National Advisory Committee on Interdisciplinary, Community-Based Linkages

2002

Second Annual Report to the
SECRETARY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
and to the
CONGRESS

U. S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

The views expressed in this document are solely those of the Advisory Committee on Interdisciplinary, Community-Based Linkages and do not necessarily represent the views of the Health Resources and Services Administration or the U.S. Government.

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Executive Summary

The Advisory Committee on Interdisciplinary, Community-Based Linkages (Advisory Committee) provides advice and recommendations on programs authorized under Title VII, Part D of the Public Health Service (PHS) Act, as amended. The Advisory Committee is governed by provisions of Public law 92-463, as amended (5 U.S.C. Appendix 2).

In November 2001, the Advisory Committee published its First Annual Report, **"Review and Recommendations: Interdisciplinary, Community-Based Linkages, Title VII, Part D, Public Health Service Act"**. The report summarized the relevant grant programs and made several recommendations based on the Advisory Committee's understanding of the original intent of the Federal legislation and current national health professions workforce needs.

Of prime importance, the Advisory Committee concluded, "… that Congress and the Secretary make every effort to maintain these clearly effective approaches to building the workforce that provide health care services to unserved, underserved, and vulnerable populations." Further, the Advisory Committee recommended "…reauthorization of the Federal interdisciplinary, community-based grant programs … and …increasing appropriations … in order to continue and expand preparation of a workforce that can meet the health care needs of older Americans, minority and immigrant populations, and people who reside in this Nation's rural and inner city areas."

In this Second Annual Report, **the Advisory Committee restates its previous position, strongly recommending that Congress and the Secretary continue these grant programs and that they be funded at a level no less than the FY 2002 amount.** The tragic events of September 11, 2001 and subsequent challenges to the Nation have required that only those efforts that address the country's most critical needs be given positive consideration by policy makers. The Advisory Committee firmly believes that these grant programs meet such national needs through local initiatives implemented in both an effective and efficient manner.

The interdisciplinary, community-based grant programs are uniquely focused on training a health care workforce that meet the vital needs of the Nation's poor and vulnerable populations. Programs such as Area Health Education Centers (AHECs), Health Education and Training Centers (HETCs), and Geriatric Education Centers (GECs) have organizational infrastructures located throughout most of the Nation that are immediately responsive to changing health care priorities, such as the ones associated with chemical and biological terrorism as well as public health preparedness in general. Other community-based, interdisciplinary grant programs also meet important health needs by preparing the allied health and behavioral health workforce and addressing special vulnerable populations such as the Nation's rural residents and the elderly.

The Federal investment in these grant programs leverages enormous returns through matching funds and in-kind services contributed by State and local governments, private foundations, corporate sponsors, educational institutions, as well as health facilities and care providers. This is a particularly important trait of these programs that magnifies their value to the Nation, particularly during a period of time when there are great economic demands (e.g., protecting against terrorism).

The Advisory Committee considers **the interdisciplinary, community-based grant programs described in Title VII, Part D of the Public Health Service Act as national resources that must be preserved, protected, and improved for the betterment of the Nation's health.** In the Second Annual Report, the Advisory Committee provides further compelling evidence in support of these grant programs.

The Advisory Committee makes several recommendations in this Report that are designed to "improve" and "focus" the Federal government's and grantees' capacity to meet critical and emerging training needs of the Nation's health care workforce. These recommendations are presented in two parts, "Recommendations for Statutory Change (Section IV)" and "Strategic Recommendations for Present Action and Future Considerations (Section V)."

The Advisory Committee addresses several statutory matters pertaining to Allied Health. Several suggestions are made that better define terminology regarding Allied Health professions and affiliated educational programs. It is believed that these changes will better align the original intent of the legislative initiative and its administration by the Health Resources and Services Administration's Bureau of Health Professions with those schools and programs that provide Allied Health professions training. The Advisory Committee also believes that the recommendations will open opportunities for participation by more disciplines, increase the number of underrepresented minorities in the Allied Health professions, and focus training on delivery of services to the Nation's populations who are in greatest need for health care.

Currently, the authorizing legislation for the Chiropractic Demonstration Projects restricts funding to research purposes. While this activity is noteworthy, the Advisory Committee recommends statutory changes that would expand the scope of allowable activities to include training chiropractic physicians. Such action should increase the number and diversity of chiropractic graduates who are prepared to practice in underserved and unserved areas of the Nation as well as to serve other vulnerable populations.

The Advisory Committee endorses recent Federal legislation that supports Graduate Psychology Education but proposes that the scope of legislative authority be broadened to also include training for social workers. In the Advisory Committee's estimate, such action is consistent with the original intent of the legislation and more directly addresses the larger geographic needs in the Nation for improving access to behavioral and mental health services.

Another recommendation suggests moving the current section for the Podiatric Medicine training grant program from Title VII, Part D, to another part of Title VII. The proposal endorses Federal funding for training podiatrists but recognizes that the intent of this legislation is not in concert with "interdisciplinary" health professions education but is a "discipline-specific" activity more like those grant programs that train physicians and nurses.

Finally, the Advisory Committee proposes that its own life be extended when Title VII, Part D programs are reauthorized. The community-based, interdisciplinary nature of the Advisory Committee's membership represents a valuable tool for Federal policy makers in exploring the future needs and options for meeting the Nation's needs for a health care workforce. Members have substantial, "first-hand" knowledge of health care services and the training, recruitment,

and retention of health care workers. Also, many members have skills and experience with policy development at the local and national level.

Section V describes a series of "administrative actions" that the Advisory Committee believes will improve the outcomes of the grant programs. In particular, the recommendations address:

- Improving Diversity in the Health Care Professions - The Secretary should encourage collaboration between grant recipients and institutions that train and/or serve largely minority populations.

- Enhancing the Status of Allied Health and Improving Program Effectiveness - Congress and the Secretary should provide a more appropriate description of "allied health" to broaden the pool of eligible applicants for Federal funding and focus limited funding resources on meeting new, emerging allied health professions and addressing existing workforce shortages.

- Partnering with Other Agencies and Using Existing Section 751-755 Programs to Enhance Bioterrorism Preparedness - Grant programs authorized under Title VII, Part D, Sections 751 through 755 of the Public Health Service Act should be eligible for funding under the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, and these grant programs should be specifically allocated a portion of these funds to develop curriculum and perform continuing professional education.

- Strengthening Linkages with Other DHHS Initiatives - The Secretary and Congress should strengthen the capacity of the grant programs to meet the needs of training the health care workforce, including NHSC providers, in the Nation's network of Federally qualified community health centers and rural health clinics.

- Representation of the Advisory Committee on the Rural Task Force - The Secretary should appoint a member of the Advisory Committee to the DHHS Rural Task Force.

The Advisory Committee presents specific strategies including future legislative actions to enact the recommendations. In some instances, the Advisory Committee suggests that it will take future action to develop more specific recommendations to the Secretary and Congress.

Section VI forecasts some of the topics for its future activities, including more detailed recommendations on matters described in Section V. The Advisory Committee also describes its intent to alter its work practice in a manner that permits it to be responsive to emerging issues. For example, the Advisory Committee met in December 2002 to focus on the topic of "Bioterrorism and Public Health Emergencies." It is hoped that such sessions will result in the Advisory Committee providing "interim reports" that can be more immediately useful to the Secretary and Congress.

Section VII recognizes the Advisory Committee members and the Federal staff who have most ably assisted with every aspect of the Committee's work. It also acknowledges the many experts in a variety of disciplines who have contributed to the work of the Advisory Committee by providing expert testimony.

I Introduction

Background

In 1998, the Congress of the United States, recognizing the beneficial impact that interdisciplinary, community-based linkages can have upon the quality and availability of health care services to populations that have traditionally been underserved or are otherwise especially medically vulnerable, adopted legislation authorizing grant funds to support the development of such linkages. The legislation, set forth in Title VII, Part D, of the Public Health Service Act ("the Act"), identified five sets of programs, all with the central mission of training and education, deemed to be particularly endowed with the potential for beneficial linkages of this nature. The programs were as follows:

Area Health Education Centers (Section 751)

Health Education and Training Centers (Section 752)

Geriatric Education and Training Programs (Section 753)

Quentin N. Burdick Program for Rural Interdisciplinary Training (Section 754)

Entities engaged in education and training for the allied health professions and other disciplines (Section 755)

Although these programs differ in detail, they share a common element: each has the potential for fostering the development and application of interdisciplinary, community-based linkages in (a) areas where such linkages are most urgently needed, on (b) health care delivery issues of greatest concern from a community standpoint, to (c) populations that are especially vulnerable or underserved.

The mission of Part D, Interdisciplinary, Community-Based Linkages of Title VII, Health Professions Education, is to assure that there is a workforce that can meet the health needs of State, local, and rural populations of the Nation, especially those with unserved, underserved, vulnerable, and disadvantaged populations; a workforce that can respond effectively to new and demanding health priorities. "Interdisciplinary" and "community-based" training are two educational strategies that help in the preparation of health professionals, who are both knowledgeable of and sensitive to the needs of these populations because they worked with and for them in the course of their education. These initiatives are effective ways to ensure that there will be an adequate health workforce to meet the needs of communities, particularly those with at-risk populations, as well as our communities as a whole.

Thus, an important component of Part D, Title VII is to integrate "interdisciplinary" and "community-based" concepts into the training of health professionals. Given the diversity of the health care workforce, incentives for these professionals to work together in teams have become imperative. Moreover, these incentives should target education in community-based settings to

optimize the delivery of the public's health care and to minimize its needs based on the goals and priorities established by Healthy People 2010. Also, by using interdisciplinary educational strategies, the quality of interactions among the professionals, quality of communications with the patient, and quality of actual services delivered will improve.

The Need is Compelling for Interdisciplinary, Community-Based Linkages Programs (ICBLP)

Interdisciplinary, Community-Based Linkages Programs (ICBLP), by virtue of their mission, prepare the health professions workforce to meet the current and future health needs in our society. These programs provide unique education and clinical training for the future health care workforce. They target this country's growing vulnerable and underserved populations in community settings, such as: the poor, homeless, frail elderly, ethnically and racially diverse, migrant, immigrants, rural, and incarcerated groups. Using a preventive, primary care and population-based approach to health care, these programs educate future generations of health professionals to deliver culturally competent, clinically effective and public health-oriented services in underserved communities. The integration of interdisciplinary and community-based concepts into the training of health professionals through these programs, demonstrates its efficacy by preparing a diverse national health workforce to provide culturally competent, high quality care to these populations. The public's health is enhanced through the population-based services delivered by these health professions learners and faculty, ultimately expanding the capacity of the current health workforce.

- Population projections predict that the U.S. will almost double its older population to 70 million people by the year 2030 and increase its very-old population five-fold to 19 million in 2050.

Without the Title VII Part D programs, interdisciplinary health professions education would be severely restricted and access to care for underserved and vulnerable populations would be reduced. Furthermore, the anticipated growth in these populations is expected to stretch health professions education and training resources well-beyond current and future capacity. Health professions' schools, deluged by these demands, are limited by the lack of available institutional resources targeted at institutionalizing service to communities. In addition, the distribution and diversity of the health workforce in these community-based settings frequently is not well matched to the populations it serves further limiting access to care. This combination of factors mandates the critical need for Federal and State support for these interdisciplinary, community-based programs.

These looming projections have been exacerbated in the wake of September 11. The health care concerns associated with bioterrorism, emergent infections and epidemics require collaboration across public health **and** primary care as well as an interdisciplinary teamwork approach. As examples, the increased incidence of West Nile Virus, anthrax, and terrorist activities over the past year, require higher levels of collaboration across systems of public health and primary care. These real threats to human health could be addressed through the efficient integration of existing Interdisciplinary Community –Based Linkage Programs mobilizing academic/ community partners to use population-based approaches to health. Through teamwork among health care providers, partnerships with public health and communities, and innovative education

and clinical training programs, we can expand new and existing programs in a cost-effective manner, avoiding duplication and fragmentation.

