

National Advisory Council on the National Health Service Corps
Meeting Minutes Summary
Hilton Washington, DC/Rockville Hotel & Executive Meeting Center, Rockville, MD
January 19–20, 2012

Day 1—Thursday, January 19, 2012

8:00 a.m.

The 2-day meeting of the National Advisory Council (NAC) on the National Health Service Corps (NHSC) was convened in Rockville, MD, on Thursday, January 19, 2012, at 8:30 a.m., chaired by Council member Dr. Byron J. Crouse.

Council: Mary Amundson, M.A.; Kristin Baird, RN, B.S.N., M.H.S.A.; Byron J. Crouse, M.D., FAAFP; John Everett, D.O.; Theresa V. Horvath, PA-C, M.P.H.; Tito Izard, M.D.; Mary Looker (by telephone); Michael D. McCunniff, D.D.S., M.S; Donald Pathman, M.D., M.P.H.; Darryl Salvador, Psy.D.; Susette M. Schwartz, J.D.; Rueben Warren, D.D.S., M.P.H., Dr.P.H., M.Div.; Ronald Yee, M.D., M.B.A.

Federal: Michael Arsenault; Ken Brown; CAPT Philip Budashewitz, RPH, M.A.; Leyla Desmond; Tami Holzman; Kim Huffman; Njeri Jones, M.P.H., CHES; Jeff Jordan, M.P.H.; Kimberly Kleine; CAPT Sheila K. Norris; Katie Root; Cynthia Segó; LaKisha Smith, M.P.H.; Rebecca Spitzgo; Laura Stillman; Lindsey Toohey; Mary Wakefield, Ph.D., RN; CAPT Jeanean Willis-Marsh, D.P.M.

Guests: Renee Butkus, American College of Physicians; Lauren Inouye, American Association of Colleges of Nursing; Carol Monaco, American Osteopathic Association; Jennifer Teters, American Academy of Physician Assistants

Seamon Corporation (logistics contractor): Alicia Corbin, Barbara Murdock, John Reistrup, Len Rickman

Welcome and Introductions—Dr. Byron Crouse (NAC Chair)

Dr. Crouse opened the meeting by welcoming everyone and complimenting the exciting developments of the National Health Service Corps (NHSC) over the past 12-18 months, including an ongoing opportunity for growth and expansion. He asked Council members, Federal staff, and guests to introduce themselves.

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

Introduction—Rebecca Spitzgo

Prior to introducing Dr. Wakefield, Ms. Spitzgo (HRSA's Bureau of Clinician Recruitment and Service's (BCRS) Associate Administrator) noted that the Council and staff are back together after 6 months. During that time much activity has taken place and staff is looking forward to discussing with the Council how to move forward and maintain the Corps' momentum.

Ms. Spitzgo indicated that it has been 2 years since Dr. Marcia Brand (HRSA Deputy Administrator) spoke at a Council meeting. She added that HRSA is fortunate to have Dr. Wakefield as its leader, addressing challenges and identifying opportunities to help ensure that HRSA programs fulfill their mission.

Dr. Wakefield

Dr. Wakefield thanked the Council for the invitation and its members for taking the time from their many responsibilities. The National Health Service Corps (NHSC) has reached new heights, due in part to the Advisory Council's very important expertise and commitment to the program's mission. Ms. Spitzgo—along with support from her team—provides strong leadership and passion, which underscores and supports how the NHSC improves access to health care in underserved rural and urban communities. In the 3 years Dr. Wakefield has been with HRSA, the accomplishments are almost unparalleled and it is not the same NHSC as it was before.

When President Barack Obama took office in 2009, there were only 3,600 NHSC providers in the field, actively serving communities. Today, the current field strength of over 10,000 providers is impressive and has exceeded the 2011 estimates that were previously announced. The cadre of current providers serves approximately 10.5 million patients in the U.S., and that shows the program's impact on access to health care services.

The program benefits from a \$1.5 billion investment over 5 years from the Affordable Care Act (ACA), plus \$300 million from the American Recovery and Reinvestment Act (ARRA). The field strength will likely remain at historic levels despite budget challenges. This is all a reflection of new concepts and innovations generated from the work of the National Advisory Council (NAC) and the hard work of NHSC staff.

For example, new program features are being launched, such as the NHSC's Students to Service (S2S) Loan Repayment program targeting primary care physicians. The idea for S2S was originally discussed by the Council, and is a good example of a new idea that HRSA has come to implement and will continue to explore similar new ideas and program developments . The S2S as well as the NHSC's Loan Repayment and Scholarship programs are vehicles to enhance incentives for primary care providers to serve in hard-to-fill positions in areas of high need. U.S. Health & Human Services (HHS) Secretary Kathleen Sebelius has said that no one in the United States should lack access to care because of where they live. Beginning this year the NHSC's Loan Repayment program will provide up to \$60,000 for primary care disciplines in medicine, dentistry, and mental and behavioral health (MBH) for providers at approved sites in a Health Professional Shortage Area (HPSA) of 14 or higher, for a 2-year full-time or 4-year part-time commitment. For HPSAs of 13 and below, HRSA will provide \$40,000 for a 2-year full-time or 4-year part-time commitment.

Dr. Wakefield stressed that the Advisory Council's advice is critical to HRSA and serves as a resource for great ideas that supplements the staff's excellent work. It is helping NHSC meet its goals and assisting HRSA in meeting its commitment to President Obama and the Nation to effectively allocate resources for access to primary care providers. HRSA hopes these efforts will also lead to better retention among dedicated physicians who choose the NHSC as a long-term career.

The program has gone through many changes in a short period of time, and new opportunities to improve will arise. Over time, providers have been given better incentives to service and improved ability to navigate the program. Another good example of Advisory Council impact is that in 2009 the NAC noted concerns over primary care providers' salaries and debt levels and the impact on the NHSC program; recently more than 1,300 physicians extended their NHSC contracts allowing them to pay down even more educational debt and remain in active service.

Overall, the primary care, oral health, and mental and behavioral health professions are competitive open markets across the United States, and not only in underserved areas. The Corps' providers are highly marketable, so the Corps must do all it can to ensure that the program is attractive.

Dr. Wakefield shared that shortly after she joined HRSA; she was invited to the White House to talk with senior staff about the ACA and workforce issues. It was a challenging conversation, based on a close look at the NHSC program and comparisons with U.S. Department of Defense (DOD) recruiting programs that also seek physicians. Today, the

abundance of resources invested in the NHSC program allows enhanced activities that were not available in the past when the program was under-resourced.

Dr. Wakefield noted that retention continues to be a challenge but is essential for meeting the long-term needs of underserved communities. It is good that 82 percent of providers continue to practice in a shortage area after their commitment; however, better data are needed on what motivates them to stay in a shortage area.

HRSA leaders want to hear about pilot programs and best practices to promote continued service to the underserved. The HHS Deputy Secretary often asks about retention because of the significant investment in the NHSC and the need for providers to recruit people for underserved communities who will stay 15–20 years. That is the goal and the expectation.

Dr. Wakefield indicated that primary care challenges, workforce, and access are embedded in the ACA. HHS senior leaders, including Secretary Sebelius, say that primary care is integral to health, and lack of access to primary care leads to greater challenges. Thanks to ACA and ARRA funding, more Americans can see a doctor. We are coming closer to realizing the Secretary's, President's, and Congressional vision for a high-performing health care system with access to primary care as the core.

For example, community health centers (CHCs) are now serving more than 19.5 million people, more patients than we have ever seen. CHCs have added more than 18,500 full-time staff, including a 25 percent increase to 46,000 physicians, which requires a sharp focus on primary care recruitment and retention. The NHSC's new Site Partnership Initiative actively promotes the NHSC to 1,100 CHC grantees that operate more than 8,500 sites due to major growth of health centers also funded by the ACA and the ARRA.

Another example of growth and expanding access to care is going from 120 to more than 400 Indian Health Service (IHS) sites in the NHSC program. Various changes have great potential to make a huge difference for vulnerable and underserved populations, and NHSC staff recognized the opportunity to work with the IHS and become more aggressive in placing NHSC providers at IHS sites which lead to this outcome.

Dr. Wakefield also commented on the improvements to the NHSC site application process. For example, the application requirements were eliminated for all federally qualified health centers (FQHCs) in an effort to reduce bureaucracy and increase efficiency, and similar improvements were made for IHS sites.

More than 17,000 NHSC rural and urban sites are approved across the United States, which means many service opportunities for providers. Dr. Wakefield goes on many site visits, including visiting many CHCs, and it is rare to find a site without at least one NHSC provider on its staff. CHC grantees are more than enthusiastic about NHSC providers working onsite.

The diversity among NHSC providers also is impressive, and that helps HRSA reach all of the goals in its strategic plan. Dr. Wakefield emphasized HRSA's four goals, which 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 and recruitment of providers from rural and urban areas through increasing the number of service locations as well as enhancing their contact with the NHSC through NHSC Ambassadors, the NAC, and other NHSC partners. While many people admire HRSA's success in achieving diversity, even more work remains in this area.

