MEETING MINUTES
Advisory Committee on Interdisciplinary Community-Based Linkages
May 1, 2020

Committee Members Present
James Stevens
Chair

Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP
Vice Chair

Geraldine Bednash, PhD, RN, FAAN
Joseph H. Evans, PhD
Roxanne Fahrenwald, MD, FAAFP
Robyn L. Golden, MA, LSSW, ACSW
Bruce E. Gould, MD, FACP
Parinda Khatri, Ph.D.
Lisa Zaynab Killinger, DC
Kamal Masaki, MD
John E. Morley, MB, BCh
Jacqueline R. Wynn, MPH

HRSA Staff in Attendance
Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, ACICBL, Division of Medicine and Dentistry
Shane Rogers, Chief, Oral Health Branch, Division of Medicine and Dentistry
Irene Sandvold, DrPH, FACNM, FAAN, Senior Advisor, Medical Training and Geriatrics Branch, Division of Medicine and Dentistry
Anne Patterson, Public Health Analyst, Division of Medicine and Dentistry
Kimberly Huffman, Director of Advisory Council Operations
Janet Robinson, Advisory Committee Liaison, Advisory Council Operations

Introduction

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 10:00 AM, on Friday, May 1, 2020. The meeting was conducted via webinar and teleconference by Health Resources and Services Administration (HRSA) staff. Dr. Joan Weiss welcomed the Committee, thanked them for their work, took roll call, and gave instructions regarding meeting participation. All of the members were in attendance. Dr. Weiss thanked Committee members for submitting responses to the Bureau of Health Workforce (BHW) questions on their institutions COVID-19 activities. She invited members who had not yet submitted questions to do so by Monday, May 4, 2020. Dr. Weiss said BHW is interested in ACICBL input regarding COVID-19. Mr. Stevens welcomed the Committee.

The Centers for Medicare and Medicaid Services
Accountable Health Communities Model and Social Care

Rivka Friedman
Director, Prevention and Population Health Group
Acting Director, State Innovations Group
Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services

Dr. Weiss introduced Ms. Friedman and thanked her for her time. Ms. Friedman said she would present: 1) background on the Accountable Health Communities (AHC) Model, which was the Center for Medicare and Medicaid Innovation's (CMMI) first effort to address social determinants of health, 2) how Model program participants are responding to COVID-19, and 3) how COVID-19 has affected the Model program.

AHC Background, CMS Work Related to Social Determinants of Health. The AHC Model program was launched in 2014. The program selects and funds community-based organizations to screen and refer to navigation any beneficiaries who present as having health-related social needs. AHC provided a foundation for more CMS work to address social determinants of health. For example, CMS launched the Integrated Care for Kids Model in 2020. The program serves women and children covered by Medicaid and the Children's Health Insurance Program (CHIP) through a broad coalition of healthcare and social service providers. AHC program participants are charged with convening clinical delivery sites, including office-based practices, hospitals, Federally Qualified Health Centers (FQHC), and behavioral health facilities. Participants also convene social service providers, who provide assistance with housing, nutrition, transportation, utilities, addressing interpersonal violence and other services. Supplemental services address disabilities, education, employment, family and community support, financial assistance, and mental health services. Program participants link the two types of provider organizations. The program currently includes approximately 30 participating "bridge" organizations serving 23 geographically diverse States. In addition to providing core services, organizations establish advisory boards to develop protocols and processes.

Discussion. Ms. Golden asked if AHC Models have demonstrated outcomes. Ms. Friedman said the program evaluation is in progress and outcome assessment results are not yet available. Dr. Brandt inquired as to what lessons CMMI and participants have learned to-date. Ms. Friedman emphasized that current information about lessons learned is anecdotal, and that information is

updating rapidly. She reported that participants have learned about needs prevalence. Need for food is most prevalent and has increased since the COVID-19 outbreak. Transportation is the next most prevalent need. Transportation is needed more in rural than urban communities. Language barriers are more prevalent among urban communities. Access to services and ability to deliver services within the constraints of the AHC model are more difficult in rural than urban communities. Most patients present with at least two needs related to social determinants of health. CMMI is interested in learning which needs are most strongly related to healthcare expenditures.

Flexibility offered by new regulations to improve response to COVID-19 has given some struggling rural healthcare provider organizations an opportunity to reach patients remotely through telephone and digital communications. Dr. Khatri said that the flexibility to deliver care through audio-only communication has been a welcome change at the FQHC where she works, since many households do not have internet access. Some households do not have cell phone access. Without the flexibility, it was not possible for providers to be reimbursed for care. Patients like these changes. Dr. Fahrenwald noted this has also been her experience. Dr. Khatri asked how long the policy changes are likely to be in effect. Ms. Friedman replied that CMMI currently is discussing the issue and she was not able to comment. Discussions include which flexibilities organizations utilize, and how, why, and when they do so. CMMI also is discussing which flexibilities beneficiaries comment about. CMMI will consider this information when deciding which flexibilities to extend. Some extensions would require legislation.
Dr. Fahrenwald said she hoped flexibilities would be permanent. Dr. Bednash noted telehealth patients are happy and will want to make access to care through telehealth permanent.

