COGME Meeting

April 22, 2009 - Bethesda, Maryland

Agenda

8:30 a.m. **Welcome and Introductions**

- Russell Robertson, M.D., Chair

8:45 a.m. **Executive Secretary's Report**

- Jerald Katzoff, Executive Secretary

9:00 a.m. **Tracking the Recommendations of COGME's 16th Report**

- Dr. Robert Phillips, Deputy Chair, COGME

Commentary by Members Regarding the Implications of the 16th Report

9:30 a.m. **Solutions to the Challenges Facing Primary Care**

The American College of Physicians

- Joseph W. Stubbs, MD, FACP
  President Elect, ACP

10:15 a.m. Break

10:30 a.m. **Update of Modeling and Analysis for Determining Supply of and Demand for Residency Positions by Specialty**

- Charles Roehrig, Vice President, Altarum

11:30 p.m.. **Public Comment**

12:00 p.m. Lunch

1:00 p.m. **Develop Recommendations for COGME's 20th Report**

4:00 p.m. **Discussion of Next Steps to Prepare 20th Report**

5:00 p.m. **ADJOURN**

Minutes

The Council of Graduate Medical Education (COGME) convened in the Doubletree Hotel and Executive Meeting Center at 8:41am April 22, 2009.

Members Present

Russell G. Robertson, M.D., Chairman
Robert L. Phillips, M.D., MSPH, Vice Chairman
Wendy Braund, M.D., M.P.H., M.S.Ed (ASH)
Denice Cora-Bramble, M.D., M.B.A.
Mary Dougherty (DVA)
Joseph Hobbs, M.D.
Mark A. Kelley, M.D.
Jerry Kruse, M.D., M.S.P.H.
Spencer G. Nabors, M.D. M.P.H., M.A.
Kendall Reed, D.O., F.A.C.O.S., F.A.C.S.
Sheldon M. Retchin, M.D., MSPH
Vicki Seltzer, M.D.
Jason C. Shu, M.D., D.O.M.
William L. Thomas, M
Leana Wen, M.A., B.S.

HRSA Staff Members:

Jerry Katzoff, Executive Secretary
Members Absent:
Tzvi Hefter (CMS)
Thomas E. Keane, M.D.

Welcome

Dr. Russell Robertson, Chair, called the meeting to order and welcomed the COGME members and guests. In his opening message, Dr. Robertson explained the importance of expediting the reporting process; announced his participation in upcoming meetings with the Medicare Payment Advisory Commission and the Brookings Institute; and detailed some of the activities within the agency that would be of interest to the COGME membership.

Executive Secretary's Report

Mr. Katzoff gave his report introducing the Division of Medicine and Dentistry's new director and staff members in attendance. Immediately following the report, Mr. Katzoff turned the meeting back over to Dr. Robertson.

Presentations to the Council

During the day, the Council members heard presentations given by Dr. Robert Phillips; Dr. Joseph W. Stubbs, President-Elect of the American College of Physicians (ACP); and Dr. Charles Roehrig and Ani Turner of the Altarum Institute.

Dr. Phillips' presentation tracked the status of recommendations presented in COGME's 16th Report on physician workforce policy guidelines. According to the 2005 report, COGME recommended that the Nation undertake a multi-pronged strategy to include: a modest increase in medical education and training capacity over the next decade; efforts to increase physician productivity; and increased tracking and assessments of the supply, demand, and need for physicians. Dr. Phillips found that while considerable progress has been made in increasing the production of medical students and the number of physicians entering residency training programs; there is still work to be done in the development of systems and studies to track and assess the supply, need, demand, and distribution of physicians in primary care.

It was also found that access to care for underserved populations and communities has greatly improved since the release of the 16th Report; and the promotion of workforce diversity has also increased significantly in the area of gender equality. Conversely, with the increase of patients receiving care in the underserved areas, the need for more practitioners has increased. In addition, while great strides have been made in gender equality for physicians, diversity in terms of race and ethnicity has not been tracked due to a lack of systems in place to collect such information.

