St. George's University
THINK BEYOND

Building a Medical School Around Social Missions

NAFSA Global Learning Colloquium on Education for the Health Professions
Denver, CO

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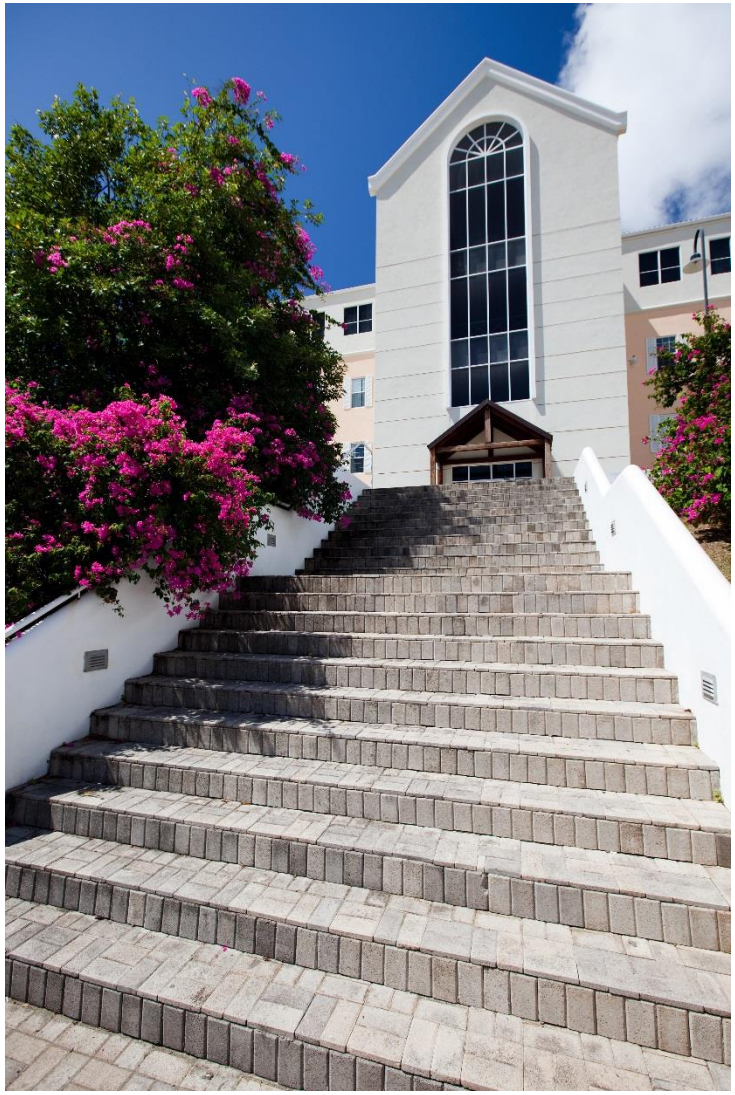
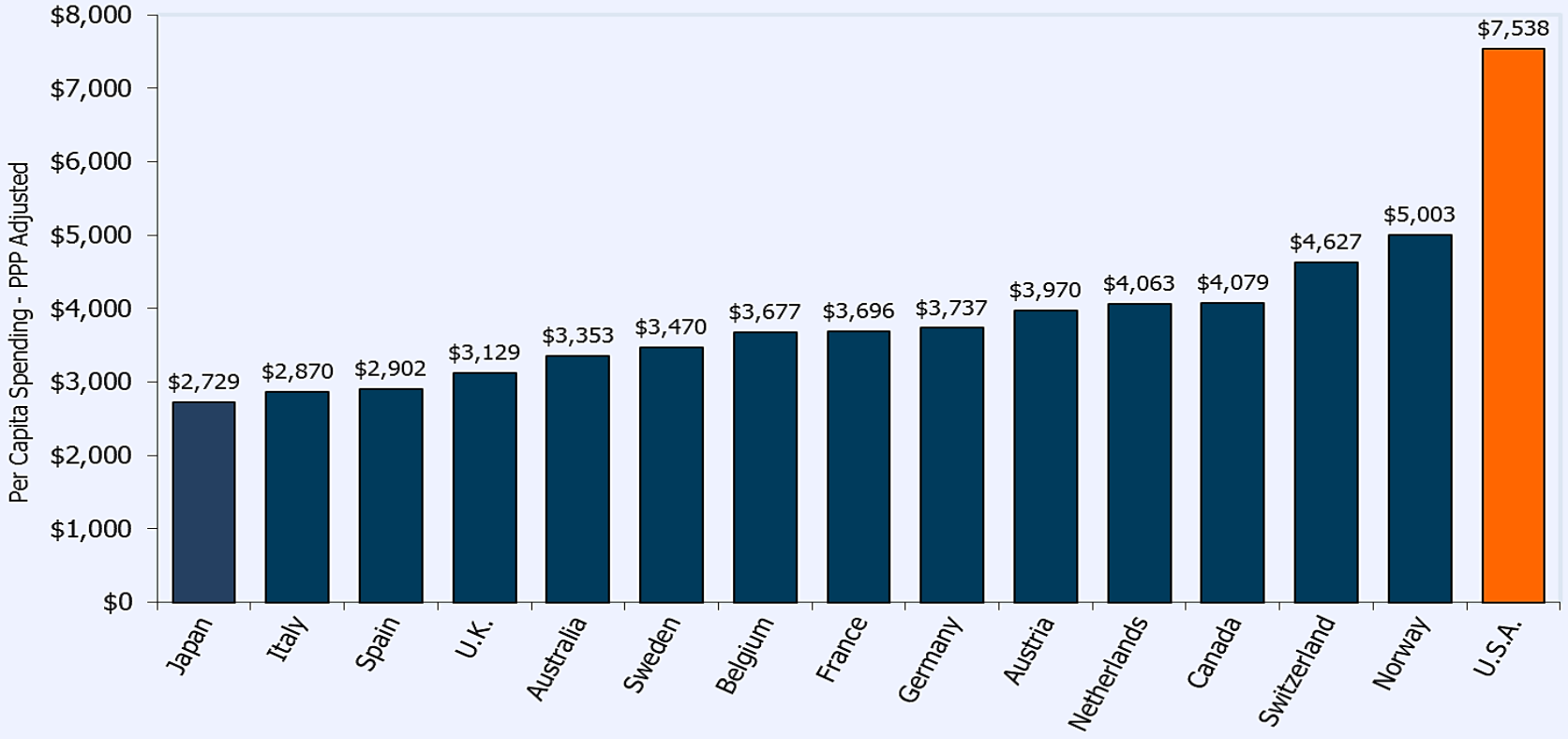
How well are current U.S. Medical Schools addressing our country's current health care needs and our projected national doctor shortage?



