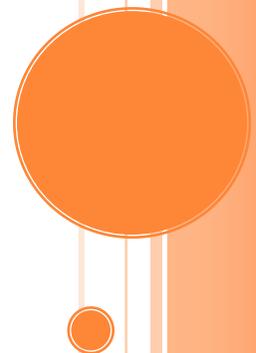


**ADVISORY COMMITTEE  
ON TRAINING IN PRIMARY CARE  
MEDICINE AND DENTISTRY**

**TRAINING HEALTH PROFESSIONALS  
IN COMMUNITY SETTINGS DURING A  
TIME OF TRANSFORMATION:  
BUILDING AND LEARNING IN  
INTEGRATED SYSTEMS OF CARE**

**ELEVENTH ANNUAL REPORT  
TO THE SECRETARY OF THE  
U.S. DEPARTMENT OF HEALTH AND HUMAN  
SERVICES  
AND TO CONGRESS**

**December 2014**



The views expressed in this document are solely those of the Advisory Committee on Training in Primary Care Medicine and Dentistry and do not necessarily represent the views of the Health Resources and Services Administration nor the U.S. Government.



## Table of Contents

<b>Advisory Committee on Training in Primary Care Medicine and Dentistry</b> ....	4
Authority .....	4
ACTPCMD Publications .....	4
Council Membership .....	6
Acknowledgement .....	8
<b>Vision</b> .....	9
<b>Summary of Recommendations</b> .....	11
<b>Background</b> .....	14
<b>Section 1: Expanding the Team: Integrating Behavioral Health and Other Services into Transformed Primary Care Practice</b> .....	16
<b>Section 2: Community Health Centers and Beyond: Collaborative Training in Community Settings for Physician Assistant Students</b> .....	20
<b>Section 3: Linking Oral Health Care Delivery with Primary Care Medicine</b> .....	24
<b>Section 4: Invest in the Future of Primary Care Medicine and Dentistry</b> .....	26
<b>References</b> .....	28

# Advisory Committee on Training in Primary Care Medicine and Dentistry

The Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) is a Federal advisory committee under the auspices of the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS). HRSA is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

HRSA's Division of Policy Information and Coordination coordinates advisory committee management activities for HRSA's 14 Advisory Committees and serves as the official liaison between HRSA and the HHS Committee Management Officer, Office of the White House Liaison, Office of the Secretary. Each advisory committee is managed by a Designated Federal Official, who is responsible for the committee's management and administrative matters. ACTPCMD's Designated Federal Official operates within the Division of Medicine and Dentistry, a part of HRSA's Bureau of Health Workforce.

## **AUTHORITY**

The Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) is authorized by sections 222 and 749 of the Public Health Service Act (PHSA) (42 U.S.C. §§ 271a, 749), as amended by section 5303 of the Patient Protection and Affordable Care Act (ACA). The ACTPCMD originally was established under the authority of section 748 of the 1998 Health Professions Education Partnerships Act.

The ACTPCMD provides advice and recommendations on policy and program development to the Secretary of the U.S. Department of Health and Human Services and is responsible for submitting an annual report to the Secretary and to Congress concerning the activities under sections 747 and 748 of the PHSA, as amended. Reports are submitted to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives. In addition, ACTPCMD develops, publishes, and implements performance measures and longitudinal evaluations, as well as recommends appropriations levels for programs under Part C of Title VII of the PHSA, as amended.

## **ACTPCMD PUBLICATIONS**

These reports can be viewed at: <http://www.hrsa.gov/advisorycommittees/bhpradvisory/actpcmd/>

## **REPORTS**

Since its establishment, ACTPCMD has submitted the following reports to the HHS Secretary and Congress:

- First Report: Comprehensive Review and Recommendations: Title VII, Section 747 of the Public Health Service Act (2001);

- Second Report: Delivering The Good: Improving The Public's Health By Enhancing The Primary Care/Public Health Interface In The United States (2002);
- Third Report: Training Culturally Competent Primary Care Professionals To Provide High Quality Healthcare For All Americans: The Essential Role Of Title VII, Section 747 In The Elimination Of Healthcare Disparities (2003);
- Fourth Report: Preparing Primary Healthcare Providers To Meet America's Future Healthcare Needs: The Critical Role Of Title VII, Section 747 (2004);
- Fifth Report: Women and Medicine (2005);
- Sixth Report: The Role Of Title VII, Section 747 In Preparing Primary Care Practitioners To Care For The Underserved And Other High-Risk Groups And Vulnerable Populations (2006);
- Seventh Report: Coming Home: The Patient-Centered Medical-Dental Home In Primary Care Training (2008);
- Eighth Report: The Redesign Of Primary Care With Implications For Training (2010);
- Ninth Report: Priming the Pump of Primary Care (2012);
- Tenth Report: Interprofessional Education (2013).

