
# MMA Primary Care Physician Workforce Expansion Advisory Task Force

## Final Report

Minnesota Medical Association

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# MMA Primary Care Physician Workforce Expansion Task Force

## MMA's Strategic Plan

In the MMAs' five year strategic plan, one of the three primary goals includes ***helping Minnesotans become the healthiest in the nation***. Within that goal, one of the key issues the MMA is looking to address is ensuring access to care by ***expanding the primary care physician workforce***. In response to this strategic directive, the MMA's Primary Care Physician Workforce Advisory Task Force was formed in January 2013. This report will provide details regarding the task force, including their efforts over the past ten months, and a list of recommendations that the task force is proposing for how the MMA can play a role in increasing Minnesota's primary care physician workforce.


## Task Force - Charge

The purpose of the MMA Primary Care Physician Workforce Expansion Advisory Task Force is as follows:

- Understand the various drivers affecting the capacity and future supply of Minnesota's primary care physician workforce.
- Identify strategies - at all levels of medical education and training and within practice settings - for increasing Minnesota's primary care physician workforce.
- Determine roles for the MMA, as well as for other potential stakeholders, in advancing specific strategies to increase Minnesota's primary care physician workforce.
- Recognize the relationship between primary care physician workforce expansion efforts and other non-physician primary care workforce initiatives.
- Partner with others, as needed, to increase the visibility and importance of the issue of Minnesota's primary care physician workforce capacity among policy makers and the public.

## Task Force - Membership

In creating a task force to examine Minnesota's primary care physician workforce shortage, the MMA brought together a group of physicians that represented the state's medical schools, residency program leadership, medical students, residents, practicing community physicians, and hospital representatives. The physicians chosen to sit on the task force represented family medicine, geriatrics, internal medicine, and pediatrics.

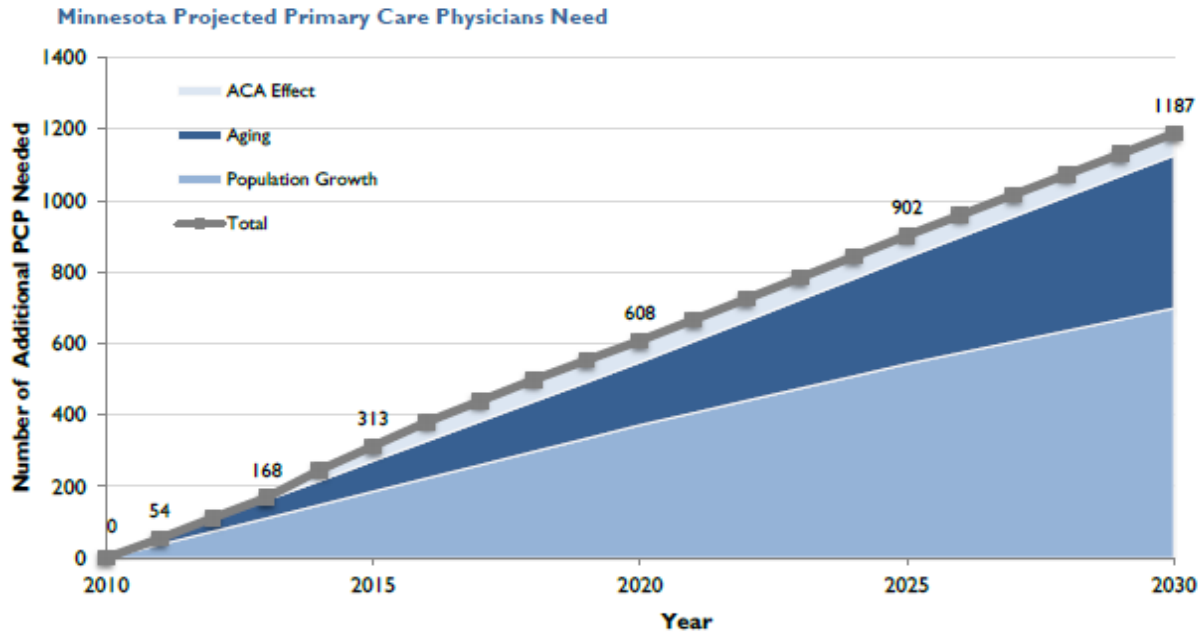
***SEE APPENDIX A FOR TASK FORCE MEMBERSHIP ROSTER.***

## PRIMARY CARE PHYSICIAN WORKFORCE SHORTAGE

### BACKGROUND

According to the Association of American Medical Colleges (AAMC), shortages in the U.S. are expected to reach 62,900 physicians by 2015, and will exceed 100,000 physicians by 2025[1]. Furthermore, AAMC projects a shortage of 45,000 primary care doctors by 2020 and a shortage of 65,000 primary care doctors by 2025.[2]

