MEETING MINUTES
Advisory Committee on Interdisciplinary Community-Based Linkages
February 20-21, 2020

Committee Members Present
James Stevens
Chair

Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP
Vice Chair

Geraldine Bednash, PhD, RN, FAAN
Joseph H. Evans, PhD
Roxanne Fahrenwald, MD, FAAFP
Robyn L. Golden, MA, LSSW, ACSW
Bruce E. Gould, MD, FACP
Parinda Khatri, Ph.D.
Lisa Zaynab Killinger, DC
Kamal Masaki, MD
John E. Morley, MB, BCh
Jacqueline R. Wynn, MPH

HRSA Staff in Attendance
Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, ACICBL, Division of Medicine and Dentistry
Captain Paul Jung, MD, MPH, MBA, Director, Division of Medicine and Dentistry
Kennita Carter, MD, Designated Federal Official, Advisory Committee on Training in Primary Care Medicine and Dentistry
Shane Rogers, Chief, Oral Health Training Branch, Division of Medicine and Dentistry
Jennifer Holtzman, Dental Officer, Division of Medicine and Dentistry
Anne Patterson, Public Health Analyst, Division of Medicine and Dentistry
Kimberly Huffman, Director of Advisory Council Operations
Janet Robinson, Advisory Committee Liaison, Advisory Council Operations
Robin Alexander, Advisory Committee Liaison, Advisory Council Operations

Day 1-May 16

Introduction

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 8:30 AM, on Thursday, February 20, 2020. The meeting was conducted in-person and via webinar and teleconference from the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 5E29, Rockville, MD 20852. Dr. Joan Weiss welcomed the Committee, thanked them for their work, took roll call, and gave instructions regarding meeting participation. All of the members were in attendance except Dr. Zaldy Tan. Mr. Stevens confirmed that a quorum was present.

DAY 1

Approval of Previous Meeting Minutes

Mr. Stevens said he would accept motions to adopt minutes from the Committee's last meeting. Dr. Morley moved to adopt the minutes, seconded by Dr. Evans. The Committee unanimously adopted the minutes without additions or corrections.

Welcome

Dr. Weiss thanked the meeting planning Committee, Dr. Khatri, Dr. Gould, Ms. Golden, Mr. Stevens, and Dr. Brandt, for their efforts to recruit the day's speakers. Dr. Weiss then reviewed the meeting agenda. She invited HRSA staff to introduce themselves. She explained that Dr. Brenner's and Dr. Fendrick's presentation slides could not be shared publicly. Dr. Weiss said the Committee was charged with making recommendations regarding workforce development relevant to HRSA's Area Health Education Center (AHEC), geriatrics, and behavioral and mental health programs.

Introductory Discussion

Mr. Stevens asked the Committee to identify key issues related to payment reform. Dr. Khatri said that the workforce needs training in areas beyond clinical competencies. Clinicians need to understand quality and efficiency metrics and data, and how these data are being tracked. Clinicians and their teams need to consider how to respond to quality measurement. She noted that quality and efficiency data are flawed, difficult to use, and defined and collected inconsistently. Dr. Gould concurred. He added that, while the Committee previously had recommended that population health should be the basis for decisions regarding care delivery, current systems are mostly fee-for-service and driven by cost. He pointed out that even systems that are labeled global and value-based have fee-for-service components, and lack quality measures based on outcomes. Dr. Gould stated that global value-based systems are necessary for providers to use data to improve metrics such as reducing hospital and emergency department visits, because, in the current system, it is not profitable to keep people healthy. It is always difficult to make changes that involve reducing profit for some parties. Dr. Gould noted that behavioral health services will be underutilized in fee-for-service systems. To achieve behavioral health payment reform, the system must regard behavioral health as an essential element of health, and must support primary prevention services that result in valued behavioral health outcomes.

Dr. Fahrenwald recalled a quote that the US currently is using a 1990s payment system for a 1980s medical system. She stated that payment reform tends to focus on how to adjust current systems to address needs rather than on initiating a new system, because developing a new system is very challenging. However, a new system may be necessary. Payment systems should evolve as medicine evolves and that definitions of quality vary widely and are not always evidence-based or patient-centered. The healthcare system is not structured to incorporate patients' input about what they want from a clinical visit. The system paternalistically defines quality without considering patient priorities. Dr. Masaki concurred and noted that payment transformation involves administrative burden that burns out physicians.

Dr. Bednash agreed with previous comments. She is a board member for a large healthcare corporation, which prioritizes healthcare quality. She stated that providers are motivated to provide better care, but do not know how. They do not understand quality metrics. Several stakeholders are invested in quality improvement and would be interested in forming partnerships, such as academic-practice partnerships, to make progress toward system transformation.

Dr. Evans echoed Dr. Khatri's point that better measures of quality are needed. He said that a managed care corporation representative had told him (Dr. Evans) that his system used only two quality measures: reducing hospital stays and reducing emergency department use. Patient outcome measures and experiences, the factors that led to reduced service use are not considered. Dr. Evans stated that those factors should be central to quality measures, otherwise purported "quality" measures are not of quality but of economy.

Dr. Morley said that machine learning and telehealth are critical influences on the direction of medical care. Telehealth reduces the need for emergency department and urgent care, and can be a vehicle for behavioral healthcare. Payment reform should consider these influences and fair reimbursement as technology changes care delivery and quality. Policy recommendations should focus on the future and on improving administration of healthcare systems. Recommendations for system redesign should consider the projected shortage of primary care physicians, the role of advanced practice nurses in addressing this shortage, and how to address payment in order to ensure quality healthcare as these changes occur.

Mr. Stevens said rural and frontier medicine is funded through the Community Health Center system, which ACICBL can influence directly. He asked if this is a fee-for-service system and if the Committee can make recommendations about payment structure in this system. He pointed out that HRSA is training providers through the Community Health Center systems. After graduation trainees could implement lessons they learn about payment during training.

Dr. Khatri stated she works in a Federally Qualified Health Center (FQHC) and more than half of its contracts have a value-based, global component. The system mostly serves rural areas, some of which do not have internet access. Transformation should include early workforce training experiences and trainees must be aware that they will be a critical influence on payment reform.

Dr. Brandt noted changes in payment structure should reflect changes in care delivery related to interprofessional models. Trainees should learn how system-level changes improve care. This could be accomplished through training in Area Health Education Centers (AHECs), behavioral health education programs, and the Geriatrics Workforce Enhancement Program (GWEP).

Dr. Fahrenwald stated that the Accreditation Council for Graduate Medical Education (ACGME), which is responsible for accrediting residency and scholarships, has a workgroup currently developing a healthcare leadership scholarship for physicians. This workgroup includes Community Health Center representatives. The scholarship will support training in healthcare administration and leadership. Dr. Fahrenwald expressed concern that nursing education is developing a parallel residency system. She said the Committee should consider a recommendation for interdisciplinary residency training in which nurses and doctors train together to prepare to practice together. This would be especially valuable preparation for providers who will serve remote rural areas where broad competencies are needed. Dr. Bednash said the Veterans Administration (VA) has applied this training approach successfully in master's and doctoral level programs.

Dr. Killinger agreed that patients' goals, not profit, should be at the center of system transformation. She said that alternative and complementary healthcare providers should provide input on payment reform. Alternative and complementary healthcare lowers costs and increases patient satisfaction. It is important while the Nation experiences an opioid crisis, to consider evidence-based alternative pain treatments, such as chiropractic care. When this approach has been implemented, it has lowered costs and prevented addiction.

Dr. Morley stated that the Centers for Medicare & Medicaid Services (CMS) requires providers to document providing several services that are not relevant to most patients, taking up nearly all of a 10-minute visit, instead of asking the patient what is most important to him or her and addressing that concern. Since CMS requires this for reimbursement, physicians learn to focus on completing documentation of requirements rather than listen to patients. Dr. Morley said reform should address this concern.

Better Care at Lower Cost: Integrated Care Models for Patients with Complex Needs

Jeffrey Brenner, MD
Senior Vice President, Clinical Redesign
UnitedHealthcare Community and State

Dr. Weiss welcomed Dr. Jeffrey Brenner. Dr. Brenner stated that he was trained as a family physician. He practiced for about 20 years in Camden, New Jersey. He also worked to found and administer a non-profit collaborative of local hospitals, non-profit organizations, and primary care practices that focused on how to improve care delivery to patients with complex care needs. Dr. Brenner has worked at UnitedHealthcare for 3 years. He joined UnitedHealthcare because he believed his work could provide a platform for scaled evidence-based practice. UnitedHealthcare provides coverage for approximately seven million Medicaid patients in 30 States. He reports directly to the Chief Executive Officer of Medicaid and he

oversees the Clinical Redesign Team, which works to build models of direct care that improve quality and reduce costs.

Dr. Brenner stated that healthcare providers are often reluctant to have patients share their stories publicly, because of the Health Information Portability and Accountability Act (HIPAA). However, it can be empowering to patients to be spokespeople for better care. He said that several patients had given him permission to share their stories during his presentation.

Dr. Brenner described an experimental healthcare program implemented in Phoenix, Arizona about 3 to 3 1/2 years ago. Arizona requires insurers to set aside cash reserves. United Healthcare received permission from the State to loan $22 million from cash reserves to a non-profit organization at a very low interest rate. The organization used the money to buy two apartment buildings, with about 400 units total, then set aside about 70 apartments for United Healthcare's program. UnitedHealthcare identifies patients whose care costs more than $50,000 annually, mostly due to emergency department and skilled nursing facility utilization and offers them housing in these apartments as well as social services. Patients can enter housing directly from the hospital or skilled nursing facility. The program applies a Housing First approach. Participants can be intoxicated or have untreated mental illness. Studies have found that housing facilitates healing and motivation to engage in treatment.

Dr. Brenner said that this Housing First approach that does not require sobriety or engagement in treatment for any mental health problems was not developed at UnitedHealthcare, but by Dr. Sam Tsemberis of New York. UnitedHealthcare is working to adopt this model to serve medically complex patients and to determine what is necessary to scale the approach. UnitedHealthcare members in Maricopa County who are homeless use the emergency department nine times more often, are admitted to the hospital six times more often, and have medical costs three times as much as other patients. Patients need better services, and UnitedHealthcare seeks to reduce its costs. Dr. Brenner's team is working to address both needs.

Dr. Brenner said that a major consideration for healthcare payment reform is whether insurance companies should administer social benefits and whether managed care should integrate payment for medical, behavioral, and social services. This approach requires responsible fiscal management and administration. The following are examples of several patients who participate in the program. One patient had a diabetic foot ulcer and lived in his car. His care costs averaged $20,000 per month. After participating in the Housing First program, the average monthly cost for this patient's care was $400, with no emergency department or inpatient service utilization. Another homeless patient, used an electric wheelchair, and did not unpack when placed in housing because she did not believe it would last. She had a history of early life trauma. Her average monthly medical expenses were $7,000. After program participation her costs dropped to $2,000 per month with about half as many emergency department visits, more than 60 percent fewer admissions to inpatient care, and nearly 70 percent fewer days in inpatient care.

Dr. Brenner said many complex patients have a history of adverse childhood experiences, including physical or sexual abuse. This kind of toxic stress changes neuroanatomy and one's

ability to navigate life. Extreme childhood adversity can reduce life expectancy by 25 years and impair ability to form trusting relationships. The UnitedHealthcare Housing First model resulted in significant reductions in emergency department, skilled nursing facility, and hospital utilizations and in monthly healthcare costs. Dr. Brenner emphasized the importance of including a control group in evaluating impact on outcomes for outliers. With no treatment, patients with high medical costs will dramatically reduce utilizations due to a tendency to regress toward the mean. He said that the treatment group's reduction in emergency department visits was 8 to 19 percent greater than the control group's reduction, and the cost reduction is 9 to 13 percent greater.

Dr. Brenner said that UnitedHealthcare initially delivered wraparound services, then determined that this would not support rapid scaling, which would require purchasing services. UnitedHealthcare developed a process for requesting proposals from vendors that would support its healthcare delivery philosophy. This model pays community vendors a capitated monthly rate for rent and wraparound services. Dr. Brenner said that Medicaid funds cannot be used for housing, so other funding sources will be necessary for scaling the model. UnitedHealthcare has successfully applied its approach in single-site, scattered-site, and congregant group homes. While housing type is not related to outcomes, vendor experience is.

Dr. Brenner noted that the intervention's cost savings are due to reductions among the 25 percent of participants with the highest healthcare costs. Participants in the lowest cost quartile are more likely to increase than to decrease costs. These results align with those of a randomized controlled trial of a Medicare chronic care demonstration project conducted about 12 years ago, which showed that encouraging people to see a doctor increases visits. However, services that are delivered to complex patients in typical healthcare delivery systems do not make these patients better. Therefore, costs increase but care does not necessarily improve. Dr. Brenner emphasized that the intervention he described is not proposed as a solution to homelessness but as an approach to serve people experiencing homelessness and complex medical problems. He said that even advanced models for addressing homelessness do not serve the needs of medically complex patients. UnitedHealthcare has conducted detailed analyses of return on investment. Over the past 2 years, about half of patients in the UnitedHealthcare intervention have not used hospital services; about one quarter have not changed frequency of health service utilization; and about one quarter use healthcare services more frequently.

Most patients graduate from the program within 12 months. UnitedHealthcare is working to improve its processes to reduce length of time in the intervention. Assistance in applying for Social Security Income and housing are keys to success. It is difficult to complete these applications while experiencing homelessness. People who lose sobriety while living in shelters and waiting for housing often are evicted from shelters and lose their place on a housing waiting list. Only 20 to 30 percent of people living in shelters for people who are homeless successfully transition to permanent housing, compared with 90 percent of people in Housing First programs. Dr. Brenner said shelters are a failed model. If they were pills, they would be considered dangerous and removed from the market in favor of Housing First.

UnitedHealthcare also is exploring models of home-based primary care. Many people are unable to leave their homes for reasons that include dependence on a respirator and quadriplegia.

Medicaid pays for transportation to medical care. Patients are carried on stretchers to an ambulance that transports them to facility waiting rooms, often to wait for more than an hour. Care providers often lack the skills to treat patients who are not ambulatory. Patients often are frustrated at having to wait for more than an hour for a 15-minute visit, and respond to this frustration by avoiding care. It is more economical to conduct home visits to these patients.

Dr. Brenner stated that complex patients often are misdiagnosed. He gave an example of a patient who was misdiagnosed with and treated for multiple sclerosis when she had Parkinson's disease. UnitedHealthcare staff assisted her in arranging to see a neurologist, who correctly diagnosed and treated her, resulting in her no longer needing a wheelchair. Mood disorder with severe trauma is often misdiagnosed as bipolar disorder, due to severe irritability being a common symptom that is lessened by the sedative drugs prescribed to treat bipolar disorder.

Medical complexity is a core problem with getting appropriate treatment from typical care delivery. Many patients may be confused by what physicians say and recommend during a 15-minute visit, but few will be hospitalized as a result, even those with mild-to-moderate chronic conditions such as diabetes or hypertension. Those with more severe chronic disease, behavioral or mental health disorders, and/or are experiencing social risk factors are not adequately served by 15-minute clinical encounters. Providers and systems are not prepared to respond to these patients' needs. Psychiatric medicine check clinics may dismiss patients for not appearing for one or two appointments. These clinics often are staffed by new residents who are not adequately supervised and/or serve no more than one half day per week, which does not support continuity of care. Most of these residents do not want to pursue careers in primary care, and may be less likely to deliver adequate services to complex patients.

Dr. Brenner asserted that successfully serving complex patients requires integrated, co-located care. He suggested considering the development of a separate track for serving complex patients, similar to distinguishing primary, urgent, and emergency care, which led to increased efficiency. Using the same approach to delivering primary care to patients of all levels of complexity is inefficient, and exhausting to providers. A separate delivery track for complex patients with co-located services, especially with models tailored for specific population's needs such as the models applied at Ryan White HIV/AIDS Program (RWHAP) clinics, Programs of All-inclusive Care for the Elderly, and Housing First, would serve patients' needs better, increase efficiency, and reduce costs. Staff for these programs need to be trained in how to serve complex patients, especially in brain science related to behavioral health and addiction, and the psychology of people's motivations. Providers typically do not understand why people engage in self-destructive behavior, which is often due to a history of trauma and/or adverse childhood experiences. Healthcare providers tend to give directions assuming that patients will change their behaviors if they fear the consequences of not doing so. However, this approach is not effective. Most providers do not understand because their personal history and motivations are different from those of their complex patients. Healthcare providers tend to be achievement-oriented with a history of being encouraged by supportive parents. They often become frustrated with traumatized patients who repeatedly return to care after not following medical recommendations. Providers often conduct excessive tests on and over-prescribe medications for these patients rather than identify and address root causes of high-risk behavior such as trauma and adverse childhood experiences. Medical and nursing schools often do not provide training

about the effects of adverse childhood experiences or trauma-informed care. UnitedHealthcare developed a 12-week training program on modern tools for behavior change. Participants earn continuing education units through this program.

