ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES (ACICBL)

ACICBL 16th REPORT DISCUSSION
ENHANCING COMMUNITY-BASED CLINICAL TRAINING SITES: CHALLENGES AND OPPORTUNITIES

Webinar and Conference Call
September 19, 2016

Committee Members in Attendance
Chair:
Peggy Valentine, EdD, FASAHP

Members:
Patrick DeLeon, PhD, JD, MPH
Jacqueline Gray, PhD
Sharon A. Levine, MD

Past Member:
Elyse A. Perweiler, MPP, RN

Ex-officio Member:
Mary Ann Forciea, MD

HRSA Staff in Attendance

Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, ACICBL; Senior Advisor, Division of Medicine and Dentistry
Kim Huffman, Director, Advisory Council Operations
Crystal Straughn, Technical Writer/Editor, Division of Medicine and Dentistry
Kandi Barnes, Management Analyst, Advisory Council Operations
Holly Shirley, Technical Assistance Assistant, Division of External Affairs

Introduction

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 10:00 AM on September 19, 2016. The meeting was conducted via webinar and teleconference from the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 15SWH01, Rockville, MD 20857.

Dr. Joan Weiss, Designated Federal Official, opened the meeting and conducted a roll call. All members were present, along with past committee members Dr. Freddie Avant, Ms. Elyse A. Perweiler, and Ms. Sandra Pope. Dr. Patrick DeLeon was present in person, the other members attended via webinar and teleconference. Dr. Weiss turned the meeting over to Dr. Peggy Valentine, the ACICBL chair.

Presentation: Community Precepting: Demand, Supply, and the Impact of the Emerging Precepting Crisis

Dr. Valentine welcomed the members, and introduced the speaker, Dr. Warren Newton, Vice Dean and Director, North Carolina Area Health Education Center (AHEC) program, and Professor, Family Medicine, University of North Carolina at Chapel Hill (UNC-CH).

Dr. Newton stated that he had been asked to discuss community precepting, and present some of the data on precepting that his group had collected in North Carolina. The North Carolina AHEC has nine regional centers and 18 residencies, provides over 200,000 hours of continuing medical education each year, and supports a number of community-based organizations and primary care practices across the state. Dr. Newton stated that growth in all of the health professions has created challenges in education and training. One major issue concerns the number, development, and quality of preceptors working with students in community health settings. Through his involvement with the North Carolina AHECs, he has studied community precepting in many areas of the state.

According to Dr. Newton, the North Carolina AHEC system is well-developed, with over 20,000 staff members from all professions across the continuum of care working in nine centers. The AHEC system covers approximately 1,500 preceptor sites across the state. A central mission of the AHECs has been to improve access to health care providers in underserved areas. The AHECs offer clinical placements to students from medicine, nursing, pharmacy, and mental health, among other disciplines, working with 10 different schools and 16 different programs.

Preceptors working with students in these settings receive a small reimbursement through AHEC funding, from $75 to $125 per week. These payments have remained flat. No new schools or programs have been added, due to cuts in funding.

From a recent survey of health professions schools, Dr. Newton noted a 40 percent increase in programs that use community precepting, particularly in two areas: obstetrics and gynecology, and pediatrics. In addition, North Carolina has signed the State Authorization of Reciprocity Agreement, which expands opportunities for students from other states, further increasing the number and size of clinical rotations and the demand for community preceptors.

Dr. Newton noted that changes in the health care system have led to the consolidation of independent hospitals and group practices into large integrated systems, which has contributed to limiting the sites available for precepting. At the same time, major changes in health professional education programs, such as the introduction of the Doctor of Nursing Practice degree, has increased demand for community preceptors.

Dr. Newton's group has conducted surveys of preceptors across all professions, and 92 percent have said they intend to continue precepting. The most common reason for continuing is professional satisfaction.

From looking at the precepting agencies, which include private practices, health departments, federally qualified health centers, and other, about 75 percent only take students from one school and often only from one profession, often due to accreditation constraints.

The shortage of clinical sites and community preceptors is a significant issue for the schools. Schools have reported that preceptors are dropping out, and there is often insufficient professional development, recognition, support, or financial rewards to entice them to stay. Dr. Newton noted that precepting students requires both time and money, while the compensation model for primary care clinicians does not include reimbursement for precepting and teaching.

