

ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES

Meeting Minutes: May 25 –May 26

Advisory Committee Members Present:

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

Others Present:

Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL), Health Resources and Services Administration (HRSA)
Candice Chen, MD, MPH, Director, Division of Medicine and Dentistry, HRSA
Crystal Straughn, Technical Writer, BHW, HRSA

Speakers (In order of presentation)

Day 1

Jim Macrae, Acting Administrator, HRSA
Luis Padilla, MD, Deputy Associate Administrator, Bureau of Health Workforce (BHW), HRSA
Sara Gallagher Williams, Acting Director, Division of Policy and Shortage Designation, BHW, HRSA
Cecilia Rokusek, EdD, RD, Assistant Dean for Education, Planning and Research, College of Osteopathic Medicine, Nova Southeastern University
Page Walker Buck, MSS, LSW, PhD, Associate Professor, Director, MSW Program, Chair, Graduate Social Work Department, West Chester University
Petra Clark-Dufner, MA, Associate Director, Connecticut Area Health Education Centers Program, Director, Urban Service Track, Center for Public Health & Health Policy, University of Connecticut Health
Cynthia Booth Lord, MHS, PA-C, Associate Professor and Founding Program Director Case Western Reserve University, School of Medicine
Mary Ann Forceia, MD, Immediate Past Chair, ACICBL, Clinical Professor of Medicine, Division of Geriatric Medicine, University of Pennsylvania Health

Day 2

Melissa B. Moore, MSW, MBA, Behavioral and Public Health Branch Chief, Division of Nursing and Public Health, BHW, HRSA
Cynthia Harne, LCSW-C, Public Health Analyst, Behavioral and Public Health Branch, Division of Nursing and Public Health, BHW, HRSA
Eileen Sullivan-Marx, PhD, FAAN, Dean, Erlene Perkins McGriff Professor, New York University, College of Nursing

Day 1
May 25, 2016
Introduction

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 8:30 AM at the Health Resources and Services Administration's (HRSA) headquarters in Room 5E-29, 5600 Fishers Lane, Rockville, MD 20857. At this meeting, the ACICBL members heard presentations from experts in the field on training health professionals to address socio-behavioral needs, opportunities, challenges, the reality of community-based clinical training for today's learner and preceptor, and the future of clinical clerkships. Dr. Joan Weiss began the meeting by providing an overview of the agenda. She then introduced Jim Macrae, Acting Administrator, HRSA who provided an update on HRSA programs, services, goals, and budget.

James Macrae, HRSA Update

Mr. James Macrae began his presentation by thanking the members for their time and expertise working on the Committee and HRSA programs. He noted that about one in three people are living at or below the poverty level and they rely on HRSA supported community centers. The centers provide care for 23 million people across the country. HRSA's Ryan White HIV/AIDS Program results in better health outcomes for 1 in 2 people diagnosed with HIV. Almost 80 percent of the patients seen in the program are virally suppressed and about 30 percent that are not in HRSA programs are virally suppressed.

The National Health Service Corps program is a critical service resource for over 10 million people living in health professional shortage areas. They receive primary medical, dental, or mental health care from 9,600 National Health Service Corps (NHSC) clinicians nationwide. More than half of pregnant women and more than a third of infants and children benefit from maternal and child health block grants. In addition, about 145,500 parents and children participate in the Federal Home Visiting Program and more than 30,000 organ transplants have been performed. HRSA also continues to focus on rural health issues. More than 800,000 Americans living in rural areas receive health services through HRSA rural community-based grants. Rural hospitals are closing at an alarming rate and this has an impact on access to care and emergency services.

HRSA Goals

Mr. Macrae then discussed HRSA goals which include: improving access to comprehensive quality health care and services; strengthening the health workforce; building healthy communities; improving health equity; and strengthening HRSA program management and operations. HRSA will release reports about the nation's health workforce specifically around physicians, nurse practitioners, physician assistants in the coming months.

Budget

HRSA requested \$10.7 billion in Fiscal Year (FY) 2017. Overall, HRSA's budget is less than one percent of the U.S. Department of Health and Human Services' budget. HIV is HRSA's second largest program at approximately \$2 billion. The Health Workforce and Maternal and Child Health programs are approximately \$1.3 billion. Rural health, healthcare systems, and program management are approximately \$150 million. The FY 2017 budget serves 27 million patients in health centers; supports additional behavioral health clinicians in the NHSC; proposes mandatory funding for Children's Hospital Graduate Medical Education (CHGME); provides care to over 500,000 people living with HIV and increases access to Hepatitis C treatment; expands the Rural Opioid Overdose Reversal program; extends and expands home visiting to millions of families; and proposes rulemaking authority for the 340B Drug Pricing Program. Mr. Macrae then answered the members' questions.

Questions and Answers

The members asked Mr. Macrae about providing quality education in clinical sites and hiring veterans in the health workforce. Mr. Macrae emphasized the importance of using service delivery and grants to support and promote training and better integration in the healthcare workforce. He also stressed the importance of veterans in the health workforce. HRSA has been working with the V.A. around the Veterans Choice Act to increase access for veterans to recognize their unique needs. He noted that approximately 300,000 veterans across the country are receiving care in health centers.

Program	Dollars in Millions
Health Center Program	\$5,092
HIV/AIDS	\$2,332
Health Workforce	\$1,273
Maternal and Child Health	\$1,250
Rural Health	\$144
Healthcare Systems	\$128
Family Planning	\$300
Program Management	\$157
Total	\$10,677

Luis Padilla, MD, FAAFP Bureau of Health Workforce Update

Dr. Luis Padilla thanked the members for their time and provided an update on the Committee's last report recommendations and on the Bureau of Health Workforce (BHW). He informed the members that two recommendations from the ACICBL 14th report, *Rethinking Complex Care: Preparing the Healthcare Workforce to Foster Person-Centered Care* are in the process of being implemented. The first recommendation implemented was: The ACICBL recommends that HRSA's Title VII, Part D education and training programs prepare students, faculty, practitioners, and direct services workers to involve patients and care partners in shared decision-making for person-centered goals of care and treatment. The Geriatrics Workforce Enhancement Program (GWEP) program was created to achieve those goals and the grantees are working to involve patients and care partners. The second recommendation implemented was: The ACICBL recommends that health professions schools integrate content about complex care and team-based collaborative practice into their curricula by utilizing the U.S. Department of Health and Human Services (HHS) Education and Training Curriculum on Multiple Chronic Conditions. Many of HRSA's grantees are integrating multiple chronic conditions content into

their curricula. HRSA is currently in the process of moving the Multiple Chronic Conditions curriculum from the HHS website to the HRSA website.

BHW Vision and Mission

Dr. Padilla then highlighted BHW's vision and mission statement, strategic goals, and budget. BHW's vision statement is: From education and training to service, BHW will make a positive and sustained impact on health care delivery for underserved communities. BHW's mission statement is: Improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. Dr. Padilla stressed the importance of reviewing investments and encouraging, incentivizing, and supporting grantees in assuring that the investments made in training a skilled workforce are working in the community.

BHW Strategic Plan

The BHW Strategic Plan covers the next three years and highlights the commitment to delivering results for a quality health workforce and the Americans it serves. The Strategic Plan goals are: 1) Guide and inform national policy around health workforce development and distribution; 2) Develop a strategic approach to health workforce investments; 3) Strengthen academic, clinical, and community partnerships to build and sustain impact in underserved communities; and 4) Inspire and align the Bureau in support of the BHW Vision.

