

**ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE
MEDICINE AND DENTISTRY (ACTPCMD)
Meeting Minutes
February 17-18, 2022**

Advisory Committee Members Present

Sandra M. Snyder, DO, Chair
Jane E. Carreiro, DO
Nancy W. Dickey, MD
Anita Glicken, MSW (Immediate Past Chair)
Jeffrey Hicks, DDS
Geoffrey Hoffa, DHSc, PA-C
Michael J. Huckabee, MPAS, PA-C, PhD
Anne E. Musser, DO
Pamela R. Patton, PA, MSP, DFAAPA
Kim Butler Perry, DDS, MSCS
F. David Schneider, MD, MSPH
Mark D. Schwartz, MD
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
Zuleika Bouzeid, Advisory Council Operations
Jennifer Holtzman, DDS, Dental Officer
Kimberly Huffman, Director of Advisory Council Operations
LaShawn Marks, Advisory Council Operations
Janet A. Robinson, Advisory Council Operations

Welcome Remarks

Shane Rogers, Designated Federal Official (DFO), ACTPCMD
Zuleika Bouzeid, Advisory Council Operations

Mr. Shane Rogers convened the virtual meeting of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD, or the Committee) on February 17-18, 2022. He welcomed all participants and provided some background on the Committee, including its purpose and purview. He said that in 2022 the Committee is scheduled to complete two reports: the 19th and 20th Reports to the Secretary and Congress. Mr. Rogers then turned the meeting over to the Chair, Dr. Sandra M. Snyder.

Agenda Review

Sandra M. Snyder, DO, Chair, ACTPCMD

Dr. Snyder welcomed everyone and reviewed the meeting's agenda. She then proceeded to conduct roll call, confirming a quorum.

BHW Updates

Luis Padilla, MD, Associate Administrator for Health Workforce, HRSA

Dr. Luis Padilla provided an overview of the Bureau of Health Workforce (BHW), its funding, programs, and the road ahead. For FY22, government-wide priorities will continue to include a response to COVID-19 and health equity. For BHW, priorities will include behavioral health and community health.

The American Rescue Plan (ARP, or Act) has added \$1.55 billion in supplemental funding to HRSA. A total of approximately \$103 million of this allocation has been dedicated to develop programs to address workforce resiliency. Awards for these opportunities are intended to help impact an organization's culture as well as provide evidence-informed planning and training in health profession activities in order to reduce burnout, suicide, and promote resiliency among the workforce.

In addition, the Act has allowed for the allocation of \$100 million to HRSA's State Loan Repayment Program and \$330 million to the Teaching Health Center Graduate Medical Education (THCGME) program. Some of the funding for the teaching health centers will support the development of new accredited primary care residency programs across the nation. BHW has also developed programs to expand access to care, training initiatives, and other programs. Loan repayment programs served 22,760 qualified clinicians working in areas of the U.S. with limited access to care. Thirty-four percent of these clinicians practice in rural communities and 53 percent practice in HRSA-funded health centers.

The application period for the THCGME program is currently open. The deadline is March 31, 2022. Estimated funding is \$19.2 million for an estimated 30 awards. This should provide funding for approximately 120 residents (approx. \$160,000 per resident).

The ARP has also provided \$28.4 million for the Teaching Health Center Planning and Development (THCPD) program, which supports the start-up of new community-based residency programs. The THCPD program supports accredited medical and dental residency

training programs that train residents in community-based training sites and focuses on producing physicians and dentists who will practice in underserved communities. Up to \$500,000 is provided per grant. Thus far, 47 awards have been made in 26 states. The project period is December 2021 through November 2023.

Another open opportunity is funding for Area Health Education Centers (AHECs). Funding is available to develop and enhance education and training networks within communities, academic institutions, and community-based organizations. A total of \$43 million will be awarded for up to 55 award recipients. The deadline for applying is April 6, 2022.

Forthcoming funding opportunities for Spring 2022 include \$239 for Community Health Worker and Paraprofessional Training (80 awards expected) and \$42 million for public health scholarships to encourage careers in public health and develop a workforce that can prepare and respond to public health emergencies.

