TRANSFORMING EDUCATION AND TRAINING PROGRAMS TO ADDRESS CURRENT TRENDS IN HEALTHCARE REFORM

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

15th Annual Report to the Secretary of Health and Human Services and the U.S. Congress

August 2017

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Transforming Education and Training Programs to Address Current Trends in Healthcare Reform

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Fifteenth Annual Report
to the
Secretary of the United States
Department of Health and Human Services
and the
Congress of the United States

August 2017

The views expressed in this report are solely those of the Advisory Committee on Interdisciplinary, Community-Based Linkages, and do not represent the perspectives of the Health Resources and Services Administration nor the United States Government.

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Acknowledgements

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) provides advice and recommendations on policy and program development to the Secretary of Health and Human Services (Secretary) and the U.S. Congress concerning the activities under Title VII, Part D, of the Public Health Service (PHS) Act as authorized by section 757 (42 U.S.C. 294f), and as amended by the Affordable Care Act, Public Law 111-148. The ACICBL is governed by provisions of the Federal Advisory Committee Act (FACA) of 1972, (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

Each year, the ACICBL selects a topic concerning a major issue within the healthcare delivery system that is relevant to the mission of the Bureau of Health Workforce (BHW) Title VII, Part D, Interdisciplinary Community-Based Linkages programs. After the ACICBL analyzes the selected topic, it develops and sends recommendations to the Secretary concerning policy and program development. In 2015, the ACICBL reviewed the programs authorized by Title VII, Part D, including their performance measures, evaluations, and appropriations levels.

This report is the culmination of the efforts of many individuals who provided their expertise to the ACICBL during three required formal meetings: the first as a scheduled conference call on January 28, 2015; the second held in Rockville, Maryland, on April 22-23, 2015; and the third as a scheduled conference call on June 17, 2015. As noted throughout the report, experts informed the ACICBL and responded to a broad array of issues concerning the programs under Title VII, Part D. The members of the ACICBL express appreciation to all presenters for their time and expertise.

Finally, this report has benefited from the capable assistance of federal staff from the Health Resources and Services Administration, Bureau of Health Workforce, Division of Medicine and Dentistry (DMD): Dr. Joan Weiss, Designated Federal Official and Senior Advisor, DMD; Dr. Candice Chen, Director, DMD; Ms. Crystal Straughn, Technical Writer, DMD; and Mr. Raymond Bingham, Technical Writer, DMD. The ACICBL appreciates the hard work and dedication of these individuals in producing this report.

Sincerely,
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**In memoriam*

The members of the Advisory Committee on Interdisciplinary, Community-Based Linkages would like to recognize the contributions to this report from Ms. Crystal Straughn, who passed away unexpectedly. Ms. Straughn served with distinction for several years as the technical writer for the Committee. Ms. Straughn epitomized the best qualities in all of us and set the bar high in terms of her kindness, caring, dedication, conscientiousness, and enjoyment of life. Her outstanding work will be remembered for many years to come, and she will be greatly missed.

Executive Summary

The United States healthcare system strives to deliver safe and effective care, while also promoting innovations in procedures, medications, and technology. Despite its strengths, the system is expensive and inefficient. As a result, the health status of the U.S. population lags behind that of many other developed countries. Furthermore, the system must now respond to changing conditions, including an aging population, an increase in chronic health conditions, and ongoing disparities in health outcomes that show the benefits of the healthcare system are not accessible to all. There is a greater emphasis on primary and preventive care, along with a shift toward value-based services.

These changes impact the healthcare workforce. However, this workforce faces several challenges, including a shortage of qualified practitioners, poor geographic distribution of practitioners that limits access to services, and an increasing average age of both current practitioners and the faculty who teach new students. Meanwhile, healthcare organizations are transitioning toward an interprofessional team-based model of care, in which traditional health professionals work alongside community health workers or other providers, bringing together complementary skills toward the goal of improving patient care. All of these factors point to an urgent need to adjust health policies, develop new methods of education, and increase investment in healthcare workforce training to promote interprofessional education and practice.

There has also been increasing discussion on improving training methods. Traditional training criteria involve the completion of a set number of training hours or types of care experiences. However, educators in many professions are examining models in which students must demonstrate their competence in fundamental skills, knowledge, and attitudes to become certified to practice. This competency-based training allows for greater individualization in the design and evaluation of learning experiences.

The Federal government, through the Health Resources and Services Administration (HRSA), supports several healthcare professions training programs under Title VII, Part D, of the Public Health Service Act. These programs include the recruitment and training of professionals to practice in rural and other underserved areas, as well as training in mental and behavioral health.

In its deliberations, the Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) noted that many funding opportunities under Title VII, Part D, are limited to schools in specific disciplines (e.g. schools of medicine, nursing, allied health professions, etc.). With the need for students to have opportunities for greater interprofessional collaboration, ACICBL recommends that applicants be encouraged to submit proposals for programs that incorporate a mix of disciplines aimed at meeting the needs of their communities. In support of the move toward competency-based training, ACICBL recommends that performance measures used to evaluate interprofessional education programs by the HRSA Bureau of Health Workforce be based on competencies of the students, and not on the outcomes of patients. After a review of all of the Title VII, Part D, programs, ACICBL recommends allowing funds for these programs to cover student stipends, as well as travel and lodging expenses to rural and remote areas. ACICBL further recommends that funding for several programs be increased or restored to better address the changing needs of the nation.

Recommendations

During its meetings over the past two years, the Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) has reviewed the programs authorized by PHS Act Title VII, Part D, including their purpose, performance measures and evaluations, and appropriation levels. The Committee has developed the following recommendations regarding policy, program development, and funding for these programs. These recommendations are designed to strengthen the role of the Health Resources and Services Administration (HRSA) in its support of health professions education and training and to broaden access to high-quality health care in underserved and rural areas.

