MEETING MINUTES
Advisory Committee on Interdisciplinary Community-Based Linkages
October 20, 2020

Committee Members Present
Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP
Chair

Geraldine Bednash, PhD, RN, FAAN
Katherine Erwin, DDS, MPA, MSCR
Roxanne Fahrenwald, MD, FAAFP
Teri Kennedy, Ph.D., MSW, LCSW, ACSW, FGSA, FNAP
Parinda Khatri, Ph.D.
Sandra Pope, MSW
James Stevens

HRSA Staff in Attendance
Shane Rogers, Designated Federal Official
Robin Alexander, HRSA Liaison, Advisory Council Operations
Kennita Carter, MD, Designated Federal Official, ACTPCMD
Kimberly Huffman, Director of Advisory Council Operations
Anne Patterson, Public Health Analyst
Janet Robinson, Advisory Committee Liaison, Advisory Council Operations
Joan Weiss, PhD, RN, CRNP, FAAN, ACICBL Subject Matter Expert, Deputy Director, Division of Medicine and Dentistry

Introduction

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 10:00 a.m. Tuesday, October 20, 2020. The Health Resources and Services Administration (HRSA) facilitated the meeting through a virtual platform. Mr. Shane Rogers welcomed the Committee, presenters, and members of the public attending the meeting. He thanked Committee Chair Dr. Nicole Brandt for her work planning and preparing for the meeting, and Mr. James Stevens, Immediate Past Chair, for his work leading the Committee and developing the 19th Report. Mr. Rogers congratulated the previous ACICBL Designated Federal Official, Dr. Joan Weiss, on her new role as Deputy Director of HRSA's Bureau of Health Workforce (BHW) Division of Medicine and Dentistry. He said that Dr. Weiss will serve as a Subject Matter Expert for ACICBL moving forward.

Mr. Rogers explained that the purpose of the Committee is to provide advice and recommendations to the Secretary of Health and Human Services and to Congress on policy and program development activities pertaining to programs authorized by Part D of the Public Health Service (PHS) Act. The Committee currently comprises eight members who represent health professions specifically noted in Part D of the PHS Act. Members also are represented geographically, and by gender, race/ethnicity, and urban and rural residence. Mr. Rogers thanked the Committee members for their work. He and Ms. Janet Robinson gave instructions regarding meeting participation. Mr. Rogers took roll call. All Committee members were present, except

Dr. Geraldine Bednash, who joined the meeting later in the day. Dr. Brandt welcomed Committee members and thanked Mr. Rogers and Dr. Weiss for their guidance and leadership. She asked Committee members to introduce themselves and participate in an ice-breaker activity, which they did.

Bureau of Health Workforce Update
Luis Padilla, MD
Associate Administrator
Bureau of Health Workforce
Health Resources and Services Administration

Dr. Brandt introduced Dr. Luis Padilla. Dr. Padilla thanked Committee members and HRSA staff for their work, especially their work serving communities during the current COVID-19 pandemic. He summarized BHW's priorities. The Bureau's priorities are: increasing access to culturally and linguistically competent services for underserved and vulnerable populations; ensuring the supply of health care workers meets demand for their services; increasing workforce distribution to meet demand for services; and providing education and training that supports development of a high-quality workforce whose services improve population and community health outcomes.

Dr. Padilla stated that BHW is examining ways it can improve support for rural and underserved communities, a core aspect of HRSA's mission, through the Bureau of Health Workforce Investments to Support Equity (BHWISE) program. BHWISE supports community needs assessments and tailors funding opportunities to address those needs. It also aims to maximize program impact through partnerships and collaboration. BHW is interested in gaining and understanding of local-level community needs, and in tailoring its programs to address these needs. The Bureau seeks advice from the Committee on ways to measure community-level needs, and use these data to inform program planning and development.

Dr. Padilla described fiscal year (FY) 2020 program accomplishments and initiatives. He noted BHW's behavioral workforce portfolio includes the Behavioral Health Workforce Expansion Program (BHWEP), Addiction Medicine fellowships, and the Opioid Impacted Family Support program. He stated that addressing the national epidemics of substance use and opioid abuse is a BHW priority. BHW is addressing these issues by increasing the number of qualified health care providers in communities in need, and by supporting integration of primary care and behavioral health services. BHWEP has trained more than 10,000 professional and paraprofessional health care providers since its inception. The program's annual budget is $40 million to train professionals and $15 million to train paraprofessional care providers. BHW expects the program to reduce the undersupply of health care providers by nearly 40 percent by 2030.

