ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES (ACICBL)

Meeting Minutes
January 25-26, 2024

Committee Members Present
Grace M. Kuo, PharmD, MPH, PhD, FCCP, FNAP (Chair)
- Pharmacy

Thomas A. Teasdale, DrPH, FGSA, FAGHE (Immediate Past Chair)
- Geriatrics

Elizabeth Bush, MS, MA
- Area Health Education Centers

Barbara Hart, MPA, MPH
- Mental and Behavioral Health - Paraprofessionals

Kevin A. Osten-Garner, PsyD, LCP
- Mental and Behavioral Health - Professionals

Naushira Pandya, MD, CMD-FACP
- Geriatrics

Jennifer Peraza, PsyD, ABPP
- Mental and Behavioral Health - Professionals

Mary Worstell, MPH
- Geriatrics, Caregiving

Health Resources and Services Administration Staff in Attendance
Shane Rogers, Designated Federal Officer
Joan Weiss, PhD, RN, CRNP, FAAN, ACICBL Subject Matter Expert, Deputy Director, Division of Medicine and Dentistry
Luis Padilla, MD, Associate Administrator for Health Workforce
Zuleika Bouzeid, Advisory Council Operations, ACTPCMD-ACICBL-COGME
Kim Huffman, Director of Advisory Council Operations
Janet Robinson, Advisory Council Operations

Welcome Remarks
Shane Rogers, Designated Federal Officer (DFO), ACICBL

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 8:30 a.m. ET on January 25, 2024. The Health Resources and Services Administration (HRSA) held the meeting in-person in Rockville, Maryland. Shane Rogers, DFO, welcomed Committee members, presenters, and members of the public.

Ms. Zuleika Bouzeid, Advisory Council Operations, provided instructions for participating in the virtual meeting. Next, Mr. Rogers explained that the Committee's purpose being to provide advice and recommendations to the Secretary of the Department of Health and Human Services (Secretary) and Congress about policy and program development pertaining to programs authorized by the Public Health Service Act, Title VII, Part D. Mr. Rogers confirmed a quorum and then turned the meeting over to the Chair, Dr. Grace Kuo.

Agenda Review / Introductions
Grace M. Kuo, PharmD, MPH, PhD, FCCP, FNAP, Chair, ACICBL

Dr. Kuo welcomed participants and reviewed the agenda. Committee members then introduced themselves. During the meeting, members heard updates on the Bureau of Health Workforce (BHW) provided by Dr. Luis Padilla as well as updates on the 21st and 22nd ACICBL reports. In addition, members heard presentations from subject matter experts on Artificial Intelligence, Substance Use Disorder (SUD) training, HRSA's Mental and Behavioral Health Education and Training (BHWET) programs, and relevant upcoming Notices of Funding Opportunity (NOFOs).

Update of the 22nd Report, *Supporting Health Care Teams for Today and Pathways for Tomorrow*
Thomas A. Teasdale, DrPH, FGSA, FAGHE, Immediate Past Chair, ACICBL

Dr. Teasdale thanked all of those involved in the development of the report, including Mr. Rogers. He informed the Committee that the report has been published and is now publicly available on the ACICBL website. In addition, it has been sent to HRSA leadership as well as the Secretary and Congressional committees.

Dr. Teasdale then provided a brief review of the 22nd Report and its recommendations. The report contains 11 recommendations which focus on behavioral health, geriatrics, and the Area Health Education Center (AHEC) programs.

Update: Dissemination Activity of the 21st Report, *Building Trust, Addressing Burnout, and Expanding the Direct Care Workforce*
Joan Weiss, PhD, RN, CRNP, FAAN, ACICBL Subject Matter Expert, Deputy Director, Division of Medicine and Dentistry Bureau of Health Workforce, HRSA
Naushira Pandya, MD, CMD-FACP, Member, ACICBL

Drs. Pandya and Weiss provided an update on dissemination efforts for the 21st Report. They submitted an abstract to the annual scientific meeting of the Gerontological Society of America (GSA), held in Tampa, Florida, on November 8-11, 2023. The abstract was accepted and they presented findings of the 21st Report (*Building Trust, Addressing Burnout, and Expanding the Direct Care Workforce*) at the meeting. Dr. Weiss provided an overview of HHS, HRSA, BHW, the background, charter, and other specifics of the ACICBL.

