Family Medicine Education in Kansas

January 27, 2016
Topeka, Kansas

Medical Education Timeline

- Admission process
- Medical School
  - Basic Sciences (years 1 and 2)
  - Clinical Sciences (years 3 and 4)
- Residency
- Continuing Medical Education

Medical Education Timeline

- **Admission process**
- Medical School
  - Basic Sciences (years 1 and 2)
  - Clinical Sciences (years 3 and 4)
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Medical Education Timeline

- Admission process
- **Medical School**
  - **Phase 1: Basic Sciences (years 1 and 2)**
  - Phase 2: Clinical Sciences (years 3 and 4)
- Residency
- Continuing Medical Education

Medical School Phase 1 Rotations

Year 1

- Foundation of Medicine
- Genetics and Neoplasia
- Inflammation and Immunity
- Cardiopulmonary
- Gastrointestinal and Nutrition
- Renal and Endocrine
- Reproduction and Sexuality

Year 2

- Musculoskeletal and Soft Tissue
- Brain and Behavior
- Blood and Lymph
- Infectious Diseases
- Integration and Consolidation

Phase 1
New Concepts in Medical Education

- Distance video lectures
- Small group teaching
- Problem – based learning groups
- Early introduction to direct patient care
- Emphasis on history-taking, physical examination and communication skills
- Standardized patients

Medical Education Timeline

- Admission process
- Medical School
  - Basic Sciences (years 1 and 2)
  - **Clinical Sciences (years 3 and 4)**
- Residency
- Continuing Medical Education

Medical School Clinical Rotations

- 3rd year students
  - Family medicine
  - Geriatrics
  - Internal Medicine
  - Obstetrics/Gynecology
  - Pediatrics
  - Psychiatry
  - Surgery
- 4th year students
  - Rural Rotation
  - Subinternship
  - Intensive Care
  - Electives

“The Match”

Medical Education Timeline

- Admission process
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  - Basic Sciences (years 1 and 2)
  - Clinical Sciences (years 3 and 4)
- **Residency**
- Continuing Medical Education

Family Medicine Residency Programs in Kansas

- Kansas City (KU Medical Center)
- Wichita
  - –Smoky Hill (Salina)
  - –Via Christi
  - –Wesley

Family Medicine Education

- All programs are accredited
- 3 years
- KC has 24 family medicine residents
- Wichita has 96 family medicine residents
- Recognized nationally for clinical education
- Top residents
- Top faculty

The first family medicine residency program in the United States started in 1967.
In what city was it established?

The first family medicine residency program started in 1967.
In what city was it established?

Wichita, Kansas 67214

What does a family medicine resident do?


KU
WICHITA


KANSAS JAYHAWKS

Why have residency programs?

- Train new doctors for Kansas
- Improves quality of care
- Culture of inquiry
- Attracts other physicians to Kansas

How are we doing?

Best Medical Schools: Primary Care

Ranked in 2015 | Best Medical Schools: Primary Care Rankings Methodology

A medical career starts with finding the program that best fits your needs. With the U.S. News rankings of the top medical schools for primary care, narrow your search by location, tuition, school size and test scores.

For full rankings, MCAT scores and student debt data, sign up for the U.S. News Medical School Compass!

Primary care rank	School name	Tuition	Total medical school enrollment
#1	University of Washington Seattle, WA	$31,992 (in-state, full-time); $60,978 (out-of-state, full-time)	938
#2	University of North Carolina—Chapel Hill Chapel Hill, NC	$18,887 (in-state, full-time); $45,766 (out-of-state, full-time)	827
#3	University of California—San Francisco San Francisco, CA	$32,106 (in-state, full-time); $44,351 (out-of-state, full-time)	664
#4	University of Nebraska Medical Center Omaha, NE	$27,992 (in-state, full-time); $69,632 (out-of-state, full-time)	515
#5 Tie	Oregon Health and Science University Portland, OR	$39,196 (in-state, full-time); $55,740 (out-of-state, full-time)	526
#5 Tie	University of Michigan—Ann Arbor Ann Arbor, MI	$31,154 (in-state, full-time); $48,862 (out-of-state, full-time)	727

