ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY (ACTPCMD)
Meeting Minutes
February 23-24, 2023

Advisory Committee Members Present
Sandra M. Snyder, DO, Chair
Ruth Wauqua Bol, DDS, MPH
Colleen M. Brickle, Ed.D., R.D.H.
Jane E. Carreiro, DO
Nancy W. Dickey, MD
Tonya L. Fancher, MD, MPH, FACP
Geoffrey Hoffa, DHSc, PA-C
Michael J. Huckabee, MPAS, PA-C, PhD
Enihomo Mary Obadan-Udoh, DDS, DMSc, MPH
Anne E. Musser, DO
Kim Butler Perry, DDS, MSCS
Jason M. Spangler, MD, MPH, FACPM
Wanda H. Thomas, MD, FAAP

Health Resources and Services Administration (HRSA) Staff Present from the Bureau of Health Workforce (BHW)
Shane Rogers, Designated Federal Officer (DFO), ACTPCMD
CAPT Paul "PJ" Jung, MD, Director, Division of Medicine and Dentistry
Zuleika Bouzeid, Advisory Council Operations
Jennifer Holtzman, DDS, Dental Officer
Kimberly Huffman, Director of Advisory Council Operations
Janet A. Robinson, Advisory Council Operations

Welcome Remarks
Shane Rogers, Designated Federal Officer (DFO), ACTPCMD
Zuleika Bouzeid, Advisory Council Operations

Mr. Shane Rogers convened the virtual meeting of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD, or the Committee) on February 23, 2023. He welcomed all participants and provided some background on the Committee, including its purpose and purview. He then turned over the meeting to the Committee's Chair, Dr. Snyder.

Agenda Review
Sandra M. Snyder, DO, Chair, ACTPCMD

Dr. Snyder welcomed everyone and reviewed the purpose of the meeting as well as its agenda. She proceeded to conduct roll call, confirming a quorum. Committee members then introduced themselves.

Update: 19th and 20th Reports
Sandra M. Snyder, DO, Chair, ACTPCMD

Dr. Snyder informed the public that the ACTPCMD published two reports in FY 2022: the 19th and 20th reports. The 19th report was titled *Supporting Dental Therapy through Title VII Programs: A Meaningful Strategy for Implementing Equitable Oral Health Care* and the 20th *Addressing Health Inequities through Title VII Training Programs: Training Clinicians to Close the Gaps in Health Equity*.

Both reports were well received. The American Dental Therapy Association invited the Committee to present the 19th Report to the association at their first national annual conference. The 20th Report was released in January 2023 and is being disseminated through the HRSA website.

Council on Graduate Medical Education's 24th Report Dissemination Strategies
Curi Kim, MD, MPH, DFO, COGME

Dr. Kim's presentation focused on the dissemination strategies adopted by another HRSA Advisory Committee to spread the word about its report and recommendations. The Council on Graduate Medical Education (COGME or Council) recently published its 24th Report, *Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities*.

COGME is charged, in part, on advising the Secretary, HHS, and Congress on matters related to the supply and distribution of physicians in the United States, the current/future shortages or excess of physicians in various specialties, issues related to foreign medical graduates, matters related to graduate and undergraduate medical education, and matters related to databases regarding these issues. The Council is required to produce a report every five years, although it can also make recommendations through issue briefs, shorter reports, and letters.

As part of the statute, Congress has authorized COGME to encourage entities providing graduate medical education to conduct activities to voluntarily achieve its recommendations. Therefore, COGME members are encouraged and authorized to disseminate its recommendations.

One of the dissemination strategies was to develop a "one-pager" to provide a quick review of the report. One of the Council members volunteered to lay out the one-pager graphically. The result was a colorful, easy-to-read brief document that summarizes the most salient points of the report. The one-pager includes the report's recommendations, five overarching principles, and a brief narrative summary. Two versions of the one-pager were developed by the group.

In addition to the one-pager, the Council's Working Group also developed a digital postcard and social media posts for Facebook, LinkedIn, Twitter, and Instagram. Each of the posts included a snippet from the report. The Council also made a conscious effort to use HRSA's various e-publications to get the word out. In addition, the Council worked with HRSA's Bureau of Health Workforce's Division of External Affairs on other dissemination efforts. The Council is

looking into the possibility of disseminating the report through medical journals or other publications more broadly, as well as the possibility of contacting local and state government bodies to make them aware of the existence of the report.

