

MEETING MINUTES
Advisory Committee on Training in Primary Care Medicine and Dentistry
January 9-10, 2019

Committee Members in Attendance

Thomas E. McWilliams, DO, FACOFP

Chair

Russell S. Phillips, MD

Bruce Blumberg, MD

Donald L. Chi, DDS, PhD

Tara A. Cortes, PhD, RN, FAAN

A. Conan Davis, DMD, MPH

Patricia McKelvey Dieter, MPA, PA-C

Rita A. Phillips, PhD, BSDH, RDH, CTCP

John Wesley Sealey, DO, FACOS

Teshina Wilson, DO

NACNEP Members in Attendance

CAPT Sophia Russell, DM, MBA, RN, NE-BC

Chair

Maryann Alexander, PhD, RN, FAAN

Ann Cary, PhD, MPH, RN, FNAP FAAN

Mary Anne Hilliard, Esq., BSN, CPHRM

Maryjoan Ladden, PhD, RN, FAAN

COL Bruce Schoneboom, PhD, MHS, CRNA, FAAN

Christopher P. Hulin, DNP, MBA, CRNA

HRSA Staff in Attendance

Kennita R. Carter, MD, Designated Federal Official, ACTPCMD

Tracy Gray, Designated Federal Official, NACNEP

Kimberly Huffman, Director of Advisory Council Operations

Janet Robinson, Advisory Committee Liaison, Advisory Council Liaison

Robin Alexander, HRSA Liaison, Advisory Council Operations

Carl Yonder, Division of External Affairs

Robin Pugh Yi, Technical Writer

Day 1 – January 9, 2019

Introduction

Dr. Kennita Carter convened the meeting of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD, or the Committee) at 9:00 a.m., January 9, 2019. The meeting was conducted in-person with remote access at the headquarters of the Health Resources and Services Administration, 5600 Fishers Lane, Rockville, MD 20857. Dr. Carter conducted a roll call that established a quorum with eight of the Committee's ten members present in person. She reviewed the meeting agenda, reminded participants of procedures, thanked members for their efforts, and introduced HRSA staff in attendance.

Dr. Thomas McWilliams expressed appreciation that the notices of funding opportunities (NOFOs) included in meeting materials reflected Committee recommendations, and believed the work funded by the new opportunities will improve the workforce serving targeted communities. He asked members to consider HRSA's needs and priorities presented during updates when contributing their own recommendations and discussion points. He invited additions to the meeting agenda and there were none.

Presentation: Bureau of Health Workforce Update

Luis Padilla, MD, Associate Administrator, Bureau of Health Workforce, HRSA

Dr. Carter introduced Dr. Padilla as the associate administrator of HRSA's Bureau of Health Workforce (BHW). Dr. Padilla thanked the Committee for their work and proceeded to provide an overview of BHW's activities. He emphasized an interprofessional approach to designing and recommending policy and program changes to HRSA's workforce programs, and added that recommendations from ACTPCMD and other advisory councils were intentionally incorporated in developing the Notice of Funding Opportunity (NOFO) for different grants.

Dr. Padilla stated that BHW's vision and mission is to realize the full potential of more than 40 workforce programs in developing skilled professionals for a positive and sustained impact on health care delivery for underserved and vulnerable populations. BHW supports students' education and training from initial stages through providing professional service. Such programs include pipeline programs, graduate medical education training programs, and service in exchange for loans and scholarships. Dr. Padilla then outline current initiatives that aligned with the four BHW priorities for 2019-20.

BHW Priority 1 Transform the health care workforce by creating training opportunities, incentives, and sustained support for clinicians working in rural and underserved areas

Dr. Padilla explained that BHW addressing the opioid epidemic improving integration of primary care with behavioral health, supporting infrastructure for behavioral and mental health

services nationally, and the number of clinicians trained in evidence-based medication-assisted treatment. He stated that additional discretionary funding allowed them to expand their training into additional rural and underserved communities. BHW also partnered with HRSA's Bureau of Primary Health Care to supplement existing grantees to provide more longitudinal training in federally qualified health centers for behavioral health students.

BHW Priority 2 Increase access to behavioral health services, including substance abuse disorder treatment

Dr. Padilla explained that BHW also used the additional discretionary funding to expand the eligibility criteria for more behavioral health clinicians to apply to their National Health Service Corps (NHSC) program. He added that BHW planned to connect other awardees to grantees from the Federal Office of Rural Health Policy, in a partnership to address substance use disorder in rural areas. Dr. Padilla described the Teaching Health Center Graduate Medical Education (THCGME) program as a successful BHW initiative that addresses the gap between the demand for primary care services and the capacity to deliver on that demand. He added that this program, the NHSC, and the health center programs face a funding cliff at the end of fiscal year 2019. He reassured the Committee that BHW is preparing for this by engaging with stakeholders and Congress about options for sustaining programs.

BHW Priority 3 Use health care workforce data to inform program and policy

Dr. Padilla stated that BHW prioritizes leveraging health workforce data to show the extent to which students support the mission of working in rural and underserved communities. For example, their tracking platform using the National Provider Identifier (NPI) to track all 15,000 alumni who served in the NHSC over the past 5 years also tracks alumni of the Nurse Corps Program. BHW hopes to expand tracking efforts to the THCGME and Children's Hospital Graduate Medical Education programs in FY 2019. Dr. Padilla confirmed that BHW's Health Workforce Research Centers concluded that this is the best approach currently available. He explained that the resultant data has already illustrated program impact and revealed connections between programs. In future, BHW hopes to collect data on the proportions who work in targeted communities, that they might identify quality indicators, such as health outcomes, that demonstrate impact on communities. Dr. Padilla encouraged the committee to read BHW's Behavioral Health Projection Report released in December 2018 for projections of behavioral health supply and demand through 2030.

