HOD ACTION: Council on Medical Education Report 8 adopted as amended and the remainder of the report filed.

REPORT 8 OF THE REPORT OF THE COUNCIL ON MEDICAL EDUCATION (A-10)
Enhancing Primary Care as a Medical Career Choice
(Reference Committee C)

EXECUTIVE SUMMARY

This report is a follow-up to Council on Medical Education (CME) Report 3-I-08, "Barriers to Primary Care as a Medical Career Choice," which was adopted as amended, and CME Report 4-A-08, "Educational Implications of the Medical Home Model," also adopted as amended. This report provides an update on primary care as a medical career choice as well as the potential for medical education and training in progressive, community-based models of medical care focused on quality and outcomes, such as the patient-centered medical home (PC-MH) and chronic care model.

There is a need to support medical education and training in such community-based models to be responsive to the medical care needs of US citizens. Success will require a shift in emphasis from fragmented care to coordination and continuity of care among specialists, the primary care physician, other health professionals, and the various institutional and community-based settings of care. Primary care, patient-centered care, new-models of practice, and payment reform will also be essential.

Identifying medical students who possess important characteristics for team-based care, such as communication and interpersonal skills and who are better suited to lead and practice within teams, may require revisions to examinations and admissions processes. New funding to increase Medicare-supported GME positions in primary care, general surgery, and other critical-shortage specialties, as well as in underserved geographic areas is also needed.

The PC-MH model has been endorsed by a broad coalition of health care stakeholders. Congress included provisions in the "Patient Protection and Affordable Care Act" (H.R. 3590 – Public Law 111-148) to establish voluntary medical home and "independence at home" pilot programs. However, most primary care physicians are not currently providing key elements of medical home or comprehensive care, and one out of four primary care physicians are not familiar with the PC-MH.

Barriers such as rising medical student debt are also impacting the choice of primary care as a specialty and field of practice. Furthermore, with the passage of Public Law 111-148, there is now the need to fully fund the increased authorizations for Title VII health professions, the National Health Service Corps, and other federal and state programs that provide incentives for primary care physicians and other health care providers to practice in physician shortage/underserved areas.

There is a high interest level in US medical schools and residency training programs to begin to incorporate the elements of the PC-MH into their curricula. The American Medical Association (AMA), through its Initiative to Transform Medical Education, is also working collaboratively with other organizations to bring substantive improvements to medical education across the continuum that will enhance both physician and health system performance.

HOD ACTION: Council on Medical Education Report 8 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 8-A-10

Subject: Enhancing Primary Care as a Medical Career Choice

Presented by: Susan Rudd Bailey, MD, Chair

Referred to: Reference Committee C
(Floyd A. Buras, Jr., MD, Chair)

Council on Medical Education (CME) Report 3-I-08, "Barriers to Primary Care as a Medical Career Choice," which was adopted as amended (D-200.979): (1) described physician selection of primary care practice, including the initial choice of a primary care specialty; (2) identified barriers impacting the choice of a primary care specialty and primary care as a field of practice; (3) summarized current factors that have the potential to overcome the barriers and enhance selection of primary care practice; (4) reviewed current American Medical Association (AMA) policy and identified gaps that should be filled; and (5) suggested strategies for collaborative action. As follow-up, the report called for our AMA, in collaboration with relevant specialty societies, to study the following related to new models of provision of primary care services, such as the medical home concept; (a) the impact on primary care physician work-life balance and satisfaction; (b) the growth/expansion of such models in the public and private sectors; (c) the availability of expanded public- and private-sector funding at the national and local levels to support implementation of such models; (d) the impact on primary care physician compensation; and (e) options that explore additional funding. The results of this study were to be reported at the 2010 Annual Meeting of the House of Delegates (HOD).

CME Report 4-A-08, "Educational Implications of the Medical Home Model," describes the educational implications of the "medical home" concept and the chronic care model, and AMA efforts to work collaboratively with other organizations to bring substantive improvements to medical education across the continuum aimed at enhancing physician and health system performance. A number of curricula and initiatives that have been developed to assist in the implementation of the patient centered-medical home (PC-MH) and chronic care models were also identified. The report called for our AMA to track the adoption of the medical home concept by teaching programs with a report back at the 2010 Annual HOD Meeting.

This report provides an update on primary care as a medical career choice, new medical models, i.e., the PC-MH, to improve primary care, and the status of new models and educational programs.