Policy Recommendations

Recommendation 1: ACICBL recommends that Congress revise the eligibility requirements for Title VII, Part D, programs. Eligibility should not be limited to specific health professions schools in isolation. To promote interprofessional education, applicants should be permitted to develop the strongest consortia available to them, based on their access to local health professions schools, the strength of available partners, and the needs of the community.

Recommendation 2: ACICBL recommends that the performance and evaluation measures of interprofessional education programs by HRSA's Bureau of Health Workforce should be based on the competencies attained by students and participants and not on the outcomes of patients. However, wherever possible, reporting on quality, safety, and cost outcomes of educational interventions should be encouraged.

Recommendation 3: To facilitate the exposure of students to a wide range of clinical training sites in rural and underserved areas, ACICBL recommends that HRSA should permit all Title VII, Part D, grantees to provide stipends and/or traineeships, if this expense would be required for success.

Recommendation 4 – Appropriation Levels:

After a review of all Title VII, Part D, programs, ACICBL recommends the following funding levels for those currently funded:

- $50 million for Area Health Education Centers.
- $50 million for Education and Training related to Geriatrics.
- $50 million for Mental and Behavioral Health Education and Training Grants (level funding).
- $8 million for graduate psychology education.

ACICBL further recommends the restoration of funding for two previously funded programs, the Quentin N. Burdick Program for Rural Interdisciplinary Training, and the Allied Health and Other Disciplines program, at the following levels:

- $10 million for the Quentin N. Burdick Program.
- $10 million for the Allied Health and Other Disciplines program.

Background

In 1998, the U.S. Congress adopted legislation authorizing grant funds to support the development of interdisciplinary, community-based linkages within the healthcare system, as set forth in Title VII, Part D, of the Public Health Service (PHS) Act. This legislation focused on supporting programs with the central mission to educate and train healthcare professionals in settings where community linkages are most urgently needed, to address healthcare delivery issues of greatest concern to the community, and to target vulnerable or underserved populations. The interdisciplinary, community-based programs under Title VII, Part D, serve to develop an adequate number of healthcare providers trained to meet the health needs of state, local, and rural areas, especially those with unserved, underserved, vulnerable, disadvantaged, and other at-risk populations, as well as to respond effectively to existing and emerging health priorities. To provide oversight and advice on these crucial programs, Title VII, Part D, also authorizes the Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL).

Programs under Title VII, Part D

750 – General Provisions
751 – Area Health Education Centers
752 – Continuing Education Support for Health Professionals Serving in Underserved Communities
753 – Education and Training Related to Geriatrics
754 – Quentin N. Burdick Program for Rural Interdisciplinary Training
755 – Allied Health and Other Disciplines
756 – Mental and Behavioral Health Education and Training Grants
757 – Advisory Committee on Interdisciplinary, Community-Based Linkages
759 – Program for Education and Training in Pain Care

An important component of Title VII, Part D, is the integration of the concepts of both interprofessional and community-based training for health professions students, faculty, and practitioners. This integration helps to prepare health professionals who are knowledgeable about and sensitive to the needs of local populations, because they have worked within and for them in the course of their training. Given the range of professionals that comprise the healthcare workforce, incentives for them to work together in teams have become imperative. Moreover, these incentives should target education in community-based settings to optimize the delivery of health care and to minimize unmet healthcare needs, based on the goals and priorities established by Healthy People 2020. Use of interprofessional educational strategies is expected to improve the delivery of healthcare services by facilitating better communication among healthcare providers and between providers and patients.

Introduction

The United States healthcare system generally delivers safe, reliable, and effective healthcare (Frankel, Haraden, Fereico, and Lenoci-Edwards, 2017). Through its emphasis on evidence-based practice, it also promotes innovations in procedures, medications and treatments, and new technologies. However, the system as a whole is expensive, consuming a growing portion of the nation's productivity, while by many global standards the health of the U.S. population lags behind that of many other developed countries. Furthermore, there are stark inequalities in healthcare outcomes between different population groups, indicating that the system's benefits are not accessible to all (National Research Council & Institute of Medicine, 2013).

The healthcare system has traditionally focused on providing acute care within a hospital or similar clinical setting. The aim of acute care is to preserve or restore health in the event of illness or injury. Acute care is episodic and tends to treat only the current problem. As such, it tends to be uncoordinated, inefficient, and expensive, often failing to address underlying health conditions or help patients reduce preventable health risks (National Quality Forum, 2015).

Today's healthcare system must respond to several national trends that are increasing the demand for services:

- the aging of the population,
- an increase in chronic health conditions and multiple morbidities, and
- ongoing disparities in access to health care and in health outcomes (Centers for Disease Control and Prevention, 2013).

Meanwhile, several challenges confront the healthcare workforce:

- shortages of qualified professionals, particularly in primary care;
- unequal geographic distribution of the workforce, resulting in poor access to services in many rural and other vulnerable areas; and
- increasing average age of both healthcare professionals and faculty, with an inadequate supply of new students, practitioners, and educators to replace those nearing retirement (U.S. Government Accountability Office, 2015).

To address these wide-ranging challenges, there are calls for the system to evolve in ways that improve the health of individuals and populations, advance patient safety and satisfaction, and lower costs (Berwick, Nolan, and Whittington, 2008). The focus of the system is shifting toward primary and preventive care to help people stay healthy, avoid chronic conditions, and reduce the need for and reliance on acute care services.

