ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY (ACTPCMD)
Meeting Minutes August 1 and 2, 2024
HRSA Headquarters, 5600 Fishers Lane, Rockville, Maryland

Advisory Committee Members Present
Chair Tonya L. Fancher, MD, MPH
Frank Ambriz, PA-C
Ruth Wauqua Bol, DDS, MPH
Colleen M. Brickle, EdD, RDH
Pangela Dawson, PhD, MSPAS, PA-C
Brandi K. Freeman, MD, MS
David Henderson, MD
Yuri T. Jadotte, MD, PhD, MPH, FACPM
Brookshield Laurent, DO
Emihomo M. Obadan-Udoh, DDS, MPH, Dr.MedSc
Hugh Silk, MD, MPH, FAAFP [virtual]
Janet H. Southerland, DDS, MPH, PhD

Health Resources and Services Administration (HRSA), Bureau of Health Workforce (BHW) Staff Present
Shane Rogers, Designated Federal Officer (DFO), ACTPCMD
Janet Robinson, Workforce Administration Team
Jennifer Holtzman, DDS, MPH, BHW Dental Officer

Contractor Present
Len Rickman, Writer, Isom Global Strategies

Thursday, August 1, 2024 **8:30 a.m. (ET)**

Welcome Remarks / Meeting Management - Shane Rogers, DFO, ACTPCMD

Mr. Rogers welcomed the members and speakers. He noted this is ACTPCMD's first in-person meeting in over four years, entire member cohorts served their terms without meeting in-person, and this is the first Committee meeting for most of today's members. **Mr. Rogers** also reminded members this is an open meeting that will be recorded and transcribed.

Janet Robinson, Workforce Administration Team, BHW

Ms. Robinson thanked everyone for their patience with travel to HRSA headquarters. She reviewed technical items related to the meeting's audio and video services and asked attendees to state their name prior to making a comment or asking a question. **Mr. Rogers** reviewed the Committee's role as an independent body whose purpose is to provide advice to the HHS (U.S. Department of Health and Human Services) Secretary and the Congress on program activities authorized in Title VII sections 747 (medical) and 748 (dental) of the Public Health Service Act. He reviewed details about the Committee's roster and governance and introduced Dr. Jennifer

Holtzman, the Committee's subject matter expert and BHW's Dental Officer. **Dr. Holtzman** said it is wonderful to be here with everyone in person and she will answer questions as best she can.

Agenda Review / Introductions - Tonya Fancher, MD, MPH, Chair, ACTPCMD

Dr. Fancher said it is an honor and privilege to run this meeting and meet everyone in person. She reviewed the busy two-day agenda and said its ambitious goal includes to review and consider ways to build and enhance existing programs. She asked members to note their areas of interest and topics for the Committee to explore and make recommendations. She conducted roll call, confirmed a quorum, and asked members to introduce themselves.

Presentation: BHW Updates - Candice Chen, MD, MPH - Acting Associate Administrator for Health Workforce, HRSA

Dr. Chen noted she recently replaced Dr. Luis Padilla who served eight years as Associate Administrator for Health Workforce. Dr. Padilla took a position at the National Association of Community Health Centers (NACHC) and it is good for BHW-based thinking to go to NACHC. She said the recent difficult years for the health workforce raised its visibility among communities and policy makers and that spurred investment that helped grow the Bureau's programs from 50 to 70. She added federal advisory committees are important to help improve program content, logistics, accountability, and advise congress. She encouraged members to think big with deliberations and recommendations and said members' range of experience and views will help push the Bureau to be better.

Dr. Chen discussed projected health workforce challenges in five professions, especially LPNs (Licensed Practical Nurses) and RNs (Registered Nurses), and in behavioral health. She noted six overall strategies for success to increase supply, advance health equity, improve distribution, promote resilience, and amplify HRSA's impact. She reviewed HRSA's FY2024 Aims to increase access, its FY2023/24 government-wide priorities, BHW focus areas, and cross-cutting themes for the workforce.

Dr. Chen reviewed BHW's budget history and proposed FY2025 budget of $2.6 billion. She reviewed key reauthorizations and mandatory funding for the National Health Service Corps (NHSC) and the Teaching Health Center Graduate Medical Education (THCGME) Program. She also reviewed select primary care investments in state primary care offices ($11M/54 awards), the Geriatric Workforce Enhancement Program ($43M/42 awards), the Teaching Health Center Graduate Medical Education Program ($215M/82 awards), and the Physician Assistant Rural Training in Behavioral Health Program ($25M/13 awards).

Dr. Chen noted new THCGME funding opportunities for academic years 2024-25 ($10M/6 awards) and 2025-26 ($80M/41 awards); and similar data for academic year 2022-2023 for primary care medicine programs, the pediatric program, and oral health programs. She also listed publicly available health workforce data, characteristics of health professional shortage areas (HPSA), medically underserved areas/populations (MUA/P), BHW's four other advisory committees, and noted the upcoming Primary Care Residency Fair on 9/25/24.

