ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES (ACICBL)
Summary of ACICBL Webinar and Conference Call
October 30, 2018

Committee Members:
Teri Kennedy, PhD, MSW, LCSW, ACSW, FGSA, FNAP, Chairperson, ACICBL
James Stevens, Vice-Chairperson, ACICBL
Geraldine Bednash, PhD, FN, FAAN
Katherine Erwin, DDS, MPA, MSCR
Joseph Evans, PhD
Robyn Golden, MA, LCSW, ACSW
Bruce Gould, MD, FACP
Parinda Khatri, PhD
Lisa Killinger, DC
Kamal Masaki, MD
John Morley, MB, BCh
Sandra Pope, MSW
Jacqueline Wynn, MPH

HRSA Staff in Attendance:
Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, ACICBL, Division of Medicine and Dentistry
LCDR Nicolette Bennett, Division of Medicine and Dentistry
Kandi Barnes, Advisory Council Operations
Robin Alexander, Advisory Council Operations
Marshala Lee, Chief, Graduate Medical Education, Division of Medicine and Dentistry
Lauren Pinckney, Division of Medicine and Dentistry

Introduction
The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 11:00 a.m., on Tuesday, October 30, 2018. The meeting was conducted via webinar and teleconference from the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 9SWH01, Rockville, MD 20852.

Dr. Joan Weiss, Designated Federal Official, opened the meeting and conducted a roll call. All of the members were in attendance except Dr. Zaldy Tan who could not attend the meeting. After the roll call, Dr. Weiss turned the meeting over to Dr. Teri Kennedy.

Discussion: Updates and Recommendation 2
Dr. Teri Kennedy opened the meeting with an update on the letter that was sent on August 6, 2018 to the Secretary of Health and Human Services (HHS), the Chair and Ranking Member of the Senate Committee on Health, Education, Labor, and Pensions, and the Chair and Ranking Member of the House of Representatives Committee on Energy and Commerce. The letter was sent in response to changes in the Centers for Medicare and Medicaid (CMS) reimbursement structure.

This change will allow the teaching physician to verify in the medical record any student documentation of components of Evaluation and Management (E/M) services, rather than re-documenting the work. The Committee noted that the term "teaching physician" does not encompass all the educators who bill for E/M codes. The Committee requested that the Centers for Medicare & Medicaid Services (CMS) allow nurse practitioners and physician assistants who precept students to use the students' note in their E/M documentation, in the same manner as teaching physicians. Dr. Kennedy reported that HHS Deputy Secretary Eric Hargan responded on October 16, 2018. The letter acknowledged the receipt of the ACICBL recommendation, which was shared with CMS. The Deputy Secretary welcomed the Committee's support of the change allowing teaching physicians to verify medical student documentation of E/M services, which will ease the administrative burden on physicians who serve as clinical teachers and preceptors. He shared the letter with CMS and will carefully consider the recommendations the Committee raised regarding further changes for E/M documentation in teaching settings. Dr. Kennedy stated that she will inform the Committee regarding any further updates.

Dr. Kennedy discussed the writing group's conference call which was held on October 2, 2018. The group discussed the recommendations from the Committee's August 6, 2018 meeting. Each member of the writing group had agreed to work on a write-up for one of the recommendations. Dr. Kennedy requested that the writing group members update the Committee on the conversations they had regarding Recommendation 2.

> Recommendation 2 (page 11 of the draft 17 brief report)
> The ACICBL recommends the adoption of value-based payment models that incentivize interprofessional age-friendly collaborative care to facilitate the transformation of existing healthcare delivery into age-friendly healthcare systems.

Sub-Committee members for writing this recommendation included Dr. Parinda Khatri, Dr. Joseph Evans, and Ms. Sandra Pope. Dr. Khatri presented for the group. She highlighted two concerns regarding Recommendation 2. The first concern centers around the language used in the recommendation. She stated that primary care value-based payment systems do not really exist. She noted that the actual recommendation should be changed to reflect what is appropriate within the providers scope as well as where providers are in terms of financing and funding of clinical services.

