

Advisory Committee on Training in Primary Care Medicine and Dentistry

Minutes of Meeting – September 29-30, 2005

(Approved on December 22, 2005)

Advisory Committee Members Present

Eugene C. Rich, MD, Chair
David P. Asprey, PhD, PA-C, Vice Chair
Man Wai Ng, DDS, MPH, Vice Chair
Diego Chaves-Gnecco, MD, MPH, Member
Tina L. Cheng, MD, MPH, Member
William A. Curry, MD, FACP, Member
Sanford J. Fenton, DDS, MDS, Member
Katherine A. Flores, MD, Member
Karen A. Gunter, Member
Bonnie Head, MD, Member
Joseph A. Leming, MD, FAAFP, Member
Perri Morgan, PA-C, MS, Member
Lauren L. Patton, DDS, Member
Joseph L. Price, PhD, Member
Raymond Tseng, Member
Surendra K. Varma, MD, Member

Others Present

M. June Horner, Deputy Associate Administrator, Bureau of Health Professions
Tanya Pagán Raggio, MD, MPH, FAAP, Director of Division of Medicine and Dentistry and Executive Secretary of the Advisory Committee
Jerilyn K. Glass, MD, PhD, Deputy Executive Secretary of the Advisory Committee
O'Neal Walker, PhD, Chief, Dental, Psychology, and Special Projects Branch, Division of Medicine and Dentistry

Thursday, September 29, 2005

The Advisory Committee on Training in Primary Care Medicine and Dentistry (Advisory Committee) convened at 8:36 a.m. in the Washington Room of the Holiday Inn Select, 8120 Wisconsin Avenue, Bethesda, Maryland 20814. Eugene C. Rich, MD, Chair, opened the meeting by inviting new members and current members to introduce themselves. He introduced M. June Horner, Deputy Associate Administrator for the Bureau of Health Professions, who gave opening remarks.

Ms. Horner brought greetings from Elizabeth M. Duke, Administrator, Health Resources and Services Administration, and Kerry Paige Nessler, RN, MS, Associate Administrator for the Bureau of Health Professions. In written remarks delivered by Ms. Horner, Dr. Duke welcomed new members and thanked retiring members, three of whom were present at the meeting. She acknowledged the timeliness of the Advisory Committee's next report on health care for vulnerable populations. Recent hurricanes have dramatically revealed what it means to be vulnerable and poor in America. She reviewed the role HRSA played in the Federal response to the hurricanes, including contacting and monitoring the conditions of grantees, deploying staff to the Gulf area, and speeding the delivery of health center new access point grants to places impacted by the hurricanes. Ms. Horner remarked on the successful all-grantee meeting on the Bureau's performance measurement system in June. The plan is to pilot test the system and have data analyzed by the next all-grantee meeting in 2007.

Tanya Pagán Raggio, MD, MPH, FAAP, Executive Secretary of the Advisory Committee and Director of the Division of Medicine and Dentistry (DMD) commended the Advisory Committee for its fifth report on

outcome measures which coordinated well with the Bureau's performance measures. She reviewed the Division's efforts to assist grantees that were directly affected by the hurricanes and invited O'Neal A. Walker, PhD, Chief of the Dentistry, Psychology, and Special Projects Branch, to share his experience providing mental health services in Gulf Port, Mississippi. Referring to the Advisory Committee's next report on vulnerable populations, Dr. Raggio underscored the Bureau's mission to improve the health status of the population by providing National leadership and resources to develop, distribute, and retain a diverse culturally competent health work force that provides the highest quality of care for all, especially the underserved. She concluded with a review of the number of Title VII, section 747 grants by grant program that were funded during the year.

Outgoing members of the Advisory Committee were formally recognized. Ms. Horner presented plaques to Michael W. Donohoo, DDS, Matilde M. Irigoyen, MD, and Rubens J. Pamies, MD.

