MEETING MINUTES
Advisory Committee on Training in Primary Care Medicine and Dentistry
March 2-3, 2021

Committee Members Present
Anita Glicken, MSW
Chair

Sandra Snyder, DO
Vice Chair

Jane Carreiro, DO
Jeffrey Hicks, DDS
Geoffrey Hoffa, DHSc., PA-C
Michael Huckabee, MPAS, PA-C, PhD
Cara Lichtenstein, MD, MPH
Anne Musser, DO
Pamela Patton, PA, MSP, DFAAPA
Kim Perry, DDS, MSCS, FACD
F. David Schneider, MD, MSPH
Mark D Schwartz, MD
Jason M. M. Spangler, MD, MPH
Wanda H. Thomas, MD, FAAP
Louise T Veselicky DDS, MDS, Med

HRSA Staff in Attendance
Shane Rogers, Designated Federal Official
Jennifer Holtzman, DDS, Subject Matter Expert
Kimberly Huffman, Director of Advisory Council Operations
LaShawn Marks, Advisory Council Operations
Janet Robinson, Advisory Committee Liaison, Advisory Council Operations
Anne Patterson, Public Health Analyst

DAY 1

The Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) convened its meeting at 10:02 a.m. Eastern Daylight Time (EDT) on Tuesday, March 2, 2021. The Health Resources and Services Administration (HRSA) facilitated the meeting through a virtual platform. Designated Federal Officer Shane Rogers welcomed the Committee members, presenters, and members of the public attending the meeting. Advisory Committee Liaison Janet Robinson provided instructions for meeting participation. Mr. Rogers thanked HRSA staff and Committee members for their efforts. He explained that the Committee's purpose is to provide

advice and recommendations to the Secretary of Health and Human Services and Congress about policy and program development pertaining to programs authorized by Public Health Service Act Title VII Sections 747 and 748. Committee members represent the range of professions specified in the authorizing legislation. Mr. Rogers conducted roll call. All members except Carrie Lichtenstein were present. Ms. Glicken welcomed the Committee and reviewed the agenda. She reminded the Committee that they would review and vote on recommendations for their 18th report to Congress. She noted that the COVID-19 public health emergency had accelerated research as well as changes in payment policy and provider roles. The pandemic has disproportionately harmed underserved populations. Ms. Glicken reported that in November 2020, the Committee wrote a letter to Secretary Azar advocating for workforce growth and optimization through training in interprofessional team-based care. The Committee also advocated for integrated care systems and payment policy reform. These themes are Committee priorities, central to discussions scheduled for the meeting.

Presentation: BHW Updates
Luis Padilla, M.D.
Associate Administrator for Health Workforce, Health Resources and Services Administration

In the U.S., demand for health care professionals has been increasing for several years. The major reason is a shrinking health workforce supply. The workforce distribution is not equitable, with rural and frontier communities especially affected by shortages. HRSA's Bureau of Health Workforce (BHW) works to strengthen the health workforce throughout the education continuum, beginning with undergraduate programs, through graduate training and residency, to service. Service is especially important now, when it is needed to address COVID-19 sequelae in underserved communities. BHW's core aims are to improve access, balance workforce supply and demand, improve distribution, and improve workforce and care quality. The aim is not only to increase the size of the workforce, but to train professionals to provide culturally competent, high quality care. BHW defines success as progress toward achieving these aims. National Health Service Corps (NHSC) and Nurse Corps are programs that support such progress. Strategies for achieving BHW's aims include training students in rural and underserved communities. Most people practice within 50 miles of where they complete their residency.

Leveraging loan and scholarship programs is another key strategy, as is supporting community-based training. BHW programs emphasize interprofessional team-based training. Integrating behavioral and oral health care into primary care is a current priority. BHW is working to develop infrastructure to support providers' resilience and well-being during public health emergencies. BHW's budget increased $400 million between 2016 and 2021.

Several external factors, including the COVID-19 pandemic, affect community and population health. COVID-19 disproportionately affects rural communities and communities of color. The current Federal administration aims to address the pandemic equitably. Value-based care has been a HRSA priority since before the COVID-19 pandemic. BHW aims to demonstrate feasibility and effectiveness of value-based care. The Bureau is working to improve care quality and equity by engaging stakeholders, including advisory committees and councils. BHW plans to meet with all committee and council chairs and is considering an all-council meeting.

The Bureau analyzes data to inform decisions regarding program planning and resource allocation. BHW analyzes data to assess community needs and determine strategies for responding. The Bureau shares data and data tools with the public. Evaluating individual programs does not adequately illustrate BHW's impact, so the Bureau aims to assess effects of program portfolios. Engaging stakeholders is a core strategy for amplifying program impact.

The Behavioral Health Workforce Pilot is working to develop shared behavioral health language, vision, and goals to apply across BHW programs. This includes development of common metrics. Results will inform future efforts to address health issues, such as equity, through program portfolios.

BHW primary care medicine programs train medical students, residents, and physician assistants. More than one-fourth (28%) of participants are from disadvantaged backgrounds. More than half (53%) currently are trained at sites in medically underserved communities. Nearly three-fourths (74%) plan to practice primary care. BHW oral health programs have trained more than 11,000 participants, 33 percent of whom are from disadvantaged backgrounds. All graduates of post-doctoral training report that they plan to practice primary care. Internal evaluations have

demonstrated that these program influence participants' decisions about where to practice. BHW has enhanced its Health Workforce Connector by allowing program graduates to create customized profiles, engaging more than 27,000 training sites, and hosting virtual job fairs.

The National Center for Health Workforce Analysis is developing an updated primary care projection report, which will discuss the impact of the COVID-19 pandemic. The Center has made the Area Health Resource File more user-friendly for non-researchers. This resource summarizes programs' performance data, including annual report cards.

