ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY (ACTPCMD)

Meeting Minutes: June 28-29, 2016

Advisory Committee Members Present:
Allen Perkins, MD, MPH, Chair
Vicki Chan-Padgett, MPAS, PA, Vice-Chair
Bruce Blumberg, MD
Donald L. Chi, DDS, PhD
Tara A. Cortes, PhD, RN, FAAN
A. Conan Davis, DMD, MPH
Patricia M. Dieter, MPA, PA-C
Elizabeth (Lia) Kalliath, DMD
Thomas E. McWilliams, DO, FACOFP
Linda C Niessen, DMD, MPH
Rita A. Phillips, BSDH, RDH, PhD, CTCP
John Wesley Sealey, DO
Eve Switzer, MD
Elizabeth Wiley, MD, JD, MPH
Stephen A. Wilson, MD, MPH, FAAFP

Others Present:
Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official (DFO), ACTPCMD, Division of Medicine and Dentistry (DMD), Bureau of Health Workforce (BHW), Health Resources and Services Administration (HRSA)
Kennita R. Carter, MD, Senior Advisor/Medical Officer, DMD, BHW, HRSA
Candice Chen, MD, MPH, Director, Division of Medicine and Dentistry, BHW, HRSA
Crystal Straughn, Technical Writer, ACTPCMD, DMD, BHW, HRSA
Kimberly Huffman, Director, Advisory Council Operations (ACO), BHW, HRSA
Kandi Barnes, Management Analyst, ACO, BHW, HRSA
Mark Diamond, Public Affairs Specialist, Division of External Affairs, BHW, HRSA

Presenters:
Day 1
Alex Huttinger, Acting Deputy Associate Administrator, BHW, HRSA
Sara Gallagher Williams, Acting Director of the Division of Policy and Shortage Designation BHW, HRSA
Katherine Morasch, PhD, Social Scientist, Performance Metrics and Evaluation Branch, National Center for Health Workforce Analysis (NCHWA), BHW, HRSA
Laura Ridder, Ethics Advisor, Office of Operations, HRSA
Diana Espinosa, Deputy Administrator, HRSA
Maria Portela-Martinez, MD, MPH Chief, Medical Training and Geriatrics Branch, DMD, BHW, HRSA
Shane Rogers, Chief, Oral Health Training Branch, DMD, BHW, HRSA

Day 2
Alexander Ross, ScD, Senior Behavioral Health Advisor, Office of Planning, Evaluation, and Analysis, HRSA
Dennis Freeman, PhD, Chief Executive Officer, Cherokee Health Systems
Laura Galbreath, MPP, Director, Center for Integrated Health Solutions, National Council for Behavioral Health
Helene Silverblatt, MD, Executive Director for Behavioral Health, Office of the Vice President for Community Health, University of New Mexico, School of Medicine
Gail S. Marion, PA, PhD, Professor, Family and Community Medicine, Maya Angelou Center for Health Equity, Wake Forest School of Medicine
Man Wai Ng, DDS, Dentist-in-Chief, Oral and Developmental Biology, Boston Children's Hospital
Hayden O. Kepley, PhD, Special Assistant to the Director, NCHWA, BHW, HRSA

Day 1- June 28, 2016

Introduction

The Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) convened its meeting at 8:30 AM at the Health Resources and Services Administration's (HRSA) headquarters in Room 18-67, 5600 Fishers Lane, Rockville, MD 20857. Dr. Joan Weiss opened the meeting and introduced Ms. Alex Huttinger, Acting Deputy Associate Administrator, Bureau of Health Workforce (BHW), HRSA. Ms. Huttinger provided an overview of BHW.

Bureau of Health Workforce Update
Alex Huttinger

Ms. Alex Huttinger informed the Committee that BHW's vision is from education and training to service. The mission is to improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. BHWs' strategic plan is comprised of four goals set to move forward through 2018. The four goals are guide and inform national policy around health workforce development and distribution; develop a strategic approach to health workforce investments that achieve the Bureau's mission and build lasting improvements; strengthen academic, clinical, and community partnerships to foster information exchange and public health leadership; and inspire and align the Bureau in support of the BHW 2018 Vision.

BHW Priorities
BHW priorities include preparing a diverse workforce, increasing access to quality healthcare by training culturally competent providers, improving workforce distribution by providing qualified professionals to high need areas, and transforming healthcare delivery with innovative models of care that integrate healthcare services and disciplines. Ms. Huttinger emphasized the significance of the three priorities. A diverse workforce is associated with improved quality of care for underserved populations, including racial and ethnic minorities and those from disadvantaged backgrounds. Forty-seven percent of trainees in BHW programs are minorities and/or come from disadvantaged backgrounds. Clinicians who receive training in community-

based and underserved settings are more likely to practice in similar settings. Approximately 87 percent of National Health Service Corp (NHSC) clinicians continue to practice in underserved areas up to two years after they complete their service commitment and 46 percent of BHW funded trainees are employed in underserved areas.

BHW is committed to advancing interprofessional training and practice because collaborative healthcare can promote active participation of each discipline, enhance patient and family centered goals and values, provide mechanisms for continuous communication among health care providers, and optimize staff participation and clinical decision making within and across disciplines. In academic years (AY) 2014 and 2015, 23 of BHW programs had an interprofessional focus, and within these programs more than 2,500 clinical training sites were engaged in team-based care.

BHW's priorities are operationalized through three program designs that focus on 1) building academic and community partnerships to prepare health professionals to address existing and emerging public health issues facing underserved communities, 2) interprofessional training and practice to support the planning, development, and operation of joint degree programs that integrate public health into primary care training, and 3) rapid cycle evaluation to better understand the impact of programs. The goal is to create a robust workforce of diverse, culturally competent health professionals that provide quality care to communities in need.

Academic and Community Partnerships

Ms. Huttinger highlighted three BHW programs that have been successful at building academic and community partnerships. The Teaching Health Center Graduate Medical Education Program (THCGME) supports primary care residency programs in community-based settings. Under THCGME, Access Health, a community health center, partnered with the West Virginia School of Osteopathic Medicine to establish and support a new residency program. The Primary Care Training Enhancement Program (PCTE) supports medical education programs for physicians and physician assistants to improve the quality, quantity, distribution, and diversity of the primary care workforce. Under PCTE, the Virginia Garcia Memorial Health Center is collaborating with Pacific University to provide a wide range of interprofessional training programs, including training physician assistant, pharmacy, psychology, and other healthcare administration students. In addition to having a PCTE award, Virginia Garcia is also a teaching health center, and an approved site for the National Health Service Corps (NHSC).

In the Geriatrics Workforce Enhancement Program (GWEP), which supports interprofessional geriatric education and training, Yale University School of Medicine's GWEP is working with two federally qualified community health centers, Cornell Scott-Hill Health Center and Fair Haven Community Health Center, to co-manage a novel geriatrics-primary care clinic and integrate geriatric specialists into the clinic.

BHW Fiscal Year (FY) 2016 Budget Highlights

In FY 2015, BHW awarded over $1 billion to more than 8,300 organizations and individuals through more than 45 workforce programs. Collectively, BHW programs increase the nation's access to quality healthcare by developing, distributing, and retaining a competent health workforce. The Medicare Access and CHIP Reauthorization Act of 2015 provided $60 million

for the Teaching Health Center Program and $310 million for the NHSC. The funding supports residency training in primary care medicine and dentistry in community-based, ambulatory settings, scholarships, and loan repayment.

FY 2017 President's Budget Highlights

The FY 2017 President's budget requested $527 million for FY 2018 through FY 2020 to support the Teaching Health Center (THC) program. The budget request for the Children's Hospital Graduate Medical Education (CHGME) Program was $295 million in new mandatory funding for a total investment of nearly $1.5 billion over the next five years to provide graduate training for physicians to provide quality care to children. The NHSC budget request was $380 million, which was a $70 million increase from 2016, in order to support new loan repayment for behavior health clinicians, address the prescription drug abuse and heroin use epidemic, and expand mental health services. This funding will allow for significant growth in field strength from 9,600 to 15,000 providers. The FY 2017 President's budget is projected to support 159 new scholarships, approximately 5677 new and continuation loan repayment awards, about 160 new Students to Service loan repayment awards, and 500 loan repayment awards through the State Loan Repayment Program.

