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

WEBINAR MEETING SUMMARY

March 22, 2017 – 1:00 p.m. EST

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

Council Members:
Tito L. Izard, MD, Chair
Joni Adamson
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Beth Dillon
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Aleisha Langhorne
Len Rickman (Contractor)
Melissa Smith
Laura McWright

Welcome and Overview

Dr. Izard welcomed everyone to the webinar. He noted interesting topics on the agenda for presentations and feedback and commentary. He thanked NHSC staff for coordinating the webinar and their background work, and noted it is helpful for him to get feedback on what staff needs. **CAPT Campbell** asked for a roll call of members, and upon completion noted a quorum was present and the meeting could proceed. She added other members indicated they will join the call as well. **Dr. Izard** noted some members are still waiting for confirmation of service on the Council and will participate informally, but at the end of the call.

Dr. Izard thanked everyone for taking the time for this meeting amidst their busy schedules. It is helpful every few months to have a follow up to the great ideas and information presented at previous

webinars since that helps understand what is going on specifically with NHSC, and generally in the changing healthcare landscape, including efforts to provide access to high-quality health care. This meeting gives good insights on considerations for communities going forward. The goal is to have members be informed and have an accurate assessment of information about NHSC and its activities.

Minutes from January 25, 2017 Meeting – Dr. Izard

Dr. Izard said he hoped everyone had the opportunity to review the minutes, and that they are available to review via download. **Dr. Salvador** moved to accept the minutes, and **Dr. Griffin** seconded. The only discussion was **Dr. Griffin** asking whether Dr. Nunez's request from the previous meeting was fulfilled for a crosswalk or table that outlined the different programs to be sent to members. **CAPT Campbell** said she believes it was sent to Dr. Nunez, and she will check to see if entire Council received it. **ACTION ITEM**. **Dr. Izard** noted he also has not seen it. The motion was passed with no opposing votes.

Provider Retention in Rural Areas

Ms. Adamson began by noting how good recruitment efforts are the initial foundation for retention, even though they are different efforts. Good recruitment paves the way and opens doors for retention. Workforce retention is a hot topic across industries, and can be daunting. Many labor shortages exist, including in education, construction, and other industries that need skilled labor. In addition, the financial industry has noted a shortage of financial advisors and accountants. That all illustrates why retention is more important than ever, including across the spectrum of healthcare settings and employees.

The titles of **Ms. Adamson's** slides are listed below in italics, along with her supplemental comments.

Core Beliefs of Retention. The process includes what needs to be adopted and put in place, but will be unique per organization. If it was just a science everyone could follow the process, but that is not the case with provider retention. Therefore, it is an art with a need for flexibility. It is essential to know who is responsible for specific tasks. Urban areas have more staff to share the responsibilities, while rural areas often have one person responsible for multiple things. Key issues include why a person chose the job, and what would make them want to stay. Seeing things from the employee's perspective takes effort since it often does not come naturally. Some level of invention is needed, but it is not "rocket science." It is about identifying the human factors that play into decisions and making sure to have the right resources, though often they already exist in other places and organizations and communities can use the relevant pieces.

Why Retention is Important: What We Know (three slides). Sometimes senior leaders do not understand why this all is important to them. Other times they are not able to grasp the effort necessary for all of the pieces, but they appreciate having it explained in their terms. Outpatient care is especially growing and will not slow down soon, in Missouri and nationally.

Why Retention is Important: What We Can Expect. Heated competition means doing everything necessary to recruit people versus other organizations.

Retention Planning (two slides). While this is the hardest time to recruit, that also means a lot of opportunity to do so. It includes how to convince people to come to specific areas, especially rural. New ways to look at methods and approach are needed. The biggest challenges to implementation are complacency about always doing things a certain way, not recognizing changing needs across generations, and not getting leadership to accept new ideas, methods, or updates. Planning should include implementation phases, including identifying the people who should be a part of the effort, such as the chief executive officer or human resources manager at a community health center, or perhaps a chief operating officer or chief financial officer. Other possible staff to include are directors in behavioral health providers, dentists, and clinical managers. In general, the efforts should include anyone who peers look at for leadership and strategy for retention. It also is important to keep perceptions of a facility accurate, including it being up to date and functional versus run down and broken. Time is a major issue, especially in rural areas, and it is necessary to make sure all the tasks are doable.