Dr. Rich introduced the first of three speakers on the topic of the sixth report on vulnerable populations, Paul H. Wise, MD, MPH, Professor of Pediatrics and Director of the Center for Policy Outcomes and Prevention at Stanford University in California. He said that training will always have to be anticipatory, relying on patterns of epidemiology. The first question is: how has the revolution in child health care altered the epidemiology of childhood, and particularly, disparities in child health? The second is: what implementations are there for child health services, health policy, and ultimately for training?

Dr. Wise reviewed national health survey data gathered over forty years. The data showed that the percentage of children who experience acute illness has not really changed; the most common illnesses remain upper-respiratory infections and otitis media. What has changed is the dramatic reduction in children staying home from school, perhaps reflecting, changes in maternal employment patterns as well as the perception in America that mild fever is not associated with a life-threatening illness. Looking at hospital stays as a proxy for serious illness in children, Dr. Wise reported a dramatic reduction in hospital discharges, related in part to increased outpatient care, impact of managed care, and possible reduction in illness severity in children. Remarkably, 75% (as opposed to 50% in the 1960s) of all hospitalizations of children in the United States are associated with some form of chronic illness. The figure is even higher at major children's hospitals. Data show that mortality from non-trauma causes is overwhelmingly due to serious chronic disorders, in part because the incidence of life-threatening diseases like epiglottitis from *Haemophilus influenzae* has been dramatically reduced with the use of effective immunizations.

A particular success, with enormous policy implications, has been the implementation of Prevnar, especially in the highest risk groups, including minority groups, resulting in a collapse in the long-standing disparities in risk of serious invasive pneumococcal morbidity and mortality in young African American children. Data indicate that about 60 percent of all excess deaths (from all causes) occurring in African American children from birth through adolescence into adulthood will take place in the first year of life. Infant mortality disparities, particularly extreme prematurity, account for more than half of all excess deaths as compared to whites. Noting a dramatic difference in the case of chronic disease, Dr. Wise pointed out significant disparities in the survival of white and African American children with acute lymphocytic leukemia, Down's syndrome, asthma, and cystic fibrosis. He characterized two epidemiologies: 1) general epidemiology with approximately 85 percent of all children being well and likely to stay well, and 2) disparity epidemiology with the remaining 15 percent having serious chronic illness accounting for most hospitalizations and non-traumatic mortality. Approximately 15 percent of all children account for about 80 percent of all childhood health expenditures in the United States today.

Dr. Wise found an apparent de-regionalization of neonatal intensive care based on the ability to pay troubling. Time and again studies have shown that premature babies born in tertiary care centers have much better outcomes than those not born in those centers. Data from California show that the likelihood of a very low-birth weight baby being born in a tertiary center has fallen from almost 60 percent to below 40 percent. He said there may be a need to have other health professionals take care of well children so that pediatricians can focus on the growing portion of children with serious chronic disorders who are particularly dependent on regionalized services.

Dr. Rich introduced the second speaker, Rubens J. Pamies, MD, Vice Chancellor for Academic Affairs and Dean for Graduate Studies at the University of Nebraska Medical Center in Omaha. He is co-author of *Multicultural Medicine and Health Disparities* (2006). Dr. Pamies defined “health disparity” as the incidence and prevalence of mortality, burden of disease, and other adverse health conditions that exist among specific population groups. A conclusion of the Institute of Medicine report on disparities was that racial and ethnic minorities tend to receive a lower quality of health care than non-minorities even when you control for access and other factors; moreover, the source of these disparities is complex, rooted in historic and contemporary inequities involving participants at many levels. The report viewed the physician/patient interaction as a contributing factor and recommended that training programs incorporate certain programs that will help health care providers understand how patients perceive health and illness, know about health disparities, understand the role of culture in health care, and be effective communicators. He stated that only 9 percent of U.S. medical schools offer a separate required course that addresses cultural competency or health disparities.

