Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL)

Meeting Minutes
June 6-7, 2018

ACICBL 17th Report Discussion:
Preparing the Current and Future Workforce to Practice in Age-Friendly Health Systems

Council Members in Attendance
In Person
Geraldine Bednash, PhD, RN, FAAN
Katherine Erwin, DDS, MPA, MSCR (Day 1)
Joseph H. Evans, PhD
Robyn L. Golden, MA, LCSW, ACSW
Bruce E. Gould, MD, FACP
Parinda Khatri, PhD
Lisa Zaynab Killinger, DC
Kamal Masaki, MD
John E. Morley, MB, B.Ch
James Stevens
Jacqueline R. Wynn, MPH

Via Teleconference
Sandra Pope, MSW

HRSA Staff in Attendance
Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, Division of Medicine and Dentistry
Ms. Kim Huffman, Director, Advisory Council Operations
Mr. Raymond Bingham, Technical Writer/Editor, Division of Medicine and Dentistry
Ms. Nicole Hollis-Walker, Technical Assistance, Division of External Affairs

Melissa Moore, MS, MBA
Sudeshna Mukherjee, PhD
Jacqueline Rodrigue, MSW
Lorener Brayboy, MSW, LICSW
Sara Williams
Kennita Carter, MD

Day 1: Wednesday, June 6, 2018

Introduction

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) held an in-person meeting at the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 15W48, Rockville, MD 20857.

Dr. Joan Weiss, Designated Federal Official (DFO) for ACICBL, called the meeting to order at 8:30 a.m. ET. She conducted a roll call, and all current members were in attendance. One member, Dr. Sandra Pope, attended via teleconference.

Dr. Weiss introduced the first speaker, Terry Fullmer, PhD, RN, FAAN, the President and Chief Executive Officer of the John A. Hartford Foundation.

Presentation: Preparing the Current and Future Health Care Workforce for Interprofessional Practice in Sustainable, Age-Friendly Health Systems, including Addressing the Quadruple Aim

Dr. Fulmer described the John A. Hartford Foundation as a private philanthropic organization, and a leader in improving care for older adults. She noted the Foundation's connection with the HRSA mission of improving health care to those who live in rural or other isolated areas, and those who are economically or medically vulnerable, including frail older adults. The three priority areas for the John A. Hartford Foundation are: age-friendly health systems, family caregiving, and serious illness and end-of-life issues. Dr. Fulmer stated that few hospitals and health systems currently meet the needs of older adults.

Dr. Fulmer added that over 18 million people in the United States serve as family caregivers to older adults, and health systems need to address the needs of these caregivers as well. Meanwhile, care during serious illness or at the end of life often fails to meet the goals or preferences of the patient and the family.

Dr. Fulmer noted that the aging of the population, with more people living past 65 years of age, is a great public health success story, and that older adults contribute to society in many ways. The goals of an age-friendly health system include better health outcomes, reduced waste, and increased use of cost-effective services. These areas are supported by the Public Health Service (PHS) Act, Title VII Part D programs that fall under the purview of the ACICBL charter.

Dr. Fulmer said that nine of the 10 "Avoidable Harm" priorities published by the Centers for Medicare and Medicaid Services (CMS) relate primarily to older adults, and include adverse drug interactions, infections, injuries from falls, and hospital readmissions, among others. She identified some current gaps in care for older adults, such as:

- Receiving unwanted care or inappropriate medications
- Failure to receive necessary or evidence-based care,
- Failure to encourage mobility,
- Disproportionate experiences of needless harm and death.

Dr. Fulmer noted that successful models of geriatric care are difficult to disseminate to all health systems, or to scale to communities of different populations sizes and resources. To help spread the development of age-friendly health systems, the Hartford Foundation encouraged health care systems to focus on the "4M" indicators for older adults

- What Matters: Knowing and acting on each patient's health care goals and preferences,
- Medication: Optimizing medications to improve effectiveness and reduce harm,
- Mobility: Maintain physical function and treat complications, and
- Mentation: Focus on reducing depression, delirium, and dementia.

Dr. Fulmer stated that under the Hartford Foundation initiative more than 30,000 patients have received age-friendly health care, while five health systems with sites in seven states have been transforming their care, and interest in other systems is growing. She cited examples from several health systems across the country.

Dr. Fulmer discussed several HRSA programs that could incorporate the concepts of age-friendly health systems, including the Area Health Education Centers (AHECs), the Geriatric Workforce Enhancement Program (GWEP), and programs in allied health, rural health care, and behavioral health, and provided several recommendations for the Committee to consider.

Q and A

Dr. Weiss opened the floor for questions.

There was a question about the involvement of chiropractic institutions in the age-friendly initiative. Dr. Fulmer replied that she had experience working with chiropractic colleges in New York, and appreciated the benefits of chiropractic care for older adults. Another question addressed maintaining quality control as the Hartford Foundation's age-friendly program expands. Dr. Fulmer referred the question to her colleague, Dr. Amy Berman, who stated that systems interested in joining the initiative need to have a commitment from their leadership, and a commitment to gather data. Participating institutions receive technical assistance to guide them in making their care models consistent with the 4M construct. Dr. Fulmer added that the initiative is not asking health systems to develop something new, but to think differently about how to modify their systems to promote age-friendly care. Another question addressed embedding the 4M concepts into the accreditation criteria of all health professions. Dr. Berman replied that there has been a lot of work done toward inclusion of aging and elder care issues within accreditation bodies, but this effort has generally failed to hone in on the essential elements. Dr. Fulmer added that the World Health Organization (WHO) began using the phrase "age-friendly" in 2010, and it has become a social movement in terms of promoting age-friendly communities, cities, and public health systems.