Retention Planning: What Matters In Rural. These are not widely different from urban areas, but they take more planning and definition. Rural areas have resources and enjoyable things to do, but too often, they are described neither well nor enticing. Negative perceptions and factors should be turned around into opportunities or positives (e.g., climate). Communications should note both the closest urban area for specific amenities (e.g., retail, restaurants), and rural amenities (e.g., hiking, fishing, personal farming).

Another idea is to buy an Amazon Prime membership for providers so goods will be shipped to them so they can avoid the difficulties of in-person shopping. Each community and state will have unique factors. While urban underserved areas have challenges to recruiting, rural areas still face more challenges. However, cost of living is typically an advantage in rural areas where people can buy larger houses and lots. Clear job descriptions are necessary, including matches with what the provider seeks. Deal breakers should be recognized and acknowledged since it is better to show someone a situation will not work versus having them come on board and be unhappy. However, sometimes specifics can be molded to make factors less of a deal breaker, but caution is necessary about the potential for provider disappointment when the site initially agrees to buy specific equipment but cannot do so due to cost (thousands of dollars).

Scope of practice includes myths about rural areas, such as not having internet access or electronic medical records, so it is important to prove otherwise. Often, providers trained in urban settings and practicing in rural areas looks a lot different even for people originally from such areas. Access to online journals and telemedicine is helpful. For support within communities, it would be interesting to hear the different perspectives between urban and rural providers. Often, rural providers are considered heroes and communities are so grateful for them, while urban providers say they know their patients appreciate them but do not understand what it means to be a community hero. Rural providers often say it is a nice area but you need to be able to handle running into patients at various places (e.g., grocery store). It is important to point out that some urban amenities or lifestyle preferences are available in rural areas, and some rural areas include partnerships among services (e.g., construction) to get things done that do not exist in urban areas. It is good to hear stories about how rural providers are

initially welcomed to town, such as real estate agents helping to locate a home, school officials noting accomplishments, and local civic leaders offering homemade foods (e.g., pie).

Retention Resources (three slides). Multiple tools and instruments are needed for retention, and recruitment. No silver bullet exists, and creativity is essential. The list in the slides is not exhaustive, but are the most prominent and widely used in Missouri. Others can be found online and elsewhere. Online academies are being planned for next year as well. The links can be used to find resources per state. It is good to identify small issues including those beyond clinical or organizational, before they become major challenges, and that helps retention. A lot of training and services in Missouri are being opened to multiple groups and communities, and cooperation and collaboration is sought across settings and organizations to keep it all moving forward.

Recap. The goal is to have people say they love the job, or perhaps it is the best job ever.

Discussion

Dr. Izard thanked Ms. Adamson for a great presentation. He reiterated urban and rural organizations face similar issues and platforms, and the importance of implementation versus more invention. He asked if all key stakeholder sites know how to take advantage of the resources, or only those who take the initiative to seek them out. **Ms. Adamson** noted multiple efforts to let organizations know about available resources, and her office works with the Missouri Office of Primary Care and the Missouri Office of Rural Health to disseminate information, but typically, state offices do not have sufficient in-house resources to do training and dissemination but can be information conduits to their networks of hospitals and clinics. The topics to emphasize were drawn from a survey of entities asked to identify five or six items where they need help with planning for next year. In the past few years, her office has strengthened its partnership with the state's hospital association and that has helped work on workforce challenges among rural providers and settings. Many similar stories and situations exist across settings. It is important to have a level field when trying to get people to come to communities. They all have the same mission of improving access and health, so it is important to let bygones go for past issues, and pull people together for training, and make everyone feel welcome among colleagues so they can ask questions and receive training, including at conferences. Partnerships are necessary to help disseminate information, including among a state's office of rural health and their state hospital association. Additionally, a specific workforce team for rural primary care, two years in the making, has multiple partners, including academic training institutions. Many experts, teams, and partnerships have similar tools for trying to achieve similar goals, but they all have a long way to go.

