

**Advisory Committee on Training in Primary Care Medicine and
Dentistry (ACTPCMD) Meeting Minutes
January 8-9, 2020**

Advisory Committee Members Present

Thomas E. McWilliams, DO, FACOFP, Chair
Donald L. Chi, DDS, PhD
Tara A. Cortes, PhD, RN, FAAN
A. Conan Davis, DMD, MPH
Patricia McCelvey Dieter, MPA, PA-C
Anita Glicken, MSW
Jeffrey Hicks, DDS
Cara Lichtenstein, MD, MPH
Pamela R. Patton, PA, MSP, DFAAPA
Rita A. Phillips, PhD, BSDH, RDH, CTCP
Mark D. Schwartz, MD
John Wesley Sealey, DO, FACOS
Louise T. Veselicky DDS, MDS, Med
Teshina Wilson, DO

HRSA BHW Staff Present

Kennita R. Carter, MD, Designated Federal Official (DFO), ACTPCMD
Robin L. Alexander, Management Analyst, Advisory Council Operations
Cynthia Harne, MSW, LCSW-C, Chief, Medical Training and Geriatrics Branch
Jennifer Holtzman, DDS, Dental Officer
Kimberly Huffman, Director of Advisory Council Operations
Paul Jung, MD, MPH, Director, Division of Medicine and Dentistry (DMD)
Luis Padilla, MD, Associate Administrator
Janet A. Robinson, Management Analyst, Advisory Council Operations
Shane Rogers, Chief, Oral Health Training Branch, HRSA

Roll Call/Agenda Review

Kennita Carter, DFO, ACTPCMD

Dr. Kennita Carter convened the in-person meeting of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD, or the Committee) on January 8, 2020. She welcomed everyone to the meeting and proceeded to conduct roll call, confirming a quorum. Participants then introduced themselves.

HRSA Welcome

Tom Engels, Administrator, Health Resources & Services Administration (HRSA)

Before joining HRSA, Mr. Engels worked as the Deputy Secretary of the Wisconsin Department of Health Services. In that role, he championed and oversaw the expansion of the state's capacity to provide mental health services, the implementation of statewide electronic health record systems, and the reduction in staff shortages at long-term care facilities. He was also an active member of the Governor's Task Force on opioid abuse and chaired the Governor's Human

Resources Shared Services Executive Committee.

Under Mr. Engel's leadership, HRSA is advancing departmental priorities, including addressing the opioid epidemic, transforming the behavioral health workforce, increasing access to health care services in rural communities, promoting maternal health, advancing kidney care in the United States, and ending the HIV epidemic.

Mr. Engels welcomed all new Committee members and thanked existing members for their service. He explained that HRSA's mission is to improve health outcomes and to address health disparities through access to quality services, a skilled workforce, and innovative high-value programs. HRSA is the primary federal agency for improving health care for individuals who are geographically isolated and medically vulnerable.

Millions of Americans receive quality, affordable health care and other services through HRSA's 90 programs and 3,000 grantees. This includes more than 28 million Americans who receive care from HRSA-funded health centers. In addition, more than half a million people with HIV receive care through the Ryan White HIV/AIDS program.

HRSA enables almost 15,000 National Health Service Corps and Nurse Corps to work in the nation's most vulnerable and underserved areas. HRSA also oversees the maternal, infant, and early childhood home visiting program, which provided nearly one million voluntary home visits to 150,000 parents and children in fiscal year 2018.

Mr. Engels said the work being carried out by the ACTPCMD is incredibly important. He added that the Committee's recommendations can help to address both existing and future challenges, including a projected shortage of primary care physicians and dentists.

Bureau of Health Workforce Overview and Priorities

Luis Padilla, Associate Administrator, BHW

Paul Jung, Director, Division of Medicine and Dentistry (DMD)

The mission of HRSA's Bureau of Health Workforce (BHW) is to improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. The programs at the BHW aim to: 1) Address access to health care by underserved and vulnerable populations, 2) Promote equilibrium in the supply and address shortages of health professionals, 3) Improve workforce distribution so all parts of the U.S. have an adequate number of providers to meet the demand for care, and 4) Develop a quality health workforce that is trained in and employs evidence-based techniques that reflect better patient care.