Dr. Parinda Khatri stated that she works with the Cherokee Health System, an integrated health care system located in Tennessee. As a federally qualified health center (FQHC), their mission is to serve the most vulnerable communities in both rural and urban areas. She asked how the age-friendly system could fit into primary care, and how it addresses the social determinants of health (SDH) that impact many of the elderly, including food insecurity, substandard housing, and poor access to transportation. Dr. Berman replied that the five prototype age-friendly health systems referred to in Dr. Fulmer's presentation include many types of community sites,

including primary care and public health clinics, inpatient/outpatient centers, and Program for All-Inclusive Care of the Elderly (PACE) and other senior centers. The program includes training on how to work with community-based supports and services to address SDH issues.

Dr. Khatri also asked how the age-friendly initiative is addressing health literacy. She stated that many older adults grew up in a more paternal health care system, and may not be accustomed to making their own health care decisions or stating their preferences. Dr. Berman stated the age-friendly initiative has engaged many experts in this area to learn how to elicit a patient's goals in care and translating those goals into treatment options that are consistent with the individual's goals and values. The program has also engaged with patient and family advisory councils to focus on what is important to older adults.

There was discussion on what HRSA could do to promote the spread of age-friendly systems, and what challenges need to be addressed. Dr. Berman said that HRSA's workforce development programs are vital in filling the need for expanding and improving the healthcare workforce. She suggested that clinical training could focus more on preparing clinicians to organize care in an age-friendly manner across all types of clinical sites. The HRSA Title VII programs can help accelerate the trend toward age-friendly systems and bring in more allied health professionals and institutions. In reply to a question on difficulties with current electronic medical record (EMR) systems in collecting and analyzing population-level health outcomes to address risk stratification, Dr. Berman responded that a Hartford Foundation workgroup will focus on the EMR issues.

Mr. James Stevens raised an issue of the challenges in rural villages in Alaska, which often have trouble filling community health aides because they are too focused on chemical dependency and substance use disorders, and not on the physical and mental health needs of geriatric populations. Dr. Berman stated that the Hartford Foundation has worked to address mental health care for the elderly in many rural states, and understands vital the role of community health aides in first-line care, while telehealth services may help extend the reach of the behavioral health providers.

Dr. Weiss thanked Drs. Fulmer and Berman for their presentation and their responses, and introduced the next speaker, Candice Chen, MD, MPH, Director of the Division of Medicine and Dentistry (DMD), Bureau of Health Workforce, at HRSA.

Update: Division of Medicine and Dentistry and the Budget Process

Dr. Chen noted that the Division of Medicine and Dentistry (DMD) focuses on programs in medicine and dentistry, but also oversees the GWEP, an interprofessional training program. She added that if GWEP is funded in FY19, DMD is planning to have a competition requiring partnerships between academia, community-based primary care delivery systems/sites, and the community-based organizations partnerships, including a focus on family caregivers. The current grant cycle has been extended from three to four years, and there will be an emphasis on enhancing evaluation during the fourth year of funding. There was some further discussion of the Geriatric Academic Career Awards (GACAs), which are intended to support junior faculty who are clinician educators. However, these awards are not currently funded.

Dr. Chen offered a review of the federal budget process. The federal budget period is from October 1 through September 30 of any given year, and currently the government is in fiscal year

(FY) 2018. In advance of almost any fiscal year, the President typically releases a budget request that reflects the administration's priorities. For example, this year the President released his request for FY 2019 in February 2018. For both FYs 2018 and 2019, the President's budget requested no appropriations for the programs under Title VII, Part D. Instead, it prioritized funding for health workforce activities that provide scholarship and loan repayment to clinicians in exchange for their service in areas of the United States where there is a shortage of health professionals, programs such as the National Health Service Corps (NHSC) and the Nurse Corps.

Dr. Chen stated that Congress determines the budget appropriations, ideally before the start of the fiscal year. In recent years, the appropriations bills have not been completed to meet this deadline. However, to keep the government funded, Congress has passed continuing resolution bills, which maintain funding at the current level.

For FY 2018, Congress passed an Omnibus Appropriations Bill in March 2018. In the Omnibus Bill, Congress not only funded most of HRSA's programs, but they increased funding for several programs, including AHEC and GWEP. In particular, mental and behavioral health mental health education was funded at $36.9 million (an increase of $27 million), while the Behavioral Health Workforce Enhancement Training (BHWET) program was funded at $75 million (an increase of $25 million). This increase in funding was largely tied to improving training to address the nation's opioid crisis.

