MEETING MINUTES
Advisory Committee on Interdisciplinary, Community-Based Linkages
February 17, 2021

Committee Members Present
Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP*, Chair*
Sandra Pope, MSW, *Vice Chair*
Geraldine Bednash, PhD, RN, FAAN
Katherine Erwin, DDS, MPA, MSCR
Roxanne Fahrenwald, MD, FAAFP
Teri Kennedy, PhD, MSW, LCSW, ACSW, FGSA, FNAP
Parinda Khatri, PhD
James Stevens

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

The Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) convened its meeting at 10:00 a.m. Wednesday, February 17, 2021. The Health Resources and Services Administration (HRSA) facilitated the meeting through a virtual platform. Designated Federal Officer Shane Rogers welcomed the Committee, presenters, and members of the public attending the meeting. Janet Robinson provided instructions for meeting participation. Mr. Rogers thanked HRSA staff and Committee members for their efforts. He explained that the Committee's purpose is to provide advice and recommendations to the Secretary of Health and Human Services and Congress about policy and program development pertaining to programs authorized by the Public Health Service Act, Title VII, Part D. Committee members represent the range of professions specified in the authorizing legislation. They also represent diverse geographic regions, and both urban and rural communities.

Dr. Brandt welcomed the Committee and reminded members that the purpose of the meeting was to make progress on ACICBL's 20th report to the Secretary and Congress. She thanked the writing committee and technical writer for work to-date on the report, then reviewed the meeting agenda. Dr. Brandt conducted roll call and invited Committee members to introduce themselves and share something they enjoy about their work.

Presentation: BHW Updates

Luis Padilla, M.D., Associate Administrator for Health Workforce

Health Resources and Services Administration

Dr. Padilla thanked the Committee for their work and noted that BHW values input the ACICBL provides through its reports. Currently, in the U.S., the demand for health care professionals is growing as the supply shrinks. The workforce distribution is not equitable. BHW's mission is to improve the health of underserved populations by strengthening the health workforce and connecting skilled professionals to communities in need through opportunities in education, training, and service. Strategies for achieving these goals include interprofessional training, longitudinal training in priority communities, and training students to integrate oral, behavioral, and public health services into primary care. Longitudinal training typically includes training in evidence-based and team-based practice.

BHW's budget increased $400 million between 2016 and 2021. Budget priorities include behavioral workforce development, the National Health Service Corps (NHSC), Nurse Corps, and Area Health Education Centers (AHEC). BHW programs' core aims are increasing access to health care, balancing workforce supply and demand, improving workforce distribution, and improving health care quality. The Bureau aims to support training a diverse workforce. BHW also aims to demonstrate how its workforce training programs improve health outcomes, which can be challenging.

Several external factors, including the COVID-19 pandemic, affect community and population health. COVID-19 disproportionately affects rural communities and communities of color. The current Federal administration aims to address the pandemic equitably. Value-based care and team-based care have been HRSA priorities since before the COVID-19 pandemic. BHW is

working to improve care quality and equity by engaging stakeholders, assessing community needs, and working to address those needs through strategic initiatives and portfolios of programs. The Bureau analyzes data to assess needs and determine strategies for responding, including which resources and partners are necessary. The Behavioral Health Workforce Pilot aims to leverage a portfolio of programs to address behavioral health needs for the public and health care providers, which have become more pressing during the pandemic. At least six BHW programs currently are training more than 7,300 health care providers and paraprofessionals to provide behavioral health services. Many trainees plan to continue to provide services in medically underserved communities. In 2020 BHW, in partnership with the U.S. Department of Labor, funded a behavioral health paraprofessional apprenticeship program, which BHW expects will diversify the workforce.

BHW's geriatrics programs provide interprofessional [professional] training and form partnerships. They offer models of training for other programs to adopt. More than 300,000 trainees participate in BHW's career development and diversity programs. BHW is considering how to improve support for these programs. The Bureau prioritizes training people from underrepresented and rural backgrounds.

BHW collects and analyzes data to inform strategic planning. The Bureau shares data about Healthcare Provider Shortage Areas (HPSA), where program participants practice, and provider retention in HPSAs. BHW also shares program performance data, and a description of the process for designating HPSAs with the public. Visualization tools make data clearer to non-researchers.

