

Commentary: A Need for Leadership in Primary Health Care for the Underserved: A Call to Action

Jeffrey F. Markuns, MD, EdM, Larry Culpepper, MD, MPH, and William J. Halpin, Jr

Abstract

Health system reform and efforts to achieve universal health coverage are under way. Community health centers have become the centerpiece of the nation's efforts to provide access to primary care for all, and the Massachusetts experience in health care reform has reinforced the need for these safety-net providers. When access is expanded, community health centers experience a greater need for primary care providers, who already are in short supply. To address this need, medical education must become a core part of the community health center mission. Academic medical centers must facilitate this process, and government agencies

must provide new regulatory and funding mechanisms. Universal access also requires skilled physician leadership for underserved settings. Leadership training has a direct impact on the ability of medical directors to make continual system improvements. New programs are needed to develop this workforce. To respond to the looming crisis in primary care staffing and leadership for community health centers, we propose as a blueprint a five-step call to action: (1) build horizontally and vertically integrated collaborations between academic medical centers and community health centers, (2) increase opportunities for trainees in underserved

primary care settings, (3) offer leadership training for physicians committed to care for the underserved, (4) create a national program to provide longitudinal training and mentorship for potential primary care physician-leaders, and (5) identify new funding mechanisms for medical education in community health centers. This blueprint outlines a process for developing collaborations among academic medicine, community-based safety-net institutions, and government that are needed to achieve meaningful health system reform.

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When you're just starting out you're saying, "This place—we could do so much better!" And then you say to yourself, "Well, maybe I'm the one who could do that."

—Community health center medical director.

In 2006, Massachusetts became the first state to legislate mandatory universal health insurance. Since then, the nation has begun to debate the merits and methods for achieving universal health coverage. While awaiting this reform, community health centers have taken a leading role in providing health care to

the uninsured and underinsured, as well as to low-income and underserved populations. Community health centers are cost-effective in providing high-quality health care to these populations while improving access to care and reducing health care disparities. As a result, the Health Resources and Services Administration (HRSA) Bureau of Primary Care Community Health Center Program has rapidly expanded and currently cares for over 16 million people.

The Massachusetts Experiment

The Massachusetts experiment in universal health coverage yields important lessons. Many previously uninsured patients have obtained health insurance, reducing the financial barriers to health care access. Coverage alone, however, has not resulted in universally improved access. A shortage of primary care providers has made access to primary care more difficult, and, as a result, emergency room utilization has increased. Community health centers are central to the struggle to provide health care to all. Prompted by the mandate for universal coverage, community health centers intensified their efforts to provide access

that otherwise would be unavailable through overtaxed primary care providers in the private sector.

Community health centers already struggle with institutional and financing challenges and face a shortage of primary care physicians. These challenges worsen when the demand for services increases in response to expanded health coverage. While there may have been an initial hope that universal health coverage would reduce the need for safety-net providers, the Massachusetts experiment proves that moving toward universal coverage will require an even greater reliance on these institutions.

Our own hospital, Boston Medical Center, has provided safety-net care for almost 150 years. Four decades ago, community health centers were added to the Massachusetts safety net through the efforts of local communities. Our own institutions have come to understand the need for strong community health centers and their vital role in providing high-quality community-responsive primary care to the underserved. Acknowledging the limitations of academic institutions in providing this type of care, we developed Boston

Dr. Markuns is assistant professor, Department of Family Medicine, Boston University School of Medicine, Boston, Massachusetts.

Dr. Culpepper is chair of family medicine, Department of Family Medicine, Boston University School of Medicine, and chief of family medicine, Boston Medical Center, Boston, Massachusetts.

Mr. Halpin is chair, Massachusetts League of Community Health Centers, and chief executive officer, South Boston Community Health Center, South Boston, Massachusetts.