Meeting the need for geriatric care is a HRSA priority. HRSA aims to improve health outcomes through education that leads to practice improvement. BHW is working to transform primary care sites and delivery systems into age-friendly health systems that address needs identified as most important to patients: "what matters", medication, mentation, and mobility. HRSA requires grantees to use four Centers for Medicare and Medicaid Services (CMS) metric-based incentive payment system (MIPS) quality indicators as performance measures. Dr. Padilla thanked Dr.

Weiss for her work to implement this requirement. BHW is exploring ways to expand this type of requirement to demonstrate program value.

The Area Health Education Center (AHEC) program trains participants to deliver high-quality, culturally competent primary care in rural and underserved communities. HRSA is interested in Committee input regarding ways community-level data can inform AHEC programming. Dr. Padilla reported that 41 percent of individuals who have completed training in a BHW program now provide health care in rural communities.

In partnership with the Bureau of Primary Health Care, BHW awarded $5.8 million to 52 States and territories, and regional Primary Care Associations (PCA). Grantees are eligible for supplemental funding in the amount of 10 percent of their PCA awards or $75,000, whichever is greater. Awards support grantees in using a validated 41-item Readiness to Train survey instrument to assess seven domains. Readiness levels are defined as "fully," "approaching," and "developing." Grantees then develop targeted efforts to increase their readiness. HRSA will use performance measure data to identify specific needs for support, and to tailor investments accordingly. BHW expects half of grantees to complete their assessments during Year 1. Following the assessment, health centers will work with PCAs to develop workforce development plans, which they will begin implementing in Year 3. Dr. Padilla asked Committee members to encourage their local PCAs to participate in this effort. He noted that success will require academic-community partnerships.

BHW's efforts to address COVID-19 focus on transformation, mobilization, support, and analysis. The Coronavirus Aid, Relief, Recovery and Economic Security (CARES) Act authorized $15 million for HRSA to increase access to telehealth and distance health care services. HRSA awarded these funds to 159 grantees through four programs. Funds are supporting tele-mental health service delivery, integration of primary care and behavioral health services, and training the health care workforce to deliver telehealth services. At the beginning of the pandemic, many academic institutions were not prepared to educate and train students and health care providers through digital platforms. These grants are helping them to address the pandemic in three areas: prevention by promoting the use of telehealth to reduce the risk of COVID-19; preparation by enhancing readiness to respond to COVID-19 through telehealth technologies; and responding by providing access to telehealth technologies to limit spread of COVID-19.

Mobilization of clinicians, residents, and faculty is necessary to address the pandemic. BHW removed barriers to mobilization by introducing flexibilities into its programming, for example, BHW suspended service obligations of National Health Service Corps (NHSC) and Nurse Corps participants who were unemployed or furloughed and unable to deliver services in-person or through telehealth. The Bureau also offers opportunities for these participants to earn credits for volunteering their services to address COVID-19. HRSA has waived fees for using the National Practitioner Data Bank. An Executive Order relieves students of obligations to pay interest on revolving student loans through the end of 2020. BHW's nine Health Workforce Research Centers are conducting 28 research projects on topics such as workforce deployment, projections, recruitment, retention, attrition, and burnout.

Section 3402 of the CARES Act requires the Secretary of Health and Human Services to develop a comprehensive and coordinated plan to develop the health care workforce through education and training. The Secretary is required to consult with the Council on Graduate Medical Education (COGME) and the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) to coordinate with other Federal agencies that support workforce education and training programs, such as the Department of Veterans Affairs (VA) and CMS. ACICBL also will be coordinating input from the other three Federal advisory committees within BHW, to include the ACICBL, as they also work on health workforce issues. The plan is due March 27, 2021. A progress report is due March 2022. HRSA currently is collaborating in developing this plan and will present an overview to the Chairs of its five advisory councils and committees in early November.

Dr. Padilla thanked Committee members for the effort and detail in their annual reports. He stated their work over the past 5 years has been especially relevant to BHW. He noted that 2015 was the last time ACICBL conducted an in-depth evaluation of programs under its purview and that BHW would provide significant programmatic updates for the Committee during its January 2021 meeting. BHW will share any data relevant to the Committee's next report.