As of 2010, Minnesota had 4,215 primary care physicians[3]. It is estimated that Minnesota will need approximately 1,187 additional primary care physicians by 2030 – a 28% increase from 2010 figures.[4]




**(Source: Robert Graham Center, "Minnesota: Projecting Primary Care Physician Workforce," September 2013)**

Factors contributing to this shortage include an aging population, a growing population, the retirement of a generation of primary care physicians, decreases in state funding for medical education, a steady or decreasing number of primary care physician residency slots, and a declining interest in primary care careers. For instance, Minnesota's 65 and older population is expected to increase from 12% to 24% between 2000 and 2030[5]. In regards to an aging workforce, in 2010, one quarter of the 242,000 primary care physicians in the US were 56 or older. Here in Minnesota, more than a third of primary care physicians were 55 or older in 2011. In addition, as of January 1, 2014, thousands of Minnesotans gained access to health care coverage – making the need to expand our primary care workforce more critical.

According to a September 2013 report[6] of the Minnesota Department of Health (MDH), Office of Rural Health and Primary Care, as of 2011-2012, there were a total of 5,064 primary care physicians licensed to practice in Minnesota. Of these physicians, 50% were board-certified in family medicine, 34% were board-certified in general internal medicine, and 16%were board-certified in general pediatrics. The MDH report noted that although over one-third of primary care physicians are internists, the workforce survey conducted suggests that up to 30% of these physicians may be working as hospitalists in acute care settings, and not in primary care clinics.

In regards to the age distribution[7] of Minnesota's primary care physician workforce, those who practice family medicine are the oldest, and have the smallest amount of younger physicians (younger than 34 years old) available to replace them upon retirement. General internists and general pediatricians were the youngest. Their median ages were 49, 46 and 47 years respectively. The MDH report noted that many generalists may go on to subspecialize and therefore fall out of the primary care cohort.

In regards to the rural-urban distribution[8] of Minnesota's primary care physician workforce, general family medicine, general internal medicine, and general pediatrics were found by MDH to be more highly concentrated in urban areas of the state (pediatricians and internists had the highest concentrations). In the rural areas, family medicine had the highest concentration, and there were few general internists and pediatricians found in the small and isolated rural areas of the state.

Finally, in regards to regional distribution[9], the MDH report found that the majority of Minnesota's primary care physicians were located in the Twin Cities region. Those physicians practicing family medicine were found to be more distributed around the state, when compared to the general internists or pediatricians. In the Twin Cities region, there was a high concentration of pediatricians, and general internists were more highly concentrated in both the Twin Cities and Southeast regions of the state.

The threat to accessing quality health care is very real. From an aging primary care physician workforce, to a geographic maldistribution of primary care physicians, this threat is particularly alarming for our state's most vulnerable populations, primarily those living in Minnesota's rural and underserved areas – areas where primary care physicians are already in short supply.

## TASK FORCE EFFORTS

The MMA's Primary Care Physician Workforce Expansion Advisory Task Force convened its first meeting on May 7, 2013. Over the course of ten (10) months, the task force held six (6) meetings, with the final meeting being convened on March 25, 2014 ***(SEE APPENDIX B FOR MEETING SUMMARIES)*.**

Before the task force could begin their examination of Minnesota's primary care physician workforce shortage, the task force members established a definition for what constitutes a primary care physician[10]. The definition arrived at by the task force was limited to practitioners in the specialties of family medicine, general internal medicine, general pediatrics, and geriatrics.

### BARRIERS TO EXPANDING PRIMARY CARE PHYSICIAN WORKFORCE

After the first meeting of the MMA Primary Care Physician Workforce Advisory Task Force, a ranking survey was sent out to task force members in order to assess what they believed were the greatest barriers to expanding the primary care physician workforce. The task force members were asked to rank a list of barriers addressed during the meeting from "most" to "least" significant barrier. The results were as follows:

1. Primary care income differential compared to other specialties
2. Perception of primary care among medical students
3. Lifestyle challenges
4. Limited residency slots
5. Access to meaningful clinical experiences
6. Cultural support for primary care within medical schools
7. Hassles for physicians associated with training (in regards to the challenges that preceptors face in training medical students)
8. Geographic maldistribution of primary care physicians
9. Unsupportive comments/experiences provided to students by primary care preceptors
10. Uncertainty about the future of primary care

The task force members were in agreement with the list of barriers, and where they ranked in importance. For the remaining task force meetings, the barriers that were addressed provided guidance for the task force as they began to explore strategies for increasing Minnesota's primary care physician workforce. ***SEE APPENDIX C FOR ADDITIONAL SURVEY RESULTS***

## SURVEYS

As part of the task force's efforts, two small surveys were conducted to understand the perception of primary care among medical students and the challenges/benefits of serving as a preceptor. The following is brief summary of the each survey.