Discussion

Dr. Jadotte asked about how technology advances will affect assumptions and planning since much can change over time. **Dr. Chen** replied the assumptions do not fully integrate technology due to uncertainty over what will or will not happen.

Dr. Obadan-Udoh asked about cross-program coordination, including conflicting issues and goals, and limits on what programs candidates may apply for. She cited specifically the challenges faced by NHSC scholars due to their required service timelines. **Dr. Chen** replied that while coordination is challenging, the Bureau is considering how to include it in the FY25 and FY26 announcements so more people are better prepared to serve in communities. While funding is limited, interprofessional practice remains a priority. She also noted BHW advisory committees sometimes collaborate on planning.

Dr. Laurent asked about regional distribution. **Dr. Chen** replied it is a major issue. Today she showed the Committee aggregate national numbers, not representative of local communities. New projections will allow state-level review, but those data do not necessarily mean sufficient workforces in local communities. The rural workforce generally is much more challenged.

Dr. Obadan-Udoh asked about retention efforts. **Dr. Chen** replied it is an ongoing challenge. While NHSC has high retention rates, including movement to other sites in HPSAs, more retention programs are needed. More than 40 organizations are working on it, including in other HRSA bureaus. **Dr. Laurent** added it is important to consider the needs of providers' families, such as childcare and education. **Dr. Chen** agreed that more investment in those areas will help, though **Mr. Rogers** added only programs provided by congress can be implemented.

Dr. Dawson said the PA profession requires newcomers to have a background in health care and asked about consideration of individuals' educational and economic longevity or upward career mobility. **Dr. Chen** replied the legislation limits what the programs can do, but career pathways are considered. While it cannot be assumed everybody wants to move, the Bureau has programs for those who do and want to be retained, including a registered apprenticeship program set up in the Department of Labor model. However, community-based organizations' limited budgets and heavy workloads make it difficult to set up and run new programs, so the Bureau has to be thoughtful in what it requires. One way to amplify HRSA's impact is to fund collaboration among centers to support best practices and growth that will advance health equity via improved supply and distribution, and the Committee can help with that.

Dr. Bol called for more focus on the dental auxiliary since their children could be future doctors but have been an untapped resource. **Dr. Chen** replied that could be included in setting priorities, though within the statute. **Dr. Jadotte** asked whether oral health is a priority. **Dr. Chen** replied the Bureau believes it is and deserves more attention. However, thus far it has not been raised as high a priority as mental and behavioral health, and community health.

<u>Presentation: History of Title VII, Section 747 - P. Preston Reynolds, MD, PhD - Professor of Medicine, Division of General, Geriatric, Palliative & Hospital Medicine, University of Virginia</u>

Dr. Reynolds discussed Title VII's history and issues with health disparities in the U.S., including how other countries outperform the U.S. on every quality measure. She reviewed how increasing the primary care clinical workforce will reduce health disparities, costs of care for patients with chronic disease, and mortality and morbidity; and how increased diversity means providers who are more likely to care for disadvantaged and vulnerable populations, care for minorities, and reduce implicit bias.

Dr. Reynolds reviewed Title VII's key impacts on primary care infrastructure, skills training, clinical programs, provider diversity, pipelines, and retention. She shared detailed historical and financial data and accomplishments (1960-2010) related to Title VII and the health professions pipeline, and four phases of workforce planning for multiple specialties and professions, residencies, and faculty. She shared curricula innovations and the history of efforts to address health disparities.

Dr. Reynolds discussed Title VII's history and undergraduate medical education including issues of debt, NHSC scholarship, exposure to primary care in medical school, salary differential between specialists and generalists, and how attendance at a public medical school and personal intentions help predict the choice of primary care. She cited several important studies and surveys regarding Title VII and choice of specialty and impact on health disparities. She discussed Title VII and faculty development, including several important studies, and workforce planning. Dr. Reynolds noted the Health Professions and Nursing Education Coalition recommends $1.51 billion for HRSA Title VII.

Discussion

Dr. Henderson said that while segregated hospitals are no longer a problem, segregated care and outcomes disparities across populations and communities continue. He asked how the Committee can address that, particularly in the current era of no affirmative action. **Dr. Reynolds** added structural racism has been baked into American medicine since the origins of medical schools, and the medical profession has not confronted it explicitly. With elimination of DEI (diversity, equity, and inclusion) in programs perhaps the Committee should call out that history and the health impacts of not teaching it. **Dr. Henderson** added neither his current residents nor medical students know this history, and the structure using community health centers (CHC) segregates the poor from people who have money.

Dr. Silk suggested showing evidence that pipelines work, but it might be better to start with K-12 versus college to drive a more diverse workforce. **Dr. Reynolds** suggested support for HCOP (Health Careers Opportunity Program), Centers of Excellence, and AHECs (Area Health Education Centers) would help increase workforce diversity. Such programs often have multiple funding sources for scholarships, loans, and minority faculty, and they recruit and expose a diverse, young group of people to the health professions. **Dr. Henderson** added the AMA (American Medical Association) passed a resolution to support K-12 education to improve workforce development and develop the pipeline more upstream.

