EDITORIAL

Obstacles and Opportunities on the Path to Improving Health Professions Education and Practice: Lessons From HRSA's Academic Units for Primary Care Training and Enhancement

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INTRODUCTION

Primary care faces major headwinds; time pressures, administrative demands, burnout, low reimbursement, and poor alignment of payment systems with patient needs are just some of the contributors.[1,2] Yet a high-functioning primary care system is often recognized as essential to healthy communities.[3] In the quest for equitable, high-quality accessible and available health care, primary care must often rapidly evolve to meet societal needs and take on additional roles. The ability to do so is especially crucial to the health of patients facing financial, logistic, or other obstacles to obtaining needed health services. These transformations take place both within mature practices and along the educational pathways preparing the next generation of clinicians.

In 2016, the Health Resources and Services Administration (HRSA) funded 6 themed Academic Units for Primary Care Training Enhancement (AU-PCTEs). The funding program sought to promote the conduct of research, the dissemination of best practices and resources, and the development of communities of practice in order to foster a well-trained, diverse primary care workforce equipped to improve the quality of care and increase health care access to underserved and marginalized communities. Inherent in this call was an acknowledgment that the US health care system at the time had multiple areas of deficit leading to failures to deliver the health outcomes that might otherwise be possible, and that improvements in these areas—particularly related to primary care—would advance health equity and the health of the entire US population.

The themes of these 6 Academic Units are integrated behavioral health and primary care; integrated oral health and primary care; health workforce diversity; training for rural practice; addressing the social determinants of health; and training for the needs of vulnerable populations.[4] Since their funding in 2016, the Academic Units have worked together to elucidate obstacles and to chart paths forward in support of their shared goal to advance health equity,[5-7] and individually have made important contributions related to facilitating positive change in each of their target areas.

Although much of the Academic Units' work has previously been published, in this supplement, we highlight a group of original research articles and commentaries related to common themes shared across the units—achieving health equity and improving primary care training to better serve the needs of patients, families, and communities—as well as new work in the individual focus areas.

PERSISTENT CHALLENGES TO BETTER HEALTH CARE

Several articles in this supplement provide new perspectives as well as data relevant to some of the societal, pedagogical, and practical obstacles to the US health care system achieving its full potential. At the same time, they also provide insights into potential opportunities for moving forward.

Enduring racism and structural racism, and the stigmatization and neglect of vulnerable and marginalized groups continue to drive worse health outcomes and also threaten members of the health care workforce.[8] The mixed methods study by Fatahi and others[9] provides insight into the current state of antiracism pedagogy in undergraduate and graduate medical education at a group of US academic medical

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centers, elucidates current barriers, and helps inform the path ahead by making practical recommendations on what is needed for progress. Additionally, other articles remind us that primary care training in its current form is not equipped to overcome barriers to health experienced by stigmatized groups. Klusaritz et al[10] conducted a qualitative study that enriches our understanding of how stigma in primary care training settings limits the number of clinicians who complete their training prepared to provide medical therapy for opioid use disorder. Juarez et al[11] describe the currently underdeveloped state of medical student and resident training in the care of transgender and gender-diverse patients. All of these articles point to specific work that can be done within the context of professional schools and residency programs to reduce stigmatization of diverse patient populations.

Primary care may fail to deliver in areas perceived to be outside its scope. Oral health is often partly or fully ignored in primary care despite the fact that in any given year, many more people see a primary care clinician than a dentist.[12] Primary care clinicians, when properly trained, are well situated to both screen and refer for some oral health problems.[13,14] They also could provide preventive oral care, such as fluoride varnish to children, which is particularly important in cases where barriers to accessing dental care exist.[15] Similar to programs preparing primary care clinicians to address oral health and the challenges they face, oral health training programs frequently omit teaching on topics seen as outside their scope. In a mixed methods study of primary care dental postgraduate program directors, Ticku et al[16] examined teaching about mental health conditions that are directly relevant to general dental practice. They showed that although curricula had high coverage of opioid use disorder—a topic included in accreditation requirements—they much less often covered the topics of depression, anxiety, eating disorders, and intimate partner violence. Integration of behavioral health into primary care has become better accepted, but a study by Phelan et al[17] of patients and clinicians in a primary care practice having integrated behavioral health found that there are still barriers related to stigma in seeking, receiving, and providing care. In addition to examining barriers to care, their qualitative study describes facilitators and recommendations for addressing this situation, including normalizing discussions of mental health and its care, and using patient-tailored communication strategies.

