Advisory Committee on Interdisciplinary, Community-Based Linkages

Minutes of Meeting
September 13–14, 2007

ATTENDANCE

Presiding
Thomas Cavalieri, D.O. F.A.C.O.I, F.A.C.P., Chair
Louis Coccodrilli, M.P.H., Designated Federal Official, ACICBL and Deputy Director, Division of Medicine and Dentistry
Alan Adams, D.C.
Mary Amundson, M.A.
Heather Karr-Anderson, M.P.H.
Hugh W. Bonner, Ph.D., FASAHP
Brandy Bush, Doctoral Student
Ann Bailey Bynum, Ed.D.
Cheryl A. Cameron, Ph.D., J.D.
William G. Elder, Jr., Ph.D.
Rosebud Foster, Ed.D. M.S.N.
Gordon Green, M.D., M.P.H.
Gail M. Jensen, Ph.D., PT
Karona Mason, D.P.M.
Andrea Sherman, Ph.D.
Stephen Wilson, Ph.D.

Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr) Staff, Division of Medicine and Dentistry, Area Health Education Centers Branch
Marilyn Biviano, Ph.D., Director
David Hanny, Ph.D., Program Officer
Norma Hatot, CAPT/USPHS, Program Officer
Adriana Guerra, MPH, ASPH Fellow
Vanessa Saldanha, MPH, ASPH Fellow

HRSA Administration and Other Staff
Marcia K. Brand, Ph.D., Associate Administrator, BHPr
Michael Millman, HRSA/Office of Planning and Evaluation
Richard C. Lee, HRSA/Bureau of Primary Health Care
Erica Person, HRSA/Bureau of Health Professions

Department of Health and Human Services Staff
Alicia Bradford, Office of National Coordinator

Private Citizen Representation
Angela L. Jeansonne, American Osteopathic Association
Dan Rode, American Health Information Management Association
Ann Walker-Jenkins, American Academy of Physicians Assistants
Tamara Thompson-Johnson, American Association of Colleges of Osteopathic Medicine
Thomas Elwood, Association of Schools of Allied Health Professions
Toba Pearlman, Association of Schools of Allied Health Professions
FORMAT OF MINUTES

These minutes consist of four sections:

1 SECTION I. TESTIMONY AND FINDINGS

2 A. TESTIMONY

Testimony addressed the federal efforts to encourage the adoption of Health Information Technology (HIT) and the Electronic Health Record (EHR), the implementation experiences of HIT in different settings (e.g., urban, rural, academic), and best practices associated with training providers in the use of HIT.

NOTE: Presenters alternately referred to the Electronic Medical Record (EMR) and the Electronic Health Record (EHR) when discussing an electronic version of paper patient records. For the purposes of clarity, all mentions are referred to hereafter, as the Electronic Health Record (EHR).

Opening Remarks

Thomas A. Cavalieri, DO, FACOI, FACP
Committee Chairperson

Dr. Cavalieri provided opening remarks on behalf of the ACICBL. He summarized the work of the committee to date: (1) the June meeting, which included testimony from experts on EHR and HIT and (2) the August conference call, where the findings and the beginnings of recommendations were developed. The overall purpose of this convening was to examine the remaining testimony, identify any remaining gaps, finalize the findings, and reach consensus on a set of recommendations.

Dr. Cavalieri concluded by thanking the HRSA leadership for attending the meeting. He introduced Mr. Louis Coccodrilli, who made opening comments.

REMARKS—Health Resources and Services Administration

Louis D. Coccodrilli, MPH
Designated Federal Official, ACICBL and Deputy Director, Division of Medicine and Dentistry (DMD)

Mr. Coccodrilli welcomed the members to the meeting on behalf of HRSA. He introduced Dr. Marcia Brand, Associate Administrator for the Bureau of Health Professions. Dr. Brand transitioned to the position of Associate Administrator in July of this year and continues to serve as the Director of the Office of Rural Health Policy (ORHP). She has held a number of previous positions within HRSA where she implemented the State Planning Grant Program in 1999–2000, coordinated the State Children's Health Insurance Program from 1997 to 2000, and served as deputy director in the Office of Research and Planning from 1995 to 1997. Prior to joining HRSA, Dr. Brand held faculty positions in Virginia and Pennsylvania.

Mr. Coccodrilli also introduced Dr. Marilyn Biviano, the Director of the DMD. Dr. Biviano has held several positions within HRSA, including pivotal roles in emergency preparedness, minority health, and with the Bureau of Primary Healthcare. Dr. Biviano previously served as the Director of the National Center for Health Workforce Analysis, where she produced extensive research and reports on workforce issues.

Welcome—Health Resources and Services Administration Leadership

Marcia K. Brand, PhD
Associate Administrator, BHPr

Dr. Brand expressed regrets from Dr. Elizabeth Duke, HRSA Administrator, who could not attend the meeting. Dr. Brand discussed the background and contributions of the committee members and expressed her pride in belonging to such a distinguished group.

Dr. Brand has extensive experience in interdisciplinary studies. She affirmed her strong belief in the importance of the work of the committee. As director of ORHP, she encountered many issues similar to those being addressed by this committee. ORHP has a staff of 40 people administering about $168 million in grants. In its policy-making capacity, ORHP provides counsel to the Secretary and Congress on issues related to rural health. In her experience, the ability to work between disciplines is of critical importance to rural communities.

BHPr currently faces several challenges, including (1) a recent turnover in leadership, (2) the need to strengthen partnerships with academic institutions and other HRSA programs, and (3) the need to better articulate to Congress the effectiveness of programs and initiatives. Performance management will be critical to BHPr in the future in light of the increasing interest in the health professions workforce both within and outside of HRSA. This is particularly true this year as many presidential candidates are addressing health professions workforce issues in their campaigns.

Dr. Brand commented on HIT and EMR, the focus of the meeting. She stated that these technologies will be important in the health care setting and especially for rural communities. When the workforce receives appropriate training, the use of HIT improves patient safety, enhances the quality of care, and ensures value in health care (e.g., pay for performance).

Marilyn Biviano, PhD
Director, Division of Medicine and Dentistry, BHPr

Dr. Biviano began by noting that the ACICBL and the other two BHPr advisory committees are the biggest assets in terms of intelligence and feedback on health professions issues. These three BHPr bodies include the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD), the Council on Graduate Medical Education (COGME), and the ACICBL.

