ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY (ACTPCMD)

Meeting Minutes: September 9, 2016

Advisory Committee Members Present:
Allen Perkins, MD, MPH, Chair
Vicki Chan-Padgett, MPAS, PA
Bruce Blumberg, MD
Donald L. Chi, DDS, PhD
Tara A. Cortes, PhD, RN, FAAN
A. Conan Davis, DMD, MPH
Patricia M. Dieter, MPA, PA-C
Elizabeth (Lia) Kalliath, DMD
Thomas E. McWilliams, DO, FACOFP
Linda C Niessen, DMD, MPH
Rita A. Phillips, BSDH, RDH, PhD, CTCP
John Wesley Sealey, DO
Eve Switzer, MD
Elizabeth Wiley, MD, JD, MPH
Stephen A. Wilson, MD, MPH, FAAFP

Others Present:
Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, ACTPCMD, Health Resources Services Administration (HRSA)
Kennita R. Carter, MD, Senior Advisor, Designated Federal Official, Division of Medicine and Dentistry (DMD), HRSA
Crystal Straughn, Technical Writer, HRSA

Presenters:
Tillman Farley, MD, Executive Vice President, Medical Services, Salud Family Health Centers, Associate Professor, Department of Family Medicine, University of Colorado School of Medicine
Alexander F. Ross, ScD, Senior Behavioral Health Advisor, Office of Planning, Analysis and Evaluation, HRSA
Lloyd Michener, MD, Chair, Duke University School of Medicine, Department of Community & Family Medicine
Vivianna Martinez-Bianchi, MD, Director, Duke Family Medicine Residency Program
Cerrone Cohen, MD, Professor, Duke University School of Medicine, Family Medicine & Psychiatry Departments

Day 1- September 9, 2016

Introduction

The Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) convened its meeting at 10:00 a.m. at HRSA headquarters in the Parklawn Building, Room 15SWH01, 5600 Fishers Lane, Rockville, MD 20857. Dr. Joan Weiss opened the meeting and welcomed the members. She then announced that Dr. Kennita Carter would become the new Designated Federal Official for ACTPCMD. Dr. Carter commented she was honored to take on her new role and to work with the ACTPCMD members. Dr. Carter turned the meeting over to Dr. Allen Perkins, ACTPCMD chair. Dr. Perkins introduced the first speakers, Dr. Tillman Farley and Dr. Alexander Ross.

Dr. Ross thanked the Committee for the opportunity to talk about "ways in which the training and education of the next generation of healthcare professionals can be enlivened by the benefits of integrated care." He noted that Dr. Farley, his co-presenter, is both an associate professor in the Department of Family Medicine at the University of Colorado, School of Medicine, and a leader at Salud Family Health Centers, a comprehensive health center located in Colorado with funding support provided by HRSA.

Community Based Considerations for Interprofessional Trainees

Tillman Farley, MD

Dr. Farley opened by stating that he is a board certified family physician. Of note, he completed a family medicine residency in Rochester, New York, where the integrated biosocial model was in full force. Since that time, his first order of business at any new practice setting has always been to start an integrated program. He stated he has served as Executive Vice President for Medical Services at Salud since 1996.

Salud is a Federally Qualified Health Center (FQHC), with 12 sites located across 15,000 square miles of northeastern Colorado. Salud provides care for almost 70,000 unique patients, with about 298,000 visits per year. Approximately 97 percent of their patients have incomes below 200 percent of the poverty line. Until the passage of the Affordable Care Act (ACA) in 2010, only about 30 percent of Salud's patients had health insurance, including Medicaid.

Healthcare Professions Training at Salud

Dr. Farley indicated that Salud provides training sites for healthcare profession students of all types, including medical assistants, physician assistants, nurse practitioners, postdoctoral psychology interns and fellows, medical students and residents. Salud also serves as a training site for four dental schools and provides dental services using an integrated care delivery model. He stated that Salud follows a holistic, behavioral health integration model in which behavioral health, medical, and dental providers work side by side in the same space, with the same patients, using the same chart.

Dr. Farley addressed the question of adapting students coming from nonintegrated care environments into the integrated care environment of Salud, such as medical students who come

from an almost completely biomedical environment. He stated that all clinical trainees are now oriented on their first day to the role of each integrated care team member.

