

Minutes
National Advisory Council on the National Health Service Corps
Meeting January 14-15, 2020

The National Advisory Council on the National Health Service Corps (NACNHSC) met on January 14-15, 2020 in-person at Healthcare Resource and Services Administration (HRSA) offices. NACNHSC is a group of healthcare providers and administrators who are experts in the issues faced by communities with a shortage of primary care professionals. The Council serves as a key source of information to the NHSC senior management, to the Secretary of the U.S. Department of Health and Human Services (HHS) and, by designation, the Administrator of the Health Resources and Services Administration. The National Advisory Council on the National Health Service Corps was established under 42 USC 254j (Section 337 of the Public Health Service Act), as amended by Section 10501 of the Affordable Care Act. The Council is governed by provisions of Public Law 92-463 (5 USC App.2) which sets forth standards for the formation and use of advisory committees. NACNHSC responsibilities are specified under Subpart II, Part D of Title III of the Public Health Service Act.

Welcome

Ms. Fabiyi-King welcomed the Council and other meeting participants, introducing herself as the Designated Federal Official for National Health Service Corps Advisory Council. She provided safety and logistical information, and instructions for meeting participation. She conducted a formal roll call and asked Council members to introduce themselves by stating their names and professional affiliations. All Council members were present, Dr. Piernot by telephone, all others in-person. After Council members introduced themselves, Ms. Fabiyi-King introduced HRSA Administrator, Tom Engels. Ms. Fabiyi-King said that Mr. Engels is leading HRSA in advancing US Department of Health and Human Services priorities such as responding to the opioid epidemic by integrating behavioral health services into primary care, transforming the behavioral health workforce, increasing rural communities' access to healthcare services, promoting maternal health, advancing kidney care, and ending the HIV epidemic.

Mr. Engels thanked the Council for their work. He praised Dr. Luis Padilla and his staff at HRSA. Mr. Engels stated that HRSA's mission is to improve health outcomes and address health disparities by increasing access to high-quality health services, supporting development of a skilled health workforce, and supporting innovation of high-value programs. HRSA is the Federal agency primarily responsible for improving health care for people who are geographically isolated, or economically or medically vulnerable. HRSA offers more than 90 programs, funding more than 3,000 grantees to help tens of millions of Americans receive affordable health care. More than 28 million people annually receive care through HRSA-funded health centers. Last year HRSA funding supported nearly 15,000 NHSC and Nurse Corps clinicians working in the Nation's most underserved communities. HRSA's Ryan White HIV/AIDS Program (RWHAP) serves a majority of Americans with HIV. The rate of viral suppression among RWHAP clients is 87 percent. HRSA's Maternal, Infant, and Early Childhood Home Visiting Program provided nearly 1 million home visits to about 150,000 volunteer parents and children in FY 2018. The agency continually works to expand its reach.

Mr. Engels said that, as former Deputy Secretary of the Wisconsin Department of Health, he is familiar with the challenges the Council must address. He assured members that their work is appreciated and that their recommendations influence NHSC program development and decisions made by the HHS Secretary and Congress.

Mr. Engels cited HRSA data that project a shortage of 23,600 physicians and 15,600 dentists by the year 2025. He said Dr. Padilla, Administrator of the Bureau of Health Workforce would discuss this issue, how HRSA hopes to address it, and the type of NACNHSC input that would be useful in this effort. He expressed confidence that HRSA has the tools, data, and leadership to address the healthcare shortage.

Dr. Billings thanked Mr. Engels and introduced Dr. Padilla.

Bureau of Health Workforce Updates and Opening Remarks

Luis Padilla, MD

Associate Administrator, Bureau of Health Workforce

Dr. Padilla welcomed Council members. He thanked HRSA staff for their work supporting Advisory Councils.

Dr. Padilla noted that NHSC was established in 1972. Its current field strength is the largest in program history. The program has bipartisan support from Congress, and this year received an increase in discretionary funding. The mandatory funding level has remained at about \$310 million annually for at least 7 years. On May 22, NHSC, HRSA's Health Center program, and the Teaching Health Center Graduate Medical Education (THCGME) program will no longer be funded. Dr. Padilla asked for NACNHSC advice on addressing this issue.

Dr. Padilla said that, although there is a healthcare provider shortage, the number of healthcare jobs increased 14 percent between 2018 and 2028. The workforce is maldistributed, with shortages in rural and underserved areas, especially in the South, Midwest, and some areas of the West Coast. Shortages are mostly in primary care. Dr. Padilla said that the most recent projected shortage estimates, released in 2016 and projecting through 2015, were based on 2013 data. In 2020, the Bureau will analyze 2019 data to project healthcare availability through 2030. This analysis will include stratification by urban, suburban, and rural residence status. For the first time, the Bureau also will analyze Medicare claims data to assess provision of mental and behavioral health services by primary care providers.

Issues affecting the provider shortage include aging populations of patients and providers, lack of interest in utilizing primary care, lack of primary care residency positions, and medical students' preferring to specialize rather than pursue careers in preventive health and primary care. The Bureau's mission is "to improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need." BHW works toward accomplishing this mission through offering more than 40 programs that support education, training, and service. The Bureau prioritizes the needs of rural and

underserved communities. BHW aims to increase the number of students who serve these communities with programs that aim to increase access, promote supply equilibrium and address shortages of healthcare professionals, improve workforce distribution, and develop a high-quality health workforce that is trained in and delivers evidence-based practices to improve patient care.

Strategies for accomplishing these goals include community-based training, training students in rural and underserved communities, leveraging loan and scholarship programs, recruiting students from communities served by programs, training interprofessional and collaborative teams, and integrating oral and behavioral health services into primary care. Research has demonstrated that clinicians and students trained in community-based settings are more likely to practice in those settings. Students have typically trained in academic tertiary hospitals located in urban settings, which increases the likelihood that students will pursue careers in these settings. BHW programs aim to change this through programs that expose students to service in communities most in need. Dr. Padilla said that BHW is interested in Council input on training models that will help to address provider shortages. BHW also solicits input from other advisory councils and committees, its nine Health Workforce Research Centers, and State Primary Care Offices.

NHSC programs include supporting fourth year medical students and fourth year dentistry students, a loan repayment program, a scholarship program, the Rural Communities Opioid Response Program (RCORP), and Nurse Corps. Nurse Corps supports nurse practitioners and registered nurses. Current priorities include mental and behavioral health, as well as maternal health.

HRSA employs several strategies to address the opioid epidemic. These include increasing the number of providers who offer medication-assisted treatment (MAT), integrating behavioral and mental health services into primary care, and increasing opportunities for students and clinicians to receive education and training about behavioral health and substance use disorder. HRSA aims to expand telehealth services in order to increase capacity for healthcare service delivery.

HRSA's Center for Health Workforce Analysis has designated more than 6,000 mental health HPSAs across the US. A report released in 2018, based on 2016 data, estimated shortages of psychologists, social workers, school counselors, and marriage and family therapists. Some professional associations have expressed concern that the report does not estimate a shortage of child psychiatrists. The Center is producing a supplemental update to address these concerns.

HRSA's Behavioral Health Workforce Education and Training (BHWET) provides training opportunities to address identified provider shortages. The program's base annual budget has been approximately \$50 million for the past 5 years. The current total annual budget is nearly \$139 million, with an emphasis on addressing needs for behavioral and mental health services. BHWET is projected to decrease shortages in targeted disciplines by 40 percent by the year 2025. BHWET also has trained 3,293 paraprofessionals, including community health workers, peer educators, and substance use/addiction workers.