Presentation / Discussion: Title VII, Section 747 - Primary Care Training and Enhancement - Cindy Harne, MSW, LCSW-C - Chief, Medical Training and Geriatrics Branch, Division of Medicine and Dentistry, Bureau of Health Workforce, HRSA

Ms. Harne shared HRSA's workforce program Aims for access, supply, distribution, and quality. She shared the program's goal and budget history (FY2020-24), including $1 million added in FY2023 for eating disorders, the FY2024 budget, and funding for the Safer Communities Act (2022-2027).

Ms. Harne shared the purpose, goals, period of performance, activities, and participant data (including graduate intent to practice setting) for Primary Care Training Enhancement (PCTE) for the Physician Assistants (PA) program (18 awards/3 cohorts); Residency Training in Primary Care (21 awards); Community Prevention and Maternal Health (30 awards-including training tracks, and activities for the Community Prevention Track and for the Primary Care Obstetrics Track); Physician Assistant Rural Training (11 awards); the Language and Disability Access Program (3 Intellectual and Development Disability (IDD), 7 Limited English Proficiency (LEP), and 8 both IDD and LEP awards), including focus areas, activities for language assistance for individuals with LEP and for individuals with physical disabilities and/or IDD; the Physician Assistant Rural Training in Behavioral Health Program (13 programs); and Residency Training in Mental and Behavioral Health. She also discussed FY2025 and FY2026 program planning.

Discussion

Dr. Jadotte asked whether the themes for community and maternal health will be renewed in 2026 or new themes created. **Ms. Harne** replied this is an umbrella program and maternal health is an HHS and HRSA priority. The recompete is underway, including a review of successes and areas for improvement. The priority is to release FY24 NOFOs (Notices of Funding Opportunity). The model is good, including for population health since physicians sent to rural areas need a handle on rural public health issues.

Dr. Silk asked whether grant recipients could be required to disseminate program information and whether supplementary funding can help programs extend lessons learned through technical assistance and other efforts. **Ms. Harne** replied that was done in the maternal program with a one-year cost extension. It was also done with other programs, including one that led to an article accepted by the American Journal of Public Health.

Dr. Freeman asked whether the community prevention program is for family medicine and whether outcomes in children will be reviewed. **Ms. Harne** replied the funding is for family medicine, general internal medicine, and general pediatrics, and the Bureau will consider outcomes in children for the next iteration. The five-year requirement for all PCTE programs has created a challenge and an A19 process might be needed. Limited funding challenged program development during the pandemic and the five-year requirement makes changes difficult, yet some HRSA programs are three years. That could challenge funding for the Committee's other priorities at least until years later when priorities could have changed. Also, grant programs have preferences and priorities that affect the rank order list.

Mr. Ambriz said the top needs in rural areas are OB (obstetrics) and maternal health, and perhaps stipends should be offered for clinical rotations.

Ms. Harne acknowledged Tracy Glascoe's hard work on the CPMH (Community Prevention and Maternal Health) program and Ms. Glascoe is now a branch chief and continues to work on that program.

Presentation/Discussion - Title VII, Section 748 Training in General, Pediatric, and Public Health Dentistry - Tracy Glascoe, MPAS, PA-C - Chief, Oral Health Branch, Division of Medicine and Dentistry, BHW, HRSA

Ms. Glascoe reviewed the Oral Health Branch's appropriations history since 2014 and its FY2024 appropriations. She discussed the Bureau's program Aims and specific programs, including outcomes for the dental faculty loan repayment program (DFLRP) ($4.84M/29 awards); clinical educator career development ($741K/4 awards); primary care dental faculty development ($664K); pre-doctoral training in general, pediatric, and public health dentistry, and dental hygiene ($4.48M/15 awards); and post-doctoral training in general, pediatric, and public health dentistry ($13.85M/27 awards).

Ms. Glascoe reviewed Section 748 language in the Public Health Service Act, 748's eight funding priorities for collaborative projects, discipline retention, student backgrounds, formal relationships, vulnerable populations, cultural competency and health literacy, placement in practice settings, and special/vulnerable populations. She reviewed the four key challenges: the required five-year project periods; the pediatric preference for pediatric faculty in the DFLRP; the required payment percentages toward faculty balance; and the difficulty getting training programs into CHCs. She reviewed details about the State Oral Health Workforce program authority and purpose, program eligibility, awards ($14.48M/37 awards), allowable activities, program flexibility, and rural capacity efforts in Arizona, Missouri, Montana, Nebraska, Nevada, South Carolina, Utah, and Wisconsin. She also reviewed HRSA-22-050: HRSA designated activities.

Discussion

Dr. Southerland said the rural model needs to be reimagined in light of imminent baby-boomer retirements and the difficulty of recruiting younger professionals with old-model methods and funding. Creative partnerships and collaboration are needed to meet younger professionals' demands for training, care models, and lifestyle. **Ms. Glascoe** responded that training and practice continues in silos, but is becoming more interprofessional, including primary care and oral health. **Dr. Obadan-Udoh** added the entire system should be reconsidered, but legislative constraints make that difficult. Conflicts between programs over requirements, restrictions, and definitions should be addressed. Programs should work in synergy and not against each other. Agencies should be better prepared to collaborate and coordinate to create and fill jobs, allow people to practice at the top of their license, and provide care.

