

MEETING MINUTES

Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) August 14, 2019

Committee Members Present

Teri Kennedy, PhD,
Chair

James Stevens
Vice Chair

Geraldine Bednash, PhD, RN, FAAN
Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP
Roxanne Fahrenwald, MD, FAAFP
Robyn L. Golden, MA, LCSW, ACSW
Bruce E. Gould, MD, FACP
Parinda Khatri, PhD
Lisa Zaynab Killinger, DC
John E. Morley, MB, BCh
Jacqueline R. Wynn, MPH

HRSA Staff in Attendance

Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, ACICBL, Division of Medicine and Dentistry
Samantha Das, MS, Designated Federal Official Liaison, ACICBL
Robin Alexander, HRSA Liaison, Advisory Committee Operations
Janet Robinson, Advisory Committee Liaison, Advisory Committee Operations
Carl Yonder, Public Affairs Specialist, Division of External Affairs

Welcome/Introductions

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 11:07 a.m., on Wednesday, August 14, 2019. The meeting was conducted via webinar from the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 15SWH01, Rockville, MD 20852. Joan Weiss, PhD, RN, CRNP, FAAN, ACICBL Designated Federal Official, welcomed Committee members and conducted a roll call of Committee participants. The following Committee members were absent: Katharine Erwin, DDS; Joseph Evans, PhD; Kamal Masaki, MD; Sandra Pope, MSW; and Zaldy Tan, MD.

Teri Kennedy, PhD, MSW, LCSW, ACSW, FGSA, FNAP, ACICBL Chairperson, welcomed everyone to the meeting. She asked if there were requests for additional items for the agenda. None were forthcoming. John Morley, MB, BCh moved that the agenda be accepted as is; Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP seconded the motion. The motion passed unanimously.

Performance Data Tool

Dr. Weiss introduced Hayden Kepley, PhD, Special Assistant to the Director, National Center for Health Workforce Analysis, Bureau of Health Workforce (BHW), HRSA, and Isaac Worede, Chief, Performance Measurement and Evaluation Branch, BHW. Dr. Kepley provided an overview and demonstration of the new Health Professions Training Programs Dashboard on the HRSA website (<https://data.hrsa.gov>). This data tool provides performance data for each of HRSA's health professions training programs from academic year 2012-2013, aggregated by year, program, and state. Data is updated annually. Available data includes participant and graduate counts, participant and graduate demographics, clinical training site locations, and program infrastructure outputs (e.g., continuing education, faculty development). Using individual programs as examples, Dr. Kepley demonstrated features of the dashboard, beginning with the Participant Summary tab which displays a map with states color-coded by the density of participants trained by all grantees; participants by key training areas (medically underserved community, primary care community, and rural area); graduate intention; and primary discipline (behavioral health, dentistry, medicine, nursing, other, public health, student). Under the Participant Demographics tab, participant age, gender, race, and ethnicity are displayed, as well as Special Category data for underrepresented minority, disadvantaged background, and rural background. Clicking the Sites Information tab reveals a color-coded map displaying the density of sites by state and the number of sites by setting (medically underserved community, primary care setting, rural area, or other). The final tab, Courses Developed, has three sub-tabs that provide data on curriculum development and academic enhancement, continuing development, and faculty development.

Geraldine Bednash, PhD, RN, FAAN observed that the maps revealed enormous training program voids in some states, suggesting where the funding priorities should be. Dr. Weiss explained that HRSA responded to this problem by including language in this year's Geriatrics Workforce Enhancement Program (GWEP) solicitation that allowed HRSA to take geographic distribution into consideration. Each state was allowed a maximum of one grant except those with more than three million older adults that could have two grants. As a result, the program is currently operating in seven additional states and two territories. Dr. Kepley commented that this is the kind of discussion that the dashboard is designed to encourage; without the data display, it had not previously been possible. Dr. Bednash further observed that some states may be limited in their ability to develop a competitive application; Dr. Weiss noted that the limit on the number of grants per state meant that multiple organizations worked together to submit a coordinated program as a single application.

