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

*Meeting Minutes*
April 18, 2022

**Committee Members Present**
Sandra Y. Pope, MSW (Chair)
Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP
Elizabeth Bush, MS, MA
Katherine Erwin, DDS, MPA, MSCR
Roxanne Fahrenwald, MD, FAAFP
Donna Marie Fick, PhD, RN, GCNS-BC, FGSA, FAAN
Teri Kennedy, PhD, MSW, ACSW, FGSA, FNAP
Kevin A. Osten-Garner, PsyD, LCP
Naushira Pandya, MD, CMD-FACP
Jennifer Peraza, PsyD, ABPP
Sara Sherer, PhD
Thomas A. Teasdale, DrPH, FGSA, FAGHE
Mary Worstell, MPH

**Health Resources and Services Administration Staff in Attendance**
Shane Rogers, Designated Federal Officer
Joan Weiss, PhD, RN, CRNP, FAAN, ACICBL Subject Matter Expert, Deputy Director, Division of Medicine and Dentistry
Zuleika Bouzeid, Advisory Council Operations, ACTPCMD-ACICBL-COGME
Cynthia Harne MSW, LCSW-C, Chief, Medical Training and Geriatrics Branch, Division of Medicine and Dentistry

**Welcome Remarks**
*Shane Rogers, Designated Federal Officer (DFO), ACICBL*

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 10:00 a.m. on April 18, 2022. The Health Resources and Services Administration (HRSA) facilitated the meeting through a virtual platform. Shane Rogers, the Designated Federal Officer, welcomed the Committee members, presenters, and members of the public.

Ms. Zuleika Bouzeid provided instructions for participating in the virtual meeting. Next, Mr. Rogers 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 the Public Health Service Act, Title VII, Part D. Mr. Rogers then turned the meeting over to Ms. Sandra Pope, the Committee's Chair.

**Agenda Review / Introductions**
*Sandra Y. Pope, MSW, Chair, ACICBL*

Ms. Pope welcomed the participants, took roll, and reviewed the agenda. The participants then introduced themselves. Ms. Pope introduced the first speaker, Ms. Cynthia Harne.

**Presentation: Addiction Medicine Fellowship and Integrated Substance Use Disorder Training Program**
*Cynthia Harne MSW, LCSW-C, Chief, Medical Training and Geriatrics Branch, Division of Medicine and Dentistry, Bureau of Health Workforce (BHW), HRSA*

Ms. Harne provided an update on two relatively new BHW programs: the Addiction Medicine Fellowship (AMF) Program and the Integrated Substance Use Disorder Training (ISTP) Program.

The purpose of the Addiction Medicine Fellowship is to expand the number of fellows who are trained as addiction medicine specialists in accredited AMF and Addiction Psychiatry Fellowship programs. These fellows will work in underserved, community-based settings that integrate primary care with mental health disorder and substance use disorder (SUD) prevention and treatment services.

As a program, the AMF has three objectives: 1) Increase the number of board certified addiction medicine or addiction psychiatry sub-specialists produced per program annually by providing stipends and support, 2) Collaborate and establish formal relationships with underserved, community-based settings to provide training of AMF Program fellows at these sites, and

3) Develop or enhance training for faculty from collaborating programs to create an infrastructure of skills and expertise that supports training fellows to provide opioid use disorder and other SUD prevention, treatment, and recovery services on integrated, interprofessional teams.

In Fiscal Year 2022, the appropriation for the AMF program is over $23 million for 43 awards. Over the 5-year life of the program, 50 percent of the funds will be used for stipends, and individual stipends may not exceed $100,000. Last year (Fiscal Year 2021) there were 98 trainees and 63 graduates.

The purpose of the ISTP program is to expand the number of nurse practitioners, physician assistants, health service psychologists, and/or social workers trained to provide mental health and SUD services, including Opioid Use Disorder (OUD) services, in underserved community-based settings that integrate primary care, mental health, and SUD services.

