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Meeting Minutes

National Advisory Council on the National Health Service Corps

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Meeting March 16-17, 2021

The National Advisory Council on the National Health Service Corps (NACNHSC or Council) met on March 16-17, 2021 via webinar. NACNHSC is a group of healthcare providers and administrators who are experts in the issues faced by communities with a shortage of primary care professionals. The Council serves as a key source of information to the National Health Service Corps (NHSC) senior management, to the Secretary of the U.S. Department of Health and Human Services (HHS) and, by designation, the Administrator of the Health Resources and Services Administration (HRSA). The NACNHSC was established under 42 USC 254j (Section 337 of the Public Health Service Act), as amended by Section 10501 of the Affordable Care Act. The Council is governed by provisions of Public Law 92-463 (5 USC App.2), which sets forth standards for the formation and use of advisory committees. NACNHSC responsibilities are specified under Subpart II, Part D of Title III of the Public Health Service Act.

Welcome and Opening Remarks

Designated Federal Officer Diane Fabiyi-King convened the meeting at 9:09 a.m. Eastern Daylight Time (EDT). She welcomed participants, introduced herself, provided instructions for meeting participation, and conducted roll call. All members except Dr. Patricia Pinto-Garcia were present. NACNHSC Chair, Keisha Callins, MD, MPH, thanked HRSA staff for supporting the Council meeting and requested a moment of silence to recognize those who have died from COVID-19. Dr. Callins encouraged Council members to consider meeting presentations when developing their recommendations.

Presentation: Bureau of Health Workforce Updates
Luis Padilla, MD, FAAFP
Associate Administrator, Bureau of Health Workforce

Dr. Padilla reported that the U.S. is experiencing a growing demand for health care professionals, partly as a result of a shrinking workforce supply. In addition, the workforce distribution is unequal. The COVID-19 pandemic has exacerbated the shortage as well as disparities in health care access. The Bureau of Health Workforce's (BHW) mission is to improve the health of underserved populations by strengthening the health workforce and connecting skilled

professionals to communities in need, through training, education, and service opportunities. HRSA workforce programs aim to make it easier for people to access health care, balance the supply of health workers with the demand for care, improve distribution of the health workforce to be more equitable, and improve the quality of the health workforce and the care they provide. BHW also aims to demonstrate how its programs impact targeted outcomes. Keys strategies for achieving BHW aims include training students in rural and underserved communities because spending a significant amount of time training in underserved areas may increase the likelihood of future practice in those communities; and providing interprofessional training can encourage clinicians to work collaboratively to deliver quality care. Community-based training also is a key BHW strategy. Loan and scholarship programs are another strategy for achieving BHW aims, as is recruiting students from priority communities. BHW is working to integrate oral, behavioral, and public health into primary care.

BHW's budget has increased steadily for the past 5 years. The American Rescue Plan Act of 2021 (American Rescue Plan) allocates more than $1.5 billion for HRSA workforce programs, with $800 million specifically for the NHSC. The budget indicates that Congress prioritizes health workforce needs and recognizes HRSA programs' ability to meet those needs. The American Rescue Plan allocates $200 million for Nurse Corps, $330 million for the Teaching Health Center Graduate Medical Education (THCGME) program, $80 million for mental and behavioral health training for health care professionals, paraprofessionals, and public safety officers, $40 million for grants for health care providers to promote mental and behavioral health among the health professional workforce, and $100 million for behavioral workforce education and training. The health workforce has responded to the COVID-19 pandemic for approximately 1 year. The Nation now is recovering from the emergency, with the workforce focused on vaccine distribution. Recovery is likely to take years and will require support to address the mental health needs of the health care workforce. The COVID-19 public health emergency confirmed the importance HRSA had already placed on racial equity, value-based care payment models, and team-based care delivery models. BHW currently focuses on assessing communities' needs and analyzing data to support decisions about how to allocate resources in order to address those needs. Partners will play a key role in stakeholder engagement, identifying data needs, and informing HRSA's understanding of communities' needs.

HRSA funds more than 35 programs, and is considering how to leverage portfolios of programs to achieve its goals. For example, multiple programs target behavioral and mental health. These programs can define a shared mission and goal, and coordinate to achieve greater impact than they would individually. HRSA is using community needs data to inform decisions about program funding, such as support for the Opioid-Impacted Family Support Program. HRSA will initiate a Substance Use Disorder Workforce Loan Repayment Program (SUD Workforce LRP) for paraprofessionals in 2021 and will engage policy makers to develop approaches to supporting health care provider well-being.

In 2020 HRSA initiated the Behavioral Health Workforce Pilot project, which comprises seven programs, including the new SUD Workforce LRP. Programs are identifying key goals and partners, partners to engage, and resources necessary for a portfolio approach to behavioral health investments. The portfolio approach will include utilization of the new $120 million allocation to increase organizations' ability to increase care provider resiliency and prevent burnout.

Post-graduate trainees tend to practice within 50 miles of where they received training. HRSA plans to enhance and expand community-based training through the Teaching Health Center Graduate Medical Education (THCGME) program. The program offers longitudinal training and encourages participants to practice primary care in high-need communities. NHSC and Nurse Corps currently serve more than 18,000 participants. NHSC is HRSA's largest program. More than 80 percent of NHSC graduates practice in rural and underserved communities. HRSA's behavioral health workforce development programs, with steady funding, would decrease the undersupply of professional and paraprofessional behavioral and mental health providers approximately 40 percent by 2030.

The U.S. public health infrastructure program is underfunded. HRSA's public health workforce development programs, with a $9 million budget prior to the COVID-19 public health emergency, were the largest Federal investment in workforce development. HRSA will use funds from the American Rescue Plan to bolster public health capacity. BHW invites Council input on integrating public health into primary care through NHSC and other programs. BHW invests more than $200 million in primary care medicine programs. The American Rescue Plan will allow investment of an additional $330 million in the THCGME program, which will support nearly doubling the number of full-time employees supported by the residency program. By the end of Fiscal Year

(FY) 2023, THCGME will have trained approximately 1,400 full-time residents, resulting in an increased primary care provider supply. The Primary Care Training Enhancement (PCTE) and Medical Student Education (MSE) programs are important for the workforce pipeline. These programs encourage students to apply for THCGME community-based programs and NHSC.

