

ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY

Meeting Minutes: August 13-14, 2015

Advisory Committee Members Present:

David J. Keahey, MSPH, PA-C, Vice Chair
Vicki Chan-Padgett, MPAS, PA-C
Frederick J. Fox, MD, MPP, FACP
Jean Johnson, PhD, RN
Elizabeth Kalliath, DMD
David Keller, MD
Allen Perkins, MD, MPH
Yilda M. Rivera Nazario, DMD
Linda C. Niessen, DMD, MPH
Gina Sharps, MPH, RDH
Eve Switzer, MD, FAAP
Elizabeth Wiley, MD, JD, MPH
Stephen Wilson, MD, MPH

Others Present:

Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, ACICBL, HRSA
Kimberly Huffman, Director, Advisory Council Operations, Bureau of Health Workforce, HRSA
Candice Chen, MD, MPH, Director, Division of Medicine and Dentistry, HRSA
Crystal Straughn, Technical Writer, HRSA

Presenters:

Ana Penman-Aguilar, PhD, MPH, Associate Director for Science Office of Minority Health & Health Equity, Centers for Disease Control and Prevention
Malika Fair, MD, MPH, Director, Public Health Initiatives, Association of American Medical Colleges
Arthur Kaufman, MD Vice Chancellor for Community Health, University of New Mexico Health Sciences Center
Melissa Klein, MD, MEd, Associate Professor of Pediatrics, Director, Primary Care Pathway of Pediatric Residency, Director, General Pediatric Master Educator Fellowship, Director, Education Section, General and Community Pediatrics, Cincinnati Children's Hospital Medical Center

Day 1- August 13, 2015

Introduction

The Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) convened its meeting at 8:30 a.m. at the Health Resources and Services Administration's headquarters in the Parklawn Building, Room 18-67, 5600 Fishers Lane, Rockville, MD 20857.

Dr. Joan Weiss opened the meeting and introduced Dr. Candice Chen, Director, Division of Medicine and Dentistry, Health Resources and Services Administration (HRSA). Dr. Weiss asked the members to introduce themselves. She then introduced Mr. Jim Macrae, Acting Administrator, HRSA.

Mr. Macrae welcomed the members and thanked them for their commitment to the Committee and HRSA. He then noted that it was an exciting and challenging time in healthcare and the members' recommendations are valued and needed at HRSA. He discussed how the Affordable Care Act has provided millions of American with health insurance. He noted that the Secretary of Health and Human Services (Secretary) challenged HRSA to think about what can be done to not only insure Americans but to transform the healthcare delivery system. The Secretary identified three primary ways to transform the delivery system: 1) Create ways to increase incentives to pay less for volume and visits and focus on quality and value, 2) Train healthcare professionals to work in teams to transform healthcare delivery and population health, and 3) Provide information to providers and patients to help them better manage their care.

Mr. Macrae expanded on the third focus, information. Providing information to providers and patients is the key to transforming health care delivery. The National Institutes of Health (NIH) is focusing on precision medicine. Precision medicine is an emerging approach for disease treatment and prevention that takes into account individual variability in genes, environment, and lifestyle for each person. NIH has asked HRSA to decipher how to support precision medicine for all the populations that are served in the country.

Mr. Macrae then addressed the Committee's meeting topic, social determinants of health. He noted that social determinants are similar to paying for quality over quantity and he is interested in how to incorporate it in ways that will make a difference. He asked the Committee to provide recommendations on how to use HRSA programs to build the next generation and make an impact on communities, patients and populations across the country.

Mr. David Keahey stated that there is a conflict between precision medicine and population health. The challenge is deciding what is best for individual patients, populations and the practicing clinician that is concerned with how they will be evaluated, graded, and reimbursed. He asked how do you measure those outcomes. Do you use surrogate markers and/or actual outcomes? Mr. Macrae acknowledged it is a challenge and emphasized that HRSA wants input on how best to navigate precision medicine and population health because there will be a focus on using information from the human genome and on tailoring specific treatment modalities. It is important to find the right balance between precision medicine, individualized treatments, and what is best for the larger population. Over the next several years, HRSA will work with patients to determine what can be done through individualized treatment.

Dr. Allen Perkins commented that graduate medical education (GME) funding needs to be changed and altered. He asked Mr. Macrae to discuss if GME funding would change and what is the timeline for that change. Mr. Macrae informed the Committee that a Government Accountability Office workforce study is currently reviewing the issues surrounding the workforce and they are developing recommendations on how to approach the workforce through HRSA investments and through the Centers for Medicare & Medicaid Services.

Dr. Stephen Wilson commented that the best evidence comes from studying large amounts of people in large trials. But individuals of lower socioeconomic level are often excluded from the trials they need the most. Mr. Macrae agreed and informed the Committee that HRSA is reviewing how to incorporate the populations they serve traditionally through HRSA programs into trials.

