

ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES

Meeting Minutes: June 17, 2015

Advisory Committee Members Present:

Mary Ann Forciea, MD, Chair
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
M. Jane Mohler, NP-C, MSN, MPH, PhD
Elyse A. Perweiler, MPP, RN
Sandra Y. Pope, MSW
Linda J. Redford, RN, PhD

Others Present:

Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, ACICBL, HRSA
Candice Chen, MD, MPH, Director, Division of Medicine and Dentistry, HRSA
Crystal Straughn, Technical Writer, HRSA

Introduction

The Advisory Committee on Interdisciplinary Community-Based Linkages (ACICBL) convened its meeting at 9:30 a.m. at the Health Resources and Services Administration's headquarters in the Parklawn Building, Room 10-95, 5600 Fishers Lane, Rockville, MD 20857. At this meeting, the ACICBL members continued their work on the ACICBL 15th report. ACICBL provides advice and recommendations to the Secretary of the Department of Health and Human Services (Secretary) concerning policy, program development, and other matters of significance related to interdisciplinary, community-based training grant programs authorized under sections 750 – 759, Title VII, Part D of the Public Health Service Act, as amended by the Affordable Care Act. The ACIBL 15th report will provide recommendations for the following targeted program areas and/or disciplines: 751 - Area Health Education Centers; 752 - Continuing Education Support for Health Professionals Serving in Underserved Communities; 753 - Geriatrics Workforce Enhancement; 754 - Quentin N. Burdick Program for Rural Interdisciplinary Training; 755 - Allied Health and Other Disciplines; 756 – Mental and Behavioral Health Education and Training, and 759 – Program for Education and Training in Pain Care. The members will finalize programmatic recommendations, review and make recommendations on each program's performance measures, and make recommendations for appropriation levels for the programs.

Discussion

Dr. Candice Chen opened the meeting by thanking the members for their service. She then took roll and turned over the meeting to Dr. Mary Ann Forciea. Dr. Forciea proposed that the members discuss the summary of potential program revisions and recommendations she developed after the last meeting and then review each program and make additional recommendations. She included the following global recommendations in her draft summary:

1. Every program should include training for interprofessional practice, even in discipline-specific programs.
2. Applicants for programs should not be limited to specific health professions schools. Applicants should be free to develop the strongest consortia available to them and present that array in their proposals.
3. Training stipends should be allowed in every program. Applicants should be free to include the costs of stipends in their proposals, if in their area this expense would be required for success.
4. Costs to the clinical sites for training should be included in annual performance reports
5. Outcomes reports for these education awards should not be linked to patient outcomes, but rather to demonstrated changes in trainee competency. The Committee thought it may be helpful to HRSA if sample competency standards were proposed for specific programs, this might be helpful to HRSA.

The Committee discussed the recommendations, specifically recommendation 4 (Cost to clinical sites for training should be included in annual performance reports.). The members requested additional clarification. Dr. Forceia explained that it is important to think about the costs for the trainings to the clinical sites that are offering the training. The Committee cannot influence Medicare to pay them more for being a training site. HRSA can ask programs for estimates on training costs in their annual performance reports and HRSA can track that information. The following comments and concerns emerged from the discussion:

- There is no mechanism to support all the sites that are needed to reimburse training sites for either being training sites for experiential interprofessional learning or to be clinical preceptor sites. Recommendation 4 may not be a reasonable approach given growing class sizes and the proliferation of medical schools and online courses needing placement sites.
- Some Federally Qualified Health Centers (FQHCs) do not want students because they believe it erodes their productivity. In smaller practices they do not have the room or physical space for students. Faculty development, practice redesigns, traditional care management and chronic care management are some incentives to reward and support practices that educate and train students.
- The Centers for Medicare & Medicaid Services (CMS) may be giving incentive payments to some sites in the future. There should be incentives for sites that want to support interprofessional education. HRSA can provide data and make recommendations internally to CMS and CMS has the flexibility to develop a different payment mechanism.
- In previous Committee discussions, there were some concerns raised about whether or not placement sites should be paid. As the need for placement sites continues to grow, HRSA funded programs cannot afford to pay sites. But newly emerging private medical schools are paying and as a result sites do not want to take students from HRSA funded programs that cannot pay them.
- There can be a recommendation that HRSA should further investigate the cost and benefit of training community-based clinical sites. It could also be a topic for a future ACICBL report where the Committee could explore it in greater detail. It is an integral

part of interdisciplinary community-based linkages, and supporting training in clinical sites and a report can provide a richer discussion.