More than 25 percent of the U.S. population is minorities, but approximately 10 percent of the physician workforce is minorities. The average minority representation among nurses, psychologists, and dentists is 7 percent. Research continues to show that minority providers are more inclined to practice in underserved communities and that patients are best served by providers who are conversant in the patients' background and culture. Approximately one-third of NHSC members are *self-reported* minorities and Hispanics represent approximately 15 percent of the NHSC's field strength. Looking at the national averages, the NHSC is progressing well on diversity, in contrast to the overall workforce, which helps improve health care equity.

The Obama administration's investment in health care included ACA support for Title VII and VIII education programs. There were \$112 million in grants for diversity, funneled through scholarships for disadvantaged students, centers of health care excellence, and a nursing diversity program among 45 teaching institutions for nurses seeking advanced degrees. Complementary efforts between the NHSC and other investments are important strategies to leverage the development of the health profession workforce. Title VII and VIII programs will be restructured to be more competitive and to better promote inter-professional education and team-based training. The goal will include a focus on collaborative practice, along with diverse services to the underserved. In addition, HRSA will collaborate with the National Governors Association in 2012 to strengthen the health care workforce and improve access to care, especially primary care services. States are important partners in health care workforce development.

Within HHS, the Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Medicare & Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) are collaborating to leverage collective assets for a stronger workforce. It is clear that workforce is the key to improved access and quality, patient-centered health care, and team-based practices.

Dr. Wakefield also spoke of efforts to leverage a subpopulation of potential next-generation health care providers. President Obama has asked to target returning armed forces veterans to strengthen the workforce. The President's initiatives for military veterans include providing them with a solid glide path to meaningful employment after discharge, and all Cabinet agencies must do their part to help. HRSA is involved and working toward the White House charge to help health care entities hire 8,000 veterans over the next few years, especially Army, Navy and Air Force medics. The White House also has directed HRSA to prioritize grants for physician assistant (PA) schools and nursing schools that train veterans.

Much work is underway to improve workforce data on supply and demand, including collaboration between HRSA and the HHS Department of Global Affairs. The World Health Organization (WHO) enacted the global code of practice on international recruitment, and HRSA is going to participate in that effort by meeting with international organizations to discuss migration patterns, how to strengthen recruitment and how to put assets into countries with major shortages of health care providers. The commitment is to train 140,000 new providers in sub-Saharan Africa.

Overall, workforce is a major issue for President Obama, and HRSA is serving a big role in addressing the challenges. Strengthening the workforce is a key priority of the Department that includes the continual addition of CHCs and IHS sites as NHSC sites and collaborating with the National Governors Association (as mentioned earlier). HRSA looks forward to seeing data that will indicate the effectiveness of these efforts.

Council Discussion

Ms. Schwartz mentioned giving excellent references to two Corps providers who left her clinic so each would stay in service to the underserved, and Dr. Wakefield noted HRSA's goal of keeping providers in communities with great needs, not just in the HPSA where they served their initial NHSC commitment.

Dr. Warren commented that in the past, arrival of NHSC providers in an underserved community could drive out existing providers, but that is changing since some join the Corps for loan repayment rather than leaving. In response, Dr. Wakefield noted that for

some providers, the LRP enables *continued* service at a free clinic or other type of underserved site.

Dr. Crouse inquired about what was happening at teaching health centers, including for team-based care and integration. Dr. Wakefield noted available resources through the ACA to support health centers, and while it was not clear whether providers would come to those settings, there turned out to be many more qualified applicants than could be funded. Resources will continue to be available, which is exciting due to the need for team-based practice and the emphasis on ambulatory care and underserved populations.

Dr. Wakefield continued by noting that team-based training and interdisciplinary care are key HRSA initiatives and includes collaboration with the Macy Foundation, the Robert Wood Johnson Foundation, the Association of American Medical Colleges, the American Association of Colleges of Nursing, and pharmacist groups. The goal is to support core interdisciplinary competencies that are relevant to all, and it is good to make training programs aware of these investments. It is about redesigning health care to include new skills and processes, rather than reengineering health care delivery systems.

Dr. Crouse noted that accrediting bodies sometimes slow down innovation, based on existing and longstanding practices, and Dr. Wakefield responded that HRSA is aware of that issue and working on it. Dr. Everett asked about plans to sustain momentum after the 5-year infusion of funds, including if a new President is elected and funding decreases. Dr. Wakefield responded that HRSA is aware of the need to review how the investment is paying off, including data on retention after the 5-year investment. Congress directs appropriations, and no one knows who will be serving in Congress in 4 years. HRSA is reviewing how to leverage assets and to strengthen workforce data to support policy decisions.

Ms. Spitzgo noted that part of the strategy is to know what can be controlled, including looking at the program's impact, based on available data. It must be clear that the program is a good investment and is efficient and visible, which means good decisions need to be made about how and where to promote it and whom to partner with. Dr. Wakefield agreed that a fundamental point is to stay focused on things HRSA can control, especially in a challenging environment.

[Break]

NHSC Program Updates—Rebecca Spitzgo, Associate Administrator, Bureau of Clinician Recruitment and Service (BCRS); Director, NHSC

Ms. Spitzgo began by noting that the senior staff meeting the day before this session included CAPT Sheila K. Norris, director of the Division of Nursing and Public Health, who discussed how the U.S. Department of Veterans Affairs (VA) asked the BCRS about its nursing and NHSC loan repayment programs. It reminded Ms. Spitzgo of how the DOD once thought the NHSC was not competitive, but now the DOD is inquiring about the NHSC's programs. She also noted how the NHSC is working with the Indian Health Service (IHS) to leverage systems and processes because only a few Federal programs make awards to individuals, and the NHSC system could be shared.

Ms. Spitzgo said Council meetings are great opportunities for staff to reflect and thoughtfully consider ways to move forward. The titles of Ms. Spitzgo's slides are listed below in italics, along with supplemental comments and discussion.

2011 NHSC LRP & Scholar Programs. Ms. Spitzgo indicated that the number of applications reflected on the slide that was presented is a little misleading because it includes applications remaining from the previous year. More than 2,000 applied who did not get funding, and in 2010 it was approximately 1,000 applicants. These numbers show that outreach is working. For the Scholarship Program, it was important to see how many applied electronically and how easy the process was.

Staff looked closely at what is meant by "disadvantaged background," and nearly 50 percent of applicants were in that category. The Corps is tasked with giving preference to people from a disadvantaged background, but it is not clear how to do so. In 2011, all such applications were reviewed versus in the past when grades were used as a cutoff point. A total of 253 scholarship awards were made which included approximately 40-45 percent from a disadvantaged background.

FY 2011 Accomplishments. Ms. Spitzgo reported that in 2011, the Corps achieved historic field strength of over 10,000. Reaching that level was announced on Corps Community Day in October 2011. The *Philadelphia Inquirer* named the NHSC as one of the top five health care workforce initiatives, and that announcement was combined with the Corps Community Day event at a Philadelphia CHC. The NHSC Ambassadors program was also re-launched in 2011; Ambassadors are now asked to do six NHSC-related events per year. And the marketing campaign now includes a new tool to monitor click-through rates on the NHSC website to determine how the promotion of the program is working among specific audiences.

Regional office site visits are supporting our retention efforts, and currently they cost less than \$300 per visit a significant cost savings. This process is efficient and manageable because it is based on multi- *versus* single-purpose trips. It includes site visits to multiple sites owned by a clinic and also presentations about the NHSC to interested stakeholder and prospective applicants. The site visits also enable tremendous learning for staff and sites have come to embrace visits versus resistance to them. Visits include good discussions with providers, though some visits reflect that much work remains, such as reviewing the types of providers and sites best suited for each other and whether or not providers are serving populations they are meant to serve.

In addition, in the past, sites were asked to update job vacancies, but many did not. Today, vacancies are open for only 3 months—unless an extension is requested and granted—and they all expired on January 1, 2012. As a result the job vacancy information is now current, and sites have not complained about the new requirements.

The newly launched online site portal includes posted job vacancies and other important data. The increase in number of sites in the program was a result of adding CHCs and IHS sites automatically, as well as building a greater awareness for the program. More than 800 non-CHC and non-IHS sites have applied to become NHSC sites, and included free, mobile, and school-based clinics, and private sites, as well as clinics operated by contractors inside Wal-Mart stores. Many sites want to be approved, but urgent care is not considered primary care and will not be approved. Approximately 25 percent of sites are not approved, based on careful review of the nature of care and who is served. As the programs grow, more entities want to participate.

Customer Service/Retention. Ms. Spitzgo noted that the customer service [satisfaction] index among NHSC providers is up two points, which is good but could have been better. To help with customer service, plans are underway for the PrimaryCareForAll.org website to be expanded. There has also been improvement with NHSC staff processing service requests and providing a response to inquiries in less than 2 days. A key goal in improving customer service is to become paperless, and challenges that go along with the elimination of paper processes include capturing all the important information and ensuring that staff members are comfortable with electronic processes. Another goal is to standardize customer service delivery and interaction with participants so they are consistent throughout the Corps.