Discussion

Dr. Killinger thanked Dr. Brenner for acknowledging that achieving improved outcomes requires changing approaches to care delivery. She said the approaches presented exemplified what the Committee had recommended during the initial discussion of this meeting.

Dr. Evans stated when physicians or psychiatrists must treat a patient with a mental health issue that is difficult to specify, they must make a diagnosis in order to be reimbursed. Recently, providers have tended to diagnose bipolar disorders in these cases. The side effects of medications to treat bipolar disorder are dangerous. Models of value-based care must consider the risks of requiring diagnoses in unclear cases.

Dr. Bednash asked what competencies, other than understanding modern tools for behavioral change, new clinicians need in order to deliver quality care to complex patients. She also asked what Dr. Brenner believed was the potential for scaling the Housing First intervention he described for patients who are homeless and/or have complex needs. In answer to the first question, Dr. Brenner stated that medical and nursing school curricula are dense. Most training is in inpatient settings, which allows students to learn about a broad range of pathology. However, more training should be done in outpatient settings. Determining how to increase training in outpatient settings has been as issue for 30 years. FQHCs make an important contribution to training in outpatient settings. However, the United States generally is not committed to supporting primary care. Primary care providers are not paid reasonably due to current fee schedules based on the relative value unit system. Attention to this issue cycles approximately every 20 years. Dr. Brenner noted professional training should include training providers to be comfortable with people who are frail, elderly, or living with severe disabilities. Providers often complete training with no experience serving these patients.

In answer to the second question, Dr. Brenner said that America's housing crisis is a political problem and that the country lacks the political will to solve it. He said that people often look for solutions in technology, especially digital technology, to solve challenging problems, rather than acknowledge that technology is only one of many ways to address a problem in a new way. Housing First and Rapid Rehousing interventions have resulted in new insight about how to serve diverse subpopulations of people experiencing homelessness. One challenge to eliminating homelessness is people not wanting housing intervention sites in their communities. Local zoning and planning boards often block development, resulting in less affordable housing. In addition, low wages make housing unaffordable to many Americans, resulting in many low-income families living in shelters, and in people with addiction and mental health issues less able to get the treatment they need. This can be changed through facilitating effective interventions such as Housing First with wraparound services.

Dr. Khatri stated that providers do not get adequate training in how to provide effective preventive care for patients with rising health risk, and that the necessary services, such as

discussing adverse childhood experiences or positive parenting, are not reimbursed. She asked how Dr. Brenner recommends addressing this issue. Dr. Brenner said that there are three levels of prevention: primary, secondary, and tertiary. Primary prevention keeps people healthy. Secondary prevention helps people effectively manage mild to moderate health issues. Tertiary prevention helps people who have experienced bad health events to regain and maintain health. Dr. Brenner presented data on a national sample of 400,000 Medicaid patients' care costs over a period of 2 years. Most patients' monthly costs are no more than $200. Among people whose monthly costs are between $5,000 and $10,000 in the first year, 46 percent had this same level of cost the second year, with 7 percent having costs increase beyond this level. About one fourth (24%) of this sample experienced reduced costs, with 16 percent using almost no services. Among patients whose monthly costs were between $1,000 and $2,000, 31 percent remain at this level in the second year, while 13 percent incur costs at a higher level, and more than half (54%) essentially stop using services. The last group of patients is typically those with rising risk. Healthcare providers know little about helping people to maintain health. Efforts such as medical tests and specialist care often are not beneficial. Highest value care is not delivered consistently or with fidelity. The Medicaid data presented suggest that half of rising risk patients do not require intervention; evidence is not clear regarding which patients do. Intervening with all of these patients will increase costs. Models should identify circumstances associated with persistent utilization that patients will not reduce without intervention, then which clinical approaches will benefit specific patient populations' needs. Many current risk models assign risk scores to patients without stratification or identification of correlated risk factors. This ignores lessons learned from market research. For example, researchers on voting would not rank all individuals from the general population on likelihood of voting. Manufacturers would not rank individuals from the general populations on likelihood of purchasing their products. They would first segment the population and apply complex non-linear segmentation models to identify people with unmet needs, then consider how to meet those needs. Healthcare should apply these types of models.

Dr. Brenner said that investing $3 per person monthly to cover the costs of Nurse-Family Partnership services for everyone in the United States would result in dramatic benefits. A 30-year randomized controlled trial has demonstrated positive health outcomes with a return on investment. The evidence for the intervention's effectiveness is profound, but the intervention has not yet been scaled. At the same time, other interventions with marginal or no benefits, or that harm users, have been scaled and generated large profits. This issue must be addressed.

Dr. Masaki thanked Dr. Brenner for mentioning the lack of primary care providers and of focus on geriatrics in the United States. She asked how he recommended changing this permanently. Dr. Brenner said Americans are aware that this is a problem. The United States spends twice as much on healthcare as other developed countries to achieve poorer outcomes. The solution does not require new technology or innovation.

Dr. Brandt asked how Dr. Brenner would recommend training the health workforce to transition to supporting and implementing a better payment model. Dr. Brenner stated more students should go to business school, which provides students with tools for managing programs, such as how to hire and fire staff, improve processes, manage metrics, and develop an organizational chart that defines roles and responsibilities. Dr. Brandt agreed.

Dr. Bednash stated that Dr. Brenner's results should be disseminated in order to inform audiences concerned with payment reform. She asked how to determine which interventions are effective for specific priority patient populations. Dr. Brenner said this has not yet been determined. Researchers are building predictive models for Housing First success that include variables such as how long participants should be in the program. Not enough information is available to draw conclusions. In general, older participants are more tired of homelessness, addiction, and mental health issues and are more ready to do what is necessary to maintain long-term housing. Stages of change are associated with housing outcomes. Contemplating change is necessary for achieving change. UnitedHealthcare Housing First staff encourage patients whose destructive behaviors lead to housing loss to stay in touch, get needed healthcare and consider making changes that will allow them to stay housed. The focus is always on behaviors, not addiction or mental health.

Dr. Gould asked how Dr. Brenner would recommend identifying potential medical students who are likely to implement the changes Dr. Brenner advocates. Dr. Gould said that the ACICBL's most recent recommendations include teaching students to use population data to improve care delivery, through approaches such as offering primary prevention services. He asked what should be done to develop a system that supports this approach to practice. In the current system, payers do not reimburse basic community work. The Committee recommended that HRSA require grantees to teach these skills; he asked how to encourage applying the skills in practice. Dr. Brenner said it is best to have some competency in a wide range of data skills, such as data visualization, coding, and biostatistics. This provides practitioners with the ability to solve complex real-world problems. Training should teach students to use large, secure hospital claims and electronic health record data sets, which provide information about real patients and situations.

Dr. Fahrenwald asked how payments should be structured to reflect value to patients, and how this value can be quantified. Dr. Brenner stated that, in his opinion, which is not UnitedHealthcare's, value-based payment is a distraction from more important issues. He said the American Medical Association's (AMA) Relative Value Unit Update Committee (RUC) comprises all specialty societies and convenes quarterly to develop recommendations to Congress regarding relative value scales and Medicare prices. The RUC defines, assigns codes, and recommends pricing for new procedures as they are developed. CMS accepts about 85 percent of these recommendations and applies them to the Medicare fee schedule. Insurers base their payment models on Medicare's fee schedule. Provider compensation is based on these relative value units. This approach to determining costs results in physicians setting their own prices through a process in which more specialists than primary care providers vote. As a result, providing counseling is undervalued compared to procedures. Codes for new procedures are based on the initial effort required. Since this effort is reduced with practice, the relative value becomes higher than it is in practice, leading to very high profits. Talking with patients is less profitable than performing tests; it is a loss leader. As long as this is the system for determining value, value-based care will not solve the problems in the current system which costs $3.2 trillion, with costs increasing 5 to 7 percent annually.

Mr. Stevens asked how UnitedHealthcare paid for housing in the intervention described. He said he was interested in considering how housing and social services could be combined to serve

tribal communities in his home State of Alaska. Dr. Brenner noted UnitedHealthcare paid for housing with cash reserves that are required to be maintained in case the amount of reimbursement claimed exceeds expected costs. For the UnitedHealthcare intervention test, the State of Arizona allowed loaning some of the cash reserves to a non-profit organization. Dr. Brenner said the approach was complicated and probably not scalable.

Dr. Weiss asked whether Dr. Brenner had questions for the advisory Committee. Dr. Brenner said he appreciated the Committee's discussing important topics. He said that progress is being made in improving health payment structures. Success will likely take multiple generations. It is important to prepare the next generation to continue making progress. Dr. Weiss thanked Dr. Brenner for his time. She said the Committee would develop recommendations for the Secretary of the Department of Health and Human Services, the Senate Health, Education, Labor and Pensions Committee, and the House of Representatives Committee on Energy and Commerce. She said ACICBL would forward its report to Dr. Brenner after submitting it to the Secretary. Dr. Brenner asked if the Committee would share its report with the AMA. Dr. Weiss said HRSA encourages Committee members to distribute the report widely and she hoped a member would share the report with AMA. Dr. Brenner thanked the Committee.

Ethics Update

Laura Ridder
Ethics Advisor, HRSA

Mr. Stevens introduced Ms. Laura Ridder, the HRSA Ethics Advisor for the Committee. Ms. Ridder asked if there were any Committee members who had not already heard the ethics presentation. All reported having heard it. Ms. Ridder asked if any Committee members had questions about which partisan political activities they are and are not allowed to engage in, about lobbying restrictions, or other ethics questions. Dr. Killinger asked if Ms. Ridder could indicate which activities are definitely authorized or forbidden.

Ms. Ridder stated the Hatch Act was passed in the 1930s to prevent political coercion of Federal employees. What it means for Federal employees during this election year is that they cannot, while on duty, engage in any political activity that targets the success or failure of a Federal, State, or local candidate, political party, or political action Committee. Activities include discussions and displaying any items, such as clothing. Time on duty includes any time in a Federal Government building, even if it is not to conduct business, and any time conducting Committee business in any location, including during meeting breaks. Committee members should avoid provoking complaints that they are engaging in partisan activity. This includes repeating campaign statements. She gave an example of a person being suspended after telling Federal employees that he or she did not expect a raise for at least 4 years if a particular candidate was elected. Someone complained, and the person was suspended. Ms. Ridder recommended avoiding political discussions in Federal buildings in order to avoid negative consequences.

Dr. Bednash asked whether Committee members could make contributions to political campaigns. Ms. Ridder stated there is no restriction on campaign contributions, but that

employees cannot engage in fundraising while on duty or in a Federal building. This includes discussing fund raising events that will occur at another time and location.

Ms. Ridder noted that if someone makes a complaint to the Ethics Department, the department gathers information to submit to the Department of Justice for investigations. It is best to avoid provoking complaints and not to engage in activity if a Committee member has doubts regarding whether it is allowed.

Mr. Stevens asked whether he could arrange a meeting between Dr. Weiss and other colleagues to address questions they have about committee activities that may be relevant to their work. Ms. Ridder stated that he could, and that Ms. Ridder also could attend the meeting if he would prefer.

Ms. Ridder affirmed that all Committee members are special government employees. These employees work for the Federal Government fewer than 130 days per year. All ACICBL members had submitted all required ethics training forms. These forms now will be due annually by May 15 rather than on hire date anniversaries. This procedural change will make tracking easier.

The conflict of interest statute makes it a criminal offense for Committee members to work on matters that could affect their own financial interests, or imputed interests that affect a member's employer, spouse, dependent child, or organization for which a member serves as a trustee or board member. Dr. Bednash stated she is on the Board of Common Spirit Health, a $30 billion corporation. She asked how she would know if her work on the Committee presents a conflict of interest with work for Common Spirit Health. Ms. Ridder said work would be in conflict if the Committee makes a recommendation that would affect the corporation financially, or that would affect corporate policies and procedures, except in the case of matters of general applicability. Committee members have a special exemption that allows them to work on matters of general applicability, which affect the interests of an identifiable class, but not specific parties belonging to that class. For example, the Committee can recommend creating a funding mechanism, but not any specific parties who would potentially benefit from the mechanism.

Dr. Morley stated that meeting topics are related to politics. Committee members develop recommendations during the meeting and advise their employers regarding topics discussed. All members are invested in policies related to the topics discussed, and all are influential through their employment, often working with elected officials to accomplish their goals. He said he was concerned that Committee discussions about political issues violated ethical rules. He asked for clarification on how Committee members could comply with ethical requirements and do the work required of the ACICBL. Ms. Ridder said only partisan political activity, not all political activity, is restricted by the Hatch Act, which specifically restricts targeting a candidate's party or candidate's group success or failure. Committee work is about political stances on issues, not parties or candidates. Committee members are convened for the purpose of discussing policies, which is the reason for the special exemption. Committee members share expertise regarding what policies are necessary. They are hired to discuss political issues and solutions, but on behalf of the Federal Government, not their employer, while they are conducting Committee business. Doing so is a service to the Federal Government, not a violation of the law. It is legal

for members to share Committee discussions with employers as long as this does not involve sharing confidential information. Committee members also can promote their employers' positions as long as they are not related to political candidates' or parties' success or failure. It is acceptable for Committee members to discuss how policies affect people, which policies are problematic and which will help to achieve goals.

Ms. Ridder explained that the employment exemption does not apply to financial holdings above a maximum threshold, usually $15,000. Holdings in pharmaceutical or information technology (which would affect telehealth industry) could present conflicts of interest because policy recommendations could affect those industries. Committee members can work only on matters of general applicability that will not distinctly affect them or their employers, and for which they do not have a financial interest exceeding the threshold. This conflict can be addressed through a waiver for cases in which an individual's expertise is critical for Committee work.

One way to address conflicts of interest is recusing oneself from work, which includes not discussing the matter with other Committee members. HRSA's Ethics staff annually sends guidance regarding when recusal is appropriate. If a person has assets that create a conflict of interest, that person may be required to divest those assets as a condition of Committee service. If a person is unable to divest for reasons such as assets belonging to another party with imputed interest or a condition of inheritance, HHS may issue a limited waiver allowing work on matters of general applicability. Committee members can ask Ethics staff about whether a potential investment would be a conflict of interest, and it is better to determine this prior to investing.

Ms. Ridder stated that the emoluments clause does not apply to Committee members since they do not control public funds. Committee members do need to comply with the Foreign Gifts and Decorations Act. Compensation for work is not considered a gift. Anything given beyond the negotiated compensation is a gift. It is not allowable to accept a gift valued at more than $390, except for travel that takes place entirely outside of the US.

Committee members must comply with 18 US Code 219, which disallows acting as an agent of a foreign principal or a lobbyist on behalf of a foreign entity. This means that Committee members cannot try to influence United States public opinion regarding foreign governments or entities or United States policies toward them. This applies to universities or non-profits that may ask Committee members who work with them to advocate for policies that affect the organization. Ms. Ridder affirmed this is a criminal statute. She encouraged Committee members to ask the Ethics staff any questions they have regarding compliance.

Committee members are prohibited from representing any party before a Federal Government agency or court regarding a party matter they participated in while serving the Government if the Government is a party or has a direct and substantial interest.

Committee members are banned for life from representing any party to a Federal entity in specific party matters in which they participated while serving in the Government. This is a criminal statute. Ms. Ridder advised members to consult Ethics staff, even after completing their service, with any questions, in order to avoid criminal charges. Attorneys work on call for HHS to address statutory questions.