Dr. Phillips concluded his presentation with the discussion of placing these recommendations along with others set forth by the Council in a proposed letter to Congress in response to the current talks on healthcare reform and the provider workforce. The purpose of the letter, as Dr. Phillips explained, would be to elevate the importance of the need to change the way graduate medical education is funded in order to produce the right workforce and avoid the consequences of not taking any action at all. The discussion culminated with Council members offering suggestions on how to effectively convey this message to Congress in order for immediate action to take place regarding the proposed recommendations.

Note: Subsequent to this meeting, a COGME letter was transmitted on May 5, 2009 to the HHS Secretary and Congress. It can be assessed through COGME's website.

The next presentation was given by Dr. Joseph W. Stubbs describing potential solutions to the challenges facing primary care. Dr. Stubbs reported that the key factors playing a role in why medical students are not entering into primary care are the high level of medical school debt, issues to exposure to training in the ambulatory setting, and the poor quality of practice life. In response to these issues, the ACP plans to release two papers offering recommendations on how to recruit and retain primary care physicians.

The first of these recommendations is to establish a national healthcare workforce policy that will educate and train the supply of healthcare professionals that meets the nation's healthcare needs and ensures adequate supply of primary care physicians. Associated with that policy is the need to establish a national commission on healthcare workforce to ensure that the actions taken by the Department of Health and Human Services and Congress serve to meet or exceed the policies that are set out by the workforce policy.

The next recommendation offered by ACP is to increase funding for the National Health Service Corps scholarship program and Title VII scholarship and loan repayment awards for primary care physicians. The organization also feels that there should be a process of deferment of educational loans throughout the duration of the training in primary care residency programs. Furthermore, ACP recommends that more training is needed in the ambulatory care setting and an increase in Title VII funding that will go towards primary care training programs, curriculum development in academic medical centers, primary care mentorship programs, and developing materials to promote careers in primary care.

Lastly, the ACP recommends that the Federal Government should focus its efforts to restore primary care compensation to be competitive with other specialties. The organization advocates that more incentives be awarded for the value of the care provided and not solely for the volume of patient services being received. ACP believes that once the Government takes the lead on this issue, this will prompt the private sector to take notice and follow their lead.

The final presentation of the day was given by Dr. Charles Roehrig and Ani Turner of the Altarum Institute, updating the Council members on the modeling and analysis for determining supply of and demand for residency positions by specialty. It was reported that the proportion of physicians in the US in primary care has remained fairly stable at about one-third. Nearly 27% of the 2008 cohort will enter primary care with about 17% selecting this field as their first choice. Ultimately, it is projected that if recent expansions in non-primary care continue, primary care participation will trend toward 17%.

Dr. Roehrig discussed that in order to avert this outcome; primary care must be promoted in multiple dimensions including the creation of incentives to ensure an adequate supply of primary care training positions and avoiding excess expansion of non-primary care training positions. If primary care preferences are not increased, the only way to maintain 30% or more in primary care is through the control of non-primary care positions offered. As a result, an essential component of increasing preferences is to increase primary care incomes relative to non-primary care incomes. Dr. Roehrig observed that increasing the average incomes of primary care physicians by 20% may keep primary care preferences at 30%.

However, Dr. Roehrig noted that incomes are only part of what needs to be done to attract more physicians into primary care. Additional strategies presented include: the modification of medical school selection criteria or recruiting applicants who are more likely to be interested in primary care; and increasing opportunities for undergraduate and graduate medical education training in quality outpatient and community settings.

He also noted that improving the primary care practice environment (i.e. reducing administrative burden) and improving perceptions of primary care practice environments and employment opportunities, are key strategies to increase primary care preference.

The presentations were followed by a discussion among Council members regarding the development of COGME's 20th Report. During this discussion, several key points were identified and a list of draft/prospective recommendations were formulated (see below).The tentative recommendations were not discussed at length or approved. it is expected that the list will serve as a basis for further COGME discussion over the next several months. This list and its accompanying discussion as well as that from the November 2008 meeting will serve as the foundation for a draft for the 20th Report. This draft will be available for discussion, review and revision by the November 2009 meeting.

Subsequent to this meeting, the recommendations formulated from the discussion were edited and compiled.