Dr. Padilla asked Committee members how the pandemic has affected their work, especially education and training. He inquired about their needs, provider burnout and resiliency, and ways HRSA support has benefited rural and underserved populations during the pandemic. He also asked how HRSA can better assist in addressing challenges, and which data would help to define community needs.

Discussion
Mr. Rogers thanked Dr. Padilla for his presentation. Dr. Brandt also thanked Dr. Padilla and asked if there were BHW priorities that Committee reports have not addressed. Dr. Padilla noted the reports have aligned well with BHW priorities citing that he 19th Report's emphasis on social media utilization was a prime example. BHW would like more information about digital literacy and preparing priority populations to use digital health care delivery platforms. BHW is also interested in information about delivering culturally competent telehealth services.

Dr. Brandt asked how Committee members can identify and contact their local PCAs. Dr. Padilla response was that BHW can request a list of PCAs from the Bureau of Primary Health Care, and provide it to Committee members.

Sandra Pope inquired as to whether Dr. Padilla anticipated changes in AHEC priorities during the next round of grants. Dr. Padilla replied that BHW will address gaps stakeholders identify in the AHEC Scholars program, and that he does not anticipate major changes in the AHEC program. He invited input about the program from Committee members.

Dr. Teri Kennedy remarked that the COVID-19 pandemic has presented an opportunity to expand telehealth capacity, to encourage health care providers to offer telehealth services, and for patients to learn the benefits of telehealth. In 2020, the National Academies of Practice identified telehealth as a policy focus area and is considering how telehealth care facilitate team-based practice. She added that some rural and frontier communities have expanded advanced

practice nurses' scope of practice in response to the public health emergency. This may continue after the emergency. The pandemic has led to increased awareness of the value of public health infrastructure and led to increased understanding of the importance of self-care for the health care workforce. She inquired whether Dr. Padilla could specify aspects of digital literacy of particular interest to BHW. Dr. Padilla concurred with Dr. Kennedy's points and responded that HRSA is considering ways to expand public health infrastructure. One potential approach is to train community health workers in public health core competencies. In addition, HRSA is interested in broad discussions about digital literacy, including barriers and ways to overcome them, tailoring digital technology to meet communities' needs, and training providers.

Dr. Katherine Erwin stated that she was an AHEC project director and has worked with the program for 15 years. The AHEC Scholars Program strengthens interdisciplinary peer networks and understanding of the value of perspectives from multiple disciplines. She thanked Dr. Padilla for supporting the program. She affirmed that the AHEC program she works with offers bimonthly lectures from expert speakers, with credit for didactic training. She noted that it would be valuable to conduct this type of training at a national or regional level, inviting experts on COVID-19 and other priority topics, such as electronic health records utilization. In addition, community members could participate and provide input on their needs and perspectives in discussions with their local AHECs. National or regional training would be a cost-effective approach to ensuring all scholars learn critical information. Dr. Padilla thanked Dr. Erwin for her suggestion. He noted that the COVID-19 pandemic has inspired discussion regarding how best to prepare students to deal with public health emergencies, as well as whether and how to incorporate students into the workforce to address public health emergencies.

Mr. James Stevens stated that transportation to medical facilities is a challenge for frontier communities. In rural Alaska, air transportation is necessary to reach any facility other than a clinic. Being in the hospital is isolating; it would be helpful to develop strategies for helping patients deal with this isolation when they are far from their home communities. In addition, bandwidth is limited in frontier communities, which is an important consideration for developing digital literacy training. Lack of bandwidth limits ability to provide telehealth services. He also noted that 80 percent of communication is non-verbal and that health care providers would benefit from training in reading body language, especially when they must rely on telehealth. Dr. Padilla agreed with Mr. Stevens' points. He commended Alaska on incorporating community health workers into its health care workforce, affirming that this is a model approach for increasing access and decreasing isolation, and noting community health workers also could help to increase digital literacy.

Dr. Roxanne Fahrenwald commented that COVID-19 has highlighted the need for more behavioral health care providers and that quarantine and social distancing have resulted in social isolation. In addition, while digital technology facilitates some types of contact, increased use has resulted in decreased physical contact and in-person interactions. This physical distancing strains mental health. She recommended supporting efforts to reduce social and physical isolation. Dr. Padilla responded that BHW prioritizes expanding the behavioral health care workforce, with a focus on integrating behavioral health care and primary care. He agreed with Dr. Fahrenwald's point and suggested that, when feasible, home visits can help to address this issue and provide an approach for assessing patients' social context, including risk factors.

