

## **ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES (ACICBL)**

**Meeting Minutes: April 22-23, 2015**

### **Advisory Committee Members Present:**

Mary Ann Forciea, MD, Chair  
Edna Apostol, MPH  
Freddie L. Avant, PhD, LMSW-AP, ACSW, C-SSWS  
Patrick DeLeon, PhD, JD, MPH  
Jacqueline Gray, PhD  
Patricia A. Hageman, PT, PhD  
Neil L. Horsley, MS, DPM, FACFAS, FACFAOM  
Sharon A. Levine, MD  
M. Jane Mohler, NP-C, MSN, MPH, PhD  
Carmen Morano, PhD  
Elyse A. Perweiler, MPP, RN  
Sandra Y. Pope, MSW  
Linda J. Redford, RN, PhD  
Peggy Valentine, EdD, FASAHP

### **Others Present:**

Joan Weiss, PhD, RN, CRNP, Designated Federal Official, ACICBL, HRSA  
Jim Macrae, MA, MPP, Acting Administrator, HRSA  
Luis Padilla, MD, FAAFP, Deputy Associate Administrator for Health Workforce, HRSA  
CAPT Phillip Budashewitz, RPh, MA, Director, Policy and Shortage Designation, HRSA  
Arpita Chattopadhyay, PhD, Chief, Workforce Analysis Branch, HRSA  
Hayden Kepley, PhD, Chief, Performance Measurement and Evaluation Branch, HRSA  
Zaldy Tan, MD, Director and Associate Professor, University of California, Los Angeles  
Christine T. Kovner, PhD, RN, FAAN, Professor, New York University  
Ronald H. Byerly, PA-C, Physician Assistant Director, Geisinger Medical Center  
Cathy Poon, PharmD, Associate Provost, University of the Sciences  
Meseret Bezuneh, MEd, Chief, Health Careers Pipeline Branch, Bureau of Health Workforce  
Cindy Harne, MSW, LCSW-C, Public Health Analyst, Mental and Behavioral Health, HRSA  
Nathan Dickey, HRSA  
Tamara Zurakowski, PhD, GNP-BC, CRNP, Public Health Analyst, HRSA  
Crystal Straughn, Technical Writer, DPHIE  
Kim Huffman, Acting Director of Advisory Councils, HRSA  
Kandi Barnes, Management Analyst, HRSA  
Cathy Kuchinsky, HRSA

### **Wednesday, April 22, 2015**

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 8:30 AM at the Health Resources and Services Administration's headquarters in the Parklawn Building, 5600 Fishers Lane, Room 18-67, Rockville, MD 20857.

The conference operator opened the meeting on behalf of the Health Resources and Services Administration (HRSA). Dr. Joan Weiss, Designated Federal Official, greeted the Committee members and introduced Dr. Luis Padilla, the Deputy Associate Administrator of the Bureau of Health Workforce. Dr. Padilla also greeted the Committee and introduced Mr. Jim Macrae, the Acting Administrator for HRSA.

In his opening remarks, Mr. Macrae spoke about his background and commented on how the work of the Committee was valued at HRSA. Mr. Macrae then shared his five operating principles: to learn from

mistakes; try different approaches to figure out how to deliver the best customer service; improve communication when disseminating information and soliciting feedback; grow and develop staff; and to demonstrate the results of the completed work. He then described the vision of healthcare set out by the HHS secretary. This vision included five strategic priorities: improving access to quality healthcare and services; strengthening, training, and diversifying the health workforce and encouraging collaboration to meet current and future needs; building healthy communities to have an impact on population health and social determinants of health; improving health equity to eliminate disparities; and strengthening internal program management and operations so that work is responsive to needs and supports innovation. He noted that the Secretary has challenged HRSA and its partners to transform care, particularly focusing on delivery system reform, smarter ways to spend money, and efforts to make people healthier. He remarked that these efforts could be supported by creating incentives that promote value-based payments or considering alternative payment models. He also suggested the integration of clinical care services so that patients were engaged in shared decision-making and had access to cost and quality information. He noted that this could be done better when electronic health information was interoperable and put to meaningful use.