Schools offer a variety of incentives for preceptors. The most common are a faculty appointment, access to information and library resources, financial payments, and appreciation dinners or other recognition events. However, it is unclear if this compensation is adequate. Serving as a preceptor may limit the number of patients a provider can see or increase the hours worked, potentially affecting income. In the move toward a pay-for-value system, compensation might be able to increase under the premise that teaching helps improve the quality of care.

In summary, Dr. Newton noted that the demand for community preceptors has considerably increased over the last five years, while the supply may be declining. As a result, schools across all professions in North Carolina are seeing significantly reduced access for students, and the trend is accelerating.

Looking ahead, Dr. Newton noted that results of a 2016 Preceptor Survey and a compensation plan survey are pending, which should provide additional information on whether health systems are investing in the next generation of preceptors. He stressed the need to engage both stakeholder schools and preceptors on educational priorities, common curricula, and best models of teaching in the community setting. He listed some important issues to consider for state policymakers:

- Determining if community precepting is a common good that merits public support,
- Aligning public and private schools, and
- Addressing the dramatic expansion of student debt.

Dr. Newton suggested some steps to reduce the administrative burden of preceptorships, including using common requirements for immunization, safety training, and electronic health record use across all sites; improving online training to better prepare students; lengthening

training rotations so students are more useful to the clinical sites; and developing a regional mechanism to control and monitor student placements. Another consideration is care transformation. HRSA grants, for example, have supported the implementation of daily interprofessional team huddles that provide great learning opportunities for students.

Another element that needs attention is moving away from the concept of a preceptor as "any warm body." Preceptors need opportunities for training, career development, and advancement. Incentives such as recognition, faculty appointments, and access to continuing education can improve retention. Precepting could also contribute to maintenance of certification requirements. Some states have passed tax deductions or credits for health professions preceptors. Dr. Newton added that HRSA could use loan repayment incentives based on teaching to encourage more clinicians to serve as preceptors. He described a visit to a Canadian medical school which had such a large pool of potential preceptors that only 20 percent were used, allowing clinical settings to be more selective and spurring competition between settings based on the scores that medical students gave their preceptors.

Discussion

Dr. Valentine thanked Dr. Newton for his presentation, bringing to light current questions and issues about preceptor training. She asked if he had noticed any changes of late in the quality of preceptors, particularly in terms of keeping abreast of current knowledge. Dr. Newton replied that there is currently no good way to monitor preceptors or to know if they are prepared or if their practices meet the standards of what students need to learn.

Dr. Sharon Levine asked Dr. Newton if he was aware that some Caribbean medical schools are paying up to $30,000 per student to hospitals and community health settings for preceptor slots, which no public or private institution can match. Dr. Newton replied that he was aware of some instances in the United States in which medical or osteopathy schools started offering modest payments for precepting slots, which instigated an "arms race" with other local schools. This problem is related to the limited number of clinical sites that will accept students. These sites may have several different schools requesting placements but cannot accept all students, so they may begin to charge for their services. He also voiced concern that some students are asked to find their own placements, which he felt should be the responsibility of the school.

Dr. Valentine asked for Dr. Newton's thoughts on blended learning, in which the preceptor works with students from different disciplines, or multiple students from the same discipline. Dr. Newton replied that this method had been tried at UNC-CH. He stated that most traditional community rotations have one student in place for the length of the assignment. There is difficulty in finding sites large enough to have two preceptors who could work with students the entire time. He added that there has been an increase in longitudinal training models in medicine, as well as for physician assistants, who are less of a burden on preceptors.

Ms. Elyse Perweiler stated that there was recently another survey done through the AHEC network by Dr. David Garr and Dr. James Ballard looking at other options for providing support for preceptors, such as tax exemptions. She stated that the Committee may need to consider such creative financing options going forward. Another member added that supporting certification requirements could also be of benefit.

