



The Teaching Health Center: Training Team Players to Provide Better Health Care to the Underserved

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Introduction/Executive Summary

Effective treatment of patients with complex medical and social situations calls for a generation of more active clinicians, not just physicians, who are willing to integrate a model of care that addresses the whole patient, not just the illness. It is time that health care evolves to not only meet the patient's medical needs, but all facets of health including a patient's environment. This requires a transdisciplinary approach to health care that needs to be ingrained into clinicians from the onset of their training. Clinicians must learn how to effectively utilize a support network of health care providers to deliver comprehensive, preventative primary care. This is especially crucial in underserved populations—these patients not only carry the largest burden of chronic disease with poorer outcomes, but also have limited access to care. Even with modest improvements in primary care reimbursement and a revised payment structure incentivizes improved health outcomes, reliance on a single clinician to effectively change health care outcomes while practicing in the current landscape is not practical.

- ❖ A transdisciplinary approach will ensure that patients are receiving effective preventative health care that moves away from the traditional dependence on the physician as a sole provider. This will reduce clinician burnout from external environmental pressures.^{7,10}
- ❖ The new transdisciplinary model will create links not only between physician specialists but also nutrition, social work, physical therapy, nursing, physician assistants, complementary and alternative medicine, the community itself, and any other medium that would work towards improving an individual's health. Preventative care is an aspect of primary care that does not have to be delivered by only a physician.

- ❖ Students and residents will receive increased exposure to underserved primary care settings and transdisciplinary care will be integrated into training. Studies have shown that increasing exposure to underserved or rural communities at the student level increases their chances of working with these populations in the future by over 50%.^{2,8}
- ❖ This effort will immediately increase the number of providers in underserved communities.⁹ At this current time, the US Health Resources & Services Administration (HRSA) reports that there are currently 6,080 Primary Care Health Professional Shortage Areas (HPSA) with 65 million living in them. In order to meet the demands, an estimated 16,585 professionals are needed.

Solution:

Develop a training health center (THC) grant system to enable partnerships between academic institutions and community health centers to provide “Underserved Teaching Fellows” available to all disciplines involved in health care delivery. Extra incentives can be provided for National Health Service Corps (NHSC) members through a reduced loan reimbursement plan to serve additional time as a teaching fellow. The teaching fellow role would include creating transdisciplinary curriculum for the residents and students across disciplines working in the same THC.

Problem:

In the present health care environment an increasing number of medical students are choosing to enter specialty fields rather than primary care. In addition, with the historic passage of health care reform legislation, there is a projected increase of 32 million patients has resulted in a huge primary care workforce demand and a steadily diminishing supply.⁵ A new Harvard study has demonstrated that lack of insurance is linked to 45,000 deaths annually, or one death every twelve minutes.⁴ The report emphasized that much of this disparity is due to lack of care for treatable chronic diseases despite the increased quality of care available to those with access to care.⁴ It is estimated that to meet patient primary care demands, the workforce needs to expand by 40,000 physicians, however currently fewer than 20% of medical students show interest in primary care.³ Practicing primary care physicians experience burn-out due the high volume demands needed to keep a practice financially viable, which furthers the workforce deficit. Fifteen minute office visits hardly allow physicians time to address the medical issues a patient presents with while providing adequate preventive care education and counseling. Preventative care is very broad and covers a spectrum of specialties and disciplines. Each specialty and discipline works as a separate silo. Many of these disciplines have very little exposure to working across these silos resulting in a disjointed system for delivery of care.

Our Interest:

The Association of Clinicians for the Underserved (ACU) is a transdisciplinary organization that promotes comprehensive health care that includes coordinated care not just between physicians but all disciplines of health care. We feel this model of care is able to be more flexible within the current environmental circumstances of health care delivery and allow for more comprehensive preventative health care, which is especially relevant to underserved populations.

Policy Options:

1. Increase THC Funding/Incentives for Medicare Graduate Medical Education (GME) to integrate a transdisciplinary team approach to health care that encompasses trainees from all disciplines.