In turn, the education and practice of health professionals will have to adapt. There is an increasing emphasis on interprofessional education and collaborative practice, bringing the knowledge and insights of several professions together to advance patient care. There is also a growing drive to base training less on classroom and clinical time, and more on the acquisition of skills and competencies needed for safe and effective practice. All of these factors, discussed separately below, result in an urgent need to adjust health policies and increase investment in healthcare training.

Interprofessional Education and Collaborative Practice

To broaden access to care and improve quality, the U.S. healthcare system is transitioning toward use of an interprofessional team-based model. The team may include traditional health professionals such as physicians, nurses, dentists, social workers, and pharmacists, working alongside other providers such as community health workers and patient navigators. The team members contribute complementary skills toward the broad goals of better care coordination, improved patient experiences and outcomes, and a lower overall cost of care (Berwick, Nolan, and Whittington, 2008; Institute of Medicine [IOM], 2015; Sullivan, et al., 2015). Respecting each team member's unique perspective fosters communication and collaboration, which helps providers better understand and influence the multiple factors that affect the health of individuals, families, and populations. No single provider or profession can address the full range of today's health care challenges alone (Newhouse et al., 2012; Sullivan et al., 2015).

Interprofessional education (IPE) and interprofessional collaborative practice (IPCP) are old concepts gaining new ground as the healthcare system places greater emphasis on quality of care and value-based reimbursement. The World Health Organization (WHO) (2010) describes IPE as a process for preparing a "collaborative practice-ready" health workforce better able to respond to both local and global health needs. According to WHO, a collaborative practice-ready health worker has learned to work within the interprofessional team, and to use the knowledge and skills of others in plans of care to achieve the health goals of patients, families, and communities.

For the interprofessional model to succeed, training for current students in the health professions will need to incorporate the value of teamwork and include collaborative experiences with other health professionals. Meanwhile, current providers will need ongoing training and support to learn how to function and collaborate within teams. This transition requires a fundamental shift in health provider education away from the traditional academic setting that "silos" each profession in separate, independent schools. Institutions that train health professions students need to develop programs that reach across old divides to allow students from two or more disciplines learn about, from, and with each other to enable effective collaboration (Centre for the Advancement of Interprofessional Education, 2002).

ACICBL Recommendation 1: ACICBL recommends that Congress revise the eligibility requirements for Title VII, Part D, programs. Eligibility should not be limited to specific health professions schools in isolation. To promote interprofessional education, applicants should be permitted to develop the strongest consortia available to them, based on their access to local health professions schools, the strength of available partners, and the needs of the community.

Rationale

ACICBL noted that HRSA funding opportunity announcements for many programs funded under Title VII, Part D, identify eligible entities by specific disciplines (e.g. schools of medicine, schools of nursing, etc.). Such a requirement often follows the language of the authorizing statute. With the need for students to engage in IPE and IPCP, this practice is overly restrictive. ACICBL recommends that applicants be encouraged to submit proposals as a consortium of

schools and training programs, with the discipline mix that provides the strongest training opportunities to meet the needs of their communities or their region.

Competency-Based Training

Along with the push for interprofessional training and practice, there has been an emerging national discussion on the methods for healthcare professionals to demonstrate competence, both for initial qualification to practice and for continuing certification. This is referred to as competency-based training. *Competence* concerns the range of professional knowledge, attitudes, and skills required to perform basic functions expected of a practicing professional, along with the development of a broader set of attributes such as perceptiveness, creativity, and communication. *Competency* refers to the transition toward the development of this professional expertise (Chuenjitwongsa, Oliver, and Bullock, 2016).

Traditional training criteria have required students to complete a set number of hours or perform a certain number of procedures, before being allowed to take certifying or recertifying examinations. However, more healthcare disciplines are looking into ways to have students demonstrate competence, and to focus training on the development and mastery of particular skills and attributes identified as crucial for competent practice. Below are three examples of the implementation of competency-based training.

Medical Education

Some medical residency programs are working toward implementing competency-based training, allowing students to progress through their training at different rates. The Accreditation Council for Graduate Medical Education (ACGME) has developed the Next Accreditation System, which includes two major competency-based programs: the Clinical Learning Environment Review (CLER), and the Milestones initiative.

Through CLER, ACGME (n.d.) places a spotlight on the environment in which training occurs, focusing attention on institutional efforts to model safe practices, support professional behaviors, and encourage improved patient care practices. CLER involves six dimensions of the learning environment: patient safety; health care quality; care transitions; supervision; fatigue management and mitigation; and professionalism.

In the Milestones initiative, residency programs are encouraged to assess student performance and proficiency with respect to competency-based "Milestones" developed by ACGME and the American Board of Medical Specialties for each specialty domain. This approach enables medical residents to progress at their own pace toward mastery of their clinical skills. The establishment of measurable, specialty-specific developmental milestones to guide the assessment of individual and program effectiveness enables ACGME to move towards more learner-centered approaches (Nasca, Philibert, Brigham, and Flynn, 2012).

In a competency-based educational program, faculty can customize instruction based on the strengths and weaknesses of each resident, while providing focused learning criteria and frequent, formative assessments. Flexibility in the design and pace of training may help attract a broader range of individuals to some specialties, promoting diversity in the workforce

(Dougherty and Andreatta, 2017). Together, CLER and the Milestones initiative promise to help assure that training programs will impart quality and safety skills crucial in the emerging delivery system, and that physicians in training are prepared for independent practice.

Dental Hygienist Education

The American Dental Education Association and the American Dental Hygienists' Association collaborated to develop a set of core competencies expected of graduates from master's level dental hygienist programs. Published in 2011, these include:

- Diversity, social, and cultural sensitivity;
- Health care policy, interprofessional collaboration, and advocacy;
- Health informatics and technology;
- Health promotion and disease prevention;
- Scholarly inquiry and research;
- Leadership;
- Professionalism; and
- Program development and administration.

