



Future of Preventive Medicine Stakeholder Meeting Summary Report

November 7, 2019 | 9 am – 5 pm, Rockville, MD



Preventive Medicine Stakeholder Meeting

November 7, 2019

Washington, DC

Introduction

The Health Resources and Services Administration (HRSA) hosted the Future of Preventive Medicine Stakeholder Meeting to discuss the future of the medical specialty of preventive medicine and recommendations on what HRSA can do to strengthen the role of preventive medicine physicians in health systems.

Based on 2019 ACGME data, approximately half of all accredited preventive medicine residency slots are currently vacant. For graduates of preventive medicine residency programs, there is no generally accepted career path and the practice of preventive medicine does not seem to be clearly understood by the public or even within the healthcare field. For these and other reasons, HRSA brought together preventive medicine stakeholders to discuss possible transformations in the specialty of preventive medicine.

Key areas of discussion included: 1) issues related to the field of preventive medicine; 2) consensus (if any) regarding the role of the specialty within the healthcare system; 3) metrics to measure the success of a preventive medicine residency program and its impacts within the community; and 4) recommendations (if any) on training structures of the residency programs. A list of representatives from participating stakeholder organizations is available at the end of this report.

Participating Stakeholder Organizations

- Accreditation Council of Graduate Medical Education (ACGME)
- Aerospace Medical Association (ASMA)
- American Board of Preventive Medicine (ABPM)
- American College of Occupational and Environmental Medicine (ACOEM)
- American College of Preventive Medicine (ACPM)
- American Public Health Association (APHA)
- Association of State and Territorial Health Officials (ASTHO)
- Centers for Disease Control and Prevention (CDC) (by consultancy)
- Health Resources and Services Administration (HRSA)
- National Academy of Medicine (NAM)
- National Association of County and City Health Officials (NACCHO)
- Public Health Accreditation Board (PHAB)
- Department of Defense - Uniformed Services University (USU)
- Department of Veterans Affairs Office of Academic Affiliations

Acknowledgements

HRSA would like to recognize the contributions of NACCHO staff to the development of this report, which included meeting support, and report development and design. HRSA would also like to thank the CDC for their support and advisement during the planning of the meeting.

Presentations

Welcome

CAPT Paul Jung, USPHS, Director, Division of Medicine and Dentistry in the HRSA Bureau of Health Workforce, provided welcoming remarks. CAPT Jung expressed HRSA's interest in receiving stakeholder insight on the future of the specialty of preventive medicine within the community writ large and recommendations on what HRSA can do to contribute to the development of preventive medicine residency training to strengthen the role of the specialty within health systems. CAPT Jung emphasized the importance of the meeting to be an interactive conversation, using stakeholders' expertise to share thoughts on the current and future challenges facing the specialty, find ways to improve recognition of the specialty of preventive medicine, and maximize the reach, capacity, and success of HRSA's programs.

Bureau of Health Workforce Priorities

Dr. Luis Padilla, Associate Administrator of HRSA's Bureau of Health Workforce, presented an overview of the Bureau's perspective of the current healthcare workforce, particularly related to shortages of health professionals. He noted that many providers are maldistributed across states and that the majority of the shortages occur in rural communities. The Bureau of Health Workforce guides its programs to address four aspects of the healthcare workforce: access, supply, distribution, and quality. Although HRSA is a significant federal funder of

workforce training programs, there is a question of whether health workforce needs are being met in the field. In other words, are we getting the providers that we need where we need them? The Bureau aims to address this by connecting education with training and with service; these are the mechanisms by which the Bureau's programs can integrate with each other to produce providers needed in the field.

HRSA Discussion Questions:

Can we determine a reasonable timeline for connecting education with training and service? If so, what is the expected timeline?

It can take anywhere from eight to 12 years to produce a physician provider. One way the Bureau is trying to tighten these connections is to offer a preference for the National Health Service Corps, our service program, to graduates of some of our education or training programs.

Currently, the National Health Service Corps laws are almost 50 years old and never envisioned physician assistants or nurse practitioners as providers of primary care services. Recognizing new medical systems of practice, updating these laws may be one way to address current workforce needs.

How are we getting other divisions to own the workforce agenda?

HRSA values program sustainability and is determined to continue collaborations with CDC and other partners so programs can continue with broad support.

Often workforce funding is isolated; however, HRSA is working deliberately to align its programs to increase access to services. For example, we have collaborated with the Bureau of Primary Health Care to require training in Federally Qualified Health Centers (FQHCs) in some of our workforce programs.

Accreditation Council for Graduate Medical Education (ACGME) Perspective

Dr. Louis Ling, Senior Vice President, Hospital-based Accreditation of the Accreditation Council for Graduate Medical Education (ACGME) and Lorraine Lewis, Executive Director of the Review Committee for Preventive Medicine presented an overview of ACGME's perspective on preventive medicine. First, the presentation pointed out that preventive medicine is different from every other ACGME specialty. Most medical training institutions have no preventive medicine residency programs and are thus unfamiliar with the specialty. There are almost 12,000 total residency programs in the U.S., of which only 75, or 0.64%, are programs in preventive medicine. It is important to note that preventive medicine is an umbrella term that includes the three specialties of public health and general preventive medicine, occupational medicine, and aerospace medicine. The Accreditation Council for Graduate Medical Education has begun work on expanding and updating its preventive medicine program requirements, the most important being that residency

programs can now integrate all the components of preventive medicine residencies into an integrated 36-month program. These changes are approved and will be effective as of July 1, 2020.

One of the primary challenges with current preventive medicine programs is the low fill rate of 50%. ACGME data shows this is likely due to unfunded spots, unqualified candidates, and a lack of capacity to train residents.

ACGME Discussion Questions:

Why are there new residency programs being created for preventive medicine if we're already at 50% fill rate? What's in it for a new program if there's a lot of supply for spots?

Multiple stakeholder participants indicated that many new programs are created in underserved areas where the need is high. Participants agreed that promoting the health of rural areas is critical and doctors who train in rural settings are more likely to practice there after they complete their residencies. When considering new preventive medicine residencies, participants agreed the goal for new programs should be to bring more preventive medicine physicians to rural areas, or other areas where the shortage of doctors is most urgent. For example, a preventive medicine residency program started in Maine because there were no preventive medicine physicians practicing in the state and the residency program helped meet those unmet needs.

Public Health Physician Workforce Data

National Association of County and City Health Officials Presentation

Dr. Debra Dekker, Director of Evaluation at the National Association of County and City Health Officials (NACCHO) highlighted research findings related to the NACCHO's 2019 National Profile of Local Health Departments. She pointed out the percentage of local health departments (LHDs) that employ public health physicians decreased from 33% in 2016 to 28% in 2019. She emphasized that larger LHDs in urban areas, particularly in the south and west, tend to employ the most physicians. In addition, physicians are the most difficult positions to fill in LHDs, primarily due to geographical location and salary issues.

Association of State and Territorial Health Officials Presentation

Dr. Cara Person, Director of Public Health Agency Research at the Association of State and Territorial Health Officials (ASTHO) and Maggie Carlin, Senior Director of Research and Evaluation at ASTHO, presented data from the 2019 ASTHO Profile of State and Territorial Public Health. They shared that 50% of states require the state health official to possess an MD or DO degree, and although 27 (53%) of current state health officials are physicians, only six of the current state health officials (Delaware, Montana, North Carolina, Ohio, Utah, West Virginia) are physicians trained in preventive medicine.

De Beaumont Foundation Presentation

Moriah Gendelman, Research Associate at the de Beaumont Foundation, presented data from the 2017 Public Health Workforce Interests and Needs Survey (PH WINS). She stated that only 1.18% of the public health workforce are physicians, and only 0.32% are self-reported public health/preventive medicine physicians. Although job satisfaction is high at 83%, more than 50% plan to retire in the next five years. When assessing workforce training needs, results indicated the top three training needs to be budget and financial management, change management, and systems and strategic thinking.

American College of Preventive Medicine Presentation

Donna Grande, Chief Executive Officer of the American College of Preventive Medicine (ACPM) highlighted research findings from a study conducted in conjunction with the Centers for Disease Control and Prevention (CDC) related to the value of preventive medicine. The study found that awareness of preventive medicine was lacking in the study population and the definition of population health varied. Yet, competencies needed by health systems aligned with the competencies that preventive medicine physicians have.

Public Health Workforce Discussion Questions

Is there available data on who provides information on the specialty of preventive medicine to medical students?

ACPM acknowledged that the American Medical Association produces a book on career and specialty choices for medical students, but the current language for the specialty of preventive medicine is vague, undetailed, and needs to be updated. In order to increase the number of preventive medicine residents, more and better information needs to be available for students and their advisors. Participants agreed that the field needs to harness more friends and advocates for the specialty of preventive medicine.

Should every LHD have a strong preventive medicine presence in their leadership team?

Participants agreed that physician leadership of public health agencies at the local level is an ideal career for preventive medicine specialists. However, the field of preventive medicine has a very small pool of specialists, the pipeline is struggling, and demand is shrinking. At this point, the ongoing challenge of funding preventive medicine residencies makes it unrealistic to expect this kind of presence without significant improvements to the pipeline. Given the struggling pipeline, one goal could be to align what little resources exist (e.g., HRSA residency funding) in order to move the needle. Participants agreed that establishing an overarching, fundamental goal

would maximize the impact of limited resources, such as HRSA residency funding. There is tremendous opportunity to address this issue, but the preventive medicine stakeholder community should establish a larger objective as a goal.

Based on the data, preventive medicine physicians have had the lowest burnout rate compared to other specialties. How could this be used as a driver to get individuals into the field?

Research indicates that preventive medicine has the lowest prevalence of physician burnout and the highest prevalence of satisfaction with work-life balance. Based on this data, participants agreed that it is critical to promote preventive medicine to medical students early, highlighting lower burnout rate compared to other specialties as one of many positive aspects of the specialty.

General Discussions

Discussion Topic 1: Careers for preventive medicine graduates. "Are there particular careers that we should prepare preventive medicine residency graduates for?"

Participants discussed the topic of careers for preventive medicine graduates and specifically, the particular ways in which HRSA could best prepare graduates of its funded programs. Participants agreed that the preventive medicine skill set aligns closely with the role of a health officer at a governmental public health agency and this could be a natural career path. Other closely aligned career paths are population

health positions within healthcare organizations, as well as other agencies within the broader health system. From this comment, a participant noted that over the past three years, there has been an interesting shift in the business sector from focusing only on employee wellness to focusing on the health of the community more broadly, opening up possibilities in sectors not traditionally considered for preventive medicine physicians. Attendees emphasized that no one should be thinking that improvements in public health or population health are only in the health department's purview; in order to improve the health of the population, we need everyone's buy-in.

Is population health the same as public health?

Participants voiced their concerns of the importance of ensuring equal understanding of the concepts of population health and public health, as the terms are used inconsistently. The field is divided; some argue that population health is the same as public health; while others believe the two concepts are distinct.

For those that fall into the latter camp, the perceived difference stems from a distinction in where the work is done: public health work occurs within a governmental public health agency at the federal, state, or local level, while population health work takes place in a health system, a hospital or other organization. There seems to be some value for preventive medicine physicians who do not work in health departments to assert that they work in "population health" as opposed to working in "public health."

Participants agreed that the desired outcomes of population health and public health are the same — to improve the health of a population and a community — and that a preventive medicine physician brings the needed skill set for that work. However, a more precise and accessible definition for each term would be beneficial.

What is the value of a preventive medicine physician in public health, compared to other physicians with a Master of Public Health (MPH) and/or a primary-care physician with an MPH?

This is a somewhat controversial issue; physicians in other specialties may feel that they do preventive medicine work by working at a health department, or because of their MPH competencies. When looking at outcomes and processes, there may be a perceived overlap, creating a false dichotomy between these groups of professionals. However, participants noted sharply the difference between a preventive medicine specialist, i.e., a physician trained in the specialty of preventive medicine, and a physician trained in another specialty who happens to work in the field of public health.

Participants agreed that preventive medicine physicians engage in a unique body of work by focusing on areas such as community health and environmental health, as well as areas that have a strong need for soft skills, including leadership and interpersonal communication. Further delineating these competencies will strengthen their value. The American College of Preventive Medicine has begun work on creating language on the value

proposition of preventive medicine physicians, focusing on their work to save lives, improve communities, and transform health systems.

How do we create a distinction between preventive medicine physicians and other clinicians engaged in public health work?

In order to promote the specialty of preventive medicine, it must have a distinct identity that is core to its value. The field must come to a shared understanding that being a physician focused on prevention does not make one a preventive medicine physician; to be a preventive medicine specialist, a physician must complete a preventive medicine residency. Participants suggested areas where distinctions could be addressed. The primary area of benefit is an ability to communicate unique competencies.

While there are overlapping competencies among physician specialties, there needs to be a clearer definition of the specific capabilities of the preventive medicine physician. Another consideration is to create a standard privileging process or template that would distill the specific duties of the preventive medicine specialist.

If preventive medicine no longer existed as a medical specialty, what would happen?

Preventive medicine focuses on preventing illness and injury instead of treating it, and eliminating this specialty could have a severe impact on healthcare delivery and health outcomes at both individual and population levels. Participants noted

that eliminating this specialty would lead to missing a unique skill set within the physician workforce.

Although preventive medicine physicians bring a valuable skill set to population health, participants agreed that health departments would not shut down if there was a decrease in the number of practitioners in the specialty or the elimination of the specialty.

Does Board certification matter?

Participants discussed the value of Board certification for prevention medicine, as well as its meaningful impact to physician practice. Although Board certification is a voluntary process, it demonstrates that preventive medicine physicians have expertise in their specialty. Additionally, it certifies to society that a preventive medicine physician is trained and has passed their exam, with a set of skills that physicians certified in other specialties do not have.

Discussion Topic 2: Measures of success for preventive medicine residency training. “How would one measure the ‘success’ of a preventive medicine residency program?”

How can we measure the impact and value of preventive medicine physicians in the community and in their jobs?

Currently there is a struggle to measure the impact and value that preventive medicine physicians bring to their jobs. Despite the tremendous work preventive medicine physicians have added to keeping populations

healthy, the field still struggles to showcase these contributions to others.

All participants agree there needs to be increased data collection efforts in order to gain a clearer picture of career progression and impact because of residency training. One recommendation is to assess data on where preventive medicine physicians go after graduation, but participants also recommended looking beyond job tracking to gather data on what preventive medicine physicians are doing in their jobs and how that ties in to changes in community health status. Another is to consider encouraging graduates to become health officers as a program funding incentive.

One participant noted that during their preventive medicine residency, he received a Pfizer rotation scholarship during his preventive medicine residency and had a great experience working at Pfizer; however, these opportunities are limited. There is a lack of awareness of the specialty of preventive medicine as well as a lack of opportunities for preventive medicine specialists to show their value. An opportunity like a Pfizer rotation allows preventive medicine residents to network with others in the specialty. Participants agreed that creating more networking opportunities to help gather sponsor support for unique rotations would help increase the number and improve exposure of preventive medicine physicians.

Outside of local health departments, where is population health valued

today and what may this mean for preventive medicine career opportunities?

The question of determining who values population health is a difficult one to answer. Organizations like the Department of Veterans Affairs, the largest single provider of healthcare training in the United States, seem like a natural fit. However, not all health organizations appear to value population health, perhaps because population health does not yet provide a financial incentive.

Integrated health systems would likely value prevention and the skills that preventive medicine physicians possess. The main challenge is exposing these systems to the specialty and proving the value of preventive medicine physicians to these health systems. One suggestion is to ensure that preventive medicine residents are routinely placed in health systems to give them the opportunity to demonstrate those skills and bring value. To the extent that residency rotations can be created within health systems would expose them and their skill set to system leadership, in addition to creating networking opportunities.

Discussion Topic 3: Structure and funding of preventive medicine residency training. “Ideally, what should a preventive medicine residency program look like, and how should it be funded?”

Is current residency program structure built properly to obtain and develop preventive medicine physician skills?

One of the primary challenges with current preventive medicine residency program structure is equivalence; for example, accepting any other specialties' clinical year as a preventive medicine clinical year. Because of this, any clinician can claim they've completed a first year of training equivalent with any preventive medicine physician. Secondly, any physician with an MPH degree can legitimately claim equivalence to two-thirds of a preventive medicine physician's training.

To avoid such equivalence, participants noted that offering a different type of degree for a preventive medicine resident might help address this issue. For example, a Master of Preventive Medicine degree, requiring a specific course only available for preventive medicine residents, could help to solidify the specialty as having different skills than that of any physician with an MPH.

The most unique aspect of the preventive medicine residency is the practicum year and its collection of rotations. Participants agree variability in the practicum year allows residents to tailor their rotation to their specific career interest. However, the minimal requirements for the practicum year still allow other specialties to approach equivalence (i.e., an internal medicine resident with well-planned electives could do the same amount of time at a local health department as a preventive medicine resident).

Is preventive medicine a primary care specialty?

The current relationship between preventive medicine and primary care is complicated. Preventive care is an important part of primary care medicine,

yet there is not enough support within the current healthcare system to consider preventive medicine physicians as primary care physicians.

The American College of Preventive Medicine has considered policies that would categorize preventive medicine as a primary care specialty. Participants noted that classifying preventive medicine as primary care may be beneficial to the specialty, but doing so would not adequately recognize the uniqueness of the preventive medicine specialty. To add clarity to the conversation, participants agree the generally accepted method of thinking about medical specialties in the context of primary care is that primary care is for individuals, whereas preventive medicine is for populations; for example, family medicine is primary care for individuals, while preventive medicine is primary care for populations.

How should residency programs be funded?

HRSA is the largest federal funder of preventive medicine residencies, but the entire preventive medicine residency budget is a tiny fraction of HRSA's overall budget. Participants acknowledge that ensuring funding sustainability for residency programs is essential to the specialty's future.

Participants examined several other avenues of residency program funding. Preventive medicine residency programs could require self-funding through tuition paid by residents. A more favorable option could be converting preventive medicine residency training into a fellowship-only specialty, where preventive medicine fellows could practice, say, 10% of their fellowship time

so that their clinical revenue might fund their fellowship training.