The Bureau supports both medical and oral health training programs. Medical training programs involve primary care physicians and physician assistants both while in school and after graduation. One of its aims is to promote long-term training in rural and underserved communities. BHW's oral health training programs support the development of innovative training models and workforce improvement programs for oral health professions. They provide opportunities both during school and at the postgraduate level to train in rural and underserved areas.

In addition, BHW supports geriatric health professions programs. The Geriatric Workforce Enhancement Program integrates geriatrics with primary care to improve health outcomes for older adults. It allows awardees the flexibility to address the education and training needs of their communities. The Geriatrics Academic Career Awards Program supports career development of junior faculty in geriatrics at

accredited schools of allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, and allied health. It supports the development of necessary skills that lead to health care transformation in a variety of settings, including rural and medically underserved settings. The National Health Service Corps (NHSC) builds healthy communities by supporting qualified clinicians working in areas of the U.S. with limited access to care. It awards scholarships and offers loan repayment to primary care providers in eligible disciplines. Since the program began, more than 50,000 primary care medical, dental, and mental/behavioral health professionals have served on the Corps. About 60 percent of NHSC clinicians serve in HRSA-funded health centers and almost 1 in 3 provide care in rural communities

The National Center for Health Workforce Analysis (NCHWA) conducts research that informs program planning, development, and policy-making by examining a broad range of issues that impact the U.S. health workforce. NCHWA conducts research on the sufficiency, geographic distribution, and education of the U.S. health workforce.

Discussion

Dr. McWilliams said that, from an osteopathic perspective, all programs are important, but the Children's Hospital Program is rising to critical levels in obtaining access, since most of the osteopathic colleges are private nonprofits and have extensive relationships with public universities and academic centers. He said there is a real need both at the undergraduate and graduate level in quality experiences to round out students in health professions.

Dr. Padilla agreed and said one of the biggest challenges in health professions training is the quality of the training environment available for training students. HRSA has focused on expanding the network of safety net organizations to address this. The goal is twofold: to increase the number of quality training environments and to increase the number of those environments in rural and underserved areas.

Dr. Davis asked about changes to the designations of Health Professional Shortage Areas (HPSA). Dr. Padilla said the methodology to define HPSAs has not changed. What has changed is the use of standardized data sets and the fact that all system scores have been updated. HPSA scores will now be able to be reviewed on an annual basis and adjusted as needed. But overall, the methodology remains the same.

Dr. Chi asked if there would be a new emphasis on postdoctoral training. Dr. Padilla said that HRSA also supports a predoctoral program so that dentists can have the necessary skills to provide services in rural and underserved areas. However, the mainstream education of a general dentist does not afford them the ability to effectively deliver care when addressing a comorbid, complex population. In some environments dentists are caring for individuals who have HIV, hepatitis, and diabetes. The goal is therefore to address both pre and postdoctoral training.

Rural Health Overview

Sarah D. Young, Deputy Director, Policy Research Division, Federal Office of Rural Health Policy, HRSA

Ms. Young provided an update from HRSA's Federal Office of Rural Health Policy (FORHP). The Office advises the Secretary of the U.S. Department of Health and Human Services on the effect that federal health care policies and regulations may have on rural communities. By

monitoring current and proposed changes, including programs established under Titles XVIII and XIX (Medicare and Medicaid), FORHP analyzes their impact on the financial viability of small rural hospitals and clinics, on the ability of rural areas to attract health professionals, and on rural areas' access to high quality care. The Office also works closely with [Rural Health Research Centers](#).

While there are various formal definitions of what constitutes “rural” (Census, OMB, FORHP), researchers generally agree that rural populations are usually seen as older, sicker, and poorer when compared with urban ones. Life expectancy is lower for rural nonmetro residents (77 years) when compared with large county metro areas (80 years). Also, in rural areas heart disease is 56 percent higher compared with urban areas. Similarly, chronic respiratory disease is 75 percent higher and unintentional injuries 37 percent higher than in urban areas.