ACTPCMD Report Dissemination Strategies
Sandra M. Snyder, DO, Chair, ACTPCMD

Following Dr. Kim's presentation, Dr. Snyder opened the meeting for members to discuss potential report dissemination strategies. The highlights of the discussion can be found below.

- Dr. Perry said it would be helpful to disseminate the report to those who can "move the dial," such as educational community health centers.
- Dr. Bol suggested that the dissemination strategy include national organizations and minority organizations in dentistry and medicine.
- Dr. Fancher commented that it could be helpful to disseminate the report's findings to accreditation organizations.
- Dr. Perry suggested writing the one-pager in language that can be understood by the general public.

Impact of COVID-19 on Oral Health Education
Nader Nadershahi, DMD, MBA, EdD, Chair of the Board of Directors, American Dental Education Association; Dean and Vice Provost, Arthur A. Dugoni School of Dentistry, University of Pacific

Dr. Nadershahi's presentation focused on the pandemic's impact on oral health education. One of the initial responses to the COVID-19 pandemic was to shelter in place and close the dental clinic and schools, making health and safety a priority. Over time, the School of Dentistry at the University of the Pacific developed various strategies to continue dental education in spite of the pandemic.

Online learning, assessment, and communication were some of the strategies used to continue teaching and learning. A protocol was developed using WebEx and Zoom to implement lectures, seminars, case discussions, and even observed clinical examinations in restorative dentistry (OSCEs).

On the exam side, the school used software products with monitoring capabilities, such as ExamSoft, which deters academic dishonesty, and ExamMaster, an online technology that provides advanced board preparation and review resources. Other software products, such as ExamMonitor, allowed for identification of individuals through a computer's camera and the ability to monitor individuals through AI so that exams could be proctored.

The school also used SoftChalk, which allows faculty to interact with students remotely and monitor their progress. Through SoftChalk, students could review dental case studies that included patient photographs and X-rays. ThingLink software allowed the university to offer interactive and immersive learning experiences that included images, videos (with clickable tags and outcomes), and branching scenarios.

Virtual reality experiences were introduced to allow learners to engage with various clinical scenarios involving patient avatars, dental personnel, and medical equipment consistent with a real-world dental office. As a means of competency assessment, students developed their own web-based e-portfolios. Starting with the class of 2020, predoctoral students are required to submit an e-portfolio as a new graduation requirement. Through their e-portfolio, students demonstrate their body of work by incorporating clinical cases, outreach activities, self-evaluation, and reflection activities.

In the area of simulation, the school created take-home simulation dental kits. Students could spend as much time in simulation, although they still needed to continue their surgical skill training. Tools like intraoral cameras, scopes, and displays were helpful in creating a simulation environment. Dr. Nadershahi also discussed various continued barriers as well as some of his thoughts in overcoming them.

Discussion
The discussion included the questions/comments below.

It seems like a lot of the planning was developed on the fly. So going forward would you suggest an action plan or a series of steps? What do dental schools need to do so the approach is planned and intentional?

Our university was able to work through it effectively because we had a crisis management plan in place for different types of crises, along with a team that was set up to do address those challenges. A basic recommendation would be that all schools have a crisis management plan for different types of crises.

Did you have to extend the curriculum for any of your learners?

Not for very many. We were able to get our students back relatively quickly.

In medicine and other health professions we found there were gaps in the learners' competencies that were not picked up immediately. Have you followed your dentistry students and were you able to identify any gaps?

We carry out exit surveys for students across the board and around the country. Here at the school, we also implement surveys of graduates at one-, three-, and seven-year intervals. So we have some information on the matter, but probably not as much as we would like. However, based on what we have at this time, we have not found gaps from graduates from our school although I would not be able to answer the question at a national level.

Supporting the Primary Care Workforce Pipeline when Training Is Disrupted
Wendy Brooks Barr, MD, MPH, MSCE, FAAFP, Director of Academic Development, One Medical; Associate Professor of Family Medicine, Tufts University School of Medicine; Immediate Past President, Association of Family Medicine Residency Directors

Dr. Barr presented on some of the current findings of the Clinical Learning Environment (CLER) COVID National Report by the Accreditation Council for Graduate Medical Education (ACGME). ACGME used a modified virtual site visit protocol to understand the impact of the

COVID pandemic on education. The visits were conducted between October 2020 and July 2022 and included a stratified random sample of 287 institutions.