### Medical Student Survey - *Perception of Primary Care*

During July 2013, 1,011 students at the University of Minnesota Medical School and Mayo Medical School were surveyed via email regarding their perceptions of primary care. Of the 1,011 surveys, 142 responses were received.

**Medical students were asked the following questions:**

1. What medical school do you attend? (The next question asked to specify the campus if University of Minnesota Medical School was chosen – *i.e.,* Twin Cities campus or Duluth campus)
2. What year of medical school are you currently in?
3. How would you characterize your interest in pursuing a career in primary care? (*i.e.,* family medicine, general internal medicine, general pediatrics, geriatrics)?
4. In your medical school, careers in primary care are encouraged and supported. (The question asked the student to answer within a range of "strongly disagree" to "strongly agree")
5. How important is clinical exposure to primary care in medical school in influencing your selection of a career in primary care?
6. Have you participated in clinical rotations?
7. How did your primary care clinical rotation experience influence your interest in a career in primary care? (if answer to Question #6 was "yes")

**Some of the comments medical students gave regarding their interest in primary care included the following:**

| **POSITIVES** |
|---|
| Broad scope of practice |
| Long-term relationships with patients |
| Variety of patients and medical conditions |
| Continuous learning |
| Duty to address the dire need for primary care in this country |

| NEGATIVES |
|---|
| Poor compensation |
| Intimidated by patient volume and charting time |
| Uncontrollable hours |
| Redundant care |
| Do not make as great of an impact as you would in other specialties |

**Some additional comments received by the medical students surveyed regarding primary care included:**

| |
|---|
| Concerns with how much primary care pays, and how higher paying specialties help students out with high medical school debt |
| Research and academic achievement are valued more |
| Cynicism among primary care providers |
| Idea that primary care is "fine" if you are not smart enough to do something else |

*SEE APPENDIX D FOR A SUMMARY OF MEDICAL STUDENT SURVEY RESULTS*

**Preceptor Interviews - Role of Preceptor**

During July 2013, twenty-five (25) interviews were conducted via phone. These interviews included preceptors and non-preceptors, and the physicians interviewed were representative of both metro and out-state Minnesota. The length of service of the preceptors ranged from two (2) years to over thirty-five (35) years. All physicians interviewed were primary care physicians (*i.e.*, family medicine, internal medicine, and pediatrics).

**Physicians were asked the following questions:**

| | |
|---|---|
| How long have you been a preceptor for? | What are some of the benefits of serving as a preceptor? |
| Why did you choose to become a preceptor? | What would make the role better? |
| What are some of the challenges you face as a preceptor? | Will you continue to serve as a preceptor? |

Some of the reasons given for serving in the role of preceptor identified by the physicians included the following:

| | |
|---|---|
| Enjoy teaching | Shortage of preceptors |
| Important role | Good for your practice |

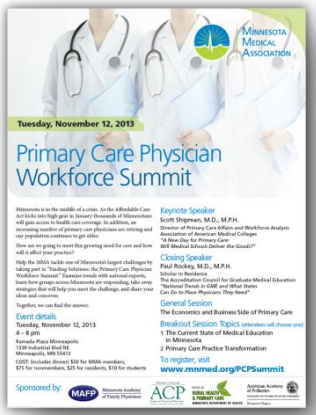
Some of the challenges identified by the physicians in serving the role of preceptor included the following:

| | |
|---|---|
| Time | Continuing to stay competent in role |
| Push to see more patients per session | Limited slots/clinical training sites available |

For those physicians interviewed that were not preceptors, they were asked to describe some of the reasons for choosing not to serve in the role of preceptor. One of the major reasons given was that their practices are too busy, and there is not enough time to serve as a preceptor.

***SEE APPENDIX E FOR A SUMMARY OF PRECEPTOR INTERVIEW SURVEY RESULTS.***

## MMA PRIMARY CARE PHYSICIAN WORKFORCE SUMMIT




On November 12, 2013, the MMA held a summit to address Minnesota's primary care physician workforce shortage. Approximately 75 physicians, community leaders, and other health care professionals attended. The summit included a discussion on possible solutions to the shortage, education on the current state of the shortage, and it provided an opportunity to examine ways to transform physicians' practices in order to reinvigorate primary care.

The summit featured a keynote presentation from Scott Shipman, MD, MPH, Director of Primary Care Affairs and Workforce Analysis at the Association of American Medical Colleges (AAMC). Dr. Shipman's presentation, "A New Day for Primary Care: Will Medical Schools Deliver the Goods?" examined national trends in medical education, and new delivery and payment models in primary care.

The summit also included three panels, (1) the economics and business side of primary care; (2) the current state of medical education in Minnesota; and (3) primary care practice transformation.

