Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD)
Meeting Minutes: March 6-7, 2017

Advisory Committee Members Present:
Vicki Chan-Padgett, PAC, MPAS, Chair
Russell S. Phillips, MD, Vice-Chair
Bruce Blumberg, MD
Donald L. Chi, DDS, PhD
Tara A. Cortes, PhD, RN, FAAN
A. Conan Davis, DMD, MPH
Patricia M. Dieter, MPA, PA-C
Elizabeth (Lia) Kalliath, DMD
Thomas E. McWilliams, DO, FACOFP
Linda C Niessen, DMD, MPH
Allen Perkins, MD, MPH
Rita A. Phillips, BSDH, RDH, PhD, CTCP
John Wesley Sealey, DO, FACOS
Eve Switzer, MD, FAAP
Elizabeth Wiley, MD, JD, MPH
Stephen A. Wilson, MD, MPH, FAAFP
Teshina Wilson, DO

Health Resources and Services Administration (HRSA) Staff Present:
From the Bureau of Health Workforce (BHW), Division of Medicine and Dentistry
Kennita R. Carter, MD, Designated Federal Official (DFO), ACTPCMD
Candice Chen, MD, MPH, Director
Raymond J. Bingham, RN, MSN, Technical Writer
Lauren Pinckney, MPH, CHES, Public Health Analyst

From the BHW Advisory Council Operations
Kimberly Huffman, Director
Kandi Barnes, Management Analyst

From the BHW Division of External Affairs
Carl Yonder, Public Affairs Specialist

Presenters:
Day 1
Jim Macrae, MS, MPP
Luis Padilla, MD
Candice Chen, MD
Timothy Brigham, MDiv, PhD
Carol Bernstein, MD
Richard Valachovic, DMD, MPH
Lawrence McEvoy II, MD

Day 2
Claudia Finkelstein, MDCM
Maria Portela-Martinez, MD, MPH

Day 1 - March 6, 2017

Introduction

Dr. Kennita Carter convened the meeting of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD, or the Committee) at 8:30 a.m., March 6, 2017, at the headquarters of the Health Resources and Services Administration, Room 5W07, 5600 Fishers Lane, Rockville, MD 20857. The meeting was also accessible by teleconference and webinar. Dr. Carter conducted a roll call, and all current members of the Committee were present in person. Dr. Carter turned the meeting over to Vickie Chan-Padgett, the ACTPCMD Chair. Ms. Chan-Padgett welcomed the Committee and provided an overview of the agenda.

HRSA Welcome

Dr. Carter introduced Mr. James Macrae, Acting Administrator of the Health Resources and Services Administration (HRSA). Mr. Macrae noted that HRSA programs are focused on increasing access to care and serving the most vulnerable populations in the country. The topics of the two upcoming Committee reports, integrated behavioral care (14th report) and health provider burnout and promoting resilience (15th report), reflect issues of concern that HRSA is hearing from front-line healthcare providers. He added that there are shortages in the rural healthcare workforce and an increase in workforce turnover, which could reflect problems with provider burnout.

Mr. Macrae informed the Committee members that HRSA performs its work mostly by providing grants to community-based organizations, private institutions, universities, or other similar entities. A current area of focus for HRSA is healthcare integration.

On the topic of the Committee's 15th Report, Mr. Macrae described burnout as a major issue impacting the future of the healthcare workforce. He noted that current medical education does a good job of teaching students the biomedical sciences and how to provide care to others, but is lacking in helping physicians deal with the emotional realities of medical practice or the trauma of seeing large numbers of people with significant health issues. Students are rarely taught how to care for themselves or encouraged to ask for help when they need it.

Mr. Macrae expressed interest in the recommendations of the Committee on ways to build team-based care, improve communication, and help support the resiliency of providers. He noted the increasing complexity of the relationship between patient and provider. Patients have access to vast amounts of health information, but may not know how to evaluate its quality. Meanwhile, advances in communication technology mean that providers are more accessible, which may decrease the "downtime" they need for emotional recovery. The healthcare environment is changing almost daily in terms of care delivery, accessibility, and reimbursement. All of these changes impact the patient-provider relationship, which he stated was an area of interest of the new Secretary of the Department of Health and Human Services (HHS).

Q and A

Dr. Allen Perkins said that the primary care clinic program at the University of South Alabama successfully integrated behavioral health providers with the help of a HRSA grant. However, he expressed concern that the program may be preparing its medical residents for a workplace that does not exist, since most primary care clinics do not have ready access to behavioral health services or a reimbursement structure to pay for them. Dr. Perkins added that his program had submitted a proposal for a supplement to partner with a local community mental health center and improve screening for substance use and treatment.

Mr. Macrae replied that the healthcare system is moving away from paying for volume toward paying for quality and outcomes, which promises to increase the impact of integrated care. As to substance use, he agreed that the problem was growing, particularly in rural areas. One possible solution was to provide more training on evidence-based practices in pain management, since many addictions arise from use of prescription pain medications to treat a legitimate pain condition.

Dr. Linda Neissen said that the dental program at her school is working with a behavioral health insurance company to integrate both behavioral and oral health in primary care. They are finding significant oral health needs particularly among young people. She also endorsed efforts by HRSA to help healthcare professionals to understand their own needs.

Dr. Thomas McWilliams expressed strong concern about the possible loss of funding for the HRSA/DMD Teaching Health Center Graduate Medical Education (THCGME) program, which promotes primary care training in medicine and dentistry. Mr. Macrae stated that each new administration looks at the need for various programs during its transition. He assured the Committee members that HRSA understood the impact of THCGME in getting more trainees interested in primary care and improving access to care in underserved communities. He acknowledged the impending "funding cliff," in which funding for THCGME will cease at the end of the current fiscal year unless reauthorized by Congress. He added that THCGME funding also affects other programs, including Community Health Centers (CHCs), the National Health Service Corp (NHSC), and home visiting programs.

Dr. Stephen Wilson said that in past years there was widespread belief that many doctors were undertreating pain. Now, many providers are reluctant to prescribe opioid pain medications for fear of getting on the "naughty list" of over-prescribers. He noted that health policies, along with measurements such as patient satisfaction, contribute to setting the course of treatment. Mr. Macrae replied that the Centers for Medicare and Medicaid Services (CMS) recently made adjustments in its patient survey tool on pain assessment to better account for non-opioid approaches.

Dr. Conan Davis said that the NHSC has a good loan repayment program, but the dates that students have to meet in the application requirements often mean they have to remain in school an extra year before applying. Mr. Macrae replied that HRSA had adjusted the dates in the past, but that the issue could be revisited.

Lastly, Dr. Donald Chi shared that he was able to train in pediatric dentistry and research under a grant from HRSA's Maternal Child Health Bureau, and as a faculty member took advantage of a loan repayment program through both HRSA and the National Institutes of Health. Such programs lower the financial stress related to years of education and training, and suggested that Federal agencies work together to make student training or loan repayment programs more accessible.

Bureau of Health Workforce Updates

Dr. Carter introduced Dr. Luis Padilla, Associate Administrator for the HRSA Bureau of Health Workforce (BHW), who stated that the BHW was formed in 2014 with the goal of helping HRSA address the continuum of health careers from education to training to service. The 40 healthcare workforce programs that BHW administers span this continuum from helping high school students explore health careers to scholarships for students to loan repayment programs that reduce student debt and encourage practitioners to practice in underserved communities. He said that BHW had begun collecting the National Provider Identifier (NPI) number of physicians and others who receive HRSA support, allowing the agency to follow their careers and evaluate the long-term success of its programs. BHW also houses the National Center for Health Workforce Analysis (NCHWA), which handles workforce projection reports.

Dr. Padilla stated that the BHW goal is to help healthcare professionals throughout their careers, and to connect skilled professionals to communities in need. He stated the BHW priorities as:

- Preparing a skilled and diverse healthcare workforce,
- Improving workforce distribution throughout the country, and
- Helping to advance modern health by transforming healthcare delivery.