Dr. Geraldine Bednash noted the Report of the Taskforce on Telehealth Policy was released approximately 3 weeks prior to the October 20, 2020 ACICBL meeting. This report discusses issues related to delivering care to people who are geographically isolated and to people who are isolated from resources.

Dr. Padilla thanked the Committee for its work. Dr. Brandt thanked Dr. Padilla for his time. Following a lunch break, Mr. Rogers conducted roll call and confirmed that all Committee members and Dr. Weiss were present.

Discussion: Potential Topics for Committee Report for Fiscal Year 2021

Dr. Brandt welcomed Committee members back from their break. She invited Dr. Weiss to comment on potential topics for the Committee's 20th Report to the Secretary and Congress. Dr. Weiss stated that potential topics members had suggested during their previous meeting included career bullying, and a review of Title VII Part D programs with recommendations regarding appropriations and performance measures.

Ms. Pope suggested conducting a review of Title VII Part D programs with an emphasis on the impact of COVID-19. Dr. Bednash supported this idea. She recommended discussing how the pandemic is affecting health care delivery and the competencies providers need. Report topics could include telehealth, and training clinicians to understand and address racial justice issues. Dr. Khatri recommended conducting a program review and examining what does and does not work, and what should be changed about the programs. She supported evaluating the effects of COVID-19 on how stakeholders perceive public health infrastructure and health care delivery, as well as identifying provider competencies that have become necessary during the pandemic. She noted that students and trainees want to deliver care during emergencies and need training that supports doing so. COVID-19 has exposed the health disparities resulting from structural racism. She recommended addressing all of these issues in the Committee's next report. Dr. Fahrenwald agreed with the suggestion to review programs with consideration of racial and economic justice issues, as well as geographic equity. Dr. Kennedy concurred with the suggestion to review programs with a focus on structural inequity, including how inequity in access to technology is related to racial inequity. Mr. Stevens agreed with the Committee members' points. Dr. Bednash state the Committee could consider making recommendations regarding public health infrastructure development, including support for internet connections.

Dr. Kennedy expressed interest in developing recommendations regarding ways to increase equity in the health workforce and agreed that telehealth is related to equity issues. She also supported consideration of career bullying as a report topic. Dr. Fahrenwald noted that both salary differences and the cost of education are sources of inequity in the health workforce. Many people assume health care education requires assuming a large amount of debt, which may deter them from pursuing a career in health care. She suggested considering education costs and health care professionals' salaries as potential report topics.

Dr. Weiss reminded the Committee that Section 755 of the Public Health Service Act pertains to educating allied health professionals and is under the Committee's authority. HRSA supports

training for allied health professionals through AHEC. However, the programs do not have statutory authority to increase the pipeline of allied health professionals. The Quentin N. Burdick Program for Rural Interdisciplinary Training focused on recruiting and retaining allied health professionals in rural areas, however the program has not been funded since 2005. She suggested the Committee may want to consider these points when developing its recommendations. Dr. Brandt agreed that the Committee should consider funding levels of existing programs and for efforts to address the priorities Dr. Padilla discussed.

Dr. Erwin stated she supported earlier comments. She recommended for the Committee to consider the issue of communicating effectively with communities about public health. There has been a great deal of miscommunication regarding COVID-19, which has increased prevalence of the virus. She suggested communication improvement as a potential report topic. Dr. Kennedy agreed that the topic of rebuilding trust and supporting the public's access to trustworthy information is important. Successful communication efforts would require community partnerships in which trusted community members endorse public health information. Dr. Brandt concurred.

Mr. Stevens inquired what the Committee can recommend regarding performance measurement. Dr. Weiss stated every BHW program must report on two types of data annually. The first is in the non-competing continuation grant applications for which grant recipients provide a description of activities the program has engaged in to accomplish its objectives as well as barriers and challenges encountered and ways they were addressed. The other type of data is reported in the Annual Performance Review which provides data on the number of program participants trained, whether they were trained in rural or underserved areas, how many served in rural or underserved areas 1 year after completing training, and the number of participants from disadvantaged or underrepresented minority backgrounds. The Committee can recommend adding or omitting data elements. Dr. Brandt asked whether BHW would like these measures to align with others. Mr. Stevens noted that performance data requirements drive work and could be a mechanism for progressing toward targeted outcomes. He inquired whether the Committee could make recommendations about performance measures with this aim. Dr. Weiss confirmed that BHW reviews performance data reports to inform program planning. GWEP grantees link education and training activities to CMS Merit-Based Payment Incentive performance measures which have led to improving the delivery of age-friendly health care in primary care sites and delivery systems in just 15 months. Mr. Rogers stated BHW could invite Bureau data experts to deliver a presentation about performance measures at the Committee's next meeting.

