ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES

"Preparing the Interprofessional Team to Care for Diverse Populations"

November 7–8, 2011

Georgetown University Hotel & Conference Center, Washington, D.C.

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
Cecilia Rokusek, EdD, RD
Jay H. Shubrook, Jr., DO, FACOFP, FAAFP
Carl M. Toney, PA

Not Able to Attend:
James C. Norton, PhD

HRSA Staff:

Joan Weiss, PhD, RN, CRNP, Designated Federal Official, ACICBL and Director, Division of Public Health and Interdisciplinary Education (DPHIE)
Louis Coccodrilli, MPH, RPh, Branch Chief, Area Health Education Centers Program, DPHIE
Norma J. Hatot, CAPT, United States Public Health Service, Senior Program Officer, DPHIE
Patrick Stephens, Technical Writer, DPHIE

Invited Guests:

Mohammad Ahkter, MD
Lisa Alexander, EdD, MPH, PA
Jordan Broderick, MA
Linda Harris, PhD
James Mason, PhD

Public Guests:

Nina Levitt, American Psychological Association
Carla Jacobs, Council on Social Work Education
Wendy Naus, Council on Social Work Education

FORMAT OF MINUTES

These minutes consist of six sections:

I. Introductions/Opening Remarks
II. Status of Previous Annual Reports
III. Expert Presentations
IV. Developing Recommendations and Topic for 12th Annual Report
V. Closing Remarks

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 some opening remarks.

Dr. Redford thanked the ACICBL for their presence, and expressed appreciation to those members who contributed to the draft outline. Dr. Redford stated this initial draft outline was a good start for the upcoming 12th Annual Report.

Dr. Janet Heinrich, Associate Administrator for the Health Resources and Services Administration (HRSA), addressed the ACICBL and commented that the two most important priorities for the upcoming All-Advisory Committee of Wednesday, November 9, 2011 were related to the update of performance measurements and the longitudinal evaluation of program participants. Dr. Heinrich then provided an overview of recent and upcoming activities and initiatives at HRSA and the Department of Health and Human Services (DHHS), stating that emphasis has been given to expanding the primary care workforce, not only with primary care physicians but also nurse practitioners (NPs), physician assistants (PAs), oral health practitioners, and psychologists. Dr. Heinrich added that HRSA and DHHS were also examining ways to expand diversity in the health care workforce, within the statutory authority established by Congress, by working with other government agencies as well as universities and institutions. Based upon previous recommendations by the ACICBL, HRSA has partnered with foundations to identify competencies in interprofessional education. Dr. Heinrich said that future work will also encompass the identification of demonstrated competencies for interprofessional practice. In addition, HRSA has recently updated the shortage designation list, and is working with the shortage committee to recommend new methodologies for designating shortage areas (e.g., geographic area, medically underserved populations). Dr. Heinrich concluded by stating that our nation's need for an increase in primary care is more likely due to the aging of our population than any projected increase in health care accessibility resulting from implementation of the Affordable Care Act.

II. STATUS OF PREVIOUS ANNUAL REPORTS

Dr. Weiss stated that the Ninth Annual Report has been printed and is awaiting dissemination and publication. The Tenth Annual Report package is in the final stages of preparation, and will be distributed for comment and signature through HRSA and DHHS. The Eleventh Annual Report draft has been approved by the ACICBL, and the report package will be prepared shortly.

III. EXPERT PRESENTATIONS

TRANSCENDING EDUCATIONAL CHALLENGES TO IMPACT MEANINGFUL IPE PRACTICE

LISA ALEXANDER, EDD, MPH, PA-C

PROFESSOR AND ASSISTANT DEAN FOR COMMUNITY-BASED PARTNERSHIPS;
DIRECTOR, DC AHEC PROGRAM;
SCHOOL OF MEDICINE AND HEALTH SCIENCES, THE GEORGE WASHINGTON UNIVERSITY,
WASHINGTON, D.C.

Dr. Lisa Alexander opened her presentation by stating that an optimal framework for the interprofessional education (IPE) of health care professionals includes mentored coaching. She commented that communities of professionals are bound by a sense of shared identity, values, and social limits that potentially encourages professional silos instead of interprofessional practice (IPP). Furthermore, each succeeding generation of professionals within a community is selected *socially*, reinforcing shared beliefs and silo creation. As a result, the target question is: Does the IPE experience require participants to deconstruct their professional identity or redefine it? Dr. Alexander stated that students may be educated interprofessionally; however, the main challenge lies in deconstructing faculty's identity from professional silos so they can provide a realistic and tangible example of IPP for students. Dr. Alexander stressed that people remember what they *do*; therefore, IPP must be: (a) embedded in the practice setting or in practice setting simulations, and (b) applied overall, not to a specific and subscribed area (e.g., patient safety). She added that simulations can be an additive, but not be a substitute for mentoring within the practice setting.

