CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

The Primary Care Workforce California Needs

Conrad Amenta - Director, Health Policy
California Academy of Family Physicians
camenta@familydocs.org

The California Academy of Family Physicians: Who we are, what we do

The California Academy of Family Physicians (CAFP) is
the only organization solely dedicated to advancing the specialty of family medicine since 1948.

There are more than 10,000 family physician, family medicine resident and medical student members.

CAFP is the largest primary care medical society in California and the largest chapter of the **American Academy of Family Physicians**.

OUR MISSION: **To empower, educate and connect family physicians to improve the health of all Californians**

But…what do you mean?

- We **ADVOCATE** on your behalf
- We **SUPPORT** you in your practice
- We **CONNECT** you with other family docs

Our policy priorities are:

- Practice Transformation
- Payment Reform
- The **PRIMARY CARE WORKFORCE**

- Identifies and supports promising medical students and family medicine residents committed to family medicine advocacy.
- Goal: to increase the number and quality of family medicine physicians trained in health care policy at the state and federal level.
- Our Fellows gain access to tools, insights and diversity of mentors to accelerate and distinguish their advocacy activities.
- The Fellowship provides an annual stipend to support participation in activities over the course of a year.
- Awarded annually to one medical student and one family medicine resident physician who have demonstrated their commitment to family medicine and interest in learning about and advocating for family medicine-driven health policy.

Criteria and application at http://www.familydocs.org/sh-fellowship

Unprecedented demand

The Value of Primary Care

An increase of one primary care doctor per 10,000 people has been shown to result in:

- 5% decrease in outpatient visits
- 5.5% decrease in inpatient admissions
- 10.9% decrease in ER visits
- 7.2% decrease in surgeries

As a result, adults in the U.S. who have a primary care provider have 19% lower odds of premature death than those who only see specialists for their care

People who have a primary care provider save 33% on healthcare over their peers who only see subspecialists.

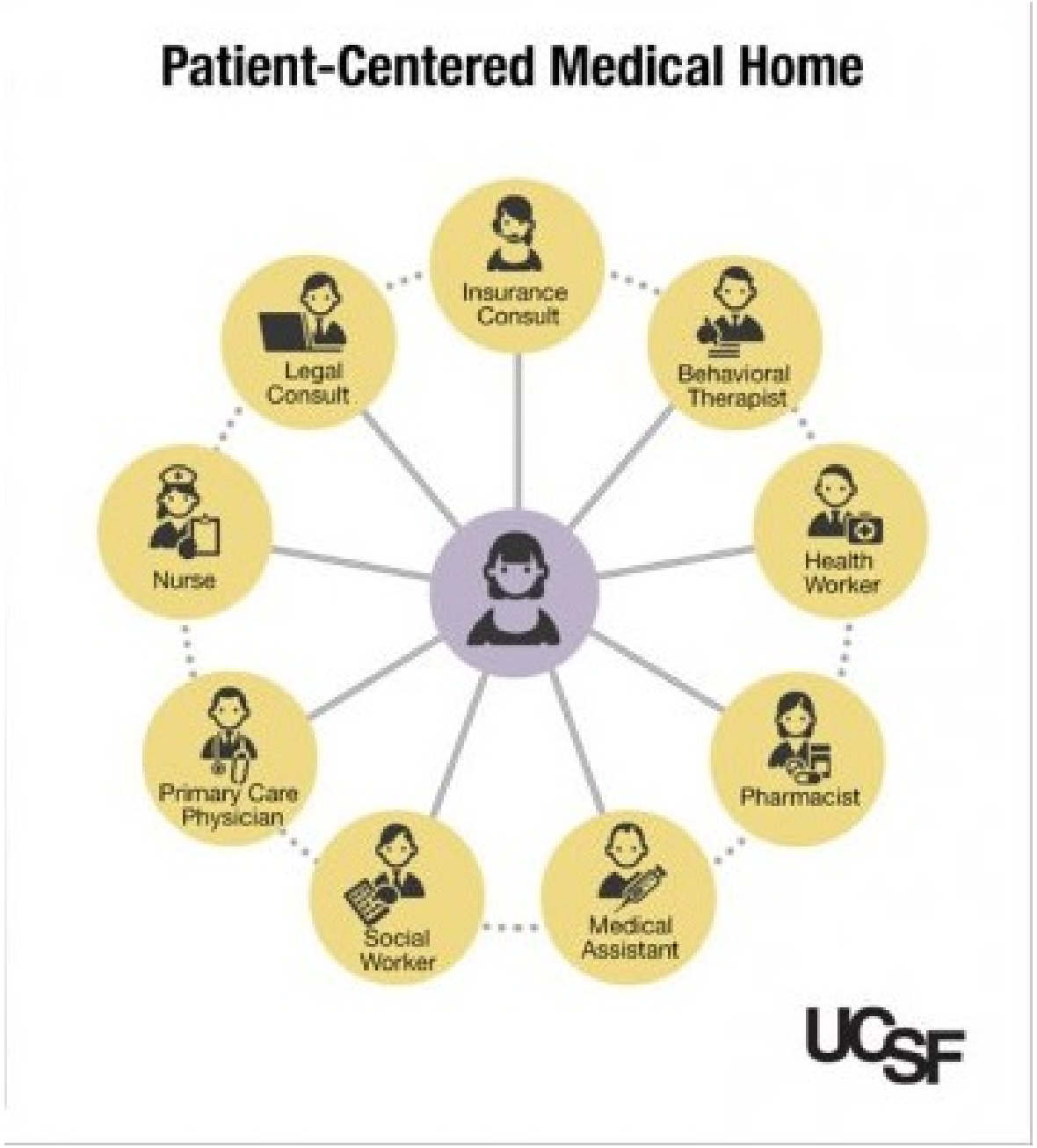
Healthforce Center at UCSF

Research Report

California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030

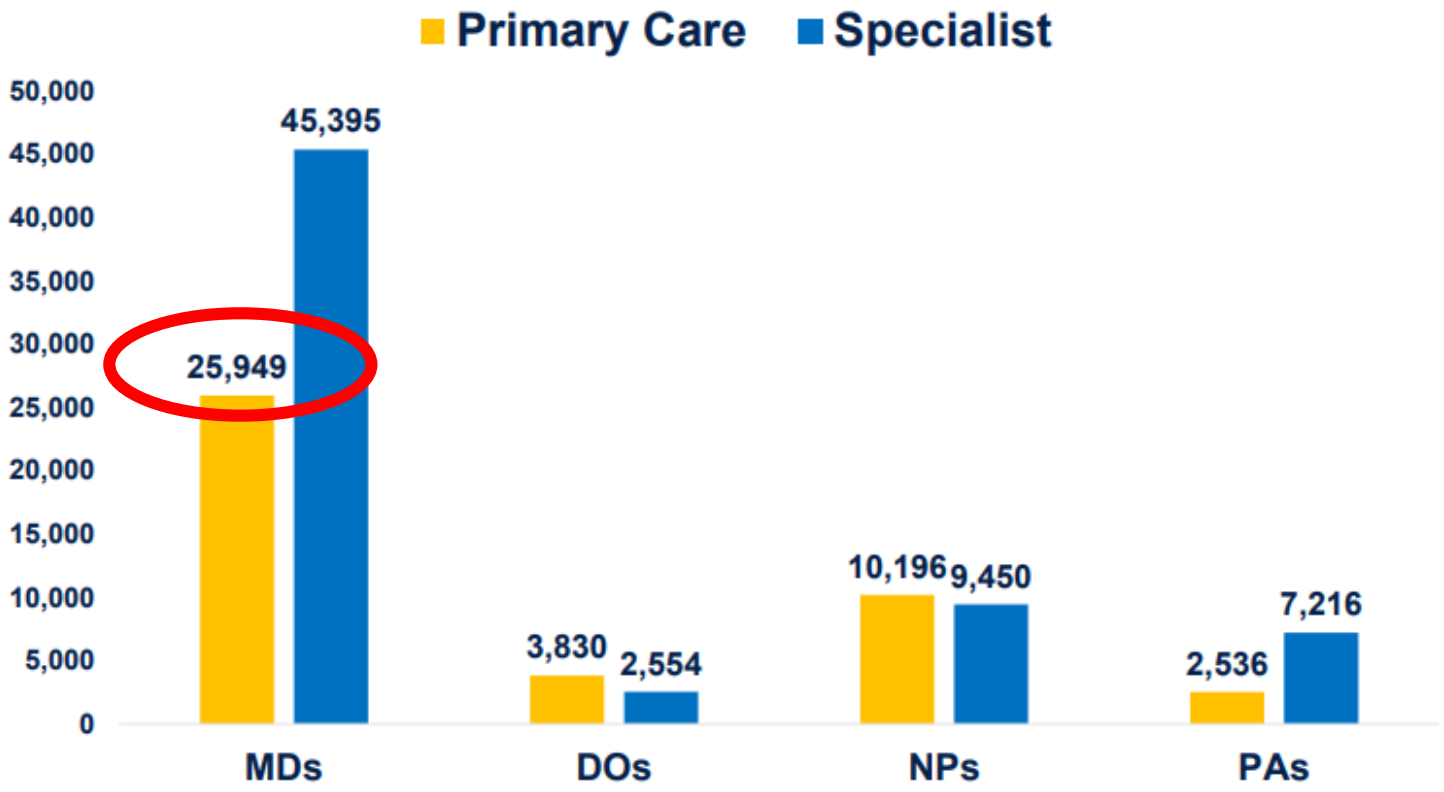
by Joanne Spetz, Janet Coffman, and Igor Geyn,
Healthforce Center at UCSF