Dr. Pandya discussed the provenance of burnout as well as factors affecting clinician overall well-being. She also discussed the impact of burnout and well-being on health care in general, along with the report's findings. In addition, she presented details from the 2022 Surgeon General's report, *Addressing Health Worker Burnout,* on actions that can be taken to address this issue by various groups including governments, health insurers, academic institutions, health workers, researchers, and others.

Dr. Pandya presented for Dr. Teri Kennedy, a former member and chair of the ACICBL. Dr. Kennedy's portion of the presentation focused on implementation and best-case examples. There was significant interest surrounding the report's topics. The report was very well received by the audience.

Discussion
The discussion included the questions/comments below.

Ms. Worstell asked if presenters could provide more detail about the interest generated at the conference and the focus of the discussion.

- Dr. Weiss said some of the questions related to HRSA programming. Dr. Pandya added that individuals shared their own experience with burnout and clinician well-being. Several people also asked what could be done to address health worker burnout, which led to discussing examples of tools and assessments included in Dr. Kennedy's presentation.

Dr. Teasdale asked if there was discussion beyond clinician burnout and the pandemic.

- Dr. Pandya replied that the discussion was broader than clinician burnout and the pandemic and included related issues. There were also concerns about health care in general, how it is being delivered, and how clinicians themselves address stressors.

Ms. Hart asked about additional dissemination activities.

- Dr. Weiss said that, although this is a report to the Secretary and Congress, it can be shared by Committee members with other parties such as state legislatures, city governments, communities, and others.

Fireside Chat and Open Discussion
Luis Padilla, MD, Associate Administrator for Health Workforce, BHW

Dr. Padilla provided an update on efforts related to the BHW and HRSA. He informed Committee members that Title VII and VIII have not yet been reauthorized, but President Biden has signed a Continuing Resolution that has extended funding at current levels for the Bureau's programs while Congress continues budget negotiations.

Using the second year of COVID data (introduced in 2021), HRSA's National Center for Health Workforce Analysis (NCHWA), recently developed projections to determine the impact of the pandemic on the health workforce. Data are not yet publicly available but will be made public once the projections are finalized.

Dr. Padilla said that one of the topics in the ACICBL report, *Addiction Medicine*, is very timely. Unfortunately, addiction and suicide rates have increased while access to care has decreased nationally. However, there are pockets of increases in the area of telehealth, which supports behavioral health care delivery.

The Geriatrics Workforce Enhancement Program (GWEP) NOFO will close on February 26, 2024, and aims to educate and train the health care and supportive care workforces to care for older adults by collaborating with community partners. The program will award approximately $43 million to 43 awardees.

The Primary Care Training and Enhancement (PCTE) NOFO for Physician Assistant Rural Training in Mental and Behavioral Health (PCTE-PARB) is planning to close on March 15, 2024. In addition, the Medical Student Education program, which has been funded by Congress for about five years, supports students that have an interest in primary care and focuses on partnerships with states and tribes that have such a need. This program is forecasted to fund 12 awards with $5 million.

Finally, Dr. Padilla informed members about two upcoming Behavioral Health Workforce Education and Training (BHWET) NOFOs: the BHWET Program for Professionals and the BHWET Program for Paraprofessionals.

Discussion
The discussion included the questions/comments below.

Ms. Hart asked if action from Congress would be needed to extend the tenure of Committee members, which is currently three years.

- Dr. Padilla said the length is different for different advisory committees, but it would likely require a statutory change. However, the ACICBL could make recommendations to such effect in their reports.

Dr. Teasdale asked Dr. Padilla if he could speak about the potential for collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA).

- Dr. Padilla said that currently HRSA and SAMHSA employees are part of a working group to address the integration of behavioral and primary care. Across HRSA, there are more touchpoints perhaps in other bureaus than there are in the BHW. For example, the Bureau of Primary Health Care (BPHC) has a strong connection with SAMHSA. One area of improvement would be exploring opportunities where SAMHSA's community-based primary health care sites could also be training sites for HRSA programs. Another area of collaboration could be school-based health.

Dr. Weiss added that a series of HRSA eating disorder webinars were implemented in collaboration with SAMHSA last year. Also, HRSA is working with SAMHSA on the Seventh Annual Older Adult Mental Health Awareness Day Symposium, scheduled for May 2, 2024.

