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

Meeting Minutes
January 19-20, 2023

Committee Members Present
Thomas A. Teasdale, DrPH, FGSA, FAGHE (Chair)
Elizabeth Bush, MS, MA
Katherine Erwin, DDS, MPA, MSCR
Donna Marie Fick, PhD, RN, GCNS-BC, FGSA, FAAN
Barbara Hart, MPA, MPH
Paul Juarez, PhD
Teri Kennedy, PhD, MSW, ACSW, FGSA, FNAP
Kevin A. Osten-Garner, PsyD, LCP
Naushira Pandya, MD, CMD-FACP
Jennifer Peraza, PsyD, ABPP
Sandra Pope, MSW
Mary Worstell, MPH

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
CAPT Paul Jung, MD, Director, Division of Medicine and Dentistry
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 10:00 a.m. on January 19, 2023. The Health Resources and Services Administration (HRSA) facilitated the meeting through a virtual platform. Shane Rogers, the Designated Federal Officer, welcomed Committee members, presenters, and members of the public.

Ms. Zuleika Bouzeid provided instructions for participating in the virtual meeting. Next, Mr. Rogers explained that the Committee's purpose is to provide advice and recommendations to the Secretary of Health and Human Services and Congress about policy and program development pertaining to programs authorized by the Public Health Service Act, Title VII, Part D. Mr. Rogers turned the meeting over to the Chair, Dr. Thomas Teasdale.

Agenda Review / Introductions
Thomas A. Teasdale, DrPH, FGSA, FAGHE, Chair, ACICBL

Dr. Teasdale welcomed participants and reviewed the agenda. Participants then introduced themselves. During the meeting, the Committee members heard presentations from experts on efforts surrounding family caregiving, healthy longevity, and age-friendly public health systems.

Committee members also received updates on the Area Health Education Centers (AHEC) program and different Title VII mental and behavioral health workforce programs under the Committee's legislative purview. The Committee held two discussion sessions to flesh out topics and develop three draft recommendations for their 2023 report.

Update: 21st Report
Sandra Y. Pope, MSW, Immediate Past Chair, ACICBL

Ms. Sandra Pope thanked the Writing Group for all their contributions in developing the ACICBL 21st Report, *Building Trust, Addressing Burnout, and Expanding the Direct Workforce.* The Committee developed three recommendations for the report and later added a fourth one regarding funding to support the other three recommendations.

The report covered various cutting-edge topics and ensured the recommendations were well-supported. It was published on November 21, 2022 and posted on the Committee's website in early December. In an effort to promote collaboration, Mr. Rogers forwarded the report to the other HRSA Advisory Committees. Various positive and supportive comments were received from the other Advisory Committees regarding the report. Overall, the report was well received.

Discussion

Dr. Teasdale said he appreciated the format and clarity of the resulting 21st Report.

Dr. Kennedy said she applauded the Writing Committee for their efforts. She added that over the last ten years or so the ACICBL had done a good job in covering various themes in depth and carrying them forward.

Dr. Pandya agreed with Dr. Kennedy and said the Committee really got to the heart of the issue in this report.

Mr. Rogers said he found it important that the report included recommendations on additional funding and that it might be helpful to include such recommendations in future reports.

Presentation: COGME's 24th Report Dissemination Strategies
CAPT Curi Kim, MD, MPH, Designated Federal Official, COGME

Dr. Curi Kim's presentation focused on the dissemination strategies adopted by another HRSA Advisory Committee to spread the word about its report and recommendations. The Council on Graduate Medical Education (COGME) recently published its 24th Report, *Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities*.

COGME is charged, in part, on advising the Secretary, HHS and Congress on matters related to the supply and distribution of physicians in the United States, the current/future shortages or excess of physicians in various specialties, issues related to foreign medical graduates, matters related to graduate and undergraduate medical education, and matters related to databases regarding these issues.

