

ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES

Meeting Minutes: December 15, 2015

Advisory Committee Members Present:

Mary Ann Forciea, MD, Chair
Peggy Valentine, EdD RN, PA Vice Chair
Jacqueline Gray, PhD
Freddie L. Avant, PhD, LMSW-AP, ACSW, C-SSWS
Patrick DeLeon, PhD, JD, MPH
Sharon A. Levine, MD
M. Jane Mohler, NP-C, MSN, MPH, PhD

Invited Previous ACICBL Members:

Elyse A. Perweiler, MPP, RN
Sandra Y. Pope, MSW

Others Present:

Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, ACICBL, HRSA
Candice Chen, MD, MPH, Director, Division of Medicine and Dentistry, HRSA
Luis Padilla, MD, Deputy Associate Administrator, Bureau of Health Workforce (BHW), HRSA
CAPT Sheila Norris, Director, Division of Health Careers and Financial Support, BHW
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 (HRSA) headquarters in the Parklawn Building, Room 5A-02, 5600 Fishers Lane, Rockville, MD 20857. At this meeting, the ACICBL members selected a topic for the ACICBL 16th report and had an in depth discussion on the redesign of the Area Health Education Centers (AHEC) Program. Dr. Weiss began the meeting by taking role and approving the most recent meeting minutes. She then introduced Dr. Luis Padilla, Deputy Associate Administrator, Bureau of Health Workforce (BHW), HRSA.

Dr. Luis Padilla provided an update on the BHW. He explained that the Fiscal Year (FY) budget of \$1.9 billion will provide BHW an opportunity to continue leveraging programs to increase the health workforce across the nation. There are three priority areas for BHW: 1) preparing a diverse workforce 2) improving workforce distribution and 3) transforming healthcare delivery. BHW is also redesigning programs in academic and community partnerships and interprofessional training and practices. It also has a greater focus on data using rapid cycle evaluations and performance data. Dr. Padilla then discussed BHW FY 2016 priorities and activities:

- Develop BHW Strategic Plan
- Continue to work on workforce analysis and dissemination through the National Center

- Expand underserved recruitment and career opportunities through improvements in the job center portal
- Continue to strengthen the organization both structurally and culturally

Dr. Padilla then asked the ACICBL members for questions and comments. Many members expressed appreciation for the opportunity to provide input on the AHEC Program redesign. Dr. Peggy Valentine expressed concern over AHEC's decreased amount of resources, specifically in North Carolina, and how the redesign would impact activities. Dr. Padilla explained that historically AHEC has had a higher budget and that there are budgetary constraints. It is important to ensure that the program is sustainable, viable, and adds value. In 2015, \$30 million was appropriated and it may be the same for 2016.

Dr. Padilla then turned the meeting over to CAPT Sheila Norris, Director, Division of Health Careers and Financial Support to discuss AHEC Program. In 2017, AHEC will be re-competed. As a result, there is currently an opportunity to look at the program and evaluate possible improvements and changes. CAPT Norris explained that there are 52 AHEC programs in 45 states and in some territories. There are 247 AHEC Centers that link the community with academia. She asked the members think about ways HRSA can maximize the reach of the AHEC Program. The members were asked to discuss the following questions:

- Considering the AHEC Legislative Purposes, what is the unifying focus of the AHEC program? What should it be?
- Which core activities or goals should be the focus of the AHEC program?
- Should the AHEC Program have a core structure? If so, what should it be?

Considering the AHEC Legislative Purposes, what is the unifying focus of the AHEC program? What should it be?

Dr. Patrick DeLeon inquired if data is collected on the cultural aspects that lead to physical and emotional healthcare issues. Dr. Padilla noted that data is collected on disadvantaged populations and underrepresented groups but information is not collected on the cultural aspects of healthcare. However, AHEC requirements allow the program to collect data in different ways. Redesign requires thinking broadly about the program before delving into the measures.

