Advisory Committee on Interdisciplinary, Community-Based Linkages

Healthcare Workforce Issues in Rural America

September 10 – 11, 2008
Meeting Minutes

ATTENDANCE

ACICBL Members
Stephen Wilson, Ph.D., Chairperson
Louis D. Coccodrilli, MPH, Designated Federal Official, ACICBL
Alan Adams, DC
Robert J. Alpino, MIA
Heather Karr-Anderson, MPH
Brandy Bush, OTD, OTR, CLVT
Ann Bailey Bynum, EdD
Jane Hamel-Lambert, PhD, MBA
Beth D. Jarrett, DPM
Gail M. Jensen, PhD, PT
Linda J. Kanzleiter, MPsSc, DEd
Barbara N. Logan, PhD, MA, MSN
David H. Perrin, PhD, ATC
Elyse A. Perweiler, RN, MA, MPP
Ronald R. Rozensky, PhD, ABPP
Steven R. Shelton, MBA, PA-C
Andrea Sherman, PhD
Laurie Wylie, MA, RN, SNP

HRSA, Bureau of Health Professions (BHPr) Staff
Marcia Brand, Ph.D./Associate Administrator, BHPr
Joan Weiss, Ph.D./Director – Division of Diversity and Interdisciplinary Education
Norma J. Hatot, CAPT/USPHS, Acting Chief, Area Health Education Centers Branch

HRSA Administration and Other Staff
Meghan Desale, Truman-Albright Fellow, Office of Rural Health Policy

FORMAT OF MINUTES

These minutes consist of five sections:

Section I. Opening Remarks

Dr. Stephen Wilson, Committee Chairperson, and Mr. Lou Coccodrilli, Designated Federal Official, welcomed Dr. Marcia Brand, Associate Administrator of the Bureau of Health Professions; ACICBL committee members; HRSA staff; and public guests. This was the first web-based conference call held by

the ACICBL. As such, the committee anticipated making recommendations moving forward.

Dr. Wilson began by introducing Dr. Brand who acknowledged the most recent appointment of Dr. Joan Weiss as the newly appointed Director of the Division of Diversity and Interdisciplinary Education. In preparation for the upcoming transition in executive leadership, Dr. Brand indicated that the Bureau had already begun to prepare briefing materials that summarize and describe the effectiveness of the current programs. After receiving more that 400 letters of intent, 231 applications were received for the Patient Navigator program. Six programs were funded. She shared the extreme makeover process of the Bureau's website. Dr. Joan Weiss offered remarks that included a review of the Division's structure with its three branches and the possibility of the Patient Navigator program becoming a part of the current portfolio.

Dr. Wilson welcomed Dr. Weiss and thanked Dr. Brand for her tremendous support of the Committee and most recent guidance with the framing of the recommendations drafted for the Seventh Annual Report. Dr. Wilson summarized his expectations for the two days of meetings by indicating that this would be an opportunity to further the interaction with experts on rural health issues and to finalize the plans for the Eighth Annual Report. During his review of the agenda, he indicated that the presentation from Dr. Gary Hart, initially scheduled for July 2008, was a part of the meeting. Copies of the draft concept paper were circulated prior to the meeting. Opening remarks concluded with Mr. Coccodrilli's review of the recommendations, rationale, and benefits that were being finalized for the Seventh Annual Report.

Section II. Review of July 2008 Meeting Minutes

The July 16 – 17, 2008 meeting minutes were reviewed and approved without any corrections necessary.

Section III: Review of Draft Recommendations and Findings for the Eighth Annual Report

The entire group offered comments on the various recommendations after having received assignments from Dr. Wilson to work on one or two specific recommendations each. While still in draft form, the Committee offered the following summary:

RECOMMENDATION #1: The Secretary should direct HRSA to approve changes in

productivity levels when providers at Community Health Centers are performing as clinical

preceptors for health professions students. *Note: Background and Rationale will be included in*

the actual report.

