

MEETING MINUTES

Advisory Committee on Training in Primary Care in Medicine and Dentistry
October 31, 2019

Committee Members Present

Chair

Thomas E. McWilliams, DO, FACOFP

Members

Russell S. Phillips, MD

Bruce Blumberg, MD

Donald L. Chi, DDS, Ph.D.

Tara A. Cortes, Ph.D., RN, FAAN

A. Conan Davis, DMD, MPH

Patricia McCelvey Dieter, MPA, PA-C

Anita Glick, MSW

Rita A. Phillips, Ph.D., BSDH, RDH, CTCP

Mark D. Schwartz, MD

Louise T. Veselicky, DDS, MDS, Med

Jeffrey Hicks, DDS

Cara Lichtenstein, MD, MPH

Pamela R. Patton, PA, MSP, DFAAPA

HRSA Staff in Attendance

Kennita R. Carter, MD (*Designated Federal Official*)

Senior Advisor, Division of Medicine and Dentistry

Robin Alexander

Liaison, Advisory Council Operations

Samantha Das

Designated Federal Official Liaison, Division of Medicine and Dentistry

Janet Robinson

Advisory Committee Liaison, Advisory Council Operations

Carl Yonder

Public Affairs Specialist, Division of External Affairs

Introduction

The Advisory Committee on Training in Primary Care in Medicine and Dentistry (ACTPCMD) convened its meeting at 10:15 a.m., on Thursday, October 31, 2019. The meeting was conducted via teleconference from the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 15SWH01, Rockville, MD 20852. Dr. Carter welcomed the Committee, thanked them for their work, took roll call, and gave instructions regarding meeting participation. All committee members were in attendance except Drs. Sealey and Wilson. Dr. Carter introduced HRSA staff and the technical writer, and asked committee members to introduce themselves. She mentioned that several members were new and asked new members to identify themselves as such. Committee Chair Dr. McWilliams thanked committee members for their participation then presented a review of the meeting agenda and asked if participants requested any changes to the agenda. No changes were requested. Dr. Carter explained that the meeting's purpose was to orient new, and to update continuing committee members regarding the Bureau of Healthcare Workforce's work and priorities, and to discuss the committee's 17th annual recommendations report.

Ethics Presentation

Dr. Carter introduced Ms. Laura Ridder, HRSA's Ethics Advisor, who made a presentation to the committee. Ms. Ridder noted that all committee members had either completed the ethics orientation or annual ethics training on the basic framework and structure of the Executive Branch's Preventive Ethics Program, which applies to all committee members as special government employees. Members are considered special government employees because they work for the Federal Government fewer than 130 days per year. This means they must follow applicable rules of ethics. The information that committee members provide in their financial disclosure reports and members' responses to the Foreign Activities Questionnaire provide HRSA with information that allows HRSA to provide respondents with ethics guidance. Ms. Ridder invited questions about the general guidance document she sent to members. No members had questions. Ms. Ridder said members are welcome to contact her or Dr. Carter after the meeting if necessary. Ms. Ridder noted the potential of violating a criminal statute and risking prosecution if a member violates an ethics guideline. She said HRSA aims to provide preventive guidance to avoid this occurrence.

Ms. Ridder noted that the Hatch Act applies to special government employees. The Hatch Act was passed during the 1930's to prevent political coercion of Federal employees. The act prohibits employees from partisan political activity while on duty, and any time while using Federal property or resources. Partisan activities include any activity targeting success or failure of a partisan political candidate, including the current President, who has filed for candidacy, party, or group, such as a Political Action Committee. Regulated activities include fundraising, comments, and social media posts. Federal resources include online resources, Federal documents, and Federal titles. Ms. Ridder noted that these rules apply even when special employees are on breaks but still on Federal property. She said that members may not use their position on the committee to bolster their partisan political views in personal discussions.

Ms. Ridder said that some special employees have asked if they could meet with their legislators on behalf of their employers or themselves when they are in Washington, DC for their work as special employees. Ms. Ridder noted there is an anti-lobbying act that prohibits use of federal appropriations for lobbying purposes. Therefore, time for which employees are being reimbursed cannot be spent lobbying. Special employees cannot use transportation, such as rental cars, for which the Federal Government is paying, to support lobbying activities. However, while special employees are in the area, during time that they are not on duty, they may meet with legislators on behalf of themselves or their employers.

Ms. Ridder encouraged committee members to contact her with any questions that arise in the future. She emphasized the importance of the committee's integrity. She stated that all committee work is for the Federal Government, not members' employers, clients, or personal concerns. Committee work must not be biased or appear to be biased. The primary purpose of ethics rules is to ensure this is the case. Ms. Ridder invited questions. There were none. Dr. Carter thanked Ms. Ridder for her presentation.

Approval of Meeting Minutes

Dr. McWilliams asked whether committee members requested any changes to the meeting minutes for the committee's meetings held January 9th-10th and June 11th. Dr. Carter said that the date for the latter minutes should be corrected in the minutes. Dr. McWilliams certified the minutes with this change.

Committee Discussion: 17th Report

Dr. Carter invited discussion about the recommendations the committee developed for its 17th report. She asked whether the committee recommended any changes to the recommendations. She said that she anticipated that there would be changes and that the committee would discuss the report further at the meeting to be held January 8th-9th, 2020. The 17th report will be due near the end of 2020.