Dr. Farley noted that Salud is in the process of launching a new training program for medical assistants, in partnership with the National Institute for Medical Assistance Advancement. The program's goal is to prepare a medical assistant workforce to participate in integrated primary care and team care, while providing a career path for local high school graduates. In addition, in 2018 Salud will start a new "one-two" medical residency program, in which residents start their first year in Denver, and then complete their remaining two years at a rural health facility in the Fort Morgan area.

Discussion: The Integration of Primary Care, Behavioral Health, and Oral Health

Trauma Informed Care: Dr. Farley responded to a question about trauma informed care by stating that the integrated behavioral health program is not purely consultative. The approach at Salud is to deliver care to the whole person, and every person is somewhere on the spectrum of psychosocial needs. Even for those who are doing very well emotionally, it is an opportunity for screening and preventive services. Salud has developed a screening tool for life stressors that includes the Patient Health Questionnaire-2 (PHQ-2) for depression, along with questions on anxiety, safety, use of alcohol and drugs. Any positive responses will trigger follow-up from a behavioral health provider.

Although, the behavioral health providers do not see all patients, they try to see every new patient as well as those patients that might potentially have a primary psychosocial, mental health or behavioral health component such as palpitations or headaches.

Formal and Informal Connections to Academia: Dr. Farley noted that Salud has formed many collaborations, both formal and informal, with academic institutions. They have agreements with two medical schools, several physician assistant and nurse practitioner programs, and a number of other colleges and universities. They are also developing relationships with the University of Santiago in Chile and University of Puerto Rico to help provide bilingual therapists. He stated that he believed every community health center should collaborate with a local health science center to teach students the connections between teaching, research, and service.

Oral Health Integration: On the connection between primary care and oral health, Dr. Farley explained that poor dentition often leads to low self-esteem and creates barriers to social support and employment. He noted that people with poor dentition often have low income and non-professional jobs, and rarely pursue professional or high-income fields. He reiterated that Salud strongly believed in whole person care. When Salud receives a request for a dental appointment from an individual who is not also a medical patient, the staff attempts to get the patient dual medical and dental appointments on the same day. Dentists need to be aware of many medical conditions, just as medical providers need to be aware of oral health. Optimal care cannot separate care of the teeth from care of the body.

Importance of physical co-location of Oral Health: Dr. Farley said that Salud makes concerted attempts to have pediatric medical patients go to the dental clinic directly across from the medical clinic. However, many patients are lost to follow-up, even when scheduled on the same day in the dental clinic directly across the waiting room from the medical clinic. Embedding a dental hygienist in the medical clinic significantly improved outcomes, indicating the importance of having medical and oral health services in the same location. The dental hygienists stationed in the medical clinic worked to provide fluoride varnishes, oral health education to the parents and establish a dental health home for the pediatric patients. Good oral health begins in childhood.

In addition, Dr. Farley noted that many primary care settings do not provide treatment for patients with substance abuse issues. However, Salud provides care for persons with substance use and other behavioral health issues. He added that medication-assisted addiction therapy and chronic pain care should be available in all primary care offices.

Questions and Comments
Dr. Stephen Wilson asked how the dental staff dealt with the primary care integration. Dr. Farley replied that the Salud clinics provide a full spectrum of dental services. The dental hygienist will typically split time between the medical and the dental clinics.

Dr. Donald Chi asked about the factors that contributed to the reduction in early childhood caries. Dr. Farley noted three interventions:

- Getting at least three or four fluoride varnishes in place,
- Providing oral health education to the parents, and
- Establishing a dental health home for the patient.

Dr Patricia Dieter asked what percentage of new patients exceed the screening cut-off of the mental health screening. Dr. Farley replied that about 47 percent of patients screen positive for life stressors such as anxieties or substance abuse, about 25 percent for depression, and about 13 percent for trauma.

Dr. Tara Cortes asked about patient access to behavioral health services. Dr. Farley replied the behavioral health provider screens most new patients. In addition, patients can request behavioral health services, or the medical provider can see a potential problem and ask for a behavioral health consult.

Dr. Alexander Ross asked how Salud was able to maintain patient flow at an efficient level, and what business model the Center uses to sustain its training. Dr. Farley replied that patients might be seen by a physician, a physician assistant, a medical student, or a nurse. Most appreciate having this access. Patients decide if the care they received was good based on whether or not they were listened to and their concerns were validated. For the dental business model, Salud serves as a clinical training site for four dental schools. Dental students assist with the dental work. Salud employs a dental preceptor and they bill for dental services.