The ARP has helped to provide communities with more than 22,000 health professionals through the National Health Service Corps (NHSC), Nurse Corps, and the Substance Use Disorder Treatment and Recovery Loan Repayment programs. Through these programs, clinicians who are working in HRSA-funded health centers represent 53 percent of awardees while clinicians serving in rural communities represent 34 percent of awardees in FY 2021.

Scholarships for the NHSC and Nurse Corps have nearly quadrupled as a result of the ARP over the last two years. There are 1,200 new scholars entering the pipeline as a result of the last cycle closing in 2021.

Dr. Padilla also discussed the new health workforce projections dashboard, the health professions education and training initiative, and the road ahead for BHW.

Discussion

The discussion included the questions/comments below.

Is there a required linkage to expand beyond ambulatory care that the Federally Qualified Health Centers and community centers may be able to provide?

In the THCGME model, the residency program has built into it the outpatient component, but it also includes inpatient rotations. Those do not go away because the individual is a THCGME recipient. The emphasis, however, is on outpatient training.

Is there a way to bring this knowledge to the National Dental Association's national conference, which includes students as participants?

HRSA staff attends medical and dental association conferences. Please let the Division of External Affairs know if there is one that would be a good venue, even if it is virtual. HRSA has also created an outreach packet and a toolkit that is available online with all the materials that any stakeholder could use. HRSA can certainly walk a Committee member through those resources.

Primary Care Training and Enhancement Programs – 2021/2022 Update

Cynthia Harne, MSW, LCSW-C, Chief, Medical Training and Geriatrics Branch, Division of Medicine and Dentistry, BHW

Ms. Cynthia Harne presented on the Primary Care Training and Enhancement (PCTE) programs. Their 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.” Annual appropriation for the programs is approximately \$49 million, with 15 percent of it going to physician assistant (PA) programs. All of the programs have a 5-year project period.

There are several programs under the PCTE umbrella. Ms. Harne discussed three of those programs: 1) The PCTE-Residency in Primary Care Training Program, 2) The PCTE-Community Prevention and Maternal Health Program, and 3) The PCTE-Physician Assistant Rural Training Program.

The PCTE-Residency in Primary Care Training Program enhances accredited residency training programs in family medicine, general internal medicine, general pediatrics, or combined internal medicine and pediatrics (med-peds) in rural and/or underserved areas. It also encourages program graduates to choose primary care careers in these areas. A total of \$9.6 million annually is allocated for 21 awards. In the 2020-2021 academic year, the program had 428 trainees. About 16 percent of the trainees were underrepresented minorities, 20 percent of rural background, and 17 percent of disadvantaged background. In addition, 99.8 percent trained in a primary care setting and 48.1 percent in a rural area.

The PCTE-Community Prevention and Maternal Health Program trains primary care physicians in maternal health care clinical services or population health in order to improve maternal health outcomes. Its goal is to increase the number of primary care physicians trained in population health with a focus on maternal health outcomes and increase the number of primary care physicians trained to provide high quality obstetrical care in rural and/or underserved areas. A total of \$16 million annually is allocated for 31 awards. The program includes a primary care obstetrics track. Performance data for these awards will be submitted in July 2022.

The PCTE-Physician Assistant Rural Training Program is a new program that develops and implements longitudinal clinical rotations in primary care in rural areas. The program also supports the training and development of preceptors in rural areas. Its goal is to increase the number of primary care PAs who choose to practice in rural areas after graduation. A total of \$2.1 million annually is allocated for seven awards. The program provides PA students with longitudinal clinical training experiences for a minimum of eight weeks in primary care in rural areas. It develops and strengthens partnerships to implement interprofessional rural clinical training experiences for primary care PA students. It also educates and trains primary care PAs to identify and address health inequities, health disparities, and social determinants of health in the communities they serve.

Discussion

The discussion included the questions/comments below.

It seems there were about 21 awards for at about \$450,000 per award. Is that correct?

Yes, there were 21 awards and there was a ceiling of \$500,000 per year. Residency programs vary, so some institutions came in at the top of the ceiling while others came in lower. This amount is per award and not per resident.

It seems that 70 percent of individuals go into primary care once the program is completed. So 30 percent do not go into primary care, which seems like a high number. Is there any follow-up information explaining why?

