Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) Meeting Minutes
June 11, 2019

Advisory Committee Members Present

Via Webinar
Thomas E. McWilliams, DO, FACOFP, Chair
Russell S. Phillips, MD, Former Chair
Bruce Blumberg, MD
Tara A. Cortes, PhD, RN, FAAN
A. Conan Davis, DMD, MPH
John Wesley Sealey, DO, FACOS

Health Resources and Services Administration (HRSA) Staff Present: From the Bureau of Health Workforce (BHW), Division of Medicine and Dentistry (DMD)

Kennita R. Carter, MD, Designated Federal Official (DFO), ACTPCMD
Janet A. Robinson, Management Analyst, Advisory Council Operations,
Robin L. Alexander**,** Management Analyst, Advisory Council Operations, BHW

Introduction

Kennita Carter, DFO, ACTPCMD
Thomas McWilliams, ACTPCMD Chair

Dr. Kennita Carter convened the virtual meeting of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD, or the Committee) on July 19, 2019. She then proceeded to conduct roll call. Six of the ten Committee members were present, establishing a quorum.

The purpose of the meeting was to review and provide feedback for three reports (14th, 16th, and 17th ACTPCMD reports). The Committee also reviewed a letter to the Secretary of Health and Human Services (HHS) with recommendations to address the opioid crisis. A brief business meeting was also held.

Committee 14th Report Discussion

Tara Cortes, PhD, ACTPCMD Member

Dr. Tara Cortes moved to the first item of the agenda, a discussion of the initial draft of the recommendations for the Committee's 14th Report, *Integrated Care: Meeting America's 21st Century Healthcare Training Needs.* After a lengthy discussion the recommendations were revised to read as follows:

1. **Experiential Learning:** Integrate primary care, oral health, and behavioral health training through experiential learning to prepare students, trainees, faculty, and practitioners as teams in the interprofessional delivery of health care.

2. **Accelerated Integration:** Increase support to accelerate creation of an environment where education and training of the future primary, oral, and behavioral healthcare workforce is integrated.

3. **Community-Based Learning:** Implement integrated education and training of the future healthcare workforce to occur particularly in community-based settings.

4. **Federal Repository of Best Practices:** Develop a repository of best practices for educating and training an integrated primary, oral, and behavioral healthcare workforce (i.e. students, trainees, and faculty) in collaboration with Health Resources and Services Administration (HRSA), the Department of Veterans Affairs (VA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other federal agencies. Include recommended methods and standards of measuring short-term and longitudinal outcomes, and an evaluation of payment models.

Committee Discussion

The Committee proceeded to discuss the report as a whole. The Committee was asked to focus on providing high-level feedback on the report. Comments under each section are presented below.

1. **Experiential Learning:** Integrate primary care, oral health, and behavioral health training through experiential learning to prepare students, trainees, faculty, and practitioners as teams in the interprofessional delivery of health care.

   Comments: Dr. Carter suggested adding a graphical representation with a patient at the center and various professions surrounding it (physicians, nursing, social work, dentists, pharmacists, etc.). This would make it clearer to the reader that various professions are involved. Committee members agreed with the suggestion.

2. **Accelerated Integration:** Increase support to accelerate creation of an environment where education and training of the future primary, oral, and behavioral healthcare workforce is integrated.

   Comments: ***Structural Barriers*** – The committee discussed the following barriers to advancing interprofessional education and training.

   - **Reimbursement** – Dr. Davis discussed the section on structural barriers and said that one of the barriers is that Medicare does not have a mandate to cover oral healthcare. Also, Medicaid coverage for oral healthcare is limited for adults. Dr. Cortes said there are models, such as Accountable Care Organizations (ACOs) and Medicare Advantage,that have integrated care across the system.

   - **Student supervision** – Dr. McWilliams said that another barrier is that

osteopathic medical students cannot be primarily supervised and trained by physician assistants or advanced practice nurses. Dr. Davis added that dental students can also only be supervised by dental faculty.