The ISTP has four objectives: 1) Increase the number of nurse practitioners, physician assistants, health service psychologists, and/or social workers trained to provide integrated mental health and SUD/OUD services in a primary care underserved community-based setting, 2) Plan, develop, and operate a training program to provide mental health and SUD/OUD services in underserved, community-based settings that integrate primary care, mental health, and SUD/OUD prevention, treatment, and recovery services, 3) Increase the number of physician assistants and nurse practitioners trained in Medication Assisted Treatment, and 4) Establish a foundation of skills and expertise for the community-based program that supports the training of nurse practitioners, physician assistants, health service psychologists, and/or social workers to provide mental health and SUD/OUD prevention, treatment, and recovery services utilizing a team-based care model.

In Fiscal Year 2021, the appropriation for the ISTP program was approximately $11 million for 5 awards. The program is still ongoing and is expected to train 93 clinicians.

*Discussion*

Ms. Mary Worstell asked how program graduates are evaluated and tracked in terms of performance. Ms. Harne replied that the program is evaluated through annual progress reports as well as performance data. HRSA also asks fellows if they are from underrepresented minorities, have rural backgrounds, where they are training, and other related questions.

Dr. Teri Kennedy said that one of the recipients in the ISTP program was a nurse practitioner. She asked how team-based training occurs. Ms. Harne replied that all programs are required to provide interdisciplinary team-based care.

Dr. Thomas Teasdale asked if there will be a list for community sites to identify those who have gone through the training because there is a scarcity of trained individuals. Ms. Harne replied that she did not know of any list of trainees.

Dr. Kevin Osten-Garner asked if the programs report on progress, barriers encountered, successes, and technical assistance efforts. Were there any interesting lessons learned regarding barriers to be overcome or any unique challenges individuals are facing out in the field?

Ms. Harne stated a progress report in narrative form is an annual requirement. Progress reports for ISTP are still outstanding, so they are not yet available. For AMF, they have received their second year progress reports and are just beginning to review and analyze them.

Dr. Osten-Garner said it would be helpful if funded programs focusing on SUD/OUD documented best practices, lessons learned, obstacles, and solutions. This information would be a helpful resource to publish for the public, other agencies, grantees, and grant programs as it would contain a treasure trove of information of ways programs have broken through barriers in delivering care. Ms. Worstell agreed and added that another item that could be shared is the program's level of impact.

**Presentation: National Alzheimer's Project Act (NAPA)**
*Joan Weiss, PhD, RN, CRNP, FAAN, Deputy Director, Division of Medicine and Dentistry BHW, HRSA*

Dr. Weiss presented on some of the federal efforts surrounding Alzheimer's disease. An estimated 6.2 million Americans aged 65 and older live with Alzheimer's dementia. This number could grow to 13.8 million by 2060, barring the development of medical breakthroughs. In 2019, official death certificates recorded 121,499 deaths from Alzheimer's disease, making it the sixth-leading cause of death in the United States.

On January 4, 2011, President Barack Obama signed into law the National Alzheimer's Project Act (NAPA). The Act requires the Secretary of HHS to take a series of actions, including but not limited to the following:

- Create and maintain an integrated national plan to overcome Alzheimer's disease
- Coordinate Alzheimer's disease research and services across all federal agencies
- Accelerate the development of treatments that would prevent, halt, or reverse the course of Alzheimer's disease
- Improve early diagnosis and coordination of care and treatment of Alzheimer's disease
- Decrease disparities in Alzheimer's disease for ethnic and racial minority populations that are at higher risk for Alzheimer's disease

- Coordinate with international bodies to fight Alzheimer's disease globally
- Establish the Advisory Council on Alzheimer's Research, Care, and Services (Advisory Council)
- Create and maintain a national plan to overcome Alzheimer's Disease and Related Dementias (ADRD) in collaboration with the Advisory Council
- Enhance care quality/efficiency and expand support for people with ADRD and their families
- Enhance public awareness/engagement and improve data to track progress