Ms. Friedman stated flexibilities concern timelines for implementation and reporting, risk-sharing, and alternative modes of care delivery. CMMI is discussing extending flexibility regarding alternative modes of care delivery that increase access. Bridge organizations have reported that their experiences with COVID-19 have accentuated the need for care that addresses social needs. Of 29 total bridge organizations, 26 have expanded screening to additional clinical sites; 23 have expanded the timeframe for screening eligibility and for patient navigation services eligibility. One bridge organization has reported that need for social services has increased markedly since the COVID-19 outbreak. Some organizations have increased rates of screening and navigation partly because some patients would not have contacted them if it were not for concerns regarding the virus. Telehealth and telephonic services also have expanded reach.

Discussion. Mr. Stevens asked whether AHC has explored alternative payment models.
Ms. Friedman replied AHC is implemented through cooperative agreements and does not pay providers directly. Other CMMI programs do apply alternative payment models. Several providers have expressed concerns about their accountability for fluctuations in demand for services due to COVID-19. Currently the Medicaid Shared Savings program is pausing both upside and downside risk for ACOs for 2020.
Dr. Gould remarked that it is important for CMMI to maintain flexibilities after COVID-19 since telehealth and telephonic care has increased reach. Patients who were deterred by transportation barriers are scheduling visits. Approximately 80 percent of diagnosis and treatment planning is

based on medical history. He emphasized the importance of keeping children's vaccinations up-to-date to avoid adding another epidemic to the current COVID-19 outbreak. He recommended considering which clinical services require face-to-face delivery and which can be delivered remotely so that more people can benefit from remote services. He expressed concern that healthcare providers serving vulnerable populations would stop operating due to economic problems caused by COVID-19.

Dr. Bednash asked how receptive communities are to efforts to monitor COVID-19 outbreaks and personal contacts. She also inquired if AHCs are considering alternative approaches to delivering necessary face-to-face contact, such as vaccines. Approaches could include nurses and public health workers making home visits. Ms. Friedman stated information is not yet available about how bridge organizations are avoiding COVID-19 risk or how they are responding to the epidemic. The current situation presents an important opportunity to leverage remote healthcare delivery. Dr. Bednash noted that, historically, public health nursing has been a foundation of intervention and that public health nurses and community health workers should travel to communities. This is critical for effectively addressing social determinants of health, especially in rural communities as well as households and communities without internet access. Ms. Friedman stated internet access is an important resource for reaching remote communities. She stated that, for this reason, telehealth infrastructure is a priority for CMMI.

Dr. Gould reported that the University of Connecticut Health Center, where he works, has recruited health professions students to monitor COVID-19 cases and suspected cases through daily calls that follow a Centers for Disease Control and Prevention (CDC) script. Implementation was challenging due to liability concerns. He suggested that CMS and HRSA collaborate to facilitate more efficiently implementing efforts to employ students' help during public health emergencies.

Mr. Stevens noted that telehealth is used extensively in Alaska. This frequently involves patients' having medical devices in their homes. He inquired if any CMMI programs support placing equipment in patients' homes. Ms. Friedman replied this has been discussed for rural model development efforts. She was unsure whether bridge organizations have done so, but believed this was likely. Dr. Fahrenwald stated the organization she works with in Montana has placed blood pressure cuffs and scales in patients' homes and these efforts have been successful.

Dr. Masaki asked whether CMS would relax Merit-based Incentive Payment System requirements due to COVID-19. Ms. Friedman replied she believed this to be the case.

Dr. Weiss thanked Ms. Friedman for her presentation. Ms. Friedman thanked HRSA and the Committee for their interest.

Bureau of Health Workforce and COVID-19 Activities
Luis Padilla, MD
Associate Administrator
Bureau of Health Workforce, Health Resources and Services Administration

Dr. Weiss introduced Dr. Padilla. Dr. Padilla thanked the Committee and HRSA staff for their work. He expressed appreciation for those providing direct healthcare services during the COVID-19 pandemic.

Dr. Padilla stated that the United States currently has approximately 2,000 disease investigators, while approximately 100,000 are necessary to address national needs for contact tracing. These services are necessary for the current situation and to address future outbreaks. The Bureau of Health Workforce would like the Committee to consider the implications of COVID-19 and future diseases for workforce education and training needs. Care delivery and professional training would not return to the status quo following COVID-19.

Dr. Padilla noted COVID-19 illustrates the importance of HRSA's mission to "Improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need." Support teams are often people of color from disadvantaged backgrounds who may be disproportionately affected by COVID-19. The demand for healthcare professionals is increasing and there are current shortages, particularly of primary care medical and dental providers. The National Center for Health Workforce Analysis is incorporating data on the impact of COVID-19 on healthcare providers into its projections.