Ms. Elyse Perweiler added that AHECs have a match requirement in terms of funding. AHEC activities in clinical integration and health service provision or anything that would lead to collecting data regarding behavioral health issues and interventions at the population level are usually are not funded with federal dollars. They are funded with the matching dollars that AHECs provide. This data is not reported because it is not specifically related to the federal dollar requirement. She noted it is important to not only look at how AHECs collect data but what is being funded. What availability is there is for funding data and what types of things should AHECs be focusing on moving forward?

Dr. Weiss then provided information on matching funds in the legislation. "Matching funds with respect to the cost of operating a program through a grant under this section, to be eligible for financial assistance under this section, an entity shall make available (directly or through contributions from State, county or municipal governments or the private sector) recurring non-federal contributions in cash or in kind, toward such costs in an amount that is equal to not less

than 50 percent of such costs. At least 25 percent of the total required non-Federal contribution shall be in cash. An entity may apply to the Secretary for a waiver of not more than 75 percent of the matching fund amount required by the entity for each of the first three years the entity is funded through a grant under subsection (a)(1).”

Ms. Perweiler noted that community-based training and education emphasizing both primary care and interdisciplinary interprofessional education and training are critical. She stated that public health could be subsumed in these areas because of the current focus on population health and behavioral intervention in terms of empowering people to take responsibility for their own healthcare. She expressed concern about AHEC K though 12 health career recruitment activities and commented that funding has been diluted because health careers activities are funded through other HRSA programming. She recommended looking at where the funding has gone over the last few years and identifying the funded work that has been done by AHECs and similar work funded by other HRSA programs. By doing this process, information could be obtained to redirect AHEC programming.

Dr. Padilla noted that there is a large focus on clinical preceptorship and that the number of participants in the AHEC program who participated in receiving interprofessional educational activities is less than 20 percent. This is an area BHW will focus on in the redesign efforts.

Ms. Perweiler added that the profile of the community-based primary care practice is changing and AHECs have to be flexible to respond and become engaged by addressing faculty development and interprofessional education. In addition, medical school and nursing school class sizes have increased and in response there has been a proliferation of online programs and private universities to meet healthcare workforce needs. Many on-line programs are paying for clinically-based preceptorships. AHECs rely on their academic, community-based partnerships for preceptors and that is becoming more challenging. There is a growing problem in how preceptors are selected, identified, and incentivized. She explained that there is not enough money in the AHEC budget to fund preceptors and there has been erosion in terms of the availability of community-based preceptors for the AHEC network.

Dr. Mary Ann Forcica agreed and added that rural and underserved areas have challenges finding existing interprofessional teams to model this kind of education for all types of trainees. HRSA can encourage applicants to present new models to stimulate team-based care in the community. It is important to allow local or regional sites to present innovative ways to bring models to clinical practice, rather than excluding programs that do not have robust practices from participation. Dr. Freddie Avant agreed that developing models is a good response. The issue is not only development, but sustainability and many times rural communities cannot access those resources if they are attempting to get grant support.

Dr. Candice Chen highlighted the efforts of the Primary Care Training and Enhancement (PCTE) program in attempting to remove barriers that would keep community-based organizations from applying for grant funding and promote interprofessional training. In the past, the PCTE program focused on training physicians and physician assistants and included a sponsoring institution requirement, such as, a school of medicine, residency program, or physician assistant program. HRSA recognized that this process did not support community-based training. As a

result, this requirement was recently removed and applicants were permitted to have a partner provide the accreditation document. In addition, the PCTE provided two options: 1) a single project option where a training program could receive up to \$250,000 a year and 2) a collaborative project (interprofessional project) with a physician, physician assistant, nurse practitioner, dentists, pharmacists, and other allied health professionals that could receive up to \$500,000 a year.

Dr. Padilla commented that the ACICBL members made significant suggestions and there are different ways to leverage legislation to include interprofessional education and partnership building. He believes hospitals and health systems across the nation need community-based organizations to effectively meet their quality objectives and the needs of the communities. AHECs have challenges with some of their Federally Qualified Health Centers (FQHCs) colleagues. Although this is an opportunity to strengthen the program, there are some challenges in the AHEC/FQHC partnership formation.