One of the IPE/IPP programs at George Washington University is the Interdisciplinary Student Community-Oriented Prevention Enhancement Service (ISCOPES), which sponsors team-based projects such as health education to a men's transitional housing program. ISCOPES offers IPE within a primary care framework, and students come from such health care disciplines as physician assistants, nurse practitioners, and physical therapists as well as medical students. An ISCOPES coach assists each student team in developing positive team-oriented attitudes, challenging the team to dispel previously held assumptions about IPP. Also, the coach assists each student team in "figuring out" answers instead of relying solely upon faculty expertise. Future objectives for the program include developing evaluations for interprofessional competencies that will be administered to participating students at the beginning and end of their ISCOPES experience. Dr. Alexander acknowledged that because mentored coaching is intensive, it is important to offer incentives to mentors such as stipends to attend conferences or professional development courses.

Other IPE/IPP efforts include the DC AHEC Scholars Program, a two-year, multi-institutional program that offers mentoring to students by professionals who work in community-based organizations such as nonprofit safety net clinics. In addition, there are two HEALing Clinic sites, embedded in local community health centers (CHCs) and operated by students. These clinics extend the capacity of the CHCs and contain electronic health records (EHRs) to facilitate the continuity of health care. At the conclusion of their clinic workday, students have a meeting to reflect how the team has worked, providing a powerful learning experience for the students and an enthusiastic response from faculty who have attended.

Dr. Alexander stated that each system is different; therefore, students must be exposed to as many clinical environments as possible. She continued by listing the skills and attributes necessary for faculty to develop and provide role modeling for students: collective orientation, measuring performance, capacity

for listening and questioning, open-mindedness, accountability for outcomes, and "owning" team results as a participant. In turn, she defined IPE team competency domains as (a) collaboration as communication, (b) teams and teamwork, (c) roles/responsibilities, and (d) values/ethics for interprofessional practice. Dr. Alexander concluded by stating that it is important to expose students to as many different interprofessional teams in as many different clinical environments as possible, because teams may differ from one clinic location to the next.

Population Health: Implications for Cultural Competency

James Mason, PhD

Executive Director, Cultural Competent Care Giving, Providence Health and Services, Portland, OR

Dr. James Mason stated that population health has a broad mandate, containing determinant factors that lie beyond the influence of health care providers, such as housing, employment, and income. As a result, it is important to focus on two population health outcomes: (a) increase overall health, i.e., years and quality of life; and (b) eliminate health disparities. Cultural competency can serve as a key factor that can contribute to reducing health disparities and increasing overall health.

Dr. Mason noted that the simple act of saying "hello" lessens cultural barriers between health care providers and patients, and requesting feedback from patients empowers them to overcome any perceived imbalances of power with their health care providers. However, cultural competency also begins with providers understanding their misconceptions and conducting an honest self assessment, both at the individual and organizational level. For instance, one common misconception is that a provider who is from a particular culture will exhibit cultural competency with patients from the same culture. Generally, that is not the case; rather, it is the exposure to many different cultures during clinical rotations that build a provider's cultural competency. Also, a provider or patient may biologically identify as one race, but culturally identify (i.e., music, literature, food) with another race. To acknowledge this possibility, Dr. Mason recommends that providers ask the patients how they identify themselves, e.g., African-American, Nigerian, Hispanic, Latino. In this regard, Dr. Mason states, classifications on forms and other official paperwork have not caught up with the diverse demographics of 21st Century.

Another misconception is the human tendency to observe the *pathology*, i.e., what's "wrong," with other cultures rather than focus on the strengths and resiliencies of other cultures. In self-assessment, Dr. Mason recommends providers identify cultures that they are *less* comfortable with, and work with those cultural groups to develop cultural competency. In addition, he suggests attending cultural events, such as Cinco de Mayo or Lesbian, Gay, Bisexual, Transexual (LGBT) pride events to gain exposure. Merchants, faith-based institutions, advocacy organizations, and municipal and state governments can offer exposure as well as provide natural networks of support for the community health team. Providers must remember that communities are dynamic and demographics change over time. Those providers who do not advocate for the cultures within the communities they serve will be viewed as a problem, not a solution, by those cultures within the community. Dr. Mason suggests that providers identify several mentors to meet the different needs of different cultures. These mentors will help providers to recognize and appreciate commonalities, not differences, of all people from different cultures. In addition, he recommends using social media such as a listserve or LinkedIn to share cross-cultural success stories. In closing, Dr. Mason advises providers to aspire, rather than achieve, cultural competence because aspiring to culture competence is a dynamic and ongoing process.