COGME is composed of 18 voting members: 14 from the public and four representatives from Federal entities. The Council is required to produce a report every five years, although it can also make recommendations through issue briefs, shorter reports, and letters.

As part of the statute, Congress has authorized COGME to encourage entities providing graduate medical education to conduct activities to voluntarily achieve its recommendations. Therefore, COGME members are encouraged and authorized to disseminate its recommendations.

One of the dissemination strategies was to develop a "one-pager" that provides a quick review of the report. Two versions of the one-pager were developed by the group. One of the group members volunteered to lay out the one-pager graphically. The result was a colorful, easy-to-read brief document that summarizes the most salient points of the report. The one-pager

includes the report's recommendations, five overarching principles, and a brief narrative summary.

In addition to the one-pager, the Working Group also developed a digital postcard and social media posts for Facebook, LinkedIn, Twitter, and Instagram. Each of the posts included a snippet from the report. The Council also made a conscious effort to use HRSA's various e-publications to get the word out. In addition, the Council worked with HRSA's Bureau of Health Workforce's Division of External Affairs on dissemination efforts. The Council is looking into the possibility of disseminating the report through medical journals or other publications more broadly, as well as the possibility of contacting local and state government bodies to make them aware of the report.

Discussion

Ms. Pope asked if there was a specific distribution plan for the one-pager. She also asked if there was a distribution list for dissemination.

Dr. Kim replied that the one-pager was developed for COGME members themselves to distribute. The group also has a SharePoint site that can be accessed by members where the materials are stored. However, there is no detailed plan for distribution.

Dr. Teasdale recognized that two, one-page summaries were developed with similar information and inquired if this was to deliver a slightly different message.

Dr. Kim said the purpose was for members to choose which format they liked better. The one-pagers were developed by a volunteer from the Writing Group.

Dr. Fick said she participated on other committees that did something similar and it was very helpful.

Dr. Kennedy said the one-pagers and social media messages were important in communicating with the public and building trust in public health.

Dr. Teasdale suggested creating a Working Group that would focus on the products presented (e.g., one-pager, social media messaging, etc.).

Presentation/Discussion: Administration for Community Living (ACL) and the National Caregiver Strategy

Greg Link, Director, Office of Supportive and Caregiver Services, ACL

The Recognize, Assist, Include, Support & Engages (RAISE) Family Caregiver's Act became law on January 22, 2018. The law has three major components to: 1) Create a Family Caregiving Advisory Council, 2) Develop an initial report to Congress with annual updates, and 3) Develop a National Strategy to Support Family Caregivers.

The Family Caregiving Advisory Council was first convened in August of 2019 and consists of 15 non-Federal members as well as representatives from Federal agencies. On September 23, 2021 the Council published its *Initial Report to Congress*. The report included a comprehensive review of the current state of family caregiving and 26 recommendations for the Federal government, states, tribes, territories, and communities.

The report articulates five priority areas for action, which were later incorporated into the National Strategy: 1) Awareness and outreach, 2) Engagement of family caregivers as partners in health care and long-term services and support, 3) Services and supports for family caregivers, 4) Financial and workplace security, and 5) Research, data, and evidence-informed practices.

The Advisory Council cast a wide net in terms of obtaining comments from the public and other stakeholders in the development of the national strategy. A request for information generated over 1,600 responses, 75% of which came from family caregivers themselves. On September 21, 2022 the Council delivered to Congress the *2022 National Strategy to Support Family Caregivers*. The Strategy incorporates four cross-cutting considerations for family caregiver support:

1. Placing the family and person at the center of all interactions.
2. Addressing trauma and its impacts on families.
3. Advancing equity, accessibility, and inclusion for family caregivers in underserved communities.
4. Elevating direct care workers as family caregiving partners.

In addition, the National Strategy includes nearly 350 actions that 15 Federal agencies can take in the near term to begin implementation of the strategy. Furthermore, it incorporates more than 150 actions others can take (e.g., states and communities).