Mr. Macrae then asked the Committee to share the challenges and opportunities that they saw in transforming the healthcare system. The discussion touched upon the issues with supporting students of color in schools and at training sites, particularly in light of the fact that sites were charging schools for training. The discussion then turned to the challenges of collaborating with partners and the need to facilitate this collaboration to reduce the duplication of programs and services. It was mentioned how joint funding efforts could be a way to address this. The burden of data collection was also discussed and it was underscored that there were barriers that prevented the sharing of information and the effective use of electronic medical health records. The Committee also pointed to the extender model as a way health centers could provide more care, although concerns about reimbursement were raised in connection with this model. The suggestion was made that grants could support this model system; however, it was also pointed out that the use of grant funding does not promote sustainability and that some providers could see extenders as a threat to their practice and license. Overall, it was determined that the realities of the clinical practice area needed to be recognized and considered while working on the goals set out by the Secretary and the HRSA administration.

CAPT Phillip Budashewitz gave a presentation on the budget process to provide the Committee with a review of how federal budgets are developed. He pointed out that budgets are a means for articulating needs and relay policy guidance and agency priorities. He noted that they also have narratives that accompany the budget. He went over the three documents that are used to create the budget: the Congressional Justification(CJ), the Office of Management and Budget Justification (OMBJ), and the Health and Human Services Justification (HHSJ). He noted that the budget for HRSA is part of the HHSJ and that it is reviewed by the Secretary's budget committee. He then reviewed the timelines for these processes noting that the cycles occur simultaneously though budget planning is done two years out. HRSA is currently spending funds allocated for 2015 while planning for 2017 and waiting to hear the reviewed comments on the proposal submitted for 2016. He described the legislative process concerning the granting of authorizations and appropriations, noting that everything has to be authorized and appropriated by Congress. Providing an overview of the government structure, he noted there are staff divisions and operating divisions, and that HRSA was one of 11 operating divisions within HHS. He then provided an example of a justification submitted by HRSA, pointing to the structure of the budget narrative and how it included program goals, descriptions, and information concerning the trends in funding. Following his presentation, he answered the Committee's questions, confirming that the recommendations they were working on for their 15th Report would inform the 2017 budget and be reflected in the HHSJ. He also remarked that individuals could provide input into the budget process by attending and participating in Congressional hearings.

Dr. Weiss then introduced the next speaker, Dr. Arpita Chattopadhyay, who gave an overview of the work done by the National Center for Health Workforce Analysis (NCHWA) and then presented the results of the recent reports published by the center. Dr. Chattopadhyay noted that the Center was created in 2010 to provide information to decision makers and that it helps meet HRSA's goals to ensure access to care. She then reviewed the methodologies and the accounting mechanisms that were used to determine the

supply and demand projections of healthcare workers. She noted that the size and characteristics of a population, as well as the changing ratios of different professions, would impact the projections and that data on the productivity of professions under new models of care were not yet available. She gave a few examples of the projections, summarizing that physician supply would increase in the coming years but not enough to meet the growing needs. She also noted that the number of non-physician clinicians would increase and that these professions could help to ameliorate the shortfall anticipated in specialty areas. She then spoke about how projections considered healthcare workers in urban and rural areas. Following the presentation, she answered the Committee's questions on how changes in training will impact the workforce projections and how the projections were based upon status quo assumptions and do not reflect changes already underway. She also noted that community health representative workers were not included in the projections, but would be incorporated into newer reports. There was further discussion about how rural and urban areas are defined and how rural areas may not have the population numbers to justify more providers but that the need may still exist. A question about when the algorithms are updated was also raised, and it was noted that newer reports would use a microsimulation model which was more complicated but also more amenable to frequent updates that could address changes, such as the rising age of retirement.

