MEETING MINUTES
Advisory Committee on Interdisciplinary Community-Based Linkages
January 14-15, 2021

Committee Members Present
Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP
Chair

Geraldine Bednash, PhD, RN, FAAN
Katherine Erwin, DDS, MPA, MSCR
Roxanne Fahrenwald, MD, FAAFP
Teri Kennedy, Ph.D., MSW, LCSW, ACSW, FGSA, FNAP
Parinda Khatri, Ph.D.
Sandra Pope, MSW
James Stevens

HRSA Staff in Attendance
Shane Rogers, Designated Federal Official
Kimberly Huffman, Director of Advisory Council Operations
Janet Robinson, Advisory Committee Liaison, Advisory Council Operations
Joan Weiss, PhD, RN, CRNP, FAAN, ACICBL Subject Matter Expert, Deputy Director, Division of Medicine and Dentistry

DAY 1

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 10:00 AM, Thursday, January 14, 2021. The Health Resources and Services Administration (HRSA) facilitated the meeting through a virtual platform. Mr. Shane Rogers welcomed the Committee, presenters, and members of the public attending the meeting. He thanked HRSA staff and Committee members for their efforts. He explained that the Committee's purpose is to provide advice and recommendations to the Secretary of Health and Human Services and Congress about policy and program development pertaining to programs authorized by Public Health Service Act Title VII Part D. Committee members represent the range of professions specified in the authorizing legislation. They also represent diverse geographic regions, and both urban and rural communities.

Dr. Nicole Brandt welcomed the Committee and presenters. She reviewed the agenda for Day 1, conducted roll call, and invited Committee members to introduce themselves, which they did. All members were in attendance.

Presentation: "Programs Update: Mental/Behavioral Health Education and Training and Graduate Psychology Education"
Patsy Cunningham, MA, NCC, LCPC
Behavioral Health and Public Health Branch Chief Bureau of Health Workforce, HRSA

The goals of HRSA's Behavioral Health Workforce Programs are to grow the behavioral health workforce, increase its capacity, improve provider distribution, and promote integration of service delivery. Most programs focus on integrating primary care and behavioral health. There are currently six behavioral health programs. The newest programs are the Addiction Medicine Fellowship Program and the Opioid-Impacted Family Support Program, which were initiated on July 1 and September 1, 2020, respectively. Other programs are the Behavioral Health Workforce Education and Training (BHWET) Program, Graduate Psychology Education, the Opioid Workforce Expansion Program (OWEP), and OWEP Paraprofessional Training program.

BHWET's $50 million budget supports 136 grantees that train professionals and paraprofessionals to serve rural and underserved communities. Paraprofessional programs often offer certification and are provided at technical colleges. Certification programs are available for peer support specialists, recovery coaches, certified addiction counselors, behavioral health aides, and other paraprofessionals. BHWET aims to expand the number of students trained and the number of field placement opportunities available to students. Training focuses on prevention and clinical intervention for behavioral health disorders, including mental health issues and substance use disorders. Training also focuses on how to engage families and develop community partnerships. The program supports curriculum development and interdisciplinary training in academic and clinical settings. BHWET supports paraprofessional career development opportunities. The program's funding will end in 2021.

The Graduate Psychology Education Program's $18 million budget supports 49 grantees. The program supports doctoral training in psychology for students who will provide behavioral health care to rural and underserved communities, and who will integrate behavioral health and primary care. Grantees are required to focus 25 percent of training on opiate and other substance use disorders.

OWEP's $57.5 million budgets funds 49 grantees to offer master's- and doctoral-level training in prevention, treatment, and recovery support for patients with opiate or other substance use disorders. OWEP's paraprofessional training program's $12.4 million budget supports 16 grantees to provide community-based experiential training. By 2022, OWEP expects the program to train 4,309 paraprofessionals, who will contribute to interprofessional teams.

The Addiction Medicine Fellowship program trains physicians to work on interprofessional teams in underserved community-based settings. BHW expects the program to train between 500 and 600 fellows over the next 5 years.

The Opioid-Impacted Family Support Program's supports 19 awards to enhance and extend behavioral health paraprofessionals' knowledge, skills, and expertise relevant to patients and family members. The program focuses on serving guardians of children impacted by the opioid epidemic. Grantees offer pre-service didactic and experiential training, with certification after a

minimum number of service hours. Certified trainees may participate in apprenticeship training, which offers financial incentives and experiential learning.

Discussion
Committee members raised the following questions and points.

Did budgets for all programs included in the presentation increase for FY 2021?
Ms. Cunningham stated this was the case. She noted that OWEP was initiated in FY 2019.

Is BHW tracking programs' success and impact on trainees? If so, how is success measured?
Performance reports and grantee reports indicate that OWEP-trained paraprofessionals address unique needs of the communities they serve. Data indicate that graduate-level trainees are employed as mental health professionals and are meeting needs of priority patient populations. BHW data focus on programs' impact on workforce capacity, not patient satisfaction. However, BHW does elicit feedback from grantees' clinical partners on how BHW program trainees compare to counterparts who have not received this training. Feedback indicates that trainees are better prepared to provide care and to recognize and address social determinants of health.

