Mission: To develop strategies to meet the primary care physician workforce needs for the citizens of Georgia by 2020.
2013 Primary Care Summit Executive Summary

Methodology: Using the recommendations developed during the 2012 Primary Care Summit, attendees were divided into three breakout groups. Each breakout group discussed recommendations related to the medical education pipeline (undergraduate medical education, graduate medical education and offshore medical students and schools). Attendees were asked to discuss and explore each recommendation and decide whether to keep, delete, or modify the recommendation. In the sections below, items that are in bold and italicized fonts are considered priority items.

The Medical Education Pipeline

<table>
<thead>
<tr>
<th>PHASE 1</th>
<th>PHASE 2</th>
<th>PHASE 3</th>
<th>PHASE 4</th>
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</thead>
<tbody>
<tr>
<td>Pre-matriculation (middle – high school)</td>
<td>Undergraduate Baccalaureate Years</td>
<td>Medical School</td>
<td>Residency / GME</td>
</tr>
</tbody>
</table>

PHASE 3 Medical School / Student Clerkships and Community Based Faculty Breakout Group:

(DELETE) Recommendation 1 – Provide start-up funds / technical assistance resources for any Georgia medical school willing to implement holistic admissions processes.

(KEEP/MODIFY) Recommendation 2 – Provide start-up funds incentives for any Georgia medical school implementing a primary care and/or rural admissions training track.

(DELETE/PARKING LOT) Recommendation 3 – Provide innovation funds to any Georgia medical school willing to implement an accelerated primary care track.

(KEEP/MODIFY) Recommendation 4 – Create incentives tied to state appropriations for high percentage of graduates selecting primary care (Family Medicine, General Internal Medicine, and General Pediatrics) specialties.

(KEEP) Recommendation 5 – Expand primary care loan forgiveness resources to allow more students to be offered these resources.

(KEEP/MODIFY) Recommendation 6 – Create capacity to award provisional loan forgiveness based on completion of primary care specialty selection for residency training.
Recommendation 7 – Increase funding to support needs of 3rd and 4th year medical students on rotations in community based training sites.

Recommendation 8 – Increased funding for travel stipends for 3rd and 4th year medical students completing rotations remote from their campus.

Recommendation 9 – Provide tax credits for primary care community based faculty precepting 3rd and 4th year Georgia medical students.

Discussion / Rationale:

Challenges/Barriers for Medical School / Student Clerkships and Community Based Faculty:

- Funding
- Transformational work to increase reimbursement, challenging to take on students.
- Increased volumes of students in all specialties/sites.
- Tie tax incentives to faculty development; who is teaching the student?
- Not enough hours in the day to supervise a first semester 3rd year medical student. Students can slow a private practice physician down.
- Competition for community based training sites in Georgia.
- Lack of incentives; provide payment of association fees, licensure and/or certifications.

Opportunities for Medical School / Student Clerkships and Community Based Faculty:

- Need to find a win/win for the schools and the preceptor sites/preceptors.
- Find a way to incentivize preceptors – supplement, EMR aid, someone available to the physician, feedback to preceptors, how to improve their teaching, tax incentives, etc.
- Create opportunities similar to Mercer’s community training where they place their students starting year 1.
- Connect with community members/resources.
- Faculty development, faculty appointment, connectivity to medical school and provide faculty status advancement quicker on campus (can be done in private schools).
- Create level playing field - incentives in packages need to be the same from medical school to medical school in order to limit competition for sites.
- Pay for association fees, licensure and certification incentives that really do work.
- Set up foundation to reward preceptors with incentive packages.

Other Strategies and Issues for Medical School / Student Clerkships and Community Based Faculty:

- Tax credits – should be main focus this year.
- Receiving feedback from medical schools, general recognition and public recognition. Provide communities and schools with information about committed community based faculty and the time and dedication the preceptors have given to training medical students in their community.
PHASE 4 Residency / Graduate Medical Education Breakout Group:

(KEEP/MODIFY) Recommendation 1 – Educate policy leaders about impact of failure to act.

(KEEP) Recommendation 2 – Request the Governor and General Assembly to appoint a Joint Legislative Committee on the GME crisis in Georgia.

(KEEP) Recommendation 3 – Adopt a Primary Care Physician Plan for Georgia with a timeline of implementation and clear outcome goals articulated.

(KEEP) Recommendation 4 – Provide funding for 400 new residency slots in Georgia.

