Advisory Committee on Interdisciplinary, Community-Based Linkages

Healthcare Workforce Issues in Rural America

Minutes of Meeting
July 16 – 17, 2008 (Combined)

ATTENDANCE

ACICBL Members
Stephen Wilson, Ph.D., Chairperson
Louis D. Coccodrilli, MPH, Designated Federal Official, ACICBL and Acting Director, Division of Diversity and Interdisciplinary Education
Alan Adams, DC
Robert J. Alpino, MIA
Heather Karr-Anderson, MPH
Brandy Bush, OTD, OTR, CLVT
Ann Bailey Bynum, EdD
Jane Hamel-Lambert, PhD, MBA
Beth D. Jarrett, DPM
Gail M. Jensen, PhD, PT
Linda J. Kanzleiter, MPsSc, DEd
Barbara N. Logan, PhD, MA, MSN
David H. Perrin, PhD, ATC
Elyse A. Perweiler, RN, MA, MPP
Ronald R. Rozensky, PhD, ABPP
Steven R. Shelton, MBA, PA-C
Andrea Sherman, PhD
Laurie Wylie, MA, RN, SNP

HRSA, Bureau of Health Professions (BHPr) Staff
Norma J. Hatot, CAPT/USPHS, Acting Chief, Area Health Education Centers Branch
Daniel Mareck, MD, Chief Medical Officer/Office of the Associate Administrator
Marie G. Ulysse, HRSA Scholar

HRSA Administration and Other Staff
William Melling, Office of Legislation
Caroline Cochran, Office of Rural Health Policy (ORHP)
Michelle Goodman, ORHP
Jennifer L. Chang, ORHP

Private Citizen Representation
Claire Wilson, Inside Policy Research
Ben Ables, Children's Defense Fund

FORMAT OF MINUTES

These minutes consist of five sections:

I. Opening Remarks
II. Review of May 2008 Meeting Minutes
III. Review of Draft Recommendations and Findings

IV. Summary of Presentations
V. Committee Business

SECTION I. OPENING REMARKS

Dr. Stephen Wilson, Committee Chairperson and Mr. Lou Coccodrilli, Designated Federal Official welcomed committee members, staff, and public guests. Dr. Wilson summarized his expectations for the two days of meetings by indicating that this would be an opportunity to interact with experts on rural health issues to include the HRSA Office of Rural Health Policy. During his review of the agenda, he indicated that the presentation from Dr. Gary Hart, initially scheduled for Wednesday, July 17, 2008 would be postponed until the September 2008 meeting. Opening remarks concluded with Mr. Coccodrilli's review of the rationale for selecting the experts confirmed for this meeting and a review of the upcoming September 2008 meeting.

SECTION II. REVIEW OF MAY 2008 MEETING MINUTES

The combined May 2008 meeting minutes were reviewed and approved with three minor corrections – page 1, under HRSA Administration and other staff, change spelling of Person to Pearson; page 2, under Discussion – Questions, line 7 – change perspective to prospective, and page 3, paragraph one, line 6– change tract to track. As a part of the review, the discussion centered on the need to finalize the recommendations and findings associated with the seventh annual report. Dr. Wilson and Mr. Coccodrilli summarized their discussion with Dr. Brand, Associate Administrator, BHPr, who suggested a review of the recommendations with the goals of making them more specific and measurable. The Committee concluded that recommendations should be targeted with identified responsible entities and the specific actions required.

SECTION III: REVIEW OF CURRENT DRAFT RECOMMENDATIONS AND FINDINGS FOR THE EIGHTH ANNUAL REPORT

Recommendation #1 – HRSA should approve adjustments in the level of productivity for clinicians who serve as health professional preceptors in health centers and Area Health Education Centers to reflect clinical teaching responsibilities.

REVISION – The Secretary shall direct HRSA to approve changes in productivity levels when providers at Community Health Centers are performing as clinical preceptors for health professions students. (Revision provided by Ms. Laurie Wylie.)

- Ms. Laurie Wylie revised this recommendation and will work further with Dr. Linda Kanzleiter to refine it for discussion during the September 2008 meeting of the ACICBL.
- Ms. Wylie provided substantial background information and rationale/justification.

Recommendation #2 – Increase research on programs exposing underrepresented populations to health careers as a means to increase retention of providers in rural areas. Rural in and rural-out programs should continue to recruit from rural areas as these students tend to practice in rural areas. After considerable discussion, the Committee decided to delete this recommendation.

