

Primary Care Workforce & Health

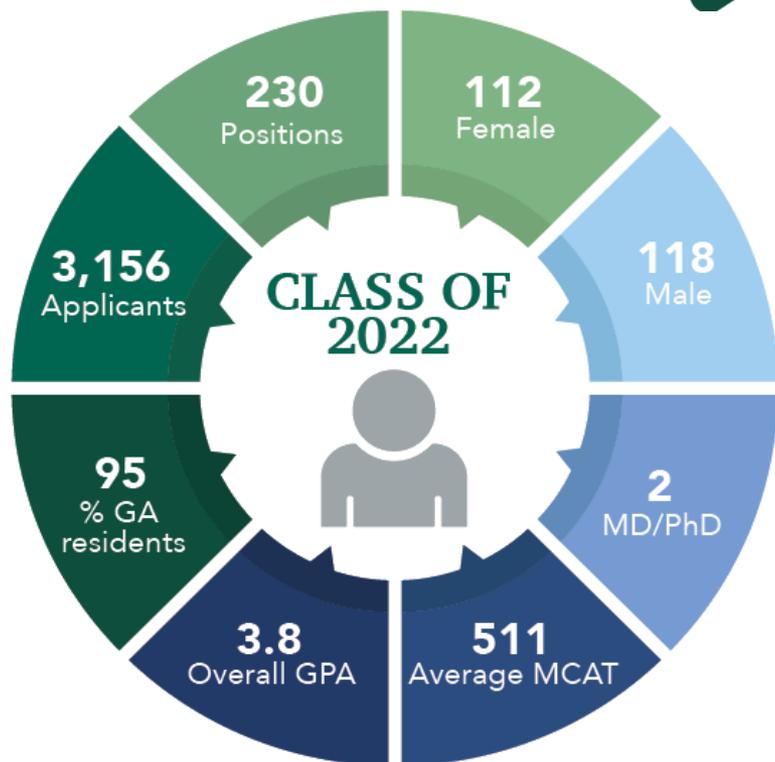
Georgia Maternal Mortality Study Committee

October 17, 2019



At a Glance

MEDICAL COLLEGE OF GEORGIA

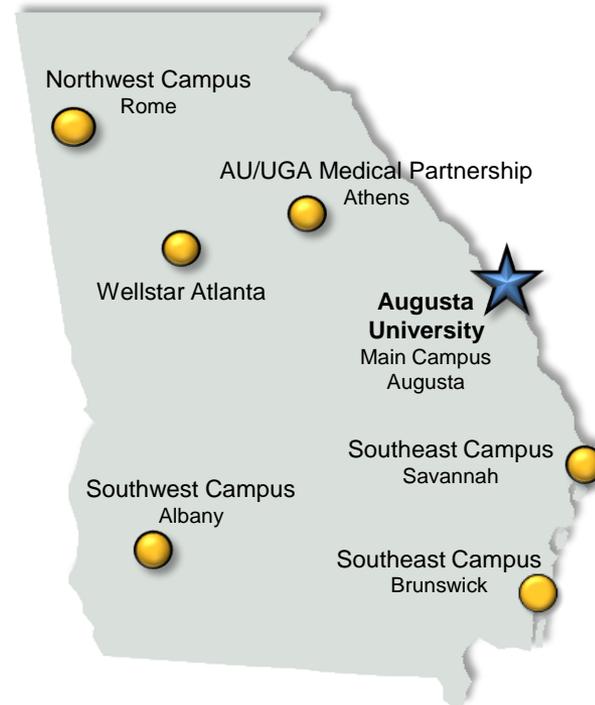


MCG's Distributed Regional Campus Model

Georgia is our Campus

Benefits of a regional campus model:

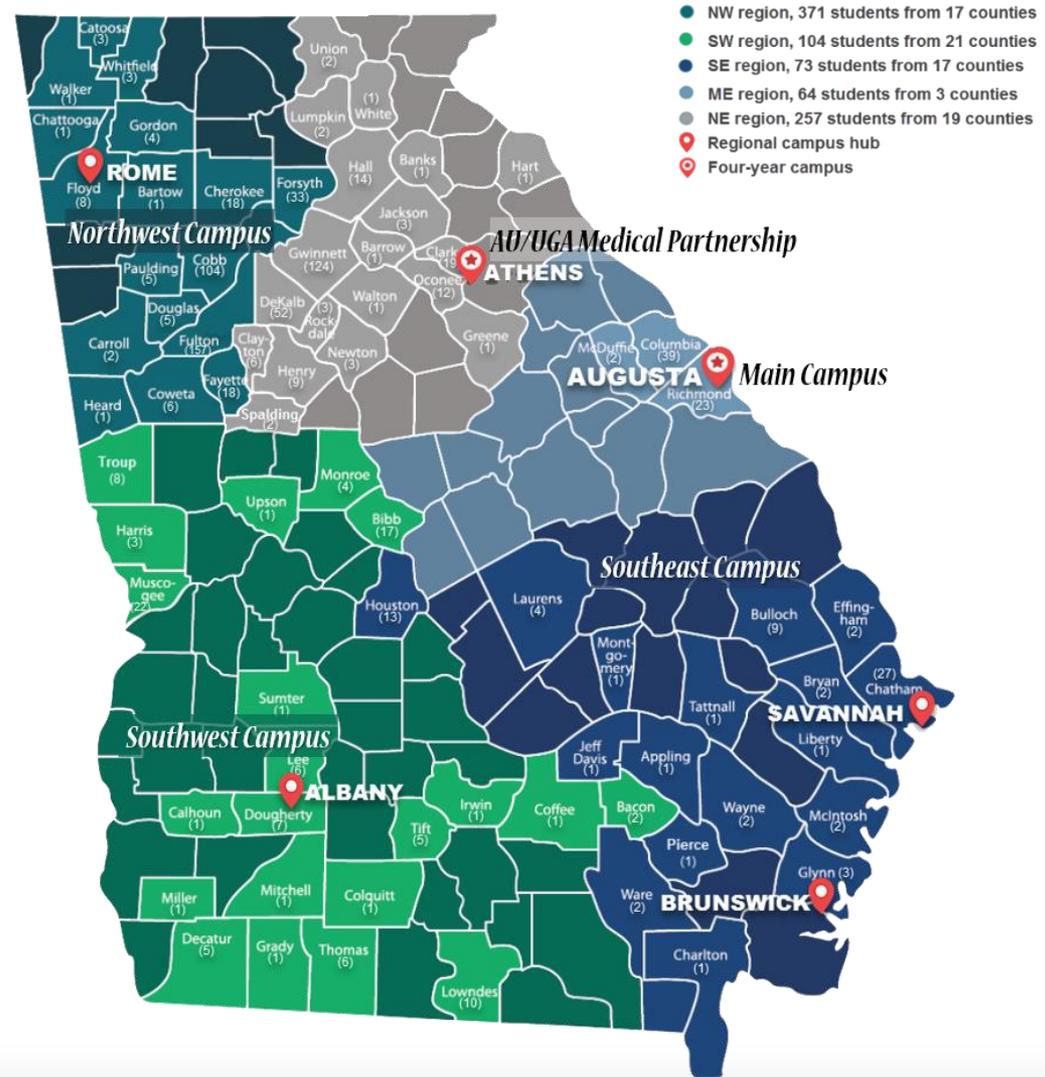
- Smaller size
- Closely connected
- Embraced by host community
- Increased clinical exposure
- Diversified learning experiences
- Addressing healthcare needs of underserved



**40% of our students
receive training
outside of Augusta**

95% of Our Students are from Georgia

- We recruit students from all across Georgia
- Many students come to MCG from underserved areas with FQHCs
- Students seek opportunities to return “home” for residency and to practice



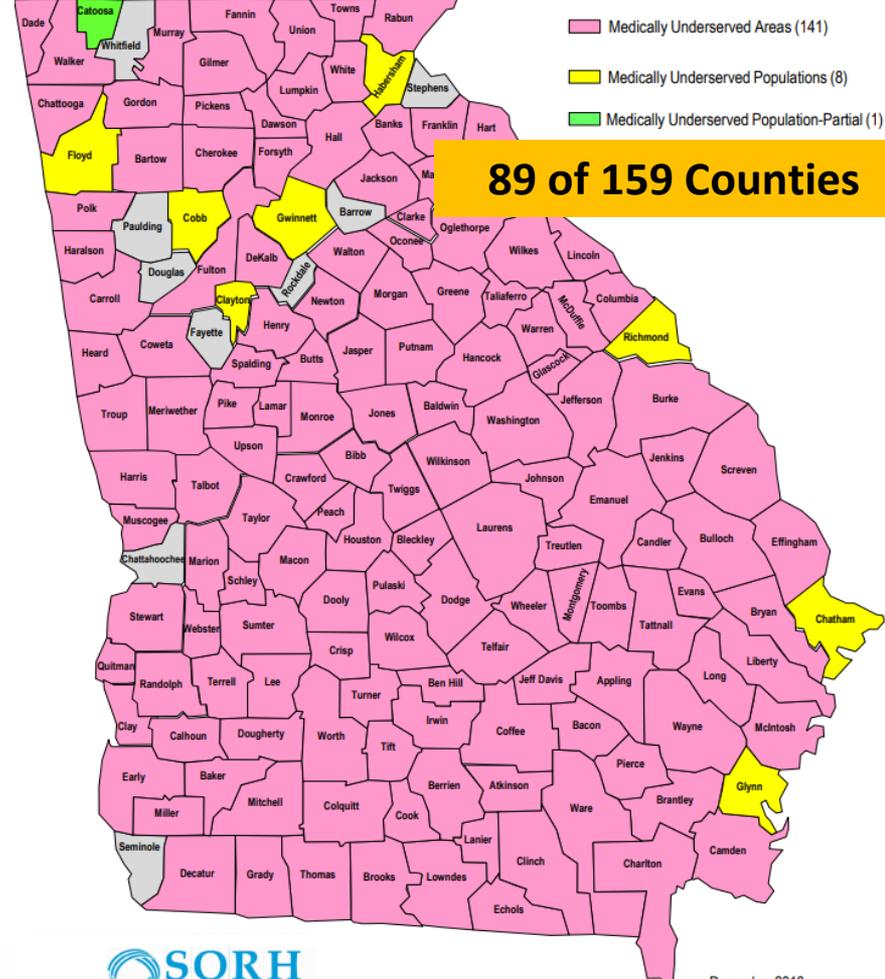
PCP Workforce Development: MCG is the Largest MD-Resident Provider in GA, 2019

	Emory	MCG	Mercer	Morehouse	PCOM - GA	Overall
Total Graduates	130	245	108	77	125	685
Total Graduates Entering GME	123	241	108	73	122	667
Entering Primary Care/Core Specialties	90	163	81	55	91	480
Graduates Staying in GA Residency	33	53	38	29	32	185