Dr. Pamies highlighted changing demographics largely due to an influx of people coming from countries that are primarily Asian and Hispanic. By the year 2050, almost half of the population will be comprised of groups that today are called minority groups. By that year, 80 million people in the United States will be from immigrant groups who came after 1994, making up a quarter of the population. One of every five children (under the age of 18) will be a child of immigrants, and 75 percent will be from regions where English is not spoken. Historically, the country has responded to physician shortage by increasing the number of physicians coming from other countries. Because the largest growing population group is Hispanic and because most of the providers are coming from non-Spanish-speaking countries, the problems will not be addressed quickly.

Presenting data on disparities, Dr. Pamies pointed out age-adjusted mortality rates indicate major differences in outcomes between African Americans and other groups for many diseases such as cancer, cardiovascular disease, and diabetes. He showed data that the Hispanic population manifests differences in health outcomes among Puerto Ricans, Mexican Americans, and Cuban Americans and that some Hispanic groups have poorer and some better health outcomes than whites. He pointed out that type II diabetes is a major problem in Asian Pacific Islanders and African Americans, with a significant increase in adolescents. He indicated that over 80 percent of new diagnoses of HIV/AIDS are in women—mostly black and Hispanic women. Dr. Pamies said that the disparity problem is even worse in dentistry. Lack of insurance is two-and-a-half times greater in the dental population than in the medical population. Of the 56 schools of dentistry in this country, only 5.4 percent of dental students are African American, and 5.9 percent are from Hispanic and Latino populations. Dr. Pamies urged training programs teach providers to watch for verbal and nonverbal cues in communication, listen to patients, assure a patient family-trusted caregiver, acknowledge similarities and differences between cultures, empower patients in their own treatment, and be sensitive and respectful.

Dr. Rich reviewed previous discussions about the sixth report. Three themes for the report were 1) conceptual framework for understanding high risk and vulnerability, 2) how training can prepare primary care practitioners to care for vulnerable patients, and 3) current Title VII section 747 programs addressing this topic. Besides papers from the three speakers, three other papers have been commissioned from Dr. Burton Edelstein, a pediatric dentist from Columbia University, New York; Dr. Nicole Lurie, a general internist and health services researcher at the RAND Corporation, Washington, D.C.; and Dr. John Frey, a former member of the Advisory Committee and Chair of the Department of Family Medicine at the University of Wisconsin in Madison. The papers are due the end of October. Members who have served on previous writing groups shared experiences and answered questions.

The Advisory Committee held annual elections for officers. Joseph A. Leming, MD, FAAFP, was elected Chair; Perri Morgan, PA-C, MS, Vice Chair; and Sanford J. Fenton, DDS, MDS, Vice Chair.

The Advisory Committee, in closed session, received ethics training from Theresa Foster of HRSA. When the Advisory Committee resumed in open session, Man Wai Ng, DDS, MPH, Chair of the Fifth Report Writing Group, gained approval from the full membership on several final changes to the draft.

Dr. Raggio presented data on Title VII, section 747 grantee efforts to prepare providers to care for vulnerable populations, derived from the Comprehensive Performance Management System (CPMS), Part III of the Uniform Progress Report for Grants and Cooperative Agreements. The Division can provide additional data on under-represented minorities and disadvantaged if desired and information on what other programs in Title VII are doing on this topic. There were questions from new members about the breadth of the topic, to which Dr. Rich responded that the topic was set broadly in order to capture as many diverse perspectives on vulnerability as possible, thus leading to a conceptual framework. Dr. Fenton suggested the use of several other data sets for the paper such as one developed by the Special Olympics on disparities in the population for individuals with intellectual disabilities and another from a collaboration of the American Academy of Developmental Medicine and Dentistry and the Special Olympics assessing curricular needs in this area. He made the point that special needs children lack access to medical and dental care when they become adults, often prompting pediatric dentists to treat them throughout their lifetimes. He hoped that eventually there would be incentives for dental practices with 50% or more of the patient base having special needs.

David P. Asprey, PhD, PA-C, suggested that the commissioned papers go in the report appendix. Dr. Raggio suggested that the presenters at this meeting be viewed as resources. Dr. Rich saw the report as having a section on where we are and where we have been as well as other sections that represent the synthetic work of the Advisory Committee leading to the recommendations.