Q and A

There was a comment about an apparent lack of value placed in the education of healthcare professionals reflected in the President's Budget. Dr. Chen replied that the funding requests from the executive branch reflect a prioritization, and the Committee provides advice to both the executive branch and Congress. The outcomes of federal investments in training programs are difficult to assess. The healthcare training programs are looking into ways to improve the clinical learning environment to improve educational outcomes, and health professions education is closely tied to healthcare delivery. Dr. Weiss added that HRSA and other agencies have been working to integrate behavioral health care into primary care, which is now being boosted by the priorities of the administration and HHS on the opioid crisis. Dr. Chen concurred that it often takes a crisis to direct attention and funding to a particular area of need. However, there is a need to maintain balance across all of HRSA's training programs. There was discussion of the vital role of other programs, in particular the AHECs, in providing ongoing education to clinicians to improve care.

There was a comment that health and health care have huge impacts on the economy, in terms of the costs of health care, employment in the health sector, and the need for a healthy workforce in all sectors of the economy. A related comment stated the need to develop a metric or some type of performance measure that evaluates the impact of healthcare on a community in terms of economics.

Update: Behavioral and Mental Health Programs

Dr. Weiss introduced the next speakers, CAPT Sophia Russell, Director of the Division of Nursing and Public Health (DNPH), and Melissa Moore, MSW, MBA, Chief of the Behavioral and Public Health Branch in DNPH. Ms. Moore stated that her branch oversees two behavioral

health training programs: Behavioral Health Workforce Education and Training (BHWET), and Graduate Psychology Education (GPE). In FY 2017, the behavioral health training component accounted for roughly $70 million in funding. These programs provide over a million hours of behavioral health services per year at approximately 3,000 clinical sites across the United States.

Ms. Moore informed the Committee that BHWET started in FY 2014, in part to address behavioral health services to at-risk youth in response to the Sandy Hook shooting. She added that GPE started in 2002 and is directed at educating and training doctoral-level students in psychology.

Ms. Moore stated that all of the behavioral health programs focus on integrating behavioral health and primary care, with the goal of developing interprofessional care teams. The programs provide training and stipends for students, as well as training faculty members and field supervisors to ensure that the entire team is at the cutting edge. The programs are also working to create partnerships with community organizations to expand services and field placements for students. These community partnerships are vital for dealing with the current opioid use epidemic in terms of providing prevention, treatment, and recovery services.

Ms. Moore noted that the behavioral health training programs received a substantial increase in funding in FY 2018, in response to the opioid epidemic, and plans for the use of the additional funds were under development. One focus would be to increase the number of providers certified in medication-assisted treatment (MAT) for substance use disorders. There is also a need for a coordinated care team with social workers, psychologists, and counselors, due to the complexity of providing addiction care.

Q and A

There was a question about the Leadership in Public Health and Social Work Education (LPHSWE) program. Ms. Moore replied that LPHSWE is a relatively small program, involving less than one million dollars and with three grant recipients. It is intended to train dual masters-level students in both social work and public health to become leaders in the field.

There was a second question relating to the possibility of leveraging some of the initiatives, for example to use GWEP to train more mental health workers with a geriatric focus. Dr. Chen replied that the AHECs are addressing some ways of "breaking down silos" by investing in a learning collaborative to bring grantees together across programs. This collaborative has just started to meet, and the initial area of focus is training for rural workforce development.

Presentation: Performance Measures and Evaluation for Health Resources and Services Administration Training Programs

Dr. Weiss introduced the next speaker, Sudeshna Mukherjee, PhD, a public health analyst with the National Center for Health Workforce Analysis (NCHWA) at HRSA, to talk about performance measurement and evaluation for the HRSA health workforce training programs.

Dr. Mukherjee stated that linking performance data to program outcomes is one way to tell a story that sheds light onto activities the programs are doing well. NCHWA is located within the HRSA Bureau of Health Workforce (BHW) and serves as a national resource for health

workforce research, information, and data to provide policymakers with information and data to help them make decisions regarding health workforce education, training, and delivery of care. NCHWA analyzes the supply, demand, distribution, and education of the nation's health workforce, and coordinates the data collection analysis and evaluation efforts for BHW programs.

Dr. Mukherjee said that NCHWA is divided into two main branches that work in tandem: Workforce Analysis and the Performance Measurement and Evaluation (PME). The Workforce Analysis Branch is external-facing, producing national projections and health workforce supply and demand data. In 2017, NCHWA released two projection reports: the national and regional projections of supply and demand for geriatricians from 2013 to 2025, and the supply and demand projections for the nursing workforce, 2014 to 2030. Both of these reports can be found on the NCHWA web site.

The PME branch is internal-facing, developing and publishing performance measures and benchmarks for BHW training and education programs, conducting performance management and measurement of grant program outcomes, and providing multi-year retrospective and prospective program evaluations. The performance measures NCHWA collects are legislatively-mandated by Congress through the Government Performance and Results Act (GPRA). The performance measures are specific to each training program within BHW, and the reporting requirements are detailed in the notice of funding opportunity (NOFO), and the program legislation. These measures provide performance metrics for training programs in medicine, behavioral health, dentistry, nursing, and public health, as well as health career pipeline programs. The types of performance data that NCHWA collects include program characteristics, demographic information, individual-level trainee data, one-year follow-up outcomes, clinical training sites and experiences, curriculum development and enhancement, faculty development, and continuing education. This information also includes the sociodemographic characteristics of trainees, total stipend support, types of training received, and graduation status.