Recommendation #3 – HRSA should provide grants to expand cross training, credentialing opportunities, and core competencies across disciplines. This expansion for allied health professionals in rural health systems would positively impact provider roles without significant increases in employer costs.

REVISION – In its 2003 report, *Health Professions Education: A Bridge to Quality*, the Institute of Medicine identified five core areas in which health professionals should develop and maintain

proficiency. These were: delivering patient-centered care, working as part of interdisciplinary teams, practicing evidence-based medicine, focusing on quality improvement and using information technology. Proficiency in these five areas may be even more critical in the rural health care environment than in urban areas due to the resource constraints common in the rural health care environment. HRSA should, through its Office of Rural Health Care Policy, add these topics to its research agenda in its Rural Health Research Centers Program and provide funding for demonstration projects that attempt to implement these proficiencies. In addition, HRSA should, through its Critical Access Hospital program and its Community Health Centers programs, provide funding for demonstration projects that attempt to implement these proficiencies. Finally, HRSA should provide funding preferences in all of its rural health grant programs when a prospective grantee can demonstrate creative approaches in assuring that its workforce is proficient in one or more of the core proficiencies. (Recommendation will be further targeted by Robert Alpino.)

- There are Title VII grants available to accomplish cross training activities. While there should be a recommendation for increased funding, increases in funding are difficult. There is a need to identify interprofessional training within HRSA along with best practices and/or other programs that represent cross training among disciplines. How can these efforts can be expanded to make training available nationwide?
- This issue is compounded by states' licensing and credentialing requirements. What are the licensing requirements in each state? How do they get accredited? Who monitors their performance? What are the key roles that will be played in a rural setting?
- Cross training is defined as training health care professionals in multiple disciplines to minimize the need to pay multiple people to perform functions that a single person could perform (if cross trained). Common core training between disciplines would be used as the basis. Additional specialty trainings will fill in the pieces that allow them to perform the functions associated with the other disciplines/programs.
- Cross training between disciplines may be difficult to accomplish due to the regulatory body of disciplines. A cross training demonstration may be needed. There are programs that exist but they have never been sustained, which may make the case for a demonstration project.
- The issue is being reviewed by State Offices of Rural Health and may be a concern for the Office of Rural Health Policy and Rural Health Resource Centers.
- Committee member Robert Alpino will revise this recommendation so that it is targeted, concise, and measurable.

Recommendation #4 – Enhance Medicaid funding for all disciplines and across States for rural healthcare to address health disparities and access to care. **(This recommendation was placed on <u>hold</u> for continued deliberations.)**

Reimbursement is critical to health care delivery systems. It should be determined which health care disciplines and services are covered by Medicaid (i.e., behavioral health, podiatry, etc).

Medicaid reimbursements are based on state contributions and not within the purview of Title VII programs. Additionally, Medicaid reimbursement structures do not support an interdisciplinary team approach.

Recommendation #5 – Provide funding and reimbursement for pharmacology services provided by nurses, pharmacists, and psychologists to address rural access to care for underserved populations.

REVISION – Include a section within the reauthorization of Title VII and Title VIII or draft new legislation that supports funding for education and training for competencies to provide pharmacological and/or psychopharmacological services provided by nurse practitioner, pharmacists, psychologists, and physician assistants in order to augment the healthcare workforce to address access to care for underserved populations. This ongoing education and training support highlights the subsequent need for the Secretary and Congress to draft and support specific legislation that assures healthcare

reimbursement [including Medicare, Medicaid, and other private healthcare reimbursement mechanisms] that supports these pharmacological and/or psychopharmacological services. **(Revision provided by Dr. Ronald Rozensky.)**

- This recommendation speaks to building workforce capacity. For example, psychologists are seeking prescribing privileges, which may address some of the psycho-pharmacology issues in rural areas.
- Nurses and practitioners should be added to the list of health professionals being described in this recommendation.
- An amendment or addition to Title VII legislation should replace "provide more funding," since there is no specificity in the current legislation regarding this. Federal officials should add more specificity and make strong suggestions on how this can be framed to match BHPr standards.

