

**U.S. Department of Health and Human Services
Health Resources and Services Administration (HRSA)
Bureau of Health Professions (BHP) (BHP)
Third Annual All-Advisory Committee (AAC) Meeting
April 21, 2010**

Mary Wakefield, PhD, RN, HRSA Administrator, delivered opening remarks to the committee. Her key points included:

- The committee's work helps reinvigorate BHP in carrying out its mission and program.
- There has been previous resistance to increasing funding for health workforce programs.
- Deployment, make-up, and total numbers of health workforce are key issues.
- The American Recovery and Reinvestment Act, the Affordable Care Act, and FY2011 Budget offer increased investments in workforce programs.
- There is a new focus on investment in public health workforce and the diversity of the workforce.
- The interdisciplinary training and practice of primary care providers is a key issue in the Affordable Care Act.

The following key members of the committees delivered welcome remarks:

- William Curry, MD, Chair, Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD)
- Maureen Keefe, PhD, RN, FAAN, Executive Committee Chair, National Advisory Committee on Nurse Education and Practice (NACNEP)
- Russell Robertson, MD, Chair, Council on Graduate Medical Education (COGME)
- Ron Rozensky, MD, Chair, Advisory Committee on Interdisciplinary, Community Based Linkages (ACICBL)

Christine Cassel, MD, President and CEO of the American Board of Internal Medicine delivered the keynote address entitled *Building Interprofessional Teams*, which detailed past work on interprofessional competencies and steps that still need to be taken.

- The Institute of Medicine's (IOM) 2000 report entitled "Crossing the Quality Chasm Report" identified the need to train health care providers differently to prepare them for practice.
- IOM's 2004 report "A Bridge to Quality" identified 5 core competencies for all health professions.
- The core competencies and interdisciplinary practice can be integrated into the system through the accreditation, licensure, certification, and delivery system accreditation processes.
- All competencies are connected, and health information technology (HIT) serves as a tool to link and support them. IOM and others have identified HIT as a competency.

- Need to redesign training and practice to get to the patient-centered medical home.
- Need new standards for evaluating competencies, and training faculty to teach new competencies.

The committee then heard presentations on interprofessional practice models from two individuals.

Bruce Hamory, MD, Executive Vice President of Geisinger Health Systems shared the following thoughts:

- Geisinger partners health care providers to work with Health Administrators to help educate staff on the business side of the house about population medicine.
- System gives financial warranty to patients that they will receive best-practice, evidence-based medical care.
- Clinical guidelines for care standardized based on clinical outcomes data and assessment of successful compliance by clinical staff implemented. The standardization resulted in increases in revenue, decreases in costs, and better patient outcomes.
- Geisinger spends 4.5% of its budget on HIT; the national average is 1%.
- Geisinger examines patients' clinical and financial data to identify high risk patients and assign these patients a case manager.

Craig Jones, MD, Director of the Vermont Blueprint for Health discussed the following:

- Delivery system reform requires
 - Focus on prevention
 - Multi-insurer payment reform
 - State wide evaluation and IT infrastructure
- Enhanced payment based on National Clinical Quality Association scores
- Development of Community Health Team to serve clusters of primary care providers (RN coordinator, social worker, nutritionist, community health worker, Medicaid coordinator, public health specialist)
 - Shared costs between practices within cluster
 - Coordinate care and linkages to other human services
- Focus on preventive care and screening as well as targeted services and coordination for specific conditions/sub-populations
- Community health team integrates patient centered health and other non-clinical services
- Development of HIT core data dictionary implemented in clinical care settings across the state
 - Utilized by community health team (preventive care, chronic disease, health maintenance, etc)

Committee Members asked several questions of the presenters.

- What about diversity within populations?
 - While it may require different skills, the tactics for providing care are still the same
- How does Disease Management work outside of clinical care setting?

- Functional teams are not brick-and-mortar; disciplines schedule different times to be in different practices; must work closely and meet to plan
- How do you evaluate the competencies of the team?
 - Lots of performance data including: individual patient satisfaction ratings by individual provider; twice a year evaluations with chiefs; check ins if data indicates a problem

The committee heard presentations from groups working to develop interprofessional competencies.

Carol Aschenbrener, MD, Executive Vice President of the Association of American Medical Colleges (AAMC) and Richard Valachovic, DMD, MPH, Executive Director of the American Dental Education Association (ADEA) described the Interprofessional Education Collaborative they both work with.

