Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) Meeting Minutes
August 4, 2020

Advisory Committee Members Present

Anita Glicken, MSW, Chair
Jane E. Carreiro, DO
Nancy W. Dickey, MD
Jeffrey Hicks, DDS
Geoffrey Hoffa, DHSc, PA-C
Michael J. Huckabee, MPAS, PA-C, PhD
Antoinette Kahan, RDH, BA, RDA, CBA
Cara Lichtenstein, MD, MPH
Anne E. Musser, DO
Pamela R. Patton, PA, MSP, DFAAPA
Kim Butler Perry, DDS, MSCS
F. David Schneider, MD, MSPH
Mark D. Schwartz, MD
Sandra M. Snyder, DO
Jason M. Spangler, MD, MPH
Wanda H. Thomas, MD, FAAP
Louise T. Veselicky DDS, MDS, Med

Health Resources and Services Administration (HRSA) Staff Present From the Bureau of Health Workforce (BHW)

Shane Rogers, Designated Federal Official (DFO), ACTPCMD
Robin L. Alexander, Management Analyst, Advisory Council Operations
Cynthia Harne, MSW, LCSW-C, Chief, Medical Training and Geriatrics Branch
Jennifer Holtzman, DDS, Dental Officer
Kimberly Huffman, Director of Advisory Council Operations
Paul Jung, MD, MPH, Director, Division of Medicine and Dentistry
Janet A. Robinson, Management Analyst, Advisory Council Operations
Erika Terl, Chief, Oral Health Branch Division of Medicine and Dentistry

Roll Call/Agenda Review

Shane Rogers, DFO, ACTPCMD

Mr. Rogers convened the virtual meeting of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD, or the Committee) on August 4, 2020. He welcomed everyone to the meeting and proceeded to conduct roll call, confirming a quorum. Participants then introduced themselves.

Meeting Overview and 17th Report Update
Anita Glicken, MSW, Chair, ACTPCMD

Ms. Glicken reviewed the agenda and then briefly updated the Committee on progress of the 17th report. The 17th report Writing Workgroup met with the technical writer to provide feedback on revisions to the report. Subsequently, the technical writer developed a new draft that included the following revisions and updates:

- The impact of COVID-19 on both patient care and telehealth services.
- The impact of provider implicit bias on health outcomes and ways to overcome such biases.
- Addition of exemplary programs in teledentistry.
- Addition of exemplary, evidence-based training programs for changing patient behaviors that lead to chronic disease.
- Discussing the crucial role that dentists can play in preventing and managing chronic disease.
- Stressing the impact of longitudinal community-based training on the recruitment/retention of rural primary care providers.
- Training providers on the social determinants of health to improve population health.
- Incorporating various new references to the report.

The Committee then proceeded to provide additional feedback for each section of the revised report. For additional flexibility, Committee members were given the option to provide additional feedback in writing after the meeting via email to Ms. Glicken by August 10, 2020.

The Committee provided the following feedback:

- Adding a broad definition of primary care provider that includes dentists, behavioral health professionals, nurses, nurse practitioners, physician assistants, etc.
- Stressing the need for partnerships between longitudinal community-based training programs are and institutional programs that can provide experience in specialty training (e.g., pediatrics, cardiology, etc.).
- Incorporating the role of behavioral health in chronic disease prevention.
- The importance of interprofessional training and practice in disease prevention.
- Discussing structural factors that contribute to social determinants of health.

The ACTPCMD then voted to approve the 17th report recommendations listed below, with the allowance for the Writing Workgroup to make editorial changes to the recommendations as long as they do not change their meaning or intent. The ACTPCMD recommended that HRSA support through funding:

- *Recommendation 1* – The incorporation of community-based resources and partnerships into community-based primary care education and training for students, trainees, faculty, and practitioners.

- *Recommendation 2* – Longitudinal community-based primary care education and training for students, trainees, and faculty.

- *Recommendation 3* – Innovative primary care programs that educate and provide training, incorporating evidence-based behavior change strategies that improve chronic disease prevention and management across primary care.

- *Recommendation 4* – Develop, implement, and evaluate faculty development designed to facilitate the education of students, trainees, and primary care providers using innovative methods in addressing population health and managing chronic disease. Support the education and training of students and trainees in addressing population health and managing chronic disease.

- *Recommendation 5* – Develop, implement, and evaluate programs that provide innovative education and training, including telehealth. Also provide funding to support programs that provide education and training in telehealth as well as other virtual health technologies.