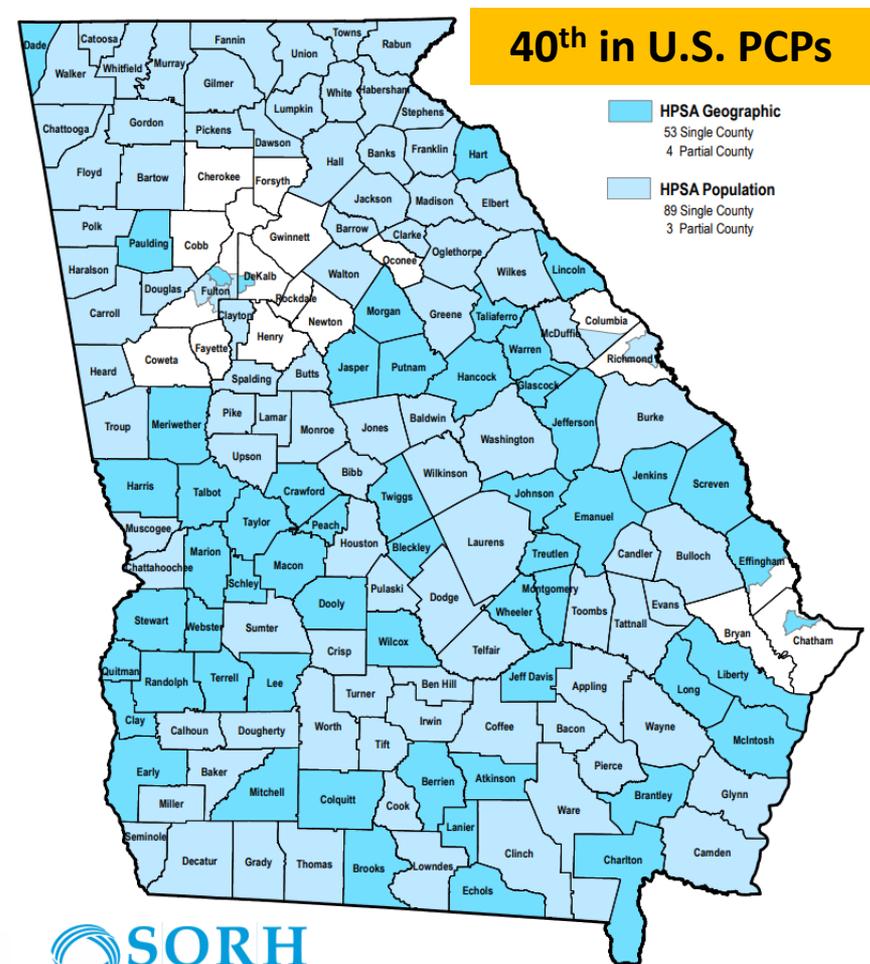
68% of MCG graduates entered primary care/core specialty residencies, and **33%** of those residencies were in Georgia

We Need More PCPs Where the Health Needs Are Greatest

Medically Underserved Populations



Primary Care Health Professional Shortage Areas (HPSA)



December 2018
<https://dch.georgia.gov/sorh>



Contribution of Primary Care to Health Systems and Health

Barbara Starfield, Leiyu Shi, and James Macinko

Abstract

Evidence of the health-promoting influence of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system. This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care. The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies. The means by which primary care improves health have been identified, thus suggesting ways to improve overall health and reduce differences in health across major population subgroups.

The term *primary care* is thought to date back to about 1920, when the Dawson Report was released in the United Kingdom. That report, an official “white paper,” mentioned “primary health care centres,” intended to become the hub of regionalized services in that country. Although primary care came to be the cornerstone of the health services system in the United Kingdom as well as in many other countries, no comparable focus developed in the United States. Indeed, the formation of one after another specialty board in the early decades of the 20th century signaled the increasing specialization of the U.S. physician workforce (Stevens 1971). The GI Bill of Rights, which supported the further training of physicians returning from service in World War II, helped increase the specialization of many who had been general practitioners (generalists) before the war. At that time, general practitioners were physicians who lacked additional training after graduation from medical school, apart from a short clinical internship.

Does Having More Physicians Lead to Better Health System Performance?

David C. Goodman, MD, MS

Kevin Grumbach, MD

2008

“One of the most durable findings from studies of physician supply is that populations tend to do better in regions and health care systems emphasizing primary care. *Although some analyses indicate that simply a greater supply of primary care physicians across regions is associated with better outcomes, the organization of care may be just as important.*

Research suggests that health systems with primary care as the foundation of care provide the best outcomes at the lowest costs. *In these primary care–oriented systems and regions, Medicare beneficiaries have fewer specialists involved in an episode of care and more visits with primary care physicians, spend fewer hospital days in intensive care, and have lower health care costs. Such high-performing health care systems include prepaid group practices, integrated delivery systems in fee-for-service payer environments, and other models organized around primary care.”*

Primary Care Physician Supply and Children's Health Care Use, Access, and Outcomes: Findings From Canada

AUTHORS: Astrid Guttman, MDCM, MSc,^{a,b,c,d} Scott A. Shipman, MD, MPH,^{e,f} Kelvin Lam, MSc,^g David C. Goodman, MD, MS,^{e,f} and Therese A. Stukel, PhD^{a,d}

^aInstitute for Clinical Evaluative Sciences, Toronto, Ontario, Canada; ^bDivision of Pediatric Medicine, Hospital for Sick Children, and Departments of ^cPediatrics and ^dHealth Policy, Management, and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada; ^eDartmouth Institute for Health Policy and Clinical Practice, Hanover, New Hampshire; and ^fDepartment of Pediatrics, Dartmouth Medical School, Hanover, New Hampshire

KEY WORDS

primary care physician supply, ambulatory care sensitive conditions

ABBREVIATIONS

PCP—primary care physician
ED—emergency department
ACSC—ambulatory care–sensitive condition
PCAS—Primary Care Access Survey
GP—general practitioner
FTE—full-time equivalent
DA—dissemination unit
CI—confidence interval
ARR—adjusted rate ratio

The views in this article are those of the authors and do not necessarily represent the views of any funding source. No endorsement by the Institute for Clinical Evaluative Sciences or the Ontario Ministry of Health and Long-term Care is intended or should be inferred.