NHSC Award Activity. Ms. Spitzgo indicated that NHSC award numbers grew based on \$290 million from the ACA and \$73 million remaining from the ARRA, the largest amount of funding the Corps has ever seen.

FY 2012 Funding Projections. The Corps did not get an annual appropriation but has ACA money that will last through 2015.

The number of 2012 projected continuation awards (2,600) is the largest ever, as a result of 2009 and 2010 participant pools. The low number (1,500) of new awards could pose a challenge, but any money that is shifted into awards will likely come from the S2S, SP or the SLRP. This year, the program will probably be unable to fund 4,000 or more LRP applicants, and there is \$76 million less for recruitment.

Ms. Amundson cautioned that extensions should not be considered retention versus people whose Corps money is gone. Ms. Spitzgo said that is how retention is calculated (those members who stay once their service agreement has been satisfied), and the Corps wants to track whether people stay with the Corps or come initially for the money. Dr. Izard asked whether the system captures continuations when a person converts from the SP to the LRP and how that affects retention numbers. Ms. Spitzgo said scholars who finish the commitment and stay at the site or go to another HPSA of 14 or higher are now permitted to come into the program as noncompetitive LRP applicants with a 2-year commitment as a new award. It is necessary to run reports to match names, and a new indicator may be needed. The General Counsel says when this non-competitive transfer occurs; the initial LRP is for 2 years of service.

ACTION ITEM. Develop a new indicator for continuations and retention data.

Ms. Spitzgo added that the ultimate retention is when a person is not getting more money, though some say people who seek continuations should be counted because they can choose to go elsewhere. Dr. Pathman said most LRP awards are for people working at sites, and that makes it a retention program; however, Ms. Spitzgo cautioned that might not be true, and the retention survey done by NHSC tried to capture information about that based on Dr. Wakefield's request. She added that most people get into the LRP within their first year at a site, and it would be interesting to see whether providers choose a specific site to ensure they qualify for the LRP. Dr. Pathman added that only 40 percent of providers know their site might qualify for the LRP before choosing it, and since the Corps is serving a retention focus, it should take credit for how long people stay in sites and should learn how to publicly claim that added retention benefit.

NHSC Loan Repayment Program. Two funding levels are being used in 2012 to encourage providers to select sites with higher HPSA scores. In addition, the noncompetitive application for scholars who want to transition into the LRP expands the application window beyond its typical period. Critical access hospitals (CAHs) were included as a pilot, but the emphasis will remain on primary care and outpatient settings, though CAHs play a critical role in many communities. The requirement to use electronic applications continues to present challenges that NHSC staff are working to solve.

In the discussion, several NAC members raised questions about how the length of retention is calculated, including the starting points, the end points, and how to count scholars who transition to the LRP. In response to Dr. Izard's question about a scholar transitioning to the LRP, Ms. Spitzgo said it is considered a new 2-year award, rather than a continuation. It could be considered either, and it will be necessary to determine how to categorize these transitions.

ACTION ITEM. Determine how to categorize scholars who transition to the LRP.

In response to a follow-up question from Ms. Horvath about counting transitions to LRP, Ms. Spitzgo said it will be useful to collect data about scholars who transition to the LRP as a separate cohort. She added that offering LRP to scholars will boost retention at specific sites and in underserved areas, especially if people establish roots in a community. CAPT Budashewitz added that those who transition to the LRP are not double-counted in the field strength data, but the LRP is an incentive to stay.

In response to Council questions regarding why the application window closes in May when scholars are not licensed until June, Ms. Spitzgo explained the reason is that the Federal fiscal year—when the program must close out all funding—ends in September. She added that it also depends on the simultaneous effort to make all SP awards. This year, the goal is to finish LRP awards by the end of July. The Bureau tries to work out end dates to remain in compliance with the legislation; however, because some new graduates are missed, the Bureau will start awarding LRPs in February and will divide the number of awards per month to ensure money does not run out before the final close date. In response to Dr. Salvador on the length of the window for applications, Ms. Spitzgo said the application period is 6 months and is not done on a rolling basis. In 2009 it was open through July, which led to a major rush of applications and awards.

Dr. Yee mentioned how the announcement about inclusion of CAHs led to questions about the HPSA score and concerns about competition for providers. Ms. Spitzgo noted the requirement to be in a primary care HPSA and among the eligible primary care

disciplines that work in a hospital. The facility must have an affiliated outpatient clinic, and providers are allowed a limited number of hours in the hospital versus the clinic. The 3-year CAH pilot program includes an evaluation component and a limit of 10 LRP participants per CAH. Thus far, the pilot has approximately 50 participants, and the Bureau will review how many awards are made to people working in a CAH. The pilot arose based on input from the White House, the National Rural Council, and others.

Students to Service Loan (S2S) Repayment Pilot. The S2S program awards will be announced soon. Thus far, 88 have applied, and more than 200 registered during the 30-day application period. Awardees must prove they applied for residency and have graduated. They will be included in the scholar placement process and at the scholar placement conference at the appropriate time. Primary care residency must be in internal medicine, family practice, OB-GYN, or pediatrics and can include a geriatrics fellowship. Payment schedules will be driven by when documents are delivered within the June deadline, and payments should be made prior to the beginning of residency in July.

In response to Dr. Everett's question about whether the Bureau has considered combined residencies that include emergency care or psychology, Ms. Spitzgo said they are not likely to be included—based on specifics in the guidance—but it is helpful to monitor changes in the field.

Dr. Iazard noted that a HPSA score of 14 defines where the person must work, but not where the residency program must be, so the new program is more flexible than the SP. Ms. Spitzgo noted that the policy to set the HPSA at 14 or higher was based on 14 being the threshold for high need. One goal is to use it consistently to report who is in high-need areas.

Dr. Pathman suggested asking people about their motivation to apply for the S2S, since the responses will help market the program. While education loans typically do not need to be paid during residency, the program offers a good incentive based on knowing money will be available after residency.

State Loan Repayment Program (SLRP). The Bureau is working to ensure that the SLRP complements the NHSC program. Many States are challenged by the required one-to-one matching, so the Corps is helping to fill the gaps. Last year not all SLRP money was spent because States asked for less than what was projected, and based on not being able to make the dollar for dollar required matching. This year could include continuation awards, and the SLRP awards do not necessarily have to be in the same 19

States. The SLRP set-aside is \$10 million, and States are being encouraged to partner with foundations for the additional match funding, though it cannot be Federal money.

NHSC Field Strength Projections. Ms. Spitzgo explained that field strength projections in 2012 could grow higher than the 9,193 projected (on the graph shown), as funding is juggled, but it is not expected to reach the 2011 level of more than 10,000 without base appropriation funding, which is unlikely.

Outreach and Communication. NHSC's first Corps Community Day that took place in October 2011 was a tremendous success with more than 75 events in 45 states and Puerto Rico, and NHSC looks forward to hosting a second Corps Community Day in October 2012. In addition, the Bureau will conduct a virtual job fair pilot in February 2012 that will include eight States initially as a result of the new technology. Providers seeking primary care jobs will be able to "see" sites and engage in a virtual conversation about potential job prospects with them during this time. And sites will be able to reach a greater number of providers and explain and personalize their site and the communities they serve. We believe this pilot has great recruitment potential for both providers and NHSC service sites alike.

Stories from the Field. NHSC's Stories from the Field, a way for the NHSC to showcase the tremendous work of NHSC providers and sites across the country, have also helped boost internal and external communications about the Corps. These profiles have been sent to the "friends of HRSA" list and generated a lot of excitement by our staff, stakeholders and state partners.

NHSC Initiatives. Provider retention in the NHSC remains a top priority and is a fundamental part of the NHSC mission. All BCRS-led initiatives are undertaken with the understanding that they directly or indirectly impact provider retention. The NHSC's examination of provider retention includes looking for best practices among NHSC sites and among other businesses to guide our future efforts. A resource that aids our retention efforts includes connecting NHSC providers to resources that help them succeed. One such resource is the PrimaryCareforall.org (PCFA) site that connects NHSC providers to each other and to resources including current educational materials and accredited primary care courses. Thus far, more than 100 continuing education (CE) credits have been issued via the PCFA Virtual Community Resource Center. The numbers of participants on the webinars on PrimaryCareforall.org vary across webinars, with our highest enrollment around 2,700 participants per month. Approximately one-third of NHSC participants have used PrimaryCareforall.org, however, a key challenge is the

timing of when to schedule webinars (among different time zones), and many prefer afternoons or evenings when not at work.

Customer Care Center—Consolidation. In an attempt to consolidate and improve our customer service delivery, BCRS welcomed a new Call Center contractor (awarded in September 2011). The new contractor TeleTech specializes in running call centers rather than operating them as a sideline and the transition went well. With the significant growth in our programs, our goal with our new contractor is to provide valuable and timely communication with our participants, and higher customer service levels than ever before.