Dr. Osten-Garner asked Dr. Padilla what has been the most helpful to him and his program staff related to the recommendations the Committee has put forward. Also, is input needed in areas related to grant funding that the Committee could advise on?

- Dr. Padilla said he looks at all of the recommendations made by the ACICBL. The agency continuously looks for ways to incorporate input from its Advisory Councils into policy and program development.

Dr. Osten-Garner asked if it would be helpful to provide advice in any specific areas.

- Dr. Padilla replied that the ACICBL has a broad breadth of recommendations that touch on various aspects of HRSA's work. One of the areas proposed for the next report, Artificial Intelligence and its connection to medicine, is very timely. Another key area, from a program and policy perspective, would be youth mental and behavioral health. The latter has long-term consequences if not addressed effectively.

Presentation: Artificial Intelligence (AI) in Healthcare and Health Professions Education
Ryan Kingsley, MPAS, Co-Director of Evaluation, Mayo Clinic PA Program Hospitalist PA, Division of Hospital Internal Medicine Assistant Professor of Medicine & Medical Education

Shant Ayanian, MD, MS, Assistant Professor of Medicine, Alix School of Medicine, Senior Associate Consultant, Division of Hospital Internal Medicine Medical Director of Domitilla 4

Dr. Ayanian and Mr. Kingsley presented on the use of AI in health care. Artificial Intelligence can be defined in various manners, but it is broadly defined as computers simulating human thinking. Machine learning, which falls within Artificial Intelligence, is a process for developing models that can serve predictive or analytical functions.

Machine Learning can be further subclassified into specific categories such as: Supervised vs. Unsupervised Learning, Classical vs. Neural Networks, and Regression vs. Classification vs. Clustering. The majority of use cases and economic value to date falls under Supervised Learning. This category requires the training data to be labeled for the model to learn the correct answer. Labeling the data can be a rate-limiting step.

Dr. Ayanian shared a few examples of how AI is being used at the Mayo Clinic. One example is an AI classification model that is currently "live" in the clinic's Epic system and works to predict admissions from the emergency department (ED). The model predicts which patients, from the moment they arrive at the ED, are more likely to be admitted to the hospital. Within 15 minutes, the Clinic has a probability of admission for the patient. The current model has a sensitivity and specificity in the low 90th percentile. It has improved the ED patient throughput and the efficiency of the ED-based hospitalist teams. The model has been used for two years and two articles have been published in the literature.

A second AI model being studied is used to predict delirium in hospitalized patients. This can help improve patient safety, prevent falls, and prevent suffering. It can also reduce the length of stay and improve resource allocation. Using a regression model, every patient gets a score between 0 and 1 every 12 hours. The higher the score, the more likely that the patient will develop delirium. The model was implemented in late November 2023 and is currently in the validation phase.

A third AI model uses clustering analysis to help identify subpopulations of diabetic patients, and then targets interventions to those specific populations. Its goal is to improve outcomes in Type 2 diabetes mellitus for patients living in rural areas. The Mayo Clinic has a large in-patient diabetes registry and the model is currently being developed with results forthcoming.

An example of an AI model that uses neural networks to improve patient outcomes is radiology interpretations. Such models can be used to enhance the efficiency and accuracy of medical imaging. This is important because access to rapid and accurate radiology interpretation can be limited, especially in underserved areas. While humans are still needed as part of the process, multiple studies demonstrate that using this model results in a more accurate interpretation.

Another example currently in development is the use of an AI model that uses data from in-room cameras to automatically track an inpatient's activity (e.g., walking, sleeping, bed exit). For example, an elderly patient with delirium could be monitored if they are at risk for a fall or are in pain and cannot reach their call light. While this model is technically feasible, there are still complex concerns about data access and privacy that must be considered.

Dr. Ayanian and Mr. Kingsley also discussed other models including those using Generative AI and Large Language Models (LLM). These models could be used for medical records summarization, drafting emails, or automating patient inbox responses. Generative AI could also be used for timely behavioral health interventions and the use of enhanced simulation in medical trainees. For the latter, an LLM could simulate conversations that clinicians have with patients. These models can be used to train clinicians to communicate more effectively and simulate difficult conversations between patients and clinicians. This training model is used at the Mayo Clinic, although further research needs to be conducted.

Discussion
The discussion included the questions/comments below.