Dr. Griffin said he is intrigued by some things in retention, and asked whether Ms. Adamson's office has had the opportunity to measure the outcomes of programs. **Ms. Adamson** replied the only measure now is based upon the State Office of Rural Health and its efforts in primary care focused around incentive programs such as loan repayment. Discussions have occurred about getting centers to provide turnover rates, especially among providers, and that would enable a benchmark to judge program success. People who have recently received a lot of job training typically change jobs within three to five years, but usually at the lower end of that. Currently, Missouri only has its state-based incentive

programs, and it would be interesting to see models for measuring outcomes. **Dr. Griffin** said he is not aware of any specific programs for measuring.

Dr. Malcom asked whether the routine state interview replaces the performance evaluation. **Ms. Adamson** replied no, and while sometimes they are incorporated together, she believes it is better if they are scheduled separately. It is hard to include corrective action at the same time as asking why a person likes the site, and neither type of interview needs to take a long time (e.g., five or 10 minutes). **Dr. Malcom** agreed that shorter means less pressure on providers (including for faster return to providing care) who will then be more forthcoming. **Ms. Adamson** added it is better to maintain a more relaxed setting.

Dr. Izard asked if the presentation will be made available for facilities. **CAPT Campbel**l noted the presentation is being recorded, so it is Ms. Adamson's decision whether it should be made available. **Ms. Adamson** said she has no objection. The information has been tested and is based on data, and resources are available across the U.S.

Redesign of Area Health Education Centers (AHEC)

Ms. Langhorne began by noting she will be out for the next six months, and **Ms. Brayboy** will be the point of contact. The program's current funding announcement is open and will close Wednesday, March 29, 2017.

The titles of Ms. Langhorne's slides are presented below in italics, along with her supplemental comments.

Definitions. An Area Health Education Program often is a medical school, but sometimes is a nursing school. They contract with health centers to coordinate and facilitate health professional workforce education and training.

Legislative Requirements (seven requirements). The legislation is much more detailed, but this slide distils it to the major points. While AHECs get funding from similar sources, each one of the 247 across the country is unique.

Academic-Community Partnerships (Current Structure). AHECs exist in 45 states and Guam and the Republic of Palau; while Delaware, Iowa, Kansas, Mississippi, and Oklahoma do not have an AHEC, and the one for Washington State also covers Idaho and Wyoming. In Alaska, Montana, and Guam the AHEC is at a school of nursing.

Key Challenges for AHEC. The 247 AHECs means 247 different ways of focusing on the seven legislative priorities, and much variety exists across programs' approach and how success or failure is measured. In addition, the question about whether HRSA and Bureau of Health Workforce (BHW) are in business to fund AHECs is frequently asked. The challenges, including frequently being zeroed out in the President's budget, were major motivators toward program redesign.

Topic, not slide: Guiding Principles for Redesign. It was important to understand how to influence and address HRSA's priorities and investment, and how AHECs help with priorities, gaps, and unmet needs. Staff reviewed data from evidence-based and evidence-informed programs. It also was important to align legislative priorities with the current and changing health workforce landscape, including finding opportunities for collaboration within HRSA and among other Federal agencies such as the Department of Education. Additionally, consideration was given to what can be measured consistently and now to establish consistency and alignment across BHW programs.
Area Health Education Centers: Summary. Another key area is where to make an impact, especially rural and underserved areas and clear measures were needed to mark progress in those areas.

Innovation & Change in FY17. Key goals were stakeholder engagement across HRSA and other Federal programs (via advisory committees), performance data, and workforce projections. A HRSA-wide, high-level workgroup identified key focus areas for the redesign. Staff participated in the National AHEC Organization Conference in June of 2016, and engaged 18 multi-level stakeholders that represent four national member organizations in all 50 states and several U.S. territories. Overall, it was a two-year process.

