NATIONAL ADVISORY COUNCIL ON THE NATIONAL HEALTH SERVICE CORPS (NACNHSC)

WEBINAR MEETING SUMMARY

June 22, 2016

Health Resources and Services Administration (HRSA)
5600 Fishers Lane
Rockville, Maryland

Attending Members:
Tito L. Izard, MD, Chair
Joni Adamson
Kristen Crawford Ellis, DDS
Wilton Kennedy, DHSc, MMSc, PA-C
Jackie Griffin
Stephanie C. Pagliuca
Darryl S. Salvador, PsyD
Scott Shipman, MD, MPH

Federal Staff:
Kandi Barnes
Anne Buckland
Kim Huffman
David Kirby, JD
Laura McWright
Luis Padilla, MD
Melissa Ryan
Monica-Tia Bullock
Melissa Smith
Caroline Taplin
CAPT Jeanean Willis-Marsh

I. Preliminary Proceedings

CAPT Willis-Marsh welcomed all attending the meeting and asked that visitors, the National Advisory Council on the National Health Service Corps (NACNHSC), and Federal staff members introduce themselves. She then turned the meeting over to Dr. Izard.

Dr. Izard said that with implementation of the Patient Protection and Affordable Care Act (ACA) and other changes occurring in the health care landscape, it is important for the National Health Service Corps (NHSC) to be at the forefront of establishing future providers in underserved communities. He said that at the March 21 and 22, 2016, meeting, the NAC started to establish some of its priorities, realizing that many questions raised will require significant research and collaborative participation from other organizations or institutions.

II. Bureau of Health Workforce (BHW) Report

Dr. Padilla thanked the Federal employees who worked to put together the webinar meeting and the NACNHSC members who took time off from busy schedules to help improve the NHSC, BHW, and HRSA in meeting needs across the country. He said the NHSC is a prominent program that is seen by many constituency stakeholders and groups as a major workforce program meeting needs nationwide, particularly in underserved areas.

Major areas of interest in BHW now related to the NHSC are the Zika virus, mental and behavioral health issues, and substance abuse. BHW is developing the Medication Assistance Training (MAT) component of program guidance in case additional funding comes through to support certification for BHW clinicians, Dr. Padilla said. He said the President's budget for fiscal year 2017 calls for $380 million for the NHSC, a $70 million increase, which would help support mental and behavioral health commissions and expand MAT certifications for clinicians across the country.

HRSA is actively collaborating with the Indian Health Service (IHS) and tribal communities to see how it can help with IHS hospitals and outpatient centers. However, Dr. Padilla acknowledged that HRSA has limited resources for this work, and without additional resources it would have to make hard decisions about what it is able to do in this area.

He acknowledged the work the NACNHSC has done in focusing on the NHSC's value-added, with its recommendations on mentoring, current clinicians, future clinicians, and supporting those clinicians and their sites. He also said the NACNHSC's focus on retention of clinicians is important for BHW.

Dr. Padilla said BHW is a data-driven organization and would like to be more data driven. It is looking at ways to leverage the data it currently collects across the organization.

At the previous meeting, the NACNHSC recommended against moving ahead with the Student to Service (S2S) program for the dental field immediately, but Dr. Padilla said that BHW had decided to proceed with it. He said that oral health disparities continue across the country, and BHW projects that demand will outstrip the supply of oral health providers. The high average award for dental scholars takes away from the NHSC's ability to divert resources to primary care loan repayment or scholarships in primary care and other disciplines, he said. BHW has located funds for expanding S2S into dental that will not deter from the loan repayment program or the scholarship program. The expansion is set to take place later this year, he said, and NHSC anticipates funding 75 dental S2S awards, all going to dental students in their fourth year of dental school. Each award would be for $120,000 in exchange for a 3-year commitment in a Health Professional Shortage Area (HPSA). In answer to a question from Dr. Izard, Dr. Padilla said that the average dental scholarship award is $279,000 and the average medical scholarship is $220,000.

Dr. Izard said that the NACNHSC supports dental expansion and dental access issues, but that it wants to make sure that data gathered as the NHSC moves forward justifies the money spent. Dr. Shipman said the NACNHSC also had a concern with the training given to dentists and their readiness upon leaving dental school without further training to step into what would be expected of them. Dr. Padilla said that post-school training for dentists is not supported in the United States, and that influences where dentists work.

