Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD)
Meeting Minutes: May 3-4, 2018

Advisory Committee Members Present:
In Person
Russell S. Phillips, MD, Chair
Thomas E. McWilliams, DO, FACOFP, Vice Chair
Bruce Blumberg, MD
Donald L. Chi, DDS, PhD
Tara A. Cortes, PhD, RN, FAAN
Patricia M. Dieter, MPA, PA-C
John Wesley Sealey, DO, FACOS

Via Webinar
Rita Phillips, PhD, BSDH, RDH, CTCP

Health Resources and Services Administration (HRSA) Staff Present:
From the Bureau of Health Workforce (BHW), Division of Medicine and Dentistry (DMD)
Kennita R. Carter, MD, Designated Federal Official (DFO), ACTPCMD
Candice Chen, MD, MPH, Director, DMD
Raymond J. Bingham, RN, MSN, Technical Writer

From the BHW Advisory Council Operations
Kimberly Huffman, Director
Kandi Barnes, Management Analyst

From the BHW Division of External Affairs
Nicole Hollis-Walker, Public Affairs Specialist

Visitors:
Julie Crockett, American Association of Colleges of Osteopathic Medicine
Eric Sid, MD, MHA, National Institutes of Health, National Center for Advancing Translational Sciences

Day 1 – May 3, 2018

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., May 3, 2018, at the headquarters of the Health Resources and Services Administration, Room 5W07, 5600 Fishers Lane, Rockville, MD 20857. The meeting was also accessible by teleconference and webinar. Dr. Carter conducted a roll call. Eight of the Committee's ten members were present in person, establishing a quorum.

Division of Medicine and Dentistry Update

Dr. Carter introduced Dr. Candace Chen, Director of the Division of Medicine and Dentistry (DMD), HRSA/BHW. Dr. Chen welcomed the members. She stated that the Committee's charge is to advise HRSA on programs that work together to strengthen the healthcare workforce, and in particular primary care physicians, dentists, physician assistants, and dental hygienist under Title VII, Part C, sections 747 and 748 of the Public Health Service (PHS) Act. Programs under section 747 provide grants to medical schools with primary care residency programs and other organizations that enhance primary care training for physicians, to encourage more physicians to enter primary care. Programs under section 748 address oral health training in primary care and they support pre-and post-doctoral dental and dental hygiene programs.

Dr. Chen provided a brief overview of the federal budget process. She reminded the members that the federal fiscal years (FY) runs from October 1 to September 31. For example, FY2018 runs from October 1, 2017 to September 31, 2018. In FY 2017, the appropriation for section 747 primary care enhancement programs was $38.9 million, and for section 748 oral health training programs the appropriation was $36.7 million.

Each year, typically around January or February, the President releases a budget request, indicating the administration's policies and priorities. For both FY 2018 and 2019, the president's budget did not request any funding for programs under sections 747 and 748, although it did request funding for other health professional training programs under the National Health Service Corps and the Nurse Corps. For FY 2018, the federal government operated under a continuing resolution until Congress passed the FY 2018 budget, which did appropriate funds for section 747 and 748 programs – for FY 2018, section 747 received an appropriation of $48.9 million, an increase of $10 million over FY 2017, while section 748 received an appropriation of $40.7 , an increase of $4 million over FY 2017. The appropriation language indicated that this increase in funding was to be used to improve training to address the nation's opioid epidemic, and DMD is determining how best to target the extra funds. She said that DMD welcomed the advice of the Committee in this area.

There was a question about what happens to programs funded in response to a notice of funding opportunity (NOFO) in FY 2018, if funding changes in later FY appropriations. Dr. Chen acknowledged the challenge presented by funding uncertainty. She said that by statute, awards under sections 747 and 748 are made as 5-year grants. However, funding for future years is not guaranteed. If Congress decreases or eliminates the allocations in future FYs, then the programs may have to be reduced or even shut down.

ACTPCMD chair Dr. Tom McWilliams asked if it was possible to combine multiple years of funding for a grant into the one-year fiscal budget, to provide for more stability in funding. Dr. Chen replied that the required five-year grant period and rules on the distribution and use of grant funds makes such forward-funding of grants challenging and impractical in most cases.

Dr. McWilliams added that section 747 and 748 programs have increasingly focused on placing more health professional students and graduates into rural and other underserved areas, and asked if the committee had responsibility to continue this trend. Dr. Chen replied that the programs have always emphasized meeting identified gaps in the health care workforce. HRSA

will continue its focus on training individuals to enter primary care and serve underserved and high-need populations, which often requires placing people into rural and underserved areas, and training them in new models of care, such as telehealth.

Dr. Bruce Blumberg asked if the increased appropriation for the section 747 and 748 programs in FY 2018 was specifically tied to funding for programs on the opioid epidemic. Dr. Chen said the appropriations language was not that specific or prescriptive. However, the opioid crisis is a priority of the current administration, and there was a general sense that the additional funding was to be used for that purpose. Leveraging funds for primary care is one way to address the opioid epidemic by training and engaging primary care providers, who are going to screen for and identify opioid disorders, and initiate treatment and/or referrals.