Dr. John Sealey asked who serves as the "captain of the ship" for patient care on the interprofessional teams. Dr. Farley answered that the lead for patient care depends on the patient's needs.

Dr. Stephen Wilson asked how aggressively Salud handles "soft" scores on the mental health screening, since the mood of a patient can fluctuate. Dr. Farley replied that not all patients require a full 50-minute session with a behavioral health therapist, but most may receive multiple 15-minute sessions in conjunction with a medical appointment that provides preventive mental health services and teaches the patient how to cope with adverse or negative emotions.

SAMHSA/HRSA Center for Integrated Health Solutions

Dr. Alexander Ross

Dr. Ross began his presentation by reminding the Committee that Dr. Farley had discussed the critical role of team-based care, in which all members of the team play a crucial part. As an example, he mentioned the importance of behavioral health screening and trauma-informed health practice in recognizing the need to consult a behavioral health provider. Dr. Ross explained the importance of having an effectively trained and available workforce, along with the financing to cover the cost of training the workforce. He discussed the importance of building the financial capacity to support and sustain the training education model. He added that it is important to have trained professionals who understand the value of data in a way that they can use to assess how their practice is doing in performance and critical measures.

Dr. Ross noted that healthcare organizations use three main types of care integration:

- **The coordinated approach**, in which patients in need of further services are referred to agencies or clinics that are not linked together under a business model and are not physically located on the same premises;
- **The co-located model**, in which two or more related two organizations share the same building or physical space, but are not in the same business unit; and
- **The fully integrated model**, that Dr. Farley described at Salud, in which different services are located in the same space and are under one business model. Each type can be beneficial depending on the local environment and the particular circumstances of the organization.

Dr. Ross added that telehealth is an effective way to extend workforce availability. He noted that the Substance Abuse and Mental Health Services Administration (SAMHSA) is looking at - substance use disorder treatment opportunities delivered by telehealth. However, it is unclear what this form of care means in the context of integrated care, and what skills and capabilities are needed for the healthcare workforce to effectively provide tele-services both from the hub location and from the clinic.

Dr. Ross noted that the issue of sustainability in the integration of care is growing in prominence, while the workforce is evolving. Trainees exposed to integration at the earliest times in their education are more likely to stay with this model. However, many organizations have indicated that they have not yet figured out how best to finance integrated care.

He added that HRSA had developed some resources on how to effectively bill and code for integration for an integrated care model. For example, the behavioral health component can be included in the business model even if providers are unable to directly bill for their services. Behavioral health providers can free up the primary care team to do what it does best, while having the staff available to do the warm handoff for behavioral health. Because primary care providers can do their billing in 15-minute increments and move through their patient flow in a more effective way, the behavioral health component can in many instances pay for itself.

Practical Playbook: The Intersection of Public Health and Integrated Care

J. Lloyd Michener, MD, Viviana Martinez-Bianchi, MD, and Cerrone Cohen, MD

Dr. Perkins introduced the speakers for the next presentation, Drs. J. Lloyd Michener, Cerrone Cohen, and Viviana Martinez-Bianchi, from Duke University. Dr. Michener opened the presentation by explaining that the Department of Community and Family Medicine, in the Duke University School of Medicine and Healthcare system, has worked with the city of Durham and the state of North Carolina on primary care and behavioral health integration. The Department serves as a point group nationally about integration programs. The primary care and behavioral health integration at Duke is occurring within the context of the larger integration of an academic health center that has an accountable care organization and Medicare shared savings program. The Duke program collaborates closely with community and state agencies, including the Medicaid program, to determine how to achieve positive health outcomes at a lower cost. Dr. Michener turned the presentation over to Dr. Cohen and Dr. Martinez-Bianchi. Dr. Cohen is double-boarded in family medicine and psychiatry, and leads the behavioral health curriculum for the family medicine training program at Duke.

Behavioral Health Integration in Primary Care Training: Dr. Cohen started by discussing the integration of behavioral health in the context of primary care training, while broadening the scope to look at behavioral health integration from a population health standpoint. The Accreditation Council for Graduate Medical Education (ACGME) guideline for Family Medicine Residency recommends that the curriculum integrate behavioral health into the resident's total educational experience. However, it does not address how to accomplish this integration. Duke's Family Medicine training program has identified three key areas that facilitate high quality behavioral health integration:

1. **Awareness and Understanding:** Using a structured curriculum can help the trainee gain *awareness and understanding* of the role the primary care physician in the behavioral health landscape. Trainees need to understand their role in patient care, particularly in managing complex, biopsychosocial issues. They also need to know when to refer a patient for behavioral health services.

