Successful Primary Care Programs: Creating the Workforce We Need

submitted for the record to the

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by the

Association of American Medical Colleges

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The Association of American Medical Colleges (AAMC) is pleased to submit this statement to the record for the April 23, 2013, hearing, “Successful Primary Care Programs: Creating the Workforce We Need,” of the Health, Education, Labor, and Pensions (HELP) Subcommittee on Primary Health and Aging.

AAMC is a not-for-profit association representing all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians.

The AAMC applauds Subcommittee Chair Bernie Sanders and Ranking Member Richard Burr for continuing their attention to the gaps in access that will occur as the demand for health care services exceeds the supply of physicians and other health professionals over the next few years. As has been widely reported, and as was described in the Subcommittee’s January 29 hearing, the nation faces a shortage of 91,500 physicians in the next decade, a consequence of an aging patient population battling multiple chronic conditions; an influx of up to 32 million newly insured individuals entering the health care system with previously untreated conditions; and attrition in the physician workforce as current practitioners near retirement.

The deficit of physicians spans evenly across both primary and specialty care, with shortages of over 45,000 primary care physicians and 46,000 specialists expected by 2020. Medical schools already have taken the first critical step to address this increased demand, enrolling by 2016, 30 percent more students compared to 2002.

Notwithstanding recent upticks in the number of medical graduates opting to pursue primary care, some have expressed concern about the level of interest in primary care careers (even among pre-medical students) and its implications, given projected shortages. In addition to the noteworthy efforts of The Brody School of Medicine at East Carolina University; the Frank H. Netter, M.D., School of Medicine at Quinnipiac University; and Morehouse School of Medicine, a number of AAMC-member institutions across the country have undertaken initiatives to facilitate interest in primary care careers. In accordance with the theme of this hearing, the AAMC offers through this statement a broad overview of these programs to supplement the testimony of the three witnesses from AAMC-member institutions. In light of the pressing health needs of the rapidly increasing Medicare population, the AAMC hopes the Subcommittee next will schedule a subsequent hearing that explores the similarly surging demand for specialty care.

Despite the best efforts of medical schools to increase the number of matriculates, such action will have a negligible effect on reversing physician shortages – in either primary or specialty care – unless Congress permits a proportionate increase in federal support for graduate medical education (GME) training positions at teaching hospitals. The limited availability of residency positions – the direct result of a cap Congress imposed in 1997, freezing Medicare support for GME at 1996 levels – soon will preclude medical graduates from completing the supervised training required for independent practice.

According to the National Resident Matching Program, in the 2013 Match, 528 qualified U.S. medical school graduates did not match to a residency training position and 99.4 percent of
positions were filled. Only 5 family medicine positions, 6 internal medicine positions, 2 pediatrics positions, 10 preliminary general surgery positions, 7 psychiatry positions, and 31 positions in a handful of other specialties remained unfilled at the conclusion of the Match and the Supplementary Offer and Acceptance Program. Regardless of a medical graduate’s specialty choice, he or she will not be able to complete the training required for independent practice unless a sufficient number of training positions is available across specialties. Thus, successfully bolstering the number of both primary care and specialty care physicians will rely on Congressional action to expand Medicare support for training positions at teaching hospitals.

Accordingly, this statement also highlights legislation recently introduced in both chambers to release this bottleneck. The “Resident Physician Shortage Reduction Act of 2013” (S. 577/H.R. 1180) and the “Training Tomorrow’s Doctors Today Act” (H.R. 1201) will be a critical element of any comprehensive national workforce strategy. Other federal programs also play a key role in promoting primary care practice. The AAMC encourages the Subcommittee to continue its longstanding tradition of support for investments in the health care workforce and to work with the Senate Finance Committee, as well as the House Ways & Means and Energy & Commerce Committees, in advancing S. 577/H.R. 1180/H.R. 1201, in the interest of improving access to care for all patients.