Dr. Padilla said that the BHW budget for fiscal year (FY) 2016 of $1.3 billion allowed it to reach over 7,400 individuals and grantee organizations. Many programs have statutory mandates that focus on improving workforce diversity, and 52 percent of BHW-funded trainees come from minority populations or disadvantaged backgrounds. He described the NHSC as a marquee program in promoting workforce distribution and diversity, as 88 percent of NHSC clinicians continue to practice in underserved areas beyond their service obligations.

Dr. Padilla stated that BHW programs serve as a catalyst for innovation and transformation in healthcare delivery. In the 2015-16 academic year, BHW provided over 250,000 training opportunities for students and clinicians, many utilizing interprofessional team-based care. The BHW Academic Unit Primary Care Training and Enhancement (AU-PCTE) program is working to provide the underlying research for curriculum and primary care development. There is a new program through the NHSC, Dental S2S (Students to Service), which allows fourth year dental students access to loan repayment in exchange for service in designated Health Professional Shortage Area (HPSA) communities.

Dr. Padilla referred to data from a recent NCHWA report showing an ongoing undersupply of primary care physicians by almost 24,000. The data also showed an oversupply of both physician assistants (PAs) and nurse practitioners (NPs), particularly in the south and west regions of the United States. He stated that the projection model incorporated the expansion of health insurance under the Patient Accountability and Affordable Care Act (ACA).

Lastly, Dr. Padilla informed the Committee members that HRSA had revamped its entire web site. He described the new BHW web site as streamlined and easier to use and a valuable tool to disseminate information, which can be accessed from any device.

Q and A

Ms. Chan-Padgett offered a comment about the utilization of PAs and NPs. The American Academy of Physician Assistants (AAPA) is pushing to relieve restrictions of PA practice to allow PAs to have full practice responsibility for treatment of their patients, and over 30 states now allow NPs to have independent practice. Dr. Padilla agreed that many states do not allow full scope of practice for PAs or NPs, adding that changes on scope of PA practice might serve as one factor to ameliorate the shortage of primary care clinicians.

Ms. Patricia Dieter asked about the source of the data leading to projections of an oversupply of PAs and NPs. Dr. Padilla replied that workforce projections are estimates of supply and demand, and must take into account a range of factors and rely on several assumptions. The study results and methodology are published on the HRSA web site for review, and other workforce research organizations had reviewed the NCWHA model and found it well-designed. Some of the data came from the American Medical Association's master file and the NPI database. He cautioned that one limitation of the NCHWA model is that it assumes healthcare delivery will not undergo significant change. While healthcare is changing, there is not enough evidence yet to say how much the changes will impact supply and demand.

Division of Medicine and Dentistry Update

Dr. Carter introduced Dr. Candace Chen, Director of the Division of Medicine and Dentistry (DMD), HRSA/BHW. Dr. Chen said that DMD administers a number of programs that fit together to strengthen the healthcare workforce, and in particular primary care physicians and dentists. These include THCGME, and the Children's Hospital Graduate Medical Education (CHGME) program, as well as programs under Title VII, Part C, Sections 747 and 748 of the Public Health Service Act.

She briefly reviewed the history of THCGME. The program was initially funded for five years through the ACA, and then an additional two years of funding was provided under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. However, it would run out of funding at the end of FY 2017. She acknowledged that the current Teaching Health Centers (THCs) within the THCGME program face a challenge with residency matches, which generally require a three to four year funding commitment.

Dr. Chen said that 2016 was the first year that THCs included NPI numbers of their trainees in their annual performance reports. In addition, CHGME programs are now also being asked to submit NPIs. THCGME supports about 700 residents, while CHGME is much bigger, supporting around 10,000 pediatric residents. The NPI data will help HRSA track long-term outcomes of individuals it supports, while reducing the reporting burden for grantee programs.

Dr. Chen moved the discussion to the Section 747 (primary care training and enhancement) and 748 (oral health training) programs. HRSA has generally supported oral health training programs at the pre-doctoral (dental hygiene and current dental students) level. In FY 2016, DMD ran a funding opportunity announcement (FOA) focused on enhancing pediatric dental training. Another recent program aimed to help junior faculty in oral health and primary care training advance in their careers and develop some innovative primary care training initiatives.

Within primary care training, opioid and other substance use disorders are becoming a priority. The field is experiencing a practice transformation to promote smarter opioid prescribing, as well as improved treatment for substance use disorders. DMD offered a small supplement to current grantees to add training activities around substance abuse screening and medication-assisted treatment. DMD is also working with other agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide training through webinars.

Dr. Chen noted that BHW/DMD has a strong interest in supporting academic-community partnerships. Academic institutions have skills and resources that could benefit CHCs and other primary care sites, while the community programs offer expanded access to training sites. One proposal would support the integration of medication-assisted treatment of opioid addition into primary care, with an explicit requirement to use PAs. Dr. Chen noted that 15 percent of DMD funding each year targets PA training.

Q and A

Ms. Chan-Padgett said that, as a Veteran, she is concerned about problems in the Department of Veterans Affairs (VA) health system and the difficulty many veterans are having getting access to medical care, especially mental health care. Through the Veteran's Choice initiative, veterans are now allowed to see civilian healthcare providers. She asked if there was a way for HRSA to work with the VA to educate civilian providers on the special healthcare needs of veterans, who represent a vulnerable population with particular needs. Dr. Chen replied that HRSA and the VA have already signed a memorandum of understanding to work together in many areas, including training. HRSA and the VA have a shared interest in promoting training and healthcare access in rural and other underserved communities. She added that HRSA and the VA are collaborating on a webinar to help HRSA grantees learn about opportunities to partner with the VA.

Another Committee member raised the issue of how HRSA measures and analyzes the efficacy of its programs, and asked if there was a way to share best practices with applicant organizations. In terms of measurement, Dr. Chen replied that grantees of programs in primary care, oral health, and geriatric workforce enhancement submit standardized performance reports that include information on the number and types of students supported, along with other elements such as patient outcomes and faculty development projects. In terms of assisting grant applicants, she said that HRSA recognized that applicant organizations come from different points in their development and have different environments. DMD tries to build its FOAs with a specific framework and direction to help applicants, while all grant applications are rated by external reviewers. She added that DMD understands that numbers do not tell the whole story, and encourages grantees to include qualitative information about program impact. Each grantee may approach a problem in a different way or with a different combination of services, and as a result may develop a different clinical training environment. DMD provides technical assistance in terms of tailoring evaluations to different locations and programs.

Committee Discussion of the 14th Report Outline: Integration of Mental and Behavioral Health in Primary Care

Ms. Chan-Padgett moved to the next agenda item, a discussion of the Committee's 14th Report on the integration of mental and behavioral health in primary care. Based on previous meetings and discussions, a draft outline had been developed, along with a draft set of recommendations:

> **Recommendation 1:** The ACTPCMD recommends that HRSA's Title VII Part C, Section 747 and 748 education and training programs provide funding to prepare the integrated health care team, including faculty and other health care team members, to lead the transformation of primary care to include behavioral and oral health.
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> **Recommendation 2:** The ACTPCMD recommends that HRSA's Title VII Part C, Section 747 and 748 education and training program that supports the preparation of students, trainees and practitioners to integrate behavioral health into primary care and oral health to achieve the quadruple aim with vulnerable populations.
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> **Recommendation 3:** The ACTPCMD recommends that SAMHSA/HRSA Center for Integrated Health Solutions develop a toolkit and repository of best practices for training programs to facilitate the design of educational programs integrating primary care, behavioral health and oral health that include methods of measuring short term and longitudinal outcomes including practice patterns for completers.

Ms. Chan-Padgett reminded the Committee members that the recommendations should be focused and concise and have measureable outcomes, and that the body of the report needs to support the recommendations. Dr. Carter reinforced the need for conciseness, with key bullet points highlighted for impact. The writing style should engage the members of Congress and their staff, whose constituents, especially in underserved communities, may be impacted by the Committee's reports and recommendations. Ms. Chan-Padgett shared some thoughts on points that she took from the HRSA briefings the Committee had received:

- The importance of interprofessional education and practice.
- The need to address substance use and opioid use.
- The need to include oral health in interprofessional education.
- The importance of interagency collaboration.