BHW Priorities

The Bureau's efforts are focused on three main priorities: preparing a diverse workforce, improving workforce distribution, and transforming health care delivery. Greater diversity among health professionals is associated with improved quality of care for underserved populations, including racial and ethnic minorities and those from disadvantaged backgrounds. Over 47 percent of trainees in BHW programs are minorities and/or come from disadvantaged backgrounds. Improving workforce distribution includes training, recruitment, and retention to improve access in underserved communities. Clinicians who receive training in community-based and underserved settings are more likely to practice in similar settings. Approximately 87 percent of NHSC clinicians continue to practice in underserved areas up to two years after they complete their service commitment and 46 percent of BHW funded trainees are employed in underserved areas.

The National Center for Interprofessional Practice and Education is now in its third year. BHW is looking at how to strengthen that program and further disseminate information. BHW is currently collecting data from over 40 grantees and nurse led clinics to analyze how those models of training and health care delivery are impacting health outcomes. Dr. Padilla emphasized that in order to transform service delivery to meet 21st century needs, a focus on quality care that encourages innovative team-based and interprofessional approaches is required. To support these priorities, BHW will release several production reports this year. In the next few weeks an update of the 2013 Primary Care Production report will be released. The reports will better inform and guide national policy workforce and internally inform BHW programs.

Dr. Padilla also reminded the members that grantees are no longer required to provide measures every six months. The Bureau is requiring measures annually and continues to rely heavily on

the rapid cycle evaluation to gain information on grantees' challenges and successes. This will lead to an improved, well-distributed, diverse, and competent workforce across the country.

BHW Programs

Dr. Padilla then discussed BHW programs. In FY 2015, BHW awarded over \$1 billion to more than 8,300 organizations and individuals through more than 45 workforce programs. Collectively, BHW programs increase the nation's access to quality health care by developing, distributing, and retaining a competent health workforce. The Division of Medicine and Dentistry (DMD) programs include: the Children's Hospital Graduate Medical Education (CHGME) Program; Teaching Health Centers Graduate Medical Education (THCGME) Program; Medical Training Programs; Predoctoral Training in General Dentistry, Pediatric Dentistry, and Public Health Dentistry, and Dental Hygiene Program, Postdoctoral Training in General, Pediatric, and Public Health Dentistry Program, and State Oral Health Workforce Program. The CHGME, THCGME Program, and Medical Training Programs support community-based training and faculty development to teach in primary care specialties. In FY 2015, HRSA increased its focus on preparing the healthcare workforce for practice in new and emerging models of care, including recruitment and retention programs, as well as practicing in advanced roles (as allowed by States).

Budget Highlights

Dr. Padilla then provided the members with BHW FY 2016 Budget Highlights and FY 2017 President's Budget Highlights. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) funding provided \$60 million for Teaching Health Centers (residency training in primary care medicine and dentistry in community-based, ambulatory settings). Congress also appropriated \$310 million for NHSC Programs (Scholarships, Loan Repayment, Students to Service Loan Repayment, and State Loan Repayment). The FY2017 President's Budget proposes \$527 million in mandatory funding from FY 2018 through FY 2020 for the THCGME. It proposes \$295 million in new mandatory funding annually for a total investment of nearly \$1.5 billion over the next 5 years for the CHGME Program to provide graduate training for physicians to provide quality care to children. The President's Budget proposes \$36 million for oral health training programs to increase access to culturally competent, high-quality dental health services to rural and underserved communities by increasing the number of oral health care providers and improving training programs.

For NHSC, the President's 2017 Budget request \$380 million, a \$70 million increase from FY 2016, to address the prescription drug abuse and heroin use epidemic, expand mental health services and support additional new loan repayment awards for behavioral health clinicians. The President's 2017 Budget also requests increases in mandatory funding to \$810 million annually in FYs 2018-2020 allowing for significant growth in field strength from 9,600 to 15,000 providers. In FY 2017, 159 new and continuation scholarships, 5677 new and continuation loan repayment awards, 167 new Students to Service loan repayment awards, and 500 loan repayment awards through the State Loan Repayment Program are projected to be funded. Dr. Padilla then answered members' questions.

Question and Answers

Dr. Peggy Valentine inquired if the Bureau is working on a plan that addresses interprofessional education with allied health and rehabilitation services as part of the team. Dr. Padilla explained that there are challenges in that area. Funding is provided through the Health Careers Opportunity Program for health and allied health professionals for pipeline programming. He noted that the BWH challenged when its efforts are geared towards established credentialed licensed professions. However, he recognized that it is important to include all members of the team in order to provide team-based patient centered care. He questioned what are the roles that are needed in the team-based model and recommended engaging our stakeholders in this area.

Dr. Patrick DeLeon expressed concern over the lack of dental therapists in health centers and he asked if HRSA has any programs to increase care. Dr. Padilla recognized that there are unmet needs in dental care and it is challenging but important to integrate oral health into primary health care delivery. Dr. Candice Chen noted that HRSA is very interested in dental therapists and excited that the Commission on Dental Accreditation recently announced they would be accrediting dental therapy programs. HRSA has been working with the National Governors Association to address issues surrounding dental therapists and scope of practice. This work resulted in providing technical assistance to states who want to adjust workforce needs. In addition, community health centers are engaged in oral access point expansion. In order to receive an oral access point grant, the oral health provider only needs to have one Full Time Equivalent (FTE).

Sara Gallagher Williams From Council Recommendation to Policy: The Process

Ms. Sara Williams presented an overview of the Committee members charge and how to draft recommendations, convert recommendations into policy, and how HRSA and HHS uses them. ACICBL is authorized by Title VII, Part D, section 757 (42 U.S.C. 294f) of the Public Health Service (PHS) Act, as amended by the Affordable Care Act, P.L. 111-148. ACICBL is authorized to a) provide advice and recommendations to the Secretary concerning policy and program development and other matters of significance concerning activities under the Title VII, Part D of the PHS b) prepare an annual report describing the activities of the Committee, including finding and recommendations and submit it to the Secretary of the U.S. Department of Health and Human Services, and the Committee on Health, Labor, Education and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives; c) develop, publish, and implement performance measures for programs under Title VII, Part D of the PHS; d) develop and publish guidelines for longitudinal evaluations for programs under Title VII, Part D of the PHS; and e) recommend appropriation levels for programs under Title VII, Part D of the PHS.

Ms. Williams explained that the Committee is strongest when considering areas where HHS and the Secretary have the authority to make a change in either program or allocated resources. It is important to consider the following questions before drafting recommendations: Is this a legislative or policy recommendation?; Does HHS have authority to make the change?; Who is the appropriate audience (Secretary, Congress, public)?; and What is the appropriate vehicle to share recommendations? Strong recommendations are those that have a precise action that can

be directly tied to a specific change that the Secretary can make. It is important to be precise in the recommendation and differentiate between a precise action item and a general consideration. For example, when drafting a precise recommendation consider what part of a regulation or program guidance needs to be changed and why. If the recommendation is a general consideration, such as, ensure access to health care services, it can still be included in the report language, but it may not rise to the level of a recommendation.

Recommendations must be focused and provide clear actionable steps on how to move them forward to ensure the Committee's vision is realized. Ms. Williams discussed the types of Committee documents that can be used to make recommendations to the Secretary: letters to the Secretary, white papers, or policy briefs and annual reports. She closed her presentation by providing the members with examples of strong recommendations.

Questions and Answers

Dr. Sharon Levine commented that she would like to have a better understanding of how decisions are made and how to draft recommendations where the Committee can have the power to influence change. Ms. Williams explained that the Secretary may award grants or contracts for any number of activities. HRSA has flexibility to guide the activities in each investment to the most effective use of their funds. In some cases, some of the activities under Title VII-Part D are outdated or no longer relevant. HRSA has a number of activities it can support and DMD develops a funding opportunity announcement with the goals and priorities in mind they want to achieve.