The Committee agreed that the Writing Workgroup would proceed to work with the technical writer to revise the body of the 17th report based on feedback provided during the meeting and finalize it by September 2020.

Council on Graduate Medical Education (COGME) Update

Thomas Tsai, MD, MPH, Vice Chair, COGME, and Assistant Professor of Surgery, Harvard Medical School

Dr. Tsai, the Vice Chair of the Council on Graduate Medical Education (COGME), primarily discussed the issue brief recently developed by COGME titled *Special Needs in Rural America: Implications for Healthcare Workforce Education, Training, and Practice.* It is the first of three briefs that will be developed with a focus on rural health care. The brief clearly describes some of the challenges with rural health care today including: lack of access, rural hospital closings, shortage of health professionals (e.g. specialists and surgeons), and understaffed facilities.

Dr. Tsai also highlighted three HRSA programs in rural health: the *Teaching Health Center Graduate Medical Education* (THCGME) program, the *Rural Training Track Technical Assistance* (RTT-TA) consortium, and the *Rural Residency Planning and Development* (RRPD) grants.

The THCGME program has had significant success in embedding residency training in community-based, rural, and primary care settings. It is estimated that the program has the potential to yield up to $1.8 billion in public program savings between 2019 and 2023. The RTT-TA supports communities, educational institutions, and others interested in developing rural training tracks. A 2016 program review found that more than 35% of graduates were practicing in rural areas seven years post-graduation. In 2019, HRSA awarded $20 million in RRPD grants to 27 organizations to increase the rural workforce through the creation of new rural residency programs.

Dr. Tsai said it is important to focus on essential health care needs in rural communities over national shortage of specific types of health care professionals. He added that Federal funding for comprehensive assessment of rural needs to identify gaps; that Federal training investments should link Graduate Medical Education (GME) funding to population health needs; and that future investments should target programs that yield high return on investment in rural communities.

In the issue brief, COGME makes the following two recommendations:

- *Recommendation 1* – COGME recommends federal funding for a comprehensive assessment of rural health needs to identify gaps in essential care. This assessment will serve to update and modify existing programs, such as the National Health Service Corps (NHSC), which targets and recruits physicians matching the needs of rural communities. HRSA's National Center for Health Workforce Analysis can undertake the data collection and analysis needed to interpret and translate findings on rural community health and workforce gaps into actionable recommendations to HRSA and CMS regarding future training investments.

- *Recommendation 2* – Federal training investments should follow the National Academy of Medicine recommendation to link GME funding to population health needs. Future investments should be targeted toward programs that yield a high return on investment in rural communities, including the NHSC, the Rural Residency Planning and Development, and other training programs funded by HRSA.

Discussion

Dr. Hicks said that once rural dental residencies are started, they are sometimes discontinued after the cessation of HRSA funding. He explained that a successful program is the partnership between NYU and NYU Langone Health, which supports residencies in rural areas, Federal prisons, and other areas of need. That program can receive GME funding for dental residencies because it has been sponsored since its inception by a hospital. He asked if there could be flexibility in the ability of rural hospitals, health centers, and dental schools in initiating programs and obtaining GME funding. This type of strategy would allow continued funding for residencies after initial funding.

Dr. Tsai agreed with Dr. Hicks. He suggested partnering with other HRSA councils and stakeholders to develop a letter to HHS supporting Dr. Hicks' recommendation.

Dr. Hoffa asked if there were any models related to teaming physician assistants (or other advanced practice clinicians) with physicians to augment the clinical effect? For example, are there studies that determine what the proper ratio of physician assistants to physicians would be?

Dr. Tsai said that COGME has met with Dr. David Meyers at the Agency for Healthcare and Quality who has done work to model the costs of a rural primary practice in order to fund and sustain primary care practices. The model includes the time/effort of the education and training of residents and other students. This model may help to examine different models of care (e.g. a team-based approach).

Title VII, Sec. 747/748 Discussion: Maternal Health, Physician Assistant Education, and Rural Dental Residencies

Paul Jung, MD, MPH, Director, Division of Medicine and Dentistry, Bureau of Health Workforce (BHW)
Cynthia Harne, MSW, LCSW-C, Chief, Medical Training and Geriatrics Branch, BHW
Erika Terl, Chief, Oral Health Branch, Division of Medicine and Dentistry, BHW

Dr. Jung provided a brief overview of the Committee's charter. The charter states that one of the Committee's duties is to "provide advice and recommendations to the Secretary concerning policy and program development and other matters of significance concerning medicine and dentistry activities under section 747 of the Public Health Service (PHS) Act." The phrase "other matters of significance" allows the Committee to discuss current issues impacting Americans in the areas of primary care and oral health training.