The National Strategy for Workforce Coordination and recent Executive Orders currently are the main policies guiding HRSA. HRSA's Bureau of Primary Health Care and Federal Office of Rural Health Policy lead the work group that addresses improving and expanding access to care for COVID-19. Dr. Padilla and Dr. Patricia Simone of the Centers for Disease Control and Prevention (CDC) co-lead a work group on establishing the COVID-19 testing board and ensuring a sustainable public health workforce to address COVID-19 and other biological threats. This work group will create a plan to implement a public health workforce program modeled on AmeriCorps and Job Corps. HRSA also supports public health data collection to support response to public health threats. The current administration issued an executive order for equitable response to the COVID-19 public health emergency. HRSA's Bureau of Primary Health Care is working with health centers to expand and accelerate capacity to provide vaccines. HRSA's Health Equity Research Centers will support these efforts.

Current Federal Government priorities are COVID-19 response and health equity. BHW focus areas are behavioral and community health, which are essential for addressing health equity. Cross-cutting themes related to these priorities include provider resiliency, telehealth, and diversity and equity. In 2020, HRSA invested $5.8 million in primary care associations (PCA) across the U.S. with the aim of preparing Federally Qualified Health Centers (FQHC) and lookalikes to increase education and training. Activities included releasing a Readiness to Train tool, a survey validated at Community Health Center, Inc. It assesses seven domains of readiness. To-date 72 percent of health centers (more than 8,000 individual responses) have completed the survey. HRSA will analyze data to identify capacity needs. Academic-community

partnerships are necessary to conduct community-based workforce training. HRSA's goal is for each health center to develop a comprehensive strategic workforce development plan within the next 3 years.

Clinician well-being is a current BHW priority. HRSA aims to support organizational capacity and to provide training or direct services to clinicians experiencing stress, anxiety, or burnout during the pandemic. Another current HRSA effort is preparing to award maternal care target areas through the NHSC. Current challenges to these efforts include COVID-19, which may extend into 2022.

Discussion
Discussion included the following questions and points.

ACTPCMD supports BHW's work and priorities.
The Committee is pleased at the recent increases in funding for programs it supports. The Committee echoes HRSA's support for patient-centered medical homes and interprofessional care, and its emphasis on identifying and addressing community needs through developing workforce capacity. The Committee also prioritizes integrating behavioral and oral health services into primary care. ACTPCMD looks forward to working with other advisory committees and councils. Transparent data will support evaluation of progress toward targeted outcomes.

How can the Committee best support BHW?
BHW refers to Committee reports as a resource for informing the Secretary and Congress of important priorities. Recommendations for the 18th Report address timely critical issues. Advocacy often has a narrow, discipline-specific focus. Interdisciplinary care is effective and should be supported by policy. The Committee's recommendations for interdisciplinary education and practice can encourage legislation that leads to improved health care systems and quality.

Does HRSA collect follow-up data on where education and training program participants practice, or factors that influence their career decisions?

HRSA is interested in addressing these questions. It is challenging to collect data after program participants graduate. HRSA is working to do so and to lessen data collection burden on grantees. HRSA uses National Provider Identifier (NPI) data to track program participants. BHW invites Committee input on data collection efforts. Eventually, the Bureau would like data on which populations program graduates serve, and the types of care graduates provide.

Has HRSA considered tracking program participants using Drug Enforcement Administration (DEA) numbers, which indicate where a provider is practicing? This is helpful when a provider is licensed to practice in multiple jurisdictions.

It is more difficult to get DEA than NPI data. HRSA is seeking additional data to inform provider tracking.

Can HRSA require grantees to track participants with NPIs for the purposes of accountability and transparency, and outcomes measurement?

Students can get NPIs during training. HRSA can require clinicians who are funded by its programs to share NPI data, but not students. Schools can encourage students to get NPIs.

Response to the COVID-19 public health emergency has included major changes in care delivery, including increased use of telehealth. Training will have to change to prepare providers to practice in the changed environment. What training changes does BHW think will be necessary?

BHW currently is considering this issue. At the onset of the pandemic, much education and training stopped due to safety concerns. There likely will be long-term consequences of lapsed training time. BHW is assessing lessons learned and how to allocate resources to prepare for future public health emergencies. Some grantees were prepared to deliver virtual training. They can provide examples to policy makers of what could be accomplished with additional resources. Some populations, including older adults, are challenged to access telehealth services, which can affect the quality of care they receive. As a result, HRSA now prioritizes digital literacy. HRSA funding opportunities now require emergency preparedness.

Dentists are not being deployed to deliver COVID-19 vaccinations, though they are competent to do so. Are policy makers considering dentists as a resource in vaccine efforts?

Oral health providers have been impacted disproportionately by the pandemic. HRSA advocates for all providers trained to deliver injections to support COVID-19 vaccination efforts. This decision rests with organizations coordinating vaccination delivery.

It is important to build trust in public health messages. What is BHW's stance on this issue?

Rebuilding trust in the U.S. Government and science are current priorities in HHS's Strategic Plan. BHW is considering approaches to supporting CDC's efforts in this area. HRSA's network includes safety net and community-based organizations that have been most burdened by the pandemic. HRSA can play a central role in reaching these communities with credible evidence-based public health messages.

Are policy makers assessing rural communities' needs for infrastructure to support telehealth?

HRSA's Federal Office on Rural Health Policy (FORHP) leads telehealth policy and is collaborating with other agencies to build rural telehealth infrastructure. BHW recognizes the need for rural health infrastructure, but the issue is beyond the Bureau's purview. Many rural communities do not have infrastructure to support broadband access. Lack of telehealth infrastructure limits education, training, and service delivery, which affect BHW's ability to achieve its aims.

Is BHW assessing and working to address challenges with clinician recruitment and retention, including workload and reimbursement?

BHW has aggregate, but not individual-level, data on number of hours program participants work and the number of patients they serve. The Institute of Medicine (IOM) 2020 report on clinician resiliency identifies several factors that can reduce workload burden. HRSA will work to implement recommendations made in this report. BHW also will consider the role of allied health professionals in relieving workload burden, which the IOM report does not address. The current budget reconciliation package allocates $40 million to support health care provider resiliency. HRSA is considering how to allocate these funds if they are disbursed.