#19 Tie	University of California—Davis Sacramento, CA	$34,874 (in-state, full-time); $47,119 (out-of-state, full-time)	437
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#19 Tie	University of California—San Diego La Jolla, CA	$31,134 (in-state, full-time); $43,379 (out-of-state, full-time)	502
#19 Tie	University of Chicago (Pritzker) Chicago, IL	$47,673 (full-time)	356
#19 Tie	University of Hawaii—Manoa (Burns) Honolulu, HI	$33,216 (in-state, full-time); $67,200 (out-of-state, full-time)	270
#19 Tie	University of Pittsburgh Pittsburgh, PA	$48,792 (in-state, full-time); $50,014 (out-of-state, full-time)	601
#19 Tie	Washington University in St. Louis St. Louis, MO	$56,212 (full-time)	474
#25 Tie	East Carolina University (Brody) Greenville, NC	$16,576 (in-state, full-time)	313
#25 Tie	Stanford University Stanford, CA	$50,715 (full-time)	473
#25 Tie	University of Kansas Medical Center Kansas City, KS	$32,523 (in-state, full-time); $57,583 (out-of-state, full-time)	828
#25 Tie	Vanderbilt University Nashville, TN	$45,350 (full-time)	429

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Family Medicine

THE OFFICIAL JOURNAL OF THE SOCIETY OF TEACHERS OF FAMILY MEDICINE

SPECIAL ARTICLES

Entry of US Medical School Graduates Into Family Medicine Residencies: 2014–2015

Stanley M. Kozakowski, MD; Gerald Fetter Jr, MSA; Ashley Bentley, MBA

BACKGROUND AND OBJECTIVES: This is the 34th national study conducted by the American Academy of Family Physicians (AAFP) that reports retrospectively the percentage of graduates from US MD-granting and DO-granting medical schools who entered Accreditation Council for Graduate Medical Education (ACGME)-accredited family medicine residency programs as first-year residents in 2014. Approximately 8.5% of the 18,241 students graduating from US MD-granting medical schools between July 2013 and June 2014 entered a family medicine residency. Of the 1,458 graduates of the US MD-granting medical schools who entered a family medicine residency in 2014, 80% graduated from 69 of the 131 schools. Eleven schools lacking departments or divisions of family medicine produced only a total of 26 students entering family medicine. In aggregate, medical schools west of the Mississippi River represent less than a third of all US MD-granting schools but have an aggregate rate of students selecting family medicine that is two-thirds higher than schools to the east of the Mississippi. A rank order list of US MD-granting medical schools was created based on the last 3 years' average percentage of graduates who became family medicine residents, using the 2014 and prior AAFP census data. US MD schools continue to fail to produce a primary care workforce, a key measure of social responsibility as measured by their production of graduates entering into family medicine. DO-granting and international medical school graduates filled the majority of ACGME-accredited family medicine first-year resident positions in 2014.

(Fam Med 2015;47(9):712-6.)

This is the 34th national study conducted by the American Academy of Family Physicians (AAFP) that reports retrospectively the percentage of graduates from Liaison Committee on Medical Education (LCME)-accredited, hereafter called US MD-granting, and of American Osteopathic Association (AOA)-accredited, hereafter called DO-granting medical schools, who enter Accreditation Council for Graduate Medical Education (ACGME)-accredited family medicine residency programs as first-year residents. Data from the AAFP's annual census of these family medicine residency programs and the LCME Annual Medical School Questionnaire Part II are used to analyze the US medical school origin of each student entering into a family medicine residency as a first-year resident.[1] This annual report is one measure of the effectiveness of medical schools to produce a primary care workforce, a key measure of social responsibility as measured by their production of graduates entering into family medicine. Medical schools that have higher entrance rates into family medicine residencies exhibit "positive deviance" from their peers and can enable others to discover uncommon strategies to implement solutions to increase student choice of primary care, particularly family medicine.

Methods

The AAFP conducts an annual online census of all residents in ACGME-accredited family medicine residency programs. This study reports on the data from the 2014 survey. Among the data collected is a list all first-year residents and their medical school, including the month and year of graduation. Residency programs that failed to respond to the initial survey were contacted by email or telephone to ensure a 100% response rate to the

From the Medical Education Division, American Academy of Family Physicians, Leawood, KS.

STFM Entry of US Medical School Graduates Into Family Medicine Residencies: 2014–2015

Table 2: Ranked Order of Medical Schools Based on the Last 3 Years' Average Percentage of Graduates Who Were Family Medicine Residents, by Type of Administrative Structure, 2014

Medical School	Percent	Administrative Structure
North Dakota, University of	20.8%	Department
Kansas, University of	19.7%	Department
Minnesota, University of	18.8%	Department
East Carolina University	18.5%	Department
Washington, University of	17.6%	Department
Oregon Health & Sciences University	16.9%	Department
Florida State University	16.2%	Department
Missouri, Columbia, University of	16.0%	Department
Wisconsin, University of	15.9%	Department
California, Irvine, University of	15.8%	Department
New Mexico, University of	15.8%	Department
Wright State University	14.9%	Department
Oklahoma, University of	14.8%	Department
Texas Tech University	14.2%	Department
Arkansas, University of	14.2%	Department
Nebraska, University of	13.9%	Department
South Dakota, University of	13.9%	Department
Colorado, University of	13.9%	Department
Southern Illinois University	13.8%	Department
Loma Linda University	13.8%	Department

http://www.stfm.org/FamilyMedicine/Vol47Issue9/Kozakowski712

The Social Mission of Medical Education: Ranking the Schools

Fitzhugh Mullan, MD; Candice Chen, MD, MPH; Stephen Petterson, PhD; Gretchen Kolsky, MPH, CHES; and Michael Spagnola, BA