Dr. Linda Niessen asked, “Is there any thought to leveraging existing HRSA programs to strengthen those community health centers? Mr. Macrae responded that HRSA is encouraging community health centers, through minor investments, to be more engaged in training. HRSA looks forward to recommendations from the Committees to discuss ways to achieve goals. Leveraging existing HRSA programs is the right place to start.

Mr. Macrae closed the discussion by emphasizing that workforce and rural health are major priorities for the Secretary. The Secretary wants HRSA to support the workforce across the country and build the next generation. In addition, the Secretary wants HRSA to focus on rural health in terms of training and service delivery. He then thanked the Committee for their time and reminded them that their feedback and suggestions are welcome.

Presentation

Dr. Ana Penman-Aguilar discussed Social Determinants of Health: A Description of Selected CDC Activities. Dr. Penman-Aguilar provided an overview of the structure and activities of the Office of Minority Health and Health Equity (OMHHE) at the Centers for Disease Control and Prevention (CDC). She also provided definitions of common terms related to social determinants of health, discussed examples of other CDC work related to social determinants of health, and some reflections on implications for primary care medicine and dentistry training. The OMHHE mission is to advance health equity and women’s health issues across the nation through CDC’s science and programs, and increase CDC’s capacity to leverage its diverse workforce and engage stakeholders toward this end. Dr. Penman-Aguilar provided the following definitions:

- **Social determinants of health** are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- **Health disparities** are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.
- **Health Equity** is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.
- **Health Equity and the Guide to Community Preventive Services:** Community Guide reviews are focused on interventions to reduce health inequities among racial and ethnic minorities and low-income populations. **Health inequities** are those health disparities that are systematic, avoidable, and unfair.

Healthy People 2020

Dr. Penman-Aguilar explained that the Healthy People 2020 represents the first effort to include social determinants of health within the structure of Healthy People objectives. Healthy People is a national agenda that communicates a vision for improving the population's health and achieving health equity. It provides a set of specific, measurable objectives with targets to be achieved by the year 2020. The overall goals of Healthy People 2020 are to: attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve the health of all groups; create social and physical environments that promote good health for all; and promote quality of life, healthy development, and healthy behaviors across all life stages.

CDC Publications and Activities

Dr. Penman-Aguilar provided a summary of recent CDC publications and their findings related to social determinants of health. The CDC Health Disparities and Inequalities report includes national level data with some state-specific results, findings, and estimates from monitoring and reporting changes in health disparities and inequalities. The report found that the prevalence of unemployment was much higher among blacks, Hispanics, American Indian, and Alaskan natives as compared to whites, and unemployed adults were much less likely to report their health as excellent. The highest percentage of adults not completing high school were Hispanic, at a very low level of income, with a disability, or foreign-born. In response to the data report, OMHHE began an initiative to describe how CDC would address some of the areas of concern in the report. In April 2014, a companion report was published which described selected interventions that are working to reduce health disparities. The findings in this supplement can be used by practitioners, the public health workforce, academia, clinical medicine, the media, and others to address disparities and help all persons in the United States live longer, healthier, more productive lives.

The CDC Vital Signs Hispanic Health publication noted that published national estimates by Hispanic origin and nativity have been lacking. Hispanics have generally been lumped together into one group, which is not the best practice. CDC found that there were large differences in prevalence of disease and risk factors when you compared to U.S. born and foreign-born Hispanics. Bilingual health education materials, increasing health insurance coverage, and access to culturally appropriate health care preventive services are critically important. Representation of Hispanics in the healthcare and public health workforce is a focal strategy for improving culturally appropriate and effective health services. Hispanics comprise only 5.8 percent of U.S. physicians and the numbers are lower for African American physicians. The Vital Signs report offers specific recommendations on what physicians and other health professionals can do to eliminate inequalities: work with interpreters to eliminate language barriers when patient prefers to speak Spanish; counsel patients on weight control and diet if they have or are at high risk for high blood pressure, diabetes, or cancer; ask patients if they smoke and if they do, help them quit; and engage community health workers (promotores de salud) to educate and link people to free or low-cost services.

Currently, OMHHE is developing a health equity framework for action. This document was created based on the recommendation of the CDC Health Disparity Subcommittee. The Subcommittee made the following recommendations:

1. Develop a CDC framework for action to achieve health equity.
2. Identify and monitor indicators of health equity.
3. Align universal interventions that promote better public health, with more targeted, culturally tailored interventions in communities at highest risk to reduce health disparities and achieve health equity.
4. Support the rigorous evaluation of both universal and targeted interventions and, where indicated, the use of culturally appropriate evaluation strategies, to establish best practice approaches to reduce health disparities and achieve health equity.
5. Build community capacity to implement, evaluate, and sustain programs and policies that promote health equity, especially in communities at highest risk.
6. Support training and professional development of the public health workforce to address health equity.