A rural safety net of providers includes critical access hospitals, rural health clinics, and Federally Qualified Health Centers (FQHCs). However, service gaps still exist for those living in rural areas – 31.7 percent of all rural counties had access to only 1 of 3 core safety net providers. Provider density is also lower in rural areas for physicians, dentists, and OB/GYNs when compared with metro areas. In rural areas, 63 percent of individuals received teeth cleaning in the past year compared with 70 percent of their urban counterparts. Similarly, 51 percent of individuals in rural areas had permanently lost any teeth compared with 44 percent in urban areas.

Rural health care is further challenged by hospital closures. Since 2010, 119 rural hospitals have closed, and some are still in high risk of financial distress. Obstetrician (OB) and family practice workforce shortages are a primary concern in availability of hospital OB services and are also factors associated with OB unit closures. As a result, smaller rural hospitals rely more heavily on family practitioners to provide OB care.

To address some of these challenges, HRSA launched the Rural Maternity and Obstetrics Management Strategies (RMOMS) Program. The program improves access to and continuity of maternal and obstetrics care in rural communities through testing models that focus on: 1) Rural hospital obstetric service aggregation, 2) A network approach to coordinating a continuum of care, 3) Leveraging telehealth and specialty care, and 4) Financial sustainability. The program began in September 2019 and three sites have received awards.

In terms of provider training, data show that the distribution of graduate medical education residents is concentrated in the Northeast of the United States as well as in urban areas. To address this, HRSA developed the Rural Residency Planning and Development (RRPD) Program. It has awarded \$20 million for 27 recipients funded across 21 states to develop rural residency programs. It is a multi-year grant that aims to expand the number of rural residency programs in family medicine, internal medicine, and psychiatry. A Technical Assistance Center has also been developed and all awardees are required to collaborate with the center to develop new, sustainable, and accredited residency programs.

Discussion

Dr. McWilliams asked Ms. Young if she had data on the effectiveness of obstetric fellowship training for family physicians. He said that although those tend to be insufficient in number, they

are highly desirable and sought after by rural hospitals and health care systems. He also asked about the role of medical malpractice and litigation in closing down obstetric units in rural hospitals.

Ms. Young said those were both excellent questions, but could not answer them off hand. She said she would take the information back to the office to determine if there is existing research that addresses either of those questions or if there is an opportunity for future research in those areas and then get back to Dr. McWilliams.

Dr. Sealey said that one of the issues is that most of the training in rural areas involves patients on Medicaid. And Medicaid reimburses if the individual is in the hospital, but most of the training- the rural communities happens in the clinic. Also, programs can at times be difficult to sustain in the long run because they are working with small hospitals in financially deprived areas.

Ms. Young said the program hones in on partnerships with urban centers, which can alleviate some of those issues. This is done in part through the RTT Technical Assistance Program, a HRSA-funded program. However, HRSA is aware of these concerns and continues to address the issue.

Dr. Schwartz said he is a VA physician and his center in New York will be funded as a National Center for Research in Telehealth for Veterans. He added that he would be happy to speak with HRSA or individuals at HRSA's Office for the Advancement of Telehealth to determine the possibility of coordinating research efforts.

Division of Medicine and Dentistry Updates

Shane Rogers, Chief, Oral Health Training Branch, HRSA

Jennifer Holtzman, Dental Officer, BHW, HRSA

Cynthia Harne, Chief, Medical Training and Geriatrics Branch, HRSA

Mr. Rogers provided the Committee with a handout which listed all the HRSA-funded rural dentistry grantee activities in two main areas across the country: 1) Predoctoral training in general, pediatric, and public health dentistry and dental hygiene, and 2) Postdoctoral training in general, pediatric, and public health. The handout also listed initiatives that focused on the state of the oral health workforce.

Mr. Rogers discussed a Notice of Funding Opportunity (NOFO) that provides funds to plan, develop, and operate postdoctoral training programs in the fields of general dentistry, pediatric dentistry, and dental public health. The NOFO encourages applicants to propose initiatives to better prepare dentists to be able to provide care within rural-based communities by developing new programs or enhancing their current programs in community-based clinical training sites in those rural areas. It will provide \$14 million in funding for about 30 grants from 2020 through 2025.