August 15, 2017



- Only 37% of patient care physicians in California are primary care physicians
- NPs and PAs contribute to the supply of primary care providers but their numbers are much smaller than the number of primary care physicians.

Numbers of MDs, DOs, NPs, and PAs in California, 2016



Sources: Medical Board of California, Survey of Licensees, 2015; American Osteopathic Association, Osteopathic Medical Profession Report, 2014. Spetz, Fraher, Li, Bates, 2015 National Commission on Certification of PAs, Profile Data 2016.

Figure 2: Forecasted Full-Time Equivalent Supply of Primary Care Physicians, California, 2016-2030

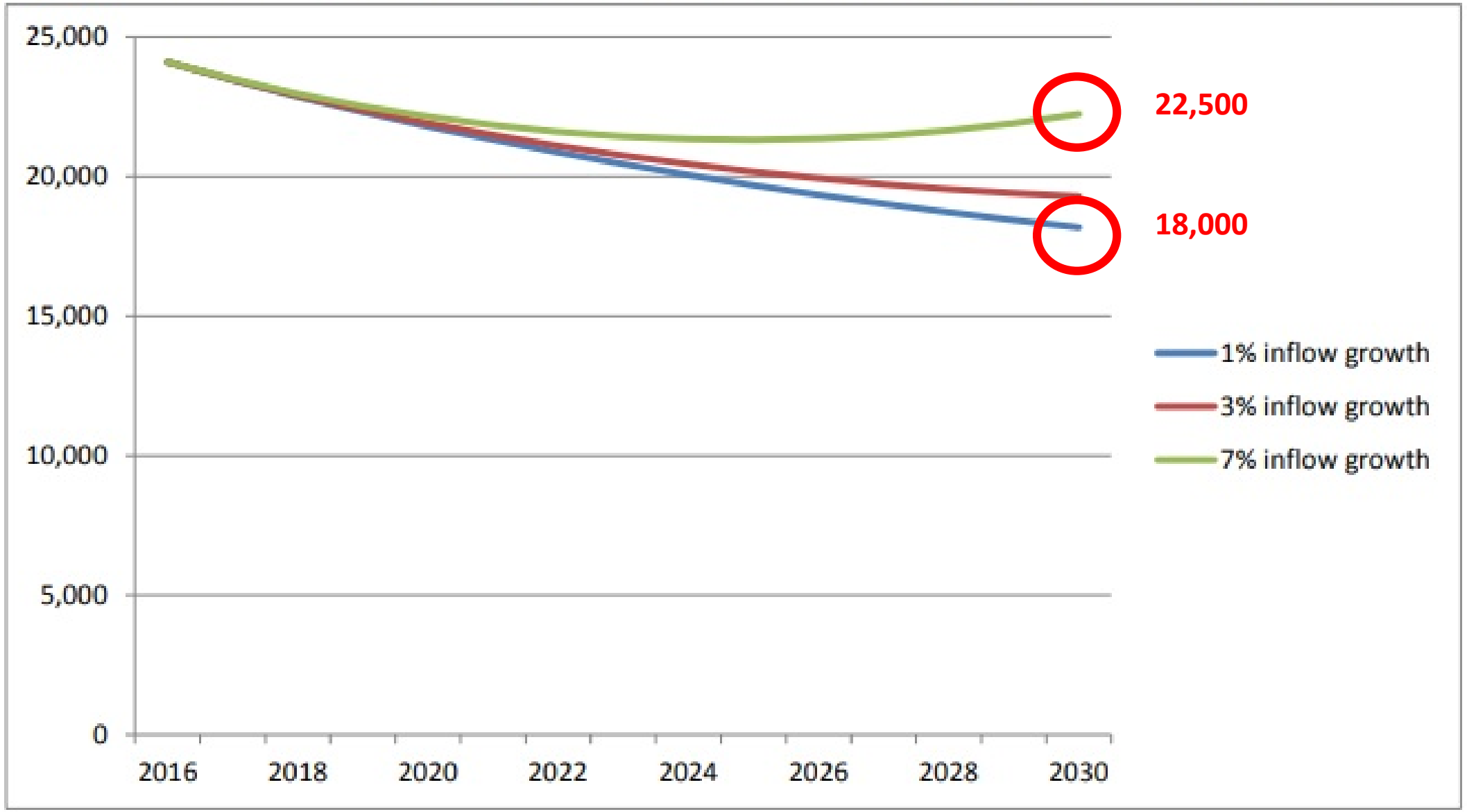
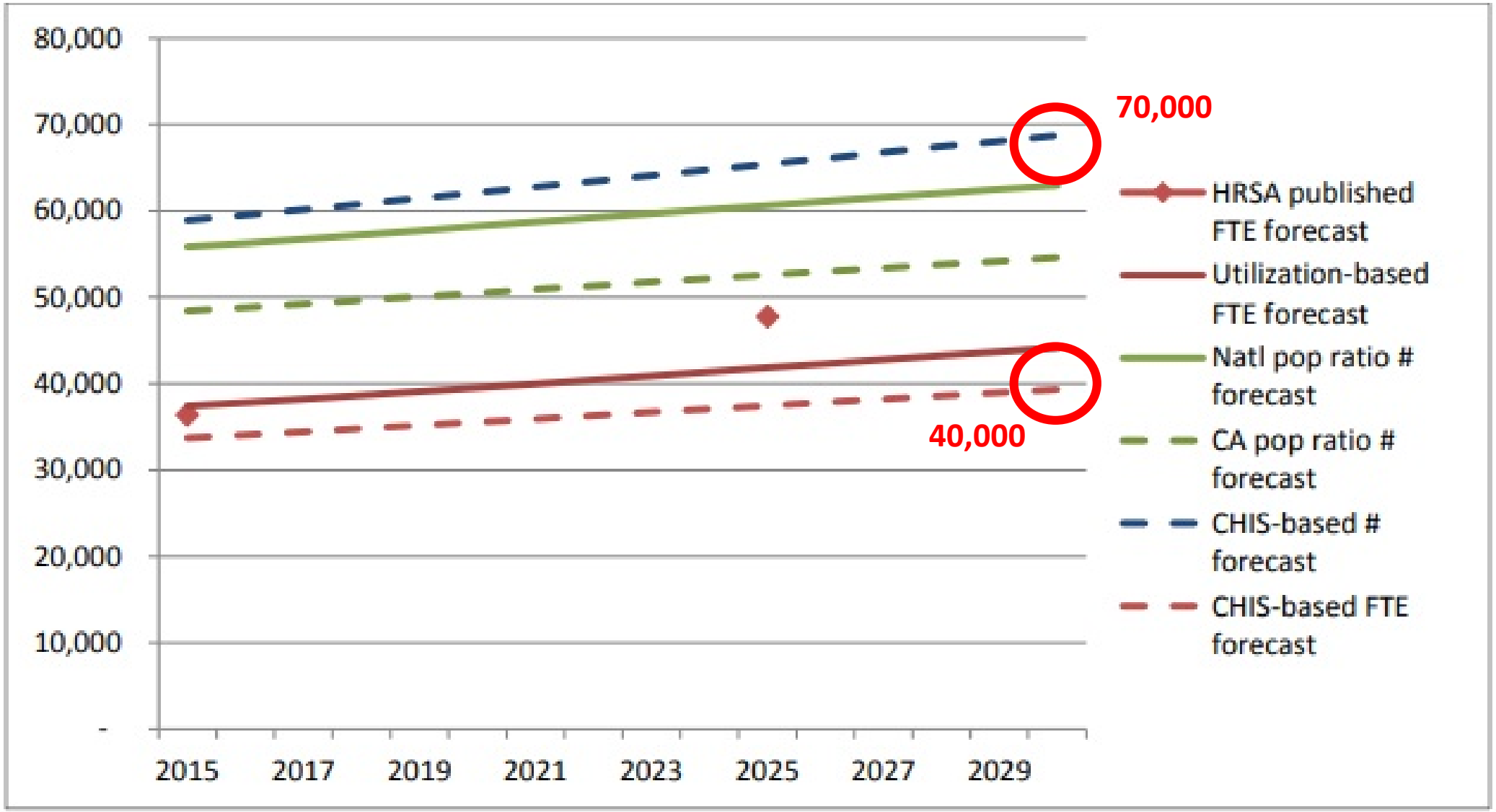