Dr. Penman-Aguilar suggested the following competencies for primary care medicine and dentistry: the ability to collect, analyze, and disseminate information in a systematic and scientific manner; participate in continuous quality improvement at the practice level; assess community linkages and relationships among multiple factors (determinants) affecting health of patients and communities; identify the needs of the population their practice serves and work to address them; and utilize population-level data for patient and community oriented advocacy, policy development, and program planning.

She also recommended didactic and experiential learning activities including training in population health and community-based participatory research, faculty development, and rigorous evaluation of curricula and activities and follow-up of graduates' careers to assess long-term impacts.

Dr. Penman-Aguilar concluded her presentation by stressing the importance of achieving health equity in the 21st century. Eliminating health disparities requires championing strategies that address social determinants of health: focusing on communities at greatest risk, valuing a diverse and public health workforce, ensuring that practitioners are culturally competent and socially informed; removing barriers to high-quality health care, ensuring that care received is culturally and linguistically appropriate and disseminating solutions.

Questions and Answers

Dr. David Keller asked if CDC is looking at how family stability and structure and social determinants of health impact individuals and children. Dr. Penman-Aguilar responded, "Yes, the concept of family and the mechanism of working with the family are implicit in some of the work that CDC is doing. For example, CDC is looking at the social determinants of teen pregnancy. This includes how the family is functioning, the presence or absence of parental figures, and the communication that happens between adults and children."

Dr. Jean Johnson inquired if CDC had given thought to developing best practices around where the areas of social determinants of health intersect and specifically how healthcare providers can be effective in creating change in those overlap areas. Dr. Penman-Aguilar explained that the Hispanic and Latino Vital Signs was an exercise in developing best practices. CDC Director Dr. Tom Frieden conducted a podcast for Medscape where he discussed the Hispanic paradox, what happens when people come to the United States and how their health often declines over time.

Their genes are not the cause of declining health because they are the same people when they arrived.

Dr. Frederick Fox asked if there are competencies surrounding social determinants and the transgender community. Dr. Penman-Aguilar explained that the Healthy People 2020 has a priority, social determinants of health area in particular, of making available data on the lesbian, gay, bisexual, and transgender (LGBT) population at a national level. LGBT population is a high priority for CDC and a CDC workgroup is working to develop interventions to address discrimination and stigma.

Presentation

Dr. Malika Fair informed the members that her presentation would describe the role of health professions education in addressing social determinants of health, define the role of universities and academic medical centers as key drivers for change in their communities and outline the partnership effort of Urban Universities for HEALTH (Association of American Medical Colleges (AAMC) initiative) to increase the quality and use of data in university strategic and action planning.

Dr. Fair opened her presentation by posing the question, “How can we develop a workforce that is poised to improve population health?” Universities have three areas of impact: access (universities can help increase access to care in underserved communities by graduating more health professionals who will serve in those communities), educational opportunity (universities can provide more educational opportunities and support for students who are underrepresented in the health professions) and competence (universities can work to ensure their graduates have the background, qualities, and skills needed to provide effective and equitable care).

Urban Universities for HEALTH is a national learning collaborative aiming to expand and enhance a culturally sensitive, diverse, and prepared health workforce to improve health and health equity in urban communities. In addition, it works to improve evidence for health workforce interventions that drive local health equity. Urban Universities for HEALTH works with 40 institutions or learning partners. But out of the 40, there are five core institutions that are part of the urban serving universities (Cleveland State University (CSU)/Northeast Ohio Medical University (NEOMED), SUNY Downstate and the SUNY Center for Health Workforce Studies, University of Cincinnati, University of Missouri Kansas City, and University of New Mexico). Over the last four years, the five demonstration sites worked together with a broader group of university leaders to pursue the partnership’s goals. These institutions captured local data, evaluated current strategies, and drove workforce improvements in common areas across sites. Each site engaged in a university-wide team including deans in nursing, medicine, dentistry, public health and allied health professions. Funding for these sites will end in June 2016. Each institution goes through five phases:

- Phase 1: Identify Systemic Health Workforce Goals
- Phase 2: Develop Metrics Aligned to Health Workforce Goals
- Phase 3: Identify University Strategies that Impact Outcomes
- Phase 4: Identify Key Performance Indicators for Dashboard
- Phase 5: Analyze Effectiveness