Recommendation #6 – Provide funding for workforce analysis across all of the disciplines for the purpose of an environmental scan and needs assessment for comprehensive rural services to include refunding the HRSA office on workforce analysis, Departments of Labor, Education, and Commerce. Build community based partnerships and economic development in rural communities to address workforce shortages.

REVISION – The Secretary shall define the health care workforce development policy for the country and reinforce HRSA's definitive role in this development. DHHS shall rely on HRSA and BHPr for workforce analysis including the supply and need for specific disciplines and provide funding for these activities. Further, the Department of Health and Human Services, DHHS, shall increase efforts to coordinate health care workforce development projects within the Departments of Labor, Education, and Commerce. **(Revision provided by Laurie Wylie.)**

Rationale: With recent continued annual decreases in funding to Title VII and VIII programs there have been associated decreases in the amount of work and activity. At the same time, other Federal agencies began to address the workforce needs of their constituencies. This has created a situation of duplication of administrative and program structures, as well as competition for limited financial resources. It is essential and appropriate that the Secretary establish the Department as the leader in health care workforce analysis and development. HRSA and the Bureau of Health Professions have a long history of health workforce development, and are the experts in this area. It is essential that the programs of BHPr not be diluted by the creation of other programs in other Agencies, and that appropriate funding be awarded so that the BHPr can execute its agenda.

Discussion: Include reference to funding partnerships that would consist of stakeholders who would provide input on multi-disciplinary training. The AHEC program guidance requires advisory boards for centers and that grantees assess the health workforce needs of their respective communities. HRSA may suggest (in the AHEC program guidance) including representatives from workforce investment boards on AHEC advisory boards

Recommendation #7 – Funding the development of best practice models of competency-based integrated/interdisciplinary shared curricula on issues of professionalism.

Discussion: This recommendation is highly relevant to rural communities and should model a team approach and a focus on sustainability. Dr. John Gilbert, University of British Columbia, will address the committee in September and may be able to provide assistance with further refinement of this recommendation. While Dr. Jane Hamel-Lambert accepted responsibility for revising this recommendation, this effort will not be needed in that the Committee decided to **combine this recommendation with #8**.

REVISION: To facilitate the transformation of the health professions education such that core competencies in patient-centered care, interdisciplinary teams, evidenced-based practices, quality

improvement and informatics are evident across disciplines, it is recommend that HRSA establish funding specifically (not sure where this would fit….) allocated to support curriculum development for best practices in health professional education. It is recommended that curriculum development grants be restricted to current training grantees to provide a mechanism that further encourages institutionalization of interprofessional programs, at the level of the curriculum, and across disciplines. Participation from two or more health professions program from a single institution and involvement of community health professionals and/or agencies health professions training programs to facilitate the joint authorship of training curricula that can be integrated across health profession programs within institutions.

Discussion: To best prepare health professionals to meet the needs of an increasing diverse population who are likely to be confronted with managing chronic health issues, our nation health education needs to move toward interprofessional models of care. Despite the formative call for strengthening of our nation's health professions education (IOM, Health Professions Education, 2003) by addressing six core competencies, our educational institutions continue to require sufficient incentives and resources to move toward the vision promotes competencies in (1) patient-centered care, (2) interdisciplinary teams, (3) evidenced-based practices, (4) quality improvement and (5) informatics. The federal training grants funded through Title VII and Title VIII are uniquely positioned to facilitate this transformation.

The goal of establishing best practices or models for infusing interprofessionalism into health profession curriculum is a complex challenge. Institutes of higher education are typically siloed by discipline, with associated professional credentialing/licensing mechanism heavily influencing the content of health profession education. Educational institutions often lack sufficient flexibility to easily create an infrastructure to supports cross-discipline courses. Interdisciplinary, team taught courses further challenge traditional mechanisms which often only recognize a single instruction of record, with associated "weighted student credit" hours going to individual departments. Moreover, even when faculty are interested in collaborative programs, degree programs often lack the flexibility to add an additional "required" course or have adequate space in schedules to enable elective training opportunities.

Community-based interprofessional training opportunities are an alternative, and complementary venue, for infusing health professions education with interprofessionalism. The involvement of the community in the development of training objectives enhances the degree to which training best prepares professional for community practice. Community-based training experiences that occur in clinical settings provide opportunities for health professional students to observe interactions between professions and to practice negotiating professional boundaries through effective communication.