Dr. Weiss presented a list of education and training activities held by HRSA from 2012 to 2022. These included the following:

- From FY 2012 to FY 2020, the Geriatrics Education Centers and Geriatrics Workforce Enhancement Programs provided 5,383 interprofessional educational offerings on dementia to 687,048 trainees
- In FY 2013, HRSA, in collaboration with Office of the Assistant Secretary for Planning and Evaluation, supported the development of a Medscape continuing education course entitled "Case Challenges in Early Alzheimer's Disease"
- In FY 2013, HRSA, in collaboration with the HHS/Office on Women's Health, supported the development of a second Medscape continuing education course on assessing, managing, and treating Alzheimer's disease in the context of multiple chronic conditions
- In FY 2016 HRSA, in collaboration with federal partners and external stakeholders, created a 16-module Alzheimer's Disease and Related Dementia's curriculum. In FY 2020, $4 million in administrative supplements were awarded to 48 grant recipients to educate and train students and clinicians on providing telehealth-enabled COVID-19 referral for screening and testing, case management, and outpatient care; and/or maintain primary care functionality away from physical sites, especially for COVID-19 positive, quarantined, elderly, and individuals at a higher risk of severe illness, including persons living with dementia and their families and caregivers.
- In FY 2021, HRSA provided support to develop a Report to Congress on Current Capacity of Dementia Specialists

*Discussion*

Dr. Nicole Brandt said that in the past there was a movement to reduce the use of antipsychotics in nursing homes, however, over the last couple of years, there has been increased intention to an increased use of psychotropic medication. Dr. Brandt asked what training modules have been completed in the area of medication?

Dr. Weiss said this would be a module that needs to be developed in the next iteration. There is a need to develop a module to address the use of antipsychotic medications for all adults, not only those in nursing homes.

Dr. Teasdale added that module 15 is *The Role of the Pharmacist*. There may be some information in there, although it might not be specific to Dr. Brandt's question. Dr. Teasdale asked if there was a group one could speak to that addresses similar topic grants funded through different mechanisms.

Dr. Weiss said that for Geriatrics Workforce Enhancement Program (GWEP), the NAPA Council interacts with federal staff from other agencies. These parties work together in developing the language of the Notice of Funding Opportunity (NOFO). Many of these sister agencies also provide resources and links for inclusion in the reference section.

Dr. Jennifer Peraza asked if the module titled *Diversity and Dementia*, as well as other modules, had been developed so that they are linguistically appropriate for those with dementia.

Dr. Weiss said that the technical experts listed in the ADRD Curriculum helped to develop a curriculum that was culturally and linguistically appropriate. There have also been requests to translate the curriculum to other languages. Currently, it is used both nationally and internationally. Because it is written in plain language, it can be used for clinicians, as well as patients, families, and caregivers who want more information.

Dr. Roxanne Fahrenwald asked when the videos will be developed and whether they will be added to the website for each module.

Dr. Weiss said before that is done they will update the content. Once that is completed, they will develop the videos.

Dr. Katherine Erwin suggested using YouTube for large distribution of the videos to the public.

Dr. Weiss said they are working with grant recipients to identify a platform and YouTube is one under consideration.

**Presentation: Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD)**
*Anita Glicken, MSW, Immediate Past Chair, ACTPCMD*

Ms. Anita Glicken provided an overview of HRSA's Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD), its history, duties, past reports, and other

efforts. The ACTPCMD was authorized in 1998. It provides advice to the Secretary and the ranking members of Congress on policy and program development and other matters of significance related to medicine and dentistry activities. The Committee is required to submit annual reports, and within those reports can also recommend appropriation levels. The Committee consists of 17 members, all of whom are appointed by the Secretary and have three-year terms. It consists of a variety of specialties, including allopathic medicine, osteopathic medicine, family medicine, general internal medicine, general pediatrics, physician assistants, general dentistry, pediatric dentistry, public health dentistry, and dental hygiene.