PRIMARY CARE AS A MEDICAL CAREER CHOICE

Entry into a Primary Care Residency

For purposes of this report "primary care" physicians are defined according to AMA policy as family physicians, general internists, general pediatricians, and obstetricians-gynecologists (Policy H-200.997, AMA Policy Database).

Using this definition, in academic year 2008-2009, women represented 55.6% of resident physicians in primary care compared with 45.1% for all specialties and subspecialties (see Table 1). International medical graduates represent 37.3% of resident physicians in primary care compared with 27.3% in all specialties and subspecialties. US and Canadian-educated MD and DO men represent fewer than 25% of the resident physicians in primary care.[1]

Influence of Debt Load

Almost nine out of ten (87%) medical students are indebted, with an average debt at $156,000. Such debt plays a major role in medical students' career choices. High medical student debt is a significant hardship throughout the loan repayment period, especially during the 3-to-7 years of training in medical residency programs. High debt load may discourage residents from training in urban areas where the cost of living is high, practicing medicine in underserved areas, starting a career in medical education or research, or practicing primary care medicine. Furthermore, funding the cost of medical education by incurring debt is one of several factors that discourage individuals from socioeconomically disadvantaged backgrounds from applying to medical school.

Tuition assistance programs encourage a more diverse medical school applicant pool. Loan deferment and forgiveness programs have become useful incentives to encourage health care professionals to practice in underserved communities across the country. The AMA supports the creation of more opportunities for debt relief through tuition assistance, expansion of loan forgiveness for service programs for primary care and other specialties with critical shortages, low interest rates for medical student loans, income tax exemptions for medical student scholarships, inclusion of dependent costs in the "cost of attendance" definition to permit trainees to claim dependent costs in loan eligibility calculations, and expansion of loan forgiveness programs to medical teaching faculty. Additionally, the AMA strongly supports reestablishing the "20/220 pathway" for economic hardship loan deferment to allow medical residents to better manage their high debt burden and focus on their medical training and development during the critical and challenging years of residency.

Work Life Satisfaction

A recent Association of American Medical Colleges (AAMC)/AMA survey found that more than one-third (36%) of US physicians in practice are age 55 or older and likely to retire in the next 10 to 15 years.[2] Furthermore, women are now 50% of medical students, 44% of residents, and 27% of the total US medical workforce, and are more likely than men to go into primary care. In 1985, women constituted 15% of the internists, pediatricians, and family physicians in the United States, but by 2005, they constituted 32% of these specialties. The responses of women in the AAMC/AMA study showed that women physicians may be more likely to work part-time and to migrate toward fields that offer a more controllable lifestyle than their male counterparts.

Overall, active physicians over 50 are satisfied with their careers (83%), and satisfaction increases for the decreasing number that stay in practice beyond the age of 60. Of currently active physicians age 50 or older, 61% anticipate they will stop providing patient care by the age of 65. When thinking about retirement plans, active physicians over 50 cite increasing regulation of medicine, decreasing clinical autonomy, and rising malpractice costs as important factors in their decision to retire.

Physicians under 50 are less likely to be satisfied with their careers (75%) than physicians over 50. Most (71%) indicated time for family/personal pursuits was very important in a desirable practice

setting. Half (50%) agreed they can balance work and home life to their satisfaction, and 85% indicated they would like to retire from medicine by the age of 65.

Physician Workforce

In response to future physician workforce needs, enrollments in medical school have been rising by about 2% per year over the past 5 years. Fifty percent of that increase has come from the creation of new medical schools and the rest from expansions of existing schools.[3] Meanwhile, graduate medical education (GME) positions have been growing by only about 1%.[4] There is little or no planning or rational connection between medical school enrollments and GME. Furthermore, much of the growth in GME is at the "back end" in subspecialty fellowships—and not at the "front-end" in core training programs.

Similar to 2009, following the 2010 National Resident Matching Program (NRMP), there were 1,060 unfilled positions in all specialties and an essentially equal number of unmatched graduates of US allopathic schools (US MDs) (1,078).[5] Most of the unfilled positions (601) were preliminary GY1 positions in surgery (461), medicine (105), and transitional year (35). These stand-alone internships do not guarantee future training at GY2 levels or entry into complete core residency programs that would provide eligibility for board certification. Board certification is becoming increasingly important to become credentialed by a hospital or insurance plan.

Expanded Title VII and NHSC

Title VII programs help increase the supply of primary medical care and preventive medicine specialists and help ensure that health care professionals are trained to provide quality care, represent the diverse makeup of the general population, and are available to communities across the country, particularly those in underserved areas. The Title VII primary care provisions are the only cluster of federal funding dedicated specifically to the education and training of the primary care workforce.