In addition, per the legislation, HRSA is funding AHEC programs that are embedded in medical schools and nursing programs (when medical schools do not exist in the state). However, matching funds provide an opportunity for the program to leverage the private sector. Many AHECs rely on their state legislature to meet the match. Other AHECs meet the match through medical school systems and foundations in addition to the private sector. HRSA is looking for ways that AHECs can partner with other organizations to help them meet their goals. There is a benefit to having more uniformity in the program and approaching it from a model perspective or a capabilities perspective to help narrow the focus of the program. Dr. Jane Mohler added that there are opportunities to have interprofessional transition of care programs that link a medical student and a pharmacy student or nursing student. This type of training offers value to Community Health Centers and can incentivize them to participate.

Which core activities or goals should be the focus of the AHEC program?

Dr. Weiss then asked the members to identify two or three major core AHEC activities. The members responded:

- Ensure that healthcare professionals and others that provide healthcare services skills and knowledge are current and they are meeting the needs of patients.
- Prepare the future health professions workforce.
- Facilitate the admission and retention of underrepresented minority and disadvantaged students.
- Emphasize community-based training and education. Both primary care and interdisciplinary interprofessional education and training are critical.
- Compensate clinical site preceptors. Stipends should be allowed for trainees in rural areas. Many trainees are unable to come to a rural setting for a month and work in the community because they cannot pay their expenses.

Should the AHEC Program have a core structure? If so, what should it be?

Dr. Padilla explained that the core structure is the core activities of the program. There are seven requirements and the AHEC Programs have the option of achieving those requirements through innovative programs, development of curricula, or other ways. There are opportunities within the legislation to redesign the program to focus on different areas. The question is what should

AHEC Programs emphasize and focus on going forward. The ACICBL members recommended that AHEC Programs:

- Reach out to the veteran community and provide them with the services they need.
- Address social determinants of health.
- Be leaders in interprofessional education and clinical practice.

Dr. Padilla thanked the members for a thoughtful discussion and their thoughtful comments. The phone lines were then opened for a discussion with AHEC grantees.

Discussion with Area Health Education Centers Program Grantees

Dr. Richard Kiovsky, Indiana, began by discussing the core goals and activities of the AHEC Program. He recommended that AHEC should focus on diversity. In Indiana, they focus on Blacks, Hispanics, and first-generation students going to college and that is a statewide initiative. Second, the lack of providers in underserved communities is a nationwide problem. AHEC should continue to improve the distribution of the workforce through an interprofessional initiative that includes interprofessional education with clinical sites evolving into interprofessional sites. In order to do that, Indiana AHEC is looking at practice transformation and a team-based model for payment working with state Medicaid. Third, population health is critical and there needs to be a public health requirement in all of the regions. He would like to see an individual with a Masters of Public Health (MPH) placed in every regional AHEC that works with community partners to address the major public health concerns in that region. Indiana could select two or three targets to focus on during the year and utilize the Master's level prepared educators to help coordinate population/public health activities within the regions and the states. Finally, AHEC could promote community partnerships to improve the academic pipeline to future health profession students. In Indiana they select the best students with high aspirations. It is disappointing when those students arrive at the application process, apply to a health professions school, and are not selected. He noted that much of this has to do with STEM issues and faculty shortages. At Indiana they look at issues at the admissions committee level and try to impact them. He also recommended that health professions disciplines strongly consider a curricular requirement of placing students in underserved communities while they are in their training.

Dr. Kiovsky emphasized the four areas in review are diversity, distribution using interprofessional education, public health and addressing population health issues, and continuing to promote the pipeline. These activities have been an integral part of what has been done in Indiana. The Federal government provides the minority of funding for the Indiana AHEC. The state is the major contributor along with community partners. The state legislature has requested they focus on underrepresented minorities and disadvantaged whites and have set a goal of 75 percent across the state. The state wants to monitor high school graduation rates, do these students enter college, are they on a health career pathway, what is the percentage of those moving into health professions careers, and are alumni practicing in underserved communities.