Dr. Chen reminded the Committee that their recommendations are for the Secretary but they are also sent to the Committee on Health, Labor, Education and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives. She recognized the challenge in developing recommendations in changing statute. She emphasized that HRSA wants to hear from the Committee and the community. She noted that the Committee's discussions are just as important as the specific recommendations. When issues like, dental therapists, different kinds of providers, community-based training, simulation versus real life experiences, and interprofessional education arise during the meeting, the Division discusses those issues and uses the Committee's discussion to frame the next funding opportunity announcement. The goal is to engage and receive substantial recommendations from the Committee. For example, the Geriatrics Workforce Enhancement Programs is in its first year but it will be up for funding again in FY 2018. The Division must start thinking about what they would like to do in FY 2018 and the member's recommendations regarding this program will be helpful.

Dr. Freddie Avant asked if the Committee could make a recommendation to focus more attention on rural communities and rural disciplinary training. Dr. Chen agreed that a focus on rural health and the rural workforce is important. The kind of recommendations made could be specifically about the Burdick program or a recommendation could be made to have all of the programs focus on rural health and greater investment in rural health. Dr. Joan Weiss reminded the members that in the draft ACICBL 15th report, the Committee reviewed all the programs and agreed that the Quentin Burdick Program should not be continued because it was subsumed

under Area Health Education Centers (AHEC). In addition, the GWEP program also includes rural training.

Cecilia Rokusek, EdD, MSc, RDN
Completing the Cycle of Education for Students in the Community:
Miles Traveled and New Curves Ahead

Dr. Cecilia Rokusek began by providing an overview of her presentation. The topics to be addressed included: issues related to a paucity of clinical training sites for health professions students, new strategies and incentives in retaining clinical faculty and clinical training sites, and future alternatives in clinical education. She emphasized that there is a growing paucity of clinical training sites for health care professionals that is compounded by a growing number of new health professions education programs. It is an issue with academic institutions, professional practitioners/preceptors in the community, and healthcare delivery system. It needs to be addressed by accrediting bodies for professional education.

Enrollment

Dr. Rokusek explained that issues are arising due to increases in enrollment. Medical school enrollment has grown 25 percent since 2002-2003 and 30 percent by 2017-2018. There has been a 185 percent increase in Doctor of Osteopathic Medicine (DO) schools and a 55 percent increase in allopathic medical schools. Half of all medical schools report concerns about their students ability to find residency positions (up from 35 percent in 2012) and 85 percent of all medical schools report concern about the number of clinical training sites and the supply of qualified primary care preceptors. In addition, 72 percent express concern about the supply of qualified specialty preceptors.

Paying for Clinical Training Slots

Medical schools (44 percent) are feeling pressure to pay for clinical training slots, even though the majority of schools do not pay. Enrollment expansion alone will not resolve the expected shortage of between 61,700 and 94,700 physicians by 2025. Medical schools will soon reach the 30 percent goal in enrollment growth, but Accreditation Council for Graduate Medical Education (ACGME) accredited entry-level residency positions will grow at a rate of only 1 percent per year. ACGME is only growing at a rate of 31 percent per year. This is an issue for funding, not only for assuring that there is an adequate supply of physicians, but other health professionals as well. It is also important to ensure that for ACGME there is adequate training for physicians now and in the future. Also, primary care physicians should be provided training in geriatrics. The geriatric skill set is going to be really critical issue as we move forward in the next 20 to 30 years.

Dr. Rokusek shared her experience of working on the Promotions Committee at Nova Southeastern University. Every year, preceptors who had been with the school for many years would drop out. She became concerned and investigated and found that over 75 percent of the preceptors dropped out because they were affiliating, most of the time, with Caribbean schools and getting paid for students. Many of the preceptors expressed that the money they received helped their children go to college. She emphasized the importance of developing ways to incentivize preceptors so they can continue to teach at U.S. schools. About 71 percent of

osteopathic schools are currently paying a stipend for placements of students during rotations and preceptorships. About 15 percent of the allopathic schools, 4 percent of nurse practitioner schools and 20 percent for physician assistant schools are also paying for student placements.

Dr. Rokusek emphasized the importance of discussing who is fronting the payment. In a 2013 study, 40 percent of the payment was from program allocation. Increased tuition and student fees also paid for placements. Currently, the average debt for students is about \$200,000 dollars for four years of study. For other health profession students it can be \$75-\$100,000 for graduate level. Requiring students to pay for preceptorship or clinical rotation will add to student debt. Other small percentages of payments may come from endowment or University department funds.

Challenges

Dr. Rokusek explained that many students have nowhere to go for clinical training. The reasons include the following: Caribbean – based medical students; new health professions programs (significant growth in osteopathic and allopathic medical schools, nurse practitioner, and physician assistant programs); increasing class sizes in medical schools, focus on patient numbers in health care delivery systems, risk of slowing down because of student teaching; sites accepting fewer students; competition for sites exploding; and a heightened sense of territoriality or unwillingness to collaborate because of competition.

Dr. Rokusek then discussed the priority challenges. She stressed that primary care needs are growing significantly and it is important to develop new and creative solutions to address these needs. Preceptor payment expectations are growing and it is vital to identify non-monetary incentives and some alternative solutions to retain clinical faculty and clinical sites.

Unfortunately, in most case the student pays for preceptors. More time and effort must be exerted by universities to work with preceptors and new interprofessional clinical sites.

There are several strategies that can be undertaken to address the priority challenges. Stronger identifiable recognition of clinical preceptors is needed. For example, an annual banquet or other event that can recognize the clinical preceptor who has been with the University for 25 years. There is also a need to identify more diverse clinical sites. There are individuals in rural areas that want be clinical preceptors, and they haven't been asked. It is important to change the location, type, and timing of student experiences and placements. Dr. Rokusek noted that at Nova Southeastern University, they rented apartments for students in some rural areas for their third and fourth rotations.

Partnerships

Dr. Rokusek stressed that the future of dealing with the paucity of clinical sites for students may be addressed by developing of new and innovative partnerships. Examples include partnerships with: 1) Community and Governmental agencies at the county or State level to provide case management services for special populations or provision of wellness clinics in housing projects, 2) Academic and corporate partnerships to provide opportunities for interprofessional clinical education in settings such as proprietary home health agencies, and 3) Community and education partnerships to provide student clinical experiences in community service agencies, health departments, hospitals, schools, local health care providers and community residents (wellness

clinics, homeless clinics, urgent care centers, senior centers). Some strategies she recommended to develop these partnerships include examine the expansion of ambulatory care within tertiary care domains (homecare, community health centers, and urgent care centers), explore and develop new models of clinical education (new partnerships and paradigms), and capitalize on the rewards and added value of forming partnerships with educational organization.

All of these types of partnerships are currently being used at Nova Southeastern University. The following are some examples of clinical training that is occurring as a result from these partnerships. The University has an interprofessional training site where students rotate and provide care for individuals and adults with intellectual and developmental disabilities. They are also focusing on individuals with Down Syndrome as they present with early signs of Alzheimer's disease. Clinical rotations also take place in homeless clinics, HIV clinics, and a hoarder's clinic. In addition, there is a new program where teams of students serve as case managers working with all the health professionals as the patient goes through their optometry, medical, and dental examinations.

Population Health

There is a shifting paradigm in clinical education as far as population health experiences versus personal health perspective. At Nova Southeastern University, the personal health perspective is still needed, but some student rotations include a population-based experience in the HIV clinic and low income housing areas. Interprofessional experiences also take place in health centers, schools, community clinics, state and county health departments. As result of these team-based primary care experiences, 64 percent of students at Nova Southeastern University enter primary care. Another way to meet unmet needs in diverse areas, students could be placed in the state where they are most likely to live and practice.

