# Advisory Committee on Interdisciplinary, Community-Based Linkages

*Optimizing the Interprofessional Team Member's Contributions to Population Health*
April 22 -23, 2013
Department of Health and Human Services, Parklawn Building, Rockville, MD.

# Meeting Minutes

## Attendance

**ACICBL Members:**
Carmen L. Morano, PhD (Committee Chairperson)
Helen M. Fernandez, MD, MPH
David R. Garr, MD
Patricia A. Hageman, PT, PhD
James C. Norton, PhD
Sandra Y. Pope, MSW
Linda J. Redford, RN, PhD
Cecilia Rokusek, EdD, RD
Jay H. Shubrook Jr., DO, FACOFP, FAAFP

**Health Resources and Services Administration (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)
Nina Tumosa, PhD, Public Health Analyst, DPHIE
Tamara L. Zurakowski, PhD, GNP-BC, Public Health Analyst, DPHIE
Crystal Straughn, Technical Writer, DPHIE

**Invited Guests:**
Janet Heinrich, Dr.P.H., R.N., Associate Administrator, Bureau of Health Professions, Health Resources and Services Administration (HRSA)
John Bulger, DO, MBA, Chief Quality Officer, Geisinger Health System
John H.V. Gilbert, C.M., Ph.D., F.C.A.H.S., University of British Columbia (UBC) Canada
Thomas E. Edes, MD, MS, Director, Geriatrics and Extended Care for Clinical Operations, Department of Veterans Affairs (VA)
Cynthia Phillips, MSW, MPH, Deputy Director, DPHIE
Kenneth Shay, DDS, MS, Director of Geriatric Programs, Department of Veterans Affairs
Gwynn Sullivan RN, MSN, Director, Access, National Hospice and Palliative Care Organization
Rachael Watman, MSW, Senior Program Officer, John A. Hartford Foundation

# Format of Minutes

These minutes consist of three sections:

I. Introduction
II. Expert Presentations
III. Proposed Recommendations and Next Steps

# I. Introduction

Dr. Joan Weiss, Designated Federal Official, welcomed Committee members and called the meeting to order. Dr. Carmen Morano, Chairperson, welcomed Committee members and thanked Dr. Linda Redford (12th report Chairperson) for her work on the ACICBL 12th report.

# II. Expert Presentations

## Bureau of Health Professions Update

***Janet Heinrich, DrPH, RN, FAAN***
Associate Administrator
Bureau of Health Professions

Dr. Janet Heinrich provided an update on Bureau of Health Professions (BHPr) activities. She opened her presentation with a brief background on HRSA and BHPr. She then discussed the recent Nurse Practitioners (NP) Data Initiatives from the National Center for Health Workforce Analysis, HRSA interprofessional efforts, and the Affordable Care Act (ACA).

### National Center for Health Workforce Analysis

The National Center for Health Workforce Analysis, has been analyzing trends in the workforce to develop new approaches to modeling the health professions. The Center is focused on building existing sources of data by collaborating with professional associations, states, and other Federal agencies. They are also working to strengthen national and state capacity for data collection and analysis within professional associations and states; develop and promote a national uniform minimum data set; and support research to better understand current and future workforce needs and dynamics.

HRSA recently commissioned a survey of 22,000 NPs to better understand current and future workforce needs and support policy analysis. The NP survey collected information on the: number of NPs practicing in an NP role; specialty distribution of NPs with a focus on estimating the number practicing in primary care; distribution of NPs across healthcare settings; job satisfaction of NPs; and employment characteristics such as hours worked, services provided, billing arrangements, and physician oversight.

**Interprofessional Efforts**
HRSA is continuing to emphasize interprofessional healthcare delivery, as well as education and training in a number of its programs and funding opportunities. Recently, the advanced nursing education program solicited applications to integrate care of individuals with multiple chronic conditions into interprofessional education opportunities for advanced nursing education students.

HRSA recently awarded a five-year cooperative agreement to the University of Minnesota to support the National Center for Interprofessional Practice and Education. HRSA funded the University of Minnesota as a coordinating center. The Center is also receiving support from the Josiah Macy Jr. Foundation, Robert Wood Johnson foundation, John A. Hartford Foundation, and Gordon and Betty Moore Foundation. A unique component of the National Center is that they are partnering with academic and practice sites throughout the United States to build a new kind of partnership between academia and delivery systems.