Presentation: Addressing Social Determinants of Health
Michelle Allender, MS, BSN, RN
Director, HRSA Office of Health Equity
Gopal K. Singh, Ph.D., M.S., M.Sc., DPS
Senior Health Equity Advisor, HRSA Office of Health Equity

HRSA's Office of Health Equity works to reduce health inequities to support optimal individual and community health through strategic internal and external partnerships, with emphasis on integrating equity concepts into policies and programs across HRSA's bureaus and offices. HRSA's Strategic Plan for 2019-2022 includes two goals focused on equity. One goal is to "foster a health care workforce able to address current and emerging needs." Objective 2.1.2 for this goal is to "ensure HRSA-trained providers can address the social determinants of health and emerging health care needs." The second goal is to "achieve health equity and enhance population health." Objective 3.1.2 for this goal is to "support community actions that address social determinants of health and improve health-related infrastructure." Addressing social determinants of health is an integral part of HRSA's work.

HRSA uses the World Health Organization's definition of social determinants of health, "the conditions in which people are born, grow, live, work, and age that affect a wide range of health functioning, and quality-of-life outcomes and risks, and the fundamental drivers of these conditions." Examples of social determinants of health include education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. Food deserts, which are geographic areas with limited access to affordable and nutritious foods, and food insecurity, in which a household lacks consistent access to adequate food to support an active and health life, are social determinants of health related to economic stability. Social determinants affect behavior, social circumstances, health care, and environmental exposure, all of which are related to probability of premature death.

A flowing stream can serve as a metaphor for social determinants of health, with upstream determinants resulting in downstream outcomes. Policies and programs are upstream. The physical environment is midstream. Disease and injury are downstream. Social inequalities affect health and mortality. The Office of Health Equity, with input from all HRSA bureaus and

offices, published health equity reports in 2017 and 2020. The more recent report focused on housing as a social determinant of health. The current administration prioritizes health equity and addressing social determinants of health.

HRSA's equity reports provide current and trend data on health disparities relevant to HRSA's programs. These include social determinants of health, maternal and child health, health care access and quality, HIV/AIDS, mental and behavioral health, chronic disease prevention and health promotion, health workforce, and geographic disparities. Data show that homeowners tend to have better health than renters. Urban residents tend to have better health than rural residents. Approximately 95 percent of U.S. residents have access to a computer; 83 percent have high speed internet access. Computer and high speed internet access are related to educational and economic attainment, community development, and accessing information related to health and health care. Computer and internet access are related to residential zip code, with rural communities having less access.

Efforts to address social determinants of health can be applied upstream, midstream, and downstream. Policies to improve community conditions can improve population health. Midstream efforts include identifying and addressing individuals' social needs. Experts at the National Academy of Medicine recommend that clinicians screen patients to assess housing instability, food insecurity, transportation needs, utility needs, and interpersonal safety. Downstream responses to the effects of social determinants include clinical care. Healthy People offers many summaries of literature about social determinants of health on its web site. HRSA's 2019-2020 Health Equity report is available on the agency web site.

Discussion
Discussion included the following questions and points.

Has the Office on Health Equity analyzed health disparities related to COVID-19, including factors that increased vulnerability? Understanding how these factors relate to disease outcomes can inform efforts to address disparities and prepare for future public health emergencies.

HRSA's Office on Health Equity is interested in this question and is exploring potential data sources. The U.S. Census Bureau collects data on economic conditions, food insecurity, diagnosis, and vaccination. Several Federal agencies, including CDC, the U.S. Department of Agriculture, and Office of Housing and Urban Development, support the Census Bureau in this effort. The Office is analyzing these data, which are updated weekly. Several non-profit organizations, such as the Kaiser Family Foundation and Pew Research Center, collect national survey data on social determinants of health. CDC collects surveillance data. Some of these surveys collect data on underlying health conditions. These data can support analysis exploring how the pandemic relates to health disparities.

Is the Office on Health Equity analyzing relationships between social media communications and social determinants of health?

HRSA's Office on Health Equity has not yet explored this issue because the data the Office currently has would not support these analyses. The Office has analyzed the digital divide and its impact on health outcomes and disparities.

How robust is internet infrastructure in rural America?

Approximately 70 percent of rural communities lack high speed internet access, which has implications for health. Definitions of high speed vary, with speeds unable to support many telehealth services sometimes labeled "high speed." Internet service may not be reliable, which is problematic for telehealth. Internet service providers may define coverage as access for at least one residence in a county, resulting in inflated estimates of internet access.

How can programs educate and train the workforce to address social determinants of health?

Competence in addressing social determinants of health should be a standard curriculum component. HRSA should define addressing equity and social determinants of health as essential training program components. Trainees should learn about population health and how to consider it in primary care practice. It is not possible to achieve complete equity in the short-term. But, with focus and effort, it is possible to achieve meaningful progress in the short-term. Students and trainees typically are invested in equity and addressing social determinants of health. Equity and public health issues should be taught as integral to the entire curriculum, not as a separate

topic. Strengthening public health infrastructure will help prepare for future public health emergencies.

Presentation: Addressing Health Equity from Education to Practice
Charles E. Moore, M.D.
Professor, Emory University
Chief of Service, Department of Otolaryngology, Grady Health System
President/Founder HEALing Community Center

When Dr. Moore began practicing at Grady Health Center, many patients presented with severe cancer, which he could treat only with palliative care. He visited patients' communities to meet residents and talk, conduct head and neck cancer screenings from the back of his car, and provide education about head and neck cancer. He observed social determinants of health, including distribution of money and resources, affecting communities. Advertisements for tobacco and alcohol, major risk factors for head and neck cancer, were prevalent. Tobacco products often were displayed next to candy, within reach of children.