Dr. Ellis said it is important to identify dental schools that focus primarily on underserved communities and partner with them to get trained dentists out to the communities where they are needed most. Dr. Izard agreed but said that such a focus should not be limited to the S2S program. Dr. Padilla said BHW's Division of External Affairs is looking at where applicant are coming from geographically, and from what schools, and is targeting schools where there is a high need but are not a lot of applicants, trying to determine why those schools are not getting applicants into the NHSC program.

III. Shortage Designation Scoring: How it Works

Ms. Ryan, of BHW's Division of Policy and Shortage Designation, explained that the idea of medically underserved areas and medically underserved populations was originally created for HRSA's health center program, while HPSAs were created for

the NHSC to help prioritize placement in the highest-need areas of the country. Currently, other programs use these concepts also, including the Medicare Incentive Payment Program, the Centers for Medicare & Medicaid Services' (CMS') Rural Health Clinic Program, and the J-1 Visa Waiver Program that allows foreign physicians who come to the United States for training to stay in the United States.

There are different types of HPSAs: which are based on a shortage of primary care providers, mental health providers, or dental health providers either in a geographic area or to serve a particular population group or a facility. There are also population HPSAs, which involve geographic areas but involve particular subsets of underserved populations within those geographic areas.

Geographic and population HPSAs are based on Rational Service Areas (RSAs), which are defined by state primary care offices and are areas that are considered to be rational or an area that people would find services in. BHW also looks at certain population-to-provider ratios, and it determines that health professionals in areas surrounding the HPSA are inaccessible in some way, Ms. Ms. Ryan said.

When examining the population-to-provider ratio for primary care HPSAs, BHW looks at practitioners in primary care, internal medicine, OB/GYN, and pediatrics. For mental health HPSAs, it looks at psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. For dental health HPSAs, it looks at dentists and dental auxiliaries, such as dental hygienists, Ms. Ryan said. A geographic primary care designation requires a primary care population-to-provider ratio of 3,500-to-1 or a dental ratio of 5,000-to-1. For a mental health ratio, BHW looks at either psychiatrists only, or at core mental health only (which includes psychiatrists), or at a comparison between core mental health and psychiatrists.

Ms. Ryan said high-need geographic HPSAs also exist, which require lower population-to-provider ratios, and in which at least 20 percent of the population is at or below the Federal poverty level.

She said that certain facilities seeking a facility designation, such as federal and state correctional institutions and state and county mental hospitals, must meet specific criteria and apply for the designation. Other facilities, including health center program grantees, health center look-alikes, tribally run clinics, urban Indian organizations, dual-funded tribal health centers, federally run Indian Health Service (IHS clinics, and rural health clinics, are deemed automatic HPSAs. There are also Other Facility HPSAs (OFACS) that are public or nonprofit medical facilities that usually are not physically located in a HPSA but can demonstrate that at least 50 percent of their patient population comes from a HPSA. The automatic HPSAs are not reviewed on a regular basis, as other HPSAs are, Ms. Ryan said.

Scores for primary care and mental health HPSAs range from zero to 25; for dental HPSAs, scores range from zero to 26, Ms. Ryan said. Scores for all three types are based on the population-to-provider ratio, the percentage of population at 100 percent of the Federal poverty level, and the travel time to the nearest source of care. Primary care scores are also based on the infant health index. Dental health scores include the water fluoridation rates in the area. Mental health scores include alcohol abuse prevalence, substance abuse prevalence, the ratio of senior citizens to the adult population under age 64, and the youth ratio. Some of these factors count more than others, depending upon the type of HPSA involved.

Ms. Ryan also described the Shortage Designation Management System (SDMS), which was launched in 2014 and will eventually allow for a fully automated and transparent method of assigning HPSA scores. It uses standard data obtained from multiple sources and implements business rules that are based on pertinent regulations. The data come from several sources: CMS, the Centers for Disease Control and Prevention, American community surveys, the Substance Abuse and Mental Health Services Administration (SAMHSA), the private company Esri for geospatial mapping, as well as state primary care offices, which will continue to provide much of the data. SDMS is expected to be fully implemented in October 2017.