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Address correspondence to Astrid Guttman, MDCM, MSc, Institute for Clinical Evaluative Sciences, 2075 Bayview Ave, G106, Toronto, Ontario, Canada M4N 3M5. E-mail: astrid.guttman@ices.on.ca

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2010

PEDIATRICS Volume 125, Number 6, June 2010



WHAT'S KNOWN ON THIS SUBJECT: Results of numerous studies have shown the value of primary care in improving health outcomes. Little is known about the relationship of local primary care supply and access, use, and outcomes of health care services for children under universal health insurance.



WHAT THIS STUDY ADDS: Under universal insurance there are still important differences in primary and ED care use and preventable admissions related to local physician supply. Physician distribution is a critical issue to address in policies to improve access to primary care.

OBJECTIVES: To describe the relationship of primary care physician (PCP) supply for children and measures of health care access, use, and outcomes.

METHODS: We conducted a population-based, cross-sectional study of all Ontario children from 2003 to 2005. We used health administrative data to calculate county-level supply (full-time equivalents [FTEs]) of PCPs. We modeled the relationship of supply to (1) recommended primary care visits, (2) emergency department (ED) use, and (3) ambulatory care–sensitive condition admissions and adjusted for neighborhood income. We used population-based surveys to describe access.

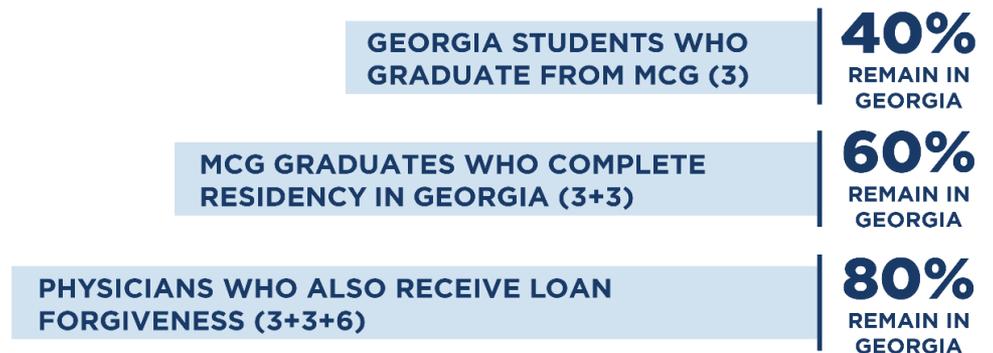
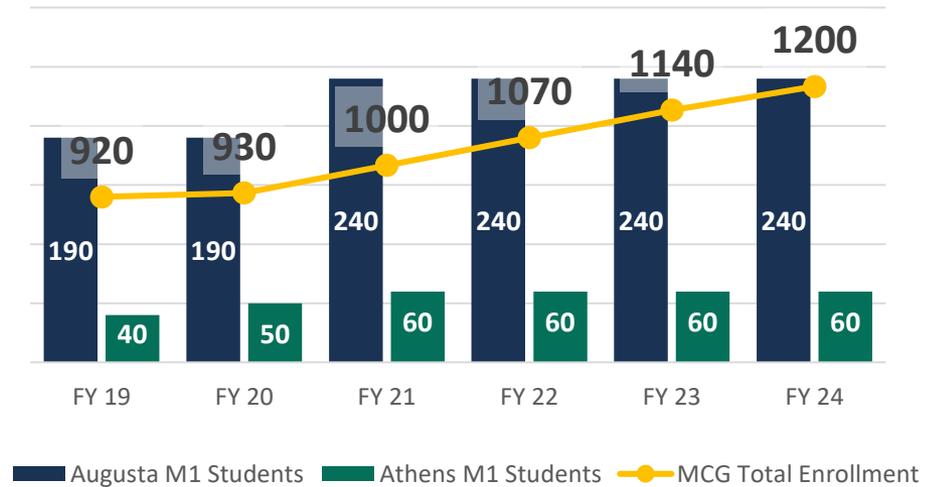
RESULTS: The county-level PCP supply ranged from 1720 to 4720 children per FTE. Of the children, 45.4% live in the highest-supply areas (<2000 children per FTE) and 8% in the lowest-supply areas (>3000 children per FTE). Compared with high-supply counties, the lowest had significantly lower rates of primary care visits (2716 vs 7490 per 1000) and higher proportions of newborns without early follow-care (58.2% vs 14.5%). Low-supply areas had higher rates of ED visits (440 vs 179 per 1000) and admissions. A stepwise gradient existed for every decrease in supply for most measures. Self-reported access barriers were most evident in areas with >3500 children per FTE (32.8% without a physician).