HRSA programs aim to improve healthcare access, supply, distribution, and quality. These priorities remain during the COVID-19 pandemic. Community-based training is a strategy for achieving these aims. HRSA is considering how to decentralize care delivery and to develop infrastructure that supports remote delivery. He confirmed Dr. Bednash's point regarding the importance of public health nurses, patient navigators, and community health workers traveling to homes to provide clinical services, surveillance, and to address social determinants of health.

Dr. Padilla shared a quote from HRSA Administrator Thomas Engels, "As a nation, we continue to adjust to the impact Coronavirus 2019 (COVID-19) is having on our lives, our communities, our friends, and loved ones. Due to the impact of the COVID-19 outbreak, we want to assure you that HRSA will do our part to help you continue your extraordinary work. Thank you for your partnership and patience as we work together to ensure our nation's health and safety. From all of us at HRSA, we wish you, your families and colleagues the best as we continue to monitor the immense impact COVID-19 is having on our country and the world."

HRSA is helping to lead the response to COVID-19. The agency plays a critical role in facilitating access to care for vulnerable communities. It awarded nearly $165 million to combat COVID-19 in rural communities. Funds support nearly 1,800 small rural hospitals and 14 Telehealth Resource Centers through technical assistance and infrastructure development. HRSA awarded more than $1.2 billion to nearly 1,400 health centers across the United Stated to

support detection, prevention, diagnosis, and treatment of COVID-19. Health centers' productivity has reduced to 50 to 55 percent of productivity levels prior to COVID-19. Centers are struggling to maintain operations. Nearly 1,800 health center sites have closed since the public health emergency emerged.

HRSA awarded $90 million to support 581 Ryan White HIV/AIDS Program participants, including city and county health departments, health clinics, community-based organizations, state health departments, and AIDS Education and Training Centers, in their efforts to prevent or minimize the impact of this pandemic on people with HIV.

Additional information about funding and programs is available on HRSA's web page. HRSA offers resources to support addressing COVID-19. BHW specifically is responding to COVID-19 with program and grant flexibilities, and telemedicine and telehealth. The Office of Management and Budget has authorized greater flexibility in grant management and reporting requirements. BHW invites programs and grantees to discuss what would benefit them during the current public health crisis. The Bureau of Health Workforce has extended deadlines for Nurse Corps and National Health Service Corps (NHSC) applications. The number of health center applications has decreased more than 40 percent. HRSA is exploring the reasons for this decrease. It may be due to necessity of providing care or because infrastructure has been taxed by addressing COVID-19. Students in Nurse Corps programs are permitted to practice provisionally if the State in which they practice allows them to do so with a temporary registered nurse license. A new NHSC and Nurse Corps site grant application cycle will begin in the summer of 2020, with expedited processes for sites addressing emergencies.

BHW soon will release $15 million for telehealth efforts, with a focus on using telehealth modalities for clinical training through Area Health Education Centers (AHEC), Centers of Excellence (COE), Geriatrics Workforce Enhancement Program (GWEP), and Nurse Education, Practice, Quality and Retention (NEPQR) programs. BHW selected these programs because they have statutory authority to provide telehealth training and have the infrastructure to apply funding immediately. In addition, all programs prioritize underserved populations disproportionately affected by COVID-19. The funding aims to address tele-mental health, behavioral health integration with a focus on opioid misuse and abuse, and community health worker training.

BHW is interested in ACICBL's input regarding barriers to deploying students and providers to address COVID-19. The Bureau of Health Workforce also requests input regarding how to leverage grant funding and community collaborations to address the pandemic. In addition, BHW is interested in lessons learned and accomplishments relevant to responding to COVID-19.

Discussion
Dr. Padilla invited questions and comments.

Dr. Khatri stated that her organization has successfully shifted to telehealth services. The most challenging aspect of transition was dealing with hardware. Students found the shift easy.

Providers found the shift more challenging. The shift has helped patients, who sometimes must save gas money over a long period for a 2-hour drive to see a provider in-person. Students are conducting outreach to patients to discuss health and safety precautions. Dr. Khatri's organization has partnerships with schools. Schools are a primary food source for many students; and closures are concerning. Program trainees and students are reaching out to local school students via telephone to provide information about where to get food as well as to provide information about structured activities. HRSA's behavioral health expansion funds purchased telehealth infrastructure to support these efforts.

Dr. Masaki commented that HRSA GWEP funding has been invaluable for supporting training and quality improvement in providing nursing home care during the COVID-19 pandemic. Staff needed training in infection control, including personal protective equipment use. Dr. Masaki's organization launched a COVID-19 training series with GWEP funding.

Dr. Brandt remarked her organization has worked with partners over the past 2 weeks to develop an online tool to help facilities address medication management burden. There are currently about 1,300 registered users, from multiple countries. The project was supported by GWEP funding. Telephonic services have increased reach to patients. Students appreciate remote learning.