BCRS Management Information System Solution (BMISS). Ms. Spitzgo reported that next year, the new online 6-month verification process run out of the BMISS system will preclude 27,000 pieces of paper typically produced for the six-month verification (SMV) reports. Six-month verifications are used to ensure participants are meeting the service hour and time-off requirements of the NHSC program and is a critical element in effectively monitoring program compliance. In addition, the new online six-month verification process significantly reduces the Bureau's reliance on contractor support and enhances data reporting and the integrity of the data. The same process will be used for the LRP employment verification. Another significant milestone will be the creation of a new recruitment site for NHSC sites, which involves the restructuring of the job opportunity list (JOL). Targeting a spring 2012 public release, the new recruitment site will improve and broaden the use and flexibility of information for participants. Staff will set up a demonstration of the enhanced JOL/new recruitment site for the Council once it has been developed.

ACTION ITEM. Set up the demonstration of the new recruitment site/enhanced JOL.

Customer Service Portal. The vision is for all program participants—NHSC LRP and SP, S2S LRP, nursing LRP and SP, and Faculty LRP—to use the online customer service portal for their customer service transactions, which supports transfers, 6-month verifications, site reassignments, contract continuations, general inquiries, and much more.

NHSC Policy & Program Considerations. In order to drive more primary care providers into high-need areas (defined by HPSA scores), the Bureau wants to set the HPSA score at a point where high-need areas are most prevalent but not discourage interest. In that regard, we are looking at HPSA scores and loan repayment awards that encourage work in communities designated with higher HPSAs. Other questions under consideration and being evaluated by our policy team include service credit for

telemedicine provided from a non-HPSA location. Given the increased number of participants in the program; the availability of new online, portal based systems to submit ISVs, site transfers, and similar requests; the need to ensure program integrity; and the desire to ensure that the mission of the program is supported, the NHSC should evaluate the levels of interest in and the criteria for a continuation contract that measure the individual's commitment to the program and compliance with program requirements.

Another policy change includes the changes to the SP placement process. The placement process was brought in-house and is now performed by the BCRS regional staff, who are our "boots on the ground" and have the ability to reach out to local Scholars and NHSC sites as well as collect necessary data. The regions also help deliver customer service to NHSC LRP providers who are already placed.

Council Discussion

As a result of the BCRS Regional Office overseeing Scholar Placement, Mr. Jordan (Deputy Director, Division of Regional Operations) noted a more consistent approach to placement, including a minimum of monthly contact with scholars and a more frequent uploading of placement documents through the online portal rather than via a paper process. He noted the increased ability of the Regions to help find employment for providers who leave or are terminated from sites. Ms. Spitzgo reiterated that it is good to stay in regular contact with scholars after their award has been made and through their education and placement process, and the changes made to our processes were based on direct feedback from our Scholars at the NHSC Scholar conferences. The conferences also have generated recommendations for NHSC Scholars to experience at least one rotation in an underserved area, which helps them gain direct exposure, experience and understanding of the needs and job requirements. The Bureau's Scholar Branch will stay in close contact while scholars are in school, residency, and 1 year before placement to get them ready, including preparation for how to benefit from the NHSC's Scholar Placement Conference.

In response to Dr. Izard's question about interdisciplinary teams at sites, Ms. Spitzgo said the Bureau is trying to ensure that sites have interdisciplinary teams available so that practitioners are not serving in isolation and so that they feel integrated into well-rounded care. She noted that the Bureau is working diligently to define a consistent set of primary care services. Scholar conferences emphasize interdisciplinary teamwork, but that team can differ across sites and communities. The requirements for interdisciplinary care are not clear, and perhaps the Council could further discuss this issue.

ITEM FOR CONSIDERATION. Consider a Council discussion about the definition or requirements for interdisciplinary care.

Ms. Spitzgo noted the need to monitor whether some sites are appropriate for NHSC providers. The Bureau continues to review strategies for NHSC site visits, including how to identify high-risk sites, based on lack of compliance or major provider turnover. It is necessary to track who is leaving from specific sites and why.

Ms. Schwartz indicated that CHCs, FQHCs, and others are islands within a community, and can get higher HPSA scores based on specific situations, including willingness to treat certain types of patients. However, some get surprisingly low HPSA scores. Ms. Spitzgo noted that HPSA data comes from State Primary Care Offices (PCOs), so inconsistencies in the data, or the need for updates should be communicated with them. BCRS staff works with the HRSA Office of Shortage Designation (OSD), on HPSA updates and designations, and it is critical that the HPSA designation is easily derived from a clear and standard set of data that is updated.

CAPT Budashewitz said primary care, dental, and mental and behavioral health criteria vary, so comparisons are not easy. A review is needed to see what data are submitted, what is measured, and when it was collected. Ms. Amundson added that dental data are difficult to obtain, and PCOs need to consider specific questions and revisiting designation decisions. She noted that PCOs are encouraging schools and sites to focus on inter-professional education and care, and she said it is good that HRSA reinstated the regional offices, especially to help PCOs seek input. Ms. Spitzgo agreed that the regional offices are a great fit, well positioned, and work well with headquarters.

In response to a question from Dr. Warren about contacts at educational institutions, Mr. Jordan noted that the Bureau's goal is to target information about the LRP and SP to specific schools and officials, based in part on the goals of health equity and directing interest toward the Corps. That includes keeping faculty, administrators, and financial aid officials informed, though it can be good to use different strategies and information for specific officials. Ms. Spitzgo suggested sending a letter to school officials to encourage broader preparation for NHSC type of care. It also is good to track how people learn about the NHSC to determine where recruitment is working and where it needs more efforts.

ITEM FOR CONSIDERATION. Consider how data about recruitment sources can guide future efforts.

Dr. Pathman noted that data from 15 years ago citing how long primary care physicians stay in practice and how they heard about the NHSC showed that retention is driven by how someone heard about the program. The most effective sources were local information and schools, while the least effective were recruiters or journal ads.

[Break for Lunch]

As follow-up to the morning discussion, Ms. Spitzgo shared data that showed 51.4 percent of SP awards went to students from a disadvantaged background. CAPT Willis-Marsh (Director, Division of the National Health Service Corps) noted that qualifications include being in the reduced lunch program in high school, attendance at a school with SAT scores below the national average, or having been on medical assistance at one time. It is a school-based designation and includes environmental or economic factors. The Federal definition leads people to know who they are, including users of the Free Application for Federal Student Aid (FAFSA). Race and ethnicity are not factors. Ms. Spitzgo added that while disadvantaged background is a factor in the LRP, it is not as important in scoring as in the SP, since the LRP is about HPSA designation. Dr. Crouse also noted that some States allow self-reporting for disadvantaged background.

2011 NHSC Customer Service and Retention Survey—Kimberly Kleine, Deputy Associate Administrator, Bureau of Clinician Recruitment and Service (BCRS)

Ms. Kleine began by reiterating that the Council's meeting last year included a review of survey data from 2010. That was the first survey in 10 years, and it provided a baseline that can be used in conjunction with data from 2011 to compare trends and progress and to help comply with Congressional reporting requirements about retention.

The customer service [satisfaction] survey included partners, LRP, and SP participants. The customer service index among partners was 73 in both years, but for participants it increased from 76 to 78. Mostly, the same set of challenges existed in both years for both segments, but new factors among providers existed, based on rollout of specific support efforts. As for short term retention rates among NHSC providers, the rate increased from 76 percent to 82 percent.

The titles of Ms. Kleine's slides are listed below in italics, along with supplemental comments and discussion.

The Organization and ACSI Method: Overview. The response rate among partners decreased from 19 percent to 13 percent, but the average on similar surveys is

approximately 7-9 percent. The index scale is like a thermometer with incremental increases.

Part 1: Partner Survey—2011 Key Findings. Ms. Kleine presented a chart showing that increased support from the NHSC is the top priority among NHSC partners, including regular communications, continued training efforts, and more one-on-one support.

NHSC partners (predominantly NHSC sites) tell us, the hardest primary care positions to fill can take at least 6 months and up to 1-2 years. A key question is why approximately 40 percent of NHSC sites do not have a recruitment and retention plan when this is the case.

Part 2: NHSC Participants Survey. The new and improved system allows wider review of Call Center data. The 2011 participant customer service [satisfaction index] findings indicate response time to inquiries is an ongoing focus, and in 2012 it is expected that more than 63 percent of responses are made within 2 days. The findings measure response rate, not resolution (resolution of the inquiry); however resolution is close to a 60 percent rate within a 48 hour time frame. It is not clear how many unresolved issues were issues beyond staff control.

Ms. Katie Root (Acting Director, Division of Program Operations) cautioned that what participants consider a resolution might not be within staff control. The Call Center currently has 14 full-time equivalent (FTE) staff serving all BCRS, NHSC, and nursing programs and her division is expanding from 30 to over 40 FTEs. The goal is to shorten turn-around time for customer service inquiries and transactions and to also improve the monitoring process of program participants. Ms. Spitzgo noted that the Bureau has 10,000 providers to monitor, but it is not clear how many go through 2 years without requiring assistance, how many have few questions, and how many require frequent assistance. Most likely, it is a little bit of each scenario. It is a challenge to know how that translates into the appropriate level of FTE staff to support a field strength of 10,000 and to ensure a 48-hour response. Staff is working on determining those ratios/numbers and as more requests come through the online portal, more tracking and monitoring of specifics and better resource planning will be possible.