In answer to a question from Dr. Shipman, Ms. Ryan said her organization is not standardizing RSAs, which are always proposed by states.

CAPT Willis-Marsh said, in response to a question from Dr. Izard, said the S2S program and the loan repayment program require participants to work in a HPSA with a HPSA score of 14 or higher. The NHSC expects to look at whether a score of 14 meets the criteria of being the minimum threshold for communities that have the most need. The HPSA score for scholarship program participants is predicated on the number of vacancies that the NHSC has, she said. The NHSC has the ability to be flexible and adjust the S2S and loan repayment scores as BHW moves forward with SDMS.

In answer to a question from Dr. Salvador, Ms. Ryan said that alcohol abuse and substance abuse data come from SAMHSA but that state primary care offices can provide alternative data for consideration. Similarly, Ms. Ryan said in answer to a question from Dr. Shipman, state primary care offices will be able to provide more information on practitioners' specialties and work status than BHW will receive from the National Provider Identifier (NPI) data it will use in the SDMS. To answer a concern raised by Dr. Izard, Ms. Ryan said the SDMS will use NPI data in a close-to-real-time way.

Ms. Ryan said her organization is in the process of looking at what impact the SDMS system will have on HPSA scores. She also said the SDMS system would retain historical data, and that one of the goals of the project is to have as much historic data as possible in the system.

IV. Retention Rates

Caroline Taplin, with the Office of the Assistant Secretary for Planning and Evaluation, said her office awarded a contract in September 2013 to study retention rates in the NHSC, which might be facing reduced funding as ACA funding expired. Most research on the NHSC focused on physicians, she said, and her office wanted to look across disciplines and to study the extent to which incentives made a difference in retention rates in the NHSC. She introduced Sebastian Mr. Negrusa, an economist with the Lewin Group, which conducted the study.

Mr. Negrusa said his organization wanted to see whether providers locate and remain in the same HPSA where they complete their initial obligation, whether they move to other HPSAs, or whether they move out of HPSAs and stop serving underserved populations. Lewin initially focused on data from 2000 to 2013. For that period, about half of NHSC primary care participants are still located in the same HPSA one year about they complete their obligations, and 82 percent are still serving in some HPSA one year after obligation completion. Approximately 35 percent of NHSC participants were located in the same HPSA, and 72 percent were in any HPSA six years after of completing their service obligation.

In response to a question from Dr. Izard, Mr. Negrusa said that his group had not looked at HPSA scores for the HPSAs in which the NHSC participants served, but that they have the data to go back and examine that issue.

The main goal of the study, Mr. Negrusa said, was to compare the retention profiles of NHSC participants with those of non-participating providers serving in the same HPSAs that NHSC participants serve in. The retention rates for NHSC participants dropped sharply in the first two years after their obligations ended, but then they taper off and are much lower than the migration rates out of HPSAs of nonparticipants, he said. The rates at which non-participants leave HPSAs altogether are relatively constant, he said.

In addition, NHSC participants consist of categories of providers who would not have been there in the absence of incentives, Mr. Negrusa said. In short, he said the NHSC is working. It is bringing in providers who would not have been there in the absence of the program.

Mr. Negrusa said Lewin obtained data from several sources: NHSC administrative files, proprietary data from the Lewin Group, and Medicare provider data. The Medicare data was able to provide the location of providers over time, and from that, Lewin could determine whether the providers were in a HPSA.

In response to a question from Ms. Pagliuca, Mr. Negrusa said Lewin did not take into account age, gender, or other characteristics that may be relevant in a decision to leave or move back to a HPSA. In response to a question from Dr. Kennedy, he said his presentation is combining participants in the loan repayment program and the scholarship program but that there were not stark differences between the profiles of the participants in the two programs.

The decline in retention of NHSC mental health providers is smaller than the decline in the retention of primary care providers, Mr. Negrusa said.

The study started with the premise that, on average, providers do not tend to locate in a HPSA but would rather locate in a non-HPSA. The aim of the NHSC incentive is to change the utility of a HPSA location for at least some providers, Mr. Negrusa said. He noted that some NHSC participants may have a preference for being in a HPSA. But the study showed that the program is successful and he noted that NHSC participants who do not like being in a HPSA will be more likely to leave the HPSA once their obligation period is over.