This would mean redefining the THC so that a Community Health Center (CHC) is designated as a "Patient Centered Medical Home" to promote coordination of care between specialists for chronic disease and disciplines for efficient and effective preventative care. For an underserved population, this means expanding the definition further to ensure social workers and the community health workers are members of the transdisciplinary team. Thus GME funding would serve to indirectly fund a CHC's ability to expand their services to more patients by directly having more providers, encourage transdisciplinary coordination of care, and increase provider exposure to underserved populations. Ideally, either these designated CHCs would train residents or integrate care with teaching institutions from other disciplines.

The Advisory Committee on Interdisciplinary Community Based Linkages (ACICBL) recommendations in 2006 to Congress also supports the expansion of community--based educational transdisciplinary learning opportunities through all levels of training: "The Secretary and Congress should provide funding incentives and demonstration projects in support of education and training to develop interdisciplinary health professions education clinical teams in conjunction with community health centers, rural health clinics, and other providers in underserved areas, to improve capacity, encourage positive evidence-based outcomes, and enhance the quality of health care. " They also recommend that, "The Secretary and Congress should support community-based linkages of health professions education programs with community health centers, rural health clinics, and other community-based sites in the development of a diverse workforce through education and recruitment activities in both rural and urban medically underserved communities."^{1,2}

Undergraduate medical education placement in community sites has also been shown to increase primary care retention while exposing students to a transdisciplinary approach to medicine. A.T. Stills University promotes "Whole Person Healthcare" and encourages students to learn across disciplines. Their program promotes the integration of students into the community and with other disciplines early on in their educations. Rather than the traditional model of two years of basic sciences curriculum and then two years of clinical rotations in local hospitals and academic

clinics, A.T. Stills places students in community campus by their second year. In this way, they are taught at the beginning of their training about the complexities of health care delivery to underserved populations and the need to integrate multiple disciplines to provide effective care. This model has proven to work in terms of student education and should be expanded to a postgraduate training level.

Although there would be an initial investment by expanding the scope of the CHCs through residency training expansion, significant health care savings are expected. Indiana CHCs have shown that every dollar spent on patient care in a CHC resulted in \$1.90 of savings in overall health care spending totaling in 473 million dollars of savings. These savings were attributed to fewer emergency room visits and decreased hospitalization from improved chronic disease management.

The Patient Protection and Affordable Care Act authorizes a new Title VII grant program for the development of residency programs at health centers and establishes a new Title III program that would provide payments to community-based entities that operate teaching programs that will directly appropriate \$230 million over 5 years for the Title III payments. It is necessary that these funds are used to promote and integrate transdisciplinary education at THCs.

2. Expanding National Health Service Corps (NHSC) stipulations to include a transdisciplinary underserved healthcare teaching role, creating a THC at NHSC clinics, through the implementation of transdisciplinary NHSC teaching teams.

The National Health Service Corps (NHSC) with its recent \$200 million dollar increase in funding through the American Recovery and Reinvestment Act will be able to affect more underserved communities. The implementation of effective prevention services, however, would require a transdisciplinary team of NHSC members to be established in these communities. If the stipulations for the NHSC were to be expanded to include a teaching role, these clinics could then be used as a site to send multiple disciplines of residents and students to match the team of NHSC members without having to fund additional faculty. Current stipulations permit grantees to spend only 20% of their time on non-direct patient care services. Time for this teaching role would have to be allocated separately from the administrative time that is currently allotted.

Although this would alter the current framework for the NHSC, the change would be minimal and the program would continue to provide direct patient care through the integration of residents and students. By matching the students and residents to the NHSC team in an underserved clinic, development of transdisciplinary skills would happen at multiple levels and provide higher quality, comprehensive prevention services. By reallocating the requirements, there would be no need to increase funding and these clinics. These NHSC designated clinics in Health Professional Shortage Areas (HPSA) would subsequently act as a THC.

