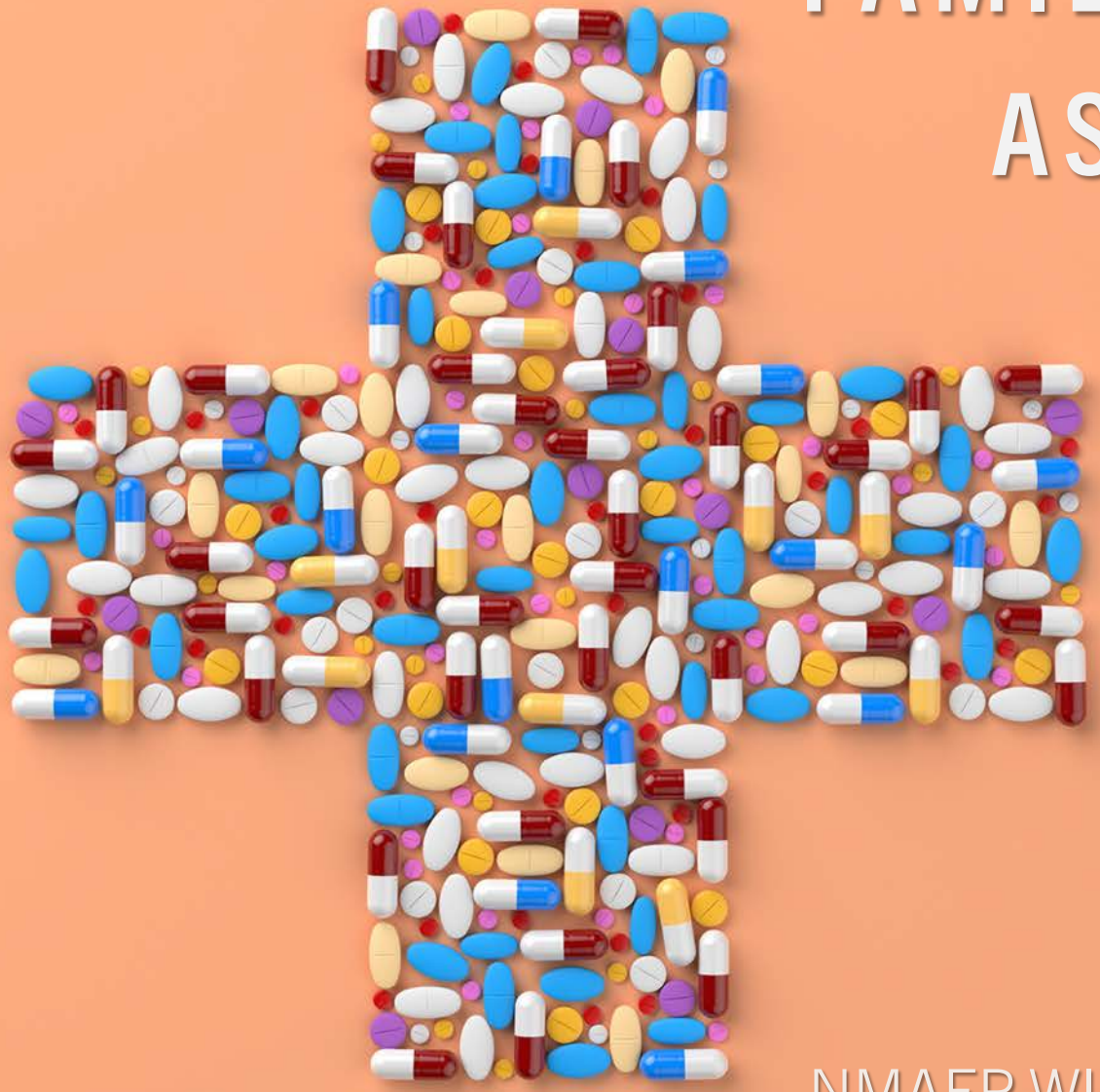
FAMILY MEDICINE AS A COMMON GOOD



NMAFP WINTER REFRESHER 2024

MOLLY MCCLAIN MD MPH

2/12/24

DISCLOSURES- NONE

OBJECTIVES

01

REVIEW "IMPLEMENTING QUALITY PRIMAY CARE"