HRSA's Oral Health Training Branch is also collaborating with HRSA's Office of Planning, Analysis and Evaluation to fund the National Conference for State Legislatures (NCSL). The conference reaches state legislatures, their staff, and the legislators themselves. The conference will emphasize access as well as some considerations for rural-based activities.

Dr. Holtzman discussed rural health efforts focused on the National Health Service Corps (NHSC). The NHSC seeks to build healthy communities by supporting qualified health care providers dedicated to working in areas of the U.S. with limited access to care. It offers a scholarship program as well as a loan repayment program for primary care clinicians and students in exchange for serving in underserved areas.

The scholarship program offers funding for tuition and other expenses for up to four years. Dental scholars can apply before their first year of dental school to receive support. They can delay service until after graduation or until they finish a general, pediatric, or dental residency program. The loan repayment program provides funding for repayment of student loans in exchange for service in a designated Health Professional Shortage Area. There currently are 1,500 dentists in the NHSC and 35 percent work in rural communities.

Ms. Harne explained that HRSA has received from Congress an additional \$50 million for the Medical Student Education Program for FY 2020. The program provides grants to public institutions of higher education to expand or support graduate education for medical students preparing to become physicians in the top quintile of states with a projected primary care provider shortage in 2025. A total of ten applicants in ten states are being considered. Awards are expected to be determined in the next month or so.

The Primary Care Training and Enhancement Residency Training in Primary Care program enhances accredited residency programs in family medicine, general internal medicine, general pediatrics, or combined internal medicine and pediatrics in rural and/or underserved areas. The program encourages graduates to choose primary care careers in these areas. The program is a \$10 million investment that is expected to fund 20 awards.

HRSA is also in the early stages of developing a program that aims to impact maternal health in rural areas. The objective is to support maternity services and care in rural areas. HRSA is currently obtaining information from stakeholders to develop the program, which is expected to launch in 2021.

Discussion

Ms. Glicken asked if Telehealth or Teledentistry were involved in any of the funded programs.

Mr. Rogers said it is a priority, particularly in the oral health area. A number of grantees are focused on those areas, although there are some challenges in terms of connectivity, equipment, and training that are necessary for usage, some of which may be addressed through the National Conference of State Legislatures Cooperative Agreement.

Ms. Patton asked if interprofessional collaboration in patient care is part of the teledentistry programs.

Mr. Rogers replied that he had not heard a lot about interprofessional collaboration when it comes to the teledentistry component.

Dr. Hicks said that a mobile practice with dental hygienists connected with telemedicine would enhance their ability to diagnose and treat patients in rural settings. And dental hygienists can practice in all 50 states. This could be an element of a future Notice of Funding Opportunity (NOFO).

Dr. Cortes asked if Ms. Harne could speak about any programs related to geriatrics.

Ms. Harne said that HRSA's Primary Care Training Enhancement Program (PCTE) focuses across the lifespan (with the exception of pediatrics). However, the current cohort of PCTE grantees does not have a special focus on geriatric populations. She added that dentistry does not have a specialty in geriatrics and that there are very few geriatric fellowships. The way this is being addressed through the NOFOs is by encouraging training for complex patients with complex medical needs.

17th Report – Innovations in Primary Care Medicine & Oral Health Education and Training

Thomas McWilliams, DO, FACOFP, Chair, ACTPCMD

Dr. McWilliams opened the floor to discussing the recommendations for the Committee's 17th Report, *Innovations in Primary Care Medicine & Oral Health Education and Training*. After a lengthy discussion, the recommendations were revised to read as follows:

1. Support the incorporation of community-based resources and partnerships into community-based primary care education and training for students, trainees, faculty, and practitioners.
2. Support longitudinal community-based primary care education and training for students, trainees, and faculty.
3. Provide funding to support innovative primary care programs that educate and provide training, incorporating evidence-based behavior change strategies that improve chronic disease prevention and management across oral health and primary care.
4. Support faculty development designed to facilitate the education of students, trainees, and primary care providers using innovative methods in addressing population health and managing chronic disease. Support the education and training of students and trainees in addressing population health and managing chronic disease.