Correspondence should be addressed to Dr. Markuns, Department of Family Medicine, Boston University Medical Center, 771 Albany Street, Boston, MA 02118; telephone: (617) 414-6256; fax: (617) 414-3345; e-mail: (jeffrey.markuns@bmc.org).

HealthNet, a network involving 15 community health centers, Boston Medical Center, and the Boston University School of Medicine. Through this network, health centers have access to academic tertiary care on their terms, and students and residents have the opportunity to learn in health center settings. We sought both horizontal and vertical integration to improve access to the academic center, including inpatient services and specialty care, and the academic medical center which works closely with the community health centers to assist them in meeting their own improvement goals.

A Need for Leadership

Through this process, we recognized the crucial role of medical directors, the physician-leaders of these institutions. Our interactions suggest that the quality of physician leadership plays a key role in the success of community health centers and their ability to make improvements and overcome their consistent and daily challenges. Individual interviews and focus groups with local medical directors were used to explore this issue. We found that many new medical directors enter their positions poorly trained in leadership skills, particularly as they relate to primary care in underserved settings. The nationwide shortage of primary care providers contributes to the lack of qualified physician-leaders, and, as a result, many physicians are recruited to these roles without leadership training beyond that provided in traditional residency or fellowship programs.

Our findings suggest a typical path to leadership for community health center physicians. Physicians join health centers with an interest in providing primary care for the underserved. They then develop a strong desire to make improvements in clinical care and operations and are recruited to the role of medical director. Many lack basic knowledge about community health centers, however, and most lack a clear understanding of the specific role of the medical director. A direct correlation exists between the degree of success in achieving institutional improvements and the degree of prior leadership training. Those with substantial training and mentorship experience greater satisfaction and display a greater ability to achieve essential improvements than do

those without sufficient leadership training, who struggle and often fail to accomplish meaningful and important changes in their institutions. The inability to make improvements results in rapid turnover in the medical director position, adding to the challenges faced by community health centers. From our experience, longitudinal training opportunities including mentoring and project work are needed to instill the transformational leadership skills required of a medical director. Training for physician-leaders should also include time with executive officers and other nonphysician administrators, as many executive relationships fail because of a lack of common understanding of the respective leadership roles.

Currently, available training opportunities for medical directors of community health centers are limited. The National Association of Community Health Centers (NACHC) provides useful, periodic entry-level training programs for medical directors, but these do not include advanced leadership training or a longitudinal component.¹ Past training programs coupling medical directors and executive officers for co-training and mentorship were highly lauded but intensive in resources and, as a result, have not survived. The Health Disparities Collaboratives developed by HRSA and the Institute for Healthcare Improvement is one model that includes longitudinal project work; however, it does not focus specifically on the leadership needs of medical directors.² Available conference training opportunities are typically one week or less and lack continuing longitudinal components. Additional leadership training programs are needed specifically for physician-leaders of community health centers and other safety-net institutions.

Expanding Medical Education

The ability to accomplish transformational system improvements in primary care, such as the creation of patient-centered medical homes, is essential to achieving universal access. This model of accomplishing health care system improvement is sophisticated and challenging, placing deliberate stress on both systems and leaders in the move toward change. Providing such medical homes will require additional primary

care providers and well-trained physician-leaders to create and manage these systems. Community health centers are a potential mechanism for rapidly building the workforce needed to create medical homes for the underserved. The current effort by academic medical centers to increase the overall physician supply to expand the primary care workforce is an important step, but it will not be enough, as evidenced by the research presented in a recent issue of *Academic Medicine* dedicated to the importance of Title VII.³ A comprehensive approach is needed to provide student and resident trainees with early exposure to successful models of primary care in underserved settings, and community health centers may be the only feasible existing mechanism for accomplishing this goal.

