ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES

"Continuing Education, Professional Development, and Lifelong Learning for the 21st Century Health Care Workforce"

Location: Telephone Conference Call
Date and Time: Tuesday, April 24, 2012, 10 am – 4 pm

MEETING MINUTES

ATTENDANCE

ACICBL Members:
Linda J. Redford, RN, PhD (Committee Chairperson)
Carmen L. Morano, LCSW, PhD (Committee Co-chair)
Helen Fernandez, MD, MPH
David R. Garr, MD
Patricia A. Hageman, PT, PhD
Swan Kwan, MPH
Sandra Y. Pope, MSW
Jay H. Shubrook, Jr., DO, FACOFP, FAAFP
Carl M. Toney, PA
James C. Norton, PhD

Not Able to Attend:
Cecilia Rokusek, EdD, RD

HRSA Staff:
Joan Weiss, PhD, RN, CRNP, Designated Federal Official, ACICBL and Chief, Geriatrics and Allied Health Branch, Division of Public Health and Interdisciplinary Education (DPHIE)
Louis Coccodrilli, MPH, RPh, Chief, Area Health Education Centers Branch, DPHIE
Norma J. Hatot, CAPT, United States Public Health Service, Senior Program Officer, DPHIE
Marian Ladipo, MPH, Public Health Analyst, DPHIE

Invited Guests:
Lloyd Michener, MD
Maria C. Clay, PhD
Annette G. Greer, PhD, MSN, RN

FORMAT OF MINUTES

These minutes consist of four sections:
I. Introductions/Opening Remarks

II. Expert Presentations

III. Recommendations

IV. Next Steps

I. INTRODUCTIONS/OPENING REMARKS

Dr. Joan Weiss, Designated Federal Official (DFO) for the Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL), welcomed Committee members, conducted an official roll call of Committee members, introduced federal staff in attendance, and public guests. Dr. Weiss then invited the ACICBL chair, Dr. Linda Redford, to provide opening remarks.

Dr. Linda Redford thanked the ACICBL for their presence, and introduced the first expert speaker, Dr. Lloyd Michener.

II. EXPERT PRESENTATIONS

Institute Of Medicine Report, "Primary Care and Public Health: Exploring Integration to Improve Population Health"

Lloyd Michener, MD
Chair, Department Of Family Medicine/Duke University –
Durham, NC
Member, Institute Of Medicine Committee

Dr. Lloyd Michener opened his presentation by stating that the Institute of Medicine report, *Primary Care and Public Health: Exploring Integration to Improve Population Health,* was requested and funded by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). The Institute of Medicine (IOM) was charged with (a) identifying the best examples of effective primary care and public health integration and the factors that promote and sustain these efforts (b) examining ways HRSA and CDC can use provisions in the Affordable Care Act (ACA) to promote the integration of primary care and public health (c) and discussing how HRSA-supported primary care systems and state and local public health departments can effectively integrate and coordinate around specific topics.

The four key terms in the IOM report are public health, population health, primary care, and integration. Public health is defined by IOM as "…fulfilling society's interest in assuring conditions in which people can be healthy." *Population health* is "… the health outcomes of a group of individuals including the distribution of such outcomes within the group." *Primary*

care is "…the provision of integrated accessible health care services by clinicians who are accountable for addressing a large minority of personal healthcare needs, developing a sustained partnership with patients and practicing in the context of family and community. Integration is the linkage of programs and activities to promote overall efficiency and effectiveness and achieve gains in population health.

The committee reviewed past integration efforts to identify ways in which primary care and public health can interact, as well as the benefits of and barriers to successful collaboration. The review revealed themes and lessons that the committee believes are essential for successful integration. The principles for successful integration are: (a) a shared goal of population health improvement, (b) community engagement in defining and addressing population health needs, (c) aligned leadership, (d) sustainability, and (e) the sharing and collaborative use of data and analysis. These principles represent a framework for accelerating progress toward achieving the nation's population health objectives through increased integration of primary care and public health services.

IOM performed a survey of programs across the country. Programs in Durham, NC, San Francisco, CA and New York, NY had a long track record of integration. In these communities there was a common goal between public health groups and primary care groups around population health improvement and the realization that neither group could do it alone. There was a process of reaching out to other community groups as intervention arms and planning groups.

The committee examined how HRSA-supported primary care systems and public health departments could integrate efforts in three areas: maternal and child health, cardiovascular disease prevention, and colorectal cancer screening. Dr. Michener noted that in the review of these areas the committee found that the different organizational structures of HRSA and CDC create logistical barriers to collaborative efforts. However, there was a genuine willingness to work together. Integration can be encouraged by using community health workers, effectively sharing data, and involving third-parties to bring the two agencies together.

Dr. Michener stated that the committee reached a number of conclusions about the integration of primary care and public health and formulated five recommendations. HRSA and CDC should: (1) link staff, funds, and data at the regional, state, and local levels, (2) create common research and learning networks to foster and support the integration of primary care and public health to improve population health, (3) develop the workforce needed to support the integration of primary care and public health, (4) improve the integration of primary care and public health through existing HHS programs, as well as newly legislated initiatives, (5) work with all agencies within the department as a first step in the development of a national strategy and investment plan for the creation of a primary care and public health infrastructure strong enough and appropriately integrated to enable the agencies to play their appropriate roles in furthering the nation's population health goals.

In closing, Dr. Michener commented that the path to population health improvement will involve significant investment in the creation of linkages and alignment across many sectors. The report

set out to highlight opportunities for the first steps toward this goal among stakeholders in two of the most critical fields in the realm of community health.