Dr. Moore decided to conduct head and neck cancer screenings in the community by going directly to patients in settings such as under bridges and in crack houses. Community members welcomed medical care. Dr. Moore expanded the services he offered to meet community needs. He engaged colleagues to join him in providing services to this community. Doing so provided an opportunity for residents to learn about social determinants of health and deliver community-based services to an underserved community. Residents provided health care in shelters and a mobile clinical unit. Residents appreciated the experience, which was the type of experience many students expect when they go to medical school. Dr. Moore and colleagues provided services from a community site, which became an FQHC about 6 years ago. The site now offers primary care, pediatrics, ob/gyn, cardiology, ear, nose and throat, nutrition, and behavioral care, and walking programs. The team also offers services at two school-based health clinics, which serve students, teachers, and community members. A new site offers primary care and dental services.

When Grady System, where Dr. Moore practices, did not have a dentist, the emergency department referred patients presenting with non-emergency dental issues for ear, nose, and throat care. Dr. Moore and colleagues created a dental diversion program to refer patients for care at one of the community sites offering dental services.

Dr. Moore engaged students from several local universities to survey Grady employees and patients about their interest in designating the hospital as tobacco-free. Hospital leaders embraced and implemented this idea. The hospital also offers free tobacco use cessation classes and nicotine replacement therapy. Some providers hesitate to initiate discussion about tobacco use with patients because they do not feel confident in doing so. The Grady program plans to train residents to approach patients to discuss utilizing these services. Patients have responded to the program with enthusiasm. Many patients started using tobacco when they were as young as 5 or 6 years old. In response, teams from Emory and Morehouse schools of public health developed and tested a tobacco use prevention curriculum for elementary and preschool school students. The curriculum includes instruction on how youth can share information about tobacco cessation support with caretakers who use tobacco.

Dr. Moore serves as Director of Emory University's Urban Health Initiative. Urban Health Initiative projects have included planting a community garden in the parking lot of the only grocery store in a low-resource community. Gardeners gave produce away and developed a partnership with the store owners, whose sales increased three percent. The Urban Health Initiative team worked with seven other grocery stores in low-resource communities to implement a stoplight (red, green, yellow) system for labeling foods' healthiness. The team trained store employees to be health advocates. Providers at the community clinic wrote prescriptions to eat more fruits and vegetables, and to walk more often. When patients presented prescriptions at participating grocery stores, staff would refer them to the FQHC where care was available regardless of insurance status.

The community garden serves as a site for teaching early literacy and life skills, such as opening and managing a bank account or obtaining a driver's license, which affect long-term opportunities. University students serve as instructors. The garden also serves as a site for senior

and intergenerational exercise programs. Dr. Moore offers a Walk with a Doc program, which encourages walking and open discussion about health issues. This program aims to serve patients who feel uncomfortable discussing their health in clinical settings.

The Urban Health Initiative works to create a pipeline of secondary school students interested in joining the health workforce. It offers supports to encourage retention through participants' early careers.

Students participating in community-based programs have said they learned about community needs, which changed their career plans. Underserved communities are not seeking handouts; they are seeking partnerships and opportunities to learn to live healthier lives.

Discussion

Discussion included the following questions and points.

Have you discussed collaboration with the CDC, which is based in Atlanta and could support dissemination and expansion?

Dr. Moore has discussed programs with CDC, but this has not yet led to collaboration.

How can educators encourage interest in serving underserved communities, addressing social determinants of health, and working toward health equity?

Immersion in underserved communities while learning to practice encourages continued service to these communities. Loan repayment programs offer incentives to serve underserved communities. It could be useful to offer programs that invest in setting up practice in underserved communities.

Tobacco and alcohol use are related to oral, general, and behavioral health. Physicians and dentists should be trained to recognize substance abuse and to refer patients with substance use issues to appropriate care. African American males are disproportionately affected by cancer and would benefit from primary care providers knowing how to screen and refer them.

The programs described are good examples of identifying community needs and offering solutions that include prevention.

What are effective approaches to integrating dentistry into primary care?
Dr. Moore and colleagues created basic educational resources on this topic that are available on the Oral Healthcare in Communities and Neighborhoods (OH I Can) program website. Interprofessional education is critical for achieving this goal.

Does the FQHC where you work use telehealth? Did it use telehealth prior to the COVID-19 public health emergency? Could community centers facilitate access to telehealth for people who do not have personal access?
The FQHC has used telehealth since before the COVID-19 public health emergency, though utilization prior to the public health emergency was minimal. Use has increased significantly during the public health emergency. Electronic reminders facilitate integration of primary, oral, and behavioral health care. Health center patients can access telehealth technology at the center. The Urban Health Initiative is discussing creating hotspots to support mentoring, tutoring, and health care access.

Taking out a loan, even with expectation of participation in a loan repayment program, and other costs such as books or deposits, may deter youth from low-income backgrounds from pursuing health professional careers. What are strategies for encouraging low-income youth to perceive health career pathways as accessible?
Guaranteeing debt-free education would encourage low-income youth to pursue health professional careers. Some medical schools do not charge tuition. It is important to recruit people of color to become health professionals. Many people of color prefer to receive care from people of the same race/ethnic background as themselves. Health professionals of color are more likely than others to serve in communities of color. Recruitment efforts should target youth starting as early as elementary school, and continue throughout their education. Efforts would include health professionals describing opportunities to students, mentoring, and experiential training such as case presentation and scientific experimentation.