**Medical Schools Are Actively Responding to the Nation’s Workforce Needs**

In 2005, the Liaison Committee on Medical Education (LCME) fully accredited a new medical school for the first time since 1986, bringing the total number of medical schools to 125. Today, after two decades of no growth, the total number of medical schools stands at 141, paralleled by increases in class sizes at existing medical schools. The proliferation of medical education programs predates enactment of the Affordable Care Act (ACA, P.L. 111-148 and P.L. 111-152), rather reflecting a recognition that the Baby Boomers soon would confront ailments common to old age – ranging from Alzheimer’s disease and dementia to heart disease to hip fractures – and the physician supply would not be sufficient to meet their needs. Extending health care coverage to as many as 32 million previously uninsured individuals through the ACA amplifies these looming physician shortages and heightens the urgency to address them.

Guided by both the benefit and challenge of building a new educational program from scratch, the new medical schools are proving eager to pursue curricular innovations to help address both national and local needs. Prevalent themes among this new cohort include early clinical experiences for students, curricular structures that integrate the basic and clinical sciences, emphasis on interprofessional educational opportunities, and case-based learning. Schools also are reporting novel approaches to advancing their specific missions, such as Cooper Medical School of Rowan University, which requires students to complete 40 hours annually of non-medical community service in the school’s neighborhood of Camden, N.J. While the mission of each medical school necessarily differs, many of the new schools report an emphasis on primary care.

Profiles of these new institutions are featured in the November 2012 AAMC report, *A Snapshot of the New and Developing Medical Schools in the U.S. and Canada*, available at: [https://members.aamc.org/eweb/upload/A%20Snapshot%20of%20the%20New%20and%20Devel](https://members.aamc.org/eweb/upload/A%20Snapshot%20of%20the%20New%20and%20Devel)
Continued study and analysis of their efforts over time will help inform opportunities to further shape medical education and the culture of medical practice.

Existing medical schools also have implemented creative initiatives to address challenges as they evolve, including some specifically targeted to promoting primary care. In a 2010 survey of medical school deans, 75 percent (94 of 125 respondents) reported current or future plans to institute programs or policies to encourage student interest in primary care. Two-thirds of those 94 schools reported refined admissions criteria and 60 percent reported expanded primary care faculty and/or resources. Most also reported new or expanded extracurricular opportunities (87 percent); new, expanded, or modified clinical rotations (74 – 73 percent); modified pre-clinical curricula (71 percent); and other activities (19 percent).

The Duke University School of Medicine officially launched the Primary Care Leadership Track in 2011 after a two-year pilot phase. The program combines community service, experience, and requires a year of community-engaged research, with a goal of preparing physicians to work with and learn from communities to improve care delivery and produce better outcomes. Similarly, the University of California, San Francisco (UCSF), School of Medicine administers the Program in Medical Education for the Urban Underserved (PRIME-US), an effort that is not a dedicated primary care track, though the majority of participants enter primary care disciplines. The program aims to produce leaders to care for urban underserved communities and embeds community-based participatory research among students’ experiences.

Some medical schools have established rural or small-town regional campuses that serve as fully functional branches of the main campus. Groups of students receive their entire four years of undergraduate medical education, or the bulk of their clinical experience, at the rural site. For example, the Columbia University College of Physicians and Surgeons in New York began accepting students in the fall of 2011, for a new rural medicine track in partnership with Bassett Healthcare System in the upstate New York village of Cooperstown. For the first 18 months of medical school, students in the Columbia-Bassett program attend core “foundations of medicine” classes at Columbia’s northern Manhattan campus, then move to Cooperstown, a town of only 2,000, for longitudinal clinical experiences. The University of Kansas School of Medicine, Indiana University School of Medicine, and the Texas Tech Health Sciences University in Lubbock – among others – boast similar programs.

