Impact of the Affordable Care Act on Grant-Supported Primary Care Faculty Development

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Abstract

Health reform requires well-trained primary care physicians with new skills. Teaching faculty need to develop proficiency to deliver care in new models and systems, to lead change, and to teach these skills to the next generation of clinicians. Title VII Section 747 of the Public Health Service Act, modified and reauthorized under the Patient Protection and Affordable Care Act (ACA), is the only federal program that specifically supports the professional development of primary care faculty. We analyzed the effect of the modifications under the ACA on a funding opportunity announcement addressing faculty development needs and attributes of funded applications, including geographic regions. The data offer useful insights to programs interested in tapping sources of support for primary care faculty development. The data also show that targeted federal funding can bring about changes that contribute to an up-to-date, responsive primary care workforce. Title VII programs, as amended by the ACA, focus on curriculum development, teaching in community-based settings, and integrating patient-centered medical home concepts and interprofessional education and practice into the training of the next generation of physicians. These strategies drive change and improve the quality of care and patient outcomes.

Background

In the 50 years since its enactment, Title VII Section 747 of the Public Health Service Act[1] has shaped health professions workforce development. The legislative authority of Title VII evolved through phases, with funding initially used to avert predicted physician and dentist shortages.[2] Subsequent emphases included strengthening primary care, supporting care in community settings, maintaining family medicine departments, and initiating key national policy initiatives.[2] The effect of Title VII on primary care includes support of collaboration among primary care specialties, strengthening primary care training, and improving the quality of training and practice through curricular enhancements.[3] Title VII funding also directly finances faculty development and supports students, residents, fellows, and faculty pursuing primary care careers.[4,5] Access to well-integrated primary care has been shown to improve patient and population outcomes and health care value.[6–8]

Enhancing access and affordability of care, themes central to the ACA, requires a high-functioning primary care system. To succeed, primary care faculty require support and development to diversify and increase scholarship and leadership opportunities.[9] Enhancing faculty development in primary care is considered important to improving patient-centered care.[10,11] Faculty must be capable of training a new generation of primary care professionals with substantially different skills,[12] including improving the health of individuals and populations.[13] Developing clinical teaching faculty members can strengthen primary care by improving their ability to succeed in evolving models and systems, by teaching new competencies, effectively leading change, and improving the quality of care.[14,15] A recent review of the general literature on faculty development describes demonstrated improvements and suggests some areas that require further focus, including interprofessional care and understanding evaluation methodologies.[16] Title VII appropriations are 1 vehicle to advance the competencies of primary care clinicians and teachers.[17]

The reauthorization of Title VII under the ACA in 2010 introduced several significant changes informed by the priorities of the primary care community and health care reform, signaling the projected direction of reform to stakeholders through funding opportunities.[18] The focus of

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Title VII is to provide training in team-based medical homes, with 6 funding opportunities that support curriculum enhancement for physician and physician assistant education. One of these, the Physician Faculty Development in Primary Care program, supports faculty development activities for existing primary care faculty and fellows. We analyzed the Physician Faculty Development in Primary Care program before and after ACA reauthorization of Title VII.

Analyzing the ACA's Effect on Primary Care Faculty Development

We assessed the changes on the Physician Faculty Development in Primary Care programs by analyzing data for fiscal year (FY) 2008, the last year faculty development funding opportunities were offered before the ACA reauthorization of Title VII and for FY 2011, when the funding opportunity announcements (FOAs) included the changes implemented under the ACA.[19,20] The analysis encompassed the text of the legislation, FOAs, and grant activities, and we explored how organizational factors and changes in administration of the grant programs may have influenced grant activities and awards. The analysis was performed by Health Resources and Service Administration (HRSA) public health analysts and program and policy experts, who reviewed FY 2008 and 2011 funded application abstracts and project narrative sections. It focused on 6 content areas: interprofessional/team care, community-based training, patient-centered medical homes, cultural competency, patient safety/quality improvement, and research.[21,22] The results provide a unique perspective on the impact of the ACA and useful pointers for programs exploring Title VII funding of faculty development.

