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

MEETING SUMMARY

March 21-22, 2016

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

Attending Members:

Tito L. Izard, MD, Chair
Joni Adamson
Adrian N. Billings, MD, PhD
Kristen Crawford Ellis, DDS
Jackie Griffin, PhD
Joan Malcolm, DMD
Felix Nunez, MD, MPH
Stephanie Pagliuca
Darryl Salvador, PsyD
Scott Shipman, MD, MPH
Cindy Stergar
Gwen L.R. Witzel, APRN, FNP, FAANP

Federal Staff:

Janeshia Bernard-Jones
Ashley Carothers
Julie Crockett
Celinda Franco
Beth Dillon
Diane Fabiyi-King
Michelle Goodman
Alexandra Huttinger
David Kirby, JD
Catherine Kuchinsky
Dana Leinbach
Jim Macrae, MA, MPP
Laura McWright
Luis Padilla, MD
Melissa Smith
Jeanean Willis-Marsh, DPM
Tracy Wilson

Day 1
March 21, 2016

I. Preliminary Proceedings

At Dr. Izard's suggestion, all members of the NAC NHSC and others in the meeting introduced themselves.

Dr. Izard outlined the NAC's role: to serve as a source of independent expertise and advise on policy and program activities, to attend scheduled meetings, and to review required materials before the meetings. He said that the NAC is a forum to identify the priorities for the NHSC and bring forth and anticipate any future program issues and concerns through ongoing communications with program staff, professional organizations, communities, and program participants. The NAC may function as a sounding board for proposed policy changes by using levels of expertise represented on the council. It may develop a white paper or brief that clearly states issues or concerns related to the NHSC and provide specific recommendations for any policy revisions.

In remarks to the NAC, Mr. Macrae said HRSA is getting inquiries from the field, as well as many Congressional inquiries, about the NHSC. He invited comments on how to handle all of the inquiries.

Mr. Macrae told the group that the current proposed budget for fiscal year (FY) 2017 included a significant increase of $70 million over the FY 2016 budget for the NHSC, with a focus on behavioral health and substance abuse, particularly mental health services. A $45 million increase is aimed at mental health services. A $25 million increase would support providers who have Medication Assistance Training (MAT) certification. The proposed budget for FY 2018 would increase the NHSC's field strength to 15,000 providers, up from the current 9,600 providers.

Mr. Macrae said that the NHSC is one of the best ways to get people interested in going into primary care, getting them interested in services to underserved communities and vulnerable populations, and providing care using an integrated, holistic approach. Pediatric care is a specialty area people have been particularly interested in.

Mr. Macrae focused on a number of areas the NAC could provide support to HRSA, by asking:

- Where do we want to focus and where do we prioritize?
- What is our process for making these determinations?
- How do we get information and resources into clinician' hands? How do we provide training? How do we provide support?

- With regard to emerging public health issues, how do we get information in the public's hands?
- Where does the NHSC fit in terms of all HRSA programs?
- How do we use the NHSC to bridge a seeming disconnect between what is going on in academia and what is going on in service delivery?
- How do we promote more team-based, integrated care?
- What are the competencies we want to see from NHSC providers? How do we best provide support to the practitioners once they are on site?

Mr. Macrae said HRSA is revising its website in terms of getting information out about its various programs, and the NHSC is ahead of the curve in this regard.

In response to a question, Mr. Macrae said an issue that has come up recently is examining how to create tests or proficiencies under which practitioners could get credit toward a degree or a license for skills that they have learned. The question comes up in terms of veterans, who have gained skills while in the service, but also for practitioners who are working in roles that carry more or different responsibilities than their training would suggest.

The NAC accepted the minutes from the previous meeting, with addition of listing Dr. Shipman as an attending member of the meeting.

## II. Bureau of Health Workforce (BHW) Updates

Dr. Padilla outlined some of the goals BHW, the HRSA bureau that oversees the NHSC, has identified in a strategic plan as goals for the next three years, including being an organization that has the capability to impact a health professional's career from training and being a thought leader in informing policymakers of the gaps between academic training and service. He noted that current BHW programs, including the NHSC, are not meeting the needs for providers at community health centers.

One significant change of policy this year requires that mental and behavioral health providers must practice in a community-based setting that provides access to comprehensive behavioral and mental health services, Dr. Padilla said. BHW has modified mental health clinician service hours to reflect parity with physical health service hours, or 32 hours.