THE OPPORTUNITY FOR HEALTH PROFESSIONAL EDUCATION ENHANCEMENT AND HEALTH CARE REFORM

MOHAMMAD AKHTER, MD, MPH

DIRECTOR, DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH, WASHINGTON, D.C.

Dr. Mohammad Akhter reported that Washington, D.C. has a robust public health system, with a nurse in every public school, treatment on demand for HIV/AIDS and substance abuse, and award winning food programs. Yet, when compared to our nation's rates for the ten leading causes of death, Washington D.C. rates are significantly higher in seven out of the ten leading causes. Dr. Akhter stated that this is due to residents (a) not seeking health care, (b) failing to follow prescribed regimen treatments, and (c) having underlying mental health issues that contribute to poor health. These disparities may be exaggerated by residents who have multiple issues (i.e., physical, behavioral, social) as well as those who fear the medical system. In addition, lack of cultural competency and follow-up by providers may result in patients' non-compliance with medical recommendations. These challenges require fundamental changes in the way patient care services are delivered, with the goal of improving patients' understanding of recommendations for their care and thereby improving health outcomes. An example of a different approach is to employ home health professionals who will visit residents in the community and assess their medical and social needs, provide preventive services and referrals, and encourage adherence to medical and treatment regimens.

Dr. Akhter commented that many patients with chronic conditions (e.g., HIV/AIDS, diabetes) or substance abuse issues have behavioral health problems that contribute to poor health. Therefore, he recommends an integration of prevention, primary and behavioral care education for all primary care providers, including physicians, nurses, and physician assistants. In addition, Dr. Akhter proposed a new type of health professional—a primary care specialist who has three to four years of training in primary care medicine, preventive medicine, public health, and behavioral health. This would ensure that treatment is provided to the *total* patient, not just to a chronic condition that may be only a *part* of a patient's health problems. This type of integration would involve a population-centric approach to health professions education, requiring health care reform that provides incentives and payments to providers for population-centric care.

In closing, Dr. Akhter shared a key discovery regarding patient care costs within the District of Columbia Department of Health. Mental health is the most frequent diagnosis for 2,002 of the most costly patients serviced by the Department. These patients often arrived at the emergency room with one or more chronic condition; however, their behavioral health was not addressed. He concluded that it is important to conduct a mental health assessment when addressing medical conditions.

PREVENTION ONLINE: COLLABORATION, INNOVATION, AND ACCOUNTABILITY

LINDA HARRIS, PHD AND JORDAN BRODERICK, MA

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Dr. Linda Harris opened her presentation by stating that the Office of Disease Prevention and Health Promotion (ODPHP) works with a wide range of agencies within the U.S. Department of Health and Human Services (DHHS) to help the DHHS Secretary and the President to speak as a single voice regarding disease prevention and health promotion. ODPHP applies health promotion and disease prevention online through collaboration, innovation, and accountability.

While our population still relies on health care information from doctors, nurses, and other health professionals, current data also indicate that significant percentages of the adult population obtain health care information, and make health care decisions, by consulting online resources. For example, 25 percent of adults have read an online commentary about another adult's health experience, and 18 percent have consulted online reviews. In tandem with these developments, there has been a dramatic increase in the use of social networking, from 5 percent of the population in 2005 to 65 percent at present. As a result, health care providers no longer have the same degree of influence over health care information and decisions. These trends signify a need to (a) shift the dissemination of health care information from a persuasion model to a decision support model; (b) provide online, evidence-based health information to assist our population in making beneficial health care decisions; and (c) engage in meaningful and productive interactions online through social media.

ODPHP has implemented the four strategies for collaboration, innovation, and accountability for prevention online:

1. Apply Health Literacy
2. Provide Decision Support
3. Engage People
4. Stress Accountability

Health literacy is defined by the Patient Protection and Affordable Care Act as "…the capacity to obtain, communicate, process, and understand basic health information and services needed to make appropriate health decisions." A disconcerting 35 percent of the adult population has basic or below basic health literacy levels, making it difficult to navigate and benefit from online resources. As a result, two new features were designed for Healthfinder.gov to accommodate those with limited health literacy: (a) myhealthfinder, and (b) Quick Guide to Healthy Living.