Total Health Expenditure per Capita, U.S. and Selected Countries, 2008



Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2011).
Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted.

Life and Health in America

- Shorter
  - Life Expectancy, Tied for 30th
- Costly
  - $6,102 per person ($2,552 avg.)
- Chronically ill
  - $1.1 trillion annually lost productivity
  - $277 billion direct medical expense

White KL, Williams TF, Greenberg BG. The ecology of medical care. N Engl J Med 1961;265:885–892.
Green LA, Fryer GE, Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. N Engl J Med 2001;344:2021–2025.

Healthcare Inequality

- Asian-American Woman in Bergen County v. Native American Male in South Dakota
  - 33 Years
- Metro Ride in DC
  - 1.5 years per mile (total 20 years)
- Males in Bangladesh v. African American Males in Harlem
- Recent Latino Immigrants (best health outcomes)

We Need Greater Value

- Costa Rica has 1/25th the per capita GNP but out-performs the U.S. in all health care benchmarks
- Focus on prevention and wellness
- Focus on cost-effective interventions
- Enhanced access
- Eliminate waste and redundancy
- Higher quality for less cost

Nationally, the AAMC projects that by 2025 the U.S. will face a doctor shortage of between 46,000 and 90,000 physicians

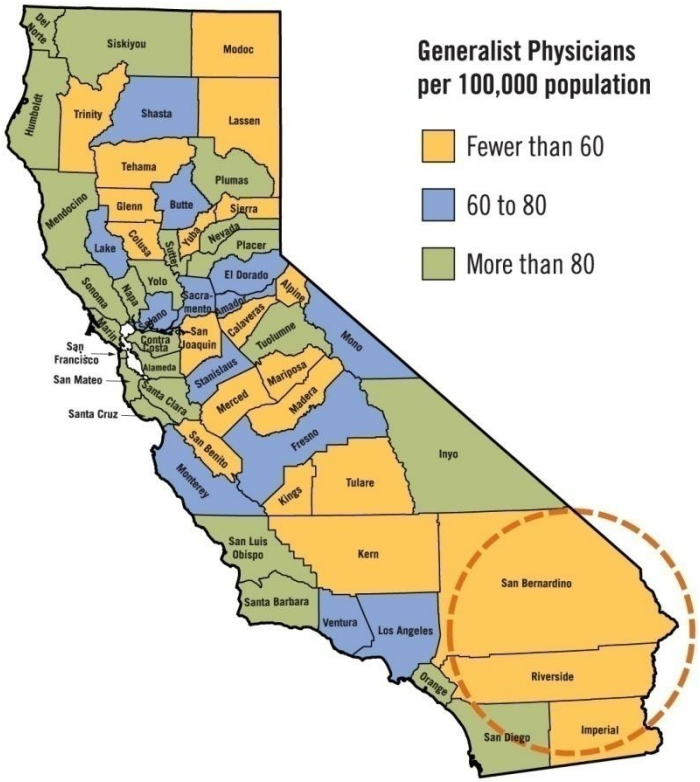
- Is the doctor shortage our society's greatest healthcare manpower problem?
- No, it's a maldistribution of doctors geographically and a maldistribution of specialties.

Inland Southern California

- Riverside and San Bernardino counties
  - Geographically larger than West Virginia
  - 4.4 million people, projected to grow 21% by 2030
  - Racial/ethnic diversity – 47% Hispanic/Latino and 7% African American (CA as a whole: 38% Hispanic/Latino and 6% African American)
- Region fares poorly in health outcomes relative to other CA counties
  - San Bernardino County ranks poorest in CA for deaths due to diabetes
  - Riverside County ranks 50th in deaths due to coronary heart disease

Physician Supply in California

- California has a marked <u>maldistribution</u> of physicians. Only a third of the residency training slots per capita than either New York or Massachusetts
- Inland Southern California has a shortage of every type of physician but plastic surgeons and only about half the recommended level of primary care physicians
  - Physician workforce does not reflect the racial/ethnic diversity of the region
  - More than 40% of physicians are 55 years and older, thus nearing retirement
  - Affordable Care Act will add about 500,000 newly insured patients, further stressing an overtaxed system

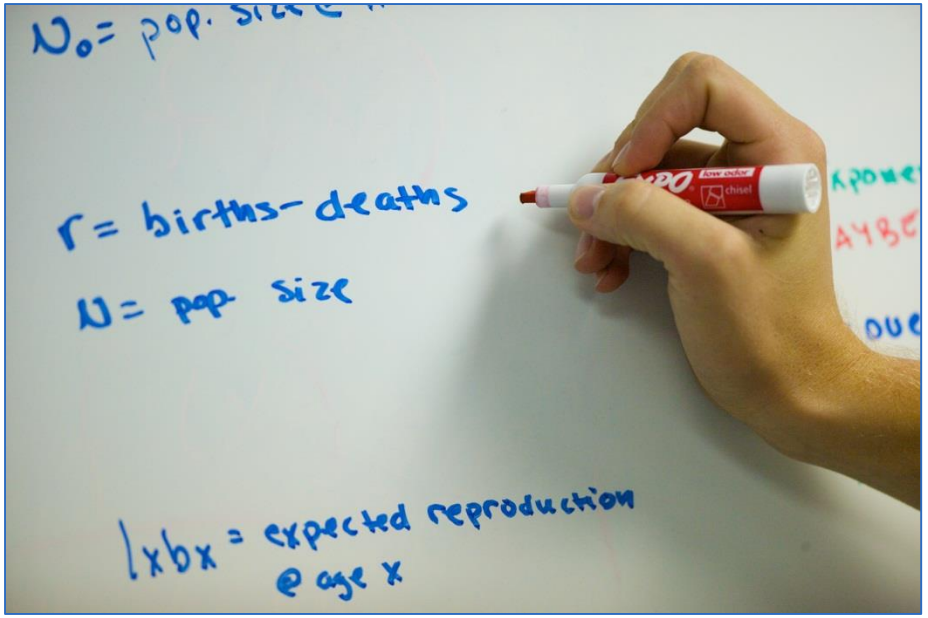


Educational Paradigm Shift Needed

- …in how we are selecting our future physicians
- …in the subject matter we are teaching them
- …in the training methods we are using
- …in the settings where physicians are training

Subject Matter

- Wellness and prevention
- Evidence-based medicine
- Cost effectiveness and value
- Population Health
- Chronic disease management



Training Methods

- Early involvement in clinical care and contextual learning
- Simulation/virtual environments
- Patients as teachers (OSCE)
- Team training & evaluation
- Intra professional training
- The best way to learn is to teach
- Must learn to work in a more electronic environment

