Supporting Health Care Teams for Today and Pathways for Tomorrow

22nd Report

Advisory Committee on Interdisciplinary, Community-Based Linkages

December 2023

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

Supporting Health Care Teams for Today and Pathways for Tomorrow

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Twenty-Second Annual Report
to the
Secretary of the United States
Department of Health and Human Services
and the
Congress of the United States

December 2023

The views expressed in this report are solely those of the Advisory Committee on Interdisciplinary, Community-Based Linkages and do not represent the perspectives of the Health Resources and Services Administration nor the United States Government.

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Authority

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL or Committee) provides advice and recommendations on policy and program development to the Secretary of Health and Human Services (Secretary) and the U.S. Congress concerning the activities under Title VII, Part D, of the Public Health Service Act as authorized by section 757 (42 USC. 294f). The Committee is governed by provisions of the Federal Advisory Committee Act (FACA) of 1972 (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

Each year, the Committee selects a topic concerning a major issue within the health care delivery system that is relevant to the mission of the Health Resources and Services Administration's (HRSA) Bureau of Health Workforce (BHW) Title VII, Part D, Interdisciplinary Community-Based Linkages programs. After the Committee analyzes the selected topic, it develops and sends recommendations to the Secretary concerning policy and program development.

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The Committee also extends their gratitude and appreciation to colleagues and fellow members who committed extra effort to the writing of this report: Thomas A. Teasdale, DrPH, FGSA, FAGHE (Chair); Sandra Y. Pope, MSW; Teri Kennedy, PhD, MSW, ACSW, FGSA, FNAP; Kevin A. Osten-Garner, PsyD; Elizabeth Bush, MS, MA; and Paul Juarez, PhD.

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Sincerely,

Thomas A. Teasdale

Tom A. Teasdale, DrPH, FGSA, FAGHE
Chair, ACICBL

Executive Summary

Positioning the public health system to meet current needs and anticipate future challenges involves simultaneously preparing teams for today and building pathways for tomorrow. To accomplish this alignment, the ACICBL provides recommendations to better position programs and activities authorized under Title VII, Part D of the Public Health Service Act. The recommendations noted here modify grant mechanisms, remove barriers to participation by trainees and sites, and improve program outcomes.

The Committee's recommendations fall into three broad programmatic areas:

- Behavioral health workforce education and training
- Geriatrics education and training
- Area Health Education Centers (AHEC) education and training

More specifically, some of the recommendations support engaging potential trainees across the life course; recognizing and training caregivers as workforce participants; revising financial support to critical programs for recruitment and retention; and updating policy terms to better address challenges in these changing times.

The ACICBL believes the recommendations listed below could be central in achieving these goals.

ACICBL Recommendations

Recommendations Related to Behavioral Health Workforce Education and Training

Recommendation 1
The ACICBL recommends that Congress update the authorizing legislation for Title VII, Part D, Section 751, Area Health Education Centers (AHEC) program, and Section 756, Behavioral Health Workforce Education and Training (BHWET) programs, to allow engagement with potential trainees across the life course, starting as early as third grade.

Recommendation 2
The ACICBL recommends that Congress increase funding to the Title VII, Part D, Section 756, BHWET programs AND the Secretary, HHS, benchmark stipends to the Ruth L. Kirschstein National Research Service Award (NRSA) stipends, tuition/fees and

other budgetary levels so that Section 756 program awardees are more equitable in recruiting trainees in underserved rural and urban areas of the country.

Recommendation 3
The ACICBL recommends that Congress update the authorizing legislation for, and that HRSA explicitly state, that the Title VII, Part D, Section 751 AHEC program and the Section 756 BHWET and Graduate Psychology Education (GPE) Programs include the education and training of paid and unpaid family and non-family caregivers as recognized workforce participants.

Recommendation 4
The ACICBL recommends that Congress increase funding to the Title VII, Part D, Section 756, GPE program AND the Secretary, HHS, benchmark internship and postdoctoral fellowship stipends to the Association of Psychology Postdoctoral and Internships Centers (APPIC) Mean Full-Time Stipend amounts so that Section 756 programs can be more equitable in recruiting trainees to more underserved rural and urban areas of the country.

Recommendation 5
The ACICBL recommends that Congress update the Title VII, Part D, Section 756, Mental and Behavioral Health Education and Training Grants programs to modify paragraph 756(d)(1) by replacing the word "priority" with "preference."