While on duty, Committee members are required to follow standards of ethical conduct set for employees of the executive branch. Ms. Ridder emphasized the importance of avoiding violating statutes, since breaking the law is irreversible. She said that it is also important not to violate regulations, which are enforced by HRSA. Regulation violation can harm individual and Committee credibility. Committee members should avoid participating in specific party matters in which they could appear to be impartial. Examples include consulting or volunteering for a party involved in the matter. Committee members are prohibited from using their position for private gain, gain of people they associate with, for positive or negative endorsements, or to coerce others. This includes bypassing proper channels to introduce people to Government staff.

Dr. Bednash asked what the Committee could discuss regarding a presentation that the presenter said included confidential information. Dr. Weiss stated that a presenter had specified that patient photos, which patients had allowed to be shared with Committee members for the meeting, could not be shared with the public. Ms. Ridder said that the presentation was on public record and can be discussed. Specific information that could identify individual patients mentioned in the presentation should not be discussed. Patient photos that were included in the presentation cannot be shared on the Committee's website. Dr. Weiss stated the model of care presented can be discussed, but information that could identify patients may not be shared.

Ms. Ridder affirmed that Committee members cannot accept gifts that may be intended to influence their work for HRSA. They may not give gifts to HHS or HRSA employees whose official responsibilities include directing or evaluating the performance of ACICBL. Members can ask Ethics staff about whether they can give or receive a specific gift.

Ms. Ridder noted that Committee members cannot accept outside compensation for teaching, speaking, writing, or editing about Committee work. It is not always clear whether this rule applies to presentations about topics for which Committee work is relevant. Ethics staff can provide guidance on complying with this rule. Dr. Weiss stated Committee Chairs often are invited to give presentations on the work of the Committees. Ms. Ridder said this is acceptable as long as they are not compensated for doing so. She added that Committee members cannot be compensated for teaching, speaking, writing, or editing on specific party matters addressed by the Committee, even if asked to do so by an employer. This can be addressed by waiving compensation.

Ms. Ridder said that Committee members may not solicit charitable funds or support for any person or entity that may be substantially affected by their performance or non-performance of duties as a Federal employee. It is acceptable to raise funds on behalf of a university employer. She believed the HHS Office of General Counsel had determined that this concern should not apply to Committee work and that she would check on this point.

HRSA has four ethics specialists. Ms. Ridder is the one directly responsible for ACICBL. Others can answer ACICBL Committee members' questions. Ms. Ridder asked if Committee members had any questions. There were none.

Mr. Stevens recessed the meeting for lunch.

The Importance of the Social Determinants of Health

Donald Berwick, MD, MPP, FRCP, KBE
President Emeritus and Senior Fellow, Institute for Healthcare Improvement

Mr. Stevens introduced Dr. Donald Berwick. Dr. Berwick noted that his presentation is focused on the social determinants of health. He explained that subway maps can be used to illustrate discrepancies in health status. The difference in life expectancy at 85th Street in Manhattan, New York City and 165th Street in South Bronx, a two a one half mile subway ride away, is 10 years. The difference in life expectancy for residents at opposite sides of Glasgow, Scotland is 28 years. The difference in life expectancy for residents at opposite sides of Flint, Michigan is 15 years. Residents of West Chicago have a 16-year shorter life expectancy than residents from other areas of the city. Dr. Berwick stated that many of his discussion points were based on the work of Sir Michael Marmot, a distinguished British epidemiologist and author of *The Health Gap*, a book published in 2015. Dr. Berwick also recommended *Well*, a book by Dr. Sandro Galea, Dean of the Boston University School of Public Health, which also discusses literature on social determinants of health.

Dr. Marmot calculated that eliminating heart disease would increase life expectancy by 4 years. This is much smaller than the effects of place in the subway map examples presented earlier. The effect of living in the South Bronx as opposed to Midtown Manhattan is two and one half times greater than eliminating all of heart disease. Dr. Berwick stated that research indicates that one year of taking statins, on average, adds one day to a patient's life; taking statins for 20 years adds 20 days of life. This is equivalent to the change in life expectancy that occurs during 7 seconds of travel on the D Train from Midtown Manhattan to the South Bronx, 43 feet of travel on Glasgow bus. Place has an enormous effect on health status, even in comparison with innovations in modern medicine. Modern medicine repairs damage that has already occurred rather than improving conditions and preventing damage.

The Health Gap summarizes epidemiological data regarding causes of health outcomes, and identifies six categories of social determinants. One category is early childhood experiences. Research conducted by Kaiser Permanente in collaboration with the Centers for Disease Control and Prevention (CDC) demonstrated that adverse childhood experiences affect health status through adulthood. Children who report at least four exposures on the Adverse Childhood Experiences Scale are at five times higher risk for depression, 12 times higher risk for attempted suicide, 15 times higher risk of learning disability, two times higher risk for cardiac disease or lung cancer, and five times higher risk for substance use than people who have not experienced an adverse childhood experience. In an assessment of 21 countries' national investment in material, educational, and behavioral supports for child well-being, the United States ranked lowest. In an Organization for Economic Cooperation and Development (OECD) study of child poverty in 35 countries, the United States ranked lower than all countries except Romania. Compared to other countries, the United States does not invest in helping children avoid adverse experiences. Discussion of health issues that emphasizes adverse childhood experience sometimes is criticized for not also acknowledging community assets. These assets are important, but it is critical to understand the influence of adverse childhood experiences on child and adult health.

Education, especially for girls and women, is another key social determinant of health. A report released by the World Bank about 15 years ago described the relationship between women's status and education, and community well-being. Educational achievement correlates strongly with life expectancy. A study of 15 nations found a 15-year difference in life expectancy between the highest and lowest quintiles of educational achievement. Within the United States, the difference in life expectancy is about 10 years. Countries that have invested in reducing income disparity, such as Portugal, Finland, and Sweden, have eliminated the relationship between educational achievement and longevity.

Conditions of work is another key social determinant of health. This includes financial compensation for work. Marmot's mentor, epidemiologist Jerry Morris, demonstrated that having adequate income for not only food, shelter, and clothing, but to participate fully in society, with dignity, increases longevity. In the United States, many people who work hard are not paid enough to participate fully in society. Another factor of work conditions is safety, including exposure to toxins. Social isolation, which is often a result of unemployment, affects longevity. A study conducted in the Czech Republic, Poland, and Russia showed that 6 years of unemployment doubled the death rate in men and women. A University College London study showed that social isolation doubled the risk of coronary heart disease.

How a society deals with aging affects the well-being of the entire community. The degree to which people are able to participate in work and society as they age is associated with longer life expectancy. A meta-analysis of 140 studies of people older than 64 years whom researchers followed for an average of 7 and a half years showed that people who were socially engaged died half as often as those who were not. Dr. Berwick acknowledged that correlation does not establish causation. However, evidence indicates that isolation causes negative health outcomes rather than poor health causing isolation.

Community resilience is another major social determinant identified by Marmot. This refers to transportation, housing, violence, and environmental conditions associated with health and well-being. Community sense of self-efficacy, or sense of control over what happens to the community, is an important component of resilience. Christopher Lalonde of British Columbia studied variation in suicide rates of indigenous communities. Results showed that communities with a sense of empowerment had lower suicide rates than those that felt disempowered. Disempowered communities had higher rates of crime, alcohol-related deaths, obesity, road traffic accidents, depression, pollution, housing shortages, and food insecurity, all of which reduce life expectancy. Empowered communities had high social cohesion, participation, security, low fear of crime, active transportation, green space, and walkability, all of which increase life expectancy.

Dr. Berwick stated improving health requires addressing root causes. This should include supporting positive early childhood experiences, education, especially for women and girls, good work conditions, opportunities for older people to participate in communities, and community resilience, especially a sense of empowerment.

The final, and most important social determinant Mamot identified is a sense of fairness. Countries that invest in reducing inequity have populations that live longer. Some people

believe that people earn their station in life and, if they work hard enough, can overcome poverty and other difficulties. However, societies that invest in overcoming inequity and the effects of place become healthier. This is associated with a sense of social solidarity, a term seldom used in the United States, but frequently in other countries. Communities that enact and embrace policies that support helping each other live longer.

Some communities in the United States are investing in addressing social determinants of health and are improving their health. Currently, there are 22 "purpose-built" communities across the United States, a social experiment initiated by philanthropist Tom Cousins, to invest in local conditions with the aim of improving community health. Cousins formulated the idea after learning about a Rutgers University study that showed 75 percent of inmates in New York State prisons came from eight New York City neighborhoods. He interpreted this to mean that investing in housing, food availability, parks and recreation, and healthcare coverage through public-private partnerships could reduce disparities. Evaluation results confirm this. The initial purpose-built community was East Lake, Georgia, where the experiment was initiated in 1995. Since then violent crime has reduced between 90 and 95 percent. Welfare dependency has declined from 59 percent to 5 percent. Unemployment of people who are not disabled or elderly has been eliminated.

Anchor institutions, described in *The Anchor Institution Playbook,* invest resources in community healthcare supply chains. One example is a consortium between the Cleveland Foundation, Cleveland Clinic, Case Western University and other participants; another is Rush University Medical Center. Healthcare accounts for 18 percent of the United States economy, with approximately $1 trillion invested in the supply chain, including local construction. Anchor institutions invest these funds in communities that are negatively affected by social determinants of health. This approach does not cost more; it invests spending where funds are most needed.

Another example of a healthcare provider addressing social determinants is Gloucestershire Health Trust in England. The organization partners with local institutions to administer drop-in centers that are open 24 hours per day, 7 days per week for people with serious mental illness. Clients can play music, work at the coffee bar, and socialize. It has dramatically reduced hospitalizations for mental illness and improved public safety. A police constable at one drop-in center told Dr. Berwick that people who used to be at the police station regularly stopped coming in after the drop-in center opened. Montefiore Health System in the Bronx has worked to address social determinants of health for 40 years. Special task forces are available to support the emergency department by assessing patients' risks and needs for housing, food, and medicine. Dr. Berwick said these examples indicate that progress is possible. He said that healthcare systems, accounting for 18 percent of the economy and being the second largest employer in the United States, have an obligation to address social determinants. Unless healthcare systems invest in community health as defined by Marmot and Galea, community health cannot be achieved. Dr. Berwick said that FQHCs are a good example of working toward community well-being rather than only to repair damage that already has occurred.

Dr. Berwick said that policy makers must consider the effects of despair, as studied by Nobel Laureate Angus Deaton and Princeton colleague Anne Case. Deaton and Case found that lack of investment in social and income equity, and lack of engagement with disadvantaged populations

is decreasing life expectancy and increasing mortality related to alcohol and other substance use. It is urgent to consider this issue while at least 60,000 people are dying annually from the opioid epidemic and the Nation's life expectancy is declining for the first time since national data collection began. Policies are decreasing support for people injured by social determinants when they should address these social determinants to achieve desired health outcomes.

Discussion

Dr. Khatri stated that she works with Cherokee Health Systems, an FQHC in Tennessee. She appreciated Dr. Berwick's work related to health equity as the fifth aim in healthcare quality. She noted that ACICBL makes recommendations regarding health workforce development. She asked how the Committee could influence the workforce to view equity as central to quality in the way that it currently views the Triple Aim. Dr. Berwick thanked Dr. Khatri for her work, stating that community health centers have experience, values, and community connection that allow progress toward health and well-being. He said the Nation needs to discuss its moral values in order to achieve the momentum necessary to address social determinants of health. National leaders need to reassert the value of taking care of each other and reject the idea that it is acceptable not to take care of each other. Currently we are not adequately caring for each other. Inclusion is the core value of equity. Achieving equity requires being united by a vision of a great, inclusive society, and investment in an ethical framework supporting that vision. To achieve this, people must criticize the current system, which does not reflect this ethical framework.

To encourage the health workforce to embrace equity as a quality aim, people should expand the definition of the healthcare workforce. Health is affected by many sectors, which can partner with conventional healthcare providers to improve health. Potential partners include teachers, employers, and the criminal justice system. Dr. Berwick suggested encouraging use of the World Health Organization's "Health in All Policies" framework for defining the healthcare workforce, which can be applied at Federal, State, and community levels. Practice also should be defined more broadly. Dr. Berwick said he disagrees with the American Medical Association's opposition to expanding advanced practice nurses' prescribing authority. Providers should not act as guilds protecting their boundaries but as respectful colleagues supporting mutual growth in ability to serve patients. Leveraging telehealth capacity is relevant to ACICBL's work. Barriers include State licensure requirements that can prevent using capacity to serve across State lines. The National Cancer Institute and Federal Communications Commission (FCC) co-sponsor the LAUNCH Project in rural Kentucky. The project uses telemedicine with broadband connectivity, which is why the FCC is involved, to deliver world-class cancer care. Dr. Berwick urged Committee members to learn more about the project.

Dr. Berwick noted community health workers have contributed significantly to health outcomes in lower incomes countries, and could do the same in the United States. The United States can learn from countries that have fewer resources. He stated that community health workers should be paid adequately and fully supported.

Dr. Berwick recommended teaching health professionals to address social determinants. This should be part of medical and nursing school curricula as well as curricula for other health

professionals. Hackensack Meridian Healthcare founded a medical school that includes a required experiential training component addressing social determinants of health. The field should learn from such prototypes and apply lessons learned to training curricula.

Ms. Golden remarked that changing payment structure is challenging. She asked Dr. Berwick to recommend levers to consider for reform. She noted that Dr. Brenner had suggested changing how the RUC influences payment. Dr. Berwick expressed appreciation for the work of

Ms. Golden's employer, Rush University Medical Center. He agreed that the current payment system is problematic. He referred to Betsy Bradley's research comparing the proportion of national government expenditures on social factors on health. All OECD countries spend between 27 and 30 percent on health and social determinants. But all OECD countries other than the United States spend twice as much on social factors as on other health expenditures. The United States spends 10 percent less on social factors than other health expenditures.

Dr. Berwick said this has resulted in the United States not being healthy and being unable to become healthy until this situation changes. Reform cannot be achieved through fee-for-service payment systems. Global budgets in population-based payment systems that pay for delivering care that improves population health would be an improvement. Some clinicians resist this payment approach because it lowers their income and autonomy, however, it is a necessary change. Systems that have implemented population-based payment systems have achieved population health improvements, such as the reductions in mental hospitalizations resulting from efforts of the National Health Service in Gloucestershire. The best United States example is Kaiser-Permanente. Dr. Berwick agreed with Dr. Brenner that the RUC is a barrier to payment reform and should be eliminated. He said this would be extremely difficult for political reasons, but should be done.

Dr. Berwick recommended expanding payment for non-physician healthcare providers, such as community health workers. He said that a major challenge is determining how to fund efforts to improve health through addressing social determinants by reforming the criminal justice system, eliminating food insecurity, and ending homelessness. Resources must come through raising taxes, which would save money in the long-term, or through reallocating money currently spent on healthcare. Reallocation to eliminate wasteful spending and increase preventive care is likely the only solution. Ms. Golden agreed.

Dr. Weiss said the cost of medical education contributes to the current system. Medical and advanced practice nursing students graduate with $200,000 to $300,000 of debt. This should be considered in plans to overhaul the payment system. She asked Dr. Berwick for his input on this issue. Dr. Berwick acknowledged that this is a challenging problem. He also noted that physicians are highly paid, with incomes at the 95th to 99th percentile for the US. Even lower paid practitioners are able to eliminate $300,000 in debt fairly quickly. Education expenses are investments, however, education debt produces maldistribution of providers. Medical students pursue specialized practice when the United States needs more primary care providers. The United States needs to adjust maldistribution. Salary payment rather than fee-for-service is one approach to addressing the issue. Salaried providers' care decisions are not influenced by the tests and procedures they conduct, freeing them to be motivated only by patients' interests. The

payment system should incentivize becoming a community health worker or advanced practice nurse. Dr. Berwick added that subsidizing medical education requires considering subsidizing education for other helping professions, such as teaching. Educational support should be in exchange for service to underserved communities.

Dr. Berwick affirmed that the Affordable Care Act provides direct support for Teaching Health Centers, which Dr. Berwick believes is a good policy. The idea was championed by the recently deceased Dr. Fitzhugh Mullan. Dr. Berwick urged the Committee to consider Teaching Health Centers as a component to solving the problem of nursing and medical education debt.