Thus far, the ACTPCMD has produced 18 reports. The titles of the latest three reports are: 18th Report – *Improving Access to Care in Underserved Rural Communities*, 17th Report – *Innovations in Primary Care Education and Training*, and 16th Report – *Primary Care and Oral Health Education in Rural and Underserved Populations.* The 19th and 20th reports are currently under development and will focus on the following topics:

> 19th Report – Prioritizing funding for training medical and dental trainees on the treatment and care of patients with Special Health Care Needs, including those with Intellectual and Developmental Disabilities. The report will also address health equity and workforce diversity.
>
> 20th Report – Will address the Dental Therapy profession and recommend that the profession be eligible for scholarships and loan repayment through the National Health Service Corps. The report will also support dental therapy training programs and allowing dental therapy faculty to be eligible for the Title VII Dental Faculty Loan Repayment Program.

The ACTPCMD also recently sent a letter to the Secretary and Congress proposing some Indian Health Service recommendations.

*Discussion*

Dr. Fahrenwald said she was particularly excited about the Committee's plans to target Indian Health Services (IHS) facilities for onsite training. She shared that she had worked with IHS, and that one of the barriers of organizing trainings at sites can be faculty, as their site staffing can change. Dr. Fahrenwald suggested that the Committee consider partnering with other regional training programs for this reason.

Ms. Glicken thanked Dr. Fahrenwald for the suggestion and asked if there are any examples that illustrate similar efforts.

Dr. Fahrenwald said she did not know of any active successful examples. However, the family medicine residency program in Montana has recently developed a rural training track in conjunction with rural hospitals and a health care system that has community health sites on nearby reservations. The Committee may also want to consider The University of Washington's WWAMI system as a partner, which supports residency programs and has a Native American track.

Ms. Worstell said when she was at HHS she worked on a project with the Administration on Community Living that focused on identifying and evaluating model community-based programs that provide free or low-cost dental services for older adults. When individuals go into a nursing home, they are required to have a dental assessment, but those assessments are sometimes done by people who are not trained to do them.

Ms. Glicken thanked Ms. Worstell and said she was one of the first reviewers of that report and would love to tap into her wisdom and experience on the topic.

**Presentation: HHS Initiative to Strengthen Primary Health Care**
*Shannon McDevitt, MD, MPH, Federal Partner Lead, Initiative to Strengthen Primary Health Care, Immediate Office of the Assistant Secretary for Health*

Dr. Shannon McDevitt presented on a new initiative by the Office of the Assistant Secretary for Health (OASH)—the HHS Initiative to Strengthen Primary Health Care. The Initiative was launched on September 2021 by the Office of the Assistant Secretary for Health. Its aim is to "Provide a federal foundation to strengthen primary health care for our nation that will ensure high quality primary health care for all, improve health outcomes, and advance health equity." The Initiative supports immediate HHS priorities.

The Initiative's first step will be to develop an initial HHS Plan to Strengthen Primary Health Care. This plan will be submitted to the Secretary in late summer 2022. The plan will recommend an HHS infrastructure for ongoing leadership, focus on ensuring high-quality primary health care for all, and include prioritized, initial actions to be taken by HHS and across HHS agencies. The Initiative has the support of HHS leaders at the highest levels, and includes meetings with the Assistant Secretary for Health, monthly updates for HHS agency administrators, and routine briefings for Secretary Becerra and the Secretary's counselors.

More than 80 stakeholders are involved and they include advocates for patients, professional societies, academia, foundations, provider organizations, payers, and other parties. These stakeholders have been involved in the process through listening sessions to hear about the work they are doing regarding primary care, training, innovative practice designs, and other efforts.