The Charter further states that another of the Committee's duties is to "develop, publish, and implement performance measures for programs under Part C of Title VII of the PHS Act." Dr. Jung said the Committee should be free to consider the effects of training as well as what, how, and where, HRSA trainees practice. HRSA is also authorized by Congress—as HRSA considers the development of primary care medical training programs under Title VII—to implement any type of training recommended by the Committee. This allows recommendations made by the Committee to be translated into programmatic actions by HRSA. Dr. Jung encouraged all Committee members to be forward-thinking in their ideas and be direct, clear, and explicit in the report's language.

Ms. Harne provided an overview of the Primary Care Training Enhancement (PCTE) program. The program's overall goal is to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers, and researchers in rural and underserved areas. The focus is to produce primary care providers who will be well prepared to practice, teach, and lead transforming health care systems to improve access, quality of care, and cost effectiveness. For fiscal year (FY) 2020, the annual appropriation for the program is approximately $48.9 M, of which 15% is obligated towards Physician Assistant (PA) programs.

The PCTE is an "umbrella" program for the following eight different programs:

- *PCTE cohort FY15* – is an interprofessional training program focused on future primary care clinicians, teachers, and researchers in rural and underserved areas.
- *PCTE cohort FY16* – same as cohort FY15
- *Academic Units for Primary Care Training and Enhancement* – establishes, maintains, or improves academic units or programs that improve clinical teaching and research in family medicine, general internal medicine, or general pediatrics.
- *Primary Care Medicine and Dentistry Clinician Educator Career Development* – provides career development awards to junior faculty to support the development of potential faculty and leaders in primary care medicine and dentistry. It also supports innovative projects that involve the transformation of health care delivery systems.
- *Training Primary Care Champions* – aims to strengthen the primary care workforce by setting up fellowship programs to train community-based primary care practitioners

and/or physician assistant champions to lead transformation of health care and improve teaching in community-based settings.

- *Integrating Behavioral Health and Primary Care Program* – funds innovative training programs that integrate behavioral health and primary care in rural and underserved settings with a special emphasis on the treatment of opioid use disorder.
- *Physician Assistant Program* – focuses on increasing the number of PAs, particularly in rural and underserved settings, and improves primary care training in order to strengthen access to primary care services nationally. It includes PA training in opioid and other substance use disorders.
- *Residency Training in Primary Care* – enhances accredited residency training programs in family medicine, general internal medicine, general pediatrics or combined internal medicine and pediatrics in rural and/or underserved areas. It encourages program graduates to choose primary care careers in these areas.

Physician Assistants can be included as part of any of the above programs. For example, of the 33 awards under cohort FY2016, 22 of them trained PAs.

Ms. Terl provided an update of HRSA's Oral Health Training Programs. For FY20, the annual appropriation is approximately $40.6 million. Title VII, Section 748 of the PHS Act authorizes programs to support and develop education and training programs in general, pediatric, and public health dentistry. These programs provide support for student financial assistance, traineeships, faculty development, and pre- and post-doctoral training, as well as the establishment or operation of a faculty loan repayment program. The oral health training programs fall into four broad areas: predoctoral, postdoctoral, dental faculty loan repayment, and career development awards, which are discussed below.

The *Predoctoral Training in General Pediatrics and Public Health Dentistry and Dental Hygiene* program focuses on the following: 1) supporting integration within the broader health care delivery system; 2) supporting oral health providers practicing in advanced roles; and 3) enhancing clinical pediatric training for children 0-5 years. The program funds 25 grants and has a FY20 budget of $3.6 M. *The Postdoctoral Training in General, Pediatric, and Public Health Dentistry* program focuses on: 1) caring for underserved and/or vulnerable populations; 2) developing/expanding rural training sites; and 3) supporting dental public health residencies. The program funds 27 grants and has a FY20 budget of $13 M.

The Dental Faculty Loan Repayment program funds 30 grants and has a FY20 budget of $6.9 M. In FY2018 there were 30 faculty enrolled. *The Dental Clinician Educator Development* program provides grants to strengthen the primary care workforce by training and supporting dentists and dental hygienists who plan to teach in the primary care fields. The program funds 6 grants and has a FY20 budget of $1.1 M.