Other institutions are building new models for primary care in the face of changing demographics and health care challenges. The Warren Alpert Medical School of Brown University is developing a novel dual-degree Primary Care and Population Health program to ensure graduates understand the clinical, behavioral, and public health contexts of patient care. Expected to begin in fall 2015, the four-year M.D./Sc.M. program would allow students to follow patients through their various interactions with the health care system by engaging in nine-month, physician practice-based clerkships. The experiences are designed to help students learn not only the medical knowledge necessary for quality care, but also public health policy, leadership skills, and familiarity with practice as part of a broader patient-care team.

At the national level, the AAMC has partnered with other health education associations through the Interprofessional Education Collaborative (IPEC) to focus on better integrating and
coordinating the education of nurses, physicians, pharmacists, dentists, public health professionals and other members of the patient health care team to provide more collaborative and team-based care. A growing body of work demonstrates that shared learning experiences of this sort can improve health outcomes. Supported by funding from the Macy Foundation, IPEC recently awarded funding to 16 interprofessional teams to accelerate education content refinement and submission for peer review to AAMC’s free, web-based MedEdPORTAL database, which will serve as a national clearinghouse of competency-linked learning resources for IPE and models of team-based or collaborative care. To date, interest in IPEC’s faculty development institutes has been so strong that registration reaches capacity only hours after opening.

In graduate medical education, too, a number of institutions have successfully incorporated key attributes of the Patient-Centered Medical Home (PCMH) model of care into their delivery system while serving as a training site for medical residents and other health professionals. In early 2010, the AAMC, in collaboration with representatives of the Society of General Internal Medicine (SGIM) and the American College of Physicians (ACP), designed a survey that was distributed to AAMC member institutions, asking participants to identify residency programs that have integrated into their care system infrastructural or workforce transformations commonly associated with the medical home. Respondents to the survey described a high level of team-based care consisting of physician and non-physician clinicians, as well as care coordinators, social workers, PharmD's, and nutritionists. Practices also noted enhanced access and communication, significant quality monitoring and improvement activities, and near unanimous access to electronic health records technology. Seven high-performing practices (including The Brody School of Medicine Department of Family Medicine) were profiled in the AAMC’s November 2010 publication, Moving the Medical Home Forward: Innovations in Primary Care Training and Delivery. The full report is available at: https://members.aamc.org/eweb/upload/Moving%20the%20Medical%20Home%20Forward.pdf.

The examples cited here are by no means exhaustive. While all medical schools are committed to producing primary care physicians in accord with the nation’s needs, it is also important to note that each medical education program is responsible for establishing a curriculum aligned with its own institutional missions and educational objectives within the framework of general competencies required for accreditation by the LCME. Medical schools serve society in many ways – they conduct groundbreaking medical research that helps address the health needs of all patients; they provide vital community services such as geriatric care, nutrition counseling, health clinics, and free screenings for the uninsured and underinsured; and they work to improve medical care not only for Americans, but also for disadvantaged populations globally. Measuring their contributions to society solely through their efforts to cultivate interest in primary care overlooks the vital role that many of these institutions play in advancing other essential components of quality health care.

Moreover, the AAMC strongly supports the ability of individual medical students and physicians to determine for themselves which area of medicine they wish to pursue. While medical schools actively carry out their responsibility to present an array of rich educational experiences across disciplines of medicine, ultimately, each individual student must determine the specialty that best suits his or her personal and career goals. Education and training cannot overcome the intense market incentives that influence physician choices.
Expanding the Physician Workforce Relies on Congress Lifting the Cap on GME Support

Before medical graduates can practice independently, they must complete advanced supervised training in the form of a residency at a teaching hospital. But, as described above, Congress has limited the availability of training positions by freezing Medicare support for GME at 1996 levels. Though medical schools will be graduating more medical students to respond to the increased demand, the overall number of physicians is likely to remain the same without Congressional action. This bottleneck will thwart efforts to expand both the primary care and specialty care workforce.

