

**Advisory Committee on Training in Primary Care
Medicine and Dentistry (ACTPCMD)
Meeting Minutes
November 2-3, 2021**

Advisory Committee Members Present

Anita Glicken, MSW, Chair
Sandra M. Snyder, DO, Vice Chair
Jane E. Carreiro, DO
Nancy W. Dickey, MD
Jeffrey Hicks, DDS
Geoffrey Hoffa, DHSc, PA-C
Michael J. Huckabee, MPAS, PA-C, PhD
Anne E. Musser, DO
Pamela R. Patton, PA, MSP, DFAAPA
Kim Butler Perry, DDS, MSCS, FACD
F. David Schneider, MD, MSPH
Mark D. Schwartz, MD
Jason M. Spangler, MD, MPH
Wanda H. Thomas, MD, FAAP
Louise T. Veselicky DDS, MDS, MEd

Health Resources and Services Administration (HRSA) Staff Present From the Bureau of Health Workforce (BHW)

Shane Rogers, Designated Federal Official (DFO), ACTPCMD
Zuleika Bouzeid, Management Analyst
Jennifer Holtzman, DDS, Dental Officer
Kimberly Huffman, Director of Advisory Council Operations
Paul Jung, MD, MPH, Director, Division of Medicine and Dentistry
LaShawn Marks, Advisory Council Operations
Janet A. Robinson, Advisory Council Operations

Roll Call/Agenda Review

Shane Rogers, DFO, ACTPCMD

Mr. Rogers convened the virtual meeting of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD, or the Committee) on November 2-3, 2021. He welcomed everyone to the meeting and proceeded to conduct roll call, confirming a quorum. He then turned the meeting over to the Chair, Ms. Anita Glicken.

Introduction

Ms. Anita Glicken, MSW, Chair, ACTPCMD

Ms. Glicken welcomed all Committee members and the public. She said the COVID-19 pandemic had created a public health crisis that amplified the inequities in our health system. It also revealed the weaknesses and challenges in our primary care system. The ACTPCMD paid close attention to the development of solutions to some of these challenges, such as the use of telemedicine, and the development of new policies and innovative programs. This meeting addresses the evolving changes in primary care training programs to improve the health of underserved and vulnerable populations.

Title VII Engagement with Indian / Tribal Entities

CAPT Paul Jung, MD, MPH, MBA, Director, Division of Medicine and Dentistry, BHW

Dr. Jung explained that American Indians and Alaska Natives suffer from significant health disparities resulting in lower life expectancy and lower health status compared to other Americans. For example, they have significantly higher rates of death from alcohol, chronic liver disease, cirrhosis, diabetes, unintentional injuries, accidents, and assaults, specifically homicide.

These disparities may be impacted, in part, due to the health workforce shortage on Indian reservations and at Indian health facilities. For instance, in 2017 nearly 30 percent of all available physician positions at all Indian Health Service (IHS) federal facilities across the country were vacant.

One approach to address this shortage is to maximize the opportunities for home-grown medical and dental training programs within federal IHS facilities. There are 24 hospitals and 51 federal health centers operated by IHS, and while many IHS facilities have rotations for medical students, residents, dental students, and physician assistants, not one has an accredited residency program.

To address this, the ACTPCMD approved a draft letter that addresses workforce shortages at IHS and other tribal health facilities, which may contribute to health disparities in the populations these institutions serve. The letter recommends that the Secretary:

- Give preference to eligible IHS and Tribal entities for all Title VII grant programs authorized under Title VII, Part C, Section 293k and 293k-2 of the Public Health Service Act.
- Interpret the term “other approved primary care dental trainees” listed under the Title VII, Section 748 authorization, to include trainees of the dental therapy profession.

In addition, the ACTPCMD letter recommends that the Secretary and Congress:

1. Develop funding programs to establish, maintain, expand, and evaluate medical, dental, and physician assistant (PA) training programs at federal IHS facilities.
2. Develop funding programs that facilitate the training and recruitment of medical, dental, and PA providers at federal IHS facilities.
3. Give graduates of HRSA-funded training programs at IHS facilities priority in obtaining National Health Service Corps Loan Repayment awards.
4. Develop mechanisms to increase technical resources available to IHS sites that are successful in establishing training programs, particularly graduate medical and dental education programs.

The letter was approved by majority vote, pending minor modifications to be undertaken by a Committee Work Group. A Committee vote approved the following modifications to be made by the Work Group:

- The Committee recommended that residency training programs include additional funding for a longer program start-up phase lasting two to three years, rather than the traditional one-year start-up. This would provide a solid foundation and better prepare the institution for accreditation of the program.
- The group recommended that Congress increase funding appropriations for such training programs, to match the increased scope. It also suggested adding a statement noting that current funding levels are not adequate for the training programs currently operating to meet the existing needs.
- The Committee agreed that the development of training programs should not be contingent on increased funding. In other words, HRSA can move forward with the development of such programs—while giving preference to eligible IHS and Tribal entities—even if funding has not yet been allocated.
- The Committee suggested that the increased funding be coordinated with other funding streams—both existing and new—that support initiatives that train health care professionals. The Committee agreed that it would be helpful to propose coordination and acknowledge other programs, such as the 2018 MISSION Act, in addition to thanking Congress for allocating such funding.