The impact of the COVID pandemic on the primary care workforce pipeline is still ongoing. There were multiple periods of severe disruption affecting clinical learning environments. The impact was different in different parts of the country and it was manifested different ways. Graduates of classes of 2020 through 2022 had their residencies partially impacted by COVID, although their undergraduate medical education was not affected. The full impact of COVID around the entire residency spectrum will start with the class of 2023, which is graduating this spring. Graduates whose undergraduate medical education was fully impacted by COVID will be the class of 2027.

A few common themes surfaced following the institutional site visits. One is that the model of care is changing rapidly and will not return to what it was before. If the care delivery model is changing, institutions might be challenged to update their training models to reflect what is taking place in practice. Therefore, the clinical learning environments have anticipated an ongoing need to develop and implement strategies to retain and rebuild their workforce into the future. In addition, the pandemic disrupted many aspects of didactic and experiential learning for residents and fellows with anticipated long-term implications.

Some examples of training disruption include the following: 1) Didactic education moved to virtual lectures; 2) In-person clinical experience was replaced with online modules and virtual learning; and 3) In-person clinical experiences were replaced with telehealth experiences. This has led to decreased hands-on learning, less group work, and impacted the development of interpersonal relationships among faculty and residents, as well as among residents themselves.

The CLER report further found that few clinical learning environments appeared to have a long-term strategy to address multiple system-level factors that impact the well-being of the clinical care team. In fact, most clinical learning environments were primarily focused on individual resilience. The pandemic also had a unique impact on residents' and fellows' well-being and their readiness for future practice. A long-term impact on faculty member workload and well-being also resulted from the pandemic.

The move to didactic and small group teaching remotely led to: Decreased student engagement, loss of social connectiveness, and decreased experience and development of teamwork skills. The conversion of patient interactions to virtual case-based experience led to: Decreased team-based skills, decreased experience in systems-based practice, and delayed professional identity development.

The survey also found that family medicine residencies were the second most affected by the pandemic, after emergency medicine. Family medicine in-training exams (ITE) are administered by the American Board of Family Medicine in October of each year and implemented at residency sites. ITE scores are used by programs as assessment of medical knowledge acquisition. A recent review found a sharp decrease in the mean ITE scores for residents in years 1 through 3. This decrease coincided with the start of the pandemic. The full impact of the pandemic among recent graduates following the start of the COVID pandemic is still unknown in practice, although significant impacts were seen in the clinical training during the pandemic.

Discussion
The discussion included the questions/comments below.

The information from the CLER report is illuminating. Do you think we need to continue to follow-up on these learners, given that the pandemic's impact on their education has anticipated long-term implications?

Absolutely. I think this is a new reality and we are still learning.

Should we look for ways to accelerate the preparation to move into residency to make that pipeline more efficient?

We have found that graduates with four years are more prepared to deal with really sick, complex patients, carry out full-time practice, and maintain a full scope of practice—whereas, three-year graduates may not always feel comfortable with those scenarios. In my ideal world, I would like it to be three years. That being said, from a wellness perspective, sometimes people need a fourth year.

Are there any medical student data about their perspective in terms of doing a four-year residency vs. three-years?

Early on in the pilot a paper was published that showed no difference between three- and four-year programs. However, some people love it and others do not. Some US medical graduates have dismissed family medicine because they do not believe it can be done in three years. So, it is not for everybody.

Accelerated Medical Pathway Programs for Workforce Development
Catherine L. Coe, MD, Assistant Professor of Family Medicine, University of North Carolina; Director, Fully Integrated Readiness for Service Training Program

Dr. Coe reviewed the history of Accelerated Medical Pathway programs as well as their outcomes both at the University of North Carolina and other institutions. Accelerated medical programs started in the US during WWII. These programs allowed students to graduate in three years, instead of four. Following the war, programs returned to their four-year schedule.

During the 1960s and 1970s, there was a surge of accelerated curricula. Due to a workforce shortage, and through federal funding support, schools were able to graduate medical students in three years. During that time, there were outcome reports showing that students were ready for transition to residency, had good readiness, and attained equal achievement when compared with four-year programs.