Dr. Fair then discussed the work of the University of Missouri, Kansas City (UMKC) to provide the Committee with an example of the process and phases. UMKC is in Jackson County, one of the poorer regions of Missouri. It has the worst health status, persistent health disparities, and problems with educational attainment in the school system compared to other parts of Missouri. UMKC was asked to go into their community and evaluate community challenges. They found that almost 60 percent lived within a primary care health professional shortage area (HPSA). Over a third lived within a dental care HPSA and the entire county is in a mental HPSA. UMKC spoke with Federally Qualified Health Centers (FQHC) and found that the average time to fill a primary care position at a FQHC was 18 months. They then engaged community partners, local foundations, the health department, stakeholders involved in a Kansas City health improvement plan, and FQHCs in conversations. They concluded that it was important to bring healthcare providers and additional staff to FQHCs. UMKC had a specific goal to increase the diversity of their student body by increasing the annual recruitment, retention, and ultimate placement of underrepresented minority students from underserved areas in Jackson County. They also sought to increase the proportion of health professions graduates throughout all their programs. Many of these graduates seek employment in underserved communities in the country. Policy recommendations were developed based on what was learned from Urban Universities for HEALTH: investment in educational opportunity; develop data infrastructure and health professions training opportunities. Dr. Fair concluded her presentation and asked for Committee questions.

Questions and Answers

Dr. Wilson asked if AAMC is working to help universities promote rural health. Dr. Fair explained that the Urban Universities for HEALTH had an urban focus because of their partnership with urban serving universities, but many of the metrics will be applicable to other underserved areas. At the end of this project, AAMC will continue to develop materials and resources for all underserved populations.

Dr. Elizabeth Kalliath asked if Dr. Fair explored the impact of how student debt affects decisions on where individuals practice. Dr. Fair informed the Committees that there are several measures on student debt, such as, level of student debt, student perception of debt, and the actual loans for which students apply.

Dr. Niessen requested that Dr. Fair share her holistic admissions process because she would be interested in how to apply it in dentistry. Dr. Fair said she would be happy to share materials and explained there was a vast array of materials available online. In the national study, however, dentistry was second in terms of the pervasiveness of holistic admissions. Dr. Niessen also inquired if there had been any research or work surrounding the first generation college student and how it changes the dynamics of the family. In addition, has Dr. Fair looked at that first generation college student who then becomes a health professional. Dr. Fair explained that one of the educational opportunity metrics is the number of first generation college students admitted. It is also the number of underrepresented minorities, people who speak English as a second language, and Pell grants.

Dr. Candice Chen commented that Dr. Fair started her presentation by stating universities have a responsibility to their local communities and inquired if the Urban HEALTH concept spread to the other medical and health professions schools. Dr. Fair explained that universities are working with their local communities to address social determinants of health and AAMC is assisting universities to disseminate their current successes to university leadership, boards, and other key stakeholders. Dr. Chen inquired about what would happen to the Urban Universities for HEALTH project after June 2016. Dr. Fair discussed ways to continue the work of the project both with their current sites and other partners.

Presentation

Dr. Arthur Kaufman opened his presentation by expressing his excitement on the topic of social determinants and its power in determining health in communities. He also provided a brief snapshot of New Mexico as a minority majority state with a very rich Hispanic tradition. He also described it as a poor rural state that has major access problems in smaller communities. He asserted that it is important to address social determinants of health in order to improve the health of communities and provided examples of Native Americans with Diabetes in New Mexico to highlight this point. Although many public and federal programs provide high quality diabetes screening and treatment for Native American populations, Native Americans continue to have the highest death rate, dialysis rates, and amputation rates of any population. Native American populations are provided high quality healthcare but have poor outcomes because low high school graduation rates, poor nutrition, social marginalization, poor housing, transportation and other social and societal factors have not been addressed.

Studies have shown that physicians from underrepresented minority background and those from rural areas are more likely to provide healthcare for these populations after their training. The Combined Bachelor of Arts (BA)/Medical Degree (MD) Program at the University of New Mexico is designed to help address the physician shortage in New Mexico by educating students from diverse backgrounds who are committed to serving New Mexico communities. This program is open to New Mexico high school seniors planning to begin college the fall semester after their high school graduation. Students first earn a baccalaureate degree through the College of Arts and Sciences to prepare them for medical school. Upon successfully completing the undergraduate academic requirements of the program, students will then transition to the University of New Mexico School of Medicine to complete their doctor of medicine degree.

By addressing social determinants of health, this program has been successful in ensuring that physicians stay in New Mexico after their training and practice in underserved areas. At the University of Mexico, there is considerable flexibility with family medicine training. Half of the 76 residents in the state train most of their time in rural New Mexico and half of them train in urban Albuquerque. Approximately 70 percent of the rural graduates stay in rural New Mexico, approximately 25 percent of the urban graduates practice in rural New Mexico, and approximately 50% of the urban graduates practice in FQHC.

Dr. Kaufman then discussed Medicaid GME funding. New Mexico is the first state to use Medicaid waivers along with FQHCs to create more primary care residency positions. This provides a solution to the dual problems of federal GME funding restrictions and teaching hospitals' focus on subspecialties that limit the number of family medicine residency positions

available. The FQHCs receive approximately \$150,000 annually for each new residency position. The first group of residents to be funded through the initiative will begin in fall 2016.