Questions and Comments

A Committee member commented that it is challenging completing reports when awardees are unsure of what HRSA wants and suggested providing a user's manual. Ms. Huttinger assured the member that BHW knows the amount of work grantees perform to report data. However, she noted it is important to tell the story of the programs, and the value that the federal government and public receives from investing in the programs. BHW added the national provider identifier (NPI) as part of the THC data collection in an effort to track resident trainees more easily. The goal is to remove some of that burden from the awardees and to do longitudinal, long term tracking as well.

From Recommendations to Policy
Sara Gallagher Williams

Ms. Sara Williams discussed the processes for developing strong Committee recommendations and translating these recommendations into policy. She reminded the members that the Committee is authorized under Title VII, Part C, Section 749 and its purposes are to:

1) provide advice and recommendations to the Secretary concerning policy and program development and other matters of significance concerning the activities under Title VII, Part C, Section 747;
2) prepare and submit an annual report describing the activities of the Committee, including findings and recommendations made by the Committee concerning the activities under section 747;
3) develop, publish, and implement performance measures for programs under this part;
4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and
5) recommend appropriation levels for programs under this part.

Ms. Williams reminded the members that the Committee recommendations are strongest when the Secretary of the U.S. Department of Health and Human Services (HHS) has the authority to make a change in either program or allocated resources. She asked them to consider: Is this a legislative or policy recommendation?; Does HHS have authority to make the change?; Who is the appropriate audience (i.e., Secretary, Congress, public)?; What is the appropriate vehicle to share recommendations?

Strong recommendations have a precise action that can be directly tied to a specific change that the Secretary can make. It is important to be precise in the recommendation and identify the part of a regulation or program guidance that needs to be changed and the reasons for the change. Issues that are of general consideration (e.g. focus on interprofessional training, ensure access to healthcare services) can be included in the report language but it may not rise to the level of a recommendation.

Ms. Williams also discussed the different ways to disseminate recommendations to Congress. Letters can be sent to the Senate Committee on Health, Education, Labor, and Pensions and the House of Representatives Committee on Energy and Commerce. Recommendations and statutory requests can be made through the A-19 process which sends legislative proposals to the Office of Management and Budget (OMB).

Questions and Comments
The members suggested drafting a white paper to address issues outside of the Committee's purview. They also asked what they could recommend to support the Teaching Health Center Graduate Medical Education (THCGME) Program. Ms. Williams explained that THCGME Program is constrained by the statute in specific ways. It is a formula-based program based on the entity's number of full-time equivalent (FTE) residents. She welcomed their thoughts and suggestions on how to continue to expand the Teaching Health Center Program within the current fiscal constraints.

A member commented that a white paper may be a good method to support THCGME. It was suggested that a recommendation be made to address the huge knowledge gap about GME funding and education and the importance of training in the right setting.

Dr. Thomas McWilliams asked is there a mechanism by which health professional shortage areas (HPSAs) could be prioritized or classified and how could ACTPCMD enable HRSA to focus on a general designation -- move the shortage designation to where the need is greatest and where the outcomes might be maximal? Ms. Williams suggested having Melissa Ryan present at another meeting to discuss HPSAs relationship with primary care offices in the states, and ways that BHW ensures that the right places are designated and the severity is accurately calculated.

Program Evaluation and Performance Measures
Katherine Morasch, PhD

Dr. Katherine Morasch provided an update on the National Center for Health Workforce Analysis (NCHWA) on the Performance Measurement, Reporting and Evaluation in BHW. In FY 2011, BHW developed and implemented a series of revised performance measures. These

revisions aimed to enhance the unit of analysis through the collection of data at the individual and program-level; establish a set of common output/outcome measures across the majority of BHW-funded programs; and lay the groundwork for enhanced accountability through the implementation of a stronger performance management framework. NCHWA also transitioned to online data collection via the electronic handbook system.

Performance measures were revised in FY 2012 and FY 2015. Currently, NCHWA is tracking 43 BHW investments, 21 of which are housed within the Division of Medicine and Dentistry. At the bureau-level, the number of forms and sub-forms decreased from 80 to approximately 50. Measures are carefully aligned with the type and legislative purpose of each program. OMB approval for annual collection has been extended through June 2019.

Dr. Morasch explained there are 3 categories of support in BHW: Direct Financial Support, Infrastructure Programs, and Multipurpose/Hybrid Programs. The Direct Financial Support Programs are designed to provide trainees with financial support for costs associated with tuition and/or allowable living expenses (Expansion of Physician Assistant Training, Dental Faculty Loan Repayment Program). Infrastructure Programs are designed to enhance the scope and/or quality of programs that are designed to provide trainees with financial support to cover costs associated with tuition and/or allowable living expenses (Expansion of Physician Assistant Training, Dental Faculty Loan Repayment Program). Multipurpose/Hybrid Programs provide direct financial support to trainees and may also engage in one or more additional activities including enhancing training infrastructure or faculty development among others (Primary Care Training and Enhancement Program, Pre-doctoral Training in Primary Care).

Dr. Morash shared the ways that NCHWA ask questions about investments. They include Program-Level Characteristics, Aggregate-Level Demographics, Individual-Level Data (Demographics, Training Characteristics, Training Outcomes, and One -Year Follow-up Employment Data), Training Sites and Experiences, Curriculum Development and Enhancement, Faculty Development, and Continuing Education. She noted that she has collaborated with the Division of Medicine and Dentistry (DMD) to establish performance measures for the new PCTE program. It is a collaborative effort to merge the outgoing primary care investments in order to strengthen the primary care workforce and emphasize promotion of practice in rural and underserved areas. NCHWA examines evaluation activities from a quantitative and qualitative perspective. It reviews the successes of the program, and the gaps and barriers, and makes recommendations to help move the program forward.

Dr. Morash discussed the development of a longitudinal evaluation framework across the Bureau of Health Workforce as mandated by the Affordable Care Act (ACA). Results from the longitudinal evaluation, combined with the recent update of the BHW strategic plan, will assist BHW in understanding how programs are affecting health workforce diversity, provider distribution to underserved areas, and practice transformation. She concluded her presentation by emphasizing NCHWA continues to ensure that performance measures are accurate, legislatively aligned, and relevant to field activities.

Questions and Comments
The members asked questions and commented on longitudinal evaluations and reporting of less data; community health centers and aligning the community training with community priorities; and providing additional information on what community health centers are measuring in order to structure recommendations.

Dr. Morash noted that NCWHA is attempting to move away from counting to focus on key impact measures. Dr. Chen commented that BHW is thinking about how to bring academic institutions and community health centers together. For example, BHW used the Dental Faculty Development and Loan Repayment Program to provide an incentive for faculty. Any faculty member supported with loan repayment has to be a community-based faculty member and BHW added requirements on how much time is expected to spend in a community-based setting.

HRSA Update
Diana Espinosa

Ms. Diana Espinosa opened her presentation by providing an overview of HRSA's programs and services. The Health Center Program serves approximately one in 3 people living at or below the poverty line. One in 2 people diagnosed with HIV receive care through the Ryan White HIV/AIDS Program. Over 10 million people living in health professional shortage areas receive primary medical, dental or mental health care from 9600 National Health Service Corps clinicians nationwide. Recently, HRSA announced $156 million for oral health expansion to ensure that health centers integrate oral health care into their regular services and expand services. With this funding an estimated 785,000 additional patients will be served and approximately 1,600 dentists, dental hygienists and other providers with be hired.

HRSA also funds the Maternal and Child Health State Block Grant program, which serves more than half of pregnant women, and about a third of infants and children and children with special health care needs. The Federal Home Visiting Program, started under the ACA, gives pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn. Approximately 145,500 parents and children participate in this program.

The Federal Office of Rural Health Policy, which has a dual function of implementing some rural health programs, serves at least 800,000 individuals in underserved rural areas. HRSA also has oversight over the organ transplantation system through the Organ Procurement and Transplantation Network. Last year, more than 30,000 organ transplants were completed. HRSA also implements the 340B drug program that provides discounts for safety net organizations when they purchase drugs.

HRSA Budget
Ms. Espinosa provided highlights from HRSA's FY 2017 budget request. The Health Center Program's goal is to increase the number of patients served to 27 million. This is primarily through new access points as HRSA continues to fund new delivery sites. There is also a proposal for a $70 million increase for the NHSC for various behavioral health initiatives, including opioid use disorder. The funding mechanism for the CHGME program has been

changed from discretionary (funding appropriated annually) to mandatory. This mandatory proposal includes five years of funding that would provide program stability. The HIV program has proposed an initiative for increasing treatment services for people with Hepatitis C. HRSA is also expanding the rural opioid reversal program that provides naloxone to first responders. Ms. Espinosa ended her presentation by emphasizing HRSA's commitment to access to quality healthcare services, strengthening the health workforce, building healthy communities, and strengthening HRSA program management and operations.