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## Vision

The Health Resources and Services Administration (HRSA) has four goals (“Health Resources and Services Administration,” n.d.-a):

- Goal I: Improve Access to Quality Care and Services
- Goal II: Strengthen the Health Workforce
- Goal III: Build Healthy Communities
- Goal IV: Improve Health Equity

These goals are met through five bureaus and five offices that provide support for primary care physicians, physician assistants, dental training and healthcare services in community health centers, people living with AIDS programs, migratory/seasonal farmworker programs, and homeless healthcare programs. Under sections 747 and 748 of Title VII, Part C of the Public Health Service Act, HRSA provides grants and contracts that support training in primary care medicine and dentistry. ACTPCMD made recommendations to guide advanced primary care education and training and emphasize the value of the health professions team in the provision of primary care services for a diverse patient population and community, at large.

ACTPCMD envisions a transformed healthcare system that is patient-centered and cares for patients through effective team-based care, aligning individual health goals with those of the community. Transformed care requires a primary care workforce that can operate as an interprofessional team relying on each discipline’s licensed scope of practice and a core of engaged patients. Primary care teams would involve an array of members, which may include but not be limited to:

- **Activated and engaged patients, lay health workers and community health professionals** (patients, patients’ families, parent partners, *promotoras*, community health workers, patient navigators, and community agency personnel).
- **Clinical professionals who provide or coordinate direct care to patients** (nurses, advanced-practice nurses, medical assistants, physical therapists, occupational therapists, speech therapists, respiratory therapists, dietitians/nutritionists, procedure technicians, radiology technicians, behavioral and mental health specialists, social workers, health educators, home health aides, child life specialists, care coordinators and managers, dental hygienists, dental health aide therapists, dentists, pharmacists, physician assistants, and physicians).
- **Service personnel who create infrastructure for care delivery** (laboratory technicians, health information technology staff, communication operators, and receptionists).
- **Population-health professionals who address system-level performance** (patient safety, quality and performance improvement, public health and prevention, program planning and evaluation, health literacy and communication, community health assessment, and cultural awareness and competency).

These teams are beginning to form in a variety of settings, forming the basis of learning healthcare systems that work with patients and communities to build health communities and increase health equity throughout the United States. To create these systems, the ACTPCMD has recommended more interprofessional training. There is also the need for site training within systems that integrate care (medical and dental, as well as behavioral health and other services) in the care of the patient. Clinical professions, service personnel, population health professionals, and community health workers are crucial to providing a comprehensive interprofessional approach to healthcare, particularly as we strive to improve health equity by addressing social determinants of health. Their work combined with an actively engaged patient can lower costs.

## Summary of Recommendations

To the extent possible, Title VII, Part C, sections 747 and 748 grantees should provide interprofessional training in sites that practice interprofessional care. Title VII, Part C grantees should:

- Conduct training in clinical environments that are transforming or have transformed to include integrated care with other health professionals (e.g. behavioral health, substance use, nutrition, care coordination, social work, nursing, oral health) such as Educational Health Centers (including the HRSA-funded Teaching Health Center Graduate Medical Education sites).
- Develop and implement curricula to give trainees the skills necessary to build and work in interprofessional teams that include diverse professions outside of medicine and dentistry.
- Develop and implement curricula to develop leaders in practice transformation. Leadership development within recipient institutions should be encouraged, leading to the creation of transformed practices in which training can occur.
- Develop faculty to teach practice transformation, and to encourage development and implementation of interprofessional faculty teams.
- Encourage the use of members of the National Health Service Corps as faculty for the trainees and provide Corps members with on-going faculty development.

HRSA should:

- Capitalize on HRSA's recent reorganization to leverage various funding streams (e.g. Title VII, Title VIII, NHSC) to reduce barriers and foster programmatic collaboration. This should include funding for collaborative interprofessional programs, which may require statutory change. The Bureau of Health Workforce was created in May 2014, integrating HRSA workforce programs previously housed in two separate bureaus: Health Professions and Clinician Recruitment and Service.
- Expand interagency efforts to promote integration of behavioral health with primary care, such as the Center for Integrated Health Solutions.
- Collaborate with agencies outside of HHS to fund interprofessional training to leverage the impact of Title VII, Part C, sections 747 and 748 grant programs on health outcomes. Potential partners may include the Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), Administration for Children and Families (ACF) and Substance Abuse and Mental Health Services Administration (SAMHSA) within HHS and the Department of Defense (DoD), Department of Veteran Affairs (VA), and the Department of Education outside of HHS.

**Community Health Centers are an ideal model for team-based training. To encourage their participation:**

- It is imperative that Congress reauthorize and increase funding for Teaching Health Center Graduate Medical Education to assure that ongoing, reliable, and stable funding is continued.

Title VII, Part C, sections 747 and 748 training grants should:

- Support educational experiences in community ambulatory patient care sites through funding of health center administration and coordination staff who would help mitigate the costs of training primary care physicians, physician assistants, and dental professional learners.
- Include guidance language that specifically addresses the creation and expansion of short term and longitudinal interprofessional training experiences in community ambulatory patient care sites for physician assistant students, and medical and dental students.
- Allow the use of grant funds to support infrastructure for interprofessional teams of learners in the same site, including faculty development, staff coordination, distance learning, and transportation and housing to cover the costs of clinical training in community ambulatory patient care sites.
- Fund a Teaching Health Centers Physician Assistant Training program with incentives to include veterans as employees and potential physician assistant students.
- Identify effective physician, physician assistant, and dental trainee experiences that increase the number of applicants for National Health Service Corps Loan Repayment programs and provide a pathway to meet future community healthcare workforce needs.
- Require that Title VII, Part C, sections 747 and 748 grantees track practice outcomes of funded trainees regarding prospective employment in health centers participating in collaborative training experiences.