Dr. Chen moved the discussion to HRSA's evaluation efforts, which are centered on three major areas. First, HRSA has an extensive collection of standardized performance measures, under the direction of the National Center for Health Workforce Analysis (NCHWA). However, adding to or changing these measures is difficult and requires review and approval from the Office of Management and Budget to assure HRSA is not placing too great a reporting burden on its grantees. This information is generally collected through HRSA's electronic handbook (EHB) platform. It includes demographic information on trainees; the number of trainees and the number and types of trainings provided; the location of training programs, and if they serve rural or other medically underserved areas; presentations and published articles from grantees; faculty training and development; and where trainees find employment after graduation, specifically if they practice in underserved areas. HRSA has also started to collect information on partner organizations of our grantees, and on payment models. However, much of the information is counts of trainees or courses, and there is not much depth to help determine impact.

Dr. Chen added that DMD is looking into collecting the National Provider Identifier (NPI) numbers for trainees. Using the NPI would help in terms of longitudinal tracking of the trainees and measuring the impact of HRSA funding, while also reducing the reporting burden for grantee institutions. One challenge is that not all medical students or trainees of other health care professions have an NPI number. DMD is working with schools and other stakeholder organizations to have all students and clinicians obtain an NPI. DMD also invested in a three-year technical assistant contract aimed at helping the grantees develop and improve their evaluation activities, which can then enhance their annual reports to HRSA.

Some of the evaluation outcomes being reported are case studies of the best practice programs. These studies can be valuable, as they help tell a story about not just how many people have gone through these training programs but towards what end and towards what impact. When Congress re-funded the teaching health center graduate medical education (THCGME) program earlier this year, they added additional reporting requirements to include items such as how many patients the teaching health center physician resident trainees see, particularly in medically underserved areas. The new requirements sent a signal that Congress will be watching the outcomes, so we will need good data to tell the complete story. She added that an upcoming speaker from NCHWA would present findings of a study on the impact of section 748 programs on dental training and access to care.

Dr. McWilliams stated that he believed the Title VII programs have had a very positive impact on the medical education system, so he agreed with placing a greater emphasis on evaluating the outcomes. In response to a concern raised in a recent report from the Government Accountability Office (GAO), he wanted to know how will the outcomes be used to improve the transparency and accountability of GME funding. Dr. Chen agreed that the GAO report raised the issue of a lack of good information on the cost of medical training. The reporting requirement of the Children's Hospital Graduate Medical Education (CHGME) and THCGME programs may serve as models to improve the evaluation of all Graduate Medical Education (GME) funding.

Dr. McWilliams also asked when information from the evaluation data being collected would become available. Dr. Chen replied that NCHWA was working on methods to best collect, analyze, and report the outcomes data.

Presentation: BHW Update

Dr. Carter introduced the next speaker, HRSA Bureau of Health Workforce (BHW) Acting Deputy Associate Administrator CAPT Sheila Pradia-Williams. CAPT Pradia-Williams described the mission of BHW as preparing a skilled healthcare workforce to address the needs of the nation, particularly in rural and underserved committees. In approaching this mission, BHW collects data and uses research from NCHWA, as well as seven Health Workforce Research Centers across the country, to provide evidence-based information on the current status of the healthcare workforce, and to anticipate future trends. To prepare a quality, skilled workforce, BHW programs work to enhance curriculum development, promote tem-based care, and provide training in community-based settings. To improve workforce distribution, BHW provides incentives to students, through scholarships and loan repayment, to train in underserved areas. Studies have shown that students tend to practice where they train after they graduate. To advance modern healthcare, BHW programs promote such innovations as telehealth, distance learning, and other ways that technology can extend the reach of healthcare training, education, and services.

CAPT Pradia-Williams said that in federal fiscal years 2016 and 2017, Title VII programs and Title VIII[1] programs provided training for about 575,000 current and future healthcare practitioners, utilizing over 8,400 training sites located in rural and underserved areas. She said that BHW is placing greater emphasis on pipeline programs, retention, and long-term program outcomes. In FY 2017, BHW awarded over $1 billion to more than 40 workforce programs. The breadth of BHWA's workforce programs provides both opportunities and challenges.

Q and A

Dr. McWilliams stated that a past ACTPCMD report recommended a national repository for HRSA's outcomes data, and asked if there was a way to coordinate data so that researchers and policy advisors could access it. CAPT Pradia-Williams replied that HRSA is developing a web site that will house much of the information coming out of and allow researchers to access it.

There was another question on how the information and data provided by HRSA grantees will help inform policy decisions at other federal agencies, such as the Centers for Medicare and

[1]HRSA Title VIII programs covers nursing education and practice. https://bhw.hrsa.gov/grants/nursing

Medicaid Services (CMS) or the Administration for Community Living (ACL). CAPT Pradia-Williams said that there are several federal agency roundtables that work to promote dialogue and share information among agencies, to promote best practices.

Dr. Bruce Blumberg asked how BHW is addressing cultural competence in healthcare training, given the rapidly changing demographics of the U.S. population. CAPT Pradia-Williams said that the concepts of cultural competence are embedded throughout the clinical experience. As an example, she cited the Area Health Education Center (AHEC) program, which funds centers across the country that emphasize longitudinal training in community settings to increase the exposure of trainees to people of different backgrounds, such as rural populations or migrant workers. Also, BHW supports needs assessment and curriculum development for training programs in cultural competency.