Traditionally, HRSA has structured its preventive medicine funding so that funds are awarded per program and not per resident. As a result, programs that have either ten residents or just one resident receive essentially the same amount of funding, which leads to an uneven distribution of funding dollars per resident. One consideration is to restructure funding from per-program to per-resident on a per capita basis. Participants noted that establishing a per-resident basis will assist in spreading the costs of financing preventive medicine residencies fairly across funded residency programs.

Participants again noted integrating residency programs with health systems could also help offset funding needs. Health systems could fund residency programs and in return, residents would have to work for the health system for a few years. In return, health systems could recoup their investments and residents would not have to worry about paying tuition. If there are health systems, and even local health departments that are natural employers of preventive medicine physicians, this could be a potential approach for funding opportunities.

Strenuous efforts should be made to strengthen linkages between health systems and preventive medicine physicians. In an effort to help strengthen these linkages, the American College of Preventive Medicine suggested an evaluation

study working with America's Essentials Hospitals (whose President and CEO is a preventive medicine physician), and non-profit medical hospitals to analyze rotation activities and their outcomes, along with a before-and-after analysis.

This type of comparison study may uncover opportunities to connect preventive medicine physicians to these health systems. Lastly, when observing the number of preventive medicine physicians leading LHDs, participants again noted very few states or counties specifically required a physician trained in the specialty of preventive medicine.

In addition to solutions, participants voiced their concern over the fact that 50% of the currently accredited residency slots are not filled. Participants questioned the incentive for HRSA to fund new residency programs, if there's a supply out there that is currently underutilized. Participants were unsure if every existing program should continue to be funded.

What are we doing differently or specifically in our training to prepare our residents for careers in preventive medicine?

Preventive medicine is a small discipline with a wide array of competencies and career tracks, therefore preparing residents for careers in preventive medicine can be challenging.

Looking towards the future structure of preventive medicine residencies, participants raised the question of whether or not a full degree is

even necessary, or can a collection of courses suffice instead? Participants acknowledged that one of the most attractive aspects of the preventive medicine residency is the funded MPH. Receiving an MPH as a required part of the residency program is one of the main selling points and without it, residencies would face challenges in recruiting residents for the training programs. However, participants supported a future where preventive medicine residencies are a 36-month unique longitudinal residency instead of a compilation of three various years of training.

How should we market preventive medicine residency programs to attract more residents?

A preventive medicine residency program can improve its leverage by enhancing its current marketing towards graduates. In order to recruit more residents, solidifying a set of expected or commonly pursued careers for preventive medicine physicians could be one way to better attract the specialty to people. Participants agreed that most preventive medicine residencies acknowledge going to a local health department is the most obvious career path; however, there are more options that can be uniformly structured and presented to these graduates. The American College of Preventive Medicine has created resources on preventive medicine that can be better leveraged to build interest.

What role would preventive medicine physicians play in rural health/ improving rural communities and health outcomes?

Delivering healthcare services in rural communities has many challenges. Yet, preventive medicine physicians compared to other specialties, are well equipped to have the skills needed to address the social determinants of health (SDOH) such as transportation, food, education, and housing. These complexities often limit access to care, harming rural communities and worsening health outcomes.

Participants noted that preventive medicine physicians see health issues through the SDOH lens and know the importance of community partnerships that are not promoted in other training programs. Preventive medicine physicians understand that health is more than just your healthcare visit. It involves policy and communities and having an SDOH lens as a key aspect and a unique qualifier for the specialty. Acknowledging this issue, the American College of Preventive Medicine is helping elected officials understand SDOH so that they may see the complexities of the issue; specifically, how preventive medicine physicians can contribute to addressing them.

Many Federally Qualified Health Centers are the de facto health departments in rural areas. There seemed to be a consensus among participants that simply placing more clinicians into a system will not necessarily solve the issues in rural communities. However, placing preventive medicine physicians in these communities could, by combining their clinical and population health skills in the role of a community health physician.

HRSA Bureau of Health Workforce, Division of Medicine and Dentistry

2019 Preventive Medicine Stakeholder Meeting “Take-Away Points”

- Preventive medicine physicians engage in a unique body of work.
- Preventive medicine physicians, compared to other specialties, are trained in the skills needed to address social determinants of health (SDOH).
- The desired outcomes of population health and public health are the same — to improve the health of the populations and the community — and a preventive medicine physician has the necessary skill set for that work.
- Since there are overlapping competencies among physician specialties, there needs to be a clearer definition of the specific capabilities of the preventive medicine physician.
- The preventive medicine skill set aligns closely with the role of a health officer at a governmental public health agency and this could be a natural career path, but it is not the only career path suited for the specialty.
- Strenuous efforts should be made to strengthen linkages between health systems and preventive medicine physicians.
- Preventive medicine residents should be routinely placed in health systems to give them the opportunity to demonstrate their skills.
- Ensuring funding sustainability for residency programs is essential to the specialty's future.
- Establishing funding on a per-resident basis will assist in spreading the costs of financing preventive medicine residencies fairly across the healthcare system.
- While available funding is critical, participants were unsure if every program should continue to be funded.
- Participants supported a future where preventive medicine residencies are a 36-month unique longitudinal residency, instead of a compilation of three various years of training.

APPENDIX A: LIST OF PARTICIPANTS

HRSA Future of Preventive Medicine Stakeholder Meeting Health Resources and Services Administration Washington, DC | November 7, 2019 List of Participants

Accreditation Council of Graduate Medical Education

Louis Ling, MD – Senior Vice President for Hospital-based Accreditation
Lorraine Lewis, EdD – Executive Director for the Review Committee for Preventive Medicine

Aerospace Medical Association

Hernando “Joe” Ortega, MD – President

American Board of Preventive Medicine

Christopher Ondrula, JD – Executive Director

American College of Occupational and Environmental Medicine

Bill Bruce, MBA, CAE – Chief Executive Officer
Charles Yarborough, MD, MPH, FACOEM, FACPM – Past President

American College of Preventive Medicine

Elizabeth Garland, MD, MS – Chair, ACPM Graduate Medical Education Subcommittee
Tonette Krousel-Wood, MD, MSPH, FACPM, FAHA – President-Elect
Donna Grande, MGA – Chief Executive Officer

American Medical Association

Andrea Garcia, JD, MPH – Director of Science, Medicine, and Public Health

Association of State and Territorial Health Officials

Wendy Braund, MD, MPH, MEd, FACPM – University of Pittsburgh School of Public Health
Maggie Carlin, MPH – Senior Director, Research and Evaluation
Alexandra Kearly, MPH – Director, Medicaid and Value Based Payment
Cara Person, PhD, MPH, CPH – Director of Public Health Agency Research

Centers for Disease Control and Prevention (by consultation)

Antonio Neri, MD, MPH – Program Director, Preventive Medicine Residency and Fellowship
Eric Kasowski, MD, DVM, MPH – Chief of the Population Health Workforce Branch

De Beaumont Foundation

Moriah Gendelman, MPH – Research Associate

Katie Sellers, DrPH, CPH – Vice President for Impact

Health Resources and Services Administration

Steven Coulter, MD – Project Officer, Division of Medicine and Dentistry

CAPT Daniel Coviello, USPHS – Deputy Director, Division of Medicine and Dentistry

Cynthia Harne, MSW, LCSW-C – Chief, Medical Training and Geriatrics Branch,
Division of Medicine and Dentistry

CAPT Paul Jung, USPHS – Director, Division of Medicine and Dentistry

Diba Rab, MPH – Program Officer, Office of External Engagement,
Office of Planning, Analysis and Evaluation

Irene Sandvold, DrPH, FACNM, FAAN – Senior Advisor, Division of Medicine
and Dentistry

National Association of County and City Health Officials

Celeste Phillip, MD, MPH – Health Officer of Sonoma County, NACCHO Representative

Debra Dekker, Ph.D. – Director of Evaluation

Helena Dessie – Senior Program Assistant

Ashley Edmiston, MPH – Director, Workforce Development

National Academies of Sciences, Engineering, and Medicine

Alina B. Baciú, MPH, PhD – Senior Program Officer of the Board on Population Health
and Public Health Practice

Office of the Assistant Secretary of Health, U.S. Department of Health and Human Services

Leith States, MD, MPH – Chief Medical Officer

Public Health Accreditation Board

Kaye Bender, PhD, RN, FAAN – President and Chief Executive Officer

Hugh Tilson, M.D., Dr. P.H., FACPM – Director, North Carolina Area Health
Education Center

Department of Defense - Uniformed Services University

CAPT Robert J. Lipsitz, USN – Chief of Direct Patient Care, Uniformed Services
University of the Health Sciences

Department of Veterans Affairs

Marjorie A Bowman, MD – Chief Academic Affiliations Officer

APPENDIX B: AGENDA

9:00 am	Welcome CAPT Paul Jung, Director, Division of Medicine and Dentistry
9:15 am	BHW Priorities Luis Padilla, MD, Associate Administrator, Bureau of Health Workforce, HRSA
9:45 am	ACGME Perspective Lorraine Lewis, EdD, Executive Director, Review Committee for Preventive Medicine Louis Ling, MD, Senior Vice President, Hospital-based Accreditation
10:15 am	Break
10:30 am	Workforce Data Moderator: Steven Coulter, MD Panel NACCHO Presentation Debra Dekker, Director of Evaluation ASTHO Presentation Cara Person, Director of Public Health Agency Research Maggie Carlin, Senior Director of Research and Evaluation Public Health Workforce Interests and Needs Survey (PH WINS) Moriah Gendelman, MPH Research Associate Katie Sellers DrPH, CPH, Vice President for Impact, de Beaumont Foundation
11:45 am	ACPM Value of Preventive Medicine in Health Care Study Donna Grande, MGA Chief Executive Officer of the American College of Preventive Medicine
12:30 pm	Lunch
1:30 pm	Discussion Topic: Careers for Preventive Medicine Graduates "Are there particular careers that we should prepare PMR graduates for?"
2:30 pm	Discussion Topic: Measures of Success for PMR Training "How would one measure the 'success' of a PMR program?"
3:30 pm	Break
3:45 pm	Discussion Topic: Structure and Funding of PMR Training "Ideally, what should a PMR program look like, and how should it be funded?"
4:45 pm	Wrap up

APPENDIX C: BHW PRIORITIES PRESENTATION



Bureau of Health Workforce Overview

November 7, 2019

Luis Padilla, M.D.
Associate Administrator
Bureau of Health Workforce (BHW)

Vision: Healthy Communities, Healthy People



The U.S. Health Workforce



Demand for health care occupations is growing:

- Health care jobs to increase by 14% from 2018 to 2028



Shortages of health professionals currently exist

- Over 20,400 current designations
- Majority in rural communities



The United States is projected to be short more than:

- 23,600 primary care physicians by 2025
- 15,600 dentists by 2025



The challenges:

- Aging population and health care workforce
- Not enough clinicians to meet demand
- Many providers are mal-distributed across states



HRSA's Bureau of Health Workforce (BHW)

MISSION: Improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need.



EDUCATION



TRAINING



SERVICE



BHW Aims to Address:

Access

- Increase access to health care for underserved and vulnerable populations

Supply

- Promote equilibrium in the supply and address shortages of health professionals

Distribution

- Improve workforce distribution so all parts of the U.S. have an adequate number of providers to meet the demand for care

Quality

- Develop a quality health workforce that is trained in and employs evidence-based techniques that reflect better patient care



Strategies for Success



Stakeholder Engagement

Our work with partners enables us to make informed decisions on policy and program planning. Together, we are creating a strong workforce of diverse health professionals who provide quality care to communities in need.

We work with stakeholders through:



Bureau of Health Workforce Programs	FY 2019 Operating Level
National Health Service Corps (<i>mandatory/discretionary</i>)	\$430 million
Children's Hospital Graduate Medical Education	\$323.4 million
Nursing Workforce Development (<i>includes ANE, NWD, NEPQR, NFLP</i>)	\$146.6 million
Teaching Health Center Graduate Medical Education (<i>mandatory</i>)	\$126.5 million
Behavioral Health Workforce Development Programs	\$111.9 million
Nurse Corps	\$86.7 million
Health Professions Training for Diversity (<i>includes HCOP, COE, SDS</i>)	\$86.4 million
Primary Care Training and Enhancement	\$48.7 million
Oral Health Training	\$40.5 million
Geriatric Programs	\$40.5 million
Area Health Education Centers	\$39.1 million
Medical Student Education Program	\$25 million
National Practitioner Data Bank (<i>User Fees</i>)	\$18.8 million
Public Health Workforce Development	\$16.9 million
Health Care Workforce Assessment	\$5.6 million
Faculty Loan Repayment	\$1.2 million
Total Program Level	\$1.55 billion



Future of the BHW Health Workforce

BHW will continue to strengthen the health workforce and support clinicians working in rural and underserved areas by making strategic investments in our programs.

- ▶ **Education**
Building a diverse and well trained workforce committed to improve the health of the underserved
- ▶ **Training**
Incorporating education and training as an essential component of quality improvement and workforce retention
- ▶ **Service**
Connecting a quality health workforce to our underserved communities



Questions



Contact Us

NAME: Luis Padilla, MD, FAAFP

Associate Administrator

Bureau of Health Workforce (BHW)

**Health Resources and Services
Administration (HRSA)**

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APPENDIX D: ACGME PRESENTATION



ACGME Perspective at HRSA

November 7, 2019

Lori Lewis, EdD

Executive Director

Review Committee for Preventive Medicine

Louis Ling, MD

Senior VP, Hospital-based accreditation

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Preventive Medicine is different (at the ACGME and elsewhere)

1. **Most ACGME Institutions have no experience with PM**
2. **Most Prev Med residents work away from other residents**
3. **Most other residents/students have never met a PM resident**
4. **Prev Med is different than every other ACGME specialties**

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Preventive Medicine is different (at the ACGME and elsewhere)

1. Clinical care is defined differently
2. Three specialties in one set of requirements and one committee
3. Masters level course work required
4. Not hospital based, so....
5. Does not fit CMS hospital-based funding model

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PM is a tiny percentage of ACGME physicians in training

ACGME all (2018-2019)

Preventive Medicine

(PH/GPM, OM and AS)

All Programs	11,685	75 (0.64%)
New Prog 5 yrs (net)	2040	3 (0.14%)
All Residents	140,391	357 (0.25%)

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PM is a tiny percentage of ACGME physicians in training

ACGME core(2018-2019)

Preventive Medicine

(PH/GPM, OM and AS)

Core Programs	4842	75 (0.4%)
New Cores 5 yrs (net)	741	3 (0.67%)
Core Residents	115,992	357 (0.31%)
Entering residents	32,603	193 (0.59%)

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What is the trend at the ACGME?

1. From minimum standard to constant improvement
2. From ACGME enforced to self-assess/improve
3. From practice in 2020 to practice in 2040
4. From GME focus to improve health and healthcare
5. From physician focus to keeping public trust

Summary: Responsive to environmental change

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What is the resulting change in program requirements?

1. **More on program aims and local environment**
2. **More on institution and program self-improvement**
3. **More on professionalism and life-long learning**
4. **More on wellness, diversity/inclusion, underserved**
5. **More on competencies and Milestones**

Summary: Wider scope for ACGME

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Preventive Medicine Requirements (unchanged)

- Requirements cover all 3 focus areas
 - Aerospace Medicine
 - Occupational Medicine
 - Public Health/General Preventive Medicine
- Can be offered in 2 ways
 - 24 month program in preventive medicine after 12 month clinical year
 - 36 month program that integrates clinical year and preventive medicine

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Requirements for resident eligibility (unchanged)

- Allows residents to enter into the second year of the program, and complete in 12 months **IF**
 - They have completed an ACGME-accredited, AOA approved, Royal College of Canada, or ACGME-I-accredited residency
 - They have completed at least 50% of requirements for Masters' degree

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New Common Requirements for program director and coordinator

- From no protected time to 12 hours/week required time for administration
 - 4 hours can be shared with Associate program director
- From no Coordinator to 20 hours/week required time

Result: May increase the cost for a program

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New Requirements for faculty

- Programs must have a minimum of 2 core faculty members
- Programs with more than 8 residents must have core faculty to resident ratio of at least 1:4

Result: May increase cost to a program

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Patient care competencies for all focus areas - examples

- Assessing and responding to individual and population risks for common occupational and environmental disorders
- Conducting research for innovative solutions to health problems
- Diagnosing and investigating medical problems and medical hazards in the community
- Informing and educating populations about health risks and threats
- Planning and evaluating the medical portion of emergency preparedness programs and training exercises

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Examples of competencies for all focus areas

- **Medical Knowledge** - lifestyle management and social determinants of health
- **Practice-based Learning and Improvement** – use epidemiology and biostatistics to characterize the health of a community, and interpret, monitor and act on surveillance data
- **Systems-based practice** – engage with community partnerships, identify and review laws and regulations relevant to area of focus, and analyze policy options for health impact and economic cost

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Curriculum organization

- Masters' degree can be in public health or equivalent
 - Must have course work in epidemiology, biostatistics, health services management, environmental health, behavioral aspects of health
- Program must assess resident knowledge, skills and competence and use that assessment to formulate an individualized educational plan
- All focus areas must have direct patient care experience

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Applications for new programs

Step 1. Complete online application

Time: Depends, up to a year

Step 2. Site visit scheduled once a completed application is received

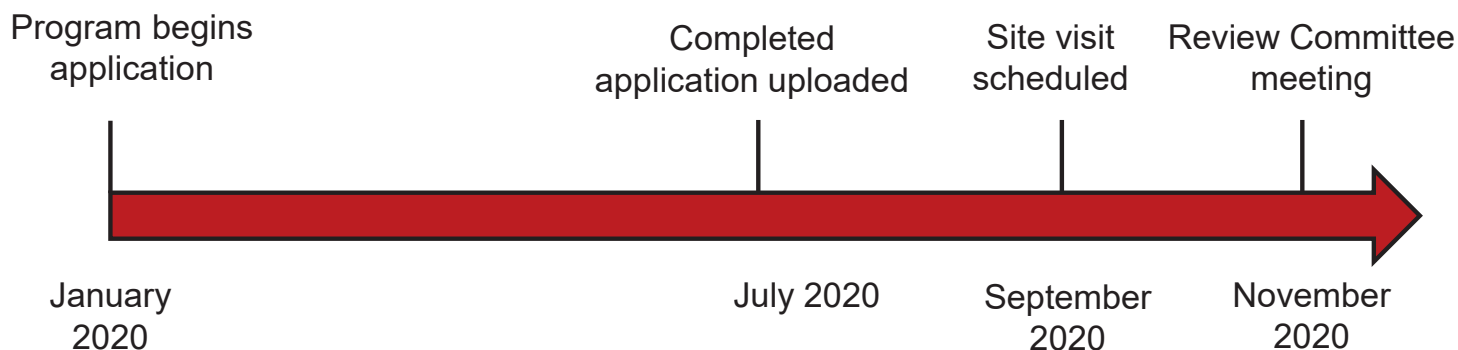
Time: Generally scheduled 60 to 90 days after completed applications is received. Generally takes 2 weeks to complete the report.

