

Fixing the Primary Care Pipeline: The Role of Teaching Health Centers

ADAM J. OBLEY, MD
THOMAS G. COONEY, MD

In the United States, an imbalance in the production of primary care and specialist physicians, the declining production and a geographic maldistribution of primary care physicians, and an adverse practice environment for primary care have proven to be vexing and seemingly intractable problems that challenge the ability of the health system to provide appropriate and timely access to primary care.¹ This also appears to be an emerging problem in other developed nations.² Despite considerable evidence that a robust primary care infrastructure produces better outcomes at lower cost,³ designing and implementing a comprehensive health care workforce policy in the United States remains a long-term policy proposal that has not been realized to date.

In this issue of the *Journal of Graduate Medical Education*, Rieselbach et al^{4,5} describe, in broad terms, 2 models to expand and elaborate on the existing Teaching Health Center Graduate Medical Education (THCGME) Program that was created by the Patient Protection and Affordable Care Act (ACA), and received appropriation of \$230 million over a 5-year period, beginning in 2011. The authors describe the community health center and academic medicine partnership—termed CHAMP; and a model using rural health center consortia. They contend that increasing training opportunities by expanding graduate medical education (GME) funding for such teaching health centers (THCs) will help alleviate the insufficiencies and maldistribution of the primary care workforce for urban and rural underserved populations. They propose that new legislation to expand the number of GME training positions should include a requirement that a substantial portion of new positions be reserved for primary care GME positions in this expanded and modified THCGME program.

Rieselbach and colleagues emphasize the need for a more goal-directed physician workforce policy and highlight that the promise of coverage expansion under ACA will exacerbate the current workforce crisis. A critical question about the merits of the proposal is whether there is evidence to support the contention that THC sites are more

likely to produce physicians who will meet our future workforce needs. There are persuasive success stories and data to support this, but it is not clear whether it is the THC training environment itself, or the fact that such sites attract residents already destined for rural and underserved primary care careers.^{6,7} Moreover, the effects of the ACA-authorized THCGME program on the workforce will likely not be known for at least 2 to 4 years after the first cohort completes training.⁸

In the absence of a comprehensive physician workforce policy, a variety of smaller-scale programs and projects have sought to bolster the primary care workforce with interventions at various points along the primary care pipeline. Area Health Education Centers,⁹ rural health tracks in undergraduate medical education,¹⁰ and rural family medicine training sites¹¹ have shown promise. Indeed, while THCs may prove to be a useful addition to the toolset at the disposal of workforce policymakers, this approach will have to be considered in the context of an array of other options that include more targeted recruitment of, and scholarship support for, medical students from rural areas or underrepresented populations, prospective service-based loan repayment programs, and special rural payment adjustments.¹² Additionally, innovations in undergraduate medical education and GME must anticipate how evolving practice models and reliance on nonphysician health care providers will affect the outputs needed from physician training. Ultimately, because the GME training environment represents only 1 part of the primary care pipeline, a comprehensive workforce policy will also need to address external factors including educational debt relief, fair remuneration, and issues related to quality of life for physicians in rural practice, and for their families.

The political feasibility of incremental expansion of GME capacity, even when intended to produce a workforce that is generally agreed to be desirable, remains unclear.¹³ A variety of recommendations from the Council on Graduate Medical Education, MedPAC, the Congressional Budget Office, and the National Commission on Fiscal Responsibility and Reform have failed to produce significant momentum for changes to the current GME cap or funding scheme.^{12,14} In a political environment in which funding for new programs is unlikely, and GME funding (particularly indirect GME funding) has been identified as a target for potential cuts, it may be necessary to consider opportunities

Both authors are at Oregon Health & Science University and Portland Veterans Affairs Medical Center. **Adam J. Obley, MD**, is Assistant Professor of Medicine; and **Thomas G. Cooney, MD**, is Professor of Medicine.

Corresponding author: Thomas G. Cooney, MD, Department of Internal Medicine, Office of Education OP30, Oregon Health & Science University, 3181 Sam Jackson Park Road, Portland, OR 97239, 503.494.8580, cooneyt@ohsu.edu

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to reform GME payments in ways that promote shared cost savings, while also giving flexibility for programs to move training to ambulatory and nontraditional sites.¹⁵

The creation of a comprehensive physician workforce policy that incorporates a variety of proven and emerging interventions along the primary care pipeline is badly needed. There is general agreement among stakeholders that undergraduate medical education and GME programs collectively bear the responsibility for workforce outcomes. Various methods for measuring the extent to which undergraduate and graduate medical education programs are achieving this social mission have been proposed.^{16,17} This may represent a starting point for comparing the effectiveness of different tools, and we believe that with more experience and data to support their use, THC's are likely to be an important component of that workforce policy. In conclusion, we support the THCGME model as a means of assuring greater accountability to workforce needs under a future GME expansion, but suggest that continued study of its cost-effectiveness and careful consideration among a variety of other policy options will be needed to ensure that the public investment in our physician workforce is well spent.

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