Dr. Padilla said that over the next 2 years $100 million would be used to combat prescription drug abuse and heroin use and for funding to support enhanced loan repayment, potentially for providers certified in Medicaid-assisted treatment.

BHW is considering expanding its Student to Service (S2S) loan repayment program to include dentists, Dr. Padilla said. Oral health training is a high-ticket item in the current scholarship program, costing anywhere from $300,000 to $500,000 of expense for one dental scholar to go through the program.

BHW is considering changing telehealth policy for mental and behavioral health, Dr. Padilla said, noting that a number of NHSC clinicians, particularly behavioral and mental health clinicians, are using telemedicine. This is part of an examination of how BHW can use existing technologies.

Dr. Padilla said BHW is also looking at the question of how to address Health Professional Shortage Areas (HPSA). Now, if you are in a HPSA, you need to maintain and provide service in the same HPSA. Also, BHW policy does not currently recognize patients' homes as National Health Center-approved sites, but more and more health systems are looking at home visits as a way to reach out and to integrate community health works and their care teams in homes.

In response to questions, Dr. Padilla explained that either clinics or networks, or individual practitioners, can qualify to prescribe medications through the MAT program. The individual practitioner program is limited to physicians.

Ms. Stergar said the MAT system works best when used in a team setting, but few places have been successful in using it, except in high-population areas such as California. But it is nice to have a public policy to address a crisis in the country, she said.

Ms. Adamson noted a concern that policy changes may take away money given to NHSC physicians, and NHSC sites continue to indicate that physician positions constitute the most vacancies they are unable to fill currently. She also said that the problem may be that not as many physicians are applying for NHSC funding as practitioners from other disciplines. Dr. Padilla said BHW would not be making policy changes without additional funding.

Dr. Nunez said his clinic has had a hard time building and maintaining a dentistry practice because of prohibitive costs. He also said that somewhere around 70 percent or 80 percent of his clinic's admissions have some relationship to substance abuse, so a focus on that is a small part of a larger problem we are trying to find a way to solve.

In response to a comment about the S2S dental proposal, Dr. Padilla said that currently dental students often are not able to apply for loan repayment programs because of licensure requirements and requirements from individual NHSC sites. Expanding the S2S program to dental students is a way to eliminate that problem.

He said that HRSA and the Department of Health and Human Services (HHS) are already preparing for a new Presidential Administration. He also said that BHW is examining changes states are making covering the scope of practice – such as the recent move by some states to license dental therapists – to make certain that BHW policies align with what is changing within the workforce.

Dr. Padilla asked for advice on how NHSC could create better connections to specialist professionals to undergird the primary care workforce in underserved areas.

In response to a comment about making loan repayers take certain continuing education, Dr. Padilla said that the MAT program is the first time BHW has recognized the need for continuing education beyond licensure. He asked for advice on the core training that should be provided in light of a concern that needs are constantly changing.

He said that putting suggestions in writing is always helpful to the staff, but that suggestions from the five BHW advisory councils vary greatly, from formal reports to less-formal papers.

## III. NHSC Satisfaction Survey: Follow-Up Discussion

Ms. Huttinger followed up on a presentation from the previous meeting with more information about participants in the NHSC. She said that the retention rate among loan repayers at NHSC sites after their service commitment was quite high, while the rate was significantly lower among participants in the scholars program.

In response to a previous question about dentistry specialties, Ms. Huttinger said that almost all dentist participants identify themselves as general dentists. She said BHW collects ZIP code information about where participants are currently working, but it does not ask alumni for ZIP code or state information where they finished their service obligation.

She asked for advice on what information the NHSC is not collecting but might be able to obtain from future surveys.

Ms. Huttinger then described the reasons practitioners gave for staying with NHSC sites or leaving them after their service commitment has ended. Alumni chose to stay with a program because of the experience they had had with the site. Loan repayers decided to leave a site because of financial considerations, while scholars said site operations were what influenced their decision to leave. Among loan repayers, 68 percent stayed at the same site, while among scholars only 32 percent stayed at the site.

Overall, the retention rate was 87 percent, a 1 percent increase from the previous year. Ms. Huttinger also provided figures breaking down retention rates by type of practitioner, by sex, by age, by racial background, and by type of site. When looking at retention rates based on the HPSA score of sites, she said, there was not much of a pattern.