The second concern is that if the group makes this recommendation it should include integrating quality and efficiency metrics about the practice component of value-based care contracts or models. The goal is to prepare students to practice in an environment in which healthcare delivery is funded by a value-based model. She confirmed that there was discussion among the writing group regarding how to prepare students but noted that many systems do not as of yet have value-based payment contracts. She then turned the discussion to incorporating didactics in the area of value-based payment systems to prepare students to practice in these systems.

Dr. Khatri expanded on her concern that the language of value-based payment systems is vague and unclear because most health care systems are fee for service. She stated that when people think of a system, they think of an organization. She proposed that the Committee could rephrase the recommendation to say operating in an environment in which there is some value-based payment. Dr. Weiss mentioned that CMS has value-based programs, which Dr. Khatri thought made more sense than value-based payment systems. Dr. Weiss understands recommendation 2 to mean that the recipient needs to collaborate with systems who are looking at adopting these value-based programs where their providers will receive a payment incentive when certain performance measures are met and reflect quality care.

The Committee reworded Recommendation 2:

> The ACICBL recommends that HRSA's Title VII, Part D funding opportunity announcements should encourage recipients to prepare students, faculty, and practitioners to participate in and understand value-based payment systems within age-friendly health care systems.

Dr. Bednash discussed the importance of value-based payment systems, the ability to link the intervention with high quality outcomes, and reimbursement for those outcomes. The issue is the quality and effectiveness of care should be the driver of value-base payments. She discussed that any provider or system that receives Medicare reimbursement is going to be monitored for their quality of care in order to receive reimbursement.

Dr. Weiss clarified that the language for this recommendation was to ensure that trainees, which includes students, faculty, and practitioners, have some knowledge of value-based payment models and then use this knowledge in practice. The recommendation was centered around developing partnerships with health care organizations that have value-based payment programs. She stated that partnerships were included because it is difficult for academia to teach value-based payment models without an entity that is actually providing care under this model. Mr. Stevens stated his concerns about how to make these programs sustainable, especially in rural areas.

Dr. Bednash made the motion to amend Recommendation 2 as discussed above. Dr. Erwin seconded the motion. Dr. Morley abstained, all other Committee members voted in favor of the amendment.

Discussion: ACICBL 17th Report, Report Discussion

Age-Friendly Health Systems

The discussion moved on to the draft of the 17th Annual Report. Dr. John Morley gave an overview of the section on age-friendly health care. Dr. Kennedy commented that the section was very well done and recommended using consistent language in relation to age-friendly versus aging friendly.

Educational Accreditation for Training in Age-Friendly Care

Dr. Kamal Masaki opened the discussion on education accreditation in relation to training in age-friendly care. During her research of accreditations standards, she found that there is a lack of current

requirements for educating students in this area for most of health professions programs. Dr. Polly Bednash stated the standards of Commission on Collegiate Nursing Education, which accredits baccalaureate and graduate nursing education programs, identifies interprofessional education, population health, and care of an increasingly aged population as essential elements of the education of professional nurses. The term "age friendly" and the 4 Ms are not included in these standards as this newer language or framework for care of older adults has not been widely understood. Nonetheless, she noted that the issues inherent in these concepts are included in the educational expectations for the program outcomes.

Dr. Morley mentioned the Accreditation Council for Graduate Medical Education (ACGME) was not included in the accreditation section of the draft report. As of 2003, 27 of the 91 accredited specialties or programs have specific geriatric training requirements. Dr. Masaki requested he email her a copy of the article he discussed so she can draft a paragraph on the ACGME for this section. Dr. Khatri commented that the field of psychology is not very specific in their requirements for age-friendly training. Dr. Killinger noted the chiropractic core curriculum has included coursework on geriatrics as an elective since the 1970's. Dr. Erwin commented that there are similar issues with minimal geriatric training in dental schools and stated she would provide a write-up for Dr. Masaki to incorporate into the report.

Dr. Kennedy discussed that interprofessional practice (IPP) is addressed in health care education and training. She noted there are inconsistencies and lack of specific terminology around age-friendly health care due to the recent development and rollout of this concept.

<u>Health Care Provider Wellness:</u>
Dr. Khatri provided an overview on the provider wellness section. The focus of this section is on establishing a rationale and background for bringing attention to provider wellness and the impact of the quadruple aim on the health care delivery system. Dr. Evans mentioned the recommendation is to provide funding that supports provider wellness for trainees and students. Dr. Bednash noted the link between provider burnout and quality of care and that it does affect reimbursement for services.