Background: The basic purpose of medical schools is to educate physicians to care for the national population. Fulfilling this goal requires an adequate number of primary care physicians, adequate distribution of physicians to underserved areas, and a sufficient number of minority physicians in the workforce.

Objective: To develop a metric called the social mission score to evaluate medical school output in these 3 dimensions.

Design: Secondary analysis of data from the American Medical Association (AMA) Physician Masterfile and of data on race and ethnicity in medical schools from the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine.

Setting: U.S. medical schools.

Participants: 60 043 physicians in active practice who graduated from medical school between 1999 and 2001.

Measurements: The percentage of graduates who practice primary care, work in health professional shortage areas, and are underrepresented minorities, combined into a composite social mission score.

Results: The contribution of medical schools to the social mission of medical education varied substantially. Three historically black colleges had the highest social mission rankings. Public and community-based medical schools had higher social mission scores than private and non–community-based schools. National Institutes of Health funding was inversely associated with social mission scores. Medical schools in the northeastern United States and in more urban areas were less likely to produce primary care physicians and physicians who practice in underserved areas.

Limitations: The AMA Physician Masterfile has limitations, including specialty self-designation by physicians, inconsistencies in reporting work addresses, and delays in information updates. The public good provided by medical schools may include contributions not reflected in the social mission score. The study was not designed to evaluate quality of care provided by medical school graduates.

Conclusion: Medical schools vary substantially in their contribution to the social mission of medical education. School rankings based on the social mission score differ from those that use research funding and subjective assessments of school reputation. These findings suggest that initiatives at the medical school level could increase the proportion of physicians who practice primary care, work in underserved areas, and are underrepresented minorities.

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For author affiliations, see end of text.

Medical schools in the United States serve many functions, but one of their most basic purposes is to educate physicians to care for the national population. During the latter half of the 20th century, with federal and state support, medical education expanded to meet population needs (1). However, 3 specific interrelated issues challenged medical educators and policymakers: an insufficient number of primary care physicians, geographic maldistribution of physicians, and the lack of a representative number of racial and ethnic minorities in medical schools and in practice.

As early as the 1950s, commissions concerned with the medical workforce in the United States issued reports that raised these concerns (2–4). These reports helped launch legislation beginning with the Health Professions Educational Assistance Act of 1963 that provided support for expansion of medical education with particular attention to primary care, physician distribution, and educational opportunities for minority medical students. The National Health Service Corps, created in 1970, provided scholarships for students who committed to practice in underserved communities. Of the 28 allopathic medical schools opened with the aid of substantial state and federal support between 1970 and 1982, the Association of American Medical Colleges designated 17 as community-based (Salsberg E. Personal communication).

Nevertheless, problems in these 3 areas remain. Evidence increasingly shows that primary care is associated with improved quality of care and decreased medical costs (5, 6). However, an insufficient number of primary care physicians has hampered efforts to provide expanded health care access in states, such as in Massachusetts (7), and business groups and insurers have begun to speak out about the need for increased access to primary care (8).

Rural communities have a chronic shortage of physicians (9, 10), and federally supported community health centers report major deficits in physician recruitment (11, 12). African-American, Hispanic, and Native-American physicians continue to be severely underrepresented in the U.S. workforce. Underrepresented minorities made up 28% of the general population in 2006 (13) but accounted for only 15% of medical students and 8% of physicians in practice (14). These minority physicians provide a dispro-

See also:

Print
Editorial comment 818

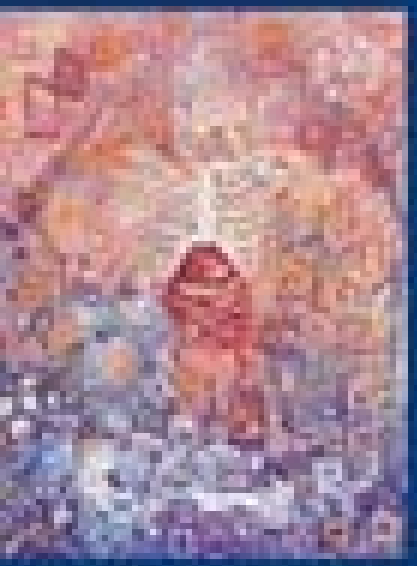
Web-Only
Appendix

Table 1. **Medical School Rankings Based on Social Mission Score***

Rank	School	State	Social Mission
Highest 20			
1	Morehouse School of Medicine	GA	13.98
2	Meharry Medical College	TN	12.92
3	Howard University	DC	10.66
4	Wright State University Boonshoft School of Medicine	OH	5.34
5	University of Kansas	KS	4.49
6	Michigan State University College of Human Medicine	MI	4.13
7	East Carolina University Brody School of Medicine	NC	3.72
8	University of South Alabama	AL	3.15
9	Ponce School of Medicine	PR	3.02
10	University of Iowa Carver College of Medicine	IA	2.97
11	Oregon Health & Science University	OR	2.93
12	East Tennessee State University Quillen College of Medicine	TN	2.88
13	University of Mississippi	MS	2.86
14	University of Kentucky	KY	2.61
15	Southern Illinois University	IL	2.59
16	Marshall University Joan C. Edwards University	WV	2.51
17	University of Massachusetts Medical School	MA	2.48
18	University of Illinois	IL	2.27
19	University of New Mexico	NM	2.25
20	University of Wisconsin	WI	2.24

ACADEMIC MEDICINE

Journal of the Association of American Medical Colleges



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 purpose of this study was to develop and test candidate GME outcome measures related to physician workforce.

Method
The authors performed a secondary analysis of data from the American Medical Association Physician Masterfile, National Provider Identifier file, Medicare 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 period, although this is an overestimate because hospitalists could not be excluded. Of 759 sponsoring institutions, 158 produced no primary care graduates, and 184 produced more than 80%. An average of 37.9% of internal medicine residents were retained in primary care, including hospitalists. Mean general surgery retention was 38.4%. Overall, 4.8% of graduates practiced in rural areas; 198 institutions produced no rural physicians, and 283 institutions produced no Federally Qualified Health Center or Rural Health Clinic physicians.

Conclusions
GME outcomes are measurable for most institutions and training sites. Specialty and geographic locations vary significantly. These findings can inform educators and policy makers during a period of increased calls to align the GME system with national health needs.

Editor's Note: Commentaries by R.B. Baron and L.M. Famiglia, M.A. Thompson, and D.F. Kupas will appear with this article in the September issue.

Graduate Medical Education (GME) plays a key role in the makeup of the U.S. physician workforce, and it represents the largest public investment in health workforce development through Medicare, Medicaid, and other federal funding. Yet, the physician workforce is struggling to meet the nation's health care needs, particularly in primary care and geographically underserved areas. Amid increasing calls for greater accountability in the GME system, we propose a method for examining institutional GME outcomes that can ultimately inform future education and policy decisions.

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Background

The GME system dictates the overall size and specialty mix of the U.S. physician workforce. With few exceptions, physician licensing in every state requires at least one year of U.S. GME. Therefore, the total availability of U.S. training positions defines the overall size of the physician workforce, and the number of GME training positions available for each specialty effectively determines the number of individuals who can pursue a career in that specialty. The location of GME programs affects long-term practice locations because physicians tend to locate in the same geographic area as their residency,[1–3] and exposure to rural and underserved settings during GME increases the likelihood of continuing to work with these populations after graduation.[4–7]