Dr. Tara Cortes offered some of the concepts she picked up from the previous presentations:

- The HHS Secretary places great value on the provider/patient relationship.
- Interprofessional and integrated health is the focus of the healthcare system.
- It is important to measure outcomes that would give validity to the concepts of interprofessional, integrated, provider/patient-centered care.

There was a proposal for a recommendation regarding ways to develop new reimbursement models for behavioral health care services. Several Committee members discussed the importance of reimbursement, along with the inherent complexity of trying to develop or study such a model. It was felt that a recommendation would not be practical.

There was a comment about the need for the Committee to address provider burnout, in terms of assessing and treating the mental and behavioral health of their patients. Ms. Chan-Padgett replied that the topics of provider well-being, resiliency, and burnout are planned for Committee's 15th Report. There was a general discussion on bridging the two Reports, by interweaving the topics of reimbursement and provider resiliency and burnout in the 14th Report, including recommended reimbursement changes to encourage providers to train students to be more resilient. Resiliency would then be more fully explored in the 15th Report.

Dr. Niessen described a potential benefit in the development of educational programs. Her organization's special needs dental facility reached out to behavioral health insurance companies, which cover individuals who have at least one of seven defined behavioral or mental health diagnoses. These insurance companies often have trouble meeting their Healthcare Effectiveness Data and Information Set (HEDIS) [a tool used by most health plans in America to measure performance on important dimensions of care and service] measurement targets in terms of oral health and other areas. Having dental students, along with students in medicine, nursing, and other disciplines, provide care for these vulnerable populations promises to help private-sector behavioral health insurance companies improve their HEDIS measures while enhancing access to care and creating rewarding educational experiences.

Dr. John Sealey emphasized the importance of training residents in population health, saying that some schools now offer a two-year certificate to provide residents with the tools to incorporate the community into their practice.

A question was raised as to why the recommendations do not include nurses and nurse practitioners, and it was noted that Federal support for nursing education and practice comes from a separate funding stream.

Dr. Chen offered her perspective on recommendations, which HRSA might then have to implement. Programs under Section 747 – primary care training and enhancement – have an annual appropriation of $39 million, while programs under Section 748 – oral health training – have an appropriation of around $36 million. The overarching question for the Committee to consider is the funding priorities, of which promoting the integration of behavioral and oral health into primary care is one option. She noted that FOAs from HRSA/DMD formerly only allowed support for physicians or physician assistants, while new FOAs include a broader range of professions to encourage interprofessional education and practice. The process of going from legislative statute to an FOA requires interpretation, which is often drawn from the advisory committee recommendations. The Committee's recommendations go to the HHS Secretary and to Congress, but they also have a wider impact in the field, particularly within academic institutions and stakeholder organizations. Thus, recommendations do not need to be limited to what could be accomplished through HRSA or HHS alone.

While the time allotted for discussion ended, there was general agreement to continue the discussion later. Ms. Chan-Padgett and Dr. Carter said they would review the agenda to determine the best time to continue the discussion, and that the members receive a document containing the revised draft Recommendations. The meeting adjourned for lunch.

Panel Presentation – The ACGME Initiative on Physician Well-Being: Deepening our Commitment to Faculty, Learners, and Patients

Dr. Carter introduced two speakers for a panel presentation on the Accreditation Council for Graduate Medical Education (ACGME) Initiative on Physician Well-Being, Dr. Timothy Brigham and Dr. Carol Bernstein.

Dr. Brigham is the Senior Vice-President for Education at ACGME, as well as a professor of medicine. By way of explaining why ACGME was involved in promoting physician well-being, he stated that the ACGME mission is to "improve healthcare and population health by assessing and advancing the quality of resident physician's education through accreditation."

ACGME accreditation emphasizes six core values: Professionalism, Systems-based Practice, Interpersonal and Communication Skills, Practice-based Learning and Improvement, Medical Knowledge, and Patient Care.

Dr. Brigham noted what he called "sobering realities." In general, medical students at orientation are psychologically and emotionally healthier than their college graduate peers. However, once they start medical school, their levels of stress, depression, and burnout quickly rise, while their levels of compassion and empathy decline. Meanwhile, among practicing physicians, 55 percent experience symptoms of burnout and physicians have a higher suicide rate than any other profession – roughly 400 physicians commit suicide each year.

Dr. Brigham said that the ACGME Resident Council, shaken by a string of resident suicides, brought the problem of burnout to the attention of the ACGME Board. He stated that at a Board meeting discussion, all physicians in the room reported having been affected either by the death of somebody that they cared about in the medical profession, or by their own suicidal ideation. He said that ACGME determined that there was a need for fundamental, transformative change in medical education to enhance physician resiliency and reduce burnout and suicide.

ACGME cannot address all areas of concern related to physician burnout and suicide, so it took the approach that building resilience in physicians required a change to the environment. The ACGME Board established an ongoing task force to spark improvement of physician well-being through education, stress management, and the evaluation of results in the clinical environment. The Task Force has three subcommittees:

- Research, to facilitate evidence-based research and disseminate materials.
- Education, to educate the GME community and share resources.
- Tools and Resources, to develop a web site and vet materials.

ACGME is trying to increase awareness by hosting an annual conference, and developing a web site to disseminate informational videos, slide sets, and tool kits. In addition, it is sponsoring a series of annual symposia on physician well-being. The goals of the symposia are to develop ways to assess, monitor, and build resilience in individuals. ACGME recognizes the need to promote well-being, reduce stigma that comes with admitting vulnerability, and have tools and resources available to help individuals and communities heal. Subgroups in the symposia have looked at such topics as innovation, mental health

services, culture change, building a comprehensive well-being program, workflow and the electronic health record (EHR), and strategies to build resilience.

ACGME efforts include reviewing the results of its annual survey of medical residents, which has a voluntary section containing questions about well-being; examining all resident deaths from 2010 – 2014; and collaborating with other groups on research into well-being and helping the suffering physician heal. ACGME has also been trying to begin conversations across businesses, specialties, professions, and cultures on steps to improve resiliency and prevent burnout.

Panel Presentation – Physician Well-Being: Challenges and Opportunities

Dr. Carter introduced the second panel speaker, Dr. Carol Bernstein, a professor at the New York University School of Medicine, and a former board member of ACGME. Dr. Bernstein stated that she is now co-chairing the ACGME physician wellness task force with Dr. Brigham. She described the purpose of the task force as working to identify the key factors that contribute to stress and burnout; the complex inter-relationships between burnout, depression, and resilience; and ways to build well-being and resilience at the individual and systemic levels. She added that physicians who take better care of themselves will take better care of others, and are less likely to commit errors or to leave the profession. Therefore, habits that promote well-being and resilience need to be cultivated across the learning continuum.

Dr. Bernstein noted that one impetus that led to the ACGME Healthy Learning Environment initiative was the suicides of two interns in New York City in 2014. Suicides capture public attention, particularly when they involve people who are young and talented and at the beginning of their careers. However, suicides are the "tip of the iceberg" in terms of the mental health issues that affect physicians, which include depression, anxiety, guilt, emptiness, and stress. Moreover, the problem is not new. In 2003, the American Medical Association issued a Consensus Statement of Physician Well-Being concluded that the culture of medicine places a low priority on physician mental health which creates barriers to asking for help or seeking treatment. Since then, though, little has changed.

Dr. Bernstein defined burnout as:

- Emotional depletion,
- Detachment and cynicism,
- Low personal achievement, and
- Depersonalization.