RECOMMENDATION #2: The Secretary should direct HRSA, through the Bureau of Health Professions (BHPr), to expand its research agenda to include the following topics: delivering patient-centered care, working as part of interdisciplinary teams, practicing evidence-based medicine, focusing on quality improvement and using information technology. Additionally, the Secretary should provide BHPr with funding for demonstration projects that aim to develop these five core proficiencies among rural health care providers. Funding preferences in BHPr's rural health grant programs should be given to prospective grantees who can demonstrate creative approaches in assuring that their workforce is proficient in one or more of these core competencies.

Background and Rationale:

Cross training is defined as training health care professionals in multiple disciplines to minimize the need to pay multiple people to perform functions that a single person could perform (if cross trained). Common core training between disciplines would be used as the basis. Additional specialty trainings will fill in the pieces

that allow health care professionals to perform the functions associated with the other disciplines/programs.

Cross training between disciplines may be difficult to accomplish due to the regulatory constraints of the disciplines. A cross training demonstration project may be needed. There are programs that exist but they have never been sustained, which may help make the case for a new demonstration project. (The issue is being reviewed by State Offices of Rural Health and may be a concern for the Office of Rural Health Policy and Rural Health Resource Centers as well.)

RECOMMENDATION #3: The Secretary should approve enhanced Medicaid funding for all disciplines and across States if rural healthcare is to address health disparities and access to care issues. In any future discussion of a national, universal healthcare system, the Secretary should recommend, and the Congress should draft legislation that includes reimbursement for services provided by all credentialed healthcare professions and interdisciplinary teams. This will assure a focus on the importance of interdisciplinary healthcare as the basis of a quality healthcare system that addresses access to care and health disparities.

Background and Rationale:

Reimbursement is critical to health care delivery systems. It should be determined which health care disciplines and services are covered by Medicaid (i.e., behavioral health, podiatry, etc). Medicaid reimbursements are based on state contributions and not within the purview of Title VII programs. Additionally, Medicaid reimbursement structures do not support an interdisciplinary team approach.

Note: As currently stated, this recommendation is too broad and needs some revising to tie it to specific activities/programs/initiatives that fall under HRSA's control. Additionally, the discussion/rationale should provide evidence of the link between Medicaid funding and reduction of health disparities/improved access to care.

A previous note indicated that this recommendation was placed on hold for continued deliberations. If the Committee decides to maintain this recommendation, it may best be combined with recommendation #10, below, with a more detailed discussion to support the recommendation. Recommendation #10 was moved up for discussion next.

RECOMMENDATION #10: The Secretary should support research in the area of minority health in rural settings to address health disparities.

Further Discussion:

What are the lessons learned from the Quentin Burdick Rural Interdisciplinary Training Grant program? (Some of the best work came from these centers.) Since the Quentin Burdick program is not currently being funded, the strengths (i.e., stipends, training curricula, etc.) and weaknesses of this program should be captured and the results incorporated into the guidance for current programs. This can possibly be subsumed into another recommendation.

RECOMMENDATION #4: The Secretary and/or the Congress should include a section within the reauthorization of Title VII and Title VIII that supports funding for education and training of nurse practitioners, pharmacists, psychologists, and physician assistants to provide pharmacological and/or psycho-pharmacological services. Such training will augment the healthcare workforce and expand access to care for underserved populations. Furthermore, the Secretary should draft and support specific legislation that assures healthcare reimbursement [including Medicare, Medicaid, and other private healthcare reimbursement mechanisms] for these pharmacological and/or psycho-pharmacological services.

Background and Rationale:

This recommendation speaks to building workforce capacity. For example, psychologists are seeking prescribing privileges, which may address some of the psycho-pharmacology issues in rural areas. Nurses and practitioners should be added to the list of health professionals being described in this recommendation.

An amendment or addition to Title VII legislation should replace the phrase "provide more funding," since there is no specificity in the current legislation regarding this issue. Federal officials should add more specificity and make strong suggestions on how this can be framed to match BHPr criteria for recommendations.

RECOMMENDATION #5: The Secretary should accept responsibility for defining a health care workforce development policy for the country, with HRSA serving as the key agency in developing this policy. Additionally, the Secretary should direct resources toward BHPr to conduct more workforce analyses, including determining the supply and demand for specific disciplines. Further, DHHS should seek to coordinate health care workforce development projects within the Departments of Labor, Education, and Commerce.