Are programs able to ensure trainees are employed and serving priority communities? What additional resources do they need to do so?
Needs vary by Region. Ms. Cunningham gave an example of a Region that underutilized professionals and did not consistently integrate them into professional care teams. BHW's Office of Regional Operations provided support for addressing this issue. Patients often have been unable to access telehealth services, due to issues such of lack of electricity in some Tribal communities. BHW is working with grantees to identify potential approaches to increasing internet access in grantee communities. Approaches include purchasing telehealth equipment, working with partners to address transportation or broadband access issues, and teaching patients how to use telehealth technology.

What have programs learned about improving digital literacy and access?
HRSA's Public Health Training Centers offer training and technical assistance to behavioral health programs in order to facilitate telehealth service delivery and access. Social distance during COVID-19 can increase patients' sense of isolation and exacerbate mental health issues. In response, trainees are monitoring patients remotely. Training Centers also provide technological resources, such as laptops and private spaces with internet access, to support online training, as well as training in how to provide services that comply with all relevant practice regulations.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act allocates $1 billion to support broadband connectivity for Tribes. How can Tribes access training in best practices in increasing connectivity?
Behavioral health programs host technical assistance calls, some of which are offered in coordination with Indian Health Services. Tribes can participate in training offered by Public Health Training Centers.

Presentation: "Programs Update: Geriatrics Workforce Enhancement Program (GWEP) and Geriatric Academic Career Awards (GACA)"
Joan Weiss, PhD, RN, CRNP, FAAN
Deputy Director, Division of Medicine and Dentistry
Bureau of Health Workforce, HRSA

Section 3403 of the CARES Act reauthorizes both GWEP and GACA by amending the corresponding sections of the Public Health Sevice Act. GWEP's purpose is to develop a health care workforce that provides value-based care to improve older adults' health outcomes by maximizing patient and family engagement, and integrating geriatric and primary care. The program invested $36.035 million in continuing 48 awards in FY 2020. GACA's budget is $1.905 million. In 2021 the budget for both programs increased $2 million. The progams apply the Centers for Medicare and Medicaid (CMS) definition of value-based care: "A form of reimbursement that ties payment for care delivery to quality of care provided, which supports better care for individuals, better care for populations, and lower costs."

GWEP trains the workforce to provide person-centered care with a focus on needs of patients, families, and caregivers. GWEPs serve rural and underserved communities in 35 States and two Territories. GWEP requires all grantees to have a reciprocal partnership with at least one academic, primary care site or delivery system, and community-based organization. Most grantees have more than the minimum number of partners. Partners provide community-based interprofessional training, integrating geriatrics and primary care, transforming clinical training environments, and transforming primary care sites into age-friendly health systems. Partners communicate with each other regarding patients' utilization of their services. All grantees and their primary care partners receive training on how to provide age-friendly care. The Institute for Healthcare Improvement designates sites that meet criteria as Level 1 or Level 2 age-friendly. To date, 125 of 391 partners have earned an age-friendly designation. The program also aims to transform communities to be dementia-friendly.

GWEP work includes evaluation and dissemination. Grantees report evidence about how they have improved patient outcomes, provided value-based care, and changed practice. From project inception, grantees propose plans for scaling and sustaining their work. Current grantees include 30 schools of medicine, nine schools of nursing, three schools of social work, one pharmacy school, one certified nursing assistant program, one Federally Qualified Health Center (FQHC), and three medical centers. GWEP grantees have 391 primary care partners: 190 FQHCs, 36 Community Health Centers, and Indian Health Service, academic, Veterans Administration, and home-based care sites. GWEP grantees' 284 community-based partner organizations include Area Health Education Centers (AHEC), Quality Improvement Organizations, health departments, and others. GWEP grant recipients also have 174 academic partners.

Grantees must demonstrate impact on health care access, quality and cost. Programs must demonstrate impact linked to the age-friendly principles regarding "What Matters, Medication, Mentation, and Mobility." Measures of age-friendliness are linked to the CMS Merit-Based Incentive Payment System (MIPS). The measure of mentation impact is dementia caregiver education and support.. The measure of medication impact is conducting evaluations or interviews for risk of opioid misuse, which is a priority for the Department of Health and Human

Services. Grantees can select additional measures of impact related to medication, such as medication management. Care plan development is the core indicator for "What Matters." Fall risk assessment and screening for future fall risk measure Mobility. BHW requested for the Bureau of Primary Healthcare to provide input on which Uniform Data Set measures they most wanted to improve. The Bureau selected colorectal cancer screening, diabetes, and hypertension, which GWEP grantees can select as performance measures.

In response to calls from the field, such as the National Academies of Science, Engineering and Medicine (NASEM) 2016 report, "Families Caring for an Aging America," GWEP prioritizes caregiver workforce development. NASEM called for identification of competencies and development of curricula and training in those competencies. GWEP grantees must allocate $100,000 of their $750,000 awards for dementia education and training. Grantees offer HRSA's Alzheimer's Disease and Related Dementias 16-module curriculum, developed with Federal and private stakeholders. Participants can earn one continuing education unit for each module completed. HRSA also developed a curriculum for caregivers.

COVID-19 has increased caregiver stress and burnout. Caregivers are more isolated during the pandemic. They may not have access to virtual training due to low digital literacy, lack of connectivity, or lack of access to a device. GWEPs are working to address these challenges. They have developed videos, and self-care resources such as online exercise groups, and poetry readings. Grantees have developed tip sheets on addressing stress and anxiety, and deep breathing and meditation reminders. Trainees are teaching patients and caregivers how to use technology and access telehealth. GWEP grantees measure success of telehealth as 1) the number and disciplines of individuals receiving training focused on transition from in-person to telehealth and other distance learning modalities, and 2) the number and types of training sites offering COVID-19-related telehealth services.