One of the resources being used to guide the process is the 2021 report by the National Academies of Science, Engineering, and Medicine, *Implementing High-Quality Primary Care*. The Initiative will use as guidance several of the recommendations from this report. Some of the recommendations listed in the report include the following:

- Primary care practices should move toward a community oriented model of primary care
- Health care organizations and local, state, and federal government agencies should expand and diversify the primary care workforce, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the workforce with the communities they serve
- The Centers for Medicare and Medicaid Services, the Veteran's Administration, HRSA, and states should redeploy or augment funding to support interprofessional training in community-based, primary care practice environments
- The Secretary's Council on Primary Care should be informed through regular guidance and recommendations provided by a Primary Care Advisory Committee that includes members from national organizations that represent significant primary care stakeholder groups, such as patients, certifying boards, professional organizations, health care worker organizations, payers, and employers

*Discussion*

Dr. Brandt asked how the Committee can bring more attention to the information and resources being developed through the efforts of the Initiative and its partners.

Dr. McDevitt said it is always helpful to publicize the efforts through the HRSA Committees. There may also be opportunities for promoting the report with professional organizations, some of which have strong advocacy arms.

Dr. Osten-Garner said there has been a significant amount of discussion about the role of burnout and resiliency within providers. Is the Initiative looking at this as one of the factors to revitalize primary care? It seems that our payment systems—which pay for volume vs. performance—help to incentivize burnout through large systems that are always looking to do more. How is the Initiative addressing resiliency and provider burnout? Are there any specific recommendations on payment models that could incentivize quality vs. volume?

Dr. McDevitt stated that instead of doing more, we want to think about practicing differently. We have to examine workflows, how teams are being structured, and make sure we have the right members for each team. We also have to be able to reimburse community health workers. Also, we need to explore how the federal government, states, and accrediting/licensure bodies can work to create flexibilities that truly meet the needs of the community, while also providing individuals with the necessary skills and the safety net of credentialing.

Dr. Kennedy asked if any efforts had been made to incorporate language around age-friendly health systems within an age-friendly ecosystem. She also asked about incorporating informaticists as part of the care team.

Dr. McDevitt said the informaticist's role is critical. It is a difficult role for primary health care practices to incorporate because these individuals can be expensive, and one needs to figure out how to meaningfully embed them within quality improvement work. It means that a practice needs to step up their quality improvement work so they can use the data and the analytics being provided. The Health Center Program has been supporting informaticists in its expansion and supplemental awards for a number of years. With respect to age-friendly ecosystems, Dr. McDevitt said she would welcome more information on related resources for dissemination or to educate staff on the intention of that vision.

Dr. Kennedy said the John A. Hartford Foundation is doing some work around age-friendly ecosystems.

Ms. Worstell encouraged OASH and the Committee to look at the issue of the demographic change in this country. There have been 10,000 people aging into Medicare every day for the past two years and this will continue. This age group will become 20-25 percent of the population while at the same time the number is geriatrics medicine physicians is diminishing. It is important to make sure there is a primary care workforce available care for older adults and for medical students to be properly trained in caring for older adults.

Dr. McDevitt said they are developing a community engagement strategy. A Request For Information (RFI) will be released in the next few weeks. It is important to get the perspective of all communities, including the geriatrics community and their caregivers. She hopes that Committee members would consider sharing their expertise through the RFI. Dr. McDevitt added she would welcome any recommendations for organizations or individuals who are working in advocating for the older adult population.

Ms. Pope said perhaps some Committee members could look at some of the reports and provide recommendations. She asked Mr. Rogers if a volunteer group could be created. Mr. Rogers said they could certainly create a work group.

Dr. Osten-Garner said the approach for resiliency should include a system-wide approach for resiliency and burnout, instead of only targeting the individual. An expert presenting to the Committee showed there are only two factors in control of the individual, with the rest being system factors. It would help to challenge the health system to create a culture and policies that

reduce provider burnout due to system inefficiencies and being overburdened and instead puts the onus on the organization.

Dr. Naushira Pandya said it is important to make access easier for patients. It is difficult for patients to navigate denials, referrals, prior authorizations, finding a specialist, and getting equipment. It is also difficult for patients to navigate the current health care system, even if they are insured. In addition, practitioners are challenged to practice at the highest level of their ability and training and also act as coordinators, social workers, and care managers for patients.

