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The American Medical Student Association (AMSA) Foundation is assisting the U.S. Public Health Service in increasing the number of primary care physicians trained and committed to practice in medically underserved areas. In collaboration with the American Academy of Family Physicians, the Ambulatory Pediatrics Association, and the Society of General Internal Medicine, AMSA conducted an assessment of federally-funded residency programs to identify and describe their affiliations with federally-funded community and migrant health centers (C/MHCs). Of the 260 programs assessed and the 147 responses, 125 offer community-based training. Of these, 73 offer training in primary care centers and 39 offer training in federally-funded C/MHCs. Residents training in the C/MHCs have positive experiences in both personal and professional development and are frequently hired by the health centers upon graduation. Benefits realized by the affiliations include a community orientation for the residents and enhancement of service and education missions for the collaborating institutions. (Henry Ford Hosp Med J 1992;40:45-9)

This is an exciting decade of looking for new solutions to old problems, tackling new problems, and preparing for the 21st century. In so doing, we have come to realize that community-based health care delivery systems have become sophisticated and are ready to share their strategies in the delivery of community-responsive ambulatory care with academic medical centers.

Background

Community and migrant health centers (C/MHCs) have just celebrated their 25th anniversary of providing preventive and primary health care services to underserved populations. Health centers were developed as the nation's response to the war on poverty by empowering local leaders to plan together to meet the health care needs of their own communities. Many centers were developed in close collaboration with residency training programs as ambulatory training sites for residents; however, with conflicts over governance as well as disruption to the primary service mission of the health centers, the relationships were dissolved (1).

There are currently 550 federally-funded C/MHCs serving 5.8 million persons. The centers receive grants from the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services to cover a portion of their costs in delivering care to disadvantaged, uninsured, and underinsured people. They also serve a paying and insured population which otherwise lacks access to care.

Of the 550 C/MHCs, more than 200 are located in urban areas. Of the patient population in the urban centers, 41% have public insurance and 46% are uninsured. Urban health centers are currently addressing the following urgent health and social needs in their communities: teen pregnancy, substance abuse, infant mortality, treatment and prevention of the acquired immunodeficiency syndrome (AIDS), and family violence. Meeting these needs requires that health professionals acquire the necessary sensitivity and skills through appropriate community health training and role models. This community health exposure and teaching can be conducted in C/MHCs by the primary health care staff of the centers. Students in health professions can learn firsthand the interrelationship of social and health problems as well as the clinical skills to manage them. The literature suggests that those medical students and residents with a personal background in underserved communities and/or positive experience in community health are attracted to advanced training and primary care careers in community-based, underserved settings (2).

Federal Initiatives

Approximately 800 physician providers are needed to fill vacancies in these health centers. The National Health Service Corps (NHSC) was created during the 1970s to alleviate short-

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ages of primary health care professionals through a scholarship and service payback system. Shortages have occurred because many students who intend to pursue primary care careers upon entry to medical school are persuaded against doing so by the financial incentives and the prestige associated with other specialties and the focus on research and specialty practice in the training institutions. Consequently, students are selecting primary care careers to a lesser degree than ever before; the proportion of medical school seniors selecting primary care specialty training fell from 37.3% in 1981 to 23.6% in 1989 (3).

With the decline in NHSC scholarship recipients during the last 10 years, the NHSC will only be able to fill approximately 100 of these 800 vacancies with its current participants. Therefore, the C/MHCs are collaborating with other community resources, including academic health centers, to resolve their problems of attracting and retaining providers to deliver medical services. Without providers, some health centers are threatening closure or cutbacks, seriously affecting access to care for many Americans.

On the federal level, the HRSA has developed a strategic plan—"Primary Care 2000"—that outlines its long-range plan for recruiting, training, and retaining health professionals. HRSA's mission is to provide leadership in assuring the delivery of primary health care, particularly to the underserved, and in developing qualified health professionals and facilities to meet the health needs of the nation (4). HRSA's two major goals for the revitalization of the NHSC are: 1) to provide an adequate supply of health professionals available to serve in the most severely underserved areas through programs that promote commitments to the NHSC and other programs; and 2) to create programs that promote the recruitment, training, and retention of health professionals most likely to provide primary care and to practice in underserved areas (3).

HRSA has identified the following barriers to be overcome in its attempts to encourage providers to enter primary care specialties: 1) lack of academic prestige associated with primary care and community practice; 2) lower reimbursement for non-procedure-oriented, ambulatory care training, creating a relative disadvantage for these programs in reimbursement-conscious medical centers; 3) lower reimbursement for primary care services; 4) lack of ambulatory training opportunities in general and specifically in underserved areas; and 5) limited coordination among federal programs and between federal, state, and local programs.