A total of eight GWEP grantees offer training on how to provide care for older adults living with HIV/AIDS. Trainees include interprofessional teams, primary care providers and staff, and older adults, families, and caregivers. Training is offered through YouTube videos, PowerPoint presentations, continuing education courses, Project Extention for Community Healthcare Outcomes (ECHO) didactic lectures, and community outreach presentations. Topics include HIV and Aging, HIV and Infectious Disease, the Intersection of HIV and Dementia, 4Ms (what matters to the individual, mentation, medication, and mobility) Age-Friendly Based Care of Older Adults with HIV/AIDS, and HIV/AIDS and Sexually Transmitted Diseases in the 55+ Population.

HRSA requires GWEP grantees to participate in training on disaster preparedness, response, and recovery. The Federal Partners Webinar series "Focus on Aging" includes a webinar on supporting older adults during emergencies. The CARES Act allocates $4.35 million for GWEP grantees to prevent, prepare for, and respond to COVID-19. Prevention efforts promote the use of telehealth technologies to reduce disease risk. Preparation efforts focus on enhancing readiness to respond to COVID-19 using telehealth technologies. Response efforts focus on providing access to telehealth technologies. Telehealth services include referrals for screening and testing, care management, and outpatient care. Grantees also can use funds to maintain primary care functionality away from physical sites, especially for patients who test positive for

COVID-19, those who are quarantined, and those who are at high risk for severe illness. Grantees can buy telehealth equipment with CARES funds. Grantees must measure the impact of their efforts with at least one CMS telehealth reimbursement measure.

GACA supports junior faculty career development in geriatrics at accredited schools of allopathic and osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or allied health. Grants are made to individuals, who must spend at least 75 percent of their time providing clinical training in geriatrics. Training must include interprofessional education. Grantees must evaluate their progress and impact. HRSA encourages grantees to use CMS MIPS measures in their evaluations. HRSA funded 25 GACA awards in FY 2020 and 26 in FY 2019 when the program started. In 2019, GACA grantees trained more than 14,000 caregivers.

Discussion
The Committee raised the following questions and points.

How do grantees deliver training to caregivers without internet access?
Grantees can use CARES funds to purchase Wi-Fi access. If this is not an option, grantees can deliver training via telephone.

COVID-19 has led to social isolation. This is a challenge for older adult rural residents with low digital literacy. Will GWEP grantees share lessons learned and best practices in reaching older adults through digital technology?
Grantees can share lessons learned after the grant period of performance ends on April 30, 2021. Grantees could confer with Committee members and Dr. Weiss to determine how best to share and disseminate information. Dr. Weiss will invite AHECs to participate in this endeavor. It may be useful for the Committee to work with other Federal Committees and Councils that are doing work in this area.

Several Federal initiatives aim to expand internet access. Can GWEP grantees collaborate with Federal partners to expand rural internet access?
The Federal Office of Rural Health Policy has an Office for the Advancement of Telehealth (OAT), which GWEP leaders can contact to discuss collaboration. OAT staff may be aware of other potential collaborators. The National Academies of Practice identified telehealth as a priority for 2021 and may be interested in a partnership. Dr. Kennedy serves on the Academies' Public Policy Committee, which is exploring the intersection between telehealth and interprofessional team-based care. Dr. Erwin offered to share information resources she obtained at the Northwest Regional Telehealth Conference.

Several Committee members asserted that affordability is the most pressing telehealth access issue. End users often cannot afford services even after Federal subsidies make them available. Community-owned internet service providers offer one solution. Committee members expressed interest in inviting a speaker to address this topic. Some Committee members were interested in a speaker representing broadband providers. Other members believed an industry representative would be unlikely to address the affordability issue. Mr. Stevens recommended inviting a speaker from the Alaska Native Tribal Health Consortium, which coordinates a broadband telehealth program. Other members supported this suggestion.

Does the Institute for Healthcare Improvement (IHI) offer resources describing best practices in age-friendly care?
Dr. Weiss will inquire at IHI and share the response with the Committee.

How have standardized evaluation data been valuable to BHW?
FY 2020 is the first year grantees have reported MIPS data on their non-competing continuing applications. Most data are baseline. Data to be reported in March 2021 will provide more information. Dr. Weiss can discuss these data with the Committee at a meeting subsequent to analyzing these data.

Telehealth is not the only way technology is changing health care delivery. Technology is supporting virtual access, ambulatory monitoring, access to resources to address social determinants of health, and education. The Committee should use general terminology when discussing the impact of technology on health care.

Presentation: "Unfunded Programs Update"
Joan Weiss, PhD, RN, CRNP, FAAN

A total of six Title VII Part D authorized programs currently are not funded, and therefore not implemented. These are: the Quentin N. Burdick program for Rural Interdisciplinary Training, Allied Health and Other Disciplines, Podiatric Training Program, Chiropractic Demonstration Projects, Education and Training in Pain Care Program, and Demonstration Program to Integrate Quality Improvement and Patient Safety in Training into Clinical Education of Health Professionals.

The Quentin N. Burdick program was last funded in 2005. The program aims to recruit and retain health professions students and providers to practice in rural communities, which continues to be a BHW priority. Much of the work of the Quentin N. Burdick program is addressed by other BHW programs especially AHEC and GWEP.