For any regression analysis of the data, Mr. Negrusa said, the only individual variables Lewin had were age and gender. Having additional data would be interesting, he said, because earlier articles have noted that characteristics such as being born and raised in a rural community, participating in rural programs in medical school, and the racial characteristics of the provider affect providers' choices of working in a rural area or in a HPSA.

Dr. Izard said that having the information from the study will be very helpful for the NAC as it tries to figure out how to balance funding for field strength and field retention.

Dr. Kennedy said that if the retention rate of loan repayers and scholars is the same, and loan repayers cost a lot less than scholars, this raises an issue to examine down the road. Mr. Negrusa noted one difference in the programs - for the scholarship program, the NHSC is paying up front for service that it will get several years down the road, while for the loan repayment program, the NHSC is paying for new providers in the current period. Ms. Taplin said that the question of scholarship versus loan repayment comes up fairly often and the general belief is that it is important to have an avenue for people who might not have gone into medicine because of the amount of loans they would have to take on to become a

doctor or a nurse practitioner. Having a program for people from severely distressed backgrounds is really important, she said.

Dr. Izard said that 10 percent of NHSC funding is supposed to go to the scholarship program but that now the level is 20 percent. He also said he had never known an underrepresented minority person who could not go to a professional graduate school because of the cost. That raises the question of what level the scholarship program should be funded at. In addition, he said, people make an assumption that there is a disincentive if potential participants know that payment is on the back end versus the front end, but he does not think that the NHSC knows this as a fact.

Mr. Negrusa said his group does not have data on ethnicity or race but that such data would be highly relevant. Dr. Izard suggested that the NACNHSC might be able to obtain such data by partnering with organizations such as the National Association of Community Health Centers and learning what the characteristics of health center employees are.

Dr. Kennedy asked whether, before this study, the NHSC knew that so many participants were moving to other HPSA areas. Mr. Negrusa said he did not think that had been pointed out in previous studies.

Mr. Negrusa said the Lewin Group had been awarded a new contract, under which it will be able to extend the survey period using 2014 and 2015 data. It also will look at providers serving in IHS facilities and see how their retention rates differ from those of typical NHSC participants. It will also try to get to cause and effect by comparing retention patterns of funded versus non-funded NHSC participants. He also said that Lewin is working with the Oregon Health Authority to evaluate program incentives that it has. He will be able to share results from the Oregon study at the end of this fiscal year.

In response to a question from Ms. Adamson, Mr. Negrusa said that in the full report he outlined in his presentation, HPSA retention patterns of dental practitioners are described.

V. Top NAC Priorities for the NHSC

Dr. Izard noted that an NHSC fact sheet says the NHSC prioritizes S2S applicants based on disadvantaged backgrounds and whether they are likely to remain in a HPSA. He asked whether those prioritizations apply to the loan repayment and scholarship programs also. CAPT Willis-Marsh said the prioritization is applicable to all NHSC programs.

For the S2S and scholarship programs, potential participants write essays and submit letters of recommendation that are part of the package sent out to independent reviewers, CAPT Willis-Marsh said. Over the past couple of years, most if not all of the participants in those programs have demonstrated that they have done volunteer work in an underserved community or in a third-world country. Practicing in an underserved community would not be foreign to them, she said. She also noted that there has been a sharp decline in the default rate for scholars, and many defaults occur because the participants have had to take a leave of absence from school or have not been able to pass the medical boards.

Dr. Izard then explained the results of recent conversations within the NACNHSC. The group has talked about creating value-added providers, especially as health care is changing. This has raised the issue of how the NHSC currently measures the investment associated with each participant's award. Similarly, there is the question of whether there are established guidelines that validate what a successful NHSC placement looks like.

The group has also talked about whether the NHSC is prepared to experience anticipated changes in the health care landscape, such as team-based care and health management through the use of analytics, Dr. Izard said. Another question is whether the NHSC should be looking only at retention rates or should also be looking at other areas.

Other questions raised include whether the NHSC is selecting the right awardees for a 21st Century health care practice, he said. Additionally, what criteria is the NHSC prioritizing during the application and selection process? At what stage of the providers' integration into practice will they obtain the knowledge, skills, and abilities necessary to provide value-added services?

