Advisory Committee on Interdisciplinary, Community-Based Linkages

September 28-29, 2006
Minutes from Conference Call

Attendance

Thomas Cavalieri, DO, Chairperson
Mary Amundson, MA
Amna Buttar, MD
Cheryl Cameron, PhD, JD
William Elder, PhD
Rosebud Foster, EdD, MSN
Gordon Green, MD, MPH
Anthony Iacopino, DMD, PhD
Karona Mason-Kemp, DPM
Andrea Sherman
Stephen Wilson, PhD

Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr) Staff

Lou Coccodrilli, MPH
Vanessa Saldanha, MPH
Jennifer Tsai, MPH

Public (September 28)

Tamara Thompson Johnson, American College of Osteopathic Medicine

Format of Minutes

These minutes consist of three sections:

I. Advisory Committee Business;
II. Recommendations, with Rationale and Benefits; and
III. Other Advisory Committee Actions.

I. Advisory Committee Business

- Review and Approval of Minutes from July 2006 Meeting
- Charter of the Committee/Status of the Committee
- Membership Issues (expiration of terms, representation of de-funded programs)
- Topics for Future Meetings

Review and Approval of Minutes from July 2006 Meeting

The Advisory Committee unanimously approved the minutes from the July 2006 meeting.

Charter of the Committee/Status of the Committee

The Advisory Committee's charter expires on March 24, 2007 and may be extended to another date.

The Chairperson of the Committee, Dr. Thomas Cavalieri, requested that Mr. Lou Coccodrilli, Designated Federal Official of the Advisory Committee, to brief committee members regarding the Committee's status.

Within BHPr, the current status of the Advisory Committee is being discussed given that many of the Title VII training programs represented by members of the Advisory Committee were not funded in fiscal year (FY) 2006, and many are not included in the FY 2007 President's Budget. While there has been no discussion of disbanding the Advisory Committee, this is a possibility depending upon future funding of the programs represented on the Advisory Committee. There may be a need to maintain the Advisory Committee for the purpose of providing advice, knowledge, and expertise to BHPr, the Secretary, and the Congress about training programs and disciplines currently represented on the Advisory Committee.

Membership Issues

The terms of 11 Advisory Committee members expire on September 30, 2006. BHPr has already extended the terms for two of these members, Thomas Cavalieri, DO and Anthony Iacopino, DMD, PhD, and is working to extend the terms of the remaining nine members. These members are: Mary Amundson, MA; Hugh Bonner, PhD; Cheryl Cameron, PhD, JD; Susan Charette, MD; William Elder, PhD; Rosebud Foster, EdD, MSN; Gordon Green, MD, MPH; Karona Mason-Kemp, DPM; and Rose Yuhos, RN. In addition, some members have expressed an interest in resigning from the Advisory Committee.

BHPr is soliciting nominations for Advisory Committee members. Even though the terms will be extended for the 11 members, nominations are still encouraged due to the time required to get new members approved.

Advisory Committee members raised the issue of whether it is appropriate to have members representing programs that have been de-funded. Currently, programs that were not funded in FY2006 are still represented on the Advisory Committee. It was expressed by members that at this point in time, representation of the de-funded programs on the Advisory Committee is even more critical.

Topics for Future Meetings

The next meeting of the Advisory Committee cannot be scheduled due to the uncertainty of the Advisory Committee's future. However, Advisory Committee members identified possible topics to be addressed in the event that issues relating to the future of the Advisory Committee are resolved. Possible topics are listed below.

- Public Health and the role of Title VII programs in the Nation's public health system.
- Documenting outcomes: identifying effective models to demonstrate program effectiveness and the achievement of identified outcomes. A recent report by the **Advisory Committee on Training in Primary Care Medicine and Dentistry addresses evaluating the impact of Title VII programs. Advisory Committee members requested copies of this report.**
- The role of professional organizations and accrediting bodies in the development of standards that Title VII programs must meet.
- The unique service delivery systems of rural health clinics. Many rural health clinics cannot provide interdisciplinary care because of the lack of specialized providers in the area and insufficient funding. This topic could be combined with a larger topic.
- Disaster Preparedness (as an aspect of public health). Many Title VII programs are preparing providers to respond to disasters such as hurricanes, earthquakes, and pandemic flu.
- New Institute of Medicine (IOM) Report on Reimbursement. IOM released a report in September 2006 calling for Medicare reimbursement to be based on the quality of care rather than the number of procedures performed or patients seen. The report mentions the importance of "teams" in the provision of care. This topic may not merit an entire meeting but could be combined with other topics.