Dr. Biviano stated that along with others in leadership at HRSA, she has been advocating greater collaboration between these committees. These committees often share similar issues at their meetings, such as health professions shortages and the need for medical homes. Further, the committees often discuss the value of HRSA-funded initiatives (e.g., Area Health Education Centers, and Geriatric Education Centers). Dr. Biviano stated that, as such, it makes sense for these committees to develop collaborative relationships on areas of mutual interest. The ACTPCMD meeting recently concluded its session with a recommendation that HRSA convene a collaborative conference of HRSA advisory committees in the spring of 2008. The purpose of this conference will be to align all committee outcomes along common themes such as health professions workforce, health professions training, access to care, and workforce diversity. Dr. Biviano encouraged the chair of the ACICBL and the other advisory committees to join the ACTPCMD in this recommendation.

DISCUSSION-QUESTIONS

- The numbers of medical schools and their class sizes are increasing, but this is no guarantee that the rural health professional shortage will abate. This concern highlights the need for a greater push for health professionals to serve in rural and frontier areas. A few states are beginning to

articulate that schools should be preparing students for rural practice. Schools are beginning to add rural experiences to their curricula with the idea that experience in, comfort with, and knowledge of rural areas will attract practitioners to these areas. Researchers are also starting to look at promoting social responsibility and increased community involvement in medical school training.

- Several grant programs have recently been discontinued. It is imperative that we clearly articulate to Congress the effect of these program cuts. Further, the programs need to clearly focus on their target populations. Some programs suffer because they do not have a well-defined stakeholder group to serve as advocates.
- What can be done to promote true interdisciplinary, inter-professional health care delivery teams? Health care is delivered by providers other than doctors, especially in rural areas. An important task for this committee, and committees like this, is to think about these issues.
- No consistent support exists for health professions education research, particularly for the non-physician health professions. A worthwhile topic for a future committee meeting would be to address how to find resources and how to quantify the outcomes of health professions education in a way that articulates the value of these programs beyond the number of providers.
- In the previous meeting, members addressed the shortage of allied health practitioners and faculty. A particular shortage of allied health practitioners exists in rural areas. Currently, such practitioners are not eligible for loan forgiveness or for the National Health Service Corps. Changing this eligibility would likely encourage more allied health practitioners to practice in underserved areas. Greater attention should be paid to the role of states in loan forgiveness and service-contingent programs rather than waiting for federal help.
- The ACTPCMD recommendation regarding advisory committee collaboration was very important. If the three HRSA committees collaborated on some of these important issues, their collective statement would enable them to carry more weight. Members requested copies of the recommendations from the other advisory committees for review.

Presentations

Building the Workforce for Health Information Transformation
Claire Dixon-Lee, PhD, RHIA, FAHIMA
Vice President for Education and Accreditation, American Health Information Management Association (AHIMA) and Executive Director, Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM)
Chicago, Illinois

Transition to an electronic health record (EHR) and to a national health information network (NHIN) requires a significant investment in technologies, people, and training to succeed. Building the HIT savvy workforce with the critical skills and competencies essential to develop the nationwide health information network is a pivotal part of addressing these needs. Several organizations work together to shape the field of Health Information Management (HIM). HIM is a profession that serves as a link between users (e.g., clinicians, payers, regulators, and patients-consumers) and technology (EHR and HIT).

The AHIMA has been in existence since 1928 and has more than 51,000 members nationwide. The recent emphasis has shifted from just the health record to the entire field of health information.

The Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM) has established educational, accreditation, and credentialing processes. There are currently 245 accredited academic programs in HIM. In 2006–2007, these programs had more than 14,000 students trained to understand both health records and technology. They are focused on understanding the entire health care organization rather than merely the records. Two professional credentials are available, specifically the Registered Health Information Administrator at the baccalaureate level and the Registered Health Information Technician at the associate level. e-HIM is an initiative of AHIMA representing the practice of HIM in an electronic environment.

Organizational goals include:

- promoting the migration from paper to an electronic medical records information infrastructure,
- reinventing how institutional and personal health information and medical records are managed, and
- delivering measurable cost and quality results from improved information management practices.

These goals apply to both hospitals and other environments, such as providers' offices, clinics, nursing homes, and assisted-living facilities. For students, HIM education operates in the following domains:

- data content, structure, and standards;
- privacy and security management;
- electronic health record life cycle;
- data administration and analytics;
- personal health information management;
- reimbursement, regulatory compliance, and fraud surveillance; and
- organization and management.

The AHIMA and American Medical Informatics Association (AMIA) developed a joint alliance, called the AAAC Alliance Committee, to work on issues of mutual interest. In 2005, the AAAC held a workforce summit, inviting 48 stakeholders representing the CEOs of health care organizations, government agencies, academic institutions and professional associations. This summit was built on some initiatives from outside the field that address the need for informatics. For example, the IOM "quality chasm" reports emphasized using informatics to support communication, decision making, and knowledge management and to prevent medical errors. The workforce summit produced a report that included five key workforce goals:

- jointly define a multi-year workforce research agenda;
- define basic competencies for those who use the EHR in daily work;
- engage informatics and information management education leaders to prepare a vision of the academic resources and network needed in the United States;
- seek federal and private funding to support initiatives; and
- secure legislative solutions for workforce development and to address retraining shortfalls.

The AAAC report addressed some corresponding issues, such as the shortage of faculty.

The AHIMA and AMIA collaborative education goals are to train the current workforce serving the health care industry to use HIT. These initiatives include educating the health professions educators and the entire HIM workforce. The workforce encompasses health information managers, health and medical informaticians (i.e., scholars working on research supporting the systems themselves), and HIT professionals (e.g., software engineers and computer scientists).

In 2007, the AHIMA and AMIA worked on a project to develop core competencies for the health workforce. These were core competencies that would apply to the entire health care profession, from admissions clerks to providers. The competencies, arranged along four core competency domains, included the following:

- health information literacy and skills;
- health informatics skills, using the EHR and personal health record;
- health information privacy and confidentiality; and
- health information-data technical security.

A fifth domain, fundamental computer literacy skills, was added, but the primary emphasis has been on the aforementioned areas.

The core competencies project used a task force of health professionals and other stakeholders to develop a matrix of settings and positions-roles for the core competencies. This matrix lists three kinds of settings:

1. medical care delivery sites, which include acute and ambulatory care, physician offices, military hospitals, enterprise-based outpatient clinics, long-term care facilities, community-based health care organizations, specialty care services, and school health centers;
2. other service delivery sites, such as magnetic resonance imaging facilities, pharmacy, dental clinics, behavioral health and rehabilitation centers, employers-occupational health; and
3. ancillary entities, which include public health agencies, regional information exchanges, and health record banks.