Finally, the summit featured a closing presentation by Paul H. Rockey, MD, MPH, Scholar in Residence at the Accreditation Council for Graduate Medical Education (ACGME). Dr. Rockey's presentation, "National Trends in GME and What States Can Do to Place Physicians They Need" examined national trends in primary care residency training.

At the end of the summit, the audience members had the opportunity to answer some questions regarding the primary care physician workforce. When the audience was asked, "what is the greatest barrier to expanding Minnesota's primary care physician workforce," 56.9% of the audience felt the greatest barrier was the lower income for primary care compared to other specialties, and 22.2% felt the greatest barrier was the negative perception some have of primary care. When the audience was asked, "what is the most important area for the MMA to address to increase the number of primary care physicians," 26% of the audience felt it was important to address the negative perceptions of primary care among medical students, 24% felt it was important to

advocate for an increase in primary care residency slots, and 22% felt it was important to work to improve primary care income.

Some of the key takeaways from the summit's keynote and closing speakers were as follows:

- **Four Ways to Address Primary Care Physician Workforce Shortage (Scott Shipman, MD, MPH):**
    1. Train more
    2. Find others to do the work
    3. Reduce the number retiring or leaving practice for other reasons, and
    4. Eliminate inefficiencies
- **Two of the most important steps to improve student interest in primary care, and the primary care pipeline (Scott Shipman, MD, MPH):**
    1. Medical school admissions making workforce priorities a specific consideration
    2. Adoption of new models of care in academic primary care practices and affiliated training sites
- **What can Minnesota do? (Paul Rockey, MD, MPH)**
    1. Assess health care workforce regularly
    2. Target GME expansion to high priority needs
    3. Develop sustainable all payer funding
    4. Train in settings accountable to populations
    5. Expand public health measures hand-in-hand
    6. Create new state-wide structure to allocate GME among specialties, geographies and sites

## RECOMMENDATIONS

### FINAL TASK FORCE RECOMMENDATIONS

Prior to the final meeting, task force members were sent a survey in which they were asked to rank a list of recommendations in the order of the most to least important recommendation. The draft recommendations in the survey represented areas the task force had identified as potential ways to increase the capacity and supply of primary care physicians in Minnesota.

In assessing the recommendations, the task force members felt it was important to look at the recommendations in terms of what was feasible, what areas the MMA could play the largest role in, and what areas could the MMA serve the role of bringing other groups together. Task force members also examined the proposed recommendations in terms of where a recommendation fit best. For example, would a recommendation best be served through state level advocacy or federal level advocacy? At the conclusion of the assessment, task force members felt that categorizing the recommendations would be the most effective vehicle. The four categories the task force members agreed upon were as follows:

1. **Recommendation for Highest MMA Priority**
2. **Minnesota State Legislative Package**
3. **Federal (AMA) Legislative Package**
4. **MMA Policy Position – No Action Required**

Although more than one recommendation is likely to be chosen, the task force members felt that one of the recommendations was the strongest, and represented the largest barrier to expanding Minnesota's primary care physician workforce. The ***Recommendation for Highest MMA Priority*** had the greatest opportunity to not only convene others involved in medical education and training, but the greatest opportunity to effectively train additional primary care physicians. This recommendation addresses the lack of clinical training sites available in Minnesota, one of the barriers to expansion of the primary care physician workforce that had been identified by the task force.

In regards to the ***Minnesota State Legislative Package***, task force members felt that some of the recommendations would have the greatest effect if brought forth as a state level "package," as the areas within these recommendations were closely linked, and

represented areas where state-level advocacy could bring about the greatest potential for change. This package contains recommendations that address the high debt load carried by medical students, a barrier to expansion as students may choose a higher paying specialty as a result. This package also includes a recommendation that addresses primary care income, another barrier addressed by the task force. Finally, this package contains two (2) recommendations that address the need for GME funding to be linked to a state's workforce needs and envisions the creation of a council by the state legislature to guide policymakers in how best to meet the state's physician workforce objectives.

In regards to the ***Federal (AMA) Legislative Package***, task force members felt that one of the recommendations would have the greatest effect if brought forward for national-level advocacy, through a vehicle such as the American Medical Association (AMA). This package represents a recommendation that would not be feasible to advocate for at the state-level, as the action requested would likely require federal legislation. The limited number of residency slots was addressed by the task force as a barrier to expansion, but understanding that a cap on the number of residency slots has existed since 1997, and the likelihood of lifting this cap is not feasible, the task force wanted to address the need for additional GME funding as a way to ensure that additional training slots are not lost. The Budget Control Act's sequestration provision, which took effect on April 1, 2013, triggered a 2 percent cut in GME programs. Through the recommendation included in this ***Federal (AMA) Legislative Package***, the task force members stressed the importance of restoring and maintaining GME funding at levels prior to the sequestration, and the need for advocacy regarding primary care residency slots.

