

March 2, 2009

The Honorable Mary Wakefield, PhD, RN, FAAN
Administrator, Health Resources and Services Administration
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Wakefield:

Congratulations on your appointment as HRSA Administrator. We look forward to working with you as you take on the responsibility of administering the federal programs aimed at improving access to quality health care.. As you know, the Title VII programs, particularly the primary care medicine and dentistry cluster, have been critically important to the academic infrastructure of family medicine. We were encouraged that the *American Recovery and Reinvestment Act* (ARRA, now Public Law 111-5) included funding for the development of the health professions workforce.

On behalf of the five organizations representing family medicine, we recommend that HRSA double the funds available for the Title VII, section 747 grant program for the two-year duration of the ARRA. This increase is in keeping with the recommendations of the House Report to accompany ARRA and is important to help meet the nation's health care workforce needs. The appropriate distribution of these economic recovery dollars is vital to support medical education and training and produce an adequate supply of primary care physicians.

Medical schools that receive primary care training dollars produce more physicians who work in Community Health Centers (CHCs) and serve in the National Health Service Corps (NHSC) compared to schools without Title VII primary care funding, according to a study published in *Annals of Family Medicine* (September/October 2008). Community Health Centers are central to federal efforts to expand access for the underserved. In spite of an effort to double their capacity between 2002 and 2006, CHCs have found it difficult to recruit a sufficient number of primary care physicians and have hundreds of vacant positions.

We commend the Congress and the Administration for including \$300 million for the National Health Service Corps in the ARRA. Those funds are an important component of the effort to recruit primary health care providers for practice in underserved communities and provide loan relief to physicians facing heavy educational debt.

As the Health Resources and Services Administration determines how to allocate the remaining \$200 million, we urge you to focus on those training activities and



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educational research activities that prepare graduates for the realities of future practice. We recommend that HRSA open a two-year grant cycle for primary care medicine training grants.

A new grant cycle should allow for departments and residency programs to develop training curricula and programs for practice in new models of care, such as the patient centered medical home (PCMH). Such new efforts in training are needed as the health care system enters a reform era focused on access, quality and accountability. Although the government and others have been financing demonstrations of the PCMH, less support has been available to transform the training programs where young doctors will learn to practice in this manner. New models require the development of new training programs and the ability to evaluate those new programs. Funding is needed to support all aspects of the educational program -- development, evaluation, and personnel. In addition, we know that the release of these funds into the departments and residency programs would increase the number of students choosing primary care careers.

The funding can be spent quickly to meet the stimulus requirements of the ARRA. People account for approximately 80% of program budgets. Medical schools and residency programs are like employers in the country and some are at risk of losing faculty and staff. These new grants can help employ people that might otherwise have to be laid off. Additionally, graduates who enter into primary care practice grow the economy of their practice region. A 2003 study by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care showed that the average family physician had an economic impact of over \$900,000 upon the local community. The mean impact of all family physicians per state was \$1.275 billion.

The ARRA resources could also allow for the acquisition of useful training equipment which would otherwise be out of reach. The historic cap on the allowable costs of such equipment in grant awards must be lifted to allow for the purchase of a broader range of equipment that will help bring training into the 21st century to meet practice needs. These new types of training equipment could add great value for students and residents, but some equipment is more costly than traditional models.

We suggest HRSA prioritize equipment that has a training function. There is a great untapped need for simulation aids and related software. Some simulation equipment will require updated physical space to accommodate their use in training. Other equipment that should fit this category would be videoconferencing and telemedicine equipment, and video recorders for direct observation of trainees and review of clinic sessions. For example, routers used for teleconferencing and telemedicine are extremely expensive, yet they can be helpful in establishing and maintaining education for residents, students and community faculty in remote locations. In addition, equipment such as colposcopes with video teaching or microscopes with teaching heads or other equipment including training videos that accompany the teaching equipment should be included. Each of these "equipment"

areas is valuable to training in general and would help promote training in rural areas.

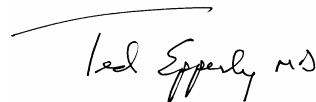
The four original HRSA funding foci (predoctoral, residency, fellowship, and academic units) continue to be critical. We need to promote training to aid in the increase of our primary care workforce; we need fellowships and faculty support for research training and primary care faculty development within academic settings.

Knowing how instrumental HRSA programs are to the production of needed physicians and other providers, and the provision of care in underserved areas, we applaud the funding that the ARRA has directed to HRSA programs. We hope that you will support our recommendations for the distribution of those funds among these key HRSA programs.

Sincerely



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