Dr. Hayden Kepley then presented on the performance measurement and evaluation conducted at NCHWA, which examines information concerning the healthcare workforce and how programs at HRSA contribute to the supply of that workforce. He also noted that the data collected and analyzed at NCHWA would be incorporated into the CJ and would be issued for public release; he also mentioned that the Center was in the process of developing factsheets for each program. He commented that programs had recently been re-categorized and that performance measures had been revamped to align with the goals and priorities of HRSA. He then reviewed the forms that program grantees complete and discussed how these forms help NCHWA collect the data needed to evaluate the programs' success in meeting their goals and objectives. He underscored this is but one source of the information used for evaluation and that other sources were also used to determine whether programmatic changes were effective or warranted. Following the presentation, he answered the Committee's questions and expressed an interest in hearing feedback from individuals in the field, especially if they had ideas regarding how to make specific changes to the current performance measures. The Committee again raised the issue of the burden of data collection, noting that the same number of forms needed to be submitted for a one-hour seminar as for an extended residency program. The point was also made that due to different academic calendars, evaluations had to be submitted before programs were completed. Thus, it was determined that flexibility was a key aspect to performance evaluation and that the process should match the program. It was also noted that reviewers should acknowledge that innovation depends on the situation, and that something may not be innovative at the national level but could be for a particular community.

Dr. Candice Chen then spoke to the Committee about some of the overarching changes that had been made to the programs in HRSA and the themes that were emphasized in recently released FOAs. She noted that technical support would be built into performance evaluation so that program officers would have assistance in conducting needs assessments and developing toolkits. She also commented that performance measures, including rapid cycle quality improvement, need to be incorporated into clinical care and the delivery of health care services so that a framework for continuous assessment and improvement was built into the program. Echoing what had been said by Mr. Macrae, Dr. Chen also spoke to the importance of gathering information from program grantees and being able to use that information to demonstrate the impact of the programs. She underscored that these changes were being made in a period of transformation and that flexibility is needed to make changes and for programs to address their specific needs. She addressed the Committee's questions on the subject of recent redesign of the geriatric programs and commented that the redesign of other programs would involve community engagement.

Dr. Weiss then reviewed five programs under Title VII, Part D: Allied Health Projects, Chiropractic Demonstration Projects, Podiatry Primary Care Residency, Continuing Education Support of Health Professions Serving Underserved Communities, and Education and Training of Pain Care. For each of these programs, she outlined their statutory purposes and histories of authorization and appropriation.

She noted that the Continuing Education and Pain Care programs had been authorized under the Affordable Care Act but had not received appropriations. The Committee inquired as to what entities could apply for these programs; how much money the Allied Health Program had allocated to its grantees; and what publications had come out of the podiatry program. The ensuing discussion brought to light that some Title VII programs lost funding in 2006 and that the geriatrics programs had been restored due to grassroots efforts. It was also noted that the program for pain care was the only one that was symptom-specific, rather than being focused on a particular discipline or population, and if given appropriations, could encourage interprofessional and team-based care.

Dr. Mary Ann Forciea, the Committee Chair, then introduced the panel of four speakers who were presenting on topics related to the role of practice redesign in healthcare transformation. The first speaker, Dr. Zaldy Tan, spoke about the experience of redesigning the UCLA Alzheimer's and Dementia Care Program. He provided an overview of how UCLA looked to the Indiana University program as a model for improving quality and reducing costs, but adapted the model to address the needs of the community in Los Angeles. He noted that this was a co-management model where program workers did not take over the primary care of their patients, but co-managed them with their doctor. He then outlined the five key components of the program: patient recruitment and the establishment of a dementia registry; the creation of a needs assessment that gathered information from patients and caregivers; the creation and implementation of patient-centered dementia care plans; the monitoring of these care plans as the patients' needs changed; and enabling access for dementia advice all day, every day. He noted that dementia care managers were essential to the program success and that specialty trained geriatric nurse practitioners were trained to become experts in dementia in order to address the medical issues, as well as the behavioral and social issues, related to dementia.

Dr. Tan then shared some of the experiences and program outcomes that had resulted from the practice redesign, noting that the outcome measures were looking at better care, better health, and better healthcare utilization. Going over some of the initial findings, he stated where some improvements could be made, specifically noting the disconnect between a well-meaning regular doctor and the system that allows patients and caregivers to get help when they needed it. He concluded his presentation stating that dementia co-management programs have a place in primary care redesign and have the potential to improve clinical performance metrics and lower costs. Following the presentation, he addressed the Committee's questions, commenting on the surprising challenges of working in partnerships, noting that that relationship is complex and work is needed to build the bridge between partners. He also noted that documentation needs improvement since some of the results, particularly around patients discontinuing medication in relation to mental status changes, appeared to be less successful due to the lack of documentation.

