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Proceedings from the Health Education Summit

October 5 and 6, 2010 • The Carter Center • Atlanta, Georgia

Five Prescriptions for Ensuring the Future of Primary Care

The Carter Center Mental Health Program, collaborating with the American College of Physicians, convened the Health Education Summit in October 2010, drawing experts and thought leaders from various health professions, institutions, practice settings, and perspectives.

The Summit considered potential reforms to health education systems to ensure that as health reform continues, patients have access to primary care that can help them better manage their total health, including behavioral health needs.

The views expressed in this document reflect the consensus views of the attendees and do not necessarily reflect the positions of any organization with which they are or have been associated.

INTRODUCTION

At the beginning of the second decade of the 21st century, health care delivery in the United States faces major challenges. In particular, the erosion of the U.S. primary care base and the lack of well-designed, person-centered care often translate into a system that is not only incomprehensible for patients and families, but also unsafe and costly. Despite spending more per person on health care than any other country, measures of quality demonstrate that the United States lags behind in many important metrics of safety, patient-centeredness, care coordination, continuity, and access to care. Further, the evidence base shows that behavioral conditions, such as depression, anxiety, and substance abuse, are highly prevalent in the primary care setting. These conditions generate significant morbidity, cost, and even mortality when associated with chronic medical illnesses, and there are significant shortfalls in the recognition and treatment of these behavioral conditions. Such findings have led to calls for the reinvention of and reinvestment in the primary care sector, with significant attention being paid to the evidence-based integration of behavioral health care and health promotion/disease prevention. A model gaining significant attention as the basis for such change is the patient-centered medical home.

In July 2009 the Carter Center Mental Health Program convened the Medical Home Summit, which brought together 40 leaders from the fields of primary care, behavioral care, and health promotion/disease prevention. The goal of the Summit was to examine, in a collaborative way, whether the patient-centered medical home could serve as the platform for integrating behavioral health care and health promotion/disease prevention, thereby addressing some of the issues of cost and quality referenced above. Summit attendees identified the current health education system as a significant impediment to this integration. With rare exception, the existing training model does not prepare students for the environment in which they can be expected to provide care as health care professionals. Efforts to improve the delivery of health care, including models such as the patient-centered medical home and the accountable care organization, will require people with new skills and a team-oriented, interprofessional approach.

To begin addressing this situation, the Carter Center Mental Health Program, in collaboration with the American College of Physicians, convened an additional meeting in October 2010. The Health Education Summit, supported by a grant from United Health Foundation, was attended by leaders from a variety of health professions, institutions,

United Health Foundation

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practice settings, and perspectives. The participants were asked to develop a concrete vision for a future health care delivery system, and then describe specific actions that could drive the development of the educational model needed to support that vision, with a specific focus on the integration of behavioral care and health promotion/disease prevention into primary care and the patient-centered medical home. Through a combination of pre-meeting surveys and in-person work, five key conclusions and associated recommendations were developed.

GOALS OF THE SUMMIT

A major goal of the Summit was to consider and promote the integration of behavioral health care, including mental health and addictions treatment, and health promotion/disease prevention into a reinvented primary care system based on the patient-centered medical home. A related goal was to increase the capacity of health care professionals (e.g., physicians, advanced practice nurses, physician assistants, pharmacists, and public health professionals) to provide evidence-based integrated care. To address these goals, Summit participants discussed changes to the design of educational and training experiences in primary care based on an interprofessional, team-based approach.

VISION

Through a set of exercises completed by the attendees during the month prior to the meeting, participants from a variety of disciplines collaboratively developed a vision for a reinvented primary health care system. Participants considered a wide range of topics, including the essential characteristics of such a reinvented system, the various skill sets and competencies required to function effectively and efficiently in such a system, and finally, the education and training necessary to impart these skill sets and competencies to health profession students. From these pre-meeting activities, a vision to frame the overall conversation at the Summit was created by the planning group and shared with the attendees at the opening session.

The Health Education Summit Vision for a Reinvented Health Care System

In a patient-centered health care system, clinical teams demonstrate respect for the needs, values, and preferences of individuals and are equipped to encourage informed decision making, self-care, and healthy lifestyles. Individual and family preferences, situations and values, and family involvement (when appropriate) are important components of support and treatment. Health care professionals encourage and support individuals to engage in their own care and provide patients with the necessary tools to support these activities.