In 2015, nine institutions started a consortium of Accelerated Medical Pathway Programs. The effort was funded by the Josiah Macy Jr. Foundation. Today, the consortium has 30 members with programs at different levels of development.

All of the Consortium's three-year programs meet the 130-week requirement from Liaison Committee on Medical Education (LCME) for medical degrees. There is less need for electives due to individualized curriculum and most students have a directed pathway to an affiliated

residency program. Residency options include family medicine, general surgery, pediatrics, and psychiatry.

Some of the benefits of accelerated medical programs include: 1) Accelerated entry into the desired field, 2) Reduced debt and earlier earnings, 3) Continuum of training from Undergraduate Medical Education (UME) through Graduate Medical Education, 4) Intensive mentorship, and 5) Integration into departments through UME.

In terms of outcomes, preparedness scores were found to be similar for accelerated pathway (AP) students when compared with traditional students in family medicine, surgery, OB/GYN, psychiatry, and pediatrics. USMLE Step 1 and 2 scores are also similar among the two groups. Surveys also showed that AP students felt confident that they had "acquired the clinical skills required to begin a residency program." Other surveys showed that a larger percentage of students in AP programs graduated with no debt or with less debt than students in standard programs.

Discussion
The discussion included the questions/comments below.

From an admissions standpoint, how are students selected? How do you garner commitment from students to remain in the program?

We select students who have a demonstrated experience in their intended career or specialty of choice. A student has to say something akin to "I know I want to do family medicine because of *x,y, or z* or this is why I know this is right for me." That is where the first six months come in, they could shadow physicians or explore some of those career opportunities.

Compared with UNC data you have collected and the national data overall—before and after COVID—have you seen any challenges in the students' learning that you had to address or offset in your three-year program?

Our outcomes and attainment on shelf scores is pretty unchanged compared to pre and post COVID. I would say our accelerated curricular students both at UNC and nationally were somewhat protected from the impacts of COVID when it came to their medical education because they have a smaller cohort and had a timeline they needed to graduate in and made sure they were ready to graduate. For example, we were able to be more creative in how we get these ten students into clinical rotations and integrate them in virtual visits. However, from an educational standpoint, we have not seen any difference in outcomes for our FIRST students.

The Impact of COVID-19 on Physician Assistant Education and Key Considerations for Health Workforce Policy
Linda Sekhon, DHSc, PA-C, President, Physician Assistant Education Association; Professor of Medical Sciences; Founding Chair, Department of Medical Sciences, High Point University

Dr. Sekhon presented on the impacts of the COVID pandemic on the education of Physician Assistants (PA). The Physician Assistant Education Association (PAEA) is the national organization that represents close to 300 PA educational programs nationwide.

During 2020 and 2021, the organization's research team undertook a project designed to better understand the impact of the pandemic on PA programs and how it might serve as a resource to get them through such difficult time. This resulted in the publication of four rapid-response reports, which provided a snapshot of how PA programs were adapting to this unprecedented challenge in medical education.

Of the 162 PA programs surveyed, the majority (50.6%) reported suspension of rotations by clinical sites and/or preceptors and a smaller number of programs (34.6%) reported unexpected cancellations, changes, and disruptions in the didactic year. In addition, about a third (29%) of the programs reported unplanned and imposed changes to or from online instruction. Didactic interruptions continued in 2021.

One of the ways that programs displayed innovation in response to the COVID-19 challenge was through increased integration of telemedicine in both the didactic and clinical years. Nearly 30% of didactic students surveyed were new to receiving telemedicine instruction as a result of the pandemic, with another approximately one-third of programs signaling their intent to add more telemedicine content in the future.

Adaptations and changes to the curriculum also took place as a response of the pandemic. About 15% reduced the number of direct patient care and hands-on clinical hours/weeks; 14.2% shortened the duration of individual supervised practice clinical experiences; 43.2% increased the adoption of telemedicine experiences; and 33.3% had call-back days that were in-person and were shorter (or fewer). Also, 29.6% of programs began to pay for clinical sites that had had not previously required payment. Unfortunately, these costs were ultimately borne by students in the form of higher tuition. Because program costs directly influence student debt levels and the resulting practice choices of graduates, this is a factor consider from a federal health workforce policy standpoint.