The second speaker on the panel, Dr. Christine Kovner, gave a presentation where she raised some issues for the Committee's consideration. Dr. Kovner began by pointing to the complex relationship between researchers and policymakers working together to develop policies that address the realities of the clinical environment. She spoke briefly about how the Affordable Care Act is changing the situation for healthcare beneficiaries, and how it has worked to build coordinated care, innovative models, and patient-centered care. She then pointed to the issue of not having data that is summarized and integrated. As an example, she noted that currently the best data for registered nurses comes from a survey last conducted in 2008. She recommended that work be done to get better sources of data about all health workers. On the subject of evaluation, she also raised the question about determining who were the best evaluators, noting that patients, family members, and health professionals would all have a perspective on the evaluation of something like care coordination.

Dr. Kovner also raised concerns about baccalaureate and associate degree nurses, remarking that many of the baccalaureate nurses often do not work in communities, yet they are the ones who are better trained in providing team-based care. She described the 3T program at New York University, which educates nurses and medical students together. She commented upon issues of scheduling and simulation, and also noted that her colleagues had learned that they needed to know more about how to teach people about building teams. She discussed overlapping roles and made the point that multiple individuals could do the same work and that it was important to teach students to work to the top of their

license and collaborate and work together in teams. Following her presentation, the Committee acknowledged that these were important issues to consider when assessing training programs. Another point was raised about the differences in the availability of information across the country.

The third speaker in the panel was Mr. Ronald Byerly who spoke about the changes in practice and in training that drive the transformation of the healthcare system. Mr. Byerly underscored the idea of growth as multidimensional, and that it does not simply equate to a greater number of hospitals and clinics; he pointed out that it relates to human resources and the expansion of programs to address the geographic and population-based needs. He compared the process to the evolution of supermarkets, noting that the economics in medicine were not different as growth enabled better and safer service. He also noted that to sustain growth, it was not necessary to tear down what previously existed but to build upon it; otherwise it would be a waste of time, effort, and money. He commented that the siloed education system had resulted in an inability of healthcare workers to communicate effectively. He thus emphasized that team-based care was needed, while also acknowledging that teams take work and that teaching team-based competency means setting clear lines of responsibility. He also noted that interprofessional faculty needed to teach the gaps, not only in clinical knowledge and professionalism, but also in performance improvement.

Mr. Byerly suggested the move from granting certificates of completion to teaching competency-based education. He also stated that clinical redesign programs should leverage information technology, and provided examples of current tele-medicine and tele-dermatology programs. He concluded his presentation by stating that the need to reengineer care delivery models involves all healthcare providers and that it is only by getting everyone on board that quality will be improved, morbidity will be decreased, and that there will be greater access to healthcare. Following the presentation, Mr. Byerly addressed the Committee's questions, noting that virtually nothing was being done in the area of physician assistant competency certification, although interprofessional education had begun in his program. Answering another question, he noted that the integration of technology would enable the higher utilization of nurse practitioners and physician assistants in the clinical environment.

Dr. Forcica then introduced the final speaker of the panel, Dr. Cathy Poon, whose presentation focused on the interprofessional education of pharmacists and how pharmacists have been underutilized in team-based models. Dr. Poon raised the point that although the scope of pharmacy practice had been expanded; pharmacy reimbursement had always been tied to a product, such as a bottle of Amoxicillin. She noted that a pharmacist can provide skills that need to be incorporated into a professional team. She then outlined some key aspects in becoming ready for advanced pharmacy practice experience, also known as APPE-ready. Future pharmacists need to be team-ready and collaborative-ready so that they are able to communicate; work together; understand different professions, roles, and responsibilities; and keep the patient at the very center of the work.

Dr. Poon then gave some examples of how pharmacists could be utilized. She suggested that pharmacists could play a significant role in drug therapy management, for example, in evaluating how the body handles medication which can be different from patient to patient, and a serious concern for geriatric patients. She turned to focus on other practice settings and shared some of her experiences in interprofessional education developed at the University of Sciences and with its partners. She noted that they were able to design a program piloting how to deliver a care plan for patients, while also incorporating the different roles and responsibilities of the team members. Speaking from this experience, Dr. Poon suggested that HRSA and other funding agencies might help get students to learn and work together to build the relationships that work later on in practice.