The Indiana State Department of Health realizes they have not figured out how to connect public health concerns with effective academic health community partnerships. This is where AHEC can make significant contributions to any state, particularly when it is done through a regional

community partnership, where FQHCs, Community Health Centers, and Rural Health Centers exist.

Dr. Padilla thanked Dr. Kiovsy. He appreciated how the discussion was framed noted that it reflected the variance of approaches in the AHEC Program. Dr. Padilla noted that the Indiana AHEC is working towards a model utilizing and extending its various workforce goals and needs and expressed interest in hearing more about their activities.

Captain Norris also appreciated Dr. Kiovsy's comments and the way the discussion was framed. She asked the ACICBL members if Dr. Kiovsy's comments are a major interest or focus for the AHEC Program and how should that guide the structure of the program? What pieces are critical to make some of these activities happen?

Dr. Valentine added that the four areas (diversity, distribution using interprofessional education, public health and addressing population health issues, and continuing to promote the pipeline) could be the pillars where every AHEC could design its program to assure it is working towards a more diverse health professions workforce, geographic distribution, and all the issues discussed in Dr. Kiovsy's comments. She explained it is important to recognize that each AHEC is different and its focus may be different, but there may be some commonalities that could be used for assessment or to make sure that everyone is on target from the HRSA perspective.

Dr. David Garr, South Carolina, stated this is an opportunity to review where the AHEC system is and where it needs to go. AHEC exists to help build and support the healthcare workforce our nation needs. He is excited to bring interprofessional practice out to communities with students, but the academic programs may not be ready to have their students leave the campus, go out into the community, and address and learn about population health issues.

Dr. Garr noted that as a previous member of the ACICBL one of the recommendations in the October, 2014 report was to have criteria where academic programs seeking funding show evidence of moving students off campus and out into communities and provide learning experiences for them in those communities. He identified a challenge in South Carolina where family medicine residents in South Carolina leave their core site and go into practices in rural communities for part of their training. However, at the present time they cannot receive federal funding for the time that they are absent from their residency. In order to advance interprofessional learning opportunities for residents in primary care they should be provided funds so they can leave their educational programs and work in communities where they can experience where health care is happening at the front lines.

Dr. Garr also stated that AHEC Centers are knowledgeable about the practices in their regions. AHEC Centers are well-positioned to identify outstanding practices that are undertaking patient-centered medical homes, using community health workers, and looking at population health issues. Those practices can be the learning laboratories for students. In addition, it is important that there are preceptors from different disciplines teaching students from different disciplines. For example, nurse practitioners teaching medical students.

Ms. Linda Cragin agreed with Dr. Kiovisky that sometimes the federal funding is the smaller portion of AHEC funding, which means that at a local AHEC Program and Center perspective they must respond to many different funders and their expectations. She commented that as HRSA and the Advisory Committee think about AHEC, they should narrow the federal funding to a specific standard or model approach. She agreed that interprofessional, community-based primary care training fits well within HRSA. AHECs should think about how they can partner with FQHCs and bring expertise and the community voice back to the medical school.

Dr. Sharon Levine expressed concern that accreditation boards are beginning to require interprofessional education that is meaningful and a standard to be met. The real issue is that it must be beneficial for the medical school and the community to train students off campus. In addition, it is not only identifying preceptors but paying for preceptors. Some Caribbean medical schools are paying \$30,000 per student in the smaller community-based sites.

The challenge for preceptorships is a significant issue for AHECs, but if a structure and focus is developed, it is could be addressed. In addition, the sites that select students have low capacity. There are not enough preceptors to address students' learning needs. It is usually the preclinical or non-clinical learning opportunities that are the most successful from an interprofessional perspective.

Ms. Kathy Vasquez, Ohio, commented that her AHEC follows a traditional model. She stated that differences come out at the AHEC Center and should be the connection to the local community needs. AHEC programs grounded in medical schools may be the best chance to have serious curricular change happen. She agreed that federal funding is minor to the support of AHEC Programs and AHEC Centers. However, she noted the match is valuable. The Ohio AHEC would not be able to have existed for the past 40 years if they had not developed long term serious community relationships with partners in those areas who have seen the value at the individual local level to support students in their communities.