BHW supports pre-professional, and residency and post-graduate training. The Bureau promotes long-term training in rural and underserved communities. THCGME was initiated in 2010. Since that time, 800 primary health care providers and dentists have graduated from the program. The program recently released a funding opportunity that will support 800 full-time residence positions through five new grantees, all of which are federally qualified health centers (FQHCs).

BHW's Children's Hospital GME program's current annual budget is approximately \$325 million, and is supported strongly by Congress. The program supports 59 free-standing hospitals and trains more than half of the country's pediatric subspecialists and nearly half of general pediatricians.

The Bureau initiated the Rural Residency Planning and Development Program in partnership with the Federal Office of Rural Health Policy. The program develops rural training tracks and residency programs. Congress increased the program budget by \$10 million this year. Funding may be used to support grant applicants that were declined last year or to augment support for psychiatry residency programs.

HRSA's budget includes \$275 million for Nursing Workforce Development. In FY 2019, the budget included \$20 million for 36 new residency programs to prepare nurse practitioners to serve rural and underserved communities. Congress appropriated an additional \$5 million for this program in FY 2020. Just more than \$42 million is appropriated for pre-doctoral, doctoral, post-doctoral, and State oral health care workforce activities programs.

Currently open funding opportunities include funding through the Primary Care Training and Enhancement-Residency Training in Primary Care (PCTE-RTPC) program, the Nurse Faculty Loan Program (NFLP), support for postdoctoral training in general, pediatric, and public health dentistry, Nurse Education Practice, Quality, and Retention (NEPQR) Interprofessional Collaborative Practice Program (IPCP) Behavioral Health Integration (BHI), and Addiction Medicine Fellowship (AMF). As many as 20 PCTE-RTPC grant awards for a total of \$10 million will support enhanced accredited residency training programs in family medicine, general internal medicine, general pediatrics, and combined internal medicine and pediatrics in rural and/or underserved areas. The application period will end in January 2020. NFLP aims to increase the number of nursing faculty in the US. A total of \$28.5 million is budgeted to support up to 90 eligible accredited nursing schools who recruit and train faculty. The application period will end February 3, 2020. HRSA has budgeted \$13 million for as many as 28 grantees to receive as much as \$450,000 annually for accredited residency training, or as much as \$650,000 annually for collaborative, multidisciplinary training in general dentistry, pediatric dentistry, or dental public health. This funding is to support grantees in improving access to and delivery of oral health services, especially in rural or underserved communities.

NEPQR IPCP BHI is offering \$8.5 million to support about 17 cooperative agreements for up to \$500,000 annually to increase access to and quality of behavioral health services through team-based models of interprofessional nurse-led primary care teams serving rural or underserved areas. The application period will end February 19, 2020. The Nursing Program submits Uniform Data System (UDS) data, which allows evaluation of participants' impact. Preliminary findings indicate the program model of training and delivery is effective.

Congress has appropriated up to \$26.7 million to support the AMF program, which includes a track for psychiatry residents and a track for primary care providers who completed residencies in pediatrics, internal medicine, or family medicine. The program is intended to support up to 500 addiction medicine fellows over a 5-year period. Grantees must provide training in community-based settings, including FQHCs and other safety net organizations. The program is linked to HRSA's Primary Care Training and Enhancement program. BHW intends to link AMF to NHSC in FY 2021 and FY 2022.

NHSC's budget for FY 2020 is \$430 million, \$120 million of which is discretionary funding to support substance use, mental and behavioral health services, and \$15 million of which is to support Indian Health Services (IHS) facilities across the country. Congress also awarded \$15 million for IHS programs in FY 2019, which, for the first time, allowed funding for all eligible applicants. HRSA hopes to fund all applicants again in FY 2020 and will explore strategies for recruiting clinicians to serve tribal communities.

THCGME's budget for FY 2020 is \$126.5 million. The program focuses on community-based, outpatient setting training for primary care residents and dentists. Behavioral Health Workforce Development programs have a budget of \$139 million in FY 2020. Nurse Corps is funded for \$88.6 million. And, the National Center for Health Workforce Analysis has a budget of \$5.7 million. HRSA was also able to budget funds for its Career Pathways programs: \$2 million for the Area Health Education Center Program, \$800,000 for the Health Careers Opportunity Program, and \$2.5 million for the Scholarships for Disadvantaged Students Program. Dr. Padilla said these programs contribute to a pipeline of diverse new clinicians.

The National Center for Workforce Analysis conducts research to inform program planning and development and policy making. The Center's most recently developed tool is a national survey sample of 3.7 million registered nurses, including nurse practitioners, the largest of its kind. Data will be collected every 3 to 4 years. The Center also maintains the National Practitioner Data Bank, a repository of information about medical malpractice and adverse actions. Its purpose is to protect the public, reduce healthcare fraud, and encourage quality healthcare. This data resource is supported through fees rather than an appropriation. Queries for this databank

have increased steadily. Data management is a key component for developing strategies to address health workforce needs. Grant program performance data are available; a clinician tracker tracks NHSC alumni. The clinician tracker includes data from more than 15,000 NHSC providers. Current data indicate that more than 80 percent of alumni continue to serve HPSAs 2 years after their service obligation has been met. HRSA intends to expand tracker data to include alumni from other programs. HRSA works to make data available to external stakeholders so that they can advocate for programs and learn about program outcomes. HRSA intends to develop grantee report cards that summarize programs' performance, allowing comparison between grantees.

HRSA's Division of Business Operations has developed the Health Workforce Connector to connect primary care providers interested in serving high-need communities with NHSC and Nurse Corps healthcare facilities. More than 24,000 sites participate. There are currently more than 6,000 job vacancies posted on the portal. The portal hosts virtual job fairs, for which clinicians develop profiles for recruiter review.

Dr. Padilla invited questions. Dr. Billings thanked Dr. Padilla for his presentation, and thanked HRSA staff and the Council for their work. Dr. Padilla observed that the NHSC has been so successful that it is sometimes viewed as a panacea for health workforce issues. While, it is an important program, it is only one component of addressing those shortages. Last year the loan repayment program received more than 9,000 applications and was able to fund just more than 4,000, declining several from HPSAs.

Dr. Piernot asked how BHW intends to spend its discretionary funding. Dr. Padilla said BHW will spend \$6.7 on the AMF program. Funds also may be expended to support behavioral health paraprofessionals serving rural and underserved areas. AHEC representatives have indicated that they are challenged to meet requirements implemented in 2017. Funding has been allocated to support grantees in making these changes. Discretionary funds for HCOP will support existing grantees' current activities. Discretionary funds for Scholarships for Disadvantaged Students will support activities described in the current funding notice, which reflects changes requested by Congress. NHSC did not receive an increase in mandatory funding, although it will be able to

use unused funds from FY 2019. Dr. Padilla invited Council input on the best use of the \$15 million in discretionary funding for IHS.

Dr. Sein asked Dr. Padilla to comment on the future of Teaching Health Center funding. Dr. Padilla said the program exemplifies HRSA's model for education and training. The Nursing Practitioner Residency Program and AMF programs are modeled after THCGME. Unstable funding for THCGME has been a problem. During Dr. Padilla's tenure at HRSA, four THCGME grantees have closed due to lack of funding. This has resulted in some participants being hesitant to recruit residents. It would be helpful to offer funding for more than 2 years, since it takes more than 2 years to train a resident. The program currently has a \$126.5 million budget and has been expanded to support new grantees. The May 22, 2020 fiscal cliff threatens program stability and recruitment efforts for Academic Year 2021.