Related to the preceptor shortage, Dr. Weiss asked Dr. Newton if he has found an increase in the use of simulation in training. She also asked if he was aware of any students having to postpone graduation because they couldn't be assigned a preceptor within an appropriate timeframe. Dr. Newton replied that the nursing profession was at the forefront in the use of simulation. However, a clinical site has an intensity and variety of cases that is difficult to simulate. He added that he was not aware of any students facing delayed graduation due to lack of preceptor availability, but cautioned that he had not looked into the issue and schools would be reluctant to admit to having such a problem.

Dr. Mary Ann Forciea asked Dr. Newton if he knew of anyone using telehealth to increase precepting capacity. He replied that there is ongoing clinical experimentation on the possible use of "tele-precepting." He stated that much of the didactic curriculum can be delivered through distance learning, but it is not possible to duplicate patient interactions. He noted that many leaders in education believe that on-line learning is less expensive than face-to-face. In North Caroline, nursing programs have been leaders in on-line education. It may be cheaper if the education only taped presentations, but most students do not like it and do not feel engaged. Research has shown that interactive, on-line educational programs, which are expensive, are better and keeping the contemporary learner engaged.

Presentation: Transforming Traditional Continuing Education (CE) into Continuing Interprofessional Education (CIPE): Lessons from a Real-World CIPE Training Initiative

In a second presentation, Dr. Newton stated that his group decided to look at continuing interprofessional education (CIPE) within the AHEC Program, with the initial focus on continuing education and continuing professional development. North Carolina AHEC received an innovative funding grant to develop a plan and conduct a summit to bring together faculty involved in professional development, along with CE planners. As a result, they created two ongoing collaboratives, one among faculty and one among the continuing education professionals, and developed a series of webinars and interactive surveys.

The group found a significant uptake in experimentation with CIPE projects, which has allowed broader groups of professionals to come together at conferences to address topics such as adverse childhood experiences or working with stroke patients. Evaluations from participants were positive and finding showed there is a need to move as quickly as possible from interprofessional education to interprofessional practice.

Dr. Newton added that schools direct most of their efforts toward the foundational programs in each discipline. However, he argued that educators need to spend more time on educating professionals across their life spans. Anywhere from two to seven percent of professionals in any discipline will be in their foundational phase, while the remainder are practicing, so there needs to be greater emphasis not just on continuing professional practice, but also on making job training richer and promoting common goals of workforce diversity and distribution.

Discussion

Dr. Levine commented that Dr. Lawrence Smith, Dean of the Hofstra North Shore-LIJ School of Medicine, has developed a program to train all new medical students as emergency medical technicians (EMTs), which allows the students to have patient contact early in their training. Dr.

Newton replied that he had been intrigued by the Hofstra program. He added that he had seen more students coming into medical school in the highest quartile of academic achievement, but with less real-world experience in dealing with patients in the health care setting. He said that one possible approach would be to change medical school admissions criteria to be more like business school, where applicants have to demonstrate experience before they are admitted.

Dr. Newton noted that published reports show between 40 and 60 percent of medical students report being burned out, while other studies report burnout among clinical nurses. He noted that the issue of burnout is complex, and one solution might be to ensure students have meaningful patient contact early in their training. Another Committee member concurred that nursing students who have had experience as a nursing assistant, EMT, or similar role tend to do better because they have the background to relate to their learning in the classroom.

Dr. DeLeon said that the National Academy of Medicine (NAM), formerly the Institute of Medicine, has started a study looking into the issue of physician suicides, which is related to burnout. Dr. Newton replied that he was aware of the NAM study, and that the problems go beyond medicine and affect many nurses and other health care professionals.

ACICBL 16th Report Discussion

Dr. Valentine moved the discussion to the ACICBL 16th report on clinical training sites. She summarized the previous discussions that covered medical education after the Flexner report, the current state of healthcare education, and defining what is meant by community-based training.

Dr. Levine said that a discussion of medical education would have to include the report from the Carnegie Foundation, written by David Irby and Molly Cook, that came out on the 100th anniversary of the Flexner report. She noted that part of the Carnegie report had also been incorporated in nursing education. The Flexner report was based on a "two by two" model, with students spending two years in didactic education, followed by two years of clinical training. The Flexner report contributed to adding science into medicine and tried to standardize how medial students are trained. The authors of the Carnegie report believe students should be immersed in meaningful interactions with patients sooner, instead of sitting in a classroom.