The Allied Health and Podiatric Training programs were last funded in 2005. Their purposes are to increase the number of trained professionals in these disciplines. Several other BHW programs, including AHEC, GWEP, GACA, and mental and behavioral health training programs now address this purpose.

The Chiropractic Demonstration Project was last funded in 2011. Its purpose was to support collaboration between chiropractors and physicians in order to identify and provide effective treatment for spinal and lower back conditions. The Program for Education and Training in Pain Care was authorized by the Affordable Care Act in 2010, but has never been funded. GWEPs currently offer training in pain care. Some GACA grantees have pursued research on palliative and pain care. Pain care without opioids is a priority for behavioral and mental health programs.

The Quality Improvement Program was authorized by the Affordable Care Act in 2010 and never funded. The program's purpose is to develop and implement academic curricula that integrate quality improvement and patient safety into health care professionals' education. All

BHW programs currently have this purpose and must demonstrate effort to achieve quality improvement and by doing so enhance patient safety.

Discussion
Committee members raised the following questions and points.

If BHW were to select an unfunded program to fund, which would it select to have the greatest impact on priority issues?
Answering this would require discussions at several agency levels. The Committee can recommend having these discussions. The ACICBL's 15th Report provides detailed information about the Committee's program review and recommendations at the time of report development.

Should unfunded programs be continued if they are redundant with other funded programs?
Congress passed the authorizing legislation. All programs were reauthorized by the CARES Act. Congress will have to decide whether to fund the programs. The Committee can make a recommendation with a justification for supporting these programs.

Panel Presentation: "Performance Measurement and Interprofessional Competencies"
Brenda K Zierler, PhD, RN, FAAN
Director of Research, Training and Faculty Development
UW Center for Health Sciences Interprofessional Education, Research, and Practice
University of Washington School of Nursing

Given the investment in interprofessional education, it is critical to know whether and when it is working, and what its outcomes are. The World Health Organization (WHO) published a framework for action on interprofessional education and collaborative practice in 2010, as a strategy for addressing the health workforce shortage. The framework's aims included developing strategies for recruiting health professions students from communities most in need of professionals and training them to deliver team-based care. The field expected this approach to improve patient and systems outcomes. In 2011 the Interprofessional Education Collaborative (IPEC) Expert Panel identified four core domains and 38 sub-domains of competence. IPEC updated these in 2016, with an emphasis on integrating patient- and family-centered care as well as community- and population-oriented care. Schools' curricula must address these competency domains in order to be accredited for interprofessional education. Educators have established that they can train students to have these core competencies. However, students cannot apply these competencies unless the institutions where they practice facilitate collaborative practice. In addition, faculty at training institutions and health system leaders often require training to understand the core competencies and their significance, as well as how to facilitate implementation. This was the basis for WHO's framework for action.

The 2011 Lancet Commission Report, "The Transformation of the Health Professions Education for a Whole New World" discussed how to develop the future workforce. The Commission identified interprofessional education as a key strategy. The Commission also emphasized the importance of the field to disseminate lessons learned. In response NASEM formed the Global Forum on Education, which reviewed information about interprofessional education around the globe. The review showed that the field wanted information about effectiveness of

interprofessional education and who should be responsible for evaluation. The Forum developed a consensus report entitled, "Measuring the Impact of Interprofessional Education and Collaborative Practice on Patient Outcomes." NASEM charged the forum with assessing whether collaborative practice occurs, whether it improves care quality and safety, whether it increases patient and provider satisfaction, and how it affects communities. NASEM also sought information about how education, training, and systems result in targeted outcomes. The Forum concluded that education and the health system were not aligned. Forum members also identified a need for a conceptual framework and taxonomies to facilitate thought and discussion on this issue, and so developed a framework. The Forum also noted a lack of research in the area. The Forum recommended identifying target health and system outcomes. Forum members also recommended collaboration between education and health care delivery systems to facilitate interprofessional practice.

A shared taxonomy is important for interprofessional collaboration. The Forum developed a definition of the interprofessional learning continuum, which begins with foundational education, then graduate education and continuing professional development. Interprofessional education should be provided throughout this continuum. The Forum proposed a modified Kirkpatrick's Evaluation Framework. Individual learner-level targeted outcomes include students' reactions, attitudes and perceptions, knowledge and skills, collaborative behavior, and performance in practice. Both individual and public health are targeted outcomes. System-level targeted outcomes include organizational change, efficiency, and cost-effectiveness. Factors that affect outcomes include professional culture, institutional culture, workplace policies, and financial policies. There are very few studies on the effects of interprofessional education on behavior or practice. The Forum recommends conducting studies to evaluate these effects.

Interprofessional competencies are difficult to measure. Measures must focus on practice. Dr. Zierler currently is working on a project to assess team communication and relationships. The project team provides instruction on practice transformation, then facilitates self-assessment and development of strategies for overcoming challenges. The team developed a reliable and valid tool for assessing relational coordination. Evaluation results indicate instruction improves team communication and functioning.