**Oral health professions training must be part of the interprofessional approach.**

Title VII, Part C, sections 747 and 748 funded programs should:

- Encourage the advancement of a common communication system and language through the electronic health record (EHR), and common diagnostic coding that allows more direct information sharing between primary care and oral healthcare providers. The most reliable system would be a shared EHR.
- Support coordination of training opportunities to enhance interprofessional experiences for oral health and primary care that include longitudinal patient-centered care and integrated payment systems with a focus on clinical outcomes and learner skill development to track, evaluate, and improve the health of communities.
- Identify trainee experiences that increase applicants for the National Health Service Corps Scholarship and Loan Repayment program and provide a pipeline to meet future community healthcare workforce needs.
- Require that Title VII, Part C, sections 747 and 748 grantees track practice outcomes of funded trainees regarding prospective employment in health centers participating in collaborative training experiences.

**Resources currently available through Title VII, Part C, sections 747 and 748 have decreased significantly over the past 10 years, and are currently inadequate to support the system changes recommended above. Therefore, Congress should:**

- Appropriate \$123 million to Title VII, Part C, sections 747 and 748 for FY 2016, restoring funding to inflation-adjusted FY 2003 levels.

- Permit annual competitive grant cycles for primary care training grants by appropriating an additional \$25 million per year over the next five years beginning in FY 2017 to Title VII, Part C, sections 747 and 748.
- Reauthorize, appropriate, and double the existing mandatory funding for the expansion and continued evaluation of the Teaching Health Center Graduate Medical Education Program for at least 5 years.
- Appropriate funds to support the expansion of the work of the National Center for Workforce Analysis to include a robust evaluation of the impact of training programs on career choice and career trajectory of health professionals.

## **Training Health Professionals in Community Settings during a Time of Transformation: Building and Learning in Integrated Systems of Care**

### **Background**

The healthcare systems of the United States are struggling to change, improve patient care and health outcomes, lower costs, and prevent and better manage chronic illness. In the past, systems have focused on delivery of specific services to the patient, rather than on the outcome of services provided. The result has patients with multiple problems receiving uncoordinated care from providers with a variety of backgrounds and little incentive for interprofessional collaboration resulting in rising healthcare costs, unsatisfactory patient experiences, and poor health outcomes (Grant Makers Health, 2012).

The future of healthcare depends on the ability to control costs, improve access to care, and create better health outcomes (Berwick, Nolan, & Whittington, 2008). This may be accomplished by coordinating care across professions and specialties (Institute of America, 2013), measuring progress toward clinical goals (Institute of America, 2001), and integrating medical practice with community resources that move patients toward health (Garg, Jack, & Zuckerman, 2013). New models of care must be researched and developed to provide the best care for the patient (McNellis, Genevro, & Meyers, 2013). Change is occurring at all levels of the healthcare system: improving access to care; delivering team-based care focusing on population health (Burns, Goldsmith, & Sen, 2013); and converting to new payment mechanisms that reward value and contain cost (Edwards, et al., 2014). A transformed healthcare system will be one grounded in primary care practice based on interprofessional teams practicing within learning organizations that facilitate patient engagement, engage in continuous quality improvement, measure outcomes, and are at the center of their medical neighborhood (Takach, 2012; Goldman, 2014). Advanced primary care practices embrace the challenge of the three-part aim and the joint principles of the Patient-Centered Medical Home (PCMH), and require a primary care workforce that is up to the task (Institute of Medicine, 2014).

The recommendations enumerated in the ACTPCMD's Tenth Annual Report to the Secretary of HHS and Congress emphasize the importance of interprofessional education in the preparation of the next generation of health professionals and greater movement toward the provision of patient-centered care. It is important to take this recommendation even further and respond to the growing trend of increased care delivery outside of the traditional hospital setting by moving training in this direction as well. The new care delivery infrastructure is being centered on community-based primary care. This requires that interprofessional training for physicians, physician assistants, and dentists within the community inhabit the new structures that are under construction, focusing on the skills needed to build and function in the new paradigm.

The 11<sup>th</sup> report of the ACTPCMD aims to integrate principles of interprofessional education with the building of community-based collaborations and partnerships in primary care practice. Many Federally Qualified Community Health Centers (FQHCs)

have been on the cutting edge of practice transformation over the past decade, and are in many ways the ideal base for clinical education in the new paradigm. While FQHCs are built on engagement with the communities they serve, individual patient engagement in care requires a renewed focus on patient-centered care. This includes the integration of medical care with service lines that have been traditionally siloed within institutions, such as mental/behavioral health, dentistry, nutrition, and social work. By engaging them in teaching the principles of interprofessional education within the evolving systems of care, the ACTPCMD proposes to train providers who are not only able to work within the new systems of care, but are able to lead that transformation over the coming decades.