Dr. Evans noted that his organization has used telehealth for some time to serve the needs of rural residents in Nebraska. Providers need training in telehealth delivery. His team developed a 5-week training module, for which 4,500 participants enrolled. Urban providers were especially in need of training. Work was funded through the Graduate Psychology Education and Behavioral Health Workforce Education and Training Programs as well as from Substance Abuse and Mental Health Services Administration funding. Dr. Padilla agreed that training to apply telehealth is important; the workforce varies in digital literacy. He added that consumers' digital literacy is also an issue. Consumers' difficulty with digital technology has resulted in continued face-to-face visits in some cases. He asked how Committee members have addressed this.

Dr. Fahrenwald stated her agency in Montana has linked teenagers with older community members to teach them to use digital technology for healthcare visits, socializing, and accessing information online. The approach has been successful. Dr. Khatri noted her AHEC program trains undergraduate students who are interested in becoming health professionals to serve as digital literacy coaches, which provides them with experience interacting with patients. Prior to COVID-19 coaches worked from waiting room kiosks to teach patients how to use portals. From this, the AHEC learned that 40 percent of patients did not have an e-mail address, which is required for portal use. Now all office staff serve as digital health literacy coaches. Personal guidance through using telehealth resources has been the only effective approach. Written guidance is not adequate. Staff and patients have enjoyed the process. Dr. Padilla invited Dr. Khatri to share written materials about digital health literacy coaching with BHW. He stated BHW is interested in measuring the impact of health literacy interventions. Digital modalities

may facilitate impact measurement. Dr. Khatri said she would send written materials describing the approach.

Dr. Padilla cautioned against telehealth resulting in overwork and provider burnout. COVID-19 has demonstrated the importance of supporting and sustaining the health workforce. This includes protecting their safety and meeting their mental health needs. Frontline providers currently are under tremendous stress similar to battlefield service. Dr. Bednash concurred. She added that providers not dealing with the pandemic are sometimes demoralized, which is another major stressor affecting the health workforce. Dr. Gould commented that senior providers and providers with chronic diseases at the University of Connecticut Health Center are engaged through the Medical Reserve Corps to serve as mentors for students who provide remote monitoring and care.

Dr. Gould requested support from BHW for logging results of students' delivering remote services, such as outreach to seniors who can no longer go to senior centers, in compliance with Health Information Portability and Accountability Act (HIPAA) requirements. Monitoring is essential because patients told to self-monitor at home often do not seek medical care until it is too late. Electronic medical record data retrieval is difficult. Excel spreadsheets have limitations. Dr. Gould asked whether HRSA could provide help in identifying a more user-friendly data platform. He stated students also are conducting COVID-19 contact tracing for health departments. It would be helpful to have a resource for these students to record summary data. Dr. Padilla replied HRSA is conducting work that probably would inform Dr. Gould's efforts, and that he and Dr. Gould should discuss this after the meeting. Dr. Gould inquired whether there is flexibility in the matching requirement for AHEC supplemental funding. Dr. Padilla stated the requirement is statutory.

Dr. Morley noted his organization hosts a large social media platform that includes Facebook, LinkedIn, and Twitter to disseminate educational material. The platform currently gets about one million hits monthly. Most users are physicians, including many geriatricians and emergency room doctors. During the last month, most work has been COVID-19 education, which has been well received. Dr. Morley's team currently is developing an approach for delivering HIPAA-compliant, user-friendly remote group therapy and Medicare annual wellness visits. Very early pilot efforts have been promising.

Dr. Fahrenwald stated HRSA and other stakeholders should review the original intent of HIPAA, which was signed in 1996. HIPAA has become a barrier to remote care, patient communication, and education efforts that use innovations made since the act was signed. Some restrictions may no longer be appropriate. Dr, Morley commented HIPAA-compliant remote care is feasible with current resources. Dr. Padilla noted HRSA is interested in comments and recommendations about potential changes to HIPAA in order to increase effectiveness of digital platforms.

Dr. Weiss thanked Dr. Padilla for his presentation.

Payment Reform Supporting the Integration of Health, Behavioral Health, and Social Services Within the Context of Team-Based Care and COVID-19

Donald Berwick, MD, MPP, FRCP, KBE
President Emeritus and Senior Fellow
Institute for Healthcare Improvement

Dr. Berwick stated that no one currently knows what the platform for healthcare will be after COVID-19. The platform will likely change. Use of telemedicine has soared since the outbreak. This change is probably permanent; and ACICBL recommendations should consider this. The change will affect workforce preparation. Primary care is likely to change. Some practices may not survive, and the nation may have to rebuild a new primary care system, which will be a challenge.

Dr. Berwick noted it is very difficult, if not impossible, to address social determinants of health in a fee-for-service system. Global payment systems make this goal more possible and also allow innovation in funding allocation with the purpose of improving population health. Medicaid, which is a critical support for vulnerable populations, is currently under siege, more than it ever has been, and probably for the long-term. It would be useful for ACICBL to recognize the potential for Medicaid to support implementation of their recommendations and vision.