Christine Arenson, MD
Co-Director
National Center for Interprofessional Practice and Education
Professor, Family Medicine and Community Health
University of Minnesota

The National Center for Interprofessional Practice and Education has developed a strategy for evaluating interprofessional education and practice using the NASEM model. The Center's team includes clinicians, educators, health service researchers, educational psychologists, and measurement experts. The Center focuses on how to measure outcomes linked to the Quadruple Aim for health care quality. The Center has identified a core data set to assess: interprofessional competencies, interprofessional education learning environment, interprofessional clinical learning environment, interprofessional education critical events, "teamness," and health and systems outcomes linked to the Quadruple Aim. Center staff have identified six foundational principles for understanding and improving interprofessional practice and education and practice: 1) The nexus is education informed by and within practice, 2) knowledge generation through research, evaluation, and informatics, with real-time evidence informing practice, 3) place-based interprofessional education designed to meet local needs for improving health and equity, 4) engage patients, families, communities, and populations in intervention design, 5) define the care team broadly, to include professionals, paraprofessionals, patients, social scientists, data scientists, and educators, 6) work to achieve the Quadruple Aim to improve care quality. Success must be defined as improving care quality and health equity.

Center researchers have identified factors critical to success of interprofessional practice. Patients, families, and communities must be engaged in design, implementation, and assessment of care. Interprofessional teams must work on community-engaged evaluation teams to identify effective strategies for interprofessional practice that supports achieving the Quadruple Aim and increasing equity. Interprofessional teams must have opportunities for work-based learning throughout the learning continuum.

The Center offers an Interprofessional Education Knowledge Generation Program. The program teaches what is known about interprofessional education as well as evaluation methods and approaches to big data utilization. The Center advocates collecting consistent and comparable data across sites, linking data across sites in order to identify factors that support effective interprofessional education and practice and to support continuous quality improvement.

Center researchers have developed a survey to assess the interprofessional education and learning environment, and a survey to assess the interprofessional education clinical learning environment. These surveys assess factors that facilitate or interfere with the success of interprofessional education and practice. Researchers assess how service utilization links to targeted health outcomes. The research team minimizes burden on organizations being evaluated by using data the organizations already collect, whenever possible.

Qualitative data are essential to identify factors that affect the success of interprofessional education and practice. Research has shown that changes in staff, partners, and other resources affect outcomes. Unforeseen forces such as the COVID-19 pandemic also affect outcomes.

Ninez Ponce, PhD
Professor
UCLA Fielding School of Public Health
Department of Health Policy and Management

Equity, diversity, and inclusion (EDI) plays a central role in interprofessional education. Addressing social determinants of health is at the core of EDI. Patients and consumers must audit training materials regularly to avoid unintentionally stereotyping and divisiveness. Training programs must aim to recruit and retain a diverse workforce. To do this, organizations must demonstrate commitment to EDI, which requires organizational transformation. Organizational transformation is the most challenging, long-term goal of EDI. A six-point continuum for becoming an anti-racist multicultural organization ranging from "exclusive" to "fully inclusive multicultural organization" can guide self-assessment and discussions about how to transform.

Team-based education involves diverse participants, trained in disciplines with diverse perspectives, terminologies, and cultures. Individual team members also have diverse backgrounds. Organizations must support team members in building consensus for learning new methods, languages, and cultures. Training program leaders and instructors must immerse themselves in the diverse cultures and languages of their team members' fields of discipline and personal backgrounds. They also must immerse themselves in patients' diverse backgrounds. Organizations must incentivize these efforts.

Evaluation of EDI training should assess professional competencies and organizational culture. Key outcomes of EDI training include trainees' understanding of social determinants of health and structural racism, workforce diversity, and organizational culture. Indicators of success include team diversity, EDI vocabulary and skills, and financial and time investment in organizational change. Case studies can illustrate how EDI perspective increases the quality of team-based care. Evaluations should assess trainees' sense of belonging to the care team, understanding patients' experiences, and perceptions of the workforce climate, and how training affects these outcomes . EDI should be considered part of core competencies. Evaluations should assess how EDI focus affects targeted changes in practice and health.

Discussion
The Committee raised the following questions and points.

How can organizational culture be improved and transformed?
It is important for organizational leaders to invest in interdisciplinary practice and be willing to take action to support it. For example, leaders can require staff to participate in interprofessional training. Dr. Zierler's team conducted an anonymous survey to assess one organization's barriers to interdisciplinary care, then provided results to management. Managers provided feedback to staff based on results, and took action when staff did not improve. Organizations must not allow disrespect toward team members. Dr. Zierler emphasized the importance of anonymous data collection. It is important to obtain information on how patients and their families perceive care teams to function. Staff also have to invest in organizational culture

change. Training should engage staff and convey the value of change. All team members must have a sense of belonging.

How is a sense of psychological safety linked to interprofessional practice and EDI?
Psychological safety is a core target outcome of EDI training. Psychological safety requires a sense of inclusion for all members of diverse teams. Interprofessional training should teach students to recognize and address implicit personal and professional biases so that they create a sense of psychological safety for the care team. Training should focus on encouraging all team members to feel safe to express themselves. This often is not part of nurses' training; overcoming this may need to be a focus of interprofessional training.

How can the field transform expectations for health care provider education and training to be interprofessional and team-based?
COVID-19 has illustrated the value of team-based care for reducing burden on care providers. Training should teach leadership skills to support trainees in applying what they learn as team and organizational leaders. Programs should teach trainees to work as team members and also to teach others to work as teams. Accountable care organizations can advocate to change payment systems to incentivize team-base care, which some are doing. Accrediting organizations have issued strong statements about the importance of interprofessionalism. Continuing education and certification programs can teach interprofessionalism as a best practice.