Innovation & Change in FY 17. A major goal was to have AHEC-funded participants train providers who can function in the high-quality, aggressive, transforming healthcare system being sought, but not ask them to change practitioners' offices. The focus is on consistent program design across the AHECs, and consistent outcomes, and ensuring they have sufficient resources for whatever issues arise in the next few years. Some states have multiple AHEC program offices, and they may not overlap, so to get funding they needed to show plans for partnerships, including potentially with Primary Care Associations (PCAs), Primary Care Offices (PCOs), state offices of rural health, health centers, and critical access hospitals.

Innovation Change in FY17: AHEC Scholars Program. While it has requirements, including a minimum of two years, the framework was kept broad to allow participants more choices in who they wanted to include in the health workforce. Some applicants have negotiated partnerships that will look at placements and potential hiring for students that finish the AHEC Scholars Program. Allowing stipends is another change. Also, the AHEC Scholars Program must have a formal application process with defined eligibility criteria to ensure AHEC Scholars reflect a diverse student body, so the program will help meet the distribution, diversity, and practice transformation goals of the overall redesign project.

Enhanced AHEC Model. Centers will no longer do the program their own way. The goal is consistent methods and measures across AHECs, including more accountability and guidance from the program offices through the statewide evaluation and the AHEC Scholar curriculum development. The activities on this slide will maximize the program's impact and outcomes.

2012-2017 Current and 2017-2022 Future. Program offices look at the structure, and process and long-term outcomes, and work with multiple players to identify problems and provide solutions.

AHEC Program. All future grantees will report on the same types of activities. They still will have some autonomy but the bureau needs to know what centers are doing with HRSA funding that is not just a

simple pass through. Quarterly updates will focus on planning. They will submit applications, and will have one year to implement what they propose.

Area Health Education Centers. Many good models exist, such as Project Echo in rural areas where doctors come in and out every quarter and provide supervision and case consulting for providers who are initially from large urban areas.

Programmatic Improvements – Continued. Success does not necessarily mean great outcomes since it could mean a good method to track students that were trained over the past 30 years. The goal is to support existing AHECs for their great work, and sustain the program and help AHECs sustain themselves over the next couple of years. In addition, it will be important to achieve the legislative goal to have an AHEC in every state.

Measuring Impact. This will be done at the HRSA level. Grantees made clear their desire for the bureau to request data and evaluate performance based on whey they actually do. One strategic focus is to work with Federally-Qualified Health Centers (FQHCs) or Community Health Centers (CHCs) to encourage applicants form partnerships. This will put in place to ensure that training in the AHEC programs occurs in the right kinds of places where the bureau wants people to work, and they already will have a good idea what that is like when they are making decisions about where to work.

Topic, not slide: frequently asked question. Many people ask what the link between AHEC scholars and NHSC is; and do the scholars get priority for NHSC funding. Therefore, a question for the Council is how should the AHEC Scholars Program fit with the NHSC?

Discussion

Ms. Adamson said this is exciting information and noted the importance of recognizing the need to be more involved in providing opportunities in rural and underserved areas. Studies show people tend to work in the types of areas they were exposed to during training, so it is crucial to expose people to rural areas. The presentation highlighted good opportunities to increase awareness of AHECs among scholars or S2S participants. Historically, information about individuals could not be given to states for recruiting, but the Corps can promote a common website to let people know about AHECs that can connect them to rural underserved areas. It would help people find opportunities across states, though it could not be mandatory to look at the website since scholars' requirements vary. **Ms. Langhorne** noted the AHEC Scholars Program piggybacks on established programs, while not actually trying to change the school. It is an enhancement that will help increase exposure to rural areas. HRSA is talking diligently about joint advertising for streamlined, collaborative, and up to date communications about funded programs.