Dr. Kennedy discussed her experience trying to get coverage for the quadruple aim for self-care activities for continuing medical education (CME) for medical providers in Arizona. All professions were able to receive credit except allopathic physicians and osteopathic physicians. She asked the Committee to consider incorporating advocacy within accreditation for CME in the report, possibly as Recommendation 5.

Dr. Morley then turned the discussion to the role of the Electronic Health Record (EHR) in provider burnout. He recommended adding a 6th recommendation about improving the functionality and usefulness of the EHR. Dr. Bednash reminded the Committee that she would have to recuse herself from the call during EHR discussions. As a result, the discussion was postponed until after public comment and Dr. Bednash did not participate.

Discussion: Selection of Topics for the 18th Report
Dr. Kennedy opened the selection of topics for the 18th report section. Dr. Khatri recommended addressing social determinants of health including marginalizing conditions in the assessment of patients/clients and comprehensive care planning. Since more practices and professions are integrating food insecurity, housing insecurity, and transportation into their comprehensive care planning, Dr. Khatri described this as a topic that should be considered.

There was discussion about the values and preferences of older adults, their families, and that caregiver willingness and/or ability to provide the care should also be assessed. Dr. Kennedy agreed and noted that death, disability, and injury can result from caregivers who may be willing, but lack the training or physical ability to provide necessary care. Family caregivers may also feel pressured to say yes to providing care even when they are not able to do so.

Mr. Stevens discussed a book called *Practical Playbook: Public Health and Primary Care* by Dr. Lloyd Michener. The book lays out how inter-sectoral coalitions based on GIS mapping can address the level of chronic disease and other issues. This allows the public health officials to pinpoint which city blocks or regions have a disproportionate share of high utilizers by disease or issue. From this data, they can start looking at root causes and address them. There was a significant amount of discussion around this topic especially regarding the opportunity to expand the interprofessional team. It bridges health care with social supports and brings in providers who are normally not a part of the health care discussion. Team members could include informaticists, health economists, GIS-mapping personnel, sanitation, housing authorities, grocers, legal aid partners, city planners, and others.

Dr. Morley expressed his concern that this is a major political issue. He discussed his work in the inner city of St. Louis, Missouri. The majority of the issues relate to infrastructure and addressing them. He believes that if this is going to be accomplished, a solution for the identified issues must be provided. He agreed that it is a great topic, but is skeptical that it should be in the report for HRSA. Dr. Bednash disagreed and supported including it. She stated that this is an issue of community investment and this prepares people to be able to handle and work towards these issues.

Framed as a Recommendation:
HRSA would promote the inclusion of population health both at the nexus of primary health care delivery as a method of identifying place-based risk.

Dr. Morley recommended the use of social media to train health professionals, older individuals, and caregivers as another potential topic. Dr. Erwin agreed that it is an innovative technology to disseminate information to a large number of people very quickly in short bites. Health care providers and educators need to approach social media differently for different age groups. Dr. Masaki agreed and suggested including health care navigators or community health workers (CHW) to help get the message on social media and out to patients/clients.

Dr. Weiss noted the Area Health Education Centers has legislation to provide support to grant recipients to train CHWs. GWEP, in addition to educating health professions students, faculty, and practitioners also educates the direct care workforce and patients, families, and caregivers. Dr. Evans affirmed the importance of CHWs and patient navigators to help patients navigate the health care system. He also stated the importance of students receiving education on how Medicaid or insurance works or ways to determine what resources are available.

Dr. Morley discussed patient-centered medicine as a possible topic to include. Patient-centered medicine looks at the patient as an individual including their environment and social determinants of health.

Dr. Bednash recommended violence as a public health issue. She stated that violence is a major public health problem. Providers may not have adequate training and education to know how to deal with violence suffered by patients, the community, or by providers. Social determinants of health, patient

navigators, CHWs, and social media can tie into this topic. Trauma-informed care and/or the impact of trauma was also mentioned as possible topic.