He said discussions had been held concerning BHW's strategic realignment, which consists of four components:

- Addressing gaps in health workforce development and distribution.
- Developing a holistic approach toward awards funding and sustainability.
- Building a bridge between academic communities and sites and the public health leadership development.
- Other particular areas of need.

When it comes to balancing the needs of field strength versus field retention, historically field strength has been easier to measure and therefore has taken precedence, Dr. Izard said. But if funding levels were to drop, the conversation regarding field strength and field retention will become more important and someone would have to make a decision on how funds are allocated. He said it is not clear how that would occur.

Another area of discussion has been whether the NHSC is creating value-added providers and whether, if so, that is happening before, during, or after the service commitment to the NHSC, Dr. Izard said. Another concern is what a reasonable expectation is for the minimum goal for a service commitment

At the last meeting, he said, the NACNHSC supported mentorship and training opportunities with NHSC-approved sites, with the expectation that NHSC members participate in educating students, particularly current health profession students, and work with academic institutes and professional to achieve this goal. Who owns this idea, Dr. Izard asked:

- The NHSC?
- Individual sites?
- Providers?
- Communities?
- Academic institutions?
- Some combination of these?

He suggested that the NACNHSC provide a recommendation on ownership.

Another discussion from the previous meeting was a recommendation to more effectively provide additional access to behavioral health within underserved communities, Dr. Izard said. Also at the previous meeting, the group ran out of time when discussing telehealth – whether the NACNHSC supports the idea and what the NHSC's role should be.

Mr. Griffin said the NACNHSC should put teeth into an orientation program for new participants. CAPT Willis-Marsh said that no orientation process exists with regard to practice at a site, but the NHSC offers a series of programs preparing participants for practice, on subjects such as preparing curricula vitae, negotiating contracts, and the different types of sites.

Ms. McWright said the NHSC offers a "welcome to service" webinar for loan repayers and for scholars to make sure they know of the obligations they have incurred – subjects such as the consequences of not finishing a service obligation, continuations, and requesting a suspension or waiver if that is appropriate for them.

CAPT Willis-Marsh noted that the NHSC has the authority to change award amounts. The pertinent statute prohibits providing more than $100,000 for initial awards, so lesser amounts are determined by policy, which the NAC could recommend.

Dr. Izard said the orientation discussion dealt more with orientation to the actual work itself. He asked whether the NHSC should take a lead role in this, or at

least encourage sites to have an orientation on-boarding process if they are going to be an NHSC-approved site.

Ms. Pagliuca suggested that the NHSC or HRSA could play a lead role by taking existing programming material and repackaging it for newer clinicians. Topics could include working in integrated practice settings, leadership, and working in a team. The package would not have to be an end-all but could consist of higher level things providers want to focus on that would help them be successful in the field.

Dr. Shipman said that having a package that was developed centrally would help. It is an exceptional site that knows what it means to on-board a provider in a thorough way, he said, let alone talking about team-based care or population health.

Ms. Pagliuca said the rural recruitment and retention network has a recruitment and retention manual with a lot of very specific items.

Ms. Adamson said many similar resources also exist. The NHSC does not need to spend time or money creating anything that is already available. Letting sites know about resources that are already available is the best we can do, she said.

She also said the NHSC should be letting sites know that they are recruiting. National trends show that people are changing jobs more frequently than before, and it makes sense that the NHSC remind sites that they will always be in a mix of both recruiting and keeping employees.

Dr. Shipman noted that real gaps in training exist. He said it would be a missed opportunity to simply point people to resources and websites.

Dr. Izard suggested a proposal – that the NACNHSC recommends that the NHSC promote the incorporation of a provider on-boarding orientation process that addresses the on-boarding process. He asked whether the on-boarding package should identify certain things or whether the proposal should leave that more open-ended.

Ms. Pagliuca said she would like to see to it that sites provide time for providers to do webinars or professional development, but not more than that.

Dr. Ellis asked whether on-boarding should occur once potential participants are identified, once they are accepted into the NHSC, or once they identify which site they are going to go to.

Ms. Pagliuca said the training should take place over the time the providers are evolving in their practice in the community, with webinars and professional development training, training that is lower cost.