BHW Priority 4 Infuse BHW values and priorities across the organization to guide policy and program decision-making

Dr. Padilla explained how core values (innovation, collaboration, results-driven) are applied to all BHW programs in stakeholder engagement, program and policy development, and assessing present and future health workforce needs across the Nation. He added that BHW holds grantees accountable for using funds to train students to work in rural and underserved areas. He also relayed statistics on the number of students and clinicians participating in BHW programs over the years, and the percentage increase of BHW graduates employed in underserved areas.

Dr. Padilla outlined how BHW implemented the recommendations from the ACTPCMD and other advisory councils in updating the language of different NOFOs. He gave an example of how BHW added NHSC for the first time a health professions grant opportunity NOFO (of the Primary Care Training Enhancement Champions program). In the NOFO, BHW gave preference in opportunities to serve under the NHSC as a strategy to encourage students to serve in rural and underserved communities after graduation.

Dr. Padilla concluded by presenting an upcoming initiative in medical student education programs for tribal communities, and promised to apply the same BHW principles to provide care in rural and underserved areas and encourage clinicians to remain serving the community after completing their residencies.

Discussion of presentation

Dr. McWilliams commented that BHW's core values align with those of the communities ACTPCMD represents, and emphasized data tracking would be discussed when developing Committee recommendations. He suggested that grantees be required to track graduates and trainees and encouraged discussion on the role of Centers for Medicare and Medicaid Services to mitigate funding uncertainty that may limit progress.

Dr. Tara Cortes expressed interest in working with NACNEP as the only nurse on ACTPCMD and urged Dr. Padilla to promote more structural opportunities for interaction across committees.

Dr. Russell Phillips asked if BHW tracking data would be publicly available that researchers might consider how best to measure clinical and community outcomes. Dr. Padilla confirmed some files are publicly available while BHW considers how best to share performance data externally by FY 2019. He asked the Committee for their input and encouraged recommendations on what data would be most useful to improve programs and outcomes.

Dr. McWilliams agreed that long-term tracking is important, and that the data be available to know the extent to which HRSA achieves the long-term goal of more clinicians serving rural and underserved communities. Dr. Padilla agreed.

In closing, Dr. Padilla welcomed Dr. Tori Mack as BHW's new Deputy Associate Administrator and Dr. McWilliams thanked him for his presentation and work.

Presentation: Division of Medicine and Dentistry Update Panel

Joan Weiss, PhD, Division Senior Advisor, Designated Federal Officer of the Advisory Committee on Interdisciplinary, Community-based, Linkages

Shane Rogers, Branch Chief, Oral Health Training Branch

Anthony Anyanwu, MD, Project Officer, Medical Training and Geriatrics Branch

Dr. McWilliams welcomed Dr. Weiss, who provided updates on the Teaching Health Center Graduate Medical Education program, Children's Hospital Graduate Medical Education program. She added that the Advisory Committee on Interdisciplinary, Community-based,

Linkages is working on their 2018 Report to prepare the healthcare workforce to practice in age-friendly health systems and their 2019 Report will focus on root causes of population health issues and having primary care providers increase their focus on prevention. Dr. Weiss also stated that the Geriatrics Academic Career Awards program and Geriatrics Workforce Enhancement Program will be available to compete for awards this FY 2019. When asked about having these awards extend support to community-based programs, Dr. Weiss confirmed that the primary care training enhancement program is available instead.

Dr. McWilliams welcomed Mr. Shane Rogers, who gave an overview of the branch and updates on Title VII Section 748 training programs in general, pediatric, and public health dentistry, and dental hygiene through pre- and post-doctoral training, faculty development, and faculty loan repayment, and financial support of dental trainees. He specified appropriations over the past five and mentioned programs funded, such as the State Oral Health Workforce program authorized by Title III, Dental Faculty Loan Repayment Program, Primary Care Clinician Educators Award Program, and supplemental opioid training grants to support teaching better practices in pain management across conditions and to train oral health care providers to identify and care for patients with substance use disorders.

Mr. Rogers concluded his presentation stating that his Branch is looking to improve the post-doctoral training programs in rural areas, and longitudinal tracking of trainees' practice locations through NPIs. When Dr. Carter asked for insight, Mr. Rogers asked the Committee to consider how the post-doctoral training program could be improved to increase grant applications in 2020 and to track grantees.

Dr. McWilliams welcomed Dr. Anthony Anyanwu, who provided updates about the various programs under Primary Care Training and Enhancement that support workforce development training for future primary clinicians, teachers, and researchers and promote practice in rural and underserved areas. Dr. Anyanwu also highlighted two upcoming competitive grants for integrating behavioral health into primary care, and physician assistant training. He concluded by asking the Committee for input on how to increase the number of physicians in rural and underserved areas.

Discussion of Presentation

Dr. Carter opened the floor for discussion with the panel and Dr. McWilliams asked the audience to consider how Committee recommendations could best facilitate HRSA's work.

Ms. Patricia Dieter expressed difficulty in meeting funding opportunity requirement of HRSA 19-087, that emphasizes physician assistant training in medication-assisted treatment because their program places only a few students at each clinical site that they may not have the standing with sites to implement interventions. She added primary care facilities should remain focused on their core mission rather than focus too much on opioid and other substance use disorders. Nevertheless, she hoped there would be many applications.