HRSA Data Warehouse Feedback Session

Elizabeth Kittrie, Senior Advisor for Data and Innovation,

Office of the Associate Administrator, BHW

Michael Arsenault, MBA, Director, Division of Business Operations, BHW

Ms. Kittrie and Mr. Arsenault gave a presentation on HRSA data and then held a listening session to obtain feedback from the Committee. HRSA is mandated by law and the Secretary to share data with the public. Ms. Kittrie explained that an effort is underway to improve BHW data on the HRSA Data Warehouse. The goals of the effort include: 1) Enhancing the findability and usability of BHW's health workforce data, 2) Presenting health workforce data more coherently across BHW programs, 3) Cleaning up data that are misaligned or outdated, and 4) Identifying data gaps and stakeholder needs. To accomplish this, the Bureau will continue to hold a series of listening sessions from October to December 2021 in order to develop a strategy and roadmap. Implementation of the identified changes will be carried out from January to June 2022.

The HRSA Data Warehouse holds a significant amount of data on various areas including data on clinician dashboards, training programs, practitioners, nurse corps, nurse surveys, shortages, workforce projections, and other data.

For example, data on shortage designation includes information on Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/P). The National Practitioner Data Bank is a national repository of medical malpractice and adverse actions related to health care practitioners, providers, and suppliers. The Health Workforce Project Tool is an interactive tool, based on HRSA's microsimulation model, that helps visualize the supply and demand of health professionals. Data on the clinician dashboards includes retention and location data of the NHSC, Nurse Corps, and other program alumni. The Health Workforce Connector is an interactive tool that allows users to search and locate open job opportunities and training sites by a range of criteria (geography, HPSA score, clinician type). Data are also available on grant awards, health professions training programs, and other areas.

Discussion

The discussion included the questions/comments below.

HRSA Question to Committee Members: How are you using the HRSA data warehouse now, if at all? What information are you seeking and what are you trying to achieve?

One member said they use data with the GIS system to map their graduates and determine whether or not they are meeting their mission. They update this information annually and use it in conversations with state and national legislators. The data are also used with various health systems to show that—from an undergraduate medical perspective—training students leads to workforce development in their health systems.

Another participant said they have found the warehouse information to be very useful in writing articles and grants, and to substantiate data published in articles. In particular, they have used the mapping ability to look for Health Professional Shortage Areas and Federally Qualified Health Centers. One suggestion related to the mapping is that the small color circles as well as the legend be made larger, as it is hard to see exactly what color is being represented on the mapping services.

HRSA Question to Committee Members: Are you aware of the following tools and have you used them: National Practitioner Data Bank, Health Resource Files, Health Workforce Projection Tool, and Shortage Designation?

A member said he had used the National Practitioner Data Bank tool and found it very useful at the state level.

HRSA Question to Committee Members: Are you aware of the following tools and have you used them: Grant Data and Health Professions Training Programs?

A member said he had been involved in physician assistant (PA) education for nearly 30 years and been the recipient of five HRSA grants. He said he wished that such a tool was available back then. It would have been an asset for grant writing and for fulfilling grant obligations.

Another member said that as a dean of an undergraduate medical school, she found the information helpful when trying to determine if they were meeting their mission and whether their graduates were ending up where they are supposed to. She suggested sharing the data with educational organizations,

such as Association of American Medical Colleges and others. Another participant suggested that the data be interactive so that it can be better used in presentations.

18th Report Final Review

Anita Glick, MSW, Chair, ACTPCMD

Ms. Glick provided an update on the Committee's 18th Report. She began by thanking all members of the 18th Report Work Group and HRSA Staff for their help and dedication. Ms. Glick then briefly reviewed the report's format.

The format was developed to be relatively concise and user friendly, so that congressional stakeholders and HRSA staff members can find what they needed quickly. The report opens with a list of recommendations followed by a brief rationale for each recommendation. This section is then followed by an executive summary, which considers the impact of the pandemic and spotlights issues related to health equity, as well as some of the changes that have occurred in policy, payment, education, and practice.

The executive summary further emphasizes the importance of comprehensive, team-based collaborative care to reduce health disparities and increase access, in both rural and underserved communities. Additional background information is then provided so that those wanting to dig deeper can learn more about each recommendation, and get a better understanding of the rationale behind the recommendation. Also supplied in this section are some current exemplars that illustrate the role of various professions and the innovative solutions used to address various needs.