Title VII Legislation

Section 747(a) directs the Secretary of the Department of Health and Human Services to award grants and contracts to plan, develop, and operate programs to (1) train students, residents, fellows, and practicing physicians and physician assistants; (2) train individuals who plan to teach in primary care settings; and (3) provide needs-based financial assistance for trainees. The revision under the ACA separated the education authorities into Sections 748 (dental) and 747 (physicians and physician assistants). Additional programmatic changes in the ACA-amended Section 747(a) statute include the following:

- Applicants must be accredited by the appropriate accrediting body;
- Geriatrics was removed as an eligible primary care specialty;
- The new legislative language formally authorizes programs in ''community-based education,'' ''medical homes,'' and ''research'';
- The ACA-amended language authorizes demonstration programs that provide training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission; and
- The new language formally requires a 5-year project period.

Title VII budgets are determined through the annual Congressional appropriations process. In 2008, there were 22 grants supported by $4.8 million awarded, compared with 23 grants funded at a collective $4.4 million in 2011.

FOAs and Grant-Funded Activities

The FY 2008 and 2011 FOAs both support grant activities to plan, develop, and operate programs to train physicians to teach primary care. In response to changes in the statute, the FY 2011 FOA requires a 5-year project period and community-based training and research, with emphasis on aligning faculty development activities with current concepts, including the patient-centered medical home, interprofessional teams, and community based-practices reaching vulnerable and underserved populations. Applicants were encouraged to collaborate across primary care disciplines, professions, and institutions. Key attributes of the 2011 FOA are shown in TABLE 1.

In FY 2008, all 6 Title VII Section 747 programs used a single FOA. In FY 2011, HRSA created separate FOAs for each program, maximizing program-specific application guidance and integrating strategic goals to increase quantity, quality, diversity, and distribution of the primary care workforce. The FY 2011 FOAs also increased the scope of activities to include capacity building and faculty development.

Funding preferences changed between 2008 and 2011. In 2008, HRSA used a pre-established threshold to determine the applications that would receive the medically underserved community (MUC) preference. In 2011, HRSA staff calculated the award threshold from data provided by applicants, resulting in funded applications that more closely align with the aim of the MUC preference.

In 2011, applicants were asked to submit an institutional diversity statement demonstrating their organization's commitment to increasing diversity, and review points were assigned to emphasize needs assessment, evaluation, and impact. Finally, applicants were encouraged to conduct a longitudinal evaluation of program completers.

Although the number of applications and the percentage funded remained largely stable, with 22 of 74

TABLE 1 **Comparison of Program Funding Opportunity Announcements Fiscal Year (FY) 2008 and FY 2011**

FOA Section	FY 2008	FY 2011
Format for FOA	All Title VII primary care training programs, including physician faculty development, presented in 1 FOA	Six distinct FOAs with integrated goals to increase the quantity, quality, diversity, distribution of the primary care workforce; required institutional diversity statement
Purpose	Support programs to train physicians who teach in family medicine, general internal medicine, and pediatrics; financial assistance for trainees	Adds combined internal medicine and pediatrics ("med-peds") as an eligible entity; excludes geriatrics as an eligible discipline; provides support for community-based training and research
Eligibility	Public or nonprofit private hospitals, schools of medicine or osteopathic medicine, public or private nonprofit entities, including faith-based and community-based organizations	*Accredited* definition includes initial/provisional accreditation, with full accreditation to be achieved before the beginning of the academic year following the normal graduation date of the first entering class
Guidance for collaborative applications	Defined collaboration across primary care disciplines, including joint decision making; shared faculty and staff appointments	Encourages, but does not require, applicants to collaborate with more than 1 primary care discipline to develop an integrated physician faculty development program
Allowed faculty development activities	Three fellowship types: primary care clinician research, primary care master educator, community preceptor faculty development	No defined fellowship types, allows for faculty development activities outside of formal programs, including episodic and part-time curricula
Major focal areas	Healthy People 2010, health disparities, community and practice research, quality and safety, professionalism, health literacy, cultural competency, web- and teleconference-based training, distance and virtual learning	Healthy People 2020, interprofessional, team-based care, PCMH, clinical training, social determinants of health, HIV/AIDS, people with disabilities, oral health, rural health, access, health literacy and behavioral health, collaboration between primary care specialties
Review criteria	Emphasized relationship among goals, objectives, and activities, resolution of challenges/barriers, joint planning and collaboration, training and evaluation	Point allocation emphasizes needs assessment, evaluation, project impact, systems change, professional competencies, practice settings, use of interprofessional teams and PCMH
Funding preferences	MUC funding preference	Requires "MUC Preference" applicants to submit data on the number of program completers entering practice in an MUC
Special consideration/public policy issuance	Underserved populations and high-risk groups, elderly, persons with HIV/AIDS, persons with substance abuse, the homeless, and victims of domestic violence	Expands underserved designation to include people with disabilities, oral health, rural health, disparities in health care access, social determinants of health, health literacy, and Healthy People 2020
Technical assistance	Telephone and e-mail technical assistance to applicants	Two webinars and telephone and e-mail technical assistance to applicants