HRSA's eight-point, long-range plan has been developed to overcome these barriers and ultimately to improve access to care. In particular, the plan addresses the need to build training programs that emphasize ambulatory training experiences with underserved populations in order to ultimately produce primary health care providers with the appropriate knowledge, skills, and attitudes to meet this population's special needs. On the federal level, a joint task force has been formed between the service and education arms of HRSA—the Bureau of Health Care Delivery and Assistance and the Bureau of Health Professions—to establish policy in support of service-education linked programs. In particular, the NHSC has a strategy for developing and recruiting appropriately trained health providers through a continuum of work-study experiences in community-responsive health care systems for health professional students (3).

Student and Resident Training

The American Medical Student Association (AMSA) is a national organization representing physicians-in-training. AMSA has worked for more than 20 years with the Public Health Service on training and recruitment issues for the NHSC, the Indian Health Service, and other programs. For the past seven years, AMSA has been developing a model community-based training program that allows medical students to live and work in underserved communities and practices. Students are placed in C/MHCs and Health Care for the Homeless Projects for six to eight weeks to conduct health promotion/disease prevention projects on behalf of the communities. While there, the medical students learn about future career opportunities in primary care with underserved populations with the NHSC or in C/MHCs.

Study Methodology

AMSA is now collaborating with the Public Health Service on the development of this continuum of community-based training opportunities for physicians-in-training through a contract with the Division of Medicine, Bureau of Health Professions, jointly supported by NHSC. AMSA is conducting the Community Responsive Residency Training (CRRT) project with a consortium of primary care specialty groups that includes the American Academy of Family Physicians, Ambulatory Pediatric Association, and Society of General Internal Medicine.

The project is based on the premise that residency training has an influence on career choice for residents, that those who train with underserved populations are more likely to choose careers to practice with the underserved. Satisfaction with the training experience and exposure to community physicians as positive role models have been influential factors in practice choice (5). These results have been reported by the following programs: Montefiore Residency Training Program in Social Medicine (6), Providence Family Practice Residency Program at Sea Mar Community Health Center (7), and University of Missouri-Columbia Family Practice Residency Program (8).

The CRRT project is studying past experience and promoting future linkages between federally-supported primary care residency training programs and C/MHCs. The four phases of the one-year project include: 1) literature search on the state-of-the-art of community-based residency training; 2) identification and assessment of current affiliations between federally-funded residency programs and C/MHCs, and analysis of these linkages (especially those with residents spending one year or more of ambulatory training in health centers for continuity of care or longitudinal training experience); 3) selection of nine pilot sites and provision of technical assistance to enhance their affiliations and assist in evaluating their programs and tracking their residents' career choices; and 4) documentation of service-education linkage experiences for others to draw upon.

During the literature search, little was found in the way of documentation of the experiences of primary care residency

programs linked with community-based primary care centers for the dual purpose of training and service delivery.

Study Findings

Of the 260 federally-funded primary care residency training programs included in the assessment, 147 responded. Of the respondents, 125 offer some sort of community-based residency training. A total of 73 provide training in a primary care center; 55 have formalized relationships with the centers; 39 provide training in federally-funded C/MHCs; but only 24 provide longitudinal training in federally-funded C/MHCs.

During the longitudinal training in the C/MHCs, residents are exposed to the personal and professional challenges of being a provider in the health center. They work with multicultural patient populations in a multidisciplinary team approach. They participate in quality assurance and practice management activities and often develop and conduct a community research or service project. Most, if not all, of these longitudinal training/service linkages are located in urban areas. On average, 6.5 residents are trained in each of the 73 residency programs providing ambulatory training in a community-based primary care center.

Most programs offering longitudinal training experiences in C/MHCs have established community-based training within the past three years and have formal agreements. In general, these residency programs also have stated missions to serve the underserved. They are located somewhat close to the health centers (usually within five miles) and assign their residents a panel of patients who are sometimes, but not always, followed by the residents on inpatient service.

According to the current assessment and the findings from a previous study (9), the benefits realized through the affiliation of health centers and primary care residency programs are: 1) an opportunity for fulfillment of the teaching institution's mission to serve the underserved; 2) a community orientation for the residents; 3) development of resident skills in real life practice management; 4) a new source of ambulatory training; 5) a good source of patient and disease/symptom mix; 6) a source of inpatients and shared faculty between the health center and the hospital or teaching program; 7) job enhancement for health center providers to become clinical faculty; 8) enhanced quality of care in the health center; 9) recruitment of health center providers from the pool of resident trainees; and 10) additional help to plan for expansion of health center services, to conduct needs assessments, and to document services provided.