The University of New Mexico developed a social determinants prescription pad which is used to determine if patients are being affected by the listed social determinants of health. In a practice of approximately 3,000 patients, 53 percent had at least one adverse social determinant.

Dr. Kaufman highlighted two community-based programs (health extension service, and the expanded role of community health workers) the University of New Mexico developed over the last six years.

These providers help to increase the capacity of the healthcare system to address social determinants of health. Most health extension providers have a master's degree with experience in health. Community health workers are typically high school graduates chosen by the local community and are culturally and linguistically competent in that community. Health insurers contract with the University to hire and train community health workers to help “manage” high users of healthcare in community.

Dr. Kaufman concluded his presentation by discussing the importance of community health workers and “Health Commons.” The Health Commons model includes the following defining characteristics:

- Promoting universal access to primary care homes as a public health measure
- Creating a one-stop, seamless system providing medical, behavioral, dental, and social services that offers advanced case management, information systems, and links to community resources through community health workers
- Expanding the training of community-based, interdisciplinary health professionals in needy communities
- Developing pipelines to build a diverse work-force of health professionals

Questions and Answers

Dr. Jean Johnson asked Dr. Kaufman to discuss how nurses, nurse practitioners, and physician assistants (PA) fit into this model? There is a free nurse advice line in New Mexico and it is a vital component of providing care. It is entirely run by nurses and the advice line receives approximately 15,000 calls a month.

Dr. Keller asked how having a community health worker has changed the training provided at the family medicine sites. Dr. Kaufman commented that the value of the community health resides with the workers community knowledge. Community health workers work side-by-side with students and residents in clinics. Students and residents conduct home visits and community visits with community health workers. On these visits, patients are much more

Social Determinants R_x

Name _____ Age _____

Address _____ Date _____

Referral to Community Health Worker for:

<input type="checkbox"/> Food Assistance	<input type="checkbox"/> Employment Assistance
<input type="checkbox"/> Housing Assistance	<input type="checkbox"/> Education Assistance
<input type="checkbox"/> Utilities Assistance	<input type="checkbox"/> Substance Abuse Assistance
<input type="checkbox"/> Transportation Assistance	<input type="checkbox"/> Safety Assistance
<input type="checkbox"/> Daycare Assistance	<input type="checkbox"/> Domestic Violence Assistance
<input type="checkbox"/> Legal Assistance	<input type="checkbox"/> Other

Provider Signature

comfortable when a community health worker from the same culture and who speaks the same language is present.

Dr. Chen asked Dr. Kaufman to provide three recommendations and three policy changes needed in training to address social determinants of health. Dr. Kaufman responded:

- 1) Our best social determinants of health learning opportunities are in the clinics with community health workers or with health extension coordinators. The paradigm of training must change to meet the new needs and the new funding that comes through managed care. It must be linked to communities.
- 2) There are disconnected resources and they are not being used in an effective way.
- 3) We need to look at the limitations of the patient centered medical home. It is not going to have the impact on community health that health commons, the community health home, and all of those broader connections with other community forces will have.
- 4) All actions must translate into measurable improvement in community health.

Presentation

Dr. Melissa Klein began her presentation by thanking the Committee for the opportunity to discuss the health care provider's role in social determinants of health, especially related to educating the workforce - the next generation of physicians and health providers. She then gave an introduction into the cases and the children that she and her team see in their primary care centers, Academic Continuity Clinic, FQHCs, or community health centers in Cincinnati. She provided examples as to why it is important for students to learn about social determinants of health. In one example, a four month old baby with Down syndrome visited the primary care center for breathing issues. Although the baby had been treated with routine medical care, the physician who saw her had a social determinant of health mindset and approached her care from a different perspective. He inquired as to what is going on in the home. The mom shared that there was mold and roaches. The medical legal partnership was consulted and provided help to remove the mold and roaches.

Dr. Klein explained that families experience food insecurity, benefit issues, utility problems, and poor housing conditions. Legal aid societies, food banks, community collaborations, and community allies that have the roots in the community can work with families to improve these issues. Individuals that experience domestic violence or intimate partner violence, mental health issues, and education issues can also utilize community liaisons, or intimate partner/violent partner shelters, early intervention behavioral health specialists and other organizations. Through this type of mindset, health care providers can have an instrumental role in addressing the social determinants. But this requires partnering with patients and families to address their needs and partnering with the community organizations that have the expertise in mitigating those issues.

Dr. Klein then explained the role of the healthcare providers in social determinants of health education. Health care providers can intervene by developing curriculum to train the next generation of providers to screen for social determinants of health and intervene on their patient's behalf. In regards to medical education and evaluation, entrustable professional activities (EPA) are new to both undergraduate medical education and GME. They assimilate the granularity of the competencies and the milestones and create a holistic description of what a

physician's developmental progression should be in the activities that are central to their specialty. The majority of pediatric providers and health care trainees will care for patients in poverty, and learning to assess and manage social determinants of health is critical to meeting the population's needs; therefore, a defined EPA in this area is necessary.