Additional Committee discussion focused on whether the number of health professions represented on the dashboard should be expanded, e.g., social work is represented under behavioral health but provides a much broader array of services. Dr. Kepley encouraged Committee members to provide feedback through Dr. Weiss about professions with large numbers of participants that should be represented on the dashboard. Dr. Weiss asked whether more detailed data under headings is available, e.g., for the Alzheimer's/dementia chronic disease topic under the Continuing Education section of the Courses Developed tab. Dr. Kepley responded that more specific data may be available upon request, but is not displayed on the dashboard. Lisa Killinger, DC inquired if there is a way to disseminate information about health professions training to chiropractic schools. Dr. Weiss suggested that the best approach is to register on grants.gov to look for Funding Opportunity Announcements (FOAs) related to chiropractic. Chiropractors are not eligible for National Service Corps funding, but may apply for GWEP. Area Health Education Centers (AHECs) may train chiropractors in their programs. Dr. Kennedy inquired if it is possible to find awardees of a program for the current year. Dr. Weiss replied that current awardee data is available on the Find Grants dashboard; Dr. Kepley demonstrated how to find and search that dashboard.

Business Meeting

Dr. Kennedy asked for corrections or additions to the minutes of the May 16-17, 2019 meeting. None were forthcoming. Dr. Killinger moved to approve the minutes as is; Dr. Morley seconded the motion. The minutes were unanimously approved by Committee members.

The Committee scheduled the following meeting dates to complete the 18th report to Congress prior to the expiration of most current members' terms in late February/March 2021: October 11, 2019 conference call; February 20-21, 2020 in-person meeting; May 1, 2020 conference call; and October 20, 2020 conference call. The Committee tentatively scheduled dates for a January 14-15, 2021 in-person meeting and a February 27, 2021 conference call.

Dr. Kennedy announced that Mr. James Stevens will assume the role of Committee Chair at the October 2019 meeting, and she will become Immediate Past Chair. That leaves the position of Vice Chair to be filled. Dr. Weiss explained that the previous committee recommended a committee structure of Chair, Vice Chair, and Immediate Past Chair to ensure a seamless transition. All current members except Dr. Brandt and Roxanne Fahrenwald, MD, FAFAP will be leaving the Committee in 2021 so one of them would be the best candidate for the Vice Chair position. This discussion was postponed so that the next presentation could proceed on schedule.

The Role of Relationships in Patient Engagement and Data Analysis

Dr. Kennedy introduced Steve Tierney, MD, Senior Medical Director of Quality Improvement at the SouthCentral Foundation (SCF) in Anchorage, Alaska. SCF is an Alaska Native health care organization that serves 65,000 tribal members across a vast geographic expanse, with many patients living in remote villages. Dr. Tierney, a family practice physician, established three objectives for his presentation: 1) to analyze the steps taken by SCF to transform its health care system into one that emphasizes patient engagement and shared responsibility with providers; 2) define the ways in which SCF supports providers in offering relationship-based care; and 3) analyze the ways in which relationship-based care and patient engagement lead to improved health outcomes and customer satisfaction.

SCF's approach, the Nuka System of Care, encompasses five key work systems: medical services, behavioral services, dental services, tribal services, and health care support. "Nuka" means "big living things" to many Alaska Native communities and represents SCF's approach, characterized by customer-ownership, relationships, and a holistic approach to health care. The approach strips most of the process steps out of the traditional health care delivery system in favor of time for staff and patient to engage and for patients to see the staff member almost on demand. Its success is demonstrated by measures such as these: a 40 percent drop in emergency room visits (2000-2017); a 36 percent drop in hospital stays (2000-2017); a 6 percent increase in operating margin (2012-2017); 75th to 90th percentile rankings on many HEDIS outcome measures; 97 percent customer-owner satisfaction; and 95 percent employee satisfaction.

These accomplishments were achieved in partnership with the community, not imposed on community members. Customer-ownership implies each member is in charge of his or her own health, and can ask for assistance in changing behaviors, rather than being told what to do by providers, i.e., it's a service model approach rather than paternalistic. SCF's Board of Directors represents the community and provides feedback on what their friends and family members are experiencing as they engage with SCF.