Dr. Bol noted a disconnect between medical and dental, including issues around sedation, and the definition of primary care. **Dr. Silk** suggested an oral health czar to drive collaboration and

practical funding solutions and ensure recipients have a humanist perspective and interest in serving communities where they are most needed. Programs should emphasize equity, social determinants of health, and cultural humility and humanism.

Dr. Southerland advised to offer more care for providers who can face burnout.

Mr. Rogers noted the Bureau tracks LRP (Loan Repayment Program) statistics and will include that in the Committee's November meeting. He will look to send something about that to members. {*ACTION ITEM*}

Presentation: Teaching Health Center Graduate Medical Education (THCGME) Program - Witzard Seide, MD, FAAP, CDR, U.S. Public Health Service - Chief, Graduate Medical Education Branch, Division of Medicine and Dentistry, BHW, HRSA

Dr. Seide shared projected workforce shortages through 2035: primary care, 35,260; behavioral health, 15,180; maternal health, 5,790; and oral health, 1,310; and data about health workforce shortage areas. She noted HRSA supports more than 90 programs through grants and cooperative agreements and serves tens of millions of people. She shared HRSA's workforce Aims and BHW's mission and the framework for its Division of Medicine and Dentistry. She shared overviews for the Graduate Medical Education (GME) programs and the Teaching Health Center (THC) programs, their legislative authority, purpose, funding history since FY2011 (nearly $175M in 2023) including the six years with no NOFOs, outcomes (2,368 graduates since 2011), resident and training characteristics (2022), and patient encounters and hours of patient care.

Dr. Seide shared data about THC planning and development, including number of grantees and grant amounts, number of awardees and project periods, number of awards in each of the nine HHS regions, number of grantees for each of eight specialties, grantees' outcomes, and the identities of 15 matched grantees and their state locations.

Dr. Seide discussed challenges for THC development, including financial uncertainty, start-up funding time frames, faculty recruitment, accreditation challenges, and hospital partnerships. She shared the THCGME plan to support programs, including a listening session, a recruitment fair, support for current programs, and new NOFOs for AY 2024-25 and 2025-26. She shared future activities related to challenges, gaps, and strategies for success.

Discussion

Dr. Jadotte suggested creative thinking is needed to overcome recruitment challenges related to uncertainties over funding and institutional eligibility. **Dr. Fancher** noted the idea of slots dependent on HRSA funding goes across programs.

Dr. Freeman asked whether partnerships are possible between communities and hospitals for this funding. **Dr. Seide** replied consortia and partnerships are possible but within the details of the announcement, including how community-based organizations must have a major role. **Dr. Freeman** asked whether a program may create a pathway residency, perhaps attached to a larger

program. **Dr. Seide** replied such opportunities might exist, depending on if they meet the definition of consortium as it relates to an announcement. **Dr. Fancher** suggested further consideration of why organizations would want to partner, or support or join a consortium.

Dr. Fancher asked how the well-funded Technical Assistance Center (TAC) drives success for an emerging program. **Dr. Seide** replied TAC helps programs with partnerships, infrastructure, recruiting, start up, and more in support of accreditation, matching, and funding. **Dr. Freeman** asked about accrediting bodies' roles. **Dr. Seide** replied the Bureau partners with ACGME (Accreditation Council for Graduate Medical Education) to review the programs and help with accreditation, if needed. She summarized CODA's (Commission on Dental Accreditation) role, its changes over time, and the Bureau's ongoing work with them.

Dr. Southerland noted differences between the ADA (American Dental Association) and the AMA (American Medical Association) and the need to coordinate with them on defining residency to help resolve funding challenges. **Dr. Bol** asked what CODA changed. **Dr. Seide** replied it was eligibility for accreditation. The structure and nature of different types of organizations, such as FQHCs (Federally Qualified Health Centers), adds to the complexity and need for consortia and partnerships. CODA accredits programs, not sites. One suggestion made to CODA was to use BPHC's (Bureau of Primary Health Care) auditing procedures for sites. **Dr. Bol** asked whether dental residency programs still require a sponsor. **Dr. Seide** noted that will be answered after CODA's August 8 meeting.

Dr. Bol asked for more detailed information. **Dr. Seide** replied it might be available in the Annual Performance Report and report to the Committee. *{ACTION ITEM}* **Dr. Bol** said that would help build a case for funding all the way down to the graduate level. **Dr. Fancher** said she would like to know where they did that training, and whether there are international grads.