With prompting from Dr. Carter, Ms. Dieter said HRSA should be mindful on how they bridge education and training to practice as educational program may find difficulty in changing practice at clinical sites. She emphasized that changes in practice require a community partner

and asked how educational programs might develop community relationships to implement such change. Dr. Sealey commented that many residency programs do not have an academic partner and thought that adjusting the requirement for an academic partner might make smaller programs eligible, and thus potentially increase impact in both urban and rural underserved communities. Dr. Anyanwu stated eligible applicants are either an accredited training program or have an accredited academic partner; He explained the intent was so an academic partnership allowed smaller organizations to compete for funding. Dr. Anyanwu and Dr. Sealey proceeded to discuss how accredited community organizations are eligible to compete for the Primary Chair Champions programs. Dr. Carter and Dr. McWilliams added there might be a need for leadership development in accredited training programs without academic partners, especially the case in rural areas. Dr. Tara Cortes clarified that the community-based sites being discussed provide primary clinical care and are not social service programs.

Dr. Russell Phillips asked how to strengthen the implementation and practice of oral health integration with primary care. He explained that his academic unit noticed champions of oral health integration have been critical to the growth of strong education programs and asked if PCTE Champions program included this element. Dr. Anyanwu confirmed current grantees have the option to train oral health practitioners in their interprofessional team-based training programs.

Dr. McWilliams commented HRSA benefit from collaborating with the American Medical Association in their support for transitions from training (undergraduate to graduate) to practice. He added that his university's Hometown Program partners with community health centers to identify potential medical students likely to serve the community after graduation and encouraged implementing similar programs elsewhere.

Dr. Donald Chi suggested the decline in applications to post-doctoral pediatric dentistry programs may be due to the decrease in pediatric dentists becoming academic professionals and proposed to issue NOFOs for scientific leadership training in pediatric dentistry. He cautioned that requiring *accredited* postdoctoral residency training programs might limit the applicant pool and training opportunities. Mr. Rogers agreed there is a need for more academic faculty in pediatric dentistry, explained HRSA attempted to address this through career development awards, and invited ideas on how to increase interest in training faculty. Dr. Chi and Mr. Rogers explored the idea of joint grantees to train people across different site, while Dr. Chi suggested grantees may not have had enough time to apply by NOFO deadlines.

Dr. Conan Davis asked if application cycles for the National Health Service Corps loan repayment program might be changed to accommodate graduation dates of dental programs and Mr. Rogers confirmed his team could present the suggestion at internal workgroup meetings.

When Dr. Rita Phillips expressed how State laws under the State Practice Act create barriers to dental hygienists providing services in underserved communities, Mr. Rogers said that HRSA cannot lobby States but has supported training for expanded professional roles when approved by State law. Dr. Tara Cortes added that State funding is critical for program sustainability and driving State policy change.

Dr. McWilliams asked for incentives to participate in education conducted in community-based practices and proceeded to discuss options with Dr. Cortez on how to support medically underserved communities, while collaborating between urban and rural areas. Dr. Sealey and Dr. Weiss discussed encouraging geriatric specialization through student fellowships.

Performance Measures and Performance Evaluation

Isaac Worede, Branch Chief, Performance Metrics and Evaluation, National Center for Health Workforce Analysis

Dr. McWilliams introduced Mr. Isaac Worede while Dr. Carter confirmed that a quorum of Committee members was present.

Mr. Worede outlined his presentation on how HRSA responds to performance measurement requirements under the Government Performance and Results Act, how logic models support performance measure development, and how results inform funding announcements, program improvement, and workforce advancement.

Using an example, Mr. Worede stated that logic models explicate program purpose and identifies data to be collected at that support program goals; thereby providing a framework for developing performance measures and funding opportunities. The models indicate which activities should be required of grantees and whether program goals have been achieved. Annual performance is assessed in July, after the academic year has finished, and analysts conduct program evaluations to assess how programs compare to others nationally, and results are used in program design and planning.

Discussion of presentation

When Ms. Patricia Dieter asked how analysts determined whether the grant programs or other factors achieved the targeted outcomes, Mr. Worede stated tracking changes during the program was limited to, in some cases, a year after completion. They discussed potential challenges in tracking physician assistants by NPI number and beyond. Dr. McWilliams, Dr. Carter, Dr. Sealey, and Mr. Worede discussed ideas for tracking where students go after graduation: (1) HRSA setting up a formal data management system; (2) making trainees aware they were receiving HRSA funding and voluntary offer information; (3) grantees tracking trainees online; (4) interviewing trainees about their plans annually during the program and the year after training completion; (5) updating HRSA's communication system with grantees and reporting requirements. The Committee also discussed how education impacts clinical outcomes and population health, and how patient-reported outcomes measures might be a good way for HRSA to demonstrate changes in population health, not just the number of people trained.

When Dr. Russell Phillips asked if retention was a priority, Mr. Worede confirmed all HRSA programs aimed to recruit and retained trainees practicing in medically underserved communities although it is difficult to assess impact after one year as grantees are only required to collect data for that time period. Dr. Phillips suggested the Committee consider how other programs could target retention, while Dr. McWilliams added it would be useful to learn about other organizations' efforts to document outcomes.

Ethics Training

Laura Ridder, Ethics Advisor

Ms. Ridder reminded Committee members that their ethics documents are due on January 20 and introduced Secure Electronic File Transfer System that allows HRSA secure return of certified review forms to refer to when completing new forms. She provide technical guidance on how to edit and submit information on the system, and highlighted some changes in required reporting.

