Ambulatory Training for Primary Care General Internists: Innovation With the Affordable Care Act in Mind

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Abstract

Background Although primary care general internists (PCGIs) are essential to the physician workforce and the success of the Affordable Care Act, they are becoming an endangered species.

Objective We describe an expanded program to educate PCGIs to meet the needs of a reformed health care system and detail the competencies PCGIs will need for their roles in team-based care.

Intervention We recommended 5 initiatives to stabilize and expand the PCGI workforce: (1) caring for a defined patient population, (2) leading and serving as members of multidisciplinary health care teams, (3) participating in a medical neighborhood, (4) improving capacity for serving complex patients in group practices and accountable care organizations, and (5) finding an academic role for PCGIs, including clinical, population health, and health services research. A revamped approach to PCGI education based in teaching health centers formed by community health center and academic medical center partnerships would facilitate these curricular innovations.

Anticipated Outcomes New approaches to primary care education would include multispecialty group practices facilitated by electronic consultation and clinical decision-support systems provided by the academic medical center partner. Multiprofessional and multidisciplinary education would prepare PCGI trainees with relevant skills for 21st century practice. The centers would also serve as sites for state and federal Medicaid graduate medical education (GME) expansion funding, making this funding more accountable to national health workforce priorities.

Conclusions The proposed innovative approach to PCGI training would provide an innovative educational environment, enhance general internist recruitment, provide team-based care for underserved patients, and ensure accountability of GME funds.

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Introduction

A well-functioning primary care system is necessary to provide high-quality, cost-effective health care and to the success of the Affordable Care Act (ACA).[1,2] Primary care general internists (PCGIs) are a key component of that system and are well-suited to care for a rapidly expanding population of complex, older patients. As the United States pursues the dual goals of making health care more accessible while improving its value and affordability, the role of PCGIs takes on additional significance.

Despite that critical role, PCGIs are rapidly becoming an endangered species. Medical school enrollment is on

track to reach a 30% increase by 2016,[2] yet will not expand the nation's primary care workforce without an increase in primary care residency positions.[3] Here, we describe an innovative approach to PCGI training, using teaching health centers (THCs) formed by community health center and academic medical center (AMC) partnerships (CHAMPs).[4] We propose that CHAMP THCs can bolster the ambulatory education of PCGIs for 21st century practice, to support and expand a crucial component of the primary care infrastructure.

The Role of PCGIs

We see PCGIs occupying these 5 critical roles in a reformed health care system:

Caring for a Defined Population of Patients These "defined populations" may be based on geography, ethnicity, language, age, disease characteristics, or some combination of these characteristics, such as older patients with complex chronic illnesses. Given the challenges of improving access, controlling costs, and optimizing quality, care for defined populations is a critical role for PCGIs in the future health care system.

Lead and Serve as Members of Multidisciplinary Health Care Teams To be an effective team member, PCGIs must become competent in team leadership and "followership."[5] *Leadership* requires skills in process improvement, workflow refinement, purposeful delegation, responding to performance metrics, and providing ongoing team member education and mentoring.[6] *Followership* involves creating conditions that foster trust and that enable others to act. At the heart of the interprofessional model is the recognition that multiple sources of expertise are needed to deliver comprehensive primary care.[6]

These health care teams would best be situated within a patient-centered medical home (PCMH) that would result in a dynamic interprofessional team approach to care.[6] Increasingly, this care will be integrated within large, multispecialty group practices, often linked to Accountable Care Organizations (ACOs), thereby achieving significant advantages in cost savings, patient convenience, and reduced fragmentation of care.

Participate in a Medical Neighborhood The PCGIs will coordinate the care of their patients with hospitalists, subspecialists, and other providers. The PCMH development has outpaced the maturation of medical neighborhoods, resulting in opportunities to shape the future of those neighborhoods. The PCGIs will be an essential hub in the coordination of future medical neighborhoods, using processes, competencies, and technologies that will enable efficient approaches to consultations and hospital care and the use of subspecialists' knowledge.

Provide Expertise in the Larger Health System The PCGIs will serve as experts in the care of patients with complex medical histories and be advocates for their needs within the group practice, medical home, or ACO. Recent research suggests that future primary care physicians will more frequently need to assume care for patients now referred to subspecialists,[7] a role for which PCGIs will be well-suited.

Have a Defined Role in Academic Medicine A subset of PCGIs will also have a role in academic medicine, carrying out clinical or health services research in conjunction with their clinical and teaching activities, especially in community health centers (CHCs).[8]

Approaches for Expanding the PCGI Supply

Despite having a critical role in the nation's primary care infrastructure, PCGIs are a dwindling resource. Primary care internal medicine is in a state of crisis, driven by threats on 2 fronts—rising demand and declining interest. Aggravating the problem is an increasingly overworked, undersized, and demoralized primary care workforce that lacks the capacity to address the surging health care needs of the population. Since 1998, there has been a dramatic decline in the percentage of internal medicine residents planning to pursue PCGI careers.[9] At present, only one-third of US physicians are in primary care specialties and 10.9% are general internists.[10] An analysis of internal medicine residents' career goals conducted as part of in-service examinations in 2012 revealed that 21% of third-year residents planned PCGI careers (S. Weinberger, MD, written communication, 2013).

Although the reduced attractiveness of general internal medicine is related to multiple factors,[11,12] a suboptimal training environment in the ambulatory care setting is an important factor. The challenges of providing care in busy, often understaffed primary care clinics may dissuade residents from pursuing primary care, when they compare their experience to more orderly and better supported subspecialty practices.[12] In addition, the curricula in primary ambulatory care often do not respond to patient demographics and expectations, quality improvement imperatives, or the use of new technology.[13]

The impaired PCGI pipeline resulting from this reduced interest will not be sufficient to refill the vacancies of PCGI retirements, let alone meet the demands of a growing and aging population. We present 5 concurrent strategies aimed at increasing recruitment and retention, and bolstering the PCGI workforce:

1. **Enhance the Role of the PCGI**, which must be seen as more than a "way stop" to a specialist. The image to be projected is that the PCGI is the "home base";

he or she knows the patient's social and family issues, coordinates the care within the medical home and across the medical neighborhood, and manages care longitudinally.

