

## **Beyond the MUC: Contributions of Title VII to Health Professions Education in the United States**

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### **I. Brief legislative history of Title VII**

As a response to widespread recognition of a projected physician shortage, Federal support of Health Professions Education began in 1963 under the Health Professions Assistance Act of 1963, PL 88-129, with capitation grants to medical schools who agreed to increase their class size and thereby, increase the number of physicians in this country. There was no explicit language targeting the production of primary care physicians or placement of physicians into underserved communities.

Primary Care came into focus in 1971 with the Comprehensive Health Manpower Training Act of 1971, PL 92-157, when Federal funds were allocated to support training of health professionals in family medicine and of physician assistants. These funds became available the next year with the first grants made to medical schools in 1972.

“Title VII” as it is generally known today with its emphasis on primary care training in medicine and dentistry emerged after two years of Congressional debate and legislative activity in the Fall of 1976 when the Health Professions Assistance Act of 1976, PL 94-484, was passed. This legislation defined for the first time primary care as family medicine, general internal medicine, general pediatrics, and obstetrics-gynecology. Federal funds were allocated to support residency training in the primary care disciplines of family medicine, general medicine, general pediatrics, as well as general dentistry and physician assistants. Federal funds were authorized to be used also for pre-doctoral education and faculty development in Family Medicine, and establishment of Departments of Family Medicine.

Debate and dialogue surrounding passage of the Health Professions Assistant Act of 1976 demonstrated a widespread recognition of four problems: a physician shortage with a focus on primary care physicians; geographic maldistribution with an over-concentration of physicians in urban areas; predominance of hospital-based training; and less than adequate preparation of foreign medical graduates (FMGs) who were entering residency training and practice in the United States. The Act was designed to address all of these problems, but most agreed that this one piece of legislation in itself could not solve the problems of geographic and specialty maldistribution, or the problem of FMG’s. The Act also provided authority to select students from disadvantaged backgrounds.

The next major change in Title VII came in 1981 when the Omnibus Budget Reconciliation Act of 1981, PL 97-35, allowed for Federal funds to be used for faculty development in general internal medicine and general pediatrics. In 1988, the Health Professions Reauthorization Act of 1988, PL 100-106, did continue funding to all three primary care disciplines for residency training and to general dentistry and physician

assistant training. It no longer required special priority be given for Family Medicine residency training over the other primary care disciplines.

While many researchers have evaluated the effectiveness of Title VII by its ability to place graduates into underserved and rural communities, the ability to direct Federal funds to achieve these specific policy objectives did not occur until passage of the Health Professions Education Extension Amendments of 1992, PL 102-408. With this legislation, special preferences (Medically Underserved Communities) and priorities (Primary Care and Disadvantaged Students) could be developed and grantees meeting specified criteria could be scored higher in the peer review process. This legislation also authorized grants to establish Academic Administrative Units in Family Medicine, general internal medicine and general pediatrics and provided funds for pre-doctoral training in general internal medicine and general pediatrics. General dentistry was expanded to include advanced training in general dentistry.

The Health Professions Partnership Act of 1998, PL 105-392 continued the program's emphasis on diversity of the health profession, preparation of primary care physicians, dentists and physician assistants to care for disadvantaged populations, and placement of graduates in underserved communities. With this legislation, the Health Resources and Services Administration also was authorized to establish the Advisory Committee on Training in Primary Care Medicine and Dentistry.

As one can see from this brief legislative history, the Health Resources and Services Administration has had authority to support the development of the primary care disciplines of family medicine and physicians assistants since 1971 (with funding beginning in 1972), and general internal medicine, general pediatrics, general dentistry since 1976 (with funding beginning in 1977-1978). Title VII has expanded in scope with added authority of faculty development in family medicine in 1976, and in general internal medicine, general pediatrics, and physician assistants training programs in 1981. Support of general dentistry has been maintained since 1976 with the addition of pediatric dentistry in 1998. The expansion of academic administrative units came into force with Federal funding beginning in the early 1990s. The program's emphasis on placement of graduates into medically underserved communities has been an explicit mandate since 1992.

## **II. Building Infrastructure and National Curricula through Grants and Contracts**

Beyond the training of students and residents in primary care medicine and dentistry, one of the most important contributions of Title VII has been the shift in pre-doctoral and residency education to ambulatory care settings and into the community. One of the first steps was proving the ability to train competent physicians in primary care residencies which was done in several studies including one by Noble et al (*Annals of Internal Medicine*, 1992) that described the board certification pass rates for categorically trained internal medicine and pediatric residents compared with those in primary care residencies and then the career choices of these primary care residency graduates.

The second major contribution of Title VII has been creation of the infrastructure of academic generalist medicine through faculty development grants and grants to establish and maintain academic administrative units that include departments of family medicine and divisions of general internal medicine and general pediatrics. The recent article by Friedman et al. published in *Academic Medicine* (November, 2004) demonstrates the impact of these Federal funds in expanding primary care divisions and departments and integrating them into the core mission of academic health centers throughout the country.

The third major contribution of Title VII funds has been through contracts to support the development and dissemination of national curricula. These contracts have been awarded to the national primary care organizations in family medicine (Society of Teachers of Family Medicine), pediatrics (Ambulatory Pediatric Association), general internal medicine (Society of General Internal Medicine), and physician assistants (Association of Physician Assistant Programs), and have supported curricula in pre-doctoral education, residency training, and faculty development. Dissemination has occurred through regional and national meetings of these organizations, presentations at annual meetings of the Association of American Medical Colleges, publications in national medical education journals, and websites.