BHW's Geriatrics Workforce Enhancement Program (GWEP) has a budget of $42.7 million. The Children's Hospital Graduate Medical Education Payment (CHGME) program has a budget of $350 million. The programs have trained nearly 70,000 participants. Approximately 75 percent of awardees collaborate with safety net partners in the Bureau of Primary Health Care (BPHC).

BHW's oral health programs have trained 11,725 participants with a budget of $26.6 million. These programs offer opportunities to train in underserved communities. All current post-doctoral program graduates plan to practice primary care. BHW's career development and diversity programs include the Area Health and Education Center program, which has a $43 million budget, focuses on health equity, and prioritizes health workforce diversity.

BHW hosts the Health Workforce Connector (HWC), an online resource to connect students and clinicians with career and training opportunities. Currently more than 27,000 sites use the HWC, which posts information about more than 4,000 opportunities. The HWC provides a platform for virtual job fairs, and clinician profiles for recruiters. Recruiters report that this resource has reduced recruitment costs.

BHW's National Practitioner Data Bank is the largest repository of adverse action data. BHW will analyze these data to inform efforts to improve health care quality and equity. BHW's National Center for Health Workforce Analysis (NCHWA) collects and analyzes workforce data, develops performance measures, and disseminates findings to inform program and policy planning and development within HRSA and other Federal agencies. NCHWA supports nine health workforce research centers. NCHWA will support efforts to respond to COVID-19 and to develop approaches for integrating public health and primary care. BHW prioritizes sharing workforce data with the public. All health workforce performance data are available at Data.HRSA.gov. The site also offers clinician dashboards, which summarize several years of data on NHSC alumni, as well as Health Professional Shortage Area (HPSA) data. BHW encourages Council comments on its public data.

The Biden Administration has issued executive orders regarding COVID-19 response, some of which focus on equity. There are executive orders to improve and expand access to care and treatments for COVID-19, establish a pandemic testing board and ensure a sustainable public health workforce to address COVID-19 and other biological threats, ensure a data-driven response to COVID-19 and future high-consequence public health threats, and ensure an equitable pandemic response and recovery. Dr. Padilla is co-leading the workgroup charged with equitable response and recovery. BHW currently does not have the data necessary for estimating public health workforce needs in the present or future. The Bureau is exploring how to address this gap.

Current Federal Government priorities relevant to BHW's work are COVID-19 response and health equity, which are intertwined. BHW focus areas are behavioral and community health. Key themes in behavioral and community health care provider resilience, telehealth, and diversity and equity. BHW partners with BPHC to fund Primary Care Associations across the U.S. to support deployment of a validated readiness to train survey. Results will inform workforce development programs at participating health centers as well as HRSA budget decisions. More than 70 percent (more than 8,000) of health centers have participated to-date. Results indicate where respondents are in their trajectory to increase education and training capacity in seven domains.

Current challenges for BHW include the continuing COVID-19 pandemic, lack of detailed community needs data, finalizing criteria for identifying maternal care shortage areas, and updating characterization of community needs.

In FY 2023 HRSA will begin issuing awards to address needs in maternal care shortage areas across the U.S. HRSA plans submit a draft national workforce coordination plan to Congress in 2021, and appreciates the Council's contributions to the plan under the leadership of Dr. Callins.

Discussion
Dr. Callins thanked Dr. Padilla for his presentation and invited questions and comments from the Council. Dr. Piernot asked how BHW plans to support telehealth and continuing the progress made in applying telehealth during the COVID-19 pandemic response. Dr. Padilla said this depends on how many regulatory flexibilities allowed by the Coronavirus Aid, Relief, and Economic Security (CARES) Act will continue after the public health emergency has been addressed. BHW advocates for continued flexibility through 2021, then assessing effects of flexibility on reimbursement. Without reimbursement for telehealth services, providers likely will

stop offering them. Changes should support the workforce. Data on how telehealth has affected staffing ratios or productivity are not yet available. The CARES Act allocated $15 million for programs for a period of performance that will end April 2021. BHW will collect data from these programs to assess what worked. BHW aims to improve digital literacy, which is critical for telehealth utilization. Gaps in digital literacy contribute to health inequity.

Dr. Schmitz said HRSA's Federal Office of Rural Health Policy (FORHP), Council on Graduate Medical Education, research centers, and the NHSC are focused on preparing health care providers to serve rural communities. This is also a priority for the Centers for Medicare and Medicaid Services (CMS) and the American Board of Family Medicine (ABFM). This shared focus and effort is likely to improve recruitment and retention. Dr. Padilla agreed and said that BHW must consider how to leverage pipeline and medical school programs to ensure qualified residents participate in training for service to rural communities.

Dr. Taylor-Desir said she appreciates BHW's current emphasis on mental health. Telehealth has increased access to mental health care for many patients and has increased provider productivity. It also has resulted in providers scheduling so many sessions in sequence that the work can tax provider resilience. This should be a consideration when planning how to implement telehealth. Dr. Taylor-Desir has served Tribal communities for more than 16 years and recommends studying how these communities have integrated public health into primary care. Dr. Padilla agreed that provider well-being must be a priority, and said this is an intent of the American Rescue Plan. The plan allocates funds for meeting providers' immediate needs, building resiliency through education and training, and helping organizations to develop cultures that support provider well-being. Well-being cannot be supported through individual-level efforts alone. BHW will refer to the Institute of Medicine's report on clinician resilience and well-being for information about evidence-based approaches to organizational change. Support must be provided to the entire care team.