Dr. Bernstein discussed how the healthcare and training environments have changed. In her training, she worked long hours. However, unlike today, most of her patients were not discharged within two days, their conditions were not generally as complex, and during her time off she could be away from the hospital environment and did not need to be always available by cell phone. There has been a loss of meaning in medicine and patient care; decreased support, flexibility, and autonomy; increased responsibility; and difficulties establishing a healthy work-life balance. General risk factors for burnout include high levels of anxiety and anger, stressful work relationships, difficulty unplugging when away from work, regular use of alcohol or other substances, and inadequate sleep. Burnout in training is highly prevalent among medical students and residents, reaching rates of 40 to up to 90 percent. The work hour restrictions imposed by ACGME on residents during training have not appeared to have the intended effect to improve sleep, or decrease fatigue, burnout, depressive symptoms, or errors.

Dr. Bernstein shared a chart showing the rates of physician burnout by specialty, with "front-line" specialties of emergency medicine, internal medicine, and neurology at the top. By career stage, burnout is highest for those in mid-career, and decreases slightly in the later years.

She said one current study is looking at a cohort of interns over the first year of their training. Among the participants, the rate of depression was under 4 percent before the start of their internship, but quickly rose to over 25 percent within three months, and stayed elevated over the first year. Another study, looking at physician mortality, found that while physicians as a whole have a longer lifespan compared to the general population or to other professionals, they also have a higher rate of suicide.

Dr. Bernstein noted some stressors specific to the learning environment, including medical and mental health issues, changes in relationships and family life, financial stress, ambivalence about career choice, and loss of control. Most medical students are very talented and have been highly successful in their academic careers. However, residency may be their first full-time job, and they have to confront set work hours and constant evaluations of their work, all while dealing with very sick patients with multiple problems. If they struggle and need help, they face many barriers to treatment. Results of a survey published in 2013 found that residents saw time pressure as the biggest barrier to seeking help. Women were more concerned about taking a break from their residency than men, while men were more likely to question the helpfulness of counseling. Another study on barriers to treatment among depressed interns found that most said they lacked time for treatment, while many cited concerns over confidentiality, stigma, and cost.

Given these issues, Dr. Bernstein stated that developing resilience is one protective factor. Resilience refers to the ability to withstand hardship, maintain a positive attitude in times of stress, retain optimism, empathy, and meaning, and engage in problem-solving. Resilience can be developed by teaching or encouraging certain attributes.

Dr. Bernstein described physician well-being as a public health concern, which can be addressed through prevention, screening, and intervention. Improving physician well-being will require the involvement of educators, program coordinators, and professional colleagues, along with a culture change to help physicians realize that self-care is not inconsistent with altruism. Some possible solutions include:

- Improving awareness of burnout and depression.
- Fostering recognition of burnout through screening or mentorship.
- Managing problems through stigma-free counseling and treatment.
- Mitigating stress through reflection, mindfulness, or other self-care steps.

Dr. Bernstein said that some residency programs have started to include training for residents in stress management and resiliency, or to promote reflection and discussion of professional and physician-patient challenges through monthly discussion sessions. Others use positive psychology coaching pairing a resident with a faculty member to enhance self-reflection and promote personal and professional growth. In addition, several web-based cognitive behavioral therapy (CBT) programs are available to address resiliency.

Q and A

Dr. Wiley asked Dr. Brigham about the pending revision of the Common Program Requirements Section 6 rules on resident work hours, which appears to roll back the resident duty hour restrictions put in place in 2011. Dr. Brigham replied that the revisions would be released soon, so he could not discuss them in detail, but they are intended to solidify patient safety and address resident supervision. Two studies on resident duty hours found no evidence the restrictions have worked to promote patient safety or resident well-being. In fact, some evidence suggests that the current 16-hour duty limits might interfere with team building and education. The goal of ACGME is to put the residents in the best clinical learning environment to facilitate learning. Dr. Brigham added that the Committee on Interns and Residents (CIR) has been involved in the ACGME well-being initiative.

Dr. Stephen Wilson asked if ACGME would consider positive deviance when looking at both cognitive behavioral and emotional focus therapy to address burnout and resilience. Dr. Brigham replied that the concept of positive deviance holds that, somewhere in the field, there is likely to be an individual or group implementing some new and innovative program that could benefit others. ACGME wants to find such programs and learn what works. ACGME is engaged in a process called Appreciative Inquiry, which looks for those pockets of people who are doing well, and then finding ways to support, expand, and disseminate these successes.

Dr. Bernstein added that factors contributing to stress and burnout would differ between two locations, such as New York vs. Nebraska, and even within different departments of a hospital or an academic institution. These factors must be discussed and identified in order to tailor the appropriate responses. Interventions such as CBT, mindfulness training, and positive psychology strategies have shown some variable benefit. However, there are often larger systemic issues affecting individual students, trainees, and practitioners.

Presentation: A Systems Approach to Addressing Stress within Health Professions Education

Dr. Carter introduced the next speaker, Dr. Richard Valachovic, president and chief executive office of the American Dental Education Association (ADEA). Dr. Valachovic started by saying that there are over 12 million healthcare workers in the United States, of which around 1 million are physicians, 3 million are nurses, over 300,000 are dentists and dental hygienists, among many other professions. All healthcare professions experience a higher level of suicide than the general population. An interprofessional perspective is needed to address the issues of resilience, burnout, suicidal ideation, and suicide.

Dr. Valachovic said his background was in pediatric and public health dentistry. In addition, he served in several capacities on the administration of the Harvard School of Dental Medicine. He stated that in these positions he witnessed the insidious impact of stress on faculty members, residents, and students.

Dr. Valachovic discussed several factors that place dentists, in particular, at high risk for stress. Most dentists practice in isolation, as over 80 percent work in one- or two-person offices. The environment of the mouth is very sensitive, and the margins for error in dentistry are miniscule, often a matter of a tenth of a millimeter. Dentists deal with both function and appearance. Thus, dentists have to be well trained, meticulous, and precise. However, dentists are often portrayed negatively as being incompetent or even malicious. Similar cases could be made for other health professionals in terms of developing stress-related disorders from dealing with high-pressures environments, facing traumatic situations, and caring for patients in pain, within a healthcare environment that is rarely helpful or supportive of their own mental health needs.

Dr. Valachovic said he has engaged in a "relentless pursuit of strategic alliances," in order to take dentistry outside of its isolation and bring it more closely into healthcare in general. In 2008, ADEA was one of six professional organizations that joined together to found the Interprofessional Education Collaborative (IPEC). IPEC has now expanded to include 20 health professions organizations. IPEC developed a set of core competencies for interprofessional education and practice, which were recently updated to place greater emphasis on public and population health. IPEC has received a grant from the Josiah Macy Jr. Foundation to create a web portal for interprofessional resources, and has worked with government agencies, including HRSA, the VA, CMS, and others, on a wide range of policy issues.

The theme for the January 2017 IPEC meeting was promoting health and wellness of health profession students through interprofessional education. Each of the 20 component associations submitted examples of work they are conducting within their own profession around wellness and resilience, but few of the

initiatives employed an interprofessional approach. IPEC is planning another session in the upcoming year with the theme of promoting health and wellness of health profession students through interprofessional education.

Dr. Valachovic also mentioned a global forum on innovation in health professional education, an on-going activity of the National Academy of Medicine (NAM) of which ADEA was a founding member. Now in its fifth year, this forum brings together stakeholders from several nations and professions, to promote the guiding principles of engaging students, being patient- and person-centered, and creating an environment of learning. A student member who had experienced the loss of a classmate to suicide raised the issues of well-being and resilience. The members of the NAM global forum determined that this topic spanned all healthcare professions, and a group recently published a paper [provided in the meeting materials for the ACTPCMD members] that examined the stressors faced by healthcare professionals from a systems approach. In addition, NAM has created an action collaborative on clinician well-being and resilience, which will work to advance clinician well-being as a national priority and generate evidence-based solutions for progress of both individual and system levels.

Dr. Valachovic offered some examples of methods to reduce stress during training:

- Implement changes in organizational structure, such as reducing the overlap of intense times in the curricula by changing the timing of exams or the sequence of the most challenging courses.
- Reduce the stigma associated with seeking services for behavioral or mental health issues, for students, trainees, and practicing professionals.
- Create and train positive role models.