Dr. Brandt asked Dr. Berwick if lessons learned from implementing Age-Friendly Health Systems could be applied to payment reform. She noted that the population's aging affects both the workforce and needs for healthcare. Dr. Berwick said the Age-Friendly Health System project is supported by the John A. Hartford Foundation. It defines age-friendly health systems based on the work of leading scholars that identifies the "four M's": "What Matters", appropriate medication management, supporting mentation, and advancing and supporting mobility. "What Matters" refers to tailoring care for individual and local needs. Hundreds of health organizations endorse the four M model, which is not optimally supported by fee-for-service care. Mobility care may require time investments not supported by fee-for-service. Medication overuse is sometimes a result of fee-for-service models. Global budgets are an important component of payment reform, especially when serving high-risk populations such as patients who are elderly. Supporting communities in supporting people results in better health outcomes than purchasing individual procedures. Payment systems should acknowledge that social supports are as medically relevant as medications. A holistic understanding of health that includes mental healthcare in healthcare is crucial. It is not reasonable to expect a single system to serve everyone well. Just as age-friendly systems are tailored for older adults, healthcare systems can be tailored for other priority populations, such as children or people who have experienced trauma, based on empirical evidence. Dr. Berwick emphasized the importance of learning from approaches implemented in other countries.

Dr. Weiss said that HRSA's GWEP is collaborating with the Institute for Healthcare Improvement, which Dr. Berwick co-founded, the American Geriatrics Society, and 391 primary care practices. Of these practices, 199 are FQHCs. The GWEP grant recipients are working to make primary care practices age-friendly. Dr. Berwick said this is another example of FQHCs' leadership in addressing problems in American medicine. It is important to monitor implementation of innovative practices to learn what barriers they face and what lessons they learn from implementation.

Dr. Gould asked Dr. Berwick how to identify healthcare profession students who are more likely to practice population healthcare and to share a vision of wellness and inequity, and how to encourage and prepare students to transform the healthcare system to support this vision. Dr. Berwick stated his first year medical students at Harvard always express compassion and a desire to serve society. He believes students do share the vision Dr. Gould described. He does not think career choices that result in maldistribution are caused by selecting the wrong students. The problem is likely caused by leadership that socializes students to lose this vision.

Dr. Berwick recalled a student interrupting a lecture on healthcare finance to say that finances were not related to his motivation to be a doctor; his motive was to help people. Hackensack Meridian Healthcare's medical school dean emphasizes acculturating students to embrace the vision Dr. Gould described. Northwell Health Systems in Long Island founded a medical school in partnership with Hofstra University which requires applicants to have experience as an emergency medical technician experience. These are examples of educational approaches that encourage students to have a different view of healthcare delivery than is currently typical.

Dr. Gould said he thought it would be useful to require students to have experience as community health workers prior to entering medical school. Dr. Berwick agreed.

Dr. Fahrenwald said that she is a physician at an FQHC that is also a Teaching Health Center. She noted that the field tends to emphasize health risks and negative factors more than strengths and resilience factors. Resource allocation and treatment approaches should be customized based on resources as well as needs. Assessment instruments emphasize risks over resilience. There is a need for tools that identify patients' strengths that can be used to combat despair and poor health. Dr. Berwick called this asset-based thinking. Sandro Galeo's book, *Well,* discusses asset-based perspectives. Angela Duckworth developed resilience measures as part of her Grit model. Katherine Gottlieb and Doug Eby of Southcentral Foundation in Alaska developed the Nuka health system, which emphasizes resilience, assets, and community resources. Dr. Berwick noted that the Nuka system has been successful. He remarked that political and economic structures can systematically bar communities' self-efficacy, which is why healthcare transformation requires moral discussion.

Dr. Bednash stated that medical and nursing schools prepare students to obtain higher paying jobs. Healthcare's focus on repair rather than wellness extends to education and accreditation institutions. She asked how Dr. Berwick would recommend changing this to produce a workforce with a holistic view of health, focused on helping people to stay healthy, and a moral investment in equity. Dr. Berwick said that leaders in healthcare must unapologetically embrace a moral stance. Currently, the opposite is too often the case. It also is necessary to demonstrate effective approaches to healthcare system transformation. Increasing emphasis on social determinants of health must not be considered adversarial to technological advances in medicine. He noted that when he first started pediatric practice, every patient with leukemia died; infants with heart defects frequently died. This is no longer the case due to advances in oncology and cardiac surgery. Plans to transform the healthcare system must balance addressing social determinants with technological progress. Quality improvement strategies also must acknowledge that much of the $3 trillion the United States annually spends on healthcare is wasted. He cited an October 2019 Will Shrank *Journal of the American Medical Association* article replicating results of a study Dr. Berwick conducted in 2012 that showed $1 trillion of annual healthcare expenditures is wasted. Leaders must acknowledge and confront this issue, and reallocate resources to address social determinants of health, increase access to primary care, and support community health organizations. Quality improvement is related to waste reduction, which presents reallocation opportunities. Current approaches to workforce training tend to encourage waste and should be changed. One strategy is to stop fee-for-service payment.

Mr. Stevens thanked Dr. Berwick for his presentation, and for his praise of Mr. Stevens' employer, Southcentral Foundation. Mr. Stevens stated he would encourage his organization to invest more in addressing social determinants of health.

Efforts to Further Comprehensive, Team-Based Primary Care and to Address Social Needs

Anne Greiner, M.A.
President and CEO, Primary Care Collaborative

Mr. Stevens introduced Ms. Greiner as the President and Chief Executive Officer of the Primary Care Collaborative (PCC). Ms. Greiner stated she would describe a team-based approach to comprehensive primary care that addresses social needs. PCC is a non-profit organization based in Washington, DC that promotes primary care with the Quadruple Aim. The organization was founded in 2006 to consider new approaches to primary care delivery and payment. At inception, PCC issued joint principles regarding patient-centered medical homes (PCMH). PCMH is a population-based model of care that leverages technology to increase access to care, including after-hours care and care other than in-person visits. Currently, 42 percent of practices with primary care physicians are in a PCMH.

PCC solicited input from 100 organizations to develop a new vision for primary care called "The Shared Principles," which are now endorsed by more than 350 organizations. The Shared Principles state that primary care should be team-based, offer continuity, help patients connect with community resources to address social factors, and include responsible resource stewardship while promoting the value of primary care. The principles include Barbara Starfield's "4 C's." One "C" is comprehensiveness. Ms. Greiner said that innovations such as telehealth, and retail and urgent care settings may not be comprehensive enough to qualify as primary care. The American Board of Family Medicine has developed a measure of comprehensiveness that she endorses. The American Board of Family Medicine also has developed a measure of what patients want from primary care.

PCC works to achieve its vision through policy advocacy, evidence and exemplary model dissemination, and through providing tools and technical assistance. PCC collaborated with the Graham Center to review evidence about PCMH. Ms. Greiner presented results of PCC evaluations of advanced primary care models. Researchers identified 1,500 articles on the topic and 50 that met inclusion criteria for scientific rigor. Results show that the PCMH model has reduced costs and improved service quality. Researchers assessed the relationship between PCMH and accountable care organizations (ACO). Results demonstrated that ACOs that decreased costs while improving quality of care were more likely than others to include physicians who practice in PCMHs. Ms. Greiner stated PCMH is a good model for payment reform and for changing care delivery to improve patient outcomes. She also noted that most primary care practices have a fee-for-service structure that allows less flexibility to support patient-centered care, or to invest in changing the model of service delivery. Therefore, PCMHs often are not supported by the resources defined in the PCMH care delivery model. For example, primary care teams may include only a physician and one other provider, not a full team with a behavioral health specialist, community health worker, and nurse practitioner. As a

result, care is not truly comprehensive. There is not yet agreement about how payment should be structured or performance measured in PCMHs. About 60 percent of providers in PCMHs or ACOs are compensated on a fee-for-service basis. A study conducted at Harvard's Center for Primary Care demonstrated that two-thirds of a practice must be under capitation to fund team-based, non-visit-based care. Primary care practices are moving slowly toward comprehensive payment.

Ms. Greiner stated that primary care has been given increased priority by the last two Federal administrations. CMS has the potential to influence the trajectory of primary care models. CMS will increase Medicare primary care evaluation and management codes in 2021, which will influence the balance of payment for primary and specialty care. The Center for Medicare and Medicaid Innovation (CMMI) is a large investor in primary care models such as Comprehensive Primary Care Plus, which currently includes 3,000 practices. In April 2019 CMMI initiated more primary care models that emphasize progress toward value-based payment. PCC is especially interested in Primary Care First because it focuses on small and mid-sized small organizations. This model supports faster shift toward risk-based performance payments, with four levels of prospective payment risk, and up to 50 percent upside performance payment and 10 percent downside investment. It is not an all-payer model, so participating practices will have different incentives and performance measures, which is challenging. The program does not include an upfront investment and is intended for practices with existing infrastructure for risk management. Ms. Greiner says it is unknown whether the program will attract enough practices to be sustained.

CMS promulgates accountable care communities, which have a broader focus that ACOs. CMS also is changing Medicare Advantage plans to pay for supplemental services that address social needs. Similar changes are occurring with Medicaid.

Ms. Greiner said that current investment in primary care in the United States is inadequate. Few people are aware of this. PCC has sought to increase awareness and discussion about this issue, including how investment in the United States compares to other industrialized countries, which approaches to investment support well-functioning systems in the United States, and understanding the broad spectrum of services that primary care providers are expected to deliver.

In 2019, with support from the Milbank Memorial Fund, PCC collaborated with the Graham Center to compare primary care expenditures at the State level across payer types (e.g., Medicare, Medicaid, commercial). Results were published in a PCC report, *Investing in Primary Care: A State-Level Analysis.* Researchers analyzed Medical Expenditure Panel Survey (MEPS) data from 29 States. Currently there is not consensus regarding the definition of primary care. Researchers used multiple definitions in their analysis to support comparisons of investments across States and ACOs, then assess the relationship between primary care investments and patient outcomes. Results showed that, using the narrow definition of primary care, States invest between 5 and 7 percent of their resources on primary care. On average, OECD countries invest 14 percent. Using a broad definition that includes behavioral health and OB/GYN services, the United States still spends less than other OECD countries, with 14 percent being the highest investment of any individual State included in the analysis. Researchers found that more primary care, defined narrowly or broadly, spending correlates with fewer emergency

department visits, fewer hospitalizations, and fewer ambulatory sensitive hospitalizations. Analyses should be conducted with claims data and using approaches that control for potential confounds. Ms. Greiner asked ACICBL to consider recommending a national standard of primary care spending that is promulgated through CMS.

State leaders have referred to *Investing in Primary Care: A State-Level Analysis* to make policy. To date, 13 States have introduced or passed legislation related to primary care investment, six in 2019. Three States- Rhode Island, Connecticut, Oregon have set spending targets that are higher than the national average. Five States have issued reports during the past 6 months and are working with multiple stakeholders to interpret results and set goals.

PCC is working to raise visibility of the issue of primary care spending impact, and compiles information about the relevant evidence base. A recent issue of *Lancet* included an opinion editorial on the topic. A recent *Health Affairs* blog discussed the importance of a standardized measure.

Ms. Greiner presented data from a 2018 National Association for State Health Policy report showing that 30 States are addressing at least one social need through their Medicaid programs. One approach is connecting primary care to community-based services. This approach is applied more often by States that invest more in primary care. Oregon found that every dollar invested in PCMH Coordinated Care Organizations saved $13. This was the basis for the argument for Oregon to adopt legislation requiring all payers to invest more in primary care. PCC is monitoring results of State programs to leverage primary care and community services to address social needs in North Carolina, Delaware, and Washington State. North Carolina is implementing Healthy Opportunities Pilots supported by a Social Security Act Section 1115 waiver. Programs offer enhanced case management to address housing, food, transportation, and interpersonal safety needs. Delaware earned a State Innovation Models (SIM) grant to implement Healthy Neighborhoods, which prioritizes healthy lifestyles, maternal and child health, mental health and addiction, and chronic disease prevention and management. Washington also earned a SIM grant and a Section 1115 waiver, and passed legislation to support Accountable Communities of Health. Grantees must address at least four Delivery System Reform Incentive Payment priorities.

Discussion

Dr. Khatri said that ACICBL provides guidance to the AHEC program, which is required to offer didactic training on PCMH. She asked Ms. Greiner what she defines a good PCMH. Ms. Greiner stated there are several definitions and the field is still grappling with this question. Emphasis on infrastructure components that facilitate population-based care management has sometimes made care more reactive than proactive. Input from providers indicates that a PCMH should facilitate proactive care, outreach to help patients manage their health, effective use of technology, and meet patients' behavioral healthcare needs.

Dr. Morley stated Ms. Greiner's data showed that the United States should invest more in training people to become primary care providers. There is no reason not to pay primary care physicians as much as specialists. He asked how medical school should be changed to meet

primary care needs. Dr. Morley said one approach would be to eliminate block rotation requirements and replace them with primary care training. He recommended a requirement to spend 6 months to a year serving as a nurse's aide, EMT, or social worker. Ms. Greiner noted that PCC's research focus is on primary care spending, not number of providers. She also acknowledged that these are related. Delaware's primary care shortage is so urgent that specialists supported legislation to increase investment in primary care. The difference between compensation for primary care providers and specialists has contributed to the shortage of primary care providers. Canada responded to a similar shortage with a single payer system. Within 3 years, great progress was made in addressing the shortage. While money is an important contributor to the shortage, there are other contributors. A Medicare Payment Advisory Commission (MedPAC) report presented evidence that nursing and medical students are discouraged from becoming primary care providers. Leaders and mentors should counter the lack of recognition of primary care's value. Ms. Greiner agreed that experience in ambulatory care, public health, and serving as an EMT is valuable.

Dr. Fahrenwald said that the University of Washington exposes medical students to primary care practice early in their training. Students spend a half day to full day every week for the first 2 years of medical school seeing patients in primary care settings. This has led to improved skills and appreciation for the value of continuity and comprehensive care. Students are less likely to believe that the smartest students should specialize rather than provide primary care. They are beginning to perceive primary care as an appropriate career choice for excellent students. Ms. Greiner stated FQHCs provide comprehensive team-based care, which is possible because of their payment model, and are an important innovation in training primary care providers.

Dr. Masaki noted the medical school at the University of Hawaii Systems strongly encourages students to pursue careers in primary care. However, she believes change requires more graduate medical education opportunities for primary care training. She expects this change to be resisted by specialists. Ms. Greiner said other national systems are more directive regarding students' career paths.

Dr. Gould introduced himself as the Associate Dean for Primary Care at the University of Connecticut, where the new dean is committed to increasing the number of graduating primary care physicians. The dean has declared career choice bullying unacceptable. Students report that they often are discouraged from becoming primary care providers because they are too smart, or will never be respected. This toxic culture must be countered. A total of 40 percent of respondents to the Graduate Questionnaire, completed by all medical students during their first year of internship, report that they infrequently observe respect between specialty areas. He suggested that, while it is necessary to improve primary care efficiency, it is also necessary to create a climate that encourages becoming a primary care provider. He asked if Ms. Greiner were aware of work in this area. Ms. Greiner agreed that this is a critical issue and said that it has been discussed by MedPAC, and that PCC will consider the issue. She said change will be difficult and take time. New investments in primary care may be helpful. It may also discourage some people who perceive the effect of this change to be commodifying primary care. Dr. Gould stated that the University of Connecticut now has to educate students and faculty about how to have an appropriate career conversation.

Dr. Evans remarked that his own advisor did not seem to be aware of primary care as a career choice for a behavioral healthcare provider. Behavioral health students are not being prepared to serve in PCMHs, other than those in in HRSA's graduate psychology education and Behavioral Health Workforce Education and Training programs. Training for allied health, supportive, and behavioral health professions should prepare students to work in primary care. Dr. Evans gave an example of a primary care group being dissatisfied with counselors they had hired because the providers were not prepared to serve in a primary care setting. He asked if Ms. Greiner had recommendations for how to address this. Ms. Greiner said the problem is bidirectional; primary care practices often are not prepared to incorporate behavioral healthcare providers. PCC offers a webinar on its website, conducted by Larry Green of the University of Colorado, who wrote a book on models for integrating behavioral health and primary healthcare. She said that the issue employers most commonly report to PCC is a need to improve behavioral healthcare and to integrate it with medical care. Dr. Evans stated that another issue is rural family physicians believing they should provide comprehensive care, and therefore also believing they should not ever refer patients to other providers. Providers need training in what resources are available and when primary care providers should refer patients to a behavioral health specialist. Ms. Greiner concurred.