Discussion/Vote: Draft Letter of Support for the THCGME Program

Mr. Rogers noted the THCGME program is not in this Committee's purview, but former members agreed it is valuable since it gets providers into communities for training and an interest in staying. This would be the third support letter since consistent funding is a challenge. The Committee discussed close review of funding and training data in different programs and sites. Key issues include: parity; revenue structures and amounts; numbers and award amounts for FTEs (full-time equivalents); certifications; and relationships among THCGME, Medicare-based GME funding, FQHCs, CHCs, hospitals, and schools. The Committee cautioned that different analyses could drive arguments in favor or against the program.

Dr. Southerland submitted a motion that the Committee accept the letter with modifications to be made by a sub-workgroup of Dr. Fancher, Dr. Jadotte, Dr. Koday, and Dr. Laurent. Dr. Brickle seconded. The motion passed unanimously.

Mr. Rogers noted Thomas Vallin sent HRSA data for demographics in the DFLRP. He showed members the data screenshots and will distribute them to members. {*ACTION ITEM*}

Discussion: Recommendations for the 23rd ACTPCMD Report

Residency

Dr. Jadotte asked about including fellows since 747 mentions financial assistance for residencies and fellowships. **Mr. Rogers** replied Congress sets funding priorities and while HRSA can assign additional points for specific activities in applications, HRSA does not have authority to expand beyond what is listed when giving additional points, though some changes under Funding Factors could be easier to implement. **Dr. Jadotte** added it says trainees and not residents, so the Committee should be very clear in what it asks for. **Dr. Fancher** said more information is forthcoming. *{ACTION ITEM}*

Mr. Ambriz suggested inclusion of physician assistants (PA) since they provide a lot of primary care. **Dr. Fancher** suggested the need to determine whether the legislative priority includes fellows and PAs. **Dr. Jadotte** cited potentially confusing differences in 747 language about priorities for training and capacity-building in rural areas. **Dr. Bol** noted the lack of American Indian dentists treating American Indians and the need for a residency on tribal land. **Dr. Fancher** said it will be important to determine who is part of the program. **Dr. Jadotte** said 747 explicitly says tribes and tribal organizations are a priority, but perhaps it is not being interpreted to the extent of the law. **Mr. Rogers** mentioned the Committee's previous support letter for tribal communities, and perhaps a sub-workgroup can address this.

Dr. Jadotte said the act is not clear whether it means training people who live in rural or tribal areas, versus just medical. **Mr. Rogers** said that is how HRSA interprets it, but the Committee can recommend expanding that without a change in legislative language. **Dr. Jadotte** suggested looking to clarify without trying to change the Act. **Dr. Fancher** cited the language about priority to qualified applicants that train residents in rural areas, including tribal organizations, and suggested changing "for" to "with" tribal organizations. **Dr. Bol** said that would make them part of the team. **Dr. Jadotte** said a recommendation to the Secretary to change the term is easier than changing a congressional act. The Committee can recommend priority for programs that train providers who live in those areas, per the Committee's goal to enhance community engagement. **Dr. Fancher** suggested including both to ensure community engagement.

Five-Year Requirement

Dr. Laurent asked whether less than five years could be easier to work with. **Mr. Rogers** noted the legislation says "five years." **Dr. Laurent** suggested it could change to say "up to" five years. **Dr. Dawson** cautioned since money is not there for new initiatives, five years keeps you roped in, and start-up times are also a key factor. **Dr. Laurent** replied the change could benefit those with flexibility to do it in under five years. **Dr. Jadotte** said more time means more security and ability to recruit, while needing to apply every two years will deter interest. Keeping it at five years would still allow reduced funding for awardees with smaller projects that operate for five years and would be more flexible than lowering the number of years. **Dr. Fancher** cautioned fewer people would apply if the amount is smaller for five years. Saying "up to" five years, with an official preference for longer, would allow for ideas better suited for a shorter program.

Dr. Jadotte said PCTE programs might not benefit from being two years, but HRSA should weigh in on that. **Dr. Fancher** noted the uncertainty and need for innovation during the COVID pandemic. Grantees might not want a five-year commitment to something unknown and could prefer two years to test and evaluate innovations such as telemedicine and others. That could be like an innovation incubator. **Dr. Jadotte** countered that is like additional funding and perhaps HRSA should seek additional funding without jeopardizing current grantees. **Dr. Fancher** said they cannot, they are obligated to five years. **Mr. Rogers** added one issue with the five-year project is less opportunity to fund more grantees. **Dr. Silk** cautioned saying “up to” five years opens a Pandora's box over where grants for less than five years will go. A change could lead to unintended consequences, such as one- or two-year grants.

Other Issues

Dr. Bol suggested FQHCs need innovative ways to keep providers, such as asking dental auxiliaries to do more and thus increase FQHC productivity and help dentists. **Dr. Freeman** said it seems programs are designed for treatment of adults even though funding is there for pediatrics. Also, perhaps grants can help FQHCs innovate around top-of-scope practice. **Dr. Southerland** discussed the importance and challenges of pediatric dentistry, including how some dentists are reluctant to treat children, especially developmentally challenged. Medical and dental integration is needed in CHCs and FQHCs. **Dr. Henderson** added it is about settings many find uncomfortable to practice and that challenges recruitment. A solution is to include broadly trained providers versus the specialty divisions that have grown over time. This includes training general dentists to do pediatrics. **Dr. Southerland** replied a model exists for general practice residency training, but it faces challenges with admissions and selection, especially in rural areas. Also, while medical teams include extended providers, dentistry training does not leverage team members. **Dr. Obadan-Udoh** suggested collaboration with local dental associations and community and technical colleges to improve interprofessional care. However, CODA can slow down innovations, including essential medical-dental integration.