Included below are these recommendations: Series of Prospective Recommendations

- The US ration of primary care physicians to specialty positions should be 50-50. 32-35% of US physicians are primary care physicians to date. Best outcomes are when that is close to the 40-50% range. Note, these vary over time and are based on needs and practice issues that should be related to this include healthcare, education, ancillary resources. We should look to decrease costs, increase equity, increased access. For example, in the current setting, breast and cervical cancer screening rates have declined.

- Non-physician clinician positions committed to primary care should increase. The percentage of primary care physicians should be at least 40% over the next 10 years.
- Healthcare reform and access to care should be based on population needs and not market needs.
- New recommendations regarding resident work hours should be taken into consideration when making physician workforce recommendations. Consider the role of resident work hours and whether or not this should be a factor in making GME recommendations.
- New and innovative solutions towards eliminating medical school debt for physicians entering primary care ought to be considered. Eliminated all debt for students committed to entering primary care, whether this would be through scholarships or loans.
- Primary care physician incomes should be at 60-70% of the incomes for all medical specialties. Incomes for primary care should be increased to a threshold of 60 percent of non primary care specialists
- Any net Increases in medical school class size or the number of new medical should produce new primary care physicians.
- Primary care physicians' pay should be reimbursed by innovative models, care coordination, pay for performance, and fee for service with the intent to a net doubling of primary care reimbursement.
- Graduate medical education payments for the ambulatory component of primary care residency should be increased.
- Programs should be developed that support ambulatory training sites such as federally qualified health centers and rural health centers, with the intent designed to reduce barriers and address needs of these communities.
- Medical schools have a societal responsibility need to produce graduates in line with societal needs if they accept federal dollars.
- Support current increases (quadrupling of National Health Service Corps scholarships).
- Undergraduate medical education, specifically the M1 and M2 year, should require a mandatory six week block doing ambulatory care with quality preceptors who are well-reimbursed to care and teach.
- Any incremental increase in the GME cap should be targeted toward primary care physicians or have strategiceffect on thehealth of the n population.
- Policy changes must result in improved geographic distribution in rural and urban settings (partnerships with community health centers/federally qualified health centers; the CHCs and FQHCs should not bear the burden of the costs of the program).
- Consideration of the Patient Centered Medical Home as the construct for GME funded ambulatory care training is recommended.
- There should be a minimum of 20% increase in reimbursement for primary care physicians based on Medicare billing codes.
- Any increases in medical school class size should be structured tracked to increasethe primary care physician production.
- Endorse patient-centered medical home and preferred funding for health information technology and interprofessional care.
- Request that specialty societies consider the availability of tracking to ambulatory care tracks.
- Create financial incentives to encourage choosing primary care training and focus in non-hospital settings.
- Any demonstration projects moving toward accountable care organizations should mandate inclusion of academic health centers.
- Workforce recommendations should be considered in the context of where the US is headed with healthcare reform.
- Some analysis of what is working and not working presently should be undertaken.

- Incentives to medical students for specific communities with a demonstrated needfor residency training in primary care should be considered.
- Salaries for residents in primary care residencies should be higher than other specialties.
- Increase income for primary care physicians.
- Increase income for primary care residents as compared to other residents.
- Medical schools should be mandated/incentivized to select a portion of students with a pre-disposition to primary care.
- Student selection at the level of med school: we should incentivize medical schools to provide high quality primary care experiences.
- Graduate medical education should be better supported and reimbursed through CMS.
- Reiterate the GME points from the 18th and 19th reports.
- GME payments should bypass the hospital completely to the primary care programs, specifically family medicine.
- There should be resident pay differentials for graduates who go into community-based practices/family medicine.
- Current GME caps should remain in place except for primary care physicians or other specialty shortages.

Adjournment

The Council adjourned at 4:15pm.

Minutes

The Council of Graduate Medical Education (COGME) convened at the Hilton Washington D.C./Rockville Executive Meeting Center in Rockville, Maryland, at 8:35am November 18, 2009.