Discussion

Dr. Pandya asked if Federal funding was available to provide relief and support to family caregivers.

Mr. Link said there is funding being made available directly to family caregivers through some Medicaid programs, but those are state administered and each one is slightly different. Because each state sets up its own system of services and supports, oftentimes there are state-funded programs that can include financial support for family caregivers. However, there does not seem to be Federal financial assistance that would completely replace the caregiver's lost income. This is an issue discussed in the strategy.

Dr. Kennedy said that one of the challenges is that direct care workers do not have a living wage. This creates economic and structural barriers for this workforce.

Mr. Link said that further support is needed for direct care caregivers, which may need to take place at the Federal level. ACL has a close partnership with the Department of Labor to explore ways to better support states, communities, and employers to create career ladders for direct care workers. ACL has also funded a new Technical Assistance Center that will focus on gathering best practices.

Dr. Teasdale said there are some circumstances where the care recipient is hesitant to accept or even acknowledge the need for care. He inquired whether there were there any initiatives to address education in this matter.

Mr. Link said he was not aware of specific initiatives but could connect members with individuals in the Administration on Disabilities to facilitate a discussion.

Ms. Worstell asked if it would be possible to share with Committee members resources that support the argument that family caregiving saves money for the national health care system.

Mr. Link said he could do that. The national strategy points out that work done by family caregivers saves approximately $470 billion per year.

Presentation/Discussion: Report on Caregiving in the US 2020
Jason Resendez, President and CEO, National Alliance for Caregiving

The National Alliance for Caregiving is an advocacy and research-based organization that advances building health, wealth, and equity for family caregivers through research, advocacy, and innovation-based initiatives. In 2020, in partnership with the American Association of Retired Persons (AARP), the National Alliance for Caregiving published its report *Caregiving in the U.S. 2020*. The report is developed roughly every five years.

The report shows that the number of caregivers has increased significantly from 43.5 million in 2015 to 53 million in 2020—an increase of 9.5 million new caregivers. On average, caregivers

of adults are 49.4 years old, with a median age of 51 years. On average, they provide care for 4.5 years and spend 23.7 hours a week providing care. Nearly 61% of caregivers are women. In addition to adult caregivers, there are at least 3.4 million youth caregivers (under age 18) who provide care to an adult.

In terms of demographics, 61% of the caregivers report being non-Hispanic White, 17% Latino, 14% African American, and 5% Asian American/Pacific Islander. In addition, 9% have served on active duty in the U.S. Armed Forces and 8% self-identify as Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ).

A greater proportion of caregivers for adults report their recipient is dealing with multiple condition categories, with 45% reporting two or more condition categories, compared to 37% in 2015. Also, 32% of caregivers indicate their recipient has a memory problem (up from 26% in 2015). The report shows that more caregivers have difficulty coordinating care. In 2015, 23% stated that providing care was "very difficult" or "somewhat difficult" compared with 30% in 2020. Nearly 36% of caregivers report having high emotional stress.

In addition, about 1 in 5 caregivers report experiencing financial strain as a result of providing care. More specifically, 28% stopped saving, 22% used their personal short-term savings, 19% paid their bills late (or left them unpaid), and 15% borrowed money from family or friends.

Most caregivers (61%) work while providing care, many (60%) of them full-time (40 hours or more). Caregiving has impacted the work of caregivers—nearly 53% go in late, leave early, or take time off, and 15% went from working full-time to part-time (or reduced worked hours). In addition, 14% took a leave of absence from their work. However, while more working caregivers report having paid leave benefits, most (61%) do not have paid family leave.

In terms of policy recommendations, data show that family caregivers want and would benefit from an income tax credit to provide care. Family caregivers are also in need of support services, with respite being one of the top areas that is important but underutilized. Therefore, more efforts to help caregivers navigate available respite services, particularly for caregivers of color, is important. Caregivers also want a variety of tailored information based on their care situation (e.g., information on keeping recipient safe at home, managing stress, making end-of-life decisions, etc.).