<div align="center">

18th Report Discussion

</div>

The 18th Report will focus on needs of underserved rural populations in the U.S. The full Committee last met in August 2020. The writing subcommittee has met weekly since January 2021. The Committee developed draft recommendations during the August meeting. The writing subcommittee has refined the recommendations text. The report will emphasize the importance of interprofessional training and collaborative integrated care, and provide examples illustrating how to implement these approaches. The report will advocate recognizing oral and behavioral health as components of overall health. Primary care providers should be able to conduct oral and behavioral health screenings, offer prevention education, and refer across a multidisciplinary health care team. The report will balance focus on longstanding issues, such as health disparities, and emerging needs, such as addressing the backlog of need for primary care resulting from the COVID-19 pandemic and the needs of COVID-19 patients experiencing long-term sequelae. The report will discuss relevance of each recommendation for COVID-19 recovery.

During the meeting, the writing subcommittee posted a draft report introduction and draft recommendations for the full Committee to discuss and further refine. The introduction states the report's focus on health equity. Although the report focuses on rural health needs, recommendations will also benefit other populations. A working title is, "Improving Access to Care in Underserved Rural Communities."

Draft Recommendation 1: "Congress should increase funding to Title VII Section 747 and 748 programs to increase the number of longitudinal primary care rotations and post-graduate residency programs providing training in underserved rural communities with an emphasis on accessible, comprehensive, equitable, and age-friendly care."

Discussion
Why does the recommendation specify longitudinal primary care rotations rather than primary care rotations?
Research demonstrates that people who are trained in rural communities are more likely to practice long-term in those communities. However, there are serious logistical challenges to offering longitudinal rural rotations. There also are several definitions of longitudinal, including

serving a few weeks at a time over the course of completing medical school, or a full rotation during third year combined with an elective rotation fourth year. Longitudinal training should be long enough to become familiar with the community and the health care providers who serve there, and to learn the experience of rural primary care practice and how it is distinct from practice in other settings. This requires more time than a typical immersion experience. Longitudinal training allows trainees to provide continuous care to individual patients. It is important to promote and offer funding incentives for longitudinal rotations rather than focus only on increasing the minimal rural experience most education programs currently offer. Trainees must have an opportunity to develop a sustained relationship with the community, which requires more than a few weeks. There are several ways to support achieving this sustained relationship.

The Committee should define what it means by "longitudinal." The 17th Report includes a definition. The 18th Report may offer a broader and more flexible definition than the 17th Report. The recommendation's central aim is to give trainees opportunities to develop sustained relationships with rural communities and provide care and advocacy for patients over several clinical encounters. Grantees can propose innovative approaches to accomplishing this.

The recommendation should be to implement evidence-based practices shown to increase likelihood of the target outcome, even if it is challenging to implement these practices. However, lack of flexibility in defining longitudinal could lead to academic leaders ignoring the recommendation because it is too difficult to implement. The report's discussion of the recommendation should acknowledge challenges to implementation. The recommendation could be for grantees to develop mechanisms to help leaders overcome challenges to implementation. For example, HRSA could offer funding to support institutions in implementing rural medicine tracks with longitudinal rotations. The recommendation should offer clear direction but allow flexibility in implementation. It may be useful to include a glossary in the report that includes a definition of longitudinal and other key words with multiple definitions.

Recommendation 2: Congress should increase funding to the Title VII Section 747 and 748 programs to increase oral and behavioral health into primary care training to support

interprofessional team-based training and practice that supports the needs of medically complex patients, including those facing racial inequities, located in underserved communities.

Discussion

The narrative should define medically complex, and discuss implications of COVID-19 long-term sequelae. Narrative discussion should make it clear that the recommendation is to train providers to offer comprehensive care, not to add oral and behavioral training as new separate requirements. Some programs have included oral and/or behavioral care training for as long as 30 years. However, these do not support integrated care to the degree the Committee recommends. The report should clearly state that efforts to train providers to offer integrated primary care need to be expanded and strengthened.

The report should define complex patients and discuss the fact that many rural complex patients not only have more than one chronic condition, but also are affected by multiple determinants of health. It may be useful for the recommendation to refer to socially complex patients.

The recommendation should refer to "racial/ethnic inequities," not just "racial inequities". The report should discuss implicit bias as a major cause of inequities. It may be useful for the report to discuss core competencies of interprofessional practice.

Recommendation 3: Congress should increase funding to the Title VII Section 747 and 748 programs to build and enhance telehealth capacity of primary care training programs to use clinical telehealth technologies for telemonitoring, remote interprofessional collaborative care, shared patient management, and telementoring in underserved rural communities.

Discussion

The recommendation is to include both telehealth capacity itself and the capacity to train people to use telehealth. The report should define telehealth, telemedicine, and telementoring. It should be clear that the recommendation applies to teledentistry.

Telehealth is a potential mechanism for expanding rural health training experiences, by allowing students to serve rural communities remotely. In addition to teaching those who intend to practice primary care, it will teach future specialty care providers about rural communities they may serve through remote consultations.

Many rural patients prefer in-person visits. They enjoy face-to-face visits and sometimes find technology challenging. Elderly patients are especially likely to find technology challenging. Providers should facilitate rural patients' embracing telehealth. Training should help to address this need. The report should discuss inequities in telehealth access.

Recommendation 4: Congress should increase funding to the Title VII Section 747 and 748 programs to support interprofessional team-based education and practice that incorporates oral health and a life course approach to proactively address disparities in maternal and infant health outcomes in underserved rural communities.

Discussion

The report should note challenges rural patients face in accessing preventive care, including lack of providers. Poor maternal outcomes are due, in part, to distance required to travel for prenatal and obstetrical care. Nutritional education is important for maternal and child care, and for dental health. The narrative should define "life course approach."

Recommendations Adoption

Dr. Hicks moved to vote on approving the recommendations. Dr. Carreiro seconded the motion. The Committee voted unanimously to approve all of the recommendations.

Public Comment

Karen Mitchell, a family physician and Medical Education Director for the American Academy of Family Physicians (AAFP), said medical schools have specific definitions of longitudinal training and that the Committee should use different terminology to communicate their intent. She said medical schools define complex patients as having multiple comorbidities as well as being affected by social determinants of health. Dr. Mitchell said the Committee's recommendations align with AAFP's current vision for the future of family medicine residency education.