There are some cautionary challenges. With the shift to the population health approach, sites usually accommodate fewer students than traditional hospital settings. Students will be placed in more diverse and geographically varied settings and a process for guiding, mentoring, and assessing students from afar will need to be outlined, such as, Sky, GoToMeeting, one-on-one weekly discussions with students that are in other areas. Dr. Rokusek referenced a recent study where 85 percent of all college students in all professions would like an international experience. At Nova Southeastern University, medicine, pharmacy, and dentistry students can do one elective rotation in another country with an approved affiliation status. It is a good experience that helps students develop an understanding of international and global health.

Solutions and Options

Dr. Rokusek provided some ideas to consider. Students can rotate their clinical experiences within one health care system but across the continuum of healthcare delivery from community clinics to inpatient care to home health. Student rotations in retirement communities, wellness clinics in housing projects, school health, pregnant teen programs, senior centers, adult day care and programs for persons with intellectual and developmental disabilities could be developed. Clinical rotations could also be provided on a 24-7 basis using night shifts, simulations, community involvement with private/office-based practitioners, and creation of an office of community physician faculty engagement. In Nevada, an office of community physician faculty engagement was created that assisted with scheduling training slots, completing evaluation

forms, and addressing student performance issues. It was not overwhelming for preceptors to mentor a student because they had someone at the University to work with them.

Dr. Rokusek also listed options for monetary and non-monetary payment for preceptors. Clinical preceptors payment ranges from \$500/week for six (6) weeks to \$3,000 for a one-month rotation. Other preceptor incentives include free continuing education/continuing medical education programs; free or reduced course options leading to a degree; computer access via the University for emails; free online library access; faculty position; public recognition; retreats or dinners; and providing computer or other technology resources.

Dr. Rokusek closed her presentation by recommending that more research is needed in simulation-based performance assessments and evaluations. She noted that the goal for simulation should be optimal student learning to provide high quality patient care. There should be increased use of computers such as avatars, comparative and private practice partnerships, emphasis on population (health vs. individuals) and thinking outside the box for academic institutions and accrediting agencies.

Geriatric Workforce Enhancement Program Committee Discussion

Dr. Joan Weiss requested feedback from the Committee on the Geriatrics Workforce Enhancement Program (GWEP). She asked the members to share what is working or not working with the GWEP and how should HRSA proceed going forward? Dr. Chen reminded the members that the four geriatrics programs were combined into one program under the GWEP and the awards started July 1, 2015. The awardees are in their first year of a three-year program. The funding opportunity announcement required partnerships with at least one primary care organization and one community-based organization. As HRSA moves into to the next competition what should the focus be, should the requirements remain the same?

A member commented that as more regulations and screenings are added to community health centers, they have a much more difficult time of incorporating content. They need assistance with Medicare materials, annual visits, templates, and quality improvement issues. The health centers also need more infrastructure support. A national model could be developed, promulgated, and rolled out. Dr. Chen commented that the feedback was valuable and she encouraged the members to send comments and suggestions on the program. She also commented that there has been much discussion on the three-year requirements for grants and she welcomed comments on that issue.

Dr. Levine commented that the outcomes that are being asked to be demonstrated are virtually impossible in the three-year cycle. Nor are they possible with the current funding allocation because to do that level of drilling down on patient outcomes requires \$200,000 or more to accomplish goals. There has to be some consideration of what was being asked for in terms of patient outcomes or other kinds of outcomes that can be realistically measured with the current allocation and within the required time frame.

Dr. Weiss concluded the discussion and asked GWEP grantees attending the meeting to participate in public comment later in the meeting or to send comments to her and Dr. Nina Tumosa.

Dr. Page Walker Buck, LSW
Training Professionals to Address Socio-behavioral Needs:
Challenges and Opportunities in Social Work Education

Dr. Page Walker Buck began her presentation with background information on social work. Its primary focus is to promote human and community well-being. It looks at the systemic issues of poverty, lack of education, incarceration, and racial and ethnic disparities. This informs understanding of the social determinants and well-being of health.

Social workers are the largest provider of mental health services in the United States. Social work is inherently collaborative, team-based, and interprofessional. Social work education is designed to help students develop the skills and knowledge to promote human and community well-being. Social determinants of health and well-being have been foundation of social work since its start. It is also a research informed profession. For example, in West Chester University's Master of Social Work Program, all of the students receive certification in trauma focused cognitive behavioral therapy, and training in motivational interviewing. They are both approved interventions for behavioral health and this is informed by the curriculum which is based in recovery resilience and capacity building.

Social Work and the Community

Dr. Buck explained that the signature pedagogy of social work education was designated in 2008 by the Council on Social Work Education. It relies heavily on community partnerships and social workers work in the community with outpatient centers and residential treatment centers. Social workers also work in mobile crisis units, clients' homes, hospitals, schools, government agencies, prisons, older adult settings, and veterans associations. These settings provide a rich and broad scope of field education placements for students. Field education requires placement hours and supervision by a social worker. These social workers are volunteers with large caseloads that work with students because it is important to them. There are a limited number of programs that pay supervisors.

Dr. Buck emphasized the importance of community partners. Partnerships are first built through field directors. Every program is required by accreditation to have a field director and this person places students, orients supervisors, and provide all the training and continuing education. Field directors are critical in maintaining community partnerships. Community advisory boards also help to structure programming.

Faculty

Dr. Buck discussed the importance of encouraging and valuing the service faculty provides. Department faculty serve as trustees and are on the board of directors. West Chester University has begun to partner with community agencies who conduct program evaluations. They teach students program evaluation and each section partners with a specific agency to help them develop a program evaluation and carry that out. They encourage faculty to become

coinvestigators on grants with community partners. However, there has been shift in community relationships. As large health care organizations are absorbing the smaller non-profits, there is a significant strain in how field education is carried out and how social work education interacts with these agencies. What used to be a handshake and a phone call requesting a student is vastly different in today's field education world.

Field Education Challenges

Dr. Buck then discussed field education challenges. There is an imbalance between needs and resources. Well-trained professionals are needed to work in challenging environments with individuals facing increasingly complex socio-behavior conditions. State funding has decreased but enrollment has stayed relatively stable. But the sister organization in the state system has declining enrollment. Community college enrollment is also down. Stakeholders have increasingly complex and competing interests. Those stressors and those demands are in competition with each other. It is important to focus on the competition and identify the challenges and solutions.

Stakeholders

Dr. Buck discussed stakeholders: students, sites and supervisors, clients and patients, faculty and administrators, and universities. She emphasized that students have high expectations for training programs and field placements and they expect customer service. They also have high academic needs. There are students coming out of high schools and undergraduate programs without all of the skills needed to enter training. Many students have family and caregiving responsibilities and mental health needs. Over 75 percent of the students in the Bachelor's program are working full time in social service and behavioral health. Students also have high debt and this dictates where they can take placements. Many students have rejected placements because they are too far and they can't afford the commute or the time away from other responsibilities. These issues have a significant impact on educating students.

Sites and supervisors dynamics have changed. They are under tremendous pressure to meet market demands with higher caseloads and it results in reduced time with clients. Their caseloads are filled with patients that have increasingly acute and chronic needs that are compounded by the effects of poverty, trauma, poor education, and incarceration. There is also tremendous workforce turnover and limited physical space. Some community centers are moving out of suburban areas to office parks, because they need more space where there is free parking. The supervisors at the site are under pressure and they have less support from their administrators to supervise. They are also facing many of the issues their students are facing. In addition, clients and patients face increased health needs. According to the Centers for Disease Control and Prevention, one of four adults had two or more chronic conditions. There is also an increase in health risk behaviors and lack of exercise, poor nutrition, and tobacco and alcohol use. In addition, the population is aging. Within the next 15 years, one-fifth of the U.S. population will be 65 or over. There is also an increase in racial and ethnic diversity. A diverse health workforce is needed to address these issues and care for these patients.