- **Availability of preceptor training sites and associated costs** – Dr. Sealy said another barrier is the lack of clinical resources – that is, not having enough learning sites available for trainees.

  Interprofessional training sites and curricular training – Dr. McWilliams said that not all training environments have programs that include primary, behavioral, and oral care. For programs that do have them, curricular scheduling challenges can sometimes be a barrier. Some institutions use technology to connect various health professions students.

3. **Community-Based Learning:** Implement integrated education and training of the future healthcare workforce to occur particularly in community-based settings.

   Comments: **Structural Barriers** – The committee discussed the following structural barriers and solutions to community-based learning.

   - **Identified barriers** – Barriers discussed included identifying sites, coordinating schedules, accreditation, reimbursement for preceptors, faculty development, competition for community-based preceptors, the monthly cost of rotations, variation among school curricula, geographic limitations among sites (i.e., distance), and the impact of earlier-level learners on productivity.

   - **Telepresence to overcome geographic barriers** – Dr. Blumberg suggested using telepresence to overcome some of the existing geographic limitations. Dr. Cortes suggested adding a graphic to better explain telepresence.

   - Dr. Carter suggested including a reference to the CMS documentation rule for medical students and adding physician assistants and nurse practitioners to the list. The latter may be an incentive for community-based providers. Committee members agreed with the suggestion.

   Comments: **Rationale Section –** Committee members identified various topics that could be addressed under the rationale section of this recommendation.

   Rationale topics – Dr. Cortes said the rationale for this recommendation could address addressing social determinants of health; a move from a hospital-centric to a patient-centric paradigm; the fact that individuals live in a community and not a hospital; and the goal of bringing education into a community to influence population health.

4. **Federal Repository of Best Practices:** Develop a repository of best practices for educating and training an integrated primary, oral, and behavioral healthcare workforce (i.e. students, trainees, and faculty) in collaboration with Health Resources and Services Administration (HRSA), the Department of Veterans Affairs (VA), the Substance Abuse and Mental Health

Services Administration (SAMHSA), and other federal agencies. Include recommended methods and standards of measuring short-term and longitudinal outcomes, and an evaluation of payment models.

Comments: **Rationale Section –** The committee made recommendations for the rationale section under this recommendation.

- Dr. Carter said it would be helpful to include in the rationale that – while SAMHSA and HRSA have a Center for Integrated Healthcare website – there are not many resources available with respect to oral health and teaching clinician faculty. Committee members agreed with the suggestion.

- Dr. Carter suggested adding resources from the Veteran's Association with respect to what to consider when treating and caring for veterans. Committee members agreed with the suggestion.

In addition, to the above high-level feedback, a Word document with edits (e.g. spelling, punctuation, grammar, etc.) resulting from the meeting was completed and will be provided to the Writing Committee for their revision.

The Committee voted unanimously to accept the recommendations and report as amended during the discussion.

Committee 16th Report Discussion

Thomas McWilliams, ACTPCMD Chair

Dr. Thomas McWilliams led the discussion on the review of the 16th Report, *Strengthening Primary Care and Oral Health Education and Training of Future and Current Health Professionals for Rural and Underserved Populations*. The Committee primarily reviewed the "A" recommendations and rationales, as the "B" recommendations were universally accepted as written at previous Writing Committee meetings. Committee members agreed with the suggestion.

Dr. Carter said that Dr. Cortes's past comments had been added to the draft being reviewed today. The Committee was once again asked to focus on providing high-level feedback for each of the report's sections. Comments under each section are presented below.

Committee Discussion

Introduction: Title VII Program Overview

Recommendation A1: Congress should increase funding of Title VII, primary care and oral health training programs from $89 million to $120 million for the next fiscal year and ensure that this funding be used to continue and expand current programs and enable longitudinal tracking of program graduates.

Comments:

- Dr. Carter suggested adding data that may speak about the role of physician assistants in primary care. Committee members agreed with the suggestion.
- Under *Addressing the Challenge*, Dr. McWilliams, Dr. Carter, and Dr. Cortes thought it would be helpful to use the terms "geographically isolated" and "medically underserved communities" when describing the populations served.