Dr. Schmitz noted that community characteristics affect clinician recruitment, retention, and attrition. He asked if HRSA is collecting and analyzing these data. Dr. Padilla said HRSA is not yet collecting these data. The clinician tracker eventually will incorporate community-level data as well as data about patients served, and support research on community factors that affect recruitment and retention.

Dr. Bockwoldt said that electronic medical record (EMR) data collection requirements are burdensome and possibly a factor in people leaving the medical profession. She asked if the Bureau has considered analyzing ways to ease data collection burden. She also noted that the complexity of patient needs has increased. Patients are going to retail clinics for less complex complaints, such as conjunctivitis, and relying on primary care providers for chronic disease management. She asked if the Bureau is considering this issue. Dr. Padilla said that the Bureau recognizes the importance of clinician resilience and burnout, and of motivating people to pursue healthcare careers. Some BHW staff have worked with the National Academy of Sciences on a primer about addressing clinician burnout. Dr. Padilla and James Macrae, HRSA's Acting Administrator, will be presenting to the National Academy of Sciences about primary care and intend to address clinician burnout issues, such as data fatigue. Dr. Padilla acknowledged that many reporting requirements are redundant. BHW wants to identify opportunities to streamline

data reporting. He noted that HRSA's work is not in direct healthcare delivery or reimbursement, which is the purview of the Centers for Medicare and Medicaid (CMS). CMS is the agency responsible for providing incentives for meaningful use of EMRs. CMS is aware of the potential burden of data collection. The HHS Secretary prioritizes value-based systems of care, which includes avoiding data collection requirements that are not associated with increased care quality or cost reductions. Dr. Billings said that EMRs are valuable for data collection, but decrease clinician efficiency in making diagnoses and offering treatment, and possibly making patients feel neglected.

Dr. Billings referred to reports that the NHSC budget should be tripled to meet program needs, and expressed concern about the upcoming fiscal cliff. He asked how the Council could impact the budget and advocate for the importance of NHSC in addressing the projected primary care physician shortage. Dr. Padilla said that BHW is working with the Office of Planning and Evaluation to support States in improving their data collection. States' data can inform State legislatures about the need for workforce development and State level funding to support it. This approach has been successful in Indiana, Ohio, Massachusetts, California, and Connecticut. He said quality of State workforce data varies, and encouraged Council members to advocate for good quality health workforce data collection in their States. States should collect data on communities' needs for providers, where providers are working, and when they are moving or transitioning out of the workforce. Dr. Padilla said data are also useful for demonstrating program impact. HRSA is thankful for bipartisan support for NHSC. But it is challenging to obtain funding to expand the program.

Dr. Etminan pointed out that, while BHW wants to increase the number of applicants to the Scholarship and Loan Repayment Programs, it also is funding only 40 percent of applicants. She said that her community's HPSA score is 22. None of the applicants working at her site were funded for FY 2020. She asked why HRSA is working to increase recruits if it does not have adequate funding to support them. Dr. Padilla said there is a need to increase the budget to support students and providers who want to serve high-need communities. Dr. Etminan said it is difficult to retain students when they expect loan repayment or scholarship support but do not receive it. She said that HRSA support for non-revenue-generating positions in data collection

and management could increase provider retention and satisfaction. She said that it is difficult for Health Centers to fund these positions, since they do not generate revenue. Dr. Padilla said he would like to discuss why providers in an area with a HPSA score of 22 did not get funded after the meeting. He also said that HRSA is considering support for data collection and management positions- “scribes.” The Health Workforce Research Center is studying the impact of Health Center scribes on recruitment, retention, and productivity. Results may demonstrate that the benefits are greater than costs.

Ms. Stergar suggested pilot programs to fund services in small areas as a strategy to address budgetary restrictions.

NHSC Overview

Israil Ali, MPA

Director, Division of National Health Service Corps

Dr. Billings welcomed and introduced Mr. Ali. Mr. Ali thanked the Council for their work. He said that BHW's mission is to improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. BHW administers NHSC and other programs. The Bureau works to ensure programs respond to changing needs and paradigms of healthcare delivery. NHSC support comprises 28 percent of BHW's budget and is the Bureau's primary mechanism for addressing healthcare provider maldistribution. NHSC works to build health communities by supporting qualified health care providers dedicated to delivering primary medical, dental, and behavioral health services to US communities with limited access to care. Support is through scholarships and loan repayment programs, which remove financial barriers to pursuing a medical education. Since inception nearly 50 years ago, NHSC has placed more than 50,000 clinicians in rural and underserved communities. The program currently supports more than 13,000 clinicians, who serve more than 13 million people. Most of these clinicians continue to serve high-need communities even after completing their service obligation. The program recently began supporting registered nurses and pharmacists through its Substance Use Disorder Loan Repayment Program.

The NHSC Loan Repayment Program provides as much as \$50,000 tax-free loan reimbursement in exchange for 2 years of primary medical, dental, or behavioral healthcare service. Participants can renew service contracts to continue to receive repayment until loans are completely repaid. The Substance Use Disorder Workforce Loan Repayment Program aims to support a comprehensive substance use disorder workforce. Awardees receive up to \$75,000 in exchange for a 3-year commitment to provide services at a substance disorder treatment facility. The program emphasized that the service requirement was to provide substance use disorder treatment.

The Rural Community Loan Repayment Program is implemented in partnership with the Federal Office of Rural Health Policy (ORHP). The program aims to recruit and retain providers in rural

communities serving at sites supported by ORHP. ORHP is working to build capacity. NHSC aims to support the necessary workforce.

Applicants to the Scholarship Program must demonstrate commitment to providing primary care to high-need communities. They must enroll full-time in an accredited school and pursue a degree in an eligible profession. Scholarships cover tuition, fees, other reasonable educational costs as well as a monthly stipend. Only the stipend is taxable. Scholars must serve in an underserved community for at least 2 years.

The Students to Service Program is for full-time students in their final year of medical or dental school. Participants receive as much as \$120,000 for loan repayment in exchange for a 3-year full-time or 6-year part-time service commitment.

The State Loan Repayment Program is part of HHS's response to substance use disorder treatment need. States must match funding. They can be creative in identifying funding sources other than the State budget, such as private institutions or municipalities.

Mr. Ali emphasized that all NHSC providers must serve at one of the 16,000 NHSC-approved sites, which are typically outpatient facilities in HPSAs that provide mental or behavioral health services, including substance use disorder treatment, regardless of patients' ability to pay. Facilities must offer a sliding fee scale and refer patients to inpatient care or specialty services as needed. HRSA's budget includes substance use disorder treatment services in its definition of primary care.

NHSC supports providers in the field through staff in 10 regional offices. These staff facilitate scholar placement and provide resources to help scholars transition from training to providing services.

Mr. Ali said current funding is not enough to support all eligible applicants to NHSC programs. NHSC has invested \$66 million in 1,000 awards to support clinicians providing evidence-based substance use disorder treatment through the NHSC SUD Workforce Program. NHSC

collaborated with new stakeholders, including the US Department of Agriculture (USDA) to initiate this program. USDA developed an opioid community assessment tool that supported collection of local data on substance use disorder mortality. Data generated with this resource were also valuable for conducting needs assessments for the Rural Community Loan Repayment Program, which invested \$14 million in 174 awards in FY 2019.