Dr. Berwick commented the Committee's recommendation for HRSA to support tele-mentoring is important. He referred to the Project ECHO (Extension for Community Healthcare Outcomes), which uses social media and virtual learning resources for "force multiplication," or equipping providers to deliver more care than they would otherwise be able to provide. He recommended contacting Project ECHO developer Sanjeev Aurora for additional information. Dr. Berwick also supported the Committee's recommendation to support experiential training to address health equity issues.

Discussion

Mr. Stevens asked what types of trainings Dr. Berwick believes are necessary to increase preparedness for public health emergencies. Dr. Berwick replied current workforce shortages are dire, and providers need to learn to provide more generalist services. Innovations resulting from efforts to address COVID-19 include rapid conversion of non-clinical spaces into hospitals, and developing the role of the Bedside Learning Coordinator. The Nightingale Hospitals in the United Kingdom developed this role, required for inclusion on every clinical team. The Bedside Learning Coordinator monitors and reports observations and shares information from the National Health Service with the clinical team.

Dr. Berwick noted it is necessary to better prepare for 21st century public health threats. Last year, he co-chaired a National Academy of Sciences Engineering and Medicine Committee that conducted four expert workshops on preparedness for emerging infectious diseases and 21st century threats. Dr. Berwick and Dr. Kenneth Shine published a summary of proceedings in the January 2020 edition of the *Journal of the American Medical Association.* The article described many deficiencies in the Nation's current preparedness, which have been demonstrated by the

subsequent COVID-19 pandemic. Dr. Berwick stated the Nation should prepare for the next threat immediately. Workforce readiness is a key component of preparedness. Just-in-time-training would be an important contribution to workforce readiness.

Dr. Khatri asked how Dr. Berwick thinks COVID-19 will affect healthcare in the short- and long-term. The hospital system is changing. Hospitals are laying off specialists. Dr. Khatri hopes that strengthened primary care will result from responses to the current crisis.
Dr. Berwick replied United States investments in healthcare are imbalanced, with a focus on treating illness and injury and an inadequate investment in prevention. Effective prevention requires addressing social determinants of health. This will be challenging to change. A global payment system is one step toward positive transformation. This change will require the political will to invest less in an over-funded high-tech system and to invest more in addressing social determinants of health. FQHCs can contribute to this change. Dr. Berwick wrote an article for the May 2020 edition of the *Journal of the American Medical Association* about the "new normal" in healthcare that will follow COVID-19. He does not know what will be normal, but he does know key questions regarding healthcare choices the COVID-19 crisis raises. These are:

1. **Tempo:** The United States is very slow to make productive changes in healthcare system design. Other countries have demonstrated faster responses to emergencies, such as the London, United Kingdom Nightingale Hospital's 3-week conversion of a convention center to an intensive care unit with thousands of beds. In contrast, CMS discussions about updating telehealth rules have lasted more than 10 years. Following COVID-19 telehealth rules changed within a matter of weeks. Biomedical information is being exchanged much more rapidly as well.
2. **Proximity:** Providers do not always have to be in the same physical space as a patient to provide care. The current system also may require encounters of that have no value. Many visits may not be needed. Eliminating unnecessary visits would make more time for necessary visits. The Federal Communications Commission and National Cancer Institute sponsor Project LAUNCH with the University of California, San Diego and the University of Kentucky to deliver cancer care to rural Kentucky through telehealth resources. Results will provide an indication of how much care can be delivered remotely.
3. **Standards:** Care varies widely, with many providers not adhering to scientifically-based standards of care. With COVID-19, more providers want to know and implement evidence-based standards.
4. **Workforce Attitude:** The United States has taken the health workforce for granted. The workforce has expressed low levels of job satisfaction. During COVID-19 there have been failures to protect the workforce physically. However, appreciation of the workforce and understanding of their needs seems to have increased during the current crisis.

5. **Preparedness:** Prior to COVID-19, the United States thought it was prepared for a public health emergency. It had scored high on the United Nations Preparedness Index, but was inadequately prepared for the pandemic, and remains unprepared for the next public health emergency. Stakeholders must reach a new understanding of preparedness, which likely will include preparedness at a regional level.
6. **Equity:** COVID-19 deaths disproportionately affect African Americans. While 30 percent of Chicago residents are African Americans, 68 percent of COVID-19 deaths are among African Americans. In Georgia, 31 percent of residents are African American and 80 percent of deaths are among African Americans. Inequity has been an issue for more than a century; COVID-19 is the most recent example of how inequity is a life and death issue. The public health emergency presents a current opportunity to address racism. The Committee's recommendations are one way to take that opportunity. Inequity occurs as a result of choice; the Nation needs to choose whether to take this opportunity to address the problem.