Dr. McWilliams opened discussion of Recommendation 1. He suggested striking "workforce" from the recommendation, and for the recommendation to refer to primary care education and training for "students, trainees, and faculty." He also said that HRSA does not provide training but encourages training through its work. He invited comments from other committee members. Dr. Cortes said primary care training includes training for practitioners. Dr. Blumberg said the committee's purview only includes practitioners who are faculty members or who are otherwise involved with training supported by HRSA funding. He said the recommendation should either specify that these are the practitioners being referred to, or omit reference to practitioners.

Dr. Blumberg agreed that the recommendation should be more accurate regarding HRSA's role. He noted that HRSA does more than encourage training activities and that recommendation wording should reflect this. Ms. Dieter suggested changing the recommendation wording to, "The ACTPCMD recommends that HRSA provide funding to promote longitudinal primary care education and training." She asked if the wording should include reference to funding. Dr.

McWilliams said providing funding describes HRSA's activities accurately. Ms. Patton concurred. Dr. Blumberg added that the recommendation could also refer to favoring proposals to offer longitudinal training. Dr. Carter said the committee would have further opportunities to determine wording of the recommendations and that the purpose of the current discussion is to ensure the content of the current recommendations is what the committee wants.

Dr. Veselicky said that the recommendations could include facilitating partnerships with communities. She also said that the recommendation to support longitudinal training should specify that this refers to a 6-month to 1-year rotation. Dr. Veselicky also suggested that the recommendation refer to embedding trainees and faculty into communities.

Dr. Blumberg reiterated that the committee's charge is to make recommendations for training to provide primary care; it is not to recommend how primary care should be practiced. He suggested that the last sentence in Recommendation 1 should refer to "primary care education and training" rather than extending primary care into the community. Dr. Cortes said that committee guidelines include making recommendations on training physicians: "... providing continuing education to primary care physicians relevant to patient-centered medical homes, providing education to physicians about new interprofessional graduate training in public health and other health professions, to providing training in environmental health and new ideas." She noted that Title VII, "...provides programs through family medicine, general and internal medicine, general pediatrics for medical students, interns, residents or practicing physicians as defined by the Secretary." Dr. Carter said the committee could decide where to recommend focusing priorities and resources.

Presentation: Health Professions Training Programs: Data Dashboards

Presenter: Hayden Kepley, Ph.D., Special Assistant to the Director National Center for Health Workforce Analysis (NCHWA)

Dr. Kepley reported that the Health Professions Training Programs data dashboards went live several months ago. These dashboards store annual performance data on the grants and cooperative agreement program, which includes the Primary Care Training and Enhancement (PCTE) Program and Oral Health Training Programs. Data are collected from all program sites. NCHWA's current performance strategy was first implemented in Academic Year 2012-13, which is when data collection began. Annual data are available from that year forward. The most recent available data are from Academic Year 2017-18. NCHWA is currently working on finalizing the 2018-19 data. Aggregated annual data can be viewed by program or State. Data include participant and graduate counts and demographics. Demographic variables include age group, gender, race, ethnicity, educational or financial disadvantage status, and rural background status. Data also include information about clinical training sites and infrastructure, such as curriculum development, faculty development, and continuing education activities. Data are located on Data.HRSA.gov, under the Dashboard tab.

Dr. Kepley demonstrated the dashboard. He showed output that included a map display of program training locations, color-coded by number of participants. Dr. Kepley demonstrated how to obtain data from a specific State, academic year, or program, and generated several dashboard examples. He then invited questions.

Dr. Veselicky asked if the dashboards summarize how many training program graduates currently practice in rural communities. Dr. Kepley said these data are available. They are not yet included in dashboard data, but will be eventually. In the next round of data collection grantees will be required to provide 1-year follow-up data on employment. Dr. Veselicky asked if NCHWA collects data on participants' reasons for not practicing in rural communities. Dr. Kepley said it does not. Dr. McWilliams confirmed that the committee is interested in data on targeted outcomes such as trainees serving underserved communities, preferably more than 1 year after completing training. Dr. Kepley said NCHWA aims to collect and report these data. Data on serving underserved communities have been collected consistently for graduate medical education programs, but not for PCTE. NCHWA plans to begin collecting these data for PCTE as well.

Ms. Patton asked if dashboards can be reproduced for use in training, presentations, and outreach. Dr. Kepley said that the data are publicly available. They can be downloaded to Excel files using instructions on the website.

Dr. Carter suggested that the committee consider how the dashboard data could be used in committee reports. She thanked Dr. Kepley for his presentation.

Presentation: Bureau of Health Workforce Clinician Tracker

Presenter: Michael Dembik, Chief, Project and Data Management Branch, Division of Business Operations

Mr. Dembik explained that his presentation would be about the process of developing an overarching data strategy, formalizing data through governance, framing analytic questions, and developing data dashboards. Mr. Dembik said that Dr. Luis Padilla, Bureau Director, led development of the data strategy 2 years ago, with the purpose of using data to their full potential. The strategic principals are: 1) ensure transparency and access to data across the bureau, 2) support analysis of available data, 3) support understanding of data through governance, and 4) create a culture that supports information-sharing.

The division houses data on thousands of National Health Service Corps (NHSC) clinicians. NHSC requires clinicians to complete service contracts at approved medical sites in Health Professional Shortage Areas (HPSA). The division piloted a project to track clinicians after service completion using data made available through NHSC loan repayment program alumni. The project's goal is to determine where clinicians practice, with a focus on whether clinicians continue to serve in medically underserved areas. The project prototype was for executive, master, and custom dashboards, and an interactive map, each of which is designed to answer

distinct types of analytic questions. Data are currently available on all NHSC nurse participants and applicants, Children's Hospital graduate medical education (CHGME) and Teaching Health Center graduate medical education (THGME) trainees with a national provider identifier (NPI) who completed service or training between 2012 and 2018. This totals approximately 43,000 people included in the database.