For curriculum development and enhancement, NCHWA captures information on the types of courses and training activities developed through HRSA funds, the professions and disciplines of trainees, and the continuing education courses that were developed. Together, these performance measures help to inform HRSA on the effectiveness of its investments. Furthermore, they are applied to the HRSA budget justifications to Congress, and used to develop peer-reviewed manuscripts on workforce analysis for publication.

Q and A

There was a brief discussion about connecting the performance measures that NCHWA collects and publishes with the impact of the programs in the communities they serve. Dr. Mukherjee stated that NCHWA is making efforts to evaluate retrospectively program effectiveness and to link investments to outcomes. However, there are limits to the data that NCHWA can collect.

Committee Discussion: GWEP

Dr. Chen led a discussion to get feedback from the Committee on GWEP. She stated that if the program receives funding for FY 2019, then HRSA would need to release a new NOFO for competition. She said the previous competition went well, with 44 grants awarded from over

150 applications. She added that HRSA has also received inquiries on reviving the GACA program, which supports clinician educators in geriatrics.

There was a comment about the need to improve the geographic distribution of the GWEP grants, since many smaller or rural states that need funding are unable to successfully compete. There was a suggestion of creating two levels of awards, allowing smaller awards to go to states trying to set up a new program. Dr. Weiss noted that there was a common complaint that larger and more sophisticated institutions have more experience in the grant application process and greater resources to devote to writing grant applications. One member suggested requiring grant applicants to develop partnerships with smaller institutions or community organizations to help with mentoring in the grant process and improve the distribution of funds. Another suggestion was to create a separate funding stream for "breakthrough" awards to encourage successful programs in rural or other resource-poor areas. There was further discussion on ways to involve smaller organizations, which often have lower overhead (indirect) costs and may have stronger connections to the community.

Update: The Area Health Education Centers Program

Dr. Weiss introduced the next speakers, CAPT Jacqueline Rodrigue, MSW, Director of the Division of Health Careers and Financial Support, and LCDR Lorener Brayboy, MSW, LICSW, a project officer with the AHEC program.

CAPT Rodrigue stated that the AHEC program was established by Congress in 1971, with the goals of increasing diversity among health professionals, enhancing health care quality, and broadening the distribution of the health workforce. AHECs have developed training networks in rural and underserved areas, and work closely with both academic and community-based partners. In FY 2017, HRSA awarded grants to 49 AHEC programs in 46 states across the country, as well as the District of Columbia, Guam, and the Republic of Palau. The funds from these grants support a total of 261 community-based centers. Of the 49 programs, 46 are located in schools of medicine, and three are located in schools of nursing. LCDR Brayboy added that AHECs receive funding from multiple sources, including federal, state, local, and community-based organizations. In FY 2016-2017, AHECs trained almost half a million practitioners. Almost two thirds were working in primary care settings, while over 60% were working in medically underserved areas and over 40% were in rural areas.

LCDR Brayboy noted that the AHEC Scholars program is a new, two-year longitudinal pipeline program designed to help health professional and allied health students get specialized training in rural and underserved areas, with a focus on interprofessional education (IPE) and patient-centered medical care. The AHEC programs are currently in the first year of a new five-year project period, which serves as a planning year for them to build their curriculum, training modules, and IPE case studies. The AHECs now require that the AHEC program director serve on the admissions committee of the school of medicine or nursing, to help increase the visibility of the program and give the directors a voice in developing more holistic approaches to admissions. LCDR Brayboy said that HRSA has hosted several webinars on the AHEC program requirements, which have helped programs in their planning process and increased dialogue between the different programs. Some of the programs are creating learning collaboratives to share best practices, ideas, and strategies to meet the programmatic requirements for this new cycle.

AHECs have been nationally recognized for innovations regarding such areas as opioid treatment, telehealth, and health literacy. The AHEC program office at HRSA was part of the first-ever federal roundtable on workforce pipeline programs, which brought together 14 separate federal programs to discuss ways to leverage resources. The AHEC program office has also encouraged partnerships between AHECs and other HRSA programs. For example, the AHEC program was mentioned as a strategic partner for the Primary Care Training and Enhancement – Training Primary Care Champions program.

There was a comment that students in the AHEC Scholars program are very excited to be selected, and over time the program will build a community of scholars and provide opportunities for mentoring. However, these students are finding that completing the additional activities of the scholars program is a challenge on top of their regular school requirements.

There was another comment to commend the program for its new branding with the scholars program. These students are now more aware of working within an AHEC, and can be tracked over a period of time. An important marketing tool for the program is interprofessional training, so that students know they will be learning with and from a range of other students. Another comment concerned the importance of training for clinical preceptors, to give them the tools to understand how to train students from multiple disciplines.