The matrix was developed for the following positions or roles in the health care system:

1. providers, such as nurses, physicians, allied healthcare providers, and pharmacists;
2. organizational staff, including IT, administrative personnel, clerical staff, and human resources; and
3. other parties, such as financial-regulatory staff, third-party payers, data analysts-providers, public health workers, consumers, educators, clinical preceptors, students, and emergency medical personnel.

The core competencies were applied across the positions and settings in the matrix to develop a list of skills and abilities required of HIT personnel. For example, for the core competency of health information literacy and skills, a staff member should be able to do the following:

- use health record data collection tools such as input screens and document templates;
- apply standard data definitions, vocabularies, terminologies, and/or relevant health care data sets such as OASIS, HEDIS, and UHDDS as used in the organization's health information systems;
- differentiate between the types and content of patient health records (such as paper-based, EHR, and personal health record);
- adhere to health record documentation requirements of external agencies and organizations such as those specified by accrediting bodies, licensure, reimbursement, and discipline-specific good practice;
- adhere to organizational health record documentation requirements, policies, and procedures; and
- ensure that documentation in the health record reflects timeliness, completeness, accuracy, appropriateness, quality, integrity, and authenticity.

The AHIMA's focus is "Quality Healthcare through Quality Information." Toward this end, AHIMA has developed an Internet-based learning lab with an array of health care technology software for HIM students. This virtual lab offers lessons and activities for student practice, instructor training support, and self-paced, instructor-led training. More than 4,000 students from 80 of the 245 programs are currently using this lab. The lab provides students with copies of popular HIT software, a shared library of lab lessons to use with the lab applications, face-to-face and Web support group training, lesson development workgroups, and a growing network of instructors.

The AHIMA has several goals for the future. The group is working toward advancing HIM standards and establishing core HIM curricular standards internationally, increasing HIM training programs internationally, and ensuring the success of EHR nationally. As an association, AHIMA is working to address the need for professional development through educational conferences, distance education, books, audio seminars, professional journals, and other electronic media. The AHIMA is also working to

provide information about HIM as a career option for young people through networking and recruiting initiatives. AHIMA is also working to develop a process for certification of EHR-HIT vendors.

DISCUSSION-QUESTIONS

- With respect to the associate, baccalaureate, and master's levels and the career-educational ladder, a different skill set exists for HIM professionals. This is currently the subject of debate within the HIM community. With an associate degree, HIM professionals are working as technicians, generalists, or medical coders. At the baccalaureate level, HIM professionals have been trained for HIM. Optimally though, management professionals hold a master's degree. Some growth has been seen in master's programs. However, at the master's level, a student has the option to enroll in a technical track (e.g., the computerized side of health information) or a managerial track. More research into HIM education is needed.
- Committee members wanted to know whether defined differences in core competencies are required at the associate, baccalaureate, and master's degree level. Dr. Dixon-Lee responded that, for the profession of HIM, there are defined competencies obtained by a job analysis at each level. The AHIMA-AMIA task force is working to develop some practice-based competencies for anyone working with health records. This task force is also working with the specific professions to relate these competencies to specific tasks. For example, nurses would take the practice-based competencies and relate them to the practice of nursing.
- The stated purposes of the EHR are to improve communication, increase efficiency, and reduce medical errors. Committee members questioned whether ongoing measurement of the EHR effectiveness exists with respect to the stated purposes. Dr. Dixon-Lee stated that ascertaining effectiveness across the board is difficult because of the great variety of different products, each with their own databases and data dictionaries. Consequently, communication is lacking across the systems. Records are not interoperable outside of individual health systems. Also, the rates of EHR adoption vary widely across settings (e.g., physician offices and ambulatory care centers).
- The virtual lab will eventually be available for all health professionals across the country. The AHIMA is working on incremental development.
- Committee members wanted to know the role of the federal government in the efforts of AHIMA. Dr. Dixon-Lee responded that currently many initiatives within AHIMA are being performed in coordination with the Secretary of the Department of Health and Human Services.
- The failure rate of large investments in HIT (e.g., when health care entities invest in HIT products that are not a good fit) is a concern for AHIMA. The whole concept of certifying vendor products is to prevent failures. If entities invest in a certified product, they should be assured through this process that it represents the best systems currently available.
- Committee members asked for more information about the strategy for integrating HIM into health professional education programs. Dr. Dixon-Lee responded that the current strategy is to bring HIM educational programs into all parts of the country and to ensure that all programs are accredited. As a profession, HIM is beginning to attract attention, which is increasing the market for HIM education programs. This does not eliminate the need for more advanced-level programs (master's and PhD degrees) and more research in HIM education. In health professions education, the most basic competency should be to understand the health professional's interaction with health information within the system (i.e., to understand how health professionals use, record, and analyze health information).

Integrating Health Information Technology into the Allied Health Professions Curricula
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Biomedical informatics is an emerging discipline that has been defined as *the study, invention, and implementation of structures and algorithms to improve communication, understanding, and management of medical information*. The end objective of biomedical informatics is the coalescing of data, knowledge,

and the tools necessary to apply that data and knowledge in the decision-making process. This focus on the ability to manipulate information is what separates biomedical informatics from other medical disciplines.

In 1999, the AMIA conceded the need to integrate informatics into health professions education and identified two areas—data mining and interdisciplinary outcome management—wherein this integration could be accomplished.

- Data mining: A growing number of health care settings use databases, thereby increasing the need for people with the skills to manipulate and extract relevant information.
- Interdisciplinary outcome management: Increasingly providers are being asked to practice evidence-based medicine and to work in interdisciplinary teams, increasing the need for new outcomes measures.

The AMIA identified several core competencies with respect to medical informatics for non-medical informatics health professionals.

- Application of a multicultural approach to outcomes: responding to the different needs of different ethnic groups. For example, certain groups respond to medications differently and, as such, there needs to be an adaptation of informatics to address these differences.
- Use of computers: understanding the basic methods of software development, software use, presentations-graphics, e-mail, Internet searches, and human-computer interactions
- Addressing issues generated by medical informatics: application of privacy and ethical issues, decision making, learning terminologies, standards, and communication methods
- Use of information: understanding user-driven clinical systems, using structured data to support evidence-based practice, learning to critically and effectively process information, and evaluating information and information technology
- Impact of technology: addressing the impact of technology on public health and how it changes the ways in which people work and live

The need for medical informatics is pervasive among every health profession, including allied health care. Allied health care accounts for myriad professions and constitutes 30% of the total health care workforce, though the estimates vary widely depending on how “allied health” is defined. These providers are involved in every aspect of patient care, but its collective voice is not often heard. Many compelling examples highlight the communication breakdowns between different allied health providers and between health and traditional allied health providers.