Dr. Klein commented that traditionally, medical education has lacked formal training on social determinants of health and its short and long term health effects. A majority of health professional trainees were not raised in poverty so they are unable to build on past experiences. They move frequently for training which leads to lack of awareness of the local community barriers and assets. Collaboration with clinical practitioners, educators, health science researchers and community partners have developed and resulted in a variety of educational experiences for pediatric residents over the past five years.

Dr. Klein then provided several examples of social determinants of health curricula and interventions. Overall training should be interprofessional (physicians, social workers, lawyers, school officials, community case workers, parents), have varied locations (medical institution, community), include a curriculum that is tailored to the level of the learner, and evaluation metrics as new curricula continues to be developed. She then outlined the potential next steps in social determinants of health education: national, standardized SDH curriculum, multi-disciplinary, team based social determinants of health training, expand social determinants of health awareness beyond primary care, population health training, and technology in social determinants of health education. She concluded her presentation by stating, "It is important to ensure our learners understand all the other issues that families and communities face so that we can holistically address the family and the patient, and improve health."

Questions and Answers

Dr. Keller asked what infrastructure support Dr. Klein received to evaluate programs and drive them forward. Did it primarily come from internal resources? Are there things the Committee could do to help others achieve the level of rigor that she achieved in developing the new curriculum? Dr. Klein explained that some of the support was internally funded. A multidisciplinary team was also helpful in developing the curriculum. For example, she is the educator that writes learning objectives and another team member is a health service researcher who emphasizes how to show outcomes. In addition it has been helpful to have families tell their story in person and virtually. She has also received assistance from community colleagues.

Dr. Wilson asked how the data and evaluation would translate from pediatrics to family or primary care/internal medicine. Dr. Klein explained that family medicine has a lot of overlap with pediatrics and can be easily translatable to internal medicine and family medicine. It is important to determine how to support parents. They are provided with job training, mental health resources and overall support to assist them in becoming the best parent. Dr. Wilson also asked Dr. Klein to comment on converting healthcare providers from thinking about the outcome for an individual patient to all patients. Dr. Klein emphasized that it is important to provide the best care for the individual patient but she would like her primary care and continuity clinics residents to think about their entire panel. For example, they may be providing quality asthma care, but do they know that their asthma patients have a five percent emergency department visit rate which is above or below that of their peers from a national or local perspective.

Update on Title VII, Part C, Section 747 and 748 Programs

Dr. Chen then provided an update on Title VII, Part C, Section 747 and 748 Programs. She reviewed last year's funding opportunity activities and discussed plans for next fiscal year. The 747 programs are the Primary Care Training and Enhancement (PCTE) programs and the 748 programs are our oral health training programs. The pre-doctoral and post-doctoral training in general pediatric and public health dentistry had a competition for funding this year. Across these two programs, HRSA focused on integrating oral health into primary care and transforming the clinical training environment. There was also a focus on training for advancing the roles for dentists as they go through residency. While not every state or program is training for advanced roles, HRSA recognizes that there is a need to ask, "How can we maximize the providers that we have and train them to maximally provide care and care particularly in underserved communities?" There was also a push in the pre-doctoral program toward public health dentistry. She commented, "As we move towards addressing the social determinants of health, and integrating population health, it is important to take providers to a point where they are not just looking at the patient in front of them, but they are thinking about the family, community and population around them."

There was also a move towards better evaluation in the pre-doctoral and post-doctoral oral health training programs and in the Primary Care Training and Enhancement program. HRSA requested that the training programs develop evaluation plans that went beyond asking for the number of students being trained to questioning whether grantees are seeing an improvement in care being provided by those clinical training environments.

The Faculty Loan Repayment Program did not have a competition this past year because there is an existing Faculty Loan Repayment Program handled by another division. The decision not to have a competition was to reduce redundancy, maximize resources, and explore ways to partner in the future. The Dental Faculty Development Program will continue to be funded through FY16. HRSA is exploring if it is the most effective use of money to compete faculty development as a separate program or to integrate it into the pre-doctoral or post-doctoral oral health training program.

Dr. Niessen commented, "When I think about faculty development, I think that embedding the faculty development into the pre-doctoral or post-doctoral grants would be a better, more effective way. As you are training the students, you need to train the faculty ahead of time. So I think that might be the better way to build your faculty development programs."

Dr. Keller was concerned about the impact that integration on evaluation. Every time another layer of program is added, another layer of evaluation is added. The traditional weakness of funding streams is there are not enough funds to do a proper evaluation. We need to be sure to allow for that extra layer of evaluation to demonstrate effectiveness. He agreed that faculty development needs to be aligned with innovation in undergraduate and graduate medical education. However, this is challenging if the grantees are attempting to do all at once in the same grant.