Presentation: From Council Recommendation to Policy: The Process

Dr. Weiss introduced the next speaker, Sara Williams, Deputy Director, Division of Policy and Shortage Designation. Ms. Williams stated that the intent of her talk was to help the Committee provide good feedback to the federal government. She reviewed the ACICBL charge, which includes providing advice and recommendations to the HHS Secretary and Congress. In developing recommendations, Ms. Williams listed the following considerations in regards to the development of recommendations:

- Is the recommendation a legislative or a policy recommendation?
- Does HHS have the authority to make the change the recommendation is proposing?
- Who is the appropriate audience?
- What is the appropriate vehicle to share the advice and recommendations?

An advisory committee's advice and recommendations are usually provided through a report, which typically contains a list of recommendations, along with supporting text. Other types of documents can include a letter to the Secretary, and a policy brief or white paper. The strongest recommendations propose a precise action that can be tied to a specific action that the Secretary can make. Ms. Williams provided examples of strong recommendations to address both legislative (recommending a specific change in legislation) and policy (addressing regulatory issues, programmatic issues, or funding priorities) concerns. As an example, she stated that the Committee might choose to recommend how HRSA could best use the added funds provided in FY 2018 to address the opioid crisis.

Ms. Williams said the recommendations for specific legislative changes may go through the A-19 process, which is an Office of Management and Budget (OMB) circular that helps guide the legislative direction for the President's budget. If the recommendation is compelling and fits

within the administration's priorities, the A-19 memo will move forward and may end up with Congress, where specific language is drafted by the appropriations committee resulting in a legislative change.

Dr. Chen stated that committees may address a broader audience than the Secretary or Congress. Sometimes a committee may make recommendations to accrediting bodies, or other institutions. Professional organizations and other stakeholders read the reports and may consider the recommendations as a way to advance the field as a whole. However, all recommendations need to link back to the charge of the committee.

Panel: Clinician Well-Being, Resilience, and Burnout

Presentation: Promoting Well-Being and Preventing Burnout

Dr. Weiss stated that a panel would present on clinician well-being, resilience, and burnout, followed by discussion. She introduced the first speaker, Kennita Carter, MD, Senior Advisor, DMD and Designated Federal Official for the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) and the Council on Graduate Medical Education (COGME). Dr. Carter noted that there is a significant amount of discussion in the literature on the "quadruple aim" of healthcare improvement: enhanced patient experience, improved population health outcomes, lower costs, and improved provider well-being. Recent surveys describe a rapidly growing problem of burnout among clinicians in several professions, indicating a strong need to address provider wellness and resilience.

Referring to Dr. Fulmer's presentation, Dr. Carter stated that preparing the current and future health workforce includes improving their working conditions and work satisfaction. The ultimate goal is to help clinicians find more vitality, self-efficacy, meaning, and fulfillment in their work, to avoid burnout. Burnout includes three components – emotional exhaustion, cynicism, and lack of joy in practice. She said she had experienced burnout herself in her academic career, which has helped inform her views on the work environment and workload.

Dr. Carter indicated that the ACTPCMD has also examined the issue of provider well-being and burnout, in the area of primary care. The ACTPCMD members discussed recommendations that HRSA identify the measurement, prevention, and mitigation of burnout among trainees as an area of emphasis across the HRSA grant portfolio. They also include a recommendation that health professions educational accreditation organizations include competencies on provider well-being. Dr. Carter added that there are several national initiatives addressing burnout, including efforts by the National Academy of Sciences, the National Academy of Medicine, the Alliance for Academic Internal Medicine, and the Accreditation Council for Graduate Medical Education. She stated that while many hospitals and health systems may provide individuals with self-care strategies, a systems-level approach is needed for meaningful and long-lasting structural change.

Presentation: Clinician Well-Being & Resiliency as a Prerequisite for the Triple Aim

Dr. Weiss introduced the second panel speaker, Angelo McClain, PhD, LCSW, the Chief Executive Officer of the National Association of Social Work. Dr. McClain stated that he had previously served as the Commissioner of Child Welfare for the Commonwealth of Massachusetts, and helped institute changes to promote the safety and well-being of social

workers while better addressing the needs of families. He noted that many of social work staff in this organization felt like they were doing "real social work," which helped reduce staff turnover.

Dr. McClain noted that any discussion on clinician well-being should cover issues of depression and suicide, to encourage open discussions and provide support. Along the same lines, improving population health requires a team of healthcare providers and clinicians who are positively engaged, as clinicians are facing increasing demands due to:

- An aging population and other demographic changes,
- Changes in disease patterns,
- Rising expectations of health care, and
- Rapid advances in medical technology.

According to Dr. McClain, studies have shown that better staff engagement is linked to better patient experiences, shorter hospital stays and fewer readmissions, improved safety, better clinician-patient communication, and a lower overall cost of care. The care of the patient requires care of the clinician.

However, clinician burnout is a significant concern. Burnout can lead to physical symptoms like headaches, fatigue, insomnia, and stomach upset, as well as anxiety, depression, and substance use disorders. Almost half of physicians report some symptoms of burnout, and physicians – and in particular female physicians – have much higher rates of suicide than the general population. Stress and burnout occur across the health professions, as one-quarter of intensive care nurses test positive for post-traumatic stress disorder. Burnout is affected by both individual traits and external factors such as sociocultural expectations, organizational practices, and the practice or learning environment.