One BHW strategy for responding to the COVID-19 pandemic is to mobilize the current health workforce, with a focus on NHSC and Nurse Corps. Initially, many participants were at risk of being furloughed. BHW supported regulatory flexibilities that allowed use of telehealth to fulfill service obligations. The Bureau waived fees for National Practitioner Data Bank queries to support credentialing. BHW aims to transform the health workforce by funding efforts to build telehealth service capacity. The Bureau has coordinated with other agencies, including the Federal Emergency Management Agency (FEMA) to respond to the pandemic, and is exploring

approaches to coordinate with other agencies such as the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Agency for Healthcare Research and Quality (AHRQ). BHW data analysis priorities during the pandemic include equity, mental and behavioral health service needs, and burnout. Data inform other policy makers in addition to BHW. Panels to implement Executive Orders pertaining to the COVID-19 public health emergency will include HRSA representatives.

BHW's health center training readiness efforts include investing in training readiness, and collaborating with partners to support more than 5 million primary care associations (PCA). BHW is supporting Federally Qualified Health Centers (FQHC) and PCAs in producing health workforce development plans and identifying gaps in training ability. In early Spring 2020, BHW will issue a contract to support NHSC in identifying ways to support clinician well-being. The Bureau is developing criteria for identifying communities in need of maternity care and updating the process for designating HPSAs. The Coronavirus Aid, Relief, and Economic Security (CARES) Act Section 3402 requires the Department of Health and Human Services (HHS) to submit a health workforce coordination plan in March 2021. All BHW work focuses on addressing the needs of vulnerable communities. The COVID-19 public health emergency has elucidated these needs, including telehealth, clinician resiliency, equity, and public health infrastructure.

Discussion

Discussion included the following questions and points.

What are BHW's priorities for enhancing its data?

The Foundations for Evidence-Based Policymaking Act requires agencies to share data with the public. Policy makers and other stakeholders need data to support decisions. BHW will collect and analyze data to determine the degree to which the research it supports aligns with Administration priorities, and which additional research and data are needed to address these priorities. It is important for BHW to demonstrate program impact through user-friendly visual data, such as grantee score cards and clinician dashboards.

Does BHW work with the National Consortium of Telehealth Resource Centers?
BHW works with several partners to address digital literacy, especially in vulnerable communities. BHW also works with partners to facilitate access to telehealth services, especially among communities of color and older people.

The National Consortium of Telehealth Resource Centers offers resources, including workshops and monthly seminars. It has an extensive reach, with approximately 5,000 participants in a recent seminar. The consortium could be a valuable partner in BHW's health literacy efforts.

How can BHW advisory committees and councils align their objectives and priorities?
The Chairs can start by learning each other's work and recommendations. Eventually, BHW would like for all council and committee members to meet, share information, and make joint recommendations.

What are potential strategies for working with communications and journalism professionals to rebuild public trust in public health?
It is especially important for the public to have confidence in the COVID-19 vaccine. Messages must convey the process of vaccine development and approval. In general, BHW must be transparent regarding its work.

Many health care providers are retiring in response to the COVID-19 public health emergency. What are the best resources and information regarding retention?
Retirement is a major driver of the health workforce shortage. Medical school applications increased during the pandemic, which many people viewed as a call to action. BHW hopes to see a similar increase in applications to nursing schools and physician assistant training programs. The National Center for Health Workforce Analysis is assessing the impact of COVID-19 on primary care supply and demand. HRSA's data dashboards present retention data for training program alumni.

What platform does the National Consortium of Telehealth Resource Centers use to support seminars with 5,000 participants?
That information is available on the consortium website.

What is the status of the Workforce Coordination Plan mandated by the CARES Act?
Developing the plan during an Administration transition was challenging. Congress is proposing significant workforce investments. Teams responsible for developing the plan have identified needs and are continuing work and will be transparent.

Has BHW considered applying approaches the military uses to address post-traumatic stress disorder (PTSD) to address health workforce needs?
BHW has communicated with the Veterans Administration about increasing resiliency and decreasing burnout in the health workforce. BHW focuses on both individual- and systems-level changes. Support must be for the entire care team. Workforce mental health is a major crisis requiring additional public health infrastructure. The field must prepare for future public health emergencies as well as ongoing high rates of burnout among primary care providers.

Dr. Padilla thanked the Committee for their input to the plan.

Presentation: Area Health Education Centers

CAPT Madelyn Reyes, DNP, MA, MPA, RN, FAAN, Deputy Director

CAPT Corey Palmer, MPH, MS, Branch Chief

Division of Health Careers and Financial Support

Division of Health Careers and Financial Support, Bureau of Health Workforce

The Public Health Service Act Section 751 authorizes the Area Health Education Centers (AHEC) program. The program's purpose is to develop and enhance education and training networks within communities, academic institutions, and community-based organizations. AHECs support increasing workforce diversity, improving workforce distribution, and improving quality of health care and care delivery to rural and underserved populations. AHEC funding supports schools of medicine and nursing in offering education and training. Currently, the program supports 48 programs, 46 in schools of medicine and two in schools of nursing. The

programs support 261 AHECs in 46 States, the District of Columbia and the Republic of Palau. The program aims to have a presence in every State.

AHEC activities align with BHW priorities. The AHEC program offers longitudinal interdisciplinary curricula with six core topic areas: 1) interprofessional education, 2) behavioral health integration, 3) social determinants of health, 4) cultural competency, 5) practice transformation, and 6) current/emerging health issues. Grantees engage key stakeholders such as PCAs, State offices of rural health, and health centers to maximize impact and sustain efforts. Grantees must participate in statewide evaluations. They must offer community-based experiential training in rural and underserved communities. Clinical rotations are team-based and include didactic training in core topics. Grantees conduct recruitment and training with high school students to teach them about health careers and how to pursue these careers. These efforts are intended to encourage members of rural and underserved communities to practice in their communities. Grantees also offer didactic and experiential training for currently practicing professionals.

Approximately 42 percent of training sites are in rural communities. Approximately 60 percent of sites are primary care settings. About 40 percent of AHEC scholars are from disadvantaged backgrounds; 29 percent are from underrepresented minority backgrounds. Interprofessional training teaches participants the roles and responsibilities associated with each professional discipline, and the value of collaboration. As a result of COVID-19, AHEC sites offer more distance learning. The program is working to address a shortage of preceptors, and to improve systems for tracking scholars after graduation.

Congress appropriated funds for AHEC simulation training programs. HRSA will release the notice of funding opportunity (NOFO) spring 2021. The current 5-year cycle of AHEC funding will end in August, 2022. The CARES Act awarded AHECs $4.2 million to address COVID-19. Grantees have used funds for several purposes included purchasing telehealth equipment, curriculum development, expanding training with distance learning platforms, and COVID-19 screening, testing, contact tracing, and culturally competent treatment.

Discussion

Discussion included the following questions and points.

What have AHEC evaluations demonstrated about best practices in cultural competency and addressing social determinants of health?

AHEC requires grantees to report how they will meet core training requirements, not outcomes.

It is important for interprofessional training to teach participants to work as a team. How does the AHEC program ensure this?

Grantees must document implementation processes and activities, and how disciplines are incorporated into experiential learning. Training in how to deliver interprofessional education, including curricula and certification, is available.

Telehealth can support training.

Telehealth training can be synchronous or asynchronous. It can offer engaging activities rather than a lecture-only format. Asynchronous training accommodates students' schedules. Telehealth, including distance learning, is a HRSA priority.

How do AHECs track effects on students' and trainees' careers over the long-term?

Tracking is challenging. BHW is interested in outcomes, especially of early pipeline programs. Some programs do track students. BHW would like to expand tracking so that it can assess national impact. It may be useful to require tracking in 2022 funding applications.

How can interprofessional health care teams use telehealth?

Telehealth is important for all HRSA programs. HRSA is exploring how to broaden applications of telehealth. It is essential for addressing COVID-19 and will continue to be essential after the public health emergency is resolved, especially for serving rural communities. However, rural areas often lack internet access. HRSA is considering how to improve access for rural and underserved communities. Academic institutions have observed the value of telehealth in addressing COVID-19 and may expand training in telehealth.

When will HRSA release the new AHEC funding opportunity announcement?

HRSA is focused on releasing FY 2021 funds, then will develop announcements for FY 2022. The Agency probably will release funding announcements toward the end of calendar year 2021.

Why did AHEC participation decline more than 25 percent between 2017 and 2018?

Several programs were focused on planning, infrastructure development, and redesign during this time.

Presentation: Telehealth in Alaska: Looking Forward

Cindy Roleff, MS, BSN, RN-BC

Director of Telehealth Program Development

Alaska Native Tribal Health Consortium

The most important current areas of need related to telehealth are: connectivity, reimbursement, regulatory standards, and education. The American Telemedicine Association defines telemedicine as, "*the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status*." It is a mode of health care delivery. Types of telemedicine include: store and forward, video, and remote monitoring. Store and forward examples include sharing a photo and patient history to a specialist. Video involves live video interaction. Remote monitoring is the use of devices to transmit information, possibly from a patient's home to a hospital.

Broadband is a term for high-speed internet. It allows the rapid data exchange necessary for video conferencing and electronic health record transmission, which are essential for quality health care. Patients' access to broadband at home is a current major issue. The Federal Communications Commission identified lack of broadband access as a major problem for rural residents. Reasons for lack of access include internet providers refusing coverage due to high costs of serving few customers, and customers' inability to pay providers' fees. Therefore, people most in need of telemedicine have the most difficulty accessing it. Those that do have access are most likely to experience service quality issues. Currently, 40 percent of Alaska communities have access only to 2G connectivity, while 5G is the current industry standard. Many communities cannot use the internet for video communication.

Several Federal agencies are investing in expanding broadband connectivity. Low Earth Orbit (LEO) satellite technologies are a new approach to high-speed internet connection. Conditions such as ice covering can interfere with ground-based elements of conventional satellite systems' capability to transmit data. LEOs orbit approximately 20 percent closer to the Earth's surface, reducing data transmission time. They support rapid downloading and uploading, whereas conventional satellites often do not support adequately fast transmission for rural communities. LEOs are less costly to operate than conventional satellite technologies. Connectivity is now an essential component of healthcare.

During the COVID-19 pandemic, the Alaska Tribal Health Consortium had to deliver care virtually. Some visits had to be audio-only because of problems with video connection. The consortium's audio/visual manager tested products to determine which were most effective for reaching patients. Some had 18 percent failure rates for supporting home visits. Implementing standard connection processes for providers reduced the failure rate to 0.3 percent. Information about the effects of processes on connection success was instrumental in staff adherence to processes. Several factors in addition to bandwidth affect telehealth quality. These include jitter, latency, reliability, and dropped packets. Cost to patients affects access. Providers must be able to support patients in addressing connection problems. Providers and patients should provide input on system design.

The Center for Telehealth and E-Health Law identifies lack of consistent and comprehensive policy for reimbursing telehealth services as a major barrier. Reimbursement rules vary by telehealth and practitioner type, patient location, service type, and payer. Some regulatory flexibilities were implemented to address needs during the COVID-19 pandemic, such as reimbursement for services delivered via telephone. Ms. Roleff advocates continuation of these flexibilities to support access to rural residents' access to health care, and to ensure providers are reimbursed for delivering care.

Licensing and credentialing are based on patient location, which is challenging when the provider is based in another State. For example, if a patient travels then contacts his or her provider, the provider may not be licensed to practice in the State from which the patient initiates

contact. Interstate compacts address this issue in some places. Stakeholders should explore solutions. Rules for practice privileges and prescribing can be confusing. Many providers are anxious that they do not understand all of the rules and may unintentionally violate them.

Education programs should teach providers how to design and implement telehealth programs. They should teach risks and risk mitigation, how to select and use equipment, what to do when patients need follow-up to a virtual visit, how to protect privacy and address breaches, how to deliver virtual team-based care, and how to ensure they understand all relevant regulations.

The consortium has four recommendations for telehealth: 1) Fund training programs for current providers and work with State and National boards to achieve consistency in education programs, 2) Work with State and National Boards to achieve consistency in regulations, 3) Lobby or advocate to continue reimbursement for telephone telehealth, and appropriate reimbursement for all telehealth modalities, and 4) Advocate for increased practical, affordable connectivity in rural communities, including legislation, infrastructure, and funding needed to accomplish this and research on how best to accomplish this goal.

Discussion

Discussion included the following questions and points.

What are some key lessons learned about reaching rural communities?

Technology should be simple and easy to use. More complicated technology does not necessarily support better data transmission. Training should be applicable to trainees' practice. Different practices require different data and processes. Training communication should be tailored to trainees' needs and expectations. Participants should learn how to understand the perspectives and communication needs of clinical partners with whom they will collaborate and share information.

What resources are necessary to support low Earth orbit satellites?

Telecommunications companies launch and employ the satellites. The Space X program has advocated LEO satellites. Rural communities sometimes have difficulty connecting through conventional satellites because these satellites do not orbit directly over more remote

communities, and it is challenging for users to place dishes at the angle necessary for transmission. Launching a new conventional satellite to orbit closer is very expensive. Homes can receive LEO satellite signals via a small antenna that transmits directly from the satellite or a local WiFi network. The technology has only been available for about a year. Some communities are waiting to observe implementation elsewhere before committing to implementing LEO satellites in their own communities. Currently, all Consortium clinics have subsidized unlimited internet access through a cell or satellite network. Residential access can be achieved by installing WiFi receptors in homes. Some clinics are concerned that subsidizing residential access will mean losing subsidized service to clinics.

Are health care providers developing telehealth applications to facilitate access independently or collaboratively?

The presentation included mention of an example of a product the Consortium designed in order to illustrate the importance of ensuring that patients and providers can use technology with ease. Application development is not a core focus for increasing rural communities' access to high-speed internet. Several vendors sell applications. When providers select products, they should focus on ease of use and practicality.

Has the Consortium been involved with developing or supporting the Protecting Access to Post-COVID-19 Telehealth Act or other policies?

This Act aims to make permanent the temporary regulatory flexibilities implemented during the COVID-19 public health emergency. It allows reimbursement for telehealth services delivered while patients are at home, and for audio-only visits.

Committee Discussion: 20th Report

The Committee made the following points regarding how the day's presentations should be considered when developing recommendations and the 20th Report.

- The AHEC program makes important contributions to interprofessional training and telehealth. Students are change agents. It may be useful for recommendations to specify how AHEC can be leveraged for implementation.

- State licensing requirement conflicts and interferes with telehealth service delivery. Federal licensing requirements could solve this problem. However, licensing is considered to be a States' right ensured by the U.S. Constitution. Licensing fees generate State revenue. Multistate compacts allowing practice in all participating States can help to address the issue. Professions' scopes of practice vary between States. It would be helpful for compacts to establish more parity. Allowing providers to practice across State lines helps to mitigate the healthcare workforce shortage. Advocates for health care access should advocate to change any policies that present barriers to care, especially for underserved and rural communities and populations.
- Education programs should develop resources and curricula to prepare health care providers to use telehealth and digital health technology. This includes training in effective interprofessional communication.

The Committee made the following comments about general considerations for report development:

- Some changes the Committee supports may be beyond its purview. However, the Committee can recommend for other entities to consider and collaborate in supporting policies that would support the Committee's activities.
- The Committee may want to recommend ideal goals in order to maximize progress, rather than limit recommendations to what is most easily achieved in the short-term.
- The Committee may want to make some recommendations via one or more letters rather than its annual report. Letters can be produced and sent more quickly than annual reports. Letters would be addressed to the HHS Secretary, and Congressional Committees on Health, Education, Labor, and Pensions; Energy and Commerce. The Committee inquired whether it can submit a letter to the President. Mr. Rogers offered to find out. Members also expressed interest in a town hall meeting between BHW advisory councils and committees and the President. Committee members requested guidance regarding whether members whose Committee terms are about to expire can write letters to the President supporting Committee recommendations.

Recommendations

The writing workgroup developed draft recommendations based on discussion during the Committee's meeting in January, 2021. The Committee discussed refining the draft recommendations.

Recommendation 1

Key points of discussion about Recommendation 1 were:

- The importance of linking the recommendation to interprofessional education and training
- The value of partnerships for education, dissemination, and outreach. Partners offer expertise and can increase efficiency and cost-effectiveness. They increase effectiveness of advocacy efforts and can contribute to workforce preparation. However, partnerships also can require reimbursing partners for time and effort.
- The need to provide connectivity to private residences, and the challenges of doing so in rural and frontier communities
- Need for training tailored for the needs of providers from different fields or disciplines.
- Telehealth is a more inclusive term than telemedicine. Virtual health refers to a broader range of technology, such as interactive texting and mobile app check-ins, than telehealth. The Committee intends for the recommendation to apply to this full range, as well as telephone services. The report should define the terms.
- Researchers at the University of Kansas have drafted a definition of "overlooked" populations: "*communities historically not included in research and clinical trials, due either to being unintentionally disregarded or intentionally ignored."* Groups may be overlooked because addressing their needs is not profitable.
- A 25 percent funding increase is necessary to implement this recommendation because it requires technology and academic partners, which have high overhead expenses. Current program budgets are not adequate to support implementation.

Recommendation 2

- Humanities and arts partners could contribute to developing cultural competent, effective public communications.
- Noted authorities, communications experts, and celebrities can be valuable communication partners.
- Priority audiences should see themselves, their experiences, and perspectives reflected in communications. Community partners can help to ensure this.
- AHECs provide education for providers and communities, and could support implementation of this recommendation.
- The value of specific types of partners can be described in the report rather than in the recommendation.

Recommendation 3

- The Quintuple Aim for health care quality includes care for all providers' well-being, not only physicians.

Recommendation 4

- Terry Fulmer's publications discuss a vision of an age-friendly ecosystem that includes the environment where people live, social determinants of health, and health care systems. Dr. Kennedy will share citations for publications that can inform report development.

Dr. Bednash moved to vote on approval of the recommendations, with expectation that the writing subcommittee may further refine the wording. Ms. Pope seconded the motion. The Committee voted unanimously to approve the recommendations.

Letter regarding support for LEO satellites

The Committee agreed to submit a letter to the Secretary and Congress about the critical value of high speed internet access for equity in health and health care, and the need for National efforts to support LEO satellites as a mechanism for increasing high-speed internet access. This aligns with priorities to develop infrastructure, create employment opportunities, and work in

public/private partnerships. Connecting people with private residential access to high speed internet service would foster success of programs under the Committee's purview. The technology also is critical for workforce education. Training and education must prepare the workforce to deliver virtual health services to rural and frontier communities. The letter should describe the technology and its advantages. It should discuss the distinct infrastructure needs of rural and frontier communities. It may discuss issues with public trust in 5G technology. Volunteers to write the letter were Mr. Stevens, Dr. Kennedy, and Dr. Erwin. Dr. Kennedy made a motion to produce the letter. Dr. Bednash seconded the motion, which passed unanimously.

Program Evaluation Discussion

It would be valuable for AHECs to report evaluation results, including promising and best practices, and lessons learned through a dashboard. FQHCs have a template for reporting promising practices. Other programs could use this template. Programs also could share information via conferences, podcasts, or other channels. HRSA describes lessons learned in annual reports. HRSA requires an AHEC program evaluation report. HRSA shares AHEC evaluation data as part of budget justification for the program.

Public Comment

Mr. Rogers invited public comment. There was none.

Business Meeting

The next meeting will be conducted virtually on August 5, 2021. During this meeting, the Committee will finalize the 20th Report and determine the topic of the 21st Report. The Committee's letter to the Secretary and Congress regarding the workforce coordination plan required by the CARES Act will be shared on the Committee web site after the Secretary has cleared the plan to be sent to Congress. The anticipated date is late March 2021. All five BHW Committees and Council produced letters, which will be incorporated into the plan. HRSA is processing nominations for nine new Committee members, and expects to make final decisions before the Committee's August meeting.

Closing Comments

Ms. Pope, acting for Dr. Brandt who had to depart early, thanked the Committee and HRSA staff for their work. She invited comments from members whose terms are ending. Drs. Khatri and Bednash stated they appreciated working on the Committee and hoped to remain in contact. Mr. Stevens and Dr. Bednash thanked HRSA staff and Ms. Pope for their work. Dr. Weiss said she hoped to work with outgoing Committee members in the future. Mr. Rogers thanked the Committee for its work. He adjourned the meeting at 4:07 p.m. Eastern Standard Time.