**HRSA and the Affordable Care Act (ACA)**
HRSA has many provisions in the Affordable Care Act to improve access to care. Three key goals have been improving access to quality primary care, strengthening the healthcare workforce, and improving health equity and eliminating disparities in access to health care. HRSA is now preparing to launch health insurance marketplaces. The Marketplace will give Americans who are uninsured or who buy their own coverage a whole new way to shop for insurance. It will be a one-stop shop to learn about health insurance, get accurate health insurance information, and compare different plans. The marketplace will also offer a single, streamlined application process to determine eligibility and qualifications for a free or low-cost plan, or a new kind of tax credit that lowers monthly premiums. More information is available at www.healthcare.gov.

Dr. Heinrich stressed that states should have the ability to monitor and plan for their healthcare workforce; there must a shift to use more community health workers because individuals rely on them as a navigators and translators; and working in teams can achieve the triple aims of increased quality, access, and decreased cost.

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## ProvenHealth Navigator®: Population Health is a Team Activity

***John B. Bulger, DO, MBA***
Chief Quality Officer
Geisinger Health System

Dr. Bulger explained that the idea of comprehensive, proactive care for the chronically ill does not exist to the extent we would like because of time restraints and lack of systems. Physicians are overwhelmed with administrative burden and if the goal is to provide preemptive population care, physicians cannot do it alone. The primary care physician needs data and partners to coordinate care and manage populations. To address these needs, Geisinger reengineered not only its patient care model but its payment system. In the Geisinger Health System, the incentives that healthcare professionals receive are based on quality and access to care, not on volume and the number of patients seen. Physicians are financially rewarded for providing quality care while eliminating unnecessary tests and reducing admissions and length of hospital stays.

At the Geisinger Health System, patient centered primary care is focuses on redesigning patient care and health care practitioner behavioral change. Behavior change "catalysts" that assist in redesign are proactive identification of patients at risk, embedded nurse case managers, and use of care team meetings to discuss patient care and health outcomes. It is also important to have team meetings on a regular basis to discuss performance reporting. These meetings are critical to creating a cohesive unit that fosters quality patient-centered care. Primary care physicians and hospitalist meetings also foster communication between groups and provide actionable information and data to drive interventions. It is important to provide feedback to the team, identifying practices that work and areas for improvement, to promote high quality, culturally competent, patient-centered care.

The clinical redesign process is focused on eliminating waste, automating information when possible and delegating tasks to the appropriate staff. Each team member practices at the top of their license. Geisinger also incorporates best practices into patient care to maximize the roles and responsibilities of the entire medical home team including health care providers and ancillary staff. For example, when it is time for a patient's annual flu shot, ancillary staff use Geisinger's patient portal, electronic health record, social media, and other electronic media to inform patients that it is time for their flu shot. Patients can then visit the clinic and receive the shot from a nurse or an assistant without having the case manager or the physician directly involved.

Dr. Bulger also discussed the importance of teams to improve patient outcomes through the Patient-Centered Medical Home Model, ProvenHealth Navigator (PHN). The success of the PHN model is its five-point framework that encompasses: patient centered primary care (primary care led team-delivered care); integrated population management (in-office case management); medical neighborhood; quality outcomes (HEDIS and bundled chronic disease metrics); and value-based reimbursement (value-based incentive payments). PHN offers a point of contact to monitor and coordinate care. It helps patients with chronic medical conditions and helps them to better understand and manage their health issues.

**Embedded Case Managers**
The Practice-Based Case Managers are specially trained RNs that are the heart of the PHN model. The Practice-Based Case Manager is located in the primary care physician's office and has direct access and interaction with the primary care physician, clinical personnel, and office staff. The Practice-Based Case Manager provides value to the patient by improving access to care, assisting the patient to adhere to best practices, coordinating services, and collaborating among the medical home team and the greater medical neighborhood. While value to the organization is derived from the prevention of costly and unnecessary acute care admissions and emergency room visits, and reduction of readmissions. Embedded case managers are responsible for most of the high risk patients (patients with chronic disease). Each case manager has about 125 to 150 high risk patients. Geisinger focuses on what care gaps are in high-risk populations and how to apply tools to close those care gaps.