Step 3. Preventive Medicine Review Committee

Time: No sooner than 45 days prior to scheduled meeting

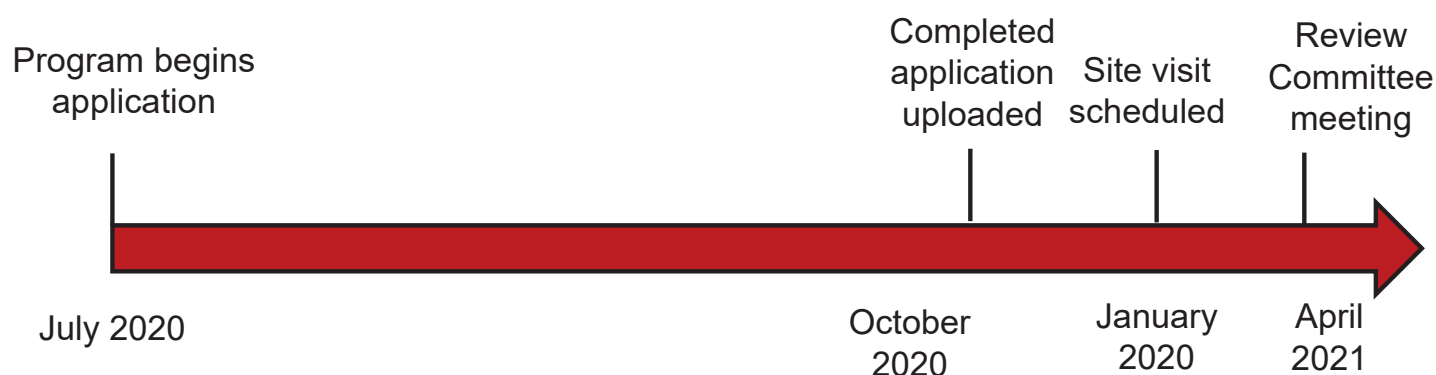
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Possible timeline for new program to begin July 1, 2021



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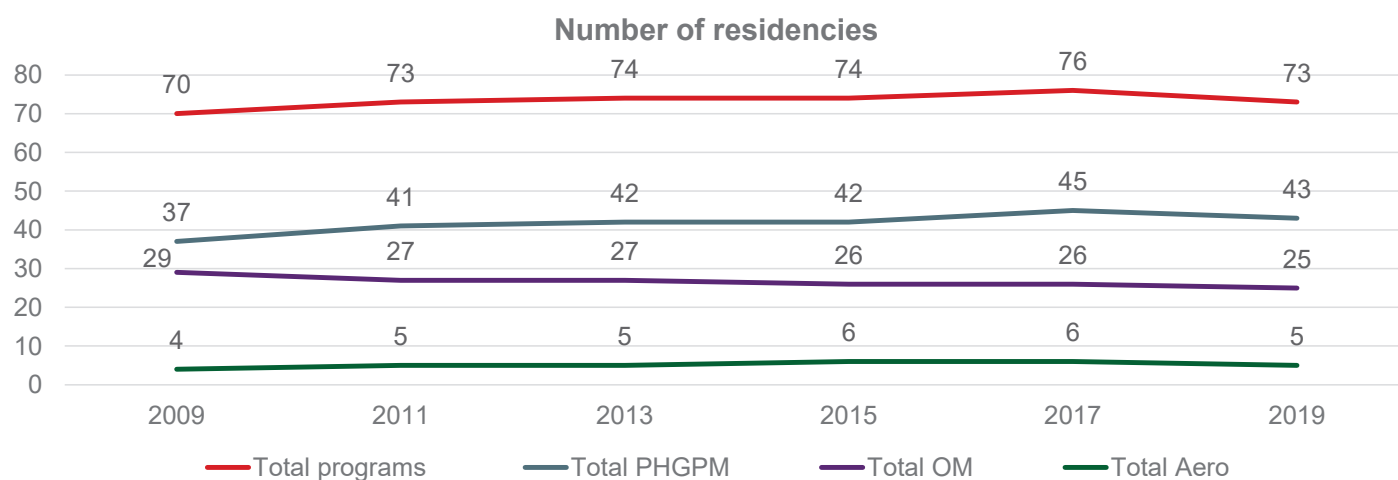
Rushed timeline for new program to begin July 1, 2021



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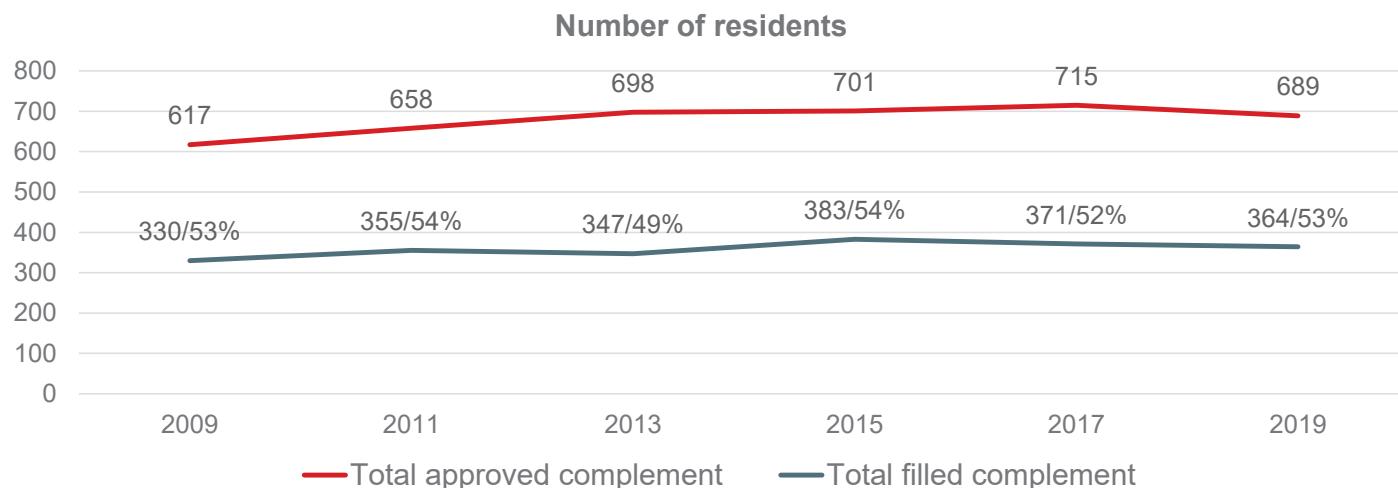
Preventive Medicine programs 10-year data



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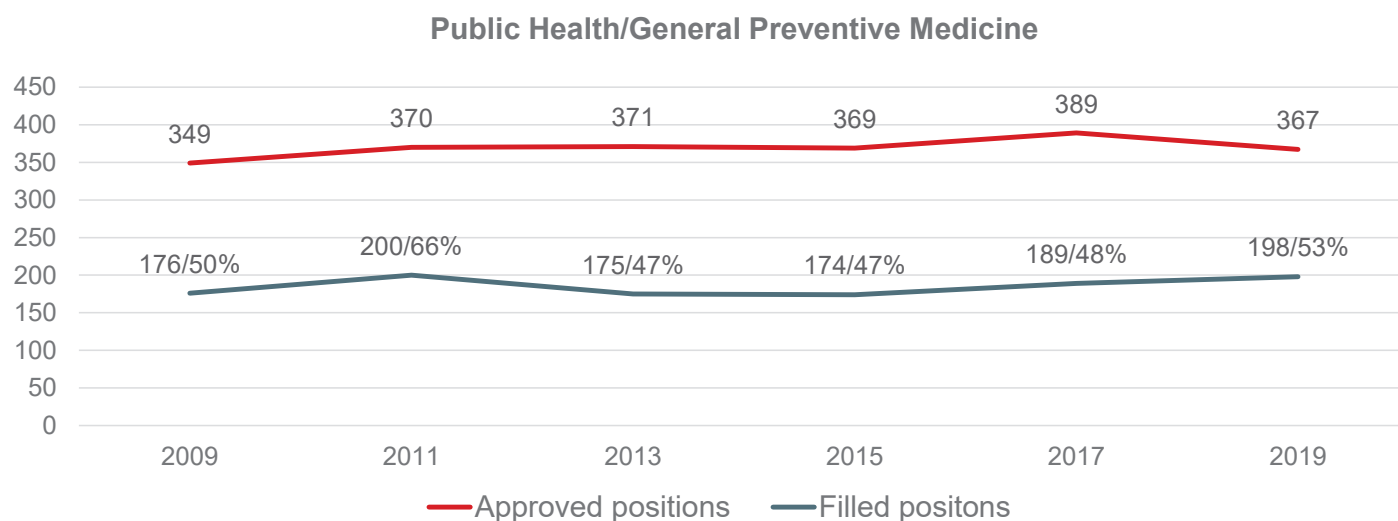
Preventive Medicine residents 10-year data



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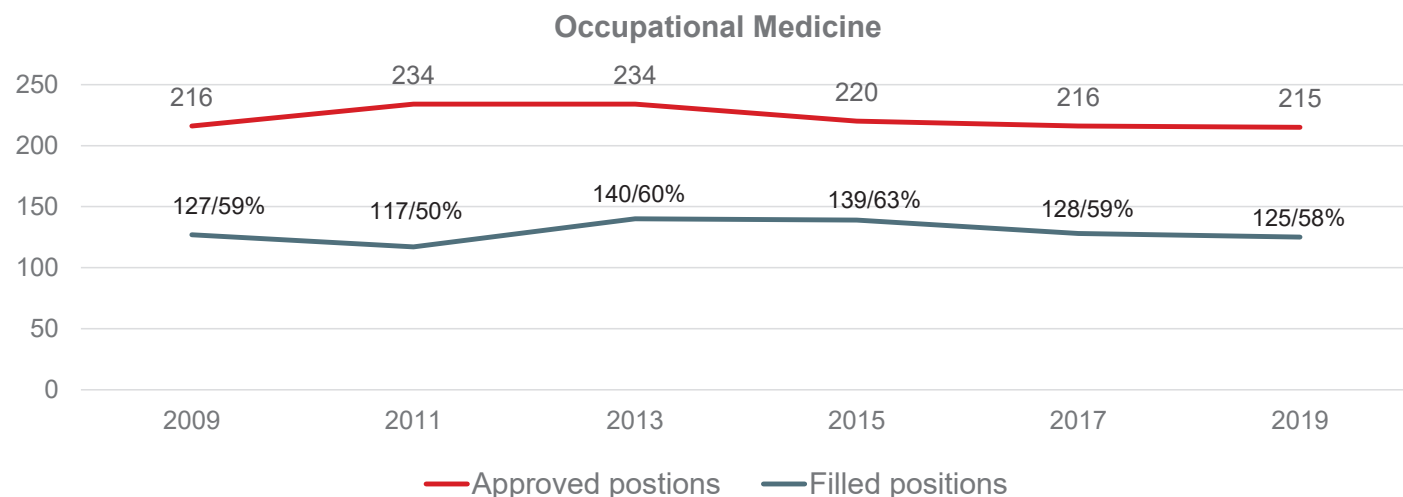
Public Health/General Preventive Medicine residents



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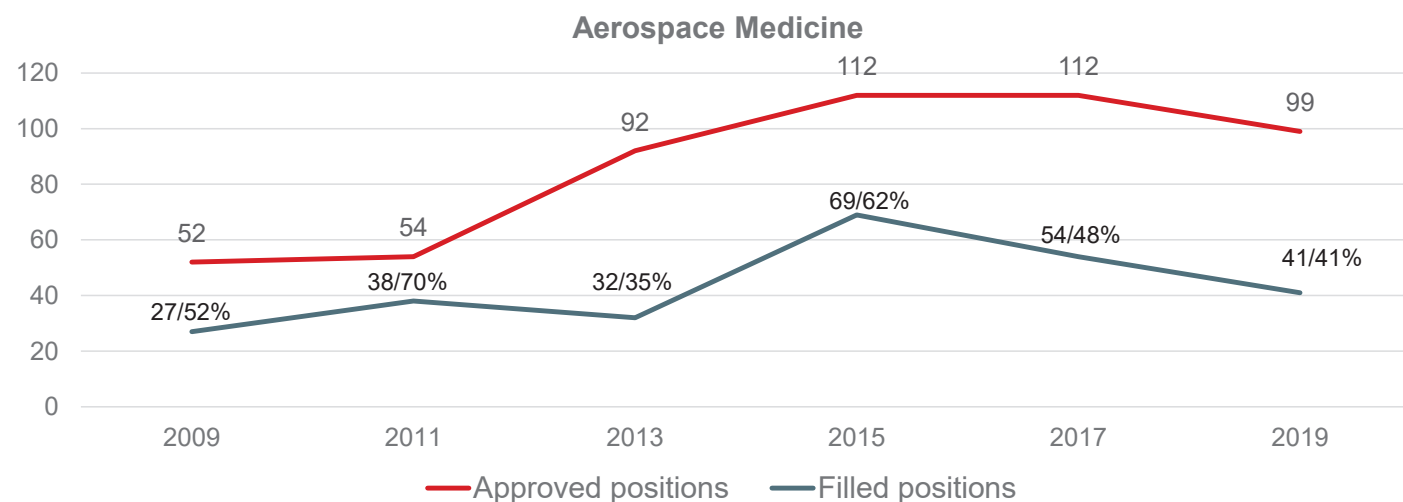
Occupational Medicine residents



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Aerospace Medicine residents

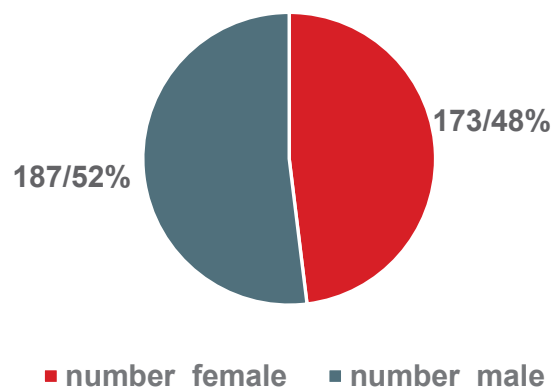


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Gender distribution 2019/2020 All PM residents

2019/2020 academic year - All residents

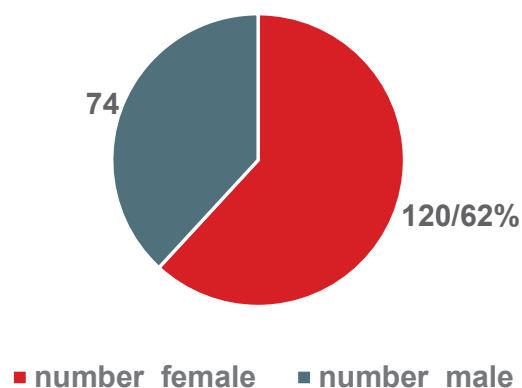


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Gender distribution 2019/2020 PH/GPM

2019/2020 academic year – 194 PH/GPM residents

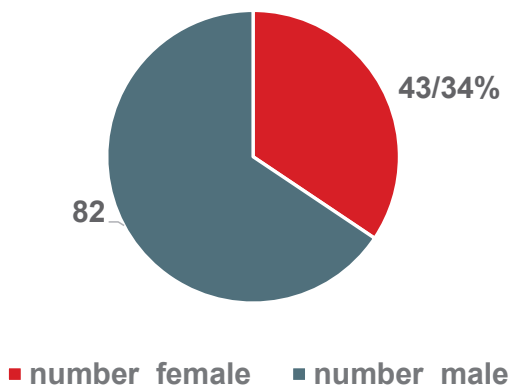


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Gender distribution 2019/2020 Occupational Medicine

2019/2020 academic year – 125 Occ Med residents

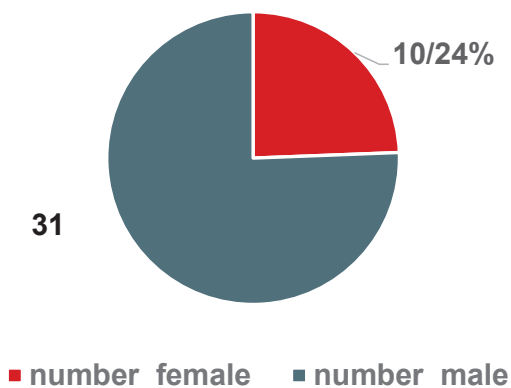


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Gender distribution 2019/2020 Aerospace Medicine

2019/2020 academic year - 41 Aerospace residents

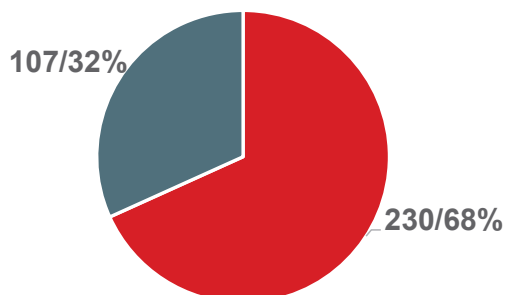


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Years of prior training 2019/2020 all PM residents