Recommendation A2: New funds should be made available to support the development and implementation of longitudinal rural primary care education and training residency programs, or rural tracks within primary care residency programs, such as those for physicians in family medicine, internal medicine, and pediatrics; for physician assistants; and for dentists in pediatric dentistry, dental public health, and advanced general dentistry.

Comments:

- For *The Challenge* section Dr. McWilliams suggested adding the following 2019 reference from the Association of American Medical Colleges: *The Complexities of Physician Supply and Demand.*

- Dr. Cortes recommended that funding not only cover initiatives for rural populations but also for urban populations. Challenges exists in both populations and both need to be addressed.

- Dr. Cortes said there are various zip code areas in New York City that are considered medically underserved areas. In these geographic areas there are not enough practitioners to serve the density of individuals living in such areas.

Recommendation A3: Funds should be targeted at developing and implementing primary care residency programs as above that focus on meeting the needs of underserved areas and vulnerable populations.

Comments:

- **Physician shortfall** – Dr. McWilliams suggested adding the following statement to the rationale "The AAMC update on physician supply and demand predicts a shortfall range that is higher than the previous (2018) study. This reflects their recalculations of the number of generalists who remain in primary care versus becoming hospitalists or later specializing in nonprimary care."

- Dr. Carter shared with Committee members a recently published article on *Health Affairs* about nurse practitioners and physician assistants. She suggested including a sentence about providers other than physicians in addressing workforce needs. Committee members agreed with the suggestion.

In addition, to the above high-level feedback, a Word document with edits (e.g. spelling, punctuation, grammar, etc.) resulting from the meeting was completed and will be provided to the Writing Committee for their revision.

The Committee voted unanimously to accept the report as amended during the discussion.

Committee 17th Report Discussion

Thomas McWilliams, ACTPCMD Chair

The Committee reviewed the 17th Report, *Innovations in Primary Care Education and Training: Developing Community Partnerships to Improve Population Health* (working title). After a lengthy discussion the recommendations were revised to read as follows:

1. Consider strategies for integration of primary care services with community-based resources and the effective use of those resources to address social determinants of health and other health-related issues.

2. Funding should support innovative primary care programs that educate faculty and trainees to use evidence-based approaches to support and track behavior change that improves chronic disease management or that improves a patient's health.

3. Educate faculty to utilize innovative methods to educate and train primary care providers in addressing population health and managing chronic disease in vulnerable populations, and then train students, trainees, and primary care providers using these approaches.

4. Funding should support programs that provide innovative education and training in incorporating telehealth for vulnerable primary care populations.

Committee Discussion

The Committee was once again asked to focus on providing high-level feedback for recommendations 1, 2, 3, and 4. Comments for each recommendation are presented below.

1. Consider strategies for integration of primary care services with community-based resources and the effective use of those resources to address social determinants of health and other health-related issues.

   Comments:

   - Dr. Sealey said that smaller programs often have less resources than larger ones, such as those held in academic hospitals, as the latter can put in more resources into programs. In other words, community-based centers cannot be an equal partner with respect to resources.

   - Dr. Sealey suggested having a reimbursement system that trains primary care physicians in the community, much like a teaching center does. This would encourage physicians to practice where they train, including underserved areas.

   - Dr. Cortes suggested the following wording for the recommendation: Provide longitudinal primary care education and training to the workforce (primary care trainees) to extend primary care into the community and incorporate community-

based resources into patient care. Dr. Carter suggested making this a "B" recommendation. Committee members agreed with the suggestion.

- Dr. Cortes suggested incorporating resources into a NOFO to fund a demonstration program that would show the effectiveness of this kind of practice.

2. Funding should support innovative primary care programs that educate faculty and trainees to use evidence-based approaches to support and track behavior change that improves chronic disease management or that improves a patient's health.

   Comments:

   - Dr. Carter said that GME training today lacks training on techniques on how to support change in patient behavior, such as motivational interviewing. Dr. Blumberg agreed and added that while there is an evidence-base for practice, there is not a significant body of evidence for training providers in the area of behavioral change.

