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

WEBINAR MEETING SUMMARY

September 28, 2016

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

Attending Members:

Joni Adamson
Kristen Crawford Ellis, DDS
Joan Malcolm, DMD
Felix Nunez, MD, MPH
Tito L. Izard, MD, Chair
Stephanie C. Pagliuca
Darryl S. Salvador, PsyD

Federal Staff:

Janeshia Bernard
Monica-Tia Bullock
Beth Dillon
Kim Huffman
Jeffrey Jordan
Diane-Fabiyi King
CAPT Jeanean Willis-Marsh
Luis Padilla, MD
Melissa Smith

Agenda

1. Welcome and Overview
2. Minutes from June 22, 2016 Meeting
3. NHSC Updates
4. Finalize Letter to HRSA Administrator
5. Public Comment
6. Discussion Topics for Next Meeting (11/9/16)

Opening Remarks

Ms. Huffman introduced herself as Director of Advisory Council Operation, and initiated the discussion and welcomed participants. She noted her role as

facilitator, and asked for a roll call (and apologized for technical difficulties with the conference call technology).

Council Chairperson **Dr. Izard** thanked everyone for taking the time to participate and help the Council move forward and seek clarity on how to help NHSC retain and recruit providers for mutually beneficial service in underserved areas. He noted his excitement that CAPT Campbell has rejoined the team (though she was not able to participate in this call).

June 22, 2016 Council Meeting Minutes

Ms. Huffman noted the June 22 meeting minutes were emailed to members prior to this meeting, and also are downloadable from Adobe Connect. One typo was noted, and **Ms. Adamson** and **Ms. Pagliuca** both noted that since they are not doctors the minutes should not refer to them as such. **Dr. Izard** thanked members for their comments and asked for a motion to accept the minutes. **Ms. Pagliuca** moved to accept the minutes, **Dr. Salvador** seconded, and the Council voted unanimously in favor.

NHSC Updates – Dr. Luis Padilla

Dr. Padilla thanked the Council for its ongoing support of NHSC and other Bureau of Health Workforce (BHW) programs; and thanked the NHSC staff for managing the Council's webinars. He also expressed appreciation for CAPT Campbell's return.

Dr. Padilla noted that while typically the Council's September meeting includes the fiscal year's tally for award amounts, field strength, and other data, the numbers are not yet available and will be sent to Council members in October. He noted NHSC's strong physician workforce diversity, especially among Hispanics where NHSC is at 17% while the national average is 4%, and among African Americans where NHSC is at 16% versus 6% nationally. He added the Corps' tier policy has successfully distributed the workforce to areas with the highest need, though sufficient funding remains a challenge.

Dr. Padilla provided an overview of his slides. *Transforming Health Care Delivery; Population-Based Health.* While the Corps' success is noteworthy, its continuing goal is to support the transformation of health care, especially to change from volume- to value-based. The Corps can support the transformation through its focus on population-based health; and its inter-professional education and training, team-based care, and integration of public health, primary care, mental health, and physical care. To support the goal, the Corps will partner with other BHW divisions, including medicine, nursing, and dentistry to further develop a model for training providers in population-based health. Partnerships will include Corps-approved sites, clinicians, and public health entities. The program has funding for FY 17, and Council members will be asked for advice.

FY 2017 President's Budget Highlights. The budget seeks to greatly expand NHSC, including for behavioral health clinicians who currently are 30% of the Corps' field strength. Later this year, a BHW report will highlight behavioral health shortages and the need for NHSC to ensure high-need areas have those services. Overall, the funding increase will enable awards in Health Professional Shortage Areas (HPSA) with scores of seven or eight, down from the current cutoff of 16.

NHSC and CHCs. NHSC and community health centers (CHC) continue to be a strong partner. The nearly 16% of the CHC clinical workforce represented by Corps providers is distributed as follows: 10.9% primary care; 3.0% dental; and 1.7% mental health. However, even with this strong partnership, NHSC is looking to expand its presence into other organizations, such as world health clinics and sites.