Ms. Golden stated that 65 percent of people who have called Rush University Medical Center, where she works, to ask about COVID-19 do not have a primary care provider. Addressing this issue should be a priority in healthcare system transformation. Dr. Berwick noted the Rush University Medical Center has been a leader in the Anchor Institution Network, which focuses on equitable supply chains, hiring, construction, and community philanthropy. He recommended reading *The Anchor Institution Playbook.* Dr. Berwick remarked that lack of primary care leads to suffering, and is a result of the current health system design. When people do not get preventive care, they become sick and the subsequent necessary care is costly. Dr. Berwick stated he does not know how this could be resolved in a fee-for-service environment. Integrated systems of care are necessary to provide needed primary care. Kaiser-Permanente has population-based budgeting and addresses social determinants of health as a matter of course. Dr. Berwick agreed that linking people to a primary care provider is an urgent need.

Dr. Bednash stated that stakeholders have discussed the need to move away from fee-for-service payment for years. She asked Dr. Berwick what he believes the major barriers are to payment model change, and what needs to happen for change to occur. Dr. Berwick replied both the Obama and Trump administrations have discussed value-based payment. However, change has been very slow. The complexity of the current multi-payer system is a barrier. It is very difficult to understand, explain, or change it. Stakeholders need to acknowledge that purchasing care by individual service cannot support integrated care, then commit to changing the payment system. Consolidating payment under a national health insurance system would be a first step toward reform. This would simplify payment through standardized coding, record-keeping, and billing. Regardless of payer, global payment is better than fee-for-service. The current system must change to be transparent and to empower patients. A single payer system would be good for patients because everyone would have health insurance coverage. Providers would know who would pay them how much and when without concern about appeals. Administrative burden and associated costs would decrease. Dr. Berwick stated political will is needed to change the payment system. Dr. Bednash agreed that administrative costs of fee-for-service are excessive and that a global payment system would increase satisfaction of patients and providers. She noted the health insurance industry is a major barrier to shifting to global payment and that some

providers do not want global payment because they perceive that a fee-for-service system offers them more earning potential. More demographic population data are needed to illustrate health equity issues. Dr. Berwick agreed and commented the data are uncomfortable to consider, which may be one reason current data are inadequate.

Dr. Berwick stated that, during the COVID-19 crisis, people covered by Medicaid in the states that did not expand services are concerned about adequate coverage. As unemployment surges, people whose insurance is purchased through employers are concerned about losing their jobs and coverage, or about the cost of paying for coverage without an employer subsidy. People who want care through the Health Care Exchange are concerned about demonstrating eligibility and about generosity of exchanges. Only people covered through the Veterans Administration and Medicare are currently not worried about healthcare coverage. This indicates benefits of a single-payer system.

Dr. Gould inquired how ACICBL recommendations could support Dr. Berwick's recommendations, and support gains made during the COVID-19 emergency. Dr. Berwick recommended recognizing the importance of sustaining and expanding Medicaid. Regulations such as work requirements for Medicaid eligibility are taking people's health insurance coverage when it is most needed. Without a robust healthcare safety net, people are seriously harmed. Dr. Berwick stated he supported the recommendation to use telehealth for workforce education. He said it would be useful for the Committee to present a vision for a new integrated primary care system. Dr. Morley asked if Dr. Berwick agreed that this system should include a more educated advanced practice nurse workforce; Dr. Berwick replied that he did. Dr. Morley remarked that education should do more to prepare students for primary care practice, and that the workforce should include more primary care providers and fewer specialists. Dr. Berwick agreed and said that the Committee could provide valuable input regarding the potential nature of the primary care workforce, including community health workers, physician assistants, and others. He said these professionals can alleviate the shortage of primary care physicians.

Dr. Morley asked Dr. Berwick to comment on the role of artificial intelligence in primary care. Dr. Morley suggested that tele-robots could deliver many primary care services. He added that regular screenings are critical for geriatric patients, but that much of this could be done through artificial intelligence. Dr. Bednash stated non-physician primary care providers also could provide most wellness services. Dr. Berwick replied the development of artificial intelligence requires an empirical basis. The COVID-19 pandemic offers an opportunity to analyze the consequences of having to miss routine care. Stakeholders should consider which clinical care may not be necessary. Periodicity standards may not be accurate and are not tailored to respond to patients' needs. Prenatal care visits, ultrasounds, and adult wellness check-ups may not need to be as frequent as currently recommended. Evidence indicates imaging is overused. This also may be the case with some surgeries. Periodicity standards should be based on empirical data. This would support value-added care. Dr. Bednash concurred.

Dr. Khatri noted the COVID-19 outbreak has illustrated the importance of health behaviors outside the clinic. She asked whether Dr. Berwick believes the increased sense of individual responsibility for community health will last. Dr. Berwick stated he hopes this is the case. He

added that individual changes happen more as a result of increased knowledge than as a result of increased sense of personal responsibility. He emphasized the value of shared decision making that addresses patients' needs. Education should include instruction on how care providers can have this type of communication with patients. This represents not a shift in responsibility but a shift of power. Health is something clinicians support patients in attaining, not a product clinicians sell to patients. Dr. Berwick remarked that lack of social solidarity is a root cause of illness. The workforce should understand and teach that solidarity is a foundation for health. All system changes should be based on this moral value.