The report's conclusion specifically notes that—although the report focused on the needs of underserved rural communities—the recommendations can benefit all populations. And although the recommendations specifically concern issues related to medicine and dental programs, the involvement of the broader health care team is recognized in addressing issues related to health equity. The report concludes with references and a glossary of definitions.

The Committee reviewed the final recommendations, which were approved at the Committee's March 2021 meeting. Through the report, the ACTPCMD made four recommendations. More specifically, the ACTPCMD recommended that Congress increase funding to Title VII, Section 747 and 748, programs to:

1. Increase the number of longitudinal primary care rotations and postgraduate residency programs providing training in underserved rural communities with an emphasis on accessible, comprehensive, equitable, and age-friendly care.
2. Integrate oral and behavioral health into primary care training to support interprofessional team-based training and practice that addresses the needs of medically complex patients, including those facing racial and ethnic inequity in underserved rural communities.
3. Build and enhance telehealth capacity of primary care training programs to use clinical telehealth technologies for telemonitoring, remote interprofessional collaborative care, shared patient management, and telementoring in underserved rural communities.

4. Support interprofessional team-based education and practice that incorporates oral health and a life course approach to proactively address disparities in maternal and infant health outcomes in underserved rural communities.

Discussion

The discussion included the questions/comments below.

Recommendation 4 reads as follows “...incorporates oral health and the life course approach.” Oral health stands out and does not seem like it belongs in that recommendation as being pulled out separately. What was the rationale for oral health being specifically mentioned in the recommendation?

One thing we know is that oral health among pregnant women is a challenge. In some states, pregnant women do not receive definitive oral health care, which means they do not have the opportunity to get a cleaning, comprehensive exam, X-rays, or get fillings done. Normally, these states only provide for emergency care—particularly under Medicaid for this patient population. We also know that there is an oral systemic link that has been recognized since 2000 of low birth weight babies and challenges with cardiovascular disease and other comorbidities. So the thought was to ensure that this patient population, during their time of pregnancy, had the opportunity to at least have a healthy outcome for themselves and their child.

That explanation for Recommendation 4 is not reflected in the text of the rationale, the background for this recommendation. So the writing group may consider adding a paragraph that might capture the above rationale. It could help the reader put the recommendation in context.

19th Report Plans

Sandra M. Snyder, DO, Vice Chair, ACTPCMD

Dr. Snyder updated the Committee on the latest efforts related to the 19th report. A writer has been secured to help the group write the report. Subject matter experts will be scheduled to present to the Committee to help inform and focus the group’s deliberations. In the last meeting, the Committee’s discussions about the topic of the 19th report focused on health equity.

The pandemic has demonstrated that the country’s infrastructure for public health and primary care is relatively poor. It also shined a light on the health disparities that exist in our country. As with the 18th report, the 19th report could focus on an interprofessional approach to improve the health of those most vulnerable in our communities.

Discussion

The discussion included the questions/comments below.

During the March 2-3, 2021 meeting there were some excellent presentations on health inequities. The Committee might consider reviewing the presentations by Dr. Singh and Ms. Allender from the Office of Health Equity titled Addressing Social Determinants of Health to pull out and expand on the health inequity topics presented.

The report could also address the movement of machine learning (or Artificial Intelligence) into medicine and the hospital home concept. For example, the report could explore how artificial intelligence will affect the total medical workforce.

One of the priorities that seems to have dropped off explicitly from HRSA's RFAs is a focus on the diversity of the workforce being trained. It might be helpful to bring back a very explicit focus on deepening the diversity of our trainees and making training a criteria for funding.

Another emphasis might be on helping health care providers to have a better understanding of social determinants of health during their training as well as an appreciation for community input.

Children with Special Health Care Needs

Anna Maria Padlan, Public Health Analyst, Maternal and Child Health Bureau

Ms. Padlan presented on the need for care integration to better serve children with special health care needs, especially those with medical complexities. Within HRSA's Maternal Child Health Bureau lies the Division of Services for Children with Special Health Needs (DSCSHN). The Division's purpose is to provide national leadership and resources to expand, strengthen, and improve the quality and equity of systems of care for children and youth with special health care needs (CYSHCN) and their families.

DSCSHN serves children or youth who have (or are) at increased risk for a chronic physical, developmental, behavioral, or emotional conditions and who require health services beyond those generally required for children. In the U.S., nearly 20 percent of children under the age of 18 have a special health care need. For these children, services may be needed from multiple systems including health care, public health, education, mental health, and social services.

A HRSA NSCH brief titled *Children with Special Health Care Needs* published on July 2020 revealed that less than half of CYSHCN had a medical home and one in three CYSHCN needed care provided at home and/or health care coordinated on a weekly basis. Also, while nearly all CYSHCN (95.8 percent) were insured at the time of the survey, only about 62 percent were reported to be adequately and continuously insured throughout the year.

