Advisory Committee on Training in Primary Care Medicine and Dentistry

Minutes of Meeting – February 12-13, 2004

(Approved on April 26, 2004)

Advisory Committee Members Present

Gregory Strayhorn, MD, PhD, Chair
David P. Asprey, PhD, PA-C, Vice Chair
Frank A. Catalanotto, DMD, Vice Chair
Margaret I. Aguwa, DO, MPH, Member
Tammy L. Born, DO, Member
Rudolfo R. Burquez, DDS, Member
Tina Lee Cheng, MD, MPH, Member
Thomas G. Dewitt, MD, Member
Michael W. Donohoo, DDS, Member
Ronald D. Franks, MD, Member
John J. Frey, III, MD, Member
Matilde M. Irigoyen, MD, Member
Man Wai Ng, DDS, MPH, Member
Rubens J. Pamies, MD, Member
Eugene C. Rich, MD, Member
Terrence E. Steyer, MD, Member
Craig Whiting, DO, FACFP, Member

Others Present

Donald L. Weaver, MD, Assistant Surgeon General
Jerilyn K. Glass, MD, PhD, Acting Deputy Executive Secretary

Thursday, February 12, 2004

The Advisory Committee on Training in Primary Care Medicine and Dentistry (Advisory Committee) convened at 8:33 a.m. in the Versailles I Room of the Holiday Inn Select, 8120 Wisconsin Avenue, Bethesda, Maryland 20814. Gregory Strayhorn, MD, PhD, Chair, opened the meeting and asked Committee members to introduce themselves.

Dr. Strayhorn introduced Elizabeth M. Duke, Administrator, Health Resources and Services Administration, who gave introductory remarks. She described the President's initiative to expand the health center network. The Agency is well on its way toward reaching the goals of expanding service from 10 to16 million people over a five-year period, increasing sites from 3,200 in 2002 to 4,400 by 2006, and increasing personnel by 36,000, which includes 11,000 clinicians. Dr. Duke applauded the service provided by the National Health Service Corps (NHSC) which has experienced 70 percent growth during her tenure as Administrator. She related that fifteen years after they finish their obligation, 55 per cent of the NHSC are still serving the underserved and that over half of the NHSC serve in community health centers. The Agency also supports the state-administered Hospital Preparedness Program which aims to increase the capacity of the Nation's hospitals to meet hazards.

Captain Kerry Paige Nesseler, RN, MS, Associate Administrator for the Bureau of Health Professions also gave welcoming remarks. She stated that one of her responsibilities is to show Title VII program accomplishments in terms of direct outputs to the health of America. The Bureau convened a forum of 60 outside organizations, stakeholders, partners, and grantees to discuss program progress. The Bureau is almost one year into a three-year effort that eventually will change the data system to reflect new core performance measures that cut across programs. A logic model has been developed for each of the

thirty-nine programs in the Bureau to illustrate how a program works to achieve intended outcomes and to demonstrate logical relationships between activities, outputs, and outcomes. Six program concepts have emerged: diversity and underrepresented minority populations, access to care, training, quality care, disparities, and primary care. Captain Nesseler sought help from the Advisory Committee in locating data that could be used to build performance measures. She thanked Donald L. Weaver, MD for assuming the role of Acting Director of the Division of Medicine and Dentistry and listed the positions in the Division that the Bureau is actively trying to fill.

Brief remarks were also given by Dr. Weaver. He mentioned that 255 Title VII, section 747 grant applications were received and that reviews will occur over the next several weeks. As Director of the National Health Service Corps, he stated that the Corps was reauthorized for five years and is looking for committed clinicians to fill 6,000 vacancies.

To begin the discussion on the Advisory Committee's fourth report, the membership heard a brief presentation from each discipline represented on the Advisory Committee. Terrence E. Steyer, MD described a joint effort of family medicine organizations, begun in 2000, to develop a strategy to transform the specialty to meet the needs of people in a changing environment. They began with a national survey of perceptions of family medicine from patients, the general public, family physicians, specialty physicians, and trainees. They found that patients value their relationship with physicians above all else and want physicians to be technologically adept. Family physicians felt confident about their contributions, but felt undervalued in the medical system. Medical students had a positive view of family medicine, but worried about financial, prestige, and lifestyle issues. The group's recommendations, not yet finalized, deal with the need for a new model of family medicine involving a relationship medical home, increased use of technology, a focus on lifelong learning, and enhanced research activities. The full report is anticipated in the March/April issue of the new journal, *The Annals of Family Medicine.*

Eugene C. Rich, MD reported the work of a Society of General Internal Medicine task force on the future of general internal medicine. The task force defined core values and competencies related to general internal medicine and reflected on how the discipline should adapt to delivery system changes. Among its recommendations was to continue the range from providing or supervising uncomplicated primary care to managing multiple, complex, chronic illnesses. They recommended a focus on changes in information systems that would increase partnerships with patients and improve outcomes. Another recommendation was for graduate and continuing medical education to be tied to mastery in care delivery and practice management, information systems, organization and management skills, and team leadership. Dr. Rich stated that Title VII, section 747 programs need to focus on evidence-based medicine, lifelong learning, information management, information systems, practice organization and quality management, team work, cultural competence, and faculty development.

Tina Lee Cheng, MD, MPH discussed a report published in 2000 on the future of pediatric education, a collaborative project of different pediatric organizations. Some of the challenges that pediatric practice will face in the future are changing practice environment and changing demographics: more children in poverty, cultural and ethnic diversity, single parent families, and different family structures. Pediatricians of the future will have expanded roles including genomic interpreter, first responder to population health issues, provider of treatment for chronic diseases, and multi-disciplinary team member. Dr. Cheng stated that pediatric training needed to mirror changing health care needs of children, including neurodevelopmental, behavioral, and genetic needs. With a focus on child and family health needs, pediatricians will be continuity providers of health care, will become adept with information technology, and will serve as public health coordinators in communities.