To redesign its service delivery, e.g., how to monitor chronic diseases in patients living far away from clinics, SCF asked community members what they wanted. The answer was that they didn't want to have to re-explain their problems to someone new each time and they wanted to see a health care professional quickly when needed. In response, SCF rebooted its system to make sure patients can quickly see a member of their health care team and that everyone in the system can link reports of their interaction with that patient to the patient's primary care provider. Appointments can now generally be obtained within the next 200 minutes. In remote villages, emergency medical technicians (EMTs) have been trained to respond to acute health needs. Candy machines are pre-stocked with common medications, so physicians can write a prescription, the pharmacist can drop it in the queue, and the patient receives it immediately. Traditional health promotion approaches, such as the use of, flyers and brochures to change health attitudes and behaviors have been replaced with personal relationships in which staff are trained to engage and relate to patients about their health concerns in what SCF regards as a bilateral collaborative agreement between these customer-owners and health care staff. Customer-owner satisfaction is measured after every health care encounter via brief iPad-based questionnaires that allows level of satisfaction to be correlated to each specific visit.

Before the introduction of the Nuka system, work flowed through the provider, leading to a cost of \$400/encounter. SCF realized that 70 percent of the care provided to patients such as providing a flu shot or refilling a medication, could be done outside the office visit. Under the new system, Health Care Support Teams composed of an RN case manager, provider, certified medical assistant, and behavioral health consultant, provide services such as medication refills, test results, chronic disease monitoring, etc. outside the traditional office visit. The case manager and support team address most of the needs of the 80 percent of patients with low to moderate intensity needs. As a result, physicians, behavioral health consultants, and pharmacists are able to focus their attention on the 20 percent with high intensity needs, such as those with serious medical conditions and reduces a physician's daily patient load from 25-30 15-minute encounters to 10-12 30-minute visits. Other professionals such as dietitians, mental health professionals, certified nurse midwives, etc. supplement the Team care as needed and can normally be deployed within 10 minutes. Patients are not lost in the process because they stay in the room and the professionals come to them. With each team managing the needs of 1100-1400 owners, staff burnout is avoided, continuity of care is ensured, trust is built between patients and providers, and healthier outcomes are achieved.

Health care staff had to adjust to a new, population-based definition of quality care rather than the traditional visit-based approach. New staff spend a year in training to learn how to behave differently as a member of a multidisciplinary, independent, customer-driven team. They are given the tools to allow them to work at the top of their license to maximize the services that can be provided to patients.

SCF employs a relational data process to consider patient trajectories and outcomes, examining data points such as medication clustering and visit types to determine how to change the trajectory of, for example, a high number of emergency room (ER) visits or readmission to the hospital within 30 days. The focus of the data is on impact, rather than process, and independent of diagnosis. Customer service data from the iPad surveys shows that the percentage of complementary feedback has increased dramatically since 2011, while the number of complaints has declined. The next step in the ongoing data collection and evaluation system is to apply artificial intelligence to look at machine learning and pattern recognition in the cloud-based database.

Dr. Kennedy invited questions from the Committee. Bruce Gould, MD, FACP inquired how SCF obtains its funding. Dr. Tierney reported that about 40 percent of funding is from block grants, 40 percent is from