Dr. Silk said communities need providers from diverse backgrounds with diverse skills so they understand their community and do not have to refer to specialists that do not exist. Not everyone has to have the full set of skills and instead, be able to refer within. That is a challenge and language is needed about priorities and awards, applicant requirements, and educational settings to help address practical realities in underserved areas. **Dr. Southerland** noted local dental organizations’ continuing education requirements and their capacity to secure funding. Training after school is expensive so it has to enhance a dentist’s practice and revenue to generate interest. Often, older dentists cannot get anybody to take over their practices, so they close and retire.

Public Comment and Business Meeting

Mr. Rogers opened the floor for public comment. None were offered. He thanked members for completing their annual ethics certifications and noted the next round will be in May 2025. He noted the Committee is short one family medicine member, but has three other members from that profession so the discipline is well represented.

Mr. Rogers discussed the Committee's 2024 meeting schedule. Per charter, and the authorization language, the Committee has to meet twice per year. However, due to the hold-up on three nomination packages in the past few years, the 2024 spring meeting was canceled, and two will be scheduled in the last half of this year. The next meeting is November 15, 2024. **Mr. Rogers** also discussed the process to review the Committee's charter and invited members' suggestions. He noted his request to add a data analyst from the National Center for Health Workforce Analysis was rejected. **Ms. Robinson** reviewed travel documentation and reimbursement procedures. She will send the travel information to members. *{ACTION ITEM}*

Day-1 adjourned at 4:47 p.m. (ET)

Friday, August 2, 2024 **8:00 a.m. (ET)**

Welcoming Remarks, Roll Call, and Agenda Review

Mr. Rogers opened the meeting and reminded members it is open to the public and will be recorded and transcribed. He called roll and confirmed quorum. **Dr. Fancher** reiterated the goal is to review Sections 747 and 748 and discuss what to include in the Committee's report.

Discussion on the 23rd ACTPCMD Report (continued)

Dr. Fancher suggested reviewing prior Committee recommendations and whether to reinforce those not implemented. **Mr. Rogers** said it usually is better to reference versus modify, and state the Committee's current thinking. Thus far, of 169 recommendations 40% have been fully, 37% partially, and 20% not at all implemented. That compares favorably versus other bodies at HHS.

Section 747

Mr. Rogers noted 747 language says the program or the Executive Branch can use the Committee's recommendations for NOFOs versus being strictly limited to the legislative wording. That allows for innovative ideas, but that language is not in 748. **Dr. Southerland** asked if that sentence can be added to 748 and whether the Committee is able to leverage other programmatic areas to support innovative projects. **Mr. Rogers** replied funds cannot be intermixed, they come down in a line from Congress. The Committee collaborates to intermix programmatic ideas, but not funds. Prior to the Affordable Care Act, all medical and dental training programs were under 747. Section 748 did not update the ACTPCMD's legislation, though it operates as if that was their intention and that has not been challenged. **Dr. Fancher** reiterated the Committee is considering revised language related to tribal, a sentence about flexibility added to 748, and including 748 in the Committee's purview.

Dr. Silk asked whether the legislation allows for pipeline work. **Mr. Rogers** replied it does not, but other HRSA bodies do that. **Dr. Silk** said the Committee expressed commitment to a future of diverse primary care professionals but has no language about it. **Dr. Fancher** replied the connection sounds good but funding is a concern, though perhaps the Committee can recommend medical schools help strengthen the pipeline. **Dr. Silk** added the idea would be to collaborate and strengthen the pipeline, but not start one. We should emphasize science and humanism to

younger students somewhere in K-12. Getting people to connect is a service to the country. **Dr. Freeman** suggested saying “pathway,” not “pipeline.” **Dr. Freeman** said medical and dental training are lifelong learning and other types of learning can also have significant health impacts. **Dr. Laurent** noted an opportunity to strengthen collaboration across the continuum of education, including undergraduate and medical schools. **Dr. Fancher** suggested expanding the recommendation to pre-health students involved in pathway programs.

Mr. Rogers reviewed the Committee’s past two recommendations about pathways. The Committee will review them to determine revisions, if any. {*ACTION ITEM*}

Dr. Laurent suggested more consideration of mental health (MH) training, including collaboration with behavioral health (BH). **Dr. Fancher** noted past grants for that and for embedding MH and BH professionals in primary care, but not as a preference or a priority. **Mr. Rogers** added while another committee addresses MH and BH, this Committee can also make recommendations. **Dr. Laurent** said it would be good to know more about MH and BH training since they might not be available in some areas, especially rural. She suggested interprofessional language include training in oral health (OH) and its integration with medical. **Mr. Rogers** replied that would revise language about collaboration among health professionals. **Dr. Freeman** advised cross training is different from interprofessional collaboration.