NHSC's \$15 million funds for tribal facilities are dedicated to supporting applicants serving in IHS, tribally operated, or urban Indian health programs (ITUs) or facilities funded by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638). This program is a collaboration between NHSC and the IHS Loan Repayment Program to optimize awards with NHSC's requirements for primary care service and IHS flexibility in awarding careers in specialized medicine. All eligible IHS applicants were awarded.

NHSC collaborated with SAMHSA to implement the Providers Clinical Support System, which connects clinicians with MAT training and a DATA 2000 waiver. NHSC providers who complete the training are eligible for a \$5,000 loan repayment enhancement. To date, NHSC has received more than 180 applications for award enhancement.

NHSC priorities for FY 2020 are to identify factors associated with providing ongoing service in HPSAs, to contribute to the workforce pipeline, and to optimize data collection and utilization in order to support the BHW with data-driven decision making.

BHW plans to assess commonalities among NHSC scholars who serve rural underserved communities in order to identify factors associated with doing so. Program applications provide data on applicants' training experiences, which can be used in these analyses. BHW is considering strategies for retaining people trained to be primary care leaders through programs such as Primary Care Training and Enhancement Fellowships in primary care practice in high-need communities. BHW is interested in identifying and supporting clinicians who can transform community health care. Serving underserved and vulnerable populations presents challenges. NHSC is exploring options for helping scholars to navigate these challenges.

One strategy for supporting the workforce pipeline is discipline expansion, especially for nurse practitioners who have completed their residency. Another strategy is evaluating scholars' readiness. NHSC also is working to increase scholar engagement. The Health Workforce Connector is an online resource that links clinicians with job vacancies at NHSC- and Nurse Corps-approved sites. Providers can search by NHSC and Nurse Corps eligibility, HPSA score, field of practice required, work schedule, and language requirements. NHSC job fairs can be tailored. They have been tailored for rural employment, behavioral health, or specific professional disciplines.

NHSC plans to focus data on outcomes evaluation and reporting rather than output description. Priorities for FY 2020 include measuring characteristics of applicants who did not receive a NHSC award. This will include assessing applicants' training experience, whether they serve a HPSA, type of employment, and employment setting. Predictive analysis of these data will inform HRSA strategies. Outcomes data will support NHSC is contributing to discourse about how its trainees affect community health.

Discussion

Dr. Billings asked which States have not been awarded State Loan Repayment Program (SLRP) funds, and how those States can be encouraged to apply for funding. Mr. Ali said that the 10 States that do not have a State Loan Repayment Award are Alabama, Arkansas, Connecticut, Delaware, Florida, Mississippi, New Hampshire, Oklahoma, South Carolina, South Dakota, and Tennessee. Dr. Billings said the Council should advocate for patients in those States.

Dr. Stergar asked if it would be helpful to provide partial, rather than full, scholarships. Mr. Ali said HRSA has considered this option and does not think it would increase impact. The agency is more focused on identifying scholars who will serve communities in need, preferably through data on their applications, such as information about their community engagement and career plans.

Dr. Taylor-Desir asked whether HRSA works with program alumni and other potential ambassadors to provide mentorship for scholars about what to expect when serving high-need

communities. Mr. Ali said HRSA is considering how to evaluate scholars' readiness. HRSA is considering asking alumni about the challenges they faced when they started service and using this to inform training and placement. Mr. Ali noted that NHSC may influence curriculum development but would not likely be directly responsible for it. He said that NHSC will issue contracts for support in evaluating applicants' readiness to serve.

Dr. Piernot asked how NHSC determines whether a facility is a substance abuse treatment center. Mr. Ali said the Division of Regional Operations requests documentation that a facility provides substance use disorder treatment. Sites must have forward-facing advertisement that they offer these services. They also must offer a sliding fee scale and offer services regardless of patients' ability to pay. Jeff Jordan, Director of the Division of Regional Operations, said sites also must document that they offer core comprehensive behavioral health service elements: screening and assessment, treatment planning, and care coordination. Sites also must have affiliation agreements with providers who offer behavioral health services not offered on-site.

Dr. Schmitz said he supports HRSA's plans to build a database to identify characteristics associated with continued service in HPSAs. He noted that urban and rural underserved communities differ with regard to availability of emergency, obstetrical, and other types of services. Education must train practitioners to meet these needs in the communities they serve, possibly through boot camp or collaboration with educators who specialize in the necessary skills. Dr. Schmitz also supported the idea of mentoring faculty to serve in high-need communities. Dr. Schmitz said that burnout is often the result of not feeling confident and that tailored training would increase skills and possibly confidence, resulting in less burnout. Dr. Schmitz referenced research on the association between scores on Duckworth's Grit scale, which assesses resilience and ambition, and physicians' pursuit of primary or specialty care, and choice of rural or urban practice. Those with high ambition scores were unlikely to choose rural practice. Those with high resilience scores were more likely to pursue rural practice. Dr. Schmitz suggested using previous research results to inform HRSA's efforts to identify potential scholars likely to remain in practice in rural and underserved areas, such as a recent article in *Family Medicine* about competency in rural medicine practice.

Dr. Callins also expressed support for utilizing data to develop profiles of scholars likely to continue service in high-need communities. She suggested that data should include where scholars trained, where they completed their residency, where they have practiced, and how long they have stayed in communities where they have practiced. This could help to develop models that predict retention.

Dr. Callins suggested that recruitment efforts should start earlier in scholars' careers. Some rural communities have no physician, so children growing up in these communities are unaware of the option of pursuing a career as a doctor. HRSA should consider how to reach out to these communities, possibly through partnership with local educational institutions. Recruitment should start before students enroll in medical school. Dr. Callins expressed concern about the lack of OB/GYNs in rural health facilities. She said that she is the only one on staff in the 16 clinic community health care system where she works in Central Georgia. She said this is especially concerning given national maternal mortality statistics. Dr. Callins suggested ensuring that at least one OB/GYN or one women's health nurse practitioner serves every region. Without that resource, women often present at emergency departments with symptoms of menopause or abnormal bleeding. She said recruitment efforts should include strategies for broadening services offered by trainees. Mr. Ali agreed that recruitment efforts should be strategic and that there are barriers to pursuing medical careers. One of the biggest barriers is need for financial support for education. NHSC is a leader in providing that support. Mr. Ali said that HRSA is working to increase awareness of NHSC. Mr. Ali said that there is legislation to support maternity care target areas. NHSC plans to provide awards to people providing maternal care services in HPSAs, though this plan is still in the conceptual stage. HRSA analysts are exploring potential measures and data sources to assess need for maternal care. The program is expected to launch in FY 2022.

Ms. Witzel noted that the HRSA efforts discussed focus on provider recruitment. She asked if there are also efforts to retain providers, or to attract providers with experience serving high-need communities, even if they are only interested in working part-time. Facilities typically search for full-time staff. There may be providers who already have a full-time position they intend to keep, wanting to do additional part-time work to help underserved communities. She asked if

NHSC is considering this option. Mr. Ali said that LRP applicants must have outstanding student loan debt, which is typically not the case for providers who have extensive experience.

Dr. Brown said that few private dental practices participate in the Health Workforce Connector. For many dental school graduates with high student loan debt, service at a community health center is not the best option because the compensation is low and/or their skills are not suited to the work. Dr. Brown asked if HRSA has considered recruiting more private practice dental offices to participate in the program. Mr. Ali said his division could coordinate with the External Affairs Division to increase awareness of the resource among private practices. Mr. Jordan said that the biggest barrier to private practice participation has been the requirement to offer a sliding fee scale. Private practices do not have grant resources that are often necessary to make sliding fees financially feasible. Mr. Ali asked how many current NHSC-approved sites are private practices. Mr. Jordan said that about 4 percent of these sites are private practice. Dr. Etminan agreed that lack of funds authorized by Section 330 of the Public Health Service Act is a barrier to private practice participation.