The final package, ***MMA Policy Position – No Action Required,*** contains a recommendation for an MMA policy position, that will require no further action if adopted. It is a recommendation regarding increasing primary care physician income. Task force members had identified primary care income as a barrier to expansion. Understanding the complexities involved with advocating for increasing income levels in one specialty versus another, the task force wanted to include this income recommendation as an acknowledgment that income does play a role in specialty choice, and the number of primary care physicians might increase if their income was brought closer to the income of other specialties.

Of the ten (10) recommendations presented, seven (7) were chosen to move forward. The recommendations decided upon by the task force are as follows:

| **RECOMMENDATION FOR HIGHEST MMA PRIORITY** |
| --- |
| The Minnesota Medical Association will work with health systems, hospitals, large practices and the state's medical schools to examine ways to increase the number of available clinical training sites in Minnesota, and examine ways to remove barriers that exist in allowing medical students to have more meaningful experiences. |

| **MINNESOTA LEGISLATIVE PACKAGE** |
| --- |
| The Minnesota Medical Association will address the high cost of medical school and the resulting medical school debt by supporting efforts that target loan forgiveness and loan repayment programs specifically to primary care, and that restores funding to levels equal to or greater than those of 2008 . |
| The Minnesota Medical Association will support efforts to sustain beyond 2014 the ACA-required Medicaid payment bump for primary care, which increases primary care Medicaid rates to Medicare levels for 2013-2014. |
| The Minnesota Medical Association will further examine the feasibility of seeking a waiver from the Centers for Medicare & Medicaid Services (CMS) that would provide for state management of GME distribution in Minnesota. For example, the waiver could link GME funding to Minnesota's primary care physician workforce needs and set up a distribution mechanism. |
| The Minnesota Medical Association will promote the creation by the state legislature of a state medical education council that includes a representative from each of the state's medical schools, representatives from teaching hospitals and clinical training sites, and other relevant stakeholders. The council would serve the purpose of providing analysis and policy guidance on how Minnesota can meet its physician workforce objectives. |

| **FEDERAL (AMA) LEGISLATIVE PACKAGE** |
| --- |
| (1) The Minnesota Medical Association will advocate that the 2011 Budget Control Act cuts to funding for Medicare-supported graduate medical education (GME) be restored and maintained at levels prior to the sequestration, which took effect in April 2013.<br>(2) The Minnesota Medical Association should take a leadership role in advocating for an adequate number of residency slots, adequate number of faculty and adjunct faculty support, and the required resources to increase the number of primary care residency slots. |

| MMA POLICY POSITION – NO ACTION REQUIRED |
| --- |
| The Minnesota Medical Association acknowledges the role that income plays in specialty choice and believes that primary care physician capacity could be improved if this disparity was addressed. |

The aforementioned recommendations represent areas the task force members believe will bring about the greatest change in primary care physician capacity and supply. The recommendations also address some of the barriers to expansion that the task force has identified throughout the course of their efforts.

## NEXT STEPS

### IMPLEMENTATION PLAN

If the task force's proposed recommendations are approved by the MMA Board of Trustees, a detailed implementation plan will be put together. The implementation plan will include guidance for how to proceed with each recommendation. For example, with regards to the recommendation for highest MMA priority - addressing the need to increase the number of available clinical training sites in Minnesota - the implementation plan will include what potential partners and resources will be needed to achieve the goals of the recommendation.

### CONCLUSION

Minnesota is facing a crisis that will only be magnified as we move forward. The solutions to how we expand Minnesota's primary care physician workforce will need the collaboration of all those who are affected by a decreased capacity in primary care physicians. Changes are needed in how we educate medical students, in how we train our residents, and how primary care is practiced. As the professional association that represents Minnesota's physicians and physicians in training, the MMA is positioned to play an important role in helping Minnesota increase its primary care physician workforce. Expanding the number of primary care physicians in Minnesota will help ensure access to quality health care in Minnesota, and will help the MMA achieve its goal of helping Minnesotans become the healthiest in the nation.