Dr. Buck stressed that faculty and administrators are focused on tenure and promotion. There is prestige in studying pedagogy in field education. There's much more prestige with doing an analysis from pre-existing data sets and that does not always include community-based

participatory research. Faculty are under pressure to secure funding. Another trend is field education is increasingly managed by staff and the risk of that is that it becomes nonacademic and it becomes non-central to the academic program. Administrators in higher education are focused on tuition generation when enrollments decline. The move towards treating students as consumers makes sense for Universities to attract students. There is an interest in accelerated programs online programs and in accreditation and is important to pay attention to accreditation standards.

Next Steps

Dr. Buck explained the next steps to addressing these issues: match stakeholders with resources, engage in research and needs assessment to identify stakeholders' perspectives, find common ground, acknowledge competing demands, and identify opportunities in the challenges. Data must be collected data from people on the ground in the forms of community meetings, and focus groups. A willingness to authentically collaborate must be demonstrated. Dr. Buck stressed that what students want isn't often what the sites can manage and what the administrator wants might be different than what faculty wants. Opportunities must be identified in the challenge.

Social Work Study

Dr. Buck shared the results of a study that she and her colleagues conducted last year. The purpose of the study was to find out how students are managing full time work, caregiving, and their school program. It was a national study of social work students. The students completed an online survey and some were invited to participate in qualitative interviews in-person. The students reported they were only able to meet the expected number of hours per week 50 percent of the time because of caregiving responsibilities, unpaid work responsibilities, and their own or family members' illness. A Masters' student of social work must complete 900 hours. Students are only getting 33 minutes of supervision on average per week and this is compared to the requirement of 60 to 90 minutes per week. Supervisors and students want to do the right thing but sometimes supervisors are too busy and students have competing personal strains. A follow-up study was conducted recently and it found that field directors are overestimating how much supervision their students are getting. Faculty, field directors, and staff are not always aware of what is happening on the ground. In addition, client needs are increasing at the same time that student training programs are experiencing significant challenges. There is also a risk that current training programs are less accessible to students with diverse socioeconomic and racial/ethnic backgrounds.

Opportunities for Improvement

Dr. Buck then discussed the opportunities for improvement. Student financial stress must be addressed through stipends to allow them to reduce full-time work. Classes should be held in the evenings, weekends, and online when appropriate. Students can be provided writing support, or financial aid counseling. Dr. Buck stressed that the better students are, the better prepared and balanced they are. Training and self-care classes should be provided to prevent trauma and burnout.

Supervisors and faculty need to receive incentives, free training, continuing education, faculty positions, and access to libraries. Site opportunities come from partnerships. They want their

issues acknowledged and they want to be invited to community advisory boards. Sites want training for their employees and collaboration around research and program evaluation. A document must be created that describes the benefit of having a student working at a site.

Dr. Buck closed her presentation by discussing the new landscape and future opportunities. Training students in community-based settings requires new thinking. It is a new landscape. Relationships with community partners are vital. Professional organizations and institutions of higher education must take the lead and academic programs may need to absorb some of the training so time in the field can be maximized. The future opportunities include: increased funding, interprofessional collaborations among training programs, developing university-community clinics, and establishing post-degree trainings.

Dr. Buck stressed that there should be a focus on interprofessional collaborations among training programs. Many times internship programs are separate and there is competition with other programs. There could be a coalition set up to have 15 students to show up in a community setting with the parameters already outlined. For example, it can describe how social work students are going to work and what they will do. This would take the burden off of community agencies and reduce competition. Dr. Buck commented that there is often discussion about programs and the desire to develop a university community clinic where the stage could be set for how training would be carried out. There has tremendous success on how this has worked. Post degree training is also important. Yale University has a clinical fellowship postmaster training programs.

The members then asked Dr. Buck questions on the social work program hours, the risk for less accessibility for diverse socio-economic and racial/ethnic backgrounds, and the social work doctorate.

Petra Clark-Dufner, MA and Cynthia Lord, PA-C
Opportunities, Challenges and Realities of Community Based Clinical Training for
Today's Health Professions Learner & Preceptor

Ms. Clark-Dufner began by explaining the three main components of the presentation: the impact, the challenges, and the opportunities available in designing and supporting quality primary care, community based clinical training for health professions students and preceptors. Impact refers to the satisfaction faculty and preceptors feel when a student shares how the clinical rotation they just completed far exceeded his or her expectations. A successful clinical rotation can truly be a life altering experience that provides trainees with affirmation about their chosen career, affinity for a special patient population, or a type of clinical care. Community-based primary care clinical rotations, especially in underserved communities, serve to expand the toolkit of health professions trainees. As learning laboratories, they also provide health professions trainees with exposures to patients, clinicians, and problem-solving. Interprofessional collaborative practice and teamwork is an essential component of community-based primary care.

Community-based clinical rotations can also reinvigorate preceptors and staff by helping them to remember why they chose healthcare as a profession. Rotations can provide rich training

opportunities that truly foster greater knowledge and skill about the complexity of healthcare and vulnerable patient populations. The national Area Health Education Centers (AHEC) network provides clinical training that improves the readiness, willingness, and ability of health professions trainees to serve in primary care and rural and underserved settings. In 2014-2015, AHEC awardees nationally facilitated more than 42,000 rotations with 33,437 of those trainees having a placement in rural and underserved locations.

Clinical Rotation Challenges

Ms. Clark-Dufner noted that designing and supporting primary care community-based clinical rotations can be broken down into four key areas: supply versus demand, alternative to the classical or traditional the health professions students, value added by learners, and recruiting, training, and supporting preceptors. In supply and demand, there is a tension between healthcare systems and preceptors that exists in part because of the competing priorities and the focus on productivity, relative value units, reimbursement, research, and time pressures. There is also a lack of relationships among health profession education programs. In addition, there is limited physical space at clinical sites for training. There are limited examination rooms and some preceptors are using the same room as an office and an examining room. This directly impacts the ability to teach in a professional collaborative practice in real time and with real patients.

Other opportunities for meaningful student engagement and training that have changed include the deconstruction of the patient visit and patient care in large health systems and utilization of the electronic medical record (EMR). One of the limitations of the EMR from the academic perspective is that it limits students' abilities to document patient visits and thus their ability to develop critical thinking skills. There are also issues in preceptor development, use of incentives, liability, the credentialing process, preceptor burnout, and an increased variability in skills and knowledge base among different health professions programs. Primary care preceptors have expressed that the number of trainees coming through the system who eventually go into primary care, does not justify the time and the resources dedicated by the preceptor. The challenges faced on the demand side include: the addition of new training programs across all health professions; increased size of training programs, which is compounded by competition within as well as outside of institutions; and a lack of coordination of clinical site placements from different health professions programs.

Competition for training spaces and varying payment for clinical sites are a major issue. For example, in Connecticut some organizations bundle preceptor payments through the main organization and use those payments to defray preceptor continuing medical education costs, while other agencies have direct payments that are received by the individual who is serving as preceptor. Offshore medical schools have also had a major impact on training sites. These schools can often pay a large amount and offer many incentives. For example, one institution received a simulation center that was built in the hospital as compensation support for taking students. Ms. Clark-Dufner then turned over the presentation to Ms. Cynthia Lord to discuss the challenges of the traditional health professional training approach, value added by learners, and preceptor recruitment and training.