Ms. Vasquez noted that FQHCs are a good laboratory for education and that FQHCs need to have a compelling reason for being part of the educational process. FQHCs are very busy and focused on providing care and that being part of the educational process may be difficult for them. It is not just productivity but it may not be aligned with their mission which is patient care. She advocated for AHECs and FQHCs to come together and acknowledged that in many places they have come together. However, she maintained that in some places collaboration between with AHECs and FQHCs may not work and deemed it will be very specific to individual AHECs and FQHCs.

Dr. Kiovisky commented on inadequate AHEC funding at the federal level. If the country is serious about addressing public health issues and social determinants of health, then they need to channel funding toward the AHEC Program. Instead of \$31 million, AHEC should receive \$75 to \$100 million with requirements of placing key people in the regional sites who can work with community partners to address population health issues, community health needs, work with state agencies like public health, and address the health concerns that the state has based on their own analysis. Indiana is willing to keep contributing to AHEC as long as they continue to receive federal dollars. Indiana has worked extremely hard to provide a system of tracking that

allows them to not only figure out what they need to focus on, but also track student outcomes. The data keeps state funding. However, the Indiana AHEC could do much more if they had more federal dollars aligned with issues that address population health, drug abuse, health disparities, and diabetes in the community. Federal funding could be better utilized in the diversified network all across the AHEC Programs and Centers. In addition, there has to be financial incentives for healthcare providers who have been trained under a siloed model. In Indiana, healthcare providers are willing to expand housing opportunities for learners if a need can be demonstrated. As a result, Indiana is doing a complete analysis of all the academic institutions that are producing healthcare professionals in a team-based model serving underserved communities.

Dr. Forcica closed the discussion by summarizing some of the comments. On behalf of the Committee, she thanked Dr. Padilla and CAPT Norris for the opportunity to share thoughts at a time when the AHEC Program redesign is still evolving. She noted that there is support for continued AHEC involvement in a professional training and pipeline issues. In addition, there is support and for identifying best practices while acknowledging that there are regional and local variations.

Dr. Padilla and CAPT Norris thanked the ACICBL members and the AHEC grantees for the thought-provoking and stimulating discussion of the AHEC Program.

16th Report Topic Discussion

The members discussed several potential topics for the ACICBL 16th report. They included: challenges in clinical site training; aging population and dementia care; advanced care planning; integrative behavioral health care; addiction and substance abuse; care of veterans in community sites; the role of the paraprofessional in the workforce; and wellness, lifestyle, and culture. The ACICBL decided the topic of the next report will be *Enhancing Community-Based Training Sites: Challenges and Opportunities*. The potential headings in the report may include:

- Payments/Incentives for clinical training sites
- Stipends for Trainees
- Model Programs: Apprenticeships/Incentive Payments
- Environmental Requirements for Staffing Resources and Interprofessional Education
- Preceptor Incentives or Special Training
- Health Systems or Productivity Implications
- Outcomes (Trainee Retention)
- Implications for State Supported Schools
- Special Populations (Veterans, Native Americans)
- Paradigm Shift in Community Training: Ownership

The members also discussed potential speakers for the next meeting in May, 2016:

- National Association of Community Health Centers (number of sites involved in training)
- School Model of Success (AT Still-Medical School Model)
- Council of Deans of Medical Schools
- Ten Year Report: Nursing, Health System Executive (Kaiser)
- Accreditation Bodies

- Clinical Education Task Force (Karen Atkins)