The Council then discussed the relative merits of responses to surveys in which respondents are self-selected, compared with other forms of data collection. Dr. Pathman suggested that it is necessary to account for types of people who are more likely to respond to a survey and, when appropriate, compare their data with findings from other surveys. Ms. Baird suggested comparing turnover data from the American

Medical Group Association (AAMGA) or Medical Management Group Association (MMGA), as medical groups constitute the biggest competitor for this talent. Ms. Kleine mentioned that NHSC is considering conducting exit interviews through the online portal for immediate feedback in the future.

Ms. Spitzgo commented on the challenge to establish the “right” retention rate and what to benchmark it against. Retention will never be 100 percent, and once the benchmark is established it can become the target and a way to measure success. Dr. Izard suggested benchmarks based on types of people interested in the program and how long people intend to stay, as well as a review of how their experience worked out.

In response to questions by Dr. Salvador and Dr. Izard regarding the basis for retention rates, Ms. Kleine and Ms. Spitzgo said retention rates are based on whether providers stay in a HPSA, and even dropping to a low HPSA still counts as retention. Ms. Spitzgo noted that the question of retention rates can include whether a person is at the same site, or another NHSC site, or another HPSA. More than 90 percent are at another NHSC site, and 80 percent are at another site in a HPSA and not necessarily an NHSC site.

Dr. Pathman suggested that it is good to ask why someone leaves a site, but it is a complex situation when a family relocates or someone loses a job. People will not admit fault as a factor in leaving, so it is better to ask for drivers of satisfaction and then compare findings among different populations.

Returning to her presentation, Ms. Kleine said that the development of questions for the 2012 retention survey is underway. Many new support and communication resources were rolled out recently but not in time to test their impact via questions in the 2011 survey. A newly formed workgroup is addressing these retention issues where strategies will focus on NHSC site support, community engagement, strengthened customer service from the NHSC, and program innovations (i.e. S2S). A sites technical assistance (TA) contract will help sites to be aware of their own retention rates and retention goals.

Council Discussion

CAPT Willis-Marsh noted that the Bureau is planning to help sites conduct an organizational assessment and to develop meaningful retention plans. Dr. Yee cautioned that site managers vary in willingness to take advice. Many long-term managers do not want to be told how to do things, but managers who believe in honest self-assessment are open to advice. A key question is how to get low-performance centers to improve, including how to identify them and address specific solutions. Ms.

Kleine suggested that the Bureau does not want to be perceived as overly aggressive or directive but wants to vigorously offer best practices and tools and to monitor usage in support of future planning.

Ms. Schwartz agreed that exit interviews are a good idea, especially to help CEOs learn what they do not know. Dr. Everett added that site turnover is high—as much as 20-25 percent—due in part to difficulty integrating with accountable care organizations (ACO) and other innovations and the need to remain eligible for the NHSC. It is good to assess struggling clinics and offer TA solutions, and that will help advertise the Corps' desire to help sites survive. If Medicare rates drop another 30 percent, it will threaten even more sites. It always comes down to having enough money to proceed.

Participating by telephone, Ms. Looker mentioned that retention will be affected by the future of practice systems and care delivery. A tremendous effort is needed to transform health care systems into patient-centered medical homes, to move to electronic health records (EHR), and to provide other items that support recruitment and excite people to be a part of service. However, much of that is not being taught, including academic institutions that are not teaching about interdisciplinary care. Pharmacists in urban and rural underserved areas also need strong support in handling the many unemployed people who are drug seekers, since they impact Corps providers. They do not want to feel as if they are working alone with that population.

Ms. Kleine added that recent innovations are the expansion of disciplines eligible for the State LRP—including pharmacists and RNs—and the expansion of eligible types of sites.

CAPT Willis-Marsh indicated that the Bureau wants to develop a business case for the value of a robust recruitment and retention plan. Many organizations in different industries do not understand the value and return on investment for such a plan. Dr. Izard added that one challenge is that managers and administrators are shortsighted versus being able to see how the entire operation works. In addition, providers' perspectives often are contrary to that of managers, so it is necessary to ensure that both sides listen to each other. It is good to have gatherings for people to interact, including thought-leader discussions about recruitment, retention, quality, etc.

Dr. Pathman agreed that it is good to show the business case for managers; especially those who refuse to see providers as people. Perhaps the Bureau should monitor the recruitment process from “applicant to engaged”, rather than from “employed to engaged”. That would be based on certain types of people who are likely to stay longer, such as those from the local area or with local personal support.

The National Rural Recruitment and Retention Network (3RNet) uses the term “recruitmention”, meaning recruit to retain, especially within factors that can be controlled. However, the types of people likely to be retained might vary among disciplines which could lead to different goals for whom to include.

Ms. Spitzgo said it is important to see the costs of *not* retaining providers, since it is likely costly and may determine whether a site can stay open. That would include the costs of hiring and orienting new employees. Information about costs could encourage managers to be more interested in retention. Dr. Yee noted that the cost of losing an employee could be one to two times the person’s annual salary.

Dr. Warren suggested a review of literature about provider choices and an effort to ask providers why they stay at sites and how to help encourage others to stay. Ms. Baird said culture is more important than strategy (“culture eats strategy for breakfast”), and the top reason people leave is typically the employer. For many, financial issues are the bottom priority, and it is important to encourage business cultures that encourage people to stay. Ms. Baird suggested that NHSC sites should use the Gallup 2012 employee engagement tool to help identify weak points and how to connect to the mission, vision, and values. The NHSC could also initiate some form of quality-oriented award similar to the Baldrige Award. Overall, retention efforts are related to patient satisfaction and care.

Ms. Kleine said it is necessary for the Corps to personalize how providers identify and choose sites, including clinical and personal factors. Ms. Schwartz added that it is good to help sites recruit, especially to help them avoid using professional recruiters. Dr. Yee suggested that a good, interactive website is helpful, though Dr. Crouse noted that a tool created by the Wisconsin Hospital Association was meant to help identify sites but was cost-prohibitive and unsuccessful. He added that part of the process is based on a personal feel for a site, managers, and communities, so personal connectivity—versus everything online—will remain important.

CAPT Willis-Marsh noted that an online site profile can include a picture of the site and information about its management team and philosophy and geography. Council members suggested that online profiles should have information about local education, amenities, hobbies, transportation, teaching opportunities, special populations, and services. Dr. Everett added that people will drill down beyond high-level information, but salary always will be a factor.

[Break]

[Note: prior to the next presentation, Ms. Spitzgo shared copies of LRP application statistics for 2012.]

NHSC Longitudinal Retention Study: First (Preliminary Findings) —Donald E. Pathman, M.D., M.P.H.; Professor, Department of Family Medicine, The University of North Carolina at Chapel Hill

Dr. Pathman began by noting that the information being presented is very recent and revisits the discussion about long-term retention that started at the Council's last meeting. At this point, all information is *preliminary*, and further analysis is planned.

The results are primarily based on email surveys among NHSC providers and site administrators, augmented by comparative data from a U.S. mail survey among a cohort from 1998 before email was widely used. Analyses were statistically weighted to be representative of NHSC providers. One goal was to document retention among current NHSC providers compared with those of the 1990s. Another was to document retention differences among key groups: scholars versus loan repayment recipients, and urban versus rural and frontier. A third goal was to examine the effects upon retention brought on by several factors: practice setting and job, satisfied spouses and children, and support received through the NHSC.

Dr. Pathman explained that retention within an NHSC service site was calculated as the months from the start of providers' service until the time they leave their first service site. Service within any underserved area or practice was calculated in the months from when the NHSC contract starts until the date a provider leaves the last sequential practice with the underserved. The study also assessed months of retention following the end of NHSC service. In the case of providers still serving, the questionnaire asked for the number of additional years the provider anticipates staying. Combining actual and future anticipated retention counts not only the length of completed service but also the stated intent or anticipation of people currently serving.

Ms. Spitzgo pointed out that the congressionally mandated report covers how many years providers stay after they complete their service. The Council discussed the definition of when in the continuum of service or a career a provider should be counted as retained. One point made was that the most meaningful measure of retention starts with the end of the contractual service commitment, rather than its beginning, and another was that the crucial measure of return on investment (ROI) on individual

providers is their continuing employment after the end of the service commitment. A third point was that counting anticipated retention among providers who are still within their commitments stretches the number of years counted as retention; however, including intent in retention data can help determine who is more likely to stay longer, and thus boost the Federal ROI.

It also could be valuable to measure length of service intention, based on impact of culture, community, and similar factors, and how that might change a person's long-term intent. Reasons can be tracked for why providers stay for less time than what they initially intended.

Continuing his presentation, Dr. Pathman noted that a person's history at a site is not being measured. Many women leave positions based on spousal employment needs, and an implication could be to increase spousal assistance in support of retention.

Turning to motivation, the survey found that the mission component has increased in comparison with the financial incentive. Ms. Spitzgo observed that increased interest in the mission indicates that the program is more competitive, which can influence how applications are evaluated, especially essays and stated intentions.

