Advocating for Family Medicine

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February 12, 2010

Jerilyn Glass, MD
Executive Secretary
ACTPCMD
Health Resources and Services Administration
Room 9A-27,
5600 Fishers Lane,
Rockville, Maryland 20857

Dear Dr. Glass,

On behalf of the Council of Academic Family Medicine (CAFM) and the American Academy of Family Physicians (AAFP), we appreciate the opportunity to comment on the draft 8th report of the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry. We support the work of the Committee and are pleased with many aspects of this report.

We have observations and recommendations for improvement in four general areas. These relate to two of the recommendations directed at Title VII, one regarding a recommendation directed to other areas of federal policy, and additionally we have a recommendation for general improvement of the report to enhance the understanding of the importance of Title VII, Section 747 to the nation's workforce.

Recommendation 1: Congress should restore and enhance funding for Title VII, section 747 programs at $234 million for the next fiscal year and ensure that this larger appropriation is *distributed more broadly across the multiple disciplines covered by these programs*. [emphasis added] We suggest some enhancements to this recommendation or we recommend that it not be included in this report. We support the augmentation of funding for these programs, but only if there is regulatory language established to ensure that the funds under this section are aimed at primary care training, not at generalist training that actually produces non-primary care graduates. So, while Family Medicine can support the expansion of funding for general internal medicine, general pediatrics and physician assistants, we are concerned that these specialties are producing higher ratios of non-primary care graduates than ever before.

According to researchers (Altarum) developing data for the Council on Graduate Medical Education (COGME), less than 25% of general internal medicine residents are now entering primary care practice, opting instead to subspecialize or work as hospitalists. The 33% growth in subspecialty training positions created over the last decade which has reduced primary care production to just 20% of residency graduates has made sustaining primary care at even 35% of total physician workforce impossible. Altarum, suggests that this outgrowth of subspecialty training is poised to reduce primary care production to just 17% in the next 5 years. In addition, approximately two thirds of physician assistants are currently going into nonprimary care specialty settings with the remaining third (37%) in primary care. (http://aapa.org/about-pas/data-and-statistics/aapa-census/2008-data page 2)

While the report is correct that Title VII funding has been important to the growth of residencies in family medicine and general internal medicine, and physician assistant programs, currently there is a distinct lack of student interest in categorical general internal medicine and a trend away from primary care physician assistants. Given the likelihood of lower allocations putting additional

pressure on the appropriations process, we cannot expect large gains in spending for Section 747. Hence, we should be cognizant of the need to direct Title VII funding to where it can do the most good in producing more primary care providers.

There are several ways to do this. Perhaps a threshold of primary care production (historic) should be the determinant of eligibility for funding. For example, only institutions that can demonstrate at least a 40% production of primary care over the last decade by counting those graduates currently in practice rather than counting entrants into residency should be required for funding under Section 747 – Training in Primary Care Medicine and Dentistry. We suggest that the definition be programs that have their graduates practicing in family medicine, general internal medicine, general pediatrics or as physician assistants in these three areas five years after their residency begins. Similar definitions to address department and predoc grants should also be included.

For those without such a history of production, but that wish to use the funding to change their ratio of primary care to subspecialty ratio, one could implement a requirement for an increase by a certain percent or number. One must ensure that the measure of success for these programs is counted far enough out from training, so that an accurate picture of practicing physicians or physician assistants is counted.

In keeping with other recommendations of this report (4, 5,6,7,and 8), and the introduction of the report that describes "The crisis in primary care," we believe it is critical that Recommendation #1 be consistent with the intent of Section 747 to produce more primary care providers. We believe all federal policies that have an impact on workforce should be directed to enhance the production of primary care providers for the benefit of the health of the nation.

Recommendation 4: Training grants should support primary care clinical training in community-based settings for providers and trainees in various disciplines, including those in Title VII programs (i.e. physicians, dentists, physician assistants) by *funding proposals to recruit and support community-based clinical educators.*

We believe this recommendation needs to be tightened if it goes forward. Moreover, we urge the Committee to revise it to state clearly that it is recommended only if there are large increases in funding of Title VII Section 747. The recommendation is unclear and not specific enough for HRSA to comply with it. While one can imagine HRSA implementing language for grants to aid in the recruitment of community based educators, it is unclear what the term "support" might mean. We have already seen issues arising from CMS rules regarding the payment of previously volunteer preceptors; it is not a simple problem to address. We are concerned that at a time when annual appropriations are strained, we do not add another category of funding that would dilute limited funds. The current program funding for each of the four cycles, department, predoc, residency and faculty development, can all be used to meet the laudable goals of this recommendation. In addition, we have been unable to find any family medicine data suggesting problems with limited preceptor sites, but we agree this could potentially be the case, especially with the establishment of many new medical schools. We suggest that a better recommendation would be for HRSA to investigate, for each of the specialties covered under this section, the breadth and depth of the problem, and recommend a range of solutions.

Recommendation 10: Congress should direct the Secretary of Health and Human Services to establish an independent health care workforce planning body that can evaluate needs and make recommendations.

We have supported proposals in various health care reform bills to establish a national workforce planning commission. We believe this should be a congressionally mandated Commission. In order for it to truly be independent it must have its own funding source and not be under the jurisdiction of the Secretary of Health and Human Services. We have seen the ability of the Medicare Payment

Advisory Commission to work independently, with its own funding source, and not be held to the whims of whatever political party holds sway at the Department. We would hope that the recommendation would be changed so that a workforce planning commission set up in a similar manner to MedPAC would be included.

In addition, we applaud the work of HRSA Administrator Mary Wakefield, PhD, in her efforts to enhance the work of the agency in workforce analysis and dissemination, something that has languished in recent years through lack of funding and support. We believe these twin efforts are needed.

Lastly, we think that the report would benefit from the inclusion of an additional chapter or section of the Introduction with a related recommendation associated with the economic benefits of a strong primary care workforce. Data exist that show the economic impact of one family physician to a community. (http://www.graham-center.org/online/graham/home/tools-resources/directors-corner/dc-economic-stimulus.html) We believe it would be helpful to have that kind of discussion available in this report as we move to a time of increased fiscal constraint and deficit reduction, with attention being paid to areas that can help improve the economy. More small businesses, more rural providers, and the creation of additional jobs are all key areas that we can use to distinguish these important programs.

As always, we are grateful for the opportunity to comment on the good work of this Committee. We support your efforts to enhance funding and identify needed federal policy changes to increase the production of primary care providers. We hope you will entertain our comments as supportive of those goals.

Sincerely,

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Society of Teachers of Family Medicine

Allen Dietrich, MD, Immediate Past-President
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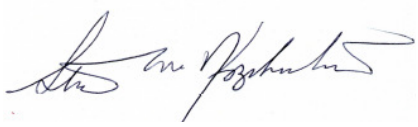

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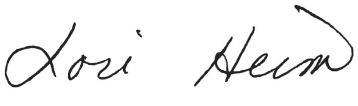

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