This set of competencies was intended to guide the curriculum development of graduate dental hygiene programs, and to clarify to students the expectations of their level of competency upon graduation. Core competencies provide direction to faculty in designing learning experiences for students. In addition, they inform stakeholders about the expectations of the graduate, and help all master's level dental hygienists understand how oral health and the profession of dental hygiene align with their post-graduate roles (American Dental Education Association & American Dental Hygienists' Association, 2011).

Certified Nurse-Midwifery Education

The clinical training of certified nurse-midwives is also shifting toward a competency-based model. Under new nurse-midwifery accreditation standards, there are no set number of hours or experiences. Rather, each educational program must describe how it ensures that all graduates have attained the set of basic core competencies, as established by the American College of Nurse-Midwives. These competencies cover: hallmarks of midwifery care; professional responsibilities; midwifery management; fundamentals; care of women; and care of newborns (American College of Nurse-Midwives, 2012).

While most programs still require a certain number of clinical hours or experiences, competency-based training allows for replacing some clinical experiences with other learning approaches such as clinical simulations, which can be effective in teaching students methods to manage emergent or rare situations such as shoulder dystocia. In addition, programs have the flexibility to award credit to students for previous experiences through successful demonstration of a skill or competency (American Association of Colleges of Nursing, 2015).

ACICBL Recommendation 2: ACICBL recommends that the performance and evaluation measures of interprofessional education programs by HRSA's Bureau of Health Workforce should be based on the competencies attained by the students and participants and not on the

outcomes of patients. However, wherever possible, reporting on quality, safety, and cost outcomes of educational interventions should be encouraged.

Rationale

Focusing on skill development and competencies, rather than the more traditional approach of requiring a pre-determined number of training hours or experiences, promotes flexibility in training, offers criterion-based objectives, and allows students to progress at their own pace. Greater flexibility could also promote a more diverse student population. In support of the move toward competency-based training, ACICBL recommends that HRSA incorporate performance measures based on student competencies for the educational programs it funds. However, where possible and feasible, grantees can also be encouraged to report on measures of quality, safety, and cost outcomes for their educational interventions, to allow for more thorough evaluations.

Student Support

Clinical or community-based health services in remote locations, such as in rural, tribal, or other underserved areas, are vital to improving access to health care and addressing health disparities. However, the training of students in these settings offers a variety of challenges. Students may have to travel substantial distances, meaning they often need to own or rent a vehicle. They often need to reside temporarily at or near the remote clinical setting, while maintaining their permanent housing at their home campus or training program. As a result, students often incur extra travel and housing expenses in order to obtain direct clinical experience in meeting the unique needs of rural and remote populations.

Recommendation 3: To facilitate the exposure of students to a wide range of clinical training sites in rural and underserved areas, ACICBL recommends that HRSA should permit all Title VII, Part D, grantees to provide stipends and/or traineeships, if this expense would be required for success.

Rationale

The travel and housing costs required for students to train in most rural or remote clinical settings have served as a disincentive for students to elect these non-traditional sites. Most Title VII, Part D, training programs prohibit the use of award funds for trainee travel and housing expenses. In addition, remote clinical settings often have limited resources in terms of access to library materials or sufficient staff to serve as preceptors, without receiving additional support. ACICBL believes constraints on student support and training costs should be eliminated, and applicants should be allowed to provide support for stipends or traineeships in their applications.

Overview of Programs under Title VII, Part D

In its meetings to inform this report, ACICBL discussed the programs authorized under Title VII, Part D, of the Public Health Service Act. Program experts reviewed the purpose of each program, the program structure, appropriations, and number of awards. The following is brief overview of each Section under Title VII, Part D.

Section 750: General Provisions

Purpose

Section 750 contains requirements for eligible entities who receive grants for interdisciplinary, community-based linkages. Eligible academic institutions must use grants in collaboration with two or more disciplines. Eligible entities must use funds to carry out innovative demonstration projects to meet national goals for interdisciplinary, community-based linkages. Authorized activities include (1) develop and support training programs; (2) faculty development; (3) model demonstration programs; (4) stipends for fellowship trainees; (5) technical assistance; and (6) other activities that will produce outcomes consistent with the purposes of this part.

Section 751: Area Health Education Centers

Purpose

Section 751 is the legislative authority for the Area Health Education Centers (AHEC) program. AHECs work to enhance access to high-quality, culturally competent care for rural and other medically underserved communities and populations by:

- expanding the primary care workforce supply, capacity, and distribution;
- promoting IPE;
- improving healthcare workforce diversity; and
- evaluating program performance and effectiveness (Bezuneh, 2015)

The AHEC program addresses these issues through cooperative agreements with schools of medicine and schools of nursing that work to develop academic and community partnerships (National AHEC Organization, 2015). AHEC legislative requirements include health professions recruitment and training in underserved areas, interprofessional education and training, continuing education, youth public health exposure, and evaluation. In 2016, 52 AHEC programs and 230 regional centers in 42 states and Guam were funded.

AHEC funding consists of two types of awards: *Infrastructure Development*, and *Point Of Service Maintenance And Enhancement*. Funds provided under *Infrastructure Development*, the initial AHEC phase, support the planning, development, and implementation of programs and centers in geographical regions not previously served by an AHEC. Each grantee can receive no more than twelve (12) years of financial support under this phase. The *Point of Service Maintenance and Enhancement* award supports implementation and sustainability for regional AHEC centers that have completed *Infrastructure Development*. The two awards collectively embrace the goal of increasing the number of students in the health professions who will pursue careers in primary care and ultimately practice in medically underserved communities.