Dr. Pandya asked about the application of AI to data from continuous glucose monitors to uncover trends in diabetes patients. She also asked about the use of AI for Long COVID.

- Dr. Ayanian replied that some studies have recently been published related to glucose monitoring. One study from the University of Zurich shows promising results in automating the process of recommending specific insulin dosing according to the patient's needs. This is a preliminary exploratory study and has not yet been implemented clinically.

  Dr. Ayanian added that the use of multimodal AI to study Long COVID is somewhat limited. However, there is one group working with clinical and other data to try to bridge the gap between those patients who are at risk for COVID and those who actually develop COVID to understand if there is a genetic substrate that is required for developing Long COVID.

Dr. Pandya asked if there is a risk in the use of AI in health care, specifically in patient long-term care, in terms of isolating the problem from the patient. Ultimately, patient care depends on health care professionals attending to the patient.

- Mr. Kingsley agreed and emphasized that the use of AI and machine learning in health care is not a panacea that will solve every clinical problem. However, when utilized in well-designed systems it can improve system efficiency and efficacy.

Ms. Worstell suggested that AI researchers consider partnering with the Patient-Centered Outcomes Research Institute (PCORI) to ensure that the perspective of the patient is incorporated in the use of AI, especially when it relates to what the patient would like to see as an outcome. Also, what would AI represent for the caregiver (both paid and unpaid)?

- Dr. Ayanian said that one of the challenges is data scarcity from the patient's home. While there may be data for patients who receive care from a home health services company or provider, there is no robust, harmonized data set for caregivers. Without these data an application of AI in the area could introduce a bias.

Dr. Osten-Garner asked how learning about AI should be integrated in HRSA's grant programs.

- Dr. Ayanian said he would start at the basic level: understanding the scope of AI and where it could improve value.

Presentation: Navigating the Future of Healthcare: Unveiling the Potential of Artificial Intelligence (AI) in Health Workforce Development, Patient Care, Mental Health, Elder Care, and Beyond

Joel Gordon, MD, Chief Medical Information Officer–UW-Health, Associate Professor, Department of Family Medicine and Community Health, University of Wisconsin School of Medicine and Public Health

Dr. Gordon provided a general overview of the use of AI in health care, including some ethical dilemmas that need to be considered. The historical context of the growth of health technology involved at least three fundamental events. The first occurred in 1999 when the Institute of Medicine published *To Err is Human: Building a Safer Health System*, which raised the profile of patient safety. The second was the Health Information Technology for Economic & Clinical Health (HITECH) Act of 2009, which required that the federal government provide incentives to meaningful users of electronic health records. The last event was the COVID-19 pandemic. The development of innovations seems to be increasing with time. However, technology must first be diffused and then be highly utilized to yield results.

Artificial Intelligence is a broad category that includes Machine Learning, Generative AI, and LLMs. Machine Learning can support physicians in the treatment of patients by incorporating factors which were initially unaccounted for. For example, for a depression diagnosis, Machine Learning can also consider insurance coverage, medication compliance, genetic predisposition, drug interactions, and other factors.

Technology has also been used within mental health. However, this technology can have untested efficacy or be misleading in terms of its claims of mental health benefits. For example, nearly 8,000 apps exist in the Apple Store, but only 10 percent or less are based on scientific evidence. Technology can create harm to the patient through malfunction, incorrect advice, or misuse.

There are ethical issues to be considered for the use of AI technology in health care. The five fundamental principles of ethics are autonomy, justice, fidelity, nonmaleficence, and beneficence. Another important factor to consider is bias. Use of AI in a system that already has bias can result in magnifying such bias.

Discussion
The discussion included the questions/comments below.

Ms. Hart said that biases existed in health care long before AI came about. How could AI be used to improve training in medical school to address these biases?

- Dr. Gordon replied that some challenges exist. Student metadata could help understand and provide appropriate training to the right learner, but it is not a "one-size-fits-all."

Dr. Teasdale asked Dr. Gordon what he would like a workforce development funding opportunity to include, with respect to curricular activities.

- Dr. Gordon said that, currently, there is a movement in terms of training the doctor. However, with team-based care increasing, it is important to also acknowledge the team members that support the work done by providers. These team members need to be evolving along with the providers.

Dr. Kuo asked if the training program at Dr. Gordon's institution is interdisciplinary in nature.