Dr. Sein asked how the American Rescue Plan funding for THCGME will be allocated, and how funding allocation can be expected to affect the program. Dr. Padilla said $100 million has been allocated for the State Loan Repayment Program (SLRP). BHW intends to invest this in States not currently participating in the program. The legislation eliminated capitation on administrative costs and matching for the program. The legislation does not specify other requirements for spending the funds. HRSA does not intend to make significant changes to SLRP over the next 2

years. The budget will allow BHW to fund nearly all eligible NHSC applicants, which is an improvement over last year, when the budget supported only about 40 percent of eligible applicants. THCGME has changed the paradigm for GME by offering community-based training in primary care for underserved populations. The new budget will double program capacity. BHW will invest funds in new residency programs for primary care, psychiatry, and ob/gyn. The Bureau wants to link THCGME to NHSC by giving NHSC participants priority for awards. This is expected to increase retention in high-need communities. Dr. Sein asked whether the funding would be offered only once. Dr. Padilla said the funding is through FY 2023, after which all BHW programs will face a funding cliff. Dr. Schmitz noted that THCGME not only supports continued practice in underserved communities, the program also teaches team-based practice.

Dr. Bockwoldt asked whether any National Provider Data are public. Dr. Padilla said only registered users can access the whole database. There is a public use database available through the web portal. BHW sometimes customizes these data for researchers.

Dr. Callins said that the presentation and discussion indicated that clinicians need training in 1) how to use telehealth, 2) how to integrate public/population health into primary care, and 3) how to support organizational culture that nurtures clinician resilience. Educational programs currently do not teach students self-advocacy or other skills related to organizational support for resilience. She thanked Council members for their questions and comments.

Presentation: Division of National Health Service Corps Update
Israil Ali, MPA
Director, Division of National Health Service Corps
Dr. Callins welcomed Mr. Ali and thanked him and his team for their work. Mr. Ali provided an overview of NHSC FY 2021 application cycles. On September 1, 2020, NHSC began recruiting care providers through its Students to Service Loan Repayment Program (S2S LRP). The program now includes nurse practitioners and nurse midwives, which resulted in a 90 percent increase in applications. NHSC's SLRP funds grants to recruit statewide primary care workforces. As a result of budget increases for 2021, NHSC expects to have the largest field strength in its history.

NHSC priorities for FY 2021 are 1) to cultivate more linkages between NHSC and health professional training programs, 2) to dedicate support to the NHSC pipeline, and 3) to optimize data collection and utilization. NHSC's linkage efforts include linkage with other BHW programs.

NHSC is encouraging BHW graduate training programs, such as THCGME, Addiction Medicine Fellowship, and nurse practitioner residency programs, to focus on preparing clinicians to serve in rural and underserved communities. All of these programs train participants to practice in ways that have the potential to transform health care. NHSC is considering how it can prioritize BHW program graduates for NHSC awards in the next application cycle. During the next year NHSC plans to collect more demographic and training data through program applications. This will provide information about which providers fulfil long-term commitments to care for vulnerable populations. Learning characteristics of successful program participants will inform NHSC marketing and outreach efforts. NHSC is assessing whether S2S LRP participants go on to participate in NHSC residency and fellowship programs, and whether they continue to practice long-term in communities where they were trained. NHSC also is interested in whether training programs outside of BHW produce successful NHSC scholars, and how best to establish linkages between NHSC and these programs.

NHSC is analyzing data to assess how pipeline programs link to participation in obligated service programs. Analyses will assess where pipeline program participants are matched for service after graduation. NHSC prioritizes education and training efforts to increase participants' readiness to serve HPSAs. Participants should learn a population health perspective and demonstrate other core competencies, including strategies to increase resilience and prevent burnout. NHSC will make substantial investments in these efforts during 2021 in order to increase program impact.

NHSC's efforts to optimize data collection and utilization include evaluating NHSC program applicants and participants to determine training needs, and tracking X waivered care providers[1]. NHSC is mobilizing the SUD workforce through collaboration with the Substance Abuse and Mental Health Services Administration to train health care providers in medication-assisted treatment at no cost. NHSC offers loan repayment enhancements of as much as $5,000 for receiving an X-waiver for completing training and Drug Enforcement Administration certification. NHSC is working to share as much data with the public as possible. Data demonstrate NHSC's contributions and inform State and local health workforce policies.

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[1] An "X waiver" refers to health care providers authorized by the Drug Addiction Treatment Act of 2020 to use buprenorphine when delivering outpatient services to patients with opioid use disorder.

NHSC works with more than 18,000 training sites. The next application cycle for new sites will begin in April 2021. Sites will be approved following completion of the process of accepting LRP applications. The site recertification process will begin in August 2021. The Division of Regional Operations will conduct site visits to ensure compliance with NHSC requirements.

NHSC will celebrate its 50th anniversary in 2022. NHSC's Division of External Affairs (DEA) is considering how to recognize the occasion and invites Council input. The DEA plans to emphasize the history and future of NHSC. Important aspects of the program's history include its rapid response to public health crises such as the Zika virus outbreak, the opioid and SUD epidemic, and the COVID-19 pandemic. The DEA is interested in sharing NHSC participant, alumni, and Federal staff stories from the field about program impact. The DEA also plans to recognize NHSC sites' diversity, growth, and impact over the last 50 years. This will include recognition of impact on rural and Tribal communities, and of how sites vary by region. The celebration will consider how the NHSC can transform health care and how NHSC itself will change in the future. Mr. Ali invited the Council to recommend alumni and participants who may be interested in anniversary activities to Ms. Fabiyi-King.

Discussion

Dr. Callins thanked Mr. Ali for his presentation and invited Council members' questions and comments. Dr. Taylor-Desir supported the ideas of highlighting NHSC's history of responding to public health crises and sharing participants' experiences with the NHSC. Dr. Piernot suggested inviting long-time participants to discuss how NHSC has affected them over the course of their careers. Ms. Fabiyi-King said these stories could be presented via video. Dr. Callins shared Dr. Pinto-Garcia's suggestion to offer a multimedia exhibit with video commentaries and interviews, pictures, interactive maps to illustrate reach and growth, an interactive timeline, and data. The exhibit could invite guests to submit items, such as reflections, videos, and pictures, for an NHSC archive. Archiving could continue beyond the 50th anniversary occasion.