Background and Rationale:

With recent continued annual decreases in funding to Title VII and VIII programs there have been associated decreases in the amount of work and activity. At the same time, other Federal agencies have begun to address the workforce needs of their constituencies to fill the void. This has caused duplication of administrative and program structures, as well as competition for limited financial resources. It is essential and appropriate that the Secretary establish the Department as the leader in health care workforce analysis and development. HRSA and the Bureau of Health Professions have a long history of health workforce development efforts, and are the experts in this area. It is essential that the programs of BHPr not be diluted by the creation of other programs in other Agencies, and that appropriate funding be awarded so that the BHPr can carry out this agenda.

Further Discussion:

Should include reference to funding partnerships that would consist of stakeholders who would provide input on multi-disciplinary training efforts. The AHEC program guidance requires both advisory boards for centers and that grantees assess the health workforce needs of their respective communities. HRSA may consider suggesting (in the AHEC program guidance) the inclusion of representatives from workforce investment boards on AHEC advisory boards.

RECOMMENDATION #6: The Secretary should direct HRSA to work through the existing AHEC Program to identify effective approaches and key indicators forretaining a diverse health care workforce throughout the continuum of education, training and practice.

Background and Rationale:

The AHEC Program has developed effective models for shaping commitment to practice in rural underserved communities throughout the pipeline of health professions education and training. It is an established fact that although there is recruitment of individuals from diverse ethnicities and backgrounds, retention of these individuals within the health professions programs requires a very different set of factors.

Existing studies of retention have focused on either the role of environment or the training context as key indicators for retention. Although these factors are important, understanding how to retain individuals throughout the pipeline of health professions education and training as well as what needs to occur to

maintain commitment to practice in a rural community needs further study. Note: This recommendation seems to be suggesting that a study be done. If that is the intention, the recommendation/rationale should state the value of and how the results of that study would be used.

RECOMMENDATION #7: The Secretary should direct HRSA/BHPr to identify best practices in health professional education. Legislation should be modified to support demonstration projects in the area of curriculum development that articulate best practices in health professions and interdisciplinary education. Priority for demonstration grants should be given to entities that have been previously successful in implementing interdisciplinary education programs.

Background and Rationale:

To best prepare health professionals to meet the needs of an increasingly diverse population who are likely to be confronted with managing chronic health issues, our nation's health professions education system needs to move toward introducing interprofessional models of care. Despite the formative call for strengthening of our nation's health professions education (IOM, Health Professions Education, 2003) by addressing six core competencies, our educational institutions continue to require sufficient incentives and resources to move toward the vision that promotes competencies in (1) patient-centered care, (2) interdisciplinary teams, (3) evidenced-based practices, (4) quality improvement and (5) informatics. The federal training grants funded through Title VII and Title VIII are uniquely positioned to facilitate this transformation.

The goal of establishing best practices or models for infusing interprofessionalism into the health professions curriculum is a complex challenge. Institutes of higher education are typically siloed by discipline, with associated professional credentialing/licensing mechanism heavily influencing the content of health profession education. Educational institutions often lack sufficient flexibility to easily create an infrastructure to supports cross-disciplinary courses. Interdisciplinary, team taught courses further challenge traditional mechanisms which often only recognize a single instruction of record, with associated "weighted student credit" hours going to individual departments. Moreover, even when faculty are interested in collaborative programs, degree programs often lack the flexibility to add an additional "required" course or have adequate space in schedules to enable elective training opportunities of this type.

Community-based interprofessional training opportunities are an alternative and complementary venue for infusing health professions education with interprofessionalism. The involvement of the community in the development of training objectives enhances the degree to which training best prepares professionals for community practice. Community-based training experiences that occur in clinical settings provide opportunities for health professional students to observe interactions between professions and to practice negotiating professional boundaries through effective communication.

Possible Strategies:

1(a) Allocate xxx% Title VII and Title VIII training grants to support the development of best practices for creating shared curricula across health professional education programs introducing interprofessionalism.

1 (b) Ensure funds in current training mechanism require interprofessional (3 or more professions) content to promote interprofessionalism across the grant programs that exist. (Primary care training grants, GEC, AHEC, etc.)