Recommendations Related to Geriatrics Education and Training

Recommendation 6
The ACICBL recommends that Congress increase funding to the Title VII, Part D, Section 753, Geriatrics Academic Career Award (GACA) AND the Secretary, HHS, allow for an increase in stipend amounts to at least $100,000 per year, so that GACA programs can be more equitable in recruiting applicants.

Recommendation 7
The ACICBL recommends that Congress update the Title VII, Part D, Section 753, Geriatric Workforce Enhancement Program (GWEP) to include under section 753(a), the following language, "SENSE OF CONGRESS. - It is the sense of the Congress that every State have a Geriatrics Workforce Enhancement Programs in effect under this subsection with corresponding funding of $1 million per state and 2 territories."

Recommendations Related to Area Health Education Centers

Recommendation 8
The ACICBL recommends that Congress increase funding to the Title VII, Part D, Section 751, AHEC program, to reach the legislative language that, "an award under this section shall not be less than $250,000 annually for each AHEC Center."

Recommendation 9
The ACICBL recommends that Congress update the authorizing legislation to eliminate the 1:1 match for supplemental funding for the AHEC program.

Recommendation 10
The ACICBL recommends that Congress update the authorizing legislation for, and that HRSA explicitly state, in Title VII, Part D, Section 751, that the AHEC program include the education and training of paid and unpaid family and non-family caregivers as recognized workforce participants.

Other Recommendations

Recommendation 11
The ACICBL recommends that the Secretary, HHS, and Congress replace the term "pipeline" with "pathway" related to all the Title VII, Part D, grant programs.

Behavioral Health Workforce Education and Training

Mental and Behavioral Health and Its Connection to Overall Health

There are distinct differences between mental health and behavioral health. Definitions vary whereby behavioral health is considered an umbrella term that covers mental health and well-being.[1] The many links between behavioral health and overall health are demonstrable and behavioral health should be considered as important as physical health.[2]

Mental health incorporates mental disorders that can impact behavior, such as anxiety, depression, PTSD, schizophrenia, eating disorders, and other disorders.[3] In addition to these, behavioral health also includes "substance use disorders, life stressors, crises, and stress-related symptoms."[4] Overall, behavioral health focuses on the prevention, diagnosis, and treatment of the above conditions.[5]

There is a significant history of studying the link between mind and body. Scientific studies have shown there is indeed a real connection between the two. Take for example the 2020 study in the *Journal of the American Medical Association Psychiatry* involving nearly half a million participants. The study documented an association between depression and cardiovascular disease (CVD) and between depressive symptoms and causes of death such as cancer.[6]

Other research has shown associations between mental health and physical health to be bidirectional. For instance, those experiencing mental health disorders such as anxiety and depression may adopt lifestyle choices that put them at higher risk for heart disease. However, anxiety and depression can also surface after having a heart attack and become an additional disorder to be treated.[7, 8] Mental health disorders such as depression have also been found to increase the risk for other physical health problems such as diabetes and stroke.

Mental Illness and Substance Use Disorder

Mental illness is the most common illness in the U.S., with nearly 1 in 5 adults (57 million people) living with mental illness. The prevalence of mental illness varies by race with multiracial individuals having the highest prevalence of any mental illness, followed by American Indian/Native American individuals. Furthermore, 1 in 25 adults have a serious mental illness such as schizophrenia, bipolar disorder, and depression. Substance use disorder (SUD) addiction is a treatable mental disorder affecting more than 20 million people in the U.S. Unfortunately, opioid overdose deaths (including those involving fentanyl) topped 106,000 in 2021 and more than a million Americans have died from an opioid overdose since 1999.[9, 10, 11, 12, 13]

Impact of COVID-19 on Adult Mental and Behavioral Health

The COVID-19 pandemic shined a bright light on the importance of behavioral health. The pandemic impacted mental health through isolation, job loss, financial issues, loneliness, grieving, and chronic and persistent illness.[14] During the pandemic, nearly 4 in 10 adults reported symptoms consistent with anxiety and depression.