Dr. Brandt introduced herself as a pharmacist. She thanked Ms. Greiner for mentioning the value of all members of a primary care team. She asked what kinds of educational initiatives PCC has implemented for non-physician providers. She also asked Ms. Greiner to share her thoughts regarding performance metrics with reimbursement potential. Ms. Greiner said PCC prioritizes developing approaches to integrating multidisciplinary primary care teams. She said both primary care physicians and pharmacists have experienced increasing corporatization over the past decade and could learn from each other about this. PCC offers webinars about the role of pharmacists on primary care teams, including medication management, medication reduction and optimization, and being responsive to patients. Ms. Greiner said she is not familiar with pharmacy performance measurement; she is more familiar with measures that apply to all members of a primary care team, which emphasize care coordination and integration, and patient education. Dr. Brandt said she would like to discuss the issue further after the meeting. Ms. Greiner agreed to do so.

Value-Based Insurance Design: Enhancing Access and Affordability to Essential Care Services

A. Mark Fendrick, MD
Professor of Internal Medicine and Health Management and Policy
University of Michigan

Dr. Kennita Carter introduced herself as a Designated Federal Official in the Division of Medicine and Dentistry, representing Dr. Weiss while she had to leave the meeting briefly. Mr. Stevens introduced Dr. Fendrick of the University of Michigan. Dr. Fendrick thanked HRSA staff and the Committee for their work, and expressed appreciation for prior presentations.

Dr. Fendrick stated that Value-Based Insurance Design (V-BID) is one of the few bipartisan and multiple stakeholder healthcare transformation ideas. His presentation provides a description of

V-BID and its relevance to ACICBL's discussion of payment transformation. Additional details, including policy accomplishments, are available on the V-BID Center website.

Dr. Fendrick remarked that he did not complete medical school to learn how to save people money. He appreciated that Committee members are focused on helping people to become healthier. Unfortunately, most discussions about healthcare transformation focus on how to spend money rather than on how to make people healthier. He stated that in 25 years of work on healthcare costs and quality, everyone from every constituency and political party has agreed that the more than $3 trillion the United States spends on healthcare is enough; 20 to 25 percent of the gross domestic product is not necessary. The United States does need to allocate resources differently. Discussion often focuses on how to pay for care, referred to as supply-side or provider-facing initiatives. "Demand-side" refers to patient engagement in health system transformation, the focus of Dr. Fendrick's discussion.

Dr. Fendrick conveyed that Americans are not concerned with healthcare costs generally, but about what their healthcare costs them in terms of premiums, deductibles, and co-payments. Underinsurance has become a critical issue. For example, people, particularly those buying individual insurance policies, often have deductibles that are thousands of dollars. The average American insured through the private sector has a $1,000 deductible. The Federal Reserve reports that 40 percent of Americans do not have $400 in the bank, making deductibles prohibitive.

Two decades ago some people promoted the idea that Americans should shop for their own healthcare coverage. Evidence has shown that this does not support people in being better consumers. Rather, "When you make people pay more for something, they'll buy less of it." Low-income people and people with multiple chronic conditions are unable to afford the deductibles and cost-sharing requirements necessary to get the care they need under the current system. Dr. Fendrick stated that, since there is enough money in the healthcare system, the solution is to spend the money where it is needed and to stop buying unnecessary procedures and prescriptions.

Dr. Fendrick collaborated with Michael Chernew, professor at Harvard Medical School and former Vice Chair of MedPAC, 20 years ago to design a system that makes it easier to obtain resources that make people healthier and harder to get resources that do not. This concept is called V-BID. Dr. Fendrick is working to convince public and private payers to redesign their benefits so that consumer cost-sharing is based on clinical benefit rather than price. V-BID implementation has steadily increased. It has earned Federal and State bipartisan support as well as support from diverse stakeholders such as pharmaceutical companies, America's Health Insurance Plans, the Pharmaceutical Benefits Management Association, the Hospital Association, and several consumer advocates.

A core value of V-BID is basing patient out-of-pocket costs on clinical benefits. Dr. Fendrick wrote the V-BID section of the Affordable Care Act (ACA), which mandates all plans that were not grandfathered to cover selected preventive services without cost sharing. Following the passage of the ACA, an estimated 150 million Americans received expanded coverage of services rated "A" or "B" by the United States Preventive Services Task Force, the CDC's

Advisory Committee on Immunization Practices, and HRSA preventive care guidelines. Dr. Fendrick noted that HRSA has played an important role in implementing V-BID. Zero cost sharing for preventive services is one of the three most popular aspects of the ACA among the general public, Republicans, and Democrats. It is difficult to argue against free immunizations, free cancer screenings, free depression screenings, free smoking cessation services, and free PrEP for HIV.

There is no secondary preventive services task force, so Dr. Fendrick and colleagues have been unable to apply the approach applied for primary preventive services to obtain clinical-driven reductions in cost sharing for chronic disease services. This is an important priority since 98 percent of Medicare expenditures are on chronic disease services. A recent Kaiser Family Foundation study showed that half of Medicare beneficiaries have an annual fixed income of less than $30,000. Cost-sharing, such as paying $5,000 annually for health insurance premiums, can be a challenge.

The legislation authorizing Medicare passed in 1965 and included an anti-discrimination clause, which requires all enrollees to have the same benefit design. However, precision medicine requires personalized benefit design and individualized V-BID, such as reducing cost sharing for eye exams just for people with diabetes. Therefore, the anti-discrimination clause is a major barrier to implementing V-BID for Medicare. In 2014 Dr. Fendrick contributed to bipartisan support to waive the clause to launch the Center for Medicare and Medicaid Innovation (CMMI) Medicare Advantage V-BID demonstration projects in seven States. The Trump administration expanded the project to all 50 States. In these demonstrations cost-sharing reductions could be tailored to individual patient's needs. Following positive response to Medicare Advantage V-BID demonstrations, CMS loosened its interpretation of the uniformity rule to expand Medicare Advantage beyond the demonstration. Secretary Azar and CMS Administrator Seema Verma refer to the expansion as V-BID 2.0, which includes telemedicine, advance care planning, hospice carve-in, and support for nutrition and transportation. Reductions in drug cost sharing for specific patient populations are restricted to demonstration projects. After hearing Senate testimony about the results of the Medicare V-BID demonstration, Senator John McCain expressed interest in applying V-BID to the Tri-Care program. With bipartisan support, V-BID was incorporated into the National Defense Authorization Act in 2017 and 2018.

The 2004 Medicare Modernization Act required anyone opening a Health Savings Account to enroll in an Internal Revenue Service-qualified high-deductible health plan. Dr. Fendrick said he supports Health Savings Accounts, for which money can be contributed, invested, and withdrawn without being taxed. Section 2713 of the ACA implements the Preventive Care Safe Harbor, which requires high-deductible health plans to cover specified preventive services without a deductible. Dr. Fendrick added that deductibles apply to treatment for existing illness. So, following a free mammogram that shows cancer or a positive depression screening, the patient is responsible for paying the deductible before receiving treatment. For 14 years Dr. Fendrick advocated for the Internal Revenue Service to allow these plans to cover very high value services voluntarily. In the summer of 2019 the Treasury Department allowed expansion of pre-deductible coverage of services to treat chronic conditions. Treasury Rule Notice 2019-45 will be revisited for possible expansion within 5 years. Dr. Fendrick said this is not soon

enough, which is why he and colleagues advocate for public policy makers to allow plans more flexibility.

Expanding pre-deductible coverage prevents people from having to pay full price for critical treatments such as insulin. This situation precipitated the third introduction of the Chronic Disease Management Act, currently in the Senate, which would allow HSA-qualified health plans to provide pre-deductible coverage for chronic disease preventive services. Dr. Fendrick invited Committee members to review information on the V-BID Center website about the impact of these plans. He also invited input about how to expand V-BID implementation. Examples of V-BID success include CVS lowering out-of-pocket costs from some pharmaceutical benefits management members in V-BID plans. In the near future a demonstration that lowers out-of-pocket costs for insulin may be approved.

Dr. Fendrick remarked some critics have stated that lowering cost sharing means someone else must cover costs or that people will over-utilize services. Studies have shown that people with V-BID coverage apply the cost savings for more services, some of which lead to reduced hospitalizations and emergency department utilization. Possible approaches for paying the cost of expanding access to quality healthcare include: 1) increasing the price of premiums, which is not politically feasible, 2) raising deductibles and co-payments, which is a tax on being sick and has resulted in reduced use of high-value services, and 3) identifying, measuring, and reducing low-value care, and reducing payments for low-value care in order to increase resources to pay for high-value care. Dr. Fendrick endorses the third option.

Dr. Fendrick and colleagues founded the National Task Force on Low Value Care. ACA Section 4105 gives the Secretary of Health and Human Services authority not to pay for services with a "D" grade from the USPSTF, which are dangerous. Dr. Fendrick does not know of examples of this authority being exercised. A recent study by Dr. Fendrick and colleagues estimated that eliminating payment for seven D-graded services would save $500 million annually.

Dr. Fendrick described V-BID X, a model plan for individual health insurance which lowers cost-sharing and expands coverage of high-value services by raising cost-sharing on low-value services, with costs determined by actuarial analysis. The result is cost neutral. CMS's 2021 Proposed Payment Notices includes the V-BID X template verbatim. The Trump administration will encourage use of V-BID qualified plans in individual markets.

Dr. Fendrick said that payment reform requires alignment of consumer and provider incentives. If these interests are at odds, alternative payment models are unlikely to be effective. Dr. Fendrick said that insurance coverage for the cost of eye exams for people with diabetes has declined over the past 20 years. Many plans do not offer pre-deductible coverage; consumers must pay full price. Dr. Fendrick's goal is to expand pre-deductible coverage and reduce cost-sharing for such high-value services so that it is easy for patients to adhere to provider recommendations. This must be accompanied by making it more difficult to obtain low-value care.

Discussion

Dr. Bednash stated that the changes Dr. Fendrick recommends will require providers to stop recommending unnecessary tests and procedures, which will be challenging. Dr. Fendrick noted this is a challenge because there are incentives for providers not to change, an issue with healthcare supply. Dr. Fendrick's presentation focus was only regarding patient demand and how V-BID can affect patients' access to services based on their clinical value. Dr. Bednash agreed with the approach Dr. Fendrick proposed but believed it will be difficult to pass supporting legislation or get support of people rewarded by incentives in the current model. Dr. Fendrick said clinicians embrace V-BID because it makes it easier for patients to adhere to their most urgent recommendations.

Dr. Fahrenwald asked if insurance companies or other stakeholders have considered providing direct-to-consumer education via media about high- and low-value healthcare services. Dr. Fendrick stated many people have learned through word of mouth that they can receive some preventive services at no cost. Some also worry that they will not be able to afford treatment if screens indicate they have a serious illness. He said the Committee could continue to reward health plans and delivery systems for providing appropriate care based on National Committee on Quality Assurance metrics and CMS star ratings, many of which align with V-BID values. Dr. Fendrick said that metrics should be improved. Plans and systems delivering low-value services should experience consequences.

Dr. Weiss asked Dr. Fendrick how to educate providers and future members of the health workforce about the benefits of V-BID and how to implement the model. Dr. Fendrick said the first step toward implementing V-BID is not using fee-for-service payment models. Otherwise, clinicians will continue to over-prescribe low-value services, and patients will continue to experience prohibitively expensive healthcare. Clinicians have embraced the possibility of V-BID making it easier for them and their patients to achieve better health outcomes at no additional cost. He recommended teaching future healthcare providers to understand that lower costs for preventive services lead to better health outcomes and less administrative burden, which will likely lead to improved clinician satisfaction. Dr. Fendrick noted V-BID offers points of agreement for diverse stakeholders. Everyone agrees that it is good to lower out-of-pocket costs for insulin. People disagree about who should pay for that decrease, the manufacturer, health plan, or pharmaceutical benefits manager. V-BID is a potential resolution.

Dr. Killinger said she believes V-BID has the potential to reform healthcare payment significantly. Dr. Fendrick stated his goal is to overcome payment structures that are barriers to Americans receiving necessary healthcare. He encouraged the Committee to support structures that align payment with clinical benefits.

Mr. Stevens remarked part of supporting patients in avoiding low-value care is to provide education about which procedures do not result in improved health. Dr. Fendrick stated everyone supports expanding coverage for services that patients need and for which harm will results if patients do not receive them. Paying for these services is a challenge. Eliminating services rated "D" by the USPSTF, and unnecessary services such as colonoscopies for people older than 85 years, which costs $100 million annually, would increase the funds available for

high-value services such as eye exams for people with diabetes, prenatal care, and PrEP. These principles are in the proposed V-BID X rule. He asked the Committee for advice about how to continue the momentum of support for implementing V-BID.

Dr. Khatri asked what Dr. Fendrick would like to include in ACICBL recommendations regarding workforce development. Dr. Fendrick said the goal of V-BID is to compensate clinicians well and to reduce barriers to providing evidence-based care. He asked the Committee to emphasize the important of aligning provider and consumer incentives to participate in quality care. Insurance plans do not always align with provider goals, but they must align to improve care quality. IRS Notice 2019-45, Senate Bill 3200, and other policies that support alignment of health plan benefits with clinical value rather than cost will help to achieve value-based care.

Dr. Weiss stated HRSA's first step toward aligning patient and provider priorities is to teach students and trainees that the workforce includes patients, families, caregivers, direct care workers, health profession students, faculty, and practitioners working in interprofessional teams. HRSA-funded education and training also includes shared decision-making as a core value. She asked if the IRS rule is proposed or final, and if the Committee should make a recommendation regarding the rule. Dr. Fendrick said the rule was proposed a week before the meeting and will be open for comment in March. It is the first to allow HSAs to cover chronic disease management services.

Dr. Masaki said the Choosing Wisely Campaign has been effective with providers and asked if a similar campaign could be implemented to teach the general public about low-value procedures. Dr. Fendrick said Choosing Wisely has resulted in minimal reductions of low-value services. Choosing Wisely reduced Vitamin D testing by only 10 percent, while after the Canadian authority made a no-payment ruling, Vitamin D testing reduced approximately 90 percent. The most effective method for reducing use of low-value procedures is probably to stop reimbursing clinicians for them. Dr. Masaki agreed.

Dr. Fendrick thanked the Committee for the opportunity to present. Dr. Weiss thanked Dr. Fendrick for his presentation.

Provider Payment Reform to Support Integrated Health/Behavioral Health

Steve Melek, FSA, MAAA
Principal and Consulting Actuary, Milliman

Mr. Stevens introduced Mr. Melek. Mr. Melek said he would discuss efforts to integrate medical and behavioral healthcare from an actuarial perspective. He has worked on this issue with Milliman for 25 years.

Mr. Melek said that only about 10 percent of people with diagnosable behavior disorders go to a specialist for treatment. Treatment is successful in about 50 percent of cases. One reason for low success rates is that patients do not adhere to treatment plans. About one-third of patients with a diagnosable behavior disorder go to primary care, which is an opportunity to reach these patients. Behavioral and medical conditions are often comorbid, leading to large patient

expenses. Mr. Melek presented results of research conducted by Jurgen Unutzer (2011) summarizing the prevalence of behavioral and medical condition comorbidity. Milliman analyzes comorbidity approximately every 2 years using insurance claims data from multiple carriers. Analysis distinguishes commercial, Medicare, and Medicaid consumers. It also distinguishes patients by diagnostic codes and claims data. Patient cohorts include: 1) those with no evidence of mental health or substance use disorders, 2) those with a serious and persistent mental illness or substance use disorder, and 3) those with a mental illness diagnosis not considered serious or persistent. Analysts then use diagnostic codes and claims data to identify costs associated with medical care, medical prescriptions, behavioral healthcare, and behavioral health prescriptions.

In 2017 about 85 percent of commercial insurance customers' data indicated no evidence of a mental health or substance use disorder. The average monthly cost for an individual in this group was $426, mostly for medical services and prescriptions. Patients with any behavioral health disorder, whether serious and persistent or less severe, incurred dramatically higher costs than patients without evidence of behavioral health issues. Costs were higher for patients with serious and persistent behavioral health problems than for those with less severe problems. Patients with comorbid medical and behavioral conditions also incur much higher medical care and prescription costs than those without behavioral health issues. Better behavioral healthcare can reduce these costs. Approximately 30 percent of commercial insurance spending, 20 percent of Medicare spending, and 40 percent of Medicaid spending, or 30 to 35 percent of total United States healthcare spending, is to pay for services for patients with diagnosed behavioral health issues.