Discussion

Dr. Spangler said that one of the activities of the PCTE FY15 and FY16 programs is to plan, develop, and operate joint-degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions. He asked if PA and dentistry schools usually have integrated public health programs like some medical schools.

Dr. Jung replied that there are indeed combined dental/MPH and PA/MPH programs, but he was not sure if those programs are directly funded by HRSA's Division of Medicine and Dentistry.

Dr. Spangler asked if there were any discussions about including social determinants of health or health care workforce diversity in both the *Academic Units for Primary Care Training and Enhancement* and the *Primary Care Medicine and Dentistry Clinician Educator Career Development* programs.

Ms. Harne said that one of the programs is addressing social determinants of health.

Ms. Patton said that one of the recommendations developed by the Committee for the 18th Report focuses on PA training, specifically in rural primary care locations—either with support of PA programs and/or PA rural primary care fellowships. The PCTE PA program discussed today does not seem to fund residencies or fellowships. The *Training Primary Care Champions* program does offer a fellowship, but it is in the areas of leadership, health care transformation, and education. She added that many of the activities under the *Residency Training in Primary Care* program mirror the Committee's thinking of increasing training of PAs through a master's program or a PA fellowship/residency. If the 18th Report includes that recommendation, she asked if it would be up to HRSA's Medical Training and Geriatrics Branch to either come up with a new program or incorporate the recommendations in one of the existing PCTE programs.

Ms. Harne said the residency program is indeed only for physicians. The PCTE programs do support the training of physicians or physician assistants teaching in community-based settings.

Rural Health Overview
Alan Morgan, MPA, Chief Executive Officer, National Rural Health Association

Mr. Morgan explained that the National Rural Health Association (NRHA) is a national nonprofit membership organization with more than 21,000 members. Its mission is to provide leadership on rural health issues through advocacy, communications, education, and research.

Approximately 62 million individuals call rural America home. Unfortunately, rural Americans as a whole tend to be older, sicker, and poorer. For example, 18% of rural residents are 65 and older, compared to 14% in urban areas. Similarly, rural areas have higher rates of risk factors and conditions such as obesity, diabetes, and smoking.

In the majority of rural counties, rural hospitals are the biggest employer. Rural hospitals play an important role in rural health as they can encompass long-term care, behavioral health, Emergency Medical Services (EMS), and opioid response initiatives within the community.

Prior to the COVID-19 pandemic, there were approximately 2,000 rural hospitals, of which 47% operated at a loss. Half of all rural hospitals had only 30 days of cash for operations on hand and more than 400 were at risk for closure. Unfortunately, rural hospitals have been closing since 2010. In 2019 alone, 17 rural hospitals closed. However, it is important to note that some rural hospitals are meeting or exceeding quality, financial, and performance measures, as well as patient satisfaction.

The COVID-19 pandemic had an important impact on rural health care. Providing health services during the pandemic threatened to accelerate closing of cash-strapped hospitals. In fact, in April 2019 four hospitals closed. Fortunately, relief was provided through the Coronavirus Aid, Relief, and Economic Security (CARES) Act passed by Congress and signed into law on March 27, 2020.

The initial act provided $100 billion dollars for rural health care. Later on, $75 billion were added—including $30 billion for Medicare providers, $15 billion for Medicaid providers, $10 billion as a carve-out for rural providers, and $4 billion for vulnerable and rural hospitals. From April to August 2020, rural hospitals were considered to be financially stable.

The pandemic has emphasized the need for innovative solutions to create a sustainable health care system for the future. Newer payment models may be needed to achieve this goal. Rural hospitals should be utilized as community hubs to facilitate networking among providers to both address work force shortages and shift the paradigm of treating patients in a rural context.

Discussion

Dr. Schwartz said he currently works as a physician for the Veteran's Administration (VA). He said the VA is globally budgeted and does not have a fee-for-service model. However, outcomes for veterans are as good, or better than, systems with other payment models. He therefore supported the idea of moving from fee-for-service to a globally budgeted model for rural hospitals. He asked Mr. Morgan to speak more about payment models.

Mr. Morgan said that the emphasis should be in primary care and general surgery. Global budgeting can only work if there is a strong primary care workforce. He added that integration of rural health, geriatric care, and behavioral health at the front end is the only way that a global budgeting model can work.