<p><b>Definitions</b></p> <p><b>Community Ambulatory Patient Care Sites:</b> Locations of outpatient clinics and facilities that include, but are not limited to: private and federally-qualified health centers; community mental health centers; rural health clinics; health centers operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization; and entities receiving funds under Title X of the Public Health Service Act.</p> <p><b>Health Team Members:</b> Clinical professionals who provide or coordinate direct care to patients that include, but are not limited to: nurses, advanced practice nurses, medical assistants, physical therapists, occupational therapists, speech therapists, respiratory therapists, dietitians and nutritionists, procedure technicians, radiology technicians, behavioral and mental health specialists, social workers, health educators, home health aides, child life specialists, care coordinators and care managers, dental hygienists, dental health aide therapists, dentists, pharmacists, physician assistants, and physicians.</p>
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This report is organized into four sections:

1. Expanding the Team: Integrating Behavioral Health and Other Services into Transformed Primary Care Practice
2. Community Health Centers (CHCs) and Beyond: Collaborative Training in Community Settings
3. Linking Oral Health into the Primary Health Care Team
4. Investing in the Future of Primary Care Medicine and Dentistry

Each section will focus on clear policy recommendations that support the overarching goal of using teams which are evolving under the ACA to train the next generation of physicians, physician assistants, and dentists to practice in the transformed practices that they are creating.

## **Section 1: Expanding the Team: Integrating Behavioral Health and Other Services into Transformed Primary Care Practice**

**Goals:** The World Health Organization (2014) defines health as “a state of physical, mental and social well-being and not merely the absence of disease or infirmity.” To improve population health, Title VII, Part C, sections 747 and 748 grant programs should promote the broad definition of health by funding programs that include care teams with multiple areas of expertise (e.g. behavioral health, substance use, nutrition, care coordination and social work). Trainees should learn in clinical settings that address medical and oral health issues in the context of the social determinants of health (e.g. homelessness, substance use, poverty and violence).

Providing care for the whole person involves more than medicine and dentistry. Behavioral health, substance abuse, nursing, nutritional support, and social services are critical components of comprehensive care necessary to improve America’s health outcomes. Integrating these services with traditional medical practice has long been a goal of the Community Health Center movement. The ACA codified the trend towards providing integrated, team-based care outside of the hospital setting in American medicine. Healthcare providers of all types need the leadership skills to guide practices through the change process and to create integrated systems of care supported by new payment models.

**Justification:** Many models exist for the integration of a wide variety of professional and paraprofessional services into the primary care team. Licensed professionals, such as social workers, nurses, educators, nutritionists, speech pathologists, pharmacists, occupational and physical therapists, medical interpreters, psychologists and attorneys have all been cited as important components of a comprehensive interprofessional approach to health. More recently, community health workers, patient navigators, peer mentors and parent partners have been proposed to meet the needs of challenging subgroups of patients, particularly those for whom the social determinants of health must be addressed. In all cases, the challenges of integration with medical practice have been similar. Each profession brings to the partnership its own perspective, including rules of conduct, social roles, behavioral norms, collaborative expectations, and professional jargon that can impede interprofessional collaboration. Traditional physician training, in particular, reinforces a sense of hierarchy that confounds the expectations of many working in interprofessional teams. Addressing these unspoken professional assumptions of role and authority, also known as the “hidden curriculum” of medicine, is one of the major challenges in the design of interprofessional curricula. Facing these challenges will be necessary to train the workforce for the integrated care delivery systems of the future.

Integrating behavioral health into primary care practice poses additional challenges. Service delivery is hampered by a complex payment structure. For example, many services have been “carved out” of managed care contracts, creating a parallel system of care that promotes care fragmentation and does not reward coordination and collaboration. Community mental health centers, though separately funded, have

traditionally prioritized care for those underserved patients with severe and persistent mental illness. Primary care physicians and mental health professionals are both in shortage in many areas and are not trained in integrated systems, widening the disconnect. In addition, primary care physicians find providing care for patients who also see mental health professionals in the fragmented current system very frustrating. Medical records are often impossible to share. Referrals are often made with no feedback in return. Referred patients do not keep appointments. Even when information is shared a common terminology is lacking. Recommendations for further care are often vague.

Unifying the primary care and mental health delivery systems will require careful attention to relationships and communication. Protocols must be developed to address the wide range of behavioral health problems that occur within a community. To transform a practice, providers must address complex issues (record-sharing, confidentiality and overcoming stigma) that work against system integration. Training providers in traditional clinical fields to build and work within interprofessional teams that incorporate behavioral health providers requires enhanced training in basic behavioral health skills and training in leadership and team-building to break down the silos that have long separated the disciplines.