2. **Forgive Student Loans** to help ensure that young PCGIs are not "swallowed up" by debt in their early years of practice.
3. **Enhance Options for Part-Time Work and Flexible Work Schedules** so that senior clinicians and young PCGIs have increased flexibility and control over their own schedules through a group practice model while maintaining health benefits and coverage.
4. **Improve PCGIs' Quality of Life**, including minimizing on-call frequency through large group practices. The PCGIs must avoid the "hamster wheel" schedule and be able to look forward to a reasonable quality of personal life.
5. **Institute Payment System Changes** that improve reimbursement and decrease time spent coding while allowing longer visits for medically complex patients and payment for nonvisit activities.

Organizing PCGI Training in the CHAMP THC

Previous articles have described how CHAMP THCs could be organized to expand the care of underserved populations while providing multiprofessional education.[4,14] The CHAMP THC model possesses several advantages, including the option to collectively train residents in several primary care disciplines, facilitating future integrated practice.[4] The model promotes high-quality and cost-effective graduate medical education (GME) in ambulatory settings by leveraging existing infrastructure and creating equitable governance and financial partnerships between CHCs and AMCs through consortium agreements.

The curricular content provided by CHAMP THCs would prepare PCGI trainees with the essential perspectives and skills for evidence-based practice, use of information technology, quality measurements and improvement, cost control, care coordination, leadership of multidisciplinary teams, and shared decision-making. The THC is an ideal site to implement such a curriculum, including elements that correspond to the 2010 and 2011 Macy conferences goals[15] for the reshaping of GME to prepare residents for 21st century practice.

The CHAMP THC model will facilitate development of a multispecialty group practice. By merging the medical technology, inpatient capabilities, and subspecialist expertise of the AMCs with the primary care expertise of THCs, the best attributes of both settings would emerge. Through dual sponsorship, CHAMP multispecialty group practices (MSGPs) would deliver high-quality, cost-effective care while honing the skills necessary for PCGI faculty and residents to create modern, adaptive practices.

The MSGP would be facilitated by electronic consultation and clinical decision-support systems. A robust internal medicine training component of a THC with electronic support should enable the resultant MSGP to provide a much greater portion of ambulatory care of complex patients without dependence on physical referral to medical subspecialists. Electronic, secure, asynchronous consultations (e-consults) between PCGIs and specialists would reduce the cost and inconvenience of separately scheduled consultations in a model that has been used in a variety of specialties.[16–20] The THC and its ACO would benefit financially from the cost savings associated with a greater percentage of care delivered by the highly cost-effective THC.[4]

Community health centers selected for MSGP development would already have developed a high-performing electronic health record system and have a well-staffed PCMH. Reimbursing subspecialists for electronic consultations is a challenge that could be overcome by MSGP participation in a CHAMP ACO. This collaborative approach would be particularly advantageous for patients on Medicaid, who comprise most of the CHC patients.[21] The THC and ACO would share the responsibility for developing appropriate payment models that align the incentives of primary and subspecialty care, promote the public's health, and reduce overuse of resources.

Implementation of the CHAMP THC

Implementation of these new primary care settings is dependent on establishing a CHAMP THC that could develop and support residency programs in any combination of the fields of general internal medicine, pediatrics, family medicine, and medicine-pediatrics. Establishing such programs would facilitate maximum flexibility, enhance the CHAMP THC's ability to build on existing relationships and affiliations, and avoid stretching the CHC beyond its capacity to accommodate residency programs. The CHCs eligible to participate in such a program would include federally qualified CHCs and centers that meet the definition of CHC, as described by the Health Resources and Services Administration, despite not receiving grant funding under Section 330 of the Public Health Services Act.[22]

Sufficient and sustainable funding is essential to the support of this innovative model. Funding the GME costs for CHAMP THCs could be accomplished via a modification of the current Medicare GME-funding mechanism that would enable a CHAMP THC consortium agreement to allow for governance and flow of funds to

assure continued high-quality GME in both the CHC and AMC.

Sustainable federal funding would depend on enactment of currently proposed legislation for expansion of Medicare GME funds.[4] Although the 2010 ACA provided $230 million for THCs over 5 years,[23] that stimulus for growth has been impeded by provisions of the ACA that limit the development of THCs for PCGI training.[4] The CHAMP THCs face an uncertain funding without Congressional appropriation in 2015.

If sustainable Medicare GME funding cannot be achieved, current state initiatives using Medicaid funding for primary care GME expansion have potential.[24] In the past year, 42 states devoted nearly $4 billion to Medicaid GME support with limited accountability.[25] Using the Medicaid waiver process, states could request additional Medicaid funding to support new or established CHAMP THCs through Section 1115 (research and demonstration projects) Medicaid waiver applications that do not require enabling federal legislation.[25]

Conclusion

The CHAMP THCs have the potential of reshaping primary care, attracting residents into primary care careers, and preparing an expanded cadre of PCGI residents for practice in the 21st century. Sustainable and adequate funding for CHAMP THCs will need to be achieved without detrimental effects on the already vulnerable funding base for GME in current inpatient settings and other venues. The proposed model, with its innovative curriculum, could be an important initiative for rejuvenating primary care general internal medicine, providing training that will prepare PCGIs to fulfill their essential role in a reformed health care system.

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