Impact of COVID-19 on Youth Mental and Behavioral Health

The pandemic also impacted behavioral and mental health in youth. As schools shuttered nationwide in 2020 to prevent the proliferation of the pandemic, many students received instruction from their homes. During the pandemic, youth faced challenges that were unprecedented. They missed opportunities to engage in academic and sporting events and competitions, graduation ceremonies, and in-person interaction with friends. A survey of more than 7,000 U.S. high school students by the Centers for Disease Control and Prevention showed that during the pandemic more than a third of students (37%) reported they experienced poor mental health. In addition, nearly half (44%) of the students reported they persistently felt sad or hopeless during the past year.[15, 16]

Suicide attempts among adolescents increased during the pandemic, especially for adolescent girls—emergency department visits for suspected suicide attempts increased by 51% in adolescent girls in 2021, compared with 2019. In contrast, for adolescent boys the increase was 4% during the same period. In addition, age-adjusted drug overdose death rates were found to increase during the pandemic (see Figure 1).[17]

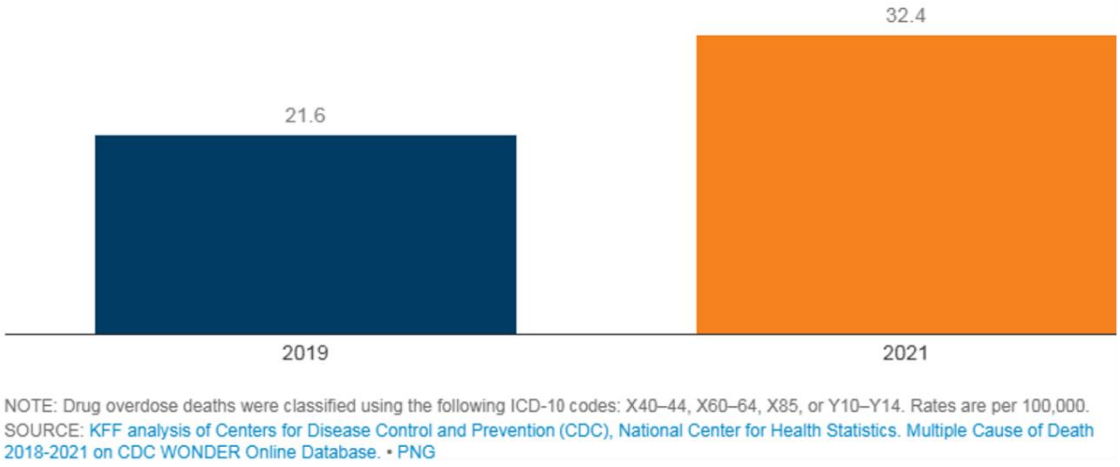

Figure 1. Age-Adjusted Drug Overdose Death Rates, Before (2019) and During (2021) the COVID-19 Pandemic. (Source: Nirmita Pacha et al., KFF, "The Implications of COVID-19 for Mental Health and Substance Use," March 20, 2023.)

Distribution of Behavioral Health Professionals

Workforce projections developed by HRSA show that out of 11 behavioral health professions, only 3 professions (Psychiatric Physician Assistants; Healthcare Social Workers; and Child, Family, and School Social Workers) will have enough providers to meet demand in 2030.[18]