Community Benefits of Interdisciplinary, Community-Based Linkages Programs (ICBLP)

The ICBLP offer real world experiences of community-based primary care education and training for health professionals, students, faculty, and community health workers. The value and benefits of each of the ICBLP are described in Chapter 2. Community benefits and outcomes that exemplify the *overall annual* impact of these programs are described below:

- Interdisciplinary community-based linkages programs have a longstanding history (since 1972) of providing education and training to develop and expand the nations health workforce, thereby improving access to care for this country's most vulnerable populations.

- Federal investment in interdisciplinary community-based programs has developed more than 180 academic/community partnerships;

- Interdisciplinary community-based programs link naturally with 530 Community Health or Migrant Health Centers and 170 National Health Service Corps training sites;

- More than 40,305 health professions students educated and clinically trained through the interdisciplinary community-based linkages programs;

- More than 340,000 students from K-12 have participated in health professions career recruitment programs;

- More that 194,000 health professionals participated in Continuing Education Programs;

- More than 70,800 individuals benefited from the delivery of health promotion programs provided by trainees;

Formation of the Advisory Committee for Interdisciplinary, Community-Based Linkages

In addition to the programs identified in Sections 751 through 755 of the Act, Section 756 authorized establishment of a committee, termed the Advisory Committee on Interdisciplinary, Community-Based Linkages, to which it assigned the following duties and responsibilities:

- provide advice and recommendations to the Secretary concerning policy and program development and other matters of significance concerning the activities under this part; and

- not later than 3 years after the date of enactment of this section, and annually thereafter, prepare and submit to the Secretary, and the Committee on Labor and Human Resources of the Senate, and the Committee on Commerce of the House of Representatives, a report

describing the activities of the Committee, including findings and recommendations made by the Committee concerning the activities under this part.

Section 756 further directed that:

- appointments to the committee be made from among individuals who are health professionals associated with schools of the types described in Sections 751 through 755,
- a fair balance be maintained among the health professions, with at least 75 percent of the appointees being health professionals,
- broad geographic representation and a balance between urban and rural members be maintained, and
- there be adequate representation of women and minorities.

A 21-member committee meeting these requirements was appointed by the Secretary and assigned a charter with an effective date of March 24, 1999. The charter was subsequently renewed on March 22, 2001.

Advisory Committee's Agenda Rationale and Progress in 2002

The Advisory Committee's First Annual Report is dated November 2001 but was not disseminated publicly until mid-2002. The work of the Advisory Committee that led to its initial report was largely aimed toward developing an understanding of the Federal intent for the grant programs, reviewing available information regarding the progress demonstrated by grantees, and identifying prospective issues for future study. However, the Advisory Committee was able to conclude that the interdisciplinary, community-based grant programs have met and continue to meet a relevant national priority for training health care workers that can meet critically important local needs. Consequently, the Advisory Committee issued a strong endorsement of continuing Federal appropriations and authorization of such efforts.

As has been noted elsewhere, the Advisory Committee was meeting in Washington, D.C. on September 11, 2001 when the terrorist attacks occurred only blocks away from the Committee's meeting site. Not unexpectedly, the Committee's work on the First Annual Report was not completed and required an additional meeting to critically review its initial report. In this meeting on February 3rd – 6th, the members performed a self-analysis of the First Report and solicited feedback on the report from HRSA representatives, including Mr. Neil Sampson and other Federal staffs that oversee the individual grant programs. The Advisory Committee also heard from a representative of State government, Mr. Tim Henderson, National Conference of State Legislatures, in recognition of the important role that States play with funding and molding the operation of these grant programs. While each reviewer generally expressed support for the findings and recommendations of the Advisory Committee, the presenters felt that recommendations lacked specificity to guide actions with regards to changes in policy and/or administrative procedures. This critical review set the stage for the scope of work for other meetings in 2002.

The Advisory Committee's findings in its first year suggested that there may be important ways in which Federal policy and administrative procedures might be revised to enhance the efficiency and effectiveness of the grant programs, even beyond the high quality of present performance. It also observed that the relevance of these grant programs to preparing an adequate and appropriate health care workforce could be further magnified through cooperative interaction with other Federal programs administered within and outside of HRSA. In the context of these major conclusions from the Advisory Committee's initial year, a scope of work was defined for the year, 2002.

The agendas for the meetings can be found in the Appendix. Other meetings took place on April 28th – 30th, June 23rd – 25th, August 4th – 6th, and October 2nd – 4th, 2002. This last meeting in October led to the final approval of the recommendations found in this report. Previous meetings included testimony and presentations addressing a wide variety of proposed changes in policy and administrative procedures. Representatives from Federal agencies, grantee constituency groups, professional associations, academia, and community interests provided testimony.

In several instances, recommendations suggested by representatives have yet to be acted upon by the Advisory Committee. Such actions may be included in the Advisory Committee's future activities (see Chapter VI). However, it should not be construed by the reader of this Report that concepts or ideas proposed to the Advisory Committee were found to be unacceptable or a "low priority" simply because they are not included in the Second Annual Report. The Advisory Committee had only limited time and resources to review the proposals and to discuss other findings, and necessarily had to limit its focus to what could be accomplished within its meeting cycle.

II Grant Program Characteristics

The five grant program areas that are authorized by Part D, Sections 751 through 755 of the Public Health Services Act and that are under the purview of the Advisory Committee include: Area Health Education Centers (AHECs), Health Education Training Centers (HETCs), Geriatric-Related Education and Training, Quentin N. Burdick Program for Rural Interdisciplinary Training, and the Allied Health Program. While these program areas focus on different constituencies, they all provide training for health professions students, medical residents and local providers in community settings. In addition, they provide a key link between the academic health institutions and communities.

Without the Federal support provided by these programs, communities of persons who are vulnerable and often ignored by our traditional health care system would be denied access to primary and preventive health care. These populations include the elderly, rural residents, inner-city minorities, and those with special needs who live in U.S./Mexican border areas.

While distinguished by their community of interest, these programs share common goals including:

- increasing the numbers of health professionals who can function in an interdisciplinary and multidisciplinary community-based setting through the training of students in the health professions, education of faculty in academic health centers, and continuing education for health care practitioners.

- promoting a redistribution of the health workforce to underserved areas within our Nation,

- improving the health status of the most vulnerable of our citizens by providing them with health care professionals who are technically well trained, culturally competent in the care they provide, responsive to the needs of the communities in which they work, and comfortable providing that care as part of an interdisciplinary team.

The success of these interdisciplinary, community-based grant programs in meeting their goals is clear. In FY 2000, the 45 AHECs and 13 HETCs trained approximately 40,000 health professions students in community-based sites. These sites, in areas designated as health professional shortage areas, may include migrant health centers, local health departments, and National Health Service Corps sites. Of that total, slightly over one-half are medical students. Reaching down into the potential health manpower pipeline even further, approximately 25,000 high school students participate each year in AHEC-sponsored health career recruitment activities.

The Allied Health Program plays a crucial role providing a rapid transition of students with a baccalaureate degree into the health-related sciences. Allied health professions encompass about 30 percent of the total health care workforce and projections are that by 2010, 5.3 million new allied health workers will be needed. Already there are shortages in critical allied health fields. For example, clinical laboratories are experiencing shortages of all types of diagnostic scientists

and technicians from the associate's degree level through graduate degrees.

In addition to student training, faculty development activities are an important part of interdisciplinary, community-based grant programs. The Burdick program trains faculty in the economic and logistical problems associated with rural health care delivery. Geriatric Education Centers train academic and clinical faculty at 170 health-related schools and 550 affiliated clinical sites. And in FY2002, 33 Geriatric Academic Career Awards were funded to train our next generation of academic geriatricians.

Continuing education is another major activity in all of the Interdisciplinary, Community-Based Grant Programs. Over 200,000 health professionals in the community received continuing education programs sponsored by the AHEC, HETC, GEC, or Burdick program in FY 2000.

Encouraging health care professionals to continue to serve in medically underserved areas or with medically underserved populations is also an important goal of Part D programs. A recent national survey of graduates of the Quentin N. Burdick Program showed that 54 percent were employed in rural or frontier areas 3 years after training. The health professions students and the community health workers who receive training by the HETCs in underserved areas ultimately remain there to continue their practice.

Thus, in combination, these programs provide important educational and clinical opportunities for a health workforce that will serve traditionally unserved or underserved populations in our Nation.

Characteristics of Individual Programs

Area Health Education Centers (Section 751)

Purpose:

The foremost purposes of Area Health Education Centers (AHECs) are to:

- improve the recruitment, distribution, supply, and efficiency of personnel who provide health services in underserved rural and urban areas or to populations with demonstrated serious unmet health care needs, and

- increase the number of primary care physicians and other primary care providers who provide services in such areas and to such populations.

Activities:

These purposes, in the paraphrased words of the legislation, are to be carried out by:

- employing recruitment and health awareness programs to recruit individuals from underserved areas and underrepresented populations,

- preparing individuals to more effectively provide health services to underserved areas or underserved populations through (1) field placements, (2) preceptorships, (3) conducting or supporting community-based primary care residency programs, and (4) agreements with community-based organizations such as community health centers, migrant health centers, Indian health centers, public health departments, etc.,

- conducting health professions education and training activities for students of health professions schools and medical residents,

- conducting at least 10 percent of the clinical education required of medical students at sites remote to the primary teaching facility of the contracting institution, and

- providing information dissemination and educational support to reduce professional isolation, increase retention, enhance the practice environment, and improve health care through the timely dissemination of research findings.

Accomplishments:

- Since 1972, AHEC programs have trained more than 1.8 million students and residents in medicine, nursing, allied health, dentistry, pharmacy, public health, and other disciplines in areas designated as health professional shortage areas.

- As of 2002, the AHEC network consisted of 45 campus-based AHEC programs affiliated with 180 community-based AHEC centers. More than 60 percent of the centers are hosted by non-profit 501(c)(3) organizations. Community colleges and universities host another 19 percent, community hospitals 9 percent, community health centers 3 percent, and other host relationships account for the remaining 6 percent.

- The 45 AHEC programs consist of 27 defined as Model (i.e., fully established) and 18 defined as Basic (under development or expansion). Well-established centers receive approximately $70,000 in Federal AHEC funds, making up the rest of their budget from State and local sources. The average AHEC employs a full-time equivalent staff of about four.

- AHEC programs exist in all but seven States and Puerto Rico. Their annual impact is briefly summarized below:

- AHECS train approximately 32,000 health professional students in community-based sites per year. Of that total, slightly over half (17,000) are medical students; the rest are students from other health professions, including allied health.

- AHECs work with approximately 530 community or migrant health centers and 475 health departments, employing approximately 170 National Health Service Corps sites as training sites.

- Approximately 25,000 high school students participate each year in AHEC-sponsored

health career enhancement or recruitment activities of 20 hours or more. An even greater number (225,000) participate in large group presentations on health careers. Approximately 90,000 students in grades K-8 participate in large group presentations as well.

- A total of 5,773 teachers and counselors were trained in 3,218 high schools.

- More than 154,000 local providers receive AHEC-sponsored education on topics relating to locally defined needs and Federal priorities. Topics covered include bioterrorism and emergency preparedness, oral health, women's health, domestic violence, adolescent issues, diabetes, HIV, and mental health. Cultural competence is featured as well.

- The BHPr, through a competitive grant cycle, awarded eight supplemental grants to AHEC programs totaling $447,600 to support the planning, development and implementation of activities in relation to bioterrorism preparedness and response training. The total estimated number of students and providers to be trained by these projects is 8,184. Partnerships play a large role in the execution of these plans, averaging seven per project, indicating that the AHECs are not working in isolation as they move forward in this important activity.