(i) Interprofessional curriculum in nursing Title VIII

(ii) Interprofessional curriculum in primary care and dentistry

(iii) Grad Psych Education Grants in BHPr

1. Given the rural workforce development emphasis of our report, recommend that HRSA allocate xxx funding to the Office of Rural Health Policy, whose programs are currently improving access and quality of care in rural communities, to create a new program specifically targeting interdisciplinary, community-based rural training grants. Note: Quentin Burdick remains a great model for this.
2. Maintain support for interprofessional, community-based training through AHEC.
3. Does special consideration language work to direct dollars? If so, increase the special consideration language in the Public Law to strengthen the attention to interdisciplinary training.
4. Somehow leverage the "medical home" movement and create a grant specific to creating curriculum that supports health professions education through a health care team construct, assuming it can be stretched to be inclusive of allied health, mental health as well as primary health care providers and families.

Further Discussion:

This recommendation is highly relevant to rural communities and should model a team approach and a focus on sustainability. Dr. John Gilbert, University of British Columbia, will address the committee in September and may be able to provide assistance with further refinement of this recommendation.

RECOMMENDATION #8: The Secretary should direct HRSA/BHPr and the Department of Labor to collaboratively recognize Patient Navigators (including community health workers and promotores) as an occupational health professions category. Additionally, the Secretary should authorize the funding of innovative demonstration programs to train Patient Navigators as part of the interdisciplinary practice team in rural communities. Further, training programs should include evaluation measures to determine the effectiveness of Patient Navigators in improving health outcomes, particularly for rural populations at risk for health disparities.

Background and Rationale:

We recommend the funding of novel demonstration programs with specialized curricula to train Patient Navigators as a part of a study that examines best practice model programs including all health disciplines versus the traditional physician/nurse-driven rural healthcare services and studies, specific outcomes that offset medical costs, and clinical outcomes like adherence, morbidity and mortality rates, and specific health outcomes.

Further Discussion:

This recommendation should endorse the Ppatient Navigator program and community health workers and expand these opportunities (based on best practices) to give them more focus.

Note: This recommendation would benefit from an explanation of what Patient Navigators are, what they do, and why BHPr should be involved in recognizing them/training them/conducting research on their effectiveness.

RECOMMENDATION #9: The Secretary should direct the BHPr and Office of Rural Health Policy to review CMS data to explore patient outcomes in selected leading disease diagnoses by provider type and location. The information should be used to develop a community-based health workforce planning model relevant to population characteristics of target communities.

Relevant Resources:

http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=937 on tele-pharmacy

http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=939 interprofessional education in rural practice

http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=836 on interprofessional curriculum for rural areas

http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=824 recruiting psychiatrists to rural areas

http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=818 sustainable rural health community development

Background and Rationale:

In rural areas, the primary care provider is not necessarily a physician. The Physician Assistant and Nurse Practitioner are the providers. Large datasets and HP 2010 objectives need to be considered. The endpoint is improved health for individuals and communities.

Note: Consider combining this recommendation with Recommendation #5 since both address workforce issues, but also consider whether resources are available to conduct the recommended reviews.

RECOMMENDATION #11: Rural in and rural out" programs should continue to recruit from rural areas as these students tend to practice in rural areas.

Further Discussion: The interdisciplinary training sections should indicate whether this training should occur at the graduate or entry level.

Note: To the extent possible, recommendations should be national in scope and should be directed towards actions for the Secretary and/or Congress. Since this recommendation reflects more of a local philosophy, the Committee might consider dropping it, or revising it. The second part of this recommendation regarding interdisciplinary training has been incorporated into Recommendation #7.

RECOMMENDATION #12: The Secretary and Congress should support provider training and continuing medical and healthcare education that address growing the diversity and the need for cultural competency in rural areas and takes into account the changing face of rural America in terms of growing ethnic minority populations. Funding could support provider training (online or in person) through community partnerships or consortia of lay, community professional, and university organizations. Use of student groups (service learning) as a community service by the university, especially using diverse groups of students could be applied. If the MD or the NP provider is the focus of the training, CME/CE credits should be offered. Existing HRSA online programs that could be used should be publicized and their use optimized.