2019/2020 residents. Years of prior training



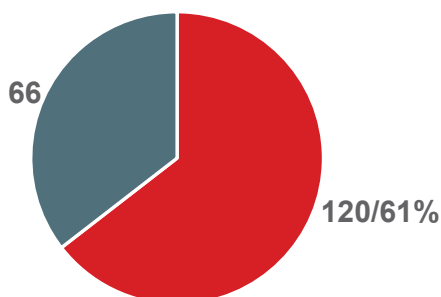
■ number 1-2 years prior training ■ number 3 + years prior training

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Years of prior training 2019/2020 PH/GPM residents

2019/2020 academic year - PH/GPM residents



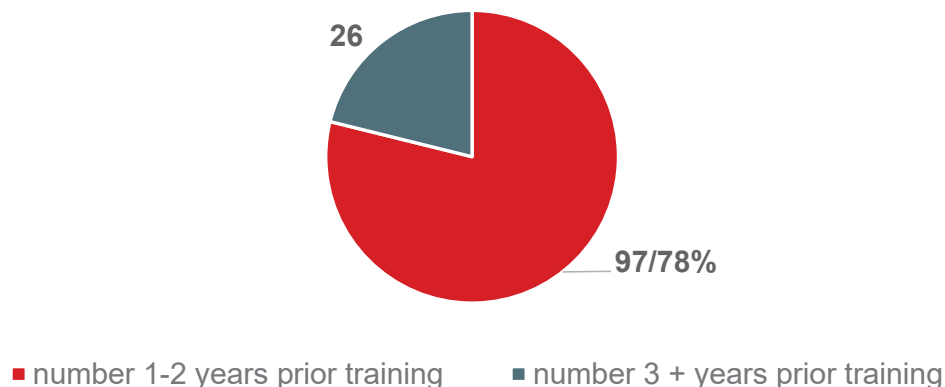
■ number 1-2 years prior training ■ number 3 + years prior training

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Years of prior training 2019/2020 Occ Med residents

2019/2020 academic year - Occ Med residents

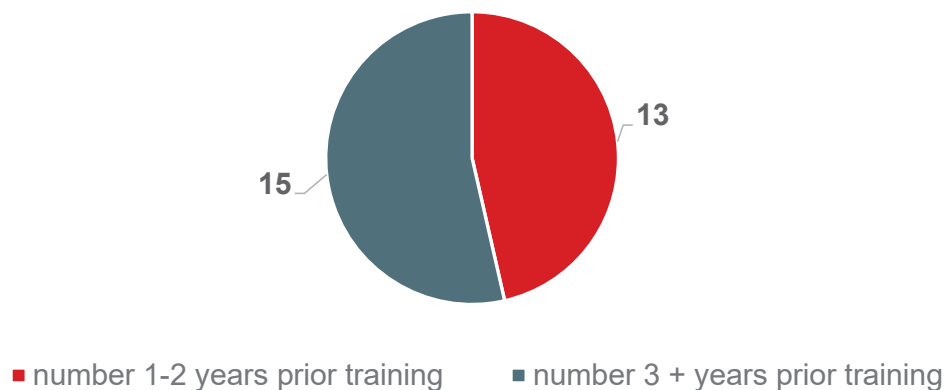


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Years of prior training 2019/20 Aerospace

2019/2020 academic year - Aerospace residents



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14 New PH/GPM programs – last 10 years

- Case Western
- Rutgers
- Univ New Mexico
- Texas A&M
- Montefiore
- University of Wisconsin
- Univ Tex Rio Grand
- UCLA
- Maine Medical Center
- Univ Mississippi
- Southern Nevada
- Washington University
- Wayne State
- Univ West VA

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3 New PH/GPM programs – last 10 years closed early

- Case Western
- Rutgers
- Univ New Mexico
- Texas A&M
- Montefiore
- University of Wisconsin
- Univ Tex Rio Grande
- UCLA
- Maine Medical Center
- Univ Mississippi
- Southern Nevada
- Washington University
- Wayne State
- Univ West VA

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8 closed PH/GPM programs – last 10 years

- Texas A&M
- Montefiore
- Univ Tex Rio Grande
- Oregon Health Sciences
- National Capitol
- Univ Texas
- SUNY Albany
- Airforce

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Other changes

Aerospace Medicine

- Wright State closed
- Army opened
- Mayo Clinic opened

Occupational Medicine

- Army opened
- Madigan closed
- Airforce closed
- UCLA closed
- Univ Connecticut closed
- Univ Texas closed

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Summary (growth)

- Growth in PM residents is 10% compared to 30% growth of all ACGME core residents
- Growth in programs is 0% compared to 30% growth of all ACGME core programs (GPM up and OM down)
- PM (PH, OM, AS) residents is about 0.3% of all residents
- PM is tiny and falling behind

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Summary (identity)

- One third of PM residents have completed prior training
- PM is virtually unknown in ACGME institutions
- Unique overlap with PH/GPM, OM and AS in requirements
- Lack of identity between PH/GPM and OM and AS

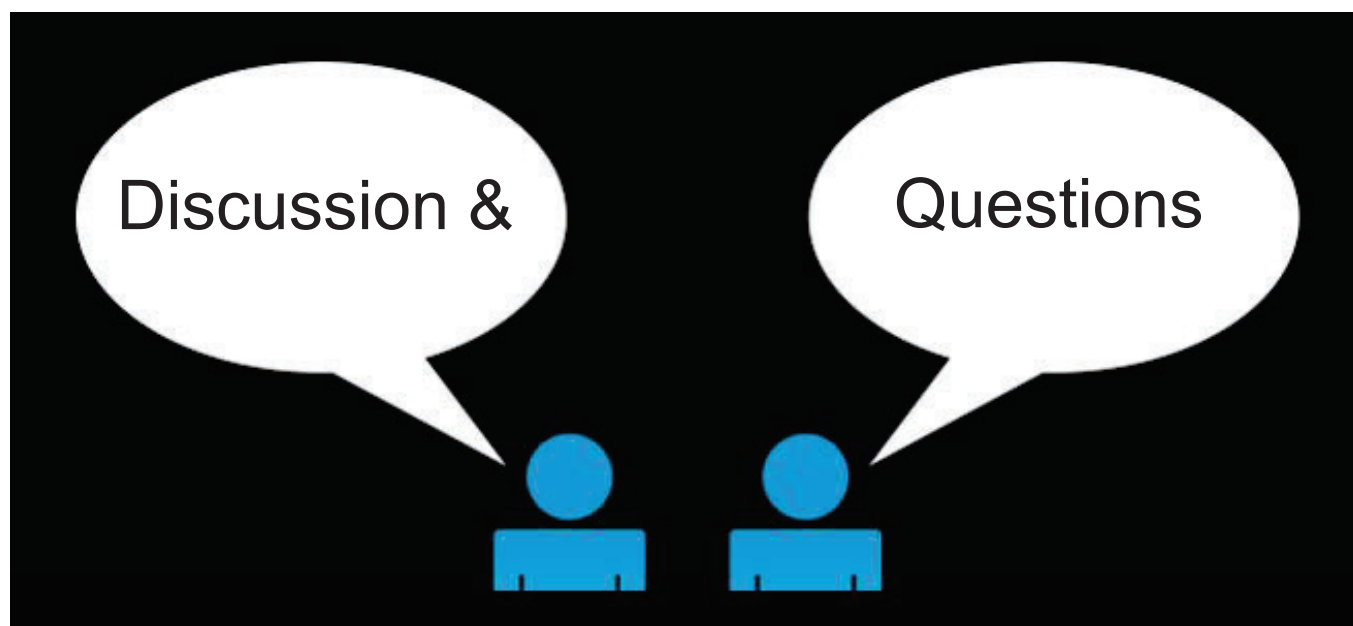
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Summary(new funding)

- Percentage of new PM program growth not keeping pace
- New Requirements for PD, PC may increase cost
- Six month timeline for ACGME accreditation process
- Programs should get accredited first and funding second

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APPENDIX E: NACCHO PRESENTATION

Where are the Public Health Physicians?

Debra Dekker, Ph.D.
Director of Evaluation



What is the Profile?

Survey of all LHDs conducted every three years

Largest, current, most reliable source of data on LHDs



Why should we care about it?

Sent to every LHD for complete and accurate data

Receive high response rates (76% in 2016; 61% in 2019)

Used by researchers, policymakers, and practitioners

Services provided at LHDs

Service	%
Adult immunization	90
Child immunization	89
Screen – BMI	49
Screen – Cancer	31
Screen – Cardiovascular disease	24
Screen – Diabetes	33
Screen – High blood pressure	52
Screen – HIV/AIDS	61
Screen – Other STDs	66
Screen – TB	83

Services provided at LHDs

Service	%
Treat – HIV/AIDS	33
Treat – Other STDs	62
Treat – TB	78
MCH – EPSDT	34
MCH – Prenatal Care	26
MCH – Well child clinics	28
MCH – WIC	65

Services provided at LHDs

Service	%
Behavioral/mental health services	10
Comprehensive Primary Care	11
Home Health Care	18
Oral Health	28
Substance Abuse services	11

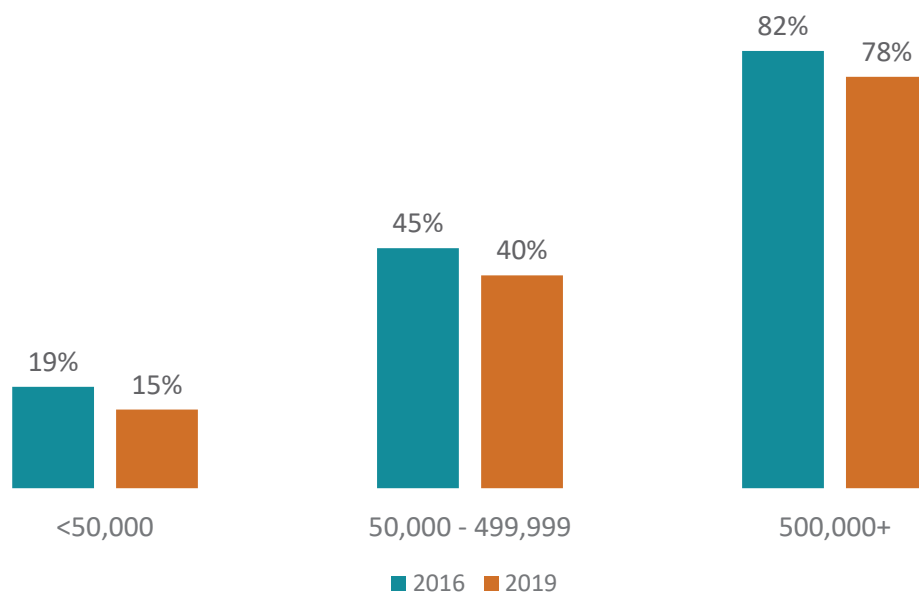
How many LHDs employ public health physicians?

2016		2019	
#	%	#	%
621	33%	498	28%

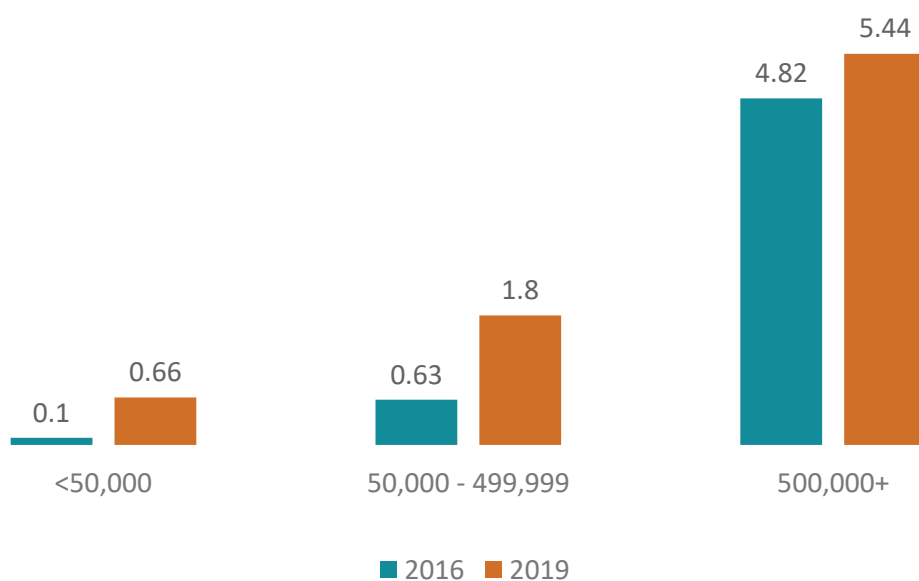
Average number of Physicians per LHD (FTE)

2016		2019	
Mean	Std. Dev.	#	%
.54	3.73	1.84	7.58

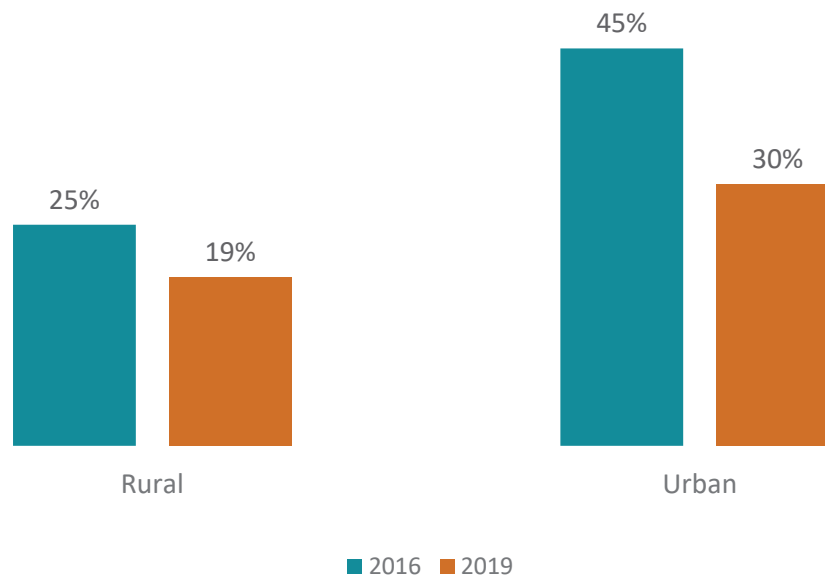
LHDs in larger jurisdictions are more likely to employ public health physicians.



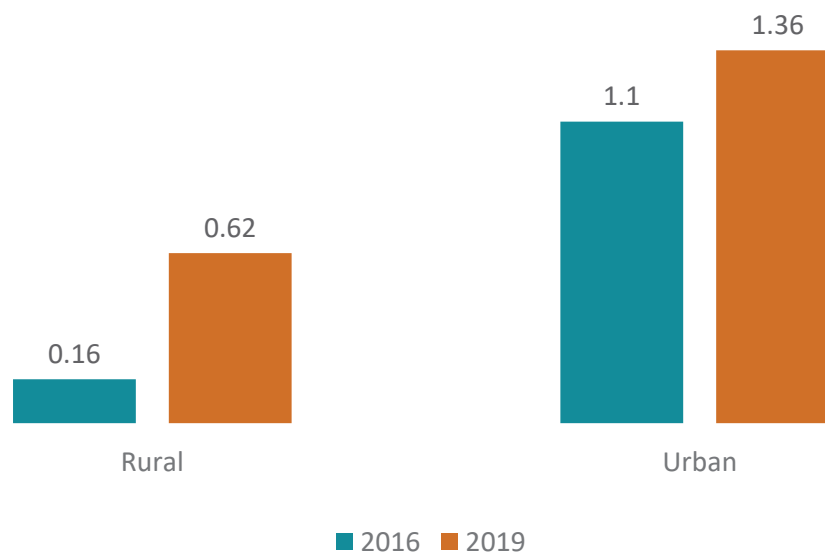
On average, LHDs in large jurisdictions employ more public health physicians.



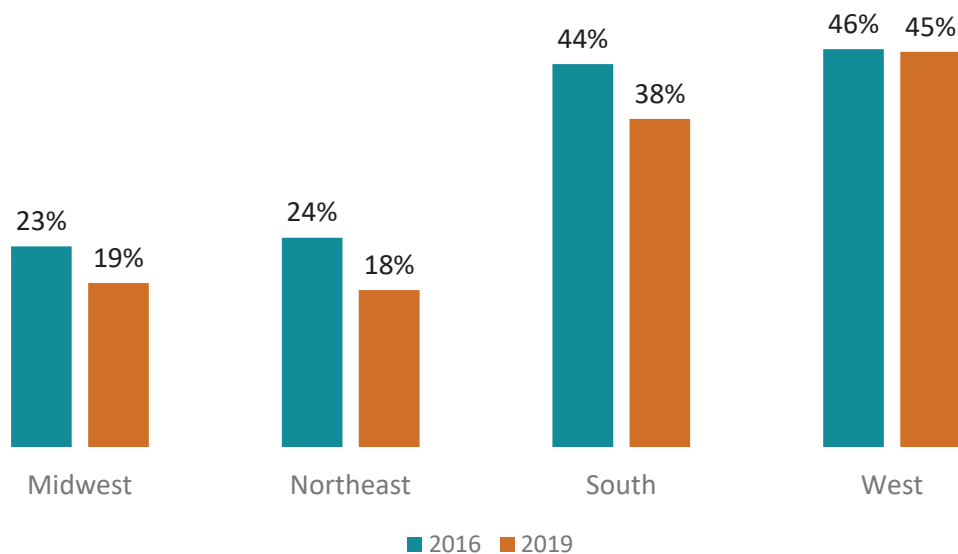
LHDs in urban communities are more likely to employ public health physicians.



On average, LHDs in urban communities employ more public health physicians.