Members Present

Russell G. Robertson, M.D., Chairman
Robert L. Phillips, M.D., MSPH, Vice Chairman
Denice Cora-Bramble, M.D., M.B.A.
Joseph Hobbs, M.D.
Mark A. Kelley, M.D.
Jerry Kruse, M.D., M.S.P.H.
Spencer G. Nabors, M.D. M.P.H., M.A.
Kendall Reed, D.O., F.A.C.O.S., F.A.C.S.
Sheldon M. Retchin, M.D., MSPH
Vicki Seltzer, M.D.
Leana Wen, M.A., B.S.
Thomas Keane, M.D.
Wendy Braund, M.D., M.P.H., M.S.Ed (ASH)
Elizabeth Truong (designate for Tzvi Hefter of CMS)
Carole Pillinger, M.D. (DVA)

HRSA Staff Members:

Jerry Katzoff, Executive Secretary
Diana Espinosa, Acting Associate Administrator, Bureau of Health Professions (BHPr)
Daniel Mareck, M.D., Director, Division of Medicine and Dentistry, BHPr
Members Absent:
Jason C. Shu, M.D.
William L. Thomas, M.D.

Welcome

Dr. Russell Robertson, Chair, called the meeting to order and welcomed the COGME members and guests. Dr. Robertson announced his participation in meetings with the Medicare Payment Advisory Commission and the Brookings Institute.

Presentations to the Council

The first presentation was by Dr. Darrell G. Kirch, President and CEO of the Association of American Medical Colleges. The topic of Dr. Kirch's presentation was medical education with respect to pending health care reform. He covered points concerning the medical education continuum, from pre-medical school experiences through practice. He also covered issues concerning the adequacy of the physician workforce supply and the role of primary care in that supply. The presentation also covered core competencies needed for every physician. Laden through his talk were observations concerning the need to transform healthcare from "sick"-care to "health"-care and the implications these observations have for medical education. He described an emerging culture for healthcare, i.e., hierarchical to collaborative, competitive to team-based, and its implications for medical education.

The next two presentations focused on whether the nation has the right number and mix of GME slots. The first presenter on this topic was Edward Salsberg, Senior Associate Vice President and Director, Center for Workforce Studies, Association of American Medical Colleges. Mr. Salsberg described the upcoming "Perfect Storm" for the physician shortage crisis facing the Nation, which among other things included upcoming healthcare reform legislation, which would provide coverage to millions of Americans who do not currently have it, the Baby Boomer generation reaching retirement age, the ongoing obesity impact in the country, disparities among the poor and minorities, and more. He went on to describe the increase demand for services by the current patient population and provided data that within the next decade, the number of physicians entering retirement age will double. He also indicated that more and more physicians are working less hours and opting for a better quality of life.

The second GME mix presentation was conducted by Dr. Fitzhugh Mullan, Murdock Head Professor of Medicine and Health Policy, George Washington University School of Public Health and Health Services. Dr. Mullan began his presentation with a historical look at physician workforce supply in America since 1900. He went on to describe physician workforce characteristics between the U.S. and other countries and concluded his presentation with some of the physician workforce requests included in the current healthcare reform proposals.

The next three presentations focused on Bureau of Health Professions Physician Workforce Studies in Development. The first of these three presentations was given by Tim Dall, Vice President of the Lewin Group. Mr. Dall began with an assessment of the current and future state-level adequacy of primary care clinicians to include physicians, physician assistants and nurse practitioners. Mr. Dall provided detailed statistics on the current and anticipated supply and demand for these clinicians through 2020 and the adequacy of the current supply and demand by state.

The second presentation on the Bureau of Health Professions Physician Workforce Studies in Development was given by Sandra Karen, Chief Operations Director, Office of Workforce Policy and Performance Management (OWPPM), BHPr. Ms. Karen's presentation described the role and responsibility of the OWPPM, including its current activities, historical perspective, and applicable statutory authorities. She concluded her presentation with a list of recent reports and products the Office was responsible for developing.

The third presentation was given by Dr. Charles Roehrig, Vice President of the Altarum Institute. Dr. Roehrig described the Physician Supply Model (PSM) and Physician Requirements Model (PRM) developed by HRSA/BHPr. He concluded his presentation on current trends for physicians entering primary care.