II. Recommendations, with Rationale and Benefits

Approved Recommendations with Rationale and Benefits

The Advisory Committee voted to approve the following recommendations along with the rationale and benefits specific to each recommendation. Additional revisions and editing may take place as the writing committee prepares the Sixth Report, which will require approval of the Advisory Committee members.

Recommendation 1: Secretary and Congress should provide incentives for colleges, universities, and health science centers to create and maintain permanent offices or departments of interdisciplinary health sciences (participating disciplines as defined by current HRSA guidelines) education.

Rationale
There has been a gradual disappearance of interdisciplinary health science education and training programs over the last 10 years. This is due in large part to loss of Federal funding and initial support for programs that were never institutionalized. Educational institutions need to take ownership of these programs and make commitments to sustainability of faculty and resources such that the programs continue to evolve and improve. Those institutions that have developed interdisciplinary offices, centers, or departments have demonstrated that they promote collaboration, rather than competition, in education and patient-care delivery, and have also demonstrated the effectiveness of this type of education and training in their communities. Thus, this is a model that should be encouraged and promoted.

Benefits
Initial incentives for colleges, universities, and health sciences centers to create their own permanent offices or departments of interdisciplinary health sciences education reduces long-term Federal costs and results in programs designed to be effective in local communities. The programs developed within these settings are more likely to be subjected to rigorous review and assessment approaches. Additionally, establishment of these infrastructures enlarges the cadre of qualified interdisciplinary faculty and the potential to enhance the pipeline of future faculty.

Recommendation 2: Secretary and Congress should support interdisciplinary geriatrics education/training programs for all professionals and paraprofessionals associated with community health centers, rural health clinics, or related networks and partnerships.

Rationale
There has been a recent Federal emphasis on community health centers (CHCs) as an approach to meeting the health care needs of the underserved. However, little attention has been given to the proper education/training of the professionals/paraprofessionals that will provide health care services within the infrastructure of CHCs, rural health clinics, and related networks and partnerships. This is especially true in geriatrics where the majority of service providers lack adequate training. The recent loss of Federal support for interdisciplinary Geriatrics education/training programs provides a sense of urgency regarding quality care for the elderly. The interdisciplinary care model has documented success in improving the quality of care and reducing overall health care costs for the elderly population. There are well established “best practice” models developed by the Geriatric Education Centers (GECs) that can be applied to education/training programs for CHC infrastructure service providers.

Benefits
Community health center infrastructures and related networks and partnerships (including rural health clinics) may not be able to provide quality care for the elderly under the present circumstances. Specific interdisciplinary geriatrics/gerontology programming will improve the quality of care, reduce overall health care expenditures, and ensure that services are provided in a culturally sensitive and appropriate fashion.

Recommendation 3: The Secretary and Congress should give greater attention to investments in programs which educate and train health care professionals and paraprofessionals through interdisciplinary and community-based programs designed to foster delivery of quality care to underserved and medically compromised populations.

Rationale
Health professions education programs that use interdisciplinary and community-based educational strategies, with measurable outcomes, are critical to the preparation of a workforce that will respond to society's greatest health care needs. The investments of the past have supported the availability of interdisciplinary and community-based educational opportunities, increased access to health care in underserved and medically compromised populations, advanced the preparation of a workforce educated to respond to increasingly complex health care needs, and sensitized health care providers to issues of diversity, cultural competence, and disparity. Examples of the breadth and depth of the impacts of the investments include:

- The Health Education and Training Centers (HETC) Program in FY 2005 facilitated collaboration with approximately 100 CHC sites, providing over 219,000 contact hours of continuing education to over 20,000 participants, enabled community-based training of nearly 7,500 health professions trainees from a broad range of disciplines, and reached out to nearly 13,000 secondary education students.
- GECs trained more than 50,665 health care providers in 35 disciplines and 9,000 students in underserved areas. They have logged more than 8.5 million patient encounters in ambulatory hospitals, long-term care settings, and senior centers.
- In the Quentin N. Burdick programs, 4,303 trainees have provided over 300,000 interdisciplinary health service encounters to diverse populations in rural, underserved areas.