In addition, nearly all specialties in at least half of the programs reported that it is either "harder" or "much harder" to obtain clinical training sites than before the pandemic, with particular challenges in pediatrics and emergency medicine.

In general, many of students displayed considerable resilience throughout the pandemic, although of the students surveyed 14.2% withdrew from the didactic program or involuntarily decelerated from the program.

Dr. Sekhon proposed the following policy recommendations: 1) Continue to support and expand targeted Primary Care Training Enhancement (PCTE) competitions which allow for direct compensation of clinical preceptors; 2) Explore opportunities to encourage grantees to leverage funding to accelerate the adoption of telehealth education; and 3) Support increased PCTE investments to support student mental health and resilience training.

Discussion

The discussion included the questions/comments below.

You raised the need for clinical site payment becoming a striking concern. In terms of looking at the Federal government to help with this, how would you suggest we do this?

I wish I had a good answer to that. In my opinion, the train has already left the station. Right now we are looking at about 50% of the programs already paying for clinical sites, and what we are trying to avoid is the cost being incurred by the students.

Primary Care Training and Enhancement – Community Prevention and Maternal Health (PCTE-CPMH) program
CAPT Paul "PJ" Jung, MD, Director, Division of Medicine and Dentistry, BHW

Dr. Jung spoke about enhancing primary care through training. Numerous medical and public health organizations have supported the integration of public health into primary care. Prior ACTPCMD reports have also supported this approach. This is supported by research that shows that clinical care is only one factor in making a community healthy.

HRSA's Primary Care Training Enhancement (PCTE) Program in Community Prevention and Maternal Health is one such approach. Its goal is to "Increase the number of primary care physicians trained in population health with a focus on maternal health outcomes and increase the number of primary care physicians trained to provide high-quality obstetrical care in rural and/or underserved areas."

The idea behind this PCTE program is to take all the resources of the Department of Health and Human Services and try to address the increasing number of maternal deaths, problems during obstetrical care, the lack of obstetrical care in certain areas, and other challenges. The PCTE in Community Prevention and Maternal Health has two tracks. One focuses on training in direct clinical care by providing obstetrics fellowships for primary care doctors and the other offers training in population health through training in preventive medicine to primary care doctors.

Obstetrical fellowships provide clinical experience in obstetrical care for family doctors, specifically for the purpose of being the primary practitioner in a given area—usually underserved and rural areas—who is able to care for pregnant women all the way through to delivery and even afterwards. The second track trains primary care physicians in preventive medicine. This means that the physician would already have completed training in internal medicine, pediatrics, or family medicine, and then would go into preventive medicine training. Preventive medicine is not simply obtaining an MPH, or taking a couple classes in epidemiology and biostatistics. Through their training, physicians have concentrated practicum experiences over the course of a minimum of 12 months in a population health setting. They have to conduct a scholarly research project on a maternal health topic and provide recommendations to be implemented in the patient population to address maternal health issues.

One example of the type of project that would be able to bring these physicians together would be local maternal mortality committees. These committees exist at hospitals or health departments and review maternal deaths that occur in the community to assess their cause and what could be done to prevent them.

In 2021 and 2022, BHW contributed to the development of two supplements in the *Journal of Management & Practice* (May/June 2021 and Sep/Oct 2022). They focused on HRSA's

investment in public health and training centers. These supplements were well received.

Going forward, BHW is planning to develop a similar supplement on the PCTE Program in Community Prevention and Maternal Health. The supplement will appear in the *American Journal of Public Health* and will consist of a collection of articles from program grantees and the various activities they are undertaking to train their fellows and residents.

Discussion
The discussion included the questions/comments below.

So, just to clarify, the model described could be applied to other areas of need, such as substance use or opiate use disorder?

Yes.

Could you talk about program outcomes thus far, specifically in the public health arm, in terms of recruitment and placement of the trained physicians?

Program awards began to be made on July 1, 2021, so we have only two years under our belt. At this point, the number of those completing the program is not that large yet. All I can tell you is that they have been successful in a sense that they have completed the training. We are trying to get more systematic data on where they are working after training.

I am reflecting on how this could apply to dentistry. Is there also a conversation about expanding and increasing public health training for primary care dentists?