Dr. Donald Chi asked about the reporting of the diversity of grantees. CAPT Pradia-Williams stated that such reporting depends on the particular program. HRSA promotes diversity in its programs and among its grant recipients, and major programs such as the National Health Service Corps (NHSC) and NurseCorps collect information on diversity and have a funding preference for students from financially disadvantaged backgrounds and underrepresented minority populations.

Dr. Russell Phillips asked if BHW has thought about collecting data on clinician wellness. CAPT Pradia-Williams said that BHW has discussed trying to collect such data from the NHSC and from the medical and dental training programs. Dr. Chen said that there is no standardized data collection, as clinician wellness is a fairly new focus area.

Title VII Section 747 and Oral Health Training Programs – Updates

Dr. Carter introduced the first speaker of the panel, Dr. Maria Portela-Martinez, the Division of Medicine and Dentistry (DMD) Branch Chief for Primary Care Training.

Dr. Portela-Martinez presented an update on the Primary Care Training and Enhancement (PCTE) programs. She stated the purpose of PCTE is "to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers, and researchers promoting primary care in rural and underserved areas." The programs were redesigned and brought under one umbrella program with a focus on care coordination, training, and integrated care, in order to promote collaborations between the different training programs. Starting in FY 2015, DMD incentivized training programs to receive a higher award if they collaborated with a separate program from another profession. For example, schools were eligible to receive twice the amount of funds if the grant application included a partner program, such as a medical school partnering with a physician assistant (PA) school or an oral health training program.

Dr. Portela-Martinez added that in FY 2016, DMD launched a competitive program under the guidance of ACTPCMD for the Academic Units in Primary Care Training and Enhancement (AU-PCTE) Centers. She reminded the Committee that Dr. Russell Phillips, the ACTPCMD chair, is the principal investigator (PI) of one such Center at Harvard University. These Centers are funded under cooperative agreements, and they focus on research, dissemination of information, and developing communities of practice. There are six AU-PCTE Centers across the country, each with a different focus area.

In FY 2017, DMD ran a competition for the clinician educator development award. Some of these funds were targeted for junior faculty members, based on feedback from grantees that programs for junior faculty were often excluded from applying for grants. In FY 2018, the Division ran a new competition for the primary care champion awards. Dr. Portela-Martinez reminded the Committee that the primary care training grants run on a 5-year cycle, which complicates the funding picture. In addition, per legislative requirements, for each fiscal year at least 15 percent of grant funds must go to physician assistant training programs.

The PCTE programs place a strong emphasis on evaluation, and DMD awarded a contract to help explore and develop evaluation capacity. The contractor produced a white paper on the current state of evaluation in primary care training, and conducted site visits to a cohort of our 2015 grantees. The outcomes will be made available on the HRSA web site soon. The contractor also produced primary care training and evaluation toolkits, which could be applicable to other training programs as well.

Dr. Portela-Martinez noted that the Division provided a supplement to its PCTE awardees to address the country's opioid use epidemic. The supplements were used to:

- Develop curricula in opioid use disorders for students and faculty across medical and PA schools.
- Enhance community-based sites and coordinate care for addiction treatment.
- Train providers in medication-assisted treatment (MAT) for opioid addition.

Dr. Carter introduced the second panel member, Mr. Shane Rogers, Branch Chief of the DMD oral health branch (OHB), responsible for overseeing oral health training programs under Title VII, section 748 of the PHS Act.

Mr. Rogers said that the OHB was formed in 2010 as a result of the expansion of dental training programs under the Affordable Care Act. This legislation supported training in general dentistry, pediatric dentistry, and public health dentistry, and eligible entities include schools of dentistry and dental hygiene. The branch currently oversees seven grant programs involving a total of 106 grantees, as well as state oral health workforce programs under Title VIII. The oral health training appropriation has increased from $32 million in FY 2014 to $40.7 million in FY 2018.

Mr. Rogers stated that the OHB pre-doctoral training program is designed to help dental and dental hygiene students prepare to practice in new and emerging models of care, with three focus areas:

- Supporting the integration of oral health within the broader healthcare delivery system.
- Supporting oral health clinicians in practicing in advanced roles.
- Enhancing clinical pediatric training to address the needs of children 0-5 years of age.

In Academic Year 2016-17, the program supported almost 5,300 students training in 175 clinical sites, of which roughly 75 percent were in medically underserved communities (MUCs).

Meanwhile, the post-doctoral program provides funding to plan, develop, and operate programs in primary care dentistry, which includes general dentistry, pediatric dentistry, and public health

dentistry. The legislative language for this program authorizes support of dental residents to receive a master's of public health. In FY 2017, the 20 grants under this program supported 460 dental residents in 160 clinical training sites, of which 64% were in MUCs. In addition, 33 percent of those who graduated from the program in the prior year are now practicing in federally qualified health centers (FQHCs) of FQHC look-alikes.