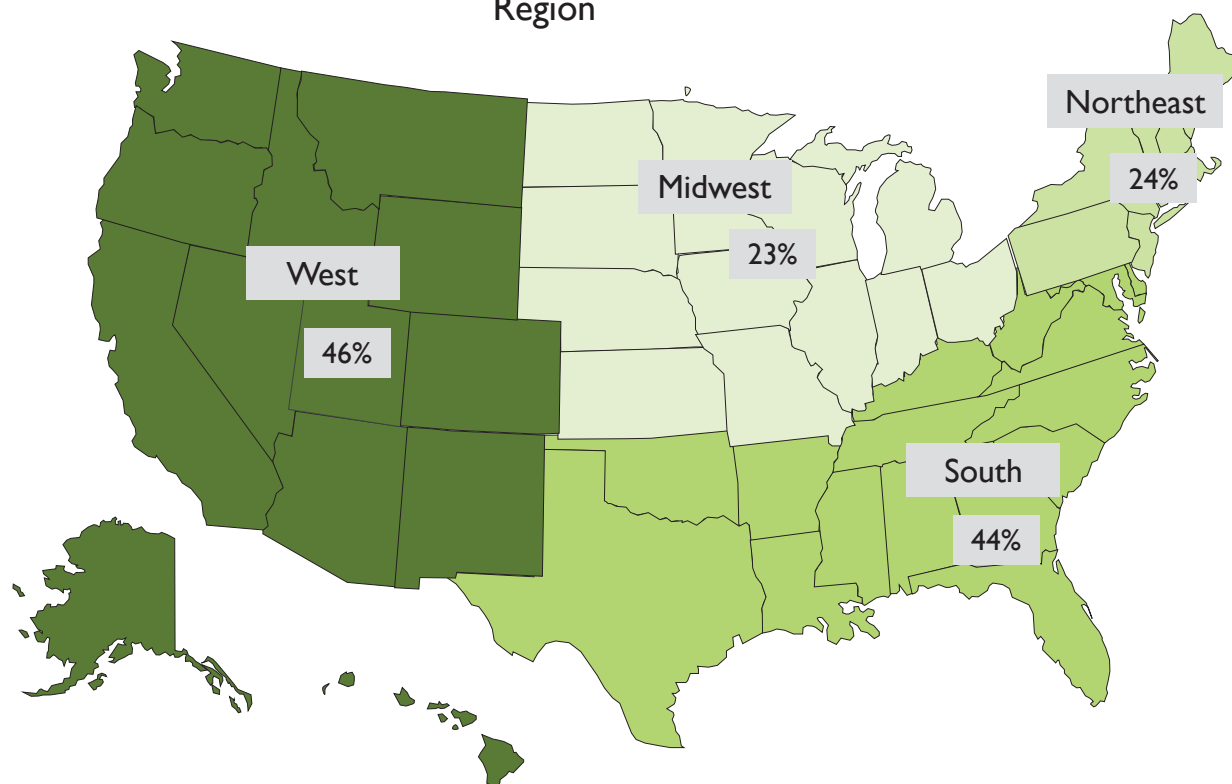


LHDs in the South and West Census Regions are more likely to employ public health physicians.

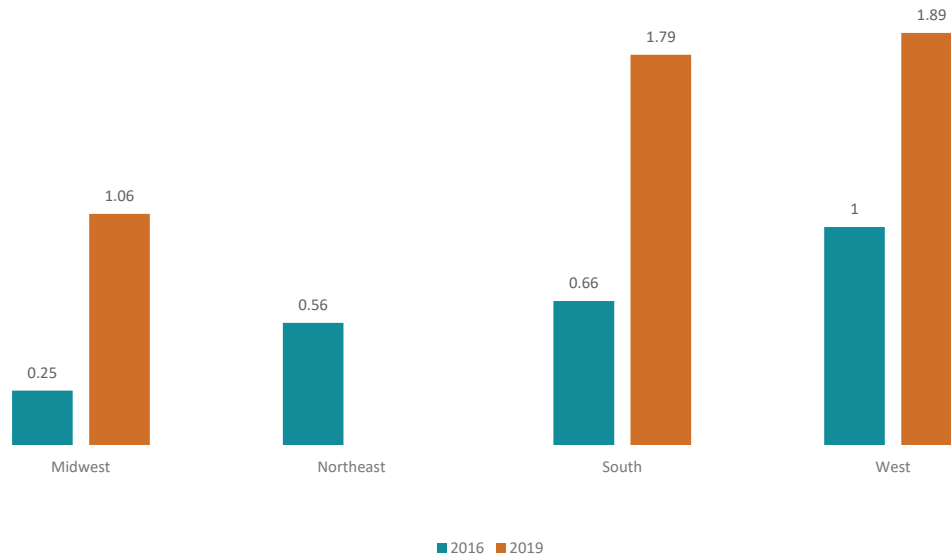


Appendix E-1

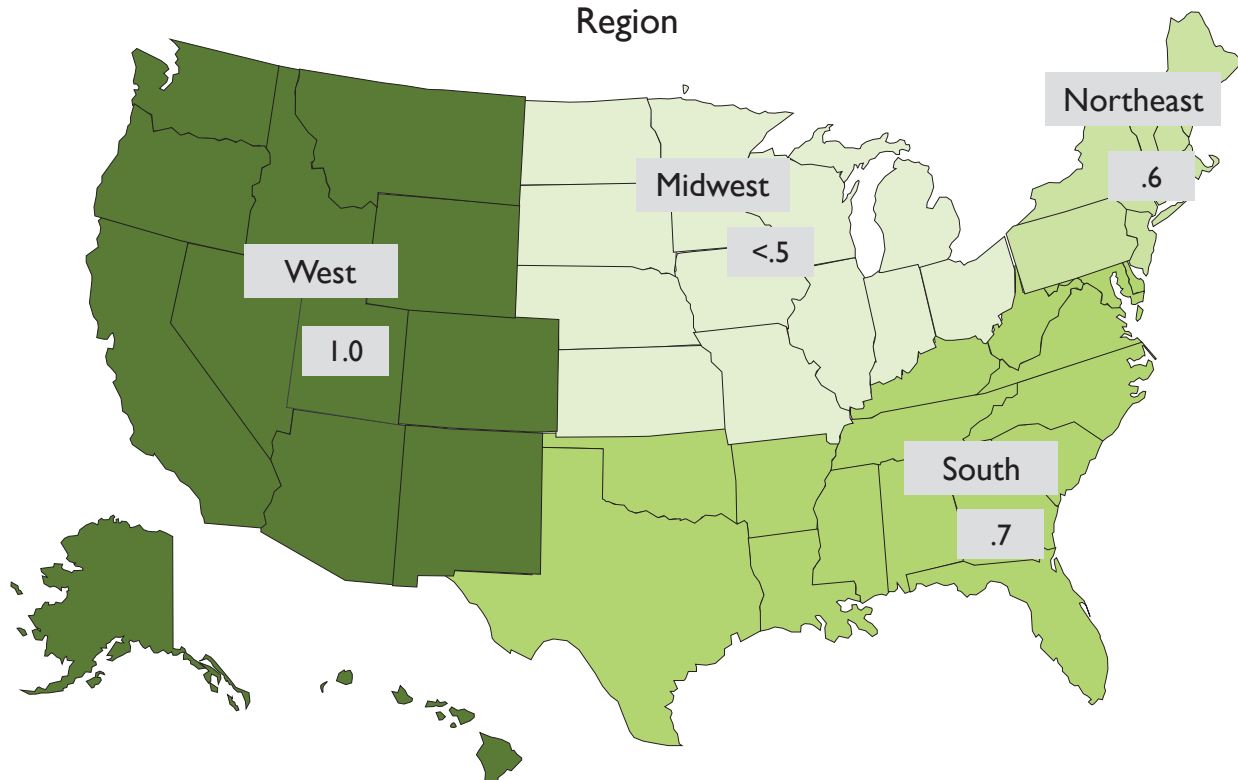
% of LHDs with Public Health Physician(s) Within Each Census Region



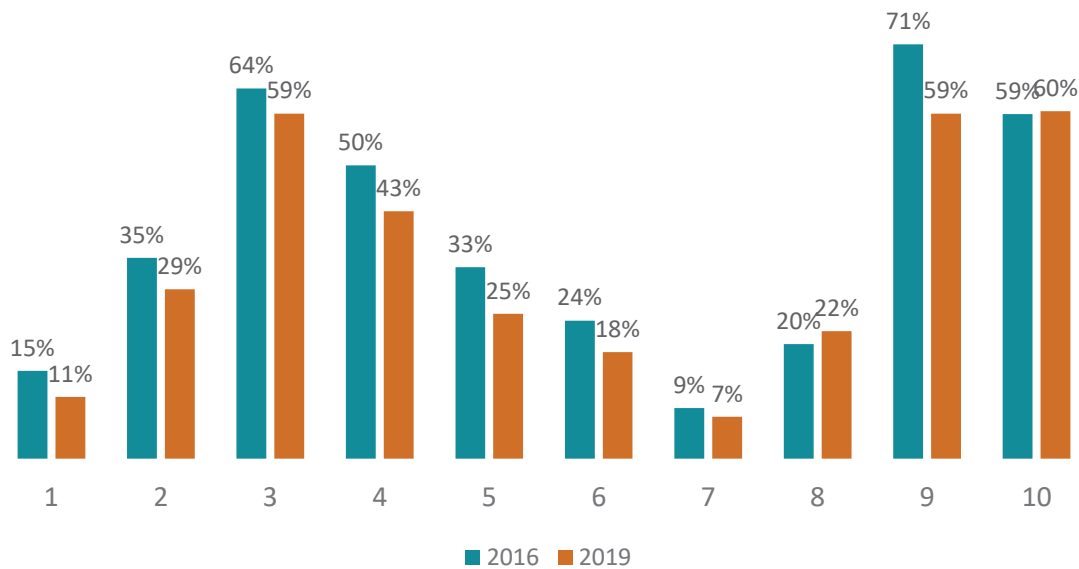
On average, LHDs in the South and the West employ a greater number of public health physicians.



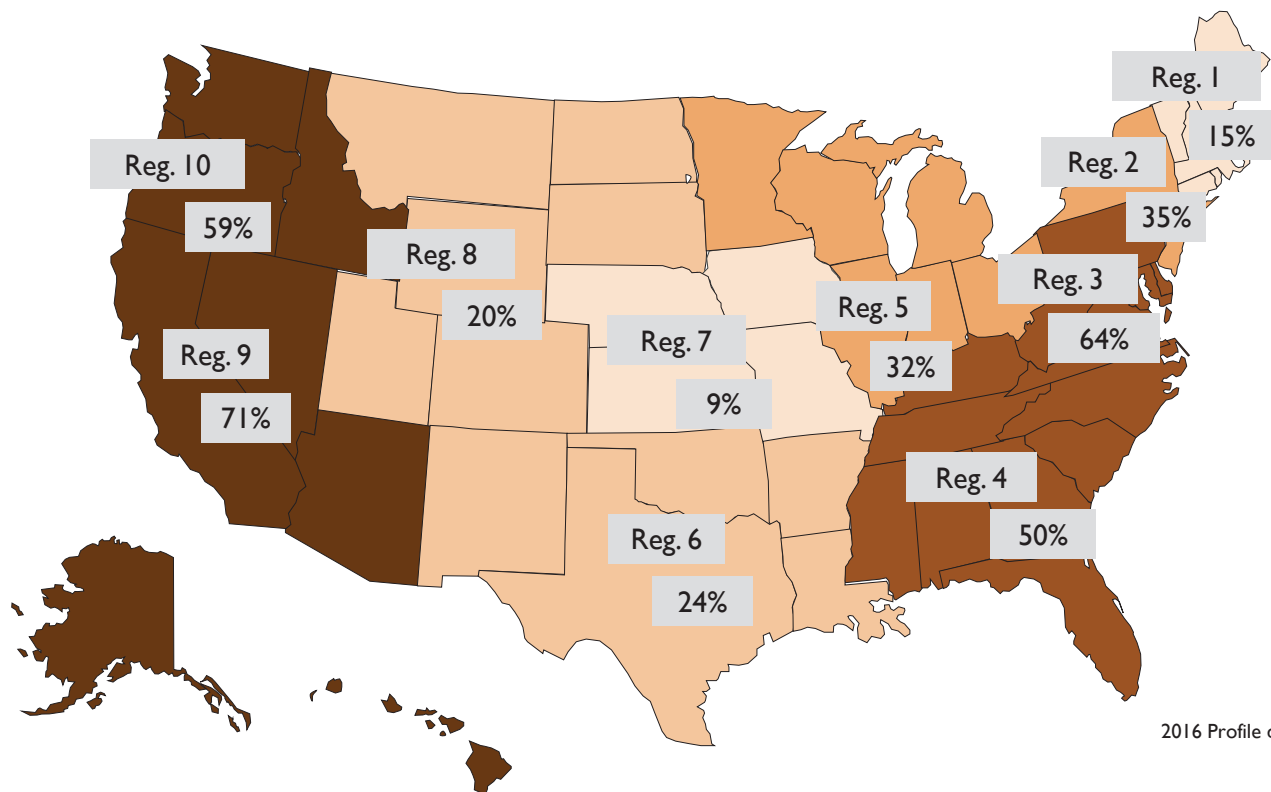
Average # of Public Health Physicians (FTE) per LHD Within Each Census Region



LHDs in HHS Regions 9, 10, and 3 (West and MidAtlantic) are more likely to employ public health physicians.

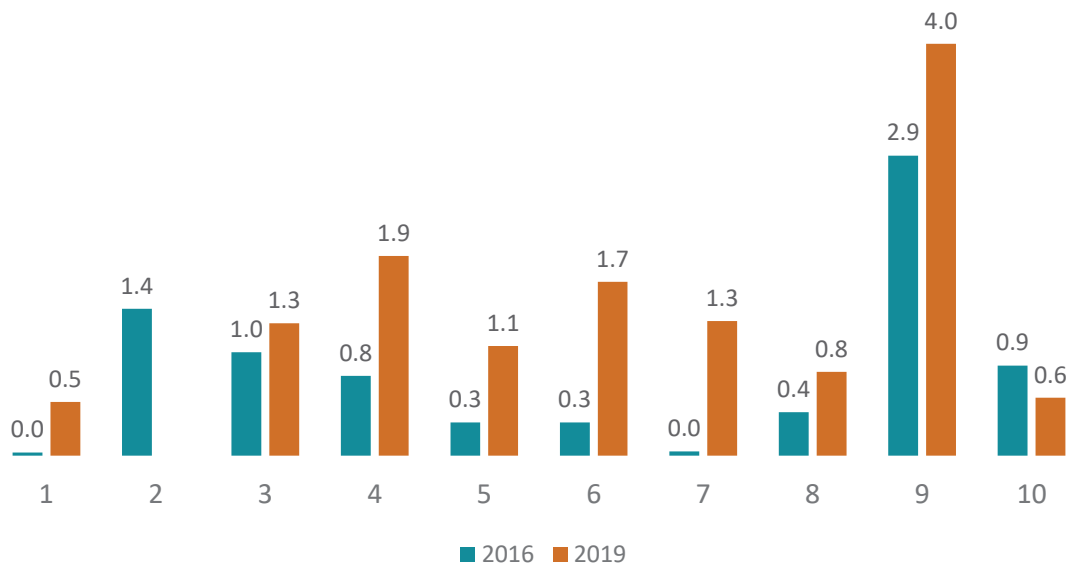


% of LHDs with Public Health Physician(s) Within Each HHS Region

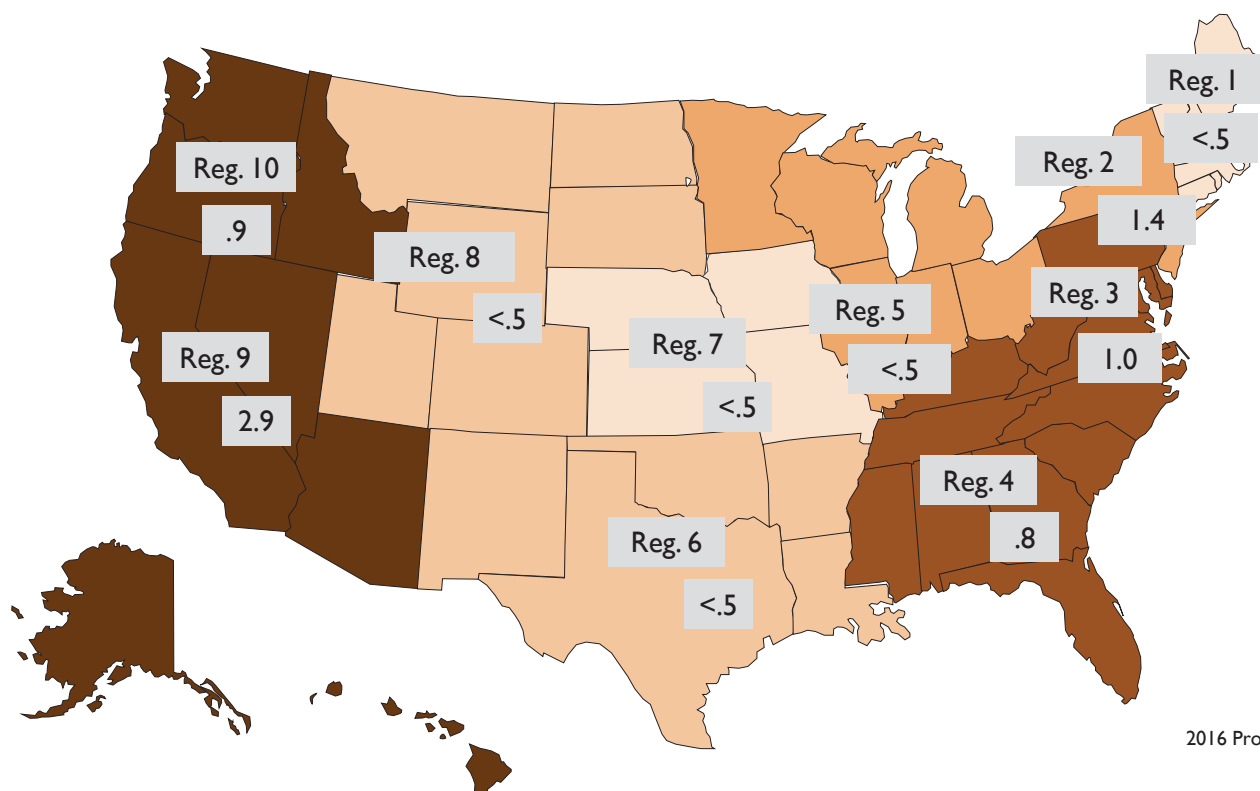


2016 Profile data

On average, LHDs in HHS Regions 9 and 2 (West and Northeast) employ a greater number of public health physicians.