Medicare/Medicaid (fee for service) and 20 percent is fee for service from private insurers. There is Joint Commission accreditation at some SCF sites. Parinda Khatri, PhD, observed that SCF's workforce of 2000 employees for 65,000 customer-owners is a rich staffing pattern. She asked how SCF recruited new staff and retained current staff in order to bring its model to fruition. Dr. Tierney responded that SCF conducted a functional analysis of people's jobs, and found that most their work activities could be repurposed, e.g., the vaccination nurse could provide a broader range of nursing services. The system redesign ensured that high impact could be achieved with low overhead, e.g., the physician authorizes a flu shot, but the medical assistant administers it. This allows SCF to maximize revenue by increasing efficiency. Positions that didn't fit into the redesigned system were eliminated, but individuals occupying them were told they could reapply for new jobs. Dr. Khatri asked for more detail about SCF's workforce development approach to recruiting and retaining employees. Dr. Tierney replied that SCF hires new employees as temporary provisional employees and provides a 12-week training program; upon successful completion, the new staff member is fully prepared. SCF also provides 30-year career ladders (medical, administrative, or technical) for all employees and recruits students at age 12 to shadow professionals at SCF so that they will aspire to a job there when they graduate from high school. In addition, SCF conducts personality profiling of all new staff in order to compose teams whose members complement one another, then provides integrated care team training. By providing multiple levels of training, incentives, and support, SCF has high retention rates: one-third of its 60 physicians have worked at SCF for more than 20 years and many have been there 15 years or longer. There is a wait list of applicants for nursing positions. The system also monitors employee work patterns to avoid burnout; most physicians work about 45 hours per week and see 10-12 patients per day. Dr. Fahrenwald inquired about how SCF approaches the dilemma of health professionals being reimbursed and evaluated on a per visit basis versus focusing on outcomes. Dr. Tierney explained that instead of relying on repeat doctor visits from the same group of people, SCF has found that new people begin signing up because they know they can quickly get an appointment with someone they know, rather than wait in the ER. A health care system will achieve what it focuses on, either numbers or outcomes. Dr. Fahrenwald noted that providing 30-minute appointments in lieu of 15-minute ones means the total number of patients is cut in half. Dr. Tierney responded that his mission is not to satisfy regulators, but to help his customer-owners. If the health care system does the right thing, the staff will support it. Dr. Fahrenwald agreed, but observed that regulators need to be educated about this point. Mr. Stevens asked how SCF works with local nonprofits to address social determinants of health. Dr. Tierney explained that SCF has sister nonprofits, such as the housing authority, criminal justice, etc., with which they operate a loose consortium. To reduce high numbers of ER visits, SCF placed an integrated care team into the local homeless shelter and teen shelter with support from the City of Anchorage, which had achieved cost savings from reduced ambulance calls. That contributed to new relationships with the City emergency medical service (EMS), police, fire department, and justice system. Dr. Kennedy thanked Dr. Tierney for his presentation. He emphasized in closing that the health care system needs to educate regulators about new ways to focus on improving health outcomes, rather than continuing their current wasteful approach.

Business Meeting Cont'd

Dr. Kennedy thanked Committee members, especially those on the writing team—Joseph Evans, PhD, James Stevens, Dr. Khatri, Dr. Morley, and Sandra Pope, MSW-- for their help in writing the 17th report to Congress. She announced there will be a Congressional briefing about the report on September 23 or 26, 2019 on Capitol Hill. She will represent the Committee; the John A. Hartford Foundation, the

Institute for Healthcare Improvement, and the Health and Aging Policy Fellows have also been invited to participate. All Committee members are welcome to attend.

Dr. Kennedy invited comments on the issue raised with Dr. Kepley above about adding social work as a separate health profession rather than subsuming it under behavioral health. She suggested it could be listed as a profession rather than as a role. Robyn Golden, MA, reported that social workers lost their status as a health care providers in the Social Security Act. Dr. Weiss explained that eligibility for HRSA funding for Title VII, Part D is established by statute by Congress, so Congressional action would be needed to change it. She noted that other HRSA Committees have made similar recommendations with no effect thus far. Committee members asked if it would be helpful to expand understanding of the variety of health professions by providing more data with the goal of becoming more inclusive across disciplines. Dr. Weiss noted that this approach was discussed in the 15th report, and suggested that the Committee review that report before making a decision. She noted that the statute states the Committee provides advice and recommendations on policy and program development. In the 15th report, the Committee reviewed all programs and recommended funding levels for them. It's been five years since that report, so the Committee may wish to revisit that approach. Dr. Weiss noted that all programs under Part D are required by statute to be interdisciplinary/interprofessional. Thus, AHECs can train all health disciplines. There are, however, limitations about which entities are eligible for funding under specific programs. Ms. Golden said her objective was not to drive eligibility nor be prescriptive, but to expand understanding of those beyond the eligibility list, i.e., to be descriptive. Dr. Weiss observed that grantees design their interprofessional training based on their community needs assessments. Dr. Morley inquired if social workers were eligible to serve as Principal Investigators (PIs). Dr. Weiss noted that Ms. Golden is the PI on a GWEP grant; Ms. Golden said the important issue is the entity that receives the funding, noting that it is unfair that Schools of Social Work are not eligible. Dr. Weiss said that all disciplines are eligible for GWEP funding and three social work schools are current grantees. The challenge is that universities often prefer their medical schools to be the applicant. Dr. Kennedy confirmed that the recommendation from the 15th report under discussion is this one: "Recommendation 1: ACICBL recommends that Congress revise the eligibility requirements for Title VII, Part D, programs. Eligibility should not be limited to specific health professions schools in isolation. To promote interprofessional education, applicants should be permitted to develop the strongest consortia available to them, based on their access to local health professions schools, the strength of available partners, and the needs of the community." Dr. Kennedy encouraged interested Committee members to review the 15th report; with sufficient interest, this topic could be revisited during the October meeting.