- Dr. Gordon said that at his institution they offer training at three levels: master's degree, postdoctoral, and a two-year fellowship.

Ms. Bush asked about the possibility of adopting technology, such as AI, in rural clinics that could get behind.

- Dr. Gordon said there are several challenges. The first is computing power. The computing power required for AI is greater than any of us would have ever dreamed. Another challenge is network bandwidth and data packaging. And finally, whether or not people have the understanding to utilize the tools.

Dr. Teasdale asked Dr. Weiss if it is too early to insert curricula into our programs if things are changing so quickly?

- Dr. Weiss said it is important to start someplace.

Ms. Worstell said that one of the issues that was raised during the presentations was that of definition and differing standards. In other words, some people are setting their own standards. Is it appropriate to say there is a need to set a public-private standard? Should HRSA take the initiative in working with the private sector to achieve this?

- Dr. Weiss said she could not speak to a public-private partnership, but the Biden-Harris administration has put out a fact sheet related to AI that could be a useful resource.

Dr. Osten-Garner commented that perhaps HRSA could support a technical assistance center to drive curriculum in a more unified way through some of the different technical assistance initiatives that HRSA already has in place.

Presentation: Thoughts on Substance Use Disorder (SUD) Training
Anthony (Tony) Schlaff, MD, MPH, FACPM, Physician/Project Officer, Medical Training and Geriatrics Branch, Division of Medicine and Dentistry, BHW

BHW currently has five Substance Use Disorder (SUD) programs, of which three are active. The three active programs are the Addiction Medicine Fellowship Program, the Opioid-Impacted Family Support Program, and the Integrated Substance Use Disorder Training Program.

Unfortunately, there are still high rates of endemic SUDs in the United States and the opioid use epidemic is continuing. Data published in 2023 shows that nearly 48.7% of those aged 12 and older have used alcohol in the past month (137.4 million). Similarly, 22% have used marijuana and 16.5% used illicit drugs.

With respect to opioids, a 2023 SAMHSA publication stated that 3% (8.5 million) of individuals 12 and older have been involved in prescription opioid misuse, 0.4% (1 million) have used heroin, and 0.4% (991,000) have used fentanyl. Opioids are of particular concern because they carry high fatalities. Between 2016 and 2021, drug overdose death showed a marked increase in deaths by use of fentanyl since 2019.

Various treatment models exist including the "hub and spoke" model. In this model, the specialized treatment of addiction would be the hub, and those in the spoke can have access to training and consultations to a large group of clinicians who can train up to their level of competence. Treatment should be integrated into primary care and one should be cognizant that many individuals with SUDs also have other mental health disorders, which requires dual diagnosis models in behavioral health care as well as people with experience in treating both. Teams should be interdisciplinary and there should be an understanding of the critical role played by the community.

One of the issues to take into consideration in training is stigma. Stigma exists both in the community and among some providers. However, there are training strategies to address and improve stigma. Another challenge is that there is an inadequate number of providers and treatment slots. In addition, only 24% of US residents in need are receiving treatment. Furthermore, some people have both pain and SUDs. Both conditions need to be treated well and there is a need for care models that will address both conditions.

Discussion
The discussion included the questions/comments below.

Dr. Teasdale asked about the importance of addressing Social Determinants of Health (SDOH). How do grant mechanisms address these?

- Dr. Schlaff replied that in the context of workforce development it is very important to emphasize SDOH. All clinicians should get public health perspective training to understand SDOH, first, because it allows them to provide better care, and second, so they could be advocates for the changes that are needed.

Ms. Hart said that in New York, one of the biggest challenges is Tranq (Xylazine)—the abuse of horse tranquilizers. How can this be addressed?

- Dr. Schlaff said it is important, because Xylazine is showing up in more toxicology screens and in the mixtures around overdose deaths.

Dr. Osten-Garner said that currently our reimbursement systems only fund interventions when there is a problem. What can be done to concurrently fund prevention programs?

- Dr. Schlaff said that there is little that works as a clinical preventive. The specialty that is more oriented to prevention is pediatrics. They do a lot of counseling and screening.

Ms. Worstell said there seems to be an increase in addiction rate in older adults. Could Dr. Schlaff speak to this?