David P. Asprey, PhD, PA-C stated that a unique feature of physician assistant training is that trainees are not required to complete post-graduate training prior to entering practice. He presented data showing that 51 percent of physician assistants are in primary care: 36 percent in family medicine, 9 percent in general internal medicine, 3 percent in pediatrics, and 3 percent in obstetrics-gynecology. The numbers can fluctuate, however, because physician assistants, with general primary care core skills, often move from one discipline to another. The field has articulated the following values: patient education, health

promotion and disease prevention, population-based medicine, patient satisfaction, a multi-disciplinary approach to patient care, and practice in underserved areas. Dr. Asprey underscored the importance of lifelong learning and a recognition of the limits of one's knowledge.

Man Wai Ng, DDS, MPH described a future shortage of dental providers due to increasing population, aging of the population, increased retention of teeth, closure of dental schools in the 1980s, and decreased dental student enrollment. The Surgeon General's report on oral health in 2000 pointed out significant disparities in dental care and access to care, in part due to lack of dental insurance. Of children with Medicaid, only 20 percent actually receive a preventive dental visit each year as compared to 80 percent receiving a medical visit. In order for the 35 million eligible Medicaid recipients to receive care, each dentist would have to see an extra 250 patients per year. Discussions in the field have centered on ways to increase diversity in the dental workforce, an interdisciplinary approach to dental care, and scholarships and loan forgiveness programs to encourage practice in underserved areas. Dr. Ng applauded Title VII, section 747 programs for successfully recruiting underrepresented minorities and for providing dental services to underserved populations. She urged program expansion to support faculty development and incorporation of public policy, public health, minority health, and cultural competence into training curricula of dental residency programs.

The Committee broke into three workgroups at 11:29 am. One workgroup focused on technology and information systems, chaired by Dr. Rich. Another focused on interdisciplinary teams as they relate to patient safety and quality, chaired by Frank A. Catalanotto, DMD. Dr. Steyer chaired a third workgroup discussing individual and community health care. The Advisory Committee reconvened at 2:05 pm. Dr. Strayhorn provided the newest member, Tammy L. Born, DO an opportunity to tell the group her background and current work.

Each chair presented the workgroup's recommendations. Dr. Rich said his group recommended that Title VII programs should lead in the development of innovative curricula for training primary care students and residents in the use of information technology (IT). The goal is to ensure that trainees have the knowledge, skills, and competencies to use a) IT for communication with patients, b) data systems to ensure quality of care, c) evidence-based medicine, and d) communication systems among health professionals. These programs should promote appropriate IT infrastructure to support training.

Dr. Catalanotto's workgroup recommended that Title VII funding should support primary care training that emphasizes integrated teams, continuous quality improvement, and evidence-based medicine and dentistry. Title VII funding should support faculty development programs in the needed concepts and skills. Training in interdisciplinary practice models that promote teamwork and the use of information technology and are designed to eliminate barriers to care should be supported.

Dr. Steyer's workgroup recommended that training should focus on eliminating health care disparities through direct involvement with public health agencies, community organizations, and policy-making bodies. Training programs should emphasize prevention and early intervention that promote healthy behaviors and establish a health career pipeline. Accrediting bodies should develop standards and ensure up-to-date education about health disparities and provide cultural competency training for all levels of learners. HRSA-funded programs should collaborate to promote interdisciplinary, community-based research and training where the emphasis is on the role of the primary care provider as first responder to public health hazards.

The Advisory Committee decided to have the Writing Group meet for one day in Rockville, MD before the meeting in May. Bryan Johnson, the report contractor, presented the accomplishment data he had gathered. The data was from the Comprehensive Performance Management System-Uniform Progress Report for the year 2002. The point was made that any analysis would profit from a comparison to schools that did not receive Title VII, section 747 funds. A small subgroup, chaired by Dr. Strayhorn, was formed to discuss further data issues at a breakfast meeting the next day. Arrangements were made

as well for Captain Nesseler to meet with the Outcomes Subcommittee at a breakfast meeting the following day.

There was no public comment. The meeting was adjourned at 4:51 p.m.

Friday, February 13, 2004

The Advisory Committee meeting re-convened at 8:14 a.m. Drs. Steyer, Rich, and Catalanotto met the preceding evening to draft a preamble with common themes for the fourth report and to consolidate the recommendations. Their work was presented, discussed, and modified by the full Committee.

Dr. Asprey, chair of the Outcomes Subcommittee, reported the points of discussion during several conference calls after the last meeting. To arrive at outcomes for Title VII programs, one suggested strategy was to poll the various disciplines regarding appropriate outcome measures. The subgroup discussed the possible benefit of developing a conceptual framework for thinking about Title VII programs and their outcomes. Another strategy was to determine what would happen if Title VII, section 747 programs did not exist. Consideration was given to examining what public health officials would like to see in trainees. If the aim is to see where graduates go, perhaps there is value in expanding beyond traditional locations like HPSAs and MUCs to any area where services are provided to the underserved, even though not officially so designated. Dr. Asprey announced that Man Wai Ng would co-chair the Outcomes Subcommittee. The Advisory Committee decided to retain the typical report schedule so that the fifth report, likely on outcomes for Title VII programs, would be launched at the October, 2004 meeting and published by November 2005.

During the public comment period a question was asked about reports posted on the Advisory Committee website, to which Dr. Glass responded. The meeting was adjourned at 10:56 a.m.