Ms. Lord explained that the traditional health professions training approach has limitations and is no longer viable. In addition, individual preceptors are expected to adjust to the presence of student trainees at their clinical site without the benefit of release times or protected times. Clinical training sites have traditionally been developed through relationships with individuals and schools. Currently healthcare organizations and administrations must be included to gain permissions for clinical rotations. In many instances a preceptor will agree to a rotation, but the organization will say no because of concerns about loss of productivity and the time commitment on the part of the preceptor. In addition, many schools are encouraging students to find their own clinical training sites. This places preceptors in an uncomfortable position because it is hard to tell a student no when they are pleading that they need a rotation to graduate.

Many preceptors and health care systems feel that the cost of clinical training far outweighs any perceived benefit or value. This thought process has been perpetuated by the fact that in the traditional health professions model there is limited research on the added value of student trainees. Ms. Lord stressed the importance of demonstrating the value of creating and supporting a diverse workforce pipeline shared between stakeholders.

There are also a disproportionate number of new preceptors as compared to new graduates. The number of new health professions graduates in all areas has increased, but there is a decrease in new preceptors. Ms. Lord emphasized that there is a great need for underrepresented minority clinicians as well as clinicians working in rural communities. Preceptors should be recruited to serve on national health professions education association clinical committees to create bi-directional communication. Preceptor training and faculty development with peer to peer mentoring is also needed. There is a need for a centralized, easily accessible location for preceptor resources including: preceptor handbooks, video resources, sharing preceptor best practices, preceptor directories, and online educational modules and resources. Ms. Lord commented that in order to support preceptor retention we need to explore new incentives and models for preceptor support such as earning category one continuing medical education units and tax exemptions for those who precept.

Opportunities in New Models of Training

Ms. Lord then discussed the opportunities that exist within new models of clinical training. The classical model is no longer viable due to the demands and challenges of community based primary care clinical training. The critical component to developing new models is engaging stakeholders (academic institutions, clinicians, professional and community based organizations, learners, patients) in conversations, strategic planning, and advocacy sessions.

As a national resource, AHECs are important because they serve as a centralizing hub between academia, clinical practice, community, and patients. As noted by Ms. Clark-Dufner, AHECs provided 42,000 community based clinical rotations last year. AHEC is a vital partner in the training of health professions students and in the expansion of the primary care workforce. In addition, interprofessional education, advocacy, and collaborative practice, should be included in new models. Resources must be in place for both students and preceptors by providing enhanced learning exposure tools and dedicated time and space.

Physician Assistant Programs

Duke University has the longest running physician assistant program in the country and for many years it was the only physician assistant program in North Carolina. Ms. Lord highlighted that currently there are many physician assistant programs in North Carolina and they collaborate to share information about their programs, determine how their programs can work together, and develop a consortium. They share resources like policies, procedures, and forms. This collaboration is building trust, and possibly in the future will lead to sharing clinical sites. Ms. Lord stressed that a centralized national database of all clinical training facility sites from large healthcare institutions, to clinics, to private practices should be developed.

Title VII Funding

Ms. Lord recognized that the state authorization reciprocity agreements between states and institutions have inadvertently led to many health professions programs having to eliminate their out-of-state rotations. It also puts some health profession programs that cannot afford those state registration fees for all their students at a disadvantage. She noted regulations that negatively impact health professional clinical education should be removed and funding for Title VII needs to improve. Expanding faculty leadership and developing opportunities to contribute and succeed in these new training models is crucial to success.

Ms. Lord emphasized that in order to address challenges in clinical education specifically within primary care, the creation of teaching laboratories in the community are needed. In addition, technology should be used where appropriate, recognizing that a simulation experience does not take the place of real patient encounters.

Ms. Clark-Dufner concluded the presentation by stressing to the members that it is their responsibility to look at the challenges and the reality of community based clinical rotations through different lenses which embrace opportunities for innovation and inclusiveness. This requires re-focusing on who the stakeholders are, how to bring them into a meaningful bi-directional conversation, providing resources to support their engagement, and finally, moving away from the traditional approaches and definition of what a primary care community based clinical rotation looks like.

Questions and Answers

Members asked questions and commented on students and the electronic health record. Ms. Clark-Dufner and Ms. Lord explained that in most institutions students are very limited to what they can do in the EHR. In addition, the EHR often means additional work for the preceptor. It is important to create more time for preceptors to teach instead of entering information. Ms. Clark-Dufner suggested the ACICBL recommend that HRSA add a student notes section to the EHR.

Mary Ann Forceia, MD Pay to Play: The Future of Clinical Clerkships?

Dr. Mary Ann Forceia opened her presentation with a brief history of medical education. In the nineteenth century, physicians were trained primarily in three ways. The most common way was to become an apprentice to a practicing physician and that physician decided when the learner

was ready to go into practice. Later in the century, there were proprietary organizations that began to offer training. These were usually hospitals that were owned by physicians. They collected tuition from students and had a variety of informal ways to train them in the hospital, in medicine, or in surgery. Later in the nineteenth century, the number of universities that offered clinical training as part of a formal curriculum began to increase.

History of Medical Education

Dr. Forceia then discussed the twentieth century and the developments and advancements in science, vaccination, antiseptic protocols on obstetrical procedures, surgical procedures, and public sanitation. There was a call for increased medical school training and access to information about science. The American Medical Association created a Council on Medical Education, and the first director of that council commissioned a survey about medical education in the United States which became known as the Flexner Report.

Flexner Report

Dr. Abraham Flexner was an educator who created innovative curricular models in Louisville, Kentucky, to address students with learning issues. He then went to Harvard Graduate School and wrote a book about the challenges of public education. Dr. Flexner was hired by the Council on Medical Education to survey all 134 U.S. medical schools. He thought it was critical that medical students had experience with patients, and encouraged student laboratory experiments. Dr. Flexner believed information should be presented in a variety of different formats, and it was critical to teach the students how they could continue to learn throughout their lives and practiced lives.

Dr. Flexner also had controversial ideas about how to fund training. He felt that the medical schools should own the hospitals where they were teaching and hospital staff should also be school faculty. He also believed there needed to be standards for admission and medical students should have some university training. He proposed that medical schools should have a four-year training program, with two years of basic science and two years of clinical science. In addition, students should not pay tuition and the costs should be covered by endowments, and faculty should donate their time. He proposed training outside the hospital and other clinical sites and he was a support of including some classic humanistic elements in the curriculum.

Cost of Medical Student Clinical Training

Dr. Forceia then highlighted the cost of medical student clinical training. She explained there are costs to creating beds in a hospital for in-hospital training and at this time it would be expensive to have a facility large enough for a medical school. If class size increases, equipment and teaching time become an issue. In the twentieth century model, many hospitals in the United States managed hospitals, but did not pay physicians who practiced there. They offered a clinical site in which physicians could pay and bill.

Productivity and Incentives

Dr. Forceia noted a study in Family Medicine that reviewed the productivity effects of having medical students in the office. They saw very little change in billing amounts when students were included, but they found that it increased the length of the workday for the physicians by about two hours. When they calculated the costs, they determined that having students in a

practice did result in increased expenses, whether it was a modest increase in productivity from administrative costs or the extra time physicians were spending with students. In early training, physicians were taught it was their duty and privilege to train future generations of medical students and residents, and it brought prestige to a practice if it was selected to be a teaching practice.