NHSC Job Centers & CHCs February 2015. The NHSC Jobs Center replaced the outdated job opportunities list. The change has been effective. Many CHCs use the new portal, though the goal is to get many more to use it.

January 2017 – Building the Foundation: Career Portal. Sites and participants are strongly interested in the bidirectional search function. Currently, the Jobs Center is more static, where sites wait for candidates to find them, and with 16,000 sites it is difficult to connect. The goal for the portal is to facilitate connections between skilled professionals and recruiters for communities in need. The portal also will have an improved search function, and be mobile device friendly. This is the first phase of the portal rollout, and eventually it will be used by all BHW stakeholders, including students, to make connections across multiple components.

Auto HPSA Process Improvements; Project Timeline – Upcoming Key Milestones. This is a multi-year project. It will lead to transition from the Auto HPSA scoring process into the Shortage Designation Management System starting in July 2017, and will eliminate the current paper-based process. The new system will not change current designation criteria or methodology, and Primary Care Offices (PCOs) will continue to submit scoring requests while PCAs continue to ask the Corps for rescoring of Auto HPSA scores. Some scores are more than 10 years old. No mechanism exists to update scores, and if a site's score drops it can keep its older, higher score. While the impact analysis target release is January 2017, it will be released sooner if available.

FY 2017 New Programs in BHW. The Students to Service Loan Repayment Program (S2S LRP) successfully launched with the addition of dentists. More than 80 applicants have successfully submitted a completed application, and will include 75 loan repayment awards that would provide $120,000 for three-year obligations to fourth-year medical and dental students. With three weeks left in the cycle more applicants are anticipated. The Primary Care Medicine and Dentistry Career Development awards will go out in FY '17, and will support junior primary care

faculty activities. The Advanced Nursing Education Workforce program also will be released in FY '17. Also, in FY '17 the Division of Health Careers and Financial Support will roll out its redesigned Area Health Education Centers (AHEC) program. The final announcement should go out later this fall. The Corps has worked with stakeholders for more than a year to ensure the program focuses on several core elements in proved metrics. The program likely will help in both value-based purchasing and in social determents of health, population health, and training and education for the future workforce needed in rural and underserved areas.

Future Workforce Development. The Corps wants to be strong partners, including for inter-professional education and training, population health, and team-based care, to help transform healthcare delivery.

The specific data in Dr. Padilla's slides are available in copies sent to Council members, and is not repeated here.

Discussion

Dr. Nunez asked for examples of community-based partnerships. **Dr. Padilla** noted an example is in the Primary Care Training and Enhancement program that requires partnerships with community-based organizations like community health centers, to consider innovative ways to integrate behavioral health geriatrics into community-based curricula. The National Association of Community Health Centers (NACHC) has discussed how CHCs can work with HRSA and BHW on community-based assets and partnerships for health profession training. **Dr. Nunez** asked whether Area Health Education Centers (AHECs) could help. **Dr. Padilla** said AHECs are a great potential partner based on their roles and positions, and that will be reflected in funding announcements in conjunction with the Bureau of Primary Health Care (BPHC). **Dr. Nunez** noted an example of a person who began as a community volunteer and worked up to being a nurse practitioner. **Dr. Padilla** said those kinds of examples show how NHSC's limited funding can be leveraged to increase the future provider pipeline.

Dr. Nunez asked whether the new portal will only be for Corps members looking for placement sites, or will also be for non-NHSC members such as people looking for VISA placements or those that are just interested in urban underserved communities not necessarily affiliated with the Corps. **Dr. Padilla** replied that the focus will be on the 16,000 sites and the disciplines supported by NHSC and by the Nurse Corps program. Support for the nurse program is new, and will be the first area of expansion by the portal. Overall, the portal will support MDs, PAs, NPs, and RNs. However, the portal also will be available to help people not in the Corps find sites, and the Corps should ensure residency and training programs are aware

of that. **Dr. Nunez** agreed that awareness of the portal's availability should be expanded.