Discussion: Innovations in Interprofessional Education and Training

Dr. Carter acknowledged NACNEP members and introduced Captain Russell as the Director of BHW's Division of Nursing and Public Health, Chair of NACNEP, and member of the US Public Health Service Commission Corps. CAPT Russell thanked the Committee for opportunity to discuss potential synergy and collaborative work in shared priority areas. She explained her Division managed grants and cooperative agreements to support nursing and education under Title VIII of the Public Health Service Act, and provided an overview of NACNEP's charter. After Dr. Carter outlined ACTPCMD's charter, the members from both Committees completed self-introductions.

Dr. McWilliams and CAPT opened discussions for collaboration opportunities between Committees in review of BHW priorities. Topics covered include: training interdisciplinary teams; involving registered nurses in developing Notice of Funding Opportunities (NOFOs) new models of funding and payment for primary care that emphasize supporting health professionals in expanding their leadership roles reviewing the current HHS Inter-agency Pain Task Force; developing NOFOs between the advisory committees and aligning their priorities and reporting. After suggestions, Dr. Cortes commented on how statute may limit the level of interprofessional education and training because they come from different funding streams (Title VII and VIII).

Ms. Mary Anne Hilliard joined the call, introduced herself, and asked if collaborative projects can use funding from multiple sources such as using telemedicine, which Ms. Gray confirmed to follow-up with HRSA. When Dr. Carter encouraged clarification on how work would comply with statutory constraints, Dr. McWilliams suggested both committees make the same recommendations and identify the same priorities to increase the probability of HRSA acting on those recommendations. Dr. Alexander concurred and added how ACTPCMD and NACNEP both value interdisciplinary practice, access to care in rural communities, and better healthcare at lower cost, through collaborative research and complementary training efforts.

Dr. Cortes and Dr. Carter then reviewed the role of nurses (specifically Registered Nurses and Nurse Practitioners) to both Committees in the context of primary care teams. To facilitate discussion, Ms. Gray gave an overview of the various programs for registered nurses that have a nurse education and practice focus, with emphasis on undergraduate training, offered by the Division of Nursing and Public Health. Dr. Sealey asked if the residency program is accredited and how supervision is evaluated. Ms. Gray explained that the programs are not required to be accredited, but the community health center itself and academic institution must be accredited. She added grantees are required to have a clinical coordinator and preceptors who oversee clinical training.

Dr. Cortes mentioned that residency programs help nurses prepare for transitions from one type of practice to another, such as acute care to long-term care. Dr. Ann Cary provided details on the residency program by the American Association of Colleges of Nursing (AACN) and encouraged more programs to become accredited. She stated that nurse residency programs increase nurse retention and knowledge of quality and safety indicators, and also increase nurses' efforts to learn about and implement evidence-based practices. She also confirmed the residency program is only for undergraduate students.

When Dr. Carter encouraged Committee members to consider topic areas of mutual interest, Ms. Gray shared NACNEP's upcoming report on ensuring that graduating nurses are prepared to care for underserved populations through community engagement. Dr. Ladden suggested training and educating health professionals to provide appropriate care for patients who have complex medical and social needs. Dr. Phillips suggested co-developing a program for on-the-ground leadership training in primary care practices.

When Dr. Teshina Wilson suggested training professional teams to innovatively address social determinants of health in community-based care, including oral health, Dr. Carter asked how NACNEP members envision integrating oral health into their programs and CAPT Russell suggested to start with nurse anesthetist training and opioid workforce expansion.

Dr. Hulin supported training primary care physicians in new opioid regulations, substance abuse treatment options, and pain management. He recapitulated that leadership training is important to responsibly manage healthcare cost, and also suggested education on multimodal therapies in prevention techniques that could reduce opioid abuse.

Dr. Conan Davis suggested educating providers on what types of healthcare resources are available in the community, while Dr. Donald Chi suggested oral health care providers could offer children early prevention services, such as screening, brief intervention, and referrals to treatment.

Dr. Carter concluded discussions; promised to share ACTPCMD's letter to the HHS Secretary about exploring preventive strategies to address the opioid crisis, and to relay discussion highlights with HRSA leadership; and invited closing remarks from Committee chairs. CAPT Russell looked forward to collaborating with ACTPCMD, while Dr. McWilliams concurred with the priority topics listed by Dr. Carter. He suggested to consider training at facilities such as the Veterans Health Administration, community health centers, Kaiser-Permanente, and other large health networks, where best practices in medicine are demonstrated to show trainees how medicine should be practiced into the future.

16th Report Committee Discussion

Contrary to the agenda, the Committee requested to discuss the 16th report before the 17th report. When Dr. Cortes asked for a review of previous discussions, Dr. Carter stated the 16th report included recommendations on appropriations, program evaluation, and the need for longitudinal training, and broadly, innovation and telehealth. When Dr. McWilliams asked to go over each recommendation, Dr. Carter said the Committee had already approved them and suggested

instead to discuss how to complete the report, especially the introduction and transitional paragraphs as they did not have a technical writer. The Committee proceeded to discuss different portions of the report, distribute responsibility among the writing committee, and how their earlier comments with NACNEP could augment content.

When discussing Part B recommendations that went outside the scope of ACTPCMD's charter, Dr. Sealey suggested more clinical positions outside hospitals are needed to care for urban and rural America and that a refining of primary care to encompass all specialties. Dr. Carter suggested postponing discussions on that issue as it would require more time to resolve than was available to complete the 16th report.

Next, the Committee deliberated on wording of the recommendation to increase program funding to ensure it was within the scope of the Committee's authority and concluded it may be better to make the recommendation through a letter rather than a report. As Designated Federal Officer to the Council on Graduate Medical Education (COGME), Dr. Carter stated this recommendation would instead fall under COGME authority.