Dr. Valachovic noted the importance of integrating these supportive policies into the culture, educational design, and clinical practice setting of the institution. He said that ADEA recently held a leadership conference focused on reducing stress and promoting well-being and resilience in students, residents, and faculties.

Dr. Valachovic added that the Centers for Disease Control and Prevention (CDC) reviews and monitors suicide trends, but the data from death certificates in many states are incomplete. CDC addresses suicide as a public health issue, and has identified several preventive strategies applicable across all sectors of society that include: enhanced social support, community connectedness, access to preventive services, reduction in stigma, and reduction in barriers to health-seeking behaviors.

Q and A

Dr. Blumberg asked about the impact of the "hidden curriculum," in which faculty tend to resist change. Dr. Valachovic replied that presenting the data on stress, burnout, and suicide, and treating these as serious and urgent issues, could help motivate change. He added that some of the attendees at a recent IPEC faculty leadership institute questioned the relevance of stress and suicide for dentistry, showing that information needs to start at the leadership level.

Dr. Davis expressed concern, noted in the panel discussion and in Dr. Valachovic's talk, that as students begin their education their stress level goes up and their empathy level goes down. Dr. Valachovic answered that dental students face the pressure of learning how to be independent practitioners in four years, while medical students get their medical degree in four years as preparation for entering residency. The systems for different professions have been in place for many years, but the amount of information that students must learn and the techniques they must master continually increases. On top of the learning pressures, there is added financial pressure within healthcare agencies to see more patients. All of these pressures can influence the outlook and priorities of students.

Ms. Chan-Padgett stated that PAs are increasingly at the forefront of primary care. While she did not believe PAs were currently experiencing major issues with burnout, she was concerned that the problem was growing. Dr. Valachovic replied that that the AAPA is now a member of IPEC.

Dr. Teshina Wilson asked about the relationship between patient care and healthcare provider resilience and burnout, in shifting the paradigm more toward preventive measures and patient advocacy in mental health. Dr. Valachovic noted that there is a conversation going on within IPEC on moving away from using the term "patient" – which comes from the Greek for "sufferer" – toward using the term "person," and including the person as part of the care team.

Dr. Perkins returned to the observation that internship may be the first real job for many medical and dental students. He noted studies that indicate stress and burnout among physicians has tended to decrease as more move from independent practice into multi-practitioner and integrated models of care, and contrasted that with the figure cited by Dr. Valachovic, that over 80 percent of dentists practice in one- or two-person offices. Dr. Valachovic noted that the model of dental practice is slowly changing as more dentists join group practices, which may help to decrease stress.

Dr. Stephen Wilson asked about the impact of student privacy on efforts to improve access to treatment. For example, because of privacy issues a student's mental health background may not be shared with the school or the student's advisors. Dr. Valachovic said that privacy concerns also extend to issues such as learning disabilities.

Public Comment

After a short break, Dr. Carter opened the floor to public comment. Hope Wittenberg, of the Council of Academic and Family Medicine, spoke in response to the discussion from earlier in the day about concern over continued funding for the THCGME program. She recommended that ACTPCMD write a letter to the two Congressional committees with jurisdiction over the THCGME program, the Committee on Energy and Commerce in the House and the Committee on Health, Education, Labor and Pensions in the Senate, in support of reauthorization and funding for the THCGME program. There were no other public comments.

Presentation: Strategies for Building Resilience in Individuals, Teams, and Health Care Organizations

Dr. Carter introduced the final speaker for the day, Dr. Larry McEvoy, an emergency medicine physician, healthcare executive, and consultant. Dr. McEvoy said he was gratified to see the Committee bringing attention to field of stress and burnout and building resilience. He acknowledged that physicians in his specialty of emergency medicine experience many risk factors for stress and have a high rate of burnout. Looking into the problem of stress and burnout promises to offer a route to redesigning healthcare and the clinician-patient interaction. His main emphasis has been on thinking about the elements of designing a resilience strategy.

Dr. McEvoy started by defining a few basic terms such as recovery, endurance, resilience and burnout. He referred to resilience as both an antidote and a vaccine for burnout. Resilience means being able to stay vital and at high performance, and to bounce back from setbacks. A resilient organism or population has strategies and capabilities for taking on stress and recovering without breaking down. When individuals, teams, or populations face stress, resilience helps them respond and recover, modify the stressful environment, and adapt to it to remain healthy. However, repeated stresses without the opportunity to recover can lead to a degradation in response. Within healthcare, more and more stressors are being identified, while less time is allowed for response and recovery.

Dr. McEvoy described his experience at a healthcare organization that prided itself on keeping beds full and having strong finances, but ignored the necessary ingredients of a healthy work environment. When the U.S. economy went into recession in 2008 and this organization started losing money, the culture fostered toxic interactions between individuals and systems that created a high level of hostility, fatigue, inefficiency, mental exhaustion, and fear. This experience sparked his interest in studying organizational design to promote resilience at both the individual and systemic levels. Studies in network science have shown that people are social creatures who are more resilient when they live and work within social organizations.

For individuals, burnout increases the risks of health conditions such as musculoskeletal disorders, obesity, depression, insomnia, alcohol or drug use, and relationship issues. These in turn lead to organizational costs that include high levels of absenteeism and staff turnover, resulting in increased costs, and declines in patient safety and quality of care. Thus, from the business perspective, healthcare organizations can benefit by improving the work environment to promote the resilience of individuals and teams.

Dr. McEvoy shared items from a *Harvard Business Review* article on ways to head off burnout:

- Watch for warning signs.
- Limit workloads and promote autonomy.
- Emphasize learning.
- Provide support and build community.
- Make work meaningful.
- Acknowledge the reality of the work environment.
- Ritualize ingenuity and adaptability.

He also shared a list of steps to prevent burnout in physicians from an article in the *Journal of General Internal Medicine* that includes:

- Make clinician satisfaction and well-being quality indicators.
- Incorporate mindfulness and teamwork into practice.
- Decrease stress related to charting and administrative work.
- Promote adequate staffing and allow time off for growth and recovery.
- Make self-care part of medical professionalism.

He stated that the goal was to create "a context of authenticity and resilience." Steps that promote a positive work environment include focusing on the well-being of patients as well as workers; encouraging creativity; emphasizing gratitude, appreciation, and respect; and recognizing the importance, purpose, and meaning of the work. Steps that can detract from a positive work environment include a push for higher productivity, a focus on making more money, and an over-reliance on policy to address workplace problems. However, he also cautioned against platitudes and lack of commitment, which he referred to as "Donuts for Doctors." It is not possible or even desirable to remove every stressor. What is important is developing an institutional culture in which people are committed to staying, having a voice, and solving institutional problems.

Q and A

Dr. Blumberg stated that burnout, like other conditions of health and illness, exists on a spectrum. Of those who report feeling burned out, some will have the capacity to recover completely, others can recover but may not return to their "baseline" state, while unfortunately some will never be able to recover and may need to retire or to enter career counseling. Similarly, of those who do not report feeling burned out, some may be approaching that state and need interventions to help prevent decline. He asked

if it was possible to find an approach that can help individuals at different points along this spectrum. Dr. McEvoy agreed with the concept of a continuum from resilience to burnout, which can ebb and flow in each individual. The biggest problem might relate to the stigma associated with seeking help. He added that this concern is not new, but may be starting to evolve away from focusing on "weakness."

Dr. Eve Switzer, a pediatrician, brought up the role in children's hospitals of the "child life specialist" who helps children adapt, and wondered if this concept could be used to help adult clinicians deal with various stressors. Dr. McEvoy replied that he liked the idea of the "life coach," and had some experience in trying to create a coaching culture. The goal was to help not only individuals, but also healthcare teams, to learn new ways to stay healthy over time. From his experience, when you can demonstrate healthy behaviors, and show the cost of damaging or unhealthy patterns, people are often quick to adapt even in a damaged environment.