Dr. Callins said Dr. Schmitz had suggested to her that a logo or slogan for NHSC could mention training competent and confident clinicians. She concurred and added that NHSC also trains clinicians to be compassionate. Dr. Schmitz concurred and said that these qualities are developed in the context of community. He soon will publish commentary for the ABFM on primary care

competence and confidence in *Family Medicine*. At Ms. Fabiyi-King's and Mr. Ali's request, Dr. Schmitz will share the publication with the Council.

Dr. Callins said car magnets could increase NHSC visibility, inspire conversations, and serve as badges of honor. Mr. Ali said DEA wants to brand NHSC participants as the prime candidates to transform health care in underserved communities. The aim is for sites to recognize NHSC participants as primary care leaders. Branding can help to increase this awareness and perspective. Clinician dashboards demonstrate participants' commitment to serve communities in need. Participants do not participate only long enough to repay loans, but continue to practice in these communities and work to address health disparities. Dr. Callins said NHSC functions as a welcoming family. Some of the students she has mentored are now scholars. NHSC participants are heroes. They are servant leaders who must integrate into and commit to the communities they serve. Dr. Callins suggested inviting participants to describe themselves in terms of their NHSC experience and to discuss what they learned from participating. Dr. Callins invited Council members to share additional ideas about the anniversary that occur to them after the meeting with Ms. Fabiyi-King and Ms. Robinson via e-mail.

Dr. Callins asked how the HWC can connect new scholars with mentors. Mr. Ali said NHSC is considering this, as well as how to connect participants with preceptors. The Students to Scholars (S2S) Loan Repayment Program (S2S LRP) is working to connect a network of prior and current scholars and current students.

Dr. Callins asked how BHW's current data collection efforts could support documenting the impact of telehealth. Mr. Ali said NHSC is assessing the degree to which applicant sites provide telehealth. At the close of the most recent application cycle, which was prior to the COVID-19 pandemic, only 10 percent of providers' time was dedicated to telehealth. Some applicants were not aware of any telehealth program at their sites. NHSC is working with providers to ensure they use telehealth resources. NHSC will analyze data to assess changes that have occurred over the past year and consider how to extend regulatory flexibilities implemented during the pandemic to support telehealth services. For example, the CARES Act allows clinicians to provide services from any location as long as they are doing so under the auspices of an NHSC site, which has likely increased telehealth care delivery. Data analysis will support assessment of whether this is the case.

Presentation: Advisory Committee on Training in Primary Care Medicine and Dentistry

Anita Glicken, MSW

Executive Director, National Interprofessional Initiative on Oral Health

Professor and Associate Dean Emerita, University of Colorado

Dr. Callins introduced Ms. Anita Glicken, Chair of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD). Ms. Glicken said the purpose of her presentation was to share information about and discuss how ACTPCMD could work with NACNHSC to support expanding and optimizing the health workforce. The COVID-19 pandemic has greatly increased the need for health care. Dr. Anthony Fauci predicts a mental health needs pandemic as well as chronic symptoms resulting from COVID-19. Programs and policies should support training the workforce to meet these challenges. The COVID-19 pandemic has changed practice, including use of technology, payment, policies, and provider roles. Advisory councils and committees must consider lessons learned from the pandemic when developing their recommendations.

Ms. Glicken explained that ACTPCMD was authorized in 1998 to provide advice and recommendations to the HHS Secretary, the U.S. Senate Committee on Health, Education, Labor, and Pensions and the U.S. House of Representatives Committee on Energy and Commerce. ACTPCMD advises on policy, program development, and matters concerning medicine and dentistry activities authorized by Public Health Service Act Title VII, Sections 747 and 748. The ACTPCMD also provides information in response to requirement of the CARES Act. ACTPCMD submits annual reports offering policy and appropriations recommendations and performance measure guidelines. Discipline focuses include family medicine, general internal medicine, general pediatrics, general dentistry, pediatric dentistry, physician assistant programs, and dental hygiene, all of which offer primary care. ACTPCMD comprises 17 members, appointed by the Secretary for 3-year terms. Members come from diverse geographic regions and racial/ethnic backgrounds. They represent both genders, rural and urban communities, and the diverse professions under ACTPCMD's purview. ACTPCMD meets semi-annually. Workgroups meet more frequently with a technical writer to develop reports.

Title VII, Section 747 programs support training in medicine, and Section 748 programs support training in dentistry. Programs train clinicians, educators, and researchers. Research supported by these programs focuses on identifying best practices in primary care as well as how best to

disseminate information about best practices. Many programs promote practice in rural and underserved communities as well as leadership for transforming health care delivery.

ACTPCMD reports align with BHW goals, typically focusing on needs related to access, supply, distribution, and quality. Topics have included chronic disease prevention and management, interprofessional education and integration, population health, social determinants of health, health literacy, cultural competency, primary care pipelines, implicit bias, structural racism, health equity, increasing workforce resiliency and mitigating burnout, and the impact of telehealth.

ACTPCMD currently is developing its 18th and 19th reports. The 18th report focuses on needs of underserved rural communities. Recommendations aim to advance health equity through enhanced primary care workforce training. They are consistent with President's Biden Executive Order calling for health equity. ACTPCMD's 18th report recommendations are to: 1) increase longitudinal primary care rotations and post-graduate residency programs in rural underserved communities, 2) build and enhance telehealth technologies for education and clinical practice, 3) integrate oral and behavioral health into primary care to support interprofessional team-based training and care for patients with chronic and/or complex medical conditions, and 4) support interprofessional education and practice to address disparities in oral, infant, and maternal health outcomes.

ACTPCMD is considering workforce diversity and expanding primary care knowledge and skills as topics for its 19th report. Key areas of knowledge and skills include health system science, addressing long-term sequelae of COVID-19, social determinants of health, intellectual and developmental disabilities, and expanding the workforce to include dental therapy and community health workers.

ACTPCMD and NACNHSC have overlapping priorities and goals. Training authorized under Title VII has a history of linking to NHSC. Examples include the Primary Care Champions program in which NHSC participants could fulfill part of their service obligations through participation in the Title VII-authorized Primary Care Champions program, which is a primary care leadership fellowship program; Residency Training in Primary Care program, which offers information about NHSC and helps graduates to find employment at NHSC-approved sites; and Title VII post-doctoral dental training, which encourages awardees to participate in NHSC

programs. ACTPCMD works to link primary care training programs with BHW placement programs.