Background and Rationale:

Given the recent influx of Latinos to rural counties and the history of poor African-American communities in rural America, HRSA could fund workforce development traineeships and apprenticeship programs that prepare the next generation of bilingual/bicultural paraprofessionals (allied health/health educators, medical interpreters, social workers, nutritionists, etc.) to serve in these regions. Providing support for continuing education workshops and support for clinicians/health care providers that goes beyond an orientation to language and culture of diverse populations could include more about practical strategies for collaborating with lay community health persons and interpreters in prevention outreach and clinical care. Providing technical assistance grants for developing rural health networks that function as coordinated support and referral resources to needed services could be in partnership with rural clinics, health departments, faith-

based organizations (e.g. the Catholic church, in the case of Latinos), and cultural community informal organizations.

Note: Is new legislation required, beyond what is already in Title VII/VIII, in order to accomplish this? We suggest being more specific as to whether the recommendation requires action on the part of a specific agency, and/or whether it requires modification of Title VII/VIII.

Section IV: Expert Presentations:

(To obtain a copy of the PowerPoint presentations, please contact the Division of Diversity and Interdisciplinary Education at (301) 443-6950.)

Advancing the Philosophy of the Medical Home Model – Training, Access, and Financing in Rural Settings

Dr. Thomas Weida, M.D., FAAFP
Professor, Department of Family and Community Medicine
Penn State College of Medicine
Speaker, Congress of Delegates/Academy of Family Physicians

Dr. Weida discussed the evolution of the "medical home" concept, which started in pediatrics. He stated that the Department of Veterans Affairs health services network represents the best example of a medical model in the United States with primary care access being an important issue. He discussed the pay for care rather than the pay for visit philosophy, which should result in better quality. He suggested a development grant program that would create 20 centers of patient-centered medical homes at medical schools.

Small Versus Large Rural Settings – Differences Encountered in Access, Workforce and Staffing Issues, Policy Implications

Dr. Gary Hart, Endowed Chair and Director
Rural Health Officers, University of Arizona College of Public Health

Dr. Hart discussed a number of strategies that are being used in rural settings to meet the demands for quality health care. He discussed the changing demographics and offered data to further emphasize his findings. These data will be included in his concept paper that will be a chapter in the Eighth Annual Report.

Sharing the Canadian Perspective – Interdisciplinary Education, Sustainability, Healthcare Management Concepts in Rural Settings

Dr. John Gilbert, Principal and Professor Emeritus
College of Health Disciplines, Chair and Lead Project Director
Canadian Interprofessional Health Collaborative
Vancouver, BC

Dr. Gilbert offered an overview of the Canadian single payer system and discussed the health professions residency programs in rural communities. He emphasized that students are made to feel special and welcomed. The 68 health profession occupations in British Columbia do not really compare to the 100 or so in the United States. The average medical student is 27. 5 years of age upon entering medical school having earned two to three degrees by that time.

Enhancing Patient Safety and Quality of Care Using Interdisciplinary Training

Dr. Mary Wakefield, PhD. RN, FAAN
Director, Center for Rural Health
University of North Dakota

Dr. Wakefield discussed the draft concept paper, Enhancing Patient Safety and Quality of Care Using Interdisciplinary Training that will be used as a part of the Eighth Annual Report. The ACICBL members offered suggestions such as including a glossary to define terms and inclusion of the impact of the changing rural landscape – such as the influence of immigration.

Section V: Committee Business

- Mr. Coccodrilli discussed the term expirations for four members and thanked them for their service. He is already working on the Federal Registry Notice required to fill the vacancies.
- The Committee discussed the three potential dates for the 2009 mandated meetings – to include a conference call for planning purposes on January 14, 2009 (discuss topics and format for the Ninth Annual Report) and two in-person meetings, one with the all advisory committees within the Bureau. The projected dates offered were April 29 – 30, 2009 (draft ninth annual paper) and August 19 -20, 2009 (finalize components of the ninth annual report). Further discussion pending.
- The need exists to develop writing and planning subcommittees. Mr. Robert Alpino agreed to chair Dr. Stephen Wilson agreed to continue as chair of the ACICBL; a co-chair will need to be identified.

The meeting was adjourned with plans to begin the discussion for the Ninth Annual Report in January 2009.