This patient-centered system is complemented by a foundation of team-based primary care that is fully integrated with behavioral and mental health care, focused on overall wellness and prevention. Health information technology plays a key role in supporting this team-based approach by facilitating the management of complex health care data and promoting appropriate information sharing among patients, families, and the health care team. Health professionals, working in teams, operate within a well-designed network of providers supported by a payment model that aligns incentives, promotes collaboration, and creates value for each member of the health care team.

Skills and Competencies Needed in a Reinvented Health Care System

Health care professionals will require important skills to add value to a patient-centered, team-based health care system. To support a health care system based on the integration of behavioral and mental health into primary care, health care professionals must be knowledgeable about common behavioral and mental health issues, and understand strategies to improve primary prevention. Health professionals must also be educated about public health, including the social determinants of health, as well as the bio-psychosocial model of health care. Primary care professionals will serve as health educators, and thus should be educated in health promotion and strategies for effective communication.

Interprofessional team-based training will support the ability of health professionals to interact with one another in this new model of patient-centered care. Health care professionals will understand their individual role in a system of team-based care and will possess skills to manage, implement, and support patient care. Individual team members will be accountable for all levels of patient care and will continue to monitor progress.

Education and Training for the Reinvented Health Care System

Education and training for health care professionals will be designed based on the concept of lifelong learning, where team members are in tune with the latest developments in clinical science and health promotion/disease prevention throughout their careers. Selection for the health professions is based on criteria that balance intellect with compassion, and quantitative skills with interpersonal characteristics. From the beginning of their education, students should train and learn collaboratively with other health professionals to develop leadership and enhance communication skills.

Core educational programs will be designed to support specialty differentiation based on student performance, skills, and preferences as well as workforce needs. Experiential learning will be a hallmark of this educational system and will take place in high-need community and ambulatory health-care settings that are patient-centered in orientation. Educational tenure and promotion guidelines will reflect the importance of classroom teaching as well as clinical supervision in an interprofessional team environment. Funding, including support from the federal government, will flow to schools to encourage training the most effective mix of health care professionals.

DISCUSSION AT THE SUMMIT

Key Obstacles

At the Health Education Summit, participants discussed significant barriers that could prevent implementation of a reinvented health care system based on the group's vision for the future. Barriers identified included the current health education system, workforce issues, financing, stigma toward primary care professions and behavioral health, and need for technology improvements.

Participants noted a broad reluctance in the health profession education system toward any significant change or reinvention as a significant barrier to an integrated health care system. The field of medical education, in particular, as opposed to the other health professions, is often concerned with maintaining strict requirements (e.g., curriculum, residency review, licensing). This can lead to the development of curricula that teach to requirements, leaving little room for issues important to an integrated health care system, such as behavioral and mental health care and health promotion/disease prevention. A shortage of instructors adept at teaching new training models also slows implementation of changes.

Additionally, it is important to recognize that academic health centers are unique, and a one-size-fits-all approach to health education improvements may not be successful. Interprofessional training may not always work in a classroom setting, such as educating physicians and nurses side by side, but it is important to seek such opportunities via experiential learning and team-based care. Finally, a prohibitively high cost of health education may lead health professionals to specialize in fields outside primary care, for purely financial reasons.

Workforce Barriers

The field of primary care suffers from the absence of credible projections of workforce needs. Without this information, academic health centers and training programs are less likely to shift priorities for training clinicians to primary care from specialty care or to redirect funding to bolster the primary care system. Limited incentives for creativity exist to support new training methods for primary care health professionals. Further, the current promotion and tenure system in academic health centers rewards discipline-specific training and recognition, especially through the pursuit of bench or clinical science research activities, instead of interprofessional collaboration and excellence in team-based care.

An additional challenge to implementation of widespread changes in the health care system is a demoralized primary care workforce. Primary care clinicians face a high patient workload, often driven solely by considerations of volume and economics rather than clinical quality and effectiveness. Such an understaffed and overworked environment creates considerable stress. Trainees are often exposed to negativity about choosing primary care as a career. This further erodes interest in the field and attaches a stigma to those in the primary care workforce, either as a primary care physician, behavioral care specialist, or health promotion provider.