Discussion

Dr. Kennedy asked if it would be possible to seize this moment to promote more paid family leave benefits or to develop a national plan for paid family leave.

Mr. Resendez replied that anything that can be done to underscore the importance of paid family and medical leave is critical. This is an issue that is beyond any agency and comes down to action by Congress to establish a national paid leave policy. This week, the House of Representatives launched a bipartisan task force to review a proposal on how to advance paid family and medical leave.

Ms. Worstell asked what the Committee could do to help within its focus, which is workforce development and training.

Mr. Resendez said workforce training was important. He added that one approach would be to ensure that providers are aware of the benefits of identifying a family caregiver. Also, it would be helpful to educate providers on codes associated with identifying supporting family caregivers within the Medicare and Medicaid programs.

Dr. Kennedy said that caregiver education and support is one of the areas that does not always gets funded for research. It is difficult to develop an evidence base unless there is research that is being funded.

Mr. Resendez said they support the creation of an Office of Caregiving Research within the National Institutes of Health (NIH), similar to the Office of Women's Health, which helps drive coordination between different NIH agencies around different Requests for Applications (RFAs) and helps leverage the monies already being invested.

Ms. Hart asked if there was information and resources available for health care workers to provide to family caregivers on how best to be of service to the family as well as how to make time to take care of themselves.

Mr. Resendez said he would be happy to get back to her through Mr. Rogers on that point.

Presentation: Age-Friendly Public Health Systems
J. Nadine Gracia, MD, MSCE, President and CEO, Trust for America's Health
Megan Wolfe, JD, Senior Policy Development Manager, Trust for America's Health

Trust for America's Health (TFAH) is a nonprofit, nonpartisan health policy advocacy organization based in Washington, D.C. TFAH develops reports and other resources and initiatives, and recommends policies to advance an evidence-based public health system that is ready to meet the challenges of the 21st century. Recent TFAH report topics include obesity, emergency preparedness, public health funding, national health priorities, and the drug, alcohol and suicide crisis.

The population of older adults is increasing in the United States. Every state across the country is experiencing growth in this population. There is also increasing diversity in the older adult population. Long-standing racial, ethnic, and socioeconomic disparities that accumulate over the life course can increase the risk of poor health among older adults. Therefore, it is important to focus the work in ensuring that equity is prioritized.

Unfortunately, the COVID-19 pandemic had a disproportionate impact on older adults. It revealed health system issues such as the ability to administer vaccinations at home, addressing issues of social isolation or food insecurity, and access to physical activity. Public health can play an important role in supporting older adult health by partnering with sectors that have long been engaged in advancing older adult health.

Through its Age-Friendly Public Health Systems (AFPHS) initiative, TFAH prioritizes the public health roles in healthy aging and encourages all state and local public health departments to make healthy aging a core function. To further incentivize this transition, TFAH has developed an AFPHS Recognition Program based on the 6Cs Framework for Creating Age-Friendly Public Health Systems and corresponding actions that, if achieved, will reflect a health department's commitment to healthy aging. The program is not intended to be prescriptive, but rather a framework for health departments to tailor to the needs of their communities.

In 2017, TFAH convened public health officials, service providers, health care professionals, government representatives, and other stakeholders to discuss the role that public health could play in partnering with other sectors to optimize older adult health. This resulted in the development of the aforementioned framework.

Since then, there has been interest by various states to support the Age-Friendly Public Health Systems initiative. In Florida, the AFPHS initiative has been adopted by 50 of its 67 county health departments. Mississippi has adopted a statewide AFPHS 6Cs action plan. Michigan has developed an age-friendly ecosystem and policy alignment. Georgia has developed a state plan on aging to identify opportunities for collaboration and synergies for state agencies to help support and promote optimal health for older adults.