Mr. Rogers described the two dental faculty loan repayment programs required under legislation, one of which includes a component of faculty development. In FY 2017, these programs awarded almost $3 million to 19 grantees.

Mr. Rogers added that the FY 2017 primary care clinician educator awards involved a combined competition with both medicine and dentistry. The Oral Health Branch awarded six (6) grants, and the program has seen success in helping junior faculty gain greater access to leadership positions in their institutions. He added that in the coming year, OHB will collaborate with NCHWA to conduct a full evaluation of its faculty development program that ran from 2012 to 2017.

Q and A

Noting that both the pre- and post-doctoral oral health programs included a funding preference for pediatric dentistry programs, Dr. Donald Chi asked if that emphasis would continue in the coming fiscal year. Mr. Rogers replied that the authorizing legislation mandated that funds be spent in that area, and there was an additional supplement included to address childhood obesity.

Dr. Russell Phillips asked about the requirements of the oral health loan repayment programs, and to what extent the programs are used to enhance the diversity of the faculty. Mr. Rogers stated that the authorizing legislation limits how prescriptive HRSA can be in designing the programs, and that awardees are granted leeway in how they implement the program requirements. He added that an emphasis on diversity is one component for the selection committees to consider in making the awards. Dr. Chen added that unless the authorizing statute specifically includes language on diversity, HRSA cannot require it in the NOFO, or include diversity as a funding priority. However, in the purpose and needs section of the grant application, HRSA can ask about the characteristics of the population to be served, and reviewers can take this information into account.

Dr. John Sealey expressed concern about the geographic distribution of the grant recipients, noting that smaller or non-academic organizations may lack the resources or sufficient training in grant writing to effectively apply for HRSA grants. He also asked how prospective grantees address population health. As to distribution, Dr. Portela-Martinez replied that language in the NOFO could state that geographic location be a consideration. She added that the Department of Health and Human Services divides the United States into 10 regions, with each region covering several states and U.S. territories. HRSA works to ensure at least some representation in each region. In population health, HRSA wants to avoid being too prescriptive in order to encourage innovation. Many grantees are using the resources available to them, such as the use of geospatial analysis to examine population health data. HRSA is working to give the schools the tools that they need to create the clinical training environment to produce better outcomes for patient and produce a more diverse workforce.

Ms. Patricia Dieter expressed concern about a shortage of clinical faculty in PA training programs, which impairs the ability of many programs to successfully compete for grants or to fulfill the grant requirements once selected. Dr. Sealey added that FQHCs and other community health centers (CHCs) may lack the staff and resources to identify and track grant opportunities, or may find the application process confusing, time-consuming, or intimidating.

Dr. Portela-Martinez stated that HRSA is aware of the need for faculty development. One common issue is that junior faculty may be discouraged from becoming faculty in the PA profession, because many feel the need to train for a certain number of years as a clinician before becoming faculty. The career development grant competition in FY 2017 was one attempt to address the development of more PA junior faculty.

Dr. Chen reminded the Committee that HRSA has a requirement to spend at least 15 percent of funds allocated in this area to support PA training. However, in some of its competitions, DMD has not received as many applications for PA faculty training and development as expected. For the primary care champion program, HRSA did significant outreach through the National Association of Community Health Centers (CHC) and other organizations. However, most applications were from universities, with all successful applicants also partnering with a CHC. HRSA has made significant efforts to recruit more grant reviewers from CHCs and similar organizations, who will better understand the community health perspective and help improve the success rate of these organizations in competing grants.

Dr. Tara Cortes mentioned the geriatric workforce enhancement program (GWEP), of which her institution was a grantee, as an example of a successful program that encouraged and developed relationships between academic institutions, clinical health systems and community-based partners. She believed that such partnerships are vital in promoting primary care and addressing the social determinants of health in local communities, and suggested that other grant programs should require similar types of partnerships.

Dr. Bruce Blumberg complimented the focus of DMD programs on data collection and analysis, but he added that many important outcomes are difficult to quantify. To cite some examples, there is no easy way to capture the impact of the primary care training and enhancement program and related programs on influencing a student to enter primary care as a result of a professor who received faculty development funding, or a patient whose quality of life is improved as a result of funding to integrate primary care and oral health, or a provider whose career and productivity are enhanced because of an investment in training programs that promoted resilience and wellness. He noted that many current family medicine departments owe their existence to Title VII grant funding from up to 20 years ago. He urged the Committee and HRSA not to lose sight of these more subtle outcomes. Dr. Chen stated that she often hears the stories from grant recipients of these types of successes, and urged the Committee members to share these types of stories in its reports to help illustrate the full impact of the programs.

Dr. McWilliams asked about some of the outcomes of the oral health programs. Mr. Rogers stated that DMD will conduct an evaluation of its recently concluded faculty development program and will attempt to track the future activities of program completers. Some activities

that have been reported include implementing curricula to better prepare community-based faculty, developing skills workshops, and initiating new primary care rotations.

Dr. Russell Phillips asked if HRSA had compared the outcomes of NOFOs with a funding preference for programs in MUCs versus NOFOs without this preference on improving access to care in MUCs. Dr. Chen said that trying to conduct such a comparison would pose many challenges, especially as most applicants for HRSA funding qualify for the MUC funding preference. HRSA tries to adjust its funding preference targets so that they have meaning in distinguishing among different applicants and getting funds to the programs most in need.