It is a priority for NHSC alumni to serve in HPSAs, so this was the project focus when data included only this group. As new data include trainees from other BHW programs, the focus can be more generally on where trainees completed their BHW-funded activities, and where these trainees are at follow-up. Data are currently available for NHSC and Nurse Corps programs. Data are complete for time of service completion. NPI is matched with other databases to determine last known work address. People have expressed concern that Centers for Medicare and Medicaid Services (CMS) databases are not updated in a timely manner. Therefore, BHW uses its Shortage Designation Management System to obtain information from State and primary care offices and to override incorrect addresses in CMS data with more current data. Mr. Dembik said the BHW database is structured to include additional data sets as they are identified and become available.

Mr. Dembik provided a demonstration of clinician tracker dashboards, which currently are available only for internal use. The bureau is soliciting input regarding requirements for an external version from stakeholders such as committee members.

Mr. Dembik explained that the purpose of the Executive Dashboard is to answer high-level questions for senior leaders, such as the HPSA retention rate of NHSC clinicians, or the number of Nurse Corps clinicians working in a particular State. HPSA retention data are reported in official reports to Congress. Mr. Dembik demonstrated how to generate this type of output. He also showed how to generate dashboard data on community measures and community retention, which is service in the same community where a program participant was trained. "Same community" is defined as same training site or census tract. Dashboards also summarize data on whether alumni currently serve rural communities.

Next, Mr. Dembik described and demonstrated the Master Dashboard, which is intended to support managers and analysts in answering specific questions, such as whether NHSC clinicians who completed service at a Federally Qualified Health Center are more likely than others to be working in a HPSA at follow-up. The dashboard supports analysis by program. Mr. Dembik demonstrated how to filter data by multiple variables.

Mr. Dembik then described and demonstrated custom dashboards, which support comparisons, and the map dashboard, which shows where clinicians completed their service and where they currently practice. He demonstrated how dashboards can be used to assess change over time. He explained that Unified Dashboards include data across systems and programs. Systems include the BHW Management Information Systems Solution (BMISS), which provides program participants' service location data, and Shortage Designation Management System, which

provides current location data for all providers. Mr. Dembik emphasized that retention is defined differently by different programs.

Mr. Dembik invited questions. Dr. McWilliams asked if the external data dashboards would support comparison of BHW-funded clinicians' data with data on the general population of clinicians. Mr. Dembik said the goal is to include all clinicians with an NPI. The database currently only includes these data for CHGME and THGME alumni.

Dr. McWilliams asked what BHW is doing to develop comprehensive and accurate data on clinicians' locations. Mr. Dembik said analysts have explored this extensively and are continually seeking additional data. They have developed an algorithm for identifying the best clinician address match.

Dr. Blumberg asked whether the database includes data on trainees before they began their training, which would be valuable for assessing factors that influence retention. For example, growing up in a State could increase the likelihood of practicing in that State. Mr. Dembik said BHW does not have access to these data. However, Mr. Dembik said that Dr. Padilla emphasizes the importance of understanding the path from education to training to service. This path may be influenced by factors such as HRSA support early in a trainee's career. BHW is planning a project to assess the influence of HRSA programs on careers. It would be useful to have data on participants before they participate in HRSA programs, but there is not currently a plan to collect and analyze these data.

Mr. Dembik asked for committee members' recommendations for external dashboards. Dr. McWilliams said it would be useful to explore how to increase service in rural communities. He noted that being raised in or having family connections to rural communities can increase the likelihood of serving them.

Dr. Carter emphasized that members' input is important for ensuring data are useful. She invited members to contact Mr. Dembik via e-mail with comments, copying her. She said this approach to follow-up responses is in compliance with Federal Advisory Committee Act (FACA). If all members are copied in e-mail, then the communication qualifies as a discussion requiring public access. Mr. Dembik asked for support in soliciting committee input. Dr. Carter said she would facilitate communication that complies with FACA, such as smaller workgroups. She thanked Mr. Dembik and Ms. Kittrie.

Presentation: Bureau of Health Workforce: Oral Health Programs
Presenter: Shane Rogers, Chief, Oral Health Training Branch

Mr. Rogers welcomed the committee and introduced himself. He provided summary data on national need for primary dental care. He noted that, while there is an adequate number of pediatric dentists and dental hygienists, there is maldistribution of these services, which affects rural and underserved communities. There is significant demand for additional training in

primary care dentistry, especially for dental residencies. For example, in Academic Year 2018-19, there were nearly 27,000 applications for 2,300 primary care dentistry resident training opportunities. Bureau of Health Workforce strategies for addressing this shortage include providing training opportunities in community and underserved settings, which is associated with continuing to practice in these settings after training completion.

Mr. Rogers said that fewer than half of dental schools offer formal faculty training programs. Training faculty to improve training is a BHW priority. BHW also aims to support identification, tracking, and evaluation of innovations to improve access to dental care. He noted that evaluation is important, since innovations cannot be assumed to be successful. He also stated that it is important to know why innovations are successful, whether success is replicable, and whether innovative approaches are sustainable. It is important to demonstrate the value of innovations.

BHW also prioritizes identifying and addressing gaps in training for dental students and residents. Training diverse providers is another priority. A total of 12 percent of 2018 dental school graduating seniors identified as underrepresented minorities; 20 percent of graduating seniors supported by Title VII pre-doctoral programs identified as underrepresented minorities. About 12 percent of 2018 general dentistry residency program graduates identified as underrepresented minorities, while this percentage was 34 for graduates supported through Title VII programs. BHW is interested in how to incentivize providers to practice in rural and underserved areas.