Dr. Valentine asked if any Committee members had comments on the outline of the report. One member asked about defining a "quality training site." Dr. Valentine replied that there might not be a standard definition yet in the literature.

There was a question about the number of community-based training sites in the country, Dr. Weiss stated that she was not aware if the information was available. She stated that a request for a rapid response brief could be made to the National Center for Health Workforce Analysis (NCHWA) at HRSA, usually with about a two-week turnaround. Dr. Valentine concurred that knowing the number of sites would provide valuable information, and asked if the Committee wanted to make a recommendation about a national resource center.

Dr. Valentine brought up the issue of preceptor preparation and quality. Referencing Dr. Newton's comments of the poor state of preceptor preparation, there was a comment that the Liaison Committee on Medical Education (LCME) requires ongoing faculty development even for voluntary and adjunct faculty. There was a question about standardizing preceptor training

and development on a national level. Most professions require some level of continuing education. However, concern was expressed that making a recommendation for such a requirement could become a difficult regulatory issue, with no means of enforcement. It was suggested that the Committee could recommend that HRSA programs include an incentive for faculty development, but not to make faculty development for preceptors a requirement.

Dr. Valentine stated that nursing schools have a rigorous requirement to have a field supervisor visit the clinical sites. Nursing faculty work with preceptors to ensure student clinical competencies are met, students have quality clinical experiences, and learning objectives are met for a particular rotation.

Dr. Valentine moved the discussion to community-based clinical training sites. She stated that Dr. Newton raised some good points in terms of the cost of preceptor development. There was a comment that Dr. Newton also mentioned that some students are responsible for identifying their own preceptor. There were questions about at what point in their educational experience might students be asked to find a preceptor, and how would they be able to judge a good preceptor.

There is also tension on how preceptors are compensated. Some schools have not paid preceptors, even as class sizes have grown and preceptors take on more responsibilities. However, some settings, including federally qualified health centers, are becoming reluctant to take students out of concern for decreased clinical productivity. Clinical care is often reimbursed through the Centers for Medicare and Medicaid Services based on relative value units (RVUs), as a result decreased productivity can lead to lower revenues. Another issue was raised related to state-supported versus private schools, as state-supported schools generally lack the sizable endowments of many private school, and have fewer resources to devote to clinical training. It was noted that students pay tuition to the schools even when they spend a significant amount of their time off-campus with a preceptor, but not all schools pay the preceptors.

Dr. Valentine asked for clarification on the outline item related to school-owned sites versus independent sites, and suggested use of the term “faculty practices” rather than school-owned sites. There was discussion that some medical schools own their hospitals or have tight linkages with a hospital system or with private practices that serve as teaching sites. One member brought up that many osteopathic school do not have their own sites, and pay for students to go to other schools for clinical placements.

Dr. Weiss mentioned telehealth or tele-education as a modality for interprofessional education (IPE) and collaborative practice, while noting that telemedicine, the provision of medical serviced remotely, is not legal or reimbursable in all states.

Ms. Perweiler suggested looking at the revised Interprofessional Education Collaborative (IPEC) competencies that were published early in the year, in particular the new guidelines on population health and collaboration. She expressed concern, though, that the definition of IPE – two or more health professions learning by, with, and from each other – did not always pertain to students. She stressed the need to view IPE in the broadest sense of collaborative practice, acknowledging that students can learn from working with other health professional team members as they are becoming members of that team. There may be adaptations needed in

HRSA's performance measures for counting IPE experiences. Ms. Perweiler suggested linking IPE with curriculum changes and developing options to attract high-quality preceptors. There was discussion of a possible recommendation to create a center that would determine a set of standards for preceptors. The standards would have to include ethical issues in practice to assure a good learning environment for students.

In terms of curriculum development, Dr. Freddie Avant mentioned the need to include professional ethics in the interprofessional context, so that all of the professions follow some type of code of ethics when working together.