Dr. Weiss asked Drs. Fahrenwald and Brandt to determine their availability and interest in serving as Vice Chair of the Committee. They will consider the position and inform Dr. Weiss of their interest.

Review of ACICBL Recommendations

The Committee's discussion of the ACICBL's draft 18th report, *Promoting the Inclusion of Population Health at the Nexus of Primary Health Care Delivery and Public Health*, focused on a review and refinement of its five draft recommendations to date:

1. Train health professionals, students, faculty, and providers to better understand the impact of population and public health data. Including use of population health data to identify location-specific risks and impediments/barriers to health in underserved community.

- a. Impediments = cultural differences in a certain population; barriers or challenges to achieving optimal health status for a community (cultural beliefs, social determinants of health).
2. Analyze population health data to identify root causes (origin of these issues/key contributors) of disease and health.
3. Develop and implement evidence-based interventions to improve health status and outcomes in underserved populations and rural areas
4. Evaluate and translate the effectiveness of evidence-based population health interventions to improve health status and health outcomes in underserved and rural areas.
5. Disseminate [and uptake the scale and spread of] training for students, identified positive health outcomes/and promising best practices to rural and underserved population using population health data (a clearinghouse for resources, refer to the previous recommendation).

Dr. Kennedy noted that the goal is to develop three to five recommendations. Dr. Weiss pointed out that the recommendations should relate to programs under Title VII Part D. Recommendations may be addressed to HRSA or other federal agencies, such as the Centers for Medicare and Medicaid Services (CMS); those to HRSA are more likely to be implemented.

Key points of the Committee's discussion include:

Cross-recommendation Considerations

1. Keep the focus of the five current recommendations, but expand the language to reflect Committee discussion below.
2. Revise the current focus to "train" relevant audiences on the use of population and public health data in the draft recommendations because "train" is too narrow. A broader focus is needed, e.g., "prepare" relevant audiences to use such data. However, because the Secretary and Congress may not understand the word "prepare," consider "Educate and prepare..." Alternatively, consider "recruit and retain."
3. Avoid redundancy across recommendations, e.g., between recommendations 1 and 2, and 4 and 5, where there may currently be some overlap.
4. Expand the focus on audience in the draft report beyond medicine, medical schools, etc.; the focus is currently too narrow. Instead, focus on the health workforce; a more interdisciplinary focus is needed.
5. Educate the population as well as providers about the use of population and public health data. A term such as "patients, families, and caregivers" will be more meaningful to the Secretary and Congress than "population." It's important for those voices to be heard. Expand relevant audiences to also include the "community at large" to empower them to be agents of change.
6. Adopt a team mentality toward the improvement of health, with team members including not only health professionals but also patients, families, and caregivers; health care administrators; and politicians who allocate funding.
7. Adopt a more demanding goal than "understanding" population/public health data, e.g., accessing, using or applying data. Currently, the healthcare community does not know what to do with the data, e.g., claims data, that it already has.
8. Consider the goal of training. It may simply be to get population health on the radar of trainees. Most people are unfamiliar with public health data, so they need to understand the basic concepts. Teaching people that such data is available and where to find it is important. Analysis

may be too demanding a goal for students. For everyone, the goal is for trainees to appreciate the importance of population health factors and then incorporate that information into the clinical encounter and in system-level interventions.