Physician Assistants and Rural Health
Howard Straker, EdD, MPH, PA-C, President, Physician Assistant Education Association (PAEA); and Assistant Professor of Health Care Sciences, George Washington University (Presented by David Keahey, MSPH, PA-C, Chief of Policy and Research Officer, PAEA)

Mr. Keahey said that Physician Assistant (PA) programs have grown significantly over the years. This is evidenced by an increased number of graduating PA students from 1984 to 2018. In 1984, 767 individuals graduated as PAs while in 2018 that number increased to 10,814, and this trend is expected to increase. The top two practice areas for students are family medicine/general practice (18%) and surgical subspecialties (18%). In contrast, pediatrics and psychiatry are the smallest practice areas (1.9 and 1.6%, respectively).

Currently, a total of 260 PA programs are active across the nation. While nearly every state has at least one PA program, there is a heavy concentration of programs in California, New York, Pennsylvania, and Florida. In terms of focus, a total of 160 programs (69%) have as their mission primary care, 98 programs (42%) focus on underserved populations, and 51 programs (22%) have a rural focus. Nearly 69% of the programs are private and 29% are sponsored by an academic health center.

The mean length of a program is 26.8 months with programs being divided into a didactic and clinical phase (the didactic phase has a mean duration of 58 weeks and the clinical phase a mean duration of 54 weeks). The heavy focus on practicing clinical medicine during study allows PAs to start practicing on day one. The clinical curriculum requires rotations in four settings: emergency department, inpatient, outpatient, and operating room.

The PA degree requires supervised clinical practical experiences (i.e., rotations) in family medicine, emergency medicine, internal medicine, surgery, pediatrics, women's health/gynecology/obstetrics, and behavioral/mental health. Some programs also offer elective other rotations. Payment for some or all rotations at the clinical site has increased from 22% in 2012 to 48% in 2018. However, 51% of clinical sites do not presently offer any payment.

PA students also receive 7 hours of oral health training. To date, according to a recent study 96% of reporting programs have integrated some type of oral health curriculum. The percentage of programs offering DEA X-waiver training (waiver to prescribe buprenorphine for opioid use disorder) has also increased significantly from 3% in 2018 to 70% today.

The COVID-19 pandemic had a significant impact on PA education, with some institutions having to make temporary changes to normal operations and requirements as a result of the pandemic. Nearly 57% of programs surveyed had to make changes to the number of direct patient care and the number of hands-on clinical hours required to complete a rotation. A total of 23% of the programs surveyed delayed the date of program completion and 19% of programs delayed graduation. Conversely, student participation in telemedicine increased significantly over the same period of time, with 56% of students newly participating in telemedicine appointments as a result of the pandemic.

The Physician Assistant Education Association made the following recommendations:

- HRSA should structure future grant competitions from those designed to support one profession to those recognizing the value of team-based care.
- Workforce development investments must address cross-disciplinary decline in primary care practice, combat cross-disciplinary disincentives to practice in rural/underserved areas, and support expanded telemedicine capacity.
- HRSA should also ensure that all HRSA-administered programs are designed to promote access to care in rural areas and support interprofessional training to the extent allowable by statute.

Rural Oral Health and Interprofessional Practice
Russell Maier, MD, Associate Dean for Graduate Medical Education, Pacific Northwest University of Health Sciences

Dr. Maier updated the Committee on the topic of oral health in the rural West. There is a divide when it comes to rural and urban health care. Populations in rural areas have challenges in accessing care and are generally poorer, both of which can be barriers to treatment. However, there are some trends to support and improve interprofessional education and interprofessional practice. This can be supported by team-based care that involves physicians, pharmacists, dentists, behavioral health professionals, and other providers.

Both dentistry and medicine seem to be moving towards population-based care—in other words, keeping a group of individuals in the community healthy. For this reason, it is important to invest in prevention. Also, to attain a long-term change in the health of a population prevention efforts need to occur throughout the health care spectrum and a variety of professionals: dentists, dental hygienists, physicians, behavioral health professionals, nurses, physician assistants, etc.

There are both barriers and opportunities related to rural health care. These include accreditation, separate finance systems, consolidation, value-based payment, and changing expectations. Accreditation could be both an opportunity or a barrier. For example, if one wanted to create a new dental school focused on training individuals for practice in community-based centers and which includes training on population-based care, it might be difficult to meet all accreditation requirements.

Having separate finance systems for medical and dental care makes value-based payments difficult. However, a consolidation of systems, which is happening in some areas, could help to implement value-based care. Some providers have expectations on providing disease-oriented care. A change to health-based care would necessitate a change of expectations in such providers to support more interprofessional practice. Dr. Maier suggested having, as a focus, funding integrated training programs that have oral health, behavioral health, and medical trainees all working together in underserved or rural settings.