Provide funding to support programs that provide innovative education and training, including telehealth. Also provide funding to support programs that provide education and training in telehealth as well as other virtual health technologies.

Discussion

Dr. Veselicky said that, due to accreditation requirements for predoctoral education, it is difficult to have a student spend a year in one area.

Dr. Carter said that Dr. Hicks examined the dental education literature and found that the term "longitudinal" is not included *per se* as a part of the language in oral health education and training. Instead the term "comprehensive" is used.

Dr. Chi said the important concept to make clear is that trainees will not be expected to be sent to a clinic for years. Instead, those training them may pick a cross section of different patients to learn about the comprehensive or longitudinal care system.

Ms. Glicker said the way they satisfied this in their medical school was by having a student go to

the same location one day a week, or every other week, for a particular period of time. In other words, the trainee did not have to go to a rural community site and live there. The requirement can also be satisfied by having a continuity of patients. For example, students would follow an individual patient and be excused from classes to attend that patient's visits.

Dr. Carter suggested that the Committee could use the word "longitudinal" in the recommendation and provide an explanation elsewhere in the report about what the literature states about oral health. The Committee agreed with the suggestion.

Dr. Schwartz said that some of the recommendations had the term "vulnerable populations" and others did not.

Dr. Carter said one approach would be to remove the language from the recommendations and add an overarching statement to the recommendations stating that one of the targets is vulnerable populations. The Committee agreed with this suggestion.

Public Comment

The following public comments were offered:

- Hope Wittenberg, with the Council of Academic Family Medicine, spoke about issues regarding statutory and regulatory limitations affecting rural training. She said that a bipartisan bill will be reintroduced in the Senate by February 2020. Currently, funding formulas in Medicare GME have hampered rural training. The bill would establish a payment rate similar to the teaching health center's payment rate for a specific FTE amount of training. But unlike teaching health centers, it would also include a cost of living adjustment. This would make funding under the Medicare formula more adequate for rural areas. The bill would also remove caps for training in rural areas.
- Karen Mitchell, MD, from the American Academy of Family Physicians (AAFP), said the AAFP is supporting similar legislative efforts. The AAFP has made sustainable funding for teaching health centers as one of its top legislative priorities. The AAFP also has as one of its highest priorities to expand the number of residency positions in rural areas.
- Dr. Mitchell explained that in family medicine, maternity care and deliveries are a required part of the residency program, although variations do exist as there are 680 different residency programs which offer different types of experiences. Some programs are already doing an excellent job in providing their residents with the training and experience that allows them to provide maternity care and deliveries right out of residency. There are also other programs where graduates need a bit more training in order to be able to carry out surgical deliveries.

Dr. Mitchell said the requirements state there must be at least one family physician providing maternity care and deliveries in a family medicine residency and at least one family physician providing inpatient pediatric care. However, this does not exclude or preclude any other teachers of any of the type of specialties. Also, family medicine requirements do allow for non-physician supervision of residents.

- Dr. Mitchell suggested that the Committee consider recommendations to support preceptorships in medical schools for rural opportunities, particularly for opportunities in maternity care. One of the ways that programs could be supported is through a course called ALSO – Advanced Life Support in Obstetrics. This program increases the confidence of doctors trained in maternity care to handle emergencies. The Committee could also consider recommendations for research in maternity care as well as other rural efforts. In particular, research and evaluation of current efforts so they can be continually improved.

Rural Health Education and Training

Randall Longenecker, MD, Assistant Dean for Rural and Underserved Programs, Ohio University Heritage College of Osteopathic Medicine

The purpose of the Rural Training Track (RTT) Collaborative is to sustain health professions education in rural places through mutual encouragement, peer learning, practice improvement, and the delivery of technical expertise, all in support of a quality rural workforce. It emerged as a sustainable nonprofit from the RTT Technical Assistance Program, a HRSA-funded program.

The Collaborative has 35 participating programs across the U.S., which vary in structure and involve both education of medical students and residents. Each program is designed to fit the assets and capacity of the specific rural community, within the rules of accreditation and finance, but creatively adapting those rules to local realities.