15th Report Discussion- Performance Measures

The 15th report focuses on programmatic recommendations for the Title VII, Part D programs. Dr. Forcica opened the discussion and identified that one missing aspect of the 15th Report related to outcomes of educational grant projects for funded Title VII, Part D Programs. She reminded the members that previous discussions on the 15th report included the geriatrics redesign program and that clinical outcomes are an expectation of successful educational programs. Many of the ACICBL members believed that was an unfair burden on grantees and that it would be better to return to more education-focused outcomes. In past meeting, the members also discussed the definition of competencies in various fields and believed it would be better for HRSA to look at competency-linked outcomes for educational programs. At the end of the June, 2015 ACICBL meeting, the members decided to look at their individual professional competency standards, determine if competency standards existed and the extent to which they might be useful to HRSA. She posed the following questions to the ACICBL: Do we still feel the same about clinical outcomes? Are all clinical outcomes wrong? Would it be fair to ask programs to do rapid cycle quality improvement and show small differences in practice outcomes? How are people feeling about outcome measurement in general at HRSA?

The members made the following comments and suggestions:

- It is important to show outcomes when it is possible but people would like to know upfront what is being measured and that the data is consistent from one program to another program.
- It is challenging to be asked to measure clinical outcomes. It is difficult to do measurements in educational intervention with the amount of money that is usually awarded in most of the grants. It is a tall order for an educational intervention to look at visible clinical outcomes. Fewer grants should be awarded with more funding to look at clinical outcomes or grantees should not be asked to address an unrealistic demand.
- For an organization developing a new program to expect an outcome without providing sufficient resources is setting people up to fail.
- Any kind of outcomes measurement has to be realistic and fair to large and small grantees. This will allow grantees to meet the requirements and make something meaningful.
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Dr. Chen expressed an understanding by BHW for realistic outcomes for the training program awardees. For example, if someone said, “The outcome I’m going to change is county level infant mortality rates,” I would probably say, “That’s probably an unrealistic outcome for the five-year grant period.” In the PCTE program they recognize everyone is doing different activities. They did not request that grantees look at a specific outcome. They explained to the grantee that when you apply for an award be prepared to think about access, quality, and cost outcomes. But focus on the outcomes that can be realistically achieved over the course of five years. Dr. Chen provided the following examples:

- Implementing an integrated behavioral health and primary care outcome – to start, they might track how many patients are being screened, what does their access look like for the mental and behavioral health providers, what kind of care do patients access.

- In five years, they might look at the rate of their patients going to the ER and who are being hospitalized because of untreated mental health issues.
- When a grantee provides evaluation outcomes that seem unrealistic we ask them to take another look at that outcome.

Dr. Forcica clarified that the Bureau would be satisfied with less global changes as long as they are important to practice. For example, if there was a curriculum in pain assessment and dementia and the trainee program used a quality improvement process to dramatically improve the number of dementia patients that were assessed for pain, the Bureau would view that as a clinical outcome. Moving forward in the recommendations regarding outcomes approaches, a section in the report could show that education programs have some impact on practice and that the demonstration of a quality improvement type of practice change documentation would fulfill this requirement.

The members continued to discuss outcomes:

- Most programs are required to produce an annual report on student enrollment (the number of graduates and where they are practicing). It would be interesting to show trends over time as a result of having HRSA funding and to what extent grantees were able to see change. In many cases it would take longer than three years, but it is something that could be continued. If improvement is shown, the program can request additional funding because grantees are having successful outcomes.
- There should be realistic expectations about the capabilities of programs to longitudinally track an individual beyond initial graduation and placement in a work site after completion of residency.
- When HRSA first started primary, secondary, and tertiary outcomes, one of the issues was that there were too many intervening variables that impact the ability to track clinical outcomes. Tracking clinical outcomes is different than tracking educational outcomes. One of the lessons learned with the evidence-based practices in the Geriatric Education Centers (GEC) program is that the ability to link training and education to clinical outcomes was only as good as the ability of partners and stakeholders to provide clinical outcomes data they were collecting. This is the same situation with the GWEP.
- An example of a clinical outcome that most systems could track would be how many referrals were registered before the intervention and after. That would have an impact and be a benefit to patients and community linkages. It would be valuable to report how staff were trained, what resources are in the community, and when to refer patients to the appropriate organization within the community.
- Tracking trainees to show that a certain percentage of trainees are evolving in a way that would be consistent with a better distributed workforce or a diverse workforce is an important goal.
- Having performance measures look at the diversity of workforce personnel that have been trained and the distribution of their practice areas are valid performance measures. There is consensus among ACICBL members that there are some clinical outcomes that can be linked to educational changes, particularly those kinds of changes that can be documented in rapid cycle data practice outcomes.