- Comprised of AAMC, ADEA, American Association of Colleges of Osteopathic Medicine, Association of Schools of Public Health, American Association of Colleges of Nursing, American Association of Colleges of Pharmacy
- We believe that interprofessional education is key to competency based learning
- Past activities include
 - Developed a statement of purpose: to do this, we had to develop a common language, define foundational competencies
 - Held meeting in March 2010 to discuss future activities
- Important areas of work going forward
 - How to prepare faculty?
 - How to disseminate resources/learning materials?
 - How do you assess interprofessional learning (must be done in community setting)?
 - How to evaluate the link between education and practice?
 - How to address scope of practice issues?
- ADEA perspective on the Interprofessional Education Collaborative
 - Oral health traditionally separated from the rest of medicine, but there is now a new understanding of relationship between dental medicine and general/systemic health emerging
 - In some populations dental visits are more common than primary care visits, so there is a growing need to make dental clinics health homes as well, not just integrating dental care into primary care home, but integrating primary care into dental clinics

Jody Gandy, DPT, PhD, PT, Director of Academic Clinical Education Affairs for the American Physical Therapy Association (APTA) discussed the Interprofessional Professionalism Collaborative

- Interprofessional professionalism is a core competency
- All professions struggle with defining, teaching, and evaluating professionalism
- Enhances communication among health professionals, improving quality of care
- Collaborative has grown and includes professions that are not always integrated into the interprofessional discussions, including physical therapy and veterinary groups
- Identified interprofessional professionalism behaviors

- Hopes to develop toolkit to evaluate at the entry level whether students will be capable of developing the interprofessional professionalism behaviors
- Faced challenges in casting a wide enough net to encompass a large number of health professions

Robert Lembo, MD, FAAP, Director of the National Institutes of Health (NIH) Clinical Center, discussed NIH's core competency training.

- Although it is a research hospital, it does have accredited training programs that must deal with interprofessional care issues
- Through a consensus process, created a core competency training common to all health professionals for professionalism, including:
 - interpersonal and communication skills
 - managing ethical challenges
 - leadership
 - conflict resolution
 - quality improvement
- Lessons learned
 - Data should drive planning process
 - Engage opinion leaders early
 - Use adult learning principles
 - Get firm commitment from stakeholders

Jan Heinrich, DrPH, RN, FAAN, Associate Administrator for the HRSA BHPr delivered a brief update on the Bureau's activities.

- Increasing appropriations over the last 3 years
- Affordable Care Act required immediate changes to existing programs
- Affordable Care Act created the National Center for Health Workforce Analysis and the National Commission

The committee heard presentations on interprofessional education models.

Doris Grinspun, MSN, RN, Executive Director of the Registered Nurses' Association of Ontario, addressed the points below:

- Interdisciplinary primary health care increases:
 - Access, quality and choice, financial sustainability, health human resources
 - The number of entry points to the health system
- It's not just about money; changes are needed to the regulatory and structural systems that encourage silos in both education and practice.
- Nurse managed care centers are proving successful in Canada
- Social services should be part of the interprofessional health team and to help people stay well.

Christine Arenson, MD, Co-Director of the Interprofessional Education Center at Thomas Jefferson University presented on her work

- Center
 - Had support of school deans
 - Funded dedicated positions to manage interprofessional training
 - Co-Directors from different disciplines

- Champions among faculty, community volunteers, school curriculum committee members
- Have a number of individual training models, but focusing more on clinical training
- Health Mentors Program
 - Mentor is adult with chronic disease or disability that teaches teams of health professions students about interprofessional clinical care
 - Content is embedded in curriculum of each profession's training
 - Student must coordinate with each other, meet with mentors and come up with a wellness plan for the mentor
- Evaluation
 - Measured student attitudes to providing care to those with chronic conditions
 - Students now think it is normal to interact with students from other health professions

Pamela Mitchell, PhD, RN, FAHA, FAAN, Community Medicine Director at the University of Washington Center for Health Sciences Interprofessional Education shared the following thoughts

- Interprofessional initiative
 - Began with funding from university
 - Continues today because of faculty champions
 - Competencies included:
 - Providers understand and respect each other's approaches
 - Providers understand the context and complexity of population health that is driving all of this, and
 - Providers are competent in basic group skills
- Interprofessional training and education must have a meaningful focus, such as service to the underserved, and be relevant to those being trained
- Wellness Clinic set up by students is the longest-running interprofessional initiative

Through consensus building exercises, the committee identified the following set of five core interprofessional competencies:

- Person (Client?)/Family/Community-Centered Care
- Interprofessional Team Functioning
- Evidence-Based Practice
- Quality Improvement and Patient Safety
- Informatics