Following the presentation, Dr. Poon answered questions about her experience working in the Office of the Provost. Dr. Poon described some of the challenges working with new faculty, who saw her participation as a top-down approach, while externally, she was in a place to build relationships outside of the institution with other academic health centers. This led to a discussion about hierarchical structures in academic institutions and how that impacts working collaboratively. The discussion then turned to the opportunity for pharmacists to engage with individuals who cannot afford the medication that health

providers may prescribe. It was determined that this was opportunity for collaboration between pharmacists and their colleagues to come up with creative solutions and alternative therapies.

After the panel, Dr. Forcica reviewed changes to the agenda and opened the line for public comment. No comments or questions from the members of the public were made. Dr. Weiss then took roll of the Committee members and briefly discussed the reports on accreditation standards and interprofessional education that the Committee would discuss during the second day of the meeting.

Dr. Forcica then started the Committee discussion on the questions about scope of practice, statutory changes, and the measures needed to determine outcomes concerning Title VII, Part D programs. The discussion began on the topic of reimbursement and the pressing need for new payment models as different members of the healthcare team can perform the work that is billed by the physician. However, it was also noted that while some team-based projects have demonstrated cost reduction, there is not enough evidence to demonstrate that interprofessional practice results in lower cost for delivery of health care. And so questions were raised about how to encourage different disciplines to work together and how to encourage change in the payment model. The Committee was encouraged to think about what was best for the country and healthcare system, considering the fact that it would be unlikely there would be additional resources. They were encouraged to think of creative and innovative solutions to strengthen the programs under Title VII, Part D to meet the needs of the country within certain budget lines.

The discussion returned to the topic of clinical training sites and the issues of private schools paying to have students participate in training sites. Since state schools and other education centers could not afford to do the same, this resulted in many students not getting the hands-on practical training that was needed to learn team-based and interprofessional care. It was proposed that the Committee make a recommendation to support open access at the clinical sites that HRSA programs support. It was also suggested that HRSA could encourage the development of experiential, community-based incubator sites. The point was also made that if HRSA provides grants to pay clinical sites, it could potentially set the precedent that HRSA would pay for students at all clinical sites. The Committee thus considered what other incentives could be used to encourage collaboration, noting examples such as access to university libraries and adjunct teaching positions. The question was raised about whether HRSA should encourage demonstration projects or non-traditional practice sites, such as at faith-based organizations. This in turn raised the discussion of whether funding opportunity announcements should suggest eligible sites or encourage partnership as a way to treat population health. It was noted that the criteria that makes an entity eligible should be defined since expanding eligibility could dilute the quality of applicants. The Committee also noted that the importance of clinical training sites was discussed in the Committee's 12th Report and that the report could be a helpful resource in writing the current report.

The Committee considered the use of simulation, noting that many disciplines were already incorporating this into their curriculum. The point was made that students in different professions could not get the needed experiential learning since some training sites did not have qualified preceptors in all of the professions. The Committee pointed out this was another area where technology could be leveraged, and that in the earlier discussions, tele-medicine had not touched upon the use of tele-education to address issues concerning the lack of preceptors in certain areas. Student stipends were also raised as another way to provide incentives for students to go out to underserved areas. The subject of accreditation standards and their impact was also raised as the Committee pointed to examples of merging accreditation bodies and training programs of different lengths. While it was acknowledged that HRSA cannot influence accreditation decisions, it was determined that these were important topics to consider.

Returning to the subject of the redesign of programs, and specifically referencing combined geriatric workforce programs, the Committee discussed the success in current collaborations and expressed the hope that soon the data would demonstrate how they were both successful and cost effective. It was also mentioned that examining what all healthcare providers can do -- considering processes, structure, models, and training -- is the first step in bridging the silos and working collaboratively with others, including non-professional healthcare providers.

After the discussion the lines were once again opened for public comment. No comments or questions were made.

The first day of the meeting was adjourned at 4:45 p.m.