Another option is to extend NHSC commitment and training by having the Scholars serve in a teaching role. By serving as a teaching attending, they could continue to work in underserved communities and receive further loan repayment. Traditionally, an attending health care

professional spends significant time in the exam with a student during times of direct patient care. With a resident, there is less patient care from a NHSC attending; nevertheless, the resident is able to care for the patient. Thus, the teaching component of the attending would now serve to help more providers learn how to give higher quality, more efficient care to underserved populations while also increasing their exposure to these populations and increasing retention of workforce in underserved communities. This would apply to all positions designated as NHSC members including physicians, nurse practitioners, certified nurse-midwives, physician assistants, dentists, dental hygienists, mental health providers, social workers, and counselors. The attending would be tasked to develop a curriculum that would be unique to underserved health care in a transdisciplinary setting.

3. Increase competitive grant funding for the development of "Underserved Health Care" Fellowships in all disciplines to serve at transdisciplinary THC.

For underserved areas, the cost of supporting a fellow would be significantly less than funding additional practicing primary care physician. The available funding would apply to fellowships in all disciplines, focusing on how care models differ in underserved areas. Clinics serving underserved populations inherently require more transdisciplinary care due to the complex social situations that many of these patients present with. By having fellows from different disciplines working together in one clinic with an overarching curriculum emphasizing serving the underserved in addition to transdisciplinary care a more cohesive workforce would be developed.

Fellowships of this nature already exist at the University of California San Diego and Northshore University Health Systems in Chicago. While increasing direct patient care and improving quality of health care delivery, it also provides an opportunity to expand the teaching capabilities of a university setting directly to the unique challenges of underserved healthcare. By promoting the entry of health care students in all disciplines into primary care and thereby, increasing the chances that they will work with underserved populations in the future. The current grants for the UCSD fellowship funds three fellows one in medicine, acupuncture, and dentistry with a two year, \$240,000 grant from the WebMD health foundation.⁴

Recommendation:

Develop a THC grant system for partnerships between academic institutions and CHCs for underserved teaching fellows available for all disciplines involved in health care delivery. Extra incentives can be provided for NHSC members through a reduced loan reimbursement plan to serve additional time as a teaching fellow. The teaching fellow role would include creating transdisciplinary curriculum for the residents and students across disciplines working in the same THC.

The THC would provide more exposure to underserved populations to both students and residents in all disciplines and create a functioning environment for them to learn how to work

with each other—a skill that will only better their professional career. There are three key players in the process of developing a THC including the academic institution, the CHC, and the health care provider. In order to effectively create a partnership between these groups they each need incentives. A CHC makes on average \$129 a visit and an attending can generally see up to 3 patients an hour. Adding a teaching component through students and residents generally reduces the number per visits to 1 to 2 patients per hour creating a revenue loss for the CHC. If a CHC, however, kept all of their current attendings full-time and could hire an additional teaching attending they would now be reaching out to more patients albeit less than a non-teaching attending. If a partnered CHC and academic institution could apply for an underserved teaching fellow grant the salary for the teaching fellow would be covered. The grant system would provide incentives for two out of the three parties involved. The CHC increases outreach and the academic institution can support a new fellow while incorporating a transdisciplinary teaching curriculum for their students and residents.

The final party in need of incentives is the health care provider. After the recent \$200,000,000 increase in funding for the NHSC, it would be most efficient to utilize these members more effectively in terms of developing a transdisciplinary workforce by allowing them to serve as a teaching fellow. Generally NHSC members are given a \$25,000 to \$35,000 loan repayment stipend in return for their service. Allowing them to continue to serve as teaching fellow could call for a lower loan repayment stipend of \$5,000 to \$10,000 a year. This would encourage those who are interested in teaching to help create a more effective workforce for healthcare delivery to the underserved.

Redefining NHSC stipulations to include a teaching component would provide an increase in the workforce through direct patient care by medical residents and learners from all disciplines as well as providing a foundation for system-based changes that need to happen to increase health professional training in transdisciplinary care. Allowing the teaching NHSC members to develop curriculum for underserved populations and transdisciplinary care would also align with recommendations from the ACICBL to Congress in terms of increasing community partnerships, developing curriculum for transdisciplinary education, and providing teaching environments where students and health professionals can work together.

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