Dr. Pathman explained on a retention graph in his slides that the curve shows a "shelf" at the start, reflecting the penalty for leaving too soon, with a sharper drop after the penalty is no longer in effect. Retirement data are reviewed based on age cohorts, such as 30-35 and 40-45. The reasons people leave differ at different time points, including factors such as family change, retirement, burnout, and site closure. Practice problems cause departure early in the curve.

Dr. Iazard said this graph indicates the LRP has a better ROI than the SP, based on more providers staying after 3-4 years, and Dr. Pathman noted that is part of the reason why the BCRS shifted its emphasis toward the LRP. Dr. Warren suggested that loan repayment recipients may be more informed about making decisions because they are already starting their practice, whereas scholars are still in school. Ms. Spitzgo noted that scholars frequently express initial passion about the mission, but many develop a strong interest to return to a home town, and others start to make decisions based on a spouse who was not a factor when the scholar first entered the SP. Many make the first decision at a young age and when older are sometimes faced with disappointment by program specifics and the reality of serving out their obligation—such as where sites are located—even though they should have been informed about the site choices when

they accepted the scholarship. This happens much more with physicians than PAs or nurses, based on a longer period of time between their award and start of service.

Continuing the presentation, Dr. Pathman displayed graphs showing combined actual and anticipated retention at the Scholars' first NHSC site, broken down by discipline. Ms. Horvath commented that it would be good to see whether specific professions—such as physician assistants (PAs)—are not holding on to the commitment and what the Corps and educators can do to address that. Dr. Pathman added that the NHSC discusses the need for certain disciplines, but some likely have unique needs, including good relationships with physicians on the part of PAs and nurse practitioners (NPs) immediately after training. However, too often it is a forced relationship or the physician does not speak to the PA. Dr. Crouse suggested that could be caused by insufficient inter-professional training, including among physicians.

As for urban versus rural and frontier sites, Dr. Pathman reported the retention data are quite similar, although more attention is paid to departures at rural versus urban sites. Ms. Spitzgo noted that recruitment time and effort is easier at urban versus rural sites, and that is why rural departures generate more discussion and concern. Dr. Pathman added that underserved areas are designated based on difficulty recruiting, rather than on retention.

Dr. Crouse concluded the session by noting that the retention factors and data presented correlate with the customer-service [satisfaction] survey findings.

[Break]

Negotiated Rulemaking HPSA's and Medically Underserved Areas and Populations—CAPT Philip Budashewitz, Director, Office of Policy and Program Development

The titles of CAPT Budashewitz's slides are listed below in italics, along with supplemental comments and discussion.

Negotiated Rulemaking. Negotiated rulemaking substitutes for the customary notice-and-comment procedure and is based on stakeholders supporting the process. In 1998 and 2008 HRSA attempted to revise how HPSAs and medically underserved areas (MUAs) are designated, but for various reasons it was not successful. This led to the HHS Secretary calling for negotiated rulemaking to devise new methodologies and criteria.

History and Definitions, and Rules for the Process. The committee represented various types of sites, as well as patient and disease groups that include HIV, disabled, and mental health. An option was to tell the Secretary that the committee did not reach consensus, but after 36 meetings over 14 months—and much technical analysis—people felt strongly that the report should be forwarded to the Secretary. One overall factor is that it is about HPSA literacy.

Timeline. The ACA was enacted in March 2010, and the schedule (in the slide) was aggressive. The committee missed a March 2011 statutory deadline for reporting to the Secretary.

Committee Recommendations: Key Aspects (multiple slides). An important question is how to count FTEs for disciplines other than physicians.

Ms. Toohey (Deputy Director, Office of Policy and Program Development) noted recent debate over counting disciplines other than physicians as a full FTE. The PA and NP communities commented that they are full time and should be equivalent to physicians as 1.0. However, rural sites have argued that if PAs and NPs are counted as less than a full FTE, it helps achieve a higher HPSA score based on provider-to-patient ratios.

CAPT Budashewitz said that while ratios can be 3,000:1 or sometimes 3,500:1, different urban and rural ratios are an issue. Another challenge is how provider-to-population ratios back out Federal investments, such as the NHSC and other programs. Much discussion has ensued over whether doing that has a positive or negative impact, including on how to define a rational service area and how to compare areas with some versus no Federal investment. Further, designation is subject to frequent change, based on a cycle of placement, subsequent denial, and future placement of providers, as well as how people are counted at centers where the Federal Government supports salaries.

Dissenting Views. For some assumptions made during committee discussions, a lack of national data—or more anecdotal than actual data—is a problem. If too many HPSAs are created, it leaves the question of whether Federal resources are truly being targeted to areas of greatest need.

Next Steps. The final rule is under consideration, and at this time the BCRS cannot publicly discuss more about what will be included or omitted.

Ms. Toohey responded to a question by noting that the committee recommended backing out people with a Federal service commitment, and that every entity that

currently is backed out should continue to be. IHS employees are counted, while VA and other Federal employees are excluded.

CAPT Budashewitz added that what is counted or not is critical to understanding how HPSA scores are determined. He also reiterated that thus far this is only about a report to the Secretary, and no specific rule is under consideration, though it does show areas where consensus was reached. HHS must now develop a new proposed rule.

Ms. Spitzgo noted that strong dissenting views among some committee members meant additional meetings would not likely resolve the issues. The process is back at HHS and the Secretary could publish the content as is, based on the level of consensus. Negotiated rulemaking combines proposed rules and comment periods, with the expectation that the public will still have opportunity for input. It is also possible that HHS will write a completely different regulation. The ACA imposed timelines on the committee—but not for the Secretary—to publish the final regulation. Ms. Toohey added that the ACA calls for 1 year of comment on any proposed final rule, and then it can be finalized.

Ms. Toohey noted that the committee had only one Federal representative who spoke on behalf of multiple agencies versus input specific to one agency's interests or opinions, and no undue Federal influence occurred. Ms. Spitzgo added that negotiated rulemaking is about stakeholder input—in place of a public comment period—to reach consensus and publish an interim rule that will not be opposed by the groups who helped craft it. Therefore, it is not a Federal rule but instead is designed to serve the people who helped craft it.

Dr. Pathman suggested that consensus among interested parties is elusive. He asked about data to show what populations would be included as a HPSA and noted that some States only require that participants are in a rural area, regardless of whether it is underserved. CAPT Budashewitz noted that the data are available on the website, and he offered to distribute data to the Council. Ms. Toohey added that while multiple ways exist to look at the results for the number of designations—and many HPSAs could shift or be lost—the goal is to maintain the same overall total of patients covered under HPSAs.

Additional Discussion

Dr. Everett noted past Council discussions about recruiting and retaining providers other than NHSC loan repayment recipients and scholars as a way to get people into shortage areas. Tax incentives and other enticements could be used. While this would change

how NHSC money is distributed and would need a legislative champion to push for it, it could reach many previously untapped providers and expand the Corps' reach. Ms. Spitzgo noted that the current legislation prohibits that kind of initiative, but one possibility without new legislation is to use the NHSC recruitment site to increase general awareness about underserved areas.

Dr. Yee noted that the movement toward patient-centered homes will result in the need to serve an additional 40 million patients, and current recruitment efforts are not likely to bring a sufficient number of providers. He suggested finding ways for NHSC providers to be the innovators for new practice models and methods of reaching the Nation's long-term goals. By equipping Corps providers with additional skills—such as practice management, inter-professional work, and more—they can have a more positive impact on sites.

Dr. Izard added that many sites struggle with how to do new models, based on fiscal challenges and issues, such as high uninsured or high Medicaid populations, as well as lack of coverage for salary and overhead. It is hard to create new and improved models of care if they are not financially sustainable.

Ms. Spitzgo asked what tools and resources are available to assist CHCs to fill the voids. Dr. Yee responded that the National Association of Community Health Centers (NACHC) created its own patient-centered medical home department and is working with CMS and the Kaiser Innovation Center to test models. Recent examples include an innovative EHR effort in Colorado, a nurse model in California, and scribes to capture information from physicians. Individual grants also exist to help change models of care. It is good when innovation improves financial viability, and it would be good for Corps providers to help make that happen and improve retention. Dr. Izard cautioned that many innovations are small scale and cannot be extrapolated to regional or national efforts; some require large financial investments to spread. Dr. Yee added that NHSC's goal is to showcase different models, but sites and States are unique, so it is best to create ideas for people to fit to their own operational and financial circumstances.

Dr. Warren praised NHSC staff for doing an outstanding job, including coordinating meetings and members' attendance. However, this is an important year and while the Corps is doing good work, public awareness about the program is not sufficient in many urban and rural areas.

Ms. Schwartz noted that the IHS is starting Year 4 in its improving care initiative. It includes different pilot projects similar to NHSC pilots, but such efforts slow down the

agency. While things like patient-centered medical homes and EHR are great ideas, they are fiscally challenging. While new services will begin in 2014, survival until 2014 can be a challenge.