Dr. Cortes asked if the Committee should look at evaluating both the quality and the cost of care in making its recommendations. Dr. Chen replied that the question addresses what an evaluation of HRSA's training programs should look like. Evaluation takes resources, and the Committee could discuss how to find the right balance between the funding required to support evaluation versus the funding that goes to support program activities. For example, the primary goal of a new program may be to establish a clinical training site in an area of need. It may not be realistic to expect one five-year award to improve quality or lower costs in an easily measurable way. The goal is to get students and practitioners into rural communities and improve access to care. Dr. Blumberg added that one difficulty of evaluation is the reliance on proxy measures. For example, program data may show the number of medical residents who go on practice in an MUC, but this is a proxy of the actual goal of improving the health of the community. We make the assumption that more practitioners means greater access to care and improved health.

Dr. Portela-Martinez stated that the AU-PCTE program has been very productive, particularly in terms of publications. Dr. Chen stated that the number of publications is impressive, given that the program has been in existence for less than two years. She recognized the efforts of Dr. Portela-Martinez in engaging federal stakeholders as a way to take advantage of their expertise, as well as to increase awareness of the efforts of HRSA in primary care training development to address primary care practitioner workforce issues.

Dr. McWilliams expressed concern that the primary care crisis in the United States is continuing, and even worsening. He asked the presenters to provide some guidance on what current or future HRSA programs might have the greatest impact in addressing the ongoing crisis. Dr. Chen replied that HRSA, with the oversight and recommendations from its advisory committees, is always looking to maximize the impact of its funding. As an example, she said that HRSA had turned away from its original Academic Unit model, after receiving feedback that was not working as intended. She further noted that HRSA had recently relaxed its rules around telemedicine to allow more funding for projects in this area. Mr. Rogers noted that HRSA provides funding to promote primary care in a large percentage of dental schools, and there had been an increase in grant applications from dental and dental hygiene schools. Dr. Portela-Martinez stated that almost a quarter of trainees identify themselves as from minority populations, and a third come from disadvantaged backgrounds.

Dr. McWilliams suggested a discussion at a future meeting around what activities and efforts are permissible under federal regulations, to help guide the Committee in its recommendations. He also said that, while the country has expanded undergraduate network and developed new

medical schools, the greatest return on investment is likely in the postgraduate arena and residency training. These programs are seeing shortages and unmatched students due to current caps and funding limitations. Mr. Rogers stated that HRSA looks for such forethought, as the required 5-year grant cycle for its funding requires significant advance planning in making the most significant investments.

Presentation: Ethics Update

Dr. Carter adjourned the meeting for a working lunch break. Laura Ridder, HRSA Ethics Advisor, provided the members with a brief overview and update of federal ethics rules and guidelines as they apply to their role as special government employees.

Presentation: The Impact of Title VII Funding on Dentists' Practice Location: Difference-in-Difference Analysis

At the conclusion of the lunch break, Dr. Carter called the meeting back to order and introduced Dr. Chiu-Fang Chou, a social scientists with NCHWA, to discuss her study on the impact of Title VII-funded oral health training programs on the practice location of dentists. Dr. Chou noted the maldistribution of dentists across the country, with populations in rural areas much less likely to have access to dental care. In addition, those dentists who practice in rural areas tend to be older and white. She noted that previous studies had shown that the content and location of training programs can influence where dentists choose to practice. HRSA's pre- and post-doctoral dental training programs seek to address workforce inequities by strengthening training and encouraging healthcare professionals to care for underserved populations.

Dr. Chou described the objective of her group's study as examining the impact of HRSA's oral health professional training programs on dentists practice locations in rural and other Dental Health Professional Shortage Areas (HPSAs). The study examined data collected on over 7,500 dentists between 2010-2015 from the HRSA electronic handbook (EHB) databases, as well as the 2015 American Dental Association (ADA) masterfile. The results found that among dentists who trained at a dental program that received HRSA funding, those who graduated between 2011-2015 were more likely to practice in a rural HPSA than those who graduated between 2004-2010, before the implementation of HRSA's pre- and post-doctoral oral health training programs. Furthermore, dentists who graduated from a school that did not receive HRSA funding were less likely to practice in a HPSA. The authors concluded that HRSA-funded dental programs, particularly the pre-dental programs, produce a greater percentage of dentists who practice in rural areas compared to school that receive no HRSA funding, and thus HRSA funding has had a positive impact on improving the distribution of dentists in rural and other underserved areas.

Dr. Fang acknowledged the co-authors of the paper, Drs. Jennifer Holtzman, George Zangaro, and Candice Chen, and Mr. Shane Rogers, as well as the assistance provided by Dr. Arpita Chattopadhyay.

Q and A

Several Committee members posed questions about how the programs were selected, and if confounding variables of the characteristics of the programs were considered. Dr. Chou said that institutional characteristics that might have influenced decisions to apply for HRSA funding or accept certain students who may be more likely to practice in rural areas were not considered,

due to the difficulty of collecting such information. Dr. Russell Phillips asked if a similar study had been conducted involving primary care physicians. She replied that NCHWA had not conducted such a study, but would consider this for the future.