Decision support is provided online through myhealthfinder and Quick Guide to Healthy Living. Health care providers can augment information given during an appointment by introducing these evidence-based online resources to patients, thereby offering a learning moment at the point-of-care. Both online features, as well as Healthfinder.gov, offer health promotion information that can assist the public in making beneficial health care decisions.

Dr. Harris stressed that social media provides a key contribution to the implementation of all four strategies, particularly the engagement of people and recoupment of financial investment. She then introduced Ms. Jordan Broderick, who addressed the last two strategies, engaging people and stressing accountability.

Ms. Broderick noted that social media provided a way to continue the conversation that Dr. Harris began. *Engage people* with social media by linking online resources with Twitter, Facebook, and LinkedIn. Healthfinder.gov, a public outline resource, is linked with Twitter through @healthfinder. ODPHP co-hosts and collaborates online events, inviting opinion leaders who provide an evidence-based voice to the discussion. This invites public response, creating a feedback loop between the opinion leader, ODPHP, and the public. HealthyPeople.gov, for health care professionals, is linked with Twitter through @gohealthypeople and as a group within LinkedIn. HealthyPeople.gov focuses on building partnerships with health care professionals to collaborate and address the topic areas, objectives, and goals of HealthyPeople.gov. Future plans include linking both Healthfinder.gov and HealthyPeople.gov with Facebook, and Healthfinder.gov with mobile devices. Plans also include linking HealthPeople.gov with

e-Learning, engaging all types of health care professionals with concepts, articles, books, video modules, quizzes, and webinars on topic areas with HealthyPeople.gov.

Stress accountability by reviewing return on investment (ROI). This is determined by adding the initial number of people reached to the number of people engaged, then dividing the total by the cost of service. It is known that social media is less expensive than other methods such as advertising; therefore, ROI is calculated to determine if using social media is cost effective and efficient.

In closing, Ms. Broderick commented that social media creates an important learning environment. Furthermore, providing e-Learning or online prevention curricula would present an opportunity for health care providers from different disciplines to problem solve together as well as learn from each other.

IV. DEVELOPING RECOMMENDATIONS AND TOPIC FOR 12TH ANNUAL REPORT

After the conclusion of expert presentations, discussion turned to developing the recommendations and the topic for the 12th Annual Report. The topic chosen during the October 4, 2011 meeting was *Preparing the Interprofessional Team to Care for Diverse Populations*. Therefore, the initial focus was on developing recommendations to (a) provide the role models, knowledge, and skills for students to serve within interprofessional teams and offer health care services to diverse populations, and (b) create collaborative programs to address and monitor the health care needs of diverse populations.

Subsequently, discussion transitioned to the establishment of interprofessional competencies and accreditation standards to address the health outcomes of populations. A consensus was reached to support an educational redesign that will prepare current and future health professionals to provide care employing a population health perspective. As a result, the ACICBL proposed the following change to the 12th Annual Report topic:

Redesigning Health Professions Education: Preparing Students, Faculty and Practitioners to provide Optimal Team-based, Coordinated Care to Populations.

The ACICBL developed two preliminary recommendations that emerged from this expanded focus:

1. Initiate the process of redesign by aligning interprofessional education with interprofessional competencies, integrating population health and including the components of primary care, behavioral health, public health, and technology.
2. HRSA should convene a national meeting in collaboration with private foundations and invited representatives of accrediting and licensing bodies, executive-level academic leadership, and organizational leaders to develop interprofessional competencies and accreditation standards that address the needs and improve the health outcomes of populations.

<u>Additional Discussion</u>

Other potential recommendations discussed included technology and continuing education:

- HRSA should identify, disseminate, assess, and evaluate existing technology components in Title VII and Title VIII programs that are used in teaching, practice, communication, and e-learning that can inform and advance population health.

- Promote a single-source application process for continuing education units (CEUs) across all disciplines, thereby facilitating interprofessional continuing education initiatives that can advance population health.

Furthermore, the ACICBL examined two definitions of population health: (a) preventing disease, prolonging life, and promoting health through organized efforts and informed choices, and (b) health outcomes of a group of individuals, including the distribution of such outcomes in that group. The ACICBL concluded that population health includes health outcomes, patterns of health determinants, and policies and interventions that link (a) and (b).

V. CLOSING REMARKS

Please Note: A transcript of the November 7–8 meeting is available. The ACICBL also approved minutes to the first meeting for the 12th Annual Report, consisting of a four-hour teleconference on October 4, 2011.

Dr. Redford, Committee Chair, thanked the ACICBL for their participation and adjourned the meeting on Tuesday, November 8, 2011.