- Dr. Schlaff said that in substance use treatment, older adults are an often neglected population. One challenge is that as individuals with a diagnosed SUD become older it leads to more harm because the body's physiology changes. There are also higher rates for depression and social isolation, which increases the risk of use. Any training program should take a geriatric population into account and address their concerns.

Presentation: Integrated, Multi-Level Interdisciplinary Addiction Medicine and Substance Use Disorder Training: The Addiction-Focused Professional's Perspective
Terrence D. Walton, MSW, Executive Director, NAADAC, the Association for Addiction Professionals

Mr. Walton explained that prior to becoming NAADAC's Executive Director he was a drug and alcohol counselor for 20 years. For most people, moving from active addiction to recovery often requires psychosocial counseling as well as other types of help. In addition, for people to get well and be of service to their community, they need purpose and direction in their own life—as well as having their own basic needs met. Therefore, recovery from addiction must address issues beyond only symptoms.

There are various places where professionals who treat addiction get trained. These include colleges and universities as well as nonprofits and the public sector. Regardless of the venue where they are being trained, it is important that the training be evidence-based. Training should include the basics as well as innovation and it is key that training be convenient and not pull professionals from their work.

Mr. Walton provided his opinion on a needed change: Peer recovery professionals and prevention professions should be approved as trainees under Title VII, Part D programs. There are more than 100,000 individuals who work daily to prevent or treat addiction. Addiction professionals who are not allied health professionals but whose specialty is in addiction should be covered under these programs, such as peer recovery professionals and prevention professionals. Institutions or organizations that train nonmedical addiction professionals but meet certain criteria should also be categorized "eligible entities."

Medicare has new rules that are more inclusive of addiction professionals and reimburses them for services through Medicare coverage. This brings positive recognition to the fact that they are career professionals who treat addiction and need to be reimbursed.

Discussion
The discussion included the questions/comments below.

Ms. Hart asked what NAADAC is doing to prevent burnout. Also, is there a way to promote self-care so professionals do not burn out?

- Mr. Walton said NAADAC is currently developing Team 270, which is training for addiction professionals that includes complete modules on the importance of self-care as well as the importance of work/life balance. It is important for people who treat addiction directly to have their own support and/or therapeutic resources.

Dr. Osten-Garner asked if Mr. Walton could provide examples of institutions or organizations that train nonmedical addiction professionals.

- Mr. Walton said that one example would be NAADAC itself, which provides a variety of trainings. NAADAC also has trainers that train addiction professionals. There are other nonprofits that treat addiction that also have training arms and might even have structured curricula.

Presentation/Update: Title VII, Section 756, Mental and Behavioral Health Education and Training Programs
Bridget Kerner, MS, Chief, Behavioral and Public Health Branch, Division of Nursing and Public Health, BHW

Ms. Kerner provided a brief overview of HRSA's behavioral health programs. HRSA's Division of Nursing and Public Health (DNPH) administers and provides oversight of nursing, behavioral, and public health workforce development programs. It has a budget of about $610 million with roughly 51 employees.

Awardees are general academic institutions, clinical facilities, and community partners. Within the behavioral and public branch, there are three funding mechanisms: grants, cooperative agreements, and one contract. The division's impact is focused around expanding academic practice, community partnerships, faculty development, enhancing curriculum and clinical training, and other continuing education opportunities.

Ms. Kerner proceeded to provide an overview of the following division's programs: BHWET—Children, Adolescents, Transitional Aged Youth Program for Professionals (BHWET-CAY); BHWET for Professionals (BHWET-Pro); Graduate Psychology Education (GPE) Program; BHWET Program for Paraprofessionals (BHWET-Para); Opioid Impacted Family Support Program (OIFSP); Health and Public Safety Workforce Resiliency Training Program (HPSWRTP); and the Technical Assistance Centers and Programs.

Ms. Kerner also discussed the forecasted funding for FY2024. Total funding for the OIFSP will be $16,800,000, with an award ceiling of $600,000. A total of 28 awards are expected. Funding for BHWET-Pro is expected to be $153 million for 204 awards.

Discussion
The discussion included the questions/comments below.

Dr. Osten-Garner said that prior to the pandemic they had a strong number of graduates going into community mental health following their internship. However, after the pandemic—with

telehealth having the same reimbursement as in-person services—there has been a shift with more graduates going into group or private practice, where telehealth can be an easy and lucrative option. So, the current incentive structure is not leaning graduates towards community mental health. Dr. Osten-Garner asked Ms. Kerner if she has seen a similar trend across other BHWET and GPE programs.