Closing Comments

Mr. Rogers and Ms. Glicken thanked the Committee for their work. Mr. Rogers adjourned Day 1 at 3:23 p.m. EDT.

DAY 2

Welcoming Remarks

Mr. Rogers convened the meeting at 10:06 a.m. EDT and took roll call. All members were present, except Dr. Lichtenstein. Ms. Glicken reviewed the agenda and encouraged all Committee members to submit input to the writing subcommittee at any time. She invited the Committee to comment on Day 1 presentations and discussions. Committee members said the draft recommendations and 18th Report accurately reflected discussions and focused on targeted outcomes. They agreed that presentations were informative. Some Committee members suggested that presentations should be briefer. Some Committee members requested presentations about barriers to implementing recommendations. Committee members suggested asking presenters to focus on issues related to health workforce training, and to discuss best practices. It would be useful for grantees to deliver presentations about how Title VII Sections 747 and 748 funds support priority outcomes. Committee members themselves could present some of this information.

Presentation: Workforce Data and its Relation to Health Equity

Clese Erikson, MPAff
Deputy Director, Health Equity Workforce Research Center, The George Washington
University Milken Institute School of Public Health
Department of Health Policy & Management

Health workforce equity is achieved when a diverse workforce has the competencies, opportunities, and courage to ensure everyone can achieve their full health potential. Health profession schools have a social mission to advance health equity and address health disparities by training a diverse workforce to practice disciplines the community needs most, with competency to address social determinants of health. Health system institutions such as Federal agencies and education institutions develop and implement policies, programs, and practices that determine whether students are trained in accordance with this social mission, which supports progress toward achieving the Quadruple Aim of health care quality.

Researchers at The Fitzhugh Mullan Institute for Health Workforce Equity developed a workforce diversity index that defines workforce diversity as the diversity of the current health workforce, by profession, divided by the diversity of the total workforce population aged 20 to 65 years. The index for the workforce pipeline is the diversity of graduates reported in the Integrated Post-secondary Education Data System (IPEDS), by profession, divided by the total population aged 20 to 35 years. Index scores indicate whether groups experience equal representation in the health workforce. An upcoming issue of *Journal of the American Medical Association* will publish Fitzhugh Mullan Institute research results on workforce diversity. Results show that minorities are underrepresented in many professional training programs. Researchers will identify programs that have increased diversity, and factors that drove improvement.

Research indicates that community colleges provide an important pipeline for race/ethnicity and socioeconomic diversity among physicians and physician assistants. Research also has shown that health professional programs frequently are biased against admitting community college students, even after controlling for grade point average and Medical College Admission Test (MCAT) scores. Only 37 percent of community college students pursue degrees from 4-year institutions. Outreach efforts could encourage more students to do so. Improved coordination

between academic medicine institutions and community colleges could address bias and strengthen the pipeline. Efforts could include outreach efforts to teach community college students about health profession careers and pathways, and mentoring.

A Fitzhugh Mullan Institute study compared proportion of participants in primary workforce training in each area of discipline who were National Health Service Corps (NHSC) participants versus those who were not NHSC participants. NHSC participants include a higher proportion of nurse practitioners. NHSC participants, especially nurse practitioners, were more likely to practice in HPSAs and high need HPSAs. It may be beneficial to recruit more nurse practitioners in order to meet the needs of communities most in need of primary care providers.

Telehealth use at community health centers surged during the COVID-19 pandemic. However, providers had little training in how to use telehealth. Demand for community health center telehealth services, including behavioral health and substance use services, is likely to continue after the pandemic. So, it is important to offer training in telehealth practice. Dental care utilization dropped dramatically during the pandemic, with telehealth not being utilized for these health services as much as for medical and behavioral health services.

Medical schools accredited since 2000 report on their web sites that they offer interprofessional education. But fewer than half of these schools offer longitudinal interprofessional education, which the Interprofessional Education Collaborative recommends. Very few offer experiential training models. One university developed partnerships with community-based service providers, and offered interprofessional team-based training in which providers meet with patients in their homes in order to learn about social determinants of health, roles of other health professionals, and value of community partners from direct experience. Program participants have reported that their experience convinced them to pursue careers in primary care. The American Association of Medical Colleges offers an interprofessional student hotspotting learning collaborative, in which students meet patients in their homes, and learn to address social determinants of health and to practice interprofessional team-based care. Students evaluated the experience positively. Participating schools are considering integrating the program into their standard curricula.

Accreditation is a major determinant of policy change. Setting standards for interprofessional education and workforce diversity is associated with improvement in these areas. Concerted efforts to increase workforce diversity are associated with increased applicant diversity. Educational efforts have improved knowledge, attitudes, and skills related to social mission. However, there is little evidence regarding whether efforts improve diversity among practicing clinicians, increase likelihood of practice in rural and underserved communities, or increase likelihood of interprofessional team-based practice or skill in addressing social determinants of health.

There is currently no widely accepted research demonstrating that these practices increase health equity. The field should invest in building a social mission research agenda. The field also must address barriers to translating education into practice. This will require establishing a researchers' Community of Practice to develop a logic model and guidelines for educational approaches that improve health equity. Education and training programs should encourage participants to obtain International Provider Identifier numbers to support tracking their progress in practice. ACTPCMD can encourage obtaining identifiers, collecting data, and funding social mission research.

Discussion
Discussion included the following questions and points.

The model for reimbursing dentistry services is generally fee-for-service, with little compensation for consultations. Most dentistry requires physical contact between patient and provider. This impedes using telehealth for dental care. However, dentists can remotely supervise auxiliary care providers in the field in delivering some preventive and diagnostic services. In States that allow it, dental therapists can perform procedures such as restorations. Allowing auxiliary providers can improve access to dental care.
This has improved dental outcomes for patients living in rural areas. Now is a good time to advocate for policies regarding reimbursement for telehealth, including expansion and extension of regulatory flexibilities implemented during the COVID-19 public health emergency.