Mr. Stevens thanked Dr. Berwick on behalf of ACICBL. Dr. Berwick thanked the Committee for their work.

ACICBL 19th Draft Report Discussion

Mr. Stevens noted that the Committee drafted its recommendations prior to the COVID-19 outbreak and that the recommendations now would be discussed and considered in the context of addressing the pandemic. He asked whether the Committee would recommend retraining specialists, and if Committee members would like to discuss other possible changes to the recommendations. There were no suggestions. Mr. Stevens invited discussions of each recommendation in order.

Discussion about Recommendation 1. The ACICBL recommends that Title VII, Part D programs require grant recipients to develop academic/practice partnerships to educate the workforce on Electronic Health Record measures, cost metrics, person-centered measures, and social prescribing strategies to provide high value-care.

Dr. Masaki stated that this recommendation is still relevant. Dr. Bednash agreed but said it was unclear why this particular set of things was recommended. Mr. Stevens replied this was intended to be a recommendation regarding a set of metrics for assessing quality improvement as indicated by the Triple Aim. Dr. Khatri suggested the recommendation should be rephrased to clarify that it is referring to measures that can be extracted from electronic health records (EHR), since EHRs are data sources, not measures. Dr. Bednash pointed out that social prescribing strategies also are not a metric.

Dr. Fahrenwald noted that EHRs vary widely. She communicated training should emphasize how to use EHR data for metrics, not on how to enter data into EHRs. Drs. Bednash, Masaki, and Gould agreed that the recommendation is to teach students and trainees how to use EHR data to improve care. EHRs can be rich repositories that are underutilized. Dr. Masaki remarked that many EHRs are not repositories of useful data. Dr. Morley agreed and pointed out that some records are inaccurate. He also stated current training in EHR use focuses on how to record services to support billing, not how to use EHRs as tools for quality improvement. Dr. Morley suggested the recommendation should be rephrased to clarify the intent with regard to EHRs.

Dr. Fahrenwald proposed the recommendation should be to teach students and trainees to obtain interdisciplinary input to generate data that can be used for quality improvement. Drs. Morley, Gould, Khatri, and Brandt concurred. Dr. Brandt emphasized the value of integrating

pharmacists' input into EHRs. Dr. Gould stated students and trainees should learn to understand how EHR data can support population health improvement. Dr. Brandt asserted that payers in global payment systems will require documentation of delivering value-added services and team-based care. Providers will need to know how to document these services in EHRs. Documentation is necessary to provide evidence regarding outcomes of value-based payment systems. Dr. Brandt stated that training students in the potential of EHRs will encourage them to improve on currently available EHRs. Dr. Fahrenwald agreed.

Dr. Khatri highlighted that COVID-19 is illustrating the importance of care coordination, of EHR documentation to facilitate team communication, and the utility of EHRs for aggregating data. She suggested that the recommendation refer to health information technology (HIT) broadly, rather than specify EHRs. All members of the Committee agreed to this change in the recommendation's wording.

Discussion about Recommendation 2. The ACICBL recommends that grant recipients educate the healthcare workforce on alternative payment models, including value-based payment models, and their impact on healthcare delivery systems and the health of communities.

Drs. Morley, Bednash, and Evans supported the recommendation as it was written originally. Dr. Weiss asked if the Committee wanted to add a reference to emerging infectious diseases or COVID-19. Dr. Morley replied the recommendation could reference COVID-19 and future pandemics. Dr. Masaki recommended referring to future public health emergencies rather than pandemics specifically. Dr. Fahrenwald affirmed the recommendation was intended to have broad long-term impact and should not narrowly focus on COVID-19. Dr. Weiss stated discussion of public health emergencies could be in the rationale for the recommendation and omitted from the wording of the recommendation. Dr. Killinger endorsed this idea. Dr. Gould recommended referring to the health of communities during emergencies and normal times. Dr. Fahrenwald agreed with this suggestion, since emergencies occur regularly. Dr. Weiss asked whether the Committee would prefer to make a separate recommendation regarding emergency preparedness, response, and recovery. Mr. Stevens suggested that the rationale include discussion of how a value-based payment system could better support the workforce during public health emergencies. Dr. Khatri recommended keeping the original wording and adding a fifth recommendation regarding emergency preparedness, response, and recovery.

Discussion about Recommendation 3. The ACICBL recommends that Congress fund demonstration projects to use social media to educate the healthcare workforce to improve health and healthcare delivery. For the purposes of this recommendation, healthcare workforce includes patients, families, caregivers, direct care workers, and health professions students, residents, fellows, faculty, and practitioners.