In summary, beyond the contribution of Title VII in training physicians, dentists and physician assistants for work as primary care health professionals in underserved and rural communities, this Federal program has provided the funds to create and sustain academic generalist medicine as viable disciplines in medical schools, to move training to the ambulatory setting and into rural communities, and to create high quality curricula for students, residents, and faculty in areas of relevance to care of disadvantaged populations as well as pediatric and adult populations that have been disseminated nationally through the primary care organizations.

Areas of Innovation FY01-FY05:

All grants are made for three years. Grantees then must re-compete for funding through submission of a new grant application. In FY05, all grantees were required to address Healthy People 2010 and propose strategies to reduce health disparities.

Cultural Competency	35% or 229 grantees out of 648 total grantees in years FY01, FY02, FY03, FY04, FY05
ACGME Competencies	60 grantees in years FY02, FY03, FY04, FY05
Geriatrics, Oral Health, Genetics	55 Geriatrics, 18 Oral Health, 27 Genetics in FY03, FY04, FY05
Professionalism and Humanism	26 grantees in FY02, FY03, FY04, FY05
Public Health and Bioterrorism	86 grantees in FY02, FY03, FY04, and FY05

Other areas of innovation included health literacy, quality and patient safety.

In FY05 244 grant applications were received

191 grants applications were approved for funding

132 grant awards were made at a total cost of \$31,377,792.

(The remaining federal appropriation for Training in Primary Care Medicine and Dentistry was spent on continuation grant awards, federal contracts and cooperative agreements, legislatively mandated committees and councils, and administrative expenses.)

Academic Administrative Units	26/37 funded	14 with MUC
Pre-doctoral Training	26/39 funded	13with MUC
Residency Training	35/53 funded	35 with MUC
Faculty Development	27/36 funded	24 with MUC
Physician Assistant Training	10/11 funded	3 with MUC
General and Pediatric Dental Residency	14/15 funded	8 with MUC

## **Impact of FY06 Budget Cuts**

1. No new grants awards for FY06. Normal Congressional appropriation of \$80 to 90 million will provide funds for 130 to 150 new grant awards.
  
2. Budget reduction for all grantees funded in FY04 and FY05
  - Family Medicine 12%
  - General Internal Medicine 30%
  - General Pediatrics 30%
  - Physician Assistant 30%
  - Dentistry 45% w/termination of all grantees funded in FY05
  
- The greatest impact of the budget cuts was felt by general and pediatric dental residency training grantees since all grantees funded in FY05 were terminated, and only those grantees entering their third year were retained in the program. Grantees funded in the faculty development program area of Title VII, were significantly impacted since HRSA would not release information or decisions until late in the academic year. This presented a significant problem with recruitment of new fellows and retention of those already in the program for all the faculty development program categories that include clinician-researchers, clinician-educators, clinician-leaders, and community faculty. Most grantees eliminated one or more program objectives since there was insufficient funding to achieve their overall grant application objectives as originally submitted for peer review and funding.
  
3. Administrative loss of staff in the Division of Medicine and Dentistry and the Primary Care Medical Education Branch in anticipation of further budget cuts.
  
4. Reduced outreach to vulnerable and disadvantaged populations, especially in the dental residency training category.
  
5. Loss of the gains in pediatric dental residency training achieved in FY04 and FY05 with increased Congressional appropriation those years for this program category.
  
6. The negative impact of these budget cuts on recruitment and retention of students and residents into primary care as a discipline has yet to be evaluated.
  
7. The lack of funds to initiate and maintain contracts and cooperative agreements with national primary care organizations and other entities reduces the impact of these dollars on the development and dissemination of innovative curricula and recruitment programs.



## **Society of General Internal Medicine Proposal for Title VII Reauthorization**

### **Introduction:**

Primary care represents the backbone of the nation's health care system, serving as the first, often the *only* contact for care and treatment of poor, uninsured and aging populations. Primary care physicians, and general internists in particular, are on the frontline of managing chronic diseases, providing comprehensive care and coordinating long-term care. Where primary care is readily accessible, the quality of care is higher and the cost of health care is lower.<sup>1,2</sup> The demand for general internists will increase by 38 percent within the next 15 years, but the number of physicians entering the field of general internal medicine has dropped by 50 percent.<sup>2</sup>

The Title VII legislation (Title VII) incorporates many grant programs that embrace the Society of General Internal Medicine (SGIM) priorities including an emphasis on diversity of the health professions and the quality of primary care training. Although Title VII includes over 40 programs, each with distinct objectives and training foci, SGIM believes it is most appropriate to comment on reauthorization of those programs relevant to its mission, namely Training in Primary Care Medicine and Dentistry (Academic Administrative Units, Pre-doctoral Training, Residency Training, Faculty Development in Primary Care, Physician Assistant Training, and General and Pediatric Dental Residency Training). In many instances, the recommendations are designed to increase synergy across HRSA programs, including those outside of the Training in Primary Care Medicine and Dentistry grant program.

Of critical importance to the future of primary care practice in this country are the pre-doctoral and residency training in primary care programs since these two programs provide explicit curricula experiences and training opportunities in primary care. They expose students to potential careers in primary care and then provide graduate training for residents that ultimately lead to practice in family medicine, general pediatrics or general internal medicine. The faculty development program with its funding for clinician-researchers, clinician-educators, clinician-leaders and community faculty ensures a quality generalist faculty in medical schools and teaching hospitals to advance the priorities of primary care and to deliver medical care to patients along the spectrum of age and disease. In addition, these programs provide training in the skills necessary to address the health needs of disadvantaged and underinsured/uninsured populations.