Discussion

Dr. Hicks asked Dr. Maier if he had interfaced with the Northwest Dental Residency program. Dr. Maier replied that he had. The residency program is one of the original HRSA Teaching Health Center grantees.

Dr. Perry said she agreed with Dr. Maier's comments about developing a dental school that addresses the needs of underserved populations. She added that A.T. Still University developed the Missouri School of Dentistry and Oral Health, which has graduated at least four classes to date. This dental school operates inside of a community health center.

Dr. Huckabee asked Dr. Maier for guidance on sustainability for training programs. Dr. Maier replied that he believed that current partnerships with Community Health Centers are the only route to a sustainable model.

Committee Discussion - 18th Report
Jeffrey Hicks, DDS, Professor of Dentistry, University of Texas

Dr. Hicks briefed the Committee on progress related to the 18th Report. The ACTPCMD full Committee met on January 8-9, 2020 and developed an initial draft of the recommendations for the report which covered primary care, maternal health, and oral health. Based on the Committee's recommendations, the technical writer developed the report's outline for review by the Writing Workgroup.

On July 24, 2020 the Writing Workgroup met to discuss the following topics: the increased closure of rural health clinics; GME-supported rural residencies; and the increased fiscal

pressures on rural hospitals and primary health practices as a result of the COVID-19 pandemic.

The Writing Workgroup also raised the following four concerns/issues related to the report: 1) health equity issues associated with underserved populations with comorbidities and how to prepare providers to meet such needs; 2) the need for funding rural residencies; 3) the fact that telemedicine is not always effectively deployed in rural communities due to barriers (e.g., cost, transportation, distance between clinics, and lower access to care); and 4) considering health equity in the recommendations, specifically in the area of maternal care.

The Writing Workgroup also suggested breaking recommendations into two areas of interest: 1) rural oral health residencies; and 2) programs that integrate rural health education collaborative practice models that support integration of oral health and primary care. Following the briefing by Dr. Hicks, the Committee provided extensive feedback for the Writing Workgroup to enhance the following three draft recommendations developed during the January 8-9 meeting:

- *Draft Recommendation 1* – Support physician assistant practice and retention in underserved rural communities, including supporting training programs by employing longitudinal rural primary care rotations or postgraduate physician assistant rural primary care residency programs.

- *Draft Recommendation 2* – Support the creation of a rural dental residency program as well as interprofessional models of primary care and oral health education and training.

- *Draft Recommendation 3* – Support educational and training programs that promote evidence-based maternal care in rural settings.

The feedback provided by the Committee on the 18th report was specific, but generally fell into one of the following six categories: 1) recruitment/retention of PAs may be improved by incentives (financial, quality of life, lower property costs, etc.); 2) partnerships with local institutions may help with interprofessional training of PAs as well as program sustainability; 3) mentorship opportunities linking those in practice to those in training could be mutually beneficial; 4) the importance of discussing the high African American maternal mortality; 5) the impact of structural racism on the health of certain populations; and 6) considering financial support for rural health care institutions facing financial challenges.

The Committee voted and agreed that the Writing Workgroup would work with the technical writer to develop a first draft of both the recommendations and the 18th Report.

Committee Business

Mr. Rogers provided a brief update on the CARES Act. Additional language was added to the Act. More specifically, Section 3402 titled Health Workforce Coordination now charges the Secretary of Health and Human Services, in coordination with the ACTPCMD, to develop a comprehensive and coordinated plan related to the health care workforce development programs of the Department of Health and Human Services, including educational and training programs.

The language requires that the plan: 1) include performance measures to determine the extent to which the programs are strengthening the nation's health care system; 2) identify any gaps that

exist between the outcomes of programs and the projected health care workforce needs identified in workforce projection reports conducted by HRSA; 3) identify actions to address such gaps; and 4) identify barriers, if any, to implementing such actions.

Mr. Rogers said that HRSA may be reaching out to Committee members to inform them of the status of this matter prior to the next ACTPCMD meeting.

Public Comment

Karen Mitchell, MD, from the American Academy of Family Physicians, recommended having an active approach in educational assistance to dismantle racist and discriminatory practices and policies.

Adjourn
Anita Glicken, MSW, Chair, ACTPCMD

Ms. Glicken thanked all Committee members for their active participation. She also thanked the HRSA team and the technical writer for their support. Ms. Glicken said she looks forward to working with the Committee.

Mr. Rogers adjourned the meeting at 5:05 p.m.