Medicare Supports GME to Ensure Access to Physicians and to Highly Specialized Services for Medicare Beneficiaries

Physician training is inextricable from patient care, and Medicare historically has paid for its share of the costs of training and the highly sophisticated health services provided by teaching hospitals. Medicare reimburses teaching hospitals for a portion of these costs.

Direct Graduate Medical Education (DGME) payments are intended to offset the direct costs of GME, such as resident stipends and benefits; supervising faculty salaries and benefits; and allocated institutional overhead costs. These payments are tied directly to a program’s “Medicare share,” an institution-specific amount that reflects Medicare volume as a percent of patient care days at the institution. According to FY 2009 Medicare cost reports (www.HealthData.gov), Medicare DGME payments reimbursed less than one quarter of the total direct costs teaching hospitals incurred in 2009. The training costs above Medicare’s share are borne primarily by the program itself.

Medicare DGME payments are not limited to teaching hospitals; currently, community health centers and other teaching settings are eligible for DGME payments that, like teaching hospitals, are calculated based on the facility’s Medicare share. Congress repeatedly has clarified that Medicare GME support should remain tied to the level of Medicare services provided, rather than diverting limited Medicare funds to providers that do not treat a substantial number of Medicare beneficiaries.

Teaching hospitals also receive Medicare Indirect Medical Education (IME) payments, but these are patient care payments that recognize the additional costs incurred by teaching hospitals because they maintain specialized services and treat the most complex, acutely ill patients. For example, AAMC member teaching hospitals operate 80 percent of Level 1 Trauma centers, 79 percent of all burn care units, 40 percent of neonatal- and 61 percent of pediatric ICUs, nearly half of surgical transplant services, and provide a range of other highly sophisticated services not offered elsewhere in communities. Compared with physician offices and other hospitals, major teaching hospitals care for patients that are sicker, poorer, and more likely to be disabled or non-white. IME payments are meant to partially offset these costs. Providers that do not incur the unique patient care costs associated with caring for highly complex, severely ill inpatients (i.e., ambulatory sites that largely provide primary, non-acute care) do not qualify for these payments.
The current caps on physician training were imposed at a time when most researchers predicted that the delivery system would change rapidly and drastically under the influence of tightly managed care. Today, the health care delivery system is in a time of significant transformation with numerous federal, state, and private efforts under way to improve coordination and quality of care, increase access, and reduce cost—which may have a significant impact on demand for physician services. It is too early to know the short- or long-term effect these nascent efforts will have on our future workforce needs, but these changes will take years to come to fruition. In the interim, it would be irresponsible to ignore the nation’s expanding health care needs. As demonstrated in Massachusetts, expanding insurance coverage leads to an initial increase in utilization of both primary and subspecialty care.

**Legislation Introduced Recently Would Strengthen the Primary and Specialty Care Workforce by Lifting the Freeze on Medicare GME Support**

Senators Bill Nelson and Chuck Schumer and Majority Leader Harry Reid recently introduced the “Resident Physician Shortage Reduction Act of 2013” (S. 577) to expand physician training support. The measure is accompanied by a bipartisan companion (H.R. 1180) in the House, introduced by Reps. Joe Crowley and Michael Grimm, as well as a similar bill, the “Training Tomorrow’s Doctors Today Act” (H.R. 1201), introduced by Reps. Aaron Schock and Allyson Schwartz. While there are some differences among the bills, all three would increase the number of residency slots by 15,000 over five years, directing half of the newly available positions to training in shortage specialties. The bills also specify priorities for distributing the new slots, such as prioritizing states with new medical schools and hospitals that emphasize training in community health centers, community-based settings, or hospital outpatient departments.

AAMC strongly supports these bills, which are consistent with the policy recommendations AAMC outlined in its statement submitted to the record for the Subcommittee’s January 29 hearing. With over 99 percent of current residency positions filled in the 2013 Match, any efforts to augment the number of practicing physicians of any specialty will rely on the availability of additional training positions. Further, proposals to undermine support to teaching hospitals threaten to weaken the nation’s physician training capacity at the most inopportune time.