**Transitions of Care**
Geisinger nurse care managers provide care transitions. Nurses ensure safe transitions from the hospital to the home. They assist with medication reconciliation and perform a safety assessment of the home. The assessment ensures that patients are able to care for themselves in the home or have the necessary social supports that enable them to remain in their home post-discharge. Nurses also call the patient at least once a week in those first 30 days, sometimes two or three times a week, to prevent the risk of hospital readmissions and provide the best outcomes for the patient.

**Geisinger Diabetes Bundle**
Geisinger created a "bundle" of best practice measures to improve the quality of diabetes care and outcomes. It has been shown to markedly improve patient health and diabetes management. The diabetes bundle includes the following nine measures:

- HgbA1C measurement: Every six months
- HgbA1C control — patient-specific goal: Less than 7 percent or 7 to 8 percent
- Low-density lipoprotein measurement: Annually
- LDL control — patient-specific goal: Less than 70 mg/dl or less than 100 mg/dl
- Blood pressure measurement: Less than 140 systolic blood pressure, less than 80 diastolic blood pressure
- Urine protein testing: Annually
- Influenza immunization: Annually
- Pneumococcal immunization: Once before 65, once after 65
- Smoking status assessment: Nonsmoker

Since the program's inception, more than 24,000 patients have shown increased control of glucose, blood pressure, and cholesterol, as well as increased vaccination rates. In the bundle, diabetic patients are automatically identified prior to their arrival at the clinic, and a patient-specific, evidence-informed order entry set is generated (including standing orders for routine testing such as for HbA1c and LDL) that can be accepted by the physician with a single click.

Automated reminders are provided to both the clinical team and patient and a self-scheduling option is available for patients using the Geisinger electronic health record. An after-visit summary is provided to each patient that shows how they are doing compared to the goal and an explanation of the risks associated with failing to achieve the goal. Performance reports are sent to each practice, detailing both individual physician and practice-site performance in comparison to the historical trend and peer sites; patients receive their own performance "report card."

Dr. Bulger closed his presentation by highlighting the benefits of team-based care. There are many members of the team (physicians, nurse practitioners, pharmacists, front office staff, etc.) that are key to successful care and improved patient outcomes. The patient-centered medical home is the foundation for improving population health.

## InnoVAtions in Interdisciplinary Team Setting, Training and Practice

***Thomas Edes, MD MS***
Director, Geriatrics & Operations

Dr. Edes' presentation focused on interdisciplinary team care for populations; settings needed to have interdisciplinary team care; training in interdisciplinary team care; and affordability of interdisciplinary team care. He opened the presentation discussing the challenges for healthcare of the aging veteran population.

Interdisciplinary teams (IDT) improve patient care and outcomes. Interdisciplinary is defined as individuals from different disciplines who meet as a team, function as a team, and create single integrated care plan as a team. Individuals with complex chronic disabling disease need IDT care the most. This care must be comprehensive (need concurrent care of all conditions, coordinated, longitudinal, and ensures continuity across time, provider, and setting).

The VA Interdisciplinary Health Care Teams are: (1) Home: HBPC; Medical Foster Home (MFH); (2) Clinic: Geriatric Patient Aligned Care Team; (3) Hospital: Palliative Care Consult Team; (4) Nursing Home: Culture Transformation- Interprofessional Palliative Care Fellowship; and (5) Across Settings: Geriatric Scholars Program; Transitional Care; Hospice Veteran Partnership; Veteran

**Health Care Challenges for Aging Veteran Population**

Demographic imperative- impact on:

- Health care workforce shortage with geriatric expertise – clinicians, direct care workers, and family caregivers
- Meeting long term care needs – with optimal health, safety, independence and purpose
- Care at the end of life – meeting goals of care
- Unsustainable health care costs – solutions

**Impact of HBPC**

- 2002 pre-post analysis: n = 11,334
- 68% fewer hospital days; 29% fewer admissions
- 88% fewer nursing home days
- 21% lower 30 day readmission rate
- 24% lower net VA cost after accounting for HBPC costs
- Clinics in Geriatric Medicine, Feb 2009
- Growth 7312 in 2000 to 29,832 in 2012. 38% rural
- 14 pilots with Indian Health Service
- 15% of Veterans in HBPC also receive Telehealth
- 6,592 Veterans in HBPC received palliative care (22%)

Community Partnerships; Geriatric Research Education and Clinical Centers (GRECC).