Day One Recap

ACTPCMD co-chair Dr. Phillips thanked the meeting organizers and HRSA staff, and offered a recap of the day's discussions. He noted that the Committee heard some issues that were concerning related on threats to the continued funding of two programs, THCGME and the NHSC. He suggested three topics for some follow-up:

- Finalizing the recommendations for the 14th Report,
- Writing Committee letters in support of THCGME and NHSC, and
- Developing recommendations for the 15th report on provider resilience and burnout.

In terms of the recommendations for the 14th Report, Dr. Phillips thought the Committee had conducted a strong discussion on the first two recommendations. However, he was less clear on the third recommendation, which involved having SAMHSA, HRSA, and the VA work together to develop a tool kit and repository of best practices for educational programs in integrated care. He recalled there was some discussion but no final agreement on working payment into the recommendation. He also wondered if this recommendation might reproduce work underway by the Centers of Excellence program, which is also looking at the integration of oral and behavioral health, and best practices in terms of education.

Dr. Carter replied that Dr. Maria Portela-Martinez, from the HRSA DMD, would be giving a talk on the AU-PCTE programs during the next day's session, and wanted feedback from the Committee members. There was consensus to table the discussion until the following day.

Regarding the proposed letters, Dr. Phillips wanted to get a sense of the role of the Committee in advocating for the THCGME and NHSC programs. There was a comment on the need to be clear and specific about what the Committee would be asking for in terms of funding levels, particularly in the current difficult fiscal environment. Ms. Chan-Padgett recalled that the Committee had sent an earlier letter in support of THCGME funding. Dr. Chen clarified that THCGME funds primary care residencies in both medicine and dentistry. There was a question about the status of the HRSA budget. Dr. Chen replied that the Federal government under a Continuing Resolution, and HRSA was awaiting further guidance on the budget.

Dr. Perkins said that he strongly supported THCGME. He believed it was a very effective program for training physicians in primary care and in community settings, and required long-term funding. He volunteered to lead a writing group to develop a letter from the Committee supporting reauthorization for THCGME. Drs. Sealey and Stephen Wilson also volunteered.

In summing up, Dr. Phillips noted that the topic of resilience and burnout is very timely and of critical importance, and many other groups had expressed concerns in this area. Any effort that HRSA might make to fund teaching or training programs to address burnout would be welcome.

The meeting adjourned for the day at 5:00 p.m.

Day 2 – March 7, 2017

The ACTPCMD meeting reconvened at 8:30 a.m. on March 7, 2017. The meeting was accessible by teleconference and webinar. Dr. Carter conducted a roll call, and all current members of the Committee were present in person. Dr. Carter turned the meeting over to Ms. Chan-Padgett, the ACTPCMD Chair.

Discussion of 14th Report Outline and Recommendations (continued)

Ms. Chan-Padgett started by recapping the previous day's discussion of the Committee's 14th Report and recommendations. She and Dr. Phillips, the co-chair, refined the wording of the recommendations to give them greater clarity and direction. They suggested reversing the positions of Recommendations #1 and #2, so that the first recommendation sets the stage of what is expected in the teaching programs and the second one talks about funding – for both educational institutions and the workplace. With the focus on interprofessional healthcare teams, there was a suggestion to change the wording from "medical care" to "health care." There was extensive further discussion on the wording of both recommendations. Dr. Perkins said the funding recommendation needs to be flexible to cover the range of healthcare professions. As a result, Recommendations 1 and 2 were revised to read:

> *Recommendation #1: The ACTPCMD recommends that primary care and oral health training programs integrate with behavior health care training using experiential learning to prepare students, faculty, and practitioners in the interprofessional delivery of health care.*
>
> *Recommendation #2: The ACTPCMD recommends that funding facilitate an environment where training of the primary, oral, and behavioral health care work force can be integrated.*

Ms. Chan-Padgett moved on to the third recommendation, which covered collaboration among Federal agencies, establishing best practices, and developing standards of measuring short-term and longitudinal outcomes. She described part of the Committee's duties as assessing the outcomes of its recommendations. There was a comment that assessing best practices should include payment models. Other members suggested using the phrase "training environments" to be more inclusive. Dr. Perkins commented that the physical environment of a healthcare organization could transform care. For example, integrating oral health into a clinic requires the presence of dental chairs in some treatment rooms, while integrating behavioral health may necessitate the removal of exam tables from some rooms. After further discussion on wording and focus, the third recommendation was revised to read:

> *Recommendation #3: The ACTPCMD recommends that HRSA collaborate with other federal agencies, such as the Department of Veterans Affairs (VA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), to develop a repository of best practices for training an integrated primary care, oral health, and behavioral health work force. Included in this repository will be recommended methods and standards of measuring short-term and longitudinal outcomes, and an evaluation of payment models.*

It was determined that the writing group for the 14th report would consist of Dr. Cortes, Dr. Neissen, Dr. Dieter, and Dr. Perkins, with Ms. Chan-Padgett and Dr. Phillips to serve as editors. However, Drs. Chan-Padgett and Carter noted that several members of the Committee were scheduled to rotate off in the coming months. There was discussion that the terms of some members could be extended until new members could be on-boarded, but Dr. Carter stated that extensions currently were not being allowed. In light of the need for a quick turn-around, Dr. Carter requested that the writing group members provide the main bullet points for their assigned sections within the next 30-60 days, along with at least one or two significant references.

Interim Report: Program Review and Outcomes

Ms. Chan-Padgett noted that the Committee's charter outlines 5 duties for programs under Title VII, Part C, Sections 747 and 748. The annual report with recommendations addresses two duties, but the Committee had work to do on the other three:

- Develop, publish, and implement performance measures;
- Develop and publish guidelines for longitudinal evaluations; and
- Recommend appropriation levels.

She suggested the formation of a subcommittee to develop a plan to address the Committee's full duties, and another group to work on the interim report.

There was a comment that the agendas of future Committee meetings need to allow time for discussion of these full duties. Dr. Chen had informed the Committee that the Section 747 programs had a total appropriation of around $39 million, and Section 748 programs had a total appropriation of around $36 million, and the Committee could provide some input on the priorities when HRSA submits its annual budget request.

Dr. Perkins recalled that the Committee had put forth recommendations on appropriations to Section 747 and Section 748 programs in its 11th Report: "Resources currently available through Title VII, Part C, sections 747 and 748 have decreased significantly over the past 10 years, and are currently inadequate to support the system changes" as recommended by the Committee. The recommendations the 11th Report also included ongoing support and dedicated funding for the THCGME program, and support for NCHWA to conduct longitudinal analyses of the impact of HRSA-supported training programs.

Ms. Chan-Padgett said that the Committee's duty to review appropriations was vital, and something the members might want to address quickly in response to the new administration. In addition, the Committee might need to develop a plan to address its duties related to evaluation and measurement.

Dr. Niessen commented that Dr. Chen had provided an excellent overview of the Section 747, 748 programs and their funding. In addition, there must be internal HRSA processes of evaluation for these programs. She wondered if it was possible for ACTPCMD to see these evaluations and to have input into the budget requests before they go forward. Dr. Carter replied that she had discussed this topic with Ms. Chan-Padgett, and a discussion was planned for a future meeting on the types of data available to the Committee members and what information can be extracted from the HRSA Electronic Handbook (EHB). Dr. Perkins suggested that the Committee needs a dashboard, providing timely information on the FOAs, grants, and funding related to the Section 747 and 748 programs.

Dr. Chen noted the suggestion that the Committee might need workgroups on an ongoing basis to manage all of its duties. She said that HRSA/BHW/DMD manages three advisory committees. The Advisory Committee on Interprofessional, Community-Based Linkages recently went through a process to review and evaluate all of the programs it oversees, which include the Geriatrics Workforce Enhancement and the Graduate Psychology Education programs, among others. They wanted to have some perspective on the full scope of the programs, so that they could make some recommendations on funding levels and priorities. HRSA is able to work with its advisory committees to provide the information they request.