Asked about the high non-response rate to the survey among NHSC alumni, Ms. Huttinger said that, for the most part, NHSC was reaching most alumni through an email outreach effort. She agreed with a comment about the possibility that non-responders might provide more useful information than do alumni who respond.

She said the NHSC does not currently collect information on how many loan repayers had had prior experience at their sites – through, for example, a student rotation – or whether prior experience made it more likely that a participant would continue to work at a site. She said such information would provide great insight.

A NAC member said it would be interesting to know whether a site was committed to teaching and mentoring medical students and residents or just, from time to time, took a student or resident on.

Ms. Huttinger said NHSC is increasing a partnership with the Indian Health Service (IHS) both to see how the two programs can work better together to increase the number of clinicians working in tribal communities and to try to better understand the IHS retention rate.

Ms. Adamson suggested it would be interesting to ask survey respondents whether they grew up in a rural area, went to high school in a rural or underserved area, or were exposed to such areas.

Dr. Shipman asked whether NHSC looks at scholars' backgrounds and relevant experiences. Ms. Huttinger said it does not but has the capacity to do so.

CAPT Willis-Marsh said NHSC has talked about looking at the relationship between where scholars are serving and where they went to school or received other training such as residencies.

A NAC member asked whether NHSC had ever determined what the best retention rate was as a target to shoot for. Ms. Huttinger said she thought 87 percent was a good retention rate, but that it is worth looking at retention beyond the two-year period past a service commitment, which is what NHSC currently examines.

Another NAC member said she would be interested in knowing what the retention rate is based on region or state, because the workforce issues vary greatly based on location.

## IV. Dental Education

Ms. Holtzman talked about issues related to dental education. In 2014, the average amount of dental school debt at graduation was $260,000, while physicians graduate with $180,000 worth of debt. Dental school students who choose to specialize often have to pay tuition for their residencies; the stipend the dentists receive as residents usually ends up balancing out the tuition.

About 20 percent of dental school students report having either no debt or less than $100,000 in debt after 4 years of dental school. Sixty-one percent owe $200,000 or more, and more than a third report owing more than $300,000. This compares to medical school graduates, 45 percent of whom report owing $200,000 or more and 12 percent of whom report owing more than $300,000.

But we are going to need more dentists, Ms. Holtzman said, with an expected shortage of more than 15,000 dentists projected by 2025. The reason is that the U.S. population is getting older, and the incidence of tooth decay in older adults is about the same as in adolescents. So there is a question of how to address the shortage to ensure that all Americans have access to quality oral health.

Dental students are not a diverse population, either racially or based on family wealth. However, Ms. Holtzman said, 26 percent of dental students say that the opportunity to serve others, and to serve vulnerable or low income populations, is important, and this number is increasing.

She said there is a broad range of dental school tuition. In Puerto Rico, it costs $36,000 to be a dentist, while out-of-state Ohio students might pay $350,000. Dental students also have to buy their own instruments, usually costing more than $20,000 during the 4 years of dental school.

In dental public health, half the programs report paying a stipend, with a mean rate of $37,000. Tuition ranges from $10,000 to $70,000. Dental public health is not a clinical program but teaches skills such as how to conduct needs assessments and how to plan community-based prevention programs. Dentists with a dental public health background may not have added clinical experience but bring a lot to the community health center or other site they are at, Ms. Holtzman said.

She said that 37 percent of community health centers report a vacancy for dentists.

When asked about the number of dentists who do a residency, Ms. Holtzman said that about half of general dentists do a residency, but they do not necessarily do one immediately after graduating from dental school. Dr. Ellis said that most of the time a general dentist decides to do a residency, it is because he or she is not comfortable with the skills acquired while in dental school.

Ms. Dillon said that a lot of NHSC dental practices do not involve creating a plan for a patient but are more a triage type of dental practice, addressing an immediate need. That situation is uncomfortable for students coming straight from school to practice. Another problem is the large volume at an NHSC dental practice, which is difficult for new dentists coming out of school.

Dr. Ellis said that if a new dentist is being exposed to triage dentistry, he or she is not getting the experience of doing private, family-practice dentistry and so will eventually leave to get more experience.