Small Group Discussions

Dr. Carter announced that the Committee would break into two small groups for 30 minutes of discussion to review the day's presentations, synthesize the information, and begin to formulate some draft recommendations. Group 1 consisted of Ms. Dieter, Dr. Chi, and Dr. Russell Phillips.

Small Group Reports

Small group discussion report-out of the main discussion topics:

Group 1: Dr. Donald Chi, Dr. Russell Phillips, Ms. Patricia Dieter

Key points:

1. Recommend more studies of outcomes data like the paper presented by Dr. Chou and the difference-in-difference analysis. These types of analyses promise to help the committee in giving advice on the types of programs needed to support primary care.

2. Given the small response noted on some of the HRSA Notice of Funding Opportunities, conduct some analysis of why a broader range of organizations are not submitting applications. In particular, with reference to the lack of applications for HRSA grants from PA programs, are there adequate faculty development or teaching fellowships available to PAs? For example, there was discussion on the shortage of faculty for PA programs. However, many PAs are faced with the need to pursue doctoral degrees. Could a HRSA career development award support PA student in their doctoral studies, and could programs support more faculty development programs for PAs?

3. As HRSA considers new funding opportunities, the Committee would benefit in their overall guidance by knowing in advance the general project areas that HRSA is considering funding.

4. The 5-year funding cycle might stifle creativity, as some organizations might not respond to such an extended cycle.

Group 2: Dr. Thomas McWilliams, Dr. Bruce Blumburg, Dr John. Sealey, and Dr. Tara Cortes

1. Success begets success, and therefore previous grantees are more likely to be successful. Would it be possible to establish a mentorship program for the grant application process, to establish connections between experienced organizations and new applicants? For example, could a funding priority be given to a submission that arose from collaboration between an experienced grantee institution and a first-time applicant? If this arrangement were possible, could HRSA allow co-principal investigators from both programs?

2. There are already many partnerships between academic units and health care organizations. Could these be expanded to include community-based organizations? The United States spends more than other Western countries on healthcare, but the outcomes do not match the health outcomes. Furthermore, healthcare is a relatively small contributor to health status. By failing to reach community organizations, the efforts of the federal government may not addressing the full range of the social determinants of health (SDH).

3. Assessment of outcomes is becoming a science, implementation is also becoming a science. Does expertise in these disciplines exist within HRSA? If not, can it be developed? Can HRSA serve as a centralized shop for these areas?

4. To address the current and worsening access to primary care clinicians and specialists, primary care training programs need to be expanded, and the number of residency slots increased. Over the last 10 years, the capacity of medical schools has increased roughly 30 percent, while the number of residency slots has only increased 10 percent. There is a need to create new GME positions in primary care, along with greater efforts to influence more students in undergraduate medical education to enter primary care specialties.

In discussion, a related topic was raised as to whether the Committee could recommend carving out a percentage the current programs funding to direct that to HRSA provide a centralized resource for outcomes research, and follow-up. There were further questions on the five-year grant cycle, and HRSA staff clarified that the five-year period was a legislative requirement with no flexibility.

Dr. McWilliams raised the issue of expanding residency slots, which represent a significant bottleneck in graduate medical education. There was discussion that HRSA's PCTE awards are not designed to provide ongoing funding or to be "forever awards." The expectation is that these grants help schools and organizations turn their programs to focus more on primary care, with the goal of becoming sustainable outside of HRSA funding.

Public Comment

After a short break, Dr. Carter opened the floor to public comment. There were no comments.

Day One Recap

Dr. Cortes reviewed the discussions of the day. She noted that Dr. Chen had presented the FY 2017 and 2018 budgets, with an increase in FY 2018 to address the opioid epidemic, as well as funding directed to address childhood eating disorders. There was a lot of discussion on different ways to conduct program evaluation and performance measures. One step would be to expand the use of NPI numbers, to allow for better longitudinal tracking of HRSA grantees. The Committee discussed the work of the federal government on expansion of the primary health care workforce, and how this work supports the transformation of the health care system as a whole. From the small group sessions and follow-up discussions, there was a general consensus of the importance of expanding primary care and increasing the focus on outcomes research, as a way of determining the impact of HRSA investments.

The meeting adjourned for the day at 5:00 p.m.

Day 2 – May 4, 2018

Advisory Committee Members Present:
Russell S. Phillips, MD, Chair
Thomas E. McWilliams, DO, FACOFP, Vice Chair
Bruce Blumberg, MD
Donald L. Chi, DDS, PhD
Tara A. Cortes, PhD, RN, FAAN
Patricia M. Dieter, MPA, PA-C
John Wesley Sealey, DO, FACOS

Welcome

The ACTPCMD meeting reconvened at 8:30 a.m. on May 4, 2018. The meeting was accessible by teleconference and webinar. Dr. Carter conducted a roll call, with seven members present, establishing a quorum. Dr. Carter turned the meeting over to Dr. Russell Phillips, the ACTPCMD Chair.