Dr. Kennedy suggested reviewing previous Committee reports to identify recommendations related to topics currently recommended that have not been implemented. In addition, she suggested reviewing programs to identify ways to eliminate or reduce structural inequities, then recommending measures to assess progress in this area. Dr. Brandt supported these suggestions and requested for HRSA to display recommendations made in the Committee's 15th (2015) Report, which HRSA staff did. Dr. Brandt asked HRSA staff to discuss whether the report's recommendations had been addressed.

Dr. Weiss noted the first recommendation in the 15th Report was related to changing Title VII Part D program eligibility requirements. Only Congress can make this change, which, to date, it

has not. Dr. Fahrenwald stated that a school of nursing operates the Montana AHEC because Montana has no medical school. The AHEC is part of the University of Washington consortium. This approach has been successful. She stated AHECs have implemented the spirit of the 15th Report's first recommendation. She believes this is the case across Title VII Part D programs. She noted that Dr. Padilla previously had invited the Committee to identify legislative and regulatory barriers to goal achievement. She suggested that the Committee do so for the 20th Report.

Dr. Bednash stated the recommendation's intent was to require interprofessional training. She asked whether the Committee can mandate this. She noted many institutions were designed to support professional homogeneity and the Committee should recommend that programs require interprofessional training. Dr. Weiss reminded the Committee that all the programs under Title VII, Part D are required to provide interdisciplinary/interprofessional training by statute. Dr. Kennedy noted that interprofessional collaboration supports equity across health professions. For example, including social workers in health care teams can help to address social determinants of health. Dr. Bednash stated programs should be required to use performance measures that indicate whether they are participating in interprofessional partnerships in which all partners play meaningful roles. Dr. Fahrenwald agreed. Dr. Brandt suggested recommending both legislative change and utilization of performance measures that assess interprofessional education and competencies.

Dr. Weiss stated the 15th Report's 2nd recommendation was that performance and evaluation measures of BHW's interprofessional education programs should be based on students' and participants' competencies rather than patients' outcomes. Dr. Weiss said she did not think these recommendations had yet been implemented. Dr. Bednash stated grantees report students' interprofessional experiences, but do not employ a performance measure of interprofessional competencies. Dr. Kennedy noted that a school of nursing in Oregon has developed and validated a tool to assess interprofessional competencies. Dr. Fahrenwald affirmed that measures of interprofessional competency and teamwork are used to assess residents. These could be adapted to assess medical students. If the Committee recommends requiring grantees to measure interprofessional competencies, it should recommend some potential measures. Dr. Kennedy confirmed that it is important to measure the impact of interprofessional care on care quality, patient experience, population health outcomes, cost reduction, and provider experience.

Dr. Bednash inquired as to why the Committee had recommended measurement of students' accomplishments rather than patient outcomes. Dr. Weiss stated that at the time of the writing of the 15th Report some Committee members expressed concerns and were not in favor of evaluating geriatric programs based on patient outcomes. They preferred evaluating educational outcomes.

Dr. Weiss stated that the 15th Report's 3rd recommendation was to allow grantees to use funds to cover expenses for students' moving to and living in rural communities. Ms. Pope said this recommendation was implemented. Dr. Weiss agreed.

Dr. Kennedy pointed out that research demonstrates that students who train in rural communities are more likely to work in those communities. The Committee could consider recommending

prioritizing support for scholars who are most likely to continue service in communities most in need. The Committee also could require a service obligation. She added that telehealth training could connect trainees with rural and underserved communities. Dr. Weiss said the NHSC and Nurse Corps do have service requirements. Service requirements can be made only through statute.