The Oral Health Branch was founded in October 2010 as a result of Affordable Care Act expansions of Title VII-authorized dental training programs. The branch is supported by a legislative authorization for dental training and an authorization supporting an oral health workforce. These authorizations support six programs and more than 100 grants. Since 2014, the branch's annual appropriations have increased from \$32 million to \$40 million, suggesting that Congress values the branch's work. Much of the increased funding has been allocated for dental faculty loan repayment programs. The Fiscal Year 2019 appropriations budget allocates a minimum of \$12 million each for general and pediatric dentistry. Previously, the minimum was \$10 million.

Title VII Section 748 authorizes support for developing education and training in general, pediatric, and public health dentistry, and dental hygiene. Support includes financial assistance for students, residents, and faculty. Faculty support includes training and loan repayment. Funding priority areas include cultural competency and health literacy, which are factors in all competitions for funding. Eligible applicants are dental and dental hygiene schools, and primary care dentistry residency training programs. A total of two-thirds of the FY2019 budget is allocated for dental training programs, with the remaining third allocated for BHW's State-based workforce program.

The current focus of the pre-doctoral training program is to prepare dental and dental hygiene students to implement new and emerging models of care designed to meet needs of vulnerable,

underserved, and rural populations. BHW focus varies for each round of funding competitions. In FY 2015, the focus was on integrating students into the broader health care delivery system, and on preparing students to practice in advanced roles. In FY 2017 the focus was improving competence in pediatric dentistry. The pre-doctoral program currently funds 25 grants for \$7 million. Grantee institutions have trained nearly 10,000 dental and dental hygiene students at 257 clinical training sites in medically underserved communities.

The post-doctoral training program, formerly known as the residency training and general pediatric dentistry program, funds planning, developing, and implementing primary dentistry post-doctoral training programs. BHW competitions encourage grantees to support collaborations across general, pediatric, and public health dentistry. Competitions also encourage development of new delivery models. The program supports dental trainees in earning master of public health degrees. The post-doctoral training program currently funds 20 grants for \$12 million. In the last academic year, grantees trained nearly 500 primary care dental residents at 137 clinical training sites, 64 percent of which were in medically underserved communities. This was a 48 percent increase in service to underserved communities from the previous academic year. Mr. Shane noted that the current 5-year funding cycle for these grants will end in 2020. HRSA anticipates releasing a notice of funding opportunity for the next funding cycle in November or December 2019.

The Primary Care Clinician Educator Career Development Awards aim to strengthen the primary care workforce through training physicians, physician assistants, dentists, and dental hygienists. There is one notice of funding opportunity for this mechanism released by HRSA's medicine and dental training branches. Grants support one junior faculty at an institution for development as a clinician educator and potential leader in primary care. Grants support junior faculty grantees' projects that aim to transform health care delivery systems. The program currently supports six grants for \$1.1 million. The current grant cycle is about half complete. Accomplishments to-date include a promotion to Assistant Professor, another to Associate Professor, and one to Residency Program Director. Residents have produced multiple abstracts and manuscripts. They have received awards, including a leadership award from the Association of American Medical Colleges, a leadership award from the American Academy of Pediatric Dentistry, and a Fulbright scholarship. Grantees have been invited to participate on institutional committees, and State and national professional meetings. They are learning grantsmanship. BHW hopes to maximize support for this program and to increase the number of applicants and awardees.

The dental faculty loan repayment program is intended to increase the number of dental faculty in the workforce by using loan repayment as an incentive for recruitment and retention. Participants must be full-time faculty in a general or pediatric dentistry program, or a dental public health program. Grants are paid to institutions, which create their own loan repayment programs, including award criteria and processes, and policies. Institutions must develop selection committees and individual contracts and repayment plans. Authorizing legislation allows repayment of no more than 10 percent of an individual's educational debt for the first year, increasing five percent annually, with the potential for total debt repayment. Annual

repayment is contingent on completing the academic year. The program currently supports 30 grants for \$5 million. Institutional operating costs vary widely.

Across pre- and post-doctoral programs, between 65 and 75 percent of trainees have gotten exposure to medically underserved communities. The Oral Health Branch would like to increase this proportion. Fewer trainees have been exposed to rural communities- just more than 16 percent of pre-doctoral and just more than six percent of post-doctoral students. The branch is considering how to increase these proportions.

The Oral Health Branch's plan for the future aligns with BHW's strategic plan to increase supply and quality, and to improve distribution and access. The branch also plans to include evaluation in future efforts, to support effective budget allocations.

Mr. Rogers invited questions. Dr. McWilliams asked what Mr. Rogers thinks is the greatest challenge in addressing rural communities' needs for primary dental care. Mr. Rogers said it is exposing trainees to communities in need. This is the branch's current focus. Dr. McWilliams asked how the committee can be helpful in expanding support for rural programs. Mr. Rogers said the branch intends to emphasize meeting rural communities' needs in future funding competitions. Possible approaches include making rural exposure a priority area, which could be addressed through approaches such as creating a new residency program for a rural community, expanding rural rotation sites, providing exposure to rural communities, or increasing relevant faculty knowledge. Mr. Rogers invited additional ideas from the committee.