Financial Barriers

Misallocation of financial resources is a significant barrier to developing a patient-centered health care system. Reimbursement rates for primary care services are typically low and may not cover the interprofessional, team-based

care desired for the future. Few funding mechanisms to encourage team-based training exist. Research agendas in academic health centers are often driven by funding formulas that undervalue innovation in education research and primary care training. Major research funding agencies, including the NIH, may be less likely to provide resources for multicomponent interventions, such as interprofessional, team-based care, because they are difficult to evaluate. Indirect support for the overall teaching mission of academic health institutions is often undervalued relative to that provided through the funding of bench research.

Discussion of Key Changes

Health Education Summit participants also discussed potential changes needed to improve health education curricula to address behavioral and mental health and health promotion/disease prevention. Discussion included a range of topics and was enhanced by the participants' diverse backgrounds, which included medicine, nursing, psychology, and pharmacy. Both policy and direct patient care backgrounds were represented.

Many participants cited the importance of including social and behavioral sciences in a new set of requirements for entrance into health professions education. Additionally, placing emphasis on wellness and prevention is needed to help students understand the context of the health care system in which they work. Behavioral health coursework can also teach students about the role of families and the importance of social support in treatment and maintenance of chronic conditions. Students should be educated about the health care system as a dynamic entity and should be versed in the structure and financial considerations of this system.

Participants also discussed the importance of teaching students to function in health care delivery teams. They stressed the importance of developing a health care workforce that can collaborate in patient care and communicate effectively with each other. The creation of interprofessional health care teams requires students to learn their discipline-specific roles as well as the roles of their colleagues. Students should be taught skills for shared decision making and responsibility and learn to be accountable for their actions. Participants also discussed strategies for encouraging this team-based education, such as changing accreditation standards to reflect team-based primary care and developing evaluation metrics that have an interprofessional, team-based component.

To develop a workforce that values integration of behavioral and mental health care in the primary health care system, it is important to change the way students are exposed to behavioral health issues. Currently, health profession students are often not required to learn about behavioral and mental health integration, and there is no requirement for supervision and training in these topics. For example, medical students are required to complete a one-month psychiatry clerkship, but it is most often conducted only in the specialty behavioral health care sector. Students are therefore exposed to the most severe cases, which may not be common in a primary care setting. Participants discussed moving the bulk of this training to ambulatory care settings, in order to train students to recognize behavioral and mental health problems in more common patient settings.

Participants also discussed the importance of introducing students to care settings that demonstrate how interesting and professionally rewarding team-based, integrated care can be. Given that students choose specialties, in part, based on experiences during their training, providing exposure to well-organized primary care practices, such as those organized as patient-centered medical homes, may encourage more students to enter both primary and behavioral care specialties. Medical schools should focus on producing the health care workforce that the nation requires and encourage students to gain experience working in high-need areas, such as primary care.

Faculty and Workforce Development

Health education should be continuous and designed on a model of lifelong learning. As the health care system moves toward establishing interprofessional, team-based care as the norm, educators should be involved in demonstration projects that aim to achieve team-based standards of care. Participants discussed the need to create new criteria for tenure and promotion: instead of "publish or perish," faculty could focus on service learning and team-based training. These types of modifications in health professions training will require programs that assist current faculty in the transition to the new curriculum and approach.

Metrics of Success

With implementation of significant changes in the health care system, it will be important to measure progress and improvement in order to gauge success. For evaluation of new models of education and training, assessments of changes in curriculum activities across representative institutions may be needed. For example, institutions could track the number of graduates of these programs practicing in interprofessional environments. Direct metrics could include tests of knowledge, skills, and abilities among health program graduates. Measurement or accreditation standards based on interprofessional

development, similar to standards already required of pharmacy and nursing students, could be created and adopted on a broad scale by health professions schools. For evaluation of overall changes in the health care system from adopting an interprofessional, patient-centered model of care, clinical outcomes and cost of care could be monitored. For assessment of the effect of a health promotion/disease prevention model of care, measures of equity could be developed. These measures could include patient and workforce experiences, size and distribution of the health professional workforce, access to care, and metrics examining health disparities in the population.

CONCLUSIONS AND RECOMMENDATIONS

At the conclusion of the Summit, a number of very specific recommendations to advance the successful implementation of the vision were compiled by the attendees. Following the meeting these recommendations were reviewed by the members of the planning group and distilled into a set of five specific conclusions and associated recommendations . . . five prescriptions, as it were, to ensure the future of primary care through carefully considered changes to the process and content of educating the health professional students of today.