Stakeholders also should consider whether this is likely to have unintended negative consequences.

State regulations can limit access to care other than dentistry, including prescription and substance use disorder treatment services. Fee-for-service payment models often limit ability to integrate and coordinate care in order to address social determinants of health. Value-based models often utilize community health workers, integrating care, and partnerships with public health and social service agencies in accountable communities for health that incentivize care coordination and efficiency.

Texas A & M College increased diversity among dental students by making it a priority to do so, ensuring the program hired faculty of color, and providing students with resources to support success. Research results on successful strategies for increasing pipeline diversity will be valuable.

People of color appear to be more afraid than white patients to go for in-person dental visits during the COVID-19 pandemic, possibly due to being disproportionately affected by morbidity and mortality.

Ms. Erikson will encourage Mullan Institute researchers to explore this.

Some medical school graduates are unable to find residencies even though the U.S. has a shortage of health care providers.

Between 500 and 1,000 medical school students annually are not matched with residencies. This is especially the case with students who have graduated from Caribbean medical schools, who have lower rates than others of passing the U.S. Medical Licensing Exam. These students often take out loans to attend medical school. Students should be educated about these risks. One Committee member advocates closing Caribbean medical schools. Graduates of Caribbean medical schools who do practice in the U.S. are more likely to serve underserved populations.

Presentation: Medical-Dental Integration and Team-Based Care
Caswell Evans, DDS, MPH
Professor Emeritus
Pediatric Dentistry, Prevention and Public Health
University of Illinois, Chicago

The U.S. health system focuses more on disease than health. Providers tend to be less skilled in prevention and health promotion and sustaining than other areas of practice. To the extent possible, the health system should maintain health and prevent people from becoming patients.

Payment for dental care is usually fee-for-service. There are few options for dental care in inner city and rural areas. People with low incomes, people of color, rural residents, people living in institutional settings, and elderly people are affected by oral health disparities. Medicare only reimburses for dental care that is considered a medical necessity. Less than 40 percent of dentists participate in Medicaid.

Oral health affects what people are able to eat and drink. It affects speech, and therefore how people are seen, self-confidence, employability, and opportunities for job promotion. Tooth decay causes tooth loss, pain, and suffering. Many children live with chronic oral pain. This compromises attention span, learning, school performance, and social behaviors. Periodontal disease also causes tooth loss, pain, and suffering. Tooth decay and periodontal disease are not self-healing, and will worsen over time without proper care. Oral health care should be fully integrated into general health care services and structure. Periodontal inflammation can spread throughout the body and exacerbate other health conditions. Medical costs are lower for patients with a periodontal regimen compared with those who have similar conditions but no periodontal regimen.

Oral cancer typically is diagnosed in late stages, with low 5-year survival rates. People of color have disproportionately high mortality from oral cancer. Treatment is disfiguring. Morbidity and mortality have not improved over the past 30 years, instead they have worsened due to effects of human papillomavirus. Few health care providers are trained to conduct oral cancer screenings.

Oral health care training should be included in education and training of all health care providers. Training should describe basic anatomy, form, and function of the oral cavity. Health care providers should be able to conduct a basic, thorough oral health examination, and be able to detect dental decay, periodontal disease, and signs of potential or overt cancerous lesions. Providers should be aware of the implications of oral inflammation for other health conditions and be able to make an active referral for oral health care. Integrating oral health training into primary care training will improve the health care system and health outcomes.

Discussion
Discussion included the following questions and points.

Dentists typically practice at separate sites from medical care providers and are not trained to be concerned with other aspects of patients' health. How can the education system and dental practice be changed so that dentists focus on overall health?
Nearly all dental school curricula focus on procedures and not the health significance of those procedures. Dental education is expensive and can result in substantial debt. Students who want to make their services available to everyone may be compelled to focus on repaying debt first. Professional organizations are not working to change the status quo and therefore,educational institutions should train dentists to change the status quo. Integrating oral health and primary care education will improve care quality and health outcomes, and broaden dental students' perspectives on health.

Community health centers are a critical source of primary care for underserved communities. Teaching them the link between oral health and overall health, and the value of oral health care for general health issues, such as diabetes and hypertension may facilitate offering integrated health care. Executive, medical, and dental directors are the main determinants of the degree of a system's medical and dental integration. Education is best when the people in these roles agree to implement integrated education.

Do you think value-based payment and a focus on prevention and population health will facilitate progress toward integrated oral and medical primary care?

Value-based care requires a system that recognizes the value of prevention for desirable health outcomes. As demonstrations show these systems to be effective, more will be implemented. The status quo has served dentistry well; there is little incentive to change. Committee recommendations can contribute to systemic change. This committee's reports are widely read by people in positions to make change.

Students, not just administrative leaders, can drive health care system change. An FQHC in Maine implemented a 3-year program that paired medical and dental students, the success of which inspired other FQHCs in the state to integrate dentistry into their practices. More than half of Maine's FQHCs now offer integrated dental services. Graduates asked for additional oral health care training when they were residents.

How much have States accepted dental therapy practice?

A total of 12 states have passed legislation regarding dental therapy and the Commission on Dental Accreditation (CODA) has approved accreditation standards for dental therapy. COVID-19 has delayed CODA's accreditation site visits, which is delaying implementation of training programs. In lieu of CODA action, states can credential programs. However, these credentials are not typically transferable to other states.

One model of dental therapy is for communities to support members' training in exchange for returning to the community to practice. Another model makes being a dental hygienist a prerequisite for training in dental therapy. There are concerns that dental hygienists may return to communities where they already practice rather than in communities with high need for more providers. CODA has not discussed whether it prefers either model, so has provided no input for states to refer to when developing legislation or licensure regulations.