After a brief lunch break Dr. Patrick Dowling, Department Chair of Family Medicine, University of California, Los Angeles, described his UCLA program to increase the number of bilingual and bicultural Hispanic family physicians in California. Dr. Dowling provided a very detailed look at the UCLA program and how it has adapted to a changing state population demographic and the anticipated shortage of 17,000 California physicians by 2015. Dr. Dowling indicated that the largest portion of the U.S. foreign-born population comes from Latin America, more specifically Mexico. One in every 10 people born in Mexico now lives within the U.S. and Mexicans now comprise 70% of all Latinos in America. He provided statistics about the U.S. surplus of GME positions versus Mexico's shortfall. There is anticipated to be between 400-2000 unlicensed IMGs in California alone. He described how the UCLA program focuses on pre-residency training to compensate for the extreme lack of knowledge of processes and skills for these IMGs to compete for residency positions. Dr. Dowling concluded his presentation to the council by describing the specifics of the UCLA program with respect to cost, challenges encountered, and immediate and long-term outcomes.

The next presentation of the day was given by Dr. Francis Crosson, Vice Chair, Medicare Payment Advisory Commission (MedPAC). Dr. Crosson's presentation described the composition and role of MedPAC and the commission's recent discussions pertaining to healthcare reform and GME.

Dr. Fitzhugh Mullan gave his second presentation of the day, which was focused on the Teaching Hospital Center and workforce provisions of the pending healthcare reform legislation. Dr. Mullan's presentation began with a comparison between the latest versions of the Senate and House healthcare reform legislation bills. He then discussed the importance of Teaching Hospital Centers with respect to promoting primary care and concluded with a review of the National Health Service Corps and how it would be affected by both pending bills.

The final presentation of the day was by Dr. Thomas Russell, Executive Director of the American College of Surgeons and focused on the anticipated coming shortage of general surgeons in America. Dr. Russell began his presentation with a short summary of historical acts that have led to this upcoming shortage. He compared the shortages of primary care physicians with those of general surgeons and how specialization has played a role in both.

The council then ended session for the day.

(Individual electronic copies of these presentations are available. Please send an e-mail to Shane Rogers to make your request.)

Review of Draft Recommendations

The council began its second day of the meeting at 7:30 a.m. The council members spent most of the day working on the development of their recommendations for its 20th Report.

Eric Moore, of the FocalPoint Consulting Group, was introduced as the contractor who will be responsible assisting the council with developing their 20th report.

The group then began supplementing and refining a base set of recommendations the council had developed during a number of conference calls conducted since September, 2009. For the calls, the council was divided into two separate groups. Group One was chaired by Jerry Kruse and co-chaired by Mark Kelley. Members consisted of Vicki Seltzer, Carol Pillinger, Ani Turner, Tom Keane, Bill Thomas and Leana Wen. Group Two was chaired by Sheldon Retchin and co-chaired by Bob Phillips. Members in the group consisted of Denice Cora Brambles, Joe Hobbs, Kendall Reed, Charlie Roehrig, Spencer Nabors, Jason Shu and Wendy Braund

During the session, the council came to agreement on a set of draft recommendations for which Jerry Kruse would work to synthesize and refine in a more presentable form send out to the council members.

Adjournment

Draft recommendations for the upcoming 20th report are listed below. These recommendations are still in a working status and will further be taken up by the Council at its next public meeting.

COGME 20th Report
Synthesized Recommendations – Working Groups 1 & 2
General Recommendations (DRAFT)

A. Primary Care.

Policies and programs should be implemented to enhance and support the practice of primary care, and to increase the supply of primary care physicians. Payment for physician services is biased in favor of hospital based and procedural services and does not provide appropriate incentives to enhance and support the practice of primary care, or to increase the supply of primary care physicians. Policy changes should be dramatic to remedy these legacy biases and have immediate effect. COGME recommends against policies that favor slow and incremental change.

B. The Number of Primary Care Physicians.

Policies should be implemented that raise the percentage of primary care physicians among all physicians to at least 40 percent from the current level of 32 percent, which is actively eroding since the proportion of current primary care trainees is even less. This goal should be measured by assessing physician specialty in practice, rather than at start of training.

