

National Advisory Council (NAC) on the National Health Service Corps (NHSC)

Executive Summary

The National Health Service Corps (NHSC) National Advisory Council (NAC) convened on January 19 and 20, 2012, in Rockville, MD, to provide guidance to the NHSC on current and future NHSC programs and activities. The Council's agenda included:

- HRSA Updates
- NHSC Program Updates
- 2011 Participant and Partner Survey and Retention Strategy Overview
- Long-Term Retention Study Update
- Negotiated Rulemaking for HPSA Designation Synopsis
- Bureau of Health Professions Workforce Program Overview
- Open Discussion and Recommendations

HRSA Updates—Mary K. Wakefield, Ph.D., RN, Administrator, Health Resources and Services

Administration (HRSA)

Dr. Wakefield opened her remarks by praising the Council and Bureau of Clinician Recruitment and Service (BCRS) leadership for helping the National Health Service Corps (NHSC) reach new heights in the Corps' field strength and service to the underserved. The Corps was expected to grow through investments from the Affordable Care Act (ACA) and the American Recovery and Reinvestment Act (ARRA), but expectations were exceeded by the increase from 3,600 providers when President Barack Obama took office in 2009 to the more than 10,000 providers currently serving. The NHSC now serves more than 10 million patients and has led to widespread representation at community health centers (CHCs) and other facilities. Dr. Wakefield indicated that the Council's valuable input has led to innovations and new dimensions to the program, such as the new Students to Service (S2S) Program, enhanced incentives to serve in hard-to-fill positions in high-need areas, and new ideas that will help respond to U.S. Health & Human Services (HHS) Secretary Kathleen Sebelius' goal to provide access to care, regardless of where a person lives.

Dr. Wakefield noted that retention continues to be a challenge but is essential for meeting the long-term needs of underserved communities. Eighty-two percent of providers continue to practice in a shortage area after their service commitment, but better data are needed on what motivates providers to continue practicing in the same area.

Dr. Wakefield praised the Health Resources and Services Administration's (HRSA's) efforts in health workforce diversity and interprofessional care. Research shows that patients are best served by providers who are conversant in their patients' background and culture. HRSA's goals are to improve access to health care, strengthen the health care workforce, build healthy communities, and improve health equity. These goals are served by the development of providers from rural areas through increasing the number of service locations and enhancing their contact with the NHSC through Ambassadors, the National Advisory Council (NAC), and other NHSC partners.

Dr. Wakefield closed her remarks by highlighting three key areas HRSA is now focusing on: collaborating with the National Governors Association on a project to assess possible reforms of state scope of practice rules as they apply to certain health professions, as well as state-level workforce supply and training capacity; participating in President Obama's charge to all Federal agencies to help returning military veterans secure meaningful employment; and the need for better workforce data at the local, state, federal and international levels. In addition, HRSA is expecting movement on the recommendations of the HPSA/MUA negotiated rule making committee, which is currently under review.

In response to Council comments and questions, Dr. Wakefield explained that HRSA wants providers to stay in communities with great need, although not necessarily the health professional shortage area (HPSA) where they served their NHSC commitment. For some providers, transitioning to the loan repayment program (LRP) will allow them to continue service at a free clinic or other underserved site. She noted that HRSA resources will continue to be available to facilities for team-based practice, interdisciplinary care, and emphasis on ambulatory care and underserved populations. She added that while future funding is uncertain, HRSA will focus on matters they can control, such as reviewing ways to leverage assets and strengthening workforce data.

NHSC Program Updates—Rebecca Spitzgo, BCRS Associate Administrator and Director of the NHSC

Ms. Spitzgo provided the Council with updates on the National Health Service Corps (NHSC) program data and initiatives. She began by highlighting key accomplishments in 2011, such as NHSC's historic field strength, continuation awards, increases in applicants from disadvantaged backgrounds, and the larger number of approved sites. Internal improvements to boost recruitment and retention included near elimination of paper files, an updated site vacancy list, staff customer service training, and quicker response time to service requests. In addition, all program participants are now using the new Customer Service Portal, and a vendor who specializes in running call centers now manages the new BCRS Call Center. The number of applications received in 2011 indicates a successful NHSC outreach effort via a multi-faceted approach including NHSC ambassadors, Corps Community Day efforts, redesign of the NHSC website, and the addition of provider "Stories from the Field" through Facebook.

Ms. Spitzgo noted that although the NHSC will not receive an annual appropriation in fiscal year (FY) 2012, Affordable Care Act (ACA) funding through 2015 will support new awards, including the new Students to Service (S2S) program for fourth-year medical students who undertake a primary care residency in internal medicine, family medicine, OB-GYN, or pediatrics. Other program changes include two loan repayment program (LRP) funding levels, based on the health professional shortage area (HPSA) score of the applicant's site; increased regional office responsibility for scholar placement and data collection; and new NHSC site eligibility for critical access hospitals (CAH). Ms. Spitzgo noted that the inclusion of CAHs as NHSC sites one of the initiatives developed by the White House Rural Council. A CAH must be in a primary care HPSA and have an affiliated outpatient clinic.