An Integrated Rural Track Training Program is a rural program that is separately accredited and, because of its generally smaller size, is substantially integrated with a larger, often more urban residency program. The program is rurally located and rurally focused, and engaged in training and/or education. It involves a track or pathway that is deliberately structured over at least 2-3 years in family medicine, including a 24-month continuity practice in a rural location.

Integration includes sharing of faculty and/or a program director, shared didactics and/or scholarly activity, and at least 4 months of structured curriculum shared by residents of both programs. The program also includes longitudinal curricula, rural pathways in an urban program, and recognition for rural program outcomes.

The rural residency program is defined as an accredited residency program in which residents spend the majority of their time training (more than 50 percent, as reported to CMS and/or HRSA) in a rural place. The location of a rural program in Family Medicine is defined by the geographic location of the primary Family Medicine Practice where residents meet the American Board of Family Medicine requirement for 24 months of continuing practice.

Dr. Longenecker offered the following policy recommendations:

- Support innovation and program development in rural places, with an eye toward sustainability (e.g. RTT-TA program consortium, Rural Residency Planning and Development).
- Right-size grant funding to the grant writing and management capacity of rural places.

- Adopt a simple targeted system of GME finance that directly pays for training in rural places, and is designed to allow multiple streams of training – other specialties and other professions – without requiring separate accreditation.

Discussion

Dr. Veselicky asked whether the rural health track training program is part of a regular family medicine residency or if it involves training beyond residency.

Dr. Longenecker said it is a three-year program, like any program in family medicine and accredited as a bridge program. In other words, the residents in a rural training track might spend their first year in an urban location participating with residents of an associated program, but then spend the rest of their training at the rural location. Integrated rural training tracks have to meet all the requirements of any other residency program in family medicine.

Dr. Lichtenstein said she found a document from the American Osteopathic Association on basic standards for rural track residency training in pediatrics and asked if there was anything similar outside of pediatrics that would require consortium programs to have other basic standards, learning objectives, topics, etc.

Dr. Longenecker said he wrote that paper with a couple of pediatricians in the fall of 2012. However, that was before the single accreditation system came along and so those requirements were actually approved but never implemented in any programs.

Dr. Longenecker added that a particular challenge in rural locations is to meet some of the requirements that are designed for urban programs. For example, if in internal medicine only internal medicine board certified physicians can teach residents, then it is very difficult to have a residency program in some rural locations where there may not be a board-certified internist and often not a board-certified cardiologist, dermatologist, or rheumatologist to teach that particular content. Sometimes what happens is that those residents are trained by the person who is most qualified to train them in a rural location, which sometimes is a family physician who has functioned as the rheumatologist to the community?

Rural Health Education and Training Update

Erin Fraher, PhD, Chair, HRSA's Council on Graduate Medical Education (COGME) Workgroup

Kristen Goodell, MD, Past Chair, COGME

HRSA's Council on Graduate Medical Education (COGME) provides an ongoing assessment of physician workforce trends, training issues, and financing policies. It recommends appropriate federal and private sector efforts on these issues to the Secretary of the U.S. Department of Health and Human Services and Congress.

In the past, COGME typically developed a substantial report with recommendations. However, it was decided that it might be useful to create shorter documents that could be digested and read more quickly. This led to the development of COGME's policy briefs. The goal is for COGME to develop three briefs.

The first brief will focus on rural health and workforce needs, the second on rural training, and

the third on payment. Each brief will include policy background as well as actionable and concrete steps that HHS, HRSA, CMS, Congress, and other policymakers can engage in immediately. Currently, the first brief is under development. The first brief recommends that new or existing assessments be used to clarify the specific health services needs of individual communities and the potential resources that exist within such communities, and that residency programs be created to optimize meeting individual community needs based on available resources.

The brief also recommends that health professions training programs in rural areas be developed to address individual community needs. Individualized programs can be created that train cohorts of different types of providers together, working as teams. Training programs will optimally integrate multiple local institutions, both public and private, which are invested in the health of the local population. Most of these providers should have close ties to and be reflective of these communities.