Committee Discussion

The Committee members held several discussions on the purpose, scope, and outcomes of the Title VII, Part C programs. For its upcoming 16th Report, the Committee members settled on two sets of draft recommendations. After a lengthy discussion on funding levels and budgets, the Committee approved by consensus a request to increase funding for Title VII primary care and oral health training programs by $18 million for FY 2019, to $89 million, as indicated in Recommendation A.1.

A. Recommendations intended to improve and expand Title VII, primary care and oral health training programs.

1. Congress should continue and increase funding of Title VII, primary care and oral health training programs at a level of $89 million for the next fiscal year and ensure that this funding be used to continue and expand current programs.
2. 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, in: family medicine, internal medicine, pediatrics, and medicine-pediatrics; pediatric dentistry, dental public health, and advanced general dentistry; and physician assistants.
3. Funds should be targeted at developing and implementing primary care residency programs as above that focus on meeting the needs of underserved areas and vulnerable populations.
4. New funds should be made available to expand educational capacity by supporting faculty development of primary care physicians, dentists, and physician assistants through career development awards and fellowship programs that focus on improving capacity to care for

complex patients in areas of behavioral health, oral health, and adverse social determinants.

5. Sufficient funds should be made available to assist HRSA in developing the expertise and capacity to evaluate longer-term outcomes of Title VII, Part C, primary care and oral health training HRSA grantees.
6. Funds should be made available to prioritize partnerships between primary care practices and community based organizations to address social determinants of health to improve quality of care and decrease costs.

B. Recommendations to support primary care as the foundation of the health system

1. Congress and the Center for Medicare and Medicaid Services (CMS) should make changes in health care financing that prioritizes primary care services using alternative payment approaches.
2. Congress and CMS should create incentives in the Graduate Medical Education system that prioritize training of primary care physicians.
3. Congress should expand the National Health Service Corps loan repayment program to increase the number of rural primary care physicians, physician assistants, and dentists practicing in medically underserved communities.
4. Congress should expand the Teaching Health Center program by increasing the number of primary care residency slots and by extending the renewal cycle to a minimum of 5 years.

Another proposed recommendation focused on addressing the nation's opioid epidemic: "New funds should be made available to support education and training within medical, dental, and physician assistant (PA) programs in the management and treatment of patients with both acute and chronic pain through the use of alternative approaches, safe opioid prescribing, and opioid use disorder." After further discussion, the Committee decided to turn this recommendation into a letter to the HHS Secretary, with Ms. Dieter taking the lead in preparing the initial draft. Ms. Dieter also agreed to draft a letter from the Committee in support of a recent rule change published by CMS regarding the use of student documentation in the medical record.

There was a suggestion to model the 16th Report after the committee's eighth report from 2010, *The Redesign of Primary Care with Implications for Training*, with the recommendations listed individually and the argument or justification for each recommendation immediately following. The members of the writing committee would develop the main points for each recommendation. Once these sections are drafted, the writing committee could work to refine the draft, and HRSA would be able to provide some technical writing support to pull the sections together.

Dr. McWilliams stated that, given the importance of the 16th Report, he wanted the Committee to have a second face-to-face meeting to continue the report discussion and development. Dr. Carter said she would explore the possibilities for a second meeting, after examining the Committee's budget, federal travel guidelines, and the availability of the members.

There was further discussion on when to schedule the next meeting. The Committee is mandated by its authorizing legislation to have 17 members, but had been operating with just 10. Dr. Blumberg expressed concern about the continuity of the Committee's leadership and work if the current members rotate off before new members are brought onboard. Dr. McWilliams supported the need to bring the Committee up to full staff to have adequate representation of the disciplines involved in primary care and supply the diversity of experiences and opinions. He urged HRSA to forward with identifying potential candidates for ACTPCMD, and get them on board as soon as practical.

After further discussion, the assignments of the writing committee for preparing the initial draft of the 16th Report were:

- Introduction – HRSA staff
- Recommendation A.1 – Dr. Sealey
- Recommendation A.2 and A.3 – Dr. McWilliams
- Recommendation A.4 – Dr. Chi
- Recommendation A.5 – Dr. Blumberg
- Recommendation A.6 – Dr. Cortes
- Recommendations B.1-4 – Dr. Russell Phillips

By consensus, the writing committee members agreed to provide some initial bullet points for their assigned section(s) within three to four weeks, with draft text to follow within about eight weeks. Dr. Carter would then schedule a conference call to develop the report outline.

Committee Discussion: 15th Report

Dr. McWilliams moved to the next agenda item, discussion of the 15th Report. Given the time constraints, he suggested the Committee focus on reviewing and revising the recommendations.

Recommendation 1 and its rationale were approved by consensus.

Recommendation 2 was revised to read:

> *ACTPCMD recommends that HRSA funds the development of innovative system approaches to the identification and alleviation of burnout among multidisciplinary trainees and practitioners and supports research pertaining to trainee and practitioner well-being and methods that effectively mitigate burnout among practitioners and trainees.*
>
> Rationale: Organizational culture penetrates all system levels from the external influences all the way to the microsystem. Leaders of these organizations must support an open and transparent dialogue that allows professionals to discuss the issues that increase their stress and work together to try to find ways to reduce workplace stress and increase provider satisfaction.

