

Good afternoon Dr. McCauley, Dr. Phillips, and members of the committee. My name is James Nixon, and I have the pleasure of serving as chair of the Board of Directors for the Alliance for Academic Internal Medicine) — a consortium of five academically focused specialty organizations representing departments of internal medicine at medical schools and teaching hospitals in the United States and Canada. The Alliance includes 94% of all allopathic internal medicine departments and represents department chairs, residency and fellowship program directors, third and fourth year student educators, and business and education administrators. We are also tightly linked to program directors in combined Internal Medicine and Pediatrics Programs. Thus, AAIM encompasses the entirety of education and training in Internal Medicine. This means our members are pivotal in training future generations of internists focused on primary care **which leads to** our intense interest in the all-important topic you will be addressing.

I am a Professor of Internal Medicine and Pediatrics at University of Minnesota Medical School and I serve as the Vice Chair for Education for the Department of Medicine, where I am responsible for overseeing our Fellowship, Residency and Student activities.

Thank you for this opportunity to present the Alliance's comments to the National Academies of Sciences, Engineering and Medicine Committee on Implementing High-Quality Primary Care. The Alliance is proud to be one of the study sponsors, and supports the committee's plan to examine the state of primary care in the United States. The Alliance is proud to be a driving force in unprecedented collaboration among the certification, accreditation, and education community in Internal Medicine working to redesign education and training for the 21st century.

The following items from the Statement of Task are of particular interest to the Alliance:

- Barriers to and enablers of innovation and change to achieve high-quality, high-value primary care;
- Education and Training needs for the changing workforce in primary care;
- The infrastructure (workforce, data, and metrics) needed to evaluate the effectiveness of innovation and its impact on health outcomes and to support data-informed decision-making.

I would like to share some Alliance member concerns, ideas, and examples of what we see as promising efforts designed to remove barriers to entering primary care and improve primary care education, **thereby** increasing the number of well-trained primary care providers in practice.

Of note, the current physician workforce helps to shape the next one. With that in mind, for any measures to be successful it is imperative that we continue to support current physicians practicing in primary care. We need sites and physicians to conduct the training who are adequately resourced to perform their jobs. If the sites are dysfunctional/understaffed/under-resourced – this will either turn students and residents away from primary care or result in sub-optimal training. It is **in the real time experiences** of working with a primary care provider during their training that students are making their career decisions and residents are learning their future practice habits.

1. The first area we would like to highlight is related to programs that either promote entry into primary care or remove barriers to entering primary care.

I suspect we all agree that to achieve high-quality, high-value primary care you need to have high-quality, well trained primary care physicians. Many talented medical students who might otherwise choose to practice primary care, are dissuaded because of the residual financial burden of their undergraduate and medical education. Some schools such as NYU have made medical school free for all students in the hopes that this removes some of the financial burden that currently influences choice of medical specialty.

Another option for eliminating this financial burden would be to expand debt repayment programs for those who pursue primary care, particularly those interested in practicing in high need sites such as rural, remote, or urban underserved areas.

We also support exploring other methods such as pathways that allow streamlined, more focused, and potentially shortened training within disciplines leading to a primary care practice. Examples of this include Education in Pediatrics Across the Continuum (EPAC). This pilot program at UCSF, Utah, Colorado and Minnesota has allowed selected students early entry into pediatrics residency and could potentially be expanded to other primary care disciplines.

Another example of shortened training linked to a primary care residency is the FIRST program at University of North Carolina. This is a program with 3 years of medical school followed by designated spots for students in primary care residencies who promise to practice in underserved areas. Support for other innovative programs that explore their value for promoting entry into primary care would be welcome.

2. The next area we would like to highlight relates to the need for diversity in the future primary care workforce.

Leaders and members of the Alliance feel strongly that it is essential that our entire population is equally afforded high quality, high value primary care. We support initiatives designed to achieve a more diverse primary care workforce and decrease health care disparities. It is imperative that we attract a more diverse group into medical school and subsequently to primary care residency who reflect the diversity of the community for which they provide care.

In addition to promoting a more diverse future primary care workforce, we also support initiatives that help our future healthcare providers understand the causes of health disparities and how to address them. One successful example of the value of incorporating an explicit curriculum to address these root societal causes of health disparities at the system, community and legislative levels are the efforts of combined internal medicine-Peds residency of my own institution, the University of Minnesota. There are likely other successful examples from which to learn.

3. The next area of concern relates to the number of primary care residency training positions.

As you know, the number of GME training slots provided by CMS is a relatively fixed number. To increase the number of primary care graduates we must increase training slots focused in primary care. We believe this increase should not be linked to decreases in other areas of training. This effort has been successful with state level funding for primary care slots in Minnesota.

4. The next area we would like to highlight are programs that promote Primary Care Physicians practicing where they are most needed, including Rural Primary Care and Urban underserved areas.

There are a number of programs that support and attract individuals with interest in rural primary care from time of entry into medical school – examples include Minnesota’s Rural Physician Associate Program and Metro Physician Associate Program, the University of South Dakota’s Frontier and Rural Medicine (FARM) program, and the University of Nebraska’s Primary Care track. These programs include the ability of trainees to interact with their communities, to have specialized experiences in distance medicine, and enjoy enhanced high-quality ambulatory clinic training. Support for further development, collaboration and research around these types of programs is needed.

5. The final area is to train Physicians for a satisfying career

The Alliance urges you to also focus on initiatives that promote the ability of the primary care physician to work at the top of their license and that help them to better incorporate advances offered by technological and other innovations in delivering patient-centered primary care, including exploring the best role for virtual care and artificial intelligence.

There are many additional dimensions to primary care physician burnout such as the burden of documentation, compensation, and other issues that are well-publicized. We urge you to fully examine those aspects of career satisfaction.

The Alliance encourages the committee to support innovation and research in initiatives such as these around the United States. In addition to targeting the barriers to entering primary care, the education and training needs for the changing workforce, and addressing health outcomes, programs such as these are training a more prepared and ultimately happier and more satisfied primary care doctor of tomorrow.

Thank you again for allowing me to speak today. Given the time constraints I was only able to highlight a few of the many initiatives of our members, but I hope you can see the value that the Alliance can bring to this conversation. The Alliance would be happy to expand on or clarify any of the issues addressed today, or serve as a resource for your committee. As the committee maps the path forward for implementing high-quality primary care, the Alliance is positioned through its unique structure to assure that graduates are prepared for this new and challenging environment.