It also should be noted that attempts to increase physicians in targeted specialties by reducing training of other specialists will impede access to care. Approximately half (or 13,000) of first-year residency training positions are in family medicine, internal medicine, and pediatrics; while many of these residents will go on to subspecialize, the number of fellowship (or subspecialty) training positions accounts for approximately 20 percent of all available GME slots. Attempting to force physicians to forgo subspecialty training by limiting fellowship opportunities would have limited effect and, even if successful, would jeopardize timely access to care for patients who require a subspecialist. Past attempts to influence specialty selection through Medicare GME payments have failed, leading the Medicare Payment Advisory Commission (MedPAC) to promote other mechanisms, such as clinical reimbursement, the National Health Service Corps (NHSC) and Title VII health professions education and training programs, instead.
Investments Are Necessary in Other Federal Programs That Promote Primary Care

Many claim prohibitive debt levels lead medical students to choose careers other than primary care, but surprisingly little evidence supports this assertion. In fact, a thorough review of the academic literature shows little to no connection between debt and specialty choice. Rather, studies show specialty choice is a complex and personal decision involving many factors. According to AAMC’s annual survey of graduating medical students, the most important factors are a student’s personal interest in a specialty’s content and/or level of patient care; desire for the “controllable lifestyle” offered by some specialties; and the influence of a role model in a specialty. Student debt consistently ranks toward the bottom of the list for this question every year. Additional discussion of such influences is included in the recent report, *AAMC Physician Education Debt and the Cost to Attend Medical School: 2012 Update*, available at: https://www.aamc.org/download/328322/data/statedebtreport.pdf.

Further, federal programs, such as the NHSC, offer incentives to help physicians manage their debt. A January 2013 study in *Academic Medicine* found that “physicians in all specialties, including primary care, can repay the current median level of education debt. At the most extreme borrowing levels … options exist to mitigate the economic impact of education debt repayment. These options include an extended repayment term or federal loan forgiveness/repayment program,” such as Income Based Repayment, Public Service Loan Forgiveness, and the NHSC. Continued investment in the NHSC and other programs designed to encourage practitioners toward primary care practice is another key component to an optimal federal workforce strategy.

**National Health Service Corps (NHSC)**

Administered by the Health Resources and Services Administration (HRSA), the NHSC provides scholarships and loan repayment to health professionals in exchange for practicing primary care in federally designated health professions shortage areas (HPSAs). The program is widely recognized—both in Washington and in the underserved areas it helps—as a success on many fronts. The NHSC improves access to health care for the growing numbers of rural and urban underserved Americans; provides incentives for practitioners to enter primary care; and reduces the financial burden that the cost of health professions education places on new practitioners.

By the end of FY 2013, the NHSC expects to have provided scholarships and loan repayment to over 44,400 health professionals committed to providing care to underserved communities over its 41-year history. In 2012, NHSC clinicians working at NHSC sites provided primary health care to 10.4 million underserved people in HPSAs. In spite of the NHSC’s success, there are still over nearly 55 million people living in 5,900 primary care HPSAs. It would take nearly 7,550 physicians to eliminate these primary care HPSAs.

The NHSC State Loan Repayment Program (SLRP) is a grant program which offers a dollar-for-dollar match for State loan repayment programs. Unfortunately, the NHSC SLRP is redundantly limited to matching the funding of state programs that address the same workforce shortages as the federal program. The AAMC recommends expanding authorization of the NHSC SLRP to allow states to address their unique primary care service shortages.
Thanks in large part to the efforts of the Chairman, the ACA provides crucial funding for the NHSC through FY 2015. The steady, sustained, and certain growth established by this mandatory funding for the NHSC has resulted in program expansion and innovative pilots such as the Student to Service (S2S) Loan Repayment Program that incentivizes fourth-year medical students to practice primary care in underserved areas after residency training.