One of the ways to better serve CYSHCN is to integrate care. Care integration can be defined as the seamless provision of health care services across the care continuum. Care integration is important because studies have shown that the system of care is fragmented, especially for children with medical complexities. Care integration also improves the quality of life and well-being of CYSHCN and their families, and yields time/cost effectiveness for families and providers. The COVID-19 pandemic further emphasized the system's fragmentation, as well as challenges in accessing: home care providers, supplies, payment/reimbursement of services, and access to therapy.

Collaborative Improvement & Innovation Networks (CoIINs) are composed of teams poised to tackle complex health problems. HRSA has developed a CoIIN to advance care for children with medical complexity (CMC) that has as a goal to improve the quality of life for children with medical complexity,

the well-being of their families, and the cost effectiveness of their care. It consists of ten state teams with project focus areas that include care coordination, supporting rural care with telemedicine and virtual care teams, innovative partnerships, and testing of innovative payment models.

In the area of care coordination, the CMC CoIIN teams have developed Get to Know Me Forms and Goal Cards; a Pediatric to Adult Care Transition Workbook; a Care Coordination Academy; and developed an agreement with a Managed Care Organization to provide service coordination. Telehealth was also used to provide care/support during the COVID-19 pandemic; strengthen family/provider partnerships; support CYSHCN/CMC home caregivers; and support care in rural or underserved areas, or areas where there is a shortage of CYSHCN/CMC specialists.

Telehealth has offered less travel time for the families and the ability to gather multiple providers from different systems at one time. Some of the existing barriers for the use of telehealth is the equipment and bandwidth required as well as issues related to reimbursement for using telehealth.

Discussion

The discussion included the questions/comments below.

During the pandemic, patients with children with special health care needs tend to shelter in place because, in some cases, those children are at risk for additional illnesses. So these individuals and their families can become isolated. Without a connection via telehealth—and without the face-to-face connection when possible—this can become a challenge.

As a practicing pediatrician of children with special needs, I sometimes run into a Catch-22. Families of children who need home health services are often the ones most reluctant to have someone come into their home, because we are behind on immunizations. There are some visits for children with special needs have that cannot be done virtually, such as some types of physical and occupational therapy, so access can become a challenge.

Title VII Grantee Panel: Intellectual or Developmental Disabilities (IDD)

Elizabeth Kapral, MS, DDS, Director of Special Needs Dentistry,

Erie County Medical Center Department of Dentistry, Buffalo, NY

Romer A. Ocanto, MEd, MS, DDS, Professor and Chair, Department of Pediatric Dentistry, Nova Southeastern University College of Dental Medicine, Fort Lauderdale, FL (presented by Dr. Jeffrey Hicks, ACTPCMD member)

Dr. Kapral's presentation focused on providing dental services to adult patients with intellectual or development disabilities (IDD) at the Erie County Medical Center, a Level 1 Trauma Center. Adult patients with IDD have a longer wait for a clinic visits compared to non-IDD patients. New patients have a 14-week wait for a 45 minute evaluation. Those patients that needed general anesthesia to have their dental treatment completed have to wait 18 months for treatment. New, non-IDD adult patients typically wait up to four weeks for their first appointment. The burden of dental disease is also higher for the adult IDD population, with 32.2 percent of patients having untreated dental caries, and about 10 percent having edentulism.

Graduating dental students report not being confident or willing to treat patients with special needs. Dentists also report a lack of training and experience as the primary barrier for providing care for adults with IDD. Reimbursement also plays a role. The vast majority of adults who have IDD have federal health insurance—like Medicaid—or third-party insurers, and they have exceptionally low reimbursement rates. Less than half of all dentists accept Medicaid.

In 2020, HRSA awarded the Erie County Medical Center with a postdoctoral training grant in general, pediatric, and public health dentistry and dental hygiene. It is a five-year award located within a state-of-the-art interdisciplinary center that provides financial support for providers, staff, and equipment. The Center partners with the University of Buffalo School of Dental Medicine and with fourth-year dental students interested in treating this population.

The program has had about a 50 percent increase in dental residency applications and five resident graduates have been hired since 2019. The treatment offered is patient-centered and it is believed that the skills that residents and students gain in treating adults with IDD can translate well to other vulnerable populations, including patients with medical complexities. Some of the challenges being faced include low reimbursement rates, program sustainability, and other challenges. Nonetheless, a pre- and post-survey showed that nearly 90 percent of the learners feel more confident in their skills and their desire to treat an IDD population in their practice at the end of the program year.

Another HRSA grantee is the College of Dental Medicine at Nova Southeastern University in Fort Lauderdale, Florida. Their training grant educates and trains future pediatric dentists who treat children with special health care needs (SHCN), thereby increasing access to dental care for these children.

The program also establishes a pediatric dental training program through inter-professional collaboration between three partners: the College of Dental Medicine, the Joe DiMaggio Children's Hospital, and the Mailman Segal Institute. A didactic training portion was designed by experts at all three institutions into a standard dental course format. The course was integrated into the first-year training schedule of first year pediatric dental and Advanced Education in General Dentistry (AEGD) residents.