## APPENDIX A –Membership Roster

| NAME | SPECIALTY | POSITION |
|---|---|---|
| David Agerter, M.D. | Family Medicine | Mayo Clinic Health System - Austin |
| Julie Anderson, M.D. | Family Medicine | MAFP Representative; St. Cloud Medical Group |
| Emily Borman-Shoap, M.D. | Pediatrics | Director, Pediatric Residency Program, University of Minnesota |
| Kathy Brooks, M.D. | Family Medicine | University of Minnesota Medical School - Rural Physician Associate Program (RPAP) Director |
| Amy Burt, M.D. | Pediatrics | MNAAP Representative; Part-Time at Medica as a Medical Director in the Public/Medical Assistance Division (returning to part-time practice at Park Nicollet Clinic – Plymouth during Fall 2013) |
| Ray Christensen, M.D. | Family Medicine | UMD Medical School - Assistant Dean for Rural Health |
| Eric McDaniel | Medical Student | Student Representative (UMD Medical School - 1st year student) |
| George Morris, M.D. | Family Medicine & Sports Medicine | CentraCare (Minnesota Hospital Association Recommendation) |
| Anne Pereira, M.D. | Internal Medicine | Director, Internal Medicine Residency Program, HCMC |
| Jacob Prunuske, M.D. | Family Medicine | Lake Superior Community Health Center (FQHC); Assistant Professor, Dept. of Family Medicine & Community Health - UMD Medical School |
| Mark Rosenberg, M.D. | Internal Medicine | Vice Dean for Medical Education, University of Minnesota |
| Nick Schneeman, M.D. | Geriatrics | Minnesota Medical Directors Association Recommendation; North Clinic Geriatric Services of MN |
| Paul Schutt, M.D. | Psychiatry Resident | Resident Representative (Mayo Medical School) |
| Jeremy Springer, M.D.* | Family Medicine | Director, Family Medicine Program, University of Minnesota - Methodist Hospital Program (Creekside Family Medicine, Park Nicollet Clinics) |

*Chair of Task Force

## APPENDIX B – Meeting Summaries

**Meeting 1**

- During the first meeting, task force members began to look at the issue of Minnesota's primary care physician workforce shortage. The Office of Rural Health & Primary Care, at the Minnesota Department of Health, presented data from what Minnesota's current primary care physician workforce looks like (in terms of gender, age, race, and regional distribution) to trends that are influencing the shortage (*e.g.,* aging workforce, aging population, health reform, etc.)
- The definition of what constitutes a primary care physician varies, and the task force engaged in a discussion surrounding what this definition should be.
- Task force members began to examine what barriers exist to expanding the primary care physician workforce (*e.g.,* education/training, payment, and practice).
- Finally, task force members heard about MMA's plans to convene a summit on the issue of expanding Minnesota's primary care physician workforce.

**Meeting 2**

- Based on input from task force members, MMA staff put together a draft definition of a "primary care physician." This draft was circulated to the task force, and presented during the second meeting. During the second meeting, task force members engaged in a discussion surrounding the draft definition, and a motion to approve the definition was passed.
- **Barriers to Expansion Survey**: Prior to the second meeting, a survey was conducted of all task force members, to get their thoughts on what they consider barriers to expanding the primary care physician workforce. The survey also assessed what barriers the MMA may have the greatest impact on.
- The second meeting was an opportunity to begin addressing the ten (10) barriers identified by the task force. One of those barriers, "**perception of primary care among medical students**", was discussed, and task force members examined the role that limited exposure to primary care early in medical school plays on the decision to practice primary care.
- Another barrier addressed was "**cultural support for primary care in medical school**." Task force members looked at the role that recruitment and lack of encouragement play. It was noted that it would be useful to survey medical students in Minnesota regarding their thoughts on the culture of primary care in medical school.

**Meeting 3**

- **Medical Student Survey:** Prior to the third meeting, a survey of medical students at Mayo Medical School and the University of Minnesota Medical School was conducted. Results of the survey were presented during Meeting 3.

- **Preceptor Interviews**: Prior to the third meeting, interviews with preceptors and non-preceptors were conducted. Results of the interviews were presented during Meeting 3.
- "**Limited Residency Slots**" was the next barrier addressed by the task force, and during Meeting 3, the roles that GME, MERC, and limited residency slots play in the primary care physician shortage were examined. Staff from the Metro Minnesota Council on Graduate Medical Education (MMCGME) presented information to the task force regarding GME in the Twin Cities, residency slot limitations, funding threats, funding alternatives, and options/solutions.
- The "**hassles for physicians associated with participating in training**," another barrier identified by the task force, was addressed during Meeting 3. Challenges dealing with time, payment, etc. were discussed.
- "**Access to meaningful clinical experiences**," another barrier identified by the task force, was examined during Meeting 3. Task force members discussed what it means for medical students to have access to a meaningful clinical experience, and the challenges that exist (*e.g.*, not being able to document, preceptors, lack of clinical sites, etc.). As part of these discussions, another barrier, "**unsupportive comments/experiences provided to students by primary care preceptors**" was examined.