Training Settings

- Ambulatory vs. in-patient
- Active vs. passive learning
- Patient advocate
- Work your way up
- Keeping students in our region for residency training (in addition to medical school)
- Importance of professionalism in the training environment
- Adopt a community and a practice, not just patients

UCR School of Medicine was chartered by the California Regents with several unique social missions

Missions of the UCR Medical School

- Expand and diversify physician workforce in our region
  - Key determinants of practice location: where physician grows up and finishes residency
  - Create pipeline programs to increase the pool of applicants
  - Train students and residents in the settings you want them to ultimately practice in
  - Create new residency programs in our community

Missions of the UCR Medical School

- Produce doctors who go into the fields we need
  - Select students with this orientation
  - Have most clinical teaching faculty come from these fields
  - Emphasis on primary care, ambulatory-based education
  - Identify other specialties in particular short supply in our region
  - Create new residency training programs in these specific fields
  - Create mission-based scholarships

Missions of the UCR Medical School

- Diversity
  - Define our own diversity
  - More than ethnic diversity
  - 80% of U.S. medical students come from top 2/5^{ths} of economic status. Less than 5% come from the bottom 5th.
  - Unique selection process
  - Doctors who come from the background of their patients are better able to change behaviors and deal with unique social barriers to health
  - By 2013 class was 48% disadvantaged, 42% underrepresented, 66% from Inland SoCal

Missions of the UCR Medical School

- Improve the health of the communities we serve
  - Collaborative vs. Competitive model
  - Create the only community-based medical school in California
  - Public health infused into curriculum
  - Change research focus: Center for Healthy Communities
  - Emphasis on prevention, wellness, chronic disease management, population health, cultural competency, quality and process improvement
  - No university hospital; the community is our training and research platform

Expanding GME

- Real choke point for training new physicians today
- 1997 CMS capped GME positions in existing teaching hospitals
- Despite this, GME size is expanding slowly but mostly in specialties that are lucrative for hospitals, not specialties in short supply
- There is a pool of new GME positions available to GME-naïve hospitals

Expanding GME cont.

- A typical 350-bed GME naïve hospital with 35% Medicare patients and 25% Medicaid patients would get $145,000 per resident per year in direct and indirect GME reimbursement, for running moderate-sized GME programs (60-80 residents)
- Through ACA, FQHC's can become teaching health centers with new GME funding
- FQHC's can allocate up to 25% teaching effort per faculty member in it's wrap around reimbursement
- Today UCR has two Family Medicine, two Primary Care, two Internal Medicine, General Surgery, OB/GYN, Primary Care Pediatrics, and Psychiatry. New residency training on 300 residents.

St. George's University

- Established in 1976, oldest Caribbean Medical School, located in Grenada
- Now comprehensive University with 7,000 students
- 1% of all practicing M.D's in the U.S. are St. George's graduates
- 2 years in Grenada, 2 years in primarily community hospitals in the U.S. and England
- All our student core rotations must be in an ACGME accredited site

St. George's University con't

- 97% of St. George's medical graduates pass step one on the first attempt
- 90% of our U.S. students at St. George match into an ACGME-accredited residency each year
- 71% of graduates go into Primary Care vs. 39% of U.S. Medical School graduates
- St. George's graduates practice more in underserved areas of the U.S. than U.S. graduates
- St. George's graduates see 18% Medicaid patients vs. 10% for U.S. graduates

Where do St. George's University students come from

- Students come from all 50 states, District of Columbia, and several territories
  - 21% California
  - 18% New York
  - 10% New Jersey
  - 9% Florida
  - 5% Texas

- Our students largely come from a lower socioeconomic background, and we have more ethnic diversity among our student body than most U.S. medical schools but not as much as UCR.
- St. George is already a international medical school with students from 140 different countries (25% of student body)

My vision for St. George's University

- Do what I planned to do at UCR on a national scale
- Look for areas with physician shortages and partner with local community hospitals and FQHC's to address the issue
- Specifically recruit students from the geographic areas surrounding a target community with the help of our local partners
- After two years in Grenada, students return to do 3rd and 4th year rotations near home
- Create new GME in specialties that are in specific short supply in that area with partners and fill them with SGU students

We believe that St. George's University is doing more today to address our nation's physician manpower needs than any other university in the world, and we plan to do an even better job in the future

Questions and Discussion

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