Questions and Answers
The members asked questions and made comments on community metrics, the Indian Health Service, HRSA's Health Workforce County Comparison Tool, medication treatment training in primary care, and social determinants of health.

Division of Medicine and Dentistry Update
Candice Chen, MD, MPH

Dr. Candice Chen opened her presentation by providing an overview of the PCTE program and the Oral Health Training programs. In the last few years, BHW has redesigned programs. In previous years, PCTE was divided into six programs. BHW found that breaking up a program that is funded just under 40 million dollars into six programs and competing it separately, was not the most efficient way of administering those programs.

The programs in the Oral Health Training Branch were also redesigned this year. The Dental Faculty Program has become the Dental Faculty Development and Loan Repayment Program. The purpose of this program is to increase the number and quality of the oral health workforce by assisting dental training programs in general, pediatric, dental public health or dental hygiene to attract, develop and retain dental faculty through both loan repayment and faculty development activities. This program focuses on faculty who are training and providing service in community-based primary care settings and applicants must propose both faculty loan repayment and faculty development activities.

Preferences and Priorities
Dr. Chen recognized the importance of understanding preferences and priorities and there was considerable discussion on this topic. For clarification, applicants who receive the preference are placed in a more competitive position among applications that can be funded. In addition, the Secretary may not give an applicant preference if the proposal of the applicant is ranked at or below the 20th percentile of proposals that have been recommended for approval by peer review groups. Applicants who receive a priority receive a set number of points which are added to their overall score. PCTE has statutory preferences and Oral Health programs have statutory priorities.

One of the challenges of the PCTE preference is that there are three pathways to requesting the preference: 1) a high rate of placing graduates in medically underserved areas, 2) a significant increase in the rate of placing graduates in medically underserved communities, or 3) as a new program. Another challenge in completing the preference for physicians is that medical schools

and medical residency programs are not immediately comparable. Some applicants have found that it is useful to use the NPI database to locate where their graduates are practicing.

Given the complexity of the Title VII, Part C, Section 747 and 748 preferences and priorities, the ACTPCMD decided to create a workgroup to further discuss this issue. Vicki Chan-Padgett will be the Chair of the workgroup with Dr. Allen Perkins, Dr. Bruce Blumberg, Dr. Lia Kalliath, and Dr. Linda Niessen as members.

Dr. Chen ended her presentation by introducing Dr. Maria Portela-Martinez who provided an update on the Medical Training and Geriatrics Branch, specifically the 747 Primary Care Training and Enhancement program.

Update on the Medical Training and Geriatrics Branch section 747 Programs
Maria Portela-Martinez, MD, MPH, Chief, Medical Training and Geriatrics Branch

Dr. Maria Portela-Martinez, Chief of the Medical Training and Geriatrics Branch in the DMD, explained there are five programs in the Medical Training and Geriatrics Branch: Primary Care Training and Enhancement, Academic Units in Primary Care Training, Preventive Medicine Residency, National Center for Integrative Primary Healthcare, National Research Service Awards, and the Geriatrics Workforce and Enhancement Program.

Primary Care Training and Enhancement (PCTE)
The purpose of the PCTE program is to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers, and researchers and promote primary care practice in rural and underserved areas. The goal of the PCTE grant program is to train primary care providers who will be well prepared to practice in and lead transforming healthcare systems aimed at improving access to healthcare, the quality of healthcare, and cost effectiveness.

Dr. Portela-Martinez emphasized that the characteristics of transformed health care delivery systems include providers across the care continuum who participate in integrated care delivery models; care is coordinated across all providers and settings; a high level of patient engagement; providers leverage the use of health information technology to improve quality; and population health measures are integrated into the delivery system. She also reminded the Committee that in FY 2015 the programs were consolidated into the Primary Care Training and Enhancement program. The PCTE program's primary focus is to train for transforming healthcare systems, particularly enhancing the clinical training experiences of trainees and promoting collaboration. BHW encourages collaboration by offering a higher funding level for projects that train across training levels and include more than one primary care profession. The PCTE also requires awardees to incorporate continuous quality improvement by integrating rapid cycle evaluation into their projects. PCTE awardees also must propose evaluation around graduate career choices, patient access, quality of care, and cost effectiveness in the clinical training environment.

Funding
Approximately $15 million was available in FY 2015 and again in FY 2016. Of this amount, at least $1.8 million is awarded to programs that provide training to PA students, faculty, or practicing PAs.

Evaluation
Dr. Portela-Martinez acknowledged that evaluation and continuous quality improvement is challenging. As a result, DMD has a PCTE evaluation contract to provide assistance to awardees on creating their evaluation plans and learning how to incorporate continued quality improvement training activities. The scope of work focuses on conducting a literature review of outcome measures, evaluation methods, available tools for workforce development programs, developing an evaluation toolkit, and providing direct technical assistance to the next cohort of PCTE awardees to enhance evaluation. The PCTE contractor is also conducting site visits to understand the range of focus and activities of PCTE awardees, capacity to do evaluation, and collect information on evaluation methods and tools.

Academic Units in Primary Care (AU-PCTE)
The purpose of the AU-PCTE program is to establish, maintain, or improve academic units or programs that improve clinical teaching and research in the fields of family medicine, general internal medicine, or general pediatrics in order to strengthen the primary care workforce. The eligible entities are accredited schools of allopathic and osteopathic medicine. The goals of the program are to a) establish academic units to conduct systems-level research to inform primary care training; b) disseminate best practices and resources; and c) develop a community of practice to promote the widespread enhancement of primary care training to produce a diverse, high quality primary care workforce. This program aims to help enhance primary care training and disseminate research and best practices that result in providing higher quality and access to care for underserved communities. In FY 2016, $4.5 million was available to support six AU-PCTE grants. Dr. Portela-Martinez reminded the Committee that the AU-PTCE program was redesigned in part because of feedback received from ACTPCMD about the need to establish evidence-based strategies in the priority areas identified in the FOA.

Questions and Comments
Dr. Bruce Blumberg asked, “What are your early thoughts about what dissemination will look like? How will we take best practices and disseminate them?”

Dr. Portela-Martinez noted that the awardees are National Centers who will develop communities of practice as part of the award activities. Awardees will also build websites as a means to share resources they develop. In addition, they will publish their research, present their work at national conferences, and create focus groups to discover the challenges and limitations for these practices to be received and adopted by the community. Internally, DMD will develop expert workgroups to discuss ways to disseminate the AU-PCTE materials.

Dr. Chen added that Dr. Portela-Martinez established six subject matter expert workgroups, one for each focus area. The purpose of these workgroups is to engage individuals with expertise in these areas to discuss a variety of topics including ways to enhance the research, communities of

practice, dissemination of activities, and collaboration between the awardees and other related programs.

Overview of Title VII, Section 748 Dental Training Programs
Shane Rogers, Chief, Oral Health Training Branch (Section 748)

Mr. Shane Rogers, Chief of the Oral Health Branch in the DMD, provided an overview of the oral health training programs. Title VII, Part C, Section 748 authorizes programs to support and develop education and training programs in general dentistry, pediatric dentistry, public health dentistry, and dental hygiene including programs for student financial assistance, traineeships, faculty development, and pre- and post-doctoral training, as well as the establishment or operation of a faculty loan repayment program. There are eight funding priorities under this authorization and all grants must be five years in duration. Accredited dental or dental hygiene schools, not-for-profit hospitals, or other public or private not-for profit entities that have accredited training programs in general dentistry, pediatric dentistry, dental public health, or dental hygiene are eligible to apply for funding under this authorization. In addition, the State Oral Health Workforce Program, authorized by Section 340G of the Public Health Service Act (42 USC §256g), provides support to States to develop and implement workforce programs designed to support innovative oral health service delivery models. The goal of the program is to increase access to high quality oral health services for underserved populations located in dental HPSAs or in other areas specifically designated as having a dental health professional shortage by the State. In FY 2016, the oral health training programs received an appropriation of approximately $36 million. Of this, $13 million was allocated to the State Oral Health Workforce Program.