Dr. Valentine brought up the discussion of payments and incentives for preceptors. Dr. Weiss supported the idea of having precepting count towards maintenance of certification (MOC). She noted that the American Board of Medical Specialties counts precepting as a quality improvement project towards MOC. There was discussion of how this could relate to other professions, such as physician assistants and nurse practitioners. Part of the incentive for preceptors is to keep skills current. Nurse practitioners can maintain certification through multiple channels, including continuing education, publication, and teaching. In relation to Dr. Newton's presentation, one member wondered how Canada was able to attract such a large number of preceptors, and suggested sending a follow-up question to Dr. Newton.

ACICBL 16th Report Discussion (continued)

After a brief lunch break, there was an extensive discussion related to health professions students' ability to document notes in a patient's electronic health record (EHR). Dr. Valentine and Dr. Avant both replied that students in their programs can document in an electronic format, but their entries do not go directly into the EHR. Dr. Levine shared that at her medical school, the medical students write full notes in the EHR under a section labeled "Student Documentation," but it is not part of the official medical record due to concerns about patient privacy and student accountability. Another member commented that doctoral-level psychology students at her school document in the EHR and sign off as a psychologist trainee, and their supervisor co-signs. It was discussed that documentation is an important part of offering students a holistic clinical experience, and could be included in the report under the section on barriers and challenges.

One member commented that practice redesign had become challenging due to the rapid pace of changes in the healthcare system. In geriatrics, Medicare payment incentives are becoming more aligned with collaborative practice and chronic care management. These changes have the potential to create new roles for students that can become integrated into a practice, which can both enrich the student experience and make the student an added value to the practice site.

Dr. Valentine proposed including a section about how faculty prepare students before they start their clinical experience, and the importance of faculty keeping their clinical skills up to date. It was suggested that this could go under a section on "preceptor and curriculum development."

Dr. Valentine shifted the discussion to the report section on "Contracts between Educational Institutions and Training Sites for Access." She stated she had trouble understanding how contracts between educational institutions and training sites related to payments and incentives. One member commented that her institution either has a memorandum of agreement (MOA), or

an affiliation agreement. She stated that in the latter, money changes hands. Another member commented some states don't use contracts or affiliations, but the MOA mechanism is used for payments, while giving the schools the opportunity to identify specific deliverables and requirements, payment arrangements, and other items such as faculty appointments or access to library services for preceptors. Dr. Levine stated that at her institution, the affiliation agreement is about supervision, emergency services to the students, availability of malpractice insurance, and other items for the students, but it does not mention money. She commented that there are different interpretations of the purpose of an affiliation agreement.

Dr. Valentine moved the discussion to the section on training stipends, noting that her institution does not pay any stipends. Dr. Avant noted that some students at his school receive a stipend provided by an outside organization and the stipend comes with some conditions, such as requiring the student to work for that organization for a defined amount of time after graduation. Dr. Valentine recalled that Dr. Newton mentioned the North Carolina AHEC system provides support for students to have housing away from their home. Another member affirmed that several AHECs provide such stipends, and the students pay a modest amount for housing. Dr. Jacqueline Gray stated that the different institutions that she has worked with have managed stipends in different ways. Some may arrange for the clinical site to pay the student, and others may pay the student directly to have a little more control over the student's experience.

There was a comment about stipends versus traineeships. Dr. Avant noted the stipend goes directly to the student and is not part of the financial aid package. Dr. Valentine added that some students at her school receive scholarships from HRSA intended for students from disadvantaged backgrounds, which are part of the school's financial aid.

Dr. Valentine asked if the report should include a mention of loan repayment programs, like the National Health Service Corps (NHSC), that provide incentives to low-income students to complete their education. She noted that such programs are offered to medical, nursing, dentistry, pharmacy, and physician assistant students. A member commented that while the NHSC provides some loan repayment mechanisms for those who work in underserved areas, there are a limited number of placement sites. Dr. Weiss noted that not all healthcare disciplines are included within NHSC, so the Committee might consider having a recommendation to expand access to NHSC to other disciplines beyond those currently included: medicine, nursing, physician's assistant, social work, and dentistry, along with geriatric medicine, dentistry, psychiatry, and nurse practitioners. It was discussed that inclusion of other disciplines would promote collaborative, team-based care models. There were suggestions to include pharmacy, and physical and occupational therapy.