After much discussion, the Committee decided to delete recommendation 4 and consider it for a future ACICBL report. The members then moved the discussion to recommendation 5 (Outcomes reports for these education awards should not be linked to patient outcomes, but rather to demonstrated changes in trainee competency. The Committee thought it may be helpful to HRSA if sample competency standards were proposed for specific programs.) The Committee agreed that recommendation 5 is important and revised it as: HRSA program reports should demonstrate changes in trainee competency. However, where possible, quality, safety, and cost outcomes should be encouraged. One member suggested competencies from different disciplines be used as examples in the report. The final draft global recommendations are:

1. Every program should include training for interprofessional practice, even in discipline-specific programs.
2. Applicants for programs should not be limited to specific health professions schools. Applicants should be free to develop the strongest consortia available to them and present that array in their proposals.
3. Training stipends should be allowed in every program. Applicants should be free to include the costs of stipends in their proposals, if in their area this expense would be required for success.
4. HRSA program reports should demonstrate changes in trainee competency. However, where possible, quality, safety, and cost outcomes should be encouraged.

A Committee member noted their disagreement with recommendation 2 (That applicants for programs should not be limited to specific health professions schools. Applicants should be free to develop the strongest consortia available to them and present that array in their proposals.). The member did not believe that applications should be open to all health professional schools. Some schools are not equipped to provide community-based education and to have partnerships in place at the level of a medical school. HRSA has not opened it to all schools in the past for a reason, and there are reasons to continue that trend. In response, members noted:

- The challenge is that physician assistants may not be part of the College of Medicine in the country. In fact, half of them are and half of them are not and yet they are a vital part of primary care. If the program is housed out of allied health, they are still going to have to be in a partnership with the College of Medicine.
- In order to move into 22nd century, it should not always be that only medicine knows best. Colleges of Pharmacy and Physical Therapy should be able to administer a program and contract with a medical school. It is inappropriate to say medicine must be there, but not the other ones. This does not reflect the way healthcare is moving.
- HRSA should outline a program with goals and each area or region should decide what schools they need to achieve that and justify it. Reviewers then decide whether the program is likely to succeed given the partners that are listed in the consortium.
- There are instances where a school of nursing, social work, pharmacy or podiatry, may have the strongest community-based presence and want to lead the effort. Individuals

should not be forced to find a medical school that is not only willing to cooperate, but be the lead. That is not the best way to structure community-based programs.

- HRSA should look for the best programs, requiring that medicine be in the group or only in some instances.
- There are places where nursing wants to take the lead and takes the lead, and that may or may not involve medicine. HRSA should be pushing competition and new models of thinking.
- For example, why does every children's hospital only have to contract with a medical school? Aren't there children's hospitals where they need mental health, social work, psychology, or pharmacy? That is not best serving children in children's hospitals.
- It is a difficult decision, particularly with regard to the Area Health Education Centers (AHEC) program, where there is a match involved and other programs do not require a match. Historically schools have not been interested in being a lead agency for an AHEC because 75 percent of the money that is allotted to an AHEC program goes to the AHEC center. Within the AHEC network there are over 50 programs, and 240 centers throughout the country that coordinate across health profession schools to achieve placements for health professions students of multiple disciplines. In some schools they may have a robust component that can assure student placement. But it also involves duplication of infrastructure and how a school handles that.

After much discussion the members decided to revisit recommendation 2 concerns and move on to recommendations for programs. The members reviewed their statutory purposes, outcomes that are specified in the existing legislation, and appropriations of individual programs.

Section 751 Area Health Education Centers (AHEC)

This section establishes two types of grant awards for academic institutions to be used in collaboration with two or more disciplines. The members reviewed the use of funds in this program and decided that some of the activities required revision and consolidation. The members also concluded that the current appropriation should remain the same: Awards must provide at least \$250,000 annually per AHEC center. This section authorizes an appropriation of \$125 million for each of FY2010 through FY2014.

752 Continuing Education Support for Health Professionals Serving in Underserved Communities

This section requires the Secretary to make grants to, and enter into contracts with, eligible entities to improve health care, increase retention, increase the representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources. The members recommended that this program not receive an appropriation because activities under this authorization are subsumed by other programs such as AHEC and Geriatrics Workforce Enhancement Program (GWEP).

Section 753 Education and Training Related to Geriatrics

The programs under this section have been reorganized under the Geriatric Workforce Enhancement Program (GWEP). The GWEP supports the development of a healthcare workforce that improves health outcomes for older adults by integrating geriatrics with primary

care, maximizing patient and family engagement, and transforming the healthcare system. It aims to provide greater flexibility to grant awardees by allowing applicants to identify the specific interprofessional geriatrics education and training needs of their communities and develop a program that is responsive to those needs.