Benefits
It is projected that between 2000 and 2012 the need for health professionals will grow at twice the rate of all other occupations and 29 percent more providers will be necessary. The geographic distribution of the workforce will also continue to be an issue. Today, there are 4,474 health professional shortage areas (HPSAs) in the United States, in which 62 million people live and 35 million are underserved. Future investments are necessary to address projected workforce shortages and health care needs.

Recommendation 4: Secretary and Congress should provide funding incentives and demonstration projects in support of education and training to develop interdisciplinary health professions education clinical teams in conjunction with community health centers, rural health clinics, and other providers in underserved areas, to improve capacity, encourage positive evidence-based outcomes, and enhance the quality of health care.

Rationale
The Fifth Report of the Advisory Committee on Interdisciplinary, Community-Based Linkages emphasized the importance of interdisciplinary health care education and training defined as a collaborative process in which an interdisciplinary care team of health care professionals provides an educational experience that "shares knowledge and decision making to create solutions to health care problems that transcend conventional discipline-specific methods and work together in service of patient-centered and/or community-centered health care needs." Recent funding reductions in a number of major BPHr programs have greatly decreased the opportunities for interdisciplinary education. In its discussions, the Advisory Committee strongly believed that despite this situation, interdisciplinary education and training of health care practitioners is of critical importance to a culturally competent, diverse and well educated workforce grounded in evidence-based outcomes and committed to quality care. Interdisciplinary education and training must continue as a core mission of BPHr.

Benefits
Community health centers and other community-based sites provide an important clinical setting for

interdisciplinary health care education. HRSA funds over 1,000 CHCs, which provided health care to over 13 million people in 2004 in rural and underserved areas, many of whom had no other way to receive these services. Community health centers have proven to be an important community-based health care delivery site and HRSA projects that CHCs will be strengthened in number and size in the coming years. Providing funding incentives and demonstration projects that foster interdisciplinary education opportunities in CHCs, rural health clinics, and other providers in underserved areas would improve the workforce and capacity of these organizations to deliver quality care while providing enhanced team-oriented clinical education opportunities in a community-based environment.

Recommendation 5: Secretary and Congress should support interdisciplinary, community-based partnerships that: a) provide education/training programs and/or demonstration projects addressing links between oral health and systemic health; b) establish new models that include oral health as part of comprehensive preventive care; or c) provide data on the overall health economics impact of preventive oral health approaches.

Rationale
Sufficient data now exist to link oral health with systemic health. Poor oral health has many systemic consequences and may initiate or exacerbate many common chronic inflammatory conditions/diseases, especially cardiovascular/cerebrovascular disease and diabetes. Thus, overall health is dependent on good oral health. This has been recognized in the recent reports by the U.S. Surgeon General and the national organization of America's Health Insurance Plans. Providing preventive oral care as part of comprehensive health care in vulnerable populations, especially those with chronic inflammatory diseases and the elderly, reduces health care expenditures in subsequent years. However, there remains a general lack of awareness of these important facts among health care professionals/paraprofessionals, educators, and the public.

Benefits
Interdisciplinary, community-based partnerships that address this important relationship will improve the quality of life for all Americans. Future information in this area will have major effects on the delivery of preventive services, design of insurance plans, and national health care costs. Federal support of pilot programs and initiatives will provide important urgency and credibility to these efforts. Greater accessibility to preventive oral care may represent the next significant public health achievement in America.

Recommendation 6: Secretary and Congress should address the need for workforce development, faculty development, clinical educator development, and access in interdisciplinary geriatrics and gerontology to meet the need for trained professionals and paraprofessionals in care of older adults across the continuum of care settings.

Secretary and Congress should address the need for workforce development, faculty development, clinical educator development, and access in interdisciplinary geriatrics and gerontology to meet the need for trained professionals and para-professionals in care of older adults across the continuum of care settings.