Dr. Weiss reported that the 2020 budget for AHEC was $41.250 million. The budget for education and training in geriatrics was $40.737 million. The budget for behavioral health workforce development programs was $138.916 million. In FY 2020, some BHW programs received additional funding to address COVID-19. Dr. Kennedy requested a graph showing programs' annual funding levels since 2015, distinguishing funds allocated specifically to address COVID-19 in 2020. Dr. Weiss and Mr. Rogers said they would provide this information. Dr. Brandt asked for information about funding limitations so that Committee recommendations could be realistic. Dr. Kennedy recommended funding programs adequately to meet their needs. Dr. Weiss said the Committee should assess programs objectively and recommend the funding level necessary for achieving programs' goals.

Dr. Brandt noted that AHEC programs are required to match funds, which is challenging. She inquired as to whether this is required by statute. Dr. Weiss stated that this is a statutory requirement, and added that as much as 75 percent matching can be in-kind. Ms. Pope and Dr. Khatri agreed that cost sharing can be burdensome. Ms. Pope said that HRSA funds are not adequate to support all work required of AHECs. Dr. Weiss stated that the original justification for requiring matching funds was that to ensure community engagement and investment. Dr. Bednash noted that many State and local governments may not be able to provide matching funds, which would prevent programs from doing important work. Dr. Fahrenwald stated matching funds may be an important contributor to the program's success in achieving targeted outcomes. She suggested that the Committee recommend allowing a greater proportion of in-kind matching rather than eliminating the matching requirement. She also suggested recommending waiving the matching requirement during the COVID-19 pandemic. Permanently eliminating the matching requirement could result in long-term damage to the AHEC program.

Dr. Kennedy inquired whether there are data available about how many programs apply for support and meet eligibility requirements but do not receive funding due to inadequate resources. She said it would be useful to know what funding would be necessary to support all eligible applicants. Dr. Bednash stated that this information would provide a rationale for requesting a funding increase.

Dr. Brandt invited further discussion about the Committee's 15th Report. There were none. She inquired whether Committee members agreed that the 20th Report would be a Title VII Part D program review with a focus on equity. The members agreed.

Dr. Brandt invited suggestions for speakers and discussion topics for the Committee's next meeting. Dr. Kennedy recommended inviting a panel of representatives from as many as three grantee organizations conducting nationally recognized high-quality work to discuss their experiences. Dr. Brandt supported this idea and suggested that these grantees discuss interprofessional training, and community and academic partnerships. Dr. Kennedy also

suggested discussing program sustainability, and possibly the National Center for Interprofessional Practice and Education's model of sustainability. Dr. Brandt supported this suggestion as well. Dr. Brandt suggested inviting Dr. Barbara Brandt, Director of the National Center for Interprofessional Practice and Education, to discuss measures to evaluate quality of interprofessional training. Dr. Kennedy supported this suggestion. Dr. Brandt said she would send Dr. Brandt's contact information to Mr. Rogers. Dr. Bednash recommended inviting Brenda Ziegler, a nationally recognized expert on interprofessional competencies who works with the Institute for Health Improvement, to deliver a presentation. Dr. Brandt supported this recommendation and requested Ms. Ziegler's contact information, which Dr. Bednash agreed to provide. Mr. Rogers stated that BHW could invite staff responsible for managing and monitoring Title VII Part D programs to provide program updates, as well as National Center for Health Workforce Analysis staff to provide performance measure data.

Dr. Brandt stated that virtual training and health care delivery are likely to continue after the COVID-19 pandemic. She asked whether Committee members would like to invite a speaker to deliver a presentation on digital literacy. Mr. Stevens recommended inviting a speaker from the Task Force on Telehealth. Dr. Kennedy noted that the National Library of Medicine focuses on telehealth and may be able to recommend a speaker. Dr. Bednash suggested inviting a speaker from the American Telehealth Association.

Dr. Bednash suggested inviting Dr. Ninez Ponce, Director of the University of California, Los Angeles Center for Health Policy Research, Co-chair of the National Quality Forum's Standing Committee to Address Healthcare Disparities, and board member of the Scientific Counselors for the National Center for Health Statistics, to deliver a presentation on racial justice and health care disparities. Dr. Fahrenwald suggested inviting a speaker to address disparities affecting rural and frontier communities. The speaker could discuss important issues such as barriers to internet and cell communication services, which prevent access to telemedicine. Dr. Kennedy recommended inviting a speaker from the National Rural Health Association. Dr. Fahrenwald supported this suggestion.

Dr. Brandt thanked Committee members for their input. She invited members to volunteer to participate in the planning subcommittee. Drs. Kennedy, Khatri, and Erwin, and Ms. Pope volunteered.