Funding:

In FY 2002, 46 AHEC programs received $32.0 million in funding, an amount essentially unchanged from the previous year ($31.6 million for 44 programs).

Health Education and Training Centers (Section 752)

Purpose:

Health Education and Training Centers (HETCs) have as their primary purpose addressing persistent and severe unmet health care needs in States along the border between the United States and Mexico and in the State of Florida. They are also charged with the same mission in other areas, urban or rural, that have populations with similar needs.

Activities:

To accomplish their mission, HETCs engage in the following activities:

- conduct training and education programs for health professions students in the assigned service area

- conduct training in community-based health education services, including training to prepare community health workers, and

- provide education and other services to health professionals practicing in the area.

In support of these activities, each HETC maintains an advisory board of health service providers, educators, and consumers from the designated area.

Accomplishments:

The most recent HETC statistics, from FY 2000, indicate that:

- 8,308 health professions students received training in underserved areas where they will ultimately practice.
- 2,397 individuals completed short-term health professions training programs that provide and support primary care.
- 342 minority or otherwise disadvantaged students enrolled in health care education programs.
- 192 local residents trained as community health workers.
- 70,845 individuals received health promotion-related services provided by the 192 community health workers trained in HETC programs.

Funding:

In FY 2002, 13 HETC programs received a total of $4.4 million in funding, with roughly half of that amount ($2.2 million) awarded to border area HETCs in Arizona, California, New Mexico, and Texas, and in Florida. Average funding per HETC program in FY 2002 was $340,000, as opposed to $480,000 in FY 2001 when there were only nine HETC programs. With the total Federal investment remaining essentially constant over time while the number of programs increases, there is an insufficiency of funds for individual programs to address worsening health education and personnel training needs, particularly in the U.S.-Mexico border region.

<u>Geriatric Education and Training Projects (Section 753)</u>

This section of the legislation, designed to improve the training of health professionals in geriatrics, consists of three components:

Geriatric Education Centers (GECs)

Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals (GT)

Geriatric Academic Career Awards (GACA)

Geriatric Education Centers (GECs)

Purpose:

The goal of the GECs is to improve the training of health professionals in geriatrics, including geriatric residencies, traineeships or fellowships, and to foster the application of the knowledges attained to produce benefits for the elderly. Such training translates to better care and also improves the quality of care and life for older people, builds cooperative relationships between health professions institutions and professionals, and provides common ground for diverse health professions disciplines to discuss their needs and create a synergy for dynamic solutions to intricate geriatric problems.

Activities:

The GECs accomplish their training goals by:

- supporting the training and retraining of faculty to provide instruction in geriatrics,

- supporting the continuing education of health professionals who provide geriatric care, and

- providing students with clinical training in nursing homes, chronic and acute care hospitals, ambulatory care centers, and senior centers.

GECs also achieve a corollary goal by developing and disseminating curricula pertaining to the treatment of the health problems of elderly persons.

Projects supported by the GECs offer interdisciplinary training involving four or more health professions disciplines. The interdisciplinary approach of the GECs fosters an interdisciplinary team approach among partners and enables this team of health professions partners to work together in ways that would not otherwise be utilized to achieve a statewide approach. Through, for example, interactive video conferencing and other state-of-the-art distance learning technologies, each project is afforded the opportunity to establish regional sites throughout any given state, thereby equipping each GEC to be an effective and efficient way to reach target populations, particularly those in rural/underserved areas.

Accomplishments:

These sets of activities have produced the following outcomes:

- It is important to note that over the last few years, the availability of funding for the purpose of establishing new GECs has been scarce, i.e., 15 new GECs were funded in FY 2000, 14 in FY 2001, and only 12 in FY 2002 with Arizona, Maryland, and Montana representing States with GECs for the first time. Although the efforts to insure the establishment of a minimum of one GEC located within each state remains to be realized,

the GECs have consistently continued to endeavor in outstanding achievements.

- Since inception in 1983, the GECs have provided geriatric training to over 400,000 health professionals in 27 disciplines and to 2,700 academic and clinical faculty at 170 health-related schools and 550 affiliated clinical sites.

- All GEC grantees have collaborated and established linkage relationships with the State and local organizations that deliver health care to increase or enhance the services provided to underserved communities and populations.

- Each GEC works with primary and secondary schools that have a high percentage of minority and disadvantaged students to increase their interest in health professions careers and subsequent expand the pool of diverse and culturally competent qualified applicants for the health professions workforce.

- The National GEC Network (NGN) has developed and continues to develop a continuum of audiovisual media for presenting educational content. The interaction continuum ranges from television with full-motion video and audio interaction to interaction with either visual or audio media. The midpoint of this continuum is the use of computers as an interactive medium for learning.

- Encouraging continued collaboration between centers and avoid redundant development, the GEC Clearinghouse Web site, http://coa.kumc.edu/gecresource/loginMain.asp, was established by the Geriatric Education Center at the University of Kansas Medical Center. The Clearinghouse is a depository of resources developed by and available from the GECs across the country. GEC resource information maintained in the Clearinghouse is searchable by title, keywords, descriptions, or authoring organization. Access to the GEC Clearinghouse is available to health professionals and the public at large.

Funding:

41 GECs received $11.6 million in FY 2002, with an average first-year award of $162,000 for a single institution and $400,590 for a consortium of three or more.

Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals (GT)

Purpose:

The goal of the GT program is to contribute to the pool of trained experts who can serve as faculty for other trainees in their respective health professions.

Training of this form, which must be based in a graduate medical education program in internal medicine or family medicine or in a department of geriatrics or behavioral or mental health, consists of two options:

- A 1-year retraining program in geriatrics for current faculty members

- A 2-year internal medicine or family medicine fellowship program, with emphasis in geriatrics, for physicians, dentists, and behavioral or mental health professionals who have completed graduate medical education or post-doctoral training.

Activities:

- The GT program provides *full-time intensive* training in a one- or two-year program for physicians, dentists, and behavioral and mental health professionals who plan to become faculty members. The GT program provides a minimum of 2,080 hours of training in a one-year program and 4, 160 hours in the two-year fellowship.

- Each program has a core curriculum for all fellows and specialized training in each discipline.

- The core curriculum addresses teaching, research, administration and clinical training.

- The programs provide fellows exposure to elderly patients in various levels of wellness and functioning and from a range of socioeconomic and racial/ethnic backgrounds.

- Service rotations include geriatric consultation services, acute care services, dental services, geriatric psychiatry units, day and home care programs, rehabilitation services, extended care facilities, geriatric ambulatory care, and community care programs for elderly persons with mental retardation.

Accomplishments:

The BHPr-supported GT program is unique in the country. It allows an integrated program that is not limited to one hospital; it has flexibility in affiliations and in curriculum; the number of clinical sites is broad and includes day and home care programs, geriatric psychiatry units, rehabilitative services, extended care facilities and community care programs for elderly persons with mental retardation. The program is the only program in the U.S. training faculty in postdoctoral geriatric dentistry.

Between 1989 and 1999, 334 fellows were trained. The seven projects scheduled to end in 2005 will train 87 fellows. Two new projects, one at an HBCU, are projected to train an additional 30 fellows by the end of the program in FY2007.

Funding:

$4.3 million was awarded in FY 2002 to nine geriatric training programs for physicians, dentists, and behavioral/mental health professionals.

Geriatric Academic Career Awards (GACAs)

Purpose:

The GACA was established in 1998 to increase teaching of geriatrics in medical schools.

Activities:

- GACAs support the career development of geriatricians in junior faculty positions who are committed to an academic career of teaching clinical geriatrics.

- GACA recipients are required to provide training in clinical geriatrics, including the training of interdisciplinary teams of health care professionals.

Accomplishments:

- The first competition for the GACA was held in 1999. The accomplishments of these junior faculty members are impressive and diverse. All are providing interdisciplinary training. Many are providing training in community-based settings in addition to hospital and medical school-based training. Their activities include curriculum development, various administrative duties at their medical schools; providing care and teaching in an wide range of clinical settings; clinical research; participating in educational programs to build their own skills; and providing continuing education to already practicing health professionals and working with other sponsored health education programs.

- In a single year (FY 2002), the 13 funded GACAs provided training to well over 4800 health professionals including medical students, residents, fellows, physicians practicing in the community, nurses, nurse practitioners, social workers, physical and occupational therapists, dentists, psychologists, respiratory therapists, ethicists, health administrators, case managers, pharmacists, community workers including police personnel, informal caregivers, and community dwelling elderly persons. Twenty new GACAs were awarded at the end of FY2002.

Funding:

The 33 Geriatric Academic Career Awards funded in FY 2002 totaled $1.8 million.

Quentin N. Burdick Program for Rural Interdisciplinary Training (Section 754)

Purpose:

Quentin N. Burdick programs have as their primary goal interdisciplinary training of health care practitioners to provide services in rural areas. Corollary goals include:

- enhancing relevant research concerning rural health care issues,

- increasing the recruitment and retention of health care practitioners in rural areas, and

- making rural practice an attractive career choice for health care practitioners.

Activities:

To accomplish these goals, Quentin N. Burdick programs conduct the following major activities:

- Provide all health related students an interdisciplinary learning experience to enhance understand and appreciation that each disciplines bring to the solution of health problems.

- Conduct workshops and education activities in rural communities for rural health professionals and community

- Provide information and awareness activities for K thru 12 grade students concerning career opportunities in the health professions.

- Funds are also used to purchase or rent transportation and telecommunication equipment where needed.

Accomplishments:

- Since 1990, over 13,000 health care providers, teachers, and students, in 23 disciplines and 31 States, have been trained through Quentin N. Burdick programs.

- The retention aspect of the program is impressive: over 50 percent of the graduates of these programs were, according to a recent nationwide survey, employed in rural or frontier areas 3 years after training.

Funding:

Since inception in 1990, $51 million has been spent to fund a total of 99 Quentin N. Burdick interdisciplinary training projects. In FY 2002, $7 million was awarded to 28 projects.

Allied Health and Other Disciplines (Section 755)

Purpose:

Section 755 has several purposes. In addition to a major emphasis on increasing the supply of individuals trained in the allied health professions, this section of the legislation authorizes support for:

- preventive and primary care residency training of podiatric physicians,

- collaborative demonstration projects involving chiropractors and physicians and the treatment of spinal and lower-back conditions, and

- graduate programs in behavioral and mental health practice.

Activities:

Allied Health - To meet the goal of increasing the supply of allied health practitioners as effectively as possible, the programs and activities funded under this Section focus on:

- professions with the greatest shortages or whose services are most needed by the elderly,

- programs that provide rapid transition training into an allied health profession for students with baccalaureate degrees in health-related sciences,

- community-based programs linking academic centers to rural clinical settings,

- career advancement training programs for allied health professionals in practice,

- programs that develop curricula involving prevention and health promotion, geriatrics, long-term care, home health and hospice care, and medical ethics,

- programs that seek to expand or establish:

    - clinical training sites in underserved or rural communities

    - interdisciplinary training to promote the effectiveness of allied health practitioners in geriatric care

    - demonstration centers that apply innovative models to link allied health practice, education, and research

    - Financial assistance, in the form of traineeships, is also provided to students who agree to practice in an allied health field in which there is a demonstrated shortage and who agree, upon completion of training, to practice in a medically underserved community.

Podiatric medicine training grants - These are used to support training programs that encourage primary care, especially for underserved, minority, and elderly populations and for persons with AIDS.

Chiropractic demonstration grants - In addition to emphasizing collaborative efforts between chiropractors and physicians, a major focus is placed on the development and application of research protocols that will significantly expand documented research in the field.

Behavioral and mental health training grants - Activities conducted in connection with these grants include: increased training in residential care, faculty support for training and/or retraining, continuing education for certified/licensed paraprofessionals, and clinical training of students in senior centers and ambulatory care settings.