Ms. Glicken invited Council members to consider the following questions:

- Does the NHSC application schedule support maximizing impact of HRSA-supported training activities?

- What are ways NHSC can improve recruitment of clinicians who have values and skills associated with commitment to meeting the unique needs of vulnerable and underserved communities?

- What are ways to help NHSC participants become better prepared to practice in Federally Qualified Health Centers (FQHC) and other safety net clinics?

- What are ways to address NHSC service training gaps?

- What characteristic distinguish NHSC participants who continue to serve communities where they were trained?

ACTPCMD provided input for the national workforce coordination plan required by the CARES Act. The letter emphasized the importance of interprofessional team-based care, and of using to data to identify and address community needs.

Discussion

Dr. Callins thanked Ms. Glicken for her presentation and invited questions and comments. Dr. Sein said that residents typically start defining career plans during their second year of training. Most family medicine programs do not offer formal tracks in areas such as rural medicine, hospitalist, or ambulatory care. However, some family medicine residents do have specific interests. Dr. Sein asked for Ms. Glicken's opinions regarding tracks within family medicine education. Ms. Glicken invited comments from Council members. Dr. Sein said many residents do not feel adequately prepared to serve rural communities, where they could be the only physician. Likewise, hospitalists benefit from training in hospital settings. Ms. Glicken said this is the rationale for ACTPCMD's recommendation to expand opportunities for training in priority communities. Tracks allow residents to get more training in the area where they plan to practice without requiring additional time.

Dr. Schmitz said that recommendations for improving matching algorithms would be helpful. He noted that institutions can make exceptions to the National Resident Matching Program for a same-sponsoring institution with undergraduate and graduate medical education programs. This can allow for more longitudinal training. However, many institutions are unaware of this option. Dr. Schmitz agreed to provide more information about this to Ms. Glicken and Ms. Fabiyi-King.

Dr. Callins agreed that the questions Ms. Glicken presented were important and expressed interest in the Council discussing them with Ms. Fabiyi-King and Mr. Ali. Dr. Callins suggested that training should teach providers who plan to serve rural communities how to build professional networks, which can mitigate isolation, increase resilience, and improve retention. In addition, training should encourage clinicians to perceive themselves as "lighthouses" for their communities, rather than focus on being isolated. This training should include teaching participants how to connect to community resources. Ms. Glicken supported this idea, noting that technology and interprofessional care can support development of professional relationships. She said that part of interprofessional care is recognizing that oral health is more than dental health. It is the responsibility of the whole primary care team, which educational institutions should teach. Programs should teach all primary care providers to conduct oral health screenings and basic exams.

Ms. Glicken said she looked forward to collaborating with NACNHSC. She noted that ACTPCMD and NACNHSC share many goals and could reinforce each other's messages. Ms. Fabiyi-King thanked Ms. Glicken for her presentation.

Presentation: Federal Office of Rural Health Policy
Kristin Martinsen
Director, Hospital State Division
Michael McNeely, MBA, MPH, CPHIMS
Director, Office for the Advancement of Telehealth
Dr. Callins introduced Ms. Martinsen and Mr. McNeely from HRSA's Federal Office of Rural Health Policy (FORHP). Ms. Martinsen presented a graphic to summarize FORHP's organizational structure. FORHP's annual budget is approximately $250 million, $100 million of which is dedicated to opioid programs. FORHP requires partners in order to accomplish its goals. It appreciates NHSC's work to expand the rural health workforce. FORHP reviews Federal

policies from multiple agencies to assess potential consequences for rural communities. FORHP also funds research, with topics including workforce, access, quality, and disparities. FORHP shares research findings on the Rural Health Research Gateway (RHRG), a web-based resource, and hosts the Rural Health Information Hub, a web-based information clearinghouse.

Rural communities are affected by disparities, including disproportionately high maternal mortality, more prevalent tobacco use, physical inactivity, obesity, diabetes, and hypertension. Rural communities have less access than other communities to mental health care. Rural hospitals are closing, which reduces care access. Transportation challenges are a barrier to health care access in rural communities, especially access to specialty services. Rural residents are more likely than others to be uninsured and to have fewer options for affordable health insurance. CDC recently conducted studies to identify rural health disparities. FORHP considers research findings in its programming decisions.

FORHP's Healthy Rural Hometowns Initiative supports communities in identifying their health needs and developing partnerships to address those needs, including addressing the five leading causes of death for rural communities. FORHP funds activities that respond to COVID-19 in rural communities, and shares information about how COVID-19 has affected rural communities. FORHP funds a program to address HIV/AIDS in rural communities. FORHP is interested in disparities affecting and those occurring within rural communities. Opioid use disorder and SUD affect rural communities, sometimes worsening during the pandemic; addressing opioid use and SUD continues to be a priority for FORHP.

FORHP's Rural Maternity and Obstetric Management Strategies pilot program aims to improve access and continuity of care in rural communities with a systems-level approach. Grantees are partner networks of at least two rural hospitals, one FQHC, State home visiting and Healthy Start programs, and State Medicaid programs that test models of care and financing.

FORHP is supporting COVID-19 testing in rural communities. FORHP worked with NHSC to initiate a new behavioral health program. FORHP funds State offices of rural health, which disseminate information and often are co-located with State primary care offices.

Telehealth is a priority for FORHP. HRSA defines telehealth as "the use of electronic information and telecommunication technologies to support and promote: long distance health care; patient

and professional health-related education; public health; and health administration." Telehealth technologies include video conferencing, internet, store-and-forward imaging, streaming media, terrestrial and wireless communications, and mobile phone use.

Telehealth increases access to service for rural and underserved communities, and improves workforce development and care delivery. It benefits patients, providers, and payers. Benefits to providers include distance learning, reduced professional isolation, the ability to serve more patients and a reduction in missed appointments. Patient benefits include increased access to care, reduced travel time and costs, less missed work and school, and reduced time waiting to receive services. Payer benefits include reduced transport costs and more timely care, which produces better outcomes at lowers costs.