According to the responses on the assessment, both the health center and the residency program must recognize the benefits of enhancing their own service and education missions by expanding the scope of activities beyond their original goals. To ensure a successful linkage and to overcome barriers posed, the following issues must be addressed during the negotiations:

- Finances: Who pays for/provides clinical faculty? Who pays the residents? Who receives the fees generated? Who supports ancillary staff?
- Health center concerns about patients used as teaching cases.
- Prestige accorded center for being recognized by major education institution center as a model teaching site.
- Balance between decreased productivity of health center clinical faculty and increased health center costs to support education in the short run and enhance recruitment and retention of providers in the long run.
- Concern for quality of training and care at the C/MHC; recent trend toward board eligibility and certification of health center physicians; need to design and provide faculty and preceptor development programs; need for close and regular monitoring by residency faculty with health center faculty; input and expertise of residency faculty into health center quality assurance program.

Residents' needs and considerations identified during the assessment include: 1) resident interests and expertise taken into account in selection and matching to C/MHC training site; 2) formal orientation to the community health experience and setting; and 3) opportunity for processing and assimilating their experiences in terms of personal, professional, and educational needs and expectations.

All the programs interviewed during the project indicated that barriers could be overcome by beginning development of service-linked educational opportunities for residents slowly and on a small scale. The process for affiliating residency programs and health centers requires open channels of communication and mutual respect and understanding. They must also have an overriding commitment to the purpose for linking and to working through any controversial issues that arise, such as control, selection of residents and faculty, finances, and liability. Both participating institutions require a certain level of stability in staffing and funding to insure continuity in their service delivery or teaching missions.

Experiences of Two Residents in Community-Based Training

The perspective of two residents involved in longitudinal ambulatory training experiences at C/MHCs are presented to illustrate the involvement of residents in the development of these training opportunities, the impact that this community-based training has had on their educational experience, and their future career selection.

Resident 1

This physician-in-training is finishing her first year of family practice residency training at Mercy Hospital in Toledo, OH. She is doing her ambulatory training at Cordelia Martin Community Health Center in Toledo and has participated in a continuum of community-based educational experiences throughout her training.

One of the reasons for selecting a residency in this program is the opportunity to participate in the development of Mercy Hospital's new Urban Track, based at Cordelia Martin Health Center. Cordelia Martin is an urban C/MHC that has served Lucas County residents for more than 20 years. Residents involved in Mercy's Urban Track participate in health center continuity clinics beginning in January of their first year. They continue to

follow and expand on this patient panel throughout their three years of training. Residents participate in all curriculum components of the Mercy Hospital Family Practice Program and have a continuity clinic at Mercy Family Practice Center as well. In addition, the Urban Track residents participate in social medicine/public health seminars on urban health and may take advantage of special electives, such as community medicine.

The advantages to training in the Urban Track are many. Unlike the Mercy Family Practice Center, Cordelia Martin is a community-based center serving a diverse population of approximately 7,000, regardless of ability to pay. The center's population is primarily African-American but also includes Caribbean and African natives, Mexican Americans, Puerto Ricans, and whites, including a large group from Appalachia. In addition to serving a large number of traditional families, Cordelia Martin attracts single-parent families, families with foster children, and homeless people. The center also serves several high-risk groups, including substance abusers, pregnant teens, and AIDS patients.

Cordelia Martin is a multiservice, multipractitioner center. In addition to providing traditional comprehensive health care services, the center also provides on-site x-ray and laboratory facilities; a pharmacy; Women, Infants and Children program services; social services; prenatal education; nutrition education; mental health services; dental services; and a comprehensive sickle cell anemia education and coordinating service.

The center also utilizes and serves as a training site for a variety of health professionals, including physicians, nurses, laboratory technicians, nurse practitioners, social workers, and nutritionists. In this setting, trainees learn to work together as a team to coordinate services for their patients and to optimize health care outcomes.

In short, according to this resident's perspective, centers like Cordelia Martin provide a better setting than hospital training programs for training health professionals interested in urban primary care. Such centers expose residents to a patient population not often found in traditional hospital-based practices. They also provide residents the opportunity to work in a community-based practice uniquely qualified to serve urban communities.

Resident 2

This resident is completing his primary care internal medicine training at Cook County Hospital in Chicago. He did his ambulatory training at Claretian Health Center in Chicago and will join the staff there, as well as the faculty at Cook County Hospital.

Cook County Hospital is one of the few remaining large metropolitan hospitals that is dedicated to delivering medical care to the indigent and medically underserved. The patient population is from the Chicago metropolitan area and surrounding counties and is also an international community. Fantus Clinic is the hospital-based clinic that delivers outpatient care to walk-in patients.