9. Convey training information about population/public health in ways that are relevant to the audience, i.e., discussions that are too technical or arcane will cause eyes to glaze over. Show how the information is directly relevant to their practice, e.g. how pollution affects asthma or how lack of transportation options causes someone to take an ambulance to the ER.
10. Train faculty about population and public health data themselves; otherwise, the information won't be taught.
11. Recognize generational differences, e.g., today's students appreciate data applications, such as geo-mapping, for mining population/public health data.
12. Consider the term "contributing factors" in lieu of "root causes" because there are multiple issues co-occurring in highly complex cases. Whether or not the term "root causes" remains in the recommendations, define root causes in the body of the report. Add a footnote to the recommendation(s) if the term is used.
13. Use social media to provide a knowledge base about population/public health for the public and for those in training.
14. Retain references to the "nexus of public health and the health care system" in lieu of references to population health or public health, which have their own (sometimes negative) connotations.
15. Consider referencing the Bronfenbrenner's systems theory approach to population health (i.e., an onion in which layers of the patient and community are peeled off) as a way to communicate how this approach works.
16. Emphasize health equity and health disparities as important themes that run throughout all the recommendations. Add a preamble to the recommendations that acknowledges health disparities and factors that are community-specific as foundational concepts to the recommendations themselves.

Recommendation-specific Considerations

1. In recommendations 1 and 2, a broad goal such as "understanding the utility" of population/public health data (e.g., to recognize health disparities) could be an overarching goal that addresses potentially different expectations for "health care professionals" and "patients, families, and caregivers" to use/apply such data.
2. For recommendation 3 about interventions, add 1) "promising practices" to the "evidence-based interventions;" 2) "identify and/or develop and implement" at the beginning of the recommendation; and 3) a footnote to the recommendation that describes what interventions might be, including policy change.
3. In recommendations 3-5, add "at-risk communities" to the underserved and rural populations referenced as target audiences for improved health status and outcomes. At-risk communities may include affluent communities that are experiencing a particular health problem.
4. In recommendation 5, note that 1) dissemination applies to public health knowledge, interventions and promising practices, and curricula. Audiences to whom to disseminate include all the audiences referenced above; and 2) reference HRSA training programs and clearinghouse. Add social media as another avenue of dissemination.

Attachment A is an updated draft of the recommendations based on the Committee's discussion. The Writing Committee for the 18th report--Dr. Kennedy, Mr. Stevens, Dr. Gould, Dr. Killinger, Dr. Khatri, and Dr. Masaki-- will be meeting weekly with the writer for the report through the end of September.

Dr. Weiss updated the Committee on the Geriatrics Academic Career Award Program awards that were released earlier in the week. These awards are to institutions that apply on behalf of individuals to promote their career development as academic geriatric specialists. By statute, the eligible disciplines are medicine, allopathic and osteopathic, nursing, dentistry, social work, psychology, pharmacy, and allied health. HRSA made 26 awards: Two from nursing, two from social work, two from pharmacy, one from physical therapy, one from occupational therapy and one from dentistry, totaling nine non-medicine disciplines; the remaining 17 were to medicine. One of the medicine awardees is a geriatric psychiatrist.

Dr. Kennedy expressed her thanks to the Committee for their support during her term as chair and said it had been an honor to serve. Committee members thanked her for her leadership and service.

Public Comment

There were no public comments.

Adjournment

Dr. Weiss adjourned the meeting at 4:54 p.m.

Attachment A

Draft Recommendations

August 14, 2019

Include a preamble in the report that we recognize that there are health disparities and inequities that are location specific and that is understood as ACICBL presents these recommendations.

1. Educate students, faculty, practitioners, the direct care workforce, patients, families, caregivers, and the community at large to understand the availability and utility of population and public health data in identifying root causes of disease and health disparities in pursuit of health equity.
2. Recruit, train, and retain the health workforce to work with the community at large to analyze population health data to identify root causes of disease and health.
3. Identify and/or develop and implement evidence-based interventions and promising practices that address identified root causes to improve health status and outcomes among rural, underserved and at-risk populations.
4. Evaluate and translate the effectiveness of evidence-based interventions and promising practices that address identified root causes to improve health status and outcomes among rural, underserved and at-risk populations.
5. Disseminate population health knowledge, evidence-based interventions, and promising practices to improve health and eliminate disparities in rural, underserved and at-risk populations through Health Resources and Services Administration training programs, a clearinghouse, and via social media.