Accomplishments:

Allied Health - Since inception, a total of 158 allied health projects have been funded under this section of the legislation. Currently, there are 45 allied health grants in place, training large numbers of students and serving people throughout the Nation.

- Allied Health programs provide access to health professions education and training to students in both minority and disadvantaged populations. For example, 95 percent of student recruitment and retention activities in Allied Health Special Projects have been offered to students from these populations.

- Grants have been awarded to academic institutions, hospital-based education programs, and consortia involving 47 different allied health disciplines in 32 States and the District of Columbia, with 14 percent of these awards going to historically black colleges and universities. Student recruitment and retention activities have affected more than 9,080 individuals, with 95 percent of these students being minority, disadvantaged, or both.

Podiatric medicine training grants - At present, there are four grants outstanding for training students in podiatric medicine.

Chiropractic demonstration grants - Since 1994, more than 7,000 patients have received chiropractic care through grants with schools of chiropractic. Chiropractic care is provided to research participants at no cost to the patient.

- Since 1994, 10 grants have been awarded and have supported institutions and practitioners in the States of California, Iowa, Illinois, Minnesota, and Texas.

- Chiropractic demonstration research grants are designed to improve the quality of chiropractic care by developing and testing new models for interdisciplinary medical and chiropractic care for the alleviation of pain and to increase mobility among back pain sufferers. This results in the continual improvement of the quality of patient care and service delivery.

Behavioral and mental health training grants - In FY 2002, a new Graduate Psychology Education Program was instituted. Fifty-two grant applications were approved and fifteen were funded. In addition, work began on three new gero-psychology projects, emphasizing the behavioral and mental health needs of the elderly.

Funding:

In FY 2002, funding under this section of the legislation was as follows:

- Seventeen new allied health projects were funded and 28 projects received continuation funds, for a total of $4.9 million.

- The four new podiatric medicine awards totaled $768,000.

- The four continuing chiropractic demonstration projects totaled $1.4 million.

- Total funding for behavioral/mental health training was $2,232,962. The fifteen Graduate Psychology Education grants totaled $2 million. The three new gero-psychology grants accounted for the rest.

III First Report: Summary of Recommendations

In its first year of operation, the Advisory Committee devoted the bulk of its effort toward developing a comprehensive understanding of the scope of the Title VII, Part D programs, their operational characteristics, and their outcomes. Conducted in what the Committee termed its "foundation" period, the Committee arrived at a series of findings and recommendations set forth in its First Report, issued in November 2001. The report contained seven major findings and ten specific recommendations (See Appendix A). The full set of recommendations presented in the First Report is briefly summarized below:

Recommendations of a legislative nature:

- Because of their clearly effective approach to building a workforce that provides health care services to unserved, underserved, and/or vulnerable populations, Federal interdisciplinary, community-based grant programs should be reauthorized.

- Appropriations for programs of this nature should be increased.

- Future legislation should encourage collaborations between these grant programs and institutions that train minority and immigrant populations.

- Future legislation should also encourage the design and implementation of funded activities relating directly to the unique health needs of a given region or area.

- Congress should establish a grant program ("Interdisciplinary Education Demonstration Projects") to encourage cooperative community-based ventures between two or more of the programs currently described in Sections 751-755 of the Act. New appropriations should be authorized for this new initiative.

- Owing to the unique nature of the target populations and economic areas served by Health Education and Training Centers (HETCs), the legislative cost-sharing requirement for such entities should be restated as a desire, not a requirement.

- The legislative authority for podiatric medicine grants, currently contained in Section 755 of the Act, should be relocated in Section 747 in association with discipline-specific grants to train family physicians, general internal physicians, and other primary health care providers.

Recommendations of an administrative nature:

- Administrative policies should be established that promote the utilization of community advisory groups by grantees as well as training protocols uniquely defined for the local service area or population.

- The administrative policy tools of "preferences and priorities" should be used to make awards to grantees that truly propose training of an interdisciplinary nature.

- The Committee endorses the 1995 recommendation of the National Commission on Allied Health that there be established within the Health Resources and Services Administration (HRSA) an organizational entity that would give greater visibility and representation to allied health.

- Federal agencies such as the National Institutes of Health, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and Food and Drug Administration should establish formal, funding-based links with HRSA to enable the entities described in Sections 751-755 to carry out continuing professional education and other forms of postgraduate training that could serve to translate research into practice.

- Federal agencies that seek to promote more "population inclusive" research should be instructed to establish funding relationships with the entities described in Sections 751-755.

- Federal criteria for cost sharing with State or local governments and private foundations should be maintained for programs that have demonstrated successful outcomes but not, as noted earlier, for Health Education and Training Centers (HETCs), because of the unique nature of their target populations and economic areas served.

IV Recommendations for Statutory Change

Introduction

The function of Title VII, Part D, Interdisciplinary, Community-based Linkages, is to assure that there is a workforce that can meet the health needs of State, local, and rural populations of the Nation, especially those with unserved, underserved, vulnerable, and disadvantaged populations; a workforce that can respond effectively to new and demanding health priorities. "Interdisciplinary" and "community-based" training are two educational strategies that help in the preparation of health professionals, who are both knowledgeable of and sensitive to the needs of these populations because they worked with and for them in the course of their education. These initiatives are effective ways to ensure that there will be an adequate health workforce to meet the needs of communities, particularly those with at-risk populations, as well as our communities as a whole.

Thus, an important component of Title VII, Part D, is to integrate "interdisciplinary" and "community-based" concepts into the training of health professionals. Given the diversity of the health care workforce, particularly Allied Health and the behavioral mental health professions, incentives for these professionals to work together in teams have become imperative. Moreover, these incentives should target education in community-based settings to optimize the delivery of the public's health care and to minimize its needs. Also, by using interdisciplinary educational strategies, the quality of interactions among the professionals, quality of communications with the patient, and quality of actual services delivered will improve.

List of Proposed New Sections in Part D:

A. **Sec. 755 Allied Health** (delete Other Disciplines)
B. **Sec. 756 Chiropractic Research and Training** (create new section)
C. **Sec. 757 Behavioral Mental Health** (create new section)
757 (a) Graduate Psychology Education
757 (b) Geriatric Psychology Education
757 (c) Graduate Social Work Education
D. **Podiatric Medicine**
Podiatric Medicine to be transferred from Part D to Part C: Family Medicine, General Internal Medicine, General Pediatrics, Podiatric Medicine, Physicians Assistants, General Dentistry, and Pediatric Dentistry.
E. **Sec. 758 Advisory Committee on Interdisciplinary, Community-Based Linkages** (move from 756 to 758)

A. Section 755 Allied Health Recommendations

The Committee recommends that:

- Section 755 be retained specifically for Allied Health education and training programs,

- Section 792, Health Professions Data, redefine and employ the new list of recognized

Allied Health professions, and

- Redefine the list of Allied Health professionals in Section 799B.

Rationale:

Maintaining Section 755 for Allied Health will enhance the opportunities for this multidisciplinary health workforce and their educators to be responsive to the needs of the Nation and its communities. These enhanced opportunities will be achieved by: training more allied health professionals to work on interdisciplinary teams with other allied health professionals and other health professions; serving in community-based settings; providing health care services to unserved, underserved and vulnerable populations; meeting new demands and emerging needs; such as bioterrorism, genomics, geriatrics, medical errors, clinical trials, patients' rights, and new advances in diagnostics, information data bases and technology.

This recommendation, accompanied by legislative changes in the language of Section 792 (Health Professions Data) and Section 799 (Definitions), Part F of Title VII, is consistent with and responds directly to our First Annual Report to the Secretary and Congress, Finding D, which stated: "…the concept of what is identified as Allied Health remains vague and is often defined by naming certain disciplines either through congressional action or by administrative policy. This approach risks failing to meet the needs of a unique health workforce of a region or, perhaps, the entire country". Reserving Section 755 for Allied Health, also specifically addresses Recommendation #6 of our First Report, as well as the following finding stated by the National Commission on Allied Health (1995): "Allied Health needs to be defined in such a manner that it can encompass current and emerging disciplines that serve in support of delivering critical health care in the Nation."

Section 755, Allied Health and Other Disciplines, is the only section of Title VII where Allied Health is mentioned as eligible for funding. The activities described for Allied Health are for: "assisting entities in meeting the costs associated with expanding or establishing programs that will increase the number of individuals trained in allied health professions." However, the allied health professions are not well defined.

The allied health professions are defined in Title VII, Part F, Section 799B. The descriptive language utilized provides an excellent example of the need for a more specific definition of an allied health professional. As presented in this section, the term "allied health professional" means a health professional (other than a registered nurse or physician assistant) who has received basically any kind of training (academic or non-academic) in a science relating to health care and shares in the responsibility for the delivery of health care services or related services. It also specifies some health professions which are not Allied Health, such as pharmacy, nursing, social work or counseling, and Public Health, just to mention a few.

All Title VII Sections pertaining to Allied Health should use the following definitions:

- School of Allied Health - means a public or nonprofit private school that provides training leading to an associate's degree, a bachelor's degree, a master's degree, a

doctoral degree, or other post baccalaureate degree from an accredited allied health program.

- Accredited Allied Health program - is a specific discipline academic program recognized by a discipline-specific body or Allied Health accrediting body approved for such purpose by the Secretary of Education or CHEA.

- Allied Health professional - means a health professional who

    - has received an associate's degree, a bachelor's degree, a master's degree, a doctoral degree, or other post-baccalaureate degree from an accredited allied health program and,

    - requires approval of a discipline – specific accrediting body; approval of an Examination Board, and acquisition of a license or an equivalent recognition process in order to be able to practice and deliver health services and,

    - shares in the responsibility for the delivery of health care services or related services, including:

        - Evaluation, diagnosis of disease, and/or the impact of disease or condition on function
        - Treatment of disease or condition
        - Prevention of injury and disease
        - Rehabilitation
        - Dietary and nutrition
        - Health promotion
        - Health systems management
        - Health information management

- Auxiliary Health personnel – means a paraprofessional, health worker technician or aide (other than nursing-related or public health personnel) who has received non-academic training in a science related to health, or an academic degree from a health related program that is not accredited or recognized by a discipline specific accrediting body approved for such purpose by the Secretary of Education.

Specific findings in Title VII related to Allied Health, other than those included in Section 755, are the following:

- Section 736 – Centers of Excellence (COE) – The designated health professions schools that qualify to apply for this grant do not include Schools of Allied Health

- Sections 737 and 738, "Scholarships for disadvantaged students" and "Loan Repayments and Fellowships Regarding Faculty" include in their language the concept of Allied

Health as one of the eligible entities. Nevertheless, these funding initiatives are available to only eight (8) Allied Health professions. More importantly, they do not include funding for the associate's degree programs, which comprise an important component of Allied Health and where most students from minority, disadvantaged, and underrepresented populations start their health careers.

- In Section 792, Health Professions Data "the Secretary shall establish a uniform health professions data reporting system, to collect, compile, and analyze data" respecting health professions personnel. This section includes a list of health professions and professional groups that demonstrates the confusion around the definition of "Allied Health" and which professions are included in the definition. Among them, it specifies Allied Health personnel, Audiologists, Speech Pathologists and Medical Technologists as separate entities for reporting health professions data. The audiologist, speech pathologist and medical technologist are clearly considered allied health professions, but are listed separately.

Benefits and Outcomes:

Implementing these recommendations would have the following benefits:

- Support training activities which are aligned with the mission and scope of both the schools and programs in Allied Health and the Bureau of Health Professions;
- More clearly define the field of Allied Health practice to help identify eligible applicants for Title VII funding;
- Assist in the redistribution of Allied Health practitioners across the United States and meet the increasing demand for Allied Health services;
- Enhance training for more of the Allied Health disciplines; and
- Increase the number of underrepresented minorities in the Allied Health professions

B. Section 756 Chiropractic Research and Training Projects

The committee recommends that:

- the legislative authority of the Chiropractic Demonstration Projects Program be expanded to establish and include training programs that will increase the number of individuals trained in Chiropractic.