In answer to a comment about the perceived or real lack of resources and support at NHSC dental practices, Ms. Holtzman said that there is an opportunity for specialist dentists to go to sites and be mentors to general dentists at the sites. Dentists are comfortable with such a mentoring model, she said. Dr. Malcolm said that some dental schools are doing such mentoring.

A NAC member wondered whether anything can be done at community health centers to give primary care providers a minimal dental education.

Another NAC member said that a number of community health centers have just opened that have experienced dentists coming to the centers to start dental programs.

## V. NHSC Award Process and Data Analysis

CAPT. Willis-Marsh provided details about the NHSC award process.

She said the scholarship application process opens every March. Through an online application, NHSC collects personal information and information about what an applicant's proposed discipline will be. There are two essays, one asking applicants to reflect on their experience and talk about their commitment to practice in underserved areas. Applicants submit two letters of recommendation, one from a professor or dean and one from a non-academic. After the applications are redacted, they are sent out for independent review by three reviewers and the scores are averaged. Reviewers are asked to look at the applicant's academic

success, essays, and letters of recommendation. The applications come back to the NHSC in rank order.

The organization looks at the money it has and determines how many applicants it can fund. It sends out confirmation of interest letters and runs credit reports on applicants. It then sends out award notices and what it calls internally "So sorry" letters, CAPT Willis-Marsh said.

For the scholarship program, NHSC pays full tuition, fees, and other reasonable costs, such as books and instruments, CAPT Willis-Marsh said. There is a limited amount of money that will allow a scholar to do an externship or visit a site. All of this is non-taxable. In addition, there is a stipend of a little more than $1,300 a month that is taxable. The program allows up to 4 years of support, and the service commitment is year for year, with a minimum commitment of two years.

The NHSC offers scholars and now S2S participants a lot of training, and scholars also are paired with regional advisors. They can receive up to $1,200 for site visits and $10,000 for relocation expenses. The NHSC does not pay for moving from the site to somewhere else.

After scholars and S2S participants finish their service commitments, they are given priority to come into the loan repayment program, CAPT Willis-Marsh said, but they must be at their original placement site.

Dentists make up more than 20 percent of scholarship awards but only 8 percent or 9 percent of loan repayment awards, she said.

Dental students cost about $54,000 more per award than medical students, and most are coming in their first year of school, CAPT Willis-Marsh said. They have a low default rate compared with medical students, who have the highest default rate among the professions served. Among all professions, most defaults are from students dismissed from schools or withdrawing from schools.

Ms. Dillon said that many people apply to the program a second time if they are not accepted the first time. Some apply a third time.

She also described the S2S program, which is open only to medical students in their fourth year. The program offers up to $120,000 in debt repayment for a 3-year service commitment. It is not as competitive as the scholarship program. If a physician still has debt after completing the 3-year service commitment, he or she is given priority to come into the loan repayment program.

CAPT Willis-Marsh said that, in the proposed dental S2S program, NHSC is looking at allowing a participant the option of going into a residency program or

going straight into practice. The residency could be in general practice, advanced education in general dentistry, or pediatric dentistry.

She said NHSC is in the process of developing a new, targeted outreach and marketing plan and will share it with the NAC once the plan is completed.

CAPT Willis-Marsh said that neither the scholarship program nor the loan repayment program is ranked by discipline, and NHSC is asked constantly by Congress and other organizations not to rank the awards by discipline.

Asked about the possibility of sponsoring face-to-face recruitment conferences, Ms. Dillon said that conferences are off the table based on Presidential directives. The NHSC has not had trouble placing people, she said.

When asked about expanding the number disciplines covered by NHSC programs, CAPT Willis-Marsh said that would water down the base, and NHSC hears constantly that physicians are the providers sites most want, followed by nurse practitioners and mental and behavioral health practitioners.

## VI. From Council Recommendation to Policy: The Process

Ms. Williams offered an overview of how the NAC should propose policy changes. She noted that the governing statute states that the NAC should consult and make recommendations to the Secretary of HHS with respect to the NAC's responsibilities. The NHSC also relies on the NAC to review and comment on regulations. The NAC's role is strongest when it considers areas where HHS and the HHS Secretary have the authority to do work and change the system, she said.