**Interdisciplinary Team Costs**
The highest cost population is individuals with serious chronic, disabling diseases, many of whom are homebound. The VA developed a robust electronic medical record, quality and performance measures, and systems specifically for chronic disabling disease (HBPC, Geriatric care) to lower healthcare costs. Their electronic medical record includes all of the VA systems across the country and health care providers can retrieve information on any veteran across the system.

**VA Home-Based Primary Care (HBPC)**
HBPC is comprehensive, longitudinal primary care delivered in the home by an interdisciplinary team (nurse, physician, social worker, rehabilitation therapist, dietitian, pharmacist, psychologist). HBPC is for patients who have complex health care needs for whom routine clinic-based care is not effective. It is also for patients who need skilled services, case management, and assistance with activities of daily living (bathing, dressing, fixing meals and taking medication). HBPC can be used in combination with other Home and Community Based Services.

The HBPC has had a dramatic effect on VA and Medicare costs. In 2006, 9625 veterans were enrolled in HBPC, and 6951 used Medicare. While in HBPC, Medicare inpatient days dropped 9.5% and Medicare costs dropped 10.2%. Enrollment into VA HBPC is also associated with a 25% reduction in combined VA and Medicare hospital admissions, 36% reduction in combined VA and Medicare hospital days and 13.4% reduction in combined VA and Medicare costs (a drop from $45,980 to $39,796 in total cost after adding in the costs of HBPC $9113 per patient/yr.)

**VA Medical Foster Home (MFH)**
When a nursing home is the only option, MFH provides another option. MFHs merge adult foster homes with VA HBPC. An individual takes a Veteran into his/her home, as an MFH caregiver. MFH caregivers provide daily supervision and personal assistance. The HBPC provides caregiver education and comprehensive medical care in home and the MFH Coordinator provides oversight. Caregivers undergo a rigorous and in-depth application process which includes a federal background check. They are allowed to care for no more than 3 individuals in their home. This program matches veterans with caregivers who are willing to provide safe, comfortable accommodations, meals, transportation and 24-hour personalized care.

The veteran is responsible for the cost which may be paid using a combination of payer sources. Veterans pay their caregivers $1,500 to $4,000 a month, depending on the level of assistance they need and their financial resources. The cost per Veteran per day is $10 MFH, $50 HBPC, $80 Veteran =$140 a day in a MFH vs. $253 a day in a nursing home. The program has an exceptional track record in veteran satisfaction and enabling self-determination among some of the most vulnerable veterans under VA care. In almost all cases, medical foster homes are a lower-cost alternative to nursing home placement.

**VA Geriatric Scholars Program**
The VA Geriatric Scholars Program is a longitudinal workforce development project that integrates state-of-the-art skills and competencies in geriatrics and gerontology into primary care settings. The Program initially focused on rural clinics and has now expanded to patient aligned care teams in all VA facilities.

The Program includes face-to-face and distance learning modalities. The mandatory components include intensive didactic geriatric medicine (≥30 hours CME/CEU); a pre-conference course in quality improvement (8 hours CME/CEU), and a local quality improvement project to improve care for older Veterans. The optional components include a clinical practicum, and interdisciplinary team training on-site. Approximately 36% of learners opt for a clinical practicum experience at a GRECC to gain additional clinical skills. Rural Interdisciplinary team training is offered to the entire Community-Based Outpatient Clinic on-site. VA Geriatric Scholars may participate via distance education or be a member of a learning community. Distance education includes enduring education materials developed for the program (e.g., the Geriatric Huddle for PACT teams) and webinars based on learners' requests.