Dr. Shipman said he liked the idea that the training would not be limited to an orientation but would occur throughout a provider's service.

Dr. Izard suggested that his proposal call for training throughout a service commitment and by the time a service commitment is completed, a provider would have been exposed to the various types of training the NACNHSC has been talking about.

Ms. Adamson said that in addition to having sites do professional training, the NHSC should ask sites to report data back to it, on subjects such as the number of patient encounters they have had or what their patient mix looks like. This would help answer return-on-investment questions and allow the NHSC to promote its achievements, she said.

Such a requirement would tie in with one of BHW's strategic goal, Ms. Pagliuca said, that of transforming the health care system into a person-oriented system.

Dr. Izard said the NACNHSC would follow up with the Federal staff on this way of measuring added value through relationships with groups like the National Association of Community Health Centers.

He also asked how the field strength number is determined. CAPT Willis-Marsh said the field strength is essentially determined by the size of the NHSC's appropriations. The actual number is set by the Health and Human Services Secretary and the head of HRSA, she said.

She then turned to the next subject – the length of a service commitment – and said that for loan repayment the appropriate statute sets a minimum of 2 years. Over 65 percent of loan repayment participants come back for a first and second continuation of 1 year each, covering their third and fourth years of service. Currently, she said, a third year of service is awarded $25,000.

Previously, it had been $35,000 for a third year of service commitment and about 72 percent of people finishing their initial commitment asked for a third year.

When the third year amount was lowered form $35,000 to $25,000, that rate dropped to 37 percent. After the amount was lowered to $25,000 those participants in their initial 2-year commitment decided to complete the program at that point. The NHSC saw an uptick in a group of participants, asking for a continuation. In

essence this cohort did not know any difference regarding the change in the dollar of amount from $35,000 to $25,000 for continuations.

Dr. Izard asked whether the current continuation rate is satisfactory or whether the NHSC has a goal to increase it. CAPT Willis-Marsh said the real goal is to reach field strength and if fewer people ask for a continuation, the NHSC will use the money for new awards so it reaches field strength either way.

Dr. Izard asked that if the decision-makers are focused on field strength, does the NAC want to push the issue of field retention. CAPT Willis-Marsh said that it would be hard to equally balance field strength and field retention because of the fact that field strength is negotiated and determined at a higher level. But the NHSC does look at field retention, she said, although field retention involves providers who are no longer under a service obligation while field strength involves providers who currently have a contract with the NHSC.

Dr. Izard asked whether it would be possible to increase the length of the service commitment in order to receive the same amount of money. CAPT Willis-Marsh said that question would have to be answered by the Office of General Counsel.

Dr. Izard then turned to the question of telehealth, noting that at the previous meeting, the group generally supported the concept. CAPT Willis-Marsh said the NHSC had learned that there's a limit on the number of hours that an NHSC provider can practice using telehealth so the NHSC has tabled that initiative. Dr. Izard said the NACNHSC would also keep the issue tabled.

He then asked if any updates were available on MAT: Has the NHSC received any money for the training yet? CAPT. Willis-Marsh said it had not received money and did not know whether it would receive funding. Dr. Izard asked whether there was a need for the NACNHSC to discuss the issue beyond the support it gave for MAT at the previous meeting. CAPT Willis-Marsh said there was not, but she noted that the NHSC will be meeting with the Bureau of Primary Health Care (BPHC) to try to determine whether, based on BPHC's experience with substance abuse grants, there is an interest at sites for supporting providers who have been certified under MAT.

Dr. Izard noted that the NACNHSC had also expressed support for mentoring and training opportunities. CAPT Willis-Marsh said BHW's Division of External Affairs manages a mentoring program for NHSC participants and the NHSC has asked that group to look at ways to boost the program.

Melissa Smith, of that division, said newly appointed scholars and S2S participants are offered the opportunity to have a mentor. Once the NHSC participant and the mentor are matched, the division leaves it up to the participant

to determine how often they speak with their mentor and what they talk about, although the division offers tips to encourage those conversations. It steps in if, for some reason, the student requests a new mentor, she said. Tomorrow is the first webinar for the program, and participation has been offered to all scholars and S2S participants, as well as to people who were not awarded scholarships because the division wants to encourage them to seek out a mentoring relationship, she said.