Public Comment

Mr. Rogers invited public comment. None were offered.

Closing Comments

Dr. Brandt and Mr. Rogers thanked Committee members for their time and effort. Mr. Rogers adjourned Day 1 at 3:00 PM. Eastern Time.

DAY 2

Mr. Rogers convened the meeting at 10:00 AMEastern Time. He conducted roll call. All Committee members and Dr. Weiss were present. Dr. Brandt reviewed proceedings for Day 1 and the agenda for Day 2.

Presentation: "CARES Act"
Shane Rogers
Designated Federal Official, ACICBL
Division of Medicine and Dentistry, BHW, HRSA

Section 3402 of the CARES Act charges the Secretary of Health and Human Services to submit a strategic plan for workforce coordination. HRSA serves as the lead agency for plan development for the department and is currently developing the plan in consultation with the Council on Graduate Medical Education and the Advisory Committee on Training in Primary Care Medicine and Dentistry. HRSA has also solicited input from ACICBL, the National Advisory Council on Nurse Education and Practice, and the National Advisory Council on the National Health Service Corps. In November 2020 HRSA convened chairs of all five committees and councils that serve BHW to present a framework for planning. Following the meeting, each council and committee

submitted a letter summarizing their input for the plan. The Secretary will submit the plan to Congress no later than March 27, 2021. The council and committee chairs may meet again to discuss how their input was incorporated into the plan.

ACICBL's letter to the Secretary emphasized the importance of payment reform that supports interprofessional education and training, person-, family- and community-centered care, integrating medical and behavioral health care and social services, and expanding telehealth services. The Committee emphasized developing workforce pipelines starting with K-12 education. The letter also recommended advancing policies that support practitioners serving to their full scope of practice, including independent practice of nurse practitioners. ACICBL recommended policies that support care for providers' well-being, and improved training for direct care, community health, and indigenous health care workers. The letter also emphasized the importance of training providers to use data and metrics.

Discussion
Council members raised the following questions and points.

Cross-council collaboration offers a promising opportunity for developing and making progress toward shared goals.

The Department of Labor has announced that it will offer $40 million in grant funding to address rural health workforce shortages. How does this relate to HRSA and ACICBL work?
The Department of Labor is engaged with HHS in developing the Health Workforce Plan required by the CARES Act. The grant funding may support implementation of the plan. Dr. Bednash will share the funding announcement with the Committee and Mr. Rogers. HRSA has a long history of partnering with the Department of Labor and may collaborate on these efforts. The Federal Government supports several overlapping projects. It may be useful to coordinate efforts to increase efficiency. However, ACICBL must focus on Title VII Part D programs, which serve a unique prupose.

Presentation: "Federal Office of Rural Health Policy (FORHP) Overview"
Nisha Patel, MA, CHES
Associate Director/Senior Advisor Federal Office of Rural Health Policy

CDR Heather Dimeris, MS, RD
Deputy Associate Administrator Federal Office of Rural Health Policy

Ms. Patel provided an overview of FORHP. CDR Dimeris discussed telehealth programs.

FORHP Overview
FORHP advises the Secretary on rural policies and funds research centers. Centers' research findings inform rural health policy development and program planning. FORHP staffs the National Advisory Committee on Rural Health and Human Services. The Office supports several programs aimed at assessing and addressing rural communities' needs, which have intensified during the COVID-19 pandemic.

The rural population size is decreasing and aging. A large proportion of rural residents do not have health insurance. Rural communities have greater need for mental and behavioral health care, and less access to these services than other communities. Rural communities experience disproportionate maternal mortality. They experience disproportionate mortality from heart disease, cancer, unintentional injuries, and chronic lower respiratory disease. FORHP sets priorities to respond to these needs and decrease disparities affecting rural communities. Current priorities are addressing the COVID-19 pandemic, maternal health, behavioral health, and equity.

FORHP programs offer direct services or support capacity building. The Healthy Rural Hometowns Initiative aims to address the five leading causes of death in rural communities through developing and implementing local efforts in response to local needs, and sharing lessons learned. Between FY 2021 through 2024 FORHP will fund several programs to support rural communities needs for health care. The Network Development Program will focus on capacity building, linking the administrative, technological, and clinical aspects of an administrative organization. Rural Health Developmental Planning Grants support community partnerships in efforts such as needs assessment and business planning. Small Health Care Provider Quality Improvement grants support efforts to improve quality of care for chronic disease management. The Delta States Rural Development Network supports wellness and education activities in the Delta States. The Rural Maternity and Obstetrics Management Strategies (MOMS) Pilot Program aims to improve access to and continuity of maternal and obstetrics care in rural communities.

FORHP is responding to the COVID-19 pandemic by assessing communities' needs. The CARES Act allocates funding to providers who have lost revenue. The Paycheck Protection and Healthcare Enhancement Act allocates $225 million for COVID-19 testing in rural health clinics. Participating clinics are documenting capacity and test results in order to inform planning to administer the vaccine. FORHP awarded $16.3 million to 57 Tribal organizations to respond to the pandemic. Tribes are using funding to hire staff, purchase personal protective equipment, and support telehealth services. FORHP awarded $150 million to nearly 1,800 rural hospitals to address COVID-19.