Dr. Jacqueline Gray recalled the comment by Dr. Newton on tax credits or tax deductions for preceptors. Ms. Perweiler referenced a survey by Dr. David Garr and Dr. James Ballard that looked into tax credits as a reimbursement incentive for preceptors, and it was suggested that Dr. Garr be contacted for more information.

Dr. Valentine moved forward to the section on "Barriers and Challenges." She noted the previous discussion about the North Carolina AHECs not including the new schools. Thus, new schools have difficulty finding clinical sites. Having alumni working in the community helps

promote a willingness to take on new students. There was discussion that the trend of consolidating practices for financial reasons may limit the number of sites willing to take on students. Dr. Avant brought up the growth of stand-alone emergency rooms and urgent care centers, which are not connected to a hospital but which are often staffed 24 hours a day. He wondered if these might create opportunities for new clinical sites. One member responded that a physician who works with a group that owns a number of urgent care centers has agreed to allow her school to arrange some community-based clinical experiences for AHEC students in urgent care centers located in underserved areas.

Dr. Valentine moved to the next section, "Security/Legal Issues." There was discussion that security relates to physical security of the trainees at their clinical sites, as well as to data encryption and the EHR. Legal issues relate to issues of patient privacy and the Health Insurance Portability and Accountability Act (HIPAA), and to malpractice coverage.

Dr. Levine shared some of the steps that her institution takes to assure student safety, especially during house calls from physicians, dentists, social workers, or visiting nurses in inner-city areas of Boston. For example, preceptors have to meet students at the school, not at a neighborhood area, students receive training from the police in situational awareness and self-defense, and students need to have a phone with them with the number for the local police. Dr. Weiss mentioned that practice redesign often emphasizes getting people out of the hospital and into the home care setting, increasing the need for house calls.

Dr. Levine mentioned liability issues for the student, which can be written into affiliation agreements. Students can be given a choice of clinical sites, if they feel very uncomfortable or unsafe. In addition, the school offers a lot of training on cultural sensitivity and ethnic and linguistic diversity. There are similar issues related to remote or rural sites. However, she emphasized that students must have to opportunity to train in a wide variety of areas, because people everywhere will need healthcare. Dr. Valentine also mentioned that students also need preparation for handling potential prejudice against them by patients.

Dr. DeLeon brought up a recent report about the lack of healthcare providers who appreciate the uniqueness of military culture, in terms of treating veterans and military families. He also mentioned the effort within psychology to get reimbursement under Medicaid for care provided by graduate students, who are often providing direct care and charting in the patient's record.

Dr. Valentine moved to the section on "Models for Clinical Education Solutions and Strategies," addressing changes in the location, type, and timing of student experiences and placements. There was discussion on the concept of tiered sites, to categorize ones that might be good for entry level students, as opposed to sites that might be more appropriate for more experienced students. There was also discussion on the use of clinical sites within non-traditional settings such as prisons, as well as sites connected to the Indian Health Service, Alaskan Native Program, Hawaiian programs, and even Project Hope.

Dr. Valentine turned the discussion to the use of simulation and computer-based supplemental education for students. She noted that nursing has been active in the use of simulation. With a shortage of clinical sites, simulation may play a growing role in student training.

Discussion: Report Recommendations

Dr. Valentine reviewed the recommendations that had been put forth for the report. The first was for the development of a National Center for Clinical Site Development, which would cover providing preceptor development, exploring non-traditional clinical partners, finding new clinical sites, and using simulation centers.

The second recommendation was, "Providing support for students through stipends and scholarships to disadvantaged students." There had been discussion on adding the National Health Service Corp and loan repayments under incentives.

The third recommendation would state that HRSA will work with other entities to provide both monetary and non-monetary incentives for preceptors. This section would include the possible use of tax incentives for preceptors.

Another recommendation covered increasing IPE through simulation and on-line education. There was discussion that this recommendation would fit with practice redesign and the role that IPE has in improving quality and reducing cost, and achieving the value proposition. Further discussion referred to including the key personnel who can help health coaching and health promotion. Other members followed that the focus on IPE and population health had created a greater emphasis promoting a culture of wellness, through health education and health coaches, as well as by utilizing technology.