The Advisory Committee convened in three workgroups. The first looked at the general concept of vulnerability. The second discussed ways in which Title VII, section 747 training can prepare providers to have an impact. The third addressed where the Program is and where it might go on this topic.

In plenary session, the Advisory Committee heard public comment. Hope Wittenberg, Director of Government Relations for the Academic Family Medicine Advocacy Alliance, commented on Family Medicine's consensus proposal regarding Title VII re-authorization. Historically, Title VII in the 1970s funded the development of the discipline of family medicine. The proposal urged the development of new programs that are accessible for outcomes measurement, creation of options because departments and programs have different needs, and designation of the bulk of funding to go to departments of family medicine because of their infrastructure needs. It proposed five new grant areas to replace existing areas: quality, access to care, practice improvement, innovator awards, and bridging NIH basic science research and physician education/clinical practice.

Myla Moss, Director of Congressional Relations and Regulatory Affairs with the American Dental Education Association, said that Title VII, section 747 funding was indispensable in training general and pediatric dentists to treat underserved populations. Her organization recommended that accredited dental schools be eligible for Title VII grants for academic administrative units, faculty development, and pre-doctoral training and that a health professions tracking database be created.

Comment was given by Laverdia Roach, Special Assistant to the Executive Director of the President's Committee for People with Intellectual Disabilities. She stated that in this country there are about 7.5 million people who have intellectual disabilities, a significant number of whom find dental care inaccessible. Her committee recommended that the intellectually disabled be identified as medically underserved and that dental students have direct contact with patients with intellectual disabilities.

David Moore, Senior Associate Vice President for Governmental Relations at the Association of American Medical Colleges (AAMC) described the recommendations on Title VII re-authorization developed by one of its committees. The centerpiece of the report was a proposed restructuring of section 747 in which grants are preferentially awarded to applicants who enter into a formal relationship (and submit a joint application) with a Federally Qualified Health Center, a FQHC lookalike, an Area Health Education Center (AHEC), a clinic located in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA), or a clinical practice setting in which at least 40 percent of the patients are either uninsured or Medicaid beneficiaries. Another component is grants for demonstration projects on improving the quality of primary care in selected areas, as determined by a national committee of stakeholders. The report

avored a National workforce tracking database to demonstrate links between Title VII and the National Health Service Corps and community health centers.

Kristin Butterfield from the Department of Federal Affairs of the American Academy of Pediatrics (AAP) stated that Title VII funding is the only support available for pediatric education beyond the hospital-based model. Because the AAP believes that the largest impact of Title VII is made at the training level, it recommends that support for quality primary care training should be a clear objective in any re-authorization of Title VII. Other objectives should be to increase interdisciplinary sharing and collaboration among programs, increase the supply of primary care professionals who are under-represented minorities, and support research and innovations in primary care training and health care delivery with demonstrated impact on quality health care.

The meeting adjourned at 4:48 p.m.

Friday, September 30, 2005

The Advisory Committee convened in plenary session at 8:02 a.m. After some discussion of previous day's public comment, the Advisory Committee broke into its three workgroups to continue their work.

At 8:53 a.m. the Advisory Committee returned to plenary session to hear reports from each workgroup, the first given by Raymond J. Tseng whose group worked on the concept of vulnerability. The Public Health Service Act defined disadvantaged as "those from disadvantaged backgrounds including racial and ethnic minorities." The legislation says that Title VII, section 747 programs that focus on the underserved and high-risk groups such as the elderly, individuals with HIV/AIDS, substance abusers, homeless, and victims of domestic violence would be given special consideration. The workgroup discussed emerging populations such as adult Down Syndrome patients and felt that the report should create a comprehensive model that includes emerging populations in the future. The workgroup defined "vulnerable populations" as "*populations of people who have an increased risk of poor health outcomes and/or are less likely to get appropriate medical and dental healthcare.*" It felt that clinicians should have both transferable skills and group-specific or region-specific skills.