The AAMC opposes any rescissions from or repeal of the NHSC Fund created under the ACA. The AAMC further requests that any expansion of NHSC eligible disciplines or specialties be accompanied by a commensurate increase in NHSC appropriations so as to prevent a reduction of awards to current eligible health professions. Despite growing health professional workforce shortages and an unprecedented access to health insurance, the NHSC Fund expires soon, leaving questions about how Congress will maintain the program after FY 2015. The AAMC encourages the Subcommittee to prioritize continued funding for NHSC beyond FY 2015, while also preserving the full spectrum of other federal health care workforce programs.

**Title VII Health Professions Programs**

The HRSA programs authorized under Title VII of the Public Health Service Act are designed to provide education and training opportunities in high-need areas to aspiring health care professionals. With a focus on primary care, they are the only federal programs designed to train providers in interdisciplinary, community-based settings to meet the needs of the country’s special and underserved populations, increase minority representation in the health care workforce, and fill the gaps in the supply of health professionals not met by traditional market forces. Celebrating their 50th anniversary in 2013, the programs’ longstanding success can be attributed to their ability to help the workforce adapt to Americans’ changing health care needs by advancing timely priorities.

For example, HRSA data from the 2011-2012 academic year show the number of Title VII participants who practice in a medically underserved community (MUC) and/or a HPSA after graduation is increasing, and on average, 1 in 3 participants enter practice in a MUC or HPSA. Further, individuals who participate in Title VII programs are more likely to join the NHSC and/or work in community health centers (CHCs).

In addition to the Title VII primary care medicine programs, the Title VII Area Health Education Centers (AHEC) program, which provides interprofessional, community-based training opportunities, trained more than 28,000 medical students in rural and or underserved communities in the 2011-2012 academic year alone. AHECs also provide academic enrichment to students and continuing education to providers on a variety of topics, including cultural competence, health disparities, diabetes, and issues affecting veterans.

Similarly, the Title VII diversity programs play an instrumental role in producing a workforce equipped to mitigate racial, ethnic, and socioeconomic health disparities. For example, the most recent data show that the diversity pipeline Health Careers Opportunity Program (HCOP) trained 5,333 disadvantaged students, a 20 percent increase over the previous year, helping students successfully complete their coursework and helping to create a more competitive applicant pool to health education programs.
Yet, despite the programs’ successes in shaping the health care workforce, their relatively modest funding continually is under siege. The AAMC recommends $520 million in FY 2014 for the Title VII health professions programs and their nursing workforce development counterpart, Title VIII.

Teaching Health Centers

The Teaching Health Center (THC) program is a new HRSA initiative, established in the Affordable Care Act and funded with a mandatory appropriation. The THC program provides payments of $150,000 per resident, per year, to community-based, ambulatory patient care centers that operate primary care residency programs. These payments are being made at a far higher level than Medicare supports teaching hospitals. The law requires programs to meet the same accreditation criteria as other residency programs, and HRSA allows THCs to satisfy this requirement through participation in a consortium that includes a hospital/other entity that is listed as the institutional sponsor.

AAMC continues to support HRSA funding for this new program, given that the agency oversees the federal health center program, health professions workforce development programs, and other community-based entities. We look forward to studying the outcomes of the initial cohort of THCs, and how continued HRSA funding can sustain the higher payments made to these facilities.

Medical schools and teaching hospitals make unparalleled contributions to improving medical care in the U.S. and around the globe through their integrated missions of education, research, and patient care. As the nation faces an unprecedented demand for health care services, continued support for these institutions will be essential.

Thank you again for the opportunity to submit this statement for the record and for your leadership in addressing this important subject. The AAMC looks forward to working with the Subcommittee in strengthening access to health care for patients across the country.