3. Educate faculty to utilize innovative methods to educate and train primary care providers in addressing population health and managing chronic disease in vulnerable populations, and then train students, trainees, and primary care providers using these approaches.

   Comments:

   - Dr. Carter suggested amending the recommendation to include urban settings. There may also be a need to retain faculty and preceptors in rural remote areas. Committee members agreed with the suggestions.

   - Dr. Phillips suggested amending the recommendation so that it also incorporates the competency to identify population health needs. This could include engaging stakeholders to develop a community needs assessment.

4. Funding should support programs that provide innovative education and training in incorporating telehealth for vulnerable primary care populations.

   Comments:

   - Dr. Carter shared with the Committee an article in telehealth education in nursing curricula. She explained that some challenges exists in incorporating telehealth into existing curricula.

   - Dr. Cortes said that instead of adding more to an existing curricula, a better strategy would be to replace some existing items with the state of the art, such as telehealth.

The Committee voted unanimously to accept the draft recommendations above, which were developed during the discussion.

Committee Opioid/Pain Management Letter Discussion

The Committee reviewed a draft letter to be sent to the Secretary of HHS regarding the opioid epidemic. Through the letter, the ACTPCMD states that it supports the following:

- Funding that educates primary care clinicians, faculty, and learners to identify opioid use disorder and include effective treatment of misuse within their practices.
- Education and training of primary care clinicians and learners on how to effectively manage pain with strategies that limit opioid use, including the use of multi-modal strategies to treat acute and chronic pain.
- Research that identifies best practices in identification and treatment of opioid use disorder within the primary care setting and for training primary care clinicians and learners to effectively manage pain, limiting opioid use.

The Committee agreed to add to the letter that there are various approaches to address pain that are both traditional (e.g., physical therapy) and non-traditional (e.g., acupuncture). It was suggested that the following references be used to support this statement: the *National Pain Strategy* and the report from the National Academies, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*.

The ACTPCMD voted unanimously to approve the letter to the Secretary as amended.

Public Comment

Kennita Carter, DFO, ACTPCMD

Dr. Carter opened the floor to comments from the public. There were no public comments.

Business Meeting

Kennita Carter, DFO, ACTPCMD

Dr. Carter informed members that a nomination package with a slate of nominees for the Committee had been forwarded to the Secretary for review.

She also informed members that extensions for their terms had been submitted. If approved, an 180-day extension would carry them through March 2020.

Next Steps

Kennita Carter, DFO, ACTPCMD

Dr. Carter described the following next steps:

1. Provide the Committee with potential dates for the next in-person meeting in September or October, 2019.

2. Submit a list of new ACTPCMD appointees to current Committee members once the list is officially approved.

Dr. Carter said that now that recommendations for the 14th Report have been approved in their current state, the report will go back to the Writing Committee which will finalize the report. The Writing Committee will be comprised of Dr. Blumberg, Dr. Cortes, Dr. Davis, and Dr. Phillips. Dr. McWilliams, the Chair, will review the final report keeping in mind that there will be no major edits, revisions, or additions.

Adjournment

Kennita Carter, DFO, ACTPCMD

Dr. Carter thanked all Committee members for their efforts. Dr. McWilliams thanked Dr. Carter for her guidance and for assembling the materials prior to the meeting.

Dr. Carter adjourned the meeting.

Abbreviations List

AAMC	Association of American Medical Colleges
ACOs	Accountable Care Organizations
ACTPCMD	Advisory Committee on Training in Primary Care Medicine and Dentistry
BHW	Bureau of Health Workforce
CMS	Centers for Medicare & Medicaid Services
DFO	Designated Federal Official
DMD	Division of Medicine and Dentistry
GME	Graduate Medical Education
HHS	United States Department of Health and Human Services
HRSA	Health Resources and Services Administration
NOFO	Notice of Funding Opportunity
SAMHSA	Substance Abuse and Mental Health Services Administration
VA	Veterans Affairs