#### **Thursday, April 23, 2015**

Dr. Forciea opened the second day of the meeting and called roll before moving into a brief logistical discussion on the Institute of Medicine handout and All-Purpose Table.

Ms. Elyse Perweiler provided an overview of the statutory regulations for the AHEC program. She highlighted the two types of awards available under AHEC: the Infrastructure Development award and the Point of Service Maintenance and Enhancement award. The Committee discussed eligibility requirements, specifically whether applicants should be limited to schools of allopathic medicine, osteopathic medicine, and nursing. It was suggested that more flexibility to incorporate non-health organizations and disciplines, such as law schools or social workers, might benefit certain communities, drive innovation, and provide services that the current awardees do not. However, it was also argued that AHECs should remain the focus due to their neutrality, resources, and interprofessional nature. The Committee agreed with broadening the statutory eligibility to include additional disciplines and organizations. Dr. Forciea suggested limiting applicants to one per institution.

Dr. Weiss introduced Ms. Cindy Harne, who took questions from program representatives on the structural aspects of two grant programs: Graduate Psychology Education, Section 755(b)(1)(j), and Mental Health Education and Training, Section 756. Dr. Carmen Morano pointed out the limitations of HRSA's fixed tuition stipends, as opposed to each institution being able to divide up their awards. Several Committee members supported flexibility for institutions to determine how awards are allocated between stipends and other associated costs. Particular attention was paid to rural, community-based placements, and providing adequate transportation, lodging, and incentives. Dr. Forciea cautioned the Committee on potential unintended consequences of relaxing award restrictions by touching on the redesigned geriatrics program, where increased spending flexibility resulted in programs abandoning their fellowships and young faculty development funding. Ms. Perweiler suggested a stronger behavioral health component for programs, especially for interdisciplinary healthcare professionals, and Dr. DeLeon praised SAMHSA and HRSA for working together in their budget justification book, specifically on mental health aid and training.

Dr. Chattopadhyay returned to take additional questions on current statutory purposes and specific grant programs. She explained that data for the supply and demand projections was gathered from MEPS, the Medical Expenditure Panel Survey, sorted at the national and regional levels, and analyzed, with the intention of moving towards localized projections. Dr. Candice Chen discussed the work done by the Utah Medical Education Council, a body that used data analysis to make state-level recommendations for workforce planning and development, and suggested it as a model for making local decisions. Ms. Perweiler, Dr. Forciea, and Dr. Levine discussed the motivation for increasing ambulatory-based community practice, spending practices for GME money, and the difficulty of funding training for various caregivers.

Mr. Nathan Dickey then presented an ethics update. He explained that the Committee members are classified as special government employees and are therefore held to the same ethical standards as regular federal employees, and that failure to comply could result in regulatory or criminal repercussions. He described the nuances of conflicts of interest, particularly where specific parties or financial and employment matters are concerned, and gave potential exemptions to the rule. Mr. Dickey also covered the restrictions on accepting gifts, outside activities classification on financial disclosure reports, and limitations on political and foreign activities.

Dr. Forciea then turned discussion to a review of accreditation standards, beginning with the "Interprofessional Education Accreditation Standards" paper from the Journal of Interprofessional Care.

She stressed the importance of interprofessional education (IPE) in accreditation as well as taking actionable steps toward implementing accreditation standards. Dr. Weiss spoke about past recommendations to accreditation bodies. It was also mentioned that IPE cannot succeed without aligning the administrative structure of clinical sites with the program's teaching goals, and that interprofessional training must go beyond current students and reach current professionals. Ms. Perweiler spoke about AHECs' abilities to implement and provide training for academic, community-based partnerships and IPE. Ms. Pope added that higher education and government agencies need to be involved to drive IPE goals forward, and Dr. Horsley spoke about the current accreditation standards in podiatry.

Ms. Perweiler then suggested that the Committee make recommendations on structure and process elements to promote IPE and collaborative practices in accrediting bodies. The Committee recognized the importance of fair goals and performance measures for programs and centers, and noted that they may serve as an avenue for recommendations. The Committee discussed the healthcare difficulties that rural, remote, and Native American populations face, and emphasized the lack of stable primary care providers. Ms. Perweiler and Dr. Levine identified opportunities in those areas for remote care, like telehealth, and interprofessional practice. Ms. Apostol raised practical concerns, such as who would provide the resources, what kind of staff would be needed, and who would deliver the funding. Dr. Weiss reminded the Committee that its recommendations have a history of being picked up by the field.