C. Mechanisms of Physician Payment for Primary Care.

To sustain and support new physician specialty preference for primary care to attain a workforce of at least 40 percent primary care physicians, it is imperative that the incomes of primary care physicians be restored to at least 70% of median incomes of specialty physicians. Additional investments in primary care infrastructure, beyond reducing income disparity, will be needed to increase interest and improvement in primary care. Payment policies should be modified to support this goal.

D. The Premedical and Medical School Environment.

Medical schools and academic health centers should strategically focus and improve their choices of medical students and residents and design of educational environments to foster a physician workforce of at least 40 percent primary care physicians.

E. The Graduate Medical Education Environment.

GME payment and accreditation policies and a significantly expanded Title VII program should support the goal of producing a physician workforce that is at least 40 percent primary care. This goal should be measured by assessing physician specialty in practice rather than at start of training. Achieving this goal will require a doubling of current primary care production from residency training for a decade or more.

F. The Geographic and Socioeconomic Maldistribution of Physicians.

So long as inequities exist, policies should support, expand, and allow creative innovation in programs that have proven effective in improving the geographic distribution of physicians serving medically vulnerable populations in all areas of the country.

Specific Recommendations

B. The Number of Primary Care Physicians.

Policies should be implemented that raise the percentage of primary care physicians among all physicians to at least 40 percent. This goal should be measured by assessing physician specialty in practice rather than at start of training.

Congress and DHHS should:

1. Implement policies that raise the percentage of primary care physicians among all physicians to at least 40 percent.
2. Implement policies that result in 1 primary care physician for every 750 to 1000 people.
3. Implement policies that increase the supply of physician assistant, nurse practitioner, nursing and other staff positions committed to primary care.
4. Explore roles of Nurse Practitioners and Physician Assistants in specialties other than primary care and how those roles can be expanded to relieve need for non-primary care physicians.
5. Provide incentives and regulatory reform so that all clinicians and staff "work at the top of their degree" regardless of specialty or setting.

C. Mechanisms of Physician Payment for Primary Care.

To sustain and support new physician specialty preference for primary care to attain a workforce of at least 40 percent primary care physicians, it is imperative that the incomes of primary care physicians be restored to at least 70% of median incomes of specialty physicians. Additional investments in primary care infrastructure, beyond reducing income disparity, will be needed to increase interest and improvement in primary care. Payment policies should be modified to support this goal.

Congress, CMS, Medicaid, and Private Insurers should:

1. Develop innovative models of blended payment systems to incentivize practice and achieve appropriate payment levels for primary care. Blended models of payment should:
    a. preferentially increase fee-for-service payments to primary care practices;
    b. add significant payments for care-coordination to primary care practices;
    c. add pay-for- performance payments; and

    d. reward the PCMH financially when its physicians meet the four essential functions and the three corollary functions of primary care, and when measures of process and quality are met and improved.
2. Implement payment models that bundle payments for full-service accountable care organizations, and/or incentivize the development of community health care organizations that provide the four essential functions of primary care through collaboration of primary care physicians, public health, care coordination organizations and mental health organizations.
3. Institute further measures, such as the 2007 CMS RVU revaluation that will correct the inequities in the fee-for-service system and will provide higher payments for primary care services.
4. Dramatically expand payments for care-coordination. Congress and CMS should expand Medicaid programs and institute Medicare programs with appropriately high payments for care coordination to primary care practices that emphasize the four essential functions of primary care. Private insurers should institute similar care coordination payments to primary care physicians in primary care practices.
5. Authorize study of systems of pay-for- performance to assure simplicity and to assure that they are based on evidence that measures improvement of patients' symptoms, problems, functioning, resiliency and slow progression of ill-health.
6. Support the Patient-Centered Medical Home model (PCMH) as the construct for the practice environment that achieves optimal care coordination and integration, use of health information technology, enhanced access, appropriate payment, and study levels of funding necessary to sustain the model, and their impact on costs in settings other than physician offices.

D. The Premedical and Medical School Environment.

Medical schools and academic health centers should strategically focus and improve their choices of medical students and residents and design of educational environments to foster a physician workforce of at least 40 percent primary care physicians.