Dr. Etminan noted that HRSA offers sites mentoring to improve Uniform Data System performance measure scores. A similar approach to retention could be useful. In some cases, health centers assume low retention is normal, because it is all they have experienced. They could benefit from learning from other centers that successfully retain clinicians. Mr. Ali said that 60 percent of NHSC awards are to providers serving at community health centers. These providers comprise 13 percent of the FQHC workforce, which may limit NHSC influence with FQHCs. Mr. Ali said he would share Dr. Etminan's idea with colleagues.

Dr. Denise Sorrell, Senior Public Health Analyst for HRSA's Division of Health Careers and Financial Support, said that she is a graduate of the NHSC program. She did not have an option to continue to serve part-time after completing her service. She said this option may help to increase the workforce. Mr. Ali said scholars do have an option to continue half-time. He said that he would discuss the issue with Dr. Sorrell after the meeting.

Dr. Sein asked how site management quality is considered when determining site eligibility and scholarship awards. Mr. Ali said the Division of Regional Operations conducts many site visits annually. Placement and award decisions focus on serving HPSAs. NHSC also offers options to transfer when a scholar is unsatisfied with a training experience. Mr. Ali said NHSC is working to do more to address management quality issues. Mr. Jordan said his division conducts about 1,000 site visits annually. Site visitors monitor sites' adherence to NHSC program requirements and provide technical assistance with tasks such as creating Health Workforce Connector profiles, and recruitment and retention planning. Sites without automatic approval must be recertified every 3 years. Mr. Jordan said it would be valuable to identify retention measures and provide technical assistance to sites with low retention rates.

Chair's Welcome and Introductions

Dr. Billings welcomed Council members and thanked them for their work. He read the NHSC's mission statement, "The National Service Corps builds healthy communities by supporting qualified health care providers dedicated to working in areas of the United States and its territories with limited access to primary health care, regular dental, behavioral health care and preventative screenings." He said this statement reminded him of a quote from Paul Farmer, a co-founder of Partners in Health, saying that the most important achievements are accomplished by working with a team. He emphasized the importance of Council teamwork to achieve positive outcomes for patients, colleagues, and staff. He requested a moment of silence to express appreciation for those people. Dr. Billings invited meeting participants to share something personal about themselves as an icebreaker exercise.

After the exercise, Ms. Fabiyi-King said that many people applied to be members of NACNHSC. There were more than twice as many applicants as there were selected members. Members were selected for their expertise and diversity. Several members are NHSC scholars, though experience as an NHSC scholar was not a selection criterion.

Following the lunch break, Ms. Fabiyi-King conducted another formal roll call and confirmed that all Council members were present in-person or via telephone.

BHW NHSC Clinician Tracker

Michael Dembik

Branch Chief, Project and Data Management Branch, Division of Business Operations

Michael Arsenault, MBA

Director, Division of Business Operations

Dr. Billings welcomed Mr. Dembik, who introduced Mr. Arsenault. Mr. Arsenault said that Dr. Padilla had requested development of data resources that would allow comparison across BHW's more than 40 programs. Currently, 10 years of robust data on NHSC and Nurse Corps clinicians are available. Dr. Padilla wanted information about where scholars and clinicians had completed service and where they practiced afterward to support analysis retention and migration patterns. In response, the Division developed the clinician tracker.

The tracker was built with Tableau software. The team focused on designing a tool that would answer the questions posed by Dr. Padilla and other related questions, not on simply displaying available data. Tracker designers envisioned a system that would include executive dashboards that answer general questions, master dashboards that support more detailed analysis, interactive maps, and custom dashboards. Examples of executive-level questions include: How many clinicians continued to serve for a minimum amount of time at the site where they had fulfilled their service obligations, and the likelihood of staying in specific locations. Master dashboards support analysis by race, ethnicity, discipline, specialty area, and geographic region. Custom dashboards allow data filtering.

Data about where and when program participants complete their service are stored in the BHW Management Information Systems Solution (BMISS). Data about where program participants currently serve are stored in the Shortage Designation Management System (SDMS). These data are obtained from CMS weekly updates and State Primary Care Offices (PCO), which provide updated addresses when they submit documentation for HPSA designations. Both databases include National Provider Identifiers (NPI) for program participants, which the tracker uses to link BMISS and SDMS data. SDMS includes data on all of the 2.4 million providers in the US who have NPIs. The information is public, so data collection places no burden on providers. The database was originally intended only for HRSA's use. HRSA now plans to make it part of

the HRSA Data Warehouse, available to external stakeholders, sometime before summer of 2020.

Mr. Dembik provided a demonstration of the tracker and invited feedback from Council members. He first showed the Executive Dashboard. Its intended audience is senior leaders. It displays HPSA retention rates, defined as whether participants continue to serve in any HPSA. These data are reported to Congress. The tracker also can report whether participants continue to serve at the same site or Census tract and whether they serve in a rural community.

Dr. Schmitz asked how tracker designers define rural. Mr. Dembik said they used HRSA's official definition. Dr. Schmitz asked how current workforce address is defined in CMS source data. Mr. Dembik said it is the address associated with practitioners' personal NPI numbers. If a State PCO updates this address, the updated address is used for the tracker.

Mr. Dembik showed how the tracker presents results by State. Ms. Stergar asked how confident analysts are that BMISS and SDMS are accurately linked. She pointed out that personal identifying information such as names can present issues for matching, such as sometimes using a middle name and other times not using a middle name to identify oneself. Mr. Dembik said the personal identification data are 100 percent accurate because NHSC applications include social security numbers and HRSA has worked with CMS to ensure accuracy of NPIs. He said data on addresses associated with NPIs may not be 100 percent accurate. Ms. Stergar asked how often data are updated. Mr. Dembik said data are available by fiscal year and were last updated October 1, 2019. BMISS and HPSA data are updated more often. Tracker data are based on year-end summaries. Ms. Stergar said NPI data are difficult to obtain. Mr. Arsenault said the data are from a public file. He said that, initially, some people were concerned that few providers would have NPIs. However, all providers with a HPSA designation have NPIs.

Mr. Dembik displayed the master dashboard, explained that it filters data and supports analyzing HPSA service and community retention trends. He showed example displays of these data reports. Mr. Dembik also demonstrated how to filter retention data by program, clinician, and location attributes. Ms. Stergar asked how NHSC clinician retention rates compare to rates

reported by Medical Group Management Association and other data sources about job retention in general. Mr. Arsenault said HRSA has not yet compared NHSC retention with other job retention data; the current focus is internal analysis to inform program planning and external stakeholders. Mr. Dembik said current data reports are descriptive and do not offer explanations for results. Mr. Stergar said she believes the retention rates are high compared to other professions and that they indicate a strong return on investment.

Dr. Schmitz asked whether the tracker supports determining correlations between training site and retention. Mr. Dembik said those data are not available for all programs. Dr. Schmitz said that this question has been a priority for more than a decade. Mr. Ali said that is why he wants to collect more data through applications, which now require more information about post-graduate education, residency training, and fellowships. Dr. Schmitz said his research on recruitment and retention in rural healthcare service indicates that it would be valuable to collect data on age and marital/partner status. Mr. Dembik said he would mention this recommendation to the tracker workgroup. Dr. Schmitz said many providers are committed to service in rural and isolated areas when they are single, then serve in urban areas when they have a partner or family. This has not been studied adequately. Mr. Dembik said age could be extrapolated from date of birth in the current data. The working group had originally decided not to do this, but could reverse this decision.

