditional funding models. This report describes 10-year outcomes of a rural training pathway developed as part of a CHAMP collaboration.

Methods: Using data from internal registries and public sources, our retrospective study examined demographic and postgraduation practice characteristics for rural pathway graduates. We identified the rates of postgraduation placement in rural (Federal Office of Rural Health Policy grant-eligible) and federally designated Medically Underserved Areas/Populations (MUA/Ps). We assessed current placement for graduates >3 years from program completion.

Results: Over a 10-year period, 25 trainees graduated from the two residency expansion sites. Immediately postgraduation, 84% (21) were in primary care Health Professional Shortage Areas (HPSAs), 80% (20) in MUA/Ps, and 60% (15) in rural locations. Sixteen graduates were >3 years from program completion, including 69% (11) in primary care HPSAs, 69% (11) in MUA/Ps, and 50% (5) in rural locations.

Conclusions: This CHAMP collaboration supported development of a rural pathway that embedded family medicine residents in community health centers and effectively increased placement in rural and MUA/Ps. This report adds to national research on rural workforce development, highlighting the role of academic-community partnerships in expanding rural residency training outside of traditional funding models.

- Evaluated outcomes of graduates (n=25) from two rural pathway programs
- Each site hosted 9 residents who spent 51% of time in rural CHCs, a rural hospital with a maternity care center and migrant farmer program
- After completing training, 92% 76% remained instate, 60% practiced in rural
- *"This report adds to the evidence the impact of rural training on future practice and highlights the role of academic-community partnerships in expanding GME into rural and underserved areas"*

Look for Gaps in Understanding: The Stages of Rural Residency Development Had Never Been Documented

STAGE 1 Exploration

Community Assets
Identify community assets and interested parties.

Leadership
Assemble local leadership and determine program mission.

Sponsorship
Identify an institutional affiliation or sponsorship. Begin to consider financial options and governance structure.

To advance to the next stage:
Make an organizational decision to proceed with investing significant resources in program development.

STAGE 2 Design

Initial Educational & Programmatic Design
Identify Program Director (permanent or in development). Consider community assets, educational vision, resources, and accreditation timeline.

Financial Planning
Develop a budget and secure funding. Consider development and sustainability with revenues and expenses.

Sponsoring Institution Application
Find a Designated Institutional Official and organize the GME Committee. Complete application.

To advance to the next stage:
Finalize a draft budget. Complete program design to include curriculum outline and site mapping. Submit a Sponsoring Institution (SI) application & receive initial accreditation.

STAGE 3 Development

Program Personnel
Appoint residency coordinator. Identify core faculty and other program staff.

Program Planning & Accreditation
Develop curricular plans, goals and objectives; evaluation system and tools; policies and procedures; program letters of agreement; faculty roster. Complete ACGME application and site visit.

To advance to the next stage:
Achieve initial program accreditation – requires successful site visit and letter of accreditation from the ACGME.

STAGE 4 Start-Up

Marketing & Resident Recruitment
Create a website. Register with required systems. Market locally and nationally.

Program Infrastructure & Resources
Hire core faculty and other program staff. Ensure faculty development. Complete any construction and start-up purchases. Establish annual budget.

Matriculate
Welcome and orient new residents.

To advance to the next stage:
Complete contracts and orient first class of residents. Hire all required faculty.

STAGE 5 Maintenance

Ongoing Efforts
Report annually to ACGME and the Sponsoring Institution. Maintain accreditation and financial solvency. Recruit and retain faculty. Track program educational and clinical outcomes. Ensure ongoing performance improvement.

Hawes EM, Weidner A, Page C, Longenecker R, Pauwels J, Crane S, Chen F, Fraher E. A Roadmap to Rural Residency Program Development. J Grad Med Educ. 2020 Aug;12(4):384-387. doi: 10.4300/JGME-D-19-00932.1.

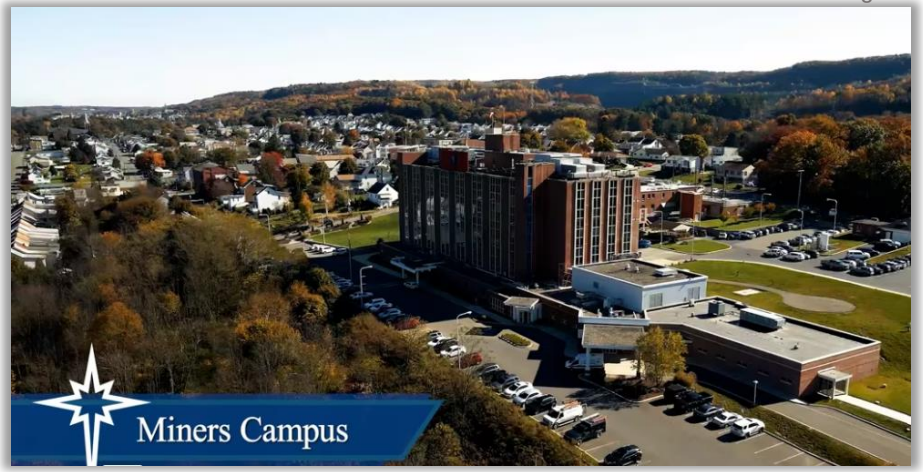
Impactful Research Does Not Have To Use Complex Quantitative Analyses

Examples from our current work

- Housing Challenges and Opportunities for Rural Residency Development *(In Press JGME)*
- Strategies to address pediatric and obstetric rotations for rural and underserved residencies
- Impact of rural residency development on a local community
  - Increasing access to care
  - Expanding clinical services (e.g. behavioral health, MAT, obstetric care, procedural availability)
  - Bolstering physician and interprofessional workforce

By identifying, documenting, and telling the story of friction you encounter in practice or training, you may influence broader policy change

Image 4



UNITED STATES SENATE
COMMITTEE ON FINANCE

ABOUT HEARINGS LE

MAY 24,2024

Wyden, Bipartisan Finance Members Outline Proposal to Improve Medicare Physician Training to Reduce Workforce Shortages

Washington, D.C. – Senate Finance Committee Chair Ron Wyden, D-Ore., today along with seven bipartisan members of the Finance Committee released a policy outline describing improvements to the Medicare Graduate Medical Education (GME) program to address physician workforce shortages across the country, primarily related to primary care and psychiatry, and to improve the distribution of physicians to rural and underserved communities.

"It has become clear that there are not enough physicians to meet the health care needs of Americans," the senators wrote. **"As a bipartisan group of members of the Senate Finance Committee, which has jurisdiction over the Medicare Graduate Medical Education program, we are interested in advancing additional Medicare GME proposals to address health care workforce shortages and gaps."**

Building the evidence needed to drive policy

- Data, evidence, stories and innovation on front-lines of FM practice can spur ***research-based policy change***
- Call for bolstering research capacity is not new (Bowman 2017; Widener 2019) but there is a unique policy window right now to increase research capacity and use it for action

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Getting this done

- Build relationships ***within*** FM to bolster clinical-research partnerships
- Bolster networks ***outside*** FM to other specialties, health services researchers, public health, sociology, economics, and other professions

Image 5

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A caveat: this isn't quick or easy

- Difficult to invest time in developing evidence and crafting policy messages with competing clinical and teaching demands
- Speaking truth to power can be risky
- Policy change is frustratingly slow and incremental, requires patience
- But growing an evidence base and persevering in messaging ***does change*** way policy makers understand, and act on, pressing policy issues

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