Several programs to integrate medical and behavioral healthcare have reduced costs. The Multifaceted Diabetes and Depression Program reduced monthly cost per patient by $39; Pathways reduced monthly cost per patient among patients with diabetes and depression by $46; IMPACT reduced average monthly cost per patient for treating depression in elderly patients by $70, or 10 percent; Missouri Community Mental Health Center increased independent living and vocational activity, and decreased overall healthcare costs by 8 percent. Across patients and over time, implementing integrated medical and behavioral healthcare for the entire United States population has the potential to save between $37 million and $67 million annually.

Approaches to integrated care include employing an integrated care manager in primary care practice, team-based care, integrated treatment planning, inviting a behavioral care provider to a medical appointment to discuss both sets of health conditions, hallway consultations to get behavioral care provider opinions, and referrals to behavioral health treatment, on-site behavioral health practitioners, and telehealth. Telehealth is useful in rural areas where the nearest therapist may be more than 50 miles away.

Mr. Melek presented payment model reform principles. He said that fee-for-service incentives do not align with the Quadruple Aim and cause administrative burden. Medicare and Medicaid do not adequately fund behavioral health services, resulting in primary care practices having to subsidize behavioral healthcare. It is unlikely that a social worker will generate enough income to cover his or her own salary and overhead expenses. Reforms should support the Quadruple Aim, preferably within a year or two. This requires the support of payers, behavioral healthcare

providers, and medical care providers. One approach is primary care capitation that applies to primary behavioral healthcare and care coordination services. Rates should be population-specific and risk-adjusted. Practices must consider the types and levels of behavioral health services to offer, and how to share risk and gain from non-primary care services. The cost impact of integrated care is due to practice beyond primary medical care services. Providers can share cost savings and also the risk of costs of increased services being higher than projected. Practices can set risk-adjusted targets according to payer type (commercial, Medicare, Medicaid) and type of service required (inpatient, outpatient, specialized care, pharmacy).

Colorado's Department of Public Health and Environment (CDPHE), with support from Milliman, implemented a 4-year State Innovation Model (SIM) supported by a CMS CMMI grant. Participating practices collected cost and utilization data. Individual participating practices were compared to the aggregate of other participating practices. The goal was to reduce or maintain costs through integration. The model aimed to offset costs associated with increasing some types of service utilization by decreasing others. CMMI required CDPHE to conduct a return on investment (ROI) analysis. Mr. Melek stated that the maximum ROI for a statewide program is about two to one. Patients were followed from baseline. Analyses were based on an all-payer claims database using only complete data files. Patients with claims that exceeded $250,000 in a calendar year were excluded from analysis, because this would have distorted results. Patients had to be insured for at least 6 months of each year to be included in analysis. Analysts applied conservative trend assumptions, adjusted for risk, and assessed trend assumption sensitivity. The goal was to improve outpatient behavioral care to reduce overdoses and acute behavioral episodes, and therefore reduce emergency service utilization and ambulance costs as well as reduce skilled nursing facility costs. CDPHE expected that primary and specialty medical care costs would increase, along with increased prescription drug costs, since patients would utilize more necessary behavioral healthcare. The first cohort of participating practices significantly reduced costs within 2 years. In the second cohort, many Medicaid patients had undiagnosed behavioral conditions at baseline, then increased spending on treatment during the first year of implementation. Treatment is expected to result in long-term savings. Pediatric practices had difficulty saving money, probably because patients initially required increases in behavioral healthcare. Participating community mental health centers reduced costs within the first 2 years.

Mr. Melek said that costs for the commercial insurance population decreased slightly over 3 years. For Medicaid patients, spending increased as healthcare needs were identified and addressed. Costs remained the same for Medicare patients. This is a success. Spending on inpatient admissions decreased by approximately one-third for commercial insurance patients and was essentially unchanged for Medicare and Medicaid patients. Emergency department use did not change for patients covered by any of these payers. Adherence to medication for chronic conditions increased and was associated with a cost increase of about 50 percent. Hospital readmissions within 30 days declined approximately 50 percent. Overall costs reduced in Years 1 and 2. Results suggest that increased spending on primary care prevents hospitalization, which indicates that sharing gain and risk is an effective approach for integrated health services.

Milliman will conduct another ROI analysis in Spring 2020.

Discussion

Mr. Melek invited questions and comments. Dr. Evans stated he participates in integrated pediatric and family medicine practices. He noted that the American Academy of Pediatrics' is encouraging practitioners to screen for depression and inquired if the subsequent increase in referrals to behavioral healthcare may have influenced Mr. Melek's data. Dr. Evans said colleagues' research has demonstrated that physicians' productivity, as measured by relative value units, increases when their team includes a behavioral healthcare provider. He cited one study that found a 15 to 20 percent increase and another that found a 40 percent increase in productivity. He asked whether Mr. Melek's team has analyzed the effects of integrated care on physician productivity. Mr. Melek stated his team has not addressed this question, but could. He said the analysis would be valuable for explaining why integrated care reduces costs and increases patient and provider satisfaction. Mr. Melek noted increased screening for depression would increase treatment and associated costs. The analyses presented did not explore which services participating practices provided. It would be useful to study how participants approached integration and which approaches were successful. Mr. Melek said he could share evaluation reports and Mr. Stevens said the Committee would appreciate that.

Dr. Morley inquired as to how much of the therapy provided by the Colorado study participants was group therapy and how much was individual therapy. He also asked if exercise groups were part of the therapy offered to older patients. Mr. Melek stated analysts only defined broader categories of healthcare utilization. Mr. Melek noted these were good questions and it would be possible to address these questions with the current dataset.

Dr. Khatri remarked that pediatric care is underfunded and that the increase in cost observed in the Colorado study was not surprising. She said so little is spent on pediatric care that there is not much to save and that increased pediatric spending is a positive outcome. Dr. Khatri appreciated Dr. Melek's practical approach to data analysis, which started with a basic assessment of whether integrated care affects costs. She asked how Mr. Melek would recommend training the health workforce to achieve cost reductions. She asked if his team has analyzed the impact of integrated care on community resilience metrics, such as education and criminal justice. Mr. Melek replied he would like to analyze effects of care integration on other public costs and social determinants of health, with outcomes including incarceration, crisis service utilization, and school attendance. He added that he hoped payers would fund programs to integrate services rather than depend on the Federal government, since integrating services will save payers money.

Dr. Killinger stated Washington State is self-insured for workers' compensation, which is very costly. About 5 percent of patients were using 80 percent of resources; these patients tended to have back pain with comorbidities such as depression that lead to poor self-efficacy. The State supported training primary care chiropractors to assess and screen patients and refer them to appropriate treatment, including behavioral healthcare. The initial intervention was minimally invasive chiropractic care, which resulted in saving tens of millions of dollars. The Governor is pleased with the result and is implementing statewide expansion. The current Federal administration is interested in national expansion.

Mr. Melek noted that all participants in the Colorado study were volunteers. Other practices' reasons for not participating may have been related to leadership and staffing resources. Training and education programs should encourage people to become behavioral healthcare providers. In addition, it is important to compensate behavioral healthcare providers adequately. Providers often leave networks after not getting a rate increase for many years. Out-of-network rates for behavioral health services are five to seven times higher than out-of-network rates for physical healthcare. Payment reform should include reforming provider compensation. Good salaries and benefits with capitation and gain sharing would be better than the current low fee-for-service payments.

Dr. Bednash stated outcomes metrics focus on costs. She said it is important to ask not only whether patients utilize emergency departments or inpatient services less often but also whether their health and well-being have improved. She asked how to develop these metrics, especially of behavioral healthcare outcomes. Mr. Melek replied TriWest measured provider and consumer satisfaction and clinical outcomes and offered to share reports. Dr. Bednash inquired if TriWest had used the Clinician and Groups Consumer Assessment of Healthcare Systems and Providers (CG-CAHPS) survey. Mr. Melek said he did not know but that this information would be in the evaluation reports. Dr. Bednash requested that Mr. Melek send her these reports and said she would share them with the Committee. Mr. Melek agreed to do so.

Mr. Stevens thanked Mr. Melek for his presentation.

Public Comment

Mr. Stevens opened the floor for public comment.

Caller Marguerite asked whether HRSA would provide a list of Congressional supporters of S. 3200. Marguerite also asked whether coverage of chronic disease prevention services includes any complementary medicine. Dr. Weiss asked the caller to send her an e-mail address so that she could share a list of supporters. Dr. Killinger said that Washington State covers chiropractic care for back pain. She is unaware of other coverage for complementary care. Dr. Killinger thinks complementary medicine has potential to improve patient satisfaction and reduce costs. Dr. Weiss and other Committee members did not know whether other complementary medicine services are covered.

Dr. Carter asked whether Mr. Melek plans to assess approaches to weight gain and management can be integrated with mental healthcare that involves prescribing antidepressants or antipsychotic medications. Mr. Melek was no longer participating . Dr. Weiss said she could e-mail the question to Mr. Melek.

Dr. Teri Kennedy said it would be valuable to explore the concepts of social prescribing, bridging medical and social care.

Day 1 adjourned at 5:00 p.m.

Day 2

The Committee convened at 8:00 a.m. on Day 2. Dr. Weiss took roll call. All Committee members were present in person or via telephone except Dr. Zaldy Tan. Ms. Robyn Golden, Dr. Kamal Masaki, and Ms. Jacqueline Wynn participated by telephone. Mr. Shane Rogers, Ms. Anne Patterson, Ms. Janet Robinson, Mr. Carl Yoder, Dr. Joan Weiss, and Dr. Robin Pugh Yi were in attendance. Dr. Weiss reviewed the meeting agenda and explained that Dr. Torey Mack, who was scheduled to present, is not able to present due to illness. Dr. Paul Jung would deliver an update on the Bureau of Health Workforce in her stead.

Committee Discussion and Recommendation Development: 19th Report

Mr. Stevens invited the Committee to make recommendations for the 19th report to the HHS Secretary and Congress.

Dr. Fahrenwald remarked that access to healthcare may have several outcomes beyond physical health for the individual, and that family members and communities can benefit when an individual's health is improved. This results in broad cost savings. These savings should be quantified and considered in payment reform.

Dr. Bednash said the Committee should consider how to prepare the workforce to practice in integrated, interdisciplinary, coordinated care with reformed payment structure. Students and trainees also should be prepared to lead discussions about payment reform, care integration, and value-based care, and to access and utilize data to transform healthcare delivery. She asked if the Committee should make recommendations about what the payment system should be, for example recommending support for Dr. Fendrick's proposed CMS rule. She noted that members could submit comments as individuals. Dr. Weiss affirmed that comments could be made by individuals. Dr. Bednash said that the Committee previously made recommendations to organizations such as those responsible for accreditation or licensing. Organizations are not required to act on recommendations.

Dr. Morley noted HRSA's main job is to educate the health workforce, which includes the community. He was impressed by Dr. Fendrick's point that provider and consumer incentives must align for a healthcare system to work. Dr. Morely stated HRSA should require grantees to use social media to educate the public. Dr. Weiss invited Dr. Masaki to describe how the GWEP program does this. Dr. Masaki said GWEP has a mandate to focus on education, health system transformation, making health systems more age-friendly, and the 4 M's.

Ms. Golden stated her organization just received its first age-friendly site visit from the American Hospital Association, the John A. Hartford Foundation, and the Institute for Health Improvement. Chief Executive Officers consistently say that her organization is delivering care as it should be delivered, then ask how this approach is paid for. Ms. Golden said that fee-for-service has been the payment structure for a long time. In addition, it is difficult to convince people responsible for primary care design to believe that an interprofessional team that includes a pharmacist, a social worker, and a psychologist is needed. She is not convinced that value-based design will convince people of the need for an interprofessional team. Having an

interprofessional workforce requires paying that workforce. Training efforts are valuable, but Ms. Golden thinks addressing the payment issue is a higher priority. She said it is critical for Committee members to read the National Academies of Science, Engineering, and Medicine (NASEM) report on social determinants of health, especially the chapter on funding. Authors include experts on potential approaches for funding social care, such as Karen DeSalvo and Cindy Mann. Dr. Weiss stated she would distribute this report to the Committee.

Dr. Weiss affirmed GWEP grantees are required to develop partnerships between academia, primary care providers, and community-based organizations. Ms. Golden said this requires infrastructure. Dr. Weiss noted the grants provide funding to build infrastructure.

Dr. Morley stated his organization is educating communities and has determined how to be compensated by CMS for educational services. He said it is critical to demonstrate that educational efforts make a difference. GWEP provides an opportunity to demonstrate the impact of innovative approaches. Educating the general public is a current priority need.

Dr. Weiss stated the HRSA GWEP provides training across the educational continuum. Programs train direct care workers, health professionals, students, faculty, and practitioners. Providers are trained to work in teams and to participate in share decision making with patients, families, and caregivers in primary care and age-friendly practices and integrated geriatrics and primary care practices. GWEP has 391 primary care partners, 190 of which are FQHCs. Training efforts link age-friendly practice to CMS's Merit-based Incentive Payment System (MIPS). MIPS provides incentive awards to providers who deliver care that meets quality standards for services such as advanced care planning, opioid treatment, and training caregivers to care for a person living with dementia. GWEP grantees are training people to engage in, document, and bill for these services. This also helps students and trainees to consider alternative payment methods and value-based care.

Dr. Morley stated CMS covers most services delivered by his organization, including physical therapy and cognitive stimulation therapy, sometimes through annual wellness visits. It has been challenging to be reimbursed for advanced directive support since the Institute for Healthcare Improvement does not accept it as part of "what matters" in an age-friendly system. Dr. Weiss said she would look into addressing this issue.

Ms. Golden said she had been discussing payments for social care with the White House, CMS, and MedPAC for the past month, with little receptivity. People's needs for social and mental health services are not being met due to difficulty in compensating these services. She reported that she had asked MedPAC representatives about payments for social care and acknowledgement of social determinants of health. They said they had not considered this very much. She also met with White House representatives in response to an executive order intended to counter Medicare for all. She and colleagues negotiated inclusion of a clause that allows other professions to be included on teams serving people who are on Medicare.

Dr. Khatri remarked the changes recommended by presenters will come from the next generation of the health workforce. The workforce should be trained to consider social determinants of health. Partnerships are critical for addressing social determinants through, for example,

improving access to healthy food and opportunities for physical activity. Students and trainees should enter the workforce prepared to address social determinants and to develop partnerships. Dr. Weiss said this could be a recommendation that HRSA require grantees to train the workforce to address social determinants.

Dr. Bednash agreed that it is necessary to educate new health professionals about system change by exposing them to new ideas and approaches to care delivery. However, norms in the workplace do not align with these lessons. For change to occur, work settings and payment incentives must align with targeted changes. HRSA must partner with payers and employers to mandate a new approach to practice, or targeted changes will not occur. Dr. Gould agreed that education alone would not be adequate. Payment reform is also necessary. Community health centers, community health workers, and others should be paid in advance for work to transform care. He gave an example of coaches analyzing practice workflow to support planning for changes. He said students may need to learn this process.

Dr. Gould said he was the Principal Investigator for the Community Healthcare Workforce Development Initiative. His team developed a certification process for Connecticut, which is promulgated through Medicaid. The program was supposed to save $38 million over 4 years. It saved $108 million and about 350,000 lives. Dr. Bednash asked how to make this type of program sustainable and scalable. Dr. Gould replied value-based payment can be translated to fee-for-service and reimbursed through Medicaid. The approach varies by State.

Dr. Khatri noted that reimbursement for meeting quality and efficiency metrics takes 18 months. Dr. Morley recommended educating people about how to get reimbursed, from payers including CMS, State programs, and local governments. This type of education should be required in medical and other health professional schools.

Dr. Gould said that one probable reason the Connecticut program was sustained is that the State's Medicaid program is self-funded. No insurance companies are involved. The program was able to initiate PCMH Plus, with a value-based component, which provides advance payments to community health workers. Half of the State's community health centers participate in PCMH Plus. Participation varies with the State budget. Dr. Morley said Missouri does not have Medicaid extensions, so it must be innovative in finding funding, and therefore in offering education in how to find finding. Dr. Morley reiterated that this type of education is critical and currently lacking.