TFAH made the following recommendations on Federal actions to support health aging:

- Authorize and fund a healthy aging program at the Centers for Disease Control and Prevention (CDC); fund state, local, tribal, and territorial health departments; and improve coordination of healthy aging policies across sectors.
- Expand data collection on older adult health and well-being.
- Encourage collaboration between public health and aging services sectors.
- Facilitate a White House Conference on Aging.

- Facilitate ongoing National Healthy Aging Summits.

Discussion

Dr. Juarez asked presenters if they could speak about existing policies and initiatives that support family care giving.

Ms. Wolfe added that TFAH has worked with The National Alliance for Caregiving on identifying the public health roles for addressing caregiver needs and raising the issue of the caregiver needs as a public health issue. The organization has encouraged local and state health departments to become a hub of information for caregiver programs, respite programs, and to increase the awareness of programs to help train caregivers—both family and paid caregivers.

Dr. Kennedy asked how one could deploy and incorporate the direct workforce, community health workers, family caregivers, and other roles to better serve and prepare the interprofessional workforce moving forward.

Dr. Gracia replied that unfortunately the pandemic highlighted long-standing and chronic underfunding in some areas of public health. Public health funding and infrastructure is one of the priority areas for TFAH. TFAH issues an annual report on chronic public health underfunding that indicates shortfalls in order to address core foundational public health capabilities.

Presentation: Global Roadmap for Health Longevity
Linda P. Fried, MD, MPH, Dean and DeLamar Professor of Public Health Mailman School of Public Health; Director, Robert N. Butler Columbia Aging Center; and Senior Vice President, Columbia University Medical Center

One of the greatest successes during the last century is the achievement of longer lives for the U.S. population as a whole. In the year 1900, only 4% of the U.S. population was 65 or older, while in 2000 this population had grown to 12%. It is expected that 27% of the population will be 65 and older in 2050.

This increase stands to fundamentally impact how families, communities, societies, industries and economies function. It will impact social infrastructure, housing, transportation, health care delivery, and the size and composition of the workforce. However, most of the current societies were developed when life expectancy was much lower and thus very few countries are prepared to both meet the needs and seize opportunities of longer lives.

While some countries and governments have begun to act and are starting plan for the long-term, many have not and few score well on the multiple dimensions of aging preparedness. As a result, five years ago the National Academies of Science, Engineering, Medicine (NASEM) reached the conclusion that preparing financially, socially, and scientifically for longer lifespans is a national and global imperative. To address this, NASEM created the Health Longevity Global Competition, and provided funding for start-up thinking and science around the world to focus on breakthrough ideas and research that will: extend the health span, achieve transformative and scalable innovation in health aging and longevity, and build a broad ecosystem of support.

In addition, NASEM commissioned the development of a report titled *Global Roadmap for Healthy Longevity*. The report recommends promising solutions for policymakers, governmental and non-governmental organizations, and the private sector to improve health, productivity, and quality of life.

The *Global Roadmap for Healthy Longevity* describes a realistic vision of healthy longevity that could be achieved by 2050. The vision includes full inclusion of people of all ages, regardless of health or functional status, in all aspects of society and societies characterized by social cohesion and equity.

To achieve this vision, the *Global Roadmap for Healthy Longevity* recommends changes that need to be made to health systems, social infrastructure, physical environments, education, work, and retirement. In some cases, the recommended changes benefit older people directly. However, when older people thrive, people of all ages benefit. The report's recommendations can help support individuals of all ages to live long, meaningful, and purpose-driven lives by 2050.

The Roadmap makes recommendations for the next five years (2022-2027), provides long-term goals, and describes the supporting structures needed to achieve those goals. The goals, structures, and recommendations span four domains: the longevity dividend, social infrastructure, physical environment, and health systems. Cross-cutting themes include the need for a life-course approach, equity, and social cohesion, accompanied by a strong social compact, the role of science and technology, and the need to measure progress toward healthy longevity goals.

Discussion

Dr. Pandya said there is a perception of the retirement age being in the 60s. She asked Dr. Fried what she thought of the idea of retiring at that age.