Ms. Amundson noted that in the 1990s, the NHSC provided technical assistance (TA) to sites on items such as billing, management, patient flow, etc. The sites appreciated it, especially when it was free. However, Dr. Pathman said Corps TA for billing for patient services—as well as management culture and style—would be a new service, and it is not clear how many sites would be open to that or resist it and how many would prefer State versus Federal support. Dr. Everett suggested Corps assistance for sites upon request, though in general it is good to help start-up sites. In some cases it would be better to recommend experts versus offering direct Federal support.

Ms. Spitzgo noted past HRSA TA efforts for sites, but it is not clear whether that is the most effective way to support them. Many models exist and could be chosen to fill the recent void and be evaluated. Good ideas include Web-based training, leveraging and disseminating best practices, and leveraging training by other Federal agencies or sites.

Ms. Spitzgo said regional staff and PCOs should be part of the process, based on their relationships with sites. Partnerships with associations such as NACHC are possible, and efforts could be in conjunction with conferences by NACHC, 3RNet, and others. Other than Webinars, the Corps has an overall void of opportunities to bring sites together. While the Corps engages in communications with sites, it is good to establish touch points up front.

Dr. Izard cautioned that recruitment of a management team is a challenge, and many managers are not familiar with best practices and solutions to certain issues. Sites willing to share and learn from each other will benefit, while others will not. Ms. Spitzgo added that it is necessary to focus on sites that want to be helped and to remain aware of how those sites can create momentum that encourages other sites to get involved. Hopefully, in 6-8 months the BCRS will see good results from the new TA contractor.

Ms. Schwartz noted past Council discussions on how training should include all providers at a site; not just those from the Corps. The most common training need would be for coding, since that is not being provided on a regular basis. Ms. Spitzgo suggested that could be Web-based training, using existing modules. Dr. Everett agreed that coding is difficult, but training is available.

Dr. Salvador noted how the Corps' contributions during its growth include the fact that NHSC placement at a site established a discipline there that can last beyond an individual's tenure. CAPT Budashewitz said that is a good example of sustainability, and Dr. Izard added that is considered in capacity-building strategies and data.

Dr. Salvador inquired about a model of Federal licensure and the ability of providers to work in different States. Ms. Spitzgo said Federal licensure has been discussed but would require a new regulation, so it is more controversial than other suggestions. It also is an example of issues related to State versus Federal control.

Day 1 adjourned at 4:25 p.m.

Council: Mary Amundson, M.A.; Kristin Baird, RN, B.S.N., M.H.S.A.; Byron J. Crouse, M.D., FAAFP; John Everett, D.O.; Theresa V. Horvath, PA-C, M.P.H.; Tito Izard, M.D.; Michael D. McCunniff, D.D.S., M.S.; Donald Pathman, M.D., M.P.H.; Darryl Salvador, Psy.D; Susette M. Schwartz, J.D.; Ronald Yee, M.D., M.B.A.

Federal: Michael Arsenault; Ken Brown; CAPT Philip Budashewitz, RPH, M.A.; Michelle Corbin, M.B.A., Leyla Desmond; Janet Heinrich, Dr.P.H., RN; Kim Huffman; Njeri Jones, M.P.H., CHES; Jeff Jordan, M.P.H.; Kimberly Kleine; Katie Root; Cynthia Segó; LaKisha Smith, M.P.H.; Rebecca Spitzgo; Laura Stillman; Lindsey Toohey; CAPT Jeanean Willis-Marsh, D.P.M.

Guests: None

Seamon Corporation (logistics contractor): Alicia Corbin, Len Rickman

Friday’s Focus—Dr. Byron J. Crouse, Council Chair

Dr. Crouse introduced Dr. Heinrich from the HRSA Bureau of Health Professions (BHP), and asked Council members and BCRS staff to introduce themselves.

Bureau of Health Professions: Workforce Program Overview—Janet Heinrich, Dr.P.H., RN; Associate Administrator, Bureau of Health Professions (BHP)

Dr. Heinrich began by expressing thanks for being invited to the NHSC NAC discussion. She praised NHSC’s recent expansion from between 3,000 and 4,000 to more than 10,000, and noted that the BHP is working hard to implement provisions of the Affordable Care Act (ACA).

The titles of Dr. Heinrich’s slides are listed below in italics, along with supplemental comments and discussion.

Bureau of Health Professions (mission statement). Dr. Heinrich indicated that Bureau funds primarily go to institutions of higher learning.

BHP Overview. Dr. Heinrich provided an overview of BHP’s structure and how they support the health professions workforce. She noted that a small psychology program is included among the Bureau’s programs and continuing education (CE) opportunities are in gerontology and public health. A key priority is disadvantaged students. The budget in 2011 was \$900 million and the budget for 2012 is approximately \$650 million.

Health Professions and the ACA. Forty distinct programs exist. Physicians include internal medicine, family practice, and pediatrics, and the programs also support physician assistants (PAs) and nurse practitioners (NPs). The ACA significantly expanded oral health programs, including for dental hygienists.

Often, funding preference is given to programs with demonstrated success with rural placement, but more evaluation of success is needed. Progress in diversity has been a challenge, especially in nursing, and the Bureau is beginning to engage with the National Institutes of Health (NIH) and its new Institute on Minority Health to address these issues.

Affordable Care Act Workforce Investments. The BHPPr supports residents in primary care specialties and over 5 years will support close to 3,000. Goals include funding expansion of the nurse primary care workforce by 5,000. Nurse-managed clinics are continuing with no cost extensions and remain engaged in communities. The Bureau has worked with labor boards not previously involved with the health care workforce, but in the recession many jobs are in health centers so the discussions were successful but difficult. Funding for front-line care has gone to six States and included a review of core competencies to guide nurse curricula. Separate training—based on types of care settings—is not needed. Per the law, the program will include careful review that includes comparison groups. The Bureau's focus on the direct-care workforce is good, but it is new compared with its past focus on graduate and undergraduate programs.

BHPPr FY 2012 Major Focus Areas (multiple slides). Dr. Heinrich indicated that the focus on health workforce issues includes work with the National Center for Health Workforce Analysis and other groups that predict shortages in various specialties, such as orthopedics and general surgery. It is necessary to ensure the right distribution of general surgery. Four programs focus on geriatric training and expertise, but some experts predict that there never will be enough providers in that area. The Bureau is preparing to release a report on supply and demand in the primary care workforce, including for NPs and PAs. Dr. Wakefield supports expansion of performance measures, and an overall goal is to expand production and distribution, along with infrastructure.

Example of BHPPr Strategy: Measuring and Evaluating Program Performance (multiple slides). The data-gathering package is under Office of Management and Budget (OMB) review, and the goal is to begin collecting program performance data in July 2012. The ACA calls for longitudinal studies, and the objective is to follow career trajectories and better understand primary care retention. The BHPPr seeks assistance, since longitudinal studies are expensive. The goal is at least a minimal dataset to track people, based on individual identifiers. This will help focus programs and ensure good stewardship of Federal money.

Example of BHPPr strategy: Growing the Primary Care Workforce (multiple slides). Dr. Brand (HRSA associate administrator) convened the BHPPr's four advisory groups, in part to discuss how an expanded workforce will require more clinical sites for training—including for PAs—and will increase the need for inter-professional training. This could possibly be done in conjunction with the National Health Service Corps (NHSC). Improved medical school clinical experience includes exposure to rural areas to help entice more students into primary care residencies. Expanded nurse training will include inter-professional training. Experts say it is easy to include didactic education, but it is not easy to include clinical experience as part of training; \$230 million is allocated for teaching health care programs.

New thinking includes how residency training does not have to be in a teaching hospital. There now are 22 designated teaching health centers in a variety of places. The mission in community health centers (CHCs) and rural health centers (RHCs) is service, but they do not share the mission for training and education.

New HRSA-funded Teaching Health Centers (THCs). Dr. Heinrich noted that the THCs include NHSC providers serving as faculty. The Bureau is determining eligibility for THCs and fought diligently to ensure that the consortium model is eligible.

The Bureau is doing interesting work on the costs of graduate medical education (GME), including working closely with the Centers for Medicare & Medicaid (CMS) to better understand GME and supporting the Medical Payment Advisory Commission's (MedPAC) work on costs, especially indirect costs for GME. There is a high cost to train physicians, and efforts to reform GME get entangled with the concepts of teaching hospitals, research, and many other factors in clinical training. The THCs are a golden opportunity to document the true costs of residency training. The programs are accredited and must measure up to any other accredited programs.

Dr. Izard asked whether the issue is cost to train residents or lack of revenue, and Dr. Heinrich said the answer is unclear. Residents' salaries are approximately \$50,000 but with much variation across the United States. While it is clear that salary and some direct costs are covered, it is not the same with indirect costs. The THC program's major costs for training residents are direct costs, and that is the opposite of how Medicare payments work.

Example of BHPPr Strategy: Interdisciplinary Work (multiple slides). A meeting co-sponsored by HRSA to promote inter-professional competencies in education, practice, training and certification programs took place in February 2011 with various private sector groups (i.e. Macy Foundation, Robert Wood Johnson Foundation), and

the Bureau continues to work with the private sector to seek strategies to fund the program and move initiatives forward. The goal is to make inter-professional competencies the norm, not the exception. Collaboration includes medicine, nursing, pharmacy, public health, PAs, and other disciplines.