Medical Schools and Academic Health Centers should:

1. Develop an accountable mission and measure of social responsibility for academic medicine to improve the health of all, to collaborate with their communities and distribute resident training accordingly, to reduce physician income disparities, and to lead in the development of new models of practice.
2. Allocate resources to:
    a. increase the involvement of primary care physicians in the first two years of medical school;
    b. fund primary care interest groups;
    c. recruit, develop and support community physician faculty members; and
    d. require student participation in rural, underserved and global health experiences.
3. Expand medical school class size strategically to address the primary care physician deficit and maldistribution.
4. Reform admission processes to increase the number of qualified students more likely to choose a primary care specialty and to serve medically vulnerable populations.
5. Require block and longitudinal experiences of sufficient length that medical students clearly understand the essential functions of primary care and the medical home.

Medical Schools, Academic Health Centers, the AAMC, the ACGME, Congress, Regulatory Agencies, and Licensing Agencies should:

6. Reform the continuum of medical education, from premedical training through continuing education, to most efficiently impart general competencies and promote the choice of primary care careers.

The Federal and State governments should:

7. Provide increased incentives for physicians who practice primary care or other critical specialties in designated shortage areas.
8. Substantially enhance funding for scholarships, loans, loan repayment, and tuition waiver programs to lower financial obligations for students who plan and choose careers in primary care.

E. The Graduate Medical Education Environment.

GME payment and accreditation policies, and a significantly expanded Title VII program should support the goal of producing a physician workforce that is at least 40 percent primary care. This goal should be measured by assessing physician specialty in practice rather than at start of training. Achieving this goal will require a doubling of current primary care production from residency training for a decade or more.

Congress, the Administration, DHHS, Accrediting Agencies and Private Insurers should:

1. Strategically increase the number of new primary care GME positions and programs to accommodate the increased production of medical school graduates and respond to the need for a workforce made up of at least 40% primary care physicians.
2. Increase training in ambulatory, community and medically underserved sites by:
    a. removal of all regulatory disincentives including the community preceptor ruling;
    b. promotion of educational collaboration between academic programs and FQHCs, RHCs and the NHSC; and
    c. implementation of new methods of funding to include reallocation of existing GME funding, new GME funding that is not calculated according to Medicare beneficiary bed-days, and substantial expansion of Title VII funding specifically for community-based training.
3. Provide financial incentives for GME that:
    a. directly provide GME funding to primary care residency programs and non-hospital community agencies to provide the proper incentive for ambulatory and community-based training;
    b. augment payments for primary care residents, including differentially higher salaries and early loan repayments, to decrease the negative impact of educational debt on primary care specialty choice;
    c. fund all primary care residency programs at least at the 95th percentile level of funding for all programs nationally (using total DME and IME payments as a basis); and

    d. reward teaching hospitals, training programs and community agencies financially on the basis of number of primary care physicians produced to be determined by specialty in practice and not at initiation of training.
4. Change ACGME regulations to support more training in outpatient settings and experimentation with practice models to appropriately prepare residents for an evolving contemporary healthcare environment.

F. The Geographic and Socioeconomic Maldistribution of Physicians.

So long as inequities exist, policies should support, expand, and allow creative innovation in programs that have proven effective in improving the geographic distribution of physicians serving medically vulnerable populations in all areas of the country.

Congress and the Administration should:

1. Quadruple the funding for the National Health Service Corps so that the NHSC can recruit more primary care physicians, provide greater support of scholars, create special learning opportunities and networks for scholars and early loan repayers, and forge formal affiliations with academic institutions and training programs.
2. Quadruple the historic highest level of funding for Title VII, Section 747, Primary Care Medicine and Dentistry cluster grants.
3. Quadruple the funding for AHRQ, and recommend that indirect cost percentages for AHRQ grants equal the percentages for indirect costs for NIH Grants.
4. Implement programs to increase funding by AHRQ, NIH, and private research enterprises for projects that stimulate primary care and community-based research and emphasize methodologies such as population-based ecological and cluster studies, qualitative behavioral studies and comparative effectiveness research.
5. Increase funding for community health centers that commit to training students and residents and AHEC programs, particularly to raise low functioning AHECS to minimum functions.