Rationale
The number of older Americans will double over the next 30 years, with a projection that by 2030, almost one in five Americans will be 65 or older. People over 85 years of age are the fastest growing segment of the population. With increasing numbers of older adults also comes an increasing population experiencing chronic illness, functional limitations, and disability. The traditional model of health care delivery in the U.S. has been a physician-centered system. The use of alternative models of care, including informal care, community-based care, in-home services, and residential facilities is expanding, and presents shifting and increasingly interdisciplinary workforce needs. Workforce studies report that the need for more health care providers for the elderly is expected to increase, both to fill new positions resulting from changing service delivery models as well as to replace older retiring providers. The availability of geriatric/gerontology clinical educators, with the training and focus on an interdisciplinary

care delivery model, is critical to the Nation's response to an increasing need and demand for health care by an aging population. Without an adequate core of qualified faculty and clinical educators, workforce shortages cannot be effectively addressed. Prior GEC authorization has not permitted the training of paraprofessionals directly, a group that is critical to meeting the health care needs of our aging population.

Benefits
Interdisciplinary training is an important educational complement to quality care. HRSA programs that are currently funded focus on training of physicians and nurses. Insufficient training opportunities are available in other health care disciplines, which are critical to the care of the aging population. The recommended funding incentives in the HRSA-funded programs can encourage the inclusion of a broader range of health disciplines in workforce, faculty, and clinical educator development programs. These incentives will expand the base of educators prepared to train current and future health care providers, as well as the base of health care providers educated, in the interdisciplinary care of our aging population. Funding incentives to support and advance careers of geriatric/gerontology clinical educators, in a variety of health disciplines, with a focus on interdisciplinary training, will address a severe shortage in the field and improve access to care for older adults.

Recommendation 7: The Advisory Committee recommends that the HRSA Bureau of Health Professions provide Section 752 Health Education and Training Centers, Section 753 Education and Training Relating to Geriatrics, and Section 754 Quentin N. Burdick Program for Rural Interdisciplinary Training grantees the option for no-cost extensions for up to 12 months to allow for effective use of funds and to preserve vital networks that are critical to addressing health care needs of some of the Nation's most vulnerable citizens.

Rationale
The Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act 2006, passed by Congress in December 2005, appropriated no funds for Section 752-Health Education and Training Centers, Section 753-Education and Training Relating to Geriatrics, and Section 754-Quentin N. Burdick Program for Rural Interdisciplinary Training. As a result, grant activities under these program will conclude at the end of the current funded budget period No-cost extensions for these unfunded grantees has been limited by BHPr to six months.

These programs have been in existence for 10 to 20 years and provide critical interdisciplinary and community-based training and education to entry-level, advanced, and faculty trainees. The program grantees have developed important partnerships with other organizations, Federal programs, and local and State agencies, schools, colleges and universities. These partnerships are vital to the success of the programs and have required trust to initiate, time to develop, and sustained effort to maintain. On-again, off-again relationships are not a viable option for the creation of infrastructures that respond to the needs of the Nation's most vulnerable citizens. Once undone, the opportunities for reestablishment of partnerships, collaborations, and networks may be limited.

Benefits
With limited additional administrative support by HRSA, grantees could be given needed flexibility in managing the expenditures of unencumbered funds, which could serve to help preserve vital collaborations and partnerships by simply expanding the time available, from six to 12 months, to develop and implement program continuation strategies. The beneficiaries of such an option for extended no-cost extensions, a commonly used strategy that encourages responsible budgeting and expenditure of unencumbered funds, are the program grantees and trainees and the underserved and vulnerable citizens served today and in the future by the program participants.

Note: Given the timely nature of the recommendation, a letter stating the Advisory Committee's recommendation was sent to HRSA by Dr. Cavalieri. HRSA responded that it did not have resources to administer and monitor the grants beyond six months. Dr. Cavalieri's letter and HRSA's response will be noted in the Sixth Report.

Recommendation 8: Secretary and Congress should support community-based linkages of health professions education programs with community health centers, rural health clinics, and other community-based sites in the development of a diverse workforce through education and recruitment activities in both rural and urban medically underserved communities.

Rationale
There currently exists a persistent need for a diverse and culturally competent health workforce that will ensure increased access to health care in medically underserved communities. An increase in community-based health professions training program linkages with CHCs and other community-based sites would promote diversity in the health care workforce and support health center providers experiencing ongoing recruitment and retention difficulties.

The Institute of Medicine Report (IOM, 2004), ***In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce***, presents an evidence-based argument to support the importance and benefits of diversity in health professions education. Moreover, affiliation with the federally qualified health centers and other community-based primary care facilities enhances the opportunity to attract and train a more diverse and competent work force. The health centers are the foundation of the Nation's formal safety net system. Through participation in public-private collaboration and partnerships with health professions education programs, these sites could effectively train and expose the full range of health professions students, including primary care residents and medical students, to the special practice characteristics of these settings while also facilitating mechanisms for future recruitment of a diverse workforce. Further, the coordination and communication among these sites with other agencies will promote innovative models of collaboration for long-term solutions to workforce development, recruitment, and retention, which can be replicated on multiple fronts.