There is no specific follow-up information, but some of those individuals are residents going into fellowships, teaching, or research.

For the PCTE-Community Prevention and Maternal Health Program awards, do we know what specialties received those awards? Were they mostly family medicine or OB programs?

There are no purely obstetric programs receiving those grants. Those awards involved enhanced residency programs where family medicine residents spend a bit more time than the regular 3-year residency and work on OB competencies.

For the 8-week rotation, does it need to be continuous and at a single site?

It does not have to be continuous or at a single site. There are different curricula and different programs, so there is flexibility.

How does HRSA verify that clinicians are in training sites located in rural and underserved areas?

Applicants for the community and maternal health program have to provide a chart for their training sites when they apply for the grant. They also have to determine if the site is considered rural using the [Rural Health Grants Eligibility Analyzer](#). Once this information is submitted, it is verified through the completeness and eligibility process at HRSA prior to going to review. There is also regular, ongoing monitoring once grants are awarded. In addition, the grantee's annual progress report must contain information on exactly where each resident or fellow practices.

Grants should have a longitudinal reporting requirement for the graduates so that one can monitor where graduates are practicing after funding ends.

One of the items being included in all new program Notice of Funding Opportunities (NOFOs) is to ensure that a grant recipient has all their trainees, students, residents, or fellows apply for a National Provider Identifier (NPI) number. NPI numbers will therefore be available once the grant closes.

General, Pediatric and Public Health Dentistry Programs – 2021/2022 Update

Erika Terl, Chief, Oral Health Branch Division of Medicine and Dentistry, BHW

Ms. Erika Terl briefed the group on the Bureau's oral health training portfolio as well as upcoming NOFOs. The portfolio consists of five programs: 1) The Postdoctoral Training in General, Pediatric, and Public Health Dentistry, 2) The Dental Faculty Loan Repayment Program (DFLRP), 3) The Primary Care Dental Faculty Development Program, 4) The Predoctoral Training in General, Pediatric and Public Health Dentistry and Dental Hygiene, and 5) The Dental Clinician Educator Development Program.

The Postdoctoral Training in General, Pediatric, and Public Health Dentistry improves access to, and the delivery of, oral health care services for all individuals, particularly low income, underserved, uninsured, underrepresented minority, health disparity, and rural populations. Its goal is to support the development or enhancement of existing residency training programs to incorporate and test new and innovative models of care delivery for rural, underserved, and vulnerable populations. A total of \$14 million annually is allocated for 27 awards.

The Dental Faculty Loan Repayment Program increases the number of dental and dental hygiene faculty in the workforce by assisting dental and dental hygiene training programs to attract and retain faculty through loan repayment. A total of \$4 million annually is allocated for 20 awards.

The Primary Care Dental Faculty Development Program creates national centers able to support the career development of junior primary care dental faculty. Its goal is to support the development of those faculty to become future clinical educators and leaders in primary care dentistry, integrate oral health and primary care in training and practice, and teach how to provide oral health care across the life span as part of age-friendly health systems. A total of \$700,000 annually is allocated for one award.

A NOFO for the Predoctoral Training in General, Pediatric and Public Health Dentistry and Dental Hygiene program was released on November 2021. The application deadline is February 7, 2022. The program's estimated annual award amount will be up to \$300,000 per year (July 1, 2022 - June 30, 2027). The program's goal is to increase the number of primary care dentists, dental hygienists, and other oral health care providers who care for rural, underserved, or vulnerable populations.

A NOFO for the Dental Clinician Educator Development Program was released on November 2021. The application deadline is February 14, 2022. The estimated annual award amount is up to \$187,500 per award, subject to the availability of appropriated funds. The program supports a single junior primary care faculty member in their career development as a future clinician educator and leader in primary care dentistry.

During the 2020-2021 academic year, these programs graduated 3,121 individuals, of which 26.8 percent were trainees from disadvantaged backgrounds.

Discussion

The discussion included the questions/comments below.

There are ten HRSA regions and eight awards. Will there be no more than one award per region?

The applications just came in. HRSA would like as often as possible to distribute awards across the regions. The programs works very closely with individuals in external affairs at regional offices to market our program.