Dr. Izard asked whether any one has assessed the capacity of urban and rural practices to see if they can take on that level of student exposure. For those who do so it is bidirectional rewarding, but education is a significant burden on a practice and its productivity. **Ms. Langhorne** noted efforts to account for that, including determining the average number of scholars in a state and awareness that FQHCs have more room for it than solo practices so the burden could be distributed equitably. Many AHECs already

were doing a similar version of this where they identified solo practitioners or were doing team-based approaches with other health providers, or cross training and collaboration among newly placed practitioners.

Ms. Adamson asked when grants will be awarded and notified. **Ms. Langhorne** replied the applications are due March 29, 2017 and will be awarded and notified this coming summer, with the intent for new programs to start August 1, 2017. More information about local AHECs is available from herself or **Ms. Lorener Brayboy**, at lbrayboy@hrsa.gov.

Dr. Salvador asked whether some of the questions on the state information and annual review interviews could be combined to keep certain factors top of mind, but he also understands the need to keep them separate given their different structures and intent.

Dr. Izard asked whether statistics exist about the workforce going into rural or urban communities. The term 'urban' typically refers to metropolitan areas but in reality can mean more than that. He also asked whether outside of Health Professional Shortage Area (HPSA) score is there any way to measure proportionality, and if it is shifting should that be a concern. **CAPT Campbell** said information is available based on zip codes, so perhaps information can be extrapolated from that outside of HPSA score, including based on site type in some cases. That is a task for the data managers, based on specific requested parameters.

Dr. Izard asked whether other significant measurements or metrics are used to determine shortage, outside of HPSA, or is that the gold standard and only definitive measurement that looks at distribution. **Beth Dillon** said Melissa Ryan would be the best person to answer that, but the bureau has worked in areas with well-known provider shortages such as near the Mexican border, and in conjunction with the Indian Health Service has been successful in increasing the number of NHSC, Nurse Corps, and S2S placements.

{Break}

<u>Health Professional Shortage Area (HPSA) Scoring Update</u>

Ms. Ryan began by noting her previous presentation to the Council was a broad overview of HPSAs and their designation and scoring criteria, and this presentation will review some of that before getting into more detail about rational service areas. The titles of Ms. Ryan's slides are listed below in italics, along with her supplemental comments.

Types of HPSAs. 'Facility' includes things like prisons and mental hospitals.

Automatically Designated HPSAs. Not all rural health clinics are included; it is only those who meet the NHSC site requirements. Additionally Medicaid patients are accepted and use sliding fee scales.

Auto HPSAs compared to other HPSAs: similar but not the same. Scores are reviewed on a regular basis by a team at the BHW. Gathering the necessary data, as well as the volume of data and work involved can be challenging.

Designation Criteria for Geographic and Population HPSAs.

Rational Service Areas

Ratio of Population to Providers: Which Providers Count?

Ratio of Population to Providers: What are the ratios? This does not apply to auto HPSAs that are designated by statute and regulation.

Review of Contiguous Area (CA) Resources. For a rational service, area that has a Medicaid-eligible population an adjacent provider that does not take Medicaid is considered inaccessible.

HPSA Scoring Calculations.

Rational Service Area (whole county).

Rational Service Area (multi-county).

Rational Service Area (sub-county). This can be a unique urban neighborhood, or places in rural areas with a physical barrier such as mountains or lakes.

Rational Service Area (states). This is not a requirement but helps ensure states look at their entire state to determine usage patterns and rational service areas. This helps states since there is no requirement for them to analyze every area in the state though BHW prefers they do so. Sometimes the bureau finds additional areas that would qualify if the PCO applies for designation. Most states send a plan, and if approved the bureau uploads it into the system so the state can use it to facilitate an application whenever they choose. It reduces the time and effort for going back and forth and justifying individual applications not based on a statewide rational service area plan. States do not have to explain each rational service area, and that makes it a very beneficial tool.

Rational Service Area (mental health). Sometimes mental health HPSAs are based on very large catchment areas, and that has advantages and disadvantages, but they do not have to conform to all the previously discussed Rational Service Area (RSA) rules.