Example of BHPPr Strategy: Diversity. The Bureau knows it has to evaluate what works, and is doing so.

Example of BHPPr Strategy: Data to Inform Decision-making. The program director at the National Center for Health Workforce Analysis and his research team have conducted good data analyses and are trying to revise how demand is predicted, however it is complex and requires research-based models. The research team is preparing to do a NP survey and so far, little is known about what NPs and PAs are doing—including where and how they practice—thus more information is needed to craft models that make sense.

Council Discussion

In response to Ms. Amundson, Dr. Heinrich noted that funding is not available for a second phase that would include State implementation grants, but planning grants continue to work and some recipients leverage their \$150,000 into further efforts.

Dr. Izard commented that workforce distribution for areas most in need should be a priority. Dr. Heinrich responded that unlike the NHSC, which focuses on placement in designated shortage areas, the Bureau's programs do not have leverage over where people go after training. It must do so indirectly, based on points for institutions with good track records in placing students and graduates in underserved areas.

Dr. Crouse suggested that the new wave of training under THCs could be tied to the NHSC's S2S program, since participants are going to communities. CAPT Budashewitz noted that the ACA allows some of that type of linkage, including how NHSC participants can teach at centers. Dr. Crouse suggested a two-tier placement structure for scholars where the HPSA score of 14 requirements could be waived for students graduating from a THC so that the person stays and has continuity. While the THC might not be in a high HPSA, this could support long-term engagement.

Dr. Crouse also cautioned about the challenge to provide education in underserved areas that already are short on providers and will struggle to add a teaching component. Sites respond to a lot of human needs, and it is not clear how to add components.

Dr. McCunniff noted that although the fact is not widely perceived, from a public health perspective there are problems in the field of dental health, including people using emergency departments for dental care. Dr. Heinrich responded that the Bureau is

working with the American Dental Association and State licensing boards to develop a minimum dataset that will help map out supply in the future.

In response to a question from Ms. Schwartz about THC funding for multiple disciplines, Dr. Heinrich noted that the law is specific about funding medical residency programs, though it does include multiple specialties. Dr. Heinrich noted that the Bureau's work with the CMS Innovation Center is in part a response to many requests for ideas on demonstrations to save money, improve quality and access, and link those efforts with recommendations for the workforce.

Dr. Heinrich concluded in saying that it is necessary to know what the workforce looks like, and to understand how a team of different disciplines can be effective. This will be an opportunity for people who want to do things differently.

Minutes from the Last Meeting (June 22-23, 2011)—Dr. Byron J. Crouse, NAC Chair

Ms. Schwartz corrected a statement in the June 2011 minutes regarding tribes and federally qualified health centers (FQHCs). Following that, a motion to approve the minutes with the noted change passed unanimously, with one abstention.

[Break]

Public Comments—Dr. Byron J. Crouse, NAC Chair

No public comments were offered.

Automatic HPSAs (not in the original agenda)

Dr. Izard asked for clarification about scholars and automatic HPSAs. Ms. Spitzgo explained that many health centers and CHCs are an automatic HPSA, as calculated by HRSA, rather than the primary care office (PCO). However, the HPSA designation tends to be low, and scholars cannot be placed in a HPSA of less than 16, so it typically is better for a CHC to get an actual versus an automatic score. Ms. Toohey added that the statute says an FQHC or a rural health centers (RHC) that meets the ability-to-pay criterion gets automatic HPSA designation. Automatic starts with a HPSA of zero, then HRSA uses data from the National Association of Community Health Centers (NACHC) to get actual scores for specific CHCs. These scores can range and include middle levels. If an individual site wants a higher score based on local data, it can provide that data or go with other types of designation. CAPT Budashewitz noted that many programs use HPSAs, and it is complex, including using the scoring process after a designation is made.

In response to Dr. Izard, Ms. Toohey said that for automatic designations the parent facility score filters to its satellite sites. In some cases satellites can get a higher score

based on local data, but sites that do not want to do the work necessary for a different designation can stay with the parent facility's designation.

Dr. IZard cautioned that sites waiting for designation cannot recruit a scholar, and some sites work with partners to recalculate data to increase the score and split the cost of the data analysis. Ms. Spitzgo noted that PCOs can update designations at any time versus waiting for the annual review. One site recently went from 12 to 16, based on a local score. The Bureau is pleased to work with centers that believe their score should be higher. CAPT Budashewitz noted that, in some cases, facilities request a facility-based designation that likely will be higher than geographic.

Agenda Topics for the Next Meeting—Dr. Byron J. Crouse, NAC Chair

The Council and BCRS staff discussed the following items listed below as potential agenda topics for the Council's next meeting:

- Discussion with CMS, including funding, productivity, workforce issues, and the CMS Innovation Center
- Discussion with the NACHC about visions for the future
- Discussion with scholars about how sites work and how changes can be made
- Issues related to the Federal Tort Claims Act, including its effect on limiting the number of disciplines involved in NHSC programs
- Experiences and opportunities related to TA for sites, including a coding Webinar
- The extent of LRP placement in facilities other than CHCs and RHCs—such as the Indian Health Service (IHS), prisons, and critical access hospitals (CAHs)—and providers' experiences related to specific facility types
- Reasons why the 7,000 CHCs newly identified as NHSC sites are interested now but were not involved earlier

In response to the suggestions for agenda items, Ms. Spitzgo noted that the Bureau is analyzing data about field strength, including trends among sites, disciplines, and HPSAs. The Bureau will share the data with Dr. Wakefield and other senior leadership and then determine what else they want to know. Bureau staff can share the data and its implications at the Council's next meeting.

Ms. Spitzgo also noted that the growth in the number of CHCs was based on how the Bureau pulled them all in since they all meet the criteria. The Bureau did a lot of data cleaning to prevent duplications and to see how Bureau of Primary Health Care data meshes with it.

Closing Remarks—Rebecca Spitzgo

Ms. Spitzgo thanked everyone for another productive meeting. She noted that Council appointments are term-based for 3 years, and some members have terms that expire this year. All members whose terms are scheduled to end this year will be asked if they are interested in continuing their service on the Council, since the ACA allows Council members reappointment to another term. The Bureau will do a *Federal Register* notice and outreach to associations to solicit Council members and describe what is sought. Overall, both continuity and fresh thinking are important as the Bureau considers new members.

ACTION ITEM. Share the *Federal Register* notice with Council members.

Ms. Spitzgo said the meeting provided valuable information to review and rich discussion about the important subject of retention. As the Bureau develops retention strategies, some areas covered at this meeting will be easy to include, such as capturing providers' intent when they apply, particularly how long they expect to work at a site and with the underserved. That strategy will send a positive message about this being a career.

Other areas with good discussion points were patient-centered medical homes, site criteria and their role in the overall process, and award amounts for specific disciplines, including how to structure them based on consideration of what is needed in the program and how to leverage funding to make that happen. Comments on the S2S program, including those in conjunction with Dr. Heinrich's presentation about BHP programs, also were important to note. The Bureau will determine how to move forward, including possibly providing TA to sites to take advantage of the tremendous opportunity for retention. However, two challenges must be overcome. The first is to determine the most valuable TA among a long list of possible components. The second challenge is to get the greatest impact for the money invested, including widespread use of effective TA components. It is also important to encourage site managers to think about the cost of not retaining staff. Many sites may not know their retention rate, and knowing it would be a big step forward for them.

The Bureau intends to create an Adobe Connect demonstration of the new recruitment site to gain Council input about it. The hope is that it will be a value-added recruitment tool for sites and to help the underserved.

After the demo, the Council can discuss the next version of the recruitment site, including how to look at recruitment from the sense of assisting the underserved beyond only the LRP and SP. Driving people to serve the underserved is good, regardless

of whether they are in the LRP or SP. Another question is how the hits on Google look and what impressions they make.

ACTION ITEM. Share the demo of the recruitment site with the Council.

Ms. Spitzgo said the Bureau appreciates the Council's good thinking and the opportunity for staff to reflect, plan, and work with Council members. Council members are encouraged to contact the Bureau, though it is likely the Council will do two rather than three meetings per year.

Dr. Crouse concluded the meeting by expressing thanks for the input and noting that he is looking forward to working together at the next meeting.

Day 2 adjourned at 11:40 a.m.

Summary of Action and Consideration Items

- Develop a new indicator for continuations and retention data—Page 10.
- Determine how to categorize scholars who transition to the Loan Repayment Program (LRP)—Page 11.
- Provide the Council a demonstration of the revised job opportunity list (JOL) for spring 2012—Page 14.
- Consider a Council discussion about the definition of or requirements for interdisciplinary care—Page 16.
- Consider how data about recruitment sources can guide future efforts—Page 16.
- Share the *Federal Register* notice with current members about recruiting new Council members—Page 36.
- Share an Adobe Connect demo of the new recruitment site with Council members—Page 37.