CONCLUSIONS: Under universal insurance there are differences in access to, and outcomes of, primary care related to local physician supply after controlling for neighborhood income. The most pronounced effect is on primary and ED care use, but there are implications for acute and chronic disease control. Physician distribution is a critical issue to address in policies to improve access to care. *Pediatrics* 2010; 125:1119–1126

MCG - on Track to be 4th Largest U.S. Medical School

- Proposed expansion plan to increase class by 20 students per year in Athens
 - Phase I: Increase from 40 to 50 in 2020-21
 - Phase II: Increase from 50 to 60 in 2021-22
- Proposed expansion plan with accelerated primary care track, **MCG 3+ Primary Care Pathway**, and increased enrollment at AU/UGA Medical Partnership will bring enrollment of the freshman class to 300 per year
- Estimated retention rates associated with the MCG 3+ Primary Care Pathway →

Proposed Class Growth with MCG 3+ Primary Care Pathway *and* Athens Expansion



MCG 3+ Med-Ed Pathways

The MCG 3+ core curriculum will accelerate our existing curriculum to efficiently prepare our students for one of three pathways:

Pathway 1

- **Primary Care PGY-1:**
primary care residency programs in Georgia

Pathway 2

- **Dual Degree:**
dual degree program (MBA, MPH, MEd, MS) at Augusta University

Pathway 3

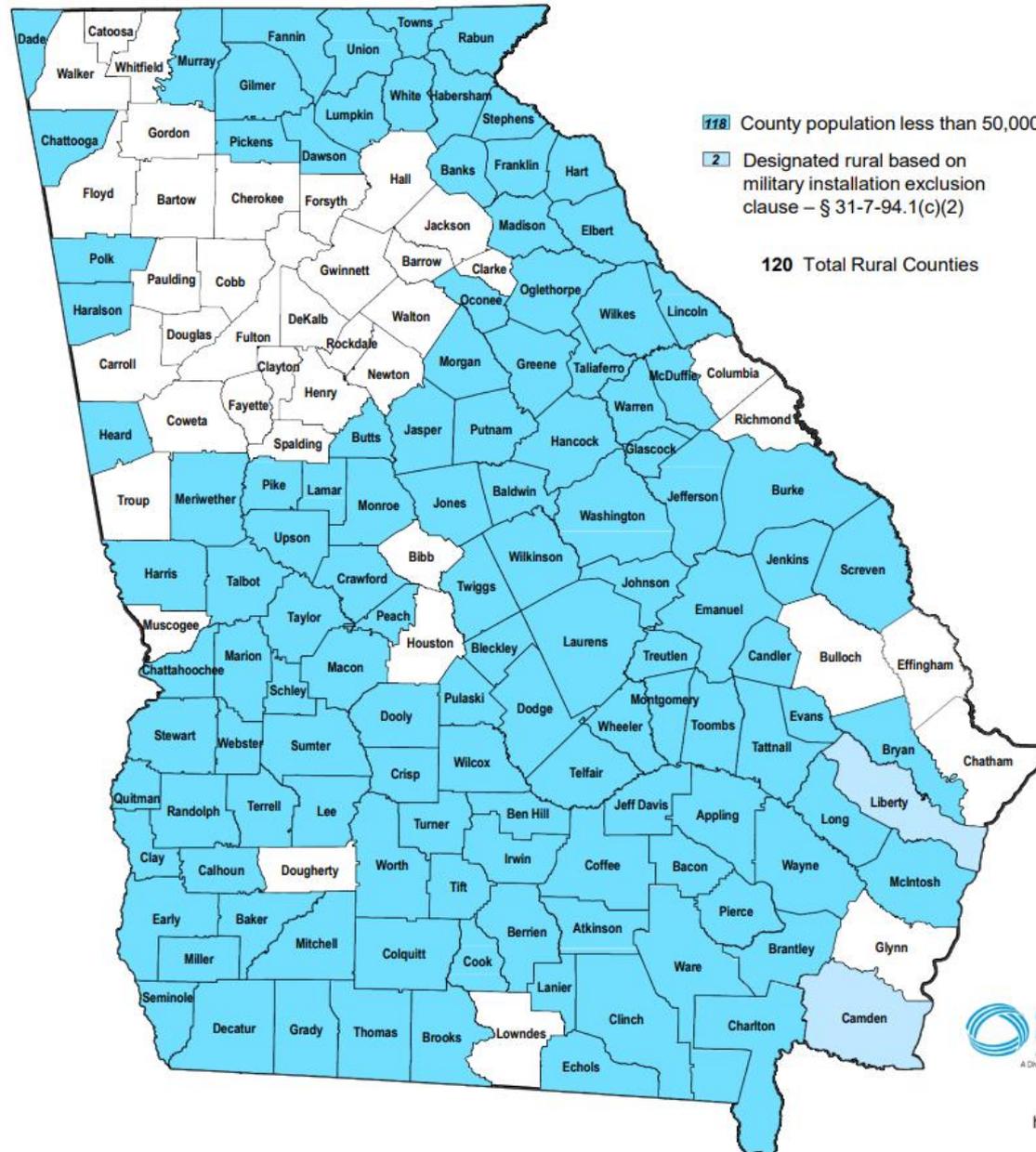
- **Advanced Residency Preparation:**
advanced clinical and research