Rationale:

There are approximately 50,000 practicing chiropractors in the United States. Between 20 and 25 million Americans seek and receive chiropractic care annually. An estimated shortage of 100,000 chiropractic clinicians exists in the United States as documented by a Rand Corporation

report in July 1996. Partly as a result of the distribution of the chiropractic colleges, the practitioners are not evenly distributed throughout the States. The American Chiropractic Association (ACA) reports that only 4.5 percent and 13.3 percent of Doctors are minorities and women, respectively.

The Chiropractic Demonstration Projects program resides in the Bureau of Health Professions (BHPr) and is authorized under Title VII of the PHS Act. The Chiropractic Demonstration Projects program is the only Federally supported program solely for the field of Chiropractic and is a research program. However, no Federal funding has ever been allocated for chiropractic training programs, such as residencies, faculty development, minority recruitment, continuing education, and etc. This amendment would expand the legislative authority of the Chiropractic Demonstration Projects Program to support training activities in chiropractic, which are aligned to the mission and scope of the Bureau and Title VII – Health Professions Education, PHS Act.

Benefits/Outcomes:

Implementing this recommendation would have the following benefits:

- Support training activities, which are aligned to the mission and scope of the Bureau of Health Professions and Title VII, PHS Act;
- Increase the number of chiropractic graduates;
- Enhance the training of the chiropractic profession;
- Assist in the redistribution of chiropractors across the United States and meet the anticipated demand for chiropractic services; and
- Increase the number of underrepresented minorities in the chiropractic profession.

C. Section 757 Graduate Programs in Behavioral and Mental Health Practice

Purpose:

To meet the costs of projects to plan, develop, and operate or maintain graduate programs in behavioral and mental health (psychology, gero-psychology, and social work).

Action:

Remove Section 755 (b) (1) (J) from Section 755 Allied Health and Other Disciplines to create the new Section 757 (a)(b)(c) in recognition:

- that behavior and health are intertwined and that there is a critical need for integrated, interdisciplinary health care services for underserved populations and in underserved areas; and

- to eliminate the perception that behavioral and mental health disciplines are traditional Allied Health disciplines.

Present Program Status:

Currently, there is a provision within Section 755 for activities that will "plan, develop, and operate or maintain graduate programs in behavioral and mental health practice." Behavioral Mental Health programs were first included in health professions grant programs with the authorization of the Health Professions Education Partnership Act of 1998. However, no line item budget was appropriated to create a separate program. Limited funding was available within the Allied Health and Other Disciplines appropriations. There was, however, no budget set-aside for these programs until FY 2002.

The FY 2002 Appropriations Report language provided $2 million to establish a graduate psychology education program to train health service psychologists in accredited psychology programs. Students who train in these programs will work with underserved populations, including children, the elderly, victims of abuse, the chronically ill or disabled and in areas of emerging needs; foster integration of health care services; and further the knowledge of the linkages between behavior and health. These one-time grant awards were for 1-year training projects only.

Recommendations:

The Committee recommends that:

- The Graduate Psychology Education Program (GPE), Section 757 (a), receive continued funding and that the GPE be expanded to address training for gero-psychologists (757 (b))

- That funds be provided for Graduate Social Work Education Programs (757 (c)) to meet the behavioral mental health needs of vulnerable and underserved populations including the elderly.

Rationale:

The 1980's Institute of Medicine Report on Health and Behavior documented that over 50 percent of mortality from the 10 leading causes of death could be traced to behavior. Six of the ten leading health indicators listed in the Healthy People 2010 Report are behaviorally based with mental health cited as another indicator. Psychology and social work are two health-related professions with long histories of service in the prevention, assessment, diagnosis, and treatment of each of these health indicators. Psychologists and social workers provide services for the amelioration of dysfunction related to substance abuse, tobacco use, injury and violence, physical activity, over weight and obesity, and sexual behavior.

The 1999 Surgeon General's Report documented that 1 in 5 American adults, approximately 44 million, experience a mental disorder in a given year and 28 percent of adults meet all criteria for

mental and addictive disorders. The Surgeon General's Reports of 2000 and 2001 confirmed that 1 in 10 children and adolescents suffer mental disorders and 20 percent of older adults experience mental disorders particularly depression. The World Health Organization in 1996 reported that depression will be the world's second most prevalent health problem in the 21st century and that many other health problems will be behaviorally based.

Role of Health Service Psychologists

Psychology is a very broad discipline and profession that ranges from providing health care services to conducting social and behavioral research. Health service psychologists have developed and provided evidence-based services in the prevention, diagnosis, treatment and rehabilitation of a wide range of health problems. Health service psychologists provide treatments to promote adherence to medical regimens, decrease behavioral health risk factors, manage physical problems such as pain and urinary incontinence, prepare patients for stressful medical procedures, promote responsible self-management, and treat psycho-physiological disorders. In addition, health service psychologists provide diagnostic and treatment services for a wide range of mental health disorders.

Role of Clinical Social Workers

Of the four categories of social workers defined by the Bureau of Labor Statistics in the 2000 Standard Occupational Classification, two categories, the Medical and Public Health Social Workers and Mental Health and Substance Abuse Social Workers, can be further defined as healthcare social workers.

In the National Association of Social Workers 2000 Practice Research Survey, 39 percent of the members reported that mental health was their primary practice area and another 8 percent reported health as their primary practice area. An additional 28 percent identified multiple areas of practice including aging, adolescents, and addictions in addition to health, mental health and/or school social work.

Healthcare social workers help patients and their families cope with chronic, acute, or terminal illnesses and handle problems that may stand in the way of recovery or rehabilitation. In mental health settings, they provide services for persons with mental or emotional problems. Such services include individual and group therapy, outreach, crisis intervention, social rehabilitation and training in skills of everyday living. They may also plan for supportive services to ease patient's return to the community.

With the increasing demand for specialized geriatric services, much of the work of healthcare social workers relates to older persons. Increasingly, geriatric social work is focusing on prevention and wellness for older persons as well as the serious health care problems encountered in later life.

Healthcare social workers provide social services in health-related settings that are now governed by managed care organizations. To contain costs, these organizations are emphasizing short-term interventions, ambulatory and community-based care, and greater decentralization of

services.

Benefits and Outcomes:

Implementing these recommendations would have the following results:

- Support training activities for specific behavioral mental health professionals which are aligned with the intent of the original legislative language to "plan, develop, and operate or maintain graduate program in behavioral mental health practice";

- Increase the number of graduate psychologists and graduate social workers to practice in underserved areas, particularly rural areas, and with vulnerable populations such as the elderly;

- Enhance the education and training capacity of graduate psychology and social work programs to more appropriately address the need for integrated, interdisciplinary primary care and behavioral mental health services;

- Assist in the redistribution of psychologists and social workers across the United States with attention to rural communities;

- Meet the anticipated growing demand for services by population groups such as the elderly; and

- Increase the number of underrepresented minorities in the behavioral mental health professions.

D. Podiatric Medicine

Purpose:

Planning and implementing projects in preventive and primary care training for podiatric physicians in approved or provisionally approved residency programs that provide financial assistance for traineeships of residents who participate in such projects and who plan to specialize in primary care.

Action:

Remove Section 755 (b)(2), Part D from Section 755 Allied Health and Other Disciplines and transfer legislative authority on Podiatric Medicine to Part C: Family Medicine, General Internal Medicine, General Pediatrics, **Podiatric Medicine**, Physicians Assistants, General Dentistry, and Pediatric Dentistry in recognition that podiatric medicine is a medical specialty and not an Allied Health discipline.

Present Program Status:

Currently, Section 755 (b)(2) authorizes the podiatric training program and is administered by the Division of Medicine and Dentistry (DMD), Bureau of Health Professions. All other programs under Part D including those covered by Section 755 are administered by the Division of State, Community and Public Health. This organizational placement of podiatric medicine in DMD reflects the BHPr's recognition of podiatrics as a medicine specialty. There is $2 million set aside from the Allied Health budget to fund these programs. This status reflects both an administrative and funding disparity.

Recommendation:

The committee recommends that:

- Legislative authority for the Podiatric Medicine Programs be transferred to Title VII, Part C;
- Continue under the management of the Division of Medicine and Dentistry; and
- Receive an appropriation separate from the Allied Health budget.

Rationale:

It is a historical oversight that podiatric medicine exists as an independent profession rather than as a specialty or subspecialty within the practice of medicine. However, it is an oversight that should be corrected in order to improve foot care for all Americans. Podiatrists represent the only group of health care providers educated and trained specifically to care for people who have foot and ankle problems.

The Doctor of Podiatric Medicine (DPM) has the same exclusive distinction as that of the MD and DO – to practice medicine within the scope of his or her license by any system or means. There are other key distinctions the disciplines share. The medical college admission test is required for matriculation to a podiatric medical school. One year of post-graduate training, an internship, in podiatric primary medical care is the minimum required for practice. The benchmark, however, includes additional years of residency training.

During the decades of the 80's and 90's podiatric medicine became a more recognized and accepted medical discipline. Podiatric residents were integrated into traditional medical rotations alongside their allopathic and osteopathic colleagues and a continuity of training was achieved. Graduates are recruited for multi-specialty clinics in increasing numbers because of the demonstrated value of their patient care and the high quality of their training.

This acceptance is also demonstrated by the fact that several of the colleges of podiatric medicine have affiliated with academic health centers and there is an increase in the number of residency training programs in both teaching hospitals and VA medical centers.

The foot is often coined "a mirror of systemic diseases." The podiatrist is trained to care for the medical needs of the foot and ankle as they relate to the patient as a whole. As such, podiatric medicine is clearly part of the interdisciplinary team that is necessary to care for people with diabetes, arthritis, the elderly, and individuals with HIV. This collaborative effort promotes the delivery of comprehensive health care to all communities and especially to the underserved, unserved, rural and those special populations with health disparities.

Benefits and Outcomes:

Implementing this recommendation would clarify the disciplinary status of both the Allied Health Professions and Podiatric Medicine and facilitate more efficient administrative program management.

E. Section 758 Advisory Committee for Interdisciplinary, Community-Based Linkages

Recommendation:

The Advisory Committee recommends that:

- this committee be reauthorized under new Section 758.

Rationale:

The Advisory Committee on Interdisciplinary, Community-Based Linkages membership is comprised of a balance of health professionals from a broad geographic region, both rural and urban. Members are chosen for their knowledge, interest, and competence in health professions education. They are participants in or have intimate knowledge of the programs for which they are charged with providing advice and recommendations to the Secretary concerning policy and program development and other matters related to Title 7, Sections 751 through 757.

Benefits and Outcomes:

The Advisory Committee on Interdisciplinary, Community-Based Linkages will be able to:

- Provide a local consumer based perspective to the efficacy of these programs,
- Develop strategies and recommendations that enable these programs to continue their efforts regarding the recruitment, quality and distribution of the health workforce that are locally responsive, cost-effective and are not duplicative of efforts currently in place;
- Provide strategies to address emerging health concerns as it relates to the above programs;
- Access experts both nationally and locally to provide testimony concerning policy, program development and other matters related to Title 7, Sections 751 through 757; and

- Foster collaboration among the grant programs and others at the Federal, State, and local levels.

V Strategic Recommendations for the Present Action and Future Considerations

This Advisory Committee is keenly aware of and sensitive to the current priorities of national health and national security and in fostering Presidential and Secretarial initiatives. Such initiatives include the President's Initiative expanding Community Health Centers and the National Health Service Corps, and the anti-bioterrorism initiative, as well as the Secretary's Rural, Border Health and Diversity Initiatives.

This report presents the 2002 strategic recommendations in two sets. One set of recommendations extends from existing or prior ones, the second set consists of new initiatives that address and respond to emerging issues. These recommendations are of an overarching strategic nature, which will necessitate both legislative and administrative action. Recommendations dealing with proposed legislative changes alone were presented in Chapter IV.