Title VII, Part C, Section748 Programs
Mr. Rogers provided information for each of the programs managed by the Oral Health Branch. The purpose of the Predoctoral Training Program is to enhance dental education and training to prepare dental and dental hygiene students to practice in new and emerging models of care that are designed to meet the needs of vulnerable, underserved, and rural populations. In FY2016, the program received $4.6 million and supported 20 awardees. In AY2014- 2015, the program trained over 2,400 dental and dental hygiene students.

The Postdoctoral Program incorporated the Residency Training in General and Pediatric Dentistry (Title VII, Section 747) and the Residency Training in Dental Public Health (Title VII, Section 765) Programs. The Postdoctoral Program provides funding to develop/test new training and delivery models in clinical training sites, or develop/test new or enhanced training in dental public health and/or population health management. In FY 2016, the program received $11.6 million and supported 26 awardees. In AY 2014-2015, 501 dental residents were trained under this program.

The Faculty Development Program provides support for the training of oral health providers who plan to teach in general, pediatric, or public health dentistry. The program also provides financial assistance in the form of traineeships and fellowships to faculty who plan to teach or are teaching in general dentistry, pediatric dentistry, public health dentistry, or dental hygiene. The last funding opportunity for this program was in 2012, six grants were funded at that time

and will end in June 2017. In 2016, the program received $2,898,974. In AY 2014-2015, 1,975 dental faculty members were trained. This program is being absorbed into the Dental Faculty Development and Loan Repayment Program.

The purpose of the Dental Faculty Development and Loan Repayment Program is to increase the number and the quality of the oral health workforce by assisting dental training programs in general, pediatric, and public health dentistry, or dental hygiene to attract, develop, and retain their dental faculty through both loan repayment and through faculty development activities. This program focuses on faculty who are training and providing service in community-based primary care settings. Applicants must propose both faculty loan repayment and faculty development activities. Individuals who participate in funded programs receive loan repayment at a rate of 10% in year 1, 15% in year 2, 20% in year 3, 25% in year 4 and 30% in year 5. At the conclusion of the 5 years, the entire amount of the loan is paid. In FY16, approximately $1,628,000 was available to fund 9 grants.

FY 2017 Oral Health Training Plans

The Oral Health Branch plans to fund the Predoctoral Program in FY 2017 and it will have a pediatric focus. Mr. Rogers explained that there is a statutory requirement to allocate $10 million for general dentistry and $10 million for pediatric dentistry. Some of the pediatric dentistry grants are ending in FY 2017, therefore, a competition will be needed to replace them and ensure that an investment of $10 million is maintained.

The Oral Health Branch is working on a qualitative analysis project using NVivo. NVivo is a data analysis software program developed for qualitative analysis. The goal is to link grant narratives with performance data to report better outcomes for our programs.

Questions and Comments

The members asked questions and commented on integrated medicine, providing dental health services in rural and underserved areas, the NPI, Commission on Dental Accreditation, and evaluation.

Committee Discussion

Performance Measurement, Program Preferences, Priorities, Appropriation Levels

The members began the discussion with the AU-PCTE program. A question was raised as to which focus areas have been awarded. Dr. Portela-Martinez responded that six focus areas have been awarded and they include: integrating behavioral health and primary care (University of Pennsylvania), integrated oral health and primary care (Harvard University), health workplace diversity (University of San Diego), training for rural practice (University of Washington), addressing the social determinants of health (Northwestern University), and training for the needs of vulnerable populations (Meharry Medical College).

The discussion continued with dissemination of the AU-PCTE awardee products. Dr. Chen noted that DMD would like to engage the ACTPCMD as the projects progress. She noted that the FOA was modeled on the NCHWA's health workforce research centers. The grants are initially focusing on systematic reviews of the literature to inform where to go with their project.

What is leading edge in these focus areas? What kind of research will actually advance the field? Each one of them might be a little bit different. Going forward we will want to engage with the ACTPCMD on this program.

Dr. Stephen Wilson inquired if the AU-PCTE integrating oral health with primary care awardee is with the medical school or the dental school. Dr. Portela-Martinez explained that by statute it is the medical school.

The discussion then turned to a focus on preferences and priorities. Dr. Weiss explained that Title VIII has a different preference than Title VII. The Title VIII preference is to substantially benefit rural or underserved populations, or help meet public health nursing needs in State or local health departments. The reviewers determine if the preference is met if at least one of these concepts is integrated throughout the application.

The members discussed preferences and priorities and decided they needed a better understanding and clearer definitions to make recommendations moving forward. They also decided to create a separate workgroup to develop a white paper or report on Section 747 and 748 programs. Vicki Chan-Padgett will Chair the workgroup consisting of Dr. Allen Perkins, Dr. Bruce Blumberg, Dr. Lia Kalliath, and Dr. Linda Niessen as members.

Public Comment

Hope Wittenberg, Director of Government Relations for the Council for Family and Academic Medicine, commented on administrative priorities. In terms of the whole question of priorities or the lack thereof for the PCTE grant, she had earlier spoken with the Director of the HRSA Division of Medicine and Dentistry about administrative priorities and the ACTPCMD DFO mentioned that in the past HRSA had administrative priorities for some programs. She recommended that ACTPCMD strongly push for an administrative priority for the following reasons. When Congress looks at the reauthorization of Title VII, and writes these sections specifically, a whole can of worms can be opened up, and you may get the flavors of the day when you want to change sections. Other people coming in and asking for changes cannot be avoided. Ms. Wittenberg expressed a concern that as things change, and once changes are in statute, they are there for a long time. An administrative priority can sunset. You can say this is what is important now, what we need to work on now, and then in a year or two do something different. Ms. Wittenberg strongly recommends an administrative priority.

Regarding the Committee's recommendations for increased funding, Ms. Wittenberg supports making the case not just in the report but to HRSA specifically make the case to the Office of Management and Budget (OMB), similar to the way the National Institutes of Health (NIH) does it doubling in five years. She noted that the ACTPCMD has the justifications and the whole list and recommended pushing it internally within the administration and with Congress. She stated that it would be helpful if is in the President's Budget.

Ms. Wittenberg looked into raising the threshold for the bottom level for the preference, currently at a 20 percent threshold, and HRSA provided some additional data in this area. Raising the threshold would have an impact in terms of funding.

Ms. Wittenberg mentioned that the move toward collaboration with the academic units grants and the PCTE grants was positive. However, support for these activities is coming out of the primary care funding. She recommended consideration for some parity as to where the funding is coming from and some way to support collaborative activities using more than one funding line (PCTE, oral health, and nursing). This approach would also free up more money within a specific area.

The question of whether the junior faculty grants should be education specific or more research focused was raised and Ms. Wittenberg thought it was a good one. She plans to work to obtain input from the field as to what would be most useful.

Teresa Baker, Senior Government Relations Representative for the American Academy of Family Physicians made the following comment. Ms. Baker echoed Ms. Wittenberg's remarks. She noted that the authorization for the Title VII programs has expired. That is not a problem as long as Congressional appropriators and the administration provide funding for the program as part of the annual appropriations process. They can effectively reauthorize it in the spending law. However, there's increasing pressure in the Congress to prohibit spending on unauthorized programs as part of the normal appropriations process. The budget process reform effort now underway, and legislation, the Unauthorized Spending Accountability or USA act, would prevent spending on any federal programs that are not authorized. The Congressional Budget Office found that Congress appropriated $310.4 billion to 256 programs that were not authorized in the current fiscal year. That's one quarter of the whole discretionary budget and half of the non-defense discretionary budget. Ms. Baker noted that if Congress suddenly had to reauthorize all of these programs, their calendar does not allow for a lot of time. She suggested making a recommendation that Congress work toward reauthorizing these vital programs.

The meeting adjourned at 5:00 PM.

Day 2- June 28, 2016

Introduction

The ACTPCMD convened its meeting at 8:30 AM at the HRSA headquarters in Room 18-67, 5600 Fishers Lane, Rockville, MD 20857. Dr. Joan Weiss opened the meeting. Dr. Allen Perkins, ACTPCMD Chair, continued the discussion of preferences and priorities that began the previous day. The Committee also reviewed the process for developing recommendations for the upcoming report.

Dr. Weiss then introduced the Panel Discussion on Primary Care Behavioral Health Integration with Dr. Alexander Ross, Dr. Dennis Freeman, and Ms. Laura Galbreadth.