Discussion / Rationale:

- Slots in Georgia are not being filled – how do we fix that?
- There are 2 MDs in the state legislature, other healthcare professionals involved in legislature, we need to utilize these people to the fullest but we need a coalition because they cannot do it all. Involve legislative people in the coalition for funding.
- Increasing the number of slots and the number of students staying in Georgia for GME, that is the central point that will help us in Georgia. How do we take the next step?
- Drill down deeper to say we need more primary care GME not just more GME.
- Explain what does this mean?
- Debt load when students graduate, ways state government could help? Many want to go into rural medicine but cannot because of debt load.
- Look at cancer coalition, tobacco coalition as examples.
- Need to look at how others have advocated for their causes and how we can mirror what they have done to be successful.
- Educate on GME, have to keep saying it again and again, how do you get the message across?
- What is the hook? What will it mean to Georgia if we have a lack of GME slots?
- Reality is legislature wants 1 page, more than 5 – 10 and they are on to something else.
- If legislators do not understand then the data is useless.
- Connect GME to the economic health of the state.
- Coalition for economic health – this is what will entice the Governor and budget office.
- It is a reality and $3.3 million are going to hospitals for primary care: internal medicine, family medicine, OBGYN, peds and general surgery. The Georgia Board is funding family medicine and pediatrics. Why can’t we go beyond 400 new slots? Currently there are five programs in SW Georgia, Lawrenceville, Athens, Gainesville and none in Atlanta. Douglasville and Rome are looking at it GME expansion.
- Expansion of existing and new programs is needed within the 400 slots available. There are approved numbers that are not funded. Funding is the issue. More money, more residency slots. Federal budget cuts are hampering this. No one really knows what is going to happen.
• Look at ways to expand current GME programs as well as what is going on with new GME slots.
• Funding should be predictable.
• Continued help for new program support would allow for growth in the future.
• Create a teaching hospital society within HCA.
• Fund existing program expansion. 40% of new graduates apply to Georgia GME programs. Georgia GME programs are being filled with out of state students or international medical graduates.
• Georgia retains ½ of GME graduates each year.

(KEEP/DELETE) Recommendation 5 – Explore legislation encouraging insurance companies to provide some level of support for GME start up and expansion.

(KEEP/MODIFY) Recommendation 6 – Create revolving fund to support new GME program start-ups and to support pairing of hospitals/programs to expand or establish primary care residency slots.

(KEEP) Recommendation 7 – Create tax incentives for hospitals to partner and collaborate to provide local funds to support GME expansion or creation of new programs.

(KEEP) Recommendation 8 – Address the existing and worsening deficit of GME faculty to support expanded residency slots by providing funding for accelerated learning and for recruitment.

(KEEP) Recommendation 9 – Increase primary care loan forgiveness programs to a minimum of $30,000 per year with a service commitment to be competitive with the National Health Service Corps and with contiguous states.

(KEEP/MODIFY) Recommendation 10 – Implement $25,000 per year salary supplements for Georgia medical school graduates selecting primary care residency programs in Georgia.

(KEEP) Recommendation 11 – Launch a high tech marketing campaign promoting Georgia primary care residency training opportunities, targeting Georgia medical school graduates and Georgia graduates from out of state / off shore medical schools.

(KEEP) Recommendation 12 – Provide cash stipends for residents completing rural residency tracks.
**Other Comments / Residency / Graduate Medical Education Breakout Group:**

- Can we find an opportunity to give new legislators a “state of the state” report on healthcare?
- Doctors retiring, how do we keep them in practice over the next 10 years?

**OFFSHORE MEDICAL STUDENTS AND SCHOOLS BREAKOUT GROUP:**

1. **Identify issues related to offshore medical schools and students:**
   - Competition with sites.
   - Potential for preceptor site education needed.
   - Accreditation standards are unclear / questionable.
   - Future accreditation will be unified. By 2023 all IMGs wishing to do a residency in the US must have graduated from a school accredited by a body whose standards have been deemed by the World Federation of Medical Education as equivalent to the US LCME standards. That body in the Caribbean is the Caribbean Accreditation Authority for Medicine and the Health Professions (CAAM-HP).
   - Georgia is international medical graduate unfriendly. 4th year IMGs are excluded from GME sites.
   - Some hospitals want offshore medical schools to have an affiliation agreement with a Georgia medical school.
   - Cost
   - Residencies with higher percentage of offshore graduates seem inferior.
   - Loan availability
   - Lack of rotation availability
   - List of school comparisons would be beneficial.
   - Procedural, technical experience is lacking.
   - Lack of understanding of the US healthcare system.
   - Relationship issues; for profit entities.
   - Hospitals / institutions struggle with balancing educational initiative and business deal.
   - Potentially create a bidding war for clinical education.