The Primary Care Program in Internal Medicine is a relatively young program. Begun two years ago, its stated goal is to train residents to be effective caregivers in the community-based, nonhospital setting. The program has formal arrangements with five to six established community clinics that deliver health care primarily to the indigent and medically underserved. This arrangement allows medical residents to spend one-half day each week working in one of the clinics in a supervised setting, beginning in the second year or after completion of the internship year. Usually, this totals two or three hours per afternoon or evening. There are currently nine second- and third-year residents training in the community health centers from the Primary Care Program.

The community health centers are a reflection of the surrounding community's ethnic makeup, and the majority of the clinic employees come from and live in the surrounding neighborhood. Each individual health center is an integral part of its community and serves to deliver important medically relevant care to the area.

In selecting residents for each health center, the program directors and planners make a concerted effort to match residents to health centers. Some of the factors considered in this match are where the resident lives and distance to the clinic; the ethnic and racial makeup of the clinic and the resident; language similarities/dissimilarities; strengths and weaknesses of the resident; and personalities of the clinic and the resident.

Each resident is also matched with a preceptor, as the experience is meant to be a learning one. Supervision by an attending physician is desirable and necessary. The responsibilities of the resident are to see patients and to learn to function in the nonhospital-based community clinic. Specific duties involve seeing patients who may be first-time visitors to the clinic, as well as those who may be regular clinic patients. Residents are trained to work with other professionals in the health community, such as nurse practitioners, psychologists, psychiatrists, social workers, and other caregivers. As this training is important, it carries over into the neighborhood clinic where usually nonmedical as well as medically related care is given. As more of the larger hospitals close and the health care system becomes more decentralized, the necessity of the community-based approach to medicine becomes paramount.

The health centers offer a wide variety of services, including medical, dental, podiatric, nursing, social, and educational services. Unlike the outpatient hospital-based clinic, the centers provide the residents with the opportunity to work in a private setting.

The resident takes up some of the supervising physician's time that could be utilized seeing patients; yet, at the same time, the resident is an extra practitioner. From the residents' point of view, there are advantages and disadvantages of working in the clinics. The advantages are: 1) opportunity to leave the hospital, 2) different atmosphere, 3) pleasant surroundings, 4) increased independence/autonomy, and 5) experience of working in the "private sector." The disadvantages are: 1) extended hours after hospital work, 2) increased travel time, 3) lack of compensation, and 4) animosity from other medicine residents who see you "leave" the hospital.

This last point is worth elaboration. The Primary Care Program is part of, but separate from, the "traditional" internal medicine program. Primary care residents focus more on the diagnosis and treatment of outpatient medical problems and psychoso-

cial issues and the roles that these issues play in the development and progression of disease. The program still leads to board eligibility in internal medicine and includes the basic specialty rotations, such as cardiology, hematology, infectious diseases, neurology, and renal medicine. More often than not, primary care residents may not rotate through all the subspecialties while the traditional residents may rotate through the same subspecialties two or three times. Primary care residents spend that "extra" time dealing with issues of preventive medicine, cancer screening, adult immunization issues, violence prevention, alcohol and drug abuse prevention and detection, AIDS, and sexual abuse and violence. Residents work on projects that reflect their personal interests and may include work with the homeless, accident prevention in the elderly, or tuberculosis exposure of residents.

One successful outcome of the training program, thus far, is that contracts have been extended from the community health centers to several of the residents to continue work after completion of their residency training. This is not only a tribute to the individual residents but also to the success of the Primary Care Program and its approach to medicine in the 1990s.

Comment

Some health centers provide their physicians financial incentives to include teaching with their practice. Most participating health centers assume that offering teaching opportunities and academic appointments in addition to clinical responsibilities will help prevent burnout among those physicians seeking job diversification. Preceptors replied on the assessment that they enjoy teaching and feel challenged to offer guidance and role modeling to younger physicians who, in turn, update them as to the latest advances in medicine. Health center providers who do not receive financial rewards, academic appointments and opportunities, or enjoyment in mentoring feel burdened with the additional responsibility and are not the appropriate candidates for carrying the dual roles in the health center of teaching and practicing. Due to the newness of residency training in the health centers, there is not enough experience with the tracking and evaluation systems to determine how long residents who have acquired appropriate training in the health centers are retained in the system. However, the data from the Oregon Health Sciences University Family Medicine Residency and Montefiore's Social Medicine Residency indicate that residents acquiring their training in the health centers and an acclimation to community medicine are more likely to choose to practice in the health centers after graduation. When the NHSC supplied the bulk of the providers to the health centers, most physicians did not stay beyond their service obligation. Therefore, it is important that health centers recruit and retain those providers who have the appropriate skills, attitudes, and commitment to work with the underserved for an extended period of time (7).

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