Consistent with the President's Community Health Initiative and the projected growth of the health centers, including their expanded medical capacity, the demand for health professionals is anticipated to grow at twice the rate of all other occupations. These workforce issues pose a significant challenge and relate to the need for systematic data on the supply and demand of health workers and the diversity imbalances of the overall health workforce to effectively inform policy makers. There needs to be more coordination across Federal agencies, especially DHHS agencies, and the Department of Education on these issues.

Benefits
The support of community-based linkages and collaborations with health centers and health professions education stimulates diversity and encourages workforce collaboratives among health professions training programs. In addition, these linkages promote innovative models on integrating recruitment and retention – best practices in medically underserved and rural community-based health centers and other community-based sites. The identification and adoption of "best practices," supported by targeted funding, promotes the availability and adequacy of a diverse and culturally competent workforce in support of health centers, ensuring access to appropriate primary and preventive care. This approach would encourage HRSA to evaluate lessons learned by multiple health centers in solving recruitment and retention problems and to identify mechanisms that are replicable in other communities. Congress should increase funding for Public Health Service Act interdisciplinary and community-based programs, such as the Area Health Education Centers (AHEC) program focused on health careers training for high school students, shown to be effective to increase the diversity of trainees in health careers programs, and develop other financial mechanisms which will enhance the diversity of the health workforce.

Recommendation 9: Secretary and Congress should recognize that community health workers are a valuable part of the safety net workforce; and should provide funding preferences to interdisciplinary academic and community-based organizations which provide education to community health workers.

Rationale
Both representing and serving resource-poor populations, community health workers (CHWs) help to meet the distinct needs of communities. They serve as liaison between their community and available

health services, and they provide health education on a "close-to-home" basis. They have the unique ability to work door-to-door in the neighborhood. Since they often arise from the community they serve, CHWs are welcomed as are no other health workers. They have little need for training in cultural competency or local linguistics. They also offer a first step on the career ladder of the health professions, as well as serving as role models for youngsters in their community. HETCs are federally-mandated to train CHWs, but other organizations could extend this training to many more communities if offered resources and incentives to do so.

Benefits
Many projects across the country have demonstrated specific value of the efforts of well-trained CHWs. A program in Texas won an innovative practice award from CMS for its efforts to enroll uninsured children in CHIP. A California program offered effective outreach in the areas of breast cancer and asthma. A CHW program to prepare "parents as teachers" is worthy of emulation. A program in Georgia developed a coalition between business interests and health services. The positive light in which CHWs are uniformly held adds a subjective imperative to the demonstrable objective successes of programs around the United States. It remains now to extend CHW programs to many more resource-poor communities, to the ultimate benefit of all.

Discussion of Recommendations and Proposed Text

Process for Generating Recommendations and Proposed Text

After the recommendations were developed at the July 2006 meeting, the Advisory Committee's writing committee began the process of developing the Advisory Committee's Sixth Report. As part of this process, the wording of some of the recommendations was revised. In addition, members of the writing committee drafted rationale and benefits to support each of the recommendations. During the conference call, revisions were made to the wording of the recommendations and one recommendation, Recommendation 8, which is listed below, was combined with Recommendation 6. Because there were significant changes made to the wording of the recommendations, the original text is provided below. Since minimal changes were made to the text of the rationale and benefits for each recommendation, the original text considered during the conference call is not included.

Recommendations submitted by Writing Committee for September 28 Call

Original Recommendation 1: Secretary and Congress should provide incentives for universities to create and maintain permanent offices or departments of interdisciplinary education.

Final Recommendation 1: Secretary and Congress should provide incentives for colleges, universities, and health science centers to create and maintain permanent offices or departments of interdisciplinary health sciences (participating disciplines as defined by current HRSA guidelines) education.

Discussion

- The term "health sciences" was added to in order to specify that the participating entities should be educating and training health care providers.
- There was concern that social work and some of the other mental health-related disciplines may not be included in "health sciences." These professions are included in the HRSA guidelines.
- The presentation by Maria A. Castillo Clay at the September 2006 Advisory Committee meeting included examples of the outcomes of interdisciplinary training, which could be used to support the benefits of this recommendation.