**Discussion: 21st Report Recommendation/Vote**
*Sandra Y. Pope, MSW, Chair, ACICBL*

Following the presentations, the Committee brainstormed and considered potential topics for inclusion in its 21st Report. The three recommendations below were developed based on the topics that surfaced from prior meetings.

**Recommendation 1**
The ACICBL recommends that Title VII, Part D programs include specific language in their Notices of Funding Opportunities (NOFOs) to support activities that work to rebuild the patient-clinician relationship through increased communication and transparency with the overall goal of enhancing public trust in the health care system.

*Rationale*
While inequity has been long noted among various populations due to issues including access, health literacy, and trust in the health care system, the COVID pandemic has exacerbated and expanded these concerns leading to increased inequity in health care and outcomes. It is imperative that these programs both continue past endeavors to reduce these barriers and also to identify new barriers as the health care system rebuilds itself after the pandemic. Two notable issues that have been significantly impacted are the health care workforce and public trust in the health care and public health systems. The repair and restoration of these will be essential in providing an ongoing foundation to address pre-existing and newly developed inequities.

**Recommendation 2**
The ACICBL recommends that Title VII, Part D programs include specific language in their NOFOs to increase the capacity of organizations to transform their organizational culture, values, and expectations to provide community-based and culturally-competent education, training, and resources to their health professional workforce(s) to enable them to manage workplace stressors.

*Rationale*
Working through the COVID-19 pandemic and its previously unimaginable surges in demand, levels of illness and deaths have taken a toll on the current health care workforce. This has led to attrition due to burnout as well as reduced engagement including resignations. As the nation emerges from the pandemic, it is imperative that employers provide programs for health care workers which are accessible, culturally appropriate, and non-judgmental that address burnout and foster resilience. Some of these will, by necessity, be aimed at individuals and some at the organizational culture. Programs should specifically indicate these needs in ongoing and future-funded programs to both integrate proven models as well as to develop and report on innovative ways to address burnout, build resilience, and promote and demonstrate retention. Programs addressing expansion of the workforce pipeline are also essential to replace those lost at all levels. Furthermore, there needs to be mental health awareness integrated into the curriculum of all health care worker training programs from day one.

**Recommendation 3**
The ACICBL recommends that Title VII, Part D programs include specific language in their NOFOs to expand the primary care workforce by developing a pipeline/career ladder for community health care workers (CHW) and other direct care workers to care for vulnerable populations located in underserved and rural areas.

*Rationale*
The COVID-19 pandemic in the United States has exacerbated and made critical a reconsideration of the structure of America's health care workforce today and in the future. With the second highest professional worker loss rate (next to service industry workers), the pandemic has laid bare the physical, mental, and emotional degradation affecting private and public health care providers, including informal family caregivers, driving individuals to personal exhaustion, career abandonment, and in some cases, illness and/or death. The burden of this has fallen inequitably on sectors of providers least able to withstand the forces for professional and personal factors. The United States must explore a new paradigm of how the country defines and mobilizes its health care workforce, with particular attention to adequate preparation, cultural competency, assignment, fair remuneration, opportunities for

advancement, and institutional support methodologies (including trauma/emotional counseling) throughout a health care provider's career.

**Public Comment**
*Shane Rogers, DFO, ACICBL*

No comments were offered.

**Wrap-Up**
*Sandra Y. Pope, MSW, Chair, ACICBL*

Ms. Pope thanked the Committee members as well as the members of the Work Group who developed the draft recommendations. She also thanked Dr. Fahrenwald for all her contributions as this was her last meeting. Ms. Pope thanked all speakers and HRSA staff for putting the meeting together as well as Shane Rogers, the DFO, and Dr. Joan Weiss, Subject Matter Expert, for all their help. The next meeting will be held on August 26, 2022. Mr. Rogers adjourned the meeting at 4:26 p.m. ET.