Dr. Bockwoldt noted that HRSA recently initiated the Nurse Practitioner Fellowship Program. She suggested exploring data collection approaches and results with this the first cohort of this new sub-population after they complete the first year of their post-graduate fellowship residency. Mr. Dembik said that new data collection efforts require Office of General Counsel clearance, which requires a rationale. He hopes to get approval for more data collection across programs. Mr. Arsenault said the current focus is to collect individual NPI data.

Dr. Piernot asked if the tracker could stratify data by HPSA scores. Mr. Dembik said that HPSA score data were not collected in the earlier years of the program so are not available in the tracker database. The database could have this capacity in about 2 years.

Dr. Etminan asked if there were data on whether providers in HPSAs are providing public aid, rather than private practice, where they may not be helping underserved people. Mr. Dembik said data only indicate whether a clinician is serving a HPSA. Ms. Stergar said that the decision not to collect these data was based on the idea that any service in a HPSA is meeting a need for healthcare.

Dr. Bockwoldt pointed out that some grants are to training sites, and applications would include site, not individual persons', NPIs. Mr. Arsenault said THCGME funds individuals and grantee annual reports provide individual-level information. Mr. Dembik said HRSA is working to develop approaches to getting complete individual-level NPI data.

Mr. Dembik explained that custom dashboards allow retention frequency and percentage analyses comparing by professional discipline, site type, race, ethnicity, years in service, and amount of award. He demonstrated examples. Dr. Schmitz pointed out that service at a critical access hospital is a potential proxy for scope of services. Dr. Bockwoldt asked if data were cumulative or annual. Mr. Dembik said data reflect a fiscal year. Dr. Bockwoldt asked if the tracker supports analysis of trends. Dr. Dembik said this will be the case moving forward, but is not the case currently because data available when the tracker was initiated did not support analysis of trends.

Mr. Dembik explained and demonstrated the interactive map dashboard, which shows where clinicians completed their required HPSA service and where they serve now. Maps illustrate which clinicians are serving in the same HPSA as when they met service requirements and when they moved to a new HPSA. Data are available at the county level. Maps can illustrate results by fiscal year and summarize migration patterns over time.

Dr. Billings asked how the tracker accounts for providers who practice in multiple counties. Mrs. Dembik said the practice that reflects the most desirable retention scenario (e.g., serving in the same site as where service requirement was fulfilled vs. serving at a different site in a HPSA, or serving at a different site in a HPSA vs. serving outside a HPSA) is recorded as the data point. Any indication of retention is an indication of program success.

Dr. Schmitz asked if the tracker includes data on participants in the SLRP. Mr. Dembik said it does not. Dr. Schmitz said it would be interesting to conduct a return on investment analysis with SLRP data. Mr. Dembik said the workgroup has discussed including SLRP data in the database and has the capacity to add it. Ms. Stergar said that State PCO HPSA data collection processes vary, making results comparisons challenging. Mr. Dembik said the tracker is designed to incorporate additional data sources easily

Dr. Bockwoldt asked what length of service tenure is defined as retention. Mr. Dembik said retention is categorized as 1-year, 2-years, or all years on the executive dashboard and can be customized for the other dashboards. Overall retention is defined as all participants who were retained for at least 1 year.

Mr. Dembik explained and demonstrated unified dashboards, which include data from multiple systems and programs. These include CHGME and THGME, which do not have HPSA retention goals. However, HRSA is interested in whether graduates are practicing in HPSAs, medically underserved communities, or rural communities. Data are available at the State level and can be filtered to identify program commonalities. Interactive State and county maps are available for unified dashboards.

Mr. Dembik invited Council members to ask questions and submit feedback through e-mail. He said the workgroup wants feedback from potential users to make the tracker as responsive as possible to users' needs. Ms. Stergar asked if HRSA would offer training on using the tracker. Mr. Dembik said this was the case.

Mr. Arsenault said the preliminary findings indicate people tend to stay in the area where they completed their service, even if they move to a different clinical site. Dr. Schmitz said that one reason for migration away after attending a rural medical school is a shortage of graduate medical education opportunities at rural medical schools. Migration data can indicate where proactive recruitment efforts would be most useful. Dr. Billings said retention data are an important indicator of program effectiveness, and that current results are a rationale for increasing the NHSC budget to meet the country's healthcare needs. Mr. Arsenault said the team

could demonstrate the Health Workforce Connector at a future meeting. The Health Workforce Connector is a recruiting tool aimed at improving the linkage between NHSC training sites and communities in need of healthcare. The development team is interested in feedback on the tool, including potential uses. Dr. Billings said the tool could support publications about how the NHSC works, how it retains participants, and how the program can be replicated and expanded to meet healthcare needs. Dr. Billings invited discussion about potential recommendations to the HHS Secretary and other senior policy makers about using tracker data to benefit patients and clinicians.

Dr. Schmitz said the tracker would be useful to all Federally funded rural health research centers and the Federal Office of Rural Health Policy. Dr. Billings agreed. Ms. Stergar emphasized the potential of the tracker to demonstrate return on investment. Dr. Schmitz said the tracker could be used to identify program characteristics associated with retention, and which predict retention specifically in urban or rural communities.

Dr. Billings said a current focus in the field is holding medical schools accountable for addressing communities' needs such as for primary care through Federal and State funding requirements. The tracker has potential for use in scoring training institutions on the degree to which they respond to communities' healthcare needs and promote health equity. Dr. Schmitz said medical education is affected by funding source. Much graduate medical education, especially in primary care, is supported by Federal funding. This is not as much the case for undergraduate as for graduate medical education. It would be interesting to compare the degree to which undergraduate and graduate education affect where graduates practice. Dr. Schmitz said it would be interesting to assess correlates of practice in maternal care target areas and of providing maternal care.

Dr. Callins noted that data indicate that participants trained in a high-need area are likely to remain in that area. She said it would be useful to assess characteristics of areas that continue to lack healthcare services, then use data to develop strategies for recruiting providers to those areas, where they will likely remain if recruitment is successful. These data can be an important resource for convincing policy makers to support efforts to recruit more providers to high-need

areas. Dr. Etminan said recruitment to very high-need areas can be challenging. One way to encourage service to high need communities is to train clinicians in telemedicine, which can support many basic clinical visits, especially for mental and behavioral health. It is not enough to have the technology for telemedicine. Practitioners need training to use the technology. Dr. Billings said that curricula for medicine in underserved communities should include training in telemedicine and maternity care. Dr. Callins said that her students worry about practicing in rural areas without backup. She advises them to develop professional networks with specialists. Students need mentoring in networking and existing resources.

HPSA Modernization Approach, Auto HPSA, FQHCs

Janelle McCutchen, DHEd, MPH, CHES

Chief, Shortage Designation Branch, Division of Policy and Shortage Designation

Dr. Billings introduced Dr. McCutchen. Dr. McCutchen welcomed Council members and thanked them for their work. She said the Shortage Designation Modernization Project was initiated in 2012. The project involves updating HPSA designations. HPSAs are designated through a 1978 statutory regulation. The purpose of the modernization process is to update the approach to designation to reflect changes in demographics, accessibility, and technical capability. The designation was developed for NHSC but is used by other programs, including Nurse Corps.