### **1. Current programmatic strengths of the Training in Primary Care Medicine and Dentistry Grant Programs:**

#### **1.a. Effective at creating a primary care workforce that is diverse and provides care in medically underserved settings**

HRSA's success in creating a primary care workforce that is diverse and provides care in medically underserved settings has been well documented.<sup>1,3,4</sup> With respect to the

primary care training programs, this success is attributable to use of funding preferences and funding priorities. SGIM urges HRSA to:

- a) **maintain the two funding priorities of improving primary care and addressing diversity;**
- b) **set goals for increasing minority enrollment into health professions training programs;**
- c) **expand funding and monitor the objective of serving medically underserved communities with graduates who subsequently practice in these populations in rural and urban settings; and**
- d) **develop means to reward training program whose graduates provide pro bono service to disadvantaged and uninsured populations.**

Such preferences and priorities should be implemented across all HRSA primary care training programs.

### **1.b. Academically Based Programs.**

A major strength of these programs has been their home in academic institutions including medical schools, colleges and universities, and community teaching hospitals. This facilitates the integration of their innovative curricula and evaluations, and promotes outreach to disadvantaged populations into the overall educational mission of each institution. Maintenance of these programs helps ensure that, as the culture of medical education evolves at these institutions, issues relevant to primary care training and diversity of the health professions remain important key components of medical education at these institutions. The ability of these programs to interact synergistically with the broad educational and patient care missions of academic health centers would be constrained severely if such programs were based outside of academic institutions. **Thus, these programs should be maintained within the existing academic health center model.**

## **2. Areas where programs need to be strengthened:**

### **2.a. Collaboration among HRSA programs:**

HRSA programs have excelled at the development and deployment of a robust primary care and ethnically diverse workforce. However, there has been little in the way of synergy and collaboration among programs. **Thus, an important goal of restructuring these programs would be the creation of Primary Care Training programs that have greater synergy and collaboration among themselves as well as with other HRSA funded programs.** SGIM proposes increased collaboration with HRSA's diversity programs, such as the Health Career Opportunity Training (HCOP), scholarships for disadvantaged students, and Centers of Excellence (COE), that have been successful at increasing minority enrollment into the health professions. Other natural partnerships are the National Health Services Corp (NHSC) and Faculty Loan Repayment (FLP) programs. Lastly, SGIM believes emphasis should be placed on expanding training sites to include AHECs, rural clinics, urban underserved clinics and community health centers, thus building linkages between the Bureau of Health Professions, the Bureau of Primary Care and the Bureau of Rural Health.

**How to ensure such partnerships are developed:**

Given that HRSA has been quite successful at using funding preferences and priorities to shape program outcomes, we recommend use of these mechanisms to enact the needed changes. Examples of such funding preferences and priorities would be:

- a) Develop new funding preferences for the use of training sites that include AHECS, rural clinics, urban underserved clinics and community health centers;**
- b) Develop new funding preferences that give credit to grantees that place trainees in rural clinics, urban underserved clinics and community health centers upon the completion of training, and that better capture volunteer service to disadvantaged populations;**
- c) Develop new funding priorities to foster ongoing training opportunities for trainees who were previously funded under other HRSA programs. Examples include NHSC recipients and HCOP and COE graduates entering HRSA funded primary care training programs; and**
- d) Develop new funding priorities that award points to grantees who matriculate NHSC recipients or who graduate trainees who enter into the NHSC loan repayment program or the faculty loan repayment program, especially if they work in Title VII funded institutions or in a Federally Qualified Health Center.**

**2.b. Need for multi-disciplinary Primary Care Training Programs**

SGIM and other professional organizations have noted the future of primary care will no longer be based in solo or small group practices, but will involve a medical home with multi-disciplinary teams composed of primary care physicians, mid-level providers, nurses, community health workers, etc.<sup>5,6</sup> While HRSA has had distinct training programs for some of these different providers, rarely have cross-disciplinary partnerships been required. **Thus, for the training programs in primary care medicine (pre-doctoral training, residency training, faculty development, academic administrative units, and physician assistant training), the evaluation criteria should include assessment of curricula that address the “medical home” and enhance training in longitudinal care of the chronically ill by such interdisciplinary teams.** The focus should be on training practitioners who can work effectively in teams. Such training would need to involve collaborative faculty across the primary care disciplines. **In addition, the Title VII programs should encourage training in strategies on reducing or eliminating health disparities. Evaluation of these programs by grantees should focus on outcomes of interventions designed to implement the “medical home”, and to eliminate health disparities among the target population.**

**2.c Need for longitudinal tracking of trainees:**

To date, HRSA has had limited ability to track trainees longitudinally. Recent reports have highlighted similar problems with NIH training programs.<sup>7</sup> The development of such mechanisms is essential in ensuring effective collaboration among programs as envisioned above. To this end we urge two important new initiatives:

- a) require all programs to include a plan for longitudinal tracking of trainees; and**

**b) charge HRSA's Training in Primary Care Medicine and Dentistry Advisory Committee with developing a viable and cost-effective uniform mechanism for HRSA to track trainees over at least 10 years.**

#### **2.d. Need for ongoing external program evaluation**

While research demonstrates the overall impact of the Title VII programs to be positive,<sup>1,3</sup> there continues to be a call for rigorous evaluation of the Title VII programs to demonstrate their effectiveness and outcomes. These recommendations have been put forth by participants of the USPHS Primary Care Health Policy Fellowship program, and by the members of the Advisory Committee on Training in Primary Care Medicine and Dentistry in its 5<sup>th</sup> Report released in January 2007.<sup>8</sup> In addition, the credibility of internal evaluation of such programs has often times been called into question due to existing political realities. Thus SGIM calls for the inclusion of **a rigorous annual evaluation component led by experts external to HRSA to ensure objectivity and access to report data.**