MCG 3+ Primary Care Pathway

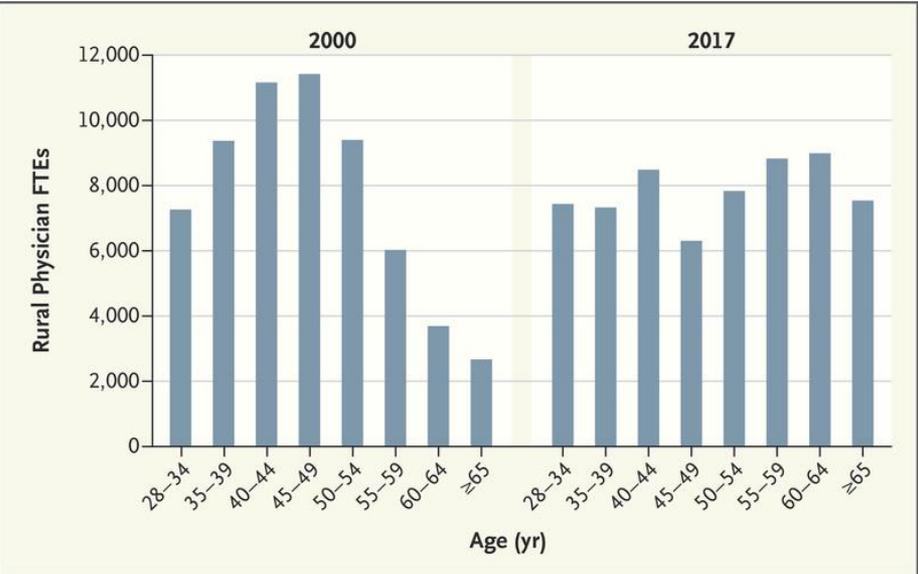
3+ (3 - 5 years of) residency training in an AU-MCG affiliated GME program specializing in primary care:

- **Family medicine** (*11 GA counties have none*)
- **Internal medicine** (*37 GA counties have none*)
- **Pediatrics** (*63 GA counties have none*)
- **Surgery** (*78 GA counties have none*)
- **Obstetrics/Gynecology** (*75 GA counties have none*)
- **Psychiatry/Mental Health** (*data unavailable*)

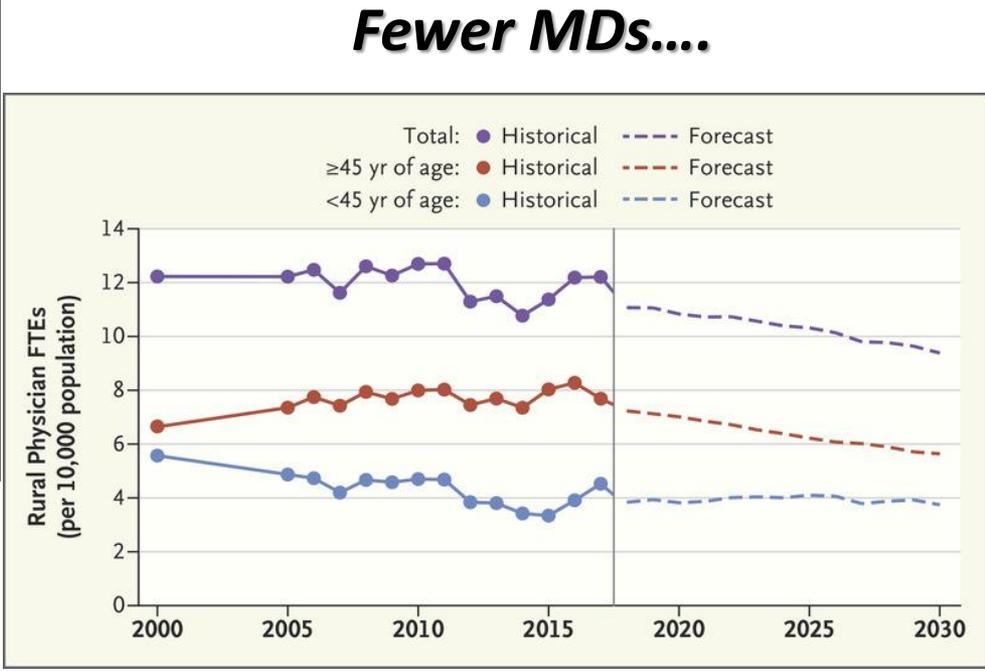
Most Georgia Counties are Rural



The Rural Physician Workforce



Aging....



Skinner, L, et al. NEJM 381: 299-301, July 25, 2019





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Public Health

journal homepage: www.elsevier.com/puhe

Exposing some important barriers to health care access in the rural USA

N. Douthit ^{a,c}, S. Kiv ^{a,c}, T. Dwolatzky ^a, S. Biswas ^{b,*}

^a Medical School for International Health, Ben Gurion University, Beer Sheva, Israel

^b Ben Gurion University, Beer Sheva, Israel

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2015

ABSTRACT

Objectives: To review research published before and after the passage of the Patient Protection and Affordable Care Act (2010) examining barriers in seeking or accessing health care in rural populations in the USA.

Study design: This literature review was based on a comprehensive search for all literature researching rural health care provision and access in the USA.

Methods: Pubmed, Proquest Allied Nursing and Health Literature, National Rural Health Association (NRHA) Resource Center and Google Scholar databases were searched using the Medical Subject Headings (MeSH) 'Rural Health Services' and 'Rural Health.' MeSH subtitle headings used were 'USA,' 'utilization,' 'trends' and 'supply and distribution.' Keywords added to the search parameters were 'access,' 'rural' and 'health care.' Searches in Google Scholar employed the phrases 'health care disparities in the USA,' 'inequalities in 'health care in the USA,' 'health care in rural USA' and 'access to health care in rural USA.' After eliminating non-relevant articles, 34 articles were included.