As the EHR is supposed to be a shared resource representing the total health care experience, all providers involved in that care should know how to use it. For example, oral health is considered a reliable predictor of overall health status. A necessary step is to ensure that oral health information is shared with the health care team. Consequently, dentists and allied dental professionals must have informatics skills that commensurate with their participation in the provision of health care. Another example is dieticians, who provide nutritional counseling for both preventive care and for specific disease and chronic disease management. Dieticians should have the informatics skills necessary to ensure that other providers understand a patient's risk for drug and food interactions. Dieticians should ensure that the nutritional history and status are included in the EHR. If these providers are not taught how to use an EHR, the health care system’s ability to respond in cases of emergencies (e.g., biomedical or bioterrorism threats) will be seriously hampered.

Pressure for practice outcomes measurement is increasing: If a provider cannot use the technology, these outcomes cannot be evaluated.

The movement toward patient-centered care means that more patients are coming to the provider with health information obtained from the Web. In these cases, providers need to be able to respond with their own information or an interpretation of what has been presented by the patients.

At the University of Me dicine and Dentistry of New Jersey, the School of Health Related Professions has established a task force to study how to integrate informatics into the undergraduate curricula of its allied health programs. This has been a difficult and time-consuming task. The task force began by working to achieve consensus on the meaning of health informatics. The task force is also grappling with computer literacy issues. Regional accreditation agencies increasingly require proof of outcomes specific to the graduate's computer literacy at the undergraduate and higher levels. The task force has begun the development of basic computer literacy skills for their students.

Students should be able to:

- access the Internet for research pertinent to courses of study;
- use software programs for presentations or papers;
- analyze and critically compare information sets;
- store, retrieve, and synthesize pertinent informational data; and
- demonstrate ethical behaviors in the use of electronic data.

For allied health students, the needs go beyond these skills. Allied health students must understand the basic underpinnings of informatics as a tool for enhanced patient care. Students should be able to manipulate data to test basic hypotheses.

DISCUSSION-QUESTIONS

- The Committee asked about the use of algorithms in teaching and practice. Dr. Gibson stated that the use of algorithms is taught to graduate level students so that they can learn to mathematically manipulate data. He noted that the use of algorithms is overall too large a topic to teach at the associate's level but that these students are offered limited use.
- The Committee requested additional information on the integration of informatics into the providers practice (i.e., how providers can use data as a tool but not to the extent that it is exclusive). Dr. Gibson responded that some elements cannot at this time be integrated into data fields. The need exists for a means to capture this type of information into the medical record because it is an important element of patient-centered care. However, no one should ever discount the impact of human interaction on health outcomes.
- The Committee stated that the different professions should be pulling together to identify and address other barriers to the development of a means of teaching common competencies to the entire health professional student body. Some barriers are based on age and profession (e.g., physical therapy does not lend itself to being taught online). However, the committee believes that when one profession embraces it, the others will eventually follow.
- The Committee requested additional information on what the federal role could be in helping with this initiative. One suggestion was formation of a multidisciplinary advisory panel. The Committee asked what it would take to try to bring the major accrediting bodies together to agree on the extent to which educational institutions ought to incorporate EHR procedures and skills in the curricula. Dr. Gibson stated that, currently, the Association of Schools of Allied Health Professions is working with a number of accrediting agencies to obtain some agreement on standardizing language across some of the professions. Currently, two meetings with deans of health professions schools and accrediting bodies are working to reach consensus.
- Regional and national accreditors are operational in terms of carrying out the requirements requested by the professions. One challenge rests with determining how to address the needs of the profession within the manner in which things are taught.

Implementation of Electronic Health Records in Health Centers

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Associate Director, Rochester Center to Improve Communication in Healthcare
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Community health centers (CHCs) serve roughly 16 million persons (i.e., one of every four persons in the United States living in poverty). They have a mission to provide health care to the underserved and function as a primary care safety net. The typical CHC patient lives in poverty and has low education, literacy and health literacy levels. They are more likely to be members of racial and ethnic minority groups and, in many cases, have limited English proficiency. Typical patients have multiple health problems. Often, patients present with three or four medical problems embedded within a milieu of complex psychosocial problems. Clinicians deal with a qualitative difference in the level of complexity.

Data and documentation are huge issues for CHCs using paper records. Owing to the fact that the CHC patient base is so complex, charts can have multiple volumes, making it very difficult to find paper records. This can mean that patients are sometimes subjected to unnecessary retesting if records cannot be located. The volume of paper can also be a safety issue, as information about a patient may be buried in a chart that the provider has not seen.

Show rate for visits is another major issue for CHCs. Overall, only 50% to 70% of patients confirm their appointments. Some patients may be absent 30% to 50% of the time. As CHCs receive visit-based reimbursements, they tend to overbook appointments to compensate for no-shows. This overbooking can lead, at times, to very rushed visits during peak patient volumes.

CHCs often experience fiscal difficulty. Half the time, CHC expenses exceed their revenues and as a consequence, limited budgetary discretion exists to address the various needs. Clinician turnover is a serious problem. The average stay for a CHC clinician is about three years. The level of turnover and change creates a certain amount of disruption that can be challenging in terms of meeting the needs of patients. The turnover can be attributed to the pace of work in CHCs, which is consistently heavy and stressful. Many clinicians who are retained end up working part-time because full-time work is too demanding to maintain over a long period.

Fundamentally, CHCs are faced with the same situation that disadvantaged patients encounter. Patients with the greatest biomedical morbidity and the greatest need for health care, often have the least ability to pay for it. The same is true for CHCs, as they serve an enormously needy population, but oftentimes do not have the resources and wherewithal to fully meet their needs. Despite many challenges, CHCs serve an essential function in the health care safety net. They provide medical homes for patients and employ clinicians committed to making a difference to their patients. The focus within CHCs is fundamentally interdisciplinary (i.e., clinicians and other allied health providers work in one site with the same patients). The major strength of this interdisciplinary focus is the ability to adapt to changes in the broader environment, based on the changing needs of the patients.