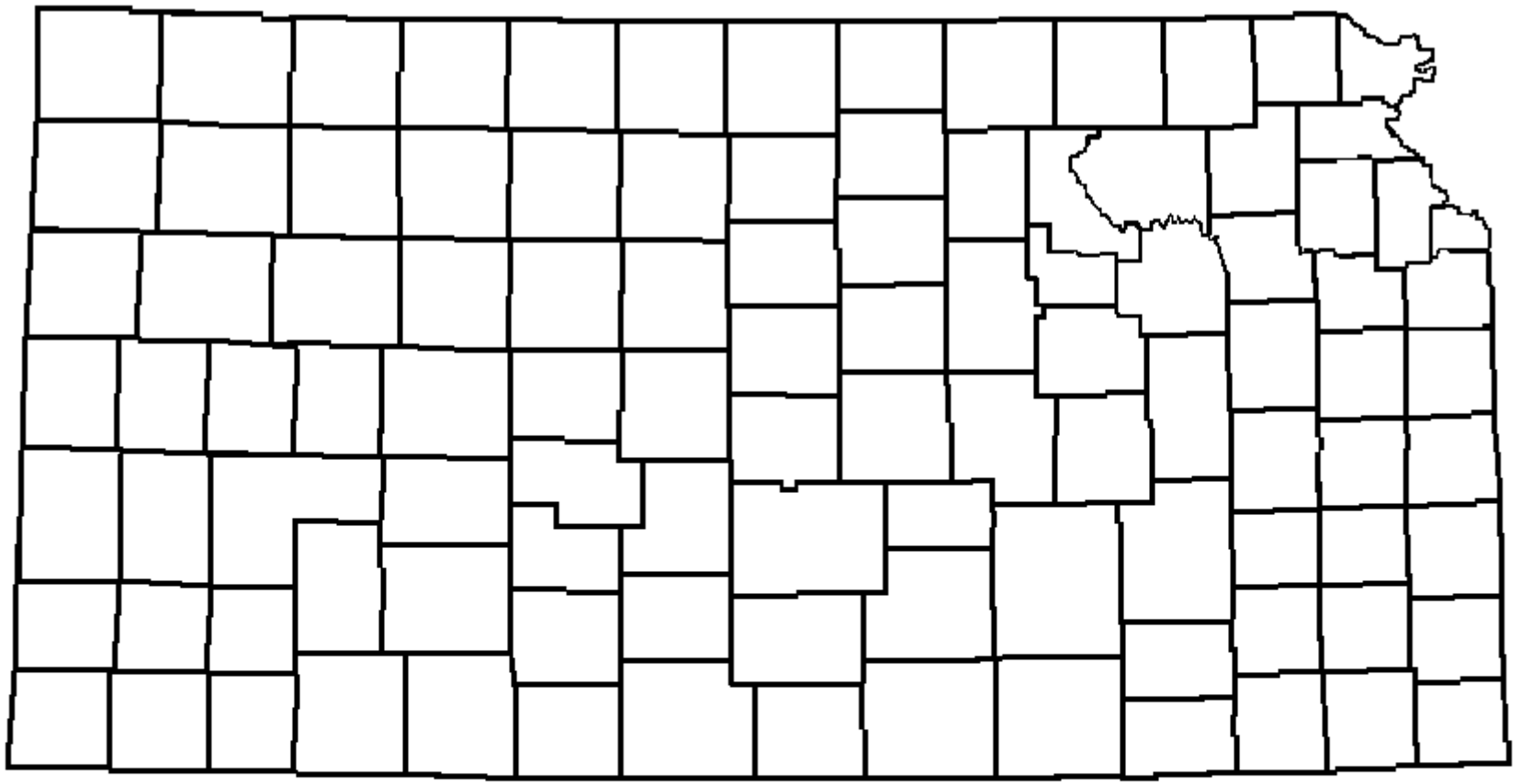
GME has been publicly funded since the passage of Medicare in 1965. In 2009, Medicare contributed $9.5 billion[8] to GME. Medicaid provided an additional $3.18 billion.[9] These two contributions represent the largest public investment in U.S. health workforce development.[10] Despite this public investment, physician shortages in certain specialties, including primary care, general surgery, and psychiatry, and in rural and underserved areas, persist.[11–18] These shortages limit access to care, and a growing number of studies suggest that health systems built on strong primary care bases improve quality and constrain the cost of health care.[19–22] Even with good evidence that the composition of the physician workforce affects access, quality, and cost, federal GME funding is provided without specialty training expectations or requirements to evaluate training outcomes.