Dr. Donald Chi said that if the Committee could demonstrate outcomes of the programs it oversees, then it could justify recommendations for sustained or even increased appropriations. He volunteered to lead a workgroup on performance measures. Drs. Teshina Wilson, Wiley, Rita Phillips and Cortes volunteered

to assist. Dr. Carter suggested that the workgroup start in a few weeks, to stagger the work of the Committee and avoid too many demands at one time.

To clarify the terms, Dr. Chi said that the annual report covers a broad topic, and the other activities under discussion were not reports. A document reviewing specific funding levels or performance measures could be a letter or memo to the HHS Secretary. To address program-funding levels, he suggested pulling out Section 4 from the 11th Report, updating the numbers and adding descriptions, and sending that forward quickly. He volunteered to take the lead, since he was familiar with the history. Dr. Stephen Wilson suggested preparing the activity document as an informational one-pager, for quick reference.

Ms. Chan-Padgett suggested that Dr. Chi could present an update on a plan to measure the long-term outcomes and longitudinal impact of the Section 747 and 748 programs at the next Committee meeting. Dr. Chi concurred, adding that the one-page summary could help him gauge the scope of the performance measure project.

Presentation: The Evolution of Burnout from an Individual to a Systems Perspective

Dr. Carter introduced the next speaker, Dr. Claudia Finkelstein, a clinical associate professor at the University of Washington School of Medicine (UW SOM). Dr. Finkelstein related that her interest in promoting resilience and preventing burnout arose from her time as a medical professor, where she observed the personal distress of many of the students and residents she taught, and saw the many issues related to poor work-life balance. She said that the wellness program at UW SOM started, as has occurred with other similar programs, after the school experienced two suicides within a matter of months. Early literature on the topic of physician wellness tended to focus on individual personality traits common to medical students and practicing physicians.

Studies have shown that physicians have similar rates of mood disturbances and substance abuse as the general population. However, compared to the general population, the rate of suicide for male doctors is 40 percent higher, and the rate of suicide for female doctors is 130 percent higher. A study by Dr. Tait Shanafelt also found that the rate of suicidal ideation, not just successful suicide, is also much higher in physicians.

In reviewing individual risk factors, Dr. Finkelstein noted that older physicians tend to have less burnout than younger ones. Among married physicians, both spouses working may slightly increase the burnout rate. High numbers of hours worked and incentive-based pay are also associated with increased burnout rate.

Dr. Finkelstein referenced a study by Michael Krasner and Ronald Epstein, published in the *Journal of the American Medical Association*, which indicated that an intervention using mindfulness and mindful communication helped reduce stress and burnout and maintained empathy and compassion among primary care physicians. However, mindfulness is not a comprehensive solution.

Dr. Finkelstein posed the business case for why healthcare institutions should care about the wellness of their workforce. Clinician burnout affects patients. Studies have shown that burnout increases rates of medical error and rates of malpractice, while it decreases patient satisfaction with care and compliance with treatment. In addition, burnout increases staff turnover, as evidence indicates that burned-out physicians retire earlier, move to non-clinical specialties, or leave medicine altogether. Replacing a physician costs roughly two to three times the physician's annual salary. In addition, stories of burned-out physicians can have a negative impact on public perception, which affects both the healthcare institution and the profession.

Another study by Dr. Shanafelt and others compared physician burnout rates in 2011 with the rates in 2014. The average burnout rate in 2011 was about 44 percent, ranging from a high in emergency medicine physicians of close to 70 percent to a low in preventive medicine physicians of around 30 percent. Three years later, the average burnout rate was 54 percent. This rapid rise has led to questions about the healthcare workplace and environment.

Dr. Finkelstein said that a survey of physicians found that the main source of satisfaction was the ability to deliver high-quality patient care. However, the leading cause of dissatisfaction was the implementation of the EHR, which can make medical records easily accessible but also often impedes the workflow and leads to frustration and lost productivity.

Many people have become familiar with the "Triple Aim" of health care, to enhance the patient experience, improve population health, and decrease the cost. Some have advocated moving toward a "Quadruple Aim," adding the wellness of the healthcare workforce, since burnout is associated with lower satisfaction, worse health outcomes, and increased costs.

Drivers of burnout are very complex, but can generally be divided into individual factors, work unit factors, organization factors, and national factors. Individual factors include workload and job demands, social support, control and flexibility over work schedules, and personality. To decrease burnout risk, the values and goals of the individual should match with the mission of the organization. Since workload can exceed the capacity of an individual provider, team and organizational factors are important in maintaining efficiency, productivity, and work satisfaction. Peer support and sense of community within a team allow practitioners to share ideas and commiserate on challenges. On a national scale, reimbursement, health insurance coverage, licensure and regulations, and care integration all affect burnout.

Dr. Finkelstein said that the growing awareness of the problems caused by burnout is creating a golden opportunity for change. Few stakeholders are happy with the current system, and the high rates of burnout in many professions make it difficult to argue that we should keep doing business as usual. There have been proposals to use workforce wellness as a quality indicator. She acknowledged the complexity of trying to work with all of the "moving parts," including undergraduate education, graduate education, faculty, and training within the evolving healthcare system. However, the stakes are even higher for inaction.

Q and A

Dr. Blumberg raised the issue of the connection between burnout and early retirement, noting that over the last 10 years these trends have not paralleled. He cited the U.S. recession of 2009 as one possible explanation, as it wiped out many retirement savings and forced more people who might have retired, including physicians and other healthcare practitioners, to continue working. He added that ample evidence shows that physician mood and burnout impacts patient satisfaction. From his experiences as a chief medical officer, he saw that patient satisfaction scores could drop precipitously when a physician was going through a period of personal trauma such as a divorce or a family illness. However, having a physician leave practice also impacts patient care, as one study showed that patients who lost a primary care physician had fewer visits and received fewer preventive measures in the following year, and were more likely to leave the practice in search of healthcare elsewhere. These results underline the business case of promoting resilience and reducing physician turnover. Dr. Teshina Wilson shared a similar concern, that when a female doctor takes maternity leave, patient satisfaction scores also go down and patients become concerned that their care is being taken from them.

Dr. Wiley brought up the mention of the EHR, and wondered if part of the problem resulted from generational differences. Many older providers may be accustomed to writing their orders and notes on

paper, while those who are younger are more comfortable working on a computer. Dr. Finkelstein replied that she was not aware of any research on generational differences in the acceptance of EHRs.

Dr. Blumberg shared an experience in one organization in which he served as the chair of physician compensation. There was a decision to increase the salaries of the primary care physician staff by 10 percent. Those that had concerns about student debt tended to maintain their workloads and accept the higher pay, but many others chose instead to reduce their workloads to remain at their current pay levels. This may point to control over workload and schedules as one element important to maintaining resilience and mental health.

Dr. Stephen Wilson commented that even those who are adept at navigating the EHR often find that it decreases time available for patient care. He also wondered if the concern expressed by several of the speakers that medical students tend to lose their idealism as they enter training was unique to medicine. Dr. Finkelstein replied that she was not aware of research specific to that issue, but noted studies have shown that the number of years of education tends to correlate with burnout – more years of education to be protective against burnout except for physicians.

Dr. Switzer brought up a recent meta-analysis that found only a small benefit for intervention programs for physician burnout. She said that the Committee had received several presentations noting the level of the problem and many of its causes, but she had not found much information on how the Committee might have an impact. Dr. Finkelstein replied that individual approaches such as the mindfulness training have been somewhat effective, while institutional approaches have not been very widespread. There is resistance to change, and institutional interventions might not be seen as generating revenue. Approaches such as improved work flexibility can create institutional challenges, as well. Despite these barriers, institutional changes are needed if there is to be a meaningful impact.

Dr. Cortes brought up differences between some of the presentations on the effect of age. Dr. Finkelstein had described age as a protective factor for burnout, while previous presentations had noted that the suicide rate increased as physicians got older. Dr. Finkelstein pointed to other factors that affect suicide rates, noting that retirement also leads to a change in life identity. She said there are two peaks of suicide; right after finishing residency and right after retirement. However, mid-career is often the peak time for burnout, given the often competing demands of clinical care, career advancement, and family.