Health Resources and Services Administration Update

Thomas Engels
Administrator, HRSA

Dr. Weiss introduced Mr. Engels, whose experience includes serving as Deputy Secretary of the Wisconsin Department of Health Services, where he advocated for and oversaw expansion of State capacity to provide mental health services, implementation of the statewide electronic health record system, and reduction in staff shortages at long-term care facilities. He was an active member of the Governor's task force on opioid abuse and Chair of the Governor's human

resources shared services Executive Committee. Under Mr. Engels' leadership, HRSA is advancing HHS priorities including ending the opioid epidemic, transforming the behavioral health workforce, increasing rural communities' access to healthcare, promoting maternal health, advancing kidney care, and ending the HIV epidemic.

Mr. Engels asked the Committee to introduce themselves. After introductions, he thanked members for their service and their work on ACICBL. He said that HRSA works to increase access to high-quality healthcare services, a skilled health workforce, and innovative, high-value programs. HRSA administers more than 90 programs through about 3,000 grant recipients, who help tens of millions of Americans to receive high-quality affordable healthcare. Grant recipients include community-based organizations, colleges, universities, hospitals, private organizations, and State, local, and tribal governments. HRSA continuously works to expand its reach. In 2018 FQHCS served 28 million people at 116 million patient visits. These patients included 385,000 United States veterans. Ryan White HIV/AIDS Program reached half of Americans diagnosed with HIV/AIDS, 87 percent of whom are virally suppressed. National Health Service Corps and Nurse Corps programs facilitate 15,000 medical, dental, and mental healthcare clinicians serving 15 million Americans in the Nation's most underserved rural, urban, and tribal communities. HRSA launched the multi-year Rural Communities Opioid Response Program (RCORP) to support opioid use disorder treatment and recovery services in rural areas. Last year RCORP awarded $103 million in grant support for community consortia to implement plans tailored for their specific needs; an additional $100 million will be awarded this year. HRSA's Maternal Health block grants supported care for 55 million pregnant women, reaching 91.5 percent of all pregnant women, 99 percent of all infants, and 54 percent of children in the United States. HRSA's Maternal, Infant, and Early Childhood Home Visiting program provided 1 million home visits to 150,000 parents and children in 2018.

AHEC programs enrolled 2,700 health profession students in medically underserved and rural communities. Students represent 15 health professions and more than 35 paraprofessional disciplines. Between 2014 and 2109 the Behavioral Health Workforce Education and Training Program (BHWET) supported more than 14,000 graduating students in entering the behavioral health workforce. These students have provided more than 4 million hours of care to patients in medically underserved areas, including 1.5 million hours in rural areas. HRSA's GWEP supports 48 grantees collaborating with 391 care providing sites to become age-friendly by integrating geriatrics into primary care. This is a priority as the population ages.

Mr. Engels said that HRSA is looking for new grant reviewers and encouraged Committee members to sign up and to suggest that qualified colleagues do so.

HRSA is the Federal entity primarily responsible for overseeing United States organ, and blood stem cell transplant systems. The United States has more than 20 million registered blood stem cell donors and more than 155 million registered organ donors. In 2019 organ donations saved more lives than ever before. However, more can be achieved. Last year 113,000 United States citizens waited for organ transplants. Twenty people per day die while waiting for a transplant. Mr. Engels asked Committee members to become organ donors and to encourage others to do so as well.

As Wisconsin's Deputy Secretary of Health Services, Mr. Engels spoke with grant recipients and observed how HRSA and other HHS programs benefit patients. He recognized the necessity and value of Medicaid. He encouraged Committee members to continue their service to the country's most vulnerable citizens.

Discussion

Mr. Stevens said that he is an organ donor. Dr. Evans said that his son was an organ donor who died in 2018. His son's donations helped 91 people. Dr. Evans encouraged others to become organ donors.

Dr. Bednash thanked Mr. Engels for his dedication and leadership.

Dr. Morley thanked Mr. Engels and HRSA as a whole for their contributions to geriatrics. He stated that there are half as many geriatricians in the United States now as when he became a board-certified geriatrician. He now serves on an interprofessional team whose patients include adults with developmental disabilities, whom few programs serve. Dr. Morley said HRSA is the guardian of geriatrics in the United States. Mr. Engels thanked him.

Dr. Wynn also thanked Mr. Engels for his leadership, outreach, and passion. She asked if HRSA funding announcements could incorporate encouragement for organ donation. Mr. Engels said he worked with the White House and HHS Secretary to change rules to expand coverage of living organ donors' expenses such as childcare and elder care costs. HRSA also released a Request for Information to solicit ideas for technology companies regarding how to improve distribution of donated organs.

Dr. Morley said he has never seen a social media campaign to encourage organ donation. He suggested that HRSA consider implementing such a campaign. Mr. Engels said he produced a 1-minute, 40-second recording encouraging organ donation, which has been released on HRSA's website, newsletter, and Twitter feed. Dr. Morley suggested expanding this effort with strategic campaigning supported by dedicated personnel. He said his own social media education campaigns reached 2.2 million people last year and had already reached 1.1 million this year. Achieving this reach requires significant time and effort. Mr. Engels thanked Dr. Morley for his input. Dr. Gould said that health profession students would likely respond positively to a campaign encouraging organ donation.

Dr.Fahrenwald said that organ harvesting is inefficient in rural areas. Organ transportation from rural areas is difficult. HRSA support for improving these processes would likely increase availability of donated organs. Mr. Engels thanked her for her comments.

Mr. Stevens thanked Mr. Engels for his commitment to geriatrics care. He stated that improvements in geriatrics care through community health clinics, and efforts to expand access to healthcare in rural and frontier areas have helped people in tribal communities to live longer. Mr. Stevens thanked Mr. Engels for his presentation.

Bureau of Health Workforce Update, and
Division of Medicine and Dentistry Investments in Community Health

Captain Paul Jung, MD, MPH, MBA
Director, Division of Medicine and Dentistry, BHW, HRSA

Dr. Weiss explained that Dr. Mack, who was originally scheduled to present the BHW update, was unable to attend the meeting. Therefore, Captain Paul Jung, Director of the Division of Medicine and Dentistry (DMD), would deliver Dr. Mack's update along with his presentation on DMD. Dr. Weiss stated the Division supports programs in geriatrics, primary care, oral health, and graduate medical education, which includes the Children's Hospital and Teaching Health Centers Graduate Medical Education programs, as well as three advisory Committees. In addition to the ACICBL, these Committees are the Advisory Committee on Training in Primary Care Medicine and Dentistry and the Council on Graduate Medical Education. Prior to his work at HRSA Captain Jung served at the Indian Health Service. He is a preventive medicine physician who prioritizes integrating population health into all Division programs.

Captain Jung stated BHW aims to get the right providers to provide the right kind of care in areas where it is needed. BHW provides education, training, and service. Education includes support for medical students. Most programs are for training, including residencies and fellowships. Service programs include the National Health Service Corp and Nurse Corps. HRSA aims to guide its programs' students and trainees to serve as workforce members in HRSA-supported service programs, such as FQHCs.

Captain Jung stated that BHW training not only prioritizes training primary care providers, but also teaches students and trainees about systems of care and team-based care. Graduate medical students in Teaching Health Centers learn how to practice medicine in a way that responds to communities' needs. BHW tends to measure success by the number of people trained and where they provide service. This is a focus on healthcare rather than health. He would like to measure population health outcomes resulting from BHW efforts.

Captain Jung was impressed by Dr. Brenner's presentation to the ACICBL. Afterward Captain Jung heard another presentation from Care Script, a private company, about how the workforce should prepare for the future of healthcare. The presentation discussed "the Amazonification of Healthcare." Presenters made several assumptions, such as, everyone will have a smartphone, and everyone will have a home where healthcare services can be delivered within 24 hours. Dr. Brenner's presentation made Captain Jung consider the implications of not having a home or smartphone. The Care Script presentation was about healthcare and not health. The current healthcare system is reinforced by those invested in it, not patients, and not always providers. Patients are frustrated. Community health problems will not be solved by only providing an adequate number of health professionals, even health professionals with ideal training.

The Division of Medicine and Dentistry has a Preventive Medicine program that trains physicians to specialize in preventive medicine, which focuses on public and population health. HRSA does not yet have a system for placing program graduates. Ideally, trainees would serve in health departments and FQHCs. Trainees would monitor effects of programs on population

health and plan how to address community health needs. Community health outcomes would indicate the success of the Preventive Medicine program. It is important to assess these outcomes in addition to the number of providers trained.

Captain Jung thanked Committee members for their service. He encouraged members to continue to include population and public health, and the specialty of preventive medicine in their recommendations, which help to guide the Division's work to address health issues and to improve health status.

Discussion

Dr. Gould stated the Committee's last report recommended training the health workforce to use GIS mapping and data to assess community health. He agreed with Captain Jung that this approach is needed to improve the health system.

Dr. Bednash supported Captain Jung's focus on health rather than healthcare, and said that this aligns with ACICBL's focus. She said that FQHCs are already committed to the model of healthcare Captain Jung described. She noted that she works for a non-profit healthcare corporation that wants system transformation toward a population health focus, and seeks experts to guide this transformation. Preventive Medicine program graduates could serve in this capacity and may be needed to influence care outside of FQHCs more than within them. Dr. Jung said this issue was discussed at a Fall 2019 meeting of preventive medicine stakeholders. He agreed that change must be implemented beyond FQHCs. Many healthcare system representatives do not understand what preventive medicine specialists do. Even some preventive medicine physicians think that public health work is conducted only by the government. Captain Jung would like to broaden public understanding of public health to be synonymous with population health, and as services offered by providers beyond the government. Captain Jung invited Committee members to notify him of healthcare systems that would be willing to accept preventive medicine residents for rotations, so that he could link these systems to residency programs.

Dr. Fahrenwald recommended recruiting people to specialize in primary care preventive medicine early in their careers, while allowing flexibility in career choice. She works at a Teaching Health Center with a Public Health and Advocacy track for residents, which encourages graduates to serve in small rural areas, meaning towns with 3,000 or fewer residents. Physicians serving these communities serve as public health leaders. Leaders in this role need training in public health. Dr. Fahrenwald stated residency training requirements for service and supervision can be barriers to training care providers in public health. For example, training for rural residents may be remote. When government funding for space exploration decreased, private funders contributed. Private investment may be needed for healthcare system transformation. HRSA's innovation programs could teach the next generation of the health workforce to promote changes such as using technology to support communication, replacing fee-for-service payments, and using community resources to improve community health. Dr. Fahrenwald suggested redesigning payment approaches so that communities invest in systems that improve their health as well as education, employment, and the justice system, resulting in

making more resources available to support that community system, so that payment reform directly benefits communities, not just insurance companies and CMS. Dr. Gould concurred.

Dr. Gould added that the Amazonification of healthcare is inevitable and that the public should be prepared for it. Amazonification may contribute to solving some healthcare issues, but not all of them. System transformation will require a visionary approach. Corporations have used their resources to address issues, their motivation is to reduce costs. This is good if it results in community benefits and inspiring others to do the same.

Dr. Gould said a rural accreditation Committee is working to reduce the barriers to completing rural residencies that Dr. Fahrenwald mentioned. The current approach to rural healthcare training is not sustainable.

Dr. Fahrenwald stated solving public health problems leads to multiple long-term, community-wide benefits. These benefits should be considered when analyzing the savings associated with investments in preventive care. Dr. Gould agreed. He noted that communities always will need doctors, even as diseases are eradicated. Training should prepare healthcare providers for long-term careers during which healthcare priorities and technology will change. Flexibility to respond as new issues arise and new technologies become available, and listening to and providing emotional support for patients are core competencies for healthcare providers. Training programs should emphasize these competencies. System transformation should focus on how best to serve patients' needs, including need for respect and emotional support from care providers.

Dr. Evans stated primary preventive medicine training should include competency in behavioral healthcare. Preventing adverse childhood experiences, including parental neglect, can prevent behavioral health problems. Dr. Gould agreed.

Mr. Stevens remarked that his home in Eagle, Alaska comprises a non-Native town and Alaskan Native village, with a total of no more than 150 residents. The village has a community health clinic with a community health aide and a behavioral health aide. The village is affected by social determinants of health including food insecurity, and high transportation costs, which have essentially eliminated hunting and fishing except by wealthy tourists. Mr. Stevens' home region in the interior of Alaska is the size of Texas. It would benefit from preventive medicine specialists. The cost of transportation to and from the community, at $400 per trip, has been a barrier. These types of barriers must be overcome to meet the healthcare needs of remote communities. Captain Jung said root causes of community health issues must be identified and addressed. This includes addressing systemic issues in addition to providing medical care. Captain Jung has tried, with limited success, to encourage people interested in global health to serve tribal reservations, which are sovereign nations with different cultures and languages with needs for additional health resources. Mr. Stevens agreed that care providers should build relationships with the communities they serve. This supports the trust and understanding necessary for, among other things, effective telemedicine.

Dr. Morley stated that efforts to educate through social media are important for promoting population health. Social media campaigns have dramatically increased recruitment to his

GWEP program. Social media is also used to send inaccurate or dangerous messages, such as anti-vaccine messaging. There should be messaging to counter this and to convey important public health messaging about issues such as vaccines, atmospheric pollution, and lead. Dr. Morley said HRSA should fund this type of social media campaign.

Dr. Morley remarked medical schools are not adequately training students to use new technologies such as ultrasound stethoscopes, artificial intelligence, and telehealth. Students must be prepared to practice in the future and to use new technologies while using effective approaches to communication. HRSA should support this. If students are not prepared, they will still have to work with new technologies, but will not know how to do so without compromising care quality. Captain Jung agreed and added that CMS also should be involved with determining how best to use emerging technology in healthcare. Medical schools do what their funding sources want, and CMS provides much more funding than HRSA. CMS tends to support the usual approach to medical education and HRSA's budget is unlikely adequate to bring about systemic change. Dr. Morley stated that HRSA consistently makes subtle and important changes and is perceived as offering the best expertise in health workforce education. Dr. Morley believes HRSA has the potential to bring about systemic change.

Dr. Bednash stated the Committee should continue to focus on population health and social determinants of health. She referred to Kristof and WuDunn's book *Tightrope* about the effects of economic decline on an Oregon community's mortality and morbidity related to substance use, depression, and violence. The Committee should maintain a broad perspective on population health interventions because health outcomes are not just due to healthcare quality but are also influenced by opportunities and risks associated with where people live.

Mr. Stevens thanked Captain Jung for his presentation.

Committee Discussion and Recommendation Development: 19th Report

Dr. Weiss expressed thanks for the service of Drs. Evans and Tan whose Committee terms are ending June 27, 2020.

Dr. Killinger stated she identified four actionable items that the Committee should consider

when developing recommendations: 1) All federally funded programs and healthcare centers should fund small grants to set up practice that is consistent with V-BID priorities; 2) In recognition of the high cost of caring for people experiencing homelessness, Federally funded programs should use any excess funds or offer grants to implement programs that provide housing and wraparound services to patients experiencing homelessness; 3) Federally funded programs should revise their payment structures to incentivize improving clinical services rather than use fee-for-service structures; 4) HRSA should support training programs to utilize data to enhance value-based care.

The Committee embarked on a discussion of shelters with Ms. Golden stating Brenner's comment that shelters are inadequate was profound. Dr. Morley commented that shelters are better than no intervention. Ms. Golden agreed but said that Housing First is better than shelters.