02

DISCUSS HEALTH AND HUMAN SERVICES RESPONSE

03

CLARIFY HOW MAKING CARE PRIMARY FITS IN

04

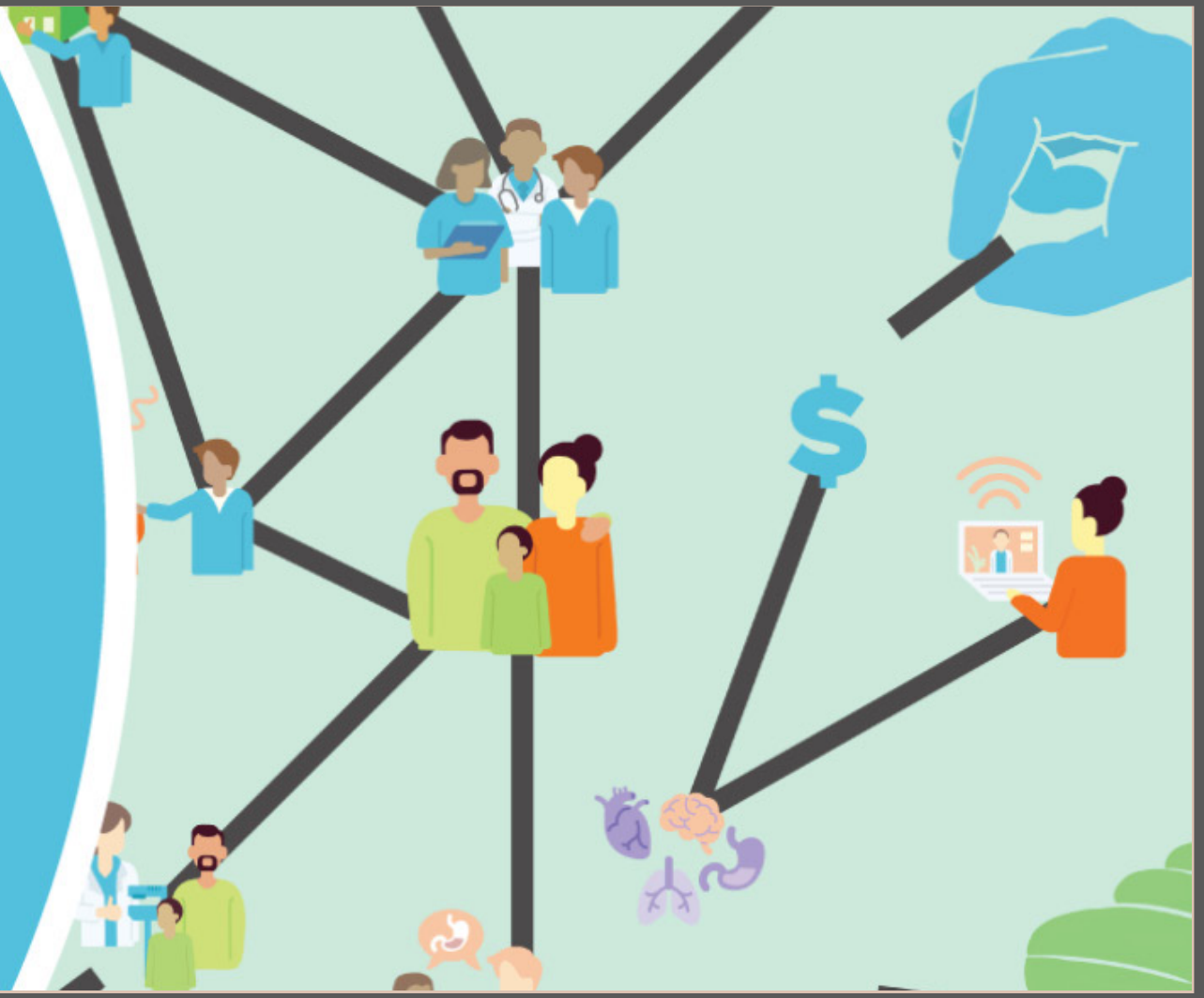
UNDERSTAND HOW NEW ACGME FAMILY MEDICINE REQUIREMENTS SUPPORT THE NASEM FINDING

05

EXAMINE OPPORTUNITIES FOR FAMILY MEDICINE LEADERSHIP, **AGAIN**

Implementing High-Quality Primary Care:

Rebuilding the Foundation of Health Care



5 Objectives for Achieving High-Quality Primary Care

1 PAYMENT
Pay for primary care teams to care for people, not doctors to deliver services.

2 ACCESS
Ensure that high-quality primary care is available to every individual and family in every community.

3 WORKFORCE
Train primary care teams where people live and work.

4 DIGITAL HEALTH
Design information technology that serves the patient, family, and interprofessional care team.

5 ACCOUNTABILITY
Ensure that high-quality primary care is implemented in the United States.

ISSUE BRIEF

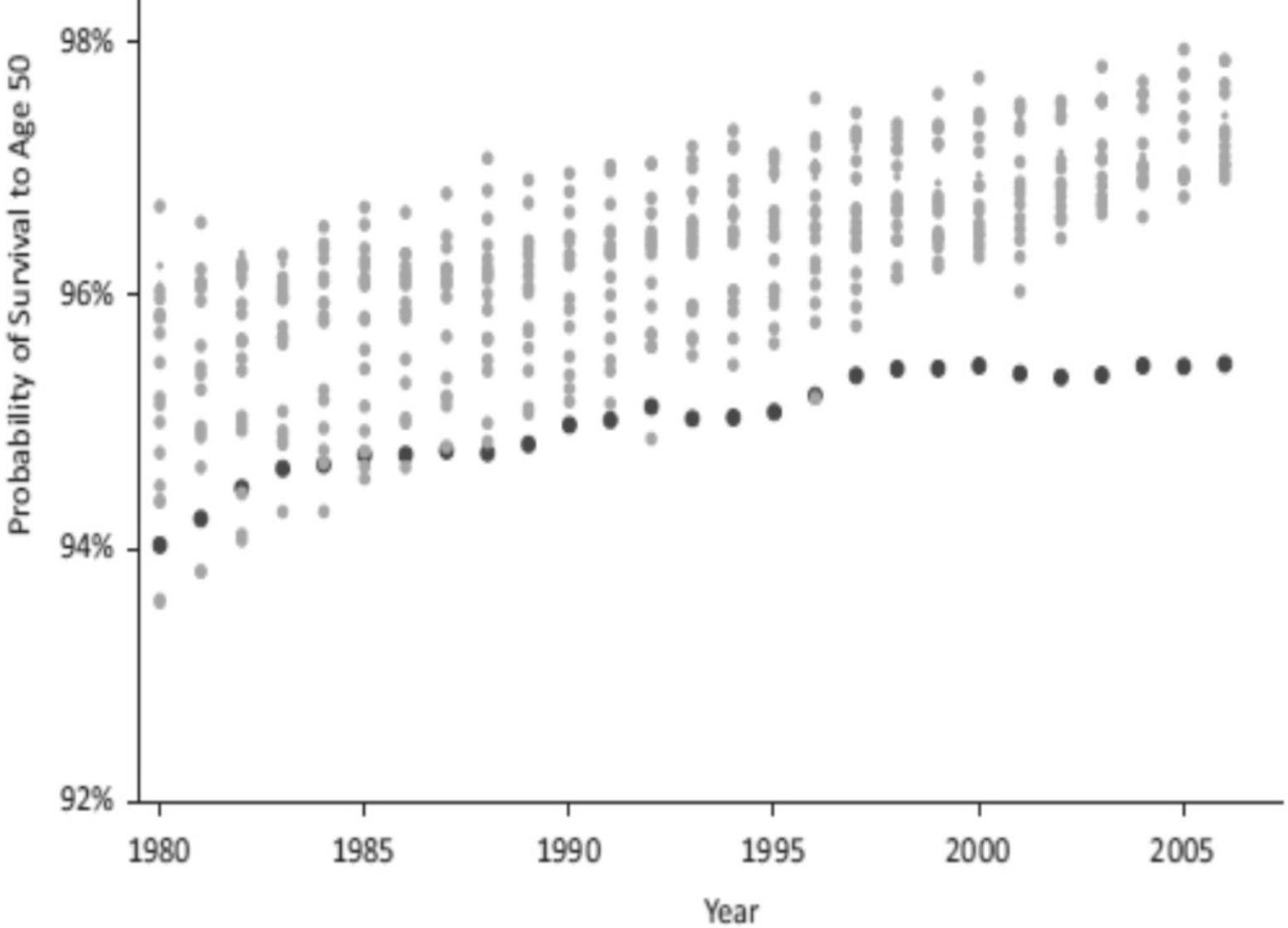
November 7, 2023

HHS IS TAKING ACTION TO STRENGTHEN PRIMARY CARE

MAKING CARE PRIMARY

ACGME ISSUES NEW PROGRAM REQS FOR FM

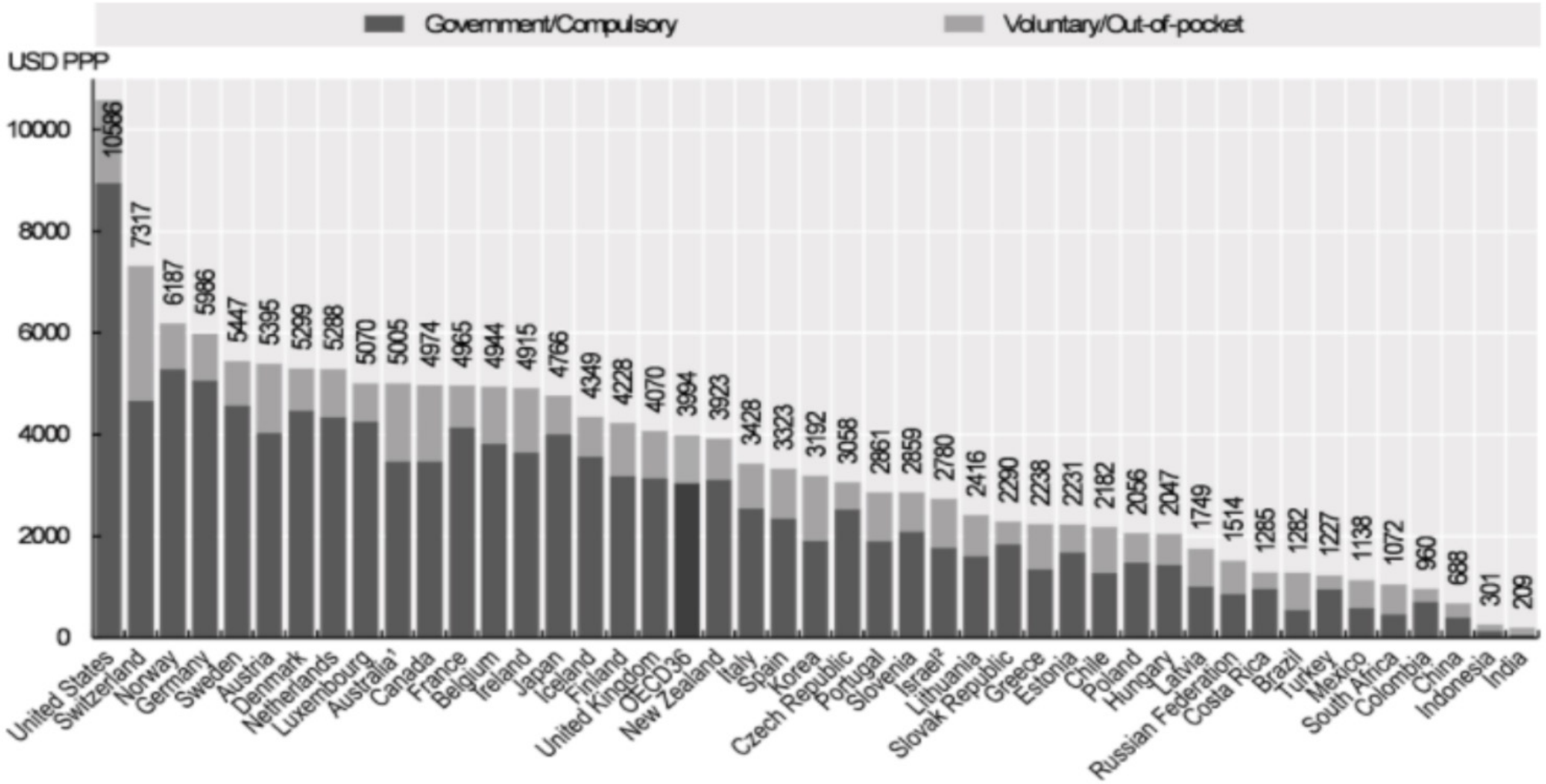
via AAFP NEWS



Probability of survival to age 50 years for females in 21 high-income countries, 1980-2006.

Notes: Black circles show the probability of a newborn female in the United States will live to age 50 years. Grey circles show the probability of survival to age 50 in Australia, Austria, Belgium, Canada, Denmark, Finland, France, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, and West Germany.