Shortage designations are used to support decisions about resource allocation. HPSAs first are identified by State primary care officers designated through a grant or cooperative agreement, who submit HPSA designation applications to HRSA. HRSA reviews applications to determine whether suggested areas meet the criteria specified in the HPSA statute. Areas that meet statutory requirements are designated HPSAs. In 2003 HRSA developed a HPSA scoring process to ensure resources are allocated to areas with greatest need. CMS pays a 10 percent bonus on Medicaid reimbursements to providers serving HPSAs. Clinics can use a HPSA designation to demonstrate eligibility for CMS's Rural Health Clinic Program. The J-1 Visa Waiver program waives the requirement for J-1 visa holders to be physically present in their countries for 2 years if the visa holder is a doctor serving a HPSA.

Shortage designations refer to geographic area, population served, or facility type. They designate a shortage of primary medicine, mental health, or dental health services. Geographic areas can be one or more counties, cities, or other civil divisions recognized by the State. Dr. McCutchen explained that special population designations require geographic boundaries that indicate where members of the population are experiencing a shortage. Automatic facility designations are made for State mental health hospitals, facilities within 50 miles of a HPSA that serve patients from the HPSA, FQHCs, NHSC-certified rural health clinics, and ITUs. These facilities are designated as serving HPSAs regardless of their HPSA score, as long as they serve patients regardless of ability to pay. Automatic HPSA facilities comprise 52 percent of HPSAs

in the US. Facilities can qualify as serving a HPSA based on results of more than one HPSA designation process. For example, an automatically designated facility can serve a geographic HPSA or a region with a special population HPSA.

Dr. McCutchen presented a slide listing HPSA scoring criteria, maximum points for each criterion, multipliers, and total possible points. She noted that score criteria for all types of healthcare shortage include population to provider ratio, the percentage of the population living below the Federal poverty threshold, and travel time and distance to the nearest care source. Nearest source of care is defined only by distance, without considering factors such as whether the provider is accepting new patients. Additional criteria are applied to score need for different types of care. Primary care medicine scoring criteria also include rates of infant mortality and low birth weight. Water fluoridation is the additional criterion for dental health need scores. Mental health need scoring criteria also include the ratio of children younger than 18 years to adults ages 18 to 64 years, the ratio of adults age 65 years and older to adults ages 18 to 64 years, substance abuse prevalence, and alcohol abuse prevalence.

Dr. McCutchen said the scoring process is transparent. Data are stored electronically in the Shortage Designation Management System (SDMS), which was designed to standardize data and the application process. Before this system was available, the paper application process required 45 days. With SDMS the process requires only 8 hours. Scoring supports accountability to the public and fair competition for Federal resources.

Data sources include the Environmental Systems Research Institute (ESRI) for travel and spatial mapping data, the US Census American Community Survey for population data, CMS data for provider data, and Centers for Disease Control and Prevention (CDC) for infant health data. A State-level summary of these data that allows analysis by county or Census tract is available to support PCOs in designating HPSAs. HRSA automatically updated all SDMS geographic, population, and facility designations in November 2017. HRSA aims to continue with automatic updates to minimize PCO burden, requiring PCOs only to review and update criterion data. The automated process also reduces data entry errors.

In updating data on automatic HPSA designations on August 30, 2019, analysts found that 69 percent of these designations were based on scores that were at least 4 years old. Data are required to be updated at least every 4 years. The updating process was supported by an external data working group and an external communications working group. Groups worked to identify the best processes for each type of facility to submit data to SDMS, ensuring accountability and parity in competition for resources. Working groups recommended flexibility regarding data sources and accommodating unique characteristics of safety net facility data. The updated process supports provider retention by not changing the status of current NSHC or Nurse Corps participants and by prioritizing continuation awards. The goal of NHSC is to retain providers in high-need areas, so that those areas lost their HPSA status. So, BHW aims to issue PCO cooperative agreements that incentivize provider retention rather than having a high number of HPSAs.

The update to automatic HPSA designations was conducted for 2,894 automatic HPSA organizations. Of these, 2,053 (52%) did not change competitiveness as a result of the update; 1,283 (33%) non-competitive organizations became competitive. A total of 244 of these organizations train or employ NHSC participants. In response, BHW is encouraging automatic HPSA organizations to use the Health Workforce Connector to recruit care providers. Updates do not affect the HPSA status of organizations that received awards in FY 2019. New scores are used for current funding applications. Scores are updated every 24 hours.

BHW is developing a Request for Information (RFI) on identifying maternity care target areas within primary care geographic HPSAs. BHW is interested in potential data sources and taxonomies, types of providers to accept, and how to calculate service hours.

BHW also will issue a RFI for HPSA scoring criteria. Dr. McCutchen's team believes the scoring process can be improved to support increasing access to care and care quality. BHW is interested in potential data sources and in considering whether to include a broader range of provider types in scoring.

Dr. McCutchen invited questions. Dr. Billings asked what the minimum scores are for a primary care, mental health, or dental health HPSA designation. Mr. Ali said the minimum score for primary care is 19. For mental and behavioral healthcare providers other than psychiatrists the minimum score is 19, which is also the score for dental care providers. The minimum score for psychiatrists is 21. The minimum score for certified nurse midwives is 16. Ms. Stergar asked what the maximum scores are. Mr. Ali said the maximum scores for dentists is 26. The maximum for all other professional categories is 25.

Dr. Taylor-Desir asked for an example of a special population. Dr. McCutchen said this includes residents affected by the Flint, Michigan water crisis, Puerto Rico during the Zika epidemic, and areas with high proportions of residents who are eligible for Medicaid.

Ms. Stergar thanked Dr. McCutchen for her team's work. She asked if 2020 Census data will be used for 2021 HPSA scoring. Dr. McCutchen said BHW annually updates SDMS data with Census micro records.

Ms. Stergar asked if responses to the scoring RFI could address how telehealth services should be considered. Dr. McCutchen said BHW is interested in this.

Dr. Schmitz said that maternity care target area designations should consider the types of services provided. BHW should consider how scoring affects ability to match providers with areas that require services that are not traditionally considered primary care, for example obstetrical and maternity care, and emergency care. These are critically important and save lives. Rural health clinics often are required to provide these services.

Dr. Schmitz said that continuous data updates can facilitate continuous recruitment, which can be critical for facilities' continuing operations. Provider facilities require a minimum number of practitioners to remain open. When few providers are on staff, one provider leaving may lead to a decision to close unless that person can be replaced in the short-term. So, data updates are likely to help healthcare facilities to continue operating, resulting in lives being saved. Dr. McCutchen said she was pleased with this change in the application and review process. She

clarified that HRSA has 90 days to review applications. Reviews typically are completed within 45 to 65 days.

Ms. Stergar asked if respondents to the scoring RFI could recommend changes to the regulatory statute such as the minimum support and types of support required to sustain a practice. Dr. McCutchen said this type of information would be welcome, and encouraged Council members to communicate with legislators empowered to change the statute. However, the focus of the RFI is on changes within HRSA's jurisdiction.

Dr. Billings said that transferring from a rural critical access hospital to a tertiary care hospital is costly and dangerous. In his community, there is no ground transportation; all transfers are through air medivac, which costs at least \$50,000 and requires flying at least 160 miles one way. Many are paid for through Medicare or Medicaid. Those paid for through private insurance raise premiums. Medivac planes crash. These factors should be considered when assessing rural healthcare needs and determining how to address them. Dr. McCutchen said this is the type of information sought through the upcoming RFI. She said it is important for stakeholders with diverse perspectives and experiences to provide input. Dr. McCutchen invited Council members to contact her directly with any questions they had after the meeting.