Figure 20. Forecasted Demand for Primary Care Clinicians, Statewide, 2016-2030



Best case scenario: 17,500 shortage

Worst case scenario: 52,000 shortage

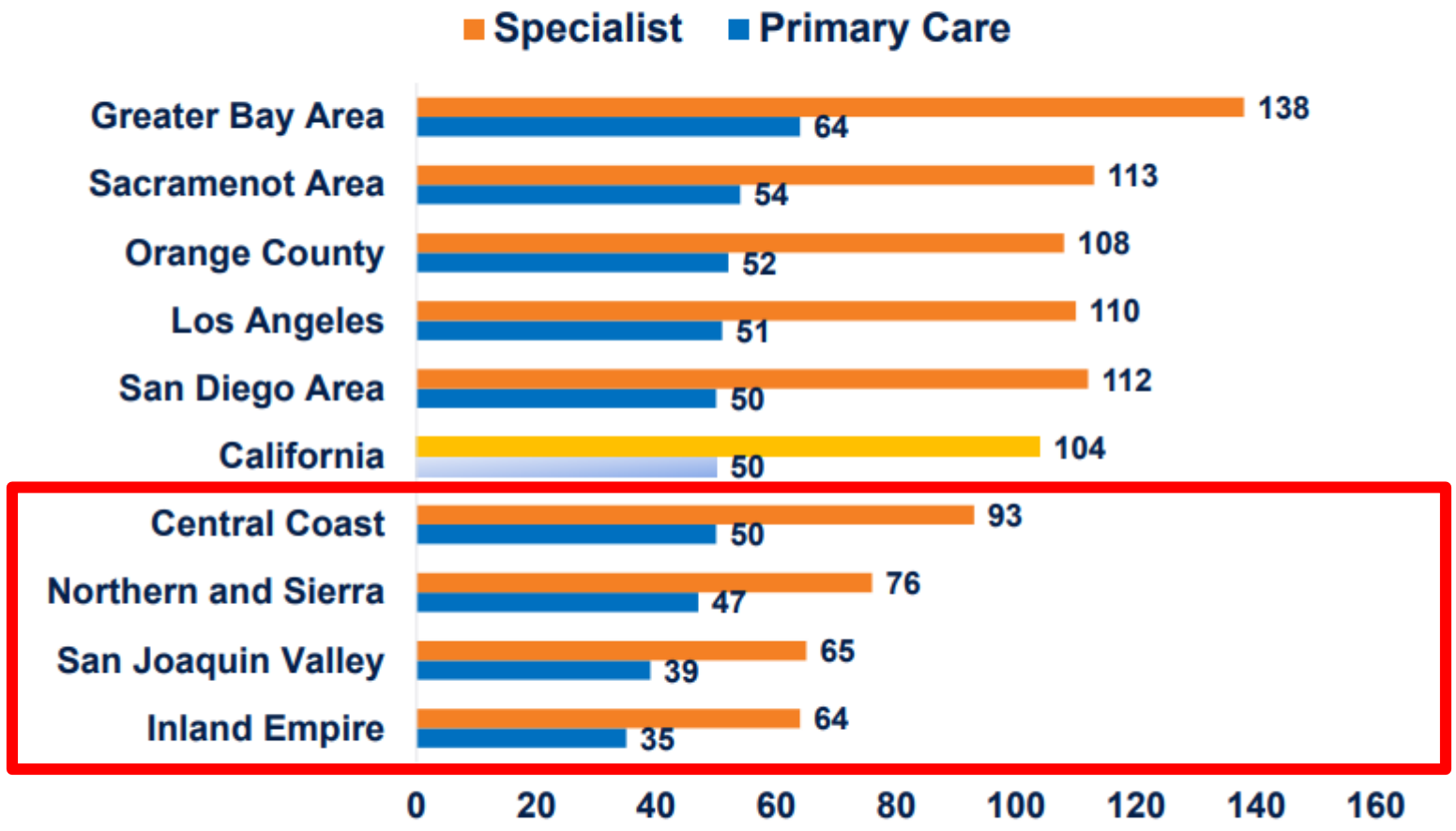
TOTAL number of FM, IM, Peds, Ob-Gyn practicing primary care in 2018 is about **26,000** ∴ in ≈ 10 years it's possible we'll see a shortage twice the size of the current primary care workforce

Solutions?

- Expand funding for primary care residency slots?
- Expand the scope of practice for non-physicians?
- Ease the pathway to licensure for international medical graduates?