The core of primary care medicine and dentistry has always been the relationship with the patient and family. In the integrated practice, when the care team includes a behavioral health provider, that relationship is enhanced. When behavioral health service providers are co-located with primary care physicians, they have positive working relationships and frequent communication exchange, including routine discussion of patient care issues prior to and after same-day hand-offs or prior to a scheduled initial visit. Co-location allows for mutual appreciation of the incentives, methods, and constraints across disciplines. Medical errors and drug interactions are reduced through entry into a single medical record. Patient satisfaction and engagement is enhanced. Co-location should also include collaborative training activities, through which behavioral health service providers provide periodic training and education for medical and dental staff on behavioral health topics (at a provider meeting, through a monthly newsletter or a lunch time training on a topic of interest to primary care providers) and vice versa.

Practices that integrate behavioral health services will care for patients differently and that their care will have a different impact on the community. Systems that have made this transition have documented improved health outcomes, improved patient self-management, reduced use of services, and improved patient and provider satisfaction. Improved system performance regarding recommended screening for depression, alcohol abuse, posttraumatic stress disorder, anxiety, drug abuse, domestic violence, and tobacco are commonplace when behavioral medicine is incorporated into primary care. In addition, training of primary care physicians, other professionals, and staff in patient activation and health behavior change methodologies by the behavioral health professionals leads to an increased likelihood of evidence-based interventions leading to improved chronic illness outcomes. Behavioral health providers are a resource in the care of patients with chronic disease. Behavioral health service providers will be available to support lifestyle changes and management of medical problems as a part of

the care team. In particular, behavioral health intervention has been shown to be helpful for management of chronic illnesses, unhealthy lifestyle behaviors, and somatic complaints that have a lifestyle or stress component. In the words of people who have made this transition: “Together, we teach others how to be a team in care of consumers and in designing a care system” (Doherty, McDaniel, & Baird, 1996).

Engagement with the community-based behavioral health resources that exist outside of the primary care setting is a key part of the PCMH environment and contributes to emotional health. Patient self-management is enhanced through contact with self-help groups, community resources (gyms, churches, housing, food support) and mental health and substance abuse specialty services. Medical homes, particularly those with behavioral support, can facilitate this contact. Care of patients with serious mental illness can be enhanced through regular problem-solving meetings between the medical home and high use agencies like the local community mental health center. Active involvement of patients and families in practice design and transformation efforts should be encouraged through the use of tools such as patient advocacy groups, as those with lived experiences usually understand the community best, especially the barriers to care that exist within the practice context.

All of these activities should help to facilitate a paradigm shift in the kind of care management offered in the context of a transformed practice. In this new environment, the integrated practice should work with the patient and the extended care team to develop patient-centered treatment plans that include both medical and behavioral health goals, using behavioral health skills (patient activation) to develop an approach that respects both the medical viewpoint and the patient and family experiences of illness. Currently, trainees see transformed practices with integrated services as an exception to the rule, dependent on grants and demonstration projects. When our trainees feel that such practices are the norm, an effective system capable of providing holistic primary care to the entire population will be achieved.

## **Recommendations**

Title VII, Part C grantees should:

- Conduct training in clinical environments that are transforming or have transformed to include integrated care with other health professionals (e.g. behavioral health, substance use, nutrition, care coordination, social work, nursing, oral health) such as Educational Health Centers (including the HRSA-funded Teaching Health Center Graduate Medical Education sites).
- Develop and implement curricula to give trainees the skills necessary to build and work in interprofessional teams that include diverse professions outside of medicine and dentistry.
- Develop and implement curricula to develop leaders in practice transformation. Leadership development within recipient institutions should be encouraged, leading to the creation of transformed practices in which training can occur.
- Develop faculty to teach practice transformation, and to encourage development and implementation of interprofessional faculty teams.

- Encourage the use of members of the National Health Service Corps as faculty for the trainees and provide Corps members with on-going faculty development.

HRSA should:

- Capitalize on HRSA's recent reorganization to leverage various funding streams (e.g. Title VII, Title VIII, NHSC) to reduce barriers and foster programmatic collaboration. This should include funding for collaborative interprofessional programs, which may require statutory change. The Bureau of Health Workforce was created in May 2014, integrating HRSA workforce programs previously housed in two separate bureaus: Health Professions and Clinician Recruitment and Service.
- Expand interagency efforts to promote integration of behavioral health with primary care, such as the Center for Integrated Health Solutions.
- Collaborate with agencies outside of HHS to fund interprofessional training to leverage the impact of Title VII, Part C, sections 747 and 748 grant programs on health outcomes. Potential partners may include the Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), Administration for Children and Families (ACF) and Substance Abuse and Mental Health Services Administration (SAMHSA) within HHS and the Department of Defense (DoD), Department of Veteran Affairs (VA), and the Department of Education outside of HHS.

## **Section 2: Community Health Centers and Beyond: Collaborative Training in Community Settings for Physician Assistant Students**

**Goals:** Health team members supported under Title VII, Part C, section 747 should be trained to practice in patient-centered, team-based community settings through clinical education in community ambulatory patient care sites. This preparation will require development of innovative clinical curricula that focus on team building and collaborative care that is patient-, community-, and population-centered. The ultimate aim is to provide community clinical education in sites where physician assistant program graduates will form a ready workforce to meet the needs of the communities where they train.