Dr. Linda Fried replied that this is a critical question. The United Nation's retirement age is 62, which aligns with many other European countries, and she thought this was quite outdated. There are immense capabilities that human beings accrue as they get older. She noted that if we talk about moving toward a world where older adults who want to work or need to work have the opportunity to do so, there could be more jobs—not less—for younger people.

Ms. Pope asked about state master plans on aging and whether any of the plans are associated with Federal funding.

Dr. Fried said she believes that California has allocated monies for their master plan on aging, as has New York, but was unsure about Federal funding. However, the fact that states are now recognizing they need a master plan is an important advance. She noted that if we could have a Federal government master plan on aging, along with a call to action, that would be important as well.

Dr. Teasdale asked Dr. Fried what she thought could be some important uses of HRSA's workforce dollars.

Dr. Fried said it would be critical to develop a vision. It is difficult to make compelling headway in meeting the needs and creating opportunities of a country without a vision for creating long lives with health.

Ms. Hart said such an approach would be nothing less than a transformation of ideology. There is a need to make changes at a societal level, not just in the health sector alone.

Dr. Fried agreed. She added that the NASEM Commission has found strong evidence that significant impact could be achieved by 2050 in various sectors if there is a shared vision.

Ms. Worstell said the demographics are changing for older adults. However, there is not always interest in discussing this increased diversity in long-term care community meetings nationally. The same is true for the LGBTQ community. She asked Dr. Fried about any insights for the Committee as it moves forward.

Dr. Fried said there are some think tanks that have been considering these issues for a while. One approach is to align in a shared social compact in a way that creates equity for everyone and coordinates shared goals.

Presentation/Discussion: Area Health Education Centers (AHEC) Program
Tammy Mayo-Blake, MEd, Chief, Health Careers Pipeline Branch, Division of Health Careers and Financial Support, BHW

Dr. Tammy Mayo-Blake provided an overview of the Area Health Education Centers (AHEC) Program. The AHEC Program is authorized under Section 751 of the Public Health Service Act. Its purpose is to develop and enhance education and training networks within communities, academic institutions, and community-based organizations.

To be eligible to participate in the program, an institution must be a public or nonprofit private accredited school of allopathic medicine or osteopathic medicine, or a consortium of such schools. In states and territories in which there are no AHEC Programs in operation (or there are no accredited schools of medicine), an accredited school of nursing would be eligible for funding. AHEC Program goals for FY2022-2027 include enhancing education, advancing health equity, increasing the workforce, promoting resilience, and amplifying HRSA's impact.

The project period for the program is September 1, 2022 through August 31, 2027, with $43.25 million allocated to the program in FY22. There currently are 49 grantees, which include 46 schools of medicine and three schools of nursing (in Alaska, Montana, and Idaho). At a national level, the program serves 4,868 sites and 214,992 participants.

AHEC Scholars receive training in a variety of settings including medically underserved communities, primary care settings, and rural areas. The AHEC Scholars Program provides students with an extension to their curriculum that infuses clinical education. The continuing education programs also enhance the education of practicing health professionals by offering a wide array of opportunities. The program now includes initiatives to help promote resilience. The COVID-19 pandemic highlighted the importance of promoting resilience within young health professionals and trainees.

Discussion

Dr. Pandya asked Dr. Mayo-Blake if she could provide a bit more information on the AHEC Scholars—who they are, how they are recruited, and the training they receive.

Dr. Mayo-Blake replied that AHEC scholars is a two-year program to better prepare health profession students for future practice in rural and urban underserved communities. They are

recruited by each AHEC. The application process and selection is up to each individual AHEC. AHECs are encouraged to recruit providers listed in the Notice of Funding Opportunity (NOFO).

Ms. Pope asked Dr. Mayo-Blake if she could provide more information about the additional funding that will be provided to AHEC awardees.

Dr. Mayo-Blake said the issue of funding distribution is still under review by HRSA.