Integrating Behavioral Health into Safety Net Primary Care Settings:
The Role of HRSA in Supporting Education and Practice
Alexander Ross, ScD

Dr. Alexander Ross discussed integrating behavioral health into safety net primary care settings and HRSA's role in supporting education and practice. He opened his presentation by asking the Committee to think about how HRSA's impact in building integration, especially in the service setting, relates to the education needs of the future generation of healthcare professionals. He reviewed the ways in which HRSA is building capacity across grant programs and the implications for health workforce development. From undergraduate to graduate levels, and as well as continuing education for those in the field, the full range of providers are needed to make integration a no wrong door approach to care.

Dr. Ross discussed the HRSA-funded safety net providers including HIV/AIDS organizations, Maternal and Child Health, the Health Center Program, the Rural Health Program, and Health Professions Training and Education. Approximately three-fourths of Ryan White funded health centers or healthcare provider organizations are providing mental health services and about a third are providing substance abuse treatment services.

HRSA's Maternal and Child Health programs serve more than 43 million women, infants, and children annually. The Maternal, Infant, and Early Childhood Home Visiting Program funds States to provide evidence-based home visitation services to improve outcomes for children and families who reside in at-risk communities. Since 1995, Bright Futures has distributed more than 1.3 million copies of their guidelines including information on drug and alcohol use/mental health screening of youth.

Dr. Ross turned his discussion to the Health Center Program. He noted over 1,300 health centers operate more than 9,000 service delivery sites that provide comprehensive primary care to over 23 million patients in every state. Almost 69% percent provide mental health treatment and counseling services and over 36 percent provide substance abuse treatment. Dr. Ross noted that there are more than 7,200 behavioral health providers working in health centers today. The Health Center Behavioral Health Integration Awards will improve and expand the delivery of behavioral health services through the integration of primary care and behavioral health at existing Health Center Program grantee sites. Over the last two years over 430 health centers received awards. A maximum of $250,000 each per year is awarded with the express intent of bringing on at least one new licensed behavioral health provider and integrating a screening brief intervention approach.

The Substance Abuse Expansion Grant Initiative is a recent program that will improve and expand the delivery of substance abuse services in existing health centers, with a focus on Medication-Assisted Treatment in opioid use disorders. A maximum of $325,000 per award will be made to 271 health centers to build medication assisted treatment capacity for opioid abuse disorders.

The Office of Rural Health Policy has a Rural Opioid Overdose Reversal Program. Each of the 18 grantees received $100,000 for one year to develop community-level partnerships comprised

of emergency local responders, schools, fire departments, police departments, and other private or public non-profit entities involved in the prevention and treatment of opioid overdoses.

In FY 2015, over one in three BHW NHSC clinicians (3,371 out of nearly 9,683 as of September 2015) provided mental and behavioral health services. This includes psychiatrists, psychiatric physician assistants, psychiatric nurse practitioners, health service psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, and psychiatric nurse specialists.

Key Components of Integration

Dr. Ross emphasized that the key components of integration include integrated care models, workforce, financing, clinical practice, operations and administration, and health and wellness. He also noted that when you have the right comprehensive workforce in place and the financing or reimbursement to support that care, integration is possible.

Dr. Ross closed his presentation by answering the following questions: What does it mean to integrate behavioral health content into primary care medicine and industry training programs? Most of all what it means to work at all levels of training. Through the Center for Integrated Health Solutions it has been learned that although there are certain things that may be taught early on regarding integration, it is important to revisit the initial core of work at different stages of training.

What are some of the challenges and barriers to integration of behavioral health content? It is important to ensure there is an effective feedback loop from the field to the academic training programs. There are many professional associations, different levels of government, and medical and other associations representing health professionals themselves. How do we make an effective feedback group so that the next generation knows what is going on in practice and is ready for that? How do we ensure training is evidence-based? The field is still working on this in integration. There is good evidence and there are other practices that are informed by doing. It is important that the next generation is trained on evidence-based practices.

Dr. Ross noted that it is important to have a balance between training on mental health issues and substance use disorder issues. There has been a focus mental health in integration efforts in the past for various reasons. However, individuals coming into safety net settings will often have multiple comorbidities and the providers treating them need to be prepared for the whole person and their needs. It is crucial to keep substance abuse disorders in front along with the mental health concerns.

Integrating Behavioral Health and Primary Care at Cherokee Health Systems: A Perspective on Education and Training in Primary Care Medicine"
Dennis Freeman, PhD

Dr. Dennis Freeman began his presentation by providing an overview of Cherokee Health Systems. Cherokee Health Systems is an integrated delivery system and a safety net provider in East Tennessee with 45 clinical locations in 13 East Tennessee counties. There are over 65,000 unduplicated individuals served, approximately 35 percent are uninsured and about 40 percent

receive Medicaid. They have 612 employees with a varied provider mix including primary care physicians, nurse practitioners, physician assistants, psychologists, master's level clinicians, psychiatrists, psychiatric nurse practitioners, community health coordinators, pharmacists, and dentists. They are committed to serving underserved populations.

Cherokee Health Systems Strategic Emphasis

Dr. Freeman explained that the strategic emphasis of Cherokee Health Systems is population-based care, blended behavioral and primary health care, outreach to underserved populations, telehealth, training healthcare providers, value-based contracting, and healthcare analytics. He noted that blending behavioral health into primary care means blending specially trained behaviorists, or behavioral health consultants, to become members of the primary care team. Cherokee Health Systems provides outreach for certain subpopulations to have equitable access to care through Telehealth. It has used Telehealth effectively for about 15 years.

Training

Cherokee Health Systems has a 40 year history of training and their goal is for the next generation of healthcare providers to have a good experience working with underserved populations. They track clinicians after completion of their training programs and about 90 percent stay with Cherokee or work with other safety net organizations in multi-disciplinary teams.

Cherokee Health Systems benefits from a HRSA-funded graduate psychology education grant and they currently have five interns. They also train postdoctoral fellows. They are a part the American Psychology accredited school consortium and they train many types of health professionals including family medicine, nursing, nurse practitioners, physician assistants, postdoctoral psychologists, social workers, nutritionists, pharmacy residents, and others.

Cherokee Health Systems trains other safety net colleagues on their integrated care model through their training academies. Approximately 70 safety net colleagues participate in the two-day training sessions. The integrated model is discussed from the clinical perspective, the operations perspective, and the financial perspective. Dr. Freeman noted that training behavioral health in primary care means training people in an environment where this integration is taking place. Behaviorists are trained with nurses, pharmacists, and other healthcare professionals to provide an integrated approach. Cherokee's behavioral health and primary care training is organized around the quadruple aim, whole person care, attention to contextual and social determinants of health, understanding the role of psychological and behavioral factors, principles and practices of behavior change, assessment and treatment of mental health and substance use disorders, individual and team-based competencies, and interprofessional education.

Best Practices

Dr. Freeman highlighted what has worked for Cherokee Health Systems in relation to integrated care. It is important to have training organized around a developmental model of learning. There are stages of progressive autonomy for providers and the supervision of those providers needs to change as they become more skilled. Clinical immersion is the best way to prepare providers and Cherokee uses a merger of academic and interactive learning. They provide didactic seminars but include supervision as a key part of their teaching, mentorship, and

coaching. Interns have a clinical mentor who assists them with professional development. There is also an abundance of team-based multi-disciplinary teaching approaches.

Challenges and Barriers
Dr. Freeman noted several challenges and barriers a safety net provider has when training health professions trainees and providers. One of these challenges is that most providers are trained in silos but then are expected to work in teams. Safety net providers have limited resources (time, money, space) to provide training. There is no reimbursement for training. If providers take time to train, there is an opportunity costs associated with it. There are also regulatory restrictions and state licensure issues. Training relationships are dependent on the interest and engagement of academic leadership and the baseline competencies of new trainees is variable and often at a low level.

Potential Solutions
Dr. Freeman recommended several solutions. He suggested broadening the teaching health center concept to include integrated provider training. He proposed a special funding consideration for training in Federally Qualified Health Centers (FQHC)/Community Health Centers. He advocated to enhance and standardize core competencies for each level of training and to build resources and supports for teaching (for programs, preceptors, and supervisors). He suggested updating regulations and accreditation requirements. He advocated for separate provisions for FQHC billing for trainees. .