Between 2018 and 2021 FORHP allocated just more than $100 million to the Rural Communities Opioid Response Program (RCORP), which supports planning to strengthen the capacity of multisector consortia; implementation of prevention, treatment, and recovery efforts; medication-assisted treatment expansion; and a program to reduce the incidence and impact of neonatal abstinence syndrome. RCORP implementation and Psychostimulant Support grant competitions currently are open. Needs assessments demonstrate that psychostimulant misuse, especially of methamphetamine, is a problem in the Midwest. FORHP initiated the Psychostimulant Support program to respond to that need. Substance misuse rates are increasing. Rural care providers report that they observe this trend and lack adequate workforce to address the problem adequately. Telehealth has helped to decrease rates of clients not appearing for counseling and treatment services. However, lack of broadband access is a barrier to telehealth services. FORHP is analyzing data to identify how best to expand rural behavioral health infrastructure.

Telehealth

FORHP's Office for the Advancement of Telehealth (OAT) defines telehealth as, "The use of electronic information and telecommunication technologies to support and promote: long distance health care; patient and professional health-related education; public health; and health administration." Telehealth technologies include the internet, video conferencing, store-and-forward imaging, streaming media, terrestrial and wireless communications, and mobile telephones. Telehealth offers benefits to patients, providers, and payers. By reducing travel burden, it increases rural communities' access to health care. Telehealth allows primary care providers to work with specialists.

Barriers to accessing telehealth include Medicare and Medicaid requirements, and restrictions on licensure, credentialing, and practice privileges. Broadband access and cost present barriers in many rural communities. Some regulation flexibility has been implemented to facilitate response to the COVID-19 pandemic. CMS has expanded reimbursement for telehealth services, and implemented cost sharing provisions. Providers can provide services to patients in other States. CMS has waived a requirement to provide services through video links, allowing delivery with only an audio link. CMS also allows provider supervision through telehealth. This flexibility has dramatically improved access to services. The HHS Office of Civil Rights has allowed flexibility in Health Insurance Portability and Accountability Act (HIPAA) requirements for use of communications applications, such as Facetime and Skype. OAT is working to collect and analyze data to demonstrate the value of the regulatory flexibility and to recommend continuing this flexibility after the pandemic. During the pandemic patients and providers have recognized the value and advantages of telehealth.

OAT administers the Telehealth Work Grant Program, which demonstrates use and outcomes of rural telehealth networks. In 2020 the program offered Tele-Emergency Department grants to expand emergency stroke and psychiatry services. OAT supports the Evidence-Based Tele-Behavioral Health Network Program to increase rural and frontier communities' access to behavioral health care. Results will guide policy and inform regulations. The current competition for up to 14 grants for $350,000 each prioritizes direct-to-consumer telehealth services. Grantees will provide services and evaluate effectiveness, benefits, and lessons learned.

Telehealth Resource Centers provide technical assistance for telehealth service delivery. The CARES Act authorizes $11.6 million to support Telehealth Resource Centers in addressing the 285 percent increase in requests for technical assistance between 2019 and 2020.

OAT's Licensure Portability Grant Program provides support for State professional licensing boards to support cooperation among States to develop and implement State policies to reduce statutory and regulatory barriers to the provision of telehealth services. Telehealth Focused Rural Health Research Centers publish data and research findings generated by FORHP programs. Telehealth Centers of Excellence explore promising approaches to telehealth.

HRSA's Telehealth Strategic Plan encourages clinical health services, tele-mentoring and distance learning, research and evaluation, and business strategy. HRSA currently supports 1,886 grants and contracts with telehealth components. These projects are implemented in 50 States and eight Territories. They support delivery of primary, behavioral, and mental health care, as well as other types of services.

In response to the COVID-19 pandemic, OAT created Telehealth.hhs.gov, which provides information about telehealth for patients and providers. Topics include reimbursement and implementation. CDR Dimeris presentated a list of HHS telehealth resources. FORHP posts weekly announcements about funding opportunities, policy and regulation developments, and research findings. Telehealth is a tool to connect patients and providers. It offers benefits and savings. But there are times when in-person care is necessary.

Discussion
Council members raised the following questions and points.

Is FORHP exploring how telehealth can be used to reduce vulnerability among vulnerable populations?
FORHP is working with other agencies, such as the Administration for Community Living to consider how to ensure universal access to telehealth. This includes ensuring providers have the resources necessary to facilitate telehealth visits with vulnerable patients, such as those with low digital literacy. It is easier to reach and train providers than patients. The Telehealth.gov web site provides some resources for facilitating visits. Rural communities in Montana have connected high school students with older adults to teach digital literacy and assist with setting up technological equipment.

The Federal Communications Commission (FCC) has allocated funding to increase broadband access. FCC is conducting a healthcare pilot program and is requesting public comment.
CDR Dimeris encouraged Committee members to comment and share their recommendations to increase access to broadband in order to facilitate health care service delivery to people living in remote communities.

Will FORHP assess the impact of regulatory flexibility on a broad range of care provider types?
CDR Dimeris is not aware of any current efforts to do this.

Committee Discussion: 20th Annual Report

The Committee's 20th report will evaluate Title VII Part D programs. The evaluation will emphasize health equity issues. Mr. Rogers presented notes from the previous meeting that mentioned potential recommendations and report discussion points. In the previous meeting, the Committee discussed career bullying as a potential report topic. This topic can be addressed in future reports rather than the 20th Report. Dr. Brandt reminded Committee members that they can express concerns not addressed in the report through letters and briefs. Letters can be submitted earlier than the report.

