Advisory Committee on Training in Primary Care Medicine and Dentistry

Unapproved Minutes of Meeting
December 7-8, 2000

The Advisory Committee met at the Madison Hotel, 15th and M Streets, NW, Washington, DC. The Meeting began at 8:30 a.m., December 7, 2000 and was adjourned at 5:00 p.m. Dr. Denise Rodgers, Chair, presided. The Advisory Committee reconvened at 8:30 a.m. and adjourned at 11:30 a.m. on December 8.

Members Present:
Ruth Ballweg, MPA, PA-C, Member
Frank Catalanotto, DMD, Member
James Crall, DDS, MS, DSc, Member
J. Thomas Cross, MD, MPH, Member
Thomas DeWitt, MD, Member
Staci Dixon, DO, Member
Julia Flanagan, MPH
Ronald Franks, MD, Member
John Frey, III, MD, Member
Julea Garner, MD, Member
Ryan Hughes, DDS, Member
Ronald Mito, DDS, Vice Chair
Carlos Moreno, MD, MSPH, Member
Harry Morris, DO, MPH, Member
Maxine Papadakis, MD, Member
Denise Rodgers, MD, Chair
Terrence Steyer, MD, Member
Joseph E. Scherger, MD, MPH, Member
Justine Strand, MPH, PA-C, Vice Chair

Others Present
Carol Bazell, MD, MPH, Executive Secretary, ACTPCMD
Stan Bastacky, DMD, MHSA, Deputy Executive Secretary, ACTPCMD
Dona L. Harris, Ph.D., Consultant to ACTPCMD
William K. Mygdal, Ed.D., Consultant to ACTPCMD

Welcoming Remarks

Denise Rodgers, MD, Chair, opened the meeting by welcoming members. Minutes for the meetings of December, 1999, April, 2000, and September, 2000 were approved.

Carol Bazell, MD, MPH, Executive Secretary and Director of the Division of Medicine and Dentistry (DMD), Bureau of Health Professions (BHPr)/HRSA, reviewed DMD administrative and personnel changes, including the creation of new Branches for Policy and Special Projects (Dr. Stan Bastacky, Chief), Dental Education (Dr. Bastacky serving as Acting Chief), and General Medical Education (Children's Hospital GME Branch). She introduced Crystal Clark, MD, new Special Assistant, and Nancy Torres, MD, new Chief of the Primary Care Medical Education Branch.

Sam Shekar, MD, MPH, HRSA Associate Administrator for Health Professions and Director of BHPr, listed the exciting changes and new programs in DMD. In noting the Committee's role in

reviewing the purpose and goals of Title VII programs, he emphasized HRSA's focus on 100% access, 0 disparities. He stated that insurance does not assure access, citing examples in which lack of providers in certain communities compromised the quality of care. The need for continued production and distribution of providers is not fully appreciated by policy makers and is the major focus for this Committee. He referred to shortages in nursing, pharmacy, public health dentistry, and other key components of the health care workforce, as well as declining applications to medical schools. He reviewed how BHPr addresses workforce issues in its current Title VII and VIII programs, with approximately $340 million allocated for these purposes. BHPr concentrates on workforce data, diversity, and distribution. Based on current projections, minorities will comprise half the US population by 2050 (within 5-10 years in Texas and Florida). BHPr Title VII programs graduate 3-5X more minorities than other programs, and 3-5X more of the graduates practice in underserved areas. He reviewed pipeline programs such as "Kids into Health Care Careers," and noted BHPr emphasis on the areas of geriatrics and genetics. He concluded with a plea for interdisciplinary efforts, stressing that health care disciplines must work together to provide a unified message to policy makers about critical workforce needs and needs for educational support.

Denise Rodgers, MD, Chair, noted the resignation of Dr. Walter Tunnessen from the Committee. She opened a discussion of the goals for and process by which the Committee should develop its report. Dr. DeWitt noted the need to advocate for the patients served by Title VII, especially culturally diverse minority and underserved populations. He argued for articulating a new vision and overcoming divisions between disciplines because asking Congress for more of the same programs is unlikely to be effective. Programs should seek the best ways to deal with future health care requirements of populations in need. Dr. Frey underscored the need to generate providers who will serve diverse populations. He noted that primary care no longer seems to be a key concern among policy makers. It may be difficult to sustain the education of primary care providers of all types. The need to advocate for primary care in Congress was echoed by others, based on the argument that a strong primary care infrastructure for training can best prepare the workforce to meet key health care problems. Committee members noted difficulties in foreseeing what Congress will want, pitfalls in appearing self-serving, the need to open discussions about collaboration, the need to align goals with needs perceived by patients and Congress, and the importance of the Committee being unified so that policy makers do not focus on disagreements that may lead to ignoring populations in need. Dr. Rodgers noted the underlying principles of increasing access and decreasing disparities. The Committee must agree on principles that will guide the structure of the formal report. She raised the question of whether changes in administration should affect the approach to the report. Dr. Bazell stressed that Congress established the Committee to decide what is needed and advocate for the necessary resources to meet those needs. She stated that it is important to set goals and priorities, make the case for them, and not get caught in responding to perceived political trends.