The Committee saw these strategic recommendations as meshing very closely with the Congressional intent set forth in Title VII, Part D, Sections 751 through 755 of the Act, with which the Committee is directly concerned. As a consequence, the Committee directed a substantial portion of its attention toward five areas of strategic action deemed to be particularly relevant to its charter. Recommendations 1 and 2 pertain to the extension of work on existing recommendations. Recommendations 3, 4, and 5 pertain to new initiatives responding to emerging issues.

- **Recommendation 1: Improving diversity of health care professions**
- **Recommendation 2: Enhancing the status of Allied Health and improving program effectiveness**
- **Recommendation 3: Using existing Title VII, Part D Programs, Partner with other agencies to educate and disseminate bioterrorism preparedness education and training**
- **Recommendation 4: Strengthening linkages between Section 751-755 grant programs and other DHHS initiatives**
- **Recommendation 5: Representation from the Advisory Committee on Interdisciplinary, Community-Based Linkages to the Rural Task Force**

Recommendations in each of these areas are presented below, along with (a) the rationale on which the recommendation is based, (b) the expected benefits, and (c) proposed strategies, both legislative and administrative, by which those benefits may be achieved.

Recommendation 1 - Improving Diversity of Health Care Professions

The Secretary should adopt measures to encourage collaboration between grant recipients and institutions that train and/or serve, largely, minority populations. Measures should be structured to achieve the following ends:

- enhance the diversity of the health professions educational pipeline,
- strengthen the academic environment through faculty development and scholarship of minority-serving institutions, and
- increase the development and exchange of culturally-attuned health information between minority- and majority-serving institutions.

Rationale:

- While notable progress has been made in the overall health of the Nation, there are continuing disparities in the burden of illness and death experienced by African-Americans, Hispanics, Native Americans, Alaska Natives, and Asian/Pacific Islanders, compared to the United States population as a whole.
- There is a national need for minority scientists in the fields of clinical, biomedical, behavioral, and health services research.
- Demographic trends prompt concern about the Nation's ability to meet its future health professions workforce needs. Historically, white males have made up the majority of the United States health workforce. While the percentage of females in the health workforce has increased dramatically, minority participation has increased at a much slower pace or remained relatively unchanged. Examining the educational pipeline, one observes that the graduating classes for some professions have shown declines in minority representation in recent years:
    - Nursing - In the academic year 1988-89, underrepresented minorities (African-Americans, Hispanics, and Native Americans) constituted 12.8 percent of all graduates from basic registered nurse programs. By 1995-96, the percentage had slipped to 10.9 percent.
    - Podiatric medicine - In 1992-93, underrepresented minorities constituted 13.8 percent of all graduates from schools of podiatric medicine. After climbing to 15.4 percent in 1995-96, the percentage dropped to 8.8 percent in 1997-98.
    - Dentistry - After reaching a high of 14.1 percent in 1990-91, the representation of underrepresented minorities among graduates from schools of dentistry declined to 10.9 percent in 1996-97.

- For all health professions, even those showing no decline in minority representation among graduates, underrepresented minorities continue to constitute a much smaller percentage of graduates than they do of the population at large. The relevant figures are as follows:

	African American	Hispanic	Native American
Percentage of overall population in 1999	12.1	11.5	0.7
Percentage of graduates (year for which applicable is shown in parentheses):			
-- Allopathic medicine (1999)	7.7	6.7	0.9
-- Osteopathic medicine (1998)	2.9	4.1	1.1
-- Dentistry (1997)	5.1	5.3	0.5
-- Pharmacy (1998)	6.0	3.6	0.4
-- Podiatric medicine (1998)	3.2	5.4	0.2
-- Nursing (1996)	6.9	3.4	0.7
-- Allied health (1995)	8.7	7.6	0.5

Source: USDHHS, Health Resources and Services Administration, Bureau of Health Professions, Health Professions Education: Diversity in the New Millennium, 2000 Edition. April 2002.

- The Hispanic and African-American population will increase significantly in the next 50 years. The size of the health workforce may decrease if participation by underrepresented minorities remains the same or shows further declines. Increasing the proportion of African-American and Hispanic health care providers can help ensure a strong health workforce.

- Minority physicians are more likely to serve patients and communities of their own racial/ethnic background. Ninety percent of minority physicians educated in Historically Black Medical Colleges live and practice in minority communities. Similar practice preferences have been demonstrated among Hispanic physicians.

- A substantial body of literature concludes that culturally competent care is good care. This means that all health professional schools must continue their commitment to ensuring that the students they train represent the rich ethnic diversity of our society. Important investments and many successes have been achieved, but this is an obligation that must be continued at each institution until it is no longer an issue. Diversifying the entering class at an institution does not in and of itself ensure an understanding and appreciation of diversity; cultural competence must be a part of the educational experience that touches the life of every student.

- In order to effectively promote a diverse and strong health professions workforce for the 21st Century, Federal agencies should expand and add programs that effectively overcome

racial/ethnic barriers.

Expected Benefits:

- By adopting measures to encourage collaboration between grant recipients and institutions that train and/or serve, largely, minority populations, the Department of Health and Human Services would help achieve two major objectives set forth under Goal 3 of the Department's Strategic Plan for FY 2003-2008. Those objectives are to expand the health care safety net (Objective 3.2) and eliminate racial and ethnic health disparities (Objective 3.4).

Proposed Strategies:

Administrative

Strategies to achieve the described benefits are primarily administrative in nature and fall into four categories:

- Pipeline – The low representation of minorities within the health professions needs to be addressed. This is not only a diversity issue but also a matter of counterbalancing provider misdistribution. As indicated above, students drawn from populations experiencing health disparities are more likely to return to their "roots". The HRSA sponsored Kids Into Health Careers program is designed to achieve this aim. Another way of encouraging this under the current program would be to award preferences to applicants that propose collaborations with institutions that have a high percentage of students from minority populations. Grant applicants would be judged not only on the likely effectiveness of the program they propose but also on the identified target audience.

- Faculty development - Strengthening the training and research capacity of minority-serving institutions is another useful tool for alleviating health disparities. Measures designed to attract and retain qualified faculty at such institutions are essential. Collaborations between minority- and majority-serving institutions, including programs where faculty and/or students go to other schools to teach or learn for designated periods, could be an effective mechanism for making this happen. Examples of such programs exist; best practices of this nature should be identified by the Department and highlighted.

- Health information – In addition to attracting a greater flow of minority students into the educational pipeline and strengthening faculty recruitment and retention as well, inter-institutional collaboration is an effective mechanism for increasing the development and dissemination of culturally attuned health information between the institutions involved, to the ultimate benefit of the population served. Again, best practices of this nature should be identified and highlighted.

- Interagency cooperation – Other DHHS agencies are charged with responsibilities related in one way or another to the goals of this program. The National Center for Health Disparities, for example, has a similar mission, albeit not directly linked to interdisciplinary, community-based practices; the National Institutes of Health's Centers of Excellence In Partnerships for

Community Outreach, Research on Health Disparities, and Training (Project EXPORT) provides funding opportunities for translating research into practice; and so on. Steps should be taken to assure that each of these agencies is aware of the activities of the others and that interagency cooperation is encouraged to the extent feasible. The HRSA Office of Minority Health could be an effective agent in this regard.

Recommendation 2: Enhancing the Status of Allied Health and Improving Program Effectiveness

This recommendation consists of two parts. The first is directed toward 1) improving the recognition of the field of Allied Health as comprised of a number of specific professions by providing more appropriated descriptions of the professions to broaden the pool of eligible applicants for Federal funding, and 2) enhancing the effectiveness of the grant program by focusing the limited funds available to meet new, emerging allied health professions and addressing existing workforce shortages.

> **Recommendation 2a.** The Congress and the Secretary should take action to strengthen the capacity of the Allied Health program in Title VII, Part D, Section 755 of the Public Health Service Act for the purpose of meeting the need for an adequate supply of qualified Allied Health workers by reserving Section 755 for Allied Health education and training only with separate funding for these programs.
>
> **Recommendation 2b.** The Congress and the Secretary should take action to increase the effectiveness of the Allied Health program by directing that funding be targeted to those Allied Health professions demonstrating workforce shortages and addressing the needs of vulnerable populations and medically underserved communities.

Rationale:

The term "Allied Health" is non-specific and ambiguous, applying to those from non-academic training programs (para-professionals, health workers, health assistants, etc.), to those with academic degrees from the associate's level to doctoral and post-doctoral degrees. This lack of a clear definition in legislative language has resulted in the relative invisibility of Allied Health in public policy decision making, conflicting views regarding what Allied Health is or is not, and a lack of recognition of how Allied Health responds effectively and efficiently to the changing demands and priorities of our Nation.

Employment data from the Bureau of Labor Statistics and the US Health Workforce indicates the following:

- Allied Health professions encompass 30 percent of the total health care workforce.
- Projections for 2000-2010 show that from the top 68 health professions in demand, 37 (54 percent) are Allied Health professions, the 10 fastest growing professions are from Allied Health as well.

- A need for 5.3 million new health care workers by 2010.

The American Hospital Association's Workforce 2001 Survey indicates an overall vacancy rate of 12 percent, a full 1 percent higher than the publicized national nursing shortage. Some Allied Health professions, such as Radiological Technology, Diagnostic Medical Sonography, and Respiratory Care, to name only three, currently have even higher vacancy rates. The Bureau of Labor Statistics projects a need for 9,300 new clinical laboratory scientists per year through 2008, while data from the National Accrediting Agency for Clinical Laboratory Science show only 4,110 graduates anticipated per year in these fields.

Allied Health is noted for its efficient and effective development of programs to respond to emergent or urgent local, regional, and national health needs and priorities. Nevertheless, the appropriations received from Section 755 Allied Health and other Disciplines Program are decreasing and do not respond to the need of these health professions to continue to develop.

Allied Health is multidisciplinary in nature and widely distributed over the health services, so that it can respond very quickly to emergent health needs, new scientific and technological advances, or changes in health priorities. Allied Health has the capacity to create quickly new programs or expand/modify existing ones to respond to such diverse developments as changes or advances in molecular diagnostics, genomics, bioterrorism, toxicology, patients' rights protection, prevention of medical errors, aquatic rehabilitation and information technology.

Expected Benefits:

- Allied Health merits a separate Section under Title VII to warrant recognition and appropriate funding to increase its participation in the development of programs that will not only supply vital health professionals with the team- work skills to serve vulnerable and underserved populations, but will also provide access for health career development to members of the populations they serve.

- Recognition of Allied Health by HRSA is needed to give visibility to its contributions to health care services delivery, to create opportunities for professional career development, and the creation of new programs to meet new needs, to assist in recruitment and enrollment of students from diverse backgrounds, to create data for workforce studies, etc.

- Allied Health educators and practitioners are valuable partners in providing the opportunity to increase diversity and distribution in the health workforce in health areas of great need and demand. For example, the associate's degrees in Allied Health are the first step on the career ladder, allowing the progression of students to higher health career degrees. It is a continuum in Allied Health education that should merit recognition and funding. One of the ways enrollment could be increased is by increasing public awareness of Allied Heath careers and the opportunities they represent.

Proposed Strategies:

- Incorporate the name "Allied Health" in a Division of the Bureau of Health Professions.

- Increase the appropriations for Allied Health to meet increasing public demand.

Recommendation 3 – Using Existing Title VII, Part D Programs, Partner with Other Agencies to Educate and Disseminate Bioterrorism Preparedness Education and Training

In response to the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, authorizes curriculum development and continuing education in bioterrorism preparedness for health professions students and practitioners. The Committee recommends that grant programs authorized by Title VII, Part D, Sections 751 through 755 of the Public Health Service Act be eligible for funding. In addition, the committee suggests that a portion of the funds be allocated for a consortium of grantees within these programs.