Interprofessional Education: Relating to Population Health and Community Engagement East Carolina University – Greenville, NC

Maria C. Clay, PhD
Director of Clinical Skills Assessment and Education Co-Director of the Office of Interdisciplinary Health Sciences Education

Annette G. Greer, PhD, MSN, RN
Assistant Professor, Dept. of Bioethics and Interdisciplinary Studies
Co-Director, Office of Interdisciplinary Health Sciences Education

Dr. Maria Clay's presentation focused on interprofessional education (IPE), community-based prevention, integrating community-based prevention and population health at East Carolina University. She discussed the four domains in which Interprofessional Education (IPE) occurs at the institution. They include:

1. Coursework (IPE and prevention that occur in classrooms and field placements);
2. Institutional support through documentation;
3. Personnel; and
4. Infrastructure.

Coursework is broken down into 3 categories: (a) Single discipline- A discipline specific course, where the students are from one discipline, such as nursing, public health, or medicine but the content in that course is interdisciplinary; (b) Interprofessional content is shared in multiple courses across multiple disciplines, but often the students attending the course are single discipline students; (c) Interprofessional content is a course that is attended by multiple students in an interprofessional fashion.

Dr. Clay also identified three domains in clinical rotations and field placements: (a) Interprofessional concepts within a single discipline placement for single discipline learners; (b) Interprofessional placement for learners from multiple disciplines, using parallel learning; (c) Learners from multiple disciplines, using interactive /integrated learning, in one location. There are several examples of using this framework. One is discussing about interprofessional education with single discipline students. Another example is to use this framework is in clinical rotations where multiple disciplines are in the same geographic location and at the same clinic learning in parallel with each other.

Dr. Clay then took the subdomains, three in coursework and three in clinical and field rotations and related them to both IPE and population and preventive health. She applied the domains found in IPE literature and studies to describe Interprofessional - Prevention and Population Health (PPH) and to provide a structure for listing illustrations and models. Prevention content is introduced into a discipline specific course, normally the students are single discipline students. Prevention content is also shared in multiple courses across multiple disciplines. Often the students attending the course are single discipline students. This allows students to have a

shared curriculum. They then have shared language, competencies, and outcomes in their individual programs. Students also learn the meaning of the terms interdisciplinary/ interprofessional, multiprofessional, and uniprofessional and the concepts of functioning teams.

The Prevention course is attended by multiple students in an interprofessional fashion. East Carolina University is part of the Area Health Education Center (AHEC) Student/Resident Experiences and Rotations in Community Health (SEARCH) Program.
The main goal of the SEARCH program is to provide opportunities for health professions students and residents to serve on multidisciplinary health care teams in underserved communities throughout the United States and its territories. The objectives of the SEARCH Program are to: 1) assist HRSA in its recruitment and the retention efforts of health care professionals for service, and 2) facilitate and strengthen the bond of community-academic linkages and define these linkages.

In order to accomplish these objectives, SEARCH program works to: 1) develop linkages between community- oriented sites and academic institutions so that students can implement classroom experiences in a health care setting; 2) provide opportunities for students and residents to train on multidisciplinary health care teams; 3) nurture the development of culturally competent, community focused primary and allied health care providers; and 4) expand Statewide partnerships including the State Primary Care Association, State Primary Care Office, Office of Rural Health, professional associations, academic institutions, and AHECs to form a network of organizations to meet the diverse primary care needs of the underserved. One of the pieces of SEARCH is an online course divided into 3 components: IP team building, prevention and how prevention manifests itself in a community, and a community project.

Students can enroll for the Prevention course as a field placement or a clinical rotation. The University of Rochester has a traditional family medicine clerkship, attended by third year medical students with a focus area on prevention. Students in this program conduct community health assessments, offer health screenings and other assignments. Each student may choose a prevention project while on their rotation but it is the content area within a single rotation in a field placement or clinical site.

Dr. Greer discussed prevention in a non- public health rotation that is shared with multiple disciplines. East Carolina University's Burdick grant funded program: Interdisciplinary Rural Health training program was a 12 year program with several sites in eastern NC. There were multiple learners at each site. Students would spend the majority of the week within their own clinical site but one day a week, the learner participated in a shared learning experience. In that model the team of students would follow a patient, develop an integrative care plan, and perform a community health assessment and community project as a team.

Dr. Clay closed the presentation with lessons learned from her own experiences as well as experiences from colleagues across the country and future needs.

Lessons learned:

1. Teams in the community require an on-site coordinator

2. Community involvement requires greater attention to community ethics
3. Prevention and Population Health can be the subject matter for IPE both on campus and in communities
4. Definitions are important for communication and measurement
5. Sustained commitment to community in terms of funding and relationships

Future needs:

1 Expand the Macy Study National Survey
2 Identify personnel policies and infrastructures on IPE presence, growth, effectiveness.
3 Assess inclusion of content areas in IPE (e.g., prevention, population health, community engagement)

IV. RECOMMENDATIONS

Within the next two years, HRSA should incorporate language into Title VII, Part D program funding opportunities that encourage inclusion of population health content and clinical activities with a focus on interprofessional health competencies across the continuum of entry level professional education. The language should also include the following:

- continuing professional development programs,
- experience with diverse populations,
- principles of cultural competency into practice,
- use of multiple technology applications to promote positive population health outcomes.

Academic institutions and other health educators should include population health content through continuing education, and include the components of primary care, allied health, behavioral health, public health, technology, and interprofessional competencies within the next 5 years.

V. NEXT STEPS

The ACICBL will continue to finalize the recommendations for the 12th Annual Report. The committee will work closely with the technical writer to write the report. Dr. Redford, Committee Chair, thanked the ACICBL for their participation and adjourned the meeting on Wednesday, April 25, 2012.