#### **2.e. Need for longer term funding of programs**

Many HRSA programs are based on a three year funding cycle. This funding cycle is much more abbreviated than those for most NIH funded programs. Such haphazard funding is problematic for institutions with long term commitments to such programs and threatens program stability. In addition, program resources need to be tapped for grant renewals on an almost ongoing basis. **Thus we recommend that program funding be extended from three to five years.**

#### **Summary:**

Primary care physicians are uniquely trained to provide comprehensive care and long-term care for patients. Federal support of programs at the pre-doctoral, residency and fellowship level that train students and doctors to provide personalized and coordinated care across a spectrum of health issues and not in a piecemeal fashion is critical for their survival. The above recommendations will further strengthen the well-documented success of these Title VII programs at creating a primary care workforce that is diverse and provides care in medically underserved settings.

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<sup>1</sup> Health Professions Programs: FY 2008 Brochure. AAMC Health Professions and Nursing Education Coalition. Available at [www.aamc.org/advocacy/hpniec](http://www.aamc.org/advocacy/hpniec)

<sup>2</sup> The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care: A Report from the American College of Physicians January 30, 2006. Available at <http://www.acponline.org/hpp/statehc06.htm> (cited March 1, 2007)

<sup>3</sup> Advisory Committee on Training in Primary Care Medicine and Dentistry. Comprehensive Review and Commendations: Title VII, Section 747 of the Public Health Service Act. Health Resources and Services Administration. November 2001.

<sup>4</sup> Department of Health and Human Services FY 2008: Health Resources and Services Administration Justification of Estimates for Appropriations Committee. Pages 299-318. Available at: <ftp://ftp.hrsa.gov/about/budgetjustification08.pdf>

<sup>5</sup> Larson E, et al. The Future of General Internal Medicine: Final Report and Recommendations. SGIM Task Force on the Future of General Internal Medicine. 2003. Available at: <http://www.sgim.org/futureofGIM.pdf>.

<sup>6</sup> Barr, M. et al The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care

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A Policy Monograph of the American College of Physicians. 2006 Available at:

[http://www.acponline.org/hpp/adv\\_med.pdf](http://www.acponline.org/hpp/adv_med.pdf)

<sup>7</sup> Committee for the Assessment of NIH Minority Research Training Programs. Assessment of NIH Minority Research and Training Programs. National Academies Press. Washington DC. 2005. Available at:

<http://www.nap.edu/books/0309095751/html/R1.html>

<sup>8</sup> Evaluating the Impact of Title VII, Section 747 Programs. Advisory Committee on Training in Primary Care Medicine and Dentistry. January 2007. Available at: <ftp://ftp.hrsa.gov/bhpr/actpcmd/fifth.pdf>



# Health Professions Programs: Over 1,000,000 Trained and Counting

FY 2008 Brochure



The Health Professions and Nursing Education Coalition (HPNEC) is an alliance of over 60 national organizations (listed on back of brochure) representing schools, programs, health professionals and students dedicated to ensuring the health care workforce is trained to meet the needs of our diverse population.

## The Health Professions Programs and Their Missions

The health professions and nursing education programs, authorized under Titles VII and VIII of the Public Health Service Act, are essential components of the nationwide health care safety net, bringing health care services to our rural and underserved communities. The health professions programs support the training and education of health care providers with the aim of enhancing the supply, diversity, and distribution of the workforce, filling the gaps in the health professions' supply not met by traditional market forces.

Through loans, loan guarantees, and scholarships to students, and grants and contracts to academic institutions and non-profit organizations, the **Title VII and VIII health professions programs are the only federal programs designed to train providers in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the health care workforce.**

*The severe cuts to Title VII in FY 2006 have had a devastating impact on the programs. The majority of these cuts were not restored in FY 2007.*

- **Minority and Disadvantaged Health Professions:** Increases minority representation in the health professions and includes the Centers of Excellence (COE), Health Careers Opportunity Program (HCOP), faculty loan repayment and fellowships and Scholarships for Disadvantaged Students (SDS).

*Federal funding for HCOP and COE programs was almost completely eliminated in FY 2006, undermining efforts to increase representation of minority and disadvantaged students in the health professions.*

- **Primary Care Medicine and Dentistry:** Expands the primary care provider workforce; includes programs in general pediatrics, general internal medicine, family medicine, osteopathic medicine, general and pediatric dentistry and physician assistants.

*Federal funding for programs under this heading was drastically reduced in FY 2006.*

- **Interdisciplinary, Community-Based Linkages:** Supports community-based training of various health professions in rural and urban underserved areas: Area Health Education Centers (AHECs), Health Education and Training Centers (HETCs), geriatric health professions, Quentin N. Burdick Rural Training, allied health, and other disciplines.

*Federal funding for HETCs, rural training, and most allied health disciplines was eliminated in FY 2006, weakening interdisciplinary education and training infrastructures across the country.*

- **Health Professions Workforce Information and Analysis:** Supports the compilation and analysis of data on the nation's health workforce.

*Federal funding for this component of Title VII was eliminated in FY 2006, hampering efforts to evaluate and assess health workforce needs and shortages.*

- **Public Health Workforce Development:** Supports public health training, preventive medicine residencies, dental public health, and health administration programs.

*The FY 2006 cuts threaten the programs' ability to develop well-trained public health workers.*

- **Nursing Workforce Development:** Provides a federal focus on the supply and distribution of qualified nurses; includes the following programs: advanced education nursing; workforce diversity; nursing faculty loan program; nurse education, practice and retention; comprehensive geriatric education; and loan repayment and scholarship.