The didactic curriculum covers a host of areas including child development, epidemiology of SHCN and autism spectrum disorders, behavioral guidance, teaching children dental care skills, working with the families, pharmacy compounding, cultural competence, telehealth, and more.

Residents rotate through the clinic four days per week for routine clinical visits and are assigned one day a week to sedation cases. Patients and their families are exposed to behavior guidance and management techniques. The behavior guidance protocol is a marriage between two disciplines (pediatric dentistry and AEGD and behavioral research) and takes into account the specific dynamic of the family being engaged. Trainees also learn behavioral guidance techniques and applied behavioral analysis. Practitioners of applied behavioral analysis examine the functional relationship between the environment and behavior to modify socially significant behaviors. Many of the prerequisite skills (behaviors) necessary for accepting treatment (e.g., sitting in dental chair, tolerating dental instruments, reducing oral defensiveness) can be taught and reinforced at home, school, or other settings.

An assessment of the program showed that out of 268 patients, only 98 (37 percent) had ever visited a dentist. A separate patient satisfaction survey of 87 patients showed high patient satisfaction (e.g., satisfaction of care with dentist was 41.4 out of a possible score of 44 and 15.1 out of 16 for residents). The impact of the program was also assessed among postgraduate students. In a survey of 14 postgraduates nearly all (93 percent) endorsed using the skills from SHCN rotation in their current practice. Residents also believed that their clinical exposure through the program increased their confidence in treating and managing children with Autism Spectrum Disorder.

Discussion

The discussion included the questions/comments below.

What percentage of patients in the cohort needed anesthesia to be treated?

In New York State, about 5 percent of adults with IDD need to be treated under general anesthesia.

Why is it that this population of patients is still so under-reimbursed?

This happens with both dental and health care reimbursement. It is a global issue of not dedicating enough monies for these patients. In the past, many of those with IDD were institutionalized in big centers where everything was provided for them. Now that everything has been deinstitutionalized, it seems they are not always getting the services they need.

Practitioners tend to spend a lot more time with IDD patients. Are there reimbursements for patients that take much longer to treat?

In New York State when a patient gets services through the Office for People with Developmental Disabilities, there is a code one can submit to Medicaid for additional time. The reimbursement is about ten dollars.

In Texas there is no such modifier. There is a behavioral procedure that one can bill, although the reimbursement is not great. It might take you 15 to 30 minutes longer to do a dental restoration, but the dentist does not get to bill 30 to 50 percent more for that same procedure.

Given the silos in our health care system, the burden of communicating all critical health information is often left up to the patient. This may be one of the biggest hurdles for families when patients have so many comorbid conditions. Can you speak to any experiences you have had with a shared electronic health record and shared patient management?

For patients treated within the County hospital system, it is exceptionally easy to send a secure message, or review the patient's history, or see when they were hospitalized or if they were in the emergency room for a dental infection. That information is critical when developing a treatment plan. However, fewer than 10 percent of my patients are treated within the hospital system.

It is imperative to address funding. The difficulty with caring for these patients has been clearly outlined for us. Even if medical professionals learn something about treating IDD patients during their training, treatment of those patients is time consuming and requires extraordinary patience. If one then adds an insurance that by definition does not cover the full costs, then it is too easy for providers not to add them to their practice. Payment needs to be adequate to attract providers to care for them.

Also, physicians treating adults are not trained to care for people with IDD. There is almost no IDD training in any specialty. What happens when these patients age out of pediatric care, become adults, and are no longer eligible for government insurance? Often times there is no one who is trained to care for them. This is an area that needs to be addressed.

Public Comment

Shane Rogers, DFO, ACTPCMD

Ms. Laura Brannon, Senior State Advocacy Manager at Community Catalyst, a national nonprofit health advocacy organization, provided a letter to the Committee on behalf of the nonprofit's Dental Access Project. The letter, which is supported by 51 state and national organizations, requested that the ACTPCMD recommend that HRSA add dental therapy to all grant programs that fund dental education and training.

Dr. Karen Mitchell from the American Academy of Family Physicians said that a program in Asheville, North Carolina offers an example of place-based interdisciplinary training. The program offers training for multiple specialties that are needed locally (e.g., family physicians, OB/GYN, psychiatry, internal medicine) as well as training for some learners from interprofessional areas (e.g., PAs, nurse practitioners, pharmacists, behavioral medicine professionals). She said such training programs demonstrate how gaps in care can be addressed.