**Meeting 4**

- During meeting 4, task force members had an opportunity to learn about the University of Minnesota Medical School Chapter of ***Primary Care Progress***, a national nonprofit that is working to engage communities to transform primary care.
- Task force members addressed three additional barriers to expanding the primary care physician workforce. In discussing **"primary care income,"** task force members engaged in a discussion regarding the differences in income between primary care and specialties. It was noted that medical students have high amounts of medical school debt, and the ability to repay this debt is a concern, and also what drives many to choose higher paying specialties.
- Another barrier discussed was **"primary care lifestyle challenges."** Task force members addressed the difficulties associated with practicing primary care (e.g., pressure to generate RVUs, stresses associated with trying to achieve the right work-life balance, etc.)
- The final barrier addressed was that of the **"uncertainty about the future of primary care."** Task force members discussed issues related to the future of primary care, including what will be the role of primary care physicians.
- Finally, task force members discussed different practice model settings – rural vs. urban, and the effect this has on the workforce shortage. It was noted that loan forgiveness might be a way to incentivize individuals to practice in rural settings.

**Meeting 5**

- This was the first meeting since the MMA held its Primary Care Physician Workforce Summit, and task force members took some time to share what they learned from the summit.
- The "geographic maldistribution of physicians," another barrier identified by the task force, was addressed during Meeting 5. In discussing the unequal distribution of Minnesota's primary care physician workforce, the task force looked at loan forgiveness, loan repayment, rural training programs in medical school, telemedicine, etc.
- Another issue examined during this meeting was the implication of Minnesota's increasingly diverse and aging population. Possible solutions examined included increasing the diversity of the primary care physician workforce, the need to train physicians in understanding how to work with diverse populations, and providing more adequate training in geriatrics.
- During this meeting, task force members learned about a proposed teaching model would that would pair community health centers (CHCs) with academic medical centers to develop a teaching health center (THC) track that would encourage students to graduate in primary care and practice in urban and rural underserved areas. The task force members noted the difficulty of a similar model succeeding in Minnesota, one reason being the low number of CHCs available in the state.

**Meeting 6**

- Meeting 6 was the final meeting of the task force. During this meeting, task force members took some time to evaluate a proposed list of recommendations that were the product of their efforts and discussions over the past ten (10) months.
- Prior to the meeting, task force members were asked to rank the list of proposed recommendations in order of most to least important, via a survey. The results of the survey were presented at the meeting.
- After a thorough discussion, task force members prepared a list of seven recommendations for expanding Minnesota's primary care physician workforce.

**APPENDIX C – Barriers to Expansion of Primary Care Physician Workforce Survey Results (Summary)**

In the survey, task force members were asked to **rank a list of ten (10) barriers** in the order of the most to least significant barrier (with "1" being the most significant barrier and "10" being the least significant barrier). The barriers were ranked as follows:

| | |
|---|---|
| 1. Primary Care Income Differential | 6. Cultural Support for Primary Care within Medical School |
| 2. Perception of Primary Care Among Medical Students | 7. Hassles for physicians associated with participating in training (*e.g.*, administrative, time, payment) |
| 3. Primary Care Lifestyle Challenges | 8. Geographic maldistribution of primary care physicians (*i.e.*, issues such as isolation of rural areas) |
| 4. Limited Residency Slots | 9. Unsupportive comments/experiences provided to students by primary care preceptors |
| 5. Access to Meaningful Clinical Experiences | 10. Uncertainty about future of primary care |

**Another question on the survey assessed what barriers the MMA may have the greatest impact on. The survey results were as follows:**

| |
|---|
| 1. Primary Care Income Differential |
| 2. Hassles for Physicians Associated with Training |
| 3. Limited Residency Slots |
| 4. Access to Meaningful Clinical Experiences |
| 5. Perception of Primary Care Among Medical Students |

## APPENDIX D – Medical Student Survey Results (Summary)

### Overview

| | |
|---|---|
| Total Students Surveyed | 1011 |
| Total Responses | 142 |
| Mayo Medical School | 23 |
| University of Minnesota Medical School | 119 |
| *Duluth Campus* | *29* |
| *Twin Cities Campus* | *90* |

**Characterization of interest in pursuing a career in primary care:**

- 40.34% of the students at the University of Minnesota Medical School said they were *very interested*, compared to 17.39% of students at Mayo Medical School.
- 15.13% of those surveyed at the University of Minnesota Medical School were *not at all interested* in pursuing a career in primary care, compared to 8.70% at Mayo Medical School.

**Whether careers in primary care are encouraged and supported at their medical school**:

- 53.78% of the students at the University of Minnesota Medical School *strongly agreed*, compared to 26.09% at Mayo Medical School (Note: Duluth Campus: 96.55% strongly agree and Twin Cities Campus - 40.00% strongly agree).
- Of the medical students surveyed, 0% of students at either the University of Minnesota Medical School or Mayo Medical School *strongly disagreed* regarding this question. 18.49% of students at the University of Minnesota Medical School gave this question a three (3), compared to 26.09 % of students at Mayo Medical School (Note: In this question, five (5) was strongly agreed, and one (1) was strongly disagreed).