The NAC should consider whether it is suggesting a policy change or a legislative change, Ms. Williams said. It also should consider the type of policy change being advocated. For example, HHS has the authority to change the Centers for Medicare & Medicaid Services payment, but the likelihood that HHS would do that based on an NAC recommendation is questionable

The NAC also should think about who the proper audience for its recommendations is. The HHS Secretary and Congress are possible audiences, but so are providers, NHSC sites, and others, Ms. Williams said.

The NHSC is looking for strong recommendations that have precise actions that can be directly tied to a specific change, she said. Being prescriptive and directive is very helpful. The NHSC can help the NAC with needed information or data. Then, possibly at the next real or virtual meeting, the NAC can put together a list of potential recommendations.

Ms. Williams offered examples of strong, weak, and inappropriate recommendations.

She also said that an appropriate type of recommendation is to write Congress in order to affect legislative action. She described the process agencies use when making legislative suggestions to Congress, acknowledging that getting such changes through is difficult. But, Ms. Williams said, strong and clear recommendations from the NAC would give the NHSC's legislative suggestions added strength.

While the NAC is charged with reviewing and commenting on proposed regulations, the NAC is also well positioned to make suggestions on the need for regulatory action, Ms. Williams said.

With a new Administration coming into office in January, the NAC is in a good place to be thinking about new regulations that might be needed, she said. She said the NHSC is seeking NAC ideas that the new administration can claim as its own and put forward in FY 2018. With a new administration, it would be helpful to have a document or recommendations that are well thought out and backed by evidence.

She also solicited thoughts and recommendations around increased funding that is being received. She also said that now is the time to start thinking about big changes that might be recommended for FY 2018.

Ms. Huttinger suggested that a white paper or formal letter is a good document in that it brings together all of the NAC's ideas. She suggested some type of formal document that all NAC members have reviewed and vetted.

In response to a question from Dr. Shipman, HRSA staff told the NAC that members can individually publish commentary related to the NHSC if it has been cleared by the NAC.

## VII. Administrative Matters

Staff reviewed reimbursable expenses connected to the 2-day meeting, paperwork that must be submitted in connection with the reimbursement claims, and taxi arrangements for the end of the second day of the meeting.

## VII. Open Discussion

Dr. Izard presented a roadmap for thinking about where the NAC would like to see the NHSC move. He suggested thinking about these questions:

- What makes the NHSC unique?
- How do we perfect our craft and what we're doing?
- How will we know when we achieve success?
- Can we, as an organization, represent, demonstrate, and get to a point where we can produce data that reflects a level of return on investment for all parties?

He said that in the past 3 years to 5 years he has seen the NHSC grow in its ability to collect information and present it in a helpful manner. He suggested considering the following specific questions:

- Should the rate of retention of NHSC providers after 2 years be higher than the current 87 percent?
- How much money should the NHSC provide to a single individual? Should the NAC look at the service commitment a provider incurs once he or she accepts more than a certain dollar amount in funding?
- Site return on investment issues: If a site takes on a practitioner for 2 years, but it takes 18 months to train him or her, is that sustainable?
- Who is the NHSC customer: The applicant? The site? The communities being served?
- Does the NHSC have a role in providing continuing education to its practitioners and alumni?
- How can NHSC providers help with community outreach – by getting practitioners outside clinics so that they know what is happening in the community? A component of this is diversity integration.
- Can the NHSC assist sites with leadership development?
- How can the NHSC assist in creating a bridge between the academic world and practice, or help practitioners transition from the academic world to practice?

NAC members responded with several specific suggestions and questions:

- There is a need to strengthen the bridge between a training program and an NHSC site. We want to make community health centers clinics of choice for patients and providers as well. This could be achieved by having stronger ties to academia and having faculty appointments as an expectation at NHSC sites.
- We should stay focused on the priorities that were laid out for us – dental health, mental health, and behavioral health.
- Is the dental S2S expansion proposal valuable? It will be good for the NHSC because it spreads awards out to more dentists and dental students. But is it good for the dentists themselves, who will be taking on more of a debt load if they do not have as many places available to them as a scholar?