Results: Significant differences in health care access between rural and urban areas exist. Reluctance to seek health care in rural areas was based on cultural and financial constraints, often compounded by a scarcity of services, a lack of trained physicians, insufficient public transport, and poor availability of broadband internet services. Rural residents were found to have poorer health, with rural areas having difficulty in attracting and retaining physicians, and maintaining health services on a par with their urban counterparts.

Conclusions: Rural and urban health care disparities require an ongoing program of reform with the aim to improve the provision of services, promote recruitment, training and career development of rural health care professionals, increase comprehensive health insurance coverage and engage rural residents and healthcare providers in health promotion.

The Role of Federally Funded Health Centers in Serving the Rural Population

Jerrilynn Regan RN, MS, MPA✉, Ashley H. Schempf BS, Jean Yoon MHS, Robert M. Politzer ScD.

First published: 08 April 2008 | <https://doi.org/10.1111/j.1748-0361.2003.tb00552.x> | Cited by: 23



2008

Abstract

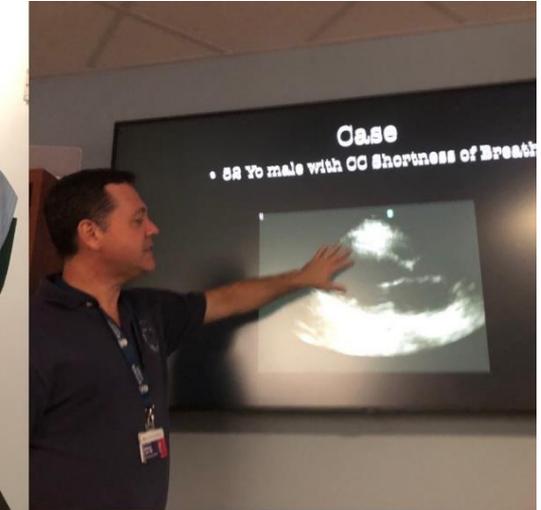
Abstract: Context: Federally funded health centers attempt to improve rural health by reducing and eliminating access barriers to primary care services. **Purpose:** This study compares rural health center patients with people in the general rural population for indicators of access to preventive services and health outcomes. **Methods:** Data from the annual reporting system for federally funded health centers, the 1999 Uniform Data System, and published national census data were used to provide sociodemographic comparisons. Selected health status indicators, preventive services utilization, and health outcomes were obtained from a survey of health center patients, and the results were compared with the National Health Interview Survey and National Vital Statistics.

Findings: Unlike the nation's rural population, the majority of rural health center patients are of minority race/ethnicity, live at or below poverty, and are either uninsured or on Medicaid. Despite having higher prevalence of traditional access barriers than the general rural population, rural health center patients are significantly more likely to receive certain preventive services and also to experience lower rates of low birthweight, particularly for African American infants. However, rural health center patients are not more likely to have received influenza vaccination or up-to-date mammogram screening.

Conclusions: Health centers provide access to essential preventive care for many of the most vulnerable rural residents. A national strategy to expand the rural health center network will likely help to ensure improved health for the considerable proportion of rural residents who still lack access to appropriate services.

- Comparison of rural patients receiving care in community health centers with patients in the general rural population
- Despite higher prevalence of access barriers, patients at CHCs were significantly more likely to have received certain preventative services such as Pap smears in the previous three years and less likely to have babies with low birth weight.

MCG Campuses Are Connected



We Reach Out With Technologies



Concept Graphic
6-17-19

MCG RECRUT REgional Campus Residency Ultrasound Training

Legend	Start Date	Connection Type
	2019	Educational Link with PACS link
	2018	Educational Link



UME GME Faculty Development

Spanning the Education Continuum

Purpose

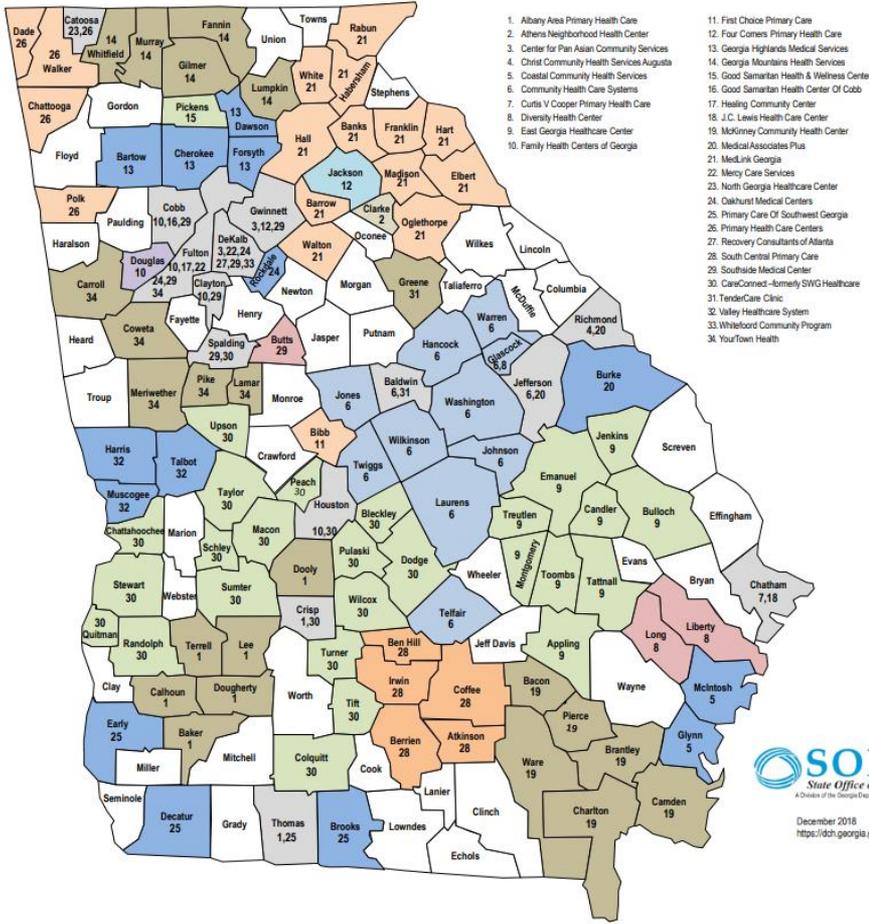
- Determine the feasibility of a remote and joint training program for continued ultrasound education (UME through GME)
- Serve as a demonstration project to refine the technology and process needed to maximize educational efficiency of the program
- To provide data for the 3+3 model for using continuation of ultrasound training as a recruitment incentive to a rural residency training location