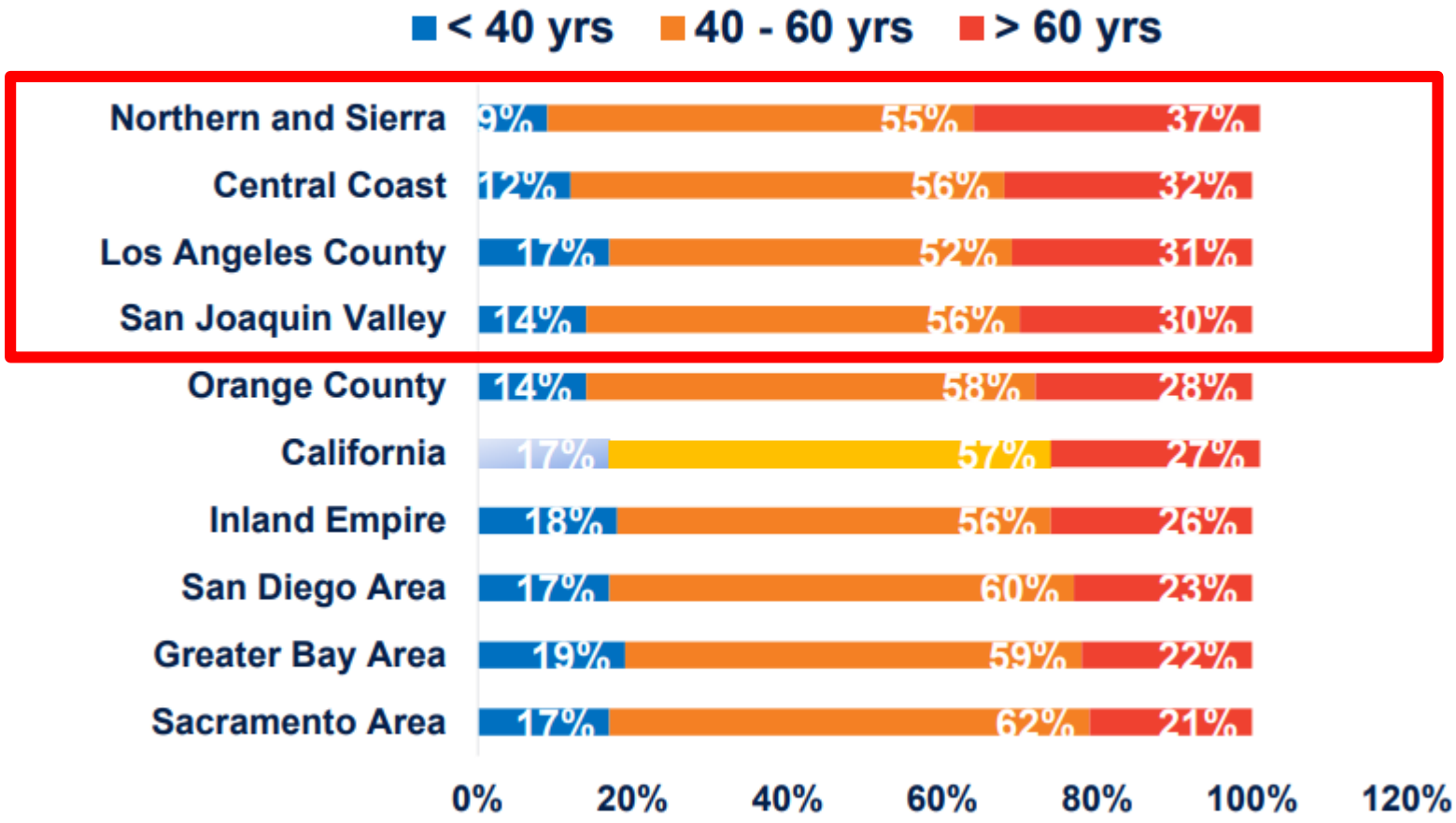
What are the trade offs?

Active Patient Care MDs per 100,000 Population, by Region of California, 2015



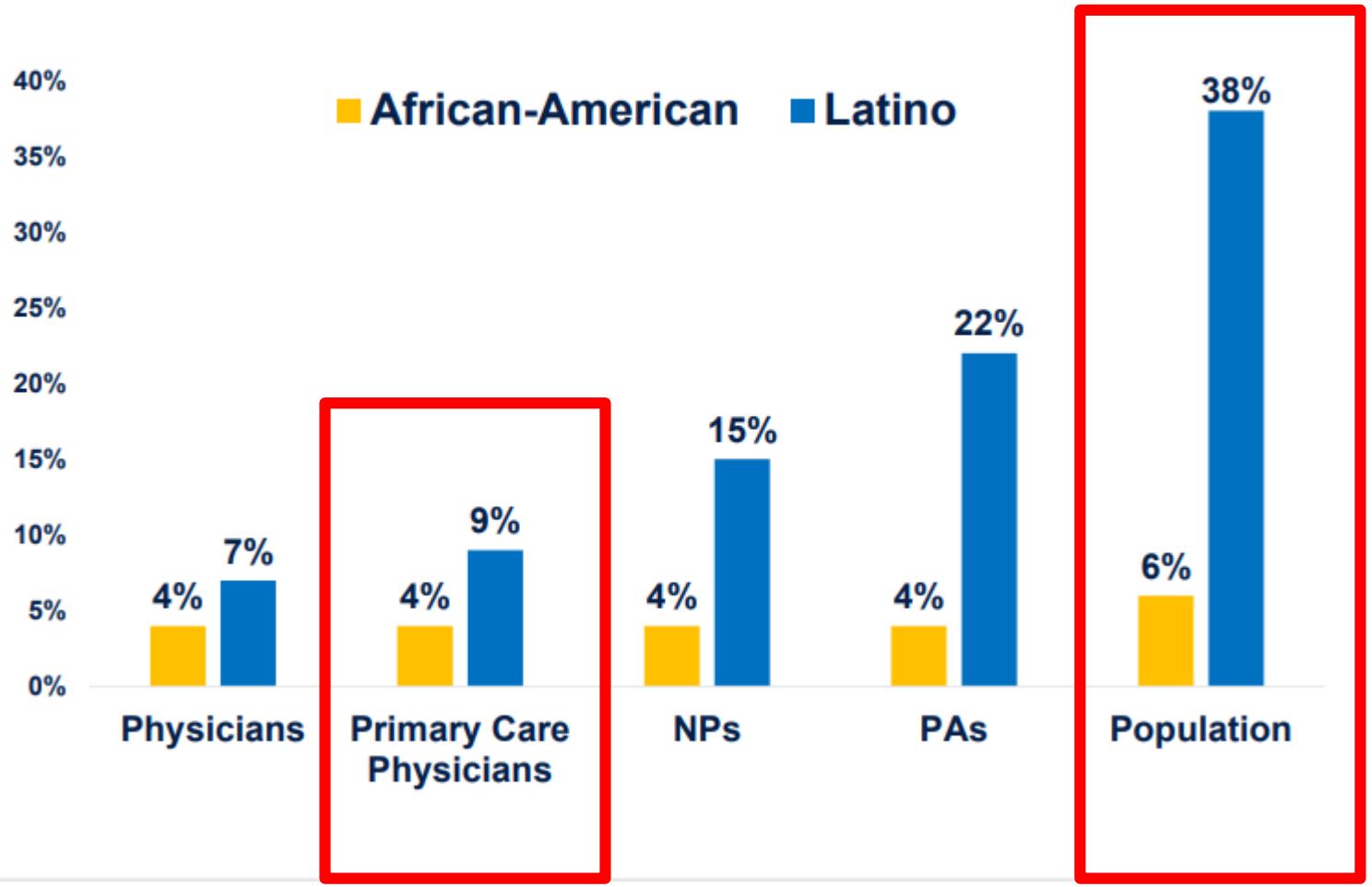
Sources: Medical Board of California, Core License File, May 2015; private tabulation. U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population: April 1, 2010 to July1, 2015.