Dr. Fahrenwald asked if the Committee could recommend integrating social media with notifications through EHRs. Dr. Gould replied this would occur through patient portals. Dr. Morley noted there would have to be a HRSA portal that would extract information from social media. Dr. Fahrenwald stated the recommendation should be for support to radically

expand patients' access to information through health information technology as few portals offer smooth interaction. Dr. Morley said the development could be a new social medium. He noted that grant applicants would be responsible for proposing demonstration projects. Dr. Brandt asked whether the recommendation should be reworded to refer to integrating social media. Dr. Bednash and Mr. Stevens agreed with this suggestion. Dr. Morley pointed out integration would be one example of a project that could be mentioned in the rationale but would not need to be specified in the recommendation.

Discussion on Recommendation 4. The ACICBL recommends didactic and experiential training experiences, conducted in collaboration with at least one partner, on how social drivers including housing status, food, security, poverty, and adverse child experiences impact individual and community health.

All Committee members agreed that the original wording was satisfactory. Dr. Evans inquired as to whether the Committee should specify types of partners. Dr. Fahrenwald stated examples could be limiting and the recommendation should leave the category open. Dr. Killinger agreed. Dr. Gould suggested the recommendation should be clearer regarding whether it requires grantees to work with an academic partner. Dr. Evans noted the current wording could be interpreted as allowing partnership with another department within a grantee's institution. He recommended rewording the recommendation to specify community partners. The Committee agreed.

Discussion about Recommendation 5. The ACICBL recommends that HRSA's Title VII Part D funding opportunity announcements include a requirement to prepare the workforce to address emergency preparedness, response, and recovery.

Dr. Fahrenwald noted that this recommendation was distinct from others. She recommended against distraction from the initial intent of the recommendations and report. She noted that other Committees were focused on emergency preparedness. Dr. Weiss agreed that many groups are currently addressing emergency preparedness but pointed out that only ACICBL is providing advice and recommendations on Title VII Part D programs. Dr. Fahrenwald stated the recommendations and report could discuss how COVID-19 has accentuated health disparities and the needs for interdisciplinary healthcare. Dr. Bednash agreed, noting that the original discussion about recommendations focused on the impact of social determinants of health. COVID-19 shows the relevance of that discussion. Dr. Gould suggested editing the recommendation to make this point clearer. Dr. Bednash agreed. Dr. Morley recommended linking the report discussion of this recommendation to a previous ACICBL recommendation about emergency preparedness, if possible. Dr. Weiss said ACICBL made the earlier recommendation in 2002 and 2003.

Dr. Killinger suggested that the recommendation require addressing emergency preparedness, response, and recovery that address social determinants of health. The Committee concurred. The Committee agreed to add Recommendation 5 with the change suggested by Dr. Killinger.

Remaining Committee Business

Dr. Weiss noted eight Committee members' terms will end June 27, 2020. The members whose terms are ending include Dr. Joseph Evans, Ms. Robyn Golden, Dr. Bruce Gould, Dr. Lisa Killinger, Dr. Kamal Masaki, Dr. John Morley, Dr. Zaldy Tan, and Ms. Jacqueline Wynn. Dr. Weiss thanked them for their work and high quality reports.

Dr. Weiss stated that Mr. Stevens' term as Chair is ending and that Dr. Brandt will succeed him. The Committee will need a new Vice Chair at the next meeting which will be held via conference call/webinar on October 20, 2020.

Dr. Weiss recommended that the Writing Committee would meet with the technical writer by mid-May since some members whose terms are ending in June, 2020 are on the writing Committee

Dr. Weiss invited suggestions for topics for the next report. Dr. Gould suggested the topic of career choice bullying and its effect on career choice. Addressing career choice bullying could increase the number of students who pursue primary care careers. Dr. Fahrenwald supported this suggestion. She noted that the current payment model rewards specialization. Dr. Bednash said that bullying is sometimes directed toward interdisciplinary training. Mr. Stevens suggested that Dr. Gould could present on this topic.

Dr. Weiss noted the Committee reviews Title VII Part D programs and makes recommendations for improvement, performance measures, and appropriation levels. The last time ACICBL did this was 2015. She suggested the Committee discuss and make recommendations in the next report

Public Comment

Teri Kennedy stated she supported retaining the original theme of the 19th report and not narrowing the focus to COVID-19. She recommended against referencing COVID-19 in the report title. Dr. Kennedy also suggested that health informatics specialist could provide valuable input regarding use of EHR data. She suggested considering a vision for primary health care as a potential topic for the next ACICBL report.

Ainel Sewell responded to Dr. Berwick's suggestion that mid-level professionals could help to address the primary care shortage. She noted that not all nurse practitioners receive the same quality of training. Many direct entry programs accept nurse practitioners with a bachelor's degree in any subject. Many online programs allow nurse practitioners to graduate without direct nursing experience. These programs allow trainees to select their preceptors. She stated vulnerable and remote communities need more primary care providers, but there are not enough residency training opportunities to address this need. She recommended promoting more residency slots for physicians to serve rural communities.

Mr. Stevens thanked commenters for their input

Mr. Stevens thanked outgoing Committee members for their work. Dr. Weiss invited those members to attend future meetings and participate in Public Comment.

Dr. Weiss adjourned the meeting at 4:00 p.m.