Dr. Erwin noted that one of the challenges for AHEC Scholars in Georgia was retention. She asked if a small stipend could be provided (or increased) to help with retention.

Dr. Mayo-Blake said that such matters are left to the discretion of the individual AHECs. She added that HRSA is undertaking the development of a Technical Assistance Webinar around recruitment and retention.

Ms. Bush said that during their first five years the Scholars program in Wisconsin, the state steadily increased its stipend. In doing so they had to sunset other programs and shift priorities, but were able to offer AHEC scholars $1,800 to be in the program. She asked if HRSA was noticing whether there are certain disciplines that AHECs are asking to add.

Dr. Mayo-Blake said they would have to collect some data to answer that question precisely.

Ms. Hart asked how outreach is being carried out within communities to inform them about the AHEC Program.

Dr. Mayo-Blake said the Centers are located in the communities and they interact with the community.

Dr. Osten-Garner said that one of the challenges is the issue of practitioner reimbursement. Reimbursement is geared towards cities and well-funded health institutions and not always towards rural or underserved neighborhoods.

Dr. Peraza agreed that increasing stipends is a good approach. She wondered if there could be cross-coordination with other HRSA programs, such as making students eligible for loan repayments. Students are coming into the profession with large student debt and some individuals go into private practice because it pays better.

Presentation/Update: Title VII, Section 756, Mental and Behavioral Health Education and Training Programs

Sara Afayee, MSW, Chief, Behavioral and Public Health Branch Division of Nursing and Public Health, BHW

Ms. Sara Afayee provided an overview of HRSA's Behavioral and Public Health (BPH) programs. HRSA has a varied portfolio of BPH programs aimed at both professionals and paraprofessionals. Programs for professionals include the following: the Behavioral Health Workforce Education and Training (BHWET-Pro) program, the Graduate Psychology Education (GPE) program, and the Opioid Workforce Expansion program (OWEP) for professionals. These programs aim to increase the supply and improve the distribution of behavioral health professionals; train psychology students, interns, and postdoctoral residents; and provide experiential training for students preparing to become behavioral health professionals with a focus on Opioid Use Disorder (OUD) and other Substance Use Disorders (SUD) prevention, treatment, and recovery services.

Programs for paraprofessionals include the following: the Opioid Impacted Family Support Program (OIFSP), the Behavioral Health Workforce Education and Training (BHWET) Program for Paraprofessionals, and the Opioid Workforce Expansion Program (OWEP) for Paraprofessionals. These programs aim to develop and expand experiential training to increase the supply and distribution of students preparing to become peer support specialists and other behavioral health-related paraprofessionals; enhance experiential training for students preparing to become peer support specialists and behavioral health-related paraprofessionals with a focus on OUD and other SUD prevention, treatment, and recovery services; and support training programs to increase the number of peer support specialists and other behavioral health-related paraprofessionals who provide services to children whose parents are impacted by OUD and SUD.

Ms. Afayee also discussed three Technical Assistance efforts being led by HRSA: 1) Health and Public Safety Workforce Resiliency Technical Assistance Center (HPSWRTAC), 2) Behavioral Health Workforce Development Technical Assistance and Evaluation (BHWD TAE) Program, and 3) Paraprofessional Apprenticeship Technical Assistance (PATA) Program. These programs will provide technical assistance in certain HRSA-funded programs for professionals and paraprofessionals. In addition, HPSWRTAC will provide tailored support to HRSA's health workforce resiliency grant recipients.

Ms. Afayee closed the presentation by discussing two additional programs: 1) the Health and Public Safety Workforce Resiliency Training Program (HPSWRTP), and 2) the Regional Public Health Training Centers (PHTC) Program. HPSWRTP will support training for health professionals to reduce and address burnout, suicide, mental health conditions and substance use disorders and promote resiliency. The PHTC Program will increase the supply and diversity of

public health professionals, enhance the quality of the public health workforce, and provide technical assistance to address emerging public health needs.