Questions and Comments
The Committee asked Dr. Freeman about immersion and the residents' role and rotation, funding, and staffing of dentists. Dr. Freeman explained Cherokee Health Systems has done a psychiatry rotation for some residency programs but did not receive direct funding for that program. They established a fellowship in behavioral medicine with a local family practice residency program. There have only been a couple of fellows in the last five years to participate in that program and those fellows spend half their time working in Cherokee's health centers and half the time in the teaching hospital. There is no direct reimbursement or payment with the training component. They do it because they believe it is important.

In addition, Cherokee Health Systems has hired a second dentist. They are in the process of expanding the dental program by contracting with a number of other dentists to increase the service area in the next few months.

Behavioral Health is Essential to Health
Laura Galbreath, MPP
Director, Center for Integrated Health Solutions
National Council for Behavioral Health

Ms. Laura Galbreath opened her presentation by providing a brief overview of the Substance Abuse and Mental Health Services Administration (SAMHSA)/HRSA Center for Integrated Health Solutions (CIHS), funded jointly for almost six years. The Center supports integrated care as the national standard of practice, creates and operates technical assistance, ensures the success of SAMHSA and HRSA funded programs, and disseminates practical tools, resources,

and lessons learned. The partnership between SAMHSA and HRSA allows for a focus on the bidirectional nature of integration that brings behavioral health into primary care as well as addressing the physical health needs for people with serious mental illness.

Behavioral Health and the Patient-Centered Medical Home

Ms. Galbreath emphasized that behavioral health is integral to the patient-centered medical home. There is a high prevalence of behavioral health problems in primary care, high burden of behavioral health in primary care, and high costs of unmet behavioral needs. When behavioral health needs are met, there are lower costs, better health outcomes, and improved satisfaction.

Behavioral Health and Dental Health

It is important to explore dental health and psychiatric disorders. Ms. Galbreath highlighted studies that show 61 percent of people with a serious mental illness report fair to poor dental health and that more than a third had oral health problems that made it difficult for them to eat. Many of these issues may be related to medications and side effects, poverty, and other social determents of health that may impact an individual's ability for good oral care. The appearance of teeth is interconnected with mood. Teeth inspire confidence and a willingness to smile more. The latest studies reveal interconnections between the brain, memory, and dental health

The opioid epidemic may have increased dental health issues in individuals who use heroin, cocaine, and methamphetamines. Content on behavioral health and substance abuse should be included as part of the formative training of dentists and dental hygienists. Dental practitioners should participate in continuing education programs to update their knowledge and skills on ways to care for individuals with behavioral health and substance abuse disorders.

Defining Behavioral Health and Integrated Care

Ms. Galbreath emphasized the importance of working from the same definition of behavioral health and integrated care to train health professionals. The Agency for Healthcare Research and Quality (AHRQ) defines behavioral health as an umbrella term for care that addresses any behavioral problems impacting health, including mental health and substance abuse conditions, stress-linked physical symptoms, patient activation, and health behaviors. AHRQ defines integrated care as the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

Ms. Galbreath noted that it is important to ensure future healthcare professionals are being trained on the full continuum of care. This means a focus on preventive care, screening, and early identification of individuals with serious and persistent mental illness or addictions.

Integration of Behavioral Health in Primary Care

Behavioral Health integration in primary care starts with care management specifically patient education and empowerment, ongoing monitoring, and care/provider coordination. Evidence-based treatments including effective medication management and psychotherapy are essential. Expert consultations are needed for patients who are not improving. Health systems should track outcomes and technology support for registries.

The CIHS supports the move to team based care, the role of recruitment and retention, education and training, supervision, partnerships with the community, and the importance of leadership. These concepts are depicted in the Mental Health Partners shadowing tool developed by Clare Scott, LCSW. This tool prepares individuals to meet the following expectations - increase system expertise, increase knowledge of clinic work flow, demonstrate how to join a team through building trust, and effective communication with medical providers and clinic staff. Ms. Galbreath emphasized that the tool is an evidence-based model for collaborative care.

Integrated care is a team-based model of care, based on the blending of expertise of numerous providers to treat a shared population through a collaborative treatment plan with clearly defined outcomes. The client and their family play a vital role as members of the team, providing input on personalized health outcomes and preferences in the treatment approach. The precise mix of providers in each setting is determined in part by the clinical setting, the population needs, funding, and pre-determined outcomes. Workforce development in integrated care has unique needs and challenges, including a focus on expansion and flexibility in provider function and roles, changes in traditional healthcare provider culture and provider training, and development of an effective and efficient team.

Essential Elements of Effective Integrated Primary & Behavioral Healthcare Teams
The CIHS published a paper on the essential elements of an effective integrated care team. Based on interviews with integrated teams within primary care settings, this resource explores four essential elements for effective integrated behavioral health and primary care teams (leadership and organizational commitment, team development, team process, and team outcomes) and provides a roadmap for organizations designing their own teams, using examples from these best practices.

Education and Training
As a new model of care, integrated care requires revisions and additions to the traditional way in which healthcare providers are educated and trained to practice. This applies to all forms of clinical care, including family practice, primary care, and behavioral health. Providers need to refine some skills with minor adjustments, and they need to learn new interventions to assist in whole person healthcare. Initially this education has been “on the job training,” however, as integrated care models increase, educational systems will need to shift to adequately prepare an integrated workforce for the future. This includes graduate education programs teaching an integrated knowledge base and shifting the cultural expectations about clinical practice. Certificate programs and post-graduate training will be needed for professionals who want to adjust their skills mid-career. In addition, integrated care may always require a certain degree of onsite training as part of the team care development process. Similarly, patient education about the model and patient activation to engage in healthcare will be an ongoing core feature of successful integrated healthcare.

Questions and Comments
The members had questions and comments on work force projections for psychiatrists, social workers and psychiatric nurses; workforce supply; finance models and value-based payments; provider burnout and resiliency; and the opportunities and challenges of using Telehealth to promote and enhance team based care. Dr. Freeman noted the importance of providing a new

practitioner with a senior practitioner as a mentor to prevent burnout. Support and outreach workers are needed to provide the social aspects of care. A behavioral health provider and a nurse manager could assist patients with complex needs.

Dr. Freeman also explained that Cherokee Health Systems telehealth has been very effective and successful. The key was educating payers on the importance of telehealth and having them visit and experience how it works. Many health plans have geographical access policies that require providers be close to their enrollees. The providers were not there, so they relied on telehealth.

Dr. Weiss then introduced the second panel which addressed primary care oral health and behavioral health education and training. The first speaker was Dr. Helen Silverblatt.

A Model for Community-Based Integrated Behavioral Health Training
Helene Silverblatt, MD

Dr. Helene Silverblatt opened her presentation by noting that approximately 25 years ago the University of New Mexico began focusing on integrating behavioral health and primary care because at that time there was a significant shortage of psychiatric services in the state and primary care providers were requesting psychiatry services in federally qualified health centers. As a result, the University applied for and received a HRSA grant and expanded it through funding from the state to create a rural psychiatry training program. Access to healthcare was improved by offering behavioral health services in primary care settings.

Program History

The Health Extension Rural Offices (HEROs) Program was started by Dr. Arthur Kaufman and was modeled primarily after cooperative extension programs that exist throughout state land grant institutions. In collaboration with the University of New Mexico's AHEC Program, community driven strategies were developed to assure health and workforce development. The AHEC/HERO collaboration built community capacity by offering access to University programs through health extension hubs placed throughout the state. Other activities included pipeline and workforce development; telehealth for training, service, and communication; community-based health professions education, clinical service improvement, and program evaluation; and technical assistance.

The program allowed psychiatry residents to rotate in primary care sites. They were also able to expand the behavioral health workforce by offering co-located, integrated services where residents were able to see patients with their primary care providers and peer specialists. The first training model for integrating primary care and behavioral health was set up at a small interdisciplinary clinic at the university hospital. Dr. Silverblatt was the attending psychiatrist. Psychiatry, internal medicine, obstetrics/gynecology, and pediatrics residents and medical students participated in the program. The program was successful in addressing patients' physical and mental/behavioral needs and providing interprofessional training.

Today the focus is to integrate all psychiatry residents into primary care sites. Joint training programs where psychiatry residents and family medicine residents see patients together have

been developed and implemented. The goal is that the majority of family medicine clinics will have an integrated model where psychiatry and primary care residents are training together.

Integrating Primary Care and Behavioral Health Expansion Activities
With funding from AHEC, the Health Careers Opportunity Program, the state, and managed care organizations, the University of New Mexico has been able to expand and sustain their integration of behavioral health in primary care program. Expansion activities include co-training psychiatry residents with family medicine residents and primary care students; co-training psychiatry residents with psychology interns and other residents in primary care clinics; integrating training for psychology interns in rural primary care; responding to community requests; and developing and implementing the Office for Community Faculty as coordinator of undergraduate and graduate interdisciplinary programs.