Dr. Izard added his division is going to both emphasize the portal's role for Corps providers while also encouraging others to use it, per its updated role after the merger of the Bureau of Clinician Recruitment and Service, and the Bureau of Health Professionals. The portal eventually will serve all of BHW's 49 training programs.

Dr. Nunez asked whether the NACNHSC also could be a partner for updated CHC information, even though it has its own job site. **Dr. Padilla** replied the emphasis will be on NHSC sites, but that includes overlap with CHCs, and the priority will be updated contact information. Another goal will be to consolidate sites' efforts to keep job postings and contact information available and up to date across multiple platforms and formats.

Dr. Izard said the new portal is exciting. **Ms. Adamson** praised the spirit of partnership and expanding information support to providers and entities beyond the Corps, based on knowing how candidates search for jobs. **Dr. Padilla** noted the goal is to leverage partnerships.

Dr. Padilla noted recent discussions with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) about future research for and beyond NHSC. He asked the Council for ideas about research topics, and offered an example of looking at the difference in Scholarship Program (SP) versus Loan Repayment Program (LRP) retention.

Dr. Izard concluded this portion of the meeting by noting Dr. Padilla will be glad to entertain questions in the future (**Dr. Padilla** strongly agreed) and Dr. Padilla's slides are available for downloading. Also, Ms. Huffman noted the slides will be posted on the Council's website, or will be sent to members upon request. **ACTION ITEM.**

IV. Finalize NACNHSC Letter to HRSA Administrator

Diane Fabiyi-King noted a draft letter was sent to Council members for review and comment, and returned comments will be visible during this meeting. She invited meeting participants to comment on the initial suggestions, or offer more, and staff will collect commentary and questions, and revise the document in real time. She noted the letter initially will be sent to Dr. Padilla, who will send it to HRSA Administrator Jim Macrae.

Ms. Fabiyi-King read aloud the letter's opening paragraph.

The National Advisory Council and the National Health Service Corps, NAC, NHSC, has concluded in discussion for fiscal year 2016, regarding

health professional shortage areas and scoring retention rates, the NSC satisfaction survey, and the award process. The purpose of this letter is to provide and describe priorities and recommendations for the National Service Corps.

No comments or suggested changes emerged.

Ms. Fabiyi-King continued with the section on NHSC priorities.

Number one: create value for providers for the NHSC approved sites. The NHSC participants who have chosen to work in high need communities represent a unique work of health professionals who confer to strengthen and fortify resources needed by the underserved communities across the country. Analysis of NHSC data shows that…

Dr. Salvador suggested to add "our health professionals are retained in the health professional shortage area after their service is complete." Discussion continued with mention of adding data about retention and its drivers from the Lewin Group, BHW staff, and the provider satisfaction survey. An additional suggestion was to add language noting Corps providers are unique and diverse, and contribute to the health of patients, communities, and populations, and boost regional economies.

Other areas of discussion were the timeframe to be included for retention results and positive local impacts; and how much historical context to include about the Corps adding value to communities, sites, and providers and the consequences of the missed opportunities since the letter will be publically accessible, but such language might distract from the letter's main purpose and instead could be a footnote.

Ms. Fabiyi-King continued with the next paragraph.

In order to promote retention of these providers, the NHSC should ensure that all sites, communities have knowledge of and access to the most current, on boarding and retention practices; as well as access to academic institutions. The NACNHSC uses the term retention to mean that participants continued in any underserved area after their service obligation is complete.

A long discussion ensued about whether it is necessary to be more specific about how communities, underserved areas, and HPSAs (including their scores), and sites are counted for retention. To help the Council understand the issue and clarify uncertainties, **Ms. Dillon**, Division Director of the Division of Regional Operations, summarized HPSA scoring, after which the Council agreed the letter would refer to retention in a 'designated HPSA.'

Ms. Fabiyi-King continued with the next paragraph.