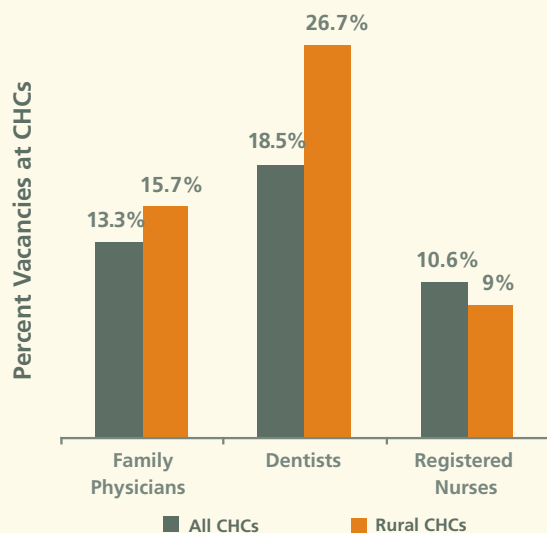
*Flat funding has stalled the training of much-needed nurses and nurse faculty.*

- **Student Financial Assistance:** Assists disadvantaged health professions students—primary care loan, health professions student loan, and loans for disadvantaged students.

# The Need for Title VII and VIII Programs

## Title VII & VIII Programs Help Alleviate Provider Shortages and Maldistribution in Rural and Underserved Communities.

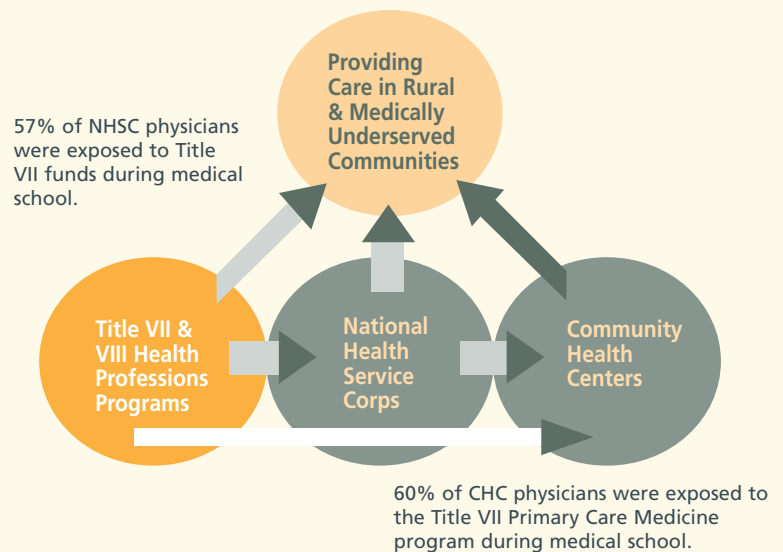
### JAMA Study Recommends Increased Title VII and VIII Support to Fill Provider Shortages at Community Health Centers



A recent study in *JAMA* found that community health centers report significant provider shortages across all disciplines.

**Data Source:** RA Rosenblatt et al. Shortages of Medical Personnel at Community Health Centers. *JAMA*. 2006; 295(9):1042-49.

### Strengthening the Health Safety Net



A forthcoming study from the UCSF Center for California Health Workforce Studies finds that over half of physicians in the National Health Service Corps and Community Health Centers were exposed to Title VII during medical school. Title VII & VIII programs work in synergy with the National Health Service Corps and Community Health Centers to strengthen the health safety net for rural and medically underserved communities.

### Addressing Provider Shortages

- Experts estimate the need for an additional 5,570 health professionals to meet an adequate provider-to-population ratio for rural shortage areas. Only about 10 percent of physicians practice in rural America, though 25 percent of the population lives in these areas. Over the past 10 years, nearly **13,000 health care providers, teachers and students** have been trained through the Quentin N. Burdick Program for Rural Interdisciplinary Training.
- Title VII is the only federal training program for the allied health professions. Nearly **44 percent of laboratories** report that they currently are experiencing difficulties in recruiting or hiring medical

laboratory personnel, as described in the August 2006 issue of *LABMED-ICINE*.

- With the increasing number of elderly, there is a projected need for 36,000 geriatricians by 2030. A network of 50 GECs has trained over **500,000 health practitioners** in 35 health-related disciplines to better serve the burgeoning elderly population.
- Title VII has spurred a dramatic increase in the number of practicing dentists with advanced training in primary care. Title VII support for General Dentistry has resulted in over **560 new positions** (representing 80% of such growth) in the past 25 years, and support for Pediatric Dentistry has resulted in over

**100 new positions** in the past six years. General Dentistry Title VII graduates establish practices and spend 50% or more of their time in health professional shortage areas or settings providing care to underserved communities. Pediatric Dentistry Title VII programs have been successful in treating children of low-income families, as 2/3 of their clinic patients are Medicaid-eligible.

- The US Bureau of Labor Statistics projects that more than **1.2 million new and replacement nurses** will be needed by 2014. Title VIII bolsters nursing education at all levels from entry-level preparation through graduate study.

## The Evidence is in. Title VII & VIII programs . . .

Increase the representation of minority and disadvantaged students in the health professions.

- A study published in *Journal of the American Medical Association (JAMA)* examines post-baccalaureate programs, which rely on Title VII, among other sources of funding. The study finds that **the programs are highly effective in increasing minority representation in medical school**, and concludes that enacted reductions in funding for Title VII may have negative consequences for these effective programs.<sup>1</sup>
- A survey of HCOP and COE program directors finds that **the programs have served over 400,000 minority and disadvantaged aspiring health professionals.**<sup>2</sup>
- A review of physician assistant graduates from 1990-2004 reveals that graduates of Title VII-supported programs were **67 percent more likely to be from underrepresented minority backgrounds** than graduates of non Title VII-supported programs.<sup>3</sup>

Improve the distribution of health care providers.