Dr. Edes closed his presentation by noting that the models of excellent interdisciplinary care and training for home and community care are HBPC, MFH, Geriatric Scholars, GRECCs, Interprofessional Palliative Care Fellowships, and Community Veteran Partnerships. The VA is using targeted interdisciplinary team care to increase access, improve quality and reduce total costs of healthcare. These goals are achieved by adding services, not restricting services. The growing VA MFH program is resulting in total taxpayer savings of $1 million every 12 days.

## The Hartford Foundation: Our New Strategic Direction and Interprofessional Education

***Rachel Watman***
Senior Program Officer
The John A. Hartford Foundation

Ms. Watman's presentation focused on the John A. Hartford Foundation's mission of aging and health. Hartford strives to improve the health of older adults by creating a more skilled workforce and a better designed health care system. Through its grant making, the Hartford Foundation has historically sought to enhance and expand the geriatrics training of doctors, nurses, social workers and other health professionals, and promote innovation in the integration and provision of services for all older people. The Hartford Foundation principles are shift "downstream" and move away from faculty production towards practice efforts, bridge the education and practice gap with increased focus on continuing education and practice redesign, mobilize their best asset –Hartford alumni, break down silos among professions and bring disciplines together, focus on the frailest and most expensive older adults, capitalize on high-leverage opportunities in reform and strategic partnerships, and support the involvement of grantees in policy.

Ms. Watman noted a significant change in the Hartford Foundation. The Foundation recently completed a two-year strategic planning process. Moving forward, the Hartford Foundation will focus their grant making on practice centered efforts. Ms. Watman emphasized that the Hartford

Foundation wants to bring what they have learned and created in academia to the clinical environment to directly improve the care of older adults. Their new theory of change places older adults firmly in the center, as they strive to support a comprehensive, coordinated, and continuous healthcare system based on expert care. The Foundation is committed to supporting efforts that reduce costs and build a business case, build IT and quality measures, engage geriatric experts and alumni; improve policy in payment, practice, and education, and support work that engages healthcare decision makers.

**Proposed New Grant Making**

Although the Hartford Foundation is proceeding with a new strategic direction, they are providing their currently funded grantees with support and capacity building years before their grants ends. It is important for grantees to define what they would like to sustain post Hartford funding and how they can secure the institutional support and resources needed. The new grants are in five core areas of programming that promote their strategic vision. The program areas are Interprofessional Leadership in Action, Developing and Disseminating Models of Care, Communications and Policy, Tools and Measures for Quality Care, and Linking Education and Practice. These program areas will:

- support 30 healthcare professionals in the delivery system with the requisite of leadership skills and the content expertise to affect practice improvement to better meet the needs of older adults,
- make sustained change in the practice environment to improve the health of older adults,
- establish virtual and in-person opportunities to break down the silos between the people they have supported in medicine, nursing and social work and provide training and resources to gain skills to make practice change,
- establish smaller practice driven networks of 12 to 14 interdisciplinary teams drawn from the larger Hartford community to focus on caregiving and medical homes,
- develop and disseminate models of care,
- create and implement a self-sustaining business model for providing care transition intervention training and technical assistance,
- expand work in communications to improve the health of older adults, and
- link education and practice.

Ms. Watman discussed the importance of Hartford continuing to pursue interprofessional education. She noted that how care is delivered is as important as to what care is delivered. Hartford recently demonstrated its commitment to interprofessional education by providing support along with HRSA and other national funding partners for a National Center on Interprofessional Practice and Education.

## Veteran Community Partnership Initiative

***Gwynn B. Sullivan, R.N, M.S.N***
U.S. Department of Veterans Affairs

***Kenneth Shay, D.D.S., M.S.***
Director of Geriatric Programs
U.S. Department of Veterans Affairs

Gwynn Sullivan opened the presentation discussing the population and health of elderly veterans. There are 23 million veterans in the United States. Only 7 million are enrolled in VA services. Those who are not enrolled will most likely access services in the community as needed. In addition, many who are enrolled do not exclusively access VA care/services. Therefore, it is imperative to reach out to VA's community partners. They are an invaluable asset to all stakeholders and veterans. Approximately 70% of VA patients over age 65 uses one or more other healthcare services, yet there is no systematic linkage among providers or services.