COMMUNITIES OF PRACTICE AS CHANGE MAKERS

Where are the foci for changing the complex systems that deliver health care and train practitioners? Communities of practice, united by shared interests and a commitment to learning and change,[18] feature heavily in the work of the Academic Units. Several articles in this supplement provide examples of communities of practice, or learning communities, applied to diverse primary care–related areas including promoting cross-disciplinary partnering between dentistry and primary care,[13] increasing research and scholarship in rural primary care programs,[19] accelerating the integration of oral health into primary care training program curricula,[14] increasing the number of primary care professionals providing oral health services,[20] addressing social determinants of health in health professions education,[21] and increasing community engagement in undergraduate medical education.[22] Collectively, these researchers explore varied facets of how these communities are formed and function, and the goals they can achieve in changing educational and clinical practices.

OPPORTUNITIES TO ADVANCE HEALTH EQUITY

Several articles in this supplement describe opportunities within the training milieu and through existing or newly curated data and resources to advance health equity in primary care. These data, resources, and strategies provide the opportunity to improve health outcomes among underserved and marginalized groups. For example, Roche and colleagues[23] describe the integration and implementation of a psychotherapy tracking database for pediatric and adult primary care patients to examine outcomes at the patient, clinician, and practice levels. The integrated tracking database, drawn from electronic health records, can be a model for examining patient outcomes, improving communication between patients and their clinicians, and conducting practice-based research, among other endeavors.

The article by Ngongo and others[24] explores the use of existing data in clinical practice to overcome the barriers of social risk factors. They conducted a scoping literature review to describe best practices in the use of Geographic Information Systems data in clinical settings to recognize and/or intervene on social risk factors. Ultimately, they did not find many studies addressing the effectiveness of using these systems in clinical care, which points to a need for future work to explore how to use these technologies to improve outcomes in practice.

In the area of education, the article by Petrie and colleagues[25] also focuses on the need to prepare health professionals to address social determinants of health in their clinical practice. They describe a dissemination platform offering a large collection of curated curricular resources that health professions educators seeking to teach about this topic might use with their students and trainees. Beyond curricular content, the article by Nguyen and colleagues[26] emphasizes the need to admit students most likely to fulfill mission-driven needs. Their special report of the 2022 Beyond Flexner Alliance preconference, The Admissions Revolution: Bold Strategies for Diversifying the Healthcare Workforce, focuses on revising the admissions process to increase the diversity of future generations of clinicians. Several proposed thematic strategies for change include using alternative metrics in the admissions process, aligning admission practices with the institutional mission, improving the support provided to

students (both in recruitment and retention), and developing relationships with community partners.

CONCLUSIONS

This supplement highlights the activities of the 6 HRSA-funded Academic Units. The previous and current work of these units offers a host of observations, insights, and ideas for advancing health care equity, promoting interprofessional collaboration, transforming education, and improving practice. Some of the findings presented here are preliminary, and some of the ideals and principles remain to be widely executed. We are hopeful that the Academic Units's work will add momentum to other efforts to reimagine primary care and create health care that is whole-person oriented, interprofessional, community focused, and equitable.[27]

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Key words: population health; health equity; primary care; workforce; curricula; medical education; dental education; organizational change; interdisciplinary health team; innovation; social determinants of health; mental health; opioid use disorder; transgender persons; racism; social stigma; social marginalization; rural health services; health care disparities; socioeconomic disparities in health; vulnerable populations