Building resilience includes practices of self-care, such as proper nutrition, sleep, and exercise; supportive personal and professional relationships; hobbies and other outside activities; humor; and time away from work to rest and recover. However, organizational strategies are needed as well to improve work efficiency, focus time on patient care rather than paperwork, establish wellness as a goal, engage leadership, and align values with a wellness culture. Dr. McClain listed some recommendations on clinician wellness for the Committee to consider:

- Establish clinician well-being as a national priority.
- Develop a national clinician well-being metric.
- Change regulations to reduce the burden of medical documentation.
- Provide incentives to create a culture of help-giving and help-seeking.
- Promote well-being best practices in educational and training programs.

Q and A

There was a comment that a major issue for health systems involves patient satisfaction. Overall, patients are not happy with the care they receive in many acute care settings, which can hurt an institution's bottom line. Establishing the link between provider well-being and patient satisfaction is crucial to get more policy-makers to understand the financial impact.

There was a discussion of the difficulties many clinicians face with the EMR. Although intended to reduce paperwork, improve efficiency, and promote communication, the EMR often frustrates

clinicians or leads to a culture where many feel that documentation involves just checking off boxes and not seeing patients. Another comment was that it sometimes takes a crisis, such as the suicide of a student or a co-worker, to get the attention of leadership and initiate change. There was further discussion that steps for self-care and resilience are not taught in medical, nursing, or other programs, and in fact many professions have a strong culture of self-sacrifice and "toughness" in the face of difficulties and a reluctance to admit weakness or seek help. As a result, promoting well-being will have to address changes to professional culture. One successful approach has been a shift to team-based care in which team members look out for each other and can intervene if a member is becoming frustrated or withdrawn.

Presentation: Helping to Make Students Important Members of the Team

Dr. Weiss introduced the next speaker, Beat Steiner, MD, MPH, Assistant Dean for Clinical Education at the University of North Carolina School of Medicine. Before the presentation started, Dr. Geraldine Bednash announced that she would need to recuse herself from any discussion related to EMR. Dr. Steiner stated that his presentation would focus on the student's role in documenting in the EMR in relation to CMS documentation rules, along with how to help students from different disciplines work together on the health care team.

Dr. Steiner outlined two interrelated problems. First, there is an inadequate supply of clinical teachers or preceptors. Part of the difficulty in attracting and retaining clinical teachers also applies to the discussion of burnout. Clinical teachers of all profession face growing demands to:

- See more patients.
- Work with more learners seeking clinical opportunities.
- Manage administrative burdens, especially around documentation in the EMR.

Second, students do not have the opportunities to learn vital clinical skills, because:

- Clinical teachers lack sufficient time to teach.
- Students are no longer a central part of the team, due to current regulations.
- Many health institutions and systems do not allow students access to the EMR to document care, or even to read the patient's chart.

Dr. Steiner referred to the previous discussion on burnout, especially around the demands of documentation. Students provide care that needs to be documented. However, CMS guidelines have restricted student activities in the EMR, so that many feel marginalized and not part of the team, while clinical instructors have to take the time to enter this documentation. In one survey, almost all respondents felt that the CMS restriction preventing student documentation from being used by the clinical preceptors was a major impediment to clinical teacher recruitment and retention. In a 2018 survey, over 90 percent of clinical teachers indicated that allowing students to help with documentation would save them up to 60 minutes of charting time for each half-day session. Allowing the use of student documentation would help clinical teachers to:

- Spend more time teaching,
- Consider precepting additional students,
- Increase their enjoyment of the practice of medicine, and
- Spend less time outside of patient care finishing their charting.

Due to the efforts of several stakeholder organizations, CMS changed their guidelines in the spring of 2018 to allow the teaching physician to use the student's notes, and not have to re-document care. Dr. Steiner emphasized that this rule revision does not change the requirement for appropriate supervision of the student. The new rule was well-received within medical education, and more physicians in ambulatory care settings have been willing to take students.

Dr. Steiner noted that integrating students more fully into the health care team can have many benefits aside from helping with documentation. In particular, student can assist with patient education, coaching, and support. He cited one example where the efforts of students in his own practice almost doubled the rate of screening for cervical cancer.

However, drawbacks and restrictions to the use of student documentation remain. Dr. Steiner noted that many people across different professions have a significant amount of information to teach all students. He requested that ACICBL help amplify the following messages to CMS:

- Allow medical student notes to be used by the resident.
- Allow teaching clinicians to use the notes of nurse practitioner (NP) and physician assistant (PA) students.
- Allow non-physician clinical teachers (NPs and PAs) to use student notes in documentation.

Q and A

There were several comments reinforcing the message that students need to be more involved in documentation, which helps them become experienced in an important clinical skill and feel more involved in providing care. There was a concern expressed that CMS may have a bias against non-physician providers and may fail to understand the value of NPs, particularly in primary care. Another concern raised was the issue of liability to the medical school in the event of a mis-documentation by a student. There was a clarification that the teaching clinician needs to read and edit the note of a student in the EMR, and can grade the student on documentation.