The AHEC academic community-based partnerships focus on training programs to improve the supply, distribution, diversity, and quality of healthcare providers, and increase access to health services by consumers in medically underserved areas or for populations that experience health disparities. The AHEC program assists educational systems in developing recruitment and retention incentives to attract and retain health care personnel in underserved areas. There is an emphasis on community-based, interprofessional training programs, and activities that will enhance primary care, quality of care, and workforce diversity. Eligible applicants are public or nonprofit private accredited schools of allopathic and osteopathic medicine; however, in states with no medical school, schools of nursing may apply (Reyes-Akinbileje, 2013).

Funding

Below is the appropriation for the AHEC budget line for fiscal years (FYs) 2014-16.

Fiscal Year	Number of Grant Awards	Appropriation
2014	52	$30,250,000
2015	52	$30, 250,000
2016	53	$30,250,000

Section 752: Continuing Education Support for Health Professionals Serving in Underserved Communities

Purpose

Section 752 allows the Secretary to make grants to, and enter into contracts with, eligible entities to improve health care, increase retention, increase the representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation. Authorized under the Affordable Care Act, this program has not received an appropriation, and its functions and objectives have been largely subsumed under the AHEC program.

Section 753: Education and Training Related to Geriatrics

Purpose

Section 753 supports education and training related to geriatric health. In FY 2015, HRSA consolidated its four geriatrics programs (Geriatric Education Center; Geriatric Training for Physicians, Dentists, and Mental and Behavioral Health Professionals; the Geriatric Academic Career Award; and the Title VIII, section 865, Comprehensive Geriatrics Education Program) into the Geriatrics Workforce Enhancement Program (GWEP). This program supports the integration of geriatrics with primary care in clinical training environments, to provide primary care practitioners with the knowledge and skills needed to provide care, address healthcare gaps, maximize patient and family engagement, and improve health outcomes for older adults. In addition, this program supports the training of family members, caregivers, direct care workers, and health professions students (including residents and fellows), faculty, and practitioners who care for older adults, as well as the faculty who train these individuals. Eligible entities are schools of the health professions, health care facilities, and training programs that provide nursing assistant certification.

Funding
Below is the appropriation for the Geriatrics budget line for FYs 2014-16.

Fiscal Year	Title VII Geriatrics Programs Appropriation	Title VIII Comprehensive Geriatric Education Program Appropriation	Combined Title VII and Title VIII Geriatrics Programs Appropriation
2014	$33,237,000	$4,350,000	$37,587,000
2015	$34,237,000	$4,500,000	$38,737,000
2016	$38,737,000	$0	$38,737,000

Section 754: Quentin N. Burdick Program for Rural Interdisciplinary Training

Purpose
Under Section 754, the Quentin N. Burdick Program for Rural Interdisciplinary Training (Burdick program) was designed to increase recruitment and retention of healthcare practitioners in rural areas, as well as to make rural practice a more attractive career choice for all healthcare practitioners. The Burdick program included support for innovative interdisciplinary methods and models designed to improve access to and delivery of healthcare services in rural areas. It gave eligible entities flexibility to develop interdisciplinary education and training programs that would address local rural needs. Specifically, the Burdick program supported:

- innovative methods to train healthcare practitioners to provide services in rural areas;
- delivery of healthcare services to individuals residing in rural areas;
- enhancement of relevant research on health care issues in rural areas;
- the establishment of post-doctoral programs; and
- training for faculty around issues confronting the rural healthcare delivery system.

The Burdick program, like the AHEC (described above), served rural populations. When the Burdick Program was funded approximately one-third of the awardees also received AHEC funding. The two programs complemented each other. Burdick program funding could be used to provide stipend support for students to cover the cost of student travel and lodging in rural areas during clinical training rotations, which the AHEC authorizing legislation did not allow.

Funding
Below is the appropriation for the Burdick program for the last three FYs it was funded (FYs 2003-5).

Fiscal Year	Number of Grant Awards	Appropriation
2003	22	$6,954,000
2004	20	$6,125,000
2005	19	$6,076,000

Section 755(b)(1): Allied Health and Other Disciplines

Purpose

The purpose of Section 755 Allied Health and Other Disciplines is to assist entities to meet the costs associated with expanding or establishing programs to increase the number of individuals trained in allied health professions. The Other Disciplines included in this section include podiatric physicians and chiropractors.

Two mental and behavioral education programs received support from this budget line. From FY 2002 – FY 2011, the Graduate Psychology Education (GPE) program was supported through this budget line, but beginning in FY 2012, it received its appropriation through the Mental and Behavioral Health Education and Training budget line (discussed below in the section on the Mental and Behavioral Health Education and Training Programs). The Graduate Geropsychology Education Program received funding in FY 2003.

Funding

Below is the appropriation for the Allied Health and Other Disciplines budget line for the last three FYs the program was funded (FYs 2003-5).

Fiscal Year	Appropriation for Allied Health, Chiropractic, and Podiatry Programs
2003	$11,922,000
2004	$11,849,000
2005	$11,753,000

Section 756: Mental and Behavioral Health Education and Training Grants

Purpose

Under Section 756, the Mental and Behavioral Health Education and Training (MBHET) programs were begun in FY 2012 and ended in FY 2015. The purpose of the MBHET grant program was to strengthen the clinical field competencies of graduate students in accredited master's degree programs of social work and accredited doctoral level programs in psychology who pursue clinical service with high need and high demand populations, including rural, vulnerable and/or underserved populations, and veterans, military personnel, and their families. There are three main programs under the MBHET programs:

- Graduate Psychology Education (GPE),
- Leadership in Public Health Social Work Education (LPHSWE), and
- Behavioral Health Workforce Education and Training (BHWET).