The American Dental Association (ADA) has rejected dental therapy. The ADA spent more than $6 million to prevent Alaska from passing legislation allowing licensed dental therapy, which was unsuccessful. Many dentists oppose dental therapy because they perceive it to be competition. However, dental therapists typically treat patients who are unable to access traditional dental care. Dental therapy is likely to become a new professional discipline.

<center>**19th Report Discussion**</center>

The Committee may make recommendations about:

- How to increase workforce diversity through changes to training programs; mechanisms could include pipeline programs and the NHSC. The recommendation could emphasize cultures of "inclusive excellence" and aim to increase representation of underrepresented groups across health professions.

- Ongoing use of telehealth, including as a strategy for increasing rural access to health care or for teledentistry.

- Addressing social determinants of health.

- Expanding capacity for accrediting dental practice beyond CODA.

- Interprofessional training.

- Continued career support for students after graduation. Support could include education about using emerging technology, resources for addressing problems, or conferring about clinical cases.

- Training health profession students to serve patients with intellectual disabilities.

- Training primary care providers to address COVID-19 sequelae and to prepare for the next pandemic, as well as to apply lessons learned.

- Expanding scope of primary care practice to include services such as bedside ultrasound, using home monitoring technologies, and oral health care. Primary care practice scope has narrowed gradually over the past 30 years to be mostly outpatient care for adults. Training for expanded scope could increase graduates' confidence that they could competently serve rural communities. Lack of this confidence is a reason for primary care provider shortages in rural areas. Small rural hospitals often do not meet American Council for Graduate Medical Education (ACGME) standards for accreditation. Forming consortia could address this problem. This recommendation would apply to physician assistants as well as physician training.

The Committee could consider making a recommendation about how medical school graduates not matched to residencies can contribute to the health workforce. In some cases, these graduates did not do well in school. But in other cases, they did well in school but did not receive adequate career advising. Not being matched during the first attempt decreases likelihood of subsequent

matching. Some residency slots remain unfilled. The Committee could explore why this happens and how it can be addressed. However, this may not be within the Committee's jurisdiction and is a very complicated issue. Fewer than 12 percent of medical school graduates were not matched with residencies in 2020; 300 slots were not filled. A substantial number of unmatched graduates had attended medical school outside the U.S. and some are not U.S. citizens. A recent news report says the size of medical school graduating classes has increased to exceed maximum residency slots. The Committee may consider recommending increasing the number of residency slots. There has been argument about whether to do so for at least two decades. It may not be worthwhile for the Committee to become involved with the argument at this time. The Council on Graduate Medical Education (COGME) currently is addressing this issue. The Committee will ask COGME to share information about this topic. The Committee should consider current efforts to address this issue, such as Congress' recent increase of residency slots before developing a recommendation.

The Committee is interested in learning more about dental therapy as an emerging profession and controversies about dental therapy. The dental therapist program in Alaska is based on the community health aide model, which the medical community has embraced for 50 years. Dental therapists in Alaska are high school graduates who practice in the communities where they grew up. Providers are reimbursed through Medicaid; so state approval of the profession is critical for sustainability. Two dental hygiene model dental therapy programs are available in Minnesota. CODA does not advocate for training approaches. Advocacy for training programs and approaches is the purview of professional practitioner associations, such as the ADA. The Committee discussed writing a letter to the Secretary and Congress advocating recognition of the profession, but decided that, if they do make a recommendation, it will be in the 19th Report. When considering the recommendation, the Committee should keep in mind that state licensing boards have jurisdiction over who can practice in a state. Some dentists would support dental therapists practicing under the supervision of a licensed dentist in order to meet needs of underserved communities. Increasing access to care for underserved communities is a core benefit of dental therapists. However, dental therapists should not compete with dentists who are willing to serve these communities, such as NHSC loan repayers. The Committee should review literature thoroughly prior to making a recommendation on this issue.

Potential topics for the 19th report include:

- Workforce diversity

- Lessons learned from COVID-19

- Dental therapy

- Supporting medical students not matched to residencies in joining the health workforce

- Expanding primary care scope of practice

- Interprofessional practice, which can be considered one approach to diversifying the workforce

- Use of technology

- Serving patients with intellectual or developmental disabilities

When prioritizing topics and recommendations, the Committee should consider which will achieve greatest impact, as well as how to measure that impact. The Committee will try to develop four or five recommendations that address all key topics and discussion points discussed during the meeting. The Committee will include all recommendations in the annual report and not develop an additional letter.

Volunteers to serve on the 19th report writing committee were: Drs. Carreiro, Lichtenstein (volunteered prior to the meeting), Patton, Schneider, Snyder, and Veselicky. The writing committee will meet after the technical writer has developed a summary of topics and potential recommendations.

Business Meeting

The Committee's next meeting is scheduled for November 2-3, 2021, when the Committee will discuss topics for its next report. In 2020, the Committee developed a letter to the Secretary to be included in HRSA's report about health workforce coordination, as required by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. HRSA solicited input from all five BHW advisory councils and committees. Committees applied a framework developed by HRSA's Office of Planning, Analysis, and Evaluation (OPAE). HRSA will submit the plan to Congress by March 27, 2021. OPAE plans to meet with the five council and committee chairs in mid-April

2021 to discuss how their letters influenced the health workforce coordination plan. HRSA will publish the letter after the plan has been submitted.

Members are required to complete ethics recertification in May 2021. A HRSA Ethics Officer will contact members with instructions.

Public Comment

Dr. Karen Mitchell said that the American Academy of Family Physicians (AAFP) strongly supports funding for graduate medical education positions that serve rural and underserved communities. She said that analysis of Supplemental Offer and Acceptance Programs data shows that very few U.S. medical school graduates are not matched to residencies (approximately 600 annually), and a very small number of residency slots remain unfilled.

Closing Comments

Ms. Glicken thanked HRSA staff, the Committee, and the technical writer for their work, and Dr. Mitchell for her comments. Mr. Rogers thanked the Committee for their work and adjourned the meeting at 2:55 p.m. EDT.