Ms. Sandra Pope referred to the comments from Dr. Steiner that students are not learning needed clinical skills. She stated that the AHEC program in West Virginia offers interprofessional rural immersion. The students become involved in interprofessional teamwork and clinical work with the staff in the primary care center, and they deal with patients in oral health, diabetes, addiction, neonatal abstinence syndrome, healthy living, and senior care. After this experience, she said that over two-thirds of the students reported feeling more confident in developing and implementing interventions, and almost all reported feeling confident in their ability to identify appropriate interventions of the other disciplines and to work collaboratively with other health professionals.

Dr. Kamal Masaki noted that her state of Hawaii recently passed a law giving tax credits to clinical teachers to encourage more teachers. Dr. Steiner stated that similar legislation has been passed or is under consideration in many other states.

There was a suggestion that the Committee draft a letter to the Secretary in support of the CMS rule change on student documentation and to request the further changes, as Dr. Steiner proposed. Dr. Weiss indicated that two other HRSA advisory committees were also looking to

write a letter on the same topic, the Council on Graduate Medical Education (COGME) and ACTPCMD. The ACICBL members could decide to write a separate letter, or send one in conjunction with the other committees.

Public comment

Dr. Weiss opened the floor for public comment. Ms. Hope Wittenberg of the Society of Teachers of Family Medicine said that a joint response from ACICBL, ACTPCMD, and COGME to the HHS Secretary might help support CMS in making changes to medical documentation regulations. Dr. Chen added that advisory committees have several avenues at their disposal in addition to writing reports, and the quickest response is often to write a letter to the Secretary.

There were no further public comments.

Business Meeting

Dr. Weiss stated the items to address in the business meeting were to select a chair and vice chair, and determine a date for the Committee's next meeting, which would be a one-day webinar. She said that the chair would serve a term of one year, then rotate off to become the immediate past chair, and the vice chair would assume the role of chair. Dr. Teri Kennedy was nominated for the position of chair, and the nomination was agreed to by consensus. Mr. James Stevens was selected as the vice chair.

After a brief discussion, the committee agreed to August 16, 2018, as the date for the next meeting.

Dr. Weiss adjourned the meeting for the day.

Day 2: Thursday, June 7, 2018

Call to Order and Roll Call

Dr. Weiss called the second day of the meeting to order at 8:30 a.m. She offered a brief review of the presentations and discussions of the previous day.

Discussion: Recommendations

Dr. Weiss reviewed the recommendations from the Committee's 15th and 16th reports. She stated that the Committee would need to develop three to five recommendations for its upcoming report. She reminded that Committee that the focus of the programs under the Committee's charge is on education and training grants.

Dr. Weiss said that the movement toward age-friendly health systems was important to HRSA, as the U.S. population is aging, and the individuals that HRSA is helping to train need knowledge of how to care for older adults. However, current HRSA NOFOs do not contain any requirements about providing training for practice in age-friendly systems. Dr. John Morely suggested that the Committee strongly recommend the re-authorization of the GWEPs, as physicians and healthcare professionals have not been well trained to care for older adults and

their family caregivers. Dr. Pope added that other programs under Title VII need to be reauthorized by Congress as well.

There was a question about how the Committee should develop its recommendations. Dr .Weiss replied that the members should discuss the recommendations they would like to make and create them in draft form by the conclusion of the meeting. The writing committee will then revise the recommendations as their work on the report progresses.

There was a comment that age-friendly refers not just to the concerns of elderly patients, but to issues that are relevant across the lifespan and that are conducive to creating a health community. As such, age-friendly systems are consistent with the quadruple aim, which provides a framework for recommendations. One member commented that the term age-friendly incorporates the need to pay attention to the developmental stage of each individual. Another member added that health systems need to be both patient-centered and provider-centered.

Discussion: Letter to the Secretary

Picking up from the discussion on Day 1, there were further comments on having the Committee write a letter to the Secretary related to the revised CMS rules on student documentation. The Committee agreed by consensus to write the letter. Dr. Weiss stated she would talk with the DFO of the other committees to see if there was interest in a joint letter. After discussion with the Designated Federal Official of the ACTPCMD and COGME, it was decided that each Committee would write separate letters.

Discussion: AHECs

Dr. Weiss welcomed back CAPT Rodrigue and LCDR Lorener Brayboy, along with CMDR Cory Palmer, the branch chief for the health careers pipeline programs within the AHEC program. CAPT Rodrigue noted that AHECs are at the forefront of pipeline development for the health care workforce.

Ms. Jacqueline Wynn asked how the increased appropriation for the AHEC programs in FY 2018 could be used to improve the 49 AHEC programs and their associated Centers. CAPT Rodrigue replied that much of the additional funding will be used to focus on three BHW priority areas: the opioid crisis, telehealth, and community-based settings. She added that the National AHEC Organization is advocating for equitable distribution of the additional funds to support all of the AHECs. There was a comment that AHEC programs could develop partnerships with GWEPs, especially in terms of offering training opportunities.

There was a comment on the importance of involving the full range of health professions in addressing a national health concern such as the opioid crisis. For example, chiropractic therapy addresses pain management and is largely an untapped resource, especially in rural areas.