Dr. Chen moved on to the Primary Care Training and Enhancement Program (PCTE). The programs under PCTE were collapsed into one competition (pre-doctoral, post-doctoral residency program, PA training, faculty development, and interprofessional joint degree programs). The programs were collapsed to give every level of training an opportunity to compete. The focus of this program is to transform clinical training environments to align with the transforming health care delivery system. In the past year, two ceiling amounts were offered. Single projects could request up to \$250,000 and collaborative projects could request up to \$350,000. Collaborative projects that proposed training across the continuum (student, resident, faculty development, and practicing primary care physician or physician assistants) and across primary care disciplines and professions (family medicine, general internal medicine, general pediatrics, physician assistants, and other primary care professions) were encouraged and qualified for the higher funding ceiling amount. The PCTE program is expected to compete again this year. In addition, the Teaching Health Center Program (THCGME) was re-funded through the Medicare Access and CHIP Reauthorization Act. The Committee recommended that the THCGME program be funded in their last report. It was funded at \$60 million for FY16 and FY17.

Committee members commented and asked questions on the objective review process, inclusion of nurses and PAs on Committees and Councils, the introduction of rapid cycle quality improvement into awards, community health workers, cost savings of addressing social determinants of health, and Medicare Access and CHIP Reauthorization Act funds.

Dr. Weiss then asked the members to review the presentations and articles on social determinants of health, and think about recommendations for the report for Day 2's discussion. She reminded the members that it is important to provide no more than five SMART recommendations. SMART recommendations are specific, measurable, achievable, relevant and time-bound. She then opened the meeting for public comment. The meeting was adjourned at 5PM.

Day 2- August 14, 2015

Introduction

The Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) convened its meeting at 8:30 a.m. at the Health Resources and Services Administration's headquarters in the Parklawn Building, Room 18-67, 5600 Fishers Lane, Rockville, MD 20857.

Dr. Weiss opened the meeting and took attendance. She then informed the meeting that they would be responding to five discussion questions. The members began the discussion by responding to the question, "What is the role of a health professional in addressing SDH?" The members made the following comments:

- Health professionals should have a basic understanding of population health and of the community they are serving.
- The role of the health professional is to facilitate and be aware of the special needs that patients have in regards to the social determinants of health.
- There should be a skill-based focus in the approach to primary care education.

- It is important to ensure that community-based training is both beneficial for learners and for the communities that are being served. In addition, there should be appropriate faculty that possesses the knowledge and skills to make those exposures positive and meaningful.
- It is important to prevent burnouts when students are working with vulnerable populations in primary care training/oral health and/or practice environments.
- Training should be integrated across clinical training environments and advocacy skills should be included.
- There should be a focus on interprofessional collaboration to address the social determinants of health. In addition, law enforcement, urban planning, and education are important to addressing social determinants of health.
- The role of the community pediatrician (and all practitioners) is to: (1) Focus on the well-being of everyone in the community; (2) Recognize that family educational, social, cultural, spiritual, economic, environmental, and political forces affect the health and functioning of children;(3) Provide a synthesis of clinical practice and public health principles to promote the health of all children within the context of family, school, and community; and (4) Make a commitment to collaborate with community partners to advocate for and provide quality services equitably for all children.
- Incentives that are aligned are linked to data-driven outcomes. Individual team members should be advocating for the patient in a cohesive way so that everything is integrated. This requires advocacy for aligning policies and reimbursement at the clinical, system, state, and national level.
- The role of health professionals in addressing social determinants of health involves asking (the patient, caregiver, and family), exploring (learning to explore the community), planning (incorporating knowledge of the community into the plan), emphasizing the value of team-based care, and improving patient and provider outcomes.
- Social determinants of health can be woven into an efficient process where screening is done in an efficient way and flags are created. It requires a culture in the healthcare system and the clinic, where the practitioner is part of a team.

The members then responded to the question, “What is the role of health professions education in addressing social determinants of health?”

- A graduate entering practice should be required to research the culture of the clinic and the community.
- There should be a holistic admissions process that is not focused on choosing the person with the highest MCAT score but on the individual who is focused on serving underserved populations.
- The role of healthcare professional education is to create awareness in the student of the need to address social determinants of health by creating an institutional culture that values and fosters this type of education. One way to promote this culture is by linking social determinants of health to the institution’s mission.
- The role of education is to commit to not just teach medicine, but teach the other things that make effective, holistic providers.