2. **Competency:** The curriculum can help ensure that family medicine residents gain *competency* in diagnosing and treating behavioral health concerns in a primary care context. Residents gain understanding of the complex bio/psycho/social factors that make up behavioral health and ways that they can intervene on both a patient and a

population health level. This training covers didactic education, along with experiential learning through clinical rotations. Teaching alone does not constitute integration.

3. **Empowerment**: The training program needs to provide adequate supervision and promoting a safe environment that allows trainees to develop and practice clinical skills with confidence, so that they feel *empowered* to utilize these concepts after residency.

Dr. Cohen explained that Duke uses a 3-tiered approach to improve and implement integration. The first tier is a foundation of creating a healthy program environment that values behavioral health and personal well-being, and promotes an environment of safety, self-care, and work/life balance. The residents and trainees interact with multiple behavioral health providers, meet monthly in a group led by a staff psychologist to discuss difficult cases that often bring up strong emotional reactions, and spend time with advisors.

The second tier is didactic learning that teaches behavioral health through a primary care lens along with community engagement. Behavioral health lectures focus on mood disorders, anxiety disorders, and substance abuse, to help residents feel comfortable with what they can do as a primary care physician. Training also emphasizes the overlap between physical and mental health care, including the physical manifestations of behavioral health issues or psychiatric illness. The curriculum is not medication-based, and residents learn some behavior interventions that include motivational interviewing and brief therapeutic interventions that can be done in clinic.

The third tier is moving towards creating relevant clinical experiences that build resident's skills. Dr. Martinez-Bianchi added that Duke has engaged different community organizations, health departments and organizations that are addressing behavioral health. Duke is working to bridge cultures and integrate other providers of care. For example, many residents work with the Department of Veterans Affairs (VA), providing an opportunity for family medicine residents to learn about the mental health issues faced by Veterans as well as addiction care. By working with different community organizations, residents see populations of patients that they might normally miss in a family medicine center.

The framework for public health action highlights the socio-economic factors that influence health. For example, according to SAMHSA, about 20 to 25 percent of the homeless population in the United States suffers from some form of severe mental illness. On the other hand, mental illness is the third largest cause of homelessness. As a result, residents conducting their population health improvement project in homelessness have the opportunity to work within the areas that address socio-economic factors that overlap with mental health. Learners need to understand mental health in the context of the community and the links between mental health and homelessness, and the must work with care managers. Residents must learn to use screening tools and be prepared to address depression, addiction, and other behavioral health issues while working on preventive service visits.

Dr. Cohen noted that there are frameworks and models to understanding a global view of mental health, along with opportunities to learn from what others across the world are doing. Frameworks created by the World Health Organization review human rights and policy for

mental health campaigns, and then collaborate with housing, pharmaceutical access for medications, human resources, and other organizations.

Locally, Duke wants to train learners to understand the opportunities for how community engagement and collaboration plays a role in behavioral health. For example, approximately 20 percent of prison inmates have a serious mental illness and 30 to 60 percent have substance abuse problems. It is important to engage and collaborate with social services, the Justice Department, education, housing, correctional officers, police departments, and other consumer groups that are working within areas that overlap with mental health services.

Dr. Cohen explained that the effectiveness of implementation strategies could be evaluated in many ways: resident's confidence in the ability to provide mental health care to patients; percent of graduates providing mental health services after graduation; graduate confidence in the care of the psychiatric patient (postgraduate surveys every 2 years and 5 years); and patient satisfaction with care. Other measures of effectiveness include making appropriate referrals and ability to work in collaborative teams.

Barriers to Increasing Integration

Dr. Martinez-Bianchi highlighted some barriers to training in integration: the challenge of finding high quality, relevant experiences that mirror the future practice; finding faculty who can see mental health through a primary care lens; and making the learning accessible to residents. In addition, lack of funding for the behavioral scientists within the department has been an issue. She noted that Duke has had to schedule shorter appointments to make up for loss of revenue, which reduced time with patients. Other barriers include lack of imagination (perception of only barriers); lack of acceptance (the biomedical model does not include behavioral health); lack of an adequate number of trained faculty; and establishing sustainability. In the past, rules from ACGME considered that one specialty should be under one roof. ACGME has now realized the benefit of integrating other specialties within the family medicine center.