The NHSC can effectively influence the recruitment and retention of these value-added providers by creating expectations for NHSC-approved sites to review selected on-boarding and retention materials on an annual basis, such as the manual created by the Rural Recruitment and Retention Network "3RNet.org". Leveraging the existing success and influence of the NHSC would help create environments at approved sites that foster the development of clinical leadership skills and provide experiences in integrated care settings that provide team-based care and take a population-health approach. The NACNHSA recommends implementing the following activities: conduct a literature review of existing successful on-boarding and retention strategies that are readily available; create a central repository of this information that is accessible to NHSC-approved sites, and program participants; require documentation of an annual review of this information.

Discussion centered on possibly adding language about how to support communities and health centers to use information made available by the Corps, and how to help site leaders integrate and share solutions and best practices for on-boarding and retention. Additional discussion was about whether to conduct training for sites on how to engage the priority activities, including with partners such as 3RNet or NACHC.

Ms. Fabiyi-King continued with the following priority area.

Establish a balance between field strength and provider retention in underserved communities throughout the service areas of the NHSC. The NACNHSA encourages more collaboration on the determination of the field strength number goal, and NHSC should more fully integrate the characteristics of those providers most likely to remain in the HPSA into the application process for all programs. These characteristics can be deduced from the NHSC satisfaction survey and a rapid-response request conducted by the HRSA-funded Carolina Health Work Force Center, CHWRC.

Discussion started with concern about unclear intent (or language), and continued with a suggestion to list one or two characteristics referenced from the satisfaction survey and the Health Work Force Center that especially influence retention (to be specified after this meeting). An additional lengthy discussion ensued about the ongoing challenge of defining, measuring, evaluating, and balancing the twin resource allocation priorities of maximizing field strength and boosting retention. To help the Council understand the resource balance, **CAPT Willis-Marsh** summarized how NHSC is funded and how it determines resources available for continuation contracts and LRP and SP awards. Further discussion focused on the 82% retention rate, including specifically citing it as the goal in the letter; comparing retention rates with the Indian Health Service and/or the U.S. Military;

historical trends overall and in light of best practices; setting goals for professions, field strength, and retention; and decision making and legislative requirements.

Ms. Fabiyi-King continued with the following three paragraphs.

The intent of the initial rapid response request was to help NHSC identify the characteristics of healthcare providers who receive financial incentives, e.g. scholarship support or loan repayment in return for service. The practice and health professional assurance area fits this that increase the likelihood of their remaining in these underserved areas after they complete their service obligations. CHWRC staff was asked to conduct a literature search and prepare a document that compares individual-level provider characteristics and external factors that are associated with provider retention. The following is a summary of the major findings of the CHWRC rapid response report that are related to retention and field strength.

"The studies vary on their definition of retention, but for the most part: finding support, relatively strong retention rate, federal and state financial incentive programs in exchange for serving in underserved areas are important levers to incent providers to work in communities with high needs."

NHSC program participants remained in practice in underserved areas 10 years after they had completed their service contracts. Data suggests that NHSC participants are more likely to practice in underserved areas over the long term compared to non-participants, but it is not clear whether this is due to NHSC participation or to career preferences that prompted their initial interest in the NHSC. The two-year retention was more likely if the clinician was working in a state where she, he, was raised or trained, but otherwise no individual characteristics were associated with retention nor with provider discipline. Retention of providers following service contract completion is related to external factors.

Discussion centered on what is meant by external factors related to retention, and how much NHSC and sites can influence them. While the satisfaction survey was recently changed, external factors likely include a provider's ethnic or racial alignment, or personal history, with the community, along with current family considerations (including school districts and commute times). Discussion also noted multiple site-related factors affect retention, especially compensation, schedules, leadership, and advancement. The Council agreed it will be important to continue to inform sites about the factors most influential in retention, especially those the sites can control, overall and as follow up to a recent webinar on the subject. Also, the webinar can be copied and distributed to sites that did not participate in it.