Recommendation 3 was revised to read:

> *ACTPCMD recommends that HRSA work across divisions and programs to address training in well-being and resilience and the prevention of burnout, to include all health professions engaged in primary care training and practice.*
>
> Rationale: Issues of clinician well-being and resilience and mitigation of burnout are not the domain of only primary care medicine and dentistry – they should be part of the work and consideration of all HRSA divisions and programs.

Recommendation 4 was revised to read:

> *ACTPCMD recommends that organizations that accredit health professional education programs include standards that promote provider well-being and resilience and the prevention of burnout.*
>
> Rationale: There are often limited standards that address faculty wellness or that speak to the need to impart to students lifelong wellness practices that will extend beyond graduation. Deliberate sustained and comprehensive efforts to reduce burnout and promote provider wellness and resilience can make a difference. Leadership and sustained attention from multiple organizations and all organizational levels are keys to progress.

After discussion, some members expressed concern that the 15th Report recommendations might represent an unfunded mandate for training programs to focus on student a provider wellness. Dr. Portela-Martinez stated that many grantees are already addressing wellness and resilience in their curricula. She said that on FY 2015, one-third of the grantee organizations funded under PCTE had a focus on behavioral health or primary care integration, with many activities including aspects of provider wellness, such as offering yoga classes, mindfulness training, and coaching. In addition, some programs have started evaluations of provider wellness. There was a question about the burden placed on grantee organizations, and Dr. Portela-Martinez replied that a greater emphasis on provider wellness could be included in the requirements of upcoming NOFOs. She added that wellness was an important piece of program evaluation, improving program retention and reducing turnover from burnout. Dr. Cortes concurred, stating that wellbeing and resilience were part of the quadruple aim in improving the health care system, and the recommendations were in line with current trends.

Public Comment

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

Committee Discussion

Dr. Carter raised the issue of the Congressional report language related to the PCTE appropriation for FY 2018. Dr. Chen explained that Congress will sometimes include language in its appropriation bills that is meant to provide guidance on activities that should be done within certain programs and funding lines. For 2018, Congress urged HRSA to support the integration of evidence-based or best practice training related to eating disorders and rare disease into its primary care training programs. This language references the 21st Century Cures Act (P.L. 114-146). HRSA takes this guidance from Congress very seriously. She stated that DMD

has begun to consider how to best address these priorities, adding that DMD also welcomed the input of the Committee. Dr. Blumberg stated he is an expert on rare diseases and offered the observation that the neglect of rare diseases has not been a problem in medical school education. He suggested that any program addressing rare diseases should focus on a generic approach to care and the alleviation of symptoms, with information on finding resources for patients with rare diseases and their family caregivers.

The next item of business was to propose dates for the next Committee meeting. Dr. McWilliams expressed a strong preference for an in-person meeting to facilitate the completion of the 16th Report. The month of September 2018 was proposed as an appropriate time, to keep the momentum on the report moving forward. Dr. Carter said that she would have to check the HRSA travel budget and address other logistical concerns to see if such a meeting was possible.

Dr. McWilliams reiterated his desire to bring the Committee up to its full membership as soon as possible. He thanked the members for their work in drafting recommendations and volunteering to draft sections of the 16th Report, and expressed a desire for adequate technical writer support from HRSA as the Committee works to finalize its 14th, 15th, and 16th Reports. Dr. Carter stated that the 14th Report is still undergoing revision, and the members agreed to review the updated draft when available.

Next Steps

Dr. McWilliams suggested including time to discuss the Committee's next report topic in the September 2918 meeting agenda. Committee members and HRSA staff will continue to work on the drafts of the three reports in the pipeline. At the conclusion of the meeting, Dr. McWilliams assumed the position of chair, with Dr. Russell Phillips as immediate past chair.

Adjournment

Dr. Carter thanked the Committee members for their time and their work during the meeting. She adjourned the meeting at 2 p.m.

Abbreviations list

ACL	Administration for Community Living
ACTPCMD	Advisory Committee on Training in Primary Care Medicine and Dentistry
AHEC	Area Health Education Center
AU-PCTE	Academic Unit Primary Care Training and Enhancement
BHW	Bureau of Health Workforce
CHC	Community Health Center
CHGME	Children's Hospital Graduate Medical Education
CMS	Centers for Medicare & Medicaid Services
DFO	Designated Federal Official
DMD	Division of Medicine and Dentistry
EHB	Electronic Handbook
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GME	Graduate Medical Education
GWEP	Geriatric Workforce Enhancement Program
HHS	United States Department of Health and Human Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
MAT	Medication-Assisted Treatment
MUC	Medically Underserved Community
NCHWA	National Center for Health Workforce Analysis
NHSC	National Health Service Corp
NOFO	Notice of Funding Opportunity
NP	Nurse Practitioner
NPI	National Provider Identifier
PA	Physician Assistant
PCTE	Primary Care Training and Enhancement
PHS	Public Health Service
PI	Principal Investigator
OHB	Oral Health Branch
SDH	Social Determinants of Health
THC	Teaching Health Center
THCGME	Teaching Health Center Graduate Medical Education