Dr. Gould noted he serves on the board of a homeless shelter and runs a homeless shelter clinic. Shifting too many resources to Housing First can lead to inadequate shelter services for people in immediate, acute need. Dr. Khatri noted she also works in a health center for people who are homeless and stated the Committee should recognize the impact of homelessness on health and understand there are varying perspectives on how to address homelessness. Her organization has partnerships with shelters and subsidized housing. Some clients prefer not to stay in housing. She recommended against the Committee prescribing a single solution. Ms. Golden proposed that the Committee should recommend forming partnerships to address homelessness, and educating students about providing care to people who are homeless. She also noted that veterans who are homeless have unique needs. Dr. Morley remarked that after a shelter

closed in St. Louis emergency department utilization and hospital admissions significantly increased. He suggested it would be good to replace all shelters with permanent housing but

this is not currently feasible. Dr. Fahrenwald affirmed that the point of Dr. Brenner's presentation was that there is a specific set of people for whom providing permanent housing results in significant savings in healthcare costs, which could be applied to providing more care to people in need. There are also people who are not ready for permanent housing and are destructive if given a permanent housing placement. She stated the Committee's recommendation should consider individual needs and community healthcare costs. Dr. Bednash stated she worked at the clinic for So Others Might Eat (SOME), which offers comprehensive services, including permanent housing, education, and healthcare. She proposed the Committee should recommend preparing academics and health professionals to understand the impact of homelessness on healthcare needs and community health, and educating them about the array of options for addressing homelessness and the healthcare needs homelessness causes. These options include policy regarding housing.

Dr. Khatri stated she does not like the term "social determinants of health" and prefers "social factors." Social factors related to health include food insecurity, trauma, adverse childhood experiences, housing, and exposure to violence. These cannot be addressed by telling an individual to make a healthy choice, such as eating a healthy diet. People in food deserts do not have this option. Healthcare providers are learning to understand this and to screen for these factors. It is important to recognize the importance of social factors' role in health and well-being. She suggested that the recommendation regarding social factors influencing health highlight specific factors that students and trainees should understand and screen for. Dr. Weiss asked Ms. Golden what term for social determinants of health was used in the recent National Academy of Sciences, Engineering, and Medicine (NASEM) report entitled *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. Ms. Golden said the report includes a detailed glossary that distinguishes terms such as "social determinants" and "social risk factors." She said she would refer to the glossary and share information with the Committee. Dr. Wynn stated that understanding homelessness requires understanding its relationship to other social determinants such as trauma and adverse childhood experiences. Ms. Golden said that she did not want to imply recommending against permanent housing interventions. Her intention was to communicate the importance of not just offering resources but offering them with competent care management, which too often does not get funded. Dr. Bednash noted the NASEM report includes several recommendations for preparing

the healthcare workforce to address social determinants of health and needs for social care. She suggested that the Committee should review those and consider supporting them with its own recommendations. Mr. Stevens asked if the report could be distributed to all ACICBL members. Ms. Golden said that she would send it to Janet Robinson.

Mr. Stevens asked Dr. Killinger if her recommendation regarding payment structure at FQHCs was about sliding scale fees. Dr. Killinger said the sliding scales are used to make services more affordable. Her recommendation was to base reimbursement for services on clinical outcomes rather than procedure cost in order to implement value-based payment structure.

Dr. Khatri noted that GWEP grantees already are required to train participants to understand and address social determinants of health. She suggested applying the language used in GWEP requirements to requirements for all Federally-funded training programs. This would direct grantees to include didactic and experiential training about social determinants, and could specify high-priority determinants. Committee members agreed that housing is a high-priority social determinant of health. Dr. Khatri stated that other high-priority social determinants are food security, poverty, health literacy, and adverse childhood experiences. Dr. Gould remarked students and trainees need to understand the interactions between social determinants of health and their effects on patients' and communities' needs. Dr. Weiss said this was similar to a recommendation in the ACICBL's 18th report. She asked him to draft a recommendation for the 19th report that was clearly distinct from the previous recommendation. Dr. Gould agreed to do so.

Ms. Golden sent two pages from the NASEM report to share with the Committee so that it could be referred to during the current discussion.

Several committee members indicated that they had additional questions and comments regarding recommendations. These included:

- Dr. Killinger asked if Federally-funded clinics currently teach about adverse childhood experiences and screening for them. She noted that presentations for this meeting indicated that adverse childhood experiences are significantly related to health. If clinics are not currently providing this training, the training should be recommended.
- Dr. Morley said the Committee should recommend that HRSA require grantees to use social media to increase awareness of population health and of the cost effectiveness of a variety of health delivery systems.
- Dr. Bednash recognized that there is some disagreement regarding terminology for social determinants of health or social drivers. She recommended that the Committee use a commonly understood term. Dr. Bednash inquired if the Committee wanted to make a recommendation to support approving the proposed 2021 CMS payment rule regarding value-based reimbursement.

Dr. Masaki suggested making a recommendation that HRSA promote the value of geriatrics and primary care as a better approach to addressing social determinants of health than the current structure of excessive subspecialty care. Dr. Weiss said this is already the case with GWEP. Dr. Masaki said the United States has a shortage of primary care and much subspecialty care, which

should be rebalanced, possibly through allocation of funding for graduate medical education programs. Dr. Weiss said this is the purview of the Advisory Committee on Primary Care in Medicine and Dentistry (ACTPCMD) and the Council on Graduate Medical Education (COGME). Dr. Bednash asked if ACICBL could make a recommendation to ACTPCMD. Dr. Weiss said ACICBL could make this recommendation to HRSA. Dr. Bednash stated there is little Federal support for graduate medical education for primary care. There should be more funding to increase the primary care workforce.

Dr. Fahrenwald suggested recommending, "Recognition of the patient as a key member of the healthcare team to ensure individuals' needs are met both through direct healthcare and through linkages to community-based resources including tracking of the wider cost and savings to all involved systems."

Dr. Bednash stated that presentations made for this meeting had focused on payment systems, not social determinants of health, although the two were linked. She proposed the Committee should make at least one recommendation about educating the health workforce to understand payment models. Dr. Gould agreed. Dr. Bednash suggested, "Prepare a health professional workforce with a clear understanding of healthcare financing, payment models and value as an element of reimbursement." Dr. Gould had written a similar draft recommendation, "How we prepare, health professions workforce to have a clear understanding of healthcare financing, payment models and values as an element of reimbursement and the understanding of the determinative and rate-limiting effect of payment systems on the nature, structure, effectiveness and reach of healthcare delivery systems and ultimately on the health of communities." Dr. Evans said he would like to recommend that HRSA and CMS collaborate to define value-based reimbursement beyond economic factors, placing a greater emphasis on quality. Dr. Khatri concurred with Drs. Gould and Bednash's recommendation to teach students and trainees about payment reform. She stated there currently is a lack of training on alternative payment models. This should be the first recommendation that serves as the basis for others that show how payment reform would transform the system. Dr. Khatri stated the Committee's scope and title emphasize partnerships. She asked if the Committee should recommend that grantees be required to develop at least one partnership with a community-based organization to address social determinants of health. Dr. Bednash said that recommendations should mention that they are, regarding interdisciplinary healthcare teams, working together toward value-based care. Ms. Golden agreed. She reiterated that there are factors that make it challenging to end fee-for-structure payment. Dr. Bednash said the recommendation was for any healthcare reimbursement system to focus on care outcomes. That is value-based, even if applied in a fee-for-service payment model.

Dr. Morley asked if the Committee could recommend a universal basic healthcare system that does not prohibit private payment for additional health insurance. The healthcare problems in the United States cannot be solved without basic universal healthcare. Dr. Weiss stated the Committee could recommend this, but BHW does not have the authority to implement the recommendation.

Dr. Morley refined the recommendation about social media to be, "The ACICBL recommends Congressional funding for demonstration projects to promote the use of social medial to increase

the knowledge of population health." Dr. Killinger inquired if it were important to specify "population health" rather than say "important health topics." Dr. Morley stated he was specifically referring to population health and that the education was to be directed toward healthcare professionals as well as the general public. Dr. Weiss said the recommendation should refer to educating the workforce. Dr. Morley said the education should be about public health and prevention topics media reports focus on. HRSA would serve as a credible source discussing evidence about these topics. He noted that care providers often have the same questions as the general public regarding evidence about these topics. He emphasized that educational communications should be at an appropriate literacy level. Dr. Weiss reminded the Committee that HRSA considers patients, families, and caregivers to be part of the healthcare workforce. Dr. Morley said this should be clear in the recommendation.

Dr. Killinger suggested combining some recommendations about the same topic that had been listed separately. Dr. Khatri said that recommendations regarding V-BID and education about payment models could be combined, and that this should be the first recommendation. She said the central point of this recommendation is that all students and trainees in HRSA-funded programs should get basic education about value-based payment models. Dr. Killinger agreed.

Dr. Weiss reminded the Committee that it is charged to make recommendations about workforce development. Dr. Gould asked if the Committee could make a recommendation stating that payment structure must change to support an increase in global team-based care. Dr. Weiss stated this would be addressed to CMS. She said she would invite a CMS representative to participate in the next meeting, and the Committee could consider whether to make the recommendation. She reminded the Committee that it also was considering a recommendation supporting CMS's proposed 2021 payment rule.

Dr. Gould suggested that the recommendation to educate students and trainees about healthcare financing models refer to "alternative payment models, including global value-based payment." Students need to understand how finance mechanisms are related to healthcare outcomes. Dr. Khatri said this could be included in the report's supporting narrative rather than the recommendation itself. Dr. Khatri noted students first need to learn about healthcare financing in general, then about specific models such as V-BID. She said V-BID could be described in the report narrative as being a current important transformative change. Understanding social determinants of health is fundamental for defining high- and low-value care.

Mr. Stevens said the recommendation to support social media education should be the second recommendation. He asked if the Committee supported making a recommendation to support education about using data to transition toward value-based care. Dr. Weiss asked Dr. Khatri if health centers could act on this recommendation. Dr. Khatri said they could not because payment structures are very complicated and vary by State. Only CMS could take action on a Federal level. Other action would have to be at the State level.

Mr. Stevens invited Committee discussion on a recommendation for Federally-funded health centers to provide small grants to support implementation of person-centered, outcome-based payment systems. Ms. Golden asked why the recommendation focused only on integrating medical, mental health, and social care through value-based payment. She said she did not agree

and did not understand the reason for the exclusive focus on value-based payment. Dr. Killinger stated the presentation on V-BID made a convincing case and that transforming systems away from fee-for-service payment was one of the best ways to reduce costs and improve outcomes. She stated the recommendation's purpose was to make progress toward moving away from fee-for-service payment structure by educating people about its negative consequences. Ms. Golden said fee-for-service would not end in the near future. She said it took 2 years to negotiate financing integration of mental healthcare into healthcare, which is described on the NASEM website. She recommended reviewing the NASEM report before finalizing an ACICBL recommendation.

Dr. Weiss stated social care was mentioned in several presentations. Ms. Golden said she would share the recommendations about healthcare financing in the NASEM report. Dr. Weiss invited Ms. Golden to discuss these recommendations. Ms. Golden stated there were separate recommendations to Medicare and Medicaid. The report includes detailed discussion of which specialists need training about social determinants of health and population health. Recommendations did not endorse value-based payments. Elements of the Chronic Care Act regarding social determinants and social care have not been implemented. Other countries have found that investing in social care improves social outcomes. The report recommends demonstration projects to assess this in the United States by analyzing the effects of Medicare Advantage supplemental benefits. This analysis would require access to large datasets that include electronic health records with community-based health data. The report discusses the necessity of interoperable health information data systems to obtain these data. Report developers discussed value-based payment, outcome measurement, corporate and social risk adjustment, and stratification, and how to align recommendations with previous recommendations. Authors also identified foundations that should fund implementing the work discussed as well as return on investment. Dr. Weiss asked Ms. Golden to write a recommendation addressing these points. Ms. Golden said she would do so. Mr. Stevens stated Ms. Golden's points were related to the Committee's second recommendation.

Mr. Stevens invited Committee discussion on the recommendation to require didactic and experiential training experiences about social determinants of health, including housing status, food security, poverty, and adversity childhood experiences. Dr. Fahrenwald stated the Committee should specify who is expected to implement the recommendation. Dr. Khatri said the recommendation is to HRSA.

Mr. Stevens invited discussion about the recommendation to educate students and trainees about the relationships between social determinants and health outcomes. Dr. Killinger noted that there were two recommendations on this topic and suggested combining them. Dr. Weiss said these recommendations seemed redundant with recommendations from the previous report. Dr. Fahrenwald said the recommendation could be for didactic and experiential training about how social determinants impact individuals and also how they impact the population. She said the recommendation could specify that grantees are required to develop at least one partnership.

Dr. Weiss invited discussion about the recommendation to increase the number of primary care providers. Dr. Weiss said this recommendation would be supported by ACTPCMD. She also

suggested considering how to integrate this recommendation with others after finalizing other recommendations.

Ms. Golden said that recommendations to address social determinants would have to include recommendations to reimburse the work. She also reminded the Committee that Dr. Brenner had recommended changing the RUC to address the issue of reimbursement for social care. Ms. Golden stated that CMS has billing codes for social care services such as finding housing and care management. Psychologists can use these codes, but social workers cannot due to a component of the Social Security Act. These issues are discussed in the NASEM report.

Dr. Killinger stated that the recommendation to educate students and trainees about value-based payment systems should state that these systems should emphasize care outcomes, not just cost. Dr. Evans said he also had made this comment because considering cost without considering outcomes would be useless.

Dr. Killinger suggested rewording Recommendation 2 to clarify the emphasis on social media: "ACICBL recommends Congress fund demonstration projects to use social media to educate the healthcare workforce and improve health and healthcare delivery." She stated that it was important for recommendations to include the importance of housing status as a social determinant of health.

Mr. Stevens confirmed that the Committee decided to use language about social determinants of health that aligned with language in the NASEM report to which Ms. Golden had contributed. Dr. Weiss suggested the following wording, "ACICBL recommends didactic experiential experiences with social drivers including housing status, food, security, property, (adversity), adverse child experiences and population health," with a requirement for partnership and supporting background narrative. Committee members agreed.

Ms. Golden said she would send her draft recommendation within half an hour. Dr. Weiss said she would distribute draft recommendations to Committee members.

Mr. Stevens asked if participants had further comments. Dr. Killinger asked Dr. Weiss if the Committee had done the work HRSA needed. Dr. Weiss said that it had and inquired if the Committee wanted to make a recommendation about primary care. Ms. Golden said the recommendation should be about primary care from an interprofessional team, not specifically physicians and not individual providers. Dr. Killinger stated she understood the goal of the recommendation to be meeting the healthcare needs of an aging population. She said the recommendation should specify how this would be accomplished, such as funding particular projects or programs, or guiding training programs to encourage students to become primary care providers. Dr. Weiss suggested developing an initial draft of the 19th report and having someone from CMS present at the next ACICBL meeting, then deciding whether to add the recommendation about increasing the primary healthcare workforce.

Mr. Stevens said he thought that a previous report discussed peer pressure for students to pursue specialized care rather than primary care. Dr. Weiss said this may have been in the 17th report, which included clinician well-being and burnout.

At the conclusion of the meeting, the draft recommendations for the 19th report are as follows:

1) The ACICBL recommends that grant recipients offer training in alternative payment models, including value-based payment models, and their impact on healthcare delivery systems and the health of communities.
2) The ACICBL recommends that Congress fund demonstration projects to use social media to educate the health care workforce, including the general public, to improve health and healthcare delivery.
3) The ACICBL recommends didactic and experiential training experiences, conducted in collaboration with at least one partner, on how social drivers including housing status, food, security, poverty, and adverse child experiences impact individual and community health.
4) The ACICBL recommends that HRSA coordinate with CMS to consider social determinants of health, social risk factors, and social needs in developing value-based reimbursement and delivery of high-quality health services.
5) The ACICBL recommends support for the Centers for Medicare and Medicaid Benefit and Payment Parameters Rule for 2021.

Dr. Weiss thanked Mr. Stevens for his work chairing the current meeting.

Public Comments

Mr. Stevens opened the floor for public comments.

Dr. Teri Kennedy called in to comment. She advocated recommending funding for academic-practice partnerships to conduct research that leverages Electronic Health R measures, cost metrics, person-centered measures, and social prescribing strategies to identify high-value treatments that inform value-based care and reimbursement. She also said that an interprofessional fellowship program could reduce the degree to which fellowship programs are siloed. In addition, she recommended considering interprofessional rotations that would include work in FQHCs, ambulatory care, and population health. Dr. Kennedy said that, in addition to considering risk factors for population health, people should consider social strengths and resources. She noted that Dr. Brenner had called homeless shelters "a failed model." Dr. Weiss thanked Dr. Kennedy for her comments.

Marguerite texted a request for the NASEM report to which Ms. Golden contributed. Dr. Weiss said that she would send the link to her.

Mr. Stevens invited further public comment. There was none.

The meeting adjourned at 1:30 p.m.