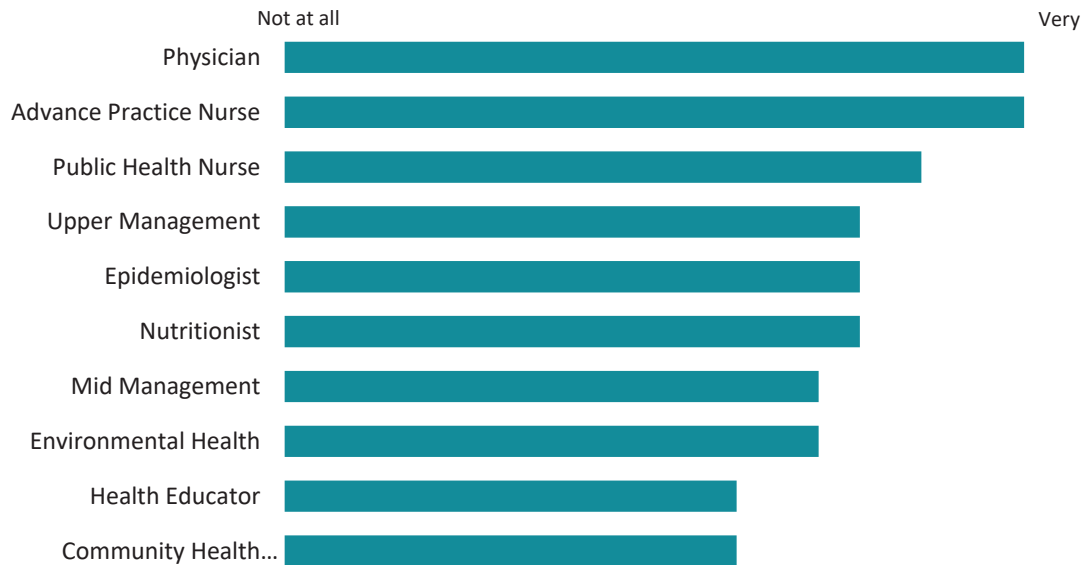


Average # of Public Health Physicians per LHD Within Each HHS Region



Physicians and nurses are the most difficult positions to fill.

Difficulty in Recruiting Various Public Health Positions



Geographical location and pay are major barriers to hiring LHD staff.

Barrier	Major	Minor	No Barrier
Recruiting process and channels do not reach enough qualified candidates.		✓	
Insufficient subject matter knowledge or skills.		✓	
Insufficient general knowledge or skills.		✓	
Insufficient position-related work experience.		✓	
Geographical location.	✓		
Pay is not competitive.	✓		
Benefits are not competitive.			✓
Hiring process is too cumbersome or slow.		✓	

Conclusions

- Small, rural LHDs employ the fewest number of physicians.
- Major barriers to recruiting physicians are geographical location and salary.
- This is evidenced by lower numbers in areas of the country such as the Midwest, Mountain States and portions of the South.
- Other incentives need to be offered to make these areas attractive.

APPENDIX F: ASTHO PRESENTATION



Preventive Medicine Physicians in the State Health Agency Workforce

Maggie Carlin, MPH

Cara Person, PhD, MPH, CPH

Future of Preventive Medicine Stakeholder Meeting

November 7, 2019

Association of State and Territorial Health Officials | astho.org



ASTHO PROFILE OF STATE AND TERRITORIAL PUBLIC HEALTH VOLUME 4

Profile Overview



- Comprehensive survey fielded every 2-3 years to collect information about state and territorial public health agencies
- Data collection years: 2007, 2010, 2012, 2016, 2019
- Supported by CDC and the Robert Wood Johnson Foundation

ASTHO Profile Purpose

To describe the activities, structure, and resources of state and territorial health agencies (S/THAs), providing a benchmark of the core functions of S/THAs and how these change over time.



Profile Survey Sections

- Public Health Agency Activities
- Health Agency Structure and Governance
- Workforce
- Finance
- Planning and Quality Improvement

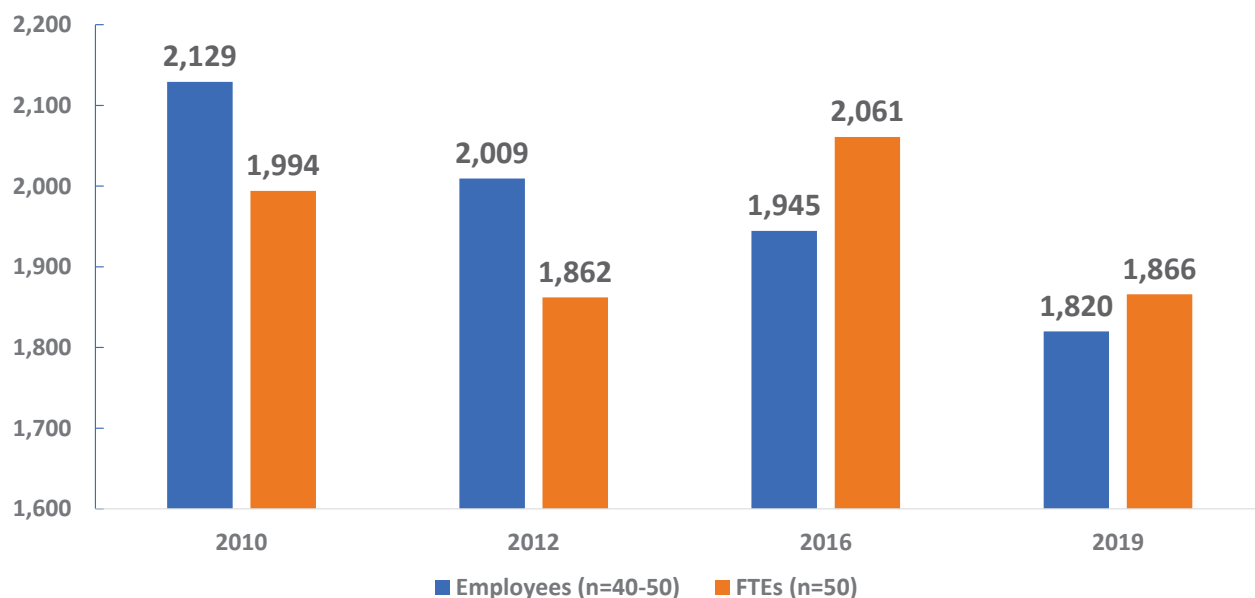


State/Territorial Health Official Data Collection

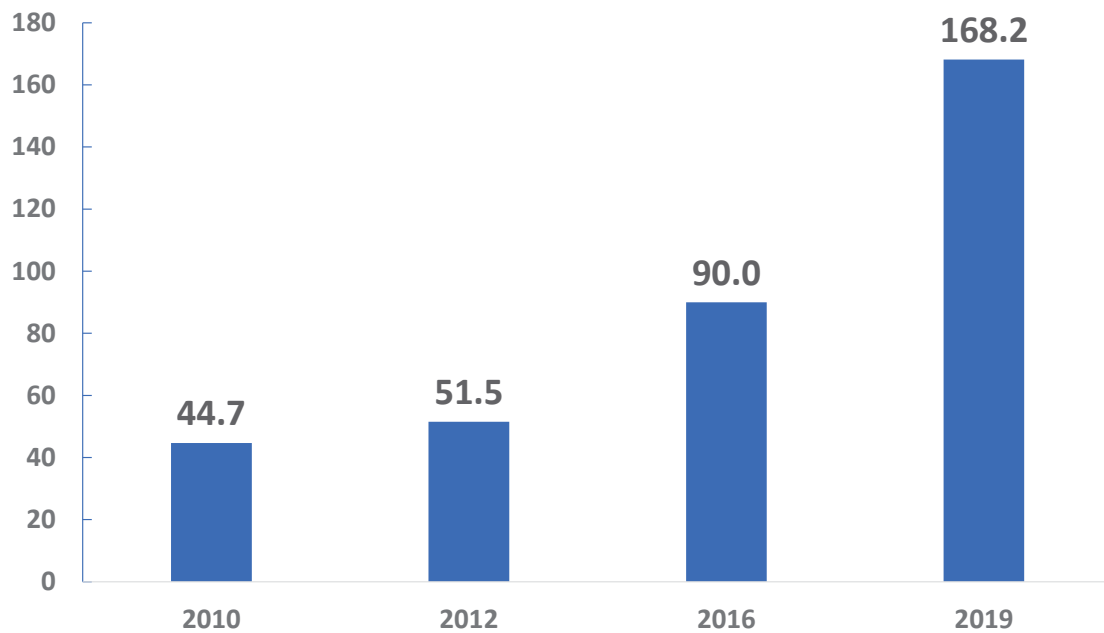
- Demographics
- Public health experience
- Public health areas of interest
- Engagement in ASTHO programs, services, initiatives



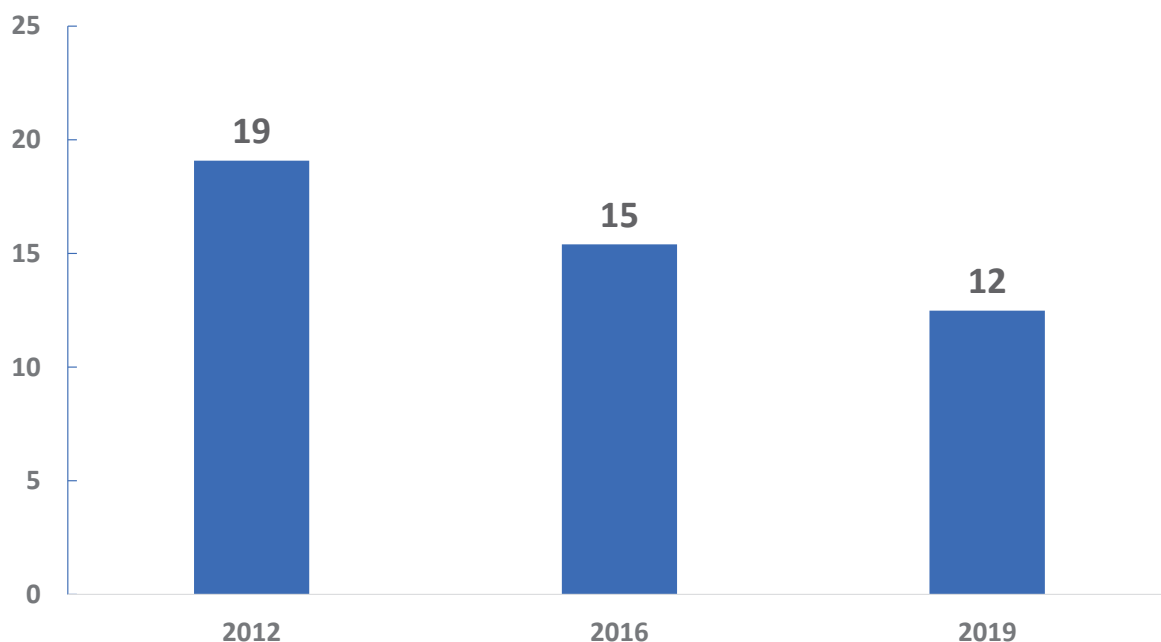
Mean Number of Employees and FTEs in State Health Agencies, 2010 – 2019



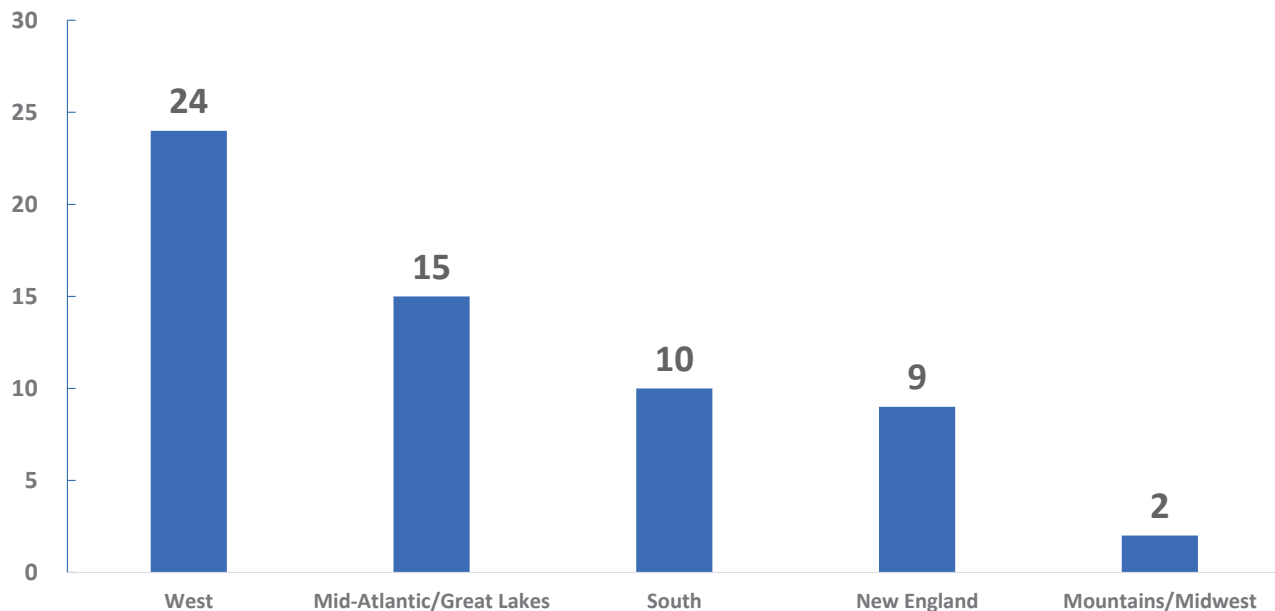
Mean Number of Positions being Actively Recruited in State Health Agencies, 2010 – 2019 (n=35-50)



Mean Number of Public Health Physicians in State Health Agencies, 2012 – 2019 (n=34-47)



Mean Number of Public Health Physicians in State Health Agencies by Region, 2019 (n=47)



State Health Official Physicians

- 25/51 (50%) of states require the state health official to possess a MD or DO
- 10/51 (20%) of states provide a salary differential for a MD or DO degree
- 27/51 (53%) of current State Health Officials are Physicians



Data Limitations



Changes to survey instrument and interpretation



Data are reported directly by agencies



Data are not available for physician specialty at the state level



State health agency governance classifications lead to some overlap with local health department workforce data



Profile@astho.org

APPENDIX G: DE BEAUMONT PRESENTATION

PH WINS

PUBLIC HEALTH WORKFORCE INTERESTS AND NEEDS SURVEY



PH WINS GOALS

- Help health agencies understand workforce strengths, gaps, and opportunities to improve skills, training, and employee engagement
- Inform and guide future workforce research and development, such as recruitment and retention efforts
- Support the workforce in modernizing their traditional public health roles to meet the evolving needs of the public
- Identify demographic trends and their implications for the workforce

PH WINS FACTS

- Fielded in 2014 & 2017
- Four Domains
 1. Workplace engagement
 2. Training needs
 3. Emerging concepts in public health
 4. Demographics
- Some changes were made to the instrument between 2014 and 2017. The most significant changes were made to the training needs section.

deBeaumont.org



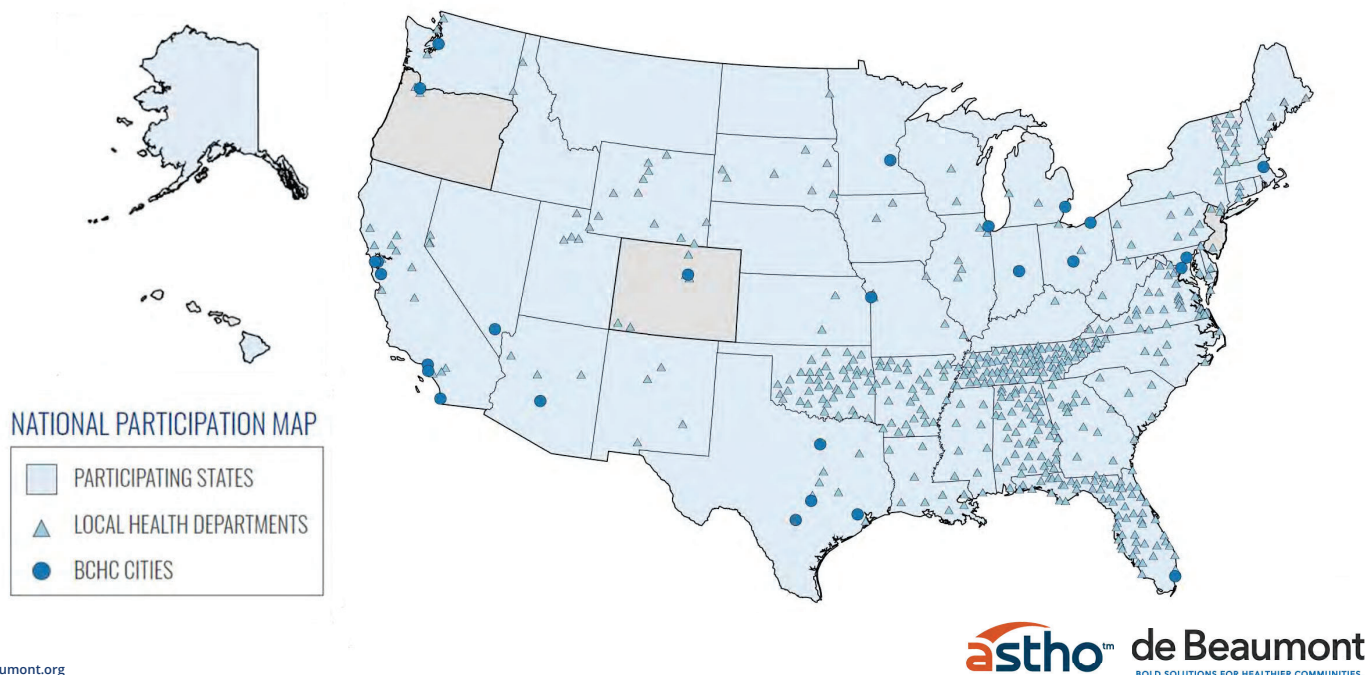
STRATEGIC SKILLS

- Effective Communication
- Data for Decision-Making
- Cultural Competency
- Budget and Financial Management
- Change Management
- Systems and Strategic Thinking
- Developing a Vision for a Healthy Community
- Cross-Sector Collaboration