A question emerged about whether the 10-year retention rate is known, since thus far the reliable data are about two years. Further investigation will be needed regarding 10-year retention. **ACTION ITEM.**

Ms. Fabiyi-King continued with the following three paragraphs.

Data indicates that participants in loan repayment programs are more likely to be retained in practices serving underserved populations that are participants -- than are participants in scholarship programs. Providers enter scholarship programs early in their professional education when they may have less clearly defined career goals and may not have narrowed their professional interests. Those who enter loan repayment programs tend to be older and may have a better sense of their intended career path, as well as the needs of their family. Studies of state scholarship and loan repayment programs demonstrate similar findings.

The data are clear that satisfaction with the professional environment plays a significant role in provider retention. Clinicians who have completed their service obligation are more likely to be retained in practice settings served -- serving underserved populations if they have good professional experiences. Specifically, the literature indicates that retention in those settings is higher if clinicians report that sites are well-run and problems are addressed quickly, and the site offers professional and development opportunities, offers opportunities for leadership, offers mentorship of new clinicians, and gives providers influence over work schedules and clinic policies.

Although not associated with marital status, retention is associated with providers reporting that their family's needs are being met. This last factor associated with retention is related to a good match between the provider's family and the community where the practice is based, such as career opportunities for a spouse or educational opportunities for his or her children.

Discussion centered on the concept of exit interviews, including for providers leaving the program or just transferring to another site. Thus far, exit interviews are at the discretion of sites, versus an NHSC-wide practice. The Council agreed that all sites would benefit from an aggregation of multi-site exit interview findings, but there was disagreement over how to handle that in this letter, and agreement that its inclusion should be determined later. **ACTION ITEM.**

Ms. Fabiyi-King continued with the following paragraph.

Other external factors for predictive retention include working in a busy practice, having a three-year term of service rather than two-year term of service, being able to provide a full scope of services, and participation in a loan repayment program rather than a scholarship program.

No discussion ensued.

Ms. Fabiyi-King continued with the following three paragraphs.

To promote provider retention, the literature suggests that interventions may be appropriate in two areas: A, improving the work environment for program participants and, B, ensuring good fits between providers and service sites with attention to the needs of the provider's families. After review of a summary report of CHWRC Response, the NACNHSC concluded that the NHSC program implications are vast, because the programs intend not only to draw health care providers to underserved areas, but also to retain them.

Specific actions should be taken to ensure clinician satisfaction with their assignments and community. Specific changes to the programs may include: developing a questionnaire for applicants to help identify to what degree the applicant exemplifies the characteristics of providers who remain working in HPSAs, instituting a more rigorous application process, utilizing in person and telephone interviews to screen for people likely to remain in the HPSAs, include retention related questions, and creating a standardized orientation for NHSC sites, before receiving a scholar or LRP recipient.

Site monitoring and tracking to ensure NHSC participant satisfaction with the work environment, a more robust psych profile that will help NHSC determine opportunities for technical assistance, offering suggestions to sites that support retention including flexible schedules and hours, part-time opportunities, and mentoring programs, Match.com-like tool to assist participants in choosing the right fit for job and community. This effort is already underway via the job portal expansion, promoting practice models that train future site leaders, and finally resuming site, school, and participant visits. There are several comments in the side from several members of the council.

Discussion was about possibly adding language about the value of using qualitative research methods, and exit interview questions, to guide interview screening questions in general, and to lay the foundation for satisfaction-driven retention.

Thus far, the survey is the primary means to assess provider satisfaction, though sites often have anecdotal data about it, especially for providers who leave. Further discussion was about how NHSC can help sites incorporate a provider's family needs when hiring, to increase provider satisfaction with the match. Current support includes technical assistance provided to sites, school visits, and provider site visits prior to matching.

Ms. Fabiyi-King continued with the third priority (Mentorship and Training throughout Service Commitment Expectations) and the following paragraphs.

NACNHSC supports mentorship and training opportunities at NHSC approved sites with an expectation that NHSC member participate in educating health professional students. The National Service Corps Mentor Program is an invaluable resource that pairs self-selected NHSC clinicians and ambassadors with NHSC scholars and lonely pairs.