**Importance of clinical exposure to primary care in medical school in influencing selection of career in primary care**:

- 43.70% of students at the University of Minnesota Medical School believed clinical exposure was *very important*, compared to 34.78% at Mayo Medical School.
- 2.52% of the students at the University of Minnesota Medical School believed clinical exposure was *not at all important*, compared to 0% of the students at Mayo Medical School.

**Whether they had participated in clinical rotations:**

- 74.79% of students at the University of Minnesota Medical School stated *yes*, compared to 43.48% of students at Mayo Medical School.
- 25.21 % of students at University of Minnesota Medical School *had not yet participated* in clinical rotations, compared to 56.52% of students at Mayo Medical School.

**APPENDIX D** (*continued*)

**Whether primary care clinical rotation experience influenced interest in primary care career (<u>Note</u>: for those that had participated in clinical rotations):**

- 36.97% of those at the University of Minnesota Medical School responded that clinical rotations *increased their interest* in primary care, compared to 13.04% at Mayo Medical School.
- For 12.61% of the students at the University of Minnesota Medical School, the clinical rotations *decreased their interest*, compared to 4.35% at Mayo Medical School.

**Additional comments regarding their interest in primary care included the following:**

| Positives | Negatives |
|---|---|
| 1. Broad scope of practice | 1. Poor compensation |
| 2. Long-term relationships with patients | 2. Intimidated by patient volume and charting time |
| 3. Variety of patients and medical conditions | 3. Uncontrollable hours |
| 4. Continuous learning | 4. Redundant care |
| 5. Duty to address the dire need for primary care in this country | 5. Do not make as great of an impact as you would in other specialties |

**Additional comments regarding primary care included the following:**

| |
|---|
| 1. Concerns with how much primary care pays, and how higher paying specialties help students out with debt. |
| 2. Research and academic achievement are valued more |
| 3. Cynicism among some primary care providers |
| 4. Idea that primary care is "fine" if you are not smart enough to do something else |

**APPENDIX E – Preceptor Interview Results (Summary)**

**Overview**

- **25 Physicians Interviewed**
  - Preceptors and Non-Preceptors
  - Metro and Out-State
  - Length of service as preceptor: 2 years to over 35 years

**Some of the reasons given for serving as a preceptor included the following:**

| |
|---|
| 1. Enjoy teaching |
| 2. Important role |
| 3. Shortage of preceptors |
| 4. Good for your practice |

**Some of the challenges noted included the following:**

| |
|---|
| 1. Time |
| 2. Push to see more patients per session |
| 3. Housing in some areas of the state (*mostly rural*) |
| 4. Continuing to stay competent in the role |
| 5. Limited slots/clinical sites available for students (*in the metro area*) |

**Some of the benefits noted included the following:**

| |
|---|
| 1. Students give preceptors energy, and keep them on their toes |
| 2. Students remind preceptors why they became physicians |
| 3. Students make physicians practice in a more evidence-based manner |
| 4. Provide an opportunity to demonstrate the work/life balance of being in primary care |
| 5. Recruiting tool |

**When asked what would make the role better, some of the comments included the following:**

| |
|---|
| 1. Additional time to precept |
| 2. Support from employer |
| 3. Stipend |
| 4. More feedback from students and medical school |
| 5. Opportunities to share best practices |

[1] Association of American Medical Colleges, "Physician Shortages to Worsen Without Increases in Residency Training," September 30, 2010; *available at:* https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf

[2] Association of American Medical Colleges, "The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025," June 2010; *available at:* https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf

[3] Robert Graham Center, "Minnesota: Projecting Primary Care Physician Workforce," September 2013; *available at:* http://www.graham-center.org/online/etc/medialib/graham/documents/tools-resources/minnesotapdf.Par.0001.File.dat/Minnesota_final.pdf

[4] *Id.*

[5] Governor's Workforce Development Council, "Minnesota's Primary Care Provider Shortage - Strategies to Grow the Primary Care Workforce," December 2011, *available at:* http://www.gwdc.org/docs/publications/Primary_Care_Report.pdf

[6] Minnesota Department of Health, Office of Rural Health and Primary Care, "Minnesota's Primary Care Workforce (2011-2012)," September 2013, *available at*: http://www.health.state.mn.us/divs/orhpc/pubs/workforce/primary.pdf

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] For purposes of the work of the MMA Primary Care Physician Workforce Expansion Advisory Task Force, the following definition was approved by the task force members: "A primary care physician serves as a patient's first point of contact with the health care system. This primary care physician continues to provide comprehensive care for a patient, collaborating or consulting with other health professionals when such a need arises. In Minnesota, this type of care is generally provided by practitioners in the specialties of family medicine, general internal medicine, general pediatrics, and geriatrics."