Dr. Martinez-Bianchi highlighted some ways to overcome barriers to integration:

- Increasing funding, which would allow for greater participation in community settings;
- Funding of behaviorists to teach in primary care settings;
- Using embedded specialists who are seeing their patients while teaching;
- Starting good integration early in career to allow acceptance;
- Promoting a safe environment for people to talk about behavioral experiences;
- Sharing data; and
- Using mental health workers in coordination with primary care.

A recent Institute of Medicine (IOM) report on integrating primary care and public health provided some model recommendations on integration:

- Develop a workforce needed to support the integration of primary care and behavioral health (identify options for graduate medical education funding and that give priority to provider-training in primary care and behavioral health settings, and specifically support problems that integrate primary care with behavioral health practice),

- Develop the workforce needed to support the integration of primary care and behavioral health (create specific Title VII and VIII criteria or preferences related to curriculum development and clinical experiences that favor the integration of primary care and behavioral health), and
- Develop training grants and teaching tools that can prepare the next generation of health professionals for more integrated clinical and behavioral health functions in practice. These tools should include a focus on cultural outreach, behavioral health education, and addiction counseling.

Questions and Comments

Dr. Perkins asked the speakers to comment on how their training program can help to train individuals to function in an accountable care community. Dr. Michener referred to a recent paper in the *Journal of the American Medical Association*, which described the need to move from focusing on healthcare alone to seeing healthcare as a way of improving health in communities and reducing disparities. Dr. Carter requested the article citation.

Dr. Michener emphasized the importance of training clinicians, and especially those in primary care, to take a broader perspective on health than just healthcare and to be able to work within integrated settings. He noted that many states are investing significant funds to implement and sustain healthcare integration. For example, New York State is investing $6 billion over five years, with the priority of integrating primary care and behavioral health. With the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and other alternative payment models, healthcare integration should be available across the United States by 2020.

Dr. Switzer asked about the incorporation of pediatric behavioral health, including services for attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, and other conditions. Dr. Cohen replied that pediatric health and behavioral health are integrated in the curriculum. For example, training includes having a practitioner who does evaluations for autism spectrum disorders discuss what primary care providers should recognize in children as young as two to three years of age, to make appropriate referrals. A similar process was done for ADHD. Primary care physicians can order stimulants to treat ADHD, but there is also a referral system available for additional consultation. Dr. Michener added that Duke works with community agencies and helps coordinate behavioral health programs in schools.

With respect to the IOM recommendations, Dr. Dieter asked the speakers to comment on the financial implications of integrating behavioral medicine within a primary care residency program. Dr. Martinez-Bianchi replied that Duke bills for behavioral health at primary care levels. She added that there is a concern with how to fund the salary of a behavioral scientist within the residency program, and grant funding may be available.

Dr. Wilson noted that residency training occurs over a fixed time, and asked what areas of training received decreased emphasis in order to increase time for integrated care training. Dr. Martinez-Bianchi replied that the decision was made to emphasize population health and integrated care, along with work in the community and ambulatory care, and integrated psychiatric care, and to place less emphasis on the work inside the hospital Changes were made

in the context of the state Medicaid/Medicare program that is working to reduce admission rates to hospitals.

Dr. Sealy asked if the psychiatry graduates in the combined program are being pulled into being only consultants or faculty. Dr. Cohen replied that the combined training opens up graduates to a world of possible career paths. He added that the best part of his job is to teach psychiatry to non-psychiatrists. He is able split time between two departments and provide a mixture of primary care and mental health care. He added that the combined training opens up a wide breadth of ideas, and is not necessarily a set track.

Dr. Carter said that the broader question concerns the spectrum of care and the continuum of care, including those patients who are otherwise doing well in their life but are facing work-related or other challenges and may need assistance, or patients with chronic conditions who may struggle with pain management. She asked about the use of self-care strategies from a behavioral health standpoint.

Dr. Cohen replied that some therapies are medication-based. However, they also use many interventions involving cognitive behavioral strategies like motivational interviewing. He added that interventions he focuses on involve holistic care, helping patients take care of their whole body. For instance, the treatment of depression often includes the need to address pain, along with other chronic conditions like diabetes and hypertension. Holistic approaches can empower patients to take charge of their own health, and help them understand more about their health conditions. The programs place a lot of emphasis on diet and exercise for self-care. Resident also have the chance to watch and participate in a centering program with pregnant patients.