Dr. Russell Phillips said the report includes a recommendation to expand the Teaching Health Center Program, without specifying a budget allocation. He asked if the Committee was considering removing that recommendation. Dr. Carter said the recommendation was to increase the number of primary care residency positions and to extend the renewal proposal. It is a B-level recommendation, meaning it is outside the Committee's scope, but the Committee considers it important for the future of primary care and likely to support work authorized under Title VII. Dr. Carter said the recommendation is appropriate because it does not recommend appropriations, will support work authorized by Title VII, and is presented as a B level recommendation. Dr. McWilliams said the paragraph introducing B-level recommendations should explain what they are. Dr. Cortes concurred.

Dr. Russell Phillips said that descriptions of the primary care shortage vary within the report. He recommended using the same quantitative estimates throughout. Dr. McWilliams asked whether the Committee should do this or explain the variation in estimates. Dr. Carter said the Committee could acknowledge reasons for variation. She pointed out that data cited tend to refer only to physician shortages, while Title VII concerns other professions as well. Dr. Sealey said there is controversy regarding shortage estimates for dentists and dental hygienists. He said that because of this controversy, the Committee did not recommend an increase in dental services. Dr. Chi said the American Dental Association reports that the number of providers is growing, but gaps in rural availability remain.

Dr. Carter asked if there were a way to discuss shortages of service without estimating numbers of providers. For example, it would be useful to describe lack of access to preventive oral healthcare among children younger than 3 years old. It is important to notify policy makers of the issue. Dr. Cortes said this is an important issue. She said the public generally does not recognize oral health as integral to health, but as cosmetic and optional. She said the committee should make the case that oral health is an essential component of health. Dr. Carter said it is important for policy makers to understand why this is the case. This will help policy makers invest in addressing the shortage of primary dental care. Clear examples and explanations also

will facilitate communication between policy makers and constituents about the importance of access to primary dental care.

Dr. Davis said the Surgeon General's report describes oral health disparities and access issues. He and Dr. Cortes also said that Medicaid fees for dentists are prohibitively low. Dr. Cortes said addressing this is outside the Committee's scope but is an important reason for lack of access to oral health care. Dr. Carter said that there are multiple ways to describe needs without exact estimates about the number of dental care providers needed. She said the report must describe these needs and the rationale for recommendations. Dr. Sealey asked Dr. Davis to send him the Surgeon General's report, which he would reference in the recommendation.

Dr. Sealey said that if providers cannot make a living, they will not practice in communities most in need. It is not enough to train providers. Programs also must pay them to practice. Dr. Chi concurred. A large proportion of children have unmet need for preventive dental services. The solution is not necessarily training more providers. The recommendation is to continue programs with the budget increase explained in the current draft report. Dr. Carter said the Committee agrees that data are important for supporting recommendations.

Dr. McWilliams asked if the Committee could recommend that HRSA provide support for a technical writer to support ACTPCMD's writing needs. Dr. Carter said HRSA is working on this. Dr. McWilliams said it is important to produce a well composed document and asked if it would be helpful for the Committee to recommend support for this work. Dr. Carter said committees are supposed to write their own reports. HRSA provides support. She said she would consider Dr. McWilliams' request and discuss it with him later. She thought this would not be an appropriate report recommendation.

Dr. Carter said there is a technical writer for the 17th report, which is expected to be finalized within 4 months. She invited writer Dr. Pugh Yi to introduce herself. Dr. Pugh Yi said she has been working with the Federal government on research and training projects for almost 30 years, including developing reports on meeting proceedings.

17th Report Committee Recommendation Development

Dr. Carter said she had previously asked the Committee to review recently released NOFOs and to consider how to advise HRSA, the Secretary, and Congress on how to move forward in the context of the current budget and funding opportunities. She referred Committee members to Dr. Padilla's presentation on BHW priorities. She said Dr. Davis' recommendation to align timing of National Health Service Corps applications with academic schedules should be submitted to a report to the administrator rather than as a report recommendation. Dr. Carter invited additional recommendations.

Dr. Cortes said the Committee should discuss how technology can support oral health care. She also said the Committee should recommend support for age-friendly dental care for middle-aged adults in order to prevent geriatric problems. Dr. Cortes said age-friendly care is important across the lifespan. She also said it is important to teach health professionals to share care planning and decision making with patients.

Dr. McWilliams said the Committee could recommend teaching value-based training, with an emphasis on increasing awareness of the cost of pharmaceuticals, which is an important issue for underserved communities. He also said that the American Medical Association recently released a NOFO for preparing trainees to transition from medical school to residency and from residency to practice. It may be useful for HRSA to offer similar training. Dr. Cortes value-based training must consider the outcomes achieved.

Dr. Russell Phillips asked whether data will be publicly available to allow assessment of program outcomes. Dr. Cortes said data should measure targeted outcomes such as recommended changes in primary care practice. Ms. Dieter said outcomes also include changes in teaching. Dr. Russell Phillips said health systems collect data on practices. These data could support outcomes assessment. Dr. Chi said HRSA could require grantees to conduct internal evaluations. Dr. Cortes said there could be a recommendation to emphasize a transformation in teaching rather than increasing the number of people trained.

Dr. Chi said previous reports have emphasized existing problems. He would like the current report to focus on how to change workforce quality. The report could discuss how to train students at pre- and post-doctoral levels to use evidence-based behavioral change practices to encourage patients to engage in preventive self-care. Dr. Chi said he would like incentives for grantees to test innovations in behavioral change. Dr. Wilson asked what evaluations would assess. Dr. Chi said they would assess changes in care delivery in the short-term and in patient behaviors in the long-term. The goal is to change training in order to change practice, which in turn changes patient behaviors and community norms, resulting in improved health outcomes.