Figure 2: OECD Health Expenditures per Capita, 2018 (or Nearest Year)



Note: Expenditure excludes investments, unless otherwise stated.

1. Australia expenditure estimates exclude all expenditure for residential aged care facilities in welfare (social) services. 2. Includes investments.

Source: OECD Health Statistics 2019, WHO Global Health Expenditure Database.

Family Medicine

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SPECIAL ARTICLES

The Time Is Now: A Plan to Redesign Family Medicine Residency Education

Larry A. Green, MD | William L. Miller, MD, MA | John J. Frey III, MD | Hilliard Jason, MD, EdD | Jane Westberg, PhD, MA | Deborah J. Cohen, PhD | Robin S. Gotler, MA | Frank Verloin deGruy, MD, MSFM

Fam Med. 2022;54(1):7-15.
DOI: 10.22454/FamMed.2022.197486

Table 2: Critical Shifts in the Perspectives of Personal Physicians

Transition From →		Transition To	
Paternalism	Knowing better than others	Collaboration	Working in partnership to set and meet patients' health goals
Disease focus	Focus on treating diseases	Person focus	Focus on caring for whole people
Intervention focus	Saving lives	Health care focus	Preserving and restoring health
Heroic physician	Lone ranger	Championship team	Jazz ensemble
Checking boxes	Focus on what is measurable	Fulfilling needs	Focus on what is often immeasurable: relationships, fulfilling diverse needs
Reductionism	Focus on small parts and pieces that may lose relevance for overall health	Generalism	A broad and holistic perspective on peoples' health
Fragmentation	Splicing health care into many silos aligned with professional specialties and disciplines	Integration	Uniting the disciplines and specialties of medical, behavioral, mental, and public health
Producing inequities	Fragmented care aggravates challenges of cost, access, and equity	Reducing disparities	Serves as common integrating source of care for all
Commercialism	Profit, wealth, and competition	Professionalism	Service, health, and collaboration
Hospital ownership	Ownership of primary care practices and top-down management	Hospital partnership	Supporting and collaborating, allowing primary care practices to engage in person- and community-aligned behavior