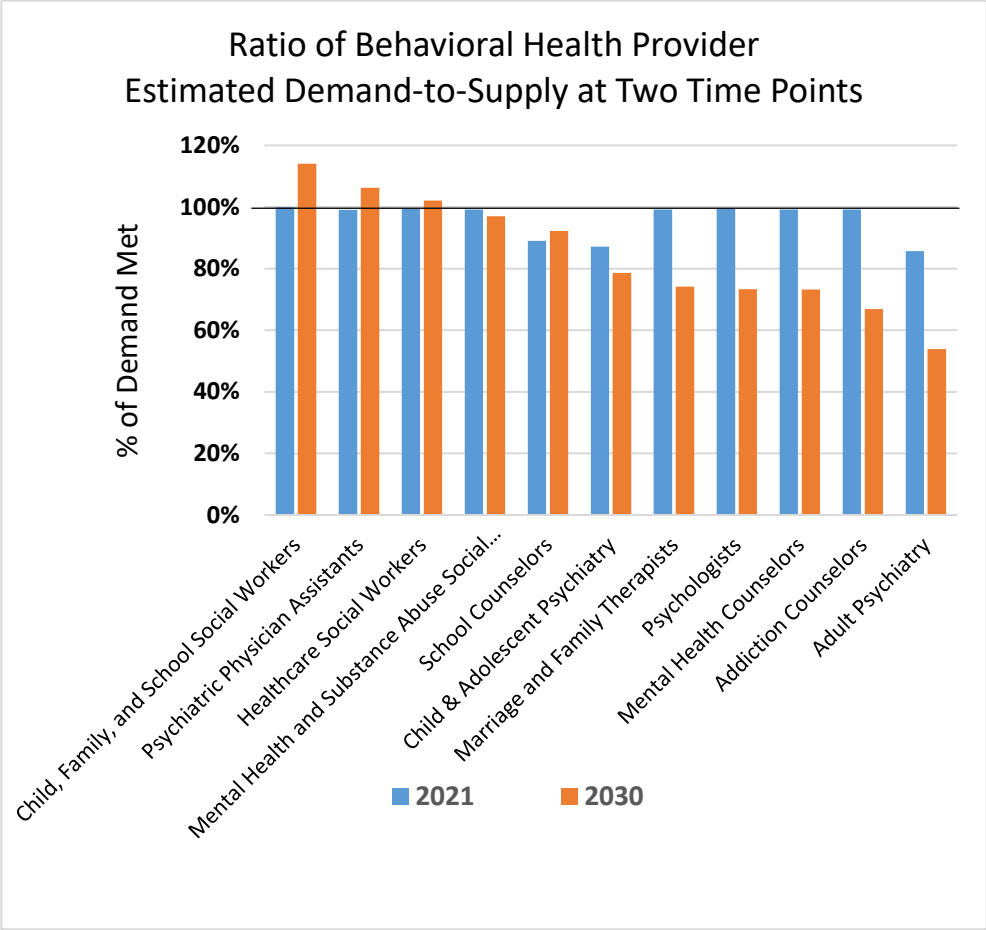

Figure 2. Ratio of Behavioral Health Providers' Estimated Demand-to-Supply at Two Time Points. Figure created using the National Center for Health Workforce Analysis: Workforce Projections Tool on November 16, 2023.

While the projected number of providers is dire for at least half the charted disciplines, the situation may be worse *at the local level*. A 2023 Commonwealth Fund publication states that many rural areas and cities experiencing economic stress have few behavioral health providers. For example, in 2018 nearly 50% of U.S. counties did not have a practicing psychiatrist and currently more than 160 million Americans live in areas experiencing shortages of mental health professionals.[19]

Access to behavioral health professionals by certain groups also remains challenging. For instance, those covered by Medicaid often have difficulty in finding behavioral health professionals who will take their insurance, in part due to low reimbursement rates. Other underserved groups, such as LGBTQIA+ individuals, non-English speakers, and people of color, face barriers to accessing behavioral health care services. Such barriers include lack of insurance coverage, stigma, and shortage of professionals in their area. An article reviewing the literature found that ethnic and racial minority groups are 20 to 50% less likely to initiate mental health use. Mental health services for LGBTQIA+ individuals are also often scarce and can be stigmatizing. This can be due to prejudice or lack of knowledge about sexual minority groups by the mental health professional.[20, 21]

Training of Behavioral Health Professionals

The strategy of training behavioral health professionals to serve in high need areas is paramount to solving many of the previously discussed distribution challenges. HRSA has incurred some gains in this area through programs such as the Behavioral Health Workforce Education and Training (BHWET) Program. The program's purpose is to increase the supply of behavioral health professionals while also improving distribution of a quality behavioral health workforce, thereby increasing access to behavioral health services. A special focus is placed on the knowledge and understanding of children, adolescents, and transitional-aged youth at risk for behavioral health disorders.[22]

Between 2014 and 2022, the BHWET program supported the clinical training of nearly 40,000 graduate-level behavioral health professionals including social workers, psychologists, psychiatrists, psychiatric nurse practitioners, marriage and family therapists, school and mental health counselors, and behavioral health support workers including community health workers and substance use/addictions workers. In its first eight years, BHWET reduced the projected shortage of psychologists, social workers, school counselors, and marriage and family therapists by 39% with the graduates it added to the workforce supply. Follow-up studies one year post program completion found that 48% of graduates were currently working in medically underserved communities or rural areas.[23] Continued support of programs such as these is therefore key to improving the number and distribution of behavioral health professionals around the country.