Dr. Weiss moved to approve the last meeting's minutes; the approval was passed.

The Committee broke for lunch at 12:01 p.m.

Dr. Forcica reconvened the afternoon session. She introduced the Committee discussion questions, with an emphasis on the first and third bullet points: How will the changing scope of practice of health professionals affect Title VII, Part D Programming? And what measures are needed for Title VII, Part D programs to have an impact on outcomes and quality?

Dr. Hageman highlighted the change in scope for physical therapy, a field where clients now have direct access to care without a physician referral. This led to discussion of the occupational therapy expansion into primary care and the areas in which it overlaps with other health professions. Dr. DeLeon described the changing scope of practice in the field of psychology: the move into health psychology, prescriptive authority, and general primary care. He also predicted a change in reimbursement models. Dr. Linda Redford stressed the importance of adopting a population health focus rather than care providers only looking at individual patients. Ms. Perweiler suggested that risk stratification of the patient population, in order to determine the appropriate care providers, may provide direction moving forward.

Discussion turned to the benefits and difficulties provided by patient-determined care. Dr. Forcica envisioned a care model where the patient chooses their type of provider to act as a primary contact point in the system of care. Dr. Valentine spoke about cost as a driver of change in patient care delivery, citing the increased reliance on midwives in nursery suites as an example. Dr. Redford added community health workers as another emerging cost-driven trend in health care delivery. Dr. Forcica and Dr. Peggy Valentine emphasized the importance of staying abreast of changes in health care and being inclusive of all health professionals, regardless of discipline or degree.

Discussion moved on to how HRSA will measure quality and outcomes in the future. Dr. Forcica spoke about the challenges and changes in the geriatrics programs that came with increased spending flexibility; namely, splitting available funds even thinner, consolidation of programs, a greater emphasis on evaluation, fulfilling difficult meaningful outcomes, and the loss of the fellowships program. The Committee agreed that efforts should be made to hold more discussions ahead of decisions. Dr. Forcica described the nuances of the 753(b) program, focusing on how the ACA expanded the definition of behavioral mental health professional to include a larger variety of disciplines in the one-year retraining program. The Committee also discussed the difficulty of maintaining training mechanisms for all three disciplines: medicine, dentistry, and psychiatry. Dr. Forcica praised HRSA for its willingness to be flexible with statutory purposes, which in turn enables innovative and local solutions to find funding.

The Committee then discussed the four geriatrics grant programs combined into the Geriatrics Workforce Enhancement Program and whether or not they could be as flexible with statutory purposes as HRSA was with the geriatrics programs. Dr. Forcica also spoke about the difficulty of linking IPE efforts to patient outcomes in order to satisfy HRSA's assessment requirements. Dr. Valentine agreed, and suggested that HRSA consider the Institute of Medicine recommendations on IPE program standards. Discussion then turned to the Quentin N. Burdick Program for Rural Interdisciplinary Training. Dr. Weiss recommended assimilating principles from previous Burdick-funded programs into existing AHEC programs. The Burdick program was also cited as a good example of expansion. Dr. Forcica summarized the group's thoughts, and recommended that the Committee members continue thinking and reading articles about practice alignments, scope of practice changes, and quality measures, so that their ideas could be incorporated into the June meeting. Ms. Perweiler commented on the difficulty of improving access to care providers in rural areas, as well as the need for technological advancement to overcome the difficulty of getting providers onsite. She also stressed the need for team-based decisions in order to provide the best care to patients at each point in their healthcare lifecycle, as well as the need for statutory changes that promote programs to move in that direction. Dr. Morano asked whether HRSA could use standardized outcome instruments for evaluation of education programs. The idea was proposed for recommendation, although Dr. Forcica cited the severe lack of potential instruments to choose from as an obstacle.

The meeting was then opened up for public comment. There were no comments made by the public or speakers. Dr. Forcica thanked the committee members for their attention and adjourned the meeting.

The meeting was adjourned at 2:15 p.m.