Dr. Freeman asked whether grantees are required to show who they are impacting. **Mr. Rogers** replied that is captured in grantees’ annual performance reports and the Committee will address that at its November meeting. **Dr. Freeman** added it is best to start training people earlier in life to drive improved health through training. She suggested the Committee should recommend tracking entries and progress through HCOP programs if it is possible. **Dr. Fancher** added federal support for tracking would be a service to the nation. **Dr. Henderson** added appropriate tracking of individuals can help verify HRSA’s impact on lives.

Dr. Silk asked whether “such as” language for interprofessional should include OH, MH, or others since that could stimulate interest among individuals, help clarify how interprofessional health is primary care, and signal a patient-centric approach. **Dr. Bol** added dental pain is related to medical conditions and cross training benefits providers and patients. **Mr. Rogers** noted the Committee and most of HRSA agree OH is primary care, but congress created a separate program and funding line for dental training.

Dr. Henderson said the wording “individuals from a minority group or a rural or disadvantaged background” is outdated and perhaps should say, “groups historically underrepresented in the health care professions.” **Dr. Freeman** added updating the word “minority” is important to stay aligned with population shifts and the term “cultural competency” might also be outdated. **Dr. Henderson** said people with disabilities could also be considered an underrepresented minority. **Dr. Fancher** said the Bureau’s data team will work on suggestions for Title VII wording updates.

Section 748 - Pediatric Dentistry

Dr. Bol said pediatric dentistry needs more faculty and outside-the-box thinking is needed for oral preventive care in communities. **Dr. Holtzman** noted recruiting faculty is difficult and that

has led to hiring those who do not have loans, so adhering to preferences can result in funding not the strongest applicants. **Mr. Rogers** added Section 748 states a preference in the Dental FLRP for applicants who are proposing pediatric dentists, but the pool is limited.

Dr. Obaban-Udoh asked whether the language could say faculty who work with pediatrics, so it does not require a legislative change. **Dr. Holtzman** replied the intent is for pediatric dentists. **Dr. Obaban-Udoh** suggested removing the preference because training programs see that pediatric dentists do not typically have loans or they cannot attract dental faculty and grantees cannot meet the grant terms. **Dr. Holtzman** added the Bureau considers funding support for general dentists as a preference. Some schools trying but unable to hire a pediatric dentist will get funded while others that do not need a pediatric dentist but want a general dentist with loans who will serve their community, children, or underserved populations might not get funded due to the preference. **Mr. Rogers** noted the preference is in the appropriation language, not the legislation, while the LRP is prescriptive in the 748 legislation. He added these are institutional grants and those who declare they will hire a pediatric dentist move to the top of the list and get funded, though sometimes are not able to hire the dentist. **Dr. Henderson** asked whether HRSA prefers pediatric dentists but, if necessary, grantees can recruit others. **Dr. Holtzman** replied yes, those institutions' grants go first versus schools that did not apply for a pediatric preference.

Dr. Silk asked about prioritizing programs training general dentists to have better pediatric skills and encouraging public versus private practice, since the need is high. **Dr. Freeman** asked how to incentivize training, including for pediatric dentistry. **Dr. Obaban-Udoh** added the preference is a challenge and if it hinders access to the LRP then it should become a priority so we know it is important, but it does not limit funding for the strongest applicants. **Dr. Henderson** asked about shifting the language from hiring pediatric dentists to providing pediatric training and since general dentists who treat children act like pediatric dentists, the appropriations language should apply to them.

Mr. Rogers suggested discussion about pediatric dentistry preferences and priorities and legislative and appropriations language continue at the next meeting, and the members agreed.

Section 748 - Time Requirements

Dr. Obadan-Udoh said some ideal candidates for postdoctoral training programs cannot participate due to grant restrictions. Specifically, NHSC Scholars' service timelines prevent them from participating in residency programs designed through training grants that emphasize special needs populations and have three-year or longer residencies. Perhaps the Committee can recommend ways to address that. **Dr. Holtzman** cited efforts by universities to address the issue, but thus far NHSC is unable to confirm its scholars can attend programs such as a three-year combined pediatric and dental public health, though separately those are okay. That means students will not apply for those programs if they cannot be guaranteed they can attend. **Mr. Rogers** noted the Committee can collaborate with other committees as it did with the Advisory Council for NHSC regarding dental therapists.

American Indians and Priorities #3 and #4

Dr. Bol suggested new language is needed about formal relationships with tribes and American Indian dentists. Problems occur when a program tries to develop a relationship with a tribe but has never had an American Indian dentist and thus, does not have the full scope of knowledge. American Indians want to take care of themselves and show their children they can be successful and not necessarily have to work for the Indian Health Service. **Dr. Fancher** said last year's Supreme Court decision about tribal affiliation differs versus other racial groups, so guidance is needed for the right language. **Dr. Bol** said language specifically including American Indian and Alaskan Native will bring them to the forefront instead of it being lost in the shuffle. It was concerning that the administration did not approve the American Indian or Tribal from previous recommendations. Some tribes are still like a third-world country and it is not those kids' faults. It is not "Native American" because anybody can say Native American. We are all native to America, so it is all American Indian. **Dr. Holtzman** suggested this issue should be addressed by a workgroup due to its complexity.