Importance of Paid and Unpaid Family and Non-family Caregivers

In the U.S., unpaid caregivers are a considerable—and often untapped—source by the health care system. A 2020 report by the American Association of Retired Persons (AARP) and the National Alliance of Caregiving, shows the number of Americans providing unpaid care to an adult with health needs growing from 43.5 to 53 million. This is an increase of *9.5 million new caregivers* from 2015 to 2020 (see Figure 3).[24]

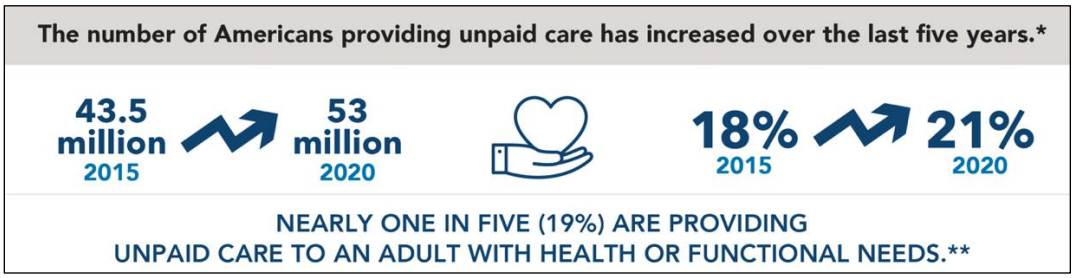

Figure 3. Infographic: Caregiving in the U.S. 2020
(Source: National Alliance for Caregiving and AARP, 2020.)

The report states that 61% of the caregivers work while providing care, with most of them working full-time. On average, caregivers spend 23.7 hours per week providing care. Of the caregivers surveyed, 45% reported that the adults they cared for had two or more conditions. Twenty-seven percent of the caregivers also reported they cared for someone with an emotional or mental health issue.[25]

Unpaid caregivers experience a series of challenges as a result of their involvement. Twenty-one percent reported being in fair or poor health, compared to 12% of non-caregivers in a national estimate. Most caregivers also report experiencing a financial strain as a result of providing care. Nearly 28% stopped saving, 23% took up more debt, 15% borrowed from friends or family, and 19% paid their bills late (or left them unpaid).[26]

In 2018, the Recognize, Assist, Include, Support & Engages (RAISE) Family Caregiver's Act became law. The Act required the development of a Family Caregiving Advisory Council, a Report to Congress, and a National Strategy to Support Family Caregivers. On September 23, 2021, the Council published its *Initial Report to Congress*, which included a comprehensive review of the current state of family caregiving and 26 recommendations for the Federal government, states, tribes, territories, and communities.[27]

The report was followed by the publication of a *National Strategy to Support Family Caregivers* in 2022. The strategy included nearly 350 actions for federal agencies and 150 actions that others could take. The strategy also highlighted the following four cross-cutting considerations for family caregiver support:[28]

- Placing the family and person at the center of all interactions
- Addressing trauma and its impacts on families
- Advancing equity, accessibility, and inclusion for family caregivers in underserved communities

- Elevating direct care workers as family caregiving partners

Paid and unpaid family and non-family caregivers serve critical roles on the broader health care team. Recognizing their role and providing access to current training opportunities will lead to better care and access to care for the patient, improved care coordination with and support of clinical staff, improved mental and physical well-being for the caregiver themself, reduced financial burden on the family caregiver and their relatives, and *importantly for Congress*, reduced short- and long-term financial burden on the US health care system.

Exemplary Program

The Integrated Model at the University of North Carolina at Chapel Hill

The University of North Carolina at Chapel Hill developed a BHWET-funded program that trained social workers using an integrated care model which coordinates physical and behavioral health. The school's BHWET training aimed to increase the students' knowledge regarding brief evidence-based treatments, prevention, screenings, interventions in integrated settings, competencies in integrated care, referrals, and working with underserved populations.