An expansive and comprehensive approach will require collaboration among community health centers, academic medical centers, and government agencies. Any program to address the workforce shortage in primary care must rapidly expand involvement of community health centers in medical education. **Increasing the number of medical students and residents trained in these settings will increase the number of graduates who subsequently enter careers in primary care for the underserved.** While staying true to their mission to provide community-directed primary care for the underserved, community health centers must also prepare physicians to meet future workforce needs. In tandem, **academic medical centers must provide institutional support for the development of mentorship opportunities and focused leadership training for the medical leaders of community health centers.** These leaders are needed to develop vertically integrated systems to achieve the necessary primary care–hospital partnerships of the future and to integrate primary care medical education programs into community health centers. Finally, **government agencies must work together to remove regulatory barriers and expand funding opportunities to develop and sustain robust medical education programs in community health centers.**

A Call to Action

A call to action is necessary if we are to succeed in the daunting challenge of

achieving universal health care. The academic medical community must take immediate steps to provide additional leadership in primary care for underserved communities.

Develop collaborations with local safety-net providers of primary health care

Academic medical centers should work quickly to identify and reach out to local community health centers and break down the barriers that have arisen between the two groups. Academic medical centers should assist in creating mechanisms for horizontal integration of local community health centers so that they can benefit from each other's success and common experiences. Academic medical centers should also offer mechanisms for effective vertical integration, enhancing communication among tertiary care centers, community hospitals, and community health centers and providing technical and educational assistance.

Increase the number of opportunities for student and resident trainees to practice in underserved primary care settings

Through the development of collaborations, academic medical centers should seek additional opportunities to provide training in primary care in underserved and health professional shortage areas. Academic health centers should maximize the number of trainees in educational programs in community health centers and other primary care safety-net institutions. Faculty working in these settings should be recruited to provide effective role modeling, mentorship, and support for the trainees.

Provide leadership training and support for trainees who are likely to serve in community health centers

Innovative programs in leadership training for primary care physicians focused on serving underserved populations are

necessary to provide equity and optimize access in a universal health care system. Programs should be longitudinal with both practical experience and mentorship components. Academic medical centers should promote these programs by collaborating with community health centers to identify trainees with interest and potential in this area and by providing grants, scholarships, and other incentives for participation. Focusing early in training on competencies in practice-based learning and improvement as well as systems-based practice in these underserved settings may help identify and prepare students with strong leadership potential. Loan forgiveness is another mechanism to encourage students to become physician-leaders in these challenging settings, perhaps as part of a program similar to the successful Teach for America, with both service and education components.

Create a national program through the Association of American Medical Colleges to bring new physician-leaders together for longitudinal training and mentorship

The Association of American Medical Colleges should support these efforts by organizing a national program for developing and building leadership skills in primary care for underserved settings. Collaboration with the NACHC would provide a rich source of valuable mentors with meaningful practical experience. Such a program would offer mentoring by highly trained and successful medical leaders and provide opportunities for networking with other primary care physician-leaders with similar interests and facing related challenges. Any new program should also engage students early in training and connect them with a national mentorship program.

Advocate for additional government funding mechanisms for community health centers to integrate medical education into their missions

Academic institutions and the Association of American Medical

Colleges should work with the HRSA Bureau of Primary Care, the HRSA Bureau of Health Professions, the Centers for Medicare & Medicaid Services, state Medicaid programs, the NACHC, and community health centers to identify mechanisms that allow community health centers to incorporate medical education into their missions and be appropriately compensated for it. Without changes in regulatory constraints and funding mechanisms at the federal level, maximizing the unique training opportunities at community health centers cannot be realized.

Conclusion

Universal health coverage is an ethical and practical necessity for our nation that will provide benefits to individuals, employers, and our nation's economy. To achieve universal access to health care, more than financing and health insurance reform is needed. Challenging issues in physician supply must be addressed, particularly in the areas of primary care and underserved settings. Key will be programs to develop strong, well-trained physician-leaders. Academic medical centers are an essential partner in developing these leaders, and the above-mentioned five steps provide a blueprint for building programs to support this crucial goal.

References

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