2. **Discuss how international medical graduates (IMGs) currently meet Georgia’s primary care needs and fill residency slots:**
   - They will fill need based on the numbers; need numbers from the GBPW; GA is about 25%, New Jersey 45%, Illinois high.
   - Get teaching hospitals to open up 4th years slots to see what offshore medical students can do.
   - As medical schools expand, they take up the spaces that offshore students want; we have to honor the students we have and who are paying for their education in Georgia. Teach teams getting too large.
   - Keep behaviors in line with what is needed (reasons to fail 3rd and 4th year students).
   - “Some of my best residents were offshore students, finest physicians”.
   - Post MD training program in residency to catch IMGs up if needed.
• GME exit survey – 1/3 of 2012 graduates came from other countries such as India and the Dominican Republic.
• Offshore medical schools are providing the largest number of primary care providers. Residency programs look for Georgia residents, even if from off shore schools. Faculty are from all over the world. Great faculty. Majority of the students come from United States and Canada.

3. **Identify strategies to partner as appropriate with offshore medical schools to meet Georgia’s primary care workforce needs:**
   - Not all offshore students are equal. Need to look for quality of teaching, studying habits and scores; clerkships vary greatly; some with great book learning but not equal clerkships experiences.
   - Primary care physicians
   - If you have seen one Caribbean medical school you have seen one Caribbean medical school; they are not the same.
   - Use personal connections to begin partnerships with offshore medical schools.

All Summits benefited from strong participation from stakeholder groups from across Georgia. Thus the work products of these Summits so not belong solely to the Statewide AHEC but rather to a much larger group of constituents. The profiles of our Stakeholders / partners provides evidence of the broad involvement of diverse groups and individuals coming together to create solutions to Georgia’s Primary Care Medical Workforce Challenges. (All Georgia medical schools were represented at each Summit.)

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<thead>
<tr>
<th>STAKEHOLDER PARTICIPANT PROFILE</th>
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<tbody>
<tr>
<td>SUMMIT</td>
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<td>Medical Schools</td>
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<td>GME Programs</td>
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<td>State Legislative Branch</td>
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<td>Non Profits</td>
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<tr>
<td>Other</td>
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<tr>
<td>AHEC Center Staff</td>
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<td>AHEC Program Office</td>
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2011-2013 Summit Evaluation Summaries

At the completion of the 2011, 2012 and 2013 Summits evaluations were emailed to all attendees. A summary of the evaluation responses are below.

<table>
<thead>
<tr>
<th>Percentage of Completed Summit Evaluations</th>
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<tbody>
<tr>
<td>2011</td>
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<tr>
<td>2012</td>
</tr>
<tr>
<td>2013</td>
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<table>
<thead>
<tr>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Abbreviated Evaluation Questions</th>
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<tbody>
<tr>
<td>82%</td>
<td>98%</td>
<td>92%</td>
<td>Attendees were either extremely or moderately satisfied with the Summit.</td>
</tr>
<tr>
<td>62%</td>
<td>74%</td>
<td>66%</td>
<td>The Summit was much better or somewhat better than attendee expectations.</td>
</tr>
<tr>
<td>79%</td>
<td>96%</td>
<td>98%</td>
<td>The Summit was extremely or very organized compared to attendee expectations.</td>
</tr>
<tr>
<td>71%</td>
<td>80%</td>
<td>89%</td>
<td>Attendees that felt the facilitators provided about the right amount of time for group discussion.</td>
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<tr>
<td>68%</td>
<td>85%</td>
<td>81%</td>
<td>Attendees that felt the Summit either met all or most of its goals.</td>
</tr>
<tr>
<td>74%</td>
<td>83%</td>
<td>75%</td>
<td>Attendees that felt the Summit covered about the right amount of information.</td>
</tr>
<tr>
<td>97%</td>
<td>96%</td>
<td>80%</td>
<td>The Summit spent either a great deal, or “a lot” of time on information important to the attendees.</td>
</tr>
<tr>
<td>68%</td>
<td>100%</td>
<td>93%</td>
<td>Attendees rated the Summit as above average or excellent.</td>
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