

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:3
I-19)

Introduced by: International Medical Graduates Section

Subject: Improvement of Healthcare Access in Underserved Areas by
Retaining and Incentivizing IMG Physicians

Referred to: Reference Committee
(Chair, MD)

1 Whereas, One in four of the practicing physician workforce in the United States of America are
2 trained at a foreign medical school¹; and
3

4 Whereas, 41% of the international medical graduates (IMG) serve in the primary care
5 disciplines, as defined by the Association of American Medical Colleges (AAMC), including
6 internal medicine, family medicine, pediatrics and geriatrics²; and
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8 Whereas, An American Medical Association and American Osteopathic Association database
9 study showed that the IMGs are more likely to serve in the rural persistent poverty areas in
10 primary care, compared to their U.S. counterparts and DOs³; and
11

12 Whereas, By 2030, an estimated shortage of between 14,800 and 49,300 primary care
13 physicians has been projected by a recent American Association of Medical Colleges report⁴;
14 and
15

16 Whereas, The U.S. population aged over 65 is estimated to grow over 50% by 2030 and one
17 third of the currently active physicians will be older than 65 in the next decade⁴; and
18

19 Whereas, If people in the underserved and rural areas and people without insurance would use
20 healthcare the same way as the people with insurance and the people in the metropolitan areas;
21 an additional 31,600 physicians were needed in 2016⁴; and
22

23 Whereas, Critical access hospitals in underserved areas continue to face a crisis due to
24 uncompensated care and limited retention of physicians; and
25

26 Whereas, The residents of the rural and underserved areas tend to be older, more chronically ill,
27 of a lower socioeconomic background and uninsured⁵, resulting in significant disparities in rural
28 and urban health care status and life expectancy⁶; and
29

30 Whereas, The overall number of U.S. medical graduates choosing careers as general internist
31 has declined over many years and retention of general practice physicians remained a
32 persistent challenge in improving health care access in these areas⁷; and
33

34 Whereas, A current Conrad 30 Reauthorization Bill (Senate Bill S948) has proposed a pathway
35 for IMGs to serve in the federally designated health professional shortage area (HPSA) with a
36 majority of Medicare/Medicaid and uninsured population for a longer duration, an increased
37 number of IMGs to be available in each state to serve in these areas and have incentives to
38 serve and settle in these areas; therefore, be it

1 RESOLVED, That our American Medical Association work with relevant stakeholders to
2 support efforts to retain and incentivize international medical graduates to remain in the
3 underserved serving in federally designated health professional shortage areas after a
4 stipulated period of time the current allocated period. (Directive to Take Action).

References

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3. Fordyce MA, Doescher MP, Chen FM, Hart LG. Osteopathic physicians and international medical graduates in the rural primary care physician workforce. *Fam Med*. 2012;44(6):396-403.
4. Dall T, Reynolds R, Jones K, Chakrabarti R, Lacobuci W. Center for Workforce Studies. *The Complexities of Physician Supply and Demand: Projections from 2017-2032*. Washington, DC; Association of American Medical Colleges; 2019. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf. Accessed August 14, 2019.
5. Rosenblatt RA, Chen FM, Lishner DM, et al.. The future of family medicine and implications for rural primary care physician supply. University of Washington, School of Medicine 2010; Available at: http://depts.washington.edu/uwrhrc/uploads/RHRC_FR125_Rosenblatt.pdf. Accessed August 14, 2019
6. Singh GK, Siahpush M. Widening rural-urban disparities in life expectancy, U.S., 1969-2009. *Am J Prev Med*. 2014
7. Whitcomb ME. The challenge of providing doctors for rural America. *Acad Med*. 2005;80:715-716

RELEVANT AMA POLICY

~~None.~~

US Physician Shortage H-200.954

Our AMA:

1. explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
2. supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
3. supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
4. encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
5. encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
6. encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
7. will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;

8. will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
9. will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
10. continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
11. continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic **health** centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether **health** care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for **health** care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, 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) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and **rural** underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other **health** care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family **health** clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in **rural** and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will 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.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile **health** care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or **rural** areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public **Health** Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired **workforce** effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other **health** care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Improving Rural Health H-465.994

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving **rural health care**, (b) urges physicians practicing in **rural** areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving **rural health care** to the profession, other concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public **health** to:

- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based **rural public health**.
- Develop an actionable advocacy plan to positively impact local, community-based **rural public health** including but not limited to the development of **rural public health** networks, training of current and future **rural** physicians in core public **health** techniques and novel funding mechanisms to support public **health** initiatives that are led and managed by local public **health** authorities.
- Study efforts to optimize **rural public health**.