- Why is the MAT program only available to physicians when there are other practitioners who prescribe medicine?
- Telehealth is going to be important, but questions remain about who employs telehealth providers offering assistance to underserved areas.
- We should revisit earlier NHSC white papers and use them as a guide to measure success.
- We should look at the idea of mentorship and the use of social media, the NHSC portal, and other media as a way of exposing people to work in rural clinics.
- Would having a supervising physician, at least in the telehealth world, allow increased access to medical services?
- Mr. Macrae sounded as if he needed help from us on access issues, particularly for specialty care.
- We should present ideas in a formal document, whether it is a white paper or a set of formal statements.
- NHSC should be asking open-ended questions, particularly of state partners, to determine what recipients are asking for or saying they need.
- At some point, the NHSC staff should give us an update on what is being done with the NHSC contract for the Association of Clinicians of the Underserved.
- What is our purpose? Is it to stabilize practitioners in community health centers and underserved areas? Is it to train and distribute practitioners proportionally based on need?
- Should there be a weighted differential when determining how much scholarship to give a provider going to a city or going to a high-impact area or high-need location?
- From everything being discussed, it appears we all want to move from volume to value when considering the care provided.
- At the NHSC, we probably all support integrated care. We recognize the importance of primary care and the consequences of having a shortage of primary care on patient health and outcomes.
- Depending on the data we have or need about retention rates, we do not want to go below the rate we have now, which is very good.
- We should do a recommendation paper laying out our support or nonsupport for the NHSC's vision and mission. We also should get into the issue of defining success. We also should make specific recommendations, such as a recommendation on how to fund scholars.
- What are the NHSC issues we care about and how do we recommend them? Issues like team-based care, value-based payments, and telehealth make me rethink some of my simplistic notions of what the NHSC is about in terms of placing providers in communities.
- Why should MAT training be for physicians only? If the only primary care provider in the area is a nurse practitioner or a physician assistant, why not allow him or her to have the training?

- We need to look at the question of retention and ask what the best use of our dollars is. Do we fund more scholarships? Do we fund more loan repayment?

At the end of the first day of the session, Dr. Izard asked the NAC members to be prepared, on the second day, to choose high priority item topics for further discussion and then ask, "Where are we going to go forward on this."

Day 2
March 22, 2016

VIII. Lessons From the Previous Day

Dr. Izard asked NAC members to tell the group what was particularly valuable to each member from the previous day's session and what could have made that session more effective. The members responded:

- Valuable: The presentation of the budget and the fact that the focus on mental health is where our resources are right now.
  Improvement: I can't think of anything right now.
- Valuable: The flow between the presentations and the opportunity for wide-ranging discussions was just right.
  Improvement: I don't know enough about the governing statute.
- Valuable: We got to our purpose for today, which is making recommendations.
  Improvement: I don't have anything else.
- Valuable: Everyone was given a chance to contribute. Information about the application data.
  Improvement: I can't think of things.
- Valuable: Learning about HRSA's transition planning for the upcoming new Administration. Information on dental school tuition.
  Improvement: "Could you expand my brain to absorb that stuff more quickly?"
- Valuable: The direction we have as a group toward oral health and the connection to overall health. The additional resources we'll be putting toward that and behavioral health and mental health
  Improvement: I felt everything went well.
- Valuable: Information about new money coming down the pipeline. The emphasis on behavioral health and telemedicine. The discussion on dental services.
  Improvement: [No comment.]
- Valuable: The information from the presentations we had. The budget information. Being able to express our views and having feedback.

Improvement: Having a synthesis of the main ideas we talked about – bullet points outside of the meeting minutes.

- Valuable: Information about the award process and how that process works.
  Improvement: Receiving a summary of the different programs that are provided.
- Valuable: The meaningful discussion around the data we've received, especially the information on the breakdown of the average scholarship award amounts and the focus on dental health.
  Improvement: A budget proposal showing how the funds would be allocated throughout the NHSC if we get the funds.
- Valuable: Information received on the MAT program and the challenges we have in recruiting dentists.
  Improvement: It would be nice to have a collection of previous white papers the NAC has put out to give us an idea of what we should be trying to formulate.
- Valuable: I appreciate the insights into dental health. Information on the behavioral health and substance abuse issues. Information on policy issues and how we craft policy.
  Improvement: Adding at least an additional day to the meeting.

Dr. Izard said he enjoyed working with the team behind the scenes. The staff provided information and guided us, he said.