Dr. Forceia commented that many healthcare professionals are suffering from productivity issues in relation to anything that interferes with the practitioner's ability, especially in primary care settings, to see patients. However, there are several incentives that are appealing to healthcare professionals including a faculty position at a university and free access to library resources. Professional development opportunities, and continuing medical education credits at no cost and participation in research or publications, are important in maintaining certification and license.

Training Site Challenges

There are an increasing number of hurdles that are created by being a teaching site. There are also legal requirements between schools of medicine and practice sites. Security is also an issue for students. Dr. Forceia noted that in order to conduct careful evaluations of student experiences, practice faculty and staff must be trained to deliver information effectively. Since 1998, 12 new medical schools have opened in the United States, each of whom has between 100 and 200 students a year. In addition, there has been tremendous growth in nurse practitioner (21.5% increase) and physician assistant programs and schools of osteopathic medicine.

There are issues with access to training sites. Even veterinary schools are experiencing problems with access to training sites. Caribbean schools contribute to this problem. St. George has 300 students per class and they enroll two to three classes a year. They offer almost no clinical training sites at their home island and they have been active in developing relationships with U.S. clinical entities to move their students over for their clinical training. Dr. Forceia noted that there has been negativity surrounding Caribbean schools and many are angry that the schools are for-profit. However, a small number of studies show that students that complete Caribbean perform as well as U.S. medical students. There is an issue with the students who make it through the first two years at these schools. These students are allowed to sit for step one, pass step one, and come to the United States for training. Half of the students who enter make it through to the third year and need clinical training. United States schools retain 95-98 percent of the students who start and Caribbean schools retain 40 percent. It is a credentialing issue.

Paying U.S. Sites for Clinical Training

Dr. Forceia commented that some schools are looking at ways to ensure their students have access to training. Some schools are making lump sum payments for a certain number of slots at an academic center. A majority of the contracts are with the health systems, the hospital entities of the training program. They are not primarily with the medical schools. Caribbean schools are making contracts with the financial entities that manage the hospitals. There are consequences of the contracts. A few schools have reported difficulties in finding placements for their students and some relationships that have been broken. A 2014 survey on medicine clerkship directors found that a quarter of them reported they were paying preceptors. This payment can be anywhere from \$20 to \$500 a week per student. The highest percentages of payment are in the Northeast and South Atlantic tier. The Midwest and the West have low rates of payment.

After Flexner Report

Since the Flexner report was published over 100 years ago there have been many changes to healthcare professional education. Schools of Medicine and health professions schools have science as part of the curriculum. Many schools make an effort to prepare students for life-long learning and move away from the idea that you will be able to practice your whole career based on the knowledge set that you will acquire in medical school. The student body is also becoming more diverse.

There was no public comment and the meeting adjourned at 5pm.

Day 2

Introduction

The Advisory Committee on Interdisciplinary Community-Based Linkages (ACICBL) convened its meeting at 8:30 AM at the HRSA headquarters in Room 5E-29, 5600 Fishers Lane, Rockville, MD 20857. Dr. Joan Weiss welcomed the members to Day 2 of the meeting and then turned the meeting over to Dr. Peggy Valentine, Chair. Dr. Valentine provided an overview of the agenda and provided a summary of Day 1 of the meeting. She noted that on Day 1 there was discussion on the value of clinical education and how clinical education is mutually beneficial to the institutions that train students as well as preceptors. Discussion also focused on preceptor incentives, barriers, competition with the emergence of new programs, and expansion of current programs. Many educational institutions are challenged with declining resources and those costs have been passed on to students to pay fees and tuition increases. Dr. Valentine noted that there was discussion about simulation and how it can be used to enhance clinical education. The members also discussed competency-based education, models of education that shorten students' educational programs, and electronic health records. Dr. Weiss then introduced Ms. Melissa Moore and Ms. Cynthia Harne who discussed BHW Behavioral and Public Health programs.

Melissa B. Moore, MSW, MBA

Mental and Behavioral Health Education and Training Program

Ms. Melissa Moore opened her presentation by discussing the Behavioral Health Workforce Education and Training Program (BHWET). BHWET is a three-year program that started in FY 2014 and was created in response to the Sandy Hook shooting. It is a collaborative project between SAMHSA and HRSA and the funding is appropriated to SAMHSA and transferred to HRSA to manage the program. The purpose of BHWET is to develop and expand the mental health and substance abuse workforce particularly focused on children, adolescents, and transitional age youth who are at risk for developing or who perhaps may have already developed a recognized behavioral health disorder.

The BHWET program has 110 awardees across the United States consisting of paraprofessionals and professionals. Psychology, psychologists, social workers, counselors, school counselors, addiction specialists, peer counselors, psychiatric mental health, and nurse practitioners are funded through this program. Currently BHWET is supporting training for 3,500 providers a year. The program's intention is to focus on preparing a diverse workforce to serve rural and underserved areas.

BHWET previously received \$35 million per year. In fiscal year 2016, BHWET received a \$15 million increase to support and expand the program. The additional funding will fully fund the final year of these programs for grants that have already been awarded and will also support a one-year funding opportunity announcement. This is the last fiscal year for this behavioral health program. In FY17, there will be another funding announcement for behavioral health. BHW had discussions with grantees, with Congressional staff, and the field to understand where the behavioral health field is moving, gaps in the existing services, and how to structure the FY17 funding opportunity. Grantees expressed a need for additional funding to support training for students, faculty, and field supervisors and curriculum development. Ms. Moore noted that in many instances students graduate with a solid understanding of the interaction and the interplay between primary care and behavioral health. The FY 17 funding announcement aims to address development of a pipeline or a career ladder between the peer counselors and the professionals, continue to increase support for behavioral health integration, and foster community partnerships.

Cynthia Harne, LCSW-C
Graduate Psychology Education Program

Ms. Cindy Harne explained that the Graduate Psychology Education Program (GPE) is the only program that focuses specifically on doctoral psychology programs. In previous years, the Mental Behavioral Health Education and Training program focused on doctoral level psychology as well as Master of Science in Social Work. BHW is redesigning the funding opportunity announcement to leverage partnerships between academic institutions and experiential training sites, continue to train health psychologists in competencies of integrated care with two or more other disciplines, and include substance abuse training and expand a culturally competent health workforce.

There are currently 40 GPE grants and there were four supplemental grants last year, which focused on military support, veterans, and their families. The program received an additional one million dollars to fund the four grants and trained additional psychologists to work with veterans and their families. In the upcoming award GPE is expected to award 31 grants. The FY 16 award goals are to incorporate internships, post-doctoral studies, and experiential sites and primary care settings.

Questions and Answers

The members asked questions on underserved populations in rural areas, rural health, increasing diversity in the workforce among the behavioral and mental health professionals and faculty, tribal colleges and mental health in older adults.

Committee Discussion

The Committee members discussed the following questions:

1. What clinical training issues are you facing in your area and your discipline?
 - In North Carolina, there are clinical training sites shortages. Large universities are able to pay, and those that are state supported do not have the resources to pay. There is increased competition and online programs especially in the disciplines of allied health and nurse practitioner. In terms of disciplines, all disciplines are affected. There are six allied health programs and a large nursing program, with five different areas in nursing that are struggling to find clinical sites to place students.
 - There are issues with training sites within community health centers, which are now using offshore medical and physician assistant students. This is a challenge because integrated health care systems provide a majority of the training for interprofessional students. They are not getting exposed to important community health conditions.
 - Supervision is a major issue in psychology at the sites because they require face-to-face supervision. The licensing accrediting authorities do not view tele-supervision as face-to-face supervision.
2. How do the issues facing clinical training affect interprofessional education activities?
 - Simulation helps but it is not sufficient. There is difficulty in terms of interprofessional education with supervision and it is important to determine how it will work.
 - It is important to acknowledge that not every clinical situation requires an interprofessional team.
3. How does telehealth fit into clinical training? How does simulation fit into clinical training?
 - Research has shown that simulation enables students to develop better critical thinking skills. They are more critical in their decision making and that makes them better clinicians. As a result, when they work with practitioners they do better than those who have not had simulation training.
 - Simulations allow for feedback from well-trained standardized patients.
 - Simulation is an excellent opportunity for students to be part of the interprofessional team, defining roles, understanding the importance of addressing social issues from child abuse, family violence, to the death of a loved one. It is also an opportunity for students to receive a foundation in the skills that will be necessary when they are placed in real life situations.
 - Simulation costs can be high. For example, a mannequin costs about \$90,000.