Performance Metrics Overview

Stephanie B. Ziomek, Chief, Performance Metrics and Evaluations Branch, National Center for Health Workforce Analysis, BHW

Ms. Stephanie Ziomek discussed some of the programs and efforts by the Performance Metrics and Evaluation Branch (the Branch), which is part of HRSA’s National Center for Health Workforce Analysis. The Branch leads program performance measurement, analysis, and reporting for BHW. It also coordinates and guides BHW’s efforts to use performance information to improve program planning and implementation.

BHW uses performance data to:

- Respond to questions from Congress and the White House
- Track and report on the Bureau’s performance
- Support evaluation and data-sharing activities as required by the Evidence Act
- Evaluate the programs funded

Performance data is distributed through data [dashboards](#) for the general public, reports published online, and presentations to stakeholders. The Health Professions Training Programs Dashboard offers information on: 1) Participants trained, 2) Faculty trained, 3) Training Sites, 4) Training programs offered, and 5) Courses developed or enhanced. The Branch has also launched a new dashboard, the BHW Grantee Scorecard. The Scorecard is designed to improve program management and performance.

Project Officers and Branch Chiefs can access performance management data. Grantees can also log into the system and see results within their grant. Program management data are also available to HRSA staff and are tailored to each project officer’s portfolio. These data are not publicly available but contain information on the number of graduates by program as well as other data. Only 15 percent of all graduates provided an NPI. Having the NPI for more graduates would allow for tracking a greater sample of providers.

Reports available online also provide important information. For example, a 5-year Outcome Report for the Primary Care Training and Enhancement Programs (PCTE) (AY 2015-2019) showed that approximately 7 percent of U.S. trainees in family medicine received training through the PCTE during that time period. During the same period, the PCTEs trained 4.7 percent of PAs and nearly 4 percent of the residents in geriatrics medicine. Similar reports can

identify graduates by gender, profession, and intention to practice in medically underserved communities or primary care settings.

Discussion

The discussion included the questions/comments below.

Would using an NPI number and a zip code plus four give the amount of granularity needed to report on the practice characteristics of a medical or dental provider in the community?

Ms. Ziomek said she believed that would be enough information to inform where the provider is practicing, but one may need to take an extra step to determine if it is a rural or underserved area.

Could the provider's DEA number be used in conjunction with the NPI to obtain additional information on where the clinician is practicing?

A few years ago, BHW decided to go with the NPI as opposed to the DEA number. Part of the reason is that there are various programs reaching numerous professions and the NPI is very broad. It is also free and takes very little time to receive. The DEA number is not available to all the disciplines the Bureau serves. There is also a cost associated with obtaining DEA numbers as well as linking them to a particular data set.

After an individual leaves a program, do they self-report on where they are practicing?

When an individual is graduating, a HRSA survey asks the clinician where they are intending to practice, such as a rural area, underserved community, or primary care setting. One year after the individual completes the program, another survey asks them where they are currently practicing. The information is available on the HRSA dashboards.

What is the degree of agreement between intent and actual location of practice?

HRSA has done limited research on the connection between what the graduate intended to do versus what they are actually doing. Some of the new outcome reports that will be published in the upcoming months will have results on the matter.

Joint Committee Telehealth Letter of Support

Shane Rogers, DFO, ACTPCMD

Sandra M. Snyder, DO, Chair, ACTPCMD

The ACTPCMD reviewed a joint letter intended for all five BHW committees ACTPCMD, Advisory Committee on Interdisciplinary, Community-Based Linkages, Council on Graduate Medical Education, National Advisory Council on Nurse Education and Practice, and National Advisory Council on the National Health Service Corps written for the Secretary, HHS, and Congress.

Through the letter, the Committees request that the Secretary and Congress urge the Centers for Medicare & Medicaid Services (CMS) to pay for telehealth services at the same rate as allowed for in-person visits during the public health emergency:

- a) To promote reimbursement parity for expanded patient care through telehealth, using either video or voice-only communications for healthcare visits including medical, dental, mental health and behavioral health, and
- b) To support reimbursement parity for telehealth clinicians across disciplines and geography, especially in rural areas.

The letter was approved by the ACTPCMD unanimously, pending minor, nonsubstantial modifications. Thus far the letter has been approved by two Committees. The letter is expected to be approved by all five Committees by the end of March.