Shortage Designation Project. The Shortage Designation Management System (SDMS) has been running since 2014. It is a single automated system for all processing and scoring to leverage standard data sets, enable regular updates, and use automation to reduce the burden on Primary Care Offices (PCOs) for submission of applications with updated HPSA data. The National Shortage Designation Update is scheduled for July of this year.

Shortage Designation Project Today & the Future. Auto HPSAs are not yet in this system.

Stakeholder Engagement Efforts. The Change Control Board includes staff at PCOs. It reviews all possible changes for need and priorities. For several months, thus far it has met every other week with the Auto-HPSA Working Group. It is trying to make it easier to identify and designate auto HPSAs versus the need for manual searchers for different points of data and multiple emails. It allows use of geographic data and an automated process. The group is making great progress.

Project Timeline and Key Milestones. Exact data sources for auto HPSA scores are still needed. That should be done as soon as possible once the Working Group agrees on the approach. The new data and process will be used to see how each current designation would fare. This will help PCOs

- prioritize and review the score and status of each designation,
- whether some potentially no longer meet the requirements

- should be proposed for withdrawal
- and if they still qualify, based on an increase or decrease in score.

One PCO did a helpful spreadsheet for prioritizing analyses.

Publication of the Federal Register Notice. The primary purpose of the notice is to de-designate everything that is in proposed withdrawal status as of the publish date. The intent is to give state PCOs as much time as possible to work on their designations after the update before something might be officially withdrawn, but official withdrawal will not happen until the Federal Register notice published in July 2018. This will give enough time to update data and submit new applications.

Discussion

Dr. Izard said FQHCs use auto HPSA scores to make it easier to look at additional sites, since they would have the main location's auto HPSA score. Moreover, he thought that process could be used for loan repayment participants but not for scholars who must use actual calculated scores. He asked how all of that will that be impacted in future. **Ms. Ryan** said she is not aware of that requirement. Site scores are stored in BMISS, and it uses whatever score is highest for a specific site. If a site is in a geographic HPSA with score of 6 but also has auto HPSA score of 17, BMISS will use the 17. In addition, she is not aware of which scores can be used Loan Repayment Participants versus Scholars, and **Beth Dillon** said the same scores are used for both.

Ms. Ryan said the bureau has data on rural placements for NHSC, but needs to examine and distribute them. **ACTION ITEM**. While it is true that other methods exist for determining need, determining health professional shortages is by medically underserved area (MUA), or Medically Underserved Population (MUP), though other methods likely exist. Many federal and state programs use MUA and MUP. **Dr. Izard** asked whether an organization looking at a particular site could consider the location, an MUA as well as taking care of a medically underserved population related to HPSA score in the future. **Ms. Ryan** replied that HPSA is a separate designation than MUA or MUP. **Dr. Izard** asked whether MUA and MUP are used to designate HPSA. **Ms. Ryan** replied they are not the same thing. MUA and MUP are primary determinants in the Health Center Program, and the authority to do those designations is in the Health Center Statute, while HPSA is part of the NHSC statute and the two programs were created for different purposes. **Dr. Izard** shared that is interesting, but it creates additional confusion. It is a challenge when the terms are used interchangeably since they are not the same. Dr. Izard further stated that other ways to determine need should exist, such as MUA and MUP, as unique and distinct ways. **Ms. Ryan** noted MUAs and MUPs are only eligible for primary care, and not dental or mental health. **Dr. Izard** said an FQHC usually is in a HPSA, but it is more likely they are in a MUP or MUA. **Ms. Ryan** noted FQHCs are auto HPSAs by virtue of being a facility HPSA, but not necessarily located in a geographic or population HPSA. The criteria for MUA and MUP are used for Section 330 funding. **Dr. Izard** suggested the need to stop saying an FQHC must be in a HPSA, since it must be in a MUA or MUP and then will become an auto-HPSA. This is a clearer way to define it. **Ms. Ryan** suggested collaboration with the Bureau of Primary Health Care for clarification and language. **ACTION ITEM**.