- There should be a statement in the outcomes section about the burden of collecting outcomes data on awardees.

Committee Business

The members voted for a new vice chair of the Committee. The current chair, Dr. Forceia will end her term as chair in a year and the current vice chair, Dr. Valentine will become the chair. The members voted for Dr. Jane Mohler as the new vice chair. Dr. Mohler was not in attendance at that time. It was decided that the DFO would reach out to Dr. Mohler and ask if she is able to accept the position. The members then thanked Dr. Forceia for her excellent leadership.

Post Meeting Note: The DFO spoke with Dr. Mohler regarding her selection as Vice Chair of the ACICBL. Dr. Mohler accepted the position and thanked the ACICBL members for their support.

Dr. Weiss acknowledged that Dr. Neil Horsley's term was expiring on December 31, 2015. She thanked him for his contributions to the work of the ACICBL.

Public Comment

The meeting was opened up for public comment.

Dr. Richard Kiofsky made the following comment:

I really enjoyed listening to this conversation, and I think all the things that HRSA's wrestling with is truly what we're wrestling with here in Indiana. So I wrote down some comments, because you're really looking for exemplars to support the academic community. As we think of what HRSA's been trying to do educationally, to promote improvement in our health care system, we have releases of grants for practice transformation. We have releases of grants to promote faculty development. We have public health integration models out there with primary care. We have things that are pushing toward workforce, using adequate workforce data to drive our educational training needs. All of those to me could serve as priority scoring for institutions who are demonstrating those activities. So in some ways, the rich get richer. But at the same time, you want to utilize academic systems that are working with their communities and are demonstrating these key issues that HRSA has already supported.

It's only a priority scoring. It doesn't mean that others who don't have that couldn't be successful. When you break this down to a clinical rotation, you have to break it down to things that are measurable. Here in Indiana, we were not implementing IPE in our clinical settings. Now one of the goals is to demonstrate IPE competencies in the clinical settings. Students are getting enhanced knowledge of IPE clinical competencies when they are in those ambulatory settings. Those are pretty much one month rotations.

Based on that clinical training opportunity, we want to measure the student's intent to see if they want to practice in a team-based model of care. We want to see what impact this has. For health profession medical students, physician assistants, and advanced-practice nurses, we want to enhance the Medicare prevention and wellness by resetting the minimum of three complete physicals when they are in that setting. We can help promote, in that practitioner site the importance of prevention in wellness, and also some of the management of chronic diseases that

are there. This could be a line and include other dyads if you get a social worker or other disciplines.

We need to promote the changes in Medicare that are really helpful. We also will measure the student intent to practice in an underserved and rural community. We want to know if our clinical placements in these sites is having, or at least demonstrating the change of intent. We also are going to be working on measuring increased knowledge of population health issues in primary care (nursing, physician assistants, pharmacy, social work, medicine. We want to work together to implement or enrich their outcomes, so that they're aligned with increased knowledge on population health issues. We also are going to focus on three social determinants of health, and we're going to try to work with the communities to figure out what they feel are the most important social determinants of health in their community, and then have that be a project that students work on while they're there for that month.

There's a number of ways that we can take all of these national initiatives, what's being asked of our academic training programs, and take that down to measureable outcomes on a clinical. If we can back these three-year grants up one after the other, then certainly patient outcome measurements, with IRB approval, could be tracked. I really enjoyed this conversation. I really think there's a way we can take all of this, and bring it down to a level that can work for a grant.

Dr. Weiss thanked Dr. Kiofsky for his comments.

Dr. Forceia and Dr. Weiss thanked the ACICBL members for their work.

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