Discussion on 19th Report

Sandra M. Snyder, DO, Chair, ACTPCMD

The Committee discussed the proposed recommendations and rationales for the 19th report. After some deliberation and modifications, the Committee agreed on the following five recommendations:

1. The ACTPCMD recommends that HRSA include specific language in its Notices of Funding Opportunities (NOFOs) for Title VII Sections 747 and 748 primary care training programs that prioritize funding for the training of medical and dental trainees on the treatment and care of patients with Intellectual and Developmental Disabilities (IDD) and other Special Health Care Needs.
2. The ACTPCMD recommends that HRSA include specific language in its NOFOs for Title VII, Sections 747 and 748 primary care training programs, that prioritizes the development and implementation of curriculum that includes health equity and cultural humility to improve the care provided to all individuals irrespective of race, ethnicity, disability, socioeconomic status, religion, gender identity, and sexual orientation, while respecting and recognizing the differences and value that each person brings.
3. To improve diversity within the future primary care workforce, ACTPCMD recommends that Title VII Sections 747 and 748 primary care training programs overtly and explicitly encourage the funding of applicants who successfully recruit learners and faculty from underrepresented backgrounds that better reflect the community of need, and place greater emphasis on specific funding factors currently available within Title VII Sections 747 and 748 authorizations.
4. The ACTPCMD recommends that HRSA expand its workforce analysis to include all trainees of federally funded programs by implementing a longitudinal trainee tracking mechanism that uses all available data resources to assess the numbers and percentages of trainees who have completed a program and are practicing primary care, and of those, how many serve underserved communities and vulnerable populations.
5. The ACTPCMD recommends that Congress award funding of Title VII, Sections 747 and 748 primary care training programs at \$200 million to ensure the future primary care

workforce receives the training and resources necessary to adequately care for the nation's most underserved and vulnerable populations.

The recommendations were approved unanimously. A working group will proceed to develop the first draft of the report for Committee review.

Discussion on 20th Report

Jeff Hicks, DMD, Member, ACTPCMD

The Committee discussed the proposed recommendations and rationales for the 20th report, which will focus on Dental Therapy. After some deliberation and modifications, the Committee agreed on the following five recommendations:

1. The ACTPCMD recommends that Congress update the authorizing legislation for the Public Health Service Act Section 748(a)(1) to explicitly include Dental Therapy programs and trainees.
2. The ACTPCMD recommends that Congress increase the funded appropriation for Title VII, Section 748 by \$6 million annually to be utilized for Dental Therapy training programs.
3. The ACTPCMD recommends that faculty of Dental Therapy training programs be eligible for the Dental Faculty Loan Repayment Program (DFLRP) authorized under Title VII, Section 748, of the Public Health Service Act and that the DFLRP receive a funding increase of \$1M to be set aside for faculty of Dental Therapy programs.
4. The ACTPCMD recommends that the Secretary, HHS, include Dental Therapy as an eligible profession for scholarship and loan repayment through the National Health Service Corps (NHSC).
5. The ACTPCMD recommends HRSA implement a longitudinal training tracking mechanism for Dental Therapy trainees, including assessing trainee and faculty diversity, retention in the profession, graduate practice location, populations served, and educational debt load.

The recommendations were approved unanimously. A working group will proceed to develop the first draft of the report for Committee review.

Using Outcomes for Focusing and Growing Training Funding

Robert L. Phillips, Jr., MD, MSPH, Founding Executive Director, Center for Professionalism and Value in Health Care, American Board of Family Medicine Foundation

Dr. Robert Phillips presented on outcome-based funding for Title VII programs. In 2009, the Council on Graduate Medical Education (COGME) recommended \$560 million (or \$660.8 in adjusted 2021 dollars) in funding for Title VII programs. Funding in 2021 was \$532.16 million, which is close to the recommended figure by COGME, although this is mostly due to the

expansion of the Teaching Health Centers Graduate Medical Education program. Dr. Phillips proposed that funding should be in the order of \$750 million to \$1 billion annually.

Outcomes for training programs should be evaluated through a low-burden, reliable manner where programs are not necessarily providing all the data, but obtaining it in different ways that are transparent and easy through collaborations with health professional organizations, certifying boards, and state licensure boards. Funding could also be subject to a geographic assessment of clinician need versus supply.