Rationale:

- Interdisciplinary, community-based programs, as defined in Title VII, Part D, Sections 751 through 755 of the Act, are excellent partners with primary care, specialty care, and public health programs for the purpose of addressing the education and training required for bioterrorism preparedness at the community level.

- Interdisciplinary, community-based programs have the capacity in well-positioned solid networks to serve as national and local resources to train teams for bioterrorism preparedness through community-based health professions education centers.

- Federal investment in community-based interdisciplinary programs has developed academic/community partnerships with the Federal government. These programs are able to respond quickly to new national priorities through their infrastructure of community networks.

- Community-based interdisciplinary programs cross traditional borders and have the capacity to deliver educational programs to special populations through linkages with Community Health Centers and the National Health Service Corps.

- Community-based interdisciplinary programs have a longstanding history of providing education and training to develop and expand the Nation's health professions workforce.

Expected Benefits:

- An established community-based infrastructure would be available to partner with Federal, State, and local organizations to develop and implement bioterrorism preparedness training programs, and to participate in their evaluation throughout the Nation.

- Bioterrorism preparedness training programs at the community level would teach interdisciplinary teams of health professionals to: recognize indications of a terrorist event in their patients; treat patients in a safe and appropriate manner; provide a rapid and effective alert of the public health system and other emergency responders; and, prepare vulnerable and disadvantaged members of the community for acts of bioterrorism.

- An assessment of outcomes and benefits would be available through a national network of Federally supported programs.

- Interdisciplinary teams would be developed, linking Community Health Centers, health departments, Area Health Education Centers, academic health centers, the National Health Service Corps, HRSA, the Centers for Disease Control and Prevention, as well as many local and State emergency preparedness organizations.

- Local delivery vehicles and learning resource centers would be created that use distance learning technology to educate health professions students, practitioners, and faculty.

- Public education would be provided in response to community-directed requests for bioterrorism preparedness training.

Proposed Strategies:

Legislative

- Enact changes linking the statutory requirements from the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 to the Public Health Services Act regarding health professions education and training in bioterrorism preparedness

- Provide sufficient appropriations to fund this priority initiative in appropriate programs within Title VII, Part D of the Public Health Services Act.

Administrative

- Encourage and enhance partnerships and collaborations across DHHS Federal agencies and within HRSA programs (BHPr and BPHC) with expertise in bioterrorism with programs in Title VII, Part D of the Public Health Service Act

- Provide continued support to the national Advisory Committee on Interdisciplinary, Community-Based Linkages to continue solicitation of appropriate testimony regarding educational needs, purposes and strategies to prepare and mobilize health professionals and health care teams in rural and urban communities in response to incidents of bioterrorism in order to inform future findings and recommendations.

Recommendation 4 - Strengthening Linkages Between Section 751-755 Grant Programs and Other DHHS Initiatives

This recommendation consists of two parts. The first is directed toward strengthening linkages between the current Title VII, Part D grant programs that fall within the Committee's purview and federally-qualified Community Health Centers (CHCs) and rural health clinics. The second is directed toward strengthening programmatic relationships between these grant programs and activities of the National Health Service Corps (NHSC).

> **Recommendation 4a.** - Strengthen the capacity of grant programs in the current Title VII, Part D, Sections 751-755 of the Public Health Service Act to assist in meeting the need for an adequate supply of qualified health care workers to serve the public through the Nation's network of Federally-qualified community health centers and rural health clinics.
>
> **Recommendation 4b.** - Create new and enhance existing linkages between the grant programs in the current Title VII, Part D, Sections 751-755 of the Public Health Service Act and the National Health Service Corps (NHSC) for the purpose of increasing the supply, ensuring the quality and cultural competency of NHSC health care providers who serve unserved, underserved, and vulnerable populations.

Rationale:

The President and Congress have been pursuing a course of action to increase the number of community and migrant health centers, rural health clinics, and other providers of health care services to meet the needs of unserved, underserved, and vulnerable populations across the Nation. These recommendations and actions acknowledge that many people in this country do not have appropriate or adequate access to needed health care services. It also recognizes that there are long-term cost savings when primary health care services are immediately available as opposed to prolonging treatment, thus often requiring more expensive services.

Community/migrant health centers and rural health clinics are unique clinical health care environments requiring certain skills and community-based educational experiences not often available to health professions students and medical residents during their ordinary training. Such skills entail a practical knowledge of public and community health, cultural and language competency, and an ability to work in within the context of an interdisciplinary team. Several of the existing Title VII, Part D training grant programs, such as AHECs, HETCs, the Quentin Burdick Rural Interdisciplinary Training Program, and Geriatric Education Centers have the capacity and experience to train future health care providers to meet the needs associated with the expansion of Federally-supported clinics. The expansion of these clinics places an even greater demand on having an available workforce with the experience and training necessary to perform optimally in providing health care to the targeted populations.

In part, the increased workforce demand is to be met through expansion of the NHSC, by increasing the number of NHSC scholarship recipients and loan repayors obligated to work in federally designated clinical sites. However, the NHSC itself has little capacity to ensure that

these scholars or loan repayors have training that is entirely appropriate to the needs of the clinic population.

Based on these considerations, the Advisory Committee feels that the capacity of the existing grant programs that fall within its purview be applied to the critical need for a health care workforce associated with the expanded vision for Federally-funded clinics, including the activities of the National Health Service Corps. The AHEC, HETC, and Rural Interdisciplinary programs already have a foundation for collaborating on such interests by providing their experience with community-based training as well as interdisciplinary education. GECs have a capacity to meet the education and training needs associated with improving health care services to the elderly. The other Title VII, Part D programs to which this recommendation applies -- geriatric-related training programs and allied health training projects -- could also be directed to meet the education and training needs of these current service providers as well as preparing future providers in these clinical settings.

Expected Benefits:

- By relating the Section 751-755 grant programs to the expansion of community/migrant health centers and rural health clinics, a pipeline would be established to supply these centers and clinics with needed health care providers. The practitioners thus trained would not only be skilled in the basics of their discipline but would also be community-oriented, culturally and linguistically competent, and committed to a clinical setting known to them through prior training experiences.

- AHECs, HETCs, Rural Interdisciplinary Training Programs, and GEC grantees could be expected to conduct activities to meet the education and training needs of the CHCs and clinics in their geographic or population-based service areas. Allied Health training projects and other geriatric-related training programs would also interact in a similar manner with the centers and clinics in their area.

Proposed Strategies With Respect To Community Health Centers and Rural Health Clinics:

<u>Legislative</u>

- Programs, such as Area Health Education Centers (AHECs), Health Education Training Centers (HETCs), Geriatric Education Centers (GECs), and Quentin Burdick Interdisciplinary Rural Health Training Grant programs should be required the to apply their health professions education-related activities to the needs of federally-qualified Community Health Centers (CHCs) and/or rural health clinics within their targeted geographic area or population when sufficient appropriations are made available for such work (see below). Such activities by these grant programs would not be exclusive of addressing workforce training and education needs other than those associated with such clinics.

- Federally qualified CHCs and rural health clinics should be required to collaborate with and provide funding support for AHECs, HETCs, GECs, and Quentin Burdick programs that operate within the clinic's geographic catchment area or serve the same population in order for the programs to perform training and education-related activities when sufficient appropriations are made available for such work.

- Allocate funds to enact the above measures by designating an amount not less than 10 percent of the total amount appropriated for Federally-qualified CHCs and rural health clinics to enable these entities to enter into agreements with the grant programs such as AHECs, HETCs, GECs, and Quentin Burdick Interdisciplinary projects.

Administrative

- Establish a funding "preference" for applicants for other (than GEC) geriatric-related grant programs as well as for Allied Health projects that propose to address the education and training needs of the health care workforce in federally-qualified CHCs and/or rural health clinics.

- Direct BHPR's Center for Health Workforce Study to use Federal funds to conduct activities that address the health care workforce needs of Federally-qualified CHCs and rural health clinics as well as evaluate the outcomes of the collaborations between the health professions education grant programs and these clinics. Funds should be allocated to enact this measure by designating an amount of not less than 2 percent of the total amount appropriated for Federally-qualified CHCs and rural health clinics to perform the such analysis and evaluation.

- Enact measures that ensure that there is substantial administrative cooperation and collaboration between the HRSA Bureaus of Health Professions and Bureau of Primary Health Care to effectively and efficiently carry out the above described measures and other such activities that link the training of health professionals with the workforce needs of federally-qualified CHCs and rural health clinics.

- Legislative descriptions of programs such as Area Health Education Centers (AHECs), Health Education Training Centers (HETCs), Geriatric Education Centers (GECs), the Quentin Burdick Interdisciplinary Rural Health Training Grant programs that require health professions education-related activities, including continuing professional education, student and medical residency training be conducted with NHSC participants within the targeted area of these grant programs and when sufficient appropriations are made available for such work.

Proposed Strategies With Respect To The National Health Service Corps (NHSC):

Legislative

- The NHSC should be directed to establish collaborative relationships with these grant programs to perform NHSC-related health professions education and allocate funds for

these activities by designating an amount not less than 5 percent of the total appropriation for NHSC for this purpose.

Administrative

- Require that AHECs and Primary Care Organizations (PCOs) collaborate with each other in carrying out the objectives of the NHSC SEARCH projects where the two entities have common geographic catchment areas. Adequate funds from the SEARCH project grant should be made available to ensure the collaboration of the AHEC in performing the education and training activities.

- Establish a funding "preference" for AHECs that apply for grants and contracts to carry out interviews and other related activities on behalf of the NHSC in selecting its Scholarship recipients.

Recommendation 5 - Representation from the Advisory Community on Interdisciplinary, Community-Based Linkages to the Rural Task Force

In response to the "One Stop" approach advocated in the July 2002 DHHS Rural Task Force Report to the Secretary, it is recommended that the Secretary appoint a member of the National Advisory Committee on Interdisciplinary, Community-Based Linkages, in an advisory capacity, to the Rural Task Force.

Rationale:

Responding to its assigned mission of examining ways to improve and enhance health care and human services for rural Americans, the DHHS Rural Task Force Report of July 2002 provided the most comprehensive discussion of rural health in the United States to date. The strategy advocated in the report was to develop a *"One Stop" One Department Serving Rural America* approach. This approach was to be accomplished by addressing five goals:

- Improving rural community access to quality health and human services

- Strengthening rural families

- Strengthening rural communities and supporting their economic development

- Partnering of State, local and tribal governments to support rural communities

- Supporting rural policy and decision-making and ensuring a rural voice in the consultative process.

There is a strong commonality between these goals and the interdisciplinary, community-based grant programs that fall within this Committee's purview. As stated in the Committee's First Report:

- "The integration of "interdisciplinary" and "community-based" concepts into the training of health professionals is an effective way to ensure that there will be a national workforce providing the best possible health care in underserved geographic regions or in service to vulnerable populations. By focusing precious national resources on interdisciplinary, community-based grant programs, the Secretary and Congress are also supporting cost-efficient measures that target the greatest needs for health professions education. The President's intent in expanding services to the Nation's neediest populations through growth in community and migrant health centers is an example of the continuing demand for educational strategies that prepare a workforce to serve in these practices." (National Advisory Committee on Interdisciplinary, Community-Based Linkages, First Annual Report, November 2001).

Additionally, the Committee observed that interdisciplinary, community-based grant programs address both quality and access issues involving health care and social services in rural areas through workforce development, training, recruitment, retention, and local collaboration in medically underserved rural communities. Having been in place for more than 10 years, these programs are all well established with well-defined infrastructures. They share the following characteristics:

- They are health workforce development programs responding to locally identified unmet needs.

- They are concerned with supplying health personnel to serve vulnerable and often-underserved populations.

- They are interdisciplinary in nature.

- They collaborate closely with local communities and other grant programs to identify health workforce and service solutions for the needs of local populations.

