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The Reply:

The role of Community Health Centers in our health care system has increased substantially since the turn of the century. From 2000 to 2011, the number of community health center visits has increased from 30 million to 80 million. Over this same period, full-time staff working at community health centers across the country has increased from 56,000 to 138,000. This trend will no doubt continue, as the Affordable Care Act (ACA) has authorized $11 billion over 5 years for federally qualified health centers. It is estimated that by 2019 the capacity of community health centers will double to 40 million patients.[1] Given their increasing prevalence and significance, as the author writes, it makes sense that community health centers become more ingrained in medical education and serve as training sites for primary care education.

In fact, the ACA created the Teaching Health Center Graduate Medical Education program to do this. The program is a $230 million 5-year program designed to train primary care residents and dentists in community-based clinics such as federally qualified health centers, as well as community mental health centers, rural health clinics, and Indian Health Service clinics.[2]

There are obvious benefits for primary care training at community health centers, particularly with respect to enhancing the mission of primary care as well as increasing health care access and quality for the underserved.

Community health centers serve a disproportionate number of low-income patients who are more likely to be on Medicaid or lack health insurance. Data from the National Ambulatory Care Survey from 2007-2010 indicated that 47% of health care visits at community health centers are to patients on Medicaid. This is in comparison with 14% of office-based visits.[1] Putting more residents in community health centers will offer providers and medical care to those patients who need them the most. Given that residents are more likely to stay in the regions where they train, this new influx of residents could increase access at community health centers even after the residents graduate. Increased training at community health centers will also help community health centers with their own primary care physician workforce shortage.

While community health center ambulatory rotations will definitely serve societal good, whether ambulatory rotations at community health centers will attract more young doctors to primary care remains to be seen. In our opinion, young doctors are choosing specialties other than primary care, not due to a lack of primary care exposure, but rather the primary care experience during that primary care exposure. These problems are a corollary of policy that is skewed against primary care and ultimately translates into declining reimbursements, increased volume, diminished patient−doctor relationship, increased paperwork, decreased professional satisfaction, and burnout. Unfortunately, these challenges facing primary care in academic centers are by no means inherent to academic medical centers, and plague other sites as well, including community health centers. Ultimately, the best way to attract more young doctors to primary care is to enact policy and operational solutions that fundamentally reform and transform primary care.

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