Ms. Dieter said that she would like more support for educating faculty about the unique needs and demands of rural and underserved communities.

Public Comment

Ms. Teresa Baker introduced herself as a senior government relations representative with the American Academy of Family Physicians. She referred to the appropriation bill the President signed on September 28, 2018. The bill allocates \$89,596,000 for Title VII program in FY 2019. The report recommendation to allocate \$89 million appears to be a request for a budget cut. Ms. Baker recommended correcting this in the final report.

Dr. Robin Pugh Yi said that other agencies are also exploring how to track trainees and it may be useful to share findings and insights about how to accomplish this. Dr. Pugh Yi said she was tracked for 20 years after completing post-doctoral training funded by the National Institute of Mental Health. She said that a departmental administrative assistant called her and other trainees approximately once a year to ask brief questions to determine whether their work matched with training grant goals. She said program mentors informed new post-doctoral trainees that the program was NIMH-funded and that documentation of training results was important for continued funding. Dr. Pugh Yi confirmed that understanding the purpose of tracking encouraged trainees to participate. She agreed with Dr. Carter's suggestion that this was important aspect of successful tracking.

Dr. Carter asked if there were additional public comments. There were none.

17th Report Committee Recommendations Development

Ms. Dieter said that increasing faculty awareness of issues unique to underserved communities could be addressed by recruiting more faculty with expertise in this area or through fellowships to train faculty about the issues.

Dr. Russell Phillips suggested consideration of how primary care trainees are prepared to engage the community and use community resources, such as community health workers, food, and housing, to address social determinants of health. Dr. McWilliams said his organization conducts annual community assessments and projects to address social determinants of health. It has been effective. Dr. Sealey said his program requires trainees to work in the community and to develop a directory of community resources.

Dr. Carter said longitudinal trainee tracking and use of technology were potential topics. She suggested that the Committee may want to consider how technology could be used in tracking.

Dr. Cortes said she was interested in how technology such as ECHO, online interactive webinar modules, and Skype could support innovative teaching and long-distance training to reach trainees in remote areas.

Dr. Carter adjourned the meeting.

Day 2- January 10, 2019

Dr. Carter conducted roll-call, welcomed meeting participants and turned the meeting over to Dr. McWilliams.

2019 Recommendations

Dr. McWilliams invited suggestions for the 17th report. Dr. Cortes said that Dr. Russell Phillips had developed and shared a framework for the report. Dr. Russell Phillips presented a list of four priority areas that he said aligned with those presented by Dr. Padilla. It emphasized social determinants of health and addressing health behaviors. It also emphasized behavioral health integration and program evaluation. All of these are part of innovation in primary care education and practice.

Dr. McWilliams suggested adding a topic related to increasing awareness among faculty and residents of treatment costs. Medical care is very costly but this issue is not addressed in medical education curricula. Dr. Russell Phillips said this is an important observation but that he was not sure how it would be a recommendation. Dr. Carter said that former HRSA division director Dr. Candice Chen conducted a study on the relationship between the costs of care where clinicians trained and where they practiced. Results show that practitioners' cost-efficiency in practice reflected what they were taught in training.

Dr. Russell Phillips said he thinks most costs of healthcare are not from primary care practice. Medical costs are typically reduced through increasing comprehensiveness, coordination and continuity. This approach is not applicable to primary care. Dr. McWilliams said knowledge of costs allows better decisions. Dr. Carter said the American College of Physicians is

implementing a high-value care initiative to avoid harm and eliminate wasteful practices. She said providers' knowledge about when to use MRI versus X-rays or when to prescribe antibiotics informs cost management and is a result of their training. Dr. Russell Phillips concurred. In addition, he said it would be useful to train primary care providers to advocate for patients and for the interests of the primary care field. He does not believe there is enough training in this area.

Ms. Dieter said the suggestions have been for new content to add to primary care education rather than change in how education is conducted. Faculty typically feel burdened by requirements to teach additional content. She said recommendations should be supported by explanations of how they will enhance educational strategies. She considers online training a true innovation in training. Dr. Carter encouraged the Committee to consider potential innovations in training and how to encourage innovation. She noted that training in community-based settings rather than hospitals or academic settings is an innovation. Ms. Dieter said the Committee should recommend innovation but not specific technologies. Dr. McWilliams concurred.

Ms. Dieter said some NOFOs require grantees to meet too many specific objectives, resulting in a narrower range of applicants. Dr. Chi concurred and suggested that the Committee prioritize topics and ideas. Dr. Cortes disagreed and said that writers should be able to competently respond to NOFOs. Dr. Carter pointed out that organizations vary in their access to grant proposal writers. Smaller organizations may be overwhelmed by broad NOFO requirements. Drs. Sealey and Russell Phillips agreed. Ms. Dieter said intimidating NOFOs could result in the same grantees continuing to win competitions, possibly reducing likelihood of innovative projects. Dr. Wilson said her experience in a federally qualified health center confirmed that smaller programs lack writing resources, infrastructure, sustainability to respond to grants that demand meeting too many objectives. Fewer objectives could encourage smaller community centers to apply. Dr. Cortes said the issues mentioned suggest that HRSA should continue to require an academic partnership. Academic institutions have the necessary resources to respond to NOFOs. Dr. Sealey said some institutions are difficult partners and thwart their partners' innovations.