The members recommended that stakeholders be involved when revisioning programs and that language is added to funding opportunities surrounding AHEC and mandating partnerships to assure ability. The members requested that the technical writer provide appropriation levels for GWEP after the meeting for further discussion.

Section 754 Quentin N. Burdick Program for Rural Interdisciplinary Training

This section authorizes the Secretary to make grants or contracts to help entities to fund interdisciplinary training projects designed to (1) train health care practitioners to provide services in rural areas; (2) demonstrate and evaluate innovative interdisciplinary methods designed to provide access to cost-effective comprehensive health care; (3) deliver health care services to individuals residing in rural areas; (4) enhance the quantity of research on health care issues in rural areas; and (5) increase the recruitment and retention of health care practitioners from rural areas. This program is unfunded and was last funded in 2005. The ACICBL recommended restoring funding of this program at the fiscal year (FY) 2005 year level (\$5-6 million).

Section 755 Allied Health and Other Disciplines

This section authorizes the Secretary to award grants or contracts to help entities fund activities that may (1) assist institutions with meeting the costs of expanding or establishing allied health professions; (2) involve planning and implementing projects in preventive and primary care training for podiatric physicians in approved or provisionally approved residency programs; and (3) carry out demonstration projects for chiropractors and physicians to collaborate on identifying and providing effective treatment for spinal and lower-back conditions. Activities may include projects that expand education and training opportunities for a broad range of health professionals.

This program was last funded in 2005. Podiatry received under \$1 million. Chiropractor received \$1 - \$1.25 million, and Allied Health was \$5 - \$7 million. The members recommended restoring Allied Health funding at \$5 million.

Section 756 Mental and Behavioral Health Education and Training Grants

The Secretary is authorized to award grants to eligible higher education institutions to support student recruitment, education, and clinical experiences in mental and behavioral health. The purpose of the Mental and Behavioral Health Education and Training (MBHET) grant program is to strengthen the clinical field competencies of graduate students in accredited master's degree program of social workers and accredited doctoral level psychology program who pursue clinical service with high need and high demand populations, including rural, vulnerable and/or underserved populations, and veterans, military personnel and their families. The members recommend this program be supported with an appropriation of \$10 million for all aspects of the program.

Section 757 Advisory Committee on Interdisciplinary, Community-Based Linkages

This section requires the Secretary to establish the ACICBL determine the appropriate number of individuals to serve on the Advisory Committee. The Secretary is required to appoint health professionals who are from a school of medicine or osteopathic medicine; an incorporated consortium of such schools, or the parent institutions of such a school, a school of nursing in a state without a school of medicine, teaching hospitals and graduate medical education programs; and programs that support the allied health professions. The members made no revisions to this program and recommended it stay at its current level.

Section 759 Program for Education and Training in Pain Care

The Secretary is authorized to award grants, contracts and cooperative agreements to health professions schools, hospices, and other public and private entities to develop and implement programs to provide education and training to health care professionals in pain care. The grant applicant must agree that the program will include information and education on (1) the means for pain assessment, diagnosis, treatment, and management, and the medically appropriate use of controlled substances; (2) applicable laws, regulations, rules, and policies on controlled substances; (3) interdisciplinary approaches to pain care assessment and pain care delivery; (4) barriers to care—including cultural, linguistic, literacy, geographic—in underserved populations; and (5) recent findings, developments, and improvements in providing pain care. This program has never been funded. The members recommended that it not be funded activities under this authorization are subsumed by all other programs.

Committee Business

The members concluded it was best to assign members to each program to make recommendations prior to the next meeting and to draft the 15th report: Global Recommendations (Mary Ann and Peggy); 751 Area Health Education Centers (Sandra and Elyse); 752 Continuing Education Support for Health Professionals Serving in Underserved Communities; 753 Geriatrics Workforce Enhancement (Linda, Sharon, Elyse, Mary Ann, and Jane); 754 Quentin N. Burdick Program for Rural Interdisciplinary Training (Pat Hageman., Linda, Carmen, and Peggy); 755 Allied Health and Other Disciplines (Peggy, Pat Hageman, and Neil); 756 Mental and Behavioral Health Education and Training (755 B1J, Jacqueline and Pat DeLeon) and 759 Program for Education and Training in Pain Care (No appropriation).

The next meeting will be held on December 15, 2015 as a conference call/webinar. The members will discuss the topic for the ACICBL 16th report.

The meeting was adjourned at 4:30 p.m.