Underserved populations need more primary care providers who benefit from interprofessional care. Trainees exposed to underserved populations while in training are more likely to practice in similar sites after training (Morris & Chen, 2009). The ACA of 2010, section 5508, included a provision for the development of the Teaching Health Center Graduate Medical Education (THCGME) Program with the goal of increasing the number of primary care physician and dental residents training in community-based clinics. Now in its fourth year of funding, the THCGME model may provide a general framework that can be applied to the training of physician assistants and medical and dental students in community ambulatory patient care sites.

**Justification:** The needs of educational programs and direct care programs supported by HRSA share complementary missions that would be enhanced through greater collaboration and cooperation. Primary care physicians, physician assistants, and dental and dental hygienists professional programs would be strengthened through expansion of clinical training opportunities in HRSA-supported health centers. These sites would benefit from potential faculty participation in care of at-risk populations, trainee exposure to community-based care, and increased interest amongst program completers and graduates in joining the community healthcare workforce. The likelihood of this later outcome could be enhanced through educational program and clinical program linkages with National Health Service Corps Loan Repayment Programs. The result of greater collaborative efforts between programs funded under the HRSA umbrella would result in a synergistic increase in healthcare access to communities.

The ACA of 2010 included a provision for the development of the THCGME Program with the goal of increasing the number of primary care physician residents training in community-based clinics (Health and Human Services, 2010). This provision of the ACA addresses the importance of capitalizing on the interconnected mission of HRSA to support primary care education and primary care services. The THCGME program seeks to increase primary care physicians receiving training in CHCs through a funding mechanism modeled after the Graduate Medical Education (GME) system that subsidizes nearly all graduate physician training in the United States. It is built upon evidence that residency program characteristics impact physician specialization and practice choices following completion of training. During the 2014-2015 academic year, 60 THCGME programs in 24 states will provide primary care graduate medical training to more than

550 medical and dental residents in FQHCs, FQHC Look-Alikes and community mental health centers, rural health clinics, Indian Health Service or Tribal clinics, and Title X clinics that provide primary care services to underserved communities across the United States. The majority of the THCGME programs are family medicine programs, but this number includes several general dentistry and general internal medicine programs (Chen, Chen, & Mullan, 2012).

Although experience with THCGME is still in the early implementation stage and outcomes are just now being evaluated, this program recognizes that a reduction in funding barriers decreases educational obstacles to the creation of high quality community-based training sites. Training physician residents under THCGME will improve the primary care workforce pool that has the knowledge, skills, and attitudes needed to staff public and privately funded community primary care clinics. It is imperative that ongoing, reliable, and stable funding be continued through reauthorization of THCGME.

The THCGME model can be adapted to other Title VII, Part C, section 747 grant programs thereby producing an interprofessional workforce to address the needs of the underserved. This adaptation of the THCGME model should include Teaching Health Center Physician Assistant Training (THCPAT) programs that would support community health center education sites for physician assistant students. Other Title VII, Part C enhancements directed towards creating new training models such as enhanced partnerships between medical and dental education programs and section 330 and other Public Health Service Act programs should be funded. This type of innovative programming will help to ensure that a multifaceted healthcare workforce is trained to address the diverse needs of the community. This support can be encouraged through specific grant guidance language that suggests sharing of grant resources between grantees and clinical training sites. These funds could be used to support clinical education coordinators and administration costs to assure that the burden of student training is mitigated in section 330 clinical training sites.

### **The Veteran Learner Connection**

Several years ago, the White House announced two initiatives for veterans. The first is titled, *We Can't Wait: New Initiatives to Help Create Jobs for Veterans* and the second is *Helping Veterans Get into Physician Assistant School* (White House, 2011). The former encourages CHCs to hire 8,000 medical and nursing veterans by 2015 and can be linked with an initiative to facilitate and expedite interested veterans progress towards careers as physician assistants:

*To fast-track medics into jobs in community health centers and other parts of the healthcare system, today HRSA pledged to open up career paths beyond nursing and expand opportunities for veterans to become physician assistants (White House, 2011).*

In response, the National Association of Community Health Centers released an announcement (“National Association of Community Health Centers,” n.d.) of a joint initiative titled, *Making The Connection between Veterans and Community Health*

*Centers.* HRSA's experience with THCGME and the Administration's veteran/CHC initiatives present a unique complementary opportunity to support returning veterans to apply and be accepted to physician assistant education programs. Many veterans possess broad medical skills in primary and emergency care, but lack the educational qualification (bachelor's degree) for entry into physician assistant programs. This pathway through employment in CHCs upon discharge would allow these veterans to seek the necessary educational qualifications while learning civilian medical skills in underserved settings. Interested veterans who achieve the necessary educational qualifications and on-the-job experience will make excellent candidates not only for physician assistant programs, but also future employment in CHCs. These efforts to bolster America's primary care workforce will benefit from coordination and interprofessional cooperation amongst all the members of the Title VII, Part C primary care cluster.