- They address workforce gaps that result in private/public health care market failures in difficult-to-serve communities.

- They foster and build collaboration among state, local and tribal entities as well as business, education systems and the health industry to best utilize limited resources for the improvement of programs and services in rural communities.

- They have a direct impact on economic development in rural underserved communities. It has been estimated that for each dollar expended, a four-fold increase is realized through activities related to:

    - housing and living expenses for health professions students

    - training and education activities for local health professionals

    - activities related to communication network and systems development

- awareness and recruitment activities involving K-12 school children.

- They respond to community driven requests for health promotion and disease prevention information, thus enabling families to be better informed and make better choices regarding their health and the services they need.

Expected Benefits:

Advisory Committee representation, in an advisory capacity, on the Rural Task Force (RTF) is consonant with the "One Stop" approach advocated by the RTF for the resolution of rural health care issues and may reasonably be expected to further the RTF goals through the commonality of interest and sharing of relevant information. Interdisciplinary, community-based programs are models of health care education at its best, capable of teaching a variety of health professionals to work independently in consultation with each other to reach diagnostic decisions faster and develop a potentially large array of treatment options for the people they serve. When health professionals work closely together, they can "get ahead of the curve", developing preventive and wellness approaches that can improve quality of life. Interdisciplinary health care is thus a cost-effective way to deliver services and improve the health of the population.

VI The Advisory Committee's Future Agenda

The Advisory Committee will continue to pursue recommendations that strengthen the capacity of interdisciplinary, community-based grant programs to meet health care workforce needs in America. In the next year's agenda, the Advisory Committee will consider more carefully those "Strategic Recommendations" made in this report and move toward making specific suggestions regarding future legislation and/or changes in administrative procedures. The topical areas to be explored include the following:

- Strengthening bioterrorism preparedness
- Collaborative means to enhance provider diversity and increase cultural competency
- Developing cooperative linkages between interdisciplinary, community-based grant programs and other federally-funded workforce interests including the Nation's network of publicly supported health care services
- Reauthorization of Federal legislation governing the development of the Nation's health care workforce and related recommendations regarding appropriations

At the time of preparing this report, a meeting has already been scheduled for December 2002 to address "strengthening bioterrorism preparedness."

The Advisory Committee will take a somewhat different approach to its work in 2003, given that many of the agenda topics pertain to time-sensitive issues. The Committee would like to issue interim reports of findings and recommendations at the conclusion of meetings. These policy-related suggestions can be forwarded to the Secretary and Congress in advance of preparing the Third Annual Report. The Advisory Committee feels that such an approach would enable it to be more responsive to national policy priorities that demand immediate considerations.

Also, the Advisory Committee will continue to examine the policy and procedural proposals provided by presenters at meetings during the previous year; many of these suggestions were offered by grantee constituency groups and address matters that could lead to significant improvement in their capacity to operate at the local level. These ideas, as well as a careful study of the matter of Federal reauthorization and appropriations for interdisciplinary, community-based programs will be a high priority in the next year.

Finally, the Advisory Committee recognizes that the investment in preparing a health care workforce is one that is shared with several partners, including State governments, academic institutions, local health care provider agencies, and private foundations. In the past year, the Advisory Committee began the process of hearing from State government but feels that it should provide even greater opportunity to solicit the response of States to Federal policy recommendations. Therefore, the Advisory Committee will define a strategy that provides for formal feedback from key representatives from within State government as well as those who represent other partner groups.

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APPENDIX A - Findings from the FY 2001 Annual Report

FINDING A: Interdisciplinary, community-based grant programs show clear and overwhelming evidence of successful outcomes. As the Nation's only health professional training programs with a mandate for, and experience in, focusing on community-based strategies, they:

- respond to unmet health needs through partnerships with communities in rural, urban, and suburban areas;
- promote best practices and models of interdisciplinary health care;
- address gaps in health service delivery resulting from private health care failures in communities that are difficult to serve; and
- educate the workforce for the nation's system of community and migrant health centers, rural health centers, and community hospitals.

FINDING B: Grant programs of this nature are most effective when the legislative language and administrative policies permit them the greatest flexibility to respond to community needs. Decision-making that takes place locally, through community-academic partnerships, results in educational strategies and program organization that best meet local and regional needs.

FINDING C: Interdisciplinary health care is an important way to meet the nation's health care needs effectively and efficiently, and is consonant with policies and standards set forth by such organizations as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the President's Advisory Commission on Consumer Protection, and the National Commission for Quality Assurance Standards.

FINDING D: Allied Health professionals have played, and will continue to play, a vital role in interdisciplinary community-based care. In this regard, however, there are two issues that need to be addressed:

- The definition of what constitutes "Allied Health" needs to be clarified.
- The visibility and representation of this set of professions needs to be strengthened.

FINDING E: Some grant programs are well positioned to serve a vital national interest by disseminating practice guidelines and research outcomes likely to improve the quality of evidence-based health care in American communities, especially in areas or for populations with the poorest current access to health care.

FINDING F: Federal criteria for cost sharing are an important aspect is ensuring successful outcomes and reducing the need for Federal funding. However, such criteria, and in particular any requirement for ultimate self-sufficiency, may be impossible to achieve in communities that are economically deprived.

FINDING G: Insofar as this legislation is concerned, the inclusion of podiatric medical residents within section 755, which pertains to allied health, is inconsistent with the organizational location of podiatric medicine within the Health Resources and Services Administration's Bureau of Health Professions, where it falls under the auspices of the Division of Medicine and Dentistry.

Each finding was accompanied by one or more recommendations, summarized below:

Finding	Associated Recommendation(s)
A	Federal interdisciplinary, community-based grant programs should be reauthorized. (Recommendation #1)
	Appropriations for programs of this nature should be increased. The accompanying legislation should encourage collaborations between these programs and institutions that train minority and immigrant populations. (Recommendation #2)
B	Future legislation should encourage the design and implementation of funded activities relating directly to the unique health needs of a region or local area. Also, administrative policies should be established to promote the incorporation of community advisory groups within the grant program organization as well as training protocols uniquely defined for the local service area or population. (Recommendation #3)
C	The administrative policy tools of "preferences and priorities" should be used to make awards to grantees that truly propose training of an interdisciplinary nature. (Recommendation #4)
	Congress should establish a grant program ("Inter-disciplinary Education Demonstration Projects") to encourage cooperative community-based ventures between two or more of the programs currently described in Title VII, Part D, Sections 751-755 of the Public Health Service Act. New appropriations should be authorized for this new initiative. (Recommendation #5)
D	The Committee endorses the 1995 recommendation of the National Commission on Allied Health that there be established within the Health Resources and Services Administration (HRSA) an organizational entity that would give greater visibility and representation to Allied Health. (Recommendation #6)
E	Federal agencies such as the National Institutes of Health, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and Food and Drug Administration should establish formal, funding-based links with HRSA to enable the entities described in Sections 751-755 to carry out continuing professional education and other forms of postgraduate training that could serve to translate research into practice. (Recommendation #7)

Federal agencies that seek to promote more "population inclusive" research should be instructed to establish funding relationships with the entities described in Sections 751-755. (Recommendation #8)

F Federal criteria for cost-sharing with State or local governments and private foundations should be maintained for programs that have demonstrated successful outcomes but not for Health Education and Training Centers (HETCs), owing to the unique nature of their target populations and economic areas served. Also, because of the unique nature of the target populations and economic areas served by HETCs, the current legislative cost-sharing requirement for such entities should be restated as a desire, not a requirement. (Recommendation #9)

G The legislative authority for podiatric medicine grants, currently contained in Section 755 of the Act, should be relocated in Section 747 in association with discipline-specific grants to train family physicians, general internal physicians, and other primary health care providers. (Recommendation #10)

APPENDIX B – FY2002 Meeting Agendas

April 28-30, 2002

Sunday, April 28, 2002
Informal Discussion and Work Group Meetings

Monday, April 29, 2002
Welcome/Introductions
Review and Approval of February 3-6, 2002 Meeting Minutes
Agenda Review
Status of Advisory Committee and First Report
Recommendation A (or #3) –

- "Legislative language should encourage funded activities (in the grant programs) that directly relate to the unique needs of a geographic region or local area and should involve community-based input" (Discussion may include work in small groups)

Reports / Conclusions for Recommendation A
Recommendation B (or #6) –

- "Congress should establish a new grant program (including appropriations) known as the Interdisciplinary Education Demonstration Projects" (Discussion may include work in small groups)

Reports / Conclusions for Recommendation B
Dissemination Work Group Report / Discussion
Other Comments

Tuesday, April 30, 2002
Workforce Shortages Areas in Geriatrics and Allied Health
Dr. Marilyn Biviano, Director, National Center for Workforce Analysis – HRSA
Recommendation C (or #13) –

- "Congress should encourage collaborations between grant programs and institutions that train minority, immigrant, underserved and unserved populations."

Discussion of IOM Report: **Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care; Chap. 6, Cross-Cultural Education in the Health Professions.** (Discussions may include work in small groups)
Report / Conclusions for Recommendation C
General Conclusions and Planning for Next Meeting
Adjournment

June 23-25, 2002

Sunday, June 23, 2002
Welcome/Introductions
Review and Approval of Minutes
Agenda Review / Meeting Objectives
Work Group Meetings

Monday, June 24, 2002

Public Health Preparedness Initiatives: Are you ready?

Neil Sampson, Deputy Associate Administrator, Bureau of Health Professions, HRSA

Title VII , Part D Grant Programs: Questions & Answers

Jeffrey Dunlap, Director, Division of State, Community and Public Health, BHPr
Marsha Davenport, MD, MPH, Deputy Director, DSCPH

Testimony Provided By Interest Groups:

Interdisciplinary, Community-Based and Related Programs, Including Area Health Education Centers, Health Education Training Centers, Geriatric Education Centers, Allied Health, Burdick Rural Interdisciplinary Training Programs, Podiatric Programs, Chiropractic Programs, and Psychology Training Programs

Lessons Learned: Testimony
General Comments

Tuesday, June 25, 2002

Welcome / Introductions / Agenda Review
Chair's Report on Advisory Committee Status and Matters Related to the First Annual Report
Member's Report on Interdisciplinary Conference
Work Group Reports: Priority Recommendations
Priority Recommendations
Agenda Setting / Other Comments And Business
Meeting Adjournment

August 4-6, 2002

Sunday, August 4, 2002

Priority Recommendation Work Group Meetings

Monday, August 5, 2002

Welcome / Introductions and Members' Comments
Agenda Review

Health Disparities and Diversity in the Health Professions

Henry Lopez, Jr., Director, Division of Health Careers Diversity and Development, BHPr, HRSA

Challenges to Advisory Committee on Bioterrorism and Emergency Preparedness Recommendation(s)

Update on Bureau of Health Professions

Marsha Davenport, MD, MPH, Acting Deputy Director, Division of State, Community, and Public Health, BHPr, HRSA

Bioterrorism and Emergency Preparedness Recommendations
Reflections on Testimony, June 24, 2002 – Proposed Recommendations
Second Annual Report: Priority Recommendations

Tuesday, August 6, 2002
Logistics: Advisory Committee Status, Committee Leadership, Other
Dissemination of First Annual Report
Second Annual Report: Priority Recommendations
Future Meetings and Agenda
Adjournment

October 2-4, 2002

Wednesday, October 2, 2002
Distribution of Draft Second Annual Report
Agenda Review and Revisions
Approval of Minutes

Thursday, October 3, 2002
Welcome
Introductions
Administrative Comments
Presentation/Review of the Draft Second Annual Report
    Discussion of Chapters I, II, & III
    Discussion of Legislative Recommendations on Allied Health
    Other Recommendations

Friday, October 4, 2002
Other Recommendations
Advisory Committee - Leadership
Final Review and Approval of the Second Annual Report
Future Activities /Advisory Committee Process
Adjournment