During COVID-19, telehealth services limited patients' and providers' exposure to the virus, reduced utilization of emergency departments, and allowed patients to receive care. Regulatory flexibilities facilitated reimbursement for telehealth services during the pandemic. Mr. McNeely noted that telehealth is not appropriate for all patients and medical situations.

Major barriers to telehealth advancement are reimbursement restrictions, prescribing restrictions, State licensure requirements, credentialing requirements, and lack of broadband access. During the COVID-19 public health emergency, regulatory flexibility and legislation have helped to address these barriers. Reimbursement varies by State and payer. Prior to the COVID-19 public health emergency, Medicare and many Medicaid programs placed telehealth reimbursement restrictions on geographic location and provider, service, and technology type. Most States have passed parity legislation for telehealth coverage and reimbursement. Before the public health emergency, providers had to be licensed in the State where the patient was located. These restrictions were loosened during the emergency. Multistate compacts offer a potential long-term solution. A recent relief bill allocates significant funds for improving broadband access. The Federal Communications Commission will invest approximately $3 billion in improving broadband access.

Most telehealth regulatory flexibilities implemented in response to the COVID-19 public health emergency will end as the emergency ends. Regulatory flexibilities include lifting geographic restrictions for patients and providers; increasing services, providers, and modalities eligible for reimbursement; and allowing supervision via telehealth. In some cases, legislation is required to

make flexibilities permanent. Many State Medicaid programs now allow telehealth services via telephone, to patient's homes, and all parity in payment for telehealth services. Most States have modified their licensure requirements. Practitioners now can prescribe controlled substances via telemedicine even for patients not at a DEA-registered facility. Qualified providers can prescribe buprenorphine to patients with opioid use disorder based on telephone evaluations.

The HHS Office of Civil Rights issued a notice of enforcement discretion to empower covered providers to use widely available communication applications without risk of penalty for violation of Health Insurance Portability and Accountability Act rules. FQHCs and rural health clinics can provide any Medicare-approved services using telehealth as a distant site. This change is long-term.

FORHP's Office for the Advancement of Telehealth (OAT) funds the Telehealth Network Grant program, which demonstrates the use of telehealth networks to improve health care services for medically underserved populations in urban, rural, and underserved communities.   Networks can be used to expand access to, coordinate, and improve the quality of health care services. They can be used to improve and expand health care provider training, as well as the quality of information available to providers, patients, and their families. The program has supported nine grantee cohorts since 2003. Previous cohorts have focused on school-based telehealth, substance use treatment, remote patient monitoring, and chronic disease management. In FY 2020 the program awarded $8.9 million to 30 grantees in 23 States to promote rural telehealth emergency services by enhancing emergency care consultations. Grantees will expand emergency services for stroke, behavioral health, emergency medical service support, pediatric emergencies, and cardiology. The program has steadily reduced distance traveled to care. In 2017, grantees saved participants 1.6 million miles; in 2018, participants saved 3.1 million miles; and in 2019, they saved nearly 3.2 million miles.

OAT's Evidence-Based Tele-Behavioral Health Network Program (EB-THNP) aims to increase rural and frontier communities' access to behavioral health care. The program evaluates services to establish an evidence base for telehealth's effectiveness. OAT supports evaluations that develop performance measures and support planning for implementing programs at larger scale. In FY 2014 EB-THNP awarded $4.7 million to 14 organizations in 13 States. These organizations served nearly 3,100 patients and saved nearly 734,000 miles in travel in 2019. OAT currently is shifting

focus from behavioral health to direct-to-consumer care, with a goal of improving services and establishing an evidence base. HRSA will fund as many as 14 awards for approximately $350,000 each. Applications for funding are due April 2, 2021.

OAT's 14 Telehealth Resource Centers (TRC) offer technical assistance to the public. Two centers are National; twelve are regional. TRCs serve all 50 States and 8 Territories. National centers focus on policy and technology. TRCs offer training and support. They disseminate information and research findings, promote collaboration, and foster telehealth use. TRCs offer webinars, individual consultations, conference presentations, and web presence. In 2019 centers responded to 4,039 technical assistance inquiries and reached nearly 9,000 attendees. TRC services increased 285 percent between April and August of 2020 as a result of the COVID-19 public health emergency.

OAT's Licensure Portability Grant Program supports State professional licensing boards in developing and implementing policies that reduce statutory and regulatory barriers to providing services through telemedicine. The program currently supports the Interstate Medical Licensure Compact, of which 30 States and Guam are members. Two members have passed legislation. The compact currently focuses on physicians and physician assistants, and plans to extend to nursing. The program also supports Psychology Interjurisdictional Compact (PSYPACT), of which 15 States are members and have enacted legislation, and two States that have passed but not yet enacted legislation. PSYPACT's focus is behavioral health, including clinical psychologists.

OAT supports two Rural TRCs, which aim to increase publicly available, high quality, impartial, clinically-informed and policy-relevant research related to telehealth. These centers produced 13 publications between 2019 and 2020. Publications are available on the RHRG web site.

OAT supports two Telehealth Centers of Excellence, which examine efficacy of telehealth services in rural and urban areas. They are located in public academic medical centers with successful, high-volume telehealth programs. Centers are financially self-sustaining. They provide services to medically underserved communities with high rates of poverty and high chronic disease prevalence. They produced 15 publications and online resources in FY 2019. These centers conduct pilots and virtual reality simulations that inform OAT planning.

FORHP administers the telehealth work group which operates under the Telehealth Strategic Plan and HRSA's Telehealth Initiative (the Initiative). The Initiative provides recommendations regarding telehealth technology to Federal and State government organizations. Recommendations focus on access, especially to behavioral health, including the opioid crisis, emergency services, HIV/AIDS, maternal and child health, and rural health. Initiative focus areas are clinical telehealth services, telemonitoring and distance learning, research and evaluation, and telehealth business strategy.