- A study published in *JAMA* finds that a **high percentage of Community Health Centers—especially those in rural areas—report provider shortages** across all disciplines. The study recommends increased support for Title VII to train health professionals who can help alleviate provider vacancies across the country.<sup>4</sup>
- A study published in the *Journal of Rural Health* finds that up to **83% of family medicine residents and 80% of nurse practitioners** who went through a program with Title VII or VIII funding chose to practice in a medically underserved or health professions shortage designated setting, post-graduation.<sup>5</sup>
- A study published in *Academic Medicine* compared students in a Title VII-supported medical education program to those in a traditional medical program. The study finds that **86% of Title VII graduates plan to work in**

**an underserved community, compared to 20% of graduates from a traditional medical program.**<sup>6</sup>

- During the 2004-2005 grant year, AHECs and HETCs recruited and maintained nearly **25,000 community-based training sites and placed over 47,000 health professions students in medically underserved communities.**<sup>7</sup>

Enhance the supply of the health professions workforce.

- An article published in *American Family Physician* finds that students who attended schools with Title VII funding were significantly more likely to choose family practice.<sup>8</sup>
- An article published in the *Annals of Internal Medicine* recommends increased support for Title VII grants and programs to improve the supply of the primary care workforce.<sup>9</sup>
- Title VIII Nursing Workforce Development programs support the recruitment, education and retention of over **52,759 nurses and nursing students.** These programs are the largest source of federal funding for schools providing education for the future nursing workforce.<sup>10</sup>

**Based on this collection of evidence, it is estimated that nearly one million practicing and aspiring health professionals have benefited from the Title VII and VIII programs.**

<sup>1</sup> Grumbach K, Chen E. *JAMA*. 2006; 296(9): 1079–1085.

<sup>2</sup> AAMC HCOP-COE Survey. Spring 2006. Available at: [www.aamc.org/advocacy/library/laborhhs/hcopcoesurvey.pdf](http://www.aamc.org/advocacy/library/laborhhs/hcopcoesurvey.pdf).

<sup>3</sup> Analysis of 2004 and 2005 AAPA Physician Assistant Census Surveys and the AAPA Masterfile (March 20, 2006).

<sup>4</sup> Rosenblatt RA, et al. *JAMA*. 2006; 295(9): 1042 – 1049.

<sup>5</sup> Edwards JB, et al. *Journal of Rural Health*. 2006; 22(1): 69–77.

<sup>6</sup> Ko M, et al. *Academic Medicine*. 2005; 80: 803.

<sup>7</sup> NAO Committee on Research and Evaluation, CPMS/UPR.

<sup>8</sup> Meyers D, et al. *American Family Physician*. 2002; 66(4): 554.

<sup>9</sup> Schwartz MD, et al. *Annals of Internal Medicine*. 2005; 142(8): 715–724.

<sup>10</sup> HRSA, Division of Nursing

## States Lose Title VII Funding in FY 2006 Budget

### Federal Funding for Health Professions and Nursing Education Under Titles VII & VIII of the Public Health Service Act FY 2005 & FY 2006

State	FY 2005	FY 2006	FY06–FY05	State	FY 2005	FY 2006	FY06–FY05
Alabama	\$9,794,178	\$9,977,935	\$183,757	Nevada	\$2,717,005	\$428,428	-\$2,288,577
Alaska	\$1,993,640	\$1,832,406	-\$161,234	New Hampshire	\$1,213,767	\$930,102	-\$283,665
Arizona	\$6,212,057	\$3,916,744	-\$2,295,313	New Jersey	\$11,219,670	\$6,595,893	-\$4,623,777
Arkansas	\$3,305,126	\$1,715,441	-\$1,589,685	New Mexico	\$6,796,328	\$2,909,746	-\$3,886,582
California	\$37,407,086	\$18,268,048	-\$19,139,038	New York	\$33,655,119	\$21,369,608	-\$12,285,511
Colorado	\$5,229,944	\$2,883,089	-\$2,346,855	North Carolina	\$13,460,569	\$9,074,633	-\$4,385,936
Connecticut	\$4,441,391	\$1,456,191	-\$2,985,200	North Dakota	\$2,624,007	\$878,489	-\$1,745,518
Delaware	\$781,759	\$352,198	-\$429,561	Ohio	\$13,223,995	\$6,552,017	-\$6,671,978
District of Columbia	\$8,797,522	\$6,038,098	-\$2,759,424	Oklahoma	\$5,158,117	\$2,809,629	-\$2,348,488
Florida	\$13,872,744	\$7,191,255	-\$6,681,489	Oregon	\$4,845,441	\$1,908,167	-\$2,937,274
Georgia	\$11,670,124	\$6,021,509	-\$5,648,615	Pennsylvania	\$13,824,270	\$9,898,571	-\$3,925,699
Hawaii	\$6,888,488	\$4,280,747	-\$2,607,741	Puerto Rico	\$7,524,897	\$4,701,489	-\$2,823,408
Idaho	\$3,356,253	\$931,068	-\$2,425,185	Rhode Island	\$2,596,660	\$1,704,464	-\$892,196
Illinois	\$15,553,393	\$8,684,134	-\$6,869,259	South Carolina	\$6,311,395	\$3,383,764	-\$2,927,631
Indiana	\$3,165,046	\$4,389,400	\$1,224,354	South Dakota	\$1,973,513	\$1,351,223	-\$622,290
Iowa	\$5,037,608	\$1,286,026	-\$3,751,582	Tennessee	\$17,887,667	\$15,544,598	-\$2,343,069
Kansas	\$6,051,577	\$3,178,362	-\$2,873,215	Texas	\$28,062,931	\$17,020,683	-\$11,042,248
Kentucky	\$8,677,937	\$3,149,066	-\$5,528,871	Utah	\$2,464,729	\$2,338,355	-\$126,374
Louisiana	\$7,620,939	\$6,012,424	-\$1,608,515	Vermont	\$1,222,432	\$584,552	-\$637,880
Maine	\$1,003,736	\$379,966	-\$623,770	Virgin Islands	\$573,878	\$37,255	-\$536,623
Maryland	\$8,587,090	\$4,257,756	-\$4,329,334	Virginia	\$9,230,683	\$5,592,809	-\$3,637,874
Massachusetts	\$12,722,907	\$6,171,041	-\$6,551,866	Washington	\$10,836,050	\$6,921,866	-\$3,914,184
Michigan	\$11,146,791	\$4,634,071	-\$6,512,720	West Virginia	\$3,469,515	\$2,441,416	-\$1,028,099
Minnesota	\$7,390,903	\$4,986,914	-\$2,403,989	Wisconsin	\$7,878,224	\$3,594,997	-\$4,283,227
Mississippi	\$2,997,343	\$3,911,871	\$914,528	Wyoming	\$639,586	\$456,248	-\$183,338
Missouri	\$5,741,515	\$3,596,949	-\$2,144,566	<b>Total</b>	<b>\$428,474,240</b>	<b>\$252,954,321</b>	<b>-\$175,519,919</b>
Montana	\$4,081,259	\$1,287,536	-\$2,793,723				
Nebraska	\$5,535,436	\$3,135,074	-\$2,400,362				