Age of Active Patient Care Physicians by Region, California, 2015



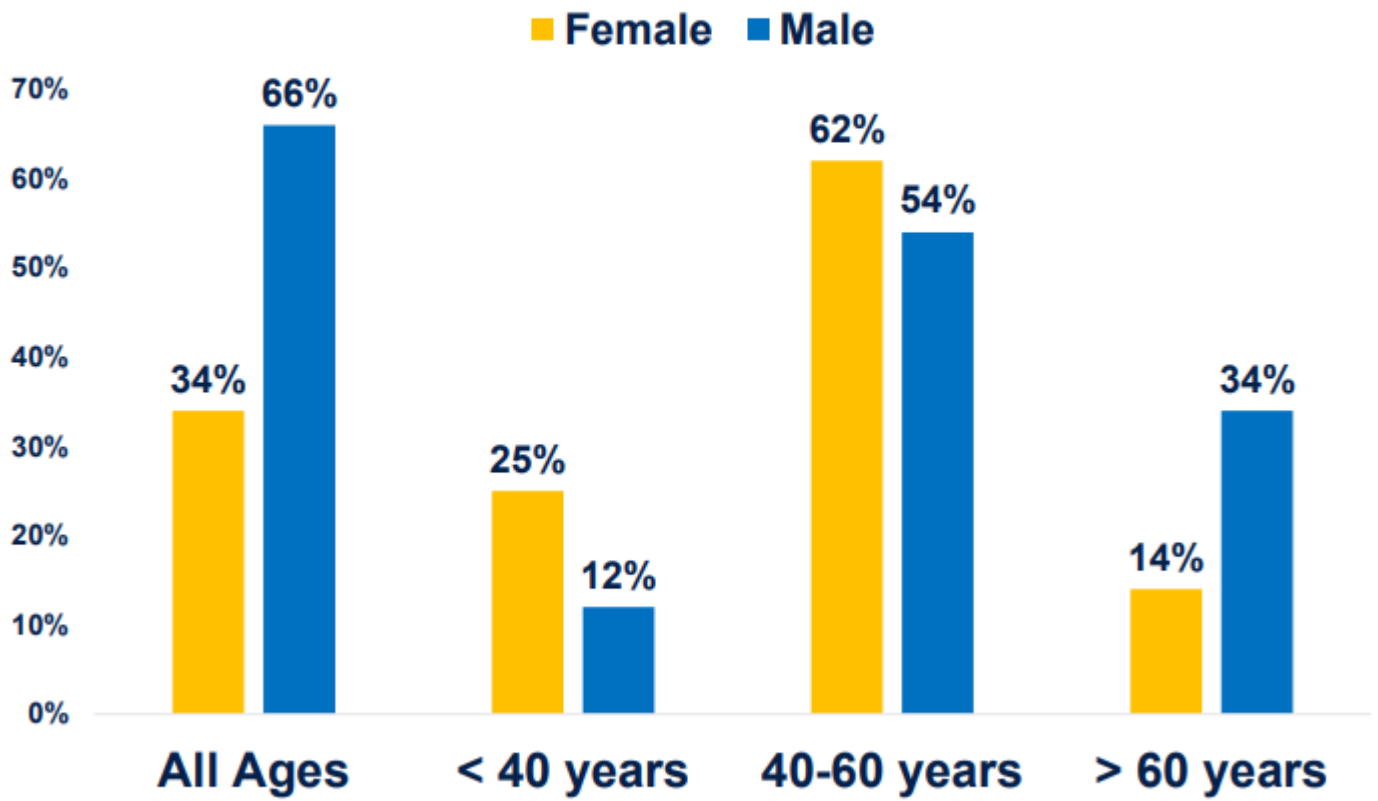
Sources: American Community Survey, Public Use Microdata Sample, 2015, private tabulation. Medical Board of California, Survey of Licensees, May 2015. May not sum to 100% due to rounding.

Diversity of California's Primary Care Providers Compared to its Population, 2015



Sources: American Community Survey, Public Use Microdata Sample, 2015, private tabulation. Medical Board of California, Survey of Licensees, May 2015; private tabulation.

Age Distribution of Active Patient Care MDs by Gender, 2015



Source: Ko, Fix, Coffman, 2018

Demographic Characteristics of Primary Care Providers

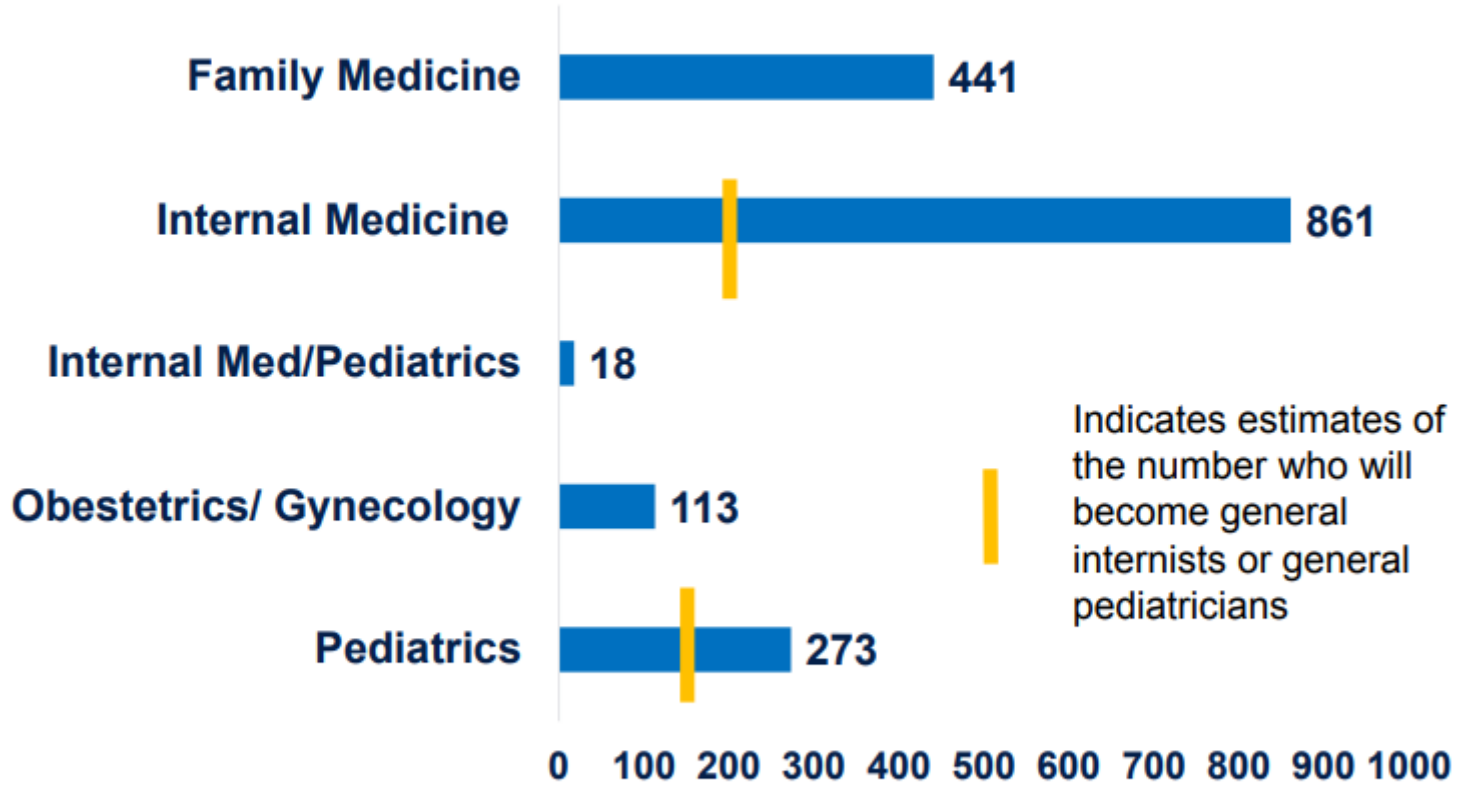
- 27% of California's active patient care physicians are over age 60 years
- Latinos and African-Americans are underrepresented among physicians, NPs, and PAs
- 34% of physicians are women

- 2,973 first-year medical residents began training in California in 2018.
  - 1,704 in primary care specialties
    - Half likely to go on to sub-specialize
  - 202 in emergency medicine
  - 1,067 in other non-primary care specialties