CHCs have limited resources and limited excess capital to devote to HIT. However, HIT offers many advantages for CHCs. HIT can enhance data retrieval by making it easier to obtain data about patients who are multifaceted with complex charts. HIT offers the ability to provide population-based care (i.e., gathering data on the health status and needs of the population through condition registries and similar processes). HIT can provide decision support at the point of care, providing integrated and relevant information at the time of service. HIT can improve efficiency in the manner in which primary care is delivered and, as a consequence, can reduce medical errors. HIT makes it easier to work within the current reimbursement system and to “up-code” procedures to maximize reimbursement. This is an incentive to use HIT for private practice and CHCs supported by private payers. CHCs that are not supported through private insurance are not going to gain much through up-coding. The implementation

of pay for performance will motivate health care entities to adopt HIT because those without it will not be able to compete as effectively.

HIT is not a magic bullet: It has several limitations. Prior to implementation, a very careful examination is needed to determine how the practice is going to be redesigned as part of the use of HIT. Some evidence suggests that when HIT is used in CHCs, it is more often used to support quality improvement as opposed to other settings. All providers face changing their focus to population health. The core mission of CHCs is to provide population care to their entire communities. However, few EHRs provide sufficient registry functions to do this alone, though many do have connectivity potential with other systems. The major issue is tracking. Without a registry, data analysis is needed to determine patients at risk for conditions and to actively work to bring them in. Once patients with the disease are identified, it is necessary to track their progress through recommended treatments and tests. Each step of a recommended treatment is a point at which the patient can get lost. Registries should be made to connect with EHRs so duplicate information is not being created and entered.

Capital costs present the biggest barrier for the use of HIT. CHCs do not have the capital available and, in many instances, many cannot borrow it. A recent Health Affairs study shows that only 13% of CHCs have EHRs that meet minimum federal standards. Several costs come into play, including implementation and that of downturn in patient volume that comes with EHR implementation. Such revenue loss can be critical to CHCs.

HIT enables team-based care, but it requires a major change, commitment, and dialogue on the part of all members of the team. Implementing EHRs is stressful for providers, particularly in CHCs wherein the work is already challenging. As such, planning is very important. Equally important, potential unintended consequences must be addressed. If the system is not well planned, not well designed, or does not fit the culture and needs of that particular setting, the consequences can be disastrous.

Though the need for HIT in CHCs is significant, the risks of acquiring and implementing HIT can also be considerable. Oftentimes, there is very limited expertise available at the CHCs. Approximately 40% of the CHCs do not have a director of IT. Overall, CHCs possess fewer reserves, in both human and economic capital. Their costs of recruitment and retention are enormous, especially in primary care and general internal medicine, where the numbers of new graduates have been declining in recent years. CHCs have the most trouble attracting primary care clinicians. If clinicians leave, a year may elapse before they can be replaced. HIT does not offer a very good return on investment for CHCs, as they are not going to recapture capital, implementation, and planning costs. Though potential savings are possible in terms of reducing medical records staff and transcription, the ongoing costs of training staff and of system maintenance will have to be covered. Oftentimes, people working in CHCs are not particularly HIT-savvy and may have unrealistic expectations of what EHRs can do. A misalignment of costs and benefits occurs. HIT can reduce overall health care costs, hospitalizations, unnecessary prescriptions, and adverse drug events, but, due to the existing reimbursement methods, the CHCs are not going to capture these savings.

The implementation of HIT presents an enormous opportunity for CHCs to learn from one another. One of the great strengths of the Health Disparities Collaborative is to bring CHCs together to share their experiences. The collaborative should be used as a model for implementing HIT in CHCs.

Keeping abreast with advances in HIT requires a dedicated staff person who is able to translate HIT into clinical practice and to adapt vendor systems to the needs of the practice. There should be a way to sort out clinical relevant information. The same is true with respect to decision support. Staff members will need to redesign the workflow, the exchange of information, and the way in which tasks are done. EHR now provides the potential for patients to actually complete information before their visit, but to do so will require change in the manner in which business is currently conducted. This will generate a huge need to train the trainer within the CHCs. Training should begin at the top with the CEO in terms of understanding the issues but will eventually need to be conducted at all levels. It is important to note that some staff

might find this change more difficult than others. Age may be a consideration along with the numbers of non-technical staff persons.

DISCUSSION-QUESTIONS

- This Committee asked how to select the systems, implementation, and redesign, while making the workflow happen in an efficient fashion. The Committee questioned whether the National Association of Community Health Centers (NACHC) is working to develop a more global CHC approach to these kinds of issues. Dr. Fiscella stated that the NACHC is convening groups and conducting trainings at annual meetings. Additionally, state-level organizations are developing consortia to buy a single EHR and to work collaboratively in the implementation process.
- The Committee inquired regarding the roles of HRSA and ACICBL with developing these capabilities. Dr. Fiscella responded that both entities could help by thinking of what is needed in terms of implementing a workflow redesign. In his experience, one good practice is having key members of the team examine the schedule and identify some of the key issues. Providing some initial consultation, using the trainer model, and bringing other CHCs to share their experiences are additional positive steps.
- The Committee asked about training recommendations, (e.g., type, need, and delivery methods). Dr. Fiscella stated that this is one area affording a potential for a great deal of training and coordination. The Department of Veterans Affairs has a difficult population similar to CHCs, but has had remarkable success in transforming its quality of care by leveraging HIT. However, CHCs are different because they comprise thousands of independently operated health centers with their own board of directors who function relatively autonomously. Coordination and collaboration between CHCs are needed. A consortium of CHCs could pool resources and expertise, develop economies of scale, and learn from one another to improve the process. A substantive need exists for coordination of the adoption and implementation of HIT within CHCs.
- The Committee questioned whether trainees in CHCs should be learning to use HIT or whether they should come to the CHCs with this knowledge. Dr. Fiscella suggested the ideal situation would result in trainees having some basic HIT training. The problem with training in the CHCs is the huge non-recoverable cost to the health center. Ideally, the students could come in and even assist the clinicians there. Such activities would significantly increase the value of the students to the health centers.
- The Committee asked about the role of the health profession schools in terms of being able to assist in the planning phases with the CHCs to develop the requisite skill training. Dr. Fiscella stated that one possibility would be to have the medical schools, the health profession schools, and the CHCs join in a collaborative relationship. Such an initiative would allow the schools to come in early to assist in developing the skills so that when students get to the health center, they would have a set of basic competencies to adjust to HIT. The competencies in informatics are critical. Understanding the functionalities of the different systems and training in how to integrate this technology into quality improvement are essential. Further, a significant opportunity arises for collaboration in terms of HIT between medical centers and CHCs. One possibility would be for the CHCs to be able to access HIT through the medical center.

