# ACTPCMD

## Advisory Committee on Training in Primary Care Medicine and Dentistry

Anita Glicken, MSW
*Chair*

Shane Rogers
*Designated Federal Official*


July 15, 2021

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Ave S.W.
Washington, DC 20201

Dear Secretary Becerra,

In response to a request for consultation (Section 3402 of the CARES Act) the Advisory Committee on Training in Primary Care Medicine and Dentistry is pleased to submit the following comments and recommendations.

The proposed strategic plan framework reflects existing BHW goals and strategies for our existing health workforce. Our assumption is that the plan buildout will also include thoughtful consideration of the dynamic shifts that have occurred across education and practice since the onset of the COVID-19 pandemic. We anticipate the plan will address government efforts to reform existing care delivery models, with an emphasis on critical factors of access, prevention, value, and population health.

COVID-19 has accelerated science and practice transformation models using technology, as well as shifts in payment, policies, and provider roles. We recommend that BHW programs incorporate emerging evidence on the positive impact of these changes as BHW considers new program development as well as continuing efforts that support growth and optimization of a health care workforce that enters practice prepared to work collaboratively in integrated health care systems providing comprehensive, equitable, and age-friendly care. Interprofessional team-based practice across collaborative, co-located and integrated care models, as well as payment and policy reforms that incentivize prevention and value, represent cross-cutting themes that can play a significant role in all areas of the strategic framework.

Data analysis, forecasting and modeling will be required to inform new education and training models that ready the workforce for a post-pandemic backlog of care along with the evolving needs for those chronically impacted by the disease. Identifying and scaling best practice models requires meaningful data to inform the development, implementation, and scale-up of innovative strategies to improve health equity and minimize the toll of disease. Continuous data collection and analysis could also be used to support optimal workforce modeling that extends beyond forecasting models related to the supply and demand of individual professions. New efforts could be directed towards identifying optimal team configurations that can best meet community-specific health care needs.

Mental health and oral health are two examples of collaborative and/or integrated care models that have shown promise in primary care settings prior to the impact of COVID -19. Emerging models, including telehealth, suggest viable, efficient ways to increase access to these services, a significant source of population health disparities. These models also address provider role expansion, particularly in underserved urban and rural settings by expanding screening and preventive services across primary care, behavioral health, and dental settings. Increasing access and collaboration requires education and training in new competencies[i] as well as interprofessional practice[ii]. Exposing students to meaningful

interprofessional education opportunities and "training up" existing workforce promotes whole person care and team-based care models that put community and patient needs and preferences at the center of care. With increasing attention to the impact of social determinants of health and new mid-level professions that increase access, support should also include dental therapists, community health workers, social workers social agencies.

The following bullets reflect specific recommendations from committee members in response to the draft Strategic Plan Framework.

Increase Supply

- Increase capacity to recruit providers that look like the communities they serve, supporting recruitment, training and retention of programs in underserved minority communities to increase workforce diversity.
- Strengthen institutional training partnerships with rural communities.
- Increase opportunities for interprofessional, team-based clinical training.
- Support UME and GME competency based accelerated pathways, including barriers associated with the existing residency match process.
- Consider relaxing regulatory barriers for IMGs.
- Increase training opportunities, and collaborations with, community workforce and leaders (community health workers, health coaches, community agencies etc.).
- Increase scholarship opportunities for loan forgiveness in high need areas.
- Support and mobilize public health workforce as integrated members of the workforce team.
- Support and "retool" returning workforce to address primary care prevention and chronic care needs.

Promote Equitable Distribution – Geographic, Health Care Disciplines, Diversity

- Increase the role and impact of telehealth in promoting equitable health workforce distribution including traditional synchronous virtual care and phone calls, remote monitoring, asynchronous care and collaborative care models.
- Develop and expand existing residency programs, including CMS capped programs within underserved rural and urban communities to support recruitment of professionals prepared to address community needs.
- Evaluate the impact of implicit bias in admissions and the education process.
- Promote exemplar models that support a diverse student body.
- Promote a holistic approach to patient centered care that engages all disciplines.

Improve Provider Quality

- Focus on prevention in quality improvement education initiatives to ready the workforce to work in, develop, implement, and scale integrated care models in oral and behavioral health (PDSA interventions to move metrics).
- Increase faculty development and student competency in maternal health, population health, telemedicine, value based care, interprofessional team-based practice, public health, as well as role and impact of racial and health inequities, implicit bias, and social determinants of health.
- Increase faculty and student proficiency in evidence-based practice.
- Increase student knowledge in health system science.

Data and Surveillance

- Monitor supply and distribution of professions across integrated care models.
- Monitor geographic distribution of team-based care and evaluate best practice models designed to increase access and outcomes.
- Support community based needs assessment and workforce modeling based on population need.
- Establish shared metrics across medicine and dentistry for common health outcomes.
- Analyze return on investment of BHW programs in addressing recruitment, training and retention of the workforce in underserved communities.
- Analyze and accelerate primary care capitation models, with clear accountability outcomes.
- Measure the impact of integrated care models on patient outcomes (UDS measures) critical to the population.
- Analyze and model the impact of integrated teams to inform optimal team configurations that reduce disparities and improve health outcomes.

Respectfully submitted,

/s/ Anita Duhl Glicken, MSW
Chair
ACTPCMD

[i] Health Resources and Services Administration. Integration of Oral Health and Primary Care Practice. In: U.S.

[ii] Interprofessional Education Collaborative. (2016).
Core competencies for interprofessional collaborative practice: 2016 update. Washington, DC: Interprofessional Education Collaborative.