lealthforce Center at UCSF

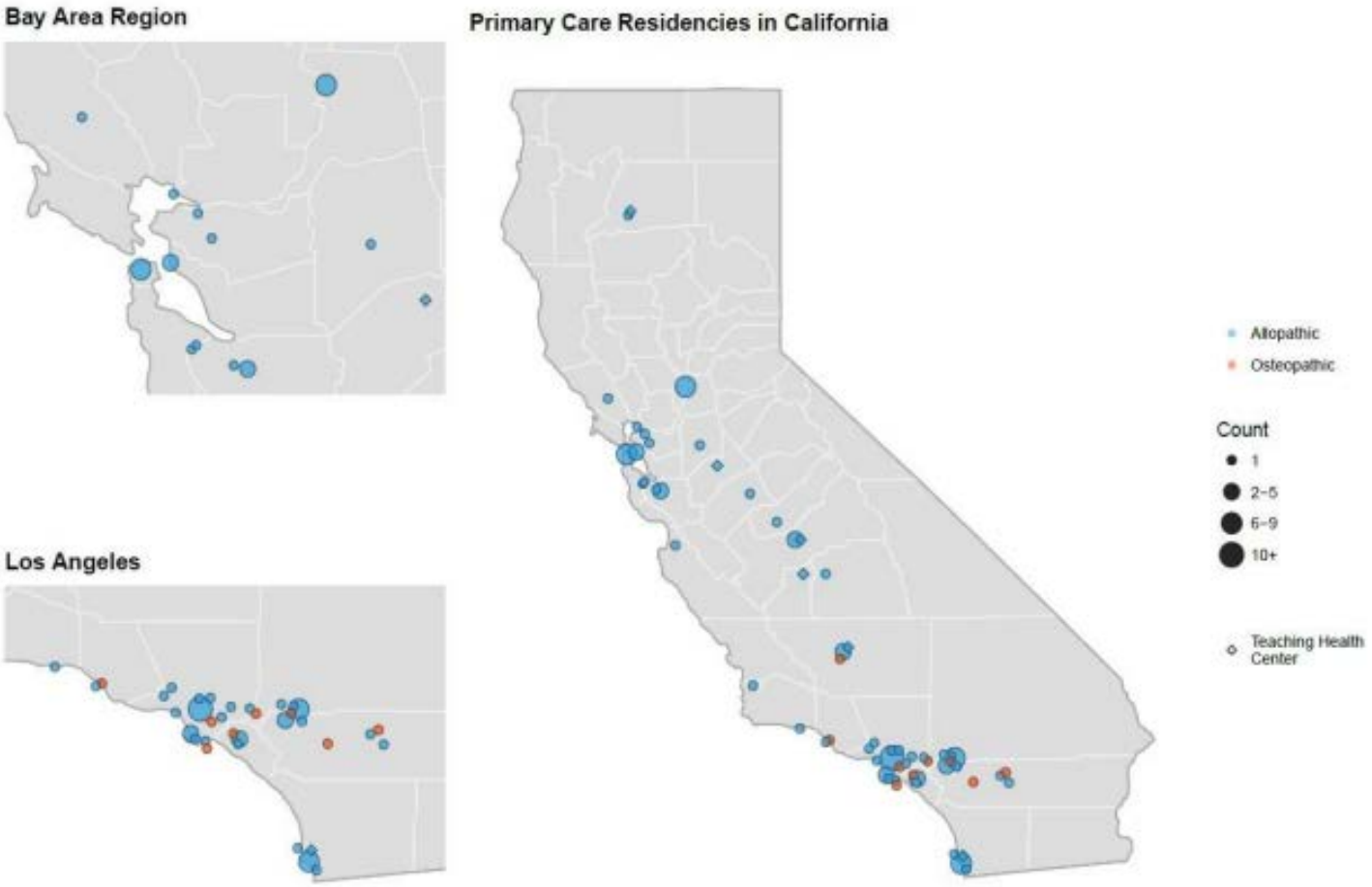
Sources: AAMC, AACOM, NRMP

First-Year Primary Care Residency Positions by Specialty, California, 2018



Source: National Residency Match Program (NRMP), "Main Match Results by State and Specialty", 2018.

Geographic Distribution of Primary Care Residency Programs in California, 2017



What makes GME in California different?

Graduate Medical Education Funding in California

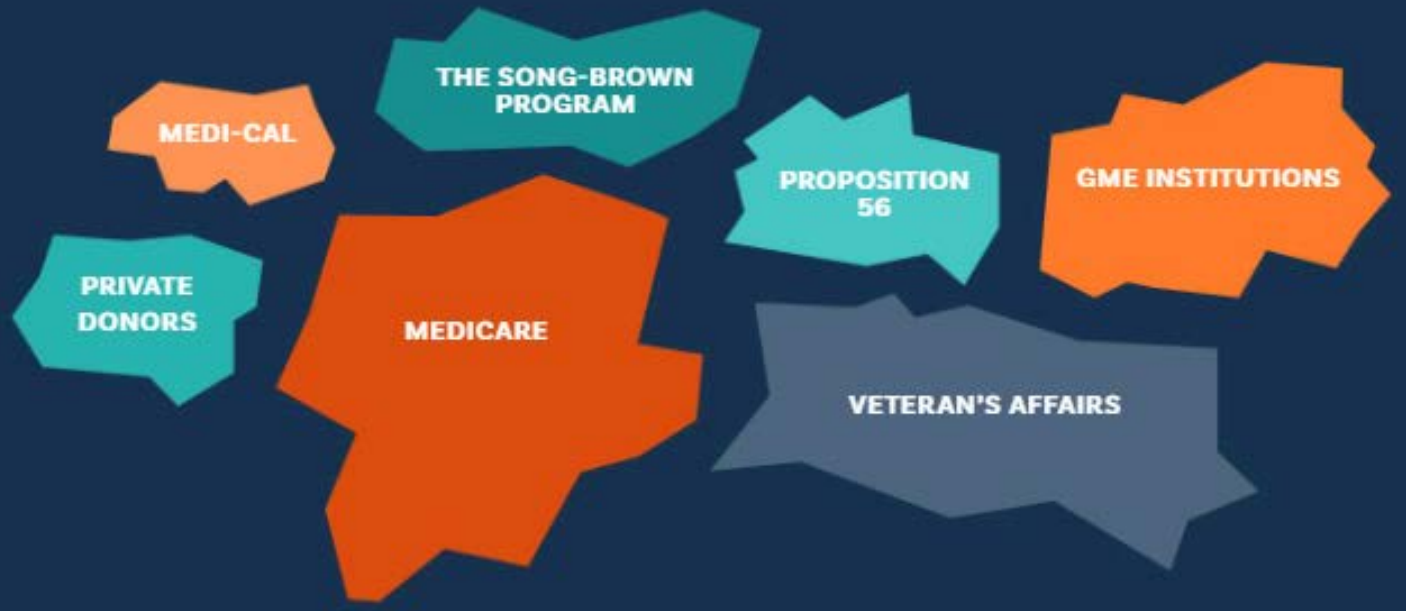
6 Key Facts

California Health Care Foundation

www.chcf.org/GME-funding

GME funding in California is fragmented and lacks coordination.

If the state wants to efficiently and effectively train our future health workforce, GME funding needs to be clearly coordinated with an eye to solving specific workforce needs.