Title VII Grantee Panel: Workforce Diversity and Implicit Bias

*Pat Matthews-Juarez, PhD, Professor, Department of Family and Community Medicine
Senior Vice President, Office of Strategic Initiatives and Innovation,
Office of the President, Meharry Medical College*

*Tonya L. Fancher, MD, MPH, FACP, Professor, Internal Medicine, Associate Dean, Workforce
Innovation and Community Engagement, University of California, Davis*

Dr. Matthews-Juarez updated the Committee a program implemented by the National Center for Medical Education, Development, and Research at Meharry Medical College. The HRSA-funded program, has as its objectives to: 1) Conduct two research projects annually for five years on topics relevant to vulnerable populations (Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ), persons experiencing homelessness, and migrant farm workers), 2) Establish three communities of practice, and 3) Translate and disseminate research findings to a wide range of audiences.

One of the first research projects the Center undertook was to learn more about physician implicit bias. They wanted to know its impact on medical education and practices, especially with vulnerable

populations. The Center also wanted to determine the impact of implicit bias on health outcomes and health equity. Implicit bias was defined as “Attitudes and beliefs that are unconscious (i.e., outside of conscious awareness) and automatic and often embody negative stereotypes.” The Center conducted a systematic review of LGBTQ-related bias literature among medical, nursing, and dental providers/students.

The review showed that LGBTQ individuals face significant disparities in physical and mental health outcomes. For example, sexual minority women report fewer lifetime pap tests; transgender youth have less access to health care; and LGBTQ individuals are more likely to delay or avoid necessary medical care compared to heterosexual individuals.

Research studies also showed that perceived discrimination from health care providers and denial of health care altogether are common experiences among LGBTQ patients and have been identified as contributing factors to health disparities. The percentage of LGBTQ population lacking a regular health care provider is significantly higher (40 percent) than for the heterosexual population (10 percent). LGBTQ patients also have higher rates of anal cancer, asthma, cardiovascular disease, obesity, substance abuse, cigarette smoking, and suicide. Findings further suggest that medical students and health care providers are likely to underestimate or to be unaware of their implicit biases towards LGBTQ patients.

While interprofessional and interdisciplinary training is effective in promoting more tolerant attitudes toward LGBTQ patients, there is limited research on the effects of providing implicit bias education to increase knowledge and comfort levels among medical, nursing, and dental students or providers towards LGBTQ persons. Dr. Matthews-Juarez offered various policy recommendations including:

- Offering cultural competence training for health care professionals who train and work in primary care clinical care settings (urban, rural, and inner-city) with LGBT populations.
- Having a comprehensive curriculum in LGBTQ health with a focus on integrated health to reinforce non-bias health care and treatment as part of the foundation of the health professions.
- Providing evidence-based primary care to encourage the acquisition of awareness, knowledge, behaviors, and skills consistent with creating an LGBTQ-patient-centered medical home.
- Educating students, residents, and practicing health care professionals to establish and build trustable and compassionated relationships to ensure positive health outcomes for LGBTQ patients.

Dr. Fancher presented on a HRSA grant received by UC Davis to support the development of a diverse health care workforce. UC Davis has increased its number of matriculants to the School of Medicine from groups underrepresented in medicine over the years. In 2000, only about 7.5 percent of their matriculants were from underrepresented groups while in 2020 that number had grown to 52 percent.

The university has re-thought about who gets to decide who gets into medical school by diversifying its admissions committee; inviting community members and multiprofessional colleagues to participate in the process; adding value to non-traditional strengths, such as having attended a community college and

coming from a disadvantaged background; by blinding the admission selection to metrics; and through implicit bias training.

The school has created a series of Pathways programs, or communities of inclusion, where students have shared values/backgrounds and students and faculty share common professional interests. Working with partners, UC Davis has Pathways programs for rural, urban, tribal, and central valley medical students, as well as those students who wish to practice in primary care. These programs have been successful in graduating more underrepresented medical students over time. UC Davis and Kaiser Permanente are now developing a program called “Avenue M” which would take students from community college to medical school. Based on pre-specified outcomes, community college students would be conditionally admitted to undergraduate studies and then to medical school. Avenue M includes longitudinal mentoring, stage-appropriate curriculum and clinical work, and professional identity formation with a culturally informed lens.

Discussion

The discussion included the questions/comments below.

Are physicians graduating from the UC Davis program improving patient outcomes?

That is a hard question to answer because it takes a lot of resources to do so. It takes a lot of expertise and data to find them. The group at NYU is following graduates through the American Medical Association master file and then connecting that to HRSA data and rural placement data.

Has UC Davis developed a strategy to work with those students who have failed to match?

The school has not yet developed a strategy. Part of the challenge with matching is the “tyranny of grading”—the metrics that have traditionally been used to predict if someone is going to be a good resident or doctor. Unfortunately, those predictions are not always true and thus, are unfair metrics. There needs to be a critical mass of medical schools that challenges such metrics for it to change.

There has to be a ranking, because that is how medical schools determine who matches into different programs. If the step exams are pass/fail, how does one rank (or choose) who matches into residency programs? Or who goes into a specific specialty or sub specialty? For instance, if there is no step score, if grades are pass/fail, then how does one select students who want to go to into neurosurgery, orthopedics, or other specialties? All specialties need more underrepresented students.