Health Resources and Services Administration

Louis D. Coccodrilli, MPH
Designated Federal Official, ACICBL, and Deputy Director, DMD

Mr. Coccodrilli provided an update on what HRSA programs had been funded for this coming fiscal year. In terms of the allied health programs, 4 chiropractic demonstration projects and 18 graduate psychology education programs were funded. Both were funded for $1.8 million. The allied health special projects were not funded this year.

Geriatric Education Centers (GECs) were funded, but the exact numbers are not available yet. The award amount will likely be similar to the last year of funding. Additionally, Geriatric Academic Career Awards (GACA) were given to 105 individuals this year.

Approximately $27 million was allocated to Area Health Education Centers (AHECs). The 13 Basic Programs, funded at $12 million, included 3 new programs. These new awards included a program in Montana at the School of Nursing and two new centers in Iowa (a school of nursing and a school of osteopathic medicine). The 40 model AHECs, which are existing programs more dependent on state funding, received $14.5 million.

In terms of faculty development, aside from the GACA awards, National Research Service Awards (NRSA) are usually given to faculty at medical schools. Some discussion continues about whether these will be continued, as these funds are provided by the National Institutes of Health for HRSA to administer. When the GECs were designed, a large faculty development component existed in their mission in that they were meant to develop health professions faculty. Currently, the emphasis is less on faculty development and more on training of health professionals. The last two funding cycles for the GECs gave priority to applications that addressed faculty development, requiring 40 hours in the last cycle. In the GECs, two programs are focused on training individuals: the GACA and Geriatric Training for Physicians, Dentists, and Behavioral-Mental Health. The GACA is a three-year direct award to an individual faculty member; it pays salary and other aspects of faculty development with the goal of developing primarily educators in geriatrics. The Geriatric Training for Faculty in Medicine, Dentistry, and Behavioral-Mental Health is for individuals who have essentially finished training in medical school and transition to a residency either in family medicine, internal medicine, psychiatry, or dentistry. The program trains them to be academics in the field of geriatrics. After training, they are not necessarily prepared to be faculty leaders and may apply for a GACA award to develop their leadership skills.

DISCUSSION-QUESTIONS

- The challenge in the Geriatrics Training for Physicians, Dentists, and Behavioral-Mental Health is to get a good mix of professionals. The Committee requested information on the types of providers funded by this program.
- The recently unfunded Quentin Burdick program had a faculty development requirement to interest students in careers in aging and to foster faculty development in rural areas. However, the latter did not have a geriatrics focus.
- The Committee questioned whether Congress truly understood the need for funding to encourage development among allied health care professions. A number of different health professions are receiving limited support from the federal level for development even though they deliver a great deal of care in rural communities. Mr. Coccodrilli mentioned that primary care appropriations for family medicine, dentistry, and pediatrics may address some of this need for training dentists but that otherwise no new allied health dollars are available. The challenge for allied health is to look across a wide range of disciplines to determine the needs and priorities, and to present them in a way that state and federal funders can best understand. Allied health needs to make itself more attractive to people on the Hill by attracting advocates. For example, the Department of Labor can provide information on shortages of allied health professionals in a way that showcases the key areas of need with respect to allied health providers.

3 SECTION II. ADVISORY COMMITTEE FINDINGS

Findings

The Committee identified a number of findings based on the presentations before the committee.

The AHIMA and AMIA are engaged in developing basic HIT competencies for the health care workforce. Participation of other disciplines is needed in the development of competencies. The AHIMA and AMIA

core competencies will be delivered within the year, raising the need for giving thought specific to identifying strategies to disseminate their findings to a larger audience.

There is a recognized need to consider the importance of outcome performance measurement and evidence-based practices with respect to HIT.

Appropriate educational research is lacking, as is sufficient research in evidence-based practice and an adequate amount of research across the health care disciplines. Education research helps to discover and measure effectiveness. Some research exists, but much of it focuses on physicians and nurses. More research needs to be done in the different health professions. Further, the different health professions need to communicate their findings to a greater extent.

Teamwork, along with an interdisciplinary approach will be needed to develop a HIT program that includes the successful implementation of HER.

Overall, 9.2% of ambulatory care settings, 13% of CHCs, and 11% of hospitals have implemented EHRs. CHCs and other training centers may not have adequate resources available to train students without additional support. Current EHR systems lack sufficient universality to enable training programs to generalize their use to actual practice settings. If EHRs were more consistent, training programs could adopt them to serve as training platforms, and students would be more prepared to use EHRs in their actual practices.

Potential limitations to HIT need to be taken into account, such as costs, need for staff training, and issues on how to implement HIT into a profession that depends so extensively on human interactions. Remaining focused on the human aspect of care will help to ameliorate some of the negatives that HIT brings to the provider-patient interaction.

There is a need to address public health effects (i.e., the unknown consequences of using HIT) and, potentially, to evaluate the ergonomic aspects of HIT use, such as repetitive stress injuries.

Specific ways must be developed to integrate interdisciplinary training, including better defining of the role of allied health. When funding is scarce, the bulk of resources are usually allocated to primary care. Allied health is at a disadvantage because the role of these providers in the health care community is not adequately understood.

EHR training will assist in the training of health professionals for emergency preparedness, such as bioterrorism events.

Faculty development across the disciplines is necessary to teach HIT. This faculty development focus requires some effort to determine the existing competencies and to decipher the gaps.

Accreditation standards should be applied across the professions with respect to the current use of HIT as well as the recommendation of competencies for inclusion in the curriculum of the health professions.

EHRs need to be able to capture patients' attitudes, affects, and methods of communicating in order to deliver patient-centered care. Patient communications should be recorded with the fullest amount of information available to assist health professionals in making appropriate decisions.

Staff members should be dually trained in both the health professions and HIT. However, not all facilities are going to have applicable persons on staff. Further, clinicians need to participate in the development of the systems so that HIT can best fit the specific circumstances under which it will be used.

There has been great concern expressed about the lack of interoperability between HIT systems. This should trigger an enhanced effort to work to increase communication between the systems. This will become an issue of greater importance, as more health care entities adopt HIT.

Creative ways are needed to provide faculty development opportunities in the health professions. This could be accomplished through independent new programs or through enhancements of existing programs. The salary support structure in geriatric education could be used as a model. Development should target the growth of the next generation of health professionals in this area, which necessitates greater development of faculty geared toward HIT. Masters prepared teachers need to be developed from the current practicing physicians (through salary support tied to the training certificate). More allied health professionals need to be prepared to teach HIT. The need also exists for incorporating professions other than allied health (e.g., psychology, chiropractic, and podiatry) as described in Title VII and VIII legislation. Some existing online programs have had success in retraining faculty members, and could be applied to this initiative.