- Ms. Kerner said she does not have any data related to post graduation employment changes, but it is something they could look into.

Ms. Hart said the population she works with has many needs, which require increased social support through social workers. Therefore, it would be helpful if HRSA would consider splitting the administrative costs 50/50 rather than 60/40.

- Ms. Kerner thanked Ms. Hart for her feedback.

Dr. Osten-Garner provided Ms. Kerner with the recommendations from the Committee's 22nd report, which includes recommendations on stipends.

- Ms. Kerner asked Dr. Osten-Garner if he had to supplement stipends in his GPE program. He replied he did indeed supplement them. Dr. Peraza said her institution was also a GPE awardee. She added that they supplement stipends by $13,000 per person above what is offered and those individuals are still in the lowest pay bracket at her hospital.

Dr. Osten-Garner said he is involved with work in rural frontier mental health centers in Southern Nevada. These centers are not always attached to a medical hospital or large organization. If the goal is to drive workforce development to underserved areas such as these, is there a way to design NOFOs to help incentivize work within those areas? Some of these organizations are not able to meet the requirements of GPE or BHWET NOFOs.

Dr. Peraza commented on the need for clinical stipends, which is related to the split for administrative costs. The pandemic has contributed to having trainees that have greater training needs. Addressing stipends and having more flexibility in administrative costs could help support supervisors to provide better training.

Dr. Teasdale asked if Ms. Kerner could comment on the challenges related to finding training sites in underserved areas. Is there a way to integrate or use the connections with SAMHSA implementation sites to assist in training?

- Ms. Kerner said that this year SAMHSA is focusing on behavioral health workforce development, so it is a topic that is of interest to them. She agreed that collaboration is key.

Dr. Peraza said her experience is with GPE and BHWET. She added that often in these grants one is only allowed to fund one discipline at one training level. However, sometimes they are asked to train for interdisciplinary work, which is challenging because they are not able to fund

trainees in different training disciplines and/or at different levels.

- Ms. Kerner thanked Dr. Peraza for her feedback.

Dr. Weiss explained that the interdisciplinary/interprofessional requirement in the NOFOs is not necessarily about funding other disciplines, but offering interprofessional training to professionals to ensure, for example, that psychologists have interactions with medicine, nursing, social work, allied health, etc.

Dr. Peraza agreed and said that, because of their setting, it is very easy to do as they are in the same teams working side by side. However, the opportunity to develop richer training experiences would be easier if the organization was able to use that funding for multiple disciplines. Currently, trainees are encouraged to go to team meetings, but it is harder to do things like sharing didactics.

Dr. Osten-Garner said that BHWET could offer a much richer experience for interprofessional development amongst community partners if it would allow grantees to fund multiple disciplines under BHWET for the purposes of developing an interprofessional experience and training.

Dr. Teasdale asked if a recommendation could be developed by the Committee to create a mechanism that would allow this?

- Dr. Weiss replied that for GWEP and GACA, the language in the NOFO comes from the statute. One would need to check whether the statute lists a single discipline.

Presentation/Update: Recent/Upcoming Title VII, Part D, Program NOFOs: GACA, ISTP, GWEP, AMF
Cynthia Harne, MSW, LCSW-C, Chief, Medical Training and Geriatrics Branch, Division of Medicine and Dentistry, BHW

Ms. Harne provided an overview of four programs: the Geriatrics Academic Career Awards (GACA) Program, the Integrated Substance Use Disorder and Treatment Program (ISTP), GWEP, and the Addiction Medicine Fellowship (AMF) Program.

GACA has as its purpose, to support the career development of junior faculty as academic geriatricians or academic geriatrics specialists. Funding for FY2023 was $2,261,428 for 26 awards. Examples of some of the awardee project topics include: telehealth and interprofessional geriatrics education for rural health systems; optimal aging lifestyle medicine, geriatric emergency department initiative, and enhancing ethnogeriatrics education.

The purpose of the ISTP is to increase the number of nurse practitioners, physician assistants, health service psychologists, counselors, nurses, and/or social workers to provide mental health and substance use disorder services in underserved community-based settings. Funding for FY2023 was $9,105,670 for 20 awards.