Dr. Wilson said larger partners sometimes do not support smaller partners' goals, discouraging smaller agencies from developing partnerships. She also said partnerships can be beneficial. She said NOFO requirements may discourage innovative small organizations from applying. Dr. Carter asked how common this problem is. Drs. Sealey and Cortes said it is common. Dr. Cortes said she had observed larger partners using funds allocated for community building to increase their administration instead. She suggested requiring that community partners receive at least half of funds granted to partnerships. Dr. McWilliams suggested considering a recommendation to prioritize support for smaller grantees who have not previously won grant awards. Dr. Russell Phillips said community-based partners are very important for improving care and serving vulnerable populations.

Dr. McWilliams asked what HRSA needs beyond the recommendation in the 16th report to allocate funds to HRSA to develop expertise and capacity to evaluate long-term outcomes. Dr. Cortes said the previous recommendation is broad and without recommendations about how to track. Dr. Carter asked the Committee to consider what type of system would be required to track applicants. Dr. Sealey said that the statute limits funds, and that recommendations should not exceed that budget.

Dr. Carter displayed Dr. Russell Phillips' framework on the screen, with a fifth recommendation to focus on value-based care- added. Dr. McWilliams said the 13th report focused on social determinants of health. He asked the Committee to review it to ensure recommendations in the 17th report are not redundant. Dr. Chi said the 5th report includes discussion of outcomes evaluation, including longitudinal tracking. Dr. McWilliams said issues discussed in previous reports may continue to be unresolved and therefore relevant. Dr. Chi agreed and said issues identified in previous reports could still influence current recommendations. Dr. Wilson said the 13th report recommends interprofessional educational activities to address social determinants of health in vulnerable populations. It also recommends that HRSA offer support for programs to assess their impact and the effectiveness of training methods. The 13th report also includes a recommendation to support Medicare in continuing development of a payment infrastructure based on value-based care.

Dr. Russell Phillips said that, given the redundancies identified with previous reports, it would be good to submit new ideas in the current report. He asked what in the posted framework is new and will inform HRSA priorities. Dr. Carter said the report theme could be partner equity across the primary care spectrum in addressing population health. Dr. Cortes suggested the phrasing, "building partner equity across the community with primary care." Dr. Russell Phillips asked if a theme of developing community partnership to improve population health would be redundant with previous reports. Dr. Cortes said the current report is different from previous reports because of the emphasis on community resources, and on community and family engagement. The idea is that leveraging community resources could increase impact on social determinants of health. Dr. Wilson suggested the wording, "Incorporate evidence-based behavioral change strategies related to healthcare costs in training curricula as well as practice settings." Dr. McWilliams said he liked the wording. Dr. Cortes said partnerships would contribute to target outcomes of a value-based payment system.

Dr. Carter said there should be discussion in the report about next steps for collaboration with NACNEP. Dr. Cortes asked if this could be a statement that ACTPCMD will communicate with other advisory committees about commonalities. She also said the report should include a paragraph stating that the groups met and discussed potential topic areas for future work. Dr. Wilson suggested reporting the groups' shared enthusiasm for training interdisciplinary teams. Dr. Davis agreed with this idea. Dr. McWilliams asked where this statement would be placed in the report.

Dr. Russell Phillips said some discussion points could be written in a letter rather than the report. Suggestions about NOFOs could be made through a letter. It also may be most effective to suggest more collaboration between advisory committees through a letter sent jointly with NACNEP. Dr. Russell Phillips said both letters would be concise.

Dr. Carter asked Committee members to consider and comment on the 15th report title: "Reducing Burnout among Primary Care Trainees and Clinicians: Managing Stress, Building Resilience, Optimizing Systems, and Promoting Well-being." The Committee revised the title to "Improving Well-being among Primary Care Trainees, Faculty, and Clinicians: Optimizing Systems to Mitigate Burnout, Promote Resilience, and Drive Quality of Care." Dr. McWilliams asked for a motion to accept this title. Dr. Wilson placed a motion and Dr. Sealey seconded it. The Committee unanimously voted to accept the title.

16th Report Discussion

Dr. McWilliams asked the Committee if they would like to increase the recommended budget allocation. Dr. Russell Phillips said the intent of the recommendation had been to increase the previous budget by \$10 million. He recommended changing the request to \$99.7 million. Dr. Carter suggested that Committee members consider potential costs of longitudinal tracking when recommending budget allocations. She pointed out that the report included a request to track clinical outcomes, which is not required by statute. Dr. Cortes suggested offering an automatic 3-year no-cost extension for \$100,000 to support grantees in efforts to track trainees. Dr. Carter said the previous recommendation focused on how to centralize the tracking process. HRSA is interested in where providers go to practice after their training is complete. She suggested returning to this topic later.

Dr. McWilliams said that programs need 2.5 to 3 percent cost of living increase in their budgets. He also suggested funding for program expansion and for longitudinal tracking. He said he did not think the Committee could recommend a tracking system at this time. He recommended requesting a 10 to 15 percent increase over the current budget. Dr. Russell Phillips suggested retaining the recommendation to assess clinical outcomes so that HRSA can obtain funding to this later.

Dr. Carter invited public comments on finalizing the 16th report. Theresa Baker of the American Academy of Family Physicians suggested that the Committee recommend inflation adjustment and consider that during one cycle programs were funded at a lower rate than they had been the previous year. Adjusting for these factors would mean recommending a budget of \$120,018,000. Dr. Carter requested additional public comments. There were none.