### **Community Health Centers' (CHC) Tradition of Team-Based Care**

CHCs and other grantees under section 330 have developed and maintained PCMH practices for decades. These programs have provided community-oriented primary care services that are responsive to the communities they serve with a broad-based team approach including the disciplines of medicine, dentistry, nursing, behavioral health, and allied healthcare coordinators. Clinical and economic outcomes assessment in the setting of limited resources and the need for careful financial stewardship are the hallmark of these HRSA-supported clinical sites. The move towards PCMH models by the rest of the primary care system, due to dramatically shifting incentives, places section 330 and other Public Health Service Act clinical programs in a position of leadership in healthcare transformation. A fundamental aspect of this change is greater emphasis on patient-centered clinical outcomes, cost, and value. A recent systematic review about the PCMH (Jackson et. al., 2013) points to the insufficient evidence about the effects of PCMH models and the need to develop systems of outcomes assessment. The educational experiences of primary care cluster students and residents should include patient outcomes and patient and staff experiences assessment to develop the skills for participation on future teams that evaluate impact.

HRSA's investment to create the primary care workforce and improve access should be accompanied by grantee-shared learner employment outcomes assessment. This effort should include tracking learners, including veterans, who are educated in section 330 and other Public Health Service Act clinical programs regarding participation in Public Health Service Scholarship and Loan Repayment sites following graduation as well as private sector practice in primary care and other medically underserved communities. Analysis of workforce outcomes will help to characterize the impact of support for educational experiences in different training sites and define the downstream effect of section 330 and other Public Health Service Act clinical program participation in collaborative grants with Title VII, Part C-funded educational institutions.

## Recommendations

- It is imperative that Congress reauthorize and increase funding for Teaching Health Center Graduate Medical Education to assure that ongoing, reliable, and stable funding is continued.

Title VII, Part C, sections 747 and 748 training grants should:

- Support educational experiences in community ambulatory patient care sites through funding of health center administration and coordination staff who would help mitigate the costs of training primary care physicians, physician assistants, and dental professional learners.
- Include guidance language that specifically addresses the creation and expansion of short term and longitudinal interprofessional training experiences in community ambulatory patient care sites for physician assistant students, and medical and dental students.
- Allow the use of grant funds to support infrastructure for interprofessional teams of learners in the same site, including faculty development, staff coordination, distance learning, and transportation and housing to cover the costs of clinical training in community ambulatory patient care sites.
- Fund a Teaching Health Centers Physician Assistant Training program with incentives to include veterans as employees and potential physician assistant students.
- Identify effective physician, physician assistant, and dental trainee experiences that increase the number of applicants for National Health Service Corps Loan Repayment programs and provide a pathway to meet future community healthcare workforce needs.
- Require that Title VII, Part C, sections 747 and 748 grantees track practice outcomes of funded trainees regarding prospective employment in health centers participating in collaborative training experiences.

### **Section 3: Linking Oral Health Care Delivery with Primary Care Medicine**

**Goals:** In March 2010, the ACTPCMD made a critical decision to further collaborate efforts linking medicine and dentistry; in this spirit, it is our recommendation that oral health should be considered part of the cornerstone to HRSA’s healthcare initiatives and strategies. A fundamental principle imperative to the overarching vision within this report is that oral healthcare as a concept is much broader although inclusive of the provision of services within the professional discipline of dentistry. For this reason, oral healthcare and all necessary sub-components should be considered an essential and primary component of the total healthcare delivery system including but not limited to, all programs within community-based settings as listed in Section 2 of this report and entities receiving funds under Title X of the Public Health Service Act.

Title VII, Part C should assist in the healthcare delivery transformation process to promote integrated and collaborative team-based training across the core cluster of professions (family medicine, physician assistant, general pediatrics, general internal medicine, dentists, dental hygienists, and new developing dental and primary care workforce models) with coordination of didactic and clinical curriculums through the use of innovative methodologies. However, before this can be done effectively, a common method of communication and coordination of services must be obtained. These methodologies should include expanded collaboration with Federally Qualified Community Health Centers authorized under section 330 of the Public Health Service Act (42 USCS § 254b) (“HRSA,” n.d.-b).

By virtue of HRSA’s overarching healthcare imperative, all healthcare delivery systems under HRSA’s purview should initiate and sustain a dental treatment sub-component as an essential primary care service within the oral healthcare component from conception. This however, isn’t the case whereas there remains a lag time for up to three years or more from the FQHC start-up phase before most FQHCs are required to have supplemental health services which include dental treatment services beyond simple preventive care as described in section 330 Public Health Service Act definition of required primary care (Government Printing Office, 2014). Rural Health Centers in contrast, have no statutory requirement to provide oral health services under the Public Health Service Act and most do not include oral healthcare among their primary care services.

**Justification:** The lack of an oral health payment system under Medicare and limited provider participation and/or state authorized dental Medicaid utilization has also resulted in extremely limited federal influence on the provision of oral healthcare delivery within safety net and community-based health systems. According to Glassman (2011), only 5.7 percent of the U.S. total dental expenditures in 2008 were paid by Medicare or Medicaid. As CMS Meaningful Use enhanced payment plans allow the option of either a Medicare or Medicaid based incentive system for EHR development, many systems with primary medical as the dominant health delivery component chose the more medically defined Medicare component. This further isolated any existing oral health dental component and gave little incentive to enhance a more integrated EHR system inclusive of oral

health (“HRSA,” n.d.-c). The delay or lack of oral health delivery from start-up creates complications for FQHCs and community-health systems with an existing medical patient population and medical EHR systems in operation at the time oral health services are added. Attempting to later add a dental EHR system is problematic. Most commercially available EHR systems fail to integrate with dental, or are so costly, that existing primary care focused community-based clinics find the effort cost prohibitive. The late addition of dental services, after the establishment of a FQHC practice, results in pent-up demand. This potentially overwhelms the dental start-up practice and challenges the seamless inclusion of all patients in essential health services that should be available within the facility.