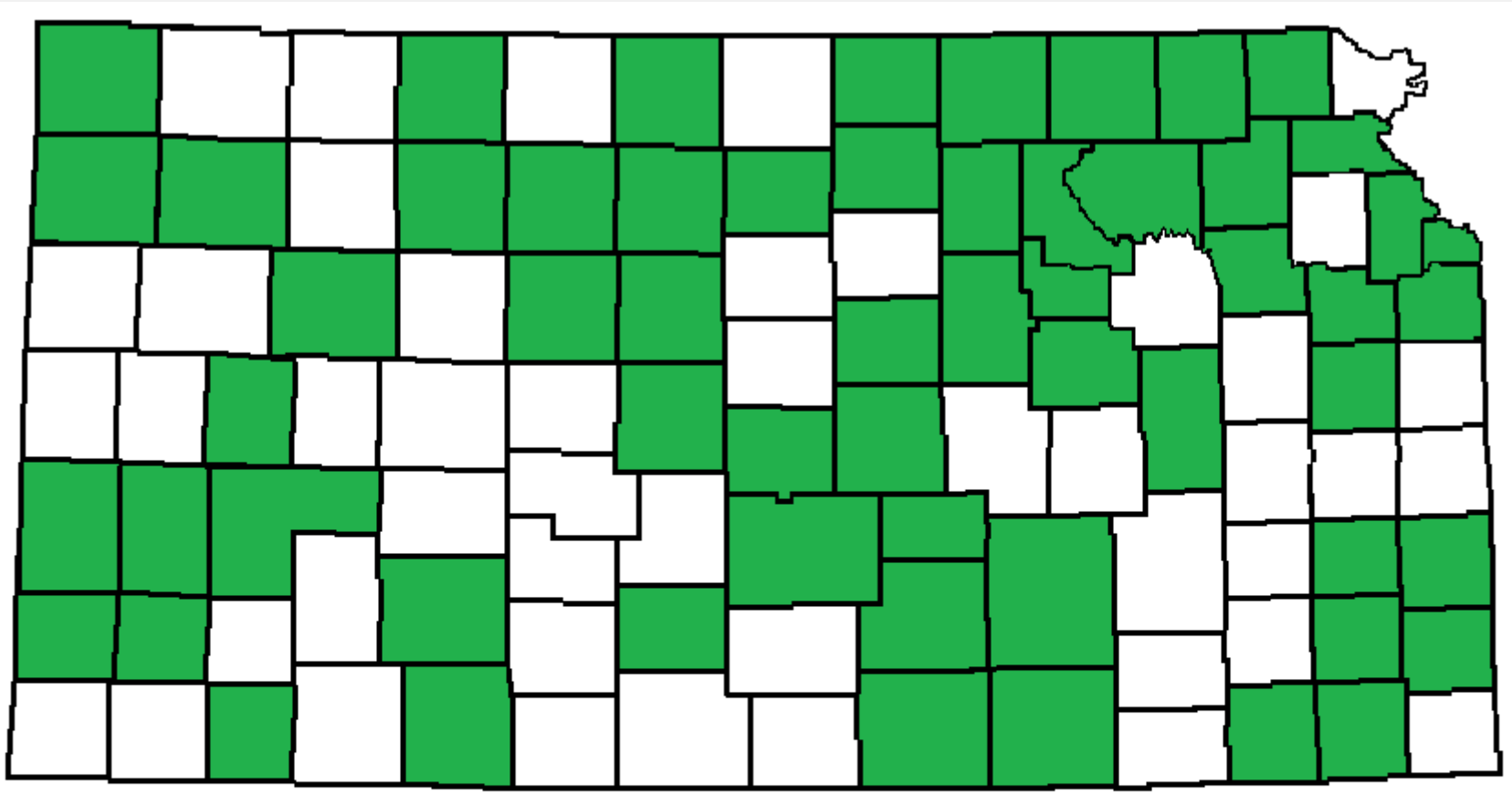
As early as 1965 and as recently as 2011, advisory bodies have recommended that GME be more accountable to the public's health needs.[23–25] In 2010, there

Appendix 1

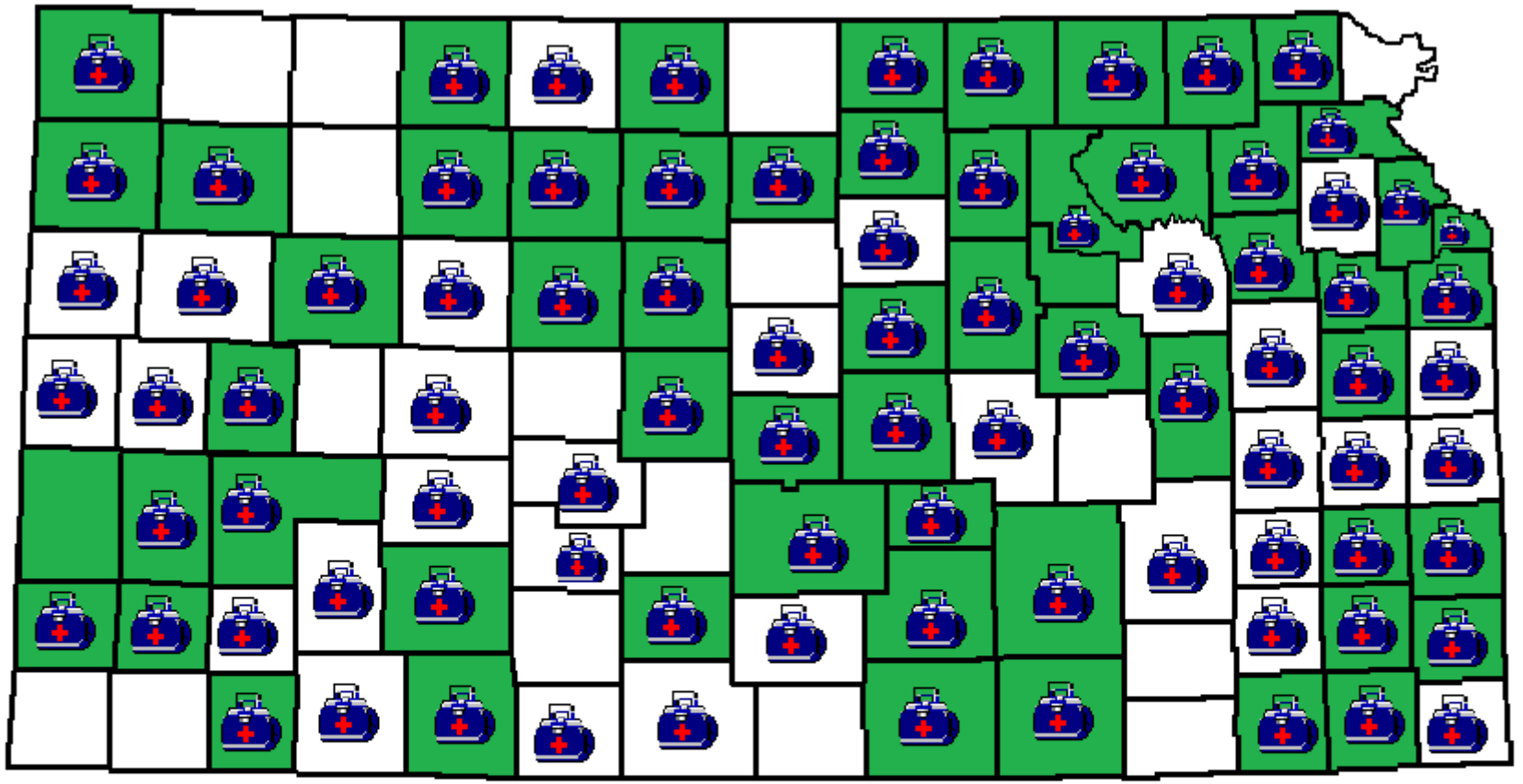
Outcomes of the Top and Bottom Producers of Primary Care Graduates, U.S. Graduate Medical Education Sponsoring Institutions With More Than 200 Graduates Between 2006 and 2008