A recent study compared BHWET program graduates from five classes (2014-2018) post-graduation with social workers not participating in the program.[29] A number of indicators demonstrate the impact of the BHWET program model. BHWET program graduates were found more likely to rate their competency in integrated care higher than those not attending the program.[30] Also, 41% of BHWET graduates surveyed were working in interprofessional teams 10 months post-graduation compared with only 23% of non-BHWET trained social workers. Employment outcomes also varied between the groups, where only 2% of BHWET graduates were unemployed compared with 12% in the non-BHWET group post-graduation. These results emphasize that social work students who received the BHWET-funded training not only reported differences in educational preparedness and competence, compared with social work students that did not receive the specialized training, but also had better employment outcomes.[31]

Geriatrics Workforce Education and Training

A Growing Older Population

In the U.S., more people are living longer than ever before. The number of those 65 and over has been steadily growing for more than 100 years, with a surge in the last decade due to the aging of the baby boomer generation. In the year 1900 there were only 3.1 million individuals aged 65 and over. In contrast, in 2020 there were 55.8 million (see Figure 4).[32]

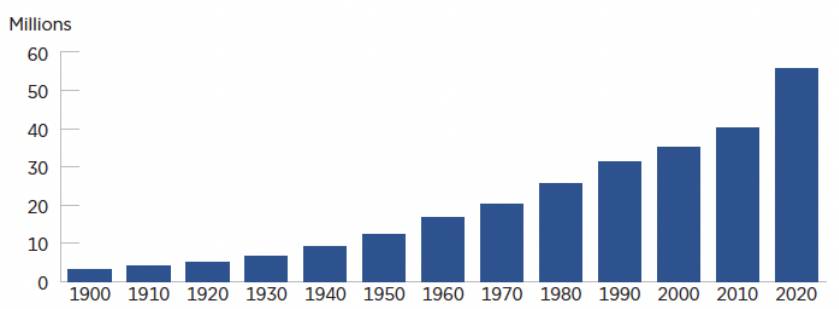

Figure 4. Population 65 Years and Over by Size and Percentage of the Total Population: 1900 to 2020 (Source: Zoe Caplan and Megan Rabe, "The Older Population 2020," U.S. Census Bureau, May 2023.)

The oldest of the old are also increasing in number. The 2020 Census counted nearly 80,000 individuals 100 years old and over (centenarians). This is significant increase from 2010, when there were about 53,000. There are several reasons for these gains in longevity—the discovery of antibiotics, protection from disease through vaccination, introduction of prenatal and maternity care, increased food quality, the development of sanitation and clean water systems, advances in health care, and in some countries, nonmedical factors such as protection from violence and improved labor conditions.[33, 34]

While we often think that increased longevity impacts only health care systems, various other areas are impacted as well. For instance, an older population needs public transportation services that are accessible, affordable, and safe so they may access health and social services. Housing that is well-designed and caters to their physical dependencies is needed as are community support services that allow them to live healthy and independent lives. Also needed are employment options for older people as well as the distribution of timely information through channels they are familiar with. Unfortunately, many countries face major challenges to adjustments in these areas and not all of them are prepared for the changes that come with a growing older population.[35, 36]

Geriatrics Workforce

A geriatrician is a physician who has received additional training to address the unique health care needs of older people. Geriatricians focus on maintaining well-being as well as diagnosing and treating conditions or geriatric syndromes (e.g., falls, dementia, frailty, incontinence, and functional decline) that may commonly occur with age. Physicians interested in this field generally complete a residency in primary care and then receive additional specialized fellowship training in treating older patients. They can also become certified in geriatric medicine by passing board examinations that demonstrate their expertise in the area.[37, 38, 39]

HRSA workforce projections predict a shortage of geriatricians. A 2022 projection estimates that by 2035 there will be a need for 1,130 additional geriatricians to meet demand at the national level. Since distribution of professionals is unequal, the adequacy of geriatricians varies from 96% adequacy in some metro areas to only 46% or less adequacy in nonmetro locations. This means that nonmetro areas will have much less supply to meet the expected demand for geriatricians in 2035.[40]

The dearth of geriatricians is not a new issue. An article published in 1976 stated that "Geriatrics has consistently failed to attract enough staff, and hence geriatric units often cannot provide a full service for the elderly." The issue grew to such importance that in 2007 the Institute of Medicine (now the National Academies of Sciences, Engineering, and Medicine) set up a committee which developed the publication *Retooling for an Aging America: Building the Health Care Workforce*.[41, 42]

In the publication, the committee stated that "*Geriatric care has not attracted health professionals in sufficient numbers in the United States*." They listed several factors as contributors to this finding:[43, 44]