Source: Bureau of Health Professions, HRSA

# Members of the Health Professions and Nursing Education Coalition

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Academy of General Dentistry	American Geriatrics Society	Association of Women's Health, Obstetric, and Neonatal Nurses
Alliance for Academic Internal Medicine	American Medical Student Association	Clerkship Directors in Internal Medicine
Ambulatory Pediatric Association	American Nephrology Nurses' Association	Community-Campus Partnerships for Health
American Academy of Family Physicians	American Nurses Association	Council of Accredited MPH Programs
American Academy of HIV Medicine	American Occupational Therapy Association	Health Professions Network
American Academy of Nurse Practitioners	American Osteopathic Association	Hispanic-Serving Health Professions Schools
American Academy of Pediatric Dentistry	American Pediatric Society	Medicine-Pediatrics Program Directors Association
American Academy of Pediatrics	American Psychological Association	National Area Health Education Centers Organization
American Academy of Physician Assistants	American Society for Clinical Laboratory Science	National Association for Geriatric Education
American Association for Marriage and Family Therapy	American Therapeutic Recreation Association	National Association for Geriatric Education Centers
American Association of Colleges of Nursing	Association for Prevention Teaching and Research	National Association of County and City Health Officials
American Association of Colleges of Osteopathic Medicine	Association of Academic Health Centers	National Association of Medical Minority Educators, Inc
American Association of Colleges of Pharmacy	Association of American Medical Colleges	National Athletic Trainers' Association
American Association of Colleges of Podiatric Medicine	Association of American Veterinary Medical Colleges	National Council for Diversity in the Health Professions
American Association of Community Colleges	Association of Departments of Family Medicine	National Hispanic Medical Association
American Association of Nurse Anesthetist	Association of Family Medicine Residency Directors	National League for Nursing
American College of Nurse Practitioners	Association of Medical School Pediatric Department Chairs	National Network of Health Career Programs in Two-Year Colleges
American Association of Occupational Health Nurses	Association of Minority Health Professions Schools	National Rural Health Association
American College of Physicians	Association of Professors of Medicine	North American Primary Care Research Group
American College of Preventive Medicine	Association of Program Directors in Internal Medicine	Society for Adolescent Medicine
American Dental Association	Association of Schools of Allied Health Professions	Society for Pediatric Research
American Dental Education Association	Association of University Programs in Health Administration	Society of General Internal Medicine
		Society of Teachers of Family Medicine



# What Grabs A Legislator's Attention?

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Lyle B. Dennis

SGIM's Government Relations Consultant

April 26, 2007



# Why Get Involved?

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“The only thing necessary for the triumph of evil is for good men to do nothing.”

~ Edmund Burke

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“Public participation in the process of  
government is the essence of democracy.”

~ Lyndon B. Johnson

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“Eighty percent of success is showing up.”

~ Woody Allen

# You're An Advocate If...

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- You care about your patients
- You care about your practice and research
- You care about your community
  
- **AND YOU SPEAK OUT!**

# When Advocacy Fails, Why?

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- It's sporadic; untimely
- It's gobbledygook
- It has no connection to the real world
- It sounds self-serving
- \$#@& happens!

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When it comes to policy,  
there are no knock-outs.