Dr. Perkins asked Dr. Finkelstein for three recommendations that the Committee could consider to make the training environment more conducive to resilient and protective from burnout. Dr. Finkelstein replied that one would be making physician wellness an educational competency. Another would be keeping program directors informed and up-to-date on promoting resilience. The third would be to advocate for decisions and interventions that might not initially appear as financially rewarding to the institution, but which can improve the system as a whole.

Academic Units –Primary Care Training Enhancement Program

Dr. Carter introduced the next speaker, Dr. Maria Portela-Martinez, the Branch Chief of Medical Training and Geriatrics within DMD. Dr. Portela-Martinez thanked the Committee for their attention to the topic of burnout, noting that she lost a colleague to suicide while in residency. She said that her talk would focus on the AU-PCTE program, under Title VII, Section 747. The goal of the program is to improve clinical teaching and research in primary care. The program recently underwent a major redesign to fund six national Centers, each with a specific focus area:

- Integration of behavioral health in primary care (University of Pennsylvania)
- Integration of oral health in primary care (Harvard University)
- Training for rural health practice (University of Washington)

- Training for the needs of vulnerable populations (Emory University)
- Health workplace diversity (University of California – Davis)
- Training in the social determinants of health (Northwestern University)

Dr. Portela-Martinez said that each Center is expected to: conduct health systems research across primary care training in its focus area, determine the health system research in the field, and create communities of practice. She added that the current emphasis for the vulnerable populations included the lesbian-gay-bisexual-transgender community, the homeless, and migrant workers, and that the ACTPCMD Vice-chair Dr. Phillips is the co-Principal Investigator for the Harvard Center.

Dr. Portela-Martinez stated that the Centers had received initial funding of their five-year awards in 2106. Every year, each Center presents four research proposals for HRSA to review. She asked the Committee members to let her know of any research gaps that they have noted, and she could pass along the recommendations to the appropriate Center.

With the focus on resilience and burnout, one Committee member suggested a research question to examine the impact of integrating behavioral health in the primary care on burnout among trainees and practitioners.

Dr. Dieter asked about the workgroups connected with each Center. Dr. Portela-Martinez replied that federal subject matter experts from several HHS agencies are involved in these workgroups. Their size ranges from five or six members up to 12 members, and they meet several times a year to review the research proposals. NCHWA also reviews the research proposals. Dr. Chen added that the idea behind the workgroups was to find expertise in different places within the Federal government. These Centers were set up as cooperative agreements, not grants, with the goal to create partnerships that capture best practices. HRSA could seek input from ACTPCMD on specific research gaps in the focus areas of each Center.

Dr. Chi said that he had a particular interest in training in the social determinants of health (SDH), as EHRs are collecting more demographic information on social factors. However, it is unclear what clinicians can do with this information, leading to a disconnect between the basic social science research on SDH and how this research is implemented in helping communities or changing policy. He said it is not enough to teach clinicians to ask patients about SDH matters such as food or housing security, if they simply document the responses and move on.

Dr. Switzer said that in her rural practice, one of the greatest difficulties has been in recruitment. Her pediatric practice covers both inpatient and outpatient services, but pediatric residents coming out of training nowadays often lack this breadth of training, or are not interested in this type of practice. She suggested one area of research would be to look at what fundamental qualities of a medical school applicant might indicate an interest in rural practice.

Dr. Perkins said that he was excited to learn that HRSA was collecting NPI data to help in tracking where physicians practice. However, he said that there was no evidence for what works in terms of training clinicians on how to deal with SDH. He believed that part of what is need involves finding learners who care and who will go that extra mile, but professional schools tend to do a poor job of identifying those types of learners.

Dr. McWilliams said that his program at the School of Osteopathic Medicine in Arizona places students in community health centers for three out of their four years. They try to select students who have a passion to work with underserved populations, even if they may be less academically skilled. He said that

the students started their own organization to impact the medical school curriculum, driving the faculty to make changes.

Dr. Blumberg noted the importance of pipeline development to address workforce diversity, but added that attrition is often neglected. He asked about the kinds of support needed to help students stay in school and complete their training. Dr. Portela-Martinez said that the Center at the University of California-Davis has a proposal to look at how many students go into primary care, broken down by race and ethnicity and other factors. Another proposal is looking at the community college as a potential tool to get more people from a wide range of backgrounds into the health professions pipeline.

Dr. Stephen Wilson noted that the experiences of trainees could lead them to place a greater or lesser value on certain aspects of SDH. For example, a trainee might work in a setting where many patients report having food insecurity but are obese. The trainee might fail to explore the connection between poor accessibility of high-quality food and body weight.

Business Meeting

Dr. Chan-Padgett reviewed the outcomes of the meeting and set out the next steps:

1. **Letter to the Secretary: Programs 747 and 748**
   Lead: Ms. Chan-Padgett, with Dr. Switzer, Dr. S Wilson
   Describing activities and impact. Include a brief summary of the programs(747, 748), what the funding levels were from the last report, high level recommendation from the 11th report and this is what that needs to be done moving forward. Include funding levels for last 1-2 FYs for 747, 748 programs.
2. **Letter to the Secretary: Support continued funding for THCs**
   Lead: Dr. Perkins with Dr Sealy, Dr. S Wilson, Dr. McWilliams
   Draft: Sent to team.
3. **Letter to the Secretary: Discussion of importance of the NHSC**
   Lead: Dr. Niessen with Dr. Davis, Dr. McWilliams, Dr. Sealy
   Update: Ms. Huffman contacted NSHC Advisory Committee DFO who will follow-up with chair to schedule a meeting.
4. **Writing group for 14th report (Integrated Care)**
   Writing Team – Ms. Padgett, Dr. Phillips, Dr. Cortes, Ms. Dieter, Dr. Davis, Dr. Niessen, Dr. Perkins
   Next Meeting – Wed, March 15 (30 min)
5. **Writing group for 15th report (Well-Being and Resilience)**
   Team -- Dr. Wiley, Dr. Blumberg, Ms. Dieter, Dr. Sealy.
   Focus- Draft Recommendation and very high level outline. Include physician well-being as a competency.
6. **Subcommittee looking at program outcomes and longitudinal evaluations**
   Lead: Dr. Chi, Dr. Teshina Wilson, Dr. Rita Phillips, Dr.Tara Cortes
   Covering Committee duties #3 and #4
   Prepare to present draft at August Webinar Meeting.
7. **Next meeting: Webinar, August 16 (tentative)**
8. **Next Face to Face meeting – March 5-6, 2018 (tentative)**

Public Comment

There were no public comments.

Adjournment

The meeting adjourned at 2:00 p.m.

Abbreviations list

AAPA	American Academy of Physician Assistants
ACA	Patient Accountability and Affordable Care Act
ACGME	Accreditation Council for Graduate Medical Education
ACTPCMD	Advisory Committee on Training in Primary Care Medicine and Dentistry
ADEA	American Dental Education Association
AU-PCTE	Academic Unit Primary Care Training and Enhancement
BHW	Bureau of Health Workforce
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center
CHGME	Children's Hospital Graduate Medical Education
CIR	Committee on Interns and Residents
CMS	Centers for Medicare and Medicaid Services
DMD	Division of Medicine and Dentistry
EHB	Electronic Handbook
EHR	Electronic Health Record
FY	Fiscal Year
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IPEC	Interprofessional Education Collaborative
MACRA	Medicare Access and CHIP Reauthorization Act
NAM	National Academy of Medicine
NCHWA	National Center for Health Workforce Analysis
NHSC	National Health Service Corp
NP	Nurse Practitioners
NPI	National Provider Identifier
PA	Physician Assistants
SAMHSA	Substance Abuse and Mental Health Services Administration
SDH	Social Determinants of Health
S2S	Students to Service
THC	Teaching Health Center
THCGME	Teaching Health Center Graduate Medical Education
UW SOM	University of Washington School of Medicine
VA	Department of Veterans Affairs