Training programs must also be allowed the flexibility to meet the needs of their communities. The brief recommends that community needs be addressed in a flexible manner. In addition, key principles must be emphasized when rural training programs are developed, including team-based care, an emphasis on generalism, and strategies for life-long, multi-modality learning.

Discussion

Dr. Hicks said that in the past COGME had also considered undergraduate medical education. She asked if there was a path forward on funding that necessary stream.

Dr. Fraher said it is important to develop a pipeline. In North Carolina, for example, those who attend medical school have an in-state retention of 42 percent. And for those who attend both medical school and residency, the retention rate is 80 percent.

Dr. Carter added that one of the decisions COGME made was to make recommendations on appropriation levels for some Title VII programs, since it is part of their charter. During its June 2019 meeting, COGME recommended increasing funding of Title VII, primary care and oral health training programs from \$89 million to \$120 million. During that meeting, COGME also recommended that new funds be made available to support the development and implementation of longitudinal rural primary care education and training residency programs, or rural tracks within primary care residency programs, such as those for physicians in family medicine, internal medicine, and pediatrics.

Dr. Hicks asked if COGME was looking at strategies for the federal government to expand GME to also include undergraduate dental education.

Dr. Carter said the Council has not yet discussed that topic. The Council is discussing professions beyond medicine due to the current interprofessional nature of practice.

Dr. Hicks said that dentistry would welcome any opportunity to be involved in the GME process. She added that without funding for graduate dental education, it can be hard to get professionals into rural communities.

Dr. Sealey said that in rural communities, hospitals may not always have the infrastructure to

carry out an assessment, especially, for very small hospitals.. He said that a Federal Qualified Health Centers (FQHCs) are likely the most sophisticated organization in a rural community and could tackle the community-based assessment, instead of the hospital.

Dr. McWilliams agreed and said that FQHCs often have resources and experts to undertake an assessment.

Dr. Fraher added that HRSA's National Center for Health Workforce analysis is charged with collecting data on health workforce needs. She suggested that perhaps a NOFO with an assessment tool could help analyze these data and identify some common rural health needs.

Dr. Sealey asked, with respect to surgery programs in rural areas, if they had spoken to accrediting bodies, as it is one of the hardest programs to get accredited due to all the requirements and resources needed.

Dr. Fraher agreed and said that accreditation can be challenging for general surgery as well as for psychiatry in rural programs. She added that there are in fact programs that have managed to work with ACGME to develop rural residency programs. She added that one of the COGME briefs will address not just payment barriers, but also accreditation and regulatory barriers. This is critical because general surgery is an important profession specialty for rural areas.

Dr. Veselicky said that one of the things that has changed in graduate medical education is the fact that today residents are only allowed to train for a certain maximum hours a week. In addition, when looking at undergraduate medical education, there seems to be a need to incorporate more personal wellness initiatives in the curricula and training programs.

Dr. Carter said that ACTPCMD's latest published report addresses the issue of burnout. The 2019 report, [*Improving Well-Being Among Primary Care Trainees, Faculty and Clinicians: Optimizing Systems to Mitigate Burnout, Promote Resilience and Drive Quality of Care*](#), discusses well-being and preventing burnout and takes a systems-level approach, as there are many factors related to these issues. It addresses the importance of addressing system-level issues that impact well-being such as patient panel size and complexity, workload/workflow, and other factors.

Dr. McWilliams said there are some commonalities in what ACTPCMD and COGME are covering. He asked if there are any specific areas that come to mind for recommendations that would help both bodies in promoting change.

Dr. Fraher said that one of COGME's areas of focus is on the needs of rural communities and interprofessional team-based models of care. Also important are pipelines, specially a rural UME pipeline, and shifting from hospital-based to community-based settings. Having two advisory bodies echoing the same themes around those issues could be very powerful.