## IX. Information on the NHSC

In response to a request, CAPT Willis-Marsh gave a presentation on the NHSC and the programs it funds. The NHSC began in the 1970s after a critical shortage of physicians was recognized, especially in rural areas. It started as a scholarship program. In the 1980s the loan repayment program was authorized, she said, which is now the flagship program. In the 1990s NHSC received a bump up in funding, and mental and behavioral health providers were added to the program. In the 2000s, the NHSC received a large increase in funding, with money coming from several federal sources.

Before 2007, CAPT Willis-Marsh said, the NHSC had not done a good job of communicating how the program worked. The organization began a robust marketing and outreach campaign.

As of September 30, 2015, NHSC had more than 9,600 practitioners at more than 5,000 sites, she said.

CAPT Willis-Marsh explained how the practitioners are funded. Once the NHSC receives appropriations, it puts aside money for the number of people it thinks will

continue on its programs. It contacts scholarship recipients who had not asked for support for all the years they are eligible and asks them if they want to continue in the program. Money is also set aside for the State Loan Repayment Program, which is a grant program, and for the S2S program.

After that, NHSC funds based on priorities, CAPT Willis-Marsh said, and, for the loan repayment program, by the sites' HPSA scores. Money allocated for a particular fiscal year does not have to all be spent in that fiscal year, she said.

She said three types of HPSA designations exist: mental, dental, and primary care. A HPSA can be a geographic area – most often a county – or a catchment area, and it can be facility-or population-based. HPSA scores are calculated from information NHSC receives from state primary care officers and consist of several data points, among them infant mortality and the time it takes to travel to a primary care provider. Sites may contact primary care office directors and request that their HPSA score be rescored.

A HRSA staffer said HPSA scoring will change in 12 months or 18 months when standardized data sets start being used.

CAPT Willis-Marsh said the scholarship program is the most competitive NHSC program. NHSC has looked previously at capping the amount of funding awarded to each scholar but was told by the general counsel's office that it could not cap; the pertinent statute says that NHSC must pay all tuition fees. NHSC could limit the number of years it gives each scholar an award.

NHSC obtains data collection worksheets from all participating schools, and these help NHSC determine tuition and fees, she said. NHSC pays these directly to the schools, not the scholars. It pays the scholar a one-year, lump-sum amount to cover reasonable costs and a monthly stipend of a little more than $1,300.

NHSC's statute says that at least 10 percent of its funds must go to scholarship awards, CAPT Willis-Marsh said, and in recent years NHSC has allocated about 20 percent of its funds to scholars. It does not make awards based on discipline. It spends between $38 million and $40 million on scholarship awards each year, funding between 195 and 210 awards. For physicians, the eligible disciplines are internal medicine, family practice, pediatrics, OB/GYN, and psychiatry. Pediatric and general practice dentists are eligible. Nurse practitioners have to be certified in a primary care area (pediatrics, adolescent medicine, women's health, or family practice) or as psychiatric nurse practitioners. Physician assistants have to specialize or go into a primary care area. The scholarship program also covers certified nurse-midwives, who typically constitute the smallest cohort in the program.

Scholars are obligated to provide a year of service for each year of support, she said, with a minimum service commitment of 2 years.

NHSC does not place scholars, although by statute it has that authority, she said. Sites the scholars choose for their service have been split evenly between rural and urban areas.

CAPT Willis-Marsh said S2S, the newest program, encourages medical students who are thinking about going into primary care but are worried about paying off medical debt. To qualify, medical students must be a U.S. citizen or national, must have been accepted to a residency in one of the primary care disciplines, and must have eligible educational debt. Participants can receive up to $120,000 tax-free and will owe a 3-year service commitment. The money is distributed over a 4-year period. When sending out information about the S2S program, NHSC contacts people who applied for but were not accepted into the scholarship program. Like scholars, once S2S participants satisfy their S2S commitment, they can receive priority to participate in the loan repayment program.

The loan repayment program makes awards of up to $50,000, which is tax free, for a 2-year commitment, CAPT Willis-Marsh said. To participate in the program, practitioners must be practicing at an eligible site or be under contract to practice. She said the process begins when an applicant establishes an account with the NHSC and completes an application. An employment verification form is sent to the site, which confirms that the applicant is working either full time or half time and is practicing in an outpatient setting. If a query on the practitioner of the National Practitioner Data Bank has not been run recently, NHSC runs one.