Dr. Asprey had envisioned the group working on a conceptual framework that identifies environmental and other factors that affect the development of vulnerable populations within the health care system. He questioned whether the unit of interest is really populations; the focus might be better placed on vulnerable individuals who may not belong to a particular demographic group. Dr. Fenton offered a change in language at the end of the definition to read "*appropriate and necessary preventive and comprehensive medical and dental health care.*" Dr. Rich questioned whether vulnerable individuals include both those who have circumstances over which they have no control and those who have induced their own vulnerability (e.g., smokers). Perri Morgan, PA-C, MS, felt that if personal choice is made part of the definition, it would be almost impossible to determine where to draw the line. Surendra K. Varma, MD, thought that lack of access was key. William A. Curry, MD, FACP, replied that one can think of examples where patients are at high risk and treatment efficacy is low; their condition and not the lack of access drives their vulnerability. Diego Chaves-Gnecco, MD, MPH, saw risk as something that you can modify to improve the condition. He referred to Dr. Pamies' presentation where even when risk factors are modified, vulnerability remains. Dr. Rich saw a distinction between limited English proficiency and smoking. Dr. Leming said that instead of using the word *increased* perhaps the word should be *excessive or disparate*. Dr. Fenton maintained the importance of inability to access health care services. Dr. Curry said that people like HIV/AIDS patients may have excellent access to health care, but they remain vulnerable. Dr. Cheng felt that *increased risk* was unacceptably broad because it means "above average" and thus suggests that at least half the population are vulnerable on some risk.

The third speaker was Leiyu Shi, Dr.P.H., M.P.A., Co-Director of the Johns Hopkins Primary Care Policy Center and co-author of *Vulnerable Populations in the United States* (2005). One of his purposes was to share his understanding of a conceptual framework to address the needs of vulnerable populations in

America. He said that despite extensive efforts to reduce health disparities, there is no consensus as to who vulnerable populations are. Vulnerability denotes a susceptibility to poor health. But most health research policy focuses on distinct population sub-groups like racial/ethnic minorities, low socio-economic status (SES), the elderly, and so forth. In his book, Dr. Shi focuses on three major risk factors currently affecting the U.S. population and most commonly cited for poor health care access, quality, and health status: racial/ethnic minority status, SES, and lack of insurance. The basis of his conceptual framework is that vulnerability risks overlap.

Models to study vulnerable populations have either focused on individuals, on communities, or on the interaction between the two. Dr. Shi presented a model that examines the level of vulnerability of populations in general, rather than sub-populations. Vulnerability at the center of the model is influenced by individual and non-individual (ecological) factors which over time will have consequences for both individual and population health outcomes. Vulnerability is defined as a convergence of risks over which individuals have little or no control. The convergence can come from three sources: pre-disposing factors, enabling factors, and specific illness or health needs. In terms of actual research and policy, the process of measuring vulnerability should move toward a pattern of addressing convergence of risks rather than one risk at a time.

Another purpose of Dr. Shi's presentation was to address strategies that enable resolution of disparities and discuss policy program implications. He presented a conceptual model with health and well being (physical, mental, and social) of the population in the center. It has been estimated that medical influences account for 20% of health while social determinants account for 80%. The latter include demographics, SES, behavior patterns, and inequality factors. Dr. Shi addressed strategies to serve vulnerable populations. The process of changing the Nation's public health faces the conflict of long versus short term gains. Effective interventions may take as much as a generation before positive sustainable outcomes are seen. The public's desire for instant results, policy makers' difficulty in allocating resources for the next generation's benefit, the public's lack of interest in providing comprehensive health care benefits to the underserved, and pressure from special interest groups complicate planning. The fragmentation of health care delivery and financing restricts access and reduces quality of care for vulnerable populations.