Day 2

18th Report – Rural Health Recommendation Development

Thomas McWilliams, DO, FACFP, Chair, ACTPCMD

Dr. McWilliams opened the floor to discussing the initial draft of the recommendations for the

Committee's 18th Report, which will address health professions education and training to increase access to needed services such as primary care, oral health, and maternity care in rural communities. After some discussion, the following recommendations developed:

1. Maternal Health – Support educational and training programs that promote evidence-based maternal care in rural settings.
2. Primary Care – Support physician assistant practice and retention in underserved rural communities, including supporting training programs by employing longitudinal rural primary care rotations or postgraduate physician assistant rural primary care residency programs.
3. Oral Health – Support the creation of a rural dental residency program as well as interprofessional models of primary care and oral health education and training.

As part of the next steps, the Committee agreed that a working group would flesh out the rationale for each of the above recommendations, based on the existing literature, and begin the development of a draft of the 18th report. The report will then be reviewed by the ACTPCMD as a whole on a subsequent public meeting.

Discussion

Ms. Glicken suggested that not only primary care providers be prepared to do screening history and some preventive intervention, but also that the dental community and dental providers be prepared to contribute in terms of primary care.

Dr. McWilliams said the NYU Langone model has been successful in “exporting” education from an academic medical center environment to a rural environment in a manner that is cost effective and yields good outcomes. Perhaps it can be mentioned in the report.

Dr. Hicks said that part of NYU's success is the fact that they received GME funding for their dental residents in general dentistry and pediatric dentistry. However, with the revision of the interpretation of the GME, dental schools are not eligible for GME funding.

Dr. Wilson said there are opportunities to promote focused fellowships along the entire spectrum. There are opportunities to integrate primary care providers such as family physicians, primary care physician assistants, and nurse practitioners in rural communities that can work with prenatal patients, which is something that is done in Northern California. Primary care physicians engage and take care of patients in their pregnancy from start to finish until the actual delivery.

Dr. Schwartz suggested considering research in the areas of primary care and maternal health – best models, best practices, best ways to transform a system of care, etc. One recommendation could be to promote training programs in research related to testing effective models of primary care in rural communities or models of care around maternal health that would reduce maternal mortality among those at highest risk.

Dr. Lichtenstein said there is a lack of mental health professionals and the literature shows that many pediatric patients are presenting to their primary care provider, instead of to a mental health specialist. She asked if there is a way to encourage primary care specialties to look at behavioral and mental health and integrating it into their training.

Ms. Patton clarified that education of physician assistants (PAs) ranges from 24 to 36 months, depending on the program. Unlike physicians, residencies for PAs are optional. Having that additional training could help PAs be more confident in practicing in a rural setting, such as a clinic, by themselves.

Dr. McWilliams said that in rural and frontier medicine, PAs have a very important role, especially in communities that may not support a full-time physician.

Ms. Dieter said her institution had a program that placed physician assistant students for longitudinal rotations in rural underserved areas. Results showed that program graduates were three times as likely to work in medically underserved communities after graduation as their cohorts and twice as likely to continue in primary care.

Dr. Lichtenstein said that perhaps the report could emphasize the importance of recruiting people who are from the community they practice in, to increase the likelihood of retention.

Ms. Glicken said that a PA with additional experience through a residency could be helpful in rural community where there is a physician available, but the doctor is too busy to train someone.

Business Meeting

Kennita R. Carter, DFO, ACTPCMD

Dr. Carter informed the Committee that the next meeting will be a webinar on August 4, 2020. She also informed the Committee that a nomination package with 11 new members had been moved forward for review. Because there are multiple levels of review and clearance, the exact approval date is not known. However, it is anticipated that new members will be coming on board by the next meeting.

The Committee also voted on the nomination of Ms. Glicken as the new ACTPCMD Chair. The group voted unanimously in favor of her being the new Chair. Dr. Carter suggested that the Committee also consider nominating a Vice Chair for continuity. All nominations, including self-nominations, are encouraged and should be submitted to Dr. Carter.

Adjourn

Kennita R. Carter, DFO, ACTPCMD

Dr. Carter thanked everyone for their input and hard work. She made a special acknowledgement and thanked members who will be rotating out, including Dr. Chi, Dr. Cortes, Ms. Dieter, Dr. McWilliams, and Dr. Wilson.

Dr. Carter adjourned the meeting at 1:45 p.m.