Possible Strategies:

1. Allocated xxx% Title VII and Title VIII training grants to support the development of best practices for creating shared curricula across health professional education programs introducing interprofessionalism.
   Ensure funds in current training mechanism to require interprofessional (3 or more professions) to promote interprofessionalism across the grant programs that exist. Primary care training grants, GEC, AHEC
   a. Interprofessional curriculum in nursing VIII
   b. Interprofessional curriculum in primary care and dentistry
   c. Grad Psych Education Grants in BHPr
2. Given rural workforce development emphasis of our report…. Recommend that HRSA allocate xxx funding to Office of Rural Health Policy , whose programs are currently improving access and quality of care in rural community to create a new program specifically targeting for interdisciplinary, community-based rural training grants. Quentin Burdick is great model for this…
3. Maintain support for interprofessional, community-based training through AHEC
4. Do special consideration language work to direct dollars? Increase the special consideration language in the Public Law to strengthen the attention to interdisciplinary

5. Somehow leverage the medical home team movement and create a grant specific to creating curriculum that support health professions education that supports the health care team construct, assuming it can be stretched to be inclusive of allied health, mental health as well as primary health care providers and families.

Recommendation #8 – The ACICBL recommends that the BHPr of HRSA collaborates with the Department of Labor in recognizing patient navigators, including community health workers and promotores) as an occupational health professions category.

REVISION – The ACIBL recommends that the Bureau of Health Professions of the HRSA collaborates with the Department of Labor in recognizing Patient Navigators (including community health workers and promotores) as an occupational health professions category, and authorizes the funding of novel demonstration programs with specialized curriculum to train these workers as part of the interdisciplinary practice team in rural communities. Further, training programs should include evaluation measures to determine the effectiveness of these workers in improving health outcomes, particularly for rural populations at risk for health disparities. **(Revision provided by Dr. Barbara Logan.)**

- The funding of novel demonstration programs with specialized curriculum to train these workers as a part of the a study examines best practice model programs including all health disciplines versus the traditional physician/nurse driven rural healthcare services and studies, specific outcomes that offset medical costs, and clinical outcomes like adherence, morbidity and mortality rates, and specific health outcomes.
- This recommendation should endorse the patient navigator program and community health workers and expand these opportunities (based on best practices) to give them more focus.
- Dr. Barbara Logan revised this recommendation and will work with Ms. Elyse Perweiler for further refinement.
- The Committee decided to combine this recommendation with number 7.

Recommendation #9 – The Bureau of Health Professions and Office of Rural Health Policy should review CMS data to explore patient outcomes in selected leading disease diagnoses by provider type and location. The information should be used to develop a community-based health workforce planning model relevant to population characteristics of target communities.

REVISION – The Bureau of Health Professions and Office of Rural Health Policy should review CMS data to explore patient outcomes in selected leading disease diagnoses by provider type and location. The information should be used to develop a community-based health workforce planning model relevant to population characteristics of target communities. **(Revision provided by Mr. Steve Shelton, along with links to relevant articles.)**

- **Tele-pharmacy**: http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=937
- **Interprofessional education in rural practice**: http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=939%20
- **Interprofessional curriculum for rural areas:** http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=939
- **Recruiting psychiatrists to rural areas:** http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=824
- **Sustainable rural health community development:** http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=818

In rural areas, the primary care provider is not necessarily a physician. The Physician Assistant and Nurse Practitioner are the providers. Large datasets and HP 2010 objectives need to be considered. The endpoint is improved health for individuals and communities.

Recommendation #10 – Enhance research in the area of minority issues in rural settings and address health disparities. (**Revision Pending from** Laurie Wylie - Summary of Best Practices, Andrea Sherman, Gail Jensen, and Jane Hamel-Lambert- former Quentin Burdick grantee.)

- What are the lessons learned from the Quentin Burdick Rural Interdisciplinary Training Grant program? (Some of the best work came from these centers.)
- Since the Quentin Burdick program is not being funded, the strengths (i.e., stipends, training curriculums, etc.) and weaknesses of this program should be incorporated into current programs and can be subsumed into another recommendation.
- This recommendation was tabled for further discussion.

Recommendation #11 – Rural in and out programs should continue to recruit from rural areas as these students tend to practice in rural areas. Interdisciplinary education at the graduate level should become a theme.