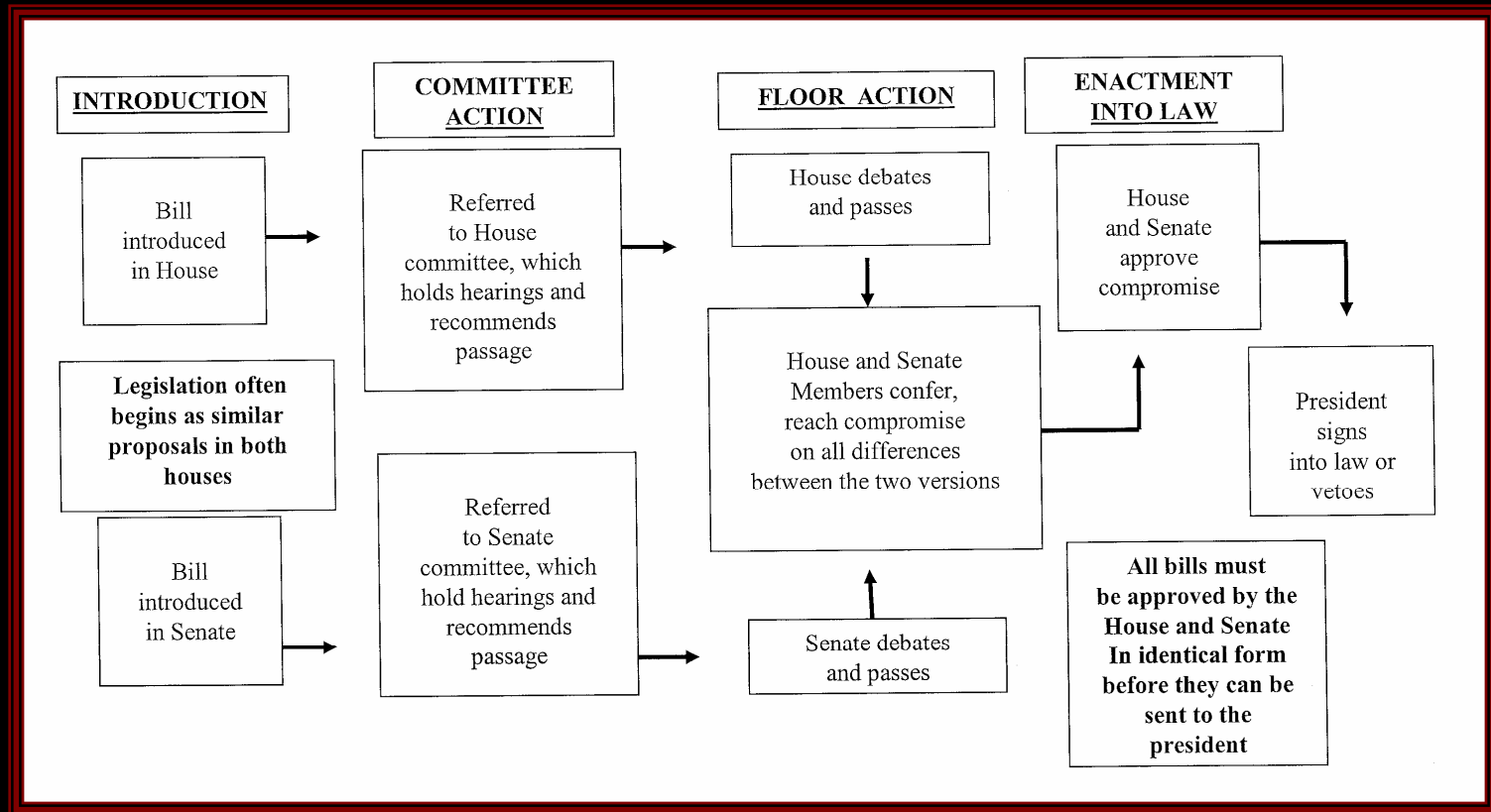
Incrementalism is realism.

# What Makes A Successful Advocate?

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- Understand the game
- Know the players
- Make a personal commitment

# Understand The Game: How Our Laws Are Made



# Committees: Where The Action Is

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- 10,000+ bills introduced in 2005-2006
- 482 bills enacted into law
- Committees act as filters
- Committee assignments are prized
- Committee members viewed as “experts”

# Key Committees

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- House Energy & Commerce
- Senate HELP
- House Ways & Means
- Senate Finance
- House Appropriations
- Senate Appropriations

# Role Of Leadership

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- Set the legislative agenda
- Determine timing of leadership action
- Guide scope & direction
- Determine “must-do” priorities

# Rank-And-File Lawmakers

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- Back-channel clout
- Tend to be less vested, more persuadable
- Leadership needs follower-ship

# Know The Players

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- 2 Senators; 1 Representative
- Cast a wider net
- Examine their philosophy & accommodate
- Find the “Sweet Spot”
- Staff role

# Make A Personal Commitment

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- Direct involvement at national, state and local level
- Cultivate grass roots (and grass tops)
- Play politics; thank them or spank them

# What Really Gets Their Attention?

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- Direct contact by you
- Political action
- Support from stakeholders
- Media focus

# What Doesn't Get Their Attention?

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- Lengthy policy papers
- Form letters
- Paid media ads

# Hill Staff: What Works Best?

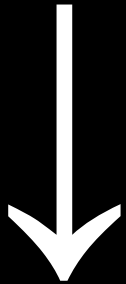
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- Office visits, phone calls
- Personal e-mails
- Phone calls from in-state community leaders
- Editorials in local newspapers
- Visits by stakeholders, e.g. patients

# Effectiveness Of Communications

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Highest



Lowest

- Personal visits (DC)
- Personal visits (district office)
- Phone calls
- E-mails/faxes
- Personal letters
- Petitions
- Mass mailings

# Before You Get There...

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- Gauge the environment
  - Tailor your case accordingly
  - Look for links
- Rehearse with the dog
  - Keep it simple
  - Use real-world examples
  - Anticipate counter-arguments

# To Make The Best Case, Keep It...

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- Short
- Simple
- PERSONAL

# Follow-Up

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- Say thank you
- Address unanswered questions
- Stay in touch – regularly



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