From the discussion, the following topics emerged. The topics were voted on via email. Recommendations (listed in order from most to least votes):

1. HRSA would promote the inclusion of population health at the nexus of primary health care delivery and public health as a method of identifying place based risks, its root causes, and possible interventions to address the structural and social determinants of health. Prepare clinicians to serve as change agents promoting primary prevention. (7 votes)
2. Our health care system is so complex, having something along the lines of health care navigators to help patients navigate the health care system. Training providers and students in the roles, competencies, and optimal use of Community Health Care Workers (CHW) as a member of the health care team. AHEC has programs for training CHW and training the direct health care workforce. (2 votes)
3. Educating providers about the significance of violence and its impact on the health of the individual and the community. Preparing providers to intervene in situations where violence is occurring or potential. (2 votes)
4. Training should prepare clinicians in the use of social media to educate and improve health for older adults and caregivers. Educate providers to improve care through the use of social media and other technology. (1 votes)
5. Educate providers about person- and family-centered care. This includes the impact of the environment and social determinants of health on that care.
6. Trauma-informed care including an understanding of clinical presentation and appropriate treatment to assess the impact on physical and psychological health status and patient engagement in health status. Dr. Weiss discussed the next step is for the in-person meeting, the planning committee would work to identify speakers to present via conference call/webinar at the meeting. HRSA staff will send out recommendations for literature for members to read. At the in-person meeting, we will discuss the information and develop a draft of the recommendations for the 18th ACICBL report.

Dr. Weiss stated they would try to get Dr. Lloyd Michener to present at the next meeting. Dr. Killinger stated that while the speakers are wonderful, the in-person meetings are so valuable for developing strategies and working together. She expressed her hope that the majority of the time for this meeting is held for the committee to work together. Dr. Weiss stated that they budgeted for five speakers. This number does not include federal speakers, which do not count against the budget. She requested that member recommendations for speakers and potential literature to be sent to Dr. Weiss and Dr. Kennedy.

Dr. Weiss called for volunteers to serve on the writing and planning committees. The following have volunteered:

Writing committee: Dr. Killinger, Dr. Gould, Ms. Wynn, Dr. Kennedy, Mr. Stevens
Planning committee: Dr. Bednash, Dr. Erwin, Dr. Gould, Dr. Kennedy, Mr. Stevens
Ms. Golden can be a reviewer but cannot serve on the writing committee.
Dr. Kennedy is the Chair this year. Mr. Stevens will serve as Chair next year.

Dr. Kennedy and Dr. Weiss thanked the team for the excellent discussion on the 17th Report. Dr. Weiss opened the meeting for public comment. There were no comments. Dr. Bednash recused herself for the discussion on EHR.

Dr. Morley started the discussion on the EHR. He stated that in the case of geriatrics, the EHR does not provide algorithmic help or guidance to the provider. As a result, few health care professionals have experience of the knowledge in geriatrics or geriatric syndromes. The EHR should be able to provide these professionals with some guidelines for this population.

Dr. Gould stated that these guidelines should exist for every age span. He also noted that most of the systems were built around billing systems with the data entry component added later. The systems are difficult to use and force the providers to add information regardless if it is in the best interest of the patient. The notes are often filled with little value that have to be sifted through to identify significant medical history, chief complaint, treatment rendered, and what the outcomes were. This increases the stress and burden on the provider. Dr. Gould stated that residents and students report issues with the EHR systems as well. With suicide rates increasing among residents and students, he voiced his concerns with this issue.

The EHR system was to be a tool to help the practitioner, communicate with the patient, reduce errors, and save money. Instead, it has increased the burden on the providers and has complicated patient communication because of unnecessary reports. The new practitioners and trainees are adept at copying and pasting notes. This has the potential to increase errors, as these notes are not always accurate. Dr. Weiss brought the conversation back to what the Committee wanted the Title VII Part D programs to do regarding workforce development.

Dr. Gould recommended a letter that identifies this topic as an issue with workforce development in that it dissuades young people from going into the profession. Furthermore, it is a major cause of burnout for students and practitioners. Dr. Morley recommended identifying and developing a solution as a joint project between HRSA and CMS. Dr. Weiss advised him that to include this in the 17th Report, it needed a recommendation. She was asked if she reach out to her colleagues at CMS first and get their thoughts on the topic. Dr. Gould will send her a short write-up of what they want to discuss with CMS.

Dr. Kennedy adjourned the meeting.