The Rural In/Out portion of this recommendation will go with number 2 and the interdisciplinary training section (last sentence) of this recommendation will go with number 7; thereby eliminating this recommendation.

The interdisciplinary training sections should indicate whether this training should occur at the graduate or entry level.

Recommendation #12 – The Committee should address growing diversity and cultural competency needs in rural areas and consider the changing face of rural America in terms of the growing population of Latinos moving into rural America and the loss of farming jobs. How are health professionals being prepared to address this new population to include the issues of language and culture?

REVISION – The Committee should address growing diversity and cultural competency in rural areas and consider the changing face of rural America in terms of growing ethnic minority populations. Funding could support provider training (online or in person) through community partnerships or consortia of lay, community professional, and university organizations. Use of student groups (service learning) as a community service by the university, especially using diversity groups of students could be applied. If MD or NP provider is the focus of the training, CME/CE credits should be offered. Existing HRSA online programs that could be used should be publicized and their use optimized.

Background and Rationale: Given the recent influx of Latinos to rural counties and the history of poor African American communities in rural America, HRSA could fund workforce development traineeships and apprenticeship programs that prepare the next generation of bilingual/bicultural paraprofessionals (allied health/health educators, medical interpreters, social workers, nutritionists, etc.) to serve in these regions. Providing support for continuing education workshops and support for clinicians/health care providers that goes beyond an orientation to language and culture of diverse populations could include more about practical strategies for collaborating with lay community health persons and interpreters in prevention outreach and clinical care. Providing technical assistance grants for developing rural health networks that function as coordinated support and referral to needed services could be in partnership with rural clinics, health departments, faith-based organizations (e.g. Catholic church, in the case of Latinos), and cultural community informal organizations. **(Revision provided by Dr. David Perrin.)**

SECTION IV: SUMMARY OF PRESENTATIONS:

(To obtain a copy of the PowerPoint presentations, please contact the Division of Diversity and Interdisciplinary Education at (301) 443-6950.)

Enhancing Patient Safety and Quality of Care Using Interdisciplinary Training
Mary Wakefield, Ph.D., RN, FAAN

Director/Center for Rural Health at the University of North Dakota
Patricia Moulton, Ph.D.
Center for Rural Health at the University of North Dakota

Dr. Wakefield accepted responsibility for the development of a concept paper, Enhancing Patient Safety and Quality of Care Using Interdisciplinary Training, to guide the committee with its recommendations and present an overview of that document for the Committee's reactions. With a focus on an interdisciplinary approach to delivery, linked with safety and quality health care in rural settings, Dr. Wakefield noted that there are challenges and opportunities. The paper will consist of 15 to 20 pages (more like 15) with the draft presentation scheduled for the September web-conference meeting of the ACICBL.

Discussion: Committee members suggested the inclusion of key definitions as they relate to BHPr, i.e., rural; debunking myths associated with rural health; impact of the changing racial and ethnic demographics in rural America; linking interdisciplinary care to quality improvement; identifying effective models of training and practice; broadening the traditional model of physician and patient and moving toward a shared team; operationalizing medical homes in rural areas; including specific examples of successful models; incorporating a public policy perspective with programmatic implications; discussing the variance between rural and urban areas in chronic disease, behavioral and mental health in rural settings, considerations for high proportion of aging population in rural areas; unique infrastructure of rural health care organizational networks and system coordination - personnel and equipment sharing, resource scarcity, and low volume and fixed overhead costs.

Office on Rural Health Policy/Overview of the Components of Annual Report
Jennifer L. Chang, Executive Secretary
Office of Rural Health Policy, HRSA
Caroline Cochran, Policy Director
Office of Rural Health Policy, HRSA

Discussion: Representatives from the Office of Rural Health Policy to include Jennifer Chang, Executive Secretary of the National Advisory Committee on Rural Health and Human Services (NACRHS) and Caroline Cochran, Director of Policy briefed the ACICBL. The NACRHS holds three annual field meetings, usually in February, June, and September with a dual focus on national and ground level perspectives and produces an annual report. The 2009 report will highlight medical homes serving at-risk children in rural communities and workforce and community development in rural communities. The ACICBL committee members suggested cross training as a focus for the RHRC, which may be a possibility with the ORHP in 2010. The next NACRHS meeting will be held in Minnesota from September 24-26, 2008.