- Geriatric specialists often earn significantly less than other specialists. For instance, income for geriatricians is near the bottom of 30 medical specialties
- Income disparity is due, in part, to a larger proportion of income from Medicare and Medicaid, which have low reimbursement rates
- Costs due to extra years of geriatric training do not always translate into additional income
- Reimbursements fail to account that care for patients with complex needs is time consuming, resulting in fewer patient encounters and fewer billings

The report also found that, "*The education and training of professionals in the area of geriatrics is hampered by a scarcity of faculty, inadequate and variable academic curricula and clinical experiences, and a lack of opportunities for advanced training*."[45]

Adding to an already familiar motif, a follow-up 2023 publication by the National Academies once again stressed the decline in geriatricians and nurse practitioners working with older adults. A systematic review related to student preferences working with older adults found that, during training programs, student preference for working with older adults actually *decreased*. Students were found to have negative perceptions of working with older adults, including that the work would be emotionally challenging or boring, the work would involve difficulties in communicating with patients, negative patient disposition, and that the focus would be on quality of life rather than treating patients.[46]

Geriatrics Training Programs

To address some of the above issues and support an increase in the number and distribution of U.S. geriatricians, HRSA has developed efforts such as the Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Awards (GACA) program.

The purpose of GWEP is to develop a health care workforce that provides value-based care which improves health outcomes for older adults by maximizing patient and family engagement as well as integrating geriatrics and primary care. The program's goals are to:[47, 48]

- Educate and train the primary care and geriatrics workforce to care for older adults in integrated geriatrics and primary care models
- Partner with community-based organizations to address gaps in health care for older adults, promote age-friendly health systems and dementia-friendly communities, and address the social determinants of health

Currently, GWEP recipients partner with 800 primary care sites and delivery systems—of which 214 are Federally Health Qualified Systems. They also partner with 519 community-based organizations, 278 academic organizations, and 1,124 nursing homes. In addition, applicants must have at least one primary care site that is a community-based care site.[49]

In Fiscal Year 2018-2019 alone, the program trained *39,585 professionals*, nearly 10% of which identified as underrepresented minorities. Approximately 40 professions and disciplines were trained through the program including health professions students, fellows, and practicing professionals. Nearly 15% of these were medical students. After completing their training, almost 63% stated that they intended to pursue further training or enter practice in medically underserved communities. In addition, close to *188,000 faculty* and practicing professionals participated in 1,342 unique continuing education courses offered by GWEP awardees.[50]

A second program, the GACA has as its purpose to support the career development of junior faculty as academic geriatricians or academic geriatrics specialists. The idea is that in order to train more geriatricians, appropriately trained faculty are needed. An article published in 2017 showed that the program had benefited 222 junior faculty members and that collectively the awardees had reached more than 40,000 learners.[51, 52]

While these gains are impressive, the ACICBL recognizes that recruitment into geriatric medicine still lags far behind many other specialties and that further support is still needed to expand the geriatrics workforce. This report makes several pertinent recommendations to address existing challenges.

Area Health Education Centers and Workforce Training

Uneven Distribution of the Health Care Workforce

HRSA designates a Health Professional Shortage Area (HPSA) as a geographic area, population, or facility that has a shortage of primary, dental, or mental health providers. Estimates show that 101 million Americans are living in areas with primary medical care shortages and 76 million live in areas with shortages in dental health professionals.[53]

The distribution of primary care professionals is uneven in the United States, with some areas having a higher concentration of these health care professionals per capita than others. Many rural areas and areas of underserved populations have traditionally faced shortages of primary care providers due to maldistribution, among other reasons. The Area Health Education Centers (AHEC) program has at its root the aim of broadening the distribution of the health workforce, particularly in rural and underserved areas.

AHEC Overview

Established in 1971 through the Comprehensive Health Manpower Training Act, HRSA's AHEC cooperative agreement program develops and enhances education and training networks within communities, academic institutions, and community-based organizations. These networks, in turn, support the strategic priorities of increasing diversity among health professionals, broaden the distribution of the health workforce, and enhance health care quality in rural and underserved areas. Today there are 48 AHECs building community partnerships and developing and implementing programmatic interventions to provide current and aspiring health professionals with specialized community-based training, inter-professional education, field placements, clerkships, and other educational and training activities designed to address local needs. The program prioritizes serving and addressing the needs of rural and underserved populations. As a result, AHECs play a central role in training and educating health care professionals in underserved areas.[54, 55]

Influence of Clerkships on Practice Setting

AHEC supports clerkship experiences in community-based settings, including rural and underserved areas. Clerkships (also known as clinical rotations) allow primary care students to undergo an educational experience in a setting such as a physician's office, dental clinic, or hospital. Research supports the premise that clerkships can influence providers on where they will practice after graduation.[56]

The Indiana AHEC Network and the Indiana School of Medicine developed a project to promote interest in rural practice. Third-year medical students were provided with the opportunity to serve alongside with community-based practitioners during their family medicine clerkship.