Dr. DeLeon revisited the issue of military culture, and specifically military retirees, who often live in rural areas. He mentioned recent reports stating that up to 20 veterans a day commit suicide, so providers may be missing something in their care. However, it was discussed that the Committee did not have the charge to make recommendations about the Department of Veterans Affairs (VA). Any recommendation from the Committee would have to be worded around ways in which HRSA programs could help veterans. Dr. DeLeon mentioned that the VA and the Department of Defense has a small pilot program to take physicians assistants with military experience and train them to be mental health providers, since they can bring a unique skill in understanding the mental health needs of veterans.

Dr. Gray brought up the issue of lack of internet access in many rural areas. Dr. Valentine suggested including a recommendation for schools to explore new curriculum models that are accessible to those living in remote or other hard to reach locations. There was also discussion on the issue of access for students with disabilities.

Dr. Valentine noted that the Committee had not discussed in detail behavioral health, outside of the concerns raised by Dr. DeLeon. There was discussion on integrating behavioral health and primary care. With the lack of mental health providers, there was discussion on creative ways to support primary care providers through telehealth, tele-education, and case-based consultation.

A question was raised related to the Substance Abuse and Mental Health Services Administration (SAMHSA), but Dr. Weiss reminded the members that the charge to the Committee does not address SAMHSA programming. There was discussion on the importance

of integrating behavioral health and primary care in terms of health promotion, chronic disease management, patient empowerment and self-management, and dealing with depression. Ms. Perweiler stated that providing holistic care and improving the health of populations in terms of health promotion and disease prevention requires incorporation of a behavioral health component.

Discussion: Upcoming meetings

Dr. Weiss brought up the need to determine a third date for the FY 2017 Advisory Committee Meetings. The first date had been set as December 8, 2016, and the in-person meeting is scheduled for March 29-30, 2017. After a brief discussion, it was determined that the third meeting would be held on May 25, 2017.

Discussion: ACICBL 15th Report

Dr. Valentine offered a brief summary of the ACICBL 15th report, which examines current programs funded under Title VII, and provides a brief history of the current grants, and a brief description of issues in healthcare practice and education such as the aging of the population, the rise in the multi-morbidity, disparity in access; use of IPE; and workforce challenges. She reviewed the recommendations in the report: IPE program eligible entities should be based on the needs of a community; outcomes of IPE programs should be competency-based not patient outcome based; and programs under Title VII that expose students to clinical training in underserved areas should be permitted to provide stipends.

Ms. Perweiler stated there is a need for Title VII programs to respond to healthcare redesign by supporting population health, IPE, and collaborative practice. She expressed concern that Title VII programs had outlived their usefulness in their current format, and emphasized the need to look at health promotion and disease prevention from a holistic perspective. She suggested a recommendation to promote competency-based training and to assure that clinical-based preceptors and faculty are trained to address population health and interprofessional collaborative practice as a part of curriculum reform.

Dr. Weiss supported the recommendation, adding that new models of healthcare require health professionals to work together as teams. Programs need to respond not only to practice redesign but to issues of diversity and distribution. She also noted a growing trend for adults aged 55 and older to join "wellness communities" focused on health promotion, providing new opportunities for the health workforce.

Ms. Perweiler noted the that the long-term goal of competency-related practitioner practice change is to improve patient outcomes. She saw the 15th report as laying a foundation for the 16th report. Dr. Valentine agreed, saying that the 16th report will address the need for preceptor and faculty training.

Dr. Valentine mentioned another recommendation that addressed redesign of the curriculum, noting that Dr. Newton had discussed blended learning. There was discussion that classroom learning is no longer sufficient, and students need more exposure to real-life opportunities, as well as to practice through simulation training. Further discussion addressed expanding the eligibility for those Title VII programs to a wider range of health professions, with the rationale to improve the availability of innovative partnerships.

Related to competency-based education, there was discussion of the required competencies for each discipline related to accreditation standards. Along these lines, there is a need to create a learning environment both in the classroom and in experiential learning sites so that students learn to demonstrate their individual competencies, as well as their ability to practice team-based competencies. Training is needed to increase the comfort of students working as a member of the team, and obtaining a better understanding of the roles of the other health professional disciplines, and how the disciplines can work together to improve care. Dr. Valentine brought up the value of knowing the contributions that can be made can be greater when health professionals work together as a team.