The National Health Service Corps (NHSC) recruits and retains primary care physicians and other health care providers (e.g., nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, and dental hygienists) in underserved rural areas by providing incentives through loan forgiveness programs and scholarships. The NHSC improves access to health care for underserved areas, provides incentives for practitioners to enter primary care, reduces the financial burden that the cost of health professions education places on new practitioners, and helps ensure access to health professions education for students from all backgrounds. A recent study found that physicians who work with the underserved in Community Health Centers (CHCs) and NHSC sites are more likely to have trained in Title VII-funded programs.[6] Since its creation, the NHSC consistently has received significantly more applications for positions than it is able to support with the funding provided by Congress.

Congress last reauthorized Title VII programs in 1998. Since then, many of the Title VII health professions and diversity programs have faced significant cuts. Funding for the NHSC has also been cut during the past 5 years by over $47 million, a 27% reduction from the $171 million in FY 2003 that was already insufficient to meet the nation's health care needs. As a result, the NHSC reduced the number of new annual scholarship and loan repayment awards by more than 30% during that period.

In 2009, President Obama's Economic Stimulus Package expanded Title VII and NHSC programs. H.R. 1, the "American Recovery and Reinvestment Act of 2009" (P.L. 111-5), included needed

health professions funding that could be allocated toward Title VII health profession and diversity programs. The NHSC estimates this will result in an additional 4,250 NHSC practitioners.

The Patient Protection and Affordable Care Act (H.R. 3590) signed into law by President Barack Obama on March 23, 2010, is now Public Law 111-148. The law:

- authorizes the awarding of state workforce development grants and national, state, and regional centers for health workforce analysis effective beginning in FY 2010;
- authorizes increased funding for CHCs effective beginning in FY 2011;
- authorizes increased funding for the NHSC scholarship and loan repayment programs, allows part-time service and teaching time to qualify towards the NHSC service requirement, increases the annual NHSC loan repayment amount from $35,000 to $50,000 effective beginning in FY 2011;
- reauthorizes and increases funding for multiple Title VII health professions and diversity programs (effective dates FY 2010 and FY 2011); and
- supports preventive medicine residency programs and public health and rural physician training under Title VII effective beginning in FY 2011.

COGME's 20th Report on Primary Care

The Council on Graduate Medical Education (COGME) 20th Report is expected to be completed at COGME's April 2010 meeting with an eye toward expanding primary care. The report will focus on the alignment of policies along the physician production pipeline, from the preparation and selection of students for medical school through physician payment policies. In light of pending legislation in 2009 on medical workforce and health system reform, COGME previewed its emerging recommendations to leaders in Congress and the Administration calling for changes in physician education and practice, including:

- Moving more physician training to non-hospital settings, including rural and underserved areas;
- Making teaching hospitals and academic medical centers more accountable for how they spend the nearly $10 billion GME funding investment by Medicare and Medicaid;
- Fixing the income disparity between primary care and specialist physicians; and
- Making GME a site for innovations in primary care delivery.[7]

Advocacy Efforts

- The AMA continues to advocate funding from all sources for medical schools and residency training programs to provide medical education in the context of the PC-MH models (Policy H-305.929).

- AMA policy authorizes new funding to increase Medicare-supported GME positions in primary care, general surgery, and other undersupplied specialties, as well as in underserved areas (Policy H-305.929).

- The AMA continues to advocate for restoring full funding of Title VII health professions, the NHSC, and other Federal and state programs that have been successful in creating incentives for physicians to practice in physician shortage/underserved areas and in undersupplied specialties (Policy H-200.983).

- AMA policy supports testing medical home models and implementing beneficial models on a broad-scale basis upon a thorough evaluation, and believes that medical homes should be led by physicians (Policies H-160.918 and H-160.919).

- The AMA generally supports accountable care organizations (ACOs) that provide for voluntary participation, and supports implementing successful models under pilot programs.

- The AMA generally supports testing "independence-at-home" medical models, and believes that demonstration programs should be led by physicians.

- The AMA supports primary care/general surgery bonus payments treated as a funded workforce investment that is not offset through a reduction in payments to other physicians.