Graduate Psychology Education

Purpose

The GPE Program provides support to accredited doctoral-level GPE schools and programs and accredited internships in public and private nonprofit institutions to health profession schools, universities, and other public or private nonprofit entities. The goals of the GPE program are to a) provide integrated and interprofessional education and clinical training leading to a doctoral degree in psychology, b) increase access to quality behavioral health services in vulnerable,

underserved, and needy populations, and c) increase the number of doctorally prepared psychologists who practice in medically underserved communities.

Funding

Below are the total grant award amounts from FY 2014-16 for the GPE Program.

Fiscal Year (FY)	Number of Grant Awards	Total Amount for Grant Awards
2014	40	$6,538,035
2015	40	$7,419,284
2016	31	$7,720,763

Leadership in Public Health Social Work Education

Purpose

The purpose of the LPHSWE Program is to support training and education, faculty development, and curriculum enhancement to prepare students for leadership roles in public health social work through enrollment in a dual master's degree program in both public health and social work. Students receive training, education, and practice experience in interprofessional practice, cultural competency, leadership and management, research and evaluation, and policy development. Eligible entities include programs that offer a dual master's degree in an accredited graduate school/program in public health and an accredited graduate school/program in social work.

Funding

Below are the grant award amounts from FY 2014-16 for the LPHSWE Training Program.

Fiscal Year	Number of Grant Awards	Total Amount for Grant Awards
2014	3	$868,128
2015	3	$899,741
2016	3	$896,822

Behavioral Health Workforce Education and Training

Purpose

In FY 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) and HRSA collaborated to launch the BHWET Program. Begun in support of the White House's *Now is the Time* initiative, the BHWET Program is focused on developing and expanding the mental health and substance abuse (jointly referred to as *behavioral health*) workforce serving children, adolescents, and transitional-age youth at risk for developing, or who have developed, a recognized behavioral health disorder. Through this program, HRSA supports the training of the behavioral health workforce to ensure an adequate supply of professionals and allied health paraprofessionals across the country, particularly within underserved and rural communities.

The BHWET Program supports the training of many behavioral health professionals, including: masters-level social workers, professional counselors, psychologists, marriage and family

therapists, psychology doctoral interns, and behavioral allied health paraprofessionals. The goal of expanding this workforce is to increase access to child, adolescent, and transitional-age youth services in order to promote early intervention for prevention and mitigation of behavioral health disorders through interprofessional service delivery.

Prior to FY 2017, the BHWET funds were appropriated to SAMHSA; however, HRSA has administered this program since its inception. In FY 2017, the Department of Health and Human Services requested that funds be appropriated directly to HRSA for two reasons: (1) to align the BHWET Program with the other mental and behavioral health workforce development programs under Title VII of the Public Health Service Act; and (2) to streamline the administration and oversight functions within a single agency. HRSA will continue to leverage SAMHSA's subject matter expertise in formulating new investments for the future.

Funding

Below are the total grant award amounts from FYs 2014-16 for the BHWET Program.

Fiscal Year (FY)	Number of Grant Awards	Appropriation
2014	111	$34,914,000
2015	110	$35,000,000
2016	Pending	$50,000,000

Section 757: Advisory Committee on Interdisciplinary, Community-Based Linkages

Purpose

The purpose of the Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) is to provide advice and recommendations to the Secretary of Health and Human Services (Secretary) concerning policy and program development, performance measures, longitudinal evaluations, and appropriation levels for programs under Title VII, Part D, of the PHS Act (Reyes-Akinbileje, 2013). The ACICBL prepares an annual report describing its activities conducted during the fiscal year, including findings and recommendations made to enhance these Title VII programs. This annual report is submitted to the Secretary and ranking members of the Senate Committee on Health, Education, Labor, and Pensions and the House of Representatives Committee on Energy and Commerce. Recent reports have focused on:

- Rethinking Complex Care: Preparing the Healthcare Workforce to Foster Person-Centered Care (2015);
- Transforming Interprofessional Health Education and Practice: Moving Learners from the Campus to the Community to Improve Population Health (2014);
- Redesigning Health Professions Education and Practice to Prepare the Interprofessional Team to Care for Populations (2013).

Section 759: Program for Education and Training in Pain Care

Purpose
Under Section 759, the statutory purposes of the Program for Education and Training in Pain Care program are to provide training on assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances. The program was designed to develop and implement education and training initiatives in pain care for healthcare professionals and provide interdisciplinary approaches to the delivery of pain care. Training would also include assisting healthcare professionals to gain an understanding of the applicable laws, regulations, rules, and policies on controlled substances. This training would be delivered through specialized centers providing comprehensive pain care treatment expertise, while also addressing cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations. This program has not received an appropriation.

Appropriation Levels for Title VII, Part D, Programs

Recommendation 4 – Appropriation Levels: The purpose of the Title VII, Part D, programs is to improve health care and expand healthcare access in rural, remote, and other underserved areas. As reflected in its recommendations, ACICBL believes that grantees should be able to provide stipends and/or traineeships that allow students to train in a wide range of clinical practice sites in rural and underserved areas.

ACICBL recommends the following funding levels for currently funded Title VII, Part D, programs:

- $50 million for AHEC.
- $50 million for geriatrics.
- $50 million for mental and behavioral health (level funding).

ACICBL further recommends that funding for the Burdick and Allied Health programs be restored at the following levels:

- $10 million for the Burdick program.
- $10 million for the Allied Health program.