The Committee agreed that the report should discuss:

- **The impact of COVID-19 on health care delivery**
  Health delivery will not return to the status quo after the pandemic has resolved. The report should consider lessons learned and implications for improving health care and increasing access.
- **The importance of internet access and telehealth for health care delivery**
  The report should discuss:
  - the importance of investing in digital infrastructure
  - the value of internet access and telehealth, including landline and cellular telephones, for reaching underserved and under-researched communities
  - best practices for using and maintaining remote monitoring equipment to improve health outcomes
  - how technology increases access to mental health services; isolation and barriers to education caused by COVID-19 response, as well as grief over COVID-19 sickness and death have resulted in mental health issues and needs for services.
  - need for and strategies to increase digital literacy among patients, health care providers, and staff
  - the value of technology for supporting supervision of health care providers in training
  - the impact of licensure mobility on rural health care providers' revenue.
- **Building trust in public health**
  - This must include effective messaging. Building trust will require addressing the fact that available evidence, research findings, and recommendations change. Communication must address how to deal with uncertainty.
  - Trust is an essential component of effective emergency preparedness, response, and recovery.
- **Unmet needs that should be addressed through future programming**
- **Health equity should be a focus throughout the report.**
  Recommendations regarding training and data reporting should acknowledge equity as a core value. Health equity is a priority for Healthy People 2030. However, the report should not be redundant with the 19th Report, which focused on health equity.
- **Performance measurement should be considered throughout the report**
  - Grantees should assess progress as they implement recommendations.
  - Where appropriate, the report should discuss tools and measures to use in performance measurement.

The report could frame discussion around "reimagining public health care infrastructure and workforce for the 21st century," which could be the report title. The report should emphasize HRSA priorities and lessons learned during the COVID-19 pandemic regarding licensure, regulations, and financing. COVID-19 also revealed vulnerability and inequity. These lessons should inform consideration of how to prepare the workforce. Discussion of lessons learned from the COVID-19 pandemic should include positive lessons such as testing innovative approaches to care and approaches to increasing health and health care equity. The report should be timely at the point of publication in Fall 2021. Age-friendly health systems are a potential approach for reimagining infrastructure and framing recommendations. The report should consider systems friendly to all age groups, not just older adults. The writing committee can consider how to streamline and organize report topics.

Initial recommendations include:

- Preparing the workforce to serve in a digital environment
- Supporting the workforce pipeline
- Supporting continuing education in interprofessional practice
- Requiring telehealth objectives for Title VII Part D programs
- Building trust in public health
- Support at the National level for opportunities for interprofessional practice
- Program appropriation levels
  Appropriation recommendations can be informed by previous budgets and estimates of what resources are necessary to implement recommended changes. The Committee can develop cost estimates after finalizing other recommendations. Recommendations will emphasize the importance of flexibility in spending in order to maximize access to health care services. The review will include currently unfunded programs.

The report could begin by describing Title VII Part D programs, then present recommendations and their rationales. Recommendations must support effective programming. Mr. Rogers encouraged the Committee to consider how HRSA can improve programs through mechanisms such as grant requirements. One approach would be a requirement for grantees to demonstrate that they obtain input from the patients, families, and communities they serve. The Committee may encourage increased support for K-12 training and training throughout the learning continuum to increase the workforce pipeline.

Members of the writing committee are: Drs. Brandt, Kennedy, and Khatri, Ms. Pope, and Mr. Stevens. The writing committee agreed to meet Friday, January 22 at 11:00 AM to articulate and refine and recommendations and topics. Mr. Rogers emphasized the importance of formalizing recommendations so that the writing process can begin. He invited Committee members to submit input prior to the writing committee meeting.

Business Meeting

Dr. Brandt suggested that it may be useful for ACICBL to coordinate with other Federal advisory committees and councils to discuss issues of shared concern, such as stress on the workforce, accreditation standards, financial issues related to interprofessional practice, and opportunities for interprofessional training and practice. The Committee could invite the Chief Executive Officer of Trust for America's Health, who led development of age-friendly public health

systems, to speak at the next meeting. The Committee is interested in a presentation from an expert on telehealth and broadband, possibly a representative of the Alaska Native Health Consortium, which is leading telehealth development in rural Alaska. Mr. Stevens will provide Mr. Rogers with potential speakers from this organization. Dr. Erwin will provide recommendations for speakers on telehealth. The Committee would like HRSA staff to discuss current requirements for programs to support interprofessional training and education. Committee members are interested in HRSA's vision for the AHEC scholars program and how it can support the workforce pipeline and continuing education in interprofessional practice.

The Committee's next meeting will be held on February 17, 2021. Dr. Padilla will deliver a presentation on the new Administration's priorities. The Committee will meet again on August 5, 2021 to finalize the report and discuss report topics for 2022.

BHW supports and is discussing how to facilitate collaboration between advisory councils and committees. HRSA is reviewing nominations for new ACICBL members.

Public Comment

Mr. Rogers invited public comment. None was offered.

Closing Remarks

Dr. Brandt thanked the Committee members and Mr. Rogers for their work, and summarized Day 2 proceedings. Mr. Rogers thanked the Committee for its work and adjourned the meeting at 3:00 PM Eastern Time.