Dr. Chi asked how HRSA and BHW are working to address maldistribution of pediatric dentists. Mr. Rogers said funding competitions can support programs that offer exposure to high-need communities. Dr. Hicks said lack of infrastructure in rural areas contributes to lack of rural exposure for residents. Current rural offices and community health centers often do not have surgical facilities that are in new offices. He asked if HRSA intends to prioritize training in these facilities over training in more modern facilities in other communities, or if HRSA would consider allocating Title VII program funding for rural facility renovation. Mr. Rogers said the budget can be used for some infrastructure, including ancillary staff and modest renovations. The Oral Health Branch is working with their Office of General Counsel to determine which expenditures are allowed and how the program can be adapted to support rural communities' needs. The branch also is coordinating with the Federal Office of Rural Health Policy to identify and address rural communities' needs.

Mr. Rogers said that another challenge is lack of potential applicants' ability to write competitive grant applications. HRSA offers technical assistance, but it is often not adequate. Larger dental training institutions typically have more capacity to produce competitive applications.

Dr. McWilliams asked whether undergraduate or graduate training yielded a greater return on investment. Mr. Rogers said the programs are interdependent.

Presentation: Overview of Primary Care Training and Enhancement (PCTE) Program
Presenter: Cynthia Harne, MSW, LCSW-C, Chief, Medical Training and Geriatrics Branch

Ms. Harne introduced herself. She said that that PCTE is HRSA's flagship primary care training program. The program's goal is to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers and researchers in rural and underserved areas. The program aims to train providers who can practice, teach, and lead healthcare system transformation to improve access, care quality, and cost-effectiveness. Ms. Harne showed a slide summarizing funding levels from 2015 to 2019 as well as the projected 2020 budget. PCTE includes joint degree, pre-doctoral training, faculty development, medical assistant training, academic units, integrated behavioral health in primary care, and physician assistant training programs. All grants are for 5-year project periods. Between 2015 and 2018 the program has trained more than 19,000 individuals. More than 4,800 have graduated or completed their training program.

The 68 interdisciplinary projects funded in FY2015 and FY 2016 aim to transform healthcare systems aim to enhance clinical training experiences, evaluate patient access outcomes, assess care quality and effectiveness, and assess the clinical training environment. For these cohorts, BHW prioritized programs that provide training in patient-centered care and medical homes. Training includes continuing education for primary care providers. Programs develop tools and curricula.

The purpose of the academic unit program is to establish, maintain or improve academic units or programs that improve clinical teaching and research in the fields of family medicine, general internal medicine, or general pediatrics. There are six grantees, each of which works in a primary care focus area: behavioral health, oral health, health workforce diversity, rural practice, social determinants of health, or needs of vulnerable populations. The program has a \$4.5 million budget and is scheduled to end in 2021. Many grantees have published research findings. They will make presentations at HRSA on November 18 and 19, 2019.

Ms. Harne noted that Mr. Rogers had already described Primary Care Medicine and Clinician Educator Career Development Award program. She added that there are 22 total current grants for 13 medical schools, four physician assistant programs, and five dental schools.

The Primary Care Champion program's purpose is to strengthen the primary care workforce through fellowship programs to train community-based primary care practitioners or physician assistants to lead care transformation and to improve teaching in community-based settings. The program is currently in its second year. Applicants are medical or physician assistant schools that partner with a community-based primary care site. HRSA encourages applicants to partner with NHSC-approved sites. Applicants are required to train 20 fellows over the course of the grant.

The Integrating Behavioral Health and Primary Care program started July 1, 2019, with the purpose of funding innovative training programs that integrate behavioral health and primary

care in rural and underserved settings, with a focus on treating opioid use disorder. The program budget is about \$3.5 million and funds nine current grant awards. Grantees represent nine of ten HRSA-defined geographic regions. Grantees must provide training in integrated behavioral and primary care using a specified framework for levels of care. They must offer training in treatment of opioid and other substance abuse disorders, and must develop and implement a systematic approach for improving training.

The physician assistant program also began in July 2019. It was designed to increase the number of primary care physician assistants serving rural and underserved communities, and to improve primary care training in order to improve access to primary care services nationally. The program is funded for \$1.6 million annually. It currently supports six grant awards.

The PCTE residency training program's purpose is to establish, maintain or improve academic units or programs that improve clinical teaching and research in the fields of family medicine, general internal medicine, general pediatrics, or combined medicine and pediatrics in rural and underserved areas. The program encourages residents to choose primary care careers in rural and underserved areas. The budget is \$10 million. BHW hopes to fund about 20 grants after reviewing applications in January 2020. Awards are higher than for other programs, and grantees are required to do more, such as develop a strategy for recruiting and training medical students from HRSA's medical student education program and other PCTE programs.

Ms. Harne said that, in addition to PCTE, the Medical Training and Geriatrics branch administers the Preventive Medicine Residency program. The purpose of this program is to increase the number and quality of preventive medicine residents and physicians in order to support access to preventive medicine, and to improve the health of communities. This program is a Title VII program that currently supports 17 grant awards. Of these, 14 are general preventive medicine and public health programs; two are occupational health programs; and one program offers training in preventive medicine and a master's degree in public health. Trainees must complete at least 1 year of graduate medical education or residency before beginning the program. Graduates are prepared to serve in leadership positions in State and local health departments, in Federal agencies, and other public health agencies.

The Medical Student Education programs is not a Title VII program, but contributes to the primary care workforce. It started in September 2019. Grant periods are 4 years. Projects are funded for between \$1 million and \$1.8 million. The purpose is to support public institutions of higher education in expanding graduate education for medical students preparing to practice in the quintile of States projected to be most affected by the primary care provider shortage in 2025. Eligible applicants were 12 public colleges of medicine in Mississippi, Alabama, Kentucky, Oklahoma, Utah, Arkansas, Missouri and Indiana. Five projects are funded. Program activities include developing and implementing new and expanded pre-clinical and clinical medical school curricula and training tracks, and branch campuses to teach medical students to assess and address primary care health needs in the communities they serve.