Dr. Billings asked if there were comments before the public comment period started. Ms. Stergar asked if there had been any response to the white paper NACNHSC has submitted to the HHS Secretary. Ms. Fabiyi-King said the Secretary had sent an appreciate response that she would share on Day 2 of the meeting.

Public Comment

Dr. Billings invited public comment. There was none.

Recap of Day 1 and Plan for Day 2

Dr. Billings said that Mr. Engels had described the Council's charge. Dr. Padilla had provided BHW updates. Mr. Ali provided an overview of NHSC programs. Council members introduced themselves. Mr. Arsenault and Mr. Dembik described and demonstrated the clinician tracker,

which Council members perceive to be a potential tool to support advocacy for patients and NHSC participants. Dr. McCutchen described the HPSA designation modernization project. A public comment period was observed.

The Council would convene at 9:00 a.m. on Day 2. The Day 2 agenda would include Dr. Billings providing the charge for the day, a presentation by Michael Berry about the process for NHSC making recommendations, open discussion, planning next steps, assigning roles and responsibilities, topic selection, discussion about preparing reports and recommendation letters, a public comment period, and closing remarks. Day 2 adjournment was scheduled for 2:00 p.m.

Dr. Billings offered to accept a motion to adjourn for Day 1. Ms. Stergar made a motion, which Ms. Witzel seconded. Dr. Billings adjourned the Day 1 meeting at 3:45 p.m.

Day 2

Ms. Fabiyi-King opened the meeting at 9:15 a.m. She took official roll call. All Council members were present. Dr. Piernot participated via telephone. All other members participated in-person.

Charge of the Day.

Dr. Billings reviewed the meeting agenda. He read a quote from former HHS Secretary Kathleen Sibelius, “It is time to refocus, reinforce and repeat the message that health disparities exist and that health equity benefits everyone.” Dr. Billings said it is the role of Council members to serve as health equity champions. He said that Dr. Fitzhugh Mullan, original NHSC Director was a health equity champion and a role model for others. Dr. Billings read an excerpt from *The Washington Post* obituary for Dr. Fitzhugh: “Fitzhugh Mullan, a social activist physician and author who wrote about healthcare inequities and his own experience as a cancer patient in his early thirties, died November 29 at his home in Bethesda. He was 77. Before joining George Washington University, Dr. Mullan served 23 years in the US Public Health Service. He was an Assistant Surgeon General and Director of the National Health Service Corps, which serves communities where healthcare is scarce or non-existent. For three years, he practiced at a community medical clinic in New Mexico.

As a medical student, at the peak of the civil rights movement, he spent a summer providing health care for medically ill-served and neglected black Mississippians in rural Holmes County. By his own account, he also took a half dozen turns sitting on the steps of an African-American church with a shotgun to protect it against night raiding marauders. Later, as a medical resident at a city hospital in New York, South Bronx, he helped organize a protest bill burning in the emergency room by moneyless patients who believe they had received excessive medical bills. Dr. Mullan and other residents were threatened with firing, but hospital authorities backed down after the New York news media covered the protest.

The son and grandson of doctors, Dr. Mullan described himself as having been raised in comfort in a New York family accustomed to the perquisites of an establishment class. But as a medical caregiver in New York, Mississippi, Chicago, and elsewhere, he learned early that patients with no money and low social standing often received substandard medical care or not at all. He wrote about medical injustice in a 1976 book, *White Coat, Clenched Fist: The Political Education of an American Physician*, which became the professional manifesto of his career. Among the white-coated aspiring doctors at the time, he later observed ‘There was a sardonic comment often applied to colleagues departing for lucrative practices: ‘White follows green’ the adage went, meaning the doctors went where the money was.’ While at GWU, Dr. Mullan was a writer and editor at the health policy journal, *Health Affairs*. In his column *Narrative Matters*, he often reflected on a system that decades into his career, he considered still broken in its treatment of the disadvantaged.

One column from 2009 noted his work at a community medical clinic in Northwest Washington, where many of his patients were undocumented arrivals to the United States from Africa, Central America and Asian. ‘These new Americans were all outside the established medical system,’ he wrote, ‘They construct buildings, staff, restaurants and clean offices and homes but have no legal standing and certainly no health coverage. The economy welcomes them but the health system does not.’

While at GWU, Dr. Mullan continued focusing on issues of healthcare equity and helped establish social justice as an important facet of medical education. He also published a book on

the history of the US public health service and led a five-year study of medical schools in sub-Saharan Africa.”

Dr. Billings requested a moment of silence to honor Dr. Mullan, his family, his patients, his co-workers, and his impact.

Council Recommendations to Policy: The Process

Michael Berry

Senior Advisor

Division of Policy and Shortage Designation

Dr. Billings introduced Mr. Berry. Mr. Berry summarized the legislative history of NHSC. The Emergency Health Personnel Act was enacted on December 31, 1970. The program was first funded in 1972, through amendments to the Emergency Health Personnel Act provided for scholarship funding and designated Health Manpower Shortage Areas, now called HPSAs. The program was renewed in 1976 through the Health Professional Education Assistance Act and in 1987 through the NHSC Loan Repayment Program Authorization, which was reauthorized in 1990 and 2002. In 2004 the American Jobs Creation Act made scholarship funding other than the stipend tax-exempt. The 2010 Affordable Care Act made loan repayments tax-exempt. All of these acts affected Section 331 of the Public Health Service Act. The Consolidated Appropriations Act of 2018, the Department of Defense and Labor, Health and Human Services, and Education Act of 2019, and the Continuing Appropriations of 2019 authorize financial support for NHSC. Regulations 42 C.F.R. 62 and 42 C.F.R. provide specific information about the program. Program policy is described in Application and Program Guidance(s) and the Site Reference Guide. NHSC's scholarship and loan repayment programs are authorized by Public Service Health Act Title III Sections 338A and 338B. The State Loan Repayment Program is authorized by Section 338 I. Substance Use Disorder Workforce and Rural Community. Loan Repayments are authorized through Section 331. The Students to Service program is authorized by a legislative provision for loan repayment contracts to students in their last year of school. The program supports fourth year medical students in exchange for choosing a primary care residency.

Ms. Stergar asked how many scholars participated when the program started. Mr. Berry said the program initially funded several thousand scholars each year, requiring them to renew annually for a maximum of 4 years. Initially the program supported a broader range of professionals, including physical therapists, pharmacists, optometrists, nutritionists, and large animal veterinarians. When funding was reduced during the early 1980s, only physicians and dentists were eligible for support. When the program was reauthorized in 1990, nurse practitioners,

physician assistance, nurse midwives, dentist, and physicians became eligible. This has not changed since.

Mr. Berry explained that NACNHSC is authorized by Section 337 of the Public Health Service Act to, “consult with, advise, and make recommendations to the Secretary with respect to his responsibilities in carrying out this subpart (other than Section 254 of this title), and shall review and comment upon regulations promulgated by the Secretary under this subpart.” Section 254 pertains to rural health program grants not under NHSC authority.

Mr. Berry said the Council develops white papers and briefs. The Council should consider who has the authority to make changes recommended. For example, the tax-exempt status of scholarship and loan repayment disbursements is part of the US tax code, not HHS policy. So, to be enacted, the recommendation had to be approved by Congress. Recommendations