Dr. Silverblatt emphasized that it is crucial for psychiatry residents to learn about and work with other behavioral health providers. As a result of these integration training efforts, the University of New Mexico redesigned the Psychiatry Department to the Department of Psychiatry and Behavioral Sciences. The Department includes psychiatrists, psychologists, social workers, and other mental health providers. It has allowed them to improve the co-training of psychiatrists, psychologists, and other mental health providers.

Community Input
Community members, through HEROs and AHECS, provide feedback about trainee preference and health care needs. The University has a new Office for Community Faculty that will coordinate all training across the medical school disciplines which includes occupational health, physical therapy, physician assistant, nursing, pharmacy, and other disciplines. Dr. Silverblatt noted the goal is to coordinate placements and preceptors to have ongoing and structurally responsive community-based training programs.

Outcomes
Dr. Silverblatt closed her presentation with the following program outcomes:

- 37 percent of residents in the rural psychiatry program were practicing in rural communities as opposed to 10 percent in traditional programs;
- 95 percent continue to work with individuals in rural and underserved communities;
- 26 percent live in communities in which they practice; and
- 28 percent use or are in process of setting up telehealth services, some to primary care sites.
- There has been additional designated funding from the state for rural resident training in primary care and psychiatry. There is also a growing community endorsement and support for integrated training hubs.

The University has received community endorsement and support for their training hubs. The goal was to have a community-based model for training and they are getting community based support to have those trainings. One example of community support is that free housing is provided for all residents and students because some of the training sites are located in remote areas and are not easily accessible. As a result, students are able to integrate their own learning by living together and learn together about interdisciplinary practice education. This learning

experience also allows students the opportunity to share ideas and information and learn about different kinds of practices in additional to traditional academic training sites.

Integrating Behavioral Health Care into Academic Family Medicine and a Federally Qualified Health Clinic
Gail S. Marion, PA, PhD, Professor

Dr. Gail Marion discussed how the integration of primary and behavioral health care creates a safety net and increases access to care. She also presented models of behavioral care, ways behavioral health can be integrated into family medicine, and barriers to care when building a team.

Why Integrated Care?
Integrated care is more cost effective and clinically effective, specifically in dealing with and treating mental health problems that can negatively impact physical healthcare. Patients in the primary care setting who need mental health services are seen immediately or within a week. In comparison, patients who are referred for mental health services outside the primary care setting usually have to wait six weeks or longer for an appointment. As a result, they frequently do not go to the appointments. When they do go to appointments, primary care providers usually do not receive follow-up information about the visit. These are some of the reasons to have integrated care on site. The integrated care providers know who their patients are seeing, they can review the behavioral health visit notes, speak with the behavioral provider at the initial visit, introduce the patient and behavioral health provider to each other, and review the notes. It is a much more comprehensive way of caring for patients who need both types of services.

Integrated care enhances primary care provider satisfaction. It also increases provider effectiveness in caring for patients who have behavior health needs such as mental health and substance abuse conditions, health behaviors problems, life stressors and crisis, stress related physical symptoms, and ineffective patterns of healthcare utilization. The integration of behavioral and physical healthcare can improve access to appropriate care and improve outcomes across a number of different physical and behavioral health related problems. Members of the healthcare team include physicians, psychiatrists, physician assistants, nurse practitioners, behavioral health providers of all varieties, pharmacists, and nurses.

Barriers to Care When Building a Team
Dr. Marion discussed the recent hiring of behavioral health providers. She noted their extensive experience but acknowledged that one of the barriers of care is the additional training needed to aid in transition. Behavioral Health Consultants typically have not been trained in an integrated care model. It takes some “untraining” and retraining to work in an integrated model. Training primary care and behavioral health providers to work in concert to address the patient’s needs onsite requires expert consultant mentoring as everyone needs to change some aspects of how to practice. In addition, it is important to create a team of diverse candidates that reflect the population served.

Implementing Integrated Care in Family Medicine
In order to integrate behavioral health care into family medicine, leadership must be committed to implementing the model and may consist of providing institutional support for a portion of the integration. A behavioral health professional and care manager who are educated in the model should be hired. Brief screening tools such as, the PHQ-4, PHQ-9, GAD-7, Mood Disorder Questionnaire, and Substance Abuse Audit, should be introduced and used as needed. The care team should also be able to address biopsychosocial-spiritual aspects of the patients' care.

Integrating Self-Management Strategies into Dental Training
Man Wai Ng, DDS

Dr. Man Wai Ng discussed integrating behavioral health content into primary care medicine and dentistry training programs, best practices that demonstrate the integration of behavioral health content into primary care medicine and dentistry education and training programs, challenges and barriers, and ways to address them. Dr. Ng shared her experience with children's dental care. She has treated many young children and children with special needs who are not able to cooperate or tolerate dental treatment in the office. She treats these children in the hospital for restorative treatment under general anesthesia. The wait times in the two hospitals where she practices is up to nine months in length. She emphasized that many children with multiple teeth with severe decay have to wait months to be treated and unfortunately that wait is not uncommon across other hospital-based dental programs in the United States. In addition, children that receive costly treatment under general anesthesia in the operating room, experience high rates of recurrent decay afterwards. She noted that dental caries is a highly preventable disease.

Dental Profession and Dental Caries
Dentistry, with its surgical tradition, commonly approaches dental caries as an acute surgical problem requiring restoration and repair rather than as a chronic medical disease process requiring individually-tailored management of etiologic factors or chronic disease management. She noted that for some time dentists have known what it takes to prevent, halt, and even reverse the caries process in patients. This concept is called caries balance. Patient behavioral changes at home specifically with diet and home care can alter the balance of pathologic risk factors and prevent the development of caries. The prevention of dental carries is only possible before infection has taken place in the oral cavity. Once there is an infection with oral bacteria, medical management, disease suppression, or active surveillance is required. Once cavitation has occurred, costly surgical treatment is necessary. The goal is to provide focused prevention by assessing and managing one's risks for caries and supporting behavioral change while repairing defects and decayed teeth.

Dr. Ng emphasized that there is a gap between what dentists know and what they actually do. Dentist know focused prevention, asses and manage risk, support behavior change, and repair defects. They practice prevention that is essentially the same for everyone with little focus on self-management, 6-month recall visits, and restore teeth. This gap can be closed by applying evidence-based practice into clinical care, changing care delivery processes, training the practicing workforce and student trainees, motivating patients to change behavior, using informational technology to track patients' health and outcomes, and aligning payment toward patient wellness.

Since 2008, Dr. NG and Boston's Children Hospital have been involved in the Early Childhood Caries Collaborative. Over 40 teams and practices nationally have been testing practice changes, collecting data, and working with clinical and quality improvement experts to implement the practice changes and protocols of this chronic disease management approach to address dental caries. The dental team at Boston Children's Hospital have developed and sustained a didactic and clinical curriculum on the disease management approach to caries for children under the age of five and for older patients and others that present with caries. The curriculum is updated annually.

Effective Patient Communication

Dr. Ng noted the importance of engaging the patient or parent in a dialogue. It takes training and experience to understand that a patient's risk for future caries can change. She uses a caries risk assessment tool that requires the interviewer to be sensitive when asking questions on the assessment tool and engaging patients and families in a conversation. Residents are trained to ask permission of the patients and parents to ask the assessment questions and provide advice. Patients are asked what is important to them in terms of the cavities. Are cavities getting worse? Is there a concern about pain or infection? Is there a concern about the cosmetic appearance of the teeth? Her team has found that handouts, flip charts, and structured communication strategies are helpful in communicating the importance of home care and diet in preventing and improving caries.

Patient Behavioral Change

When working with a patient on behavioral change, Dr. Ng believes it is important to follow up with the patient one to three months later instead of the traditional every 6 months approach. When possible, they coordinate behavioral health components with the restorative or surgical care visits that the patient would be having. They also use quality improvement strategies to facilitate practice redesign in order to adopt the disease management approach and the self-management strategies needed to address dental caries.

Data and Technology in Practice

Dr. Ng stressed that measurements and data are necessary to know if patient changes have resulted in improvement. Her team uses dental practice management systems to gather data at an individual and population level. It aids in tracking patient diagnoses and conditions. They also use data in clinical practice to evaluate practice patterns and practice consistency among care providers. Audits are conducted to determine how providers are doing with caries risk assessment and self-management goal setting.