**Veteran and Community Partnership (VCP) Initiative**

The focus of the Veteran and Community Partnership (VCP) initiative is to foster seamless access to, and transitions among, the full continuum of non-institutional extended care and support services in VA and the community. Veterans deserve ready access and choice of the widest range of services available. Most Veterans are not enrolled in VA, and exclusively access community resources for their health and support care needs. Additionally, veterans who do receive VA health services also access non-VA services. Therefore, it is imperative that VA and community agencies establish and nurture these partnerships. The need for VCP reflects that community partnership and participation with VA providers is an invaluable asset to all stakeholders and veterans. The VCP also acknowledges and aims to support caregivers of Veterans, as they play an indispensable role in the care and lives of Veterans. Each local VCP will be unique according to the diversity of resources within its community, will build on its local resources and strengths, and will facilitate collaboration and involvement of all partners. VCP will provide a mechanism to integrate knowledge and action for the combined mutual benefit of all those involved, and for those for whom they care.

VCPs are partnerships through which local VA facilities connect with state and local community service agencies in an effort to enhance and improve access to quality healthcare; promote seamless transitions, educate community agencies and VA providers, support caregivers; and develop and foster strong relationships between VA and community agencies and providers.

VCP is a formalized partnership. A formalized partnership is an alliance among individuals, agencies, or groups, that cooperates in joint action, each in its own self-interest, joining forces together for a common cause and mutual benefit of all those involved. In order to start partnerships it is important to:

- Identify the "home team"—colleagues who also work with the community,
- Assemble lists of community contacts,
- Convene a first meeting,
- Identify a community-based co-leader,

- Focus on the unique needs of Veterans and their families,
- Brainstorm activities and then prioritize ,
- Develop workgroups, and
- Allow "The Partnership" to make it happen – not individuals.

**VCP Activities**

VCP conducts assessments to determine the unique needs of Veterans within communities, for example, does a veteran need transportation or Adult Day Health Care? VCP also exchanges information between VA and community agencies in an effort to keep both agencies informed of local VA resources, strengths, and potential growth areas. VCP educates community Agencies about specific veteran-related issues and benefits. This includes sharing information by presenting at local/state conferences and informing partners of the unique needs veterans. Local, regional and statewide events are held for both community and VA stakeholders to provide information on continuum of care options and information on resources for veterans, in VA healthcare system and in the community. VCP creates and disseminates educational tools that partners can access for the most current and complete information.

VCP plans to use 2013 funding to engage more national partners, create more VCP sites and sustain VCP as a national initiative long term. VCP is developing and implementing a strategic communications plan to increase awareness and education about VCP. Overall, VCP's goal is to generate a sustainable initiative and network that will enhance the quality of care and services for Veterans and their families as well as enlighten communities about their unique needs.

## Performance Measurement, Reporting and Evaluation in the Bureau of Health Professions: An Update from the Office of Performance Measurement

***Alex Camacho, PhD, CHES, CADC, CPP***
Social Scientist
Division of Workforce and Performance Management, HRSA

Dr. Camacho opened his presentation by reminding members that the Division of Workforce and Performance Management was officially reorganized into the Office of Performance Measurement (OPM) in October 2012. OPM's responsibilities are: (1) lead, guide, and coordinate performance measurement, performance reporting, and program evaluation activities of the Bureau's Divisions and Offices; (2) coordinate and guide BHPr's efforts to use performance information to improve program planning and implementation; (3) maintain effective relationships within HRSA and with other federal and non-federal agencies engaged in program evaluation; (4) promote quality improvement in health professions education through collaboration and partnerships with national and international institutes and centers for quality improvement; and (5) work collaboratively with the National Center for Health Workforce Analysis. OPM serves as the Bureau focal point for performance measurement coordination, reporting, evaluation, and analysis.

BHPr engaged in a lengthy effort to develop and implement a series of revised performance measures for the fiscal year (FY) 2011 data collection cycle (Academic Year 2011-2012). In summary, these revisions aimed to enhance the unit of analysis through the collection at the

individual and program-level data, establish a set of common output/outcome measures across the majority of BHPr-funded programs, and lay the groundwork for enhanced accountability through the implementation of a stronger performance management framework. Data collection requirements must be in alignment with the types of programs funded by BHPr, able to demonstrate compliance with each program's legislative purposes or requirements, ensure that all budget measures can be updated appropriately and accurately, useful for the performance management of grant programs, and useful for grantees and stakeholder community.