Dr. Jadotte noted Title VII definitions include underrepresented, but not specifically American Indian. **Dr. Bol** suggested adding the word "tribal" to priority #4, and noted "tribal health centers" is the right language. **Mr. Rogers** suggested recommended additions should include the groups that need help, such as CHCs. {*Note:* the Committee discussed using "such as" in Priority #4 but did not come to a conclusion.}

Dr. Bol said many American Indian dentists return to their community to try to have their own practice and the term "tribal health center" would not include them, but we want American Indians to have private practices. **Dr. Jadotte** asked if anything precludes the recommendation mentions private practices. **Dr. Laurent** asked whether any health entity not named is precluded from the program resources. **Dr. Bol** replied in our payback for Indian Health Service scholarships we are allowed to go to the Indian Health Service or we are allowed to go to a tribal health center, but not a private practice. **Dr. Jadotte** asked if the suggestion is to change the priority language to be more inclusive as long as the training is in a health facility that is caring for this population. **Dr. Bol** replied yes, the Committee should help with that. {*Note:* The Committee agreed to continue work on language about American Indians in Priority #4 sometime after this meeting.}

Other Topics

Dr. Brickle suggested working with community colleges (CC) since many dentists, hygienists and assistants, and medical physicians and nurses start there and go on to serve communities, including with activities beyond practice. Ideas from those settings can lead to innovative delivery modes and they also work with K-12 health sciences pathways. **Dr. Fancher** suggested the workgroup can think about engagement for CCs. **Mr. Rogers** agreed but cautioned about CCs' lack of resources to submit competitive applications. **Dr. Brickle** added they look for innovations in fields such as nursing and dental hygiene and what programs or partnerships to look into. Innovative ideas are needed to pursue this area, including with priorities or preferences for CC applications. **Dr. Freeman** suggested adding language similar to that about training programs that work with CHCs, tribal health centers, and rural health centers.

Dr. Freeman suggested including dental hygiene as part of the training programs and make it a

priority for general public health programs to work with schools of dental hygiene to further enhance those programs. **Mr. Ambriz** added faculty recruitment, training, and retention is a resounding topic that keeps coming up and should be explored further.

Topics for the 24th Annual Report

Dr. Fancher noted topics for 2025 can be broad, but should be within the Committee's purview.

Dr. Laurent suggested discussion about artificial intelligence (AI) and public health, especially how innovative use of AI can help meet program goals and enhance training and practice. **Dr. Dawson** suggested looking at tie-ins between AI, retention, and wellness for those who take care of America, including with the backdrop of provider stress during and after the COVID pandemic. Another important topic is student well-being, including issues like food deserts and people living in their cars and starving. **Dr. Jadotte** said HRSA should prepare physicians and dentists for what will happen as AI continues to mature and can be both disruptive and beneficial. AI can help with both patient care and the broader population lens. **Mr. Rogers** noted the Advisory Committee on Interdisciplinary Community-Based Linkages, and the Advisory Committee on Nursing have begun to address AI, including ethics issues, but cautiously since AI is evolving. **Mr. Rogers** said he will share presentations on the topic. *{ACTION ITEM}* **Dr. Obadan-Udoh** asked whether the Committee can write a letter to Congress in support of other committees' AI recommendations. **Mr. Rogers** replied the Committee will discuss that.

Dr. Freeman noted a National Academies report about faculty retention, specifically pediatric, that warned of impending shortages. Dr. Chen was on that Committee so perhaps this Committee should invite her to speak. **Dr. Fancher** agreed Dr. Chen should be invited to speak.

Dr. Bol said pathways and recruitment and retention of American Indian health providers and faculty in tribal communities needs to be addressed. Also important is to have individuals not from American Indian backgrounds train in tribal communities, including rotations. While the Indian Health Service does good work, the idea is to create more homegrown services. **Mr. Rogers** suggested Dr. Bol recommend whether the Committee should address this topic in a full report or revisit and update its past letter. **Dr. Bol** agreed to do so. *{ACTION ITEM}*

Public Comment and Wrap-Up/Next Steps

Mr. Rogers asked for public comments, none were offered. **Dr. Fancher** thanked members for joining the Committee, traveling to this meeting, and for their hard work at the meeting. She said much work lies ahead and reiterated Mr. Rogers will send information about the workgroups and the letter. She noted the next full-Committee meeting will be a one-day virtual meeting in November. **Mr. Rogers** said he will invite HRSA data officials. *{ACTION ITEM}* He added the meeting will be 10:00 a.m. to 5:00 p.m. so he will review whether there will be time for an external speaker. *{ACTION ITEM}*

The meeting adjourned at 1:07 p.m. (ET)