Between 2009 and 2014, 587 third-year family medicine students completed the clerkship and were included in the study. Students were surveyed on their self-reported intent to practice in a rural setting upon graduation. Approximately 21% of those who participated in the study reported greater intent to practice in a rural setting following graduation, compared with about 12% of their fellow students participating a clerkship in a non-rural setting. This shows a connection between student participation in an AHEC rural clerkship program and their increased intent to practice in an underserved setting.[57]

AHEC Outcomes

AHEC grantees serve learners along the full spectrum of the health career pathway. They can provide programming designed to increase the awareness, interest, and intent to pursue health professions among youth; offer community-based learning experiences to health profession college and graduate students; and provide continuing education for practicing health professionals. During academic years 2014-2019, AHEC grantees trained over 1.8 million individuals and delivered over 21,000 continuing education courses. The most frequent topics for these courses were in clinical, behavioral health, and population-based topics.[58]

AHECs strategically recruit learners with shared experiences and identities as the communities they serve and provide them with meaningful community-based training opportunities. Across all AHECs, 42% of AHEC program completers from 2014 to 2019 identified as coming from a rural background and 40% from a disadvantaged background. Also, at least 40% of the AHEC experiential training sites were in designated rural areas and more than 60% in medically underserved communities. These outcomes demonstrate the impact of the AHEC program in supporting the distribution and training of primary care providers in rural and underserved communities.

AHECs are pivotal to addressing the current and future health care workforce needs of rural and underserved communities. Expansion of the AHEC program through supporting the ACICBL's recommendations would afford greater returns on investment through collaborative and innovative programming interventions that connect learners to our community assets.[59]

Summary

This report touches on three areas the ACICBL has identified as critical to supporting the health care teams of today as well the teams of the future:

- Behavioral health workforce education and training
- Geriatrics education and training
- Area Health Education Centers education and training

The COVID-19 pandemic showed us that such public health emergencies can impact not only our physical health but also our mental and behavioral health. During the pandemic, nearly 4 in 10 adults reported symptoms consistent with anxiety and depression and overdose death rates increased. Despite these statistics, more than 160 million Americans still live in areas experiencing shortages of mental health professionals. Therefore, supporting the education and training of behavioral health workforce remains crucial—especially for those in rural and underserved areas.

A growing older population has created an increased need for services provided by the health care system. Nonetheless, projections expect a *significant shortage* of geriatricians by 2035. Geriatric training programs like GWEP and GACA have provided some gains in supporting the development of geriatricians and academic geriatric specialists, but the ACICBL recognizes that recruitment into geriatric medicine still lags far behind many other specialties and that further support is still needed to expand the geriatrics workforce, including paid and unpaid family caregivers.

Finally, the involvement of AHECs in the training of aspiring and practicing health professionals has been found to increase the number of professionals serving in rural and underserved areas. Some studies show a link between where a health professional trains and practices. Therefore, training health professionals though community-based learning experiences such as clerkships at AHECs is pivotal to addressing the current and future health care workforce needs of rural and underserved communities.

The recommendations in this report are geared to support the development of the three areas described above. The ACICBL believes these recommendations can be pivotal in strengthening the nation's current health care workforce as well as the workforce of the future.

List of Acronyms and Abbreviations

ACICBL	Advisory Committee on Interdisciplinary, Community-Based Linkages
AHEC	Area Health Education Centers Program
APPIC	Association of Psychology Postdoctoral and Internship Centers
BHW	Bureau of Health Workforce
BHWET	Behavioral Health Workforce Education and Training Program
GACA	Geriatrics Academic Career Award
GPE	Graduate Psychology Education
GWEP	Geriatrics Workforce Enhancing Program
HHS	US Department of Health and Human Services
HPSA	Health Professional Shortage Area
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual
NRSA	National Research Service Award

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