Prescription 1: The Importance of Teaching Context

The cumulative actions and decisions of health care providers in the service of patients ultimately determine the quality, costs, and outcomes of our health care system. At the same time, these decisions and actions are directly affected by many externally imposed requirements that often add little value to the actual delivery of care, but do add substantially to the overall cost. In an era of constrained resources, ever-increasing administrative expenses, and well-documented variability in the quality and cost of care delivered, health care professionals must seek opportunities to achieve more efficiency and effectiveness. While regulatory and legislative advocacy are important, it is critical that health care professionals also focus on areas of direct influence. One particular opportunity is to sensitize the entire health care workforce to the effects of everyday decisions and actions on the overall performance and cost-effectiveness of the health care delivery system. This understanding is a prerequisite for achieving the Institute of Medicine's six aims for 21st century health care and particularly relevant for primary care clinicians. Every well-functioning health care system around the world to which the United States can be legitimately compared is based on the foundation of a well-organized and appropriately supported primary care workforce.

Recommendation: Health professions students should be educated about the demographic, socioeconomic, financial, quality, political, and cultural issues affecting health care services. They should be taught, ideally through experiential learning, about the health care system in which they will work, and they should receive training that will allow them to understand issues of population health and the use of evidence-based guidelines to effectively manage health care resources. This additional perspective on the population as well as the individual may well require the modification of undergraduate training and the selection process for health professional training programs. Specific actions include the following:

- Encourage health professional programs to establish requirements to include the social sciences (e.g., psychology, anthropology, sociology) for entrance into graduate health professional training programs
- Educate health professional students about the health care system (e.g., structure, financing, workforce issues) and the basic concepts and tools for managing health at not just the level of the individual patient but also at the level of a defined population (e.g., registries, panels of patients, and even communities)
- Teach new models of technology-enabled care
- Develop incentives through modification of existing public policy, regulations, and payment mechanisms to encourage innovative approaches to training students in managing the health of defined populations, perhaps beginning with the covered population of academic institutions or their communities

Prescription 2: The Importance of Teaching Teamwork

As the scope and complexity of the work within the primary care setting continue to expand, both clinically and administratively, efficient and effective practices will need to operate as high-functioning teams rather than as a collection of specialized individuals. These teams will be composed of a variety of providers, including but not limited to physicians, advanced practice registered nurses, nurses, physician assistants, behavioral health specialists, health promotion specialists, clinical pharmacists, and nonprofessional staff such as health coaches and peer specialists. Some team members may be employees of the practice, others part of a virtual team. In either case, access to the skills of all these providers will be required for optimal functioning. Therefore, knowledge of not only the competencies and strengths of the different providers, but also the basic principles of team management, will be essential to support a highly effective team.

Over the last decade, considerable evidence has shown that the integration of behavioral care and primary care is essential to maximize efficiency and effectiveness. The evidence also reveals that the way in which integration is done also matters.

Recommendation: Health students must be educated about the development, management, and improvement of high-functioning teams within the primary care setting and about how to support patients and families through team efforts. Health students should be taught about the various core competencies and skill sets of all primary care team members and how these various resources together can maximize clinical outcomes and resource allocation at the level of both the individual patient and the population and community. Specific actions include the following:

- Modify accreditation standards and associated curricula to include specific requirements in interprofessional practice, team-based care, and partnerships with patients and families
- Develop these curricula based on a person-centered approach rather than a disease-centered one
- Incorporate lessons from other professions on the teaching of team process and functioning
- Implement faculty development programs that support emphasis on interprofessional, team-based care
- Involve patients and families in teams by using technology that both supports the independence and competency of individuals to manage their own care, and by supporting appropriate connectivity to health professionals

Prescription 3: The Importance of Teaching Integration

Evidence shows that over 50 percent of patients in primary care have some behavioral component to their clinical presentation. These may include a behavioral condition, such as depression, anxiety, or difficulties with substance abuse as the primary problem, or as a secondary complication of a medical problem, such as heart disease or diabetes. Persons with chronic medical conditions are particularly prone to co-morbid behavioral problems. In addition, risky or noncompliant behaviors contribute to the overall burden of disease within the primary care setting. Over the last decade, considerable evidence has shown that the integration of behavioral care and primary care is essential to maximize efficiency and effectiveness. The evidence also reveals that the way in which integration is done also matters. There are functions—such as measurement of treatment results and progress using validated, reliable tools and stepped, evidence-based responses—that reveal clinical progress, or lack thereof.