Ms. Harne invited questions. Dr. McWilliams asked if applicants for Medical Student Education program grants must have continuing accreditation. Ms. Harne said applicants can be provisionally accredited at the time of application, but must have continuous accreditation before the end of the grant period. Dr. McWilliams pointed out that many osteopathic programs that may be innovative and effective do not yet have continuing accreditation. Ms. Harne said these programs can apply with provisional accreditation.

Dr. Veselicky asked why nurse practitioners, social workers, and psychologists are not eligible for residency program funding. Ms. Harne said other PCTE programs fund training for these disciplines. This particular program is specifically to support medical residents. Dr. Veselicky said psychologists and social workers make important contributions to addressing major health issues, such as addiction, in rural communities. Ms. Harne agreed, saying addiction is a BHW priority. HRSA offers other programs to support social workers, psychologists, mental health counselors, and addiction counselors. Divisions collaborate to ensure training needs are met. Dr. Cortes said that Title VIII, the Nursing Workforce Reauthorization Act, authorizes funding for nursing education, including for nurse practitioners and registered nurses.

Discussion: 17th Report - Innovations in Primary Care Medicine & Oral Health Education and Training

Dr. McWilliams asked Dr. Carter what outcomes she desired from discussion about the committee's 17th report. Dr. Carter asked the committee to review their recommendations and revise them as needed, to discuss whether the report content aligns with recommendations, whether information is missing from the report, and whether the report tone is appropriate for the intended audience, which is the HHS Secretary and Congress. Dr. Carter noted that committee members' colleagues are a secondary audience. She said the current discussion should be about content, not grammar.

Recommendation 1

Dr. McWilliams asked the committee to consider changing the wording of Recommendation 1 to "...encourage and support longitudinal primary care education and training," or "...encourage longitudinal primary care education and training." He supported the former option, as did Dr. Cortes, because the committee intends to recommend more than encouragement. Dr. Carter said other considerations could include "advance" or "promote." Dr. Blumberg agreed that the recommendation should clearly indicate more than encouragement; it should indicate that the committee recommends that HRSA provide incentives, such as funding and preference in grant applications. Ms. Patton said the wording could include "encourage to facilitate" or "encourage and facilitate." Dr. Carter said a committee working group can develop options for the committee to consider at the January meeting. Dr. McWilliams supported the idea, saying this approach has been successful previously.

Ms. Glicken asked what the committee meant by the phrase “to extend primary care into the community.” She asked whether the recommendation was to support longitudinal education in a setting that extends care into the community, or was intended to say that the training should encourage future providers to practice in primary care. Dr. Carter said her recollection was that the training itself should occur in the community. Dr. Cortes said the intent also was to teach trainees to leverage community resources and understand their role in healthcare. Dr. Carter said that the report will include discussion along with recommendations, which will clarify intent. She also said that, if a recommendation becomes very complex, the committee may want to divide it into more than one recommendation. Ms. Glicken suggested changing the Recommendation 1 phrasing to “longitudinal community-based primary care education and training.” Ms. Dieter said that prefacing “primary care” with “community-based” captures the committee’s intent for the recommendation. Dr. Cortes agreed.

Dr. Chi suggested that some audience members might not understand the meaning of the word “longitudinal” in this context, and suggested replacing it with “ongoing.” The technical writer commented that “longitudinal education” is a standard term used in the field and in the literature about this type of training versus block rotations. Dr. McWilliams agreed that “longitudinal education” is common terminology. Dr. Carter recommended including both words so that the recommendation is clear to all target audience members. Dr. Blumberg pointed out that the report text defines longitudinal education. The committee agreed to add “ongoing” in parentheses after “longitudinal” so that the recommendation will be clear to all targeted audience members.

Dr. Carter said the phrasing at the end of Recommendation 1 was unclear. She asked the committee to consider the following wording: “...encourage longitudinal community-based primary care education and training, and incorporate community-based resources. Ms. Glicken suggested changing the phrase to, “primary care education and training, incorporating community-based resources.” Dr. Cortes concurred with the latter suggestion, and suggested changing the end of the recommendation to, “community-based resources and partnerships.” Dr. Carter asked the committee to consider in future discussion whether the intention of the recommendation is for practitioners to become preceptors. Dr. McWilliams asked for further comments from the committee. There were none.

Recommendation 2

Dr. McWilliams read Recommendation 2 aloud, “The ACTPCMD recommends that HRSA provide funding to support innovative primary care programs that educate and provide training that incorporates evidence-based behavior change that improves chronic disease care in patients (chronic disease management and substance use/abuse disorder) in future oral health and primary care practice,” and invited comments. Dr. Carter recalled that the recommendation resulted partly as a result of comments from Dr. Chi, and invited him to initiate current discussion. Dr. Chi said the recommendation captured the committee’s intent to recommend support for evidence-based strategies. Dr. Carter asked the committee to consider the role of health

promotion and healthy behaviors, in addition to chronic disease care. She noted that the role of health promotion is discussed in the rationale. Dr. Hicks suggested changing “incorporates” to “incorporating,” to parallel the structure of Recommendation 1. He also suggested removing the text in parentheses. Dr. Carter said that this text could be included in the recommendation’s rationale and discussion. Dr. Chi suggested deleting the phrase “care in patients.”