- Students should be exposed to different systems of care so they will be sensitive to the needs of the population they serve. There should be a standardized curriculum that would be appropriate for all of the disciplines.
- It is important for health professions education to address the issue of loss of empathy through medical education. Empathy can be taught through careful experiential learning and a very strong reflection component.
- Health professions education is the place where innovation and testing new models happens. Teachers have a huge role in creating the right cohort of people who are going to test and advance the models.
- Social determinants of health should be milestones in many of the competencies.

The members then moved on to the question, “What are the implications for the Section 747 and 748 programs?”

- Centers of innovation should be encouraged to teach social determinants of health and to create real world experiences for students that are connected with didactic and classroom experiences as well.
- One of the implications with 747 and 748 is how to measure outcomes. Service learning and reflection are important to health professions education. But there are no established measures. We need to have a way to measure the effect of the programs.
- Metrics need to be changed to reflect more practice change and ensure that people are being trained in an environment that captures using social determinants to improve health outcomes.
- There should be an inclusion of homelessness and the LGBT community in the granting process as an emphasis.
- Reimbursement is important. Individuals perform duties when they are paid. Metrics linked to social determinants of health that could become reimbursable would be helpful.
- Faculty should be recruited from backgrounds that can provide a unique perspective on communicating social determinants of health ideas to their students.

Committee Recommendations

After responding to the discussion questions and identifying key issues for the report, the members developed the following draft recommendations:

1. Develop, implement, and evaluate curricula to provide trainees with the knowledge, attitudes, and skills needed to address the social determinants of health in providing care to patients, families, and populations.

Content should include a longitudinal experiential component, reflection, advocacy, and techniques on ways to collect information on the social determinants of health. Care should be team-based. Team members should include health professionals and members from social services that can address issues related to housing, food insecurity, law enforcement, legal, and transportation. Clinical care environments should include the primary care setting, home, and telemedicine.

2. Incorporate rapid cycle quality improvement and measures that capture the impact of training that addresses social determinants of health into Title VII, Part C, section 747 and 748 programming. HRSA should develop a repository of best practices for teaching social determinants of health and evaluating the impact of this training on individuals, families, and communities. HRSA should partner with ACGME and the primary care specialty Boards to develop robust measures on the incorporation of SDH into primary care curricula
3. HRSA should partner with the Center for Medicare & Medicaid Innovation to develop payment models that include social determinants of health in innovative programming.
4. Community medicine and faculty development and support: Training opportunities for adjunct faculty should be made available and should include memberships in professional associations, ongoing support for transformation beyond didactics, and faculty trained in educational process. In addition, measures of time/payment should be changed to encourage participation in educational activities, instruction of self-care should be included as part of faculty development, and changes in 330 rules regarding productivity requirements to reflect the realities of productivity loss when engaged in teaching should be pursued.
5. Reimbursement/Incentives/Payment model development and sustainability: Organizations (i.e. Medicaid managed care or for profit systems) that benefit from the work of HRSA Title VII grant projects should contribute to financial sustainability of the program and HRSA is directed to use leverage to accomplish this.
6. HRSA Title VII, Part C, section 747 and 748 programs should include language in their funding opportunity announces to allow grantees to provide training in public health that culminates in a public health certificate.

Committee Business and Next Steps

Dr. Weiss reminded the Committee that several members are coming off the Committee. She thanked Dr. Caswell Evans, Dr. David Betz, Mr. David Keahey, Dr. Frederic Fox, Dr. Jean Johnson, Dr. Yilda Rivera Nazaro, and Ms. Gina Sharps for serving on the Committee and for their valuable contributions. She reminded the members to keep this in mind when they select a new Chair and Vice Chair. The members elected Dr. Allen Perkins, Chair and Ms. Vicki Chan-Padgett, Vice Chair.

Dr. Chen then suggested that an outline be drafted to develop the report based on the recommendations discussed during the meeting. The outline should be sent to the members after the meeting for review and revision.

Dr. Elizabeth Wiley suggested that the Committee draft a second letter on teaching health center funding given that the circumstances had changed. She said, “And perhaps in the context of our upcoming report, making the argument about the importance of these types of opportunities for addressing social determinants in medical education or health professions education. We must also address the permanency issue and the need for a more sustainable funding structure.” Mr.

Keahey agreed. He noted that the letter is congruent given the fact the community health centers work with populations with access issues that are often influenced by the social determinants of health.

Dr. Keller stated that the letter should address the issue of stable funding. The idea of the instability of the funding is that the current vehicle that was used reauthorizes the program for two years and that a residency program is three years long. The Committee suggested recommending a permanent funding source and highlighted some of the hardships that are faced by programs because of the inadequacy of the Medicare Access and CHIP Reauthorization Act extension. Dr. Wiley volunteered to draft the letter with Dr. Stephen Wilson. The Committee decided that the letter to the Secretary letter would discuss supporting continued funding of the Teaching Health Centers Program. .

Dr. Weiss then opened the floor to public comments. There were no comments. The meeting was adjourned at 5:00 p.m.