HRSA's most recent data on telehealth activities are for FY 2019. During this period, approximately 1,886 awards included a telehealth component, which represented a 37 percent increase from FY 2018. Awards were made to applicants from all 50 States and 8 Federal Territories. Awardees' priority populations included underserved and rural communities, and health care providers. HRSA supported telehealth activities to provide direct clinical services, infrastructure development, workforce training, and distance learning. Focus areas were primary care, behavioral/mental health, and SUD, including opioid use disorder. In summer 2021 HRSA will initiate a new program to support workforce development through academic institutions, using an approach similar to the Project Extension for Community Healthcare Outcomes (Project ECHO).

During the COVID-19 public health emergency, HRSA played a major role in increasing awareness and adoption of telehealth. HRSA worked with HHS to launch Telehealth.hhs.gov, a trusted, current, comprehensive web-based telehealth information resource for patients and providers. Information addresses best practices, implementation instructions and resources, and policy and reimbursement updates. OAT updates the web site regularly, with a recent addition being a toolkit for implementing direct-to-consumer care. HRSA has awarded $54.6 million dollars to support COVID-19 response activities. Of this investment, $15 million supports 159 organizations in five health workforce programs to increase telehealth capabilities. HRSA's Maternal and Child Health Bureau (MCHB) awarded $15 million to four recipients. Projects address pediatric care, maternal health care, State public health systems, and family engagement for children with special needs. FORHP awarded $11.6 million to TRCs for COVID-19 response. FORHP awarded $5 million to assist telehealth clinicians with licensure and portability. Grantees developed two web sites to assist volunteers working to address needs during the pandemic.

Experiences during 2020 demonstrated that telehealth offers significant benefits. Telehealth reduced COVID-19's disruption to health care. Telehealth's reach extended beyond rural populations. A range of specialty care providers now use telehealth. HRSA expects telehealth utilization to continue to increase. HRSA will continue to monitor changes in telehealth regulations and build partnerships to advance the field. In 2020 HRSA worked with the Federal Communications Commission and the U.S. Department of Agriculture to expand broadband access. OAT currently administers a pilot program to identify gaps in broadband service and speeds needed in 25 communities across four States. FORHP publishes a weekly newsletter, to which Mr. McNeely encouraged Council members to subscribe.

Discussion

Dr. Callins asked how to promote policy changes that promote integrating telehealth into health care. Mr. McNeely said some changes require legislation. CMS has made some regulatory changes and is reviewing others. Audio-only services have facilitated delivery of behavioral health care. Some regulatory agents are concerned about this mode's potential for fraud. Education about how audio-only services can be equivalent to in-person care is necessary to address this issue. Being compelled by the public health emergency to use telehealth expedited awareness of telehealth's benefits and demonstrated feasibility of implementation. Demonstrations of telehealth's value are a critical way to encourage policy change. Some demonstrations are supported by third party payers, which can be influential in changing CMS policy.

Dr. Callins inquired about why there were so few FY 2019 HRSA awards with a maternal health focus. Mr. McNeely said FORHP has been working closely with HRSA's MCHB. Awareness and investments in telehealth for maternal and child health have increased, mostly during the past 2 years. Increases will be reflected in new grant cycles.

Dr. Schmitz said that telehealth is a geographic disrupter, expanding the clinicians who can offer services, the patients who can receive them, and the locations from which care is delivered. The field must consider unintended consequences. It is important to determine which services cannot be delivered via telehealth, and to consider how telehealth implementation will affect the workforce. Ms. Martinsen concurred. She said one consideration is ensuring rural areas have enough clinicians to offer in-person services as it becomes more possible to serve rural communities from an urban location. Mr. McNeely added that telehealth implementation can

impact local economies, which should be considered during planning. Dr. Callins thanked Ms. Martinsen and Mr. McNeely for their presentation.

Public Comment

Ms. Fabiyi-King invited public comment; none was offered.

Day 1 Recap, Overview of Work Group Activities

Dr. Callins reminded the Council that their role includes advocacy for patients and communities, which Council recommendations should reflect. Council responsibilities include identifying priorities for NHSC, and anticipating program issues and concerns. In addition, the Council is to provide input regarding policy, and to develop reports and briefs about NHSC issues and concerns, with recommendations for policy change. Two work groups are developing such reports with the support of a technical writer assigned by HRSA.

Dr. Callins asked Council members to consider key points made during the meeting when developing reports. One key point was the importance of integrating public health into primary health care. Another focus was linking education, training, and practice. Dr. Callins noted the importance of supporting students, scholars, and clinicians, at each stage of education and practice. The Council should consider how to empower NHSC participants to become leaders in institutional support for clinician resilience. In addition, the Council should consider how to support clinicians in meeting their mental health needs during the recovery from the COVID-19 pandemic. The Council should consider how to use technology, such as the Health Workforce Connector, to support networking and mentoring. For example, technology could support tele-shadowing and virtual book clubs. Council members should consider how to train clinicians to serve patients with complex needs, and how to address social determinants of health when caring for these patients. Members also should consider how data can inform their recommendations. Members should consider whether recommendations address oral health care, population health, clinician well-being and resilience, telehealth, maternal health, behavioral health needs of vulnerable populations, community engagement, pipeline mentorship, and how to deliver interprofessional team-based care.

Dr. Schmitz concurred and thanked Dr. Callins for articulating Council priorities. He noted that the priorities are broad, and work groups will have to balance breadth with depth to make practical policy recommendations. Dr. Callins agreed with this point. Dr. Bockwoldt said the Council must

consider what is necessary to implement recommendations, such as telehealth infrastructure and access. Dr. Jones said the Council should focus on the need to retain NHSC participants to practice in high-need communities.

Dr. Callins asked how much Dr. Jones utilizes telehealth in practice. Dr. Jones said telehealth is now a normal part of his practice. It increased access to care during the pandemic. Patients now take it for granted and are sometimes frustrated when they do need to get in-person care. His practice currently delivers approximately 40 percent of care through telehealth and 60 percent in person.