CAPT Rodrigue said that BHW is continuing to work on grantee engagement plans, which emphasize bi-directional communication between HRSA and its grantee organizations. The plan has five "buckets," including:

- Peer-learning teams.
- Academic and community partnerships.
- Rural health.

- Grand Rounds webinars.
- Federal partnerships.

CAPT Rodrigue stated that a number of grantees across BHW are participating in the peer-learning teams through a variety of venues, including facilitated discussions, webinars, and a web portal to share best practices, tools, and other resources. BHW is also planning a virtual meeting among all behavioral health programs.

Dr. Bednash brought up a concern of inconsistency in the program evaluation and outcomes. She stated that some of the program evaluations emphasize individual outcomes from each program. However, she recommended a consistent framework for gathering information about program outcomes that can be aggregated to show effectiveness to legislators and other policymakers in a more direct and concrete fashion.

There was a question raised about the difficulty in recruiting students to the AHEC Scholars program. Dr. Wynn replied that there are challenges in engaging students from rural and frontier areas. Some programs are starting to focus on educational foundation and college readiness for health care careers. There are efforts to encourage more students from rural or disadvantaged backgrounds to be AHEC Scholars, and then into the NURSE Corps or National Health Service Corps programs for careers in public health. There was a comment that the AHEC Scholars Program tends to center on medicine and nursing, but would benefit by expanding its reach into other health profession to meet the needs of the local community. Another question came about the connection of the AHEC program to K through 12 students. CAPT Rodrigue noted that AHECs have a history of working with younger students to provide models for health careers. However, she noted difficulties in trying to demonstrate effectiveness.

Discussion: Writing and Planning Committees

Dr. Weiss requested volunteers to serve on the writing committee, to help develop the Committee's report, and the planning committee to plan the speakers and agenda for the August meeting. It was decided that Dr. Kennedy, as the chair, and Mr. Stevens as the vice chair, would serve on both committees.

Writing committee:
- Dr. Evans
- Dr. Khatri
- Dr. Masaki
- Dr. Morely
- Dr. Pope

Planning committee:
- Dr. Bednash
- Dr. Erwin
- Dr. Gould
- Dr. Killinger
- Ms. Wynn.

Discussion: National Health Service Corps

Mr. Israel Ali provided a brief overview of the National Health Service Corps (NHSC) program, and discussed some of the connections between the NHSC and the AHEC programs.

Discussion: Follow-up on Behavioral and Mental Health Programs

Dr. Weiss introduced Ms. Moore to answer any follow-up questions related to HRSA's behavioral and mental health training programs. There was a question how the additional FY 2018 appropriations would be spent. Ms. Moore replied that the behavioral and public health branch has two funding lines: Mental and Behavioral Health (MBH), and BHWET. There is a specific line in the BHWET budget of $8 million to link FQHCs with BHWET students to provide training in opioid care. Other programs are in the development phase and the information is not yet public. She added that the BHWET program serves as a safety net program across the country to increase access for opioid addition treatment.

There was a comment that the GPE will be ending in FY 2019. Ms. Moore confirmed that the current GPE cycle will end, and the President's Budget did not request further funding for this and the BHWET programs. However, Congress has not yet made the FY 2019 appropriations.

Ms. Moore said that two BHWET programs provide support for full-time students in psychology, social work, counseling, psychiatric mental health nurse practitioner programs, and others, for field placements in rural and underserved areas working on integrated care. She added that BHWET supports students in both professional and para-professional programs. Between 50 and 75 percent of the students are serving in medically underserved programs. However, HRSA does not have the ability to track these students over time.

Discussion: Recommendations (continued)

In their discussions, the Committee members outlined recommendations focused on:

- Strengthening the health care system through collaborations between programs and the dissemination of best practices;
- Prioritizing funding to train providers to work in age-friendly health systems;
- Encouraging grantees to include training in provider well-being and resilience;
- Reauthorizing and funding Title VII Part D programs, and
- Improving outcomes-based research of HRSA's training programs.

Conclusion

Dr. Weiss adjourned the meeting at 1 p.m.

Abbreviations list

ACICBL	Advisory Committee on Interdisciplinary, Community-Based Linkages
ACTPCMD	Advisory Committee on Training in Primary Care Medicine and Dentistry
AHEC	Area Health Education Center
BHW	Bureau of Health Workforce
CHGME	Children's Hospital Graduate Medical Education
CMS	Centers for Medicare and Medicaid Services
DFO	Designated Federal Official
DMD	Division of Medicine and Dentistry
EMR	Electronic Medical Record
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GACA	Geriatric Academic Career Award
GME	Graduate Medical Education
GPRA	Government Performance and Results Act
GWEP	Geriatric Workforce Enhancement Program
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IPE	Interprofessional Education
LPHSWE	Leadership in Public Health and Social Work Education
MAT	Medication-Assisted Treatment
NCHWA	National Center for Health Workforce Analysis
NHSC	National Health Service Corp
NOFO	Notice of Funding Opportunity
NP	Nurse Practitioner
PA	Physician Assistant
PACE	Program for All-Inclusive Care of the Elderly
PHS	Public Health Service
SDH	Social Determinants of Health
WHO	World Health Organization