On the other side of our set of offices we have the preventive medicine program. When the preventive program and the PCTE started talking, fireworks happened. We have a public health dental residency program in the Oral Health Branch, so it would not be difficult for us to come up with a way to take general dentists and train them using the two-track model, giving them additional clinical training or training them in public health dentistry. The PCTE authority does not specifically allow a public health dental residency training using PCTE dollars. But if there is an ACTPCMD recommendation on training general dentists in public health dentistry, that would allow us the authorization to utilize PCTE funds for that purpose.

Measuring Equity
Janice C. Probst, PhD, Associate Director, Rural & Minority Health Research Center; Distinguished Professor Emerita, Arnold School of Public Health, University of South Carolina

Dr. Probst presented in the area of measuring equity. Certain rural myths and biases seem to persist, such as rural areas can be presented as pastoral and idyllic by some and as sites of poverty, dilapidation, and as the "new inner city" by others. The truth may lie somewhere in between, but one of the facts is that rural America is economically diverse. It includes not only agriculture, but also recreational, mining, and manufacturing industries. In fact, farming-depending counties in rural America are only a small portion (only about 20%) of all rural counties. In addition, rural America is also racially diverse and includes areas that are more than 20% non-Hispanic black, Hispanic, or American Indian/Alaska Native.

The burden of disease in rural areas can be higher than those in metro areas. While age-adjusted mortality had been decreasing for the past 20 years, the COVID pandemic caused a sharp increase in all areas, with higher mortality per 100,000 residents in rural areas compared with metro areas. This increase in mortality in rural areas was seen in minority populations as well, including Hispanics and non-Hispanic Black residents–both of which were higher than in metro areas. One of the challenges is the dearth of some types of practitioners in rural areas compared to metro. The percentage of physicians, dentists, and registered nurses is below parity in rural areas.

Equity can be measured using Donabedian's model, which uses a three-component approach for evaluating the quality of care: structure, process, and outcomes. The thought is that structure measures can have an effect in process measures, which in turn affect outcomes, and should therefore be taken into account.

Some of the health disparities in rural areas occur because there are not enough practitioners (e.g., physicians, dentists, RNs, etc.) to reach parity with those in the rural population. In addition, practitioners are not distributed evenly creating rural health care "deserts." Dr. Probst also discussed some barriers and measures that could be incorporated to improve the recruitment and retainment of minority faculty.

Discussion
The discussion included the questions/comments below.

I am American Indian. Some American Indians students who had a National Health Service Scholarship left their community site because of bad bosses. What are your thoughts about tracking those type of instances?

I am in favor of taking measurements. Perhaps conduct an exit interview with anyone who leaves the organization to determine why they are leaving.

I am wondering about outcomes of site and training programs within rural counties, versus trying to make residency or training programs more accessible to people from rural counties or disadvantaged backgrounds. Do you think there is an advantage to one approach versus the other?

In my opinion, I would like rural residency training (e.g., physicians, dentists) to take place in the rural area. The big reason is that it convinces people that they can live there. For people who grew up in rural areas, it allows them to go back into the sort of environment in which they lived.

Kaiser Permanente Internal Medicine Residency Program, Master's in Public Health Track
Joan Lo, MD, Assistant Program Director, Kaiser Permanente Oakland Internal Medicine Residency; and Senior Research Scientist, Division of Research Kaiser Permanente Northern California

Dr. Lo spoke about the institutions master's in public health track at Oakland. In 1942, the first Kaiser Permanente hospital opened in Oakland and four years later the internal medicine

residency program began. The program was founded by Dr. Morris Collen who also founded the institution's division of research in 1961.

During the programs' early years of growth, research and education were high priorities for the organization as they stimulated high quality of care and the advancement of medicine. Academic affiliation was considered through a master's degree training in coordination with residency training, but it was not logistically possible at the time.

Today, Kaiser Permanente has a robust graduate medical education program. The program's mission is to "[P]rovide academic training within a world-class health care organization for a large patient population. Our programs foster the professional and personal development of residents in an integrated, scholarly, and supportive, managed-care environment. We follow patients longitudinally through all aspects of the continuum of care, giving trainees exposure to principles of population management, evidence-based medicine, and team-based chronic care—the cornerstones of Kaiser Permanente medicine…"

In 2008, the Graduate Medical Education leadership realized there was a need for newer education models, particularly to prepare trainees for clinical practice in the context of public health. As a result, a partnership grew with UC Berkeley's School of Public Health to develop a master's in public health (MPH) track. The plan was to have two medical students match each year into a joint internal medicine track. This was later followed with pediatrics, which is another residency program offered on Kaiser's campus.