The National Health Service Corps should be made available to allied health graduates.

Safety net providers need assistance in implementing these systems. While the VA was able to reallocate their resources for this type of training, the CHCs are independent agencies and have fewer resources available for such initiatives.

Addressing ethical and privacy issues is important with respect to the adoption of EHRs. A concerted effort should be made to address these issues and to learn more from existing health systems that have found solutions to privacy and ethical issues. More research needs to be done to identify solutions.

More collaborative work should be conducted with the other Advisory Committees (e.g., the Spring 2008 meeting).

4 SECTION III. ADVISORY COMMITTEE RECOMMENDATIONS

Recognizing the need for a set of core competencies, the ACICBL recommends that the HRSA convene a "best practices" conference that features programs-curricula designed to train current and future providers across the health disciplines in the core HIT-EHR competencies. Best practices should include program-curricula that address cultural, generational, geographic, and disciplinary differences.

Discussion: This recommendation reiterates a recommendation from the Fourth Annual Report. The Committee wishes to emphasize the importance of this issue by restating it as the first recommendation in this report. This conference should include input from education associations.

The ACICBL recommends that the HRSA collaborate with the Association of Schools of Allied Health Professions and the National Network for Health Professions Educators to stimulate integration of HIT and EHRs into didactic curricula ensuring that the components taught fulfill the basic competencies needed to operate a variety of EHR systems.

Discussion: The goal of this recommendation is to ensure that students have a baseline understanding before entering the clinical component of their education or training. The type of collaboration would require contracting with one of these associations to create a curriculum document addressing competencies for HIT. The HRSA should be sensitive to the needs of the whole range of constituency groups represented by the stakeholders. With regard to curricular development, the HRSA more often defers to the associations and to the schools themselves. Most often, the HRSA's influence is in the form of incentives or directions for grant program applications.

The ACICBL recommends that support be provided by the HRSA to CHCs and other safety net providers in the development and implementation of HIT systems accommodating the special services provided by these health systems through the appointment and support of regional resource centers in providing technical assistance in the process.

Discussion: The Committee should consider adding language about workforce training. The Office for the Advancement of Tele-Health, through the HRSA, has set up regional resource centers around the country to provide the expertise needed for tele-health technologies. A similar model could be used in this endeavor.

The ACICBL recommends that the Office of the National Coordinator (ONC) for Health Information Technology and the HRSA's Office of Information Technology, in their efforts to promote the adoption and effective use of HIT, identify, document, and disseminate lessons learned and best practices regarding the training and adoption of HIT among health care professionals with a particular focus on interdisciplinary training.

Discussion: Projects funded under programs wherein HIT is featured on the grant training objective employ IT systems that offer universal user interface and interoperability with regional systems. The ONC, the Secretary, and Centers for Medicare and Medicaid Services (CMS) have already incorporated similar language into any federal program requiring that, if there is a Certification Commission for Healthcare Information Technology (CCHIT) approval of a system, it has to be used for any program that is using federal funds. However, CCHIT is only beginning the process of looking at regional health networks.

The ACICBL recommends that training competencies for the health care workforce embrace a patient-centered care approach in the use of an EHR with a focus on continuity of care (medical home), communication, culture throughout the life cycle, and ethical-privacy issues associated with HIT.

Discussion: An important factor to embrace is the concept of respect for human dignity that is central to patient-centered care; it is a basic premise in ethical codes. Equally important is to ensure the correct interpretation of continuity of care. The concern is that EHRs are seen as providing the continuity rather than continuity being the relationship between providers and their patients. Continuity can also be viewed as communications between different providers about their patients, particularly with respect to geriatrics.

It is recommended that Secretary and Congress should appropriate funding for health professions workforce training (students, residents, and practicing providers using existing Title VII Section 751, 752, 753, 754 and 755 programs) in the use of emerging HIT-EHR systems in interdisciplinary, community-based, and underserved areas. This is imperative to implement these systems to help to (1) improve quality of care, (2) improve care to underserved populations, (3) increase patient safety, (4) decrease health care errors, and (5) reduce the digital divide in the delivery system.

Discussion: Does HIT actually reduce health disparities? One aspect of disparities that can be addressed is in underinsured and uninsured patients in CHCs. Those patients sometimes come into the system with multiple chronic conditions that HIT can help providers manage. The data clearly show that individuals who have difficulty gaining access to care do receive some care but that it is episodic. EHR can increase the communication between episodes, so that there is more likely to be follow-up and enhancement in the quality of care. Note: The wording of the recommendation was changed to "improve care to underserved populations."

The ACICBL recommends that the Secretary and Congress authorize the HRSA to create a new interdisciplinary faculty development program for all faculty in all Title VII and Title VIII areas in which there is no current HRSA faculty development available. The Secretary and the Congress should authorize and fund institutions with accredited health professions programs to meet the costs of projects to (1) plan and develop interdisciplinary faculty development programs to

include post-doctoral fellowships, scholarships, teaching and service training for junior faculty, and mentoring and retention support through demonstration models; and (2) provide financial assistance to fellows and faculty enrolled in such programs

Discussion: Expertise in the clinical application and education of HIT could be one of the aspects of this faculty development program. One challenge of this Committee with respect to this recommendation is the fact that some categories of training programs have support in these areas and some do not. For example, to include geriatrics may be redundant because geriatrics already has faculty development programs, so it may be more appropriate to focus on allied health or other disciplines. Some question concerned whether community-based programs and community preceptors should be included. The Committee decided that this should be made into a separate recommendation. Some discussion centered on whether HIT should be the focus of this recommendation or whether other issues, such as cultural development, should be mentioned. It was decided that emphasizing HIT over the greater system of health care would cloud the issue. Allied health has many needs with respect to faculty development, and emphasizing HIT solely could shortchange the other needs. HIT issues are going to be a major concern for every single grantee, regardless of the focus of that grantee. Therefore, HIT should be a core part of every single Title VII/VIII grantee.

The ACICBL recommends funding of demonstration programs to support the development of interdisciplinary teams focusing on HIT-EHR education and training in CHCs and other ambulatory care training sites, working collaboratively with academic health centers and health professions education programs.

Discussion: There was debate about the focus of rural health issues in a recommendation; the consensus was to address rural health in a future report. The presence of HIT-/EHR can be considered a retention tool for CHCs, as it makes them more competitive in the job market.