Dr. Russell Phillips asked how Committee members felt about this proposed allocation. Dr. Chi said he supports requesting this amount with a justification. Dr. Cortes agreed, saying Congress would not increase the budget over the request, but could allocate less money. Dr. Russell Phillips said he would justify the amount as a 25 percent increase to support program expansion and 5 percent to support longitudinal tracking, and made a motion to accept a recommendation for a \$120 million budget. Dr. Sealey seconded. The motion passed unanimously. Dr. Carter said the Committee should add additional language to explain the budget rationale. Dr. Cortes agreed that the justification for recommendation for additional funds should be clear. Dr. Phillips suggested adding, ““The US population is estimated to grow by nearly 11% with those over age of 65 to increase by 50%. In addition, primary care patients faces challenges associated with transitions to value based care. And HRSA faces challenges in longitudinal tracking of its program graduates. In this context the committee recommends a new budget of \$120 million - approximately a 30% increase over current funding levels.”

Dr. McWilliams asked if the Committee approved the current recommendation. Dr. Russell Phillips said the recommendation included redundant text, but this could be resolved by the writing committee. Dr. McWilliams asked for a motion to approve the recommendation. Dr. Sealey motioned. Dr. Cortes seconded. The motion passed unanimously.

Dr. McWilliams read the next motion, “New funds should be made available to support the development and implementation of rural primary care residency programs or rural tracks within

primary care residency programs for physicians in family medicine, internal medicine, pediatrics and physician assistants, and for dentists in pediatric dentistry, dental public health and advanced general dentistry.”

Dr. Cortes said this recommendation duplicates Recommendation 3 except that it concerns only rural communities and Recommendation 3 concerns rural and urban medically underserved communities. Dr. Cortes asked if the recommendations could be combined. Dr. McWilliams said he remembered there being a reason for separating the recommendations. Dr. Cortes said that if the recommendations remain separated, one should refer only to rural, the other only to underserved communities. Dr. Wilson said the Committee should recommend the same resource allocations for underserved communities as it does for rural health. Ms. Dieter said the language for Recommendation 3 refers only to physicians, although the purpose of the residency referenced was to include dentists and physician assistants. The recommendation should refer to these professions.

Dr. McWilliams asked Dr. Sealey to add this reference. Dr. Sealey said the Committee and HRSA have different definitions of primary care, which can be confusing. Dr. Carter said the recommendations all refer to programs authorized by Sections 747 and 748; primary care is defined by terms in those sections of the statute. Dr. Sealey said HRSA sometimes includes psychiatry in its definition of primary care; and psychiatric services are urgently needed in rural and underserved communities. Dr. Carter said that, while this is true, the definition in Sections 747 and 748 does not include psychiatric services. The Committee must make recommendations in the context of the statute. However, Committee members can refer to broader community needs in reports in order to raise awareness of issues.

Dr. Russell Phillips asked if current rural residency programs are efficient, or if the Committee should recommend expanding them. Dr. McWilliams says he does not think the program is sufficient to meet community needs. Dr. Cortes said that, since the report’s purpose is to recommend appropriations levels, the Committee should leave Recommendations 2 and 3 separate as recommendations for different programs that target different populations. Dr. Chi said Recommendation 2 is place-based, targeting rural areas. Recommendation 3 is population-based. He recommended editing the recommendations to make this clear. Dr. Cortes concurred.

Dr. Carter asked how the report would acknowledge the new rural residency program and also continued need for such programs. It is important for the Secretary and Congress to know the Committee made recommendations based on current information.

Public Comment

Dr. Carter opened the floor for public comment.

Robin Pugh Yi thanked the committee for discussing prioritizing value-based primary care. In response to the question of whether primary care physicians control costs, she gave an example of being prescribed prohibitively expensive pharmaceuticals. Since one Committee member said costs are often not specified in discussions about the issue, Dr. Pugh Yi wanted to give a concrete example.

She said her family doctor had discussed health risks and benefits of treatment for a chronic condition, then prescribed medication. It was not until she went to fill the prescription that she learned that the cost, with insurance coverage, was \$1,250 monthly for an indefinite amount of time. Paying this amount was not an option for her. She pointed out that this is roughly the monthly income of a person working full-time for minimum wage, meaning there are large numbers of people who could not afford this option. The relationship of this event to primary care quality is that Ms. Pugh Yi's provider's lack of cost awareness meant she had not made a fully informed care decision and had to schedule another office visit to discuss options. If the provider had been aware of cost issues, she would have had a more positive experience and fewer clinical visits. She said she is likely typical in this regard and thanked the Committee for considering the issue. Dr. Carter thanked her for her comments and invited additional comments. There were no further comments.

Wrap-up Discussion

Dr. McWilliams said work on the 16th report, informed by relevant developments since the first draft, would continue. Dr. Carter said Drs. McWilliams, Russell Phillips, Cortes, and Davis had volunteered to finalize the 16th report. The group made recommendations for the 17th report and will continue work on it at the next meeting. Ms. Dieter, Dr. Wilson, and Dr. Sealey volunteered to work on recommendations for the 17th report. Dr. Carter said the next meeting would be via webinar on June 11.

Dr. Carter invited discussion of the B recommendations. Dr. Russell Phillips said the third recommendation should be rephrased to clarify that its purpose is to address need in both rural and medically underserved communities. Dr. Cortes recommended changing the recommendation title to read "Congress should expand the National Health Service Corps loan repayment program to increase the number of primary care physicians, physician assistants, and dentists practicing in rural and medically underserved communities." Dr. Russell Phillips agreed with this change.

Drs. McWilliams and Carter thanked the Committee members and support staff for their work.

Dr. Carter adjourned the meeting at 2:30 p.m.