At Mr. Rogers' request, Dr. Brandt confirmed that the 20th report would be a programmatic review with a focus on health equity. Dr. Erwin recommended that the report include discussion of approaches to rebuilding community trust in public health. This topic will be especially timely when a COVID-19 vaccine becomes available. Dr. Erwin noted that current data indicate a large proportion of the public has expressed distrust of the potential vaccine. Dr. Brandt invited further discussion of whether the program review should include recommendations based on lessons learned during the pandemic. Dr. Kennedy suggested that the Committee make a list of potential specific topics for presentations and the reports. These could include building community trust, health literacy, digital literacy, and health communication. She suggested that a speaker from the Alan Alda Communication Center could deliver a presentation about effective communication about research for lay audiences. Dr. Erwin supported this suggestion.

Ethics Update
Laura Ridder
Ethics Advisor
Health Resources and Services Administration

Mr. Rogers introduced Laura Ridder. Ms. Ridder said HRSA is working to make the system for submitting ethics forms automated, easier to use, and more accessible. She invited questions about the training materials HRSA had sent to Committee members before the meeting. There were none.

Ms. Ridder explained that Committee members are special government employees, who serve the Federal Government fewer than 120 days annually. They are legally responsible for adhering to Criminal Statute 18 USC 208, which pertains to personal or imputed conflicts of interest. Imputed interests are those of a spouse, minor child, general business partner, or organization where the employee serves as an officer, director, trustee, general partner, or employee, as well as any organization with which the employee has an arrangement for prospective employment or is negotiating for employment. The Code of Federal Regulations exempts special government employees who serve on advisory committees to allow them to participate in matters generally applicable to a class of entities, such as universities, community health care providers, or health insurance companies, as long as the matter does not have a distinct effect on the committee member's employer. This is because people with the expertise necessary to serve on an advisory committee are likely to be employed in a field related to committee matters.

Ms. Ridder said that Committee members cannot work on any particular matters that affect their own personal or imputed financial interest. Members must recuse themselves from work on these matters. Recusal involves leaving the room, or, during virtual meetings, muting and remaining inactive during discussion of the particular matter.

Holding broadly diversified investment funds is exempt from the conflict of interest statute. Holding publicly traded securities worth $15,000 or less is not considered a conflict of interest for specific party matters. Holdings worth $25,000 or less are exempt for general policy matters. Sector holdings worth less than $50,000 are exempt. Ms. Ridder said it is important for Committee members to provide complete and accurate information on their OGE 450 Financial Disclosure Reports, so that HRSA can assess potential conflict of interest. She said that these reports are confidential and not subject to the Freedom of Information Act. They are subject to court subpoena. Ms. Ridder invited Committee members to contact her or another Ethics Advisor with any questions about financial conflicts of interest. An advisor is always available during business hours.

Employees of multi-campus State universities can work on matters that affect only one campus, when the employee does not work on that campus and does not have multi-campus responsibilities. In some cases, the Department of Health and Human Services Office of General Counsel issues a waiver to allow work when a special government employee has a conflict of interest. Waivers are available only for matters of general applicability. Waivers are granted when a member's holdings would prevent work on most Committee matters, and the member's expertise is considered critically important to the Government. The Government rarely issues these waivers.

Special government employees are not supposed to work on any specific party matters involving an entity with which the employee has a relationship that would put the employee's impartiality into question, unless the employee receives authorization. Special government employees cannot use their position for private gain for themselves or their associates. They cannot use their position to endorse programs, activities, or initiatives. They cannot use their position to coerce a person or entity to give any benefit to the special government employee or his or her associates. Special government employees cannot use any non-public government information obtained through ACICBL work to further the interests of themselves or anyone else. They cannot disclose this information without authorization. Special government employees cannot accept gifts given because of their position, or from any source prohibited by HRSA. Prohibited sources are those that conduct business with HRSA, or are seeking to conduct business with HRSA. Gifts given as a result of non-governmental work are not considered to be a conflict of interest.

Special government employees may not give gifts valued at more than $10, with the exception of refreshments shared in a workplace or personal hospitality provided at a residence, to an official government superior. For ACICBL this includes any HRSA or HHS employee with responsibilities to direct or evaluate the Committee's performance. Gifts given for special infrequent occasions such as weddings, birth of a child, or illness or death in the family are acceptable. Gifts for seasonal holidays are not permitted.