Rationale for Increased AHEC Funding

ACICBL is recommending a $50 million funding level for the AHEC Program for FY 2018, an increase of $19.75 million over the FY 2017 level of $30.25 million. Over the past several years, HRSA has asked AHEC awardees to do more training and education on a broad variety of topics in order to meet the Federal programmatic requirements. There has also been an increasing demand for better evaluation tools and measurements to track short- and long-term outcomes and demonstrate impact on patient outcomes and practice transformation. In particular, this funding would expand the capacity of the AHEC program in ***five*** areas to address the training needs of the growing numbers of students and health care professionals, as noted below.

1. Evaluation and data collection to facilitate reporting of short- and long-term outcomes and demonstration of impact.

AHECs have been asked to meet new reporting requirements, resulting in the need to develop more sophisticated systems for data collection that include long-term tracking. In addition, reporting impact on patient outcomes and practice change requires more funding to support staff time, expertise, and effort involved in data extraction and aggregation, while ensuring compliance with the Health Insurance Portability and Accountability Act (HIPAA). Previous AHEC programmatic funding has been insufficient to hire and support skilled evaluation staff that can design and create tools and systems, and use technology for consistent and timely collection, compilation, and analysis of data.

2. Housing and transportation for health professions students doing rotations in rural and underserved areas at a distance from the main campus.

Current levels of funding for the AHECs are not sufficient to support housing and transportation needs of students required to travel a significant distance from the main campus to participate in community-based rotations and clinical practicums in rural or underserved areas. AHECs are dedicated to improving the supply, distribution, retention, and quality of primary care and other health practitioners in medically underserved areas; engaging students in the community; facilitating linkages to local resources and housing options; and building community relationships. These objectives are facilitated by having students/trainees actually live and work in rural and underserved areas where they are doing their rotations.

3. Expansion of academic and community-based partnerships to provide additional education and leveraging of resources with primary care providers and community-based organizations.

HRSA programs are being redesigned to meet the changing healthcare environment. AHECs often serve as a link to a variety of organizations and agencies that can facilitate the changing healthcare needs of the practice environment, supporting program redesign, team-based care, and population health approaches that can better address wellness, health promotion, and empowerment of patients and caregivers.

4. Preceptor recruitment and development to respond to increasing demands for student placements in primary care, community-based organizations and rural, underserved areas.

As the size of health professions school classes continues to grow and more on-line programs and off-shore medical and health professions schools seek clinical placement sites for their students, there is an inadequate supply of skilled preceptors who are willing and able to accept students and to ensure that students have a meaningful experience in their primary care and community-based rotations. Faced with the lack of skilled preceptors, competition for community and primary care clinical settings willing to accept students, and lack of incentives for precepting students, our medical and health professions education system is at risk. Additional funding will permit AHECs to work in collaboration with academic sites to identify and offer incentives to preceptors, preparing them to be positive role models and mentors.

5. Increased operational costs to sustain AHEC programs and centers at viable levels in today's environment

The AHEC program has received only a slight increase in Federal appropriations in the last decade. As medical school and other health professions class sizes continue to grow, AHEC programs and centers have been required to fulfill a broad array of statutory purposes, including placing increased numbers of health professions students in primary care and community-based settings in rural and underserved areas, providing additional patient and caregiver education, and addressing population health concerns at local levels. Many of the AHEC centers are nonprofit organizations that leverage funds from local grants or a variety of other sources, all of which help them meet the federally mandated matching requirement. An appropriations increase to support AHECs will help them maintain their viability, sustain their activities, and keep up with the increased costs of doing business in today's environment.

Rationale for Increased Geriatric Training Funding

ACICBL is recommending a $50 million funding level for the Geriatric Training program for FY 2017. The average age of the U.S. population is increasing, with a particular increase in the number of individuals over 65 years of age. This funding will increase the capacity of the GWEP program to address the training needs of students and health care professionals to address the complex needs of elderly patients, who often have multiple chronic conditions. Increased funding is needed because:

- HRSA received over 150 applications and only had funds to award 44 grants;
- the population of elderly patients is projected to increase steadily;
- primary care providers do not have the knowledge and skills to care for older adults;
- due to population increases and increases in multi-morbidity, healthcare providers in all areas will need education and training updates;
- patient-centered care for these older patients will require interprofessional teams; and
- training competencies in IPE have been defined and mandated, but are often underfunded.

The consolidation of programs under GWEP brought challenges and changes that came with increased spending flexibility by diluting available funds, consolidating programs, and placing a greater emphasis on evaluation. The Committee expressed concern about the lack of external stakeholder engagement in the revision and development of the GWEP, and about the loss of the geriatrics fellowships program.

Rationale for Maintaining Mental and Behavioral Health Funding

The mental and behavioral health training programs support masters and doctoral students in psychology, social work, and related fields. These practitioners provide clinical services to high-need and high-demand populations, including rural, vulnerable and/or underserved populations, and veterans. Maintaining these programs is crucial, as many of the challenges our nation faces today, such as high rates of depression, homelessness, suicide, and opioid addiction, involve mental and behavioral health issues. The growing emphasis on integration of behavioral health and primary care further underscores the need for more training in mental and behavioral health for current healthcare practitioners, faculty, staff in community-based agencies, health professions students of multiple disciplines, direct service workers, families, and caregivers.

Rationale for Restoring Funding to the Burdick Program

The Burdick program was designed to provide services to often-neglected rural areas in the United States. When previously funded, the Burdick program focused on the unique needs and challenges of rural America, allowed significant flexibility on how to support students, promote interdisciplinary training, encourage innovative approaches to train in rural areas, and collaborate with rural health care agencies. Between 1990 – 2002, over 13,000 healthcare practitioners, faculty, and students in 23 disciplines and 31 states participated in rural interdisciplinary training and 54% of the graduates were employed in rural or frontier areas 3 years after their training. In 2005, 831 students and rural health care providers trained in interdisciplinary community-based rural settings (Advisory Committee on Interdisciplinary, Community-Based Linkages, 2003). Restoring funding to the Burdick program would facilitate training a competent rural healthcare workforce; aid in the recruitment of students from to practice in rural communities; and allow students to live, train, and work in rural communities.