The goal is not to get rid of standards. In fact, there should be standards. But it is important that each committee that governs medical education examine the standards. Is the standard as relevant today as it was in 1913 when there was a study to determine whether or not a medical school met the standard? What is important to note, is that at the time of the study there were issues with discrimination as well as other issues that have since come forward. Moving forward, there has to be an analytical, data-driven understanding about what should be done about creating a new, diverse workforce for the country.

One of the biggest challenges is the faculty's implicit bias and the structures created over the years. Where does one begin if the bias that exists within those that are teaching is not addressed?

Some faculty who sit on admission committees want to admit students that they feel they can teach, mentor, coach and have a professional relationship with. My recommendation would be to cultivate and train junior faculty that are outside of the teaching process to be a part of admissions. Those individuals should be coached and mentored by external parties who may belong to schools that are very different.

In one instance in a rural setting, the providers were people of color and the population they served was primarily White. Their challenge was that the population held biases about people of color, and felt that the providers did not have the necessary skills to care for them. Can you speak to this?

The idea of implicit bias in a rural community where the providers are of color and the population is all White speaks to the test of trust and trustworthiness. It also speaks to the issue of community engagement. We have to find a way for providers to understand that implicit bias is real. That is why we should recommend that licensing boards take a look at implicit bias in the same way they take a look at other matters, such as prescribing.

Dental Therapy

*Colleen M. Brickle, EdD, RDH, RF, Dean of Health Sciences,
Normandale Community College Bloomington, MN*

Valerie Nurr'araaluk Davidson, JD, President, Alaska Native Tribal Health Consortium, Anchorage, AK

Dr. Brickle briefed the Committee on efforts in Minnesota to license dental hygienists and dental therapists. Dental therapy is a relatively new model in the U.S., although in other countries, such as New Zealand, dental therapists have been part of the oral health workforce for more than 100 years.

The Surgeon General reports of 2000 and 2003 heightened awareness about enhancing the oral health care work force team. In rural Minnesota, there was a shortage of dentists as well as some groups of dentists that were close to retirement. There was a long waiting list for oral health services at community clinics, and emergency rooms were seeing cases of treatable dental care disease. There was therefore a need to expand the workforce with professionals who could provide oral health services to vulnerable patients and also enable clinics in rural and urban areas to provide more efficient and timely care to their patients.

The Minnesota legislative bodies developed statutes to create the dental therapist and advanced dental therapists professions. Dental therapist work with dentists in the clinic and under their direct supervision, while advanced dental therapist have a broader scope related to assessment, reasoning, and treatment planning and are able to work in an office when the dentist is not there or in community settings.

HRSA has provided funding for *Innovative Pathways to Advanced Practice for Dental Hygienists: Meeting the Needs of Minnesota Underserved Populations*. Through this award, a third dental therapy program was established at a university to meet the needs of rural Minnesotans. Pipeline programs were created for dental therapy programs and health equity was integrated throughout the curriculum. Every course includes racial sensitivity, cultural competency, and health literacy. The funding also helped to develop a toolkit for dental therapy titled *Dental Therapy: Dental Hygiene-Based Model*. The Minnesota model includes licensure and certification, a board of dentistry program approval process, and accreditation through the Commission on Dental Accreditation.

Dental therapist and advanced dental therapist surveys were administered by the Minnesota Department of Health. State results from 2014 to 2018 showed a total of 121 dental therapists, with 85 of them having their advanced therapy credential. The survey showed that 95 percent of them are currently working; that they plan to work for more than 10 years; and that they are a more diverse profession than dentists in the state. Their geographical distribution is similar to the distribution of the population in the state, with some of them working in rural areas.

Patient satisfaction with dental therapists is high, with no complaints to the Board of Dentistry related to the quality of care. Dental therapists are consistently meeting or exceeding production goals, while having lower employment costs than a dentist. Challenges include the fact that there are few scholarship opportunities, no federal loan forgiveness programs, and portability barriers due to different licensure requirements.

Ms. Davidson said the Alaska Tribal Health System is a voluntary affiliation of Tribes and Tribal organizations providing health services to Alaska Native and American Indian people and includes approximately 11,600 employees statewide. Dental therapists are part of the system. Today there are 60 dental health aides and over 20 dental therapists.

In Alaska, dental therapists are defined as primary oral health care professionals who provide basic clinical dental treatment and preventive services. They are members of a multidisciplinary team, advocate for the needs of their clients, and refer for services beyond the scope of the dental therapist's practice. The dental health program is a two-year educational program with the second year curriculum focusing heavily on clinic training. The dental therapist education meets the same standards as other dental professional education and began receiving accreditation from the Commission on Dental Accreditation in 2020.