Admissions Policy

Recent attention has been directed to changes in medical school admissions policies. A growing body of evidence correlates selecting future medical students based on non-quantitative criteria with the likely selection of careers in primary care and underserved rural and urban locations.[8] The AAMC has sponsored a "Holistic Admissions Project" to guide medical schools in best practices for use of non-quantitative data (Medical College Admission Test [MCAT] and grade point average) when selecting future medical students.[9] A tool kit to assist medical schools in using holistic methods for admissions is available at the AAMC Web site. In addition, a comprehensive review of the MCAT is underway, also sponsored by the AAMC. The MR5, as the review committee is named, has the goal of analyzing the strengths and gaps of the current MCAT test and to make recommendations for change in admissions criteria.[10] The AMA, through its Initiative to Transform Medical Education (ITME), is actively engaged with the AAMC on these projects and sponsored an ITME conference in December 2009 to identify recommendations for action in selection of future medical students with attributes likely to enhance professionalism.

PROGRESSIVE, COMMUNITY-BASED MODELS OF MEDICAL CARE

The Need for New Models of Medical Education and Patient Care

In 2005, 133 million (50%) Americans had at least one chronic condition and 77% of senior citizens suffered from multiple chronic conditions.[11] By 2030, the number of Americans with chronic conditions is expected to reach 171 million. Both the "Medical Home" and "Chronic Care" models provide excellent opportunities for improving patient care and developing teaching programs. The clinical education of medical students should emphasize multiple patient encounters in different health care settings to help students gain an understanding of the challenges patients with chronic illness face and to appreciate the importance of the doctor-patient relationship, which only comes from regular interactions with patients over time.

The AMA, through ITME, is working collaboratively with other organizations to bring substantive improvements to medical education across the continuum aimed at enhancing physician and health system performance. A new curriculum, focused on managing chronic disease, could reinforce the importance of translating research into practice, teach practice innovation and quality improvement, and provide outpatient training that reinforces the Chronic Care model.

In addition, these progressive models emphasize coordination and continuity of care among specialists, the primary care physician, other health professionals, and the various institutional and

community-based settings of care. In a medical practice that operates a PC-MH, the principal care physician leads a team of qualified health care professionals who collectively take responsibility for the ongoing care of the patient. Principal care physicians include medical specialists and subspecialists when they are the patient's principal source of care. For example, under this model, it may be appropriate for endocrinologists to coordinate the care of patients with diabetes, nephrologists for patients with kidney failure, and pediatric pulmonologists for children with cystic fibrosis.

National/local Funding to Support the PC-MH

P.L. 111-148 establishes an "independence-at-home" demonstration program to bring primary care services to the highest cost Medicare beneficiaries with multiple chronic conditions in their homes. Health teams could be eligible for shared savings if they achieve quality outcomes, patient satisfaction, and cost savings. Nurse practitioners and physician assistants could lead the home-based primary care team as part of independence-at-home medical practice.

Impact of New Models on Primary Care Compensation

The Patient Centered Primary Care Collaborative (PCPCC) (*www.pcpcc.net*) is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, clinicians, and many others who have joined together to develop and advance the PC-MH. The PCPCC has more than 500 members and is compiling information on the status of current reimbursement models being used in PC-MH models. The PCPCC has three core components: (1) the Medicaid working group; (2) a task force focused on the state government as an employer and purchaser of health care; and (3) a task force to address the federal program system (Medicare, Veterans Affairs, Department of Defense, etc.).

STATUS OF NEW MODELS (PC-MH) AND EDUCATION PROGRAMS

- *American College of Physicians (ACP) Medical Home Builder*
  The ACP Medical Home Builder (MHB) provides affordable, accessible, online guidance and resources for practices involved in incremental quality improvement changes - or significant transformation of their practices. The ACP MHB is available to individuals, residency training programs, independent practice associations (IPAs), and PC-MH demonstration projects. ACP members may qualify for up to seven AMA Physician Recognition Award (PRA) Category 1 credits™.
  www.acponline.org/medicalhomebuilder

- *Preparing the Personal Physician for Practice (P^4) Program*
  Fourteen residency programs chosen from 84 applications in 2007 constitute the P^4 program sponsored by the American Academy of Family Physicians (AAFP) and the Association of Family Medicine Residency Directors and coordinated by TransforMED (a practice redesign initiative of the AAFP). As of December 2009, there have been 464 residents enrolled in the 14 demonstration programs providing care in 25 continuity practice sites. The P^4 program's length, structure, content, location of training, and expanded measurements of competency are being evaluated to determine what changes are needed to implement these new models of residency education. Carney et al. were the first to study the status of implementation of the PC-MH in continuity clinics that are part of the P^4 program. The study showed that many features of the PC-MH (i.e., EMR in practice, fully secured remote access, electronic patient notes/scheduling/billing, chronic disease management registries, etc.) were already established in programs participating in the P^4.[12] Future studies of the P^4 program are expected to guide

revisions in accreditation and content of family medicine training.
http://www.transformed.com/p4.cfm