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PARTICIPATION

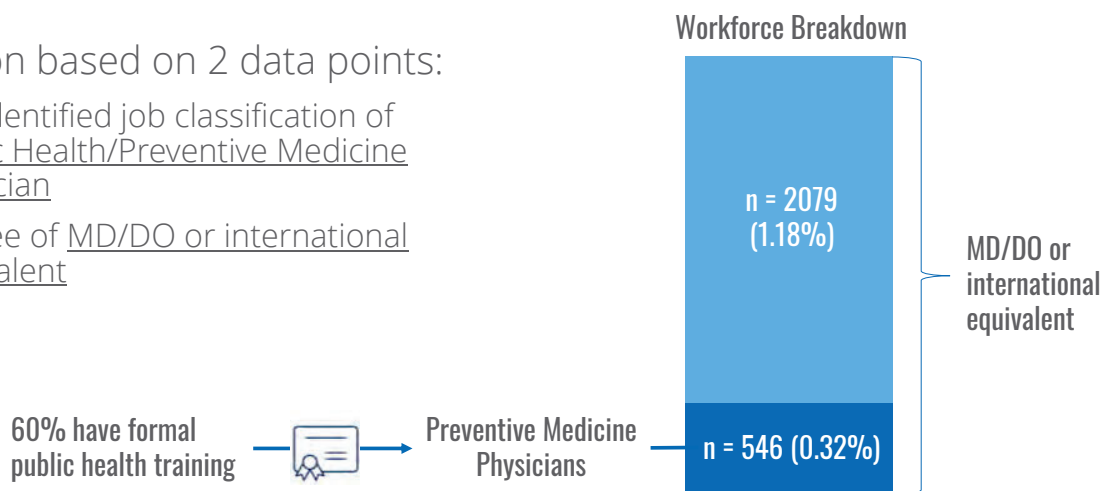


PREVENTIVE MEDICINE PHYSICIANS

THE WORKFORCE

Definition based on 2 data points:

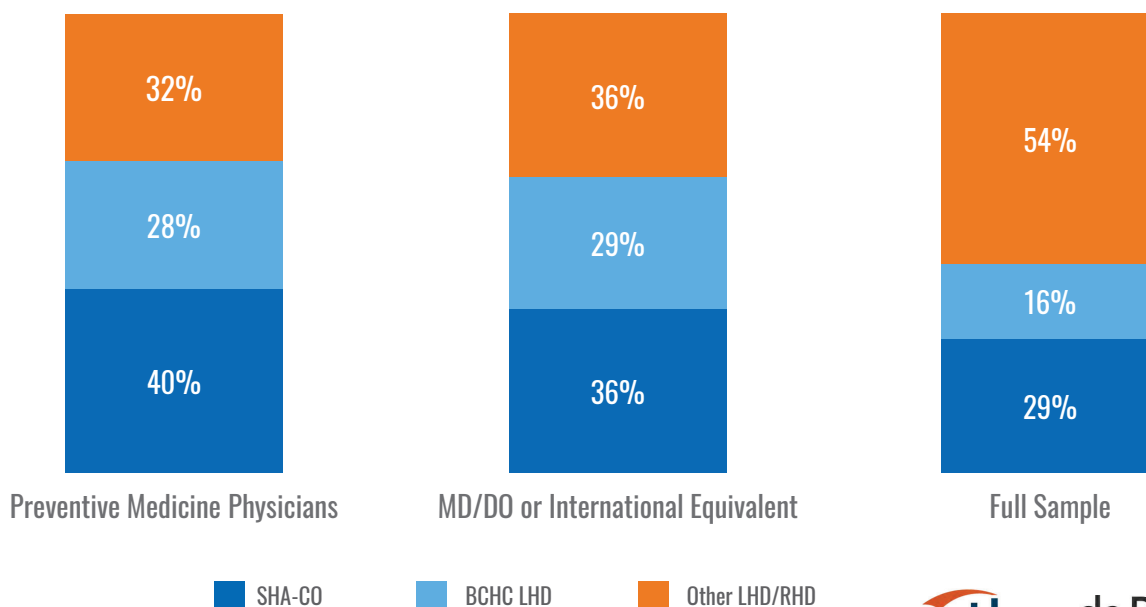
1. Self identified job classification of Public Health/Preventive Medicine Physician
2. Degree of MD/DO or international equivalent



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 BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES.

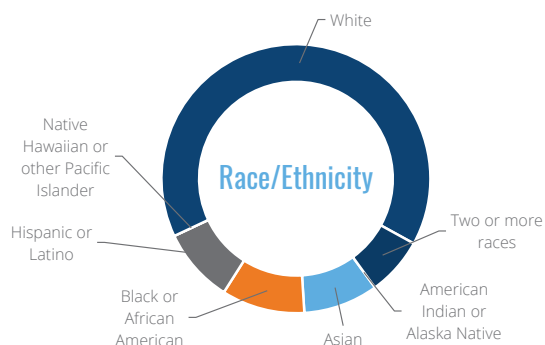
WORKFORCE BREAKDOWN BY SETTING



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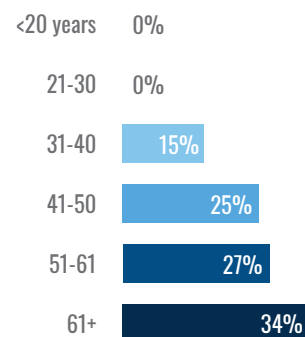
DEMOGRAPHICS (1/2)



Gender



Age

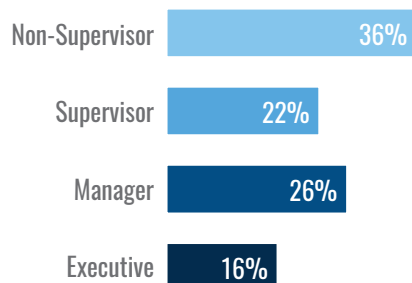


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DEMOGRAPHICS (2/2)

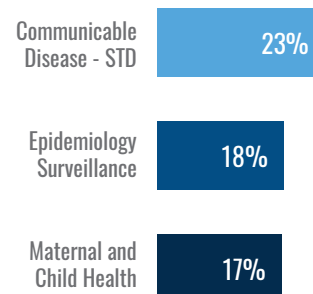
Supervisory Status



Tenure

- 68% in current position for <5 years
- 45% in current agency for <5 years
- 24% in public health practice for <5 years & 28% for 21+ years

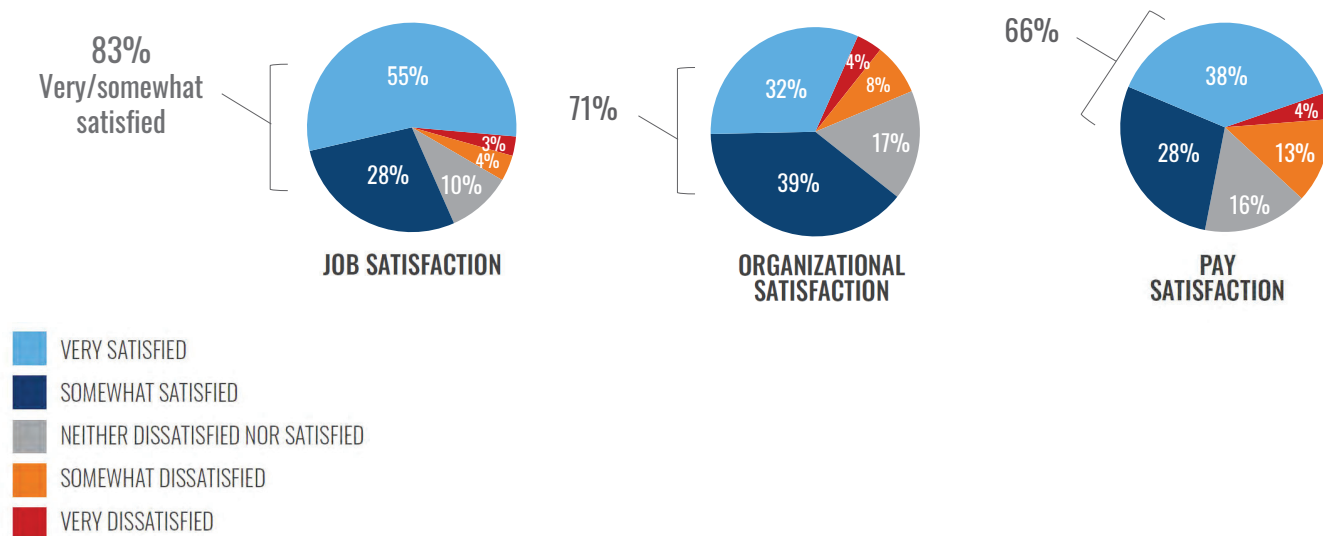
Top 3 Program Areas



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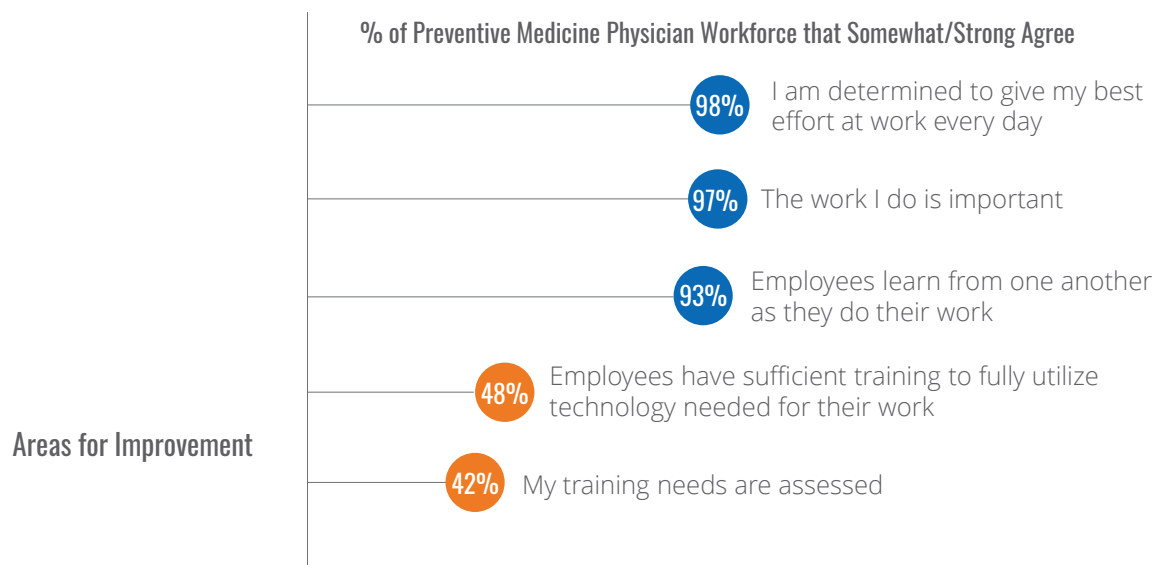
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SATISFACTION



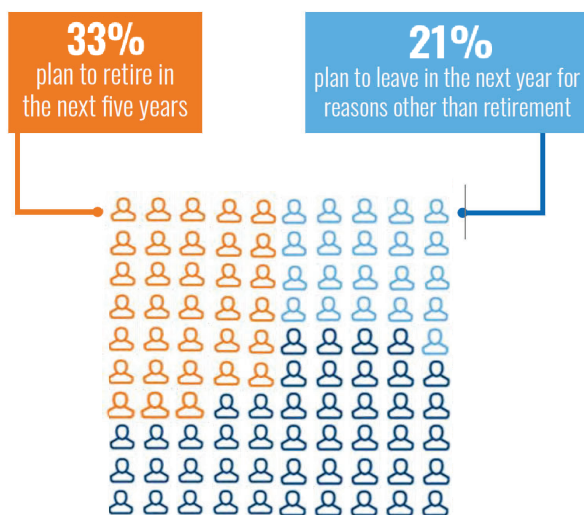
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EMPLOYEE ENGAGEMENT



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INTENT TO LEAVE



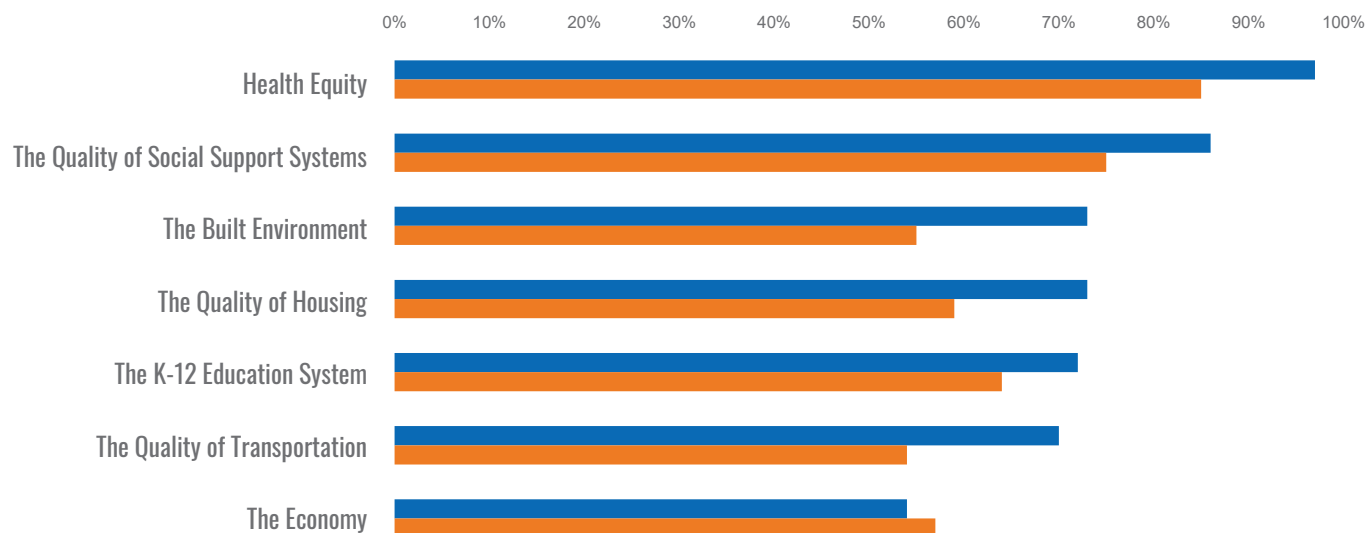
TOP 3 REASONS FOR LEAVING

WORK OVERLOAD/BURNOUT	33%
WORKPLACE ENVIRONMENT	33%
STRESS	24%

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 BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES.

SOCIAL DETERMINANTS OF HEALTH

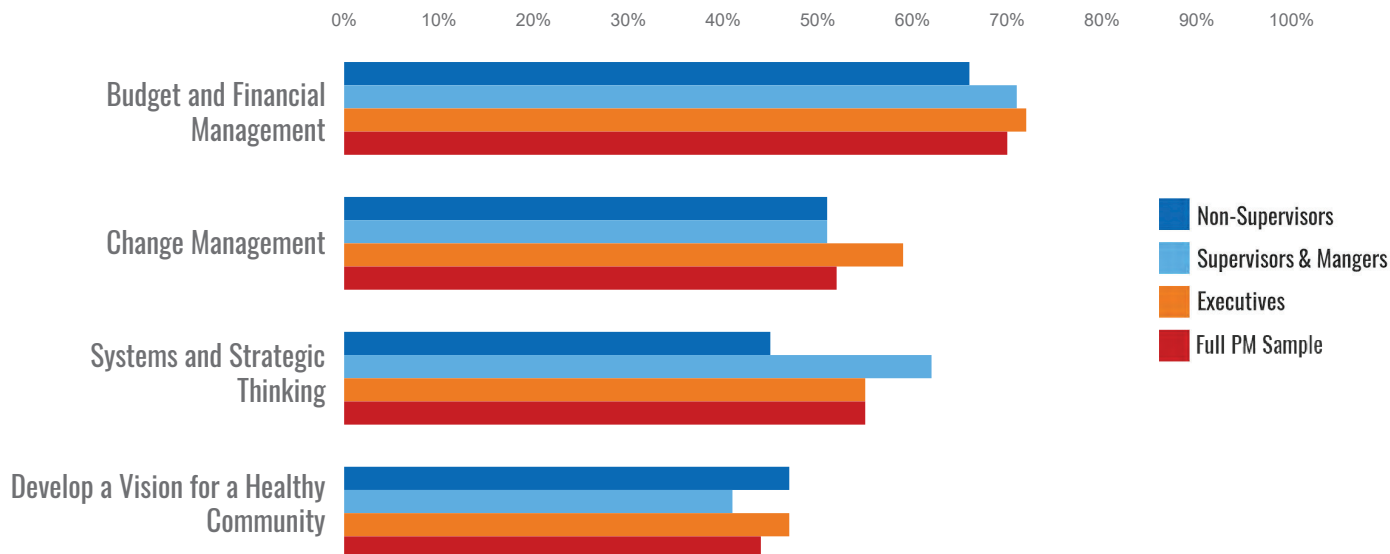


■ Preventive Medicine Physicians ■ Full Sample

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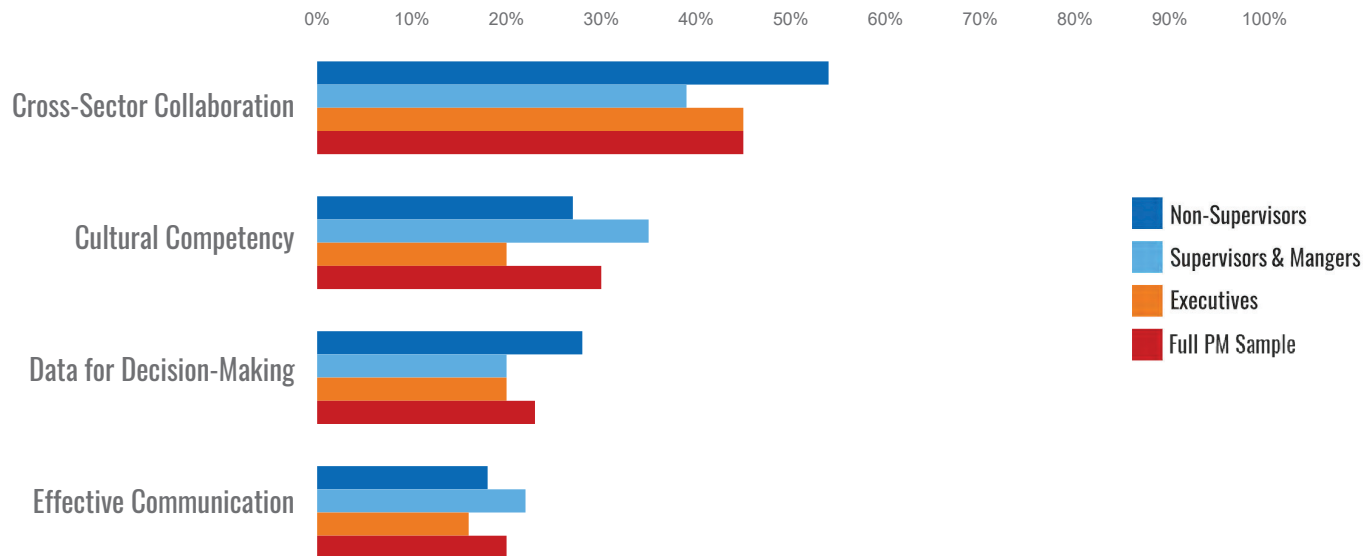
TRAINING NEEDS (1/2)