The overall goal is to allow providers to share their experiences, best practices and other lessons learned with young students who are transitioning from training to service. Mentors are available to discuss a variety of issues including but not limited to: new trends in primary care, challenges faced during in-school training, service site selection, and professional development. Ultimately, the NHSC mentor program is the means for which students can get the additional support they will need to enhance their ability to successfully practice in communities of greatest need. NACNHSC supports the use of the mentor program throughout the clinician's service commitment and beyond.

Discussion was about the need to add updated information about how the referenced components currently are working, especially the number of new scholars per year who request a mentor and are matched with one. Also, data should be made available from the new question in the satisfaction survey that asks about the effect of the voluntary mentoring on program participation. Further discussion ensued about mentorship program history and detail.

Ms. Fabiyi-King continued with the letter's final paragraph.

The mentor program could also be extended to site POCs, who may find it useful to collaborate on issues such as recruitment and retention. Persons should work to partner NHSC sites with academic institutions to educated future providers about how professional shortage areas and access to care in underserved communities.

No discussion ensued.

Public Comment

The only public comment was about the especially difficult challenge of provider retention in rural communities, and agreement with NHSC making that a priority (including in its budget).

Discussion Topics for the November 9, 2016 Meeting

Dr. Izard thanked BHW staff for their work with Council members in developing the HRSA Administrator letter, and he also thanked Council members for taking time to bring their expertise and diverse perspectives to these calls. He reiterated the importance of his continuing receipt of programmatic data, and noted the outstanding request to see data about the HPSA scores of where NHSC clinicians are located. **ACTION ITEM.**

The Council noted future meeting topics can include information that helps them understand the program, issues that arise in sites and communities, and feedback from program participants. Six specific ideas for future meetings are listed below

1. The proper channel to communicate positive or negative feedback (ideas, suggestions, concerns) Council members receive from a wide variety of entities beyond NHSC participants, especially those that the individual member cannot or is not comfortable addressing alone.
2. How to help sites make better use of the Jobs Center 2.0 online platform to simplify providers' efforts to find sites.
3. Progress updates, the status of Council recommendations, and ongoing goals for specific programs as follows:
    - Telehealth Program update and the number of cap hours allowable by a provider at a CHC. Jeffrey Jordan, DRO Deputy Director, along with a BPHC representative possibly can do a presentation for the Council.
    - Medication Assistant Training (MAT) Program certification expansion to include nurse practitioners and physician assistants.
4. Dentist eligibility and the application process in the S2S LRP Program.
5. The research capacity of the Assistant Secretary for Planning and Evaluation (ASPE), and its contractor the Lewin Group.
6. NHSC and HPSA scores updates.

Dr. Izard noted Council members are free to suggest future topics at any point, via the Council email group, and **Ms. Fabiyi-King** added BHW staff also should receive those communications.

Concluding Remarks

CAPT Willis-Marsh thanked everyone for their hard work during the call and previously for creating the Council's recommendations. The Council should be

proud of the results, and BHW is excited about them. While this is a fairly new process, BHW will look forward to continued thought provoking recommendations to improve NHSC, and to future similar calls even though they can be a difficult process. BHW staff will use notes from this call to finalize the recommendations and forward them for Dr. Izard's signature and submittal to Mr. Macrae. **ACTION ITEM.**

CAPT Willis-Marsh added BHW staff will distribute topics for the next meeting, and will respond to a recent email asking about the ASPE research capacity. **ACTION ITEMS.** The operator reiterated the invitation for additional meeting topics, and the next meeting is scheduled for November 9. **Dr. Izard** said this was a good discussion and expressed his appreciation for participants' input. The Council should be given an opportunity and schedule for reviewing the meeting's proceedings, and encouraged members to look for the email requesting their review before the information is finalized.

Dr. Izard thanked NACNHSC members and the staff for their hard work, and adjourned the meeting.