These professionals work under the supervision of a dentist within the tribal health system. Dental therapists have been well accepted in Alaskan tribal villages with high levels of patient satisfaction and no reports of patient harm.

Discussion

The discussion included the questions/comments below.

What prerequisite education is needed for people to enter a dental therapy program? Does the ADA have a stance on dental therapists?

In Alaska, the minimum educational prerequisite to enter the program is having a high school education. The Alaska program is accredited by the Commission on Dental Accreditation, which is part of the American Dental Association.

In Minnesota, as per statute, the minimum educational prerequisite to enter the program is a bachelor's degree for therapists and a master's degree for advanced therapists. In Minnesota, the American Dental Association is neutral.

In Minnesota there used to be a stipulation for private practitioners that they could take on dental therapists as part of their private practice as long as they had a certain percentage of Medicaid patients. Is that still the case?

In Minnesota the law states that a dental therapist working for a private provider must have at least 50 percent of the therapist's patient base as being low-income, uninsured, or underserved. Or, they must be working in a health professional shortage area.

19th Report Recommendations Discussion

Sandra M. Snyder, DO, Vice Chair, ACTPCMD

The Committee held a brainstorming session surrounding the topics to be covered in its 19th report. A productive discussion yielded a preliminary series of topics. These topics will be further discussed and might eventually distilled into recommendations. Overall, there was consensus that a report should focus on dental therapy, especially its role and impact on rural and underserved communities. Additional topics that held the group's consensus included:

- **Special health care needs**, including the needs of those with intellectual and developmental disabilities (IDD). Also, training programs for providers to be able to deliver care for those with special needs, including training for PAs and professionals in oral health
- **Implicit bias** as it relates to provider training (e.g., care for those with IDD) and its impact on health equity
- **Reimbursement challenges** and the need for reimbursement increases, especially for IDD, as most of the reimbursements in the U.S. are made through public programs
- **The impact of COVID-19** in spurring rapid changes in the delivery of health care and health care education
- **Geriatrics** and the current trend that less physicians seem to be choosing the specialty, despite a growing need for geriatricians

As part of the next steps, the Committee agreed that a Working Group of volunteers would be created to further develop a draft of the recommendations and other aspects of the report based on the discussion. The draft recommendations would then be reviewed by the ACTPCMD as a whole on a subsequent public meeting.

Discussion

The discussion included the questions/comments below.

- There should be consideration as to whether learners cannot only manage, but also treat the IDD population as part of their dental school curriculum
- Consider increased use of telehealth for IDD patients, especially in rural areas
- Create more dental therapists so that they can meet the need for oral care, especially in areas where there is great need, such as rural areas
- While it is helpful to meet the need in some areas, it must be met with competent care
- Add to the report the impact of telehealth education during the COVID-19 pandemic
- Determine how this new dental therapy model would impact established practices, especially in urban areas where minority dentists practice
- Address whether those initially thinking of becoming a dentist would instead be drawn to a dental therapy program, therefore further diminishing the number of graduating minority dentists
- Consider that geriatrics, homeless populations, and other groups also have a need for more professionals to provide oral care
- With respect to matriculating more underrepresented students, go beyond only modifications to the curricula and also consider other strategies such as increasing faculty diversity, the diversity of the selection committee, etc.
- Include Dental Therapists in the glossary, along with a definition and focus
- Health care providers should be introduced to geriatrics through a positive experience rather than a worst-case scenario
- Highlight programs that link undergraduate to graduate programs (e.g. Pathways) to address equity in the health care professions
- The Commonwealth Fund will be releasing a comprehensive summary on dental health over the next year, so a report on the same topic would help to support their findings
- It would be helpful to address how dental therapy can help address health equity
- Instead of a report on dental therapy, the Committee could release a brief, summary, or two-page letter on the topic

Business Meeting

Shane Rogers, DFO, ACTPCMD

Mr. Rogers informed the group that the meetings for next year will take place on February 17-18 and August 2, 2022. All meetings will be held virtually.

The Coronavirus Aid, Relief, and Economic Security Act, or CARES Act, was signed into law on March 2020. The Act requires that the Department of Health and Human Services develop a Health Workforce Plan. HRSA was tasked with the lead in developing the plan in consultation with five committees, including ACTPCMD.

The 80+ page plan was made public through HRSA's website last week. The consultation letters drafted by the committees, including the ACTPCMD consultation letter, will be posted shortly by HRSA's IT department.

Mr. Rogers said he will reach out to all Committee members via email to determine if they would like to participate in Work Groups for the development of the 19th report and other deliverables.

Adjourn

Anita Glicken, MSW, Chair, ACTPCMD

Ms. Glicken thanked all Committee members for their active participation. She also thanked the HRSA team and the technical writer for their support. Ms. Glicken said that Dr. Snyder will be taking over as Chair starting with the February 2022 meeting.

Mr. Rogers adjourned the meeting at 2:57 p.m. (ET).