A recent article by Dr. Phillips and colleagues titled [*Increasing Transparency for Medical School Primary Care Rankings—Moving From a Beauty Contest to a Talent Show*](#) demonstrates how they persuaded the *U.S. News & World Report* educational ranking to modify their ranking system for Best Medical Schools for Primary Care rankings in 2021 so that “30 percent of the score is now based on graduates practicing primary care after their residency training rather than those entering primary care training” (*JAMA Health Forum*. 2021;2(11):e213419. doi:10.1001/jamahealthforum.2021.3419). This has allowed the ranking to be more data-driven.

Similarly, HRSA funding could be more strategic by evaluating the programs in the institutions to be funded by their rank in producing primary care physicians. This would make funding more data-driven with respect to that measure. Programs could also be evaluated as to where their graduates are practicing (e.g., rural and underserved communities).

In addition, the evaluation could include an assessment of the number of program graduates practicing in health professional shortage areas. Using those metrics could help to prioritize funding. Another way to rank programs is to use the [*Residency Footprinting*](#) software by *HealthLandscape*, which shows the “historical relationship between a family medicine residency program and its community, county, state, and region.” This shows which programs are providing clinicians for specific counties, including rural counties. The use of metrics such as the ones discussed above could better determine the need for resources for specific programs.

Discussion

The discussion included the questions/comments below.

How could one require residency programs to report NPI data of their graduates?

It may not be needed because the American Medical Association (AMA) master file is really good at tracking students’ training histories. One may just need to tap data sources and not put the burden on programs.

The data on their own are powerful and can inform decision making, but there are multiple stakeholders. Who should be held accountable for outcomes? Trainees, the programs, funders?

On the GME side, it would be the institutions and programs as there is good evidence about the types of models that produce different workforce outcomes. On the Title VII side, one should think about it as a strategic investment in picking and sustaining those who are producing the workforce needed. Incentivizing would be better than penalizing.

What specific outcomes should one examine and how does one get those measurements?

Outcomes have been specified in Dr. Phillip's GME accountability studies. Also, the National Academy of Medicine had two workshops that discussed outcomes. The AMA has data in terms of a training pipeline, plus one could also examine other data sources such as Medicare, Medicaid, DEA, or NPI to locate the workforce and understand who they are working for. So it would be a combination of datasets.

A participant said the Committee is trying to come up with a financing recommendation. Would it be better to ask for a specific dollar allocation or would it be better to ask for something related to outcomes?

In a rational world, one would build dollars out to try and achieve particular outcomes and then commit to metrics. Another way to go would be to start with a number and then assess outcomes. So there are two approaches.

What organization should take the lead in providing and utilizing the data?

This could be an opportunity to build HRSA's own capacity for workforce assessment. It could also work in collaboration with CMS to inform your funding or at least better understanding of outcomes. If HRSA takes the lead on evaluation, it would likely mean committing more financial resources.

Public Comment

Shane Rogers, DFO, ACTPCMD

No public comments were offered.

Business Meeting

Shane Rogers, DFO, ACTPCMD

Mr. Rogers confirmed all volunteers for the 19th and 20th report work groups. He reminded participants about the [Bureau of Health Workforce All Grantee and Stakeholder Virtual Meeting](#), planned for April 5-6, 2022. The meeting will address various topics including COVID-19, behavioral community health, telehealth, health equity/diversity, and other topics. Mr. Rogers will send an invitation to the event and asked members to please share it with other interested parties. He added the Committee's next public meeting will be held on August 2, 2022.

Adjourn

Sandra M. Snyder, DO, Chair, ACTPCMD

Dr. Snyder thanked all Committee members for an informative and productive meeting. She also thanked the HRSA team, especially Mr. Rogers and Dr. Jennifer Holtzman, for their expertise and support. Dr. Snyder also took some time to thank and acknowledge the contributions of those members who will be rotating off this year, including Ms. Anita Glicken, Dr. Jeff Hicks, Ms. Pamela Patton, Dr. Mark Schwartz, and Dr. Louise Veselicky.

Mr. Rogers adjourned the meeting at 3:04 p.m.