Recommendation: Health students must be educated about the incidence and prevalence of behavioral conditions in the primary care setting. Students should also be made aware of the range of evidence-based interventions for effective, integrated care, as well as the appropriate role of the specialty sector in the treatment of more severe behavioral health problems. In addition, students should be made aware of evidence-based interventions that decrease risky behaviors, such as smoking, lack of exercise, and poor nutrition, and those that increase compliance with treatment regimens. Specific actions include the following:

- Emphasize in all health education curricula the prevalence, impact (both clinical and financial), and evidence-based approaches to recognition and treatment of common mental health and behavioral problems
- Create a cultural shift within health education that acknowledges that behavioral issues often complicate the risk for and management of common medical problems
- Modify required clinical experiences in behavioral care so that they focus on the primary care rather than the specialty care setting
- Provide an interprofessional, team-based educational experience in behavioral care
- Increase the focus on evidence-based health promotion and disease prevention interventions

Prescription 4: The Importance of Providing Resources

The kinds of changes to curricula, methods, and orientation necessary to prepare the primary care workforce for efficient and effective operation in the future will require adequate resources. Some institutions have already begun to adopt some of the practices required to prepare the clinicians of tomorrow for the challenges they will face; others will need to make such changes soon. Hopefully, as the health care delivery system itself changes to better support a central role for primary care, necessary modifications will become easier to adopt. One major shift must be the elimination of any stigma associated with becoming a member of the primary care workforce, as a primary care, behavioral care, or health promotion provider.

Recommendation: With increased recognition of the importance of primary care to a high-functioning health care delivery system, resources should be directed to the establishment of appropriate training settings and curricula to prepare the primary care workforce of the future. Historically, available funding has not proved adequate to accomplish this transformational change. Significant investments will be required to develop and implement the Health Education Summit vision. Education institutions should reflect this focus in their missions and initiate activities that support it. Public and private funders should back this expanded emphasis on primary and integrated care. Specific actions include the following:

- Use savings identified from population-based approaches to health care delivery (see below) to fund interdisciplinary and interprofessional educational activities
- Seek an increase in the amount of funding for research and evaluation of health profession education and training programs
- Modify the guidelines for training grants to allow higher amounts to support new curricula, interprofessional learning laboratories and facilities, and faculty training programs
- Promote modification of funding under Title VII and Title VIII of the Public Health Services Act to support interdisciplinary training
- Endorse the concept of allowing Title VII and Title VIII funding to flow directly to community-based programs
- Encourage collaboration within the U.S. Department of Health and Human Services (including but not limited to the Centers for Medicaid & Medicare Services, Health Resources and Services Administration, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and Agency for Healthcare Research and Quality) to develop new grant programs to train health care professionals in interprofessional, fully integrated approaches to primary care

Prescription 5: The Importance of Measuring Results

The types of significant modifications to both the health care delivery system and the health education system envisioned by participants in the Health Education Summit must be informed from their inception by appropriate evidence and improved over time by ongoing measurement and analysis. Continuing to develop a compelling research base for ongoing changes to the primary care sector (and the health care delivery system as a whole) is essential. Research alone, however, will be neither adequate nor sufficient to support the necessary movement to scale required for widespread positive impact on people's health status and the cost of care. Measured approaches based on engineering principles must be included in all efforts to reform and reinvent the primary care system, including but not limited to the impact of the full integration of behavioral care and health promotion/disease prevention into primary care.

Recommendation: A research agenda should be established that will inform changes to the curricula, methods, and processes of institutions of health education. Equally important is the ongoing measurement of the results of implementing these new approaches in the reformed and reinvented primary care sector. Ongoing evaluation should be employed to both identify opportunities for improvement and provide evidence for the development of new structures in the primary care sector, specifically those that support the integration of behavioral care and health promotion/disease prevention. Specific actions include the following:

- Invest in studies to quantify the potential savings associated with population-based approaches to health care delivery
- Teach industrial approaches to quality and process improvement to health education students
- Support the development and implementation of appropriate performance metrics on interprofessional and integrated care by organizations involved in measure development (e.g., National Quality Forum, National Committee on Quality Assurance, Agency for Health care Research and Quality, the Joint Commission)

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