The partnership between Kaiser and UC Berkeley was innovative because it took a three-year program and paired it with an established one-year graduate training program with the interdisciplinary MPH track at Berkeley. The cost of the one-year program is covered by the Kaiser Permanente Community Health Program, along with tuition. The training was placed in the final year of internal medicine training after the three-year accredited portion.

The program's first three years include clinical health disparities research, quality improvement and patient safety, and health policy or global health electives. In addition, the first three years include clinical rotations and an annual interdisciplinary MPH meeting. The fourth year is an 11-month program primarily focused on MPH training. It includes summer, fall, and spring courses; a longitudinal weekly MPH seminar course; and a nine-month MPH capstone project. The fourth year also offers various clinical options in primary care, specialty, and hospital-based clinical work. Teaching is tailored to the individual's career path.

Because they are graduate students in Berkley's School of Public Health, those in the program have the opportunity to take courses from the undergraduate campus, the law school, the business school, and the Richard and Rhoda Goldman School of Public Policy, depending on the schedule and availability of openings. This creates a rich educational environment for residents.

Enabling residents to undertake a dedicated year of public health training allows them to establish a strong quantitative foundation. There are summer and also fall and spring semester courses focused on epidemiologic methods, probability and statistics, statistical programming, optional electives, multivariable statistics, and causal inference.

One key component of the program is the interdisciplinary seminar, which provides formal

education to the entire cohort (about 30 students) in a variety of areas including mixed methods research, survey design, ethics in public health research, policy review, media advocacy, and leadership.

The combination of taking MPH courses coupled with a capstone project allows those in their fourth year to bridge residency to fellowship, residency to faculty career, or residency to leadership career. This provides trainees with a chance to solidify their career and figure out their direction. Residents in the program have gone onto careers that include clinical and specialty medicine, academic research, graduate medical education, community health, clinical careers, and community health leadership careers.

In terms of federal funding, funding mechanisms exist that can support the training of full-time employees, but there are few funding mechanisms that support public health-focused research, or clinical research in general, during the training years. It would be helpful to see new funding mechanisms that support this during the training years, and provide more support for resident mentors who, year-after-year, are donating their efforts to support residents.

Discussion
The discussion included the questions/comments below.

How does the program impact the students' financials? In other words, if students take an extra year to obtain this training it would delay their entry into the workforce. Does this cause more burden or do you find this extra skill increases their earning capacity because they can go onto leadership roles?

We have now had about 20 graduates in total and the plan is to carry out a formal assessment this year. In general, we have been able to attract residents who want to use the public health degree for their clinical practice careers and public health goals. But there does not seem to be one theme in particular. Students have gone into hospital-based medicine, medical care, research, clinical careers, etc. I do think the MPH is helpful for future leadership skills, but I think residents are not necessarily going into public health training for any sort of financial incentive.

We are exploring how the model can be used in a variety of professions such as dental hygiene, dentistry, and PA. Where do you see the far-reaching cost benefits that would come from this type of an approach?

It is fantastic that the Committee is thinking outside the box and considering a variety of professions for receiving public health training. I would say the cost of the public health training is not that high, particularly if you could partner with institutions that can cover some of the salary costs.

When examining outcomes and talking to medical students who are going into a residency program, in terms of extending a year, would you say this increases earning potential? Or do you look at it from the vantage point that they will now be able to practice medicine with a public health background, in addition to residency?

I cannot say there is any future financial incentive, so that would not likely be part of our message. However, I do feel that the additional training will allow them to build public health

into their clinical practice and be in a better position to have a future leadership role in their career. This may lead to larger professional satisfaction.

Discussion: 2023 Reports
Sandra M. Snyder, DO, Chair, ACTPCMD

The Writing Work Groups for each of the upcoming reports presented their draft recommendations to the Committee as a whole. After significant deliberation and revisions, the recommendations for both reports were voted and approved with the allowance for the Work Groups to make editorial changes that would not change the meaning or intent of the recommendations. The recommendations for each report are listed below.