Even though it is #1 of all states in population size,

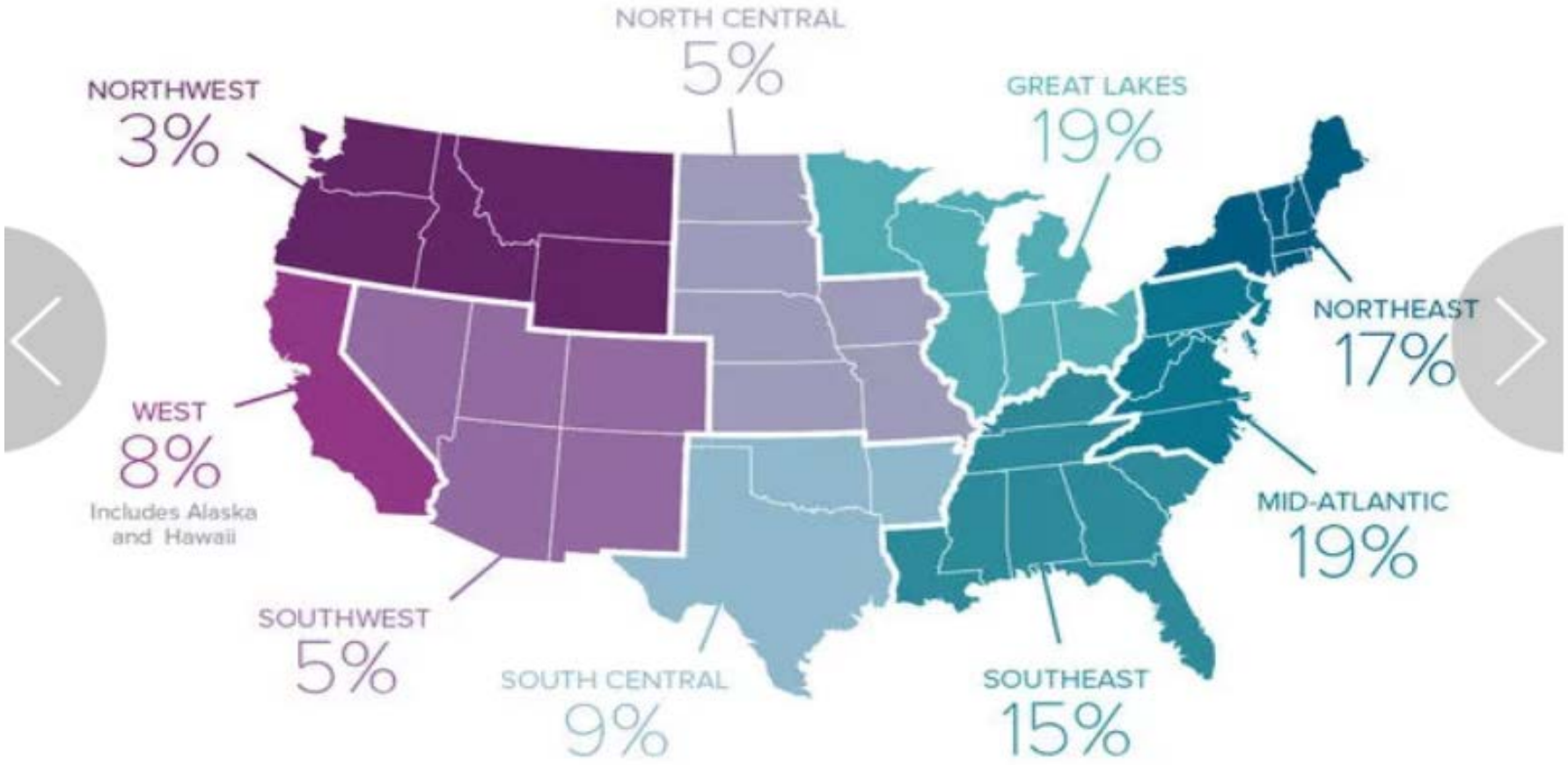
California is #26 in the number of Medicare GME FTE positions funded

(between FY 2008 and FY 2010)

NY MA RI PA MI CT OH VT LA IL MO WV DE MD NJ MN NE NH TN WI NC ME VA IA OK CA UT KY SC KS NM AL TX CO IN GA AR WA AZ FL HI OR ND MS NV SD WY AK ID MT

MOST — NUMBER OF MEDICARE GME FTE POSITIONS IN EACH STATE — LEAST

Where Residency Programs Are Located



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California is one of eight states in the US that do not have dedicated Medicaid funding for GME. Instead, California hospitals receive discretionary funding through Medi-Cal that they can choose to use—or not use—on GME.

CALIFORNIA IS ONE OF EIGHT STATES THAT DO NOT HAVE DEDICATED GME FUNDING

DISCRETIONARY FUNDING MAY OR MAY NOT GO TO GME

STATE FUNDING FOR GME IN CALIFORNIA

The Song-Brown Healthcare Workforce Training Programs

- Grants to primary care residency programs: family medicine, internal medicine, ob/gyn, pediatrics, family nurse practitioner and physician assistants
- Emphasizes programs that serve underserved patient populations and recruit underrepresented minorities
- Also provides loan-repayment and scholarships to health workforce trainees

STATE FUNDING FOR GME IN CALIFORNIA

Proposition 56, Tobacco Tax Increase

- **Increased the taxes on packs of cigarettes, tobacco products and e-cigarettes by $2 (up from .87 cents)**
  - Allocate $48 million to enforcing tobacco laws
  - **$40 million to physician training to increase the number of primary care and emergency physicians**
  - $30 million toward preventing and treating dental diseases
  - $400,000 to the California State Auditor to audit funds from the new tax.
  - Allocate 82 percent of remaining funds toward services related to Medi-Cal
  - 11 percent of remaining funds toward tobacco-use prevention
  - 5 percent of remaining funds toward research into cancer, heart, and lung diseases and other tobacco-related diseases
  - 2 percent of remaining funds toward school programs focusing on tobacco-use prevention and reduction.

INTERESTING POLICY QUESTIONS

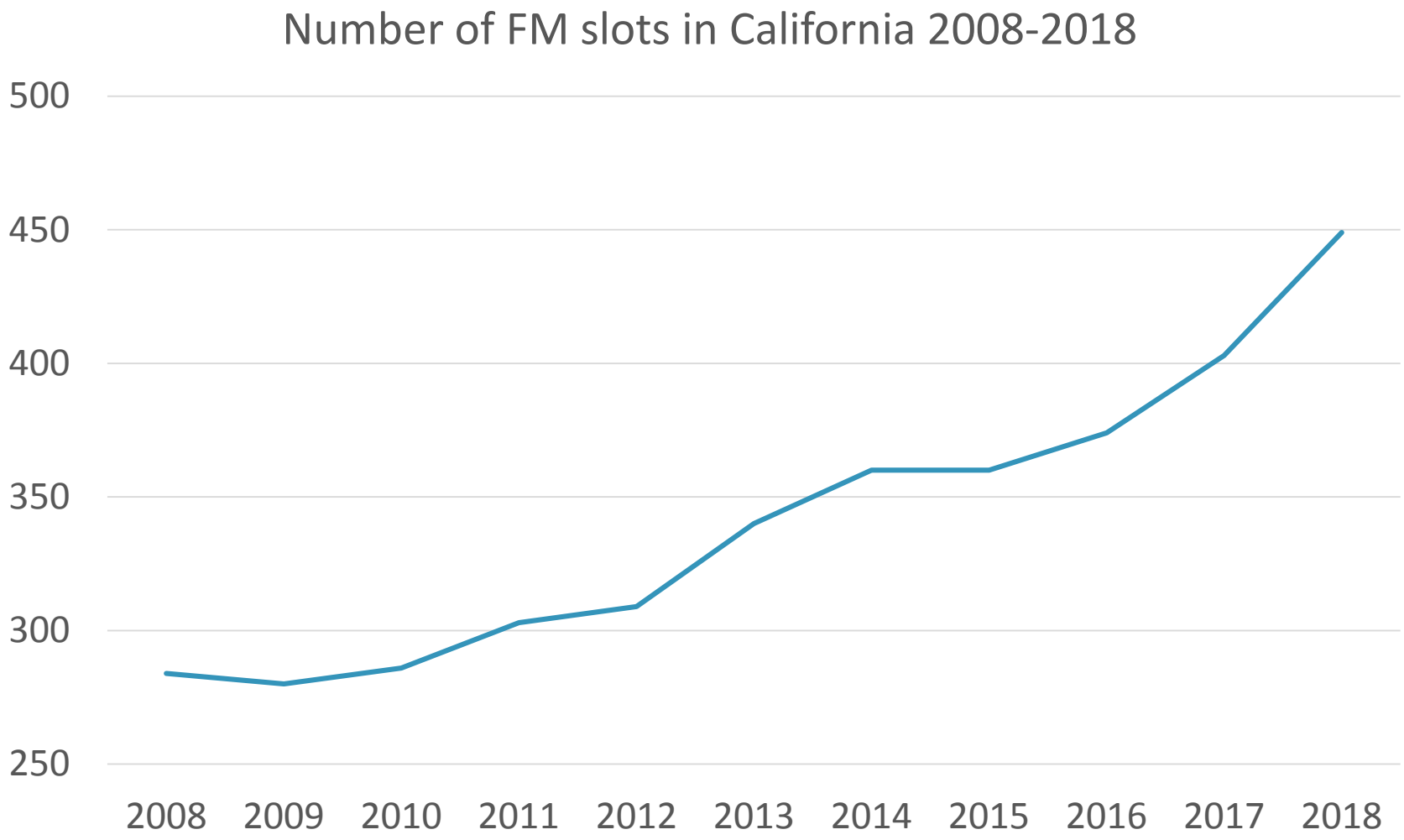
- **How do we define primary care?**
- **How do we define underserved, both geographically, demographically and via payer-mix?**
- **How do we define underrepresented minorities?**
- **What degree of control do applicants have over these things?**
- **How large do grants have to be before they influence where programs invest?**
- **How do you measure exclusivity in primary care?**
- **How much does it cost to train a resident, anyway?**
- **How much does it cost to start a brand new residency program?**
- **How do you schedule the funding?**
- **Should a state-based program complement federal funding?**
- **Who really needs the money and how do you accurately measure that?**