Sponsoring institution	Location	Total no. of graduates	No. of specialties trained	No. (%) in primary care	% Retained in general internal medicine	No. in general surgery	No. in psychiatry	No. in obstetrics–gynecology	No. in an HPSA*,†	No. in a rural area*,†	No. in an FQHC*	No. in an RHC*	No. in the NHSC*
Top producers of primary care graduates													
1. University of Nevada School of Medicine	Reno, Nev	239	11	129 (54.0)	56.64	8	18	11	42	11	5	4	1
2. Bronx-Lebanon Hospital Center	Bronx, NY	286	12	143 (50.0)	75.25	16	8	14	47	19	20	4	1
3. Kaiser Permanente Southern California	Los Angeles, Calif	286	16	140 (49.0)	37.25	8	1	15	21	3	3	0	0
4. Brooklyn Hospital Center	Brooklyn, NY	227	9	109 (48.0)	57.14	15	1	13	35	14	2	1	0
5. James H. Quillen College of Medicine	Johnson City, Tenn	240	12	113 (47.1)	37.50	15	10	8	47	40	14	5	1
6. University of Kansas School of Medicine (Wichita)	Wichita, Kan	233	11	108 (46.4)	45.45	14	12	15	83	46	4	27	3
7. Atlantic Health	Florham Park, NJ	244	10	110 (45.1)	55.10	12	1	1	20	6	4	0	1
8. UCSF Fresno Medical Education Program	Fresno, Calif	206	9	86 (41.8)	35.06	9	15	8	25	6	1	5	1
9. Advocate Lutheran General Hospital	Park Ridge, Ill	205	11	85 (41.5)	34.04	0	7	9	18	5	6	1	1
10. Kaiser Permanente Medical Group	Oakland, Calif	227	4	94 (41.4)	46.47	0	1	32	9	2	2	0	2
11. University of Illinois College of Medicine at Peoria	Peoria, Ill	201	13	78 (38.8)	28.85	7	0	7	75	20	4	7	2
12. New York Methodist Hospital	Brooklyn, NY	256	14	98 (38.3)	47.58	10	0	12	25	7	2	0	0
13. Southern Illinois University School of Medicine	Springfield, Ill	268	22	98 (36.6)	22.39	2	7	11	72	43	14	14	3
14. Long Island College Hospital	Brooklyn, NY	203	7	72 (35.5)	37.74	0	1	11	20	8	2	1	0
15. Wright State University School of Medicine	Dayton, Ohio	340	18	120 (35.3)	70.33	25	21	19	67	18	3	0	1
16. Eastern Virginia Medical School	Norfolk, Va	313	24	109 (34.8)	39.68	5	12	12	31	26	4	0	3
17. Grand Rapids Medical Education Partners	Grand Rapids, Mich	278	14	93 (33.5)	82.35	14	0	25	40	19	7	1	2
18. Brookdale University Hospital and Medical Center	Brooklyn, NY	257	10	85 (33.1)	59.38	9	11	15	54	12	4	0	1
19. Good Samaritan Regional Medical Center	Phoenix, Ariz	239	15	79 (33.1)	47.25	10	10	21	59	7	1	4	4
20. Pitt County Memorial Hospital	Greenville, NC	321	28	106 (33.0)	51.79	4	14	16	51	31	4	4	2