After the 2-year commitment, if a participant still has educational debt, including undergraduate educational debt, he or she can request a continuation until the debt is satisfied, she said. Continuations are annual, and the first two continuations award up to $20,000 per year. After that, continuations award up to $10,000 per year. Most people seek two continuations.

Dr. Izard said the NAC would like to see award money go to people who are more likely to stay at sites for the underserved.

CAPT Willis-Marsh also described the NHSC's online Job Center, which is undergoing an upgrade. Sites in the NHSC program can post vacancies, which can be searched by site name, HPSA score, or state. NHSC is looking at allowing sites not in the NHSC program to post vacancies. "We want for underserved communities to be like Monster.com or Indeed.com," she said.

Sites that have the most robust profiles typically have the most traffic, she said. Among other items, sites can post photos, check off the services they offer, and

provide information about how large the facility is and the affiliations they have with other health facilities or systems.

Ms. Dillon said that to become an approved NHSC site, a location must submit an application. If it meets NHSC requirements, it will be approved and receive technical assistance. Sites are recertified for eligibility every 3 years.

X. Working Session

Dr. Izard summarized the discussions held and questions asked by the NAC during the meeting. One major topic was the question of where the NHSC fits between academics and clinical practice. Another question was how the NHSC should support and distribute resources.

Dr. Izard then tried to summarize the issues and questions raised by NAC members on the first day of the meeting (see page 12) and asked members to clarify his summaries.

He said the first question to be asked of any recommendation the NAC makes is who has ownership of the change being proposed – the NHSC, individual sites, a community, academic institutions, or others. The NAC wants to be able to say that for a recommendation to be successful, it must be owned by specific parties, and the NAC must ask how it can influence the recommendation. He suggested establishing priorities and then doing research to establish what must be done to gain ownership of a particular issue.

Dr. Izard then led the NAC in formulating positions on several issues raised during the meeting:

- First: The NAC recognizes the existing disparities for dental access within underserved communities but at this time does not support the extension of the S2S program to the dental profession due to (1) limited data that supports an effective return on investment and (2) a concern that an extension would pull funds from other needed areas. The NAC is committed to continuing dental access to the loan repayment and scholar programs and to exploring the dental S2S program once it receives more data.
- Second: The NAC supports mentorship and training opportunities within NHSC-approved sites, with an expectation that Corps members participate in educating students, particularly current health professional students, and working with academic institutions and professional schools to achieve the goal.
- Third: In order to more effectively provide additional access to behavioral health within underserved communities, the NAC supports evidence-based training such as the Medication Assistance Training program (MAT) for

substance abuse disorders, working collaboratively with other agencies, and considering the expansion of MAT to include licensed non-physician providers. The NAC supports including in the program providers with MAT certification in addition to comprehensive behavioral health treatment.

The NAC also discussed issues relating to telehealth and generally agreed with expanding the concept. However, because of a lack of information and a feeling that the group was trying to rush to a consensus, it tabled any further discussion on the subject.

Dr. Padilla thanked NAC members for the time and effort they gave the council. He said the NHSC is in good shape, with a field strength higher than it has been before. The NHSC has been funded through FY 2017, and with the bipartisan support the organization has received because of its success, he said the NHSC will receive funding in additional years. He also asked the NAC to reconsider its stand on the expansion of the S2S dental program.

Dr. Izard said the meeting had contained great discussions but also left issues to be discussed at future meetings:

- Examining how the NHSC compares to other workforce organizations, such as the IHS, with respect to retention rates and other issues.
- Discovering what is happening to improve Corps member experiences.
- Getting more familiar with state program funding.
- Looking at how many positions still need to be funded through the NHSC website.

## XI. Public Comment

Karen Studwell, representing the American Psychological Association, said the NHSC statute authorizes mental behavioral health professionals to participate in the scholarship program, but, to date, doctoral psychologists have not been able to participate. She asked that the NAC look into the issue. Psychologists are 7 years out of training before they can work in the loan repayment program, following an internship and a post-doctoral fellowship.

## XII. Closing Comments

CAPT Willis-Marsh thanked the group for its work. Even if the NAC did not discuss all issues as a council, she said, it provided the NHSC staff with a running list of items the staff can take to Dr. Padilla to begin internal discussions

Dr. Izard thanked NAC members, asked that the NAC staff be applauded for its hospitality, and adjourned the meeting.