- *Duke University Family Medicine Program*
  Duke University provides training in the elements of the PC-MH. Duke works with its community preceptors to incorporate the model into their practices and teaches its students how they can complete projects (such as analysis of registry data, or determination of needed community resources) as part of their required family medicine clerkship. The Department of Family Medicine serves as the home organization for a six-county Medicaid network, part of Community Care of North Carolina. Duke is planning a 4-year parallel curriculum in primary care leadership, which will expand beyond the core training to incorporate a greater emphasis on the population sciences, and on the role of the physician as a member of an interprofessional health team, leading improvements in health outcomes for patients, a practice, a network of practices, and a whole community. Duke has overhauled its family medicine practice and residency around this model, has attained a level 3 National Committee for Quality Assurance (NCQA) medical home, and received a 5-year accreditation. There was a striking level of student interest in the program—Duke received 400 applicants for its four positions in 2009 curriculum year. Duke offers similar training to residents in medicine, pediatrics, emergency medicine, and a surgery resident. Duke also offers assistance to a variety of training practices in the United States as they go through the complex process to get NCQA recognition for the PC-MH.

- *University of Oklahoma School of Medicine*
  The University of Oklahoma has a program for medical, nursing, pharmacy, and social work students in the PC-MH. The University has a longitudinal clinic in which the students provide care for a panel of patients applying all of the principles of the PC-MH. It has been in place for more than 2 years. The students are not only working in the clinic with their respective faculty, but they are involved in designing the improvements that take place in the clinic.

DISCUSSION

Being responsive to the medical care needs of US citizens will require greater flexibility in the training of physicians. Success will require a shift in emphasis from fragmentation to coordination and continuity of care among specialists, the primary care physician, other health professionals, and the various institutional and community-based settings of care.[13] Primary care, patient-centered care, new-model practice, and payment reform will also be essential.

Barriers impacting the choice of a primary care specialty and field of practice still exist. Rising medical student debt is playing a major role in medical students' career choices. Funding of Title VII health professions, the NHSC, and other federal and state programs has not been restored. These programs have been successful in creating incentives for primary care physicians and other health care providers to practice in physician shortage/underserved areas and in undersupplied specialties.

Identifying medical students who possess important characteristics for team-based care, such as communication and interpersonal skills and who are better suited to lead and practice within teams will require revisions to the examinations and admissions processes.[14]

New funding to increase Medicare-supported GME positions in primary care, general surgery, and other critical-shortage specialties, as well as in underserved areas, is also needed. The number of active physicians approaching retirement age is increasing, and one-third of active physicians over

age 50 will retire in the next 10 to 15 years. The increase in the number of female physicians also has had a significant workforce impact. Women physicians may be more likely to work part-time and to migrate toward fields that offer a more controllable lifestyle than their male counterparts. Most primary care physicians are not currently providing key elements of medical home or comprehensive care, and one out of four primary care physicians are not familiar with the PC-MH.[15] However, the PC-MH model has been endorsed by a broad coalition of health care stakeholders that include major employers, consumer groups, patient quality organizations, health plans, labor unions, many specialty societies, hospitals, and clinicians. Congress has also included provisions in the Patient Protection and Affordable Care Act to establish voluntary medical home and "independence at home" pilot programs.

Implementation of collaborative education programs remains a challenge to institutions that must address priorities at the clinic, residency, department, and university levels.[14] However, medical schools and residency training programs throughout the US have begun to incorporate the elements of the PC-MH into their curriculums. There is a high interest level in these training programs, and some have attained NCQA accreditation.

SUMMARY AND RECOMMENDATIONS

There is a need to support new progressive, community-based models of medical care focused on quality and outcomes in educational settings. The AMA, through its Initiative to Transform Medical Education, is working collaboratively with other organizations to bring substantive improvements to medical education across the continuum aimed at enhancing physician and health system performance. The Council on Medical Education recommends that the following be adopted and that the remainder of the report be filed.

That our American Medical Association:

1. Work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. (Directive to Take Action)

2. Advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. (Directive to Take Action)

3. Advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. (Directive to Take Action)

4. Advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919. (Directive to Take Action)

Fiscal Note: Less than $5,000 for staff time.

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