4. What technical support is clinical training required to be effective in the future?
 - In terms of technical support, students should understand the electronic health record, decision support and how to use decision support, quality and safety, and population health tools.
 - Most providers underutilize the templating and the automated features of EHRs, and they could be much more robust and better done with support.
 - AHECs could coordinate training for those that do not have a simulator.
 - There is great potential for interprofessional community-based quality and safety initiatives in collaboration area agencies on aging or disability centers.
5. What are possible solutions or best practices that can be used to enhance clinical training?
 - Students must have a strong foundation in the basic sciences.
 - Consortiums (sites working together for interprofessional education and practice at state and regional levels to foster clinical education) should be created.
6. What recommendations can the ACICBL make to HRSA/BHW to address these solutions?
 - a) The ACICBL recommends HRSA support development of a National Center for Clinical Site Development. This Center would develop best practices to be disseminated across sites as funding opportunities with group evaluation. The Center would encourage clinical sites working together to foster capstone research project to improve quality and safety. In addition, the Center would provide preceptor development and work with non-traditional partners to develop new clinical training sites and simulation centers.
 - b) THE ACICBL recommends providing support for students through stipends, scholarships for disadvantaged students, and expanding student clinical site exposure. They should receive travel and housing in rural settings or areas with limited access (legislative change).
 - c) The ACICBL recommends monetary and non-monetary incentives for preceptors. This should include a preceptor income tax exemption,
 - d) Interprofessional Education learning through simulations.
 - e) AHEC Revisions - Redesign of the AHEC funding opportunity -ensure that higher educational institutions, community centers are connected to provide training on new technologies and new emerging health practice systems for the future. Assess the health needs of communities and to engage academic partners in helping to solve those problems across different sites of care, including the home and community.
 - f) Behavioral Health Program – Tele-supervision
 - g) Graduate Psychology - Department of Veterans Affairs

The members identified potential topics for the report including: payments/incentives for clinical training sites, developing new sites and preserving existing sites, security/legal issues, preceptor training and payment, and preceptor and curriculum development. The members decided to use Dr. Mary Ann Forceia's presentation as a foundation for the report outline. It would include historical background, training site challenges and barriers and proposed models.

**Eileen Sullivan-Marx, PhD, FAAN,
Current and Future Climate for Clinical Nursing Education**

Dr. Eileen Sullivan-Marx opened her presentation by discussing the recommendations that recently were published in the American Association of Colleges of Nursing (ACCN) report on academic health centers and the relationship to academic nursing. That means health systems and schools of nursing working better together to enhance both groups. The recommendations from the report, *Advancing Healthcare Transformation: A New Era for Academic Nursing* include: 1) Embrace a new vision for academic nursing; Enhancing the clinical practice of academic nursing; 2) Enhance the clinical practice of academic nursing; 3) Partner in preparing the nurses of the future; 4) Partner in the implementation of accountable care; 5) Invest in nursing research programs and better integrate research into clinical practice; and 6) Implement an advocacy agenda in support of a new era for academic nursing. The new vision per the ACCN report includes schools of nursing as an academic partner, nursing school participation in academic health center governance, collaborative workforce preparation, and leadership development.

Leadership Preparation

Dr. Sullivan-Marx noted that leadership issues are crucial as we prepare nurses for the future. In research leadership it is important to ensure people have exposure to evidence-based practice at the patient level. New York Presbyterian and New York University Langone have set up dedicated education areas where students are assigned with them for a much longer period and are part of the team. In research leadership, we want to ensure there is exposure to implementation leadership of evidence-based practice at the patient level. Patient-Care Leadership includes nurse managed/led community/primary care and patient/family centered programs. Workforce Development Leadership includes doctoral preparation, and interprofessional education and practice.

Dr. Sullivan Marx commented that some medical schools have set up programs where medical students follow families for three or four years. Nursing has not done that and are there enough demonstrated nurse managed community care/primary care programs for advanced practice nurses to be exposed to such continuity of care. In the future, there should be more primary care programs run by nurses, but there are not enough programs to train them. At Memorial Sloan Kettering they wanted students who would work with their nurse in an ambulatory care practice. But they also wanted to educate future employees in the new ambulatory nurse role. Dr. Sullivan- Marks commented more systems should follow this model.

Dr. Sullivan Marx emphasized that in classroom or simulation, we are only guessing at what the real world is going to look like. While simulation is important, it is hard to teach systems both at the Doctor of Nurse Practitioner and at the master's level. At the clinical level for advanced nurse practitioners, they are trying to absorb the clinical information and at the DNP at the system level.

Dr. Sullivan- Marx highlighted that through the Affordable Care Act approximately \$200 million was appropriated to support the Graduate Nursing Education Pilot. It is in its fourth year of funding, the aim was to increase the number of nurse practitioners in the primary care workforce. The issue was often preceptors were not able to take nurse practitioner students because it impacted their financial and patient outcomes. If they could be paid under a system similar to graduate medical education and health systems, perhaps that would increase the number of nurse

practitioners. This was a pilot to look at using the GME model of payment to preceptors, but the payment has to go through the training hospital systems. The funding for the graduate nursing education pilot has been done in five regions: Philadelphia, Texas (UT), Arizona, Chicago (Rush), and North Carolina (Duke). The ability to pay preceptors has increased the number of nurse practitioners that schools could take on and then send to ambulatory care centers or primary care centers.

Common Daily Experiences at Schools

Dr. Sullivan-Marx explained that in regards to training sites and preceptors there are many common experiences that occur at schools. They include insufficient number of preceptors, site competition, generalist versus specialty site competition, “employee” requirements are time consuming and costly (check resume, vaccinations, and background checks), frequent cancellations at the last minute; school of nursing faculty too “hands off”, and preceptor support and education to manage learning and problem issues with students.

Recommendations

The focus should be on developing learners using the best clinical experience. Market influences or payment should not be allowed to drive how people are trained. There are cost issues for the schools and site and preceptor recognition and incentives are very important. There is no consistent interprofessional platform and it is needed to address issues of how to best prepare learners with both primary and mental health comorbidity and integration of care. The AACN report is major step in moving ahead and starting a dialogue about these principles and how to prepare together.

Questions and Answers

The members asked questions about the challenges of sites about nursing students who want to do research and capstones and collaborations and competition for slots.

Public Comment

Dr. Kennita Carter:

My comment is in reference to the accreditation discussion. The National Academy of Medicine, formerly known as the Institute of Medicine, has convened a global forum. It has a series of workshops that are sponsored by 60 organizations. In April, they had a forum on the role of accreditation in enhancing quality and innovation in health professions education. Social work, psychology, nursing, medicine, and others including veterinary medicine, dentistry, all convened to talk about the challenges around accreditation. HRSA is one of the sponsors and I can send you the link to the workshop. Several presentations and the agenda can be found at the site. They discussed the barriers and challenges and how accreditation might potentially drive innovation.

The meeting adjourned at 3PM.