Dr. Salvador asked is just a HPSA what counts for NHSC eligibility. **Ms. Ryan** replied that is correct. **Dr. Izard** asked if any changes in scholar placement would occur in the current cycle. **Ms. Ryan** noted preparation is underway for the Federal Register notice, and it will be forthcoming shortly. **Dr. Izard** said he thought scholars would need a 14 HPSA for placement. **Ms. Ryan** noted Scholar placement

scores sometime differ from Loan Repayment, but there are not different scores for each site, just different requirements for minimum scores to qualify. The bureau is required each year to publish a scholar placement score, and it must provide for at least one job opportunity, and not more than two, for every scholar coming into the cycle. A lot of math is required to get the threshold score to meet that requirement, and the bureau does its best to get as close to two as possible without going over. By law, it must publish the number, and chooses to do so in the Federal Register. A site with a HPSA of 16 means it might not be eligible for a scholar but perhaps for a loan repayor, as that threshold is determined. Historically, the scholar score placement crept up. It was 16 for a long time, but last year was 17. It is different from for tier-one for LRP, which is 14, and above.

Summary of the Day

Dr. Izard noted seeing excellent recommendations during his tenure with the Council, and staff has implemented significant progress. He is honored to have been part of this group for a number of years and serve as Chair. His time for participation is coming to an end, and **CAPT Campbell** and her staff will find the next person to serve as Chair.

Dr. Izard said continuing questions are about who is the NHSC, who is the customer, and how to keep the mission sustainable beyond the service commitment and annual appropriations. This is a paramount issue in discussions during each election cycle, including the challenge to determine or establish the balance between field strength and provider retention within the underserved communities throughout service areas. Moving forward, the Council should have an ongoing conversation, and good data will be needed to provide recommendations to NHSC about how to effectively support participants in the LRP, SP and S2S Programs. Also, as most practices are moving to value and not just volume it will be especially important for NHSC to help sites evaluate how to have value-added providers for approved sites, and whether that can be measured. Other important factors will continue to be things like workforce sustainability, best practices for training, and diversity. As communities change, it will be even more important to provide practitioners more resources to adequately reflect the communities they serve and who participates in community outreach. As a result, the service commitment extends beyond health care delivery to the big picture. **Ms. Adamson's** presentation about recruitment and retention captures some of that. It will be important to have providers see the big picture of leadership development, not just as practitioners, to help organizations achieve their larger mission and goals. The foundation is to ensure appropriate access to quality of care and culturally compassionate customer service. The Council needs to continue to ask those questions and continue to have presentations like today to help understand the criteria out there so it can incorporate them into future recommendations to NHSC. Also, hopefully the Council will push forward with recent discussions about opportunities for collaborative training with other organizations to address the holistic needs of underserved populations. Much has been accomplished over past few years, but a lot remains to do.

Dr. Izard said he is thankful to staff for their great comments, questions, and information to allow all of us to serve the NHSC.

CAPT Campbell acknowledged the service of Council members whose terms are ending this month, and by mandate must roll off. She acknowledged **CAPT Tracy Wolfe** for her dedicated service, and **Dr. Tito Izard** for his leadership on the Council and for keeping members thinking of innovative ways to move

NHSC forward. These members' time and efforts are appreciated, and they will be missed. Perhaps all retiring members will get a chance to talk again. It is a labor of love to serve on this advisory committee.

Public Comment

No public comments ensued.

Closing Remarks

Several people on the call sent congratulations and appreciation to Dr. Izard for his leadership. **Dr. Izard** thanked everyone for participating, and said the presentations were helpful and educational. Even after years of participation, one can learn new things. The addition of future Council members means the direction will continue to be exciting. He will continually support NHSC, and will look forward to meeting bright young minds who come to his center through the support of NHSC.

CAPT Campbell thanked everyone for participating.

The meeting adjourned at 4:05 p.m.