Dr. Schwartz observed that the recommendations do not address prevention or health promotion, and asked whether this was intentional. Dr. Carter asked if the committee would like to mention prevention and health promotion in the recommendations. Dr. Schwartz said he would. Dr. Hicks suggested changing the final phrase to “primary care promotion and practice.” Dr. Chi said the recommendation should address prevention, and suggested the phrasing, “...that improve chronic disease prevention and management in future oral health and primary care practice.” Dr. Carter, Dr. McWilliams, and several committee members supported this phrasing.

Dr. Schwartz asked for clarification regarding the distinction between “educate” and “train.” Dr. McWilliams said “education” pertains to classroom settings while “training” refers to activities in clinical settings.

Ms. Glicken suggested changing “future oral health and primary care practice” to “across oral health and primary care practice.” Dr. Carter suggested deleting “practice” and several committee members concurred.

Dr. McWilliams invited additional comments about Recommendation 2. There were none.

Recommendation 3

Dr. McWilliams read Recommendation 3 aloud, “The ACTPCMD recommends that HRSA support faculty development to utilize innovative methods in addressing population health and managing chronic disease of vulnerable population, and then train students, trainees, and primary care providers using these approaches,” then invited comments. Dr. Schwartz said the phrasing was awkward. He suggested that the recommendation should say that faculty would utilize innovative methods to train, then explain what students, trainees, and primary care providers would be trained to do. He recommended moving the last clause to follow “faculty development.”

Dr. Blumberg noted the importance of the recommendation and its clear intention to influence practice through training, which is the committee’s charge.

Ms. Glicken pointed out that not all population health strategies are innovative. She asked if the committee should recommend using population health strategies generally for preventing and managing chronic disease in vulnerable populations, or if the recommendation should specify use of innovative strategies. Dr. Cortes said the emphasis was on prevention and management. Dr. Schwartz endorsed not specifying that the population strategies should be innovative. Dr.

McWilliams said the original discussion emphasized the importance of innovative methods. Dr. Cortes concurred. She said the committee had discussed innovative methods such as telemedicine and artificial intelligence. Dr. Carter asked that the committee consider the current status of teaching population health strategies and how HRSA can support improving this status. Teaching these strategies is itself an innovation. Dr. Cortes suggested the recommendation read, "...to encourage students, trainers and trainees, and primary care providers to use innovative methods in addressing..." Dr. Carter said "encourage" is probably not a strong enough word; the recommendation should be clearly for action that results in an expected outcome. Dr. McWilliams said that Dr. Cortes' points could be addressed in the recommendation rationale and background.

Dr. Hicks said the recommendation should be reworded to, "...support faculty development that is designed to facilitate the education of..." since faculty development itself does not educate students.

Dr. Carter asked if the committee was satisfied with the content of the recommendation. Committee members indicated that they were.

Recommendation 4

Dr. McWilliams read the recommendation aloud, "The ACTPMCD recommends that HRSA provide funding to support programs that provide innovative education and training that incorporate telehealth when providing care to vulnerable populations."

Dr. Veselicky asked why the recommendation targets only telehealth. Dr. Cortes said she did not think this had been the intention. Ms. Patton suggested changing the wording to, "including telehealth."

Dr. Cortes asked how Recommendations 3 and 4 are different. Dr. Carter said Recommendation 3 emphasizes importance of population health while Recommendation 4 emphasizes use of technology. She suggested referring to technology, which had been the discussion focus, rather than specifying telehealth. Dr. McWilliams agreed that the discussion focus had been technology use, such as telehealth and artificial intelligence. Dr. Carter asked the committee to consider the current state of artificial intelligence and how it is being used. It may not yet be linked to outcomes, which should be considered when making recommendations. Dr. Hicks asked if the recommendation should specify supporting innovative methods that produce measurable outcomes when providing care to vulnerable populations. Dr. Veselicky said that telehealth works better in a team-based care model. She suggested considering whether the recommendation should refer to team-based care. Dr. Carter said the last two comments could be addressed in discussion about the recommendation rationale. She asked if committee members needed more time to consider this recommendation. Dr. McWilliams said this was the case.

Report Content

Dr. Carter invited comment on the report tone and rationales for recommendations. Dr. McWilliams' first comment was on the Executive Summary. He said it resembled meeting minutes and did not focus on expected outcomes of implementing the recommendations, which is the most important aspect of the report. He suggested major modification of this section. He invited comments from other committee members. Dr. Schwartz asked if the final summary section was more what Dr. McWilliams had in mind for the Executive Summary. Dr. McWilliams said it was, that he found the final summary more compelling. Dr. Cortes said the executive summary could be written more like a policy brief with a problem statement followed by recommendations. Ms. Glicker said that the Executive Summary should start with a compelling argument, then present the evidence, rather than starting with committee recommendations and following them with supporting evidence.

Dr. McWilliams said the sections of the report providing background for the recommendations aligned with his expectations. He expressed appreciation for the extensive use of citations to back up statements.

Dr. Carter asked whether committee members thought the rationales in the report support recommendations. She acknowledged that new members have had little time to review the report.

Dr. McWilliams said some exhibits in the report did not have clear purpose. He suggested replacing the telemedicine graphic and SAMHSA Quick Guide cover with other exhibits, such as a table of services listed in the Quick Guide. Dr. Carter clarified that the exhibits in the current report draft are intended mostly as placeholders, and that committee members can recommend exhibits to include in the report. For example, the Quick Guide is relatively old; members may want to replace the image of it with a more recent resource, or with another image or graphic. She said the report should include more graphics and images relevant to oral health. Images also could portray team-based care and priority patient populations.