Behavioral Health Training Issues in Rural America
Dennis Mohatt
Vice President, Behavioral Health
WICHE

Discussion: Mr. Mohatt's focused on the workforce issues in meeting the challenges of behavioral health concerns in rural America and highlighted accessibility, availability, and acceptability from a rural perspective. He indicated that law enforcement officials usually respond to these situations in lieu of trained professionals. In an effort to address these workforce issues, he suggested looking at Australia where effective mental health first aid exists.

- There is a need to focus on mid-level strategy as there is not a consistent mid-level pool or a consistent set of core competencies.
- There is a delay from the science to service with the trend to do the affordable rather than evidence based strategies.

- Not enough is being done to interest youth in mental health careers. Rural internships are helpful with retention efforts, but remain rare. The economics of retention in mental health is divided and fragmented resulting in no one system having enough money to effectively run a healthy business. These fragmented systems need to become an integrated system of care.
- Mental health work environments are being labeled as "toxic" due to lack of quality supervision, mentorship and training. Strategies should be examined on the national level that pays for supervision and stipends (i.e., NHSC scholarship program or something similar).
- Changes in the reimbursement models in rural settings need to be addressed.

Medical Home Concepts
Michael Barr, MD, MBA, FACP
Vice President
Practice Advocacy and Improvement
American College of Physicians

Dr. Barr discussed health care reform due to a number of concerns that include poor access to care, increasing costs that are not linked to quality, dysfunctional payment systems, etc. He discussed the joint principles of the patient centered medical home, which should be team-based care.

Discussion: The Patient-Centered Medical Home represents a vision of healthcare as it should be and a framework for organizing systems of care at the practice and society levels (micro and macro). The model should be used to test, improve, and validate outcomes. The collective principles of the Patient-Centered Medical Model include a team-based approach that includes a physician directed care that is coordinated and integrated, focuses on quality and safety, enhances accesas Another example included the electronic medical record, which he suggested was used for billing and not quality improvement. Many physicians are apprehensive with the use of email. Opportunities to change the health care system seem to occur every 15 years. While the question was presented regarding interjecting the training needs into demonstration projects and models, there is no clear response.

Utility of Telemedicine in Meeting the Training Needs of Health Professions in Rural Settings
Dena S. Puskin, Sc. D.
Director, Office for the Advancement of Telehealth
HRSA Office of Technology

Dr. Puskin focused on the retention concerns in rural settings because of the legitimate feelings of professional isolation expressed by providers. Technology can be one of the keys to getting training to providers and care to consumers. Telehealth is broad and includes telemedicine, which uses telecommunication to provide clinical care from a distance. Examples include radiology's use of telemedicine and E-intensive care units. The University of Phoenix is a distance learning example. Other examples include telemedicine on wheels, video home visiting systems used for monitoring and training. The telepharmacy model has been successful in Spokane, Washington. The IPhone software is another inexpensive consideration for use by physicians. Telehealth Network Grants focus on rural settings as recipients.

Discussion: Licensure and state practice requirements have produced a growing body of knowledge around telemedicine, which allows service collaboration. Need to work with states to demonstrate safety and effectiveness. Clinical outcomes exist for telehealth in dermatology, cardiology applications, radiology; and home care/monitoring applications.

- Telehealth is not the synonymous with the electronic medical health record, but can be used to enhance the delivery of clinical care.
- The Arkansas Area Health Education Centers program has implemented telehealth into their programs to train medical residents and expand their outreach to rural areas. With an estimated

23,000 expected health vacancies during the next 5 years, telehealth will be considered one of the primary ways to train allied health professionals and others.

- Microsoft, Intel, and big hospital groups are part of a consortium interested in telehealth. Collaboration will be beneficial for all concerned.

SECTION V: COMMITTEE BUSINESS

- The Committee will consider the recommendations offered by Dr. Brand with regard to the seventh annual report.
- Mr. Coccodrilli confirmed the assistance of a writer, Dr. Claire Wilson to assist with the development of the eighth report. Dr. Wilson will be reviewing the recommendations offered by suggested that members be specific, brief, and use direct language as they work to consolidate related recommendations.
- The Committee needs to consider three dates for the 2009 mandated meetings.
- The Committee leadership needs to be clarified during the September meeting in that several members will be rotating off to include Drs. Wilson and Jensen, the current chair and co-chair. Leadership for the Planning and Writing Subcommittees need to be confirmed also.