The ACICBL recommends that the Agency for Healthcare Research and Quality be charged with providing research funding for studies of issues related to the adoption and implementation of HIT systems in health care settings. Potential research topics could focus on (1) barriers in the health care workforce (level of knowledge, age of workers, quality of leadership) that impair the adoption of HIT; (2) socio-cultural factors in implementation of EHR that affect the quality of patient care; (3) the relationship between HIT implementation and the quality of health care (reduced medical errors, more efficient care); and (4) cost benefit analyses, training, and time factors related to adoption and implementation of HIT-EHR in health care facilities, including ambulatory care and CHCs.

Discussion: Some consideration should be given to conducting a literature review regarding the potential obstacles of implementing EHR, including cost, training, and time. The Committee recommended that it be completed with respect to health care facilities of large, medium, and small size. Those results should be available for administrators to review when considering the implementation of an EHR system in their facilities.

The ACICBL recommends the expansion and appropriation of adequate resources for the inclusion of allied health professionals documented by the Department of Labor, Bureau of Labor Statistics, and the VA as part of the workforce shortage in the National Health Service Corps Scholarship and the loan repayment program. There should be eligibility within these programs for health professionals with a degree from a higher educational institution.

Discussion: This supports the recommendations in the Fourth Annual Report specific to identifying the critical nature of workforce shortages. The allied health professions are so numerous and varied. If this recommendation is accepted, it would generate a further need to determine applicability.

In response to the growing shortage of allied health faculty, the ACICBL recommends that the Secretary and Congress authorize and fund a loan repayment program, similar to the Title VIII programs, for those earning advanced degrees.

Discussion: This is critical to address the looming faculty shortage. The emphasis should be on building a case for the importance of the impending shortage of allied health professionals. This is not limited to professionals with doctoral degrees; it could also apply to master's-degreed faculty with clinical experience.

The ACICBL recommends that the HRSA initiatives (Office of National Coordinator and Office of HIT) that support the development and adoption of HIT by safety net providers and the training of current and future health care providers should include outcomes evaluation processes that provide evidence of successes and limitations.

Discussion: Committee members felt that a focus on outcomes research was critically important, particularly in health care facilities where staff lack the time and training to do this type of research.

Following up on the recommendations made in the Fourth and Fifth Annual Reports, and the Advisory Committee on Training in Primary Care Medicine and Dentistry resolution, the ACICBL recommends that the HRSA convene a collaborative conference of the four Title VII and Title VIII Bureau Advisory Committees in the Spring of 2008 for the alignment of work products along common themes, such as health professions workforce, health professions training, access to care, and workforce diversification.

Discussion: The Committee resolved to endorse this recommendation and to submit a letter to the HRSA Administrator, Dr. Elizabeth Duke specifically requesting this meeting.

The Secretary and Congress should encourage Title VII Interdisciplinary, Community-Based Training Grant Programs to enhance the use of information technology, tele-education, and tele-health in education and training strategies to reach and retain health care professionals in remote and underserved areas.

Discussion: This is a restatement of recommendation Number 15 from the Fourth Annual Report.

5 SECTION IV. ADVISORY COMMITTEE BUSINESS

- Approval of Minutes
- Introduction of New Chair and Vice Chair
- Committee Membership
- Topics for Future Meetings
- Adjournment

Approval of Minutes

The Advisory Committee unanimously approved the minutes from the July 2007 meeting and the August 2007 conference call.

Introduction of New Chair and Vice Chair

The Committee welcomed new Chair, Stephen Wilson, PhD, and new Vice Chair, Gail M. Jensen, PhD, PT. Additionally, Dr. Wilson, PhD will chair the writing subcommittee, while Dr. Andrea Sherman, PhD will chair the planning subcommittee.

Committee Membership

The terms of the following members will conclude as of September 30, 2007: Thomas Cavalieri, DO; Tony Iacopino, DMD, PhD; Mary Amundson, MA; Hugh Bonner, PhD; Cheryl Cameron, PhD, JD; Susan Charette, MD; William Elder, PhD; Rosebud Foster, EdD, MSN; Gordon Green, MD, MPH; Karona Mason-Kemp, DPM; and Rose Yuhos, RN. The Committee acknowledged these members for their excellent service and thanked them for their hard work. Currently, the nomination process for new members is moving forward. HRSA staff is reviewing 10 nominees as part of a nomination package that will be forwarded for review and confirmation by the Secretary. The next meeting is scheduled for April or May of next year. The Committee members currently on the writing committee agreed to provide their input for the sake of continuity, so that the current report can be completed.

One member expressed concern about committee members missing multiple meetings and asked whether about guidelines or warnings for frequent absentees. The Committee asked for input from the members on some specific recommendations to address these issues with the feedback pending.

Topics for Future Meetings

The Committee suggested several potential topics future meetings:

- The relationship between HRSA programs and public health;
- Faculty and workforce development, with a special emphasis on the issue of faculty shortages;
- Diversity in the health professions;
- Care-giving;
- Interdisciplinary education, training, and practice within medical homes; and
- Leadership training in team-based care.

Some discussion among the members revolved around coordinating meeting topics across the four HRSA committees. Committee members debated whether the focus should be on topics of the combined committee meetings or, alternately, on the topics of the individual committee meetings. Committee members resolved to review the upcoming meeting topics of the other committees in an attempt to coordinate all discussions around similar topics. Another suggestion was to review the meeting minutes of the other two committees to get ideas about topics of mutual interest. In its Fifth Annual report, the ACICBL recommended that all HRSA committees address issues of interdisciplinary education and training. One member suggested reviewing the last five ACICBL annual reports to see what topics have been covered in the past and what recommendations have been followed to inform the selection of new topics or to determine past topics that need revisiting. The Committee agreed and resolved to review previous reports before deciding on a topic for the upcoming meetings, particularly in light of potential topics that may be raised during the cross-committee meeting.

Questions were raised about a potential cross-committee meeting and whether it would replace, or be an addition to, individual committee meetings. Mr. Coccodrilli asked for feedback from committee members. Several members felt that, since there will be so many new committee members, having a longer meeting would be good, with the individual committee meeting taking place immediately before the cross-committee meeting. The cross-committee meeting should be at least one day long to be productive. Some concern was also expressed about the hotel in which the meeting was located. The issue will be addressed and revisited next time.

Adjournment

The committee members had several concluding comments.

- It is important that new committee members be mentored by existing members, especially those who will work with the writing subcommittee.
- One member recommended having a facilitator at the next meeting to address logistical issues so that the chairs will not have to address those issues.
- Members acknowledged the excellent contribution of HRSA staff in facilitating the committee's work.

After this discussion, the committee adjourned.