Dr Martinez-Bianchi asked Dr. Carter if her question also referred to the residents themselves, adding that the program teaches residents that improving their own self-care often translates to care of their patients, and they provide a good support system for residents.

Dr. Cortes asked how the program handles patients who have acute psychiatric needs like bipolar disorder or schizophrenia. Dr Cohen replied that there is a co-located clinic within the family medicine building, which allows him to see psychiatric patients alongside his other primary care patients. He added that there is a new pilot program as an elective, which allows a primary care resident to train in the mental health clinic to help them see more of the breadth of care. For most primary care providers, the primary role should not include managing patients with advanced schizophrenia, but they need to know how to assess patients, what basic treatments are available, and when to refer.

ACTPCMD Writing Group Update: Program Review for Primary Care and Oral Health

Dr. Carter opened the discussion by informing the members that the writing group for the White Paper Report on ACTPCMD Program Evaluation for 747 and 748 programs has been meeting and discussing program preferences and priorities. There is a level of complexity involved around the preferences and priorities, and in reviewing the programs. She invited Dr. Maria Portela-Martinez and Mr. Shane Rogers to talk about their programs and to answer any questions the Committee may have.

ACTPCMD 14th Report Discussion

The Committee discussed the outline and recommendations for the ACTPCMD 14th Report, *Integrated Health Services for Trainees: Primary Care, Oral Health and Behavioral Health.* They stated that the Duke program should be included the report as a best practices resource, both in terms of how to implement it and what the graduates are doing after they complete the program. They also discussed funding, interprofessional team care, experiential learning Medicaid reimbursement for dental services, faculty development, primary care, oral health and behavioral integration, policy development and training. After much deliberation, the Committee developed the following draft recommendations:

> **Recommendation 1:** The ACTPCMD recommends that HRSA's Title VII Part C, Section 747 and 748 education and training programs provide funding to prepare the integrated health care team; including faculty and other health care team members, to lead the transformation of primary care to include behavioral and oral health. Note: The Committee suggested outlining in the discussion that there are options beyond including dentists such as health professionals with oral health training, dental hygienists, emerging professionals (peer support specialist, community health workers)
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> **Recommendation 2:** The ACTPCMD recommends that HRSA's Title VII Part C, Section 747 and 748 education and training program that supports the preparation of students, trainees and practitioners to integrate behavioral health into primary care and oral health to achieve the quadruple aim with vulnerable populations.
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> **Recommendation 3:** The ACTPCMD recommends that SAMHSA/HRSA Center for Integrated Health Solutions develop a toolkit and repository of best practices for training programs to facilitate the design of educational programs integrating primary care, behavioral health and oral health that include methods of measuring short term and longitudinal outcomes including practice patterns for completers.

Business Meeting/Committee Discussion

The ACTPCMD members elected a new vice-chair, Dr. Russell Phillips and welcomed Vicki Chan-Padgett as the new chair. Dr. Weiss and the members also thanked Dr. Perkins for his service as chair for ACTPCMD.

The members then discussed the topic for the next ACTPCMD report. Dr. Carter reminded the members the topic of the ACTPCMD 15th report is Provider Wellness and the Quadruple Aim. The report would have an interprofessional focus that explores looking across the spectrum, resiliency to risk for depression, impairment, and suicide prevention. It is also an opportunity to highlight that interprofessional care is associated with better outcomes regarding the quadruple aim. The members then discussed provider burnout and retirement age and suggested an expert from ACGME present at the next meeting on resident wellness and duty hours.

The members volunteered to participate on the Planning Committee for the ACTPCMD 15th Report on Provider Wellness and Resiliency and the Writing Committee for Integration of Primary Care and Behavioral Health. The Planning Committee members are Vicki Chan-Padgett (chair), Russell Phillips (vice-chair), Bruce Blumberg, John Sealey, Elizabeth Wiley, and

Stephen Wilson. The Writing Committee members are Vicki Chan-Padgett (chair), Russell Phillips (vice-chair), Tara Cortes, Allen Conan Davis, Patricia Dieter, Linda Niessen, and Allen Perkins. Dr. Kennita Carter thanked the members for volunteering to serve on the planning and writing committees. She would be reaching out to both committees in the next few weeks to discuss the outline and recommendations for the ACTPCMD 14th report and speakers and objectives for the ACTPCMD 15th report.

Public Comment
There was no public comment.

Adjournment
The meeting adjourned at 4 p.m.