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TRAINING NEEDS (2/2)

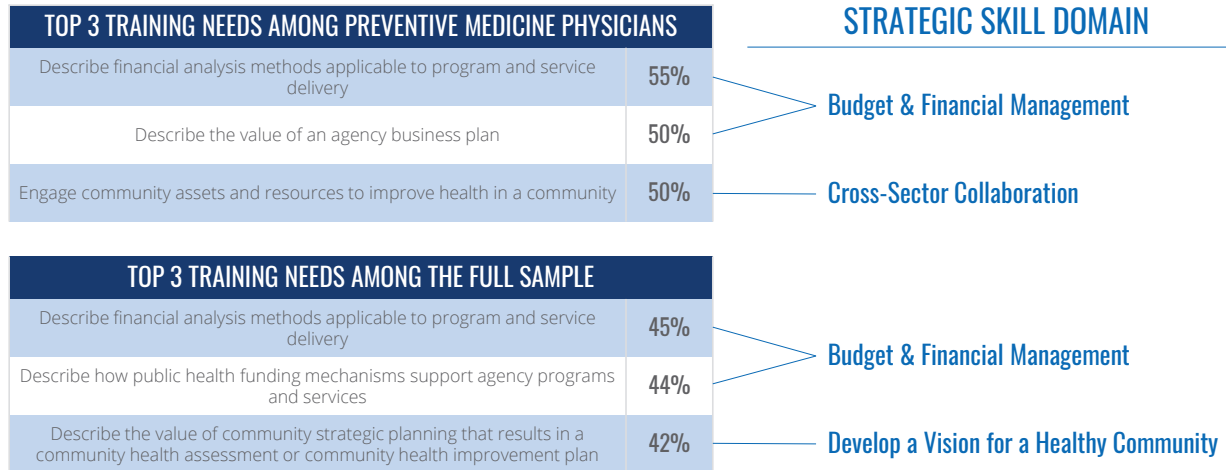


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TOP TRAINING NEEDS

NON-SUPERVISORS

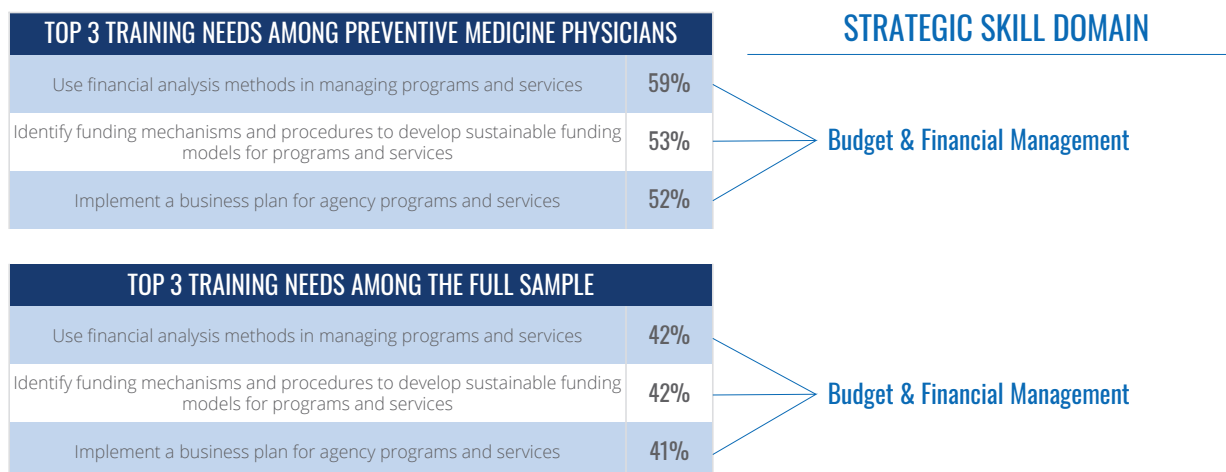


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TOP TRAINING NEEDS

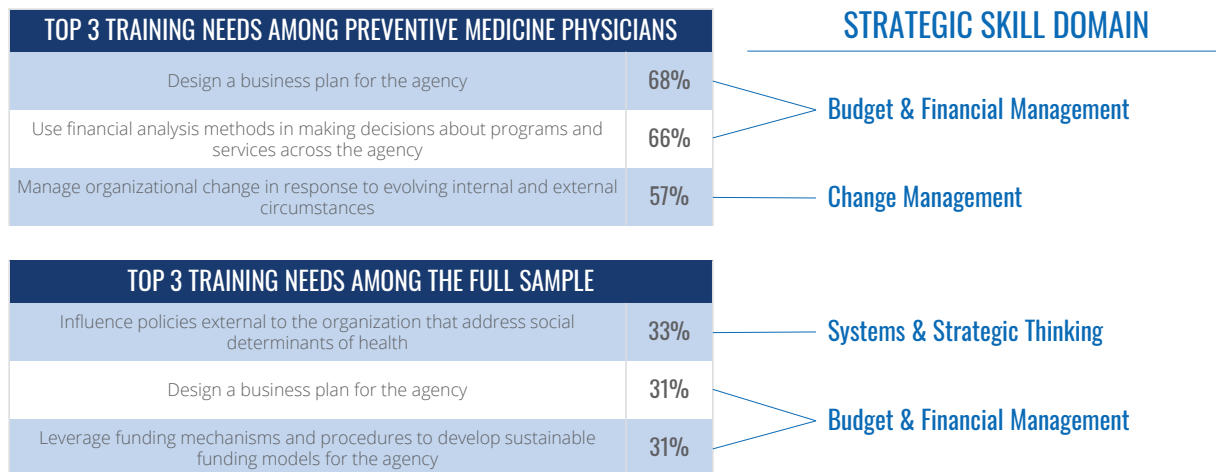
SUPERVISORS & MANAGERS



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TOP TRAINING NEEDS EXECUTIVES



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THANK YOU!

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APPENDIX H: ACPM PRESENTATION



American College of Preventive Medicine
physicians dedicated to prevention



American College of Preventive Medicine
physicians dedicated to prevention

Donna Grande, MGA

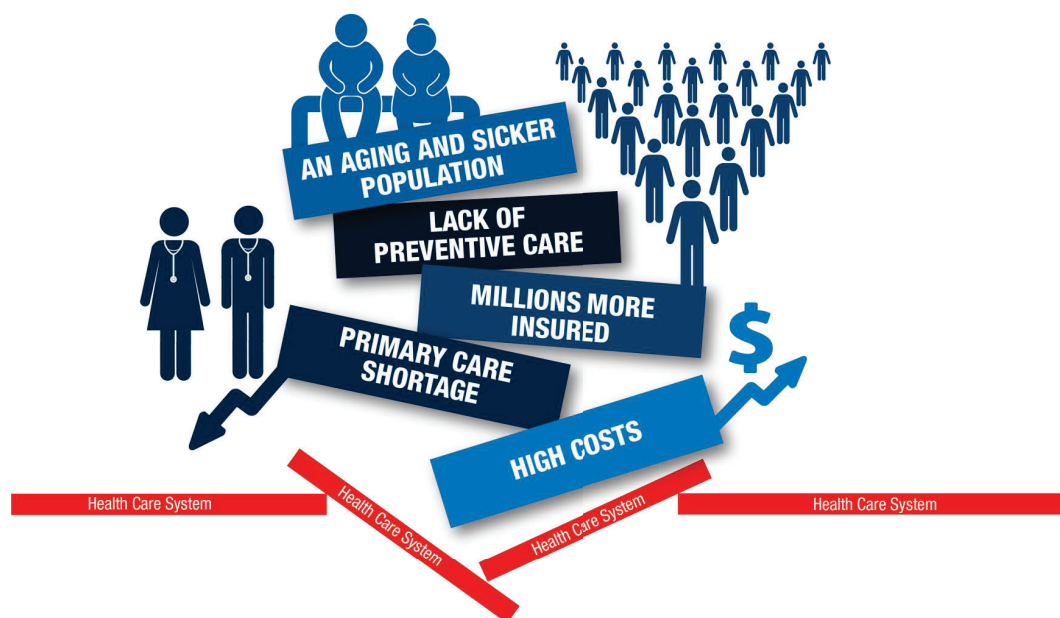
ACPM Chief Executive Officer

November 7, 2019



What is the PM imperative?

ACPM Presentation
HRSA Preventive Medicine
Stakeholder Meeting
November 7, 2019



ACPM

Value of Preventive Medicine (study)

Study Team Members

- **Deborah Porterfield**, MD, MPH, FACPM
 - **Eric Deussing**, MD, MPH, FACPM
 - **Paul Jung**, MD, MA, MBA, MPH, FACPM
 - **Shosana Levy**, MD, MPH, FACPM
 - **Paul Remington**, MD, MPH
 - **Mike Parkinson**, MD, MPH, FACPM
 - **Sanjeev Sripal**, MD, JD
 - **ACPM Staff-D. Grande, A. Balin, R. Stahlhut**
- **Health care leaders and managers'** "definition" of population health and skills/competencies required of persons employed to perform population health-based functions;
 - Employment/functions of **Preventive Medicine (PM) physicians** in the workforce (hiring process, career trajectories, training needs); and
 - Alignment between needs of employers, PM physicians and competencies.

ACPM

Overview

ACPM Presentation
HRSA Preventive Medicine
Stakeholder Meeting
November 7, 2019

- Methods

- Focus Group—Advanced and onsite recruitment of C-Suite representatives from ACHE for 90 min session
- Key Informant Interviews—Convenience Sample of HC Execs (PM/Non) for 60 min /semi-structured interviews



- Analyses

- Transcripts through Qualitative Analysis software

Project Funding

CDC CSTLST Cooperative
Agreement with Drs. Tony Neri
and Eric Kasowski

ACPM

Study Participants

- Focus Group—C-Suite leaders of hospitals/ healthcare settings and organizations (N=9)
- Key Informant Interviews—Healthcare Executives (N=14/15)
 - Roles—C-Suite
 - Functions—CMO, Quality, Directors (Disease Management, Population Health, Health Promotion, Patient Safety) Primary Care, University Researcher, Military and OccMed
 - Settings—Private, Nonprofit, Academia, Govt.

Findings

- Awareness of Preventive Medicine lacking
- Definition of Population Health varied
- Competencies needed or seeking aligned

Quote: *“Wow, you’ve got exactly what we’re looking for in this position. How come I didn’t know this existed?”*

ACPM

Findings (continued)

Competencies Needed

- Finance and Business Acumen
- Informatics
- Leadership
- Clinical Expertise
- Management/Teamwork



PM Competencies Aligned

Conclusions and Next Steps

- Opportunity to raise awareness about PM
- PM Residency Rotations in Hospitals/Health Systems
- Submit manuscript
- Write/publish complementary articles
- Hospital outreach (AEH)
- Medical student outreach
- Increased GME Funding



Questions?

Thank you!



American College of Preventive Medicine
physicians dedicated to prevention



APPENDIX I: EVALUATION

Future of Preventive Medicine Stakeholder Meeting

Evaluation

Date: November 7, 2019
Meeting Room: 5 N 76

Location: 5600 Fishers Lane
Rockville, MD 20857

Thank you very much in advance for your time and thoughtful assessment in completing this evaluation. We use your comments in planning for future meetings and webinars. Please also send us any additional recommendations or assessments to Ms. Cynthia Harne at charne@hrsa.gov.

The goal of this meeting is to discuss the future of the specialty of Preventive Medicine and consider recommendations on what HRSA can do to strengthen the role of preventive medicine physicians in public health. We envision this meeting to be an interactive conversation, using your expertise to share thoughts on the current and future challenges facing the specialty, find ways to improve our work, and maximize the reach, capacity, and success of our programs.

- Please insert a check mark indicating your assessment of each statement:

	Strongly Agree	Somewhat Agree	Neither Agree nor disagree	Somewhat disagree	Strongly Disagree	N/A
The content of the meeting (e.g., agenda, discussion, presentations, handouts) met the purpose of the organizational stakeholder meeting.						
The duration of the meeting was the right length for the topics covered.						
Enough time was allotted on the agenda for open discussion.						
The room was conducive to a productive meeting.						
Microphones and other audiovisual equipment worked as expected.						
Overall, this meeting met my expectations.						

- What do you think could have been improved about this meeting?
- What do you think were the strengths of this meeting?
- Please list aspects of the meeting that were most useful for your work.
- What do you wish to happen as a result of this meeting?
- Please let us know your recommendations for future HRSA actions to support preventive medicine.

APPENDIX J: EVALUATION RESULTS

Future of Preventive Medicine Stakeholder Meeting

Evaluation Results

	Strongly Agree	Somewhat Agree	Neither Agree nor disagree	Somewhat disagree	Strongly Disagree	N/A
The content of the meeting (e.g., agenda, discussion, presentations, handouts) met the purpose of the organizational stakeholder meeting.	9 (82%)	2 (18%)				
The duration of the meeting was the right length for the topics covered.	6 (55%)	4 (36%)		1 (9%)		
Enough time was allotted on the agenda for open discussion.	7 (64%)	3 (27%)		1 (9%)		
The room was conducive to a productive meeting.	8 (73%)	1 (9%)	2 (18%)			
Microphones and other audiovisual equipment worked as expected.	10 (91%)	1 (9%)				
Overall, this meeting met my expectations.	10 (91%)	1 (9%)				

Comments:

- **What do you think could have been improved about this meeting?**
 - Do we want to limit to public health and preventive medicine and not discuss occupational medicine and aerospace?
 - Need more private sector preventive medicine perspective.
 - Excellent session; perhaps expanding to decision maker who may have insights into improving.
 - Receive materials prior to meeting for review.
 - Advanced materials/data to be prepared.
 - More diverse participants-age, race/ethnicity, setting of practice.

- **What do you think were the strengths of this meeting?**
 - The expertise in the room.
 - Collegial engaging discussion, great exchange of views and ideas.
 - Open discussions and frankness welcomed.
 - Great thinkers, great data, fantastic discussions.
 - The variety of people's perspectives represented. Thanks for including me.
 - Solid presentation provided foundation for excellent discussion.
 - Attendees' knowledge and perspective.
 - Start of a dialogue.
 - Open dialogue.
 - Having all voices at table.
 - Start the discussion of grant criteria earlier.

- **Please list aspects of the meeting that were most useful for your work.**
 - The need for outcomes would be very helpful for ACGME.
 - All of this translates to resident reaching material.
 - Stimulated my thinking on the topic.
 - Networking-open discussion – demographic data.
 - Setting the larger perspective from multiple viewpoints.
 - Discussions on presentations.
 - ACGME data were very helpful in framing this issue.
 - Varied perspective and deep expertise.
 - Considering new partners for training opportunities.
 - Workforce stats/ presentations.
 - Wow! What a great group!

- **What do you wish to happen as a result of this meeting?**
 - Funding cycle follows accreditation cycle.
 - I think this meeting is pushing to a more socialist type of health system. Need buy-in from more free marked minds.
 - Discussion with colleagues.
 - Improved awareness from all levels, re: preventive medicine specialties.
 - Continued dialogue. A system for measuring success of residency programs.
 - Issue summary report with suggested deliverables or next steps.
 - Increased funding and clarity about Preventive Medicine Residency programs and impact.
 - Funding for Preventive Medicine Residency programs.
 - More input in funding options.
 - Allocating of resources, clear agenda forward. Synthesize ideas.
 - The people, the discussions!

- **Please let us know your recommendations for future HRSA actions to support preventive medicine.**
 - Stable funding for now.
 - Gather many players and look for partners and advocates in other USG organizations to help with this effort.
 - I like HRSA's support of the preventive medicine community, but I think preventive medicine would be best served if our residency programs were all funded (all residencies) by same source.
 - Fund currently accredited programs only.
 - Sharing of relevant data for further study.
 - More surveys/data to make informed decisions.
 - Engage private sector.
 - Support all types of preventive medicine workforce; help to expand definition of the preventive medicine doctor.
 - More recognition of preventive medicine.