Discussion

Dr. Teasdale asked how providers could access the list of HRSA-program graduates to determine if there could be a recruitment discussion. Just like there are warm handoffs for patients, he noted that we should think of creating warm handoffs for trainees.

Ms. Afayee replied that if funding were available it would help to continue the pathway towards placing graduates into practice. If funding is not available, some low-hanging fruit activities could include a virtual job fair or making a list available.

Dr. Peraza said that, as a psychologist, it is not uncommon to see patients that have co-occurring substance use and behavioral health problems, who are aging and have no caregivers. Those aging individuals that have a history of substance use and behavioral health issues are particularly vulnerable, so supporting caregivers is important.

Ms. Worstell said there is a change in demographics in the United States, with a fast-growing population of individuals 65 and older. She asked if this is being seen as an emerging public health issue and also asked if there could be a focus on older adult health and training in the BPH programs.

Ms. Afayee replied that the Public Health Training Centers do a great job on focusing on a variety of different topics, including women's health and older adult's health.

Dr. Teasdale said that in Oklahoma they focused on training of Community Health Workers that visited older individuals and individuals living alone.

Dr. Peraza said that in 2019, their psychology interns were making less money than bus drivers in the Denver metro area and that is one example of how stipends are out of date. She noted that an argument could be made that professionals and paraprofessionals are not being paid adequately for their commitment.

Dr. Kennedy said that there is an additional $22 million from the American Rescue Plan which allows HRSA to fund 60 more applicants. She asked what would be needed so that these applicants are not cut off when the funding goes away.

Ms. Afayee said their annual funding helped to fund the original 112 individuals plus 56 more through the American Rescue Plan. All of them will get funding for four years. It is not clear at

this time whether HRSA would receive an additional $22 million for the next four years. That is yet to be decided.

Dr. Pandya asked if there is a formal exit process when individuals finish their training and if so, could this be the beginning of the follow-up process.

Ms. Afayee said that many grantees do have a formal exit process, but it is not consistent across the board.

Discussion: 2023 Report
Thomas A. Teasdale, DrPH, FGSA, FAGHE, Chair, ACICBL

The Committee held brainstorming sessions to discuss the focus of their next report, which will be on Healthy Longevity and/or Well-Being. Working titles for the report being considered include, *Healthy Longevity: Teams for Today and Pathways for Tomorrow* and *Attaining Optimal Health and Well Being Across the Life Course: Teams for Today and Pathways for Tomorrow.*

The Committee developed the following draft recommendations:

1. Recommend that Congress update the authorizing legislation for BHWET, GPE, and AHEC to require the education and training of families, paid, and unpaid caregivers.
2. Update the AHEC program to remove the 10% limitation recommendations and the 9-12 grade requirement.
3. Recommend that Title VII, Part D programs abandon the term "pipeline" and adopt the more inclusive term, "pathway."

These recommendations will be reviewed/enhanced by the Writing Work Group and then reviewed by the Committee as a whole during the April meeting.

Public Comment
Shane Rogers, Designated Federal Officer, ACICBL

Public comments were requested but none were offered during the meeting.

Business Meeting
Shane Rogers, Designated Federal Officer, ACICBL

Dates for upcoming meetings are April 17 and August 3, 2023. The April meeting will focus on solidifying recommendations for the 22nd Report. A tentative in-person meeting might be held in January 2024.

Wrap-Up, Next Steps, and Closing Remarks
Thomas A. Teasdale, DrPH, FGSA, FAGHE, Chair, ACICBL

Dr. Teasdale thanked all Committee members, speakers, and HRSA staff for putting the meeting together as well as Ms. Pope, Shane Rogers, and Dr. Joan Weiss for all their help. He also thanked HRSA's support staff for all their logistical support. Dr. Teasdale encouraged members to join the Working Group to provide valuable input and ideas towards the development of the next report. Mr. Rogers adjourned the meeting at 4:22 p.m. ET.