Dr. Shi offered ten steps for resolving disparities: 1) enhance awareness, 2) demonstrate severity, 3) establish relevance, 4) expand the focus to multiple risk factors, 5) stress the multilevel integration of interventions, 6) ensure feasibility, 7) apply effective implementation strategies, 8) persevere, 9) use guided incrementalism, and 10) evaluate and refine programs and initiative. The public needs to know that primary care is associated with improved population health status such as longer life expectancy, lower age-adjusted total mortality, lower age-adjusted stroke mortality, and lower infant mortality. The primary care workforce should be expanded in areas with higher socio-economic disparities and health disparities because their presence moderates the adverse impact of social and economic risk factors. Community health centers should be strengthened and expanded.

Dr. Shi recommended that primary care training be linked to service in medically underserved communities and with vulnerable populations. At the individual level, there should be a stepped-up effort to recruit racial/ethnic minorities, disadvantaged students, and those residing in medically underserved areas. At the institution level, there needs to be enhanced diversity of faculty, innovative curricula, and interdisciplinary approaches. At the community level, there needs to be more partnerships with the goal of enhancing access to care, reducing emergency room use, and improving population health outcomes. Dr. Shi stated that primary care providers need to focus on multiple rather than single risks. Further research is needed to assess the relationship between education/training and improved health care outcomes as measured by access, efficiency, quality, health status of vulnerable populations, and reduced health and health care disparities.

The work of the second workgroup on training was presented by Dr. Fenton. One of the themes of the group was that training cannot simply be exposure; hands-on experience is vital. Providers need to be trained in cultural competence, how to provide preventive and comprehensive health care to vulnerable

populations, the epidemiology of chronic and complex disease and health disparities, and communication competency with disabled patients. In terms of access, Dr. Fenton said that Medicaid does not cover adult dental services in the majority of states. The workgroup favored attention to the transitioning of care from childhood through the lifespan for disabled individuals with a focus on combined training in medicine and pediatrics. The most direct way to curricular change is the addition of clinical assessments regarding vulnerable populations on board certification and re-certification examinations. Targeted admission of students and faculty with medical or physical disabilities or other special needs can yield important role models.

Dr. Cheng recommended a pediatric focus on adult precursors of disease, a movement in primary care from the individual level to the population level to the community level, and models seen by trainees that work in addressing issues of vulnerability. Dr. Rich suggested the report say that more capacity and more training are needed and acknowledge that it will take more of a primary care professional's time to address these needs. Dr. Chaves-Gnecco said that the report could suggest that primary care providers return to the old model of practicing in the community.

Dr. Cheng gave the presentation for the third workgroup on what Title VII programs are doing to address vulnerable populations. The workgroup felt that in addition to efforts of grantees within section 747, the work being done by grantees in other Title VII programs should be included. Dr. Raggio would explore the notion of querying grantees for descriptive information on training projects dealing with service to vulnerable populations. The workgroup discussed sampling methods; a revision of the UPR-CPMS list that addresses vulnerability based on a framework, *Healthy People 2010* objectives, and input from the Advisory Committee; and the development of an inventory of best practices related to outcome measures set forth in the Fifth Report. Dr. Curry added that the group was trying to suggest the importance of building more of an evaluative process into the work of grantees. Dr. Rich reminded members that the Fifth Report had an objective which specifically referred to vulnerable populations and community engagement, and several near-term and long-term measures broadly relevant to the Sixth Report. In a response to Katherine A. Flores, MD, Dr. Rich said that during the development of the Fifth Report, there was no explicit consideration of a national database. Dr. Cheng added that it would be a huge undertaking and without a comparison group of non-grant funded programs, pose a huge dilemma in how to interpret the data.

The Advisory Committee discussed next steps for the Sixth Report. Staff will look into the possibility of having a protected website to which members could post comments. Typically, communication has been through the use of conference calls and one-day meetings in Rockville for the Writing Group. The decision was made that staff would contact Writing Group members regarding availability for a one-day meeting in early December. Dr. Rich suggested that the three experts who could not attend this meeting be invited to the February meeting, thus affording an opportunity for interaction with the full Committee. The Writing Group decided to meet over lunch after the meeting was adjourned.

There were no public comments. The meeting adjourned at 12:02 pm.