Barriers, Challenges and Opportunities

Dr. Ng discussed barriers, challenges, and opportunities associated with adopting and disseminating disease management approaches to addressing dental caries. Barriers include obtaining staff buy-in and time constraints including uncompensated time to be able to engage with and coach patients and parents on behavioral changes. Challenges include follow-ups for disease management (having time for visits and cost of visits) and data collection. Dental practice management systems are not patient registries and using dummy codes is not ideal and does not always produce reliable data. Disease management protocols are new to dentistry and

continuous training and retraining is necessary. Finding regular time to meet with staff and providers is also important. Quality improvement strategies have been successful and teams have been able to adopt and disseminate the disease management approach in health centers, hospital-based dental practices, dental schools, and private practices. Data collection has been successful in improving patient oral health and outcomes.

Dr. Ng ended her presentation by reiterating that the disease management approach with behavioral health content can be implemented into dental clinical practice and incorporated into student and resident education and training. Quality improvement methods along with use of data and measurement can facilitate practice change. Financing is needed to pay for education, self-management strategies, and patient and family coaching. She also noted that graduates of the program are working in health centers and they recognize the challenge of treating a high-risk patient population. Graduates have also reached out to the program to gain access to the tools from their training and to strategize on how to incorporate the disease management approach in their health centers.

Questions and Comments

The members asked the panel questions on supervision of psychiatry residents' rotation, use of telehealth technology in an integrated team based approach, addressing culture in dental health, behavioral health consultant and care manager relationships, and overcoming funding barriers for hiring non-physicians.

Behavioral Health Integration Training Needs in Health Care Delivery System Reform
Hayden O. Kepley, PhD

Dr. Hayden Kepley discussed the need for primary care and behavioral health integration. He explained that there are two major barriers to obtaining behavioral health treatment - access and reimbursement. It is challenging for patients to receive an appointment with a specialist or behavioral health practitioner and as a result they visit their primary care provider. Traditionally primary care providers such as pediatricians, internists, and family medicine physicians have not received behavioral healthcare training, yet they are faced with a number of patients with behavioral health disorders. Reimbursement is a major issue because many places including some major academic medical centers only accept cash. In addition, if a patient is trying to be reimbursed they are faced with a confusing process and paperwork through insurance.

Dr. Kepley then informed the members that behavioral health and physical health are interlinked and co-occurring. Individuals with behavioral health diagnoses have a higher instance, usually two or three times, of diabetes and cardiovascular disease. Many of the medications that are used to treat depression and other serious mental illness may cause diabetes or significant weight gain. Individuals with mental illnesses or substance use disorders purchase approximately 40 percent of the cigarettes sold. He noted that individuals with mental disorders died an average of 8.2 years younger than the rest of the population, mainly from cardiovascular disease (33.9 percent), cancer (21.0 percent), and pulmonary disease (13.5 percent). In addition, individuals with chronic medical conditions are 2 to 3 times more likely to have mental health problems. Meta-analyses indicate that the rate of depression in patients with type 2 diabetes is 1.6 to 2.0

times higher than that in the general population; and is associated with poorer treatment adherence.

Delivery System Reform
Dr. Kepley emphasized that better care and smarter spending results in healthier people. Better care means that primary care is the locus of coordinated care; more preventive screening and health promotion; co-location of behavioral and physical health care; and efforts to promote team-based care with primary care practitioners and behavioral health professionals. Smarter spending means moving away from fee-for service and moving towards global payments for care and management of conditions. It is important to pay providers for outcomes and performance.

National Center for Health Workforce Analysis
Dr. Kepley then discussed NCHWA's six core activities: 1) health workforce data collection and analysis; 2) projections of supply and demand/need; 3) dissemination of findings, data, and information especially to key stakeholders; 4) collaboration with states to collect and analyze health workforce data and identify needs; 5) performance measurement, data collection and analysis; and 6) evaluations of BHW programs.

NCHWA's Health Workforce Research Center Program supports high quality, impartial, policy-relevant research on the health workforce and provides technical assistance to states, local/regional entities and others in the collection, analysis, and reporting of health workforce data. The Behavioral Health Workforce Research Center is working on 12 projects under three major areas. The first area is to develop a minimum data set for behavioral health workforce professions, evaluation of workforce data sources that can be included in the minimum data set, development of the actual minimum data set, and pilot testing it with selected occupations.

The second major focus area is around developing a comprehensive profile of the size and the composition of the national behavioral health workforce including practice setting and workforce characteristics. This includes projects that enhance behavioral health workforce diversity and service delivery for vulnerable and underserved communities, and development of a team-based care and core competency model.

Dr. Kepley noted that a NCHWA funded health workforce research center released a report on behavioral health integration in early spring. The report cites that despite high disease prevalence and growing awareness of the importance of treating behavioral health issues, access remains a problem. The report also discussed barriers including stigma associated with receiving behavioral healthcare, lack of health insurance coverage, and shortages of qualified behavioral health professionals.

Case Example—Durham Veterans Administration (VA) Training
The Behavioral Health Workforce Research Center is looking at different approaches to team-based care within behavioral health integration. Durham's VA Medical Center in North Carolina is an example of a program training psychology fellows through the integration of behavioral health and primary care. Primary care medical residents as well as medical students train in this same setting with the psychology fellows. There are two primary care teams usually consisting of a physician, nurse, and licensed practical nurse. Social work, clinical pharmacy, and nutrition

services are also provided. The psychology fellows spend several days a week co-located in the primary care clinic providing clinical assessment, treatment, and consultation services to each of the clinics' respective primary care teams. The psychology fellows deliver brief evidence based treatments including individual and group based psychotherapy. In addition, in collaboration with the primary care team, they lead a variety of treatment groups on behavioral health issues such as stress management, chronic pain, and insomnia. By working together primary care and behavioral health professionals and trainees, gain an understanding of each of other and how to work with together to increase access to high-quality health care.

Outcome Evidence
Dr. Kepley emphasized that primary care settings promote relationships of trust between patients and their primary care providers. These settings are ideal for screening and treating a number of behavioral health problems. Patients who receive behavioral healthcare in integrated settings are more likely to receive individualized care plans, experience reduction in service duplication and medical errors, show modest improvements in depression and anxiety, and report greater satisfaction with their care. Integrating behavioral healthcare increases access to services and reduces exposure to stigma associated with receiving treatment.

Questions and Comments
The members asked Dr. Kepley questions on cost of care increases; integration of behavioral health and oral health in primary care; provider level outcomes; use of behavioral health integrated with primary care, particularly around complex frail adults with both chronic diseases and mental health issues; and acute care resources.

Committee Discussion

The Committee considered the following possible topics as the focus of their 14th report.

- following subjects,
- experiential learning,
- faculty development,
- interprofessional training,
- earning with each other,
- simulation and virtual modules;
- team-based care,
- interprofessional care (scope of practice),
- teaching health centers,
- telehealth,
- financing for care and education (business case), qualitative and quantitative,
- evaluation,
- quadruple aim,
- create and support model sites (Cherokee Health Systems),
- patient education in team-based care,
- MACRA; role of dental workforce,
- role of education,

- best practices (identify map/resource,;
- dissemination, scale, and spread,
- student, provider, faculty wellness and resiliency (address burnout), and
- service learning.

The Committee identified the following subject areas to be included as draft recommendations in the 13th report:

1) Interprofessional Care Teams - fund innovative experiential learning opportunities with interprofessional care teams related to integrated care,
2) Faculty Development around behavioral health (integration of oral health and primary care) telehealth, staff development, wellness and resiliency,
3) Dissemination, scale and spread - develop a repository of best practices (behavioral health including substance abuse), and
4) Adequate funding to ensure program activities and evaluation.

Business Meeting

The members discussed volunteers for the writing committee and dates for 2017 meetings. The members of the writing committee for the ACTPCMD White Paper/Report (Review of Title VII, Section 747 and 748 programs) are Vicki Chan-Padgett, Allen Perkins, Bruce Blumberg, Lia Kalliath and Linda Niessen. The next ACTPCMD meetings are scheduled for September 9, 2016, March 6-7, 2017 (in-person) and August 4, 2017 (conference call/webinar).

Public Comment: There were no public comments.

Adjourn: The meeting was adjourned at 4:00 PM.