Original Recommendation 2: Secretary and Congress should support interdisciplinary geriatric education and training entities for all professionals and paraprofessionals associated with community health centers (CHCs) and associated networks and partnerships.

Final Recommendation 2: Secretary and Congress should support interdisciplinary geriatrics education/training programs for all professionals and paraprofessionals associated with community health centers, rural health clinics, or related networks and partnerships.

Discussion

- To broaden the impact of this recommendation, rural health clinics were added. Rural health clinics face the same challenges and serve similar populations as community health centers. Many areas are served solely by rural health clinics.

Original Recommendation 3: To help eliminate health disparities, to increase access to care, and to develop a workforce prepared to address changing demographics, we recommend the Secretary and Congress give greater attention to investments in programs which train health care professionals and paraprofessionals, through interdisciplinary and community-based training programs designed to foster delivery of quality care to underserved and medically-compromised populations.

Final Recommendation 3: The Secretary and Congress should give greater attention to investments in programs which educate and train health care professionals and paraprofessionals through interdisciplinary and community-based programs designed to foster delivery of quality care to underserved and medically compromised populations.

Discussion

- The recommendation was reworded to make it consistent with the other recommendations.
- Discussion of elimination of health disparities, access to care, and workforce preparedness was moved to the rationale and benefits section.

Original Recommendation 4: Secretary and Congress should provide funding incentives and demonstration projects in support of education and training to develop interdisciplinary health professions education clinical teams in conjunction with community health centers (CHCs), to improve capacity of rural health clinics and other providers in underserved areas, to encourage positive evidence-based outcomes, and to enhance the quality of healthcare.

Final Recommendation 4: Secretary and Congress should provide funding incentives and demonstration projects in support of education and training to develop interdisciplinary health professions education clinical teams in conjunction with community health centers, rural health clinics, and other providers in underserved areas, to improve capacity, encourage positive evidence-based outcomes, and enhance the quality of health care.

Discussion

- The recommendation was reworded to clarify the role rural health clinics play in improving capacity, encouraging positive evidence-based outcomes, and enhancing the quality of health care.

Original Recommendation 5: Secretary and Congress should support interdisciplinary community-based partnerships that: provide education/training programs and/or demonstration projects that address the links between oral health and systemic health; establish new models for comprehensive preventive care; or provide data on health economics impact of oral health and systemic health.

Final Recommendation 5: Secretary and Congress should support interdisciplinary, community-based partnerships that: a) provide education/training programs and/or demonstration projects addressing links between oral health and systemic health; b) establish new models that include oral health as part of

comprehensive preventive care; or c) provide data on the overall health economics impact of preventive oral health approaches.

Discussion

- The original recommendation was reworded to clarify that the support should be for partnerships that provide data on preventive oral health approaches.

Original Recommendation 6: Secretary and Congress should address the need for workforce, faculty development, and access in interdisciplinary geriatrics and gerontology to meet the need for trained professionals and paraprofessionals in care of older adults across the continuum of care settings.

Final Recommendation 6: Secretary and Congress should address the need for workforce development, faculty development, clinical educator development, and access in interdisciplinary geriatrics and gerontology to meet the need for trained professionals and paraprofessionals in care of older adults across the continuum of care settings.

Discussion

- This recommendation was combined with the original Recommendation 8.
- The original Recommendation 6 broadly addressed the issue of workforce and faculty development in geriatrics and gerontology. The original Recommendation 8 focused on clinical educators. Recommendation 6 was expanded to include clinical educators in geriatrics and gerontology.
- Paraprofessionals were added because they currently cannot be trained by AETCs.

Original Recommendation 7: The Advisory Committee recommends to agency (Health Resources and Services Administration) a no-cost extension for Geriatric Education Centers (GECs), Health Education Training Centers (HETCs), and Quentin N. Burdick programs to 12 months (instead of 6 months) to allow for effective use of funds, and to preserve vital networks that are critical to addressing health care needs of some of this Nation's most vulnerable citizens.