Starting with the FY 2011 data collection cycle, OPM has insourced all data analysis activities. This helps maximize accuracy in the reporting and interpretation of measures that support BHPr's annual appropriations request. BHPr is developing a framework for the longitudinal evaluations of its programs. Results will assist BHPr in understanding factors associated with recruiting, retaining, and diversifying the healthcare workforce and how selected BHPr health professions training and loan programs are contributing to the overall supply of the healthcare workforce. The framework for the longitudinal evaluation of BHPr programs will reflect the following priority areas:

Priority #1: Increase capacity and improve distribution of the primary care workforce through enhanced education and training opportunities;

Priority #2: Support innovations in health professions training that include team-based models of care founded on interprofessional education and clinical training experiences;

Priority #3: Reduce health disparities and promote health equity by increasing health care workforce diversity;

Priority #4: Enhance geriatric/elder care training and expertise

Performance measures have been revised to reduce burden and measures are now aligned with the types of legislative purposes of each program. Semiannual reporting will assist BHPr in establishing a stronger performance management strategy across the bureau.

## Health Insurance Marketplaces

Cindy Phillips, MSW, MPH
Deputy Director, Division of Public Health and Interdisciplinary Education
Bureau of Health Professions

On October 13, 2013, consumers in all states will be able to choose new affordable health insurance options through a new Health Insurance Marketplace. Some states are setting up a State-based Marketplace, other states will work with the federal government in a State Partnership Marketplace and the remaining states will have a Federally-facilitated Marketplace. There are several ways to assist consumers with choosing insurance such as, navigators, in-person assistance personnel or certified application counselors, agents, and brokers.

Ms. Phillips explained that although the Centers for Medicare & Medicaid Services (CMS) is primarily responsible for providing materials for individuals to enroll in the health exchanges, HRSA is interested in educating health professionals on ways to assist individuals to enroll in health insurance plans. Ms. Phillips asked committee members for recommendations on how grantees under Part D of Title VII can assist with recruiting and enrolling patients in the new health insurance exchanges.

**ACICBL Member Recommendations:**

- Town hall meetings were held in the past to help with individual enrollment. There were literacy and language issues. Social workers spent four hours from their daily work activities for several months to assist with enrollment. It is important to hold informational sessions and ensure you have individuals that can help with literacy, language and technology barriers.
- Individuals who work in billing offices can be trained to be navigators. Retirees and other individuals could be trained and volunteer to do this work.
- Grantees can make people aware of the upcoming health exchanges. They can identify a point person within their organization who will take charge of how it is rolled out and what gets done within their organization.
- Grantees can conduct meetings to discuss how to help with outreach.
- Navigators should be place in public libraries. This is where some low income families, homeless and individuals without computer access go for information.

## Interprofessional Education, The Canadian Experience

***John H.V.Gilbert, C.M., Ph.D., F.C.A.H.S.,***
University of British Columbia, Canada

Dr. Gilbert discussed interprofessional education and collaborative patient-centered practice in Canada. The Canadian Interprofessional Health Collaborative (CIHC) definition of interprofessional education is two or more professionals that learn with, from and about each other in order to improve collaboration and quality of care. Collaborative patient-centered practice is the active participation of each discipline in patient care. It provides an environment where patient and family goals and values are enhanced, mechanisms are in place for continuous communication among caregivers, there is optimal staff participation in clinical decision making within and across disciplines, and respect for contributions of all professionals.

Dr. Gilbert explained that there is a lack of good continuous communication during, for example, the life of a patient in the acute care system. There is a breakdown in communication which results in a breakdown in collaboration. Canadian professionals are looking at mechanisms to put in place that would insure that throughout the course of patient care the focus is on communication. The CIHC built a knowledge base for collaborative patient care by bringing together materials from projects across Canada in one place. The CIHC website has free studies, tools, and measurements on interprofessional education and practice. CIHC has found that there is a need to develop a body of quantitative and qualitative scientific evidence linking IPE with more collaborative practice and better patient care.