ANNALS OF FAMILY MEDICINE™

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Editorial | Editorial

Time for Family Medicine to Stop Enabling a Dysfunctional Health Care System

Kurt C. Stange

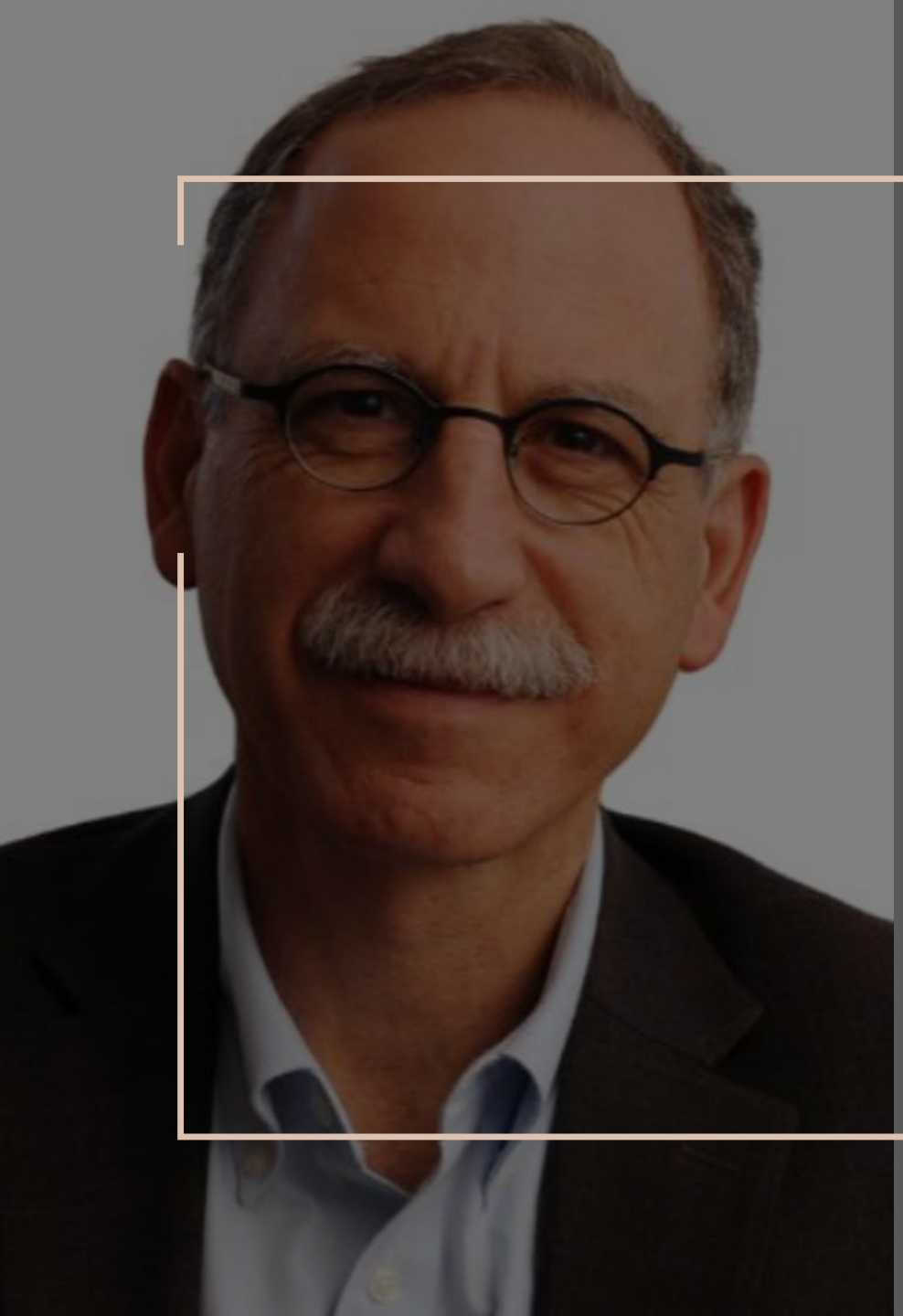
The Annals of Family Medicine May 2023, 21 (3) 202-204; DOI: https://doi.org/10.1370/afm.2981

REFLECTION

Forging a Social Movement to Dismantle Entrenched Power and Liberate Primary Care as a Common Good

Kevin Grumbach, MD

Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California, San Francisco, San Francisco, California



1. Primary care is a common good
2. Market-based systems are inimical to the common good of primary care
3. Professionalism has two sides in this conversations
4. Family Medicine must embrace its roots with a "counterculture professionalism" to work with others to restructure the healthcare system and democratize health

- WE SEE THE NEED EVERY DAY
- BECAUSE OF SYSTEM CONSTRAINTS WE CAN'T HELP OUR PATIENTS
- PATCHES WE'VE TRIED HAVE MADE THINGS WORSE
- MODELS AND MOTIVATION TO DO IT DIFFERENTLY EXIST
- WE NEED TO DEMAND BETTER

George Gayle Stephens

"Medicine is a moral vocation that is practiced best when patients have a personal physician who can help them get what they need from the larger system in a manner that does not demean or exploit them, a personal physician who is able and willing to attend to their patients' life experiences and individual preferences."


THANK YOU