Family Medicine rises to meet the demand

Number of family medicine residency slots in California in 2018: 441

2008–2012:
8.8% increase

2012–2018:
45% increase



Source: National Resident Matching Program

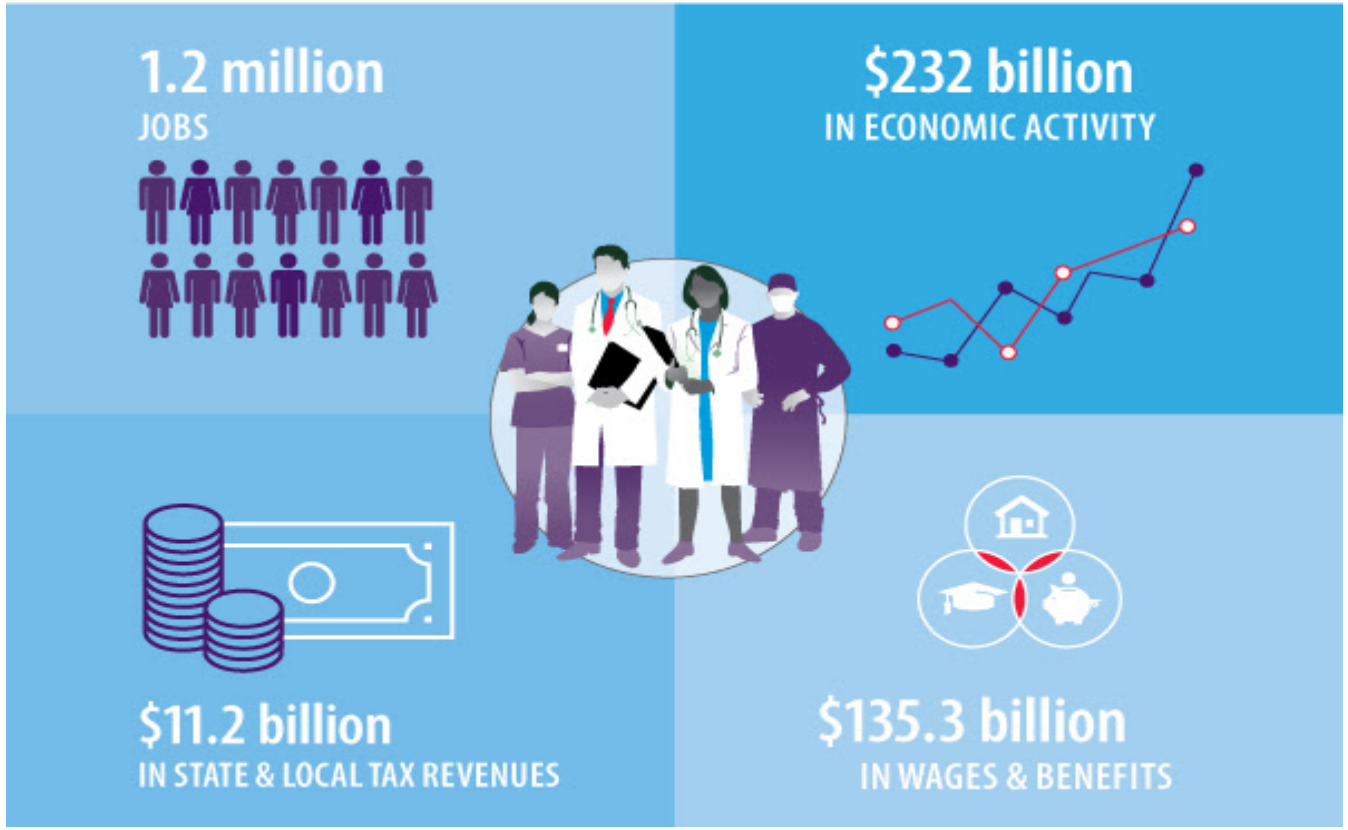
Number of accredited family medicine residency programs 2018-2019 Academic Year: **60**

California is a nice place:

The percentage of MDs and DO Medical School Graduates entering Family Medicine Residency Programs in the same state they attended medical school was higher in California than anywhere else: **78%**

Physicians bring economic health to our communities.

Physicians' impact is felt far beyond the exam room, reaching through local communities, producing a network of jobs and spurring local investment.



- Source: http://www.cmanet.org/files/assets/news/2018/01/ca-study.pdf

2017 ABFM Certification Candidate (Resident) Survey

WHICH OF THE FOLLOWING DESCRIBES THE SITE THAT WILL BE YOUR PRINCIPAL PRACTICE AFTER RESIDENCY	State N=332	National N=2958
	Pct	Pct
Not Applicable	0%	0%
Unknown	35%	30%
Hospital-/health system-owned medical practice (not including managed care or HMO)	11%	24%
Independently-owned medical practice	4%	9%
Managed care / HMO practice	8%	3%
Academic health center / faculty practice (residency or university teaching environment)	9%	9%
Federally Qualified Health Center or Look-Alike	16%	9%
Rural Health Clinic (federally qualified)	3%	5%
Indian Health Service	1%	1%
Government clinic, non-federal (e.g., state, county, city, maternal and child health, public health center, etc.)	6%	2%
Federal (Military, Veterans Administration/Department of Defense)	5%	4%
Workplace clinic	2%	2%
Other	1%	1%

WHICH OF THE FOLLOWING BEST DESCRIBES THE ROLE YOU WILL HAVE IN THE OWNERSHIP OF YOUR PRINCIPAL PRACTICE AFTER RESIDENCY

	State N=247	National N=2475
	Pct	Pct
No official ownership stake (100% employed)	70%	79%
Sole owner	1%	2%
Partial owner or shareholder	23%	13%
Self-employed as a contractor (including locums)	6%	4%
Other	0%	1%

APPROXIMATELY HOW MUCH EDUCATIONAL DEBT (UNDERGRADUATE PLUS GRADUATE) DO YOU HAVE

State N=362	National N=3369
Avg	Avg
193,578	204,933

I PLAN ON PERSONALLY PROVIDING THE FOLLOWING CARE AFTER RESIDENCY (SELECT ALL THAT APPLY)	State N=362	National N=3369
	Pct	Pct
Prenatal care	54%	41%
Delivering babies	21%	20%
Newborn hospital care	24%	27%
Pediatric hospital care (not newborn)	9%	18%
Pediatric outpatient care	73%	68%
Adult hospital care	45%	49%
Intensive care/ICU-CCU	9%	14%
Behavioral health care	46%	44%
Complementary & alternative medicine (e.g. acupuncture, massage therapy, etc.)	23%	18%
End of life care	36%	38%
None of the above	11%	10%

Trends

Our Markets Are Changing…

- Consolidation of physician practices in large systems, fewer “smolos”
- Consolidation of payers and plans
- Vertical integration, e.g., Aetna-CVS merger

- Emerging interest in direct primary care
- Increased reliance on telemedicine; will it enhance or replace access?
- Scope of practice battles; will autonomous practice for NPs arrive in California?
- **Will artificial intelligence support physician diagnosis or replace it?**

Will the social contract be re-written?

"Society granted physicians status, respect, autonomy in practice, the privilege of self-regulation, and financial rewards on the expectation that physicians would be competent, altruistic, moral, and would address the health care needs of individual patients and society"

- Cruess RL, Cruess SR. Teaching medicine as a profession in the service of healing. *Acad Med*. 1997;72(11):941-952.