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References

1. Bodenheimer T. Revitalizing primary care, part 1: root causes of primary care's problems. *Ann Fam Med*. 2022;20(5):464-468. 10.1370/afm.2858
2. Bodenheimer T. Revitalizing primary care, part 2: hopes for the future. *Ann Fam Med*. 2022;20(5):469-478. 10.1370/afm.2859
3. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502. 10.1111/j.1468-0009.2005.00409.x
4. Sandvold I, Holtzman J, Douglas-Kersellius N, et al. Academic Units for Primary Care Training and Enhancement: improving evidence and training to strengthen primary care. *J Health Care Poor Underserved*. 2020;31(4S):139-143. 10.1353/hpu.2020.0145
5. Ackerman-Barger K, Sandvold I, Patterson DG, Brown KY, Douglas-Kersellius NV. Leveraging collective impact to promote health equity. *J Health Care Poor Underserved*. 2020;31(4S):91-98. 10.1353/hpu.2020.0139
6. Ravenna PA, Bream KD, Fancher T, et al. Who, what, and where: transforming primary care education to advance health equity. *J Health Care Poor Underserved*. 2020;31(4S):128-138. 10.1353/hpu.2020.0144
7. Doubeni CA, Fancher TL, Juarez P, et al. A framework for transforming primary care health care professions education and training to promote health equity. *J Health Care Poor Underserved*. 2020;31(4S):193-207. 10.1353/hpu.2020.0150
8. Gonzalez-Flores A, Clay W, Madzia J, Harry-Hernandez S, Henderson D. Our souls look back and wonder: reflections on belonging and being invisible in medicine. *Ann Fam Med*. 2023;21(Suppl 2):S106-S108. 10.1370/afm.2916
9. Fatahi G, Racic M, Roche-Miranda MI, et al. The current state of antiracism curricula in undergraduate and graduate medical education: a qualitative study of US academic health centers. *Ann Fam Med*. 2023;21(Suppl 2):S14-S21. 10.1370/afm.2919
10. Klusaritz H, Bilger A, Paterson E, et al. Impact of stigma on clinician training for opioid use disorder care: a qualitative study in a primary care learning collaborative. *Ann Fam Med*. 2023;21(Suppl 2):S31-S38. 10.1370/afm.2920
11. Juarez PD, Ramesh A, Reuben JS, et al. Transforming medical education to provide gender-affirming care for transgender and gender-diverse patients: a policy brief. *Ann Fam Med*. 2023;21(Suppl 2):S92-S94. 10.1370/afm.2926
12. Vujicic M, Israelson H, Antoon J, Kiesling R, Paumier T, Zust M. A profession in transition. *J Am Dent Assoc*. 2014;145(2):118-121. 10.14219/jada.2013.40
13. Cardenas K, Weilnau T, Aguilar C, et al. Partnering for integrated care: a learning collaborative for primary care and oral health teams. *Ann Fam Med*. 2023;21(Suppl 2):S22-S30. 10.1370/afm.2918
14. Ticku S, Savageau JA, Riedy CA, Harvan R, Silk H. 100 Million Mouths Campaign: creating a pilot program to advance oral health equity. *Ann Fam Med*. 2023;21(Suppl 2):S86-S91. 10.1370/afm.2930
15. Romano J, Silk H. Why are family doctors still not addressing oral health? *Ann Fam Med*. 2023;21(Suppl 2):S103-S105. 10.1370/afm.2929
16. Ticku S, Jiang T, Alhazmi H, et al. Behavioral health within primary care postgraduate dental curricula: a mixed methods study. *Ann Fam Med*. 2023;21(Suppl 2):S4-S13. 10.1370/afm.2931
17. Phelan SM, Salinas M, Pankey T, et al. Patient and health care professional perspectives on stigma in integrated behavioral health: barriers and recommendations. *Ann Fam Med*. 2023;21(Suppl 2):S56-S60. 10.1370/afm.2924
18. Wenger E. *Communities of Practice: Learning, Meaning, and Identity*. Cambridge University Press; 1998.
19. Schmitz DF, Casapulla S, Patterson DG, Longenecker R. Building rural primary care research by connecting rural programs. *Ann Fam Med*. 2023;21(Suppl 2):S82-S83. 10.1370/afm.2928
20. Jiang T, Savageau JA, Russinof H, Riedy CA, Silk H. Evaluation of the Oral Health Knowledge Network's impact on pediatric clinicians and patient care. *Ann Fam Med*. 2023;21(Suppl 2):S39-S48. 10.1370/afm.2921
21. Hasnain M, Darcy-Mahoney A. Let's not reinvent the wheel: using communities of learning and practice to address SDOH and advance health equity. *Ann Fam Med*. 2023;21(Suppl 2):S95-S99. 10.1370/afm.2917
22. Ramesh A, Brown KY, Juarez PD, Tabatabai M, Matthews-Juarez P. Curricular interventions in medical schools: maximizing community engagement through communities of practice. *Ann Fam Med*. 2023;21(Suppl 2):S61-S67. 10.1370/afm.2925
23. Roche AI, Savitz ST, Kelpin SS, et al. Study what you do: developing a psychotherapy tracking database in a large-scale integrated behavioral health service. *Ann Fam Med*. 2023;21(Suppl 2):S49-S55. 10.1370/afm.2927
24. Ngongo WM, Peterson J, Lipiszko D, et al. Examining how social risks factors are integrated into clinical settings using existing data: a scoping review. *Ann Fam Med*. 2023;21(Suppl 2):S68-S74. 10.1370/afm.2932
25. Petrie C, Persell SD, Scharle EA. A curated curriculum collection to support social determinants of health education for the health professions. *Ann Fam Med*. 2023;21(Suppl 2):S84-S85. 10.1370/afm.2923
26. Nguyen M, Dent R, Fancher TL, et al. Revolutionizing health professions admissions to achieve an inclusive workforce. *Ann Fam Med*. 2023;21(Suppl 2):S75-S81. 10.1370/afm.2922
27. National Academies of Sciences, Engineering, and Medicine. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. The National Academies Press; 2021.