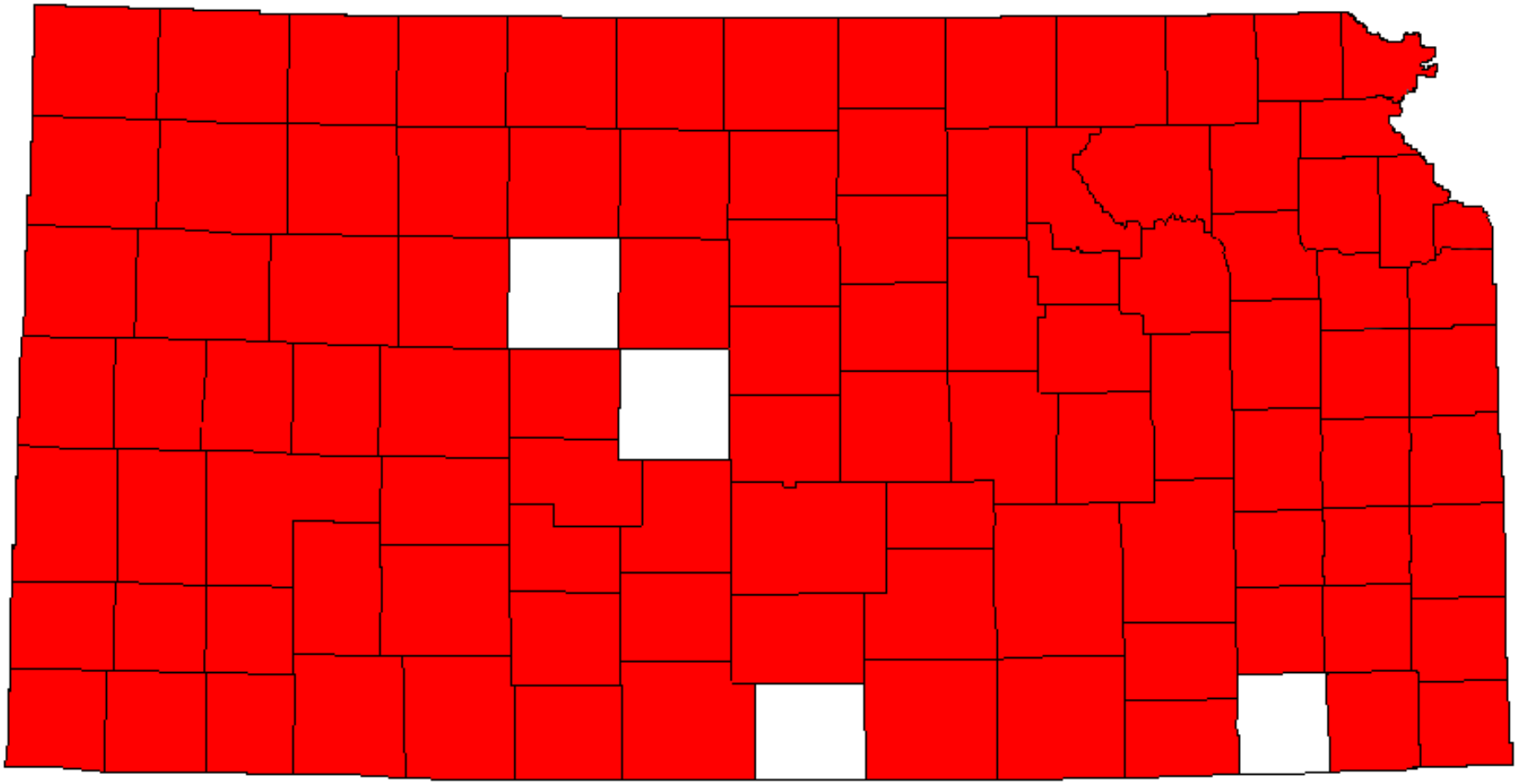
Hospital that had a birth in 2015



Hospital that had a birth in 2015

Family Physician located in this county

Primary Care Underserved Areas in Kansas



Governor designated underserved areas for Primary Care

Location of Family Medicine Physician