Final Recommendation 7: The Advisory Committee recommends that the HRSA Bureau of Health Professions provide Section 752 Health Education and Training Centers, Section 753 Education and Training Relating to Geriatrics, and Section 754 Quentin N. Burdick Program for Rural Interdisciplinary Training grantees the option for no-cost extensions for up to 12 months to allow for effective use of funds and to preserve vital networks that are critical to addressing health care needs of some of the Nation's most vulnerable citizens.

Discussion

- This recommendation is discussed in a letter that has been sent to HRSA. HRSA is unable to extend the no-cost extensions because it does not have sufficient resources to administer and monitor the grants past six months. In the Sixth Report, an editorial note will be added that discusses the letter and HRSA's response.

Original Recommendation 8: Secretary and Congress should provide funding incentives to support and advance careers of geriatric/gerontology clinical educators with a focus on interdisciplinary training, to address a severe shortage in this field and improve access to care for older adults.

Discussion

- This recommendation was combined with Recommendation 6.

Original Recommendation 9: Secretary and Congress should support community-based linkages of health professional education programs with community health centers, as well as other community-based sites, in the development of a diverse workforce through recruitment activities in both rural and under-served communities.

Final Recommendation (now numbered Recommendation 8): Secretary and Congress should support community-based linkages of health professions education programs with community health centers, rural health clinics, and other community-based sites in the development of a diverse workforce through education and recruitment activities in both rural and urban medically underserved communities.

Discussion

- Rural health clinics were added since they can also play a role in the development of a diverse workforce through education and recruitment activities.
- Education activities were added since they will be an outcome of linkages between education programs and providers, in addition to recruitment.

Original Recommendation 10: Secretary and Congress should recognize that community health workers are a valuable part of the safety net workforce, and should provide funding preferences to interdisciplinary academic and community-based organizations which provide education to community health workers.

Discussion

- No changes were made to Recommendation 10 (now number Recommendation 9).

General Discussion of Recommendations and Proposed Text

- In reviewing the original recommendations, Advisory Committee members discussed how community-based, interdisciplinary programs should be presented. Specifically, there was concern about use of the term "Title VII programs." It was suggested that references to Title VII programs be removed from the report since some people have a negative view of these programs and Title VII may not exist in the future. Title VII should only be used when writing specifically about past funding.

III. Other Advisory Committee Actions

Letter on Restoration of Funding

The Advisory Committee discussed developing an additional recommendation relating to the possible restoration of funding and the fairest way to allocate the funds in this event. Advisory Committee members expressed several opinions about how funds should be distributed in the event of a restoration of funding. HRSA has already stated that in the event of restoration, all programs—current, former, and new grantees—will have to compete for funds. Some members felt that this was unfair, especially for grantees that were de-funded in the middle of their grant cycle. It was suggested that priority could be given to these grantees. Others felt that this might result in the funding of some programs that are weak—open competition would provide an opportunity for house cleaning. Others countered that this should not be the time to eliminate programs that are perceived to be weak since some programs have a slow start and need a few years to establish networks and programs.

Since it is not known if funding will be restored, the Advisory Committee decided that there was insufficient information on which to base a recommendation. However, they did feel it was important to raise the issue with HRSA and others and that the most appropriate course of action would be to draft a letter stating the Advisory Committee's concerns. It was suggested that the letter be sent to officials at

various levels, i.e. the BHPr Associate Administrator, the HRSA Administrator, and the Secretary. The Committee leadership would decide who would receive the letter.

The Advisory Committee developed the following language, which will be incorporated into the letter.

"In the event of restoration of all or part of the funding of allied health, gerontological, psychological, rural health, and interdisciplinary training centers, the Secretary and Congress should develop a process within the HRSA funding review which gives full consideration both to new starts and to current grantees (that is, grantees which were within their funding cycle or project period in 2006 at the time when funding was discontinued) for program restoration, with priority goals of continuity of education, continuance of service provision, and preservation of networks."

Fast Track of Recommendations

Given the time that it takes to review and produce the Advisory Committee's reports, members decided to take a "fast track" approach to disseminating their recommendations. This will allow the recommendations to be disseminated in timelier manner. Under the fast track approach, recommendations will be presented in a letter from the Chair of the Advisory Committee, Thomas Cavalieri, DO.

Dr. Cavalieri will work with BHPr staff to determine the appropriate recipients of the letter. Most likely, the letter will be sent to the regular recipients of the Advisory Committee's reports, as specified in the charter of the Advisory Committee. This includes the Secretary and Congress.