There are a number of interprofessional projects occurring across Canada. A interprofessional group of students from the University of Victoria in British Columbia were sent to work in a community where they lived and worked together for approximately a month. They had curricula designed specifically for the area they were assigned. The students enjoyed the experience and learned to work in teams to help a community. When you give students the opportunity to live and work and experience what other health professionals do, they have a very different view of their profession when they are ready to practice. Dr. Gilbert believes it is important to expose students to team-based care very early in their training. Early exposure allows students to develop a sense of their profession and allow students to understand the importance of collaboration.

Interprofessional education enhances practice, improves the delivery of services and may also have a positive impact on patient care. It can address challenges in chronic disease management, improve workplace safety and job satisfaction, improve organizational care (e.g. referrals), build efficient work patterns, and improve documentation (e.g. guidelines, protocols). In order for interprofessional education to be successful it is important to be flexible in looking at both academic settings and clinical settings. In Canada, the settings, populations, organizations, and units are tailoring their surroundings to IPE.

Canada has been proactive in developing collaborative learning environments within the healthcare system. The Canadian federal government has invested approximately $8 million in collaborative learning environments. To build collaborative work environments you must integrate with health/wellness goals, create collaborative platforms across education institutions, find and champion existing interprofessional teams to develop innovative learning environments, and support student-led initiatives. Structures must be modified to support collaboration. There must be interprofessional leadership and planning groups, incentives for interprofessional teaching/learning, and mechanisms for interprofessional communication.

Dr. Gilbert closed his presentation by emphasizing the importance of work in the community. In Canada they work with first responders, paramedics, Department of Defense and others to look at ways to strengthen communities. One of the requests from the Canadian federal government is to insure that knowledge transfer and exchange mechanisms are developed for getting all of the work about interprofessional education out to communities. Interprofessional education is growing and developing in Canada and there are 12 centers across the country building the foundations for education and practice.

# III. ACICBL Report Discussion

Dr. Weiss discussed the status of the 12th report and next steps. The report is being reviewed by office staff and will be printed and posted on the ACICBL website soon. The 13th report must be completed by September 2013. The writing committee for the 13th report includes Dr. Carmen Morano, Dr. Jay Shubrook, Dr. Patricia Hageman, and Dr. James Norton. The draft title of the report is now *Transforming Interprofessional Health Education and Practice: Moving Learners from the Campus to the Community to Enhance Population Health.*

**Proposed Recommendations for 13th report**

Committee members identified four priority areas and then crafted recommendations. Multiple versions of the recommendations were discussed during the development process. The final versions are presented below.

Recommendation 1: Establish and nurture alliances between academic programs and community-based clinical practices to help community practices become a learning laboratory for interprofessional and population-focused education and care.

- convince health system leaders to be supportive
- addressing triple aim - improving outcomes and decreasing costs
- preparing future providers to work in new and emerging health care system (EHRs etc.)
- convince Payers of their role

Recommendation 2: Provide an incentive and recognition system designed to recruit and sustain the involvement of community-based providers in teaching and modeling the provision of interprofessional and population-focused health care.

- providing financial incentives for practices that accept students
  - Medicaid
  - academic programs pay preceptors
  - examine non-financial incentives
- free continuing education, other perks (library access, conference attendance)
- special certificate of added qualification in interprofessional education or population health

Recommendation 3: Provide ongoing faculty development and team-based training for campus and community- based teachers who will be leaders in interprofessional and population health education.

- provide lifelong interprofessional learning opportunities for health professionals that improve their abilities to enhance their capacity to practice interprofessional education (technology)
- online education, conferences, certificate programs, involvement in research
- provide training for the team
- exploring option of credit bearing certificate that can be used for degree
- all members of team can be teachers

Recommendation 4: Advance the education of students for interprofessional practice by enabling, encouraging and rewarding the active teaching and precepting of students by clinicians from other professional disciplines

- joint appointments
- promotional guidelines and rewards for faculty based on interprofessional education

**Next Steps**

The writing committee will meet to discuss the recommendations and outline developed during this meeting. The technical writer will draft the 13th report and the ACICBL will have another meeting in June to discuss the final report.