With a new emphasis on oral health inclusion from conception in all community-based primary care health systems, primary care physician, physician assistant and dental professional programs would be strengthened through the development of mutually inclusive newer methodologies centering on advance application of EHR, coding, and training opportunities in HRSA-supported health centers. These sites would benefit from increased use of a common language, shared database capacity, and better coordination of services in care for at-risk populations. Trainee exposure to community-based care with these capabilities will benefit from increased interest amongst program completers and graduates in joining the community healthcare workforce. The likelihood of this later outcome could be enhanced through educational program and clinical program linkages with National Health Service Corps Scholarship and Loan Repayment Programs. The result of greater collaborative efforts between programs funded under the HRSA umbrella would result in a synergistic increase in healthcare access to communities.

## **Recommendations**

Title VII, Part C, sections 747 and 748 funded programs should:

- Encourage the advancement of a common communication system and language through the EHR, and common diagnostic coding that allows more direct information sharing between primary care and oral healthcare providers. The most reliable system would be a shared EHR.
- Support coordination of training opportunities to enhance interprofessional experiences for oral health and primary care that include longitudinal patient-centered care and integrated payment systems with a focus on clinical outcomes and skill development to track, evaluate, and improve the health of communities.
- Identify trainee experiences that increase applicants for the National Health Service Corps Scholarship and Loan Repayment Programs and provide a pipeline to meet future community healthcare workforce needs.
- Require that Title VII, Part C, sections 747 and 748 grantees track practice outcomes of funded trainees regarding prospective employment in health centers participating in collaborative training experiences.

#### **Section 4: Invest in the Future of Primary Care Medicine and Dentistry**

**Goal:** The Federal government should provide adequate resources to academic health centers and other entities that are creating an environment to train future healthcare leaders.

**Justification:** The Primary Care Training and Enhancement program (PCTE) (Title VII, section 747 of the Public Health Service Act) has a long history of providing indispensable funding for the training of primary care physicians. Care delivery is now being transformed as individual relationships with care providers are being enhanced. This is done through the use of non-traditional team members, training in non-traditional settings, and adding oral health to the care environment, leading to a more stable workforce. The PCTE is the mechanism through which these changes are introduced, faculty is engaged in new models of training and practice, and learners are recruited into sites where integrated care is being delivered. The Institute of Medicine calls the Title VII program an “undervalued asset.” This is one of the few programs aimed directly at training the primary care workforce.

The healthcare system is rapidly changing. With each successive reauthorization, Congress has modified the Title VII, Part C, sections 747 and 748 health professions programs to address relevant workforce needs. The most recent authorization directs HRSA to prioritize training in the new competencies relevant to providing care in the PCMH model. It also calls for the development of infrastructure within primary care departments for the improvement of clinical care and research critical to primary care delivery, as well as innovations in team management of chronic disease, integrated models of care, and transitioning between healthcare settings. The program has, as a priority, emphasized training in underserved areas. As a consequence, several studies of the impact of the Title VII program have found that physicians who work with the underserved in Community Health Centers and National Health Service Corps sites are more likely to have trained in Title VII-funded programs.

Despite this, the Federal government has provided little funding to support changes in the systems of education and postgraduate training for those working in those systems. Over the past 20 years, funding to support Title VII, section 747 has gone from a high of just under \$100 million in FY 2002 to under \$40 million in 2013, despite the increasing cost of developing and maintaining health professional training programs. The consequence of the switch to a 5-year cycle has meant that several years have gone by with the funding encumbered by previously funded projects, stifling innovation at a time when it is most needed. Despite the teaching health center funding, the vast majority of funding for GME of physicians continues to flow primarily to hospitals through CMS, creating incentives to keep resident physicians on the hospital wards rather than in community-based setting like those described previously. Changing this paradigm requires an investment in infrastructure, which is not possible without renewed commitment to funding change in medical and dental education.

## **Recommendations**

Congress should:

- Appropriate \$123 million to Title VII, Part C, sections 747 and 748 for FY 2016, restoring funding to inflation-adjusted FY2003 levels.
- Permit annual competitive grant cycles for primary care training grants by appropriating an additional \$25 million per year over the next five years beginning in FY 2017 to Title VII, Part C, sections 747 and 748.
- Reauthorize, appropriate, and double the existing mandatory funding for the expansion and continued evaluation of the Teaching Health Center Graduate Medical Education Program for at least 5 years.
- Appropriate funds to support the expansion of the work of the National Center for Health Workforce Analysis to include a robust evaluation of the impact of training programs on career choice and career trajectory of health professionals.

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