GWEP aims to improve health outcomes for older adults by developing a health care workforce that maximizes patient and family engagement, and by integrating geriatrics and primary care. Funding for FY2024 will be $43 million for approximately 43 awards. The NOFO was released on November 27, 2023, and the due date for proposals is February 26, 2024.

The purpose of the AMF Program is to increase the number of fellows at accredited AMF and Addiction Psychiatry Fellowship programs in underserved, community-based healthcare settings. The AMF program encompasses both psychiatry and addiction subspecialties for primary care doctors. Funding for FY2023 was $23,468,099 for 42 awards. For this program, there are a few issues under review including the recruitment of fellows, provider stigma, the impact of the national match on the program, stipends, and funding structure (i.e., administrative costs).

Discussion
The discussion included the questions/comments below.

Dr. Teasdale asked if the ISTP NOFO allows for the supervising of clinicians to receive some compensation for their time.

- Ms. Harne said it depends on how the grant is structured. If the professional is already on the institution's payroll it cannot be added on. However, the grant allows for trainees and preceptors from outside the institution to be brought into the program, in addition to employees.

Open Panel Discussion with HRSA Part D Program and Grant Leads

Cynthia Harne, MSW, LCSW-C, Chief, Medical Training and Geriatrics Branch, Division of Medicine and Dentistry, BHW

Bridget Kerner, MS, Chief, Behavioral and Public Health Branch, Division of Nursing and Public Health, BHW

Jamie King, Branch Chief, Division of Grants Managements Operations, Office of Financial Management, HRSA

Tammy Mayo-Blake, MEd, Chief, Health Careers Pipeline Branch, Division of Health Careers and Financial Support, BHW

Committee members held an open discussion with four HRSA senior staff.

The discussion's main points were:

- After the pandemic some programs have required more staff supervisors. Modifying the administrative cost split could help in that area.
- An important consideration when calculating costs is *who* is being trained. For example, training a fellow can be very different from training a paraprofessional who works with individuals in recovery. More support would be needed for training the latter.
- The timing of the award and the match process need to work hand-in-hand.

- Stipends should take into consideration smaller nonprofit organizations that have less resources.
- The Association of Psychology Postdoctoral and Internship Centers has data on the match and internship programs with the highest, lowest, and mean salary.
- One strategy to consider is providing technical assistance on basic AI literacy through existing HRSA TA centers.
- Consider evaluating whether the currently available basic AI literacy training is appropriate versus creating something new.
- Conversations are ongoing with the National Health Service Corps (NHSC) about partnering for their loan repayment and scholarships programs for AHEC Scholars.

Discussion: Topic Development, 23rd Report
Grace M. Kuo, PharmD, MPH, PhD, FCCP, FNAP, Chair, ACICBL

Dr. Kuo guided Committee members on brainstorming sessions to develop topics for the 23rd Report. The following items emerged as potential topics:

- Artificial Intelligence literacy and ethics for health care professionals
- Workforce development for addiction professionals
- Back to Basics: Workforce development on professionalism

All Committee members volunteered for at least one of the three workgroups to further review these topics in preparation for developing draft recommendations that will be reviewed and voted-on by the members at their upcoming April 19, 2024, virtual meeting.

Public Comment and Business Meeting
Shane Rogers, DFO, ACICBL

Mr. Shane Rogers, ACICBL DFO, announced dates for the upcoming virtual Committee meetings as April 19, 2024, and September 6, 2024.

Public comments included Andrew Herrin, on behalf of the Council on Social Work Education, who inquired about prelicensure training eligibility in the Integrated Substance Use Disorder Training Program. More specifically, Mr. Herrin inquired if HRSA was exploring prelicensure training for other programs and explained that once social workers and other mental health professionals graduate, hundreds of hours are still needed to meet licensure requirements. Mr. Herrin added that any additional pathways of support would be helpful across the professions. Mr. Rogers recommended that Mr. Herrin reach out to the HRSA project officer for the Integrated Substance Use Disorder Training Program for additional guidance.

Wrap-Up and Adjourn
Grace M. Kuo, PharmD, MPH, PhD, FCCP, FNAP, Chair, ACICBL
Shane Rogers, DFO, ACICBL

Mr. Rogers and Dr. Kuo thanked all Committee members for their work. They also thanked HRSA staff for their logistical support. Mr. Rogers adjourned the meeting at 2:42 p.m. ET.