Requirements

- Residency must host MCG students for clerkship
- Faculty must have MCG FM appointment
- Residency is willing to provide dedicated educational time and ultrasound equipment
- Residency will share educational data for quality assurance, educational outcomes tracking and competency assessment

Overlapping Partnership Opportunities

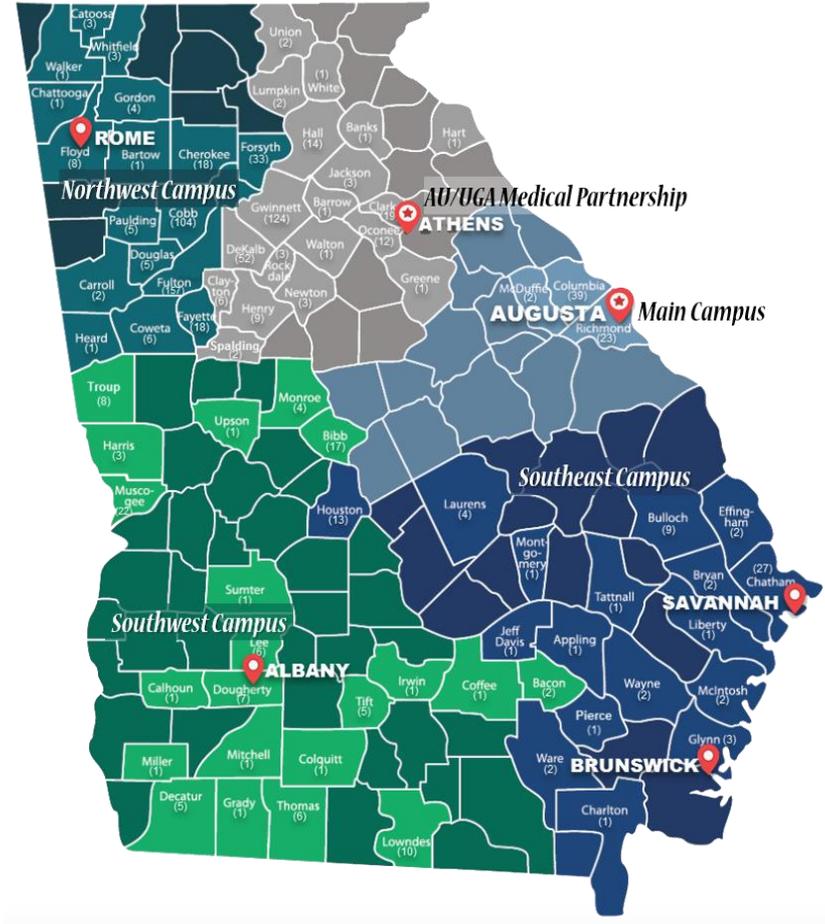
FQHCs



1. Albany Area Primary Health Care
2. Athens Neighborhood Health Center
3. Center for Pan Asian Community Services
4. Christ Community Health Services Augusta
5. Coastal Community Health & Wellness Center
6. Community Health Care Systems
7. Curtis V. Cooper Primary Health Care
8. Diversity Health Center
9. East Georgia Healthcare Center
10. Family Health Centers of Georgia
11. First Choice Primary Care
12. Four Corners Primary Health Care
13. Georgia Highlands Medical Services
14. Georgia Mountains Health Services
15. Good Samaritan Health & Wellness Center
16. Good Samaritan Health Center Of Cobb
17. Healing Community Center
18. J.C. Lewis Health Care Center
19. McKinney Community Health Center
20. Medical Associates Plus
21. MedLink Georgia
22. Mercy Care Services
23. North Georgia Healthcare Center
24. Oakhurst Medical Centers
25. Primary Care Of Southwest Georgia
26. Primary Health Care Centers
27. Recovery Consultants of Atlanta
28. South Central Primary Care
29. Southside Medical Center
30. CareConnect—formerly SWG Healthcare
31. TenderCare Clinic
32. Valley Healthcare System
33. Whitford Community Program
34. YourTown Health

SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health
December 2018
<https://dch.georgia.gov/sorh>

MCG Students



Northwest Campus (ROME)
Southwest Campus (ALBANY)
Southeast Campus (ATHENS)
Main Campus (AUGUSTA)

AU/UGA Medical Partnership

Thank you

Doug Miller, MD, CM, FACC, FRCPC

Vice Dean, Academic Affairs

ddmiller@augusta.edu

706-755-5365