Dr. Rodgers led a discussion to define the key themes of access, disparities (as a subset of quality), cultural competence, oral health, diversity, quality, emerging primary health care issues (*e.g.*, geriatrics, genetics), and emerging information technology. Work Group B had prepared discipline-specific reports and themes that addressed these same issues. She challenged members to consider what Title VII programs can contribute and noted a need to define each theme is impacted on by other areas. Members pointed out that the relatively small amounts of money appropriated for these programs could not be expected alone to solve these problems. It was important to make primary care providers aware of the goals and to work in concert with others both inside and outside of government to address these issues, and set up programs that serve as catalysts for focusing efforts on national health problems. The importance of

addressing quality in evolving new models of care was noted, especially in emphasizing how a well trained primary care provider can add value by improving efficiency and quality while facilitating improved access. Competence and quality of care apply directly to improving access and decreasing disparities among the underserved. Since legislative guidelines and all programs stress improving care for the underserved, that should be the primary emphasis, but everyone benefits from improved quality. Most members felt that quality would be a worthy theme for training, and might include patient safety, evidence/knowledge-based medicine, service needs of patients, and health services research. This theme should include an emphasis on population and community health needs and would address disparities. Interdisciplinary collaboration was considered to be important as well. Complexities involved in training to decrease disparities and teach cultural competency were discussed, including changing demographics and the need to recruit a diverse faculty and broaden curricula with highly constrained resources. It was suggested that Title VII be described as the major training vehicle to enable providers to be responsive to emerging primary health care issues and for timely implementation of new and innovative applications of information technology for education, communication, decision support, and other uses. Many members stressed caution with regard to expectations and promises by programs of limited scope supported by limited funding.

Pipeline programs were discussed as mechanisms for meeting diversity needs. Most members argued that there was a crucial need to improve the flow of minorities into health professions careers, but that the limited funding available for current training programs made it impossible to accomplish using Title VII funds. Rather than setting aside dedicated funds to support pipeline programs, pipeline development could be built into a variety of training programs as an ancillary piece, based on models from current BHPr pipeline programs. One example might be to have training residents serve in pipeline development programs.

With regard to funding, there was general agreement that none of the individual disciplines advocated taking away levels of funding that are now distributed to each discipline, but that distribution of any new funding for innovative programs should be discussed. The general concept of funding for multidisciplinary programs had strong broad support. Several alternative options were reviewed and discussed, including scenarios that would include major increase in appropriations to support training. Most members argued for maintenance of major, discipline-specific divisions of funding, with some allotments for interdisciplinary work. However, Dr. Rodgers pointed out that it was not yet clear how any of these proposed formulas for apportionment of funds for disciplinary infrastructures would relate to or meet the themes and goals proposed in earlier discussions. It was important to determine whether the current system of preferences and priorities for grant awards should be continued or, in the event of changes, what the incentives should be. The meeting was then adjourned.

On the second day of the meeting, Dr. Rodgers outlined a series of possible plans for funding: (1) discipline-specific; (2) topic-specific; (3) interdisciplinary-specific (2 or more disciplines); and (4) category specific (*e.g.*, pre-doctoral, GME, faculty development, academic administrative units). Members discussed the merits of dividing all funds by disciplines, setting discipline-specific "floors" for allocation of funds, and considering program or topic specific areas. Members reviewed different scenarios based on increases from the current $79.3 million funding level to an "ideal" $192 million funding level, which would provide each discipline with what each of their individual organizations considered to be desirable levels of funding ($18 million for PA programs, $96 million for Family Medicine, $38 million for General Internal Medicine, $31 million for General Pediatrics, and $9 million for General Dentistry). A formula for apportionment of funds was then discussed which would center on discipline-specific allocations for most support, but with 25% of any newly appropriated increases in funds ($112.7 million) set

aside for interdisciplinary areas. It was agreed that General Dentistry should not allot any of their new funding to these interdisciplinary grants (*i.e.*, 25% of any new funding should be set aside for interdisciplinary grants from any new funding allotments to Family Medicine, General Internal Medicine, General Pediatrics, and PA programs, but not General Dentistry). Thus, $28.2 million should be set aside to fund interdisciplinary grants if the entire $112.7 million increase were to be appropriated by Congress. The amounts allotted (in millions of dollars) were as follows:

Discipline	Ideal Funding Level	Contribution to Interdisciplinary Projects	Remaining Funding Floor
PA	$18	$3	$15
Fam. Med.	$96	$12.2	$83.8
Int. Med./Ped.	$69	$13	$56
Dental	$9	0	$9
TOTALS	**$192**	**$28.2**	**$163.8**

Oral health was judged to be one worthy area for interdisciplinary projects. It was agreed that existing Med.-Peds. Programs should not be considered by themselves as applicants for new interdisciplinary grants, but would need a collaborating Family Medicine, PA, or General Dentistry Program. However, Dr. Rodgers noted that it would still be necessary to discuss how to link these proposed general or interdisciplinary funding allotments to stated themes and goals set during the first phase of the meeting. Problems associated with the application of priorities and preferences were discussed. Concerns were raised that some established programs that were "doing the right thing" might not be recognized. Questions were raised about whether programs should be judged by the extent to which they train providers to care for the underserved or provide service to the underserved. While multiple issues were raised about the ability to measure certain outcomes, no detailed suggestions of alternatives emerged from the discussion.

It was decided that an additional one-day meeting would be needed in January. Several topics remained to be covered, such as what should be included in recommended legislative language, what should be required of those applying for grants in particular categories, and what should be included in the list of important program areas. Some members argued that it was currently difficult to meet broad programmatic needs with the current "locked in " categories for grants (*i.e.*, administrative units, pre-doctoral, post-doctoral, faculty development). Others felt that it would be disruptive to eliminate categories, but that funding of academic administrative units allowed funds to cover broad categorical needs. However, it would still be necessary to define categories and priorities so that proposals could be properly evaluated.