Rationale for Restoring Funding to the Allied Health Program

According to the Association of Schools of Allied Health Professions, the Bureau of Labor Statistics Occupational Outlook (2014-2024) found that half of the highest growing jobs in the U.S. economy are in allied health professions, including physical and occupational therapists, physician assistants, and genetic counselors. Allied health occupations comprise a minimum of one-third of our health care workforce, equivalent to the size of the nursing profession, and range from certificate to doctoral level degrees in health-related sciences.

However, unlike medicine or nursing, the Federal government has devoted no funding to help meet the expanding need for allied health professionals since 2006. Along with the lack of federal funding, high "State Authorization" fees and administrative costs imposed by states for placement of students in vital out-of-state clinical education programming is having a chilling effect on allied health education. Restoring funding to the Allied Health program would help schools meet the growing need for allied health professionals to provide an array of services that help promote the health and improve the lives of individuals from all areas, supporting the current focus on population health.

Rationale for Maintaining Support for ACICBL

Advisory committees play an important role in shaping programs and policies of the federal government. Through enactment of the Federal Advisory Committee Act (FACA) of 1972 (Public Law 92-463), the U.S. Congress formally recognized the merits of seeking the advice and assistance of our nation's citizens. At the same time, the Congress also sought to assure that advisory committees:

- Provide advice that is relevant, objective, and open to the public;
- Act promptly to complete their work; and
- Comply with reasonable cost controls and record keeping requirements.

With the expertise from advisory committee members, federal officials and the nation have access to information and advice on a broad range of issues affecting federal policies and programs. The public, in return, is afforded an opportunity to provide input into a process that may form the basis for government decisions.

ACICBL members are drawn from health professionals from schools of the types described in Title VII, sections 751(b)(1)(A), 753(b), and 755(b). There is a fair balance between the health professions, a broad geographic representation of members, a balance between urban and rural members, and representation of women and minorities. Members are appointed based on their competence, interest, and knowledge of the mission of the profession involved. As a result, ACICBL members have both the expertise and professional skills that parallel the Title VII, Part D, programs.

The ACICBL recommends that the Committee continue to provide advice and recommendations to the Secretary of Health and Human Services (Secretary) concerning policy, program development, and other matters of significance related to interdisciplinary, community-based training grant programs authorized under sections 750-759, Title VII, Part D, of the Public Health Service (PHS) Act.

Summary

Despite its many strengths, the United States healthcare system is expensive and inefficient, resulting in poorer health outcomes compared to many other developed countries. The system must adapt to changes that include an aging population, an increase in chronic conditions, and ongoing health disparities. Other factors placing stress on the healthcare system include shortages and poor geographic distribution of the healthcare workforce and faculty, new training methods focused on competency, and new models of care based on interprofessional teams. Together, these changes point to an urgent need to adjust health policies in ways that promote interprofessional education and practice, improve evaluation methods, broaden the clinical experiences of students, and sustain or increase support of healthcare workforce education programs. ACICBL has reviewed the workforce training programs authorized by PHS Act Title VII, Part D, and developed the following recommendations.

Recommendation 1: ACICBL recommends that Congress revise the eligibility requirements for Title VII, Part D, programs. Eligibility should not be limited to specific health professions schools in isolation. To promote interprofessional education, applicants should be permitted to develop the strongest consortia available to them, based on their access to local health professions schools, the strength of available partners, and the needs of the community.

Recommendation 2: ACICBL recommends that the performance and evaluation measures of interprofessional education programs by HRSA's Bureau of Health Workforce should be based on the competencies attained by students and participants and not on the outcomes of patients. However, wherever possible, reporting on quality, safety, and cost outcomes of educational interventions should be encouraged.

Recommendation 3: To facilitate the exposure of students to a wide range of clinical training sites in rural and underserved areas, ACICBL recommends that HRSA should permit all Title VII, Part D, grantees to provide stipends and/or traineeships, if this expense would be required for success.

Recommendation 4: After a review of all Title VII, Part D, programs, ACICBL recommends the following funding levels for those currently funded:

- $50 million for Area Health Education Centers.
- $50 million for Education and Training related to Geriatrics.
- $50 million for Mental and Behavioral Health Education and Training Grants (level funding).
- $8 million for graduate psychology education.

ACICBL further recommends the restoration of funding for two previously funded programs, the Quentin N. Burdick Program for Rural Interdisciplinary Training, and the Allied Health and Other Disciplines program, at the following levels:

- $10 million for the Quentin N. Burdick Program.
- $10 million for the Allied Health and Other Disciplines program.

Acronym and Abbreviation List

ACICBL	Advisory Committee on Interdisciplinary, Community-Based Linkages
ACGME	Accreditation Council for Graduate Medical Education
AHEC	Area Health Education Centers
BHWET	Behavioral Health Workforce Education and Training
CLER	Clinical Learning Environment Review
FY	Fiscal year
GPE	Graduate Psychology Education
GWEP	Geriatrics Workforce Enhancement Program
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine [Note: now the National Academy of Medicine (NAM)]
IPCP	Interprofessional Collaborative Practice
IPE	Interprofessional Education
LPHSWE	Leadership in Public Health Social Work Education
MBHET	Mental and Behavioral Health Education and Training
PHS	Public Health Service
SAMHSA	Substance Abuse and Mental Health Services Administration
WHO	World Health Organization

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