Dr. Shipman noted that at the previous meeting, the NACNHSC discussed trying to leverage sites to be clinical preceptor sites for students. The discussion was along the lines of offering incentives to sites that provided clinical training for students or that committed to do so.

Ms. Pagliuca said that at the previous meeting there had been discussion about different ways of communicating the NACNHSC's recommendations and about the importance of documenting those recommendations. Dr. Izard said that in general the NACNHSC supported the concept of pushing forward the recommendations, but he said he did not think there was enough clarity in the recommendations to proceed.

Kim Huffman described the process used by other advisory committees to record their recommendations. Usually they use the committee meetings to discuss what they would like the recommendations to be then they will have smaller group discussions outside the larger meetings, and sometimes they will form a subcommittee that will write a report, she said.

Dr. Izard asked whether it made sense for the NACNHSC to try to put out one report with all its recommendations or to prepare the recommendation piecemeal. Ms. Huffman said that either way would be appropriate. CAPT Willis-Marsh recommended that, to get something out in a timely manner, the suggestion to do separate reports might be the way to go. Ms. Huffman said BHW could provide assistance with any sort of smaller meeting.

Dr. Shipman asked whether there was an interest on the part of the Federal staff in getting a recommendation from the NACNHSC to accommodate the coming change in Administrations. CAPT Willis-Marsh said that getting a report no later than October would be good, but a report by the end of the fiscal year on September 30 would be preferable.

VI. Summary and Next Steps

CAPT Willis-Marsh asked the NACNHSC to look at the meeting summary for the previous meeting and approve it. Ms. Huffman suggested NACNHSC members

take until Friday, June 24, to review the summary and then respond by email if they approve it. Dr. Izard agreed with that suggestion.

CAPT Willis-Marsh listed tasks the Federal staff will undertake:

- Asking the Office of General Counsel to determine whether the NHSC can extend the service commitment of scholars based on the award amount.
- Working with the Lewin Group to determine the HPSA score of HPSAs NHSC providers moved to.
- Examining whether data exists that supports the notion that individuals decide not to pursue a health professions career because of a lack of money.
- Pulling together data on whether specialty health career choices may be affected by the perceived debt burden relative to the career salary.
- Providing information on the existing selection criteria for awardees.

Dr. Izard asked that the selection criteria task also examine whether traits such as underrepresentation, minority status, and a disadvantaged background have a high correlation with the selection criteria. CAPT Willis-Marsh said the Federal staff would include those details.

VII. Public Comment

Adrian Billings said that the American Academy of Family Physicians and the Society of Teachers of Family Medicine is holding a preceptor summit to try to identify ways to promote more community preceptors at hosting medical students in order to encourage more medical students to go into family medicine. He said he believes trying to tie academia and NHSC sites is a good idea for recruitment of clinician students into underserved medicine and also makes the providers provide better quality care because of the challenges and questions that the clinician students ask.

Craig Kennedy, executive director of the Association of Clinicians for the Underserved, said he wanted to specifically reconfirm the importance of Mr. Griffin's comments about orientation and note that it aligns with the mentorship program. Support for clinicians in the field is critical to the success of clinicians in the field, he said. Furthermore, orientation and continuing mentoring will lead to greater retention. He also said that Congress is always asking about retention.

He said he recommended having someone from the primary care offices on the NACNHSC. Particularly, as the NACNHSC looks into the new shortage designation system, having someone like that as part of the conversation would be incredibly important.

He also said that Congress is making several recommendations on changing the NHSC - some as part of active legislation and some as part of report language that could impact all of the discussion at this meeting. The NACNHSC could be helped by understanding some of the congressional activity that is occurring, especially the report language through the appropriations process, in order to prioritize the NHSC's placements toward certain providers and changes to the breadth of providers that would be eligible under the NHSC. Congress originally proposed changing the HPSA process, the placement process, and the types of providers, he said. He also recommended the NACNHSC hold discussions in those areas.

VIII. Conclusion

CAPT Willis-Marsh thanked everyone for participating in the meeting. Dr. Izard asked for and received a motion and second to conclude the meeting and the motion was approved. He thanked everyone for attending the webinar.