Committee members cannot accept compensation for teaching, speaking, or writing related to their official Federal duties. If a member is invited to participate in any activity primarily because of his or her position on the Committee, participation requires approval from the Committee Chair and Designated Federal Officer. Members may not accept invitations to teach, speak, or write from any entity with interests substantially affected by Committee work. These regulations apply to editing. They do not apply to general work within the discipline that qualifies a member to serve on the Committee, such as teaching an established university curriculum- only to outside work directly related to Committee work.

Ms. Ridder said some rules apply specifically to special government employees who work for the Government at least 60 days per year. She advised Committee members to notify her if their work across Federal agencies requires this much time.

Ms. Ridder explained that the Hatch Act was enacted to prevent political coercion of Federal employees while they are working. The Act disallows partisan special government employees from engaging in partisan political activities while they are conducting Government business or are in a workplace for Federal employees, including during work breaks. Partisan political activity is any activity directed toward the success or failure of a political party, candidate, or group. This includes National, State, and local politics. Activities include social media communications, such as "liking" partisan political posts. Violations could result in being removed from the Committee.

Committee members are not subject to the Emoluments Clause, which prohibits Federal employees from acting as foreign government agents. Committee members are subject to the Foreign Gifts and Decorations Act, which prohibits accepting any gift valued at more than $390

from a foreign government or international organization, other than travel taking place entirely outside of the United States. Expenses for travel to or from the United States may not exceed $390. This also applies to spouses and dependents. This restriction does not include compensation for employment with a foreign government or entity, which is not a gift. Special government employees may not lobby on behalf of foreign entities. They cannot attempt to influence any agency, policy maker, or the public to change domestic or international policy on behalf of a foreign government or entity.

There is a lifetime ban on members representing any parties involved in matters addressed during Committee work to any Federal agency or in court. Members may contact an Ethics Advisor with questions about this, even after their terms end. Committee members may not solicit funding or other support from any person or entity with interests that could be affected by Committee work. This does not apply to general fundraising required for members' professional jobs.

Ms. Ridder provided contact information for her and another Ethics Specialist. She invited questions. There were none. Mr. Rogers thanked her for her presentation.

Business Meeting

Mr. Rogers said HRSA expected to post the Committee's 19th report to its website the following Friday. The report then would be publicly available. Dr. Brandt said Committee reports require much effort and include important information. She invited discussion about how best to disseminate Committee reports. Dr. Kennedy said that when she was Chair, the Committee produced a report on age-friendly health care systems. She and the Designated Federal Officer discussed presenting key points from the report at professional conferences and on Capitol Hill. They also discussed publishing key findings in professional newsletters. She said it would be helpful for the Committee to have a dissemination plan approved by HRSA administration and Ethics Advisors. Dr. Brandt concurred. Mr. Stevens said he had shared previous reports with his professional network. He agreed that it would be valuable to share findings at professional meetings, but said his organization does not have a travel budget. Mr. Stevens said having limited or no travel funds is a challenge for many organizations. Dr. Weiss said HRSA shared the report on age-friendly health care systems with a representative from the Gerontological Society of America. She said HRSA should share reports with all Title VII Part D grantees. She also said it would be useful to share reports with professional organizations and to provide Congressional briefings. She said HRSA cannot issue Congressional briefings, but ACICBL can do so independently. Dr. Weiss emphasized that HRSA leadership implements Committee recommendations, so it is important for the Committee to engage them and ensure their support for these recommendations.

Mr. Rogers said the Committee typically has a Vice Chair. He said this position was temporarily on hold until upcoming new Committee members are enrolled. He said the Committee's next meeting was scheduled to be held via webinar on January 14-15, 2021. The following meeting will be held on February 17, 2021. The final meeting for 2021 will be held on August 5.

The Committee is authorized to include 14 members. It currently has eight. Mr. Rogers said nominations for new members are currently being reviewed. He said he hoped nominations

would be approved in time for new members to participate in the January meeting. He thanked Dr. Weiss for her work processing nominations.

Public Comment

Mr. Rogers invited public comment. There was none.

Closing and Adjournment

Mr. Rogers invited additional comments. Dr. Brandt thanked Committee members and support staff for their work. Mr. Rogers said he would work with the Planning Committee to select and recruit subject matter experts to present at the January meeting. He adjourned the meeting at 4:14 p.m.