Dr. Callins asked whether Council members think there should be standards for balancing telehealth with in-person care. Dr. Jones said standards can be unnecessarily rigid and present barriers to care. Dr. Taylor-Desir said professional organizations should be responsible for setting standards for their areas of discipline. Dr. Sein said his clinic has delivered few services via telemedicine, because few patients have broadband access and many find the platforms difficult to use. Dr. Callins said she has used telehealth visits to triage patients. Dr. Schmitz said all recommendations for regulations must be made with specific goals in mind, and that all Council recommendations must focus on needs of patients and communities. Dr. Callins said it is important to consider how to prevent increased telehealth use from resulting in increased health disparities caused by disparities in access.

At the Council's request, Mr. Ali rejoined the discussion to answer their questions. Dr. Taylor-Desir asked how NHSC facilitates connection between scholars and loan repayors preparing to transition to the field with those already practicing in the field. Mr. Ali said NHSC is not currently providing a mechanism for this type of connection, but it does plan in 2021 to invest in preparing scholars for practice in the field.

Dr. Bockwoldt said it would be helpful if telehealth could be applied to addressing workforce maldistribution. Mr. Ali said NHSC allowed participants serving at sites that closed to complete their service obligations at temporary emergency sites. He welcomed recommendations for how to use telehealth technology to address workforce maldistribution.

Dr. Callins thanked the technical writer for her support. Ms. Fabiyi-King said she would facilitate communication and scheduling with the writer. Dr. Callins thanked the Council and HRSA staff

for their work. Ms. Fabiyi-King reminded work groups of their scheduled meeting times and adjourned the meeting at 2:33 p.m. EDT.

DAY 2

Ms. Fabiyi-King convened the meeting at 11:45 a.m. EDT. She conducted roll call. All members except Dr. Pinto-Garcia were present. Dr. Callins thanked HRSA for providing technical writing support for work group projects.

Work Group 1 Report

Dr. Schmitz reported that Work Group 1 had developed a draft outline for a paper with the working title, "Health Care Providers' Readiness to Serve in Underserved Communities." The report will focus on NHSC's success in placing scholars and loan repayors, in supporting NHSC participants when they are in practice, and in supporting communities providing NHSC placements. The report will describe NHSC site types and their needs. It will summarize literature on factors affecting recruitment and retention of providers to underserved communities. It will describe skills and competencies needed to serve underserved communities, and discuss how to measure these competencies. The report will describe current HRSA data collection efforts relevant to assessing readiness to practice in underserved communities. The report will conclude with recommendations for improving NHSC efforts to recruit and retain clinicians in high-need communities. Recommendations are to: 1) define and operationalize readiness to provide primary care in HPSAs, 2) identify education and training approaches associated with readiness to serve, such as mentoring and developing communities of practice, 3) support efforts to develop measures of readiness, and 4) support efforts to measure the degree to which education and training programs apply best practices, 5) support collection and analysis of participant readiness data to inform education and training efforts, and 6) continue to support NHSC as a critical resource to provide training and incentives to provide primary care services in HPSAs. The report aims to inform efforts to improve recruitment and retention for HPSAs.

Dr. Sein asked Dr. Schmitz to define frontier communities. Dr. Schmitz said "frontier" is a Federal designation indicating low population density and geographic isolation, defined by different parameters to address varying policy and planning needs. The Rural Information Hub's Am I Rural web site presents multiple definitions.

Dr. Callins asked whether the group's discussion of skills and competencies had addressed integrating public health into primary care. Dr. Schmitz said the report discusses the importance of cultural humility as a core competency for practice in underserved care. Cultural humility is an aspect of applying a public health perspective to practice. Dr. Callins thanked Work Group 1 for their efforts.

Work Group 2

Dr. Jones said Work Group 2's report will focus on recommendations for improving health care access, supply, distribution, and quality. Increasing underserved communities' access to telehealth is a priority. The report also will discuss the importance of training NHSC participants to leverage community resources and professional networks to enhance patients' access to care when cost is a barrier. Serving needs for maternal care target areas is a third priority. Finally, the report will discuss the importance of effective recruitment and retention efforts. Discussion will address systemic challenges and provider resiliency.

Dr. Taylor-Desir asked what actions the work group is recommending. Dr. Callins said the report will discuss challenges identified in literature and recommendations for addressing those challenges, including innovative approaches to practice. Discussion will include lessons learned from the pandemic about the priority areas. The report may be in the format of a letter to the HHS Secretary. Ms. Fabiyi-King noted that both work group reports will be submitted to the HHS Secretary simultaneously. Dr. Schmitz suggested that the reports should reference each other.

Public Comment

Ms. Fabiyi-King invited public comment; none was offered.

Closing Remarks

Dr. Callins reminded the Council that its next meeting will be June 22-23, 2021 via Zoom. She thanked HRSA staff, the technical writer, and the Council for their work. She said that work groups would meet to make further progress on reports after the technical writer has produced revised drafts based on the most recent work group discussions. She encouraged Council members to review reports Dr. Padilla referenced in his presentation. She also encouraged Council members to recommend speakers for future NACNHSC meetings, and to consider nominees for the Council. Dr. Callins encouraged Council members to share their publications, presentations, and media interviews with the group. Dr. Piernot asked which factors members should consider to ensure

nominations support balance on the Council, such as professional discipline. Ms. Fabiyi-King said she would share this information in follow-up communication. Some information is available on the NACNHSC web site.

Dr. Callins invited Council members to share final thoughts. Dr. Bockwoldt said the meeting was motivating and she looked forward to continued work on the Council's reports. Dr. Sein said he appreciated the presentations delivered at the meeting and HRSA's recent funding appropriations. Dr. Schmitz endorsed branding NHSC as training confident, competent, compassionate clinicians. Dr. Piernot said the meeting and work groups were productive, and that she appreciated checking in with Dr. Callins prior to the meeting. Dr. Taylor-Desir said she appreciated the discussion about the current status of telehealth. She commended BHW's virtual job fairs. Dr. Jones appreciated discussion of telehealth, and provider recruitment and retention. All members endorsed the Zoom platform.

Dr. Callins encouraged members to be "relentless and resilient" in efforts to improve outcomes for underserved patients and communities. She adjourned the meeting at 2:55 p.m. EDT.