Dr. Valentine brought up the issue of the aging workforce. Some studies indicate that, even with the current strong enrollment in health professions education across all disciplines, the numbers are not sufficient to replace those who will be retiring. She added that educators are aging out of the workforce as well, and it is unclear if there are enough in the pipeline to take their place.

Dr. Weiss suggested revisiting options like apprenticeship models and more intensive preceptorship models, which may require curriculum reform. She noted that not all professionals are interested in teaching or in academia. She also mentioned models in which students mentor each other, or professionals from a different discipline offering mentoring, especially in terms of IPE. One benefit of competency-based training is that a professional from other disciplines may still be able to teach a particular skill or competency. Dr. DeLeon added that healthcare redesign and the pace of change in technology make it difficult to know what skills providers may need and what professional responsibilities will be five years down the line.

Dr. Valentine noted that the nursing profession does a good job in preparing the next cadre of nurse educators, while other disciplines may not offer the same focus of developing new leaders. Ms. Perweiler said that geriatrics offers academic career awards and fellowships designed to train new academicians, but medicine as a whole does not promote teaching in the same way. Dr. Valentine suggested reviewing these trends and looking at how grant programs can meet the current workforce needs as well as for the next five to ten years. Dr. Weiss concurred that such a focus could make a significant contribution.

Dr. DeLeon brought up the role of foundations, such as the Robert Wood Johnson Foundation (RWJF) or the John A. Hartford Foundation, in promoting the health professions. He noted that RWJF had spent over $100 million in addressing the future of nursing. Dr. Weiss agreed that opportunities to leverage funding from other sources can help to build a pipeline that can address the needs of the new healthcare system, and Dr. Valentine mentioned the possible role of public-private partnerships.

Dr. Weiss asked Ms. Crystal Straughn to bring up the funding table for Title VII programs. Under the section for Interdisciplinary Community Based Linkages, there were entries for AHECs, geriatrics, mental and behavioral health, and "Clinical Training and Interprofessional Practice." Dr. Avant spoke in support of the Quentin A. Burdick Program for Rural Interdisciplinary Training (Burdick), which addressed preparation of a healthcare workforce for rural communities that lack access to quality health services.

Dr. Valentine stated that the 16th report contains discussion on the importance of having online trainings, better rural access, and having clinical sites work together in a consortium. In addition, the report should include the need to train the healthcare workforce on the integration of behavioral health and primary care, faculty development, and tele-supervision.

Dr. DeLeon noted that the Burdick Program is authorized but has not been funded since 2005 and would like to include a recommendation to provide funding for this program. For Title VII, Part D Programs the Committee recommended that program eligibility should be expanded to other disciplines in addition to the disciplines identified in the legislation and be based on the needs of the community.

Dr. Weiss stated that the goal is to finish the 15th report by mid-December. HRSA would revise the draft and send it to the writing committee to finalize the recommendations. Ms. Straughn stated she might need some assistance in writing the background materials, and Dr. Valentine suggested that the committee members could provide some background articles. Dr. Weiss reminded the Committee that the review would only go back to the Health Professions Partnership Act of 1998, and it would cover other legislation up to the current Affordable Care Act.

Dr. Weiss also asked the members to begin thinking about a topic for their next report.

Public Comment

Dr. Valentine opened the phone lines to public comment.

Dr. Jan Towers asked if the discussion of the Committee reflected all of the health professions, or was the focus primarily on nursing and medicine Title VII programs. Dr. Valentine replied that the Committee's deliberations were intended to be inclusive for all health disciplines.

Dr. Towers also expressed concern on the issue of funding, stating that some recommendations have a cost but others can be done with no added costs. She noted that the Title VII appropriations are not very high, so the concern is to make sure the available funding goes to where it is most needed. It is also important to note that some programs that the Committee may recommend for funding may ultimately lead to a cost savings in the long term.

There were no other public comments.

Dr. Valentine adjourned the meeting at 4 p.m.