Abbreviations: FOA, Funding Opportunity Announcement; PCMH, patient-centered medical home; MUC, medically underserved community.

TABLE 2 **Comparison of Program-Funded Application Content Areas in Fiscal Year (FY) 2008 and FY 2011**

	FY 2008	FY 2011
Content Area	Funded Applications, No. (%), n = 22	Funded Applications, No. (%), n = 23
Interprofessional/team care	13 (59)	21 (91)
Community-based training	22 (100)	23 (100)
Patient-centered medical home	5 (23)	18 (78)
Cultural competency	20 (91)	22 (96)
Patient safety/quality improvement	22 (100)	23 (100)
Research activities	21 (95)	23 (100)

applications (30%) funded in 2008 and 23 of 70 applications (33%) funded in 2011, analysis of funded applications for FY 2008 and 2011 shows significant changes in the use of Title VII funds. The most striking trend in faculty development curricula enactment of the ACA is a growing emphasis on training in interprofessional and team-based care and in patient-centered medical homes. In 2011, 21 funded applications (91%) emphasized interprofessional team-based care, compared with 13 (59%) in 2008. The percentage of funded applicants focusing on patient-centered medical homes rose from 5 (23%) in 2008 to 18 (78%) in 2011 (TABLE 2).

Geographic Distribution of Funded Programs

Improving the distribution of primary care services to areas of need is a national priority.[23,24] Significant numbers of medically underserved communities are located in the southern United States. The region is characterized by low ratios of primary care physicians to population, higher

rates of poverty, and the highest rate of obesity, making it a target for enhanced primary care physician training. Eight (35%) of the applications funded in 2011 were from organizations in the Department of Health and Human Services Regions 4 (southern) and 6 (south-central), compared with 2 (9%) in FY 2008.

ACA Impact on Primary Care Faculty Development

Through Title VII Section 747 faculty development grants, the ACA promotes successful programs capable of producing a workforce to drive health reform. The changes to the Physician Faculty Development in Primary Care program under the ACA had a significant effect on grant-funded efforts, particularly growth in interprofessional and patient-centered medical home grant activities. Community-based education, cultural competency training, efforts to improve the quality and safety of care, and research continued to be central, and, similar to 2008, nearly all FY 2011 applications included these emphases.

Although providing a useful description of grant-supported work and associations among statutes, FOAs, and grant activities, this analysis is an initial step in the extensive evaluation necessary to comprehensively assess the effect of the Title VII programs. Additional monitoring and program evaluation is needed to ensure full implementation of physician faculty development activities. An example is the Primary Care Faculty Development Initiative conducted by Oregon Health & Science University. That demonstration project, conceived with input by the physician-certifying boards of family medicine, internal medicine, and pediatrics, is funded through a competitive contract by HRSA to implement and evaluate new primary care faculty development activities. The methods developed by that initiative will contribute to more comprehensive evaluation strategies to better ascertain program success in fulfilling the vision of health care reform.

Well-targeted federal funding can ignite changes needed to build a primary care workforce that is better aligned with the aims of health care reform. Our analysis shows that the changes in the law have led to changes in the funded applications, with post-ACA grantees engaged in faculty development programs focused on the development of curricula to enhance teaching in community-based settings, integrating patient-centered medical homes, and interprofessional education and practice. Dissemination of successful projects to the larger community can help drive national change in response to the ACA, with broad implications for primary care training in the future.

Broad implementation of successful faculty development strategies will prepare the next generation of primary care physicians to implement and use new models of care and improve patient care and outcomes. The ACA has facilitated opportunities for such innovation and will continue to do so as national health reform moves forward.

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