21st Report Recommendations

1. Recommend that Congress increase Title VII, Section 747 funding by $[TBD] to be used for accelerated pathway programs for primary care practice for both medical and physician assistant students.
2. Recommend that Congress increase the Title VII, Section 748 funding by $[TBD] to increase the number of community-based primary care dental training programs.
3. Recommend that Congress update the Title VII, Section 747 and 748, legislation to create innovative career-changer programs that support the additional training of Community Health Center staff to broaden their scope of primary care practice.
4. Recommend that Congress and the Secretary, HHS, allow Title VII, Section 747 and 748, funding be utilized to pay community-based clinical sites and preceptors to effectively support training clerkships for primary care medical, Physician Assistant, and dental students.
5. Recommend Congress and the Secretary, HHS, support new models of payment/patient care reimbursement for rural based community hospitals, FQHC's, and health centers to support the training of medical, Physician Assistant, and dental students in those settings.

22nd Report Recommendations

1. Recommend the continuation of the Primary Care Training and Enhancement-Community Prevention and Maternal Health (PCTE-CPMH) program, with additional funding to expand the Community Prevention track to include Physician Assistants ($2.4M, 15%) and dentists ($16M).
2. Recommend the creation of new training (e.g., tracks, rotations, fellowships, certificate programs, MPH) in public health/population health and preventive medicine in primary care medicine residencies, physician assistant programs, primary care dental residencies and dental hygiene programs with an additional $80M in funding.
3. Recommend that Congress and the Secretary, HHS, fund and create a Collaborative Center(s) to develop and disseminate successful models of training in primary care medical residencies, physician assistant programs, primary care dental residencies, and dental hygiene programs in the event of a massive training disruption (e.g., pandemic, natural disaster, power grid failure, war).

Public Comment
Shane Rogers, DFO, ACTPCMD

The floor was opened to public comments, which are summarized below.

Samuel Frimpong, MD, MPH—a family medicine specialist practicing in Florida—provided his comments exclusively in writing. He proposed that financial support be provided to disadvantaged physicians for USMLE Step examination preparation, board review courses, and examination registration costs so that they may not drop out of the physician workforce. Dr. Frimpong also proposed removing systemic barriers and providing a mid-level physician license to those who have passed USMLE Step 1&2 examination and completed 1-3 years of Medical Specialty Residency Training to work in their medical specialty under supervision of a full-license independent physician.

Kae Livsey MPH, PhD, RN, an associate professor at Western Carolina University's School of Nursing, said she applauded the recommendations of the ACTPCMD's 20th Report, especially those around developing and implementing a curriculum that includes cultural humility. She added that all nursing curricula include some training on cultural awareness, sensitivity, and humility.

Tiffany Ostovar-Kermani, MD, MPH, a postdoctoral research fellow at Baylor College of Medicine, said she is one of nearly 7,400 medical doctors who has not been able to match with a program. She would like to hear more about collaborative practice agreements or legislative agreements to allow individuals like herself to get into practice.

Meaghan P. Ruddy, PhD, senior vice president of academic affairs, enterprise assessment and advancement; and Chief Research and Development Officer for The Wright Center, made a comment regarding training capacity. Clinicians and staff are being ever more careful about their time, so the programs developed need to consider the number of students that can be placed in a specific environment at a specific time. She said that having a way to measure training capacity, perhaps utilizing HRSA data, would be very helpful.

Manu Matthew, MD, said he is in a similar position to Dr. Ostovar-Kermani. He is part of a national advocacy group that has reached out to 50 states, medical societies, associations, boards, and legislators to address the issue of a shortage of physicians and unmatched medical doctors. In some states, there is a type of licensure or permit for trainees to work under a doctor for a year. It would be great is this approach could be expanded to a national level as this would increase a doctor's chance to match into a program.

Kim Butler Perry, DDS, associate vice president of university strategic partnerships and an ACTPCMD member, said there have been national discussions regarding the lack of matches. In particular, the National Association of Community Health Centers (NACHC) is working to identify the issue and determine how to move forward.

Adjourn
Sandra M. Snyder, DO, Chair, ACTPCMD

Dr. Snyder thanked all speakers for taking time out of their busy schedules to offer their expertise to the Committee. She also thanked Committee members and members of the public for providing feedback to the Committee to help it make recommendations that improve the health of our country. She said she appreciated all the help provided by HRSA's staff.

The next meeting will be held on August 17, 2023.

Mr. Rogers adjourned the meeting at 4:02 p.m. (EDT).