Session: Committee Next Steps

Facilitator: Kennita Carter, MD, Designated Federal Official, ACTPCMD

ACTPCMD 17th Report - Innovations in Primary Care Medicine & Oral Health Education and Training

Dr. Carter said that the terms of committee members who are not new would end March 2020. She said she would establish writing groups that include both new and senior committee members and that represent the diverse professions of the committee. The groups cannot exceed eight members. Dr. Carter said she would send writing group assignments within a few days of the meeting.

Dr. Carter asked if the committee is satisfied with the current sequence of the recommendations. Ms. Dieter said she thought the current order reflected the logical order of the committee's

discussion about developing them. Ms. Patton, Dr. McWilliams, Dr. Cortes, and Dr. Schwartz agreed.

Dr. Carter asked whether committee members would prefer to review the entire report or to assign different sections for each writing group to review. Drs. Schwartz and Veselicky said they would prefer for all members to review the entire report. Dr. Carter said this approach would help to prepare new members to work on the report and to orient incoming committee members. Dr. McWilliams agreed. He said this would help the report be more cohesive after initial review. Other committee members also agreed. Ms. Patton said that it would be valuable for all committee members to review the entire report, but it would be inefficient to have separate groups discussing specific revisions. Writing group meetings also will include discussions about how the committee functions and reasons for the current approach to committee work.

ACTPCMD 18th Report - Rural Health Education and Training

Dr. Carter noted that the 17th report is due in 2020 and that the committee is ahead of its goals for completion. She invited the committee to suggest topics for the 18th report. She noted that rural health is currently a high-priority at HRSA. It is a current priority for the Council on Graduate Medical Education. There is an established need for more primary care medicine and dentistry in rural areas. Dr. McWilliams agreed that this would be a good focus area for the 18th report. Ms. Glick said that the 17th report lacks recommendations for interprofessional, team-based, integrated care. She said this should be addressed in the 18th report, possibly as an element of rural care delivery. Dr. Schwartz asked why the report should focus on rural health rather than on the broader underserved population. Dr. Carter said this is because of the specific conditions affecting rural communities, and challenges with distribution of providers in rural and frontier areas. January meeting topics will include rural health issues, and what urban centers, faculty, and healthcare professionals should know about health challenges in rural America. Since telemedicine is one way to increase rural residents' access to the healthcare, the meeting could include discussion about what an urban provider serving a rural patient through telemedicine should know. Dr. McWilliams said that, while the problems of urban underserved communities are important, data indicate unique healthcare access problems for rural and frontier communities. Dr. Cortes said that the committee is charged with considering needs of rural and underserved communities and should not omit either in its recommendations. Dr. McWilliams said that Dr. Sealey, who was not at the current meeting, has consistently agreed with Dr. Cortes' point. Dr. Carter stated that the committee may develop high priority recommendations for covering the ACTPCMD charge.

Ms. Patton said that the federally designated rural health clinic where she has worked recently closed. She said this is a pattern. Rural clinics are closing across the Nation, leaving patients with access to few resources, likely to let their medical needs escalate, and to seek care only in emergency rooms. Therefore, she endorsed addressing rural health needs in the 18th report. Dr. Cortes said that discussion of rural health clinics closing should address potential reasons for closing, such as lack of provider preparation, or lack of State funding.

Dr. McWilliams suggested reviewing prior committee reports to ensure the 18th report is not redundant with previous reports. He also noted that reports sometimes include Level A recommendations, which focus on the charge of the committee, and Level B recommendations, that pertain to broader issues beyond the committee's purview. This may be the case for the 18th report.

Dr. Carter said that the committee makes recommendations for appropriations levels for Title VII programs. These recommendations can include a case for supporting programs for both rural and underserved communities. The committee also can address this and other issues it finds important through correspondence. In addition, the annual report can include additional items that the committee prioritizes.

Public Comment

Dr. McWilliams invited public comments. There were none.

Business Meeting

Dr. Carter asked committee members to submit their travel preferences to the HRSA travel office by close of business November 7, 2019.

Dr. Carter said the committee would elect a Chair at the next meeting. She requested that nominations for the Chair be sent to her by November 15 via e-mail, with a brief paragraph explaining why the nominee would be a good Chair. Members eligible for nomination are those who recently joined and whose terms will not expire in March 2020. These members are Ms. Glicken, Dr. Hicks, Dr. Lichtenstein, Ms. Patton, Dr. Schwartz, and Dr. Veselicky. Members can self-nominate. Members whose terms will expire in March can nominate the next Chair. Dr. Carter will contact nominees who did not self-nominate to confirm that they are willing and able to serve as Chair. She and Dr. McWilliams will announce nominees at the next meeting. Nominees will make brief statements about why they would like to serve. The committee will then vote through e-mail messages to Dr. Carter, who will tally the votes. Dr. Carter invited questions about the process of electing the next committee Chair. There were none. She said that she works closely with the Chair and that the Chair should attend writing group meetings.

Dr. Carter said the writing group should meet two or three times before the January meeting. She asked committee members to notify her of days they would not be able to meet. She said that she will review the agenda with committee members about a week before the meeting. The purpose of the review is to ensure all members understand the meeting's purpose and goals. HRSA's leadership has been invited to provide an overview of priorities. There will be an update on the data initiative discussed at the current meeting. The Oral Health and Primary Care Branch Chief will provide an update and address questions. There will be presentations on rural health. Dr. Carter invited committee members to recommend speakers on education and training in oral

health and primary medicine for rural communities. She would like to extend invitations within 2 weeks of the current meeting. Dr. Carter noted that there is a stipend for speaking, but no travel reimbursement for speakers who are not members of the committee.

Drs. McWilliams and Carter thanked the committee for their work. Dr. Carter adjourned the meeting at 4:00 p.m.