In response to Council comments and questions, Ms. Spitzgo said the Bureau is not yet requiring sites to have interdisciplinary teams but encourages them to explore new approaches to the delivery of health care and is working to define a consistent set of primary care services. Meanwhile, the Bureau continues

to develop its site visit strategy, including how to identify high-risk sites based on lack of compliance or significant provider turnover. Bureau of Clinician Recruitment and Service (BCRS) continues to work with sites to help ensure that sites are supportive of the NHSC providers and the Corps' mission.

2011 Participant and Partner Survey and Retention Strategy—Kim Kleine, Deputy Associate Administrator, Bureau of Clinician Recruitment and Service (BCRS)

Ms. Kleine presented the 2011 survey among National Health Service Corps (NHSC) program participants and partners. Overall, participants' index of satisfaction increased from 2010. Participant short-term retention—a participant's service commitment ending in fiscal year (FY) 2009 and FY 2010 remaining in a health professional shortage area (HPSA)—rose from 76 percent in 2010 to 82 percent in 2011. For 2012, the Bureau is working on a retention strategy and will strive to improve in other areas, such as adding support for NHSC sites, strengthening customer service delivery for providers, and promoting community engagement. NHSC sites reported that approximately 56 percent have a recruitment and retention plan. A key question remaining to be addressed is why approximately 40 percent of sites do not have a recruitment and retention plan. In response to Ms. Kleine's presentation, the Council discussed different methods to define and measure retention, including appropriate targets and benchmarks. Other discussion focused on the difference between service-request response and resolution, and the importance of a business case for recruitment and retention plans, including the cost of turnover. The Council cautioned that surveys can be misinterpreted, based on response rates, and that supplemental measures of customer service are important, including participant input about facility culture and engagement while in service or via exit interviews.

Long-Term Retention Study Updates—Donald Pathman, M.D., M.P.H., Professor of Family Medicine, The University of North Carolina at Chapel Hill (and a Council member)

Dr. Pathman presented the Council with updates on the ongoing retention study, noting that this was preliminary information that is still being developed. Key findings from the study thus far include: longer retention associated with a greater interest in the NHSC mission, rather than just the financial incentive; spousal support could boost retention, especially among women providers; and reasons clinicians leave are related to factors such as their satisfaction with their communities and jobs and how well they integrate into their communities.

Council discussion following Dr. Pathman's presentation included how retention data should be calculated. Other discussion included how the data indicate that the loan repayment program (LRP) offers a better return on investment than the scholarship program (SP), which led the NHSC to shift emphasis toward the LRP.

Negotiated Rulemaking HPSAs and MUA/Ps—CAPT Philip Budashewitz, Director, Office of Policy and Program Development

CAPT Budashewitz described the negotiated rulemaking process required by the Affordable Care Act (ACA) for establishing new health professional shortage areas (HPSAs) and medically underserved areas or populations (MUA/Ps). Instead of the standard procedure involving notice and comment, it called for a 28-member committee of stakeholders to reach consensus. Members interpreted "consensus" as requiring unanimity, and only 21 members agreed on recommendations, which they forwarded to the

U.S. Department of Health & Human Services (HHS) in lieu of adopting them formally. According to ACA guidelines the HHS Secretary must publish a proposed final rule, even though the committee did not reach a consensus. In response to questions from Council members, National Health Service Corps (NHSC) staff explained that the proposed final rule could differ from the recommendations that were submitted and will be open for comment for 1 year.

Bureau of Health Professions Workforce Programs Overview—Janet Heinrich, Ph.D., RN, Associate Administrator, Bureau of Health Professions (BHP)

Dr. Heinrich presented an overview of Bureau of Health Professions (BHP) workforce programs, noting that the BHP is striving to implement provisions of the Affordable Care Act (ACA) as it funds institutions of higher learning. The Bureau's programs support residencies and other needs for the physician, physician assistant, nurse practitioner, and the oral health workforce. Key priorities include opportunities for disadvantaged students, more provider diversity and interdisciplinary collaboration, better supply and demand data, and expanded training. Other priorities for 2012 include support for the newly formed teaching health centers (THCs) and data on long-term provider retention.

In response to Council comments and questions, Dr. Heinrich said that although the BHP has no leverage over where people go after their Bureau-supported training, it can use indirect methods, such as funding preference for institutions that more frequently place providers in underserved areas.

Open Discussion and Recommendations

Key recommendations and considerations that came out of the open discussion among Council members include:

- NHSC should make use of its recruiting and publicity tools (e.g., website) to increase awareness about serving in underserved areas.
- NHSC should focus support on sites that are more open to innovations despite resistance within some facilities to equip Corps providers with skills in practice management and interprofessional work.
- Consider how data on recruitment sources can guide future program efforts.
- Consider the definition and requirements for interdisciplinary care.
- Develop new indicators for continuations and retention data.
- Create more publicity about the impact of the Corps.

Other important items and future agenda topics that emerged prominently during the Council's discussions included:

- Looking at the different ways retention can be calculated, depending on the starting point and length of service
- Automatic HPSA designations having a negative impact on eligibility for NHSC scholars if they are lower than the cutoff score
- Experiences and opportunities related to training assistance for sites (i.e. a coding Webinar)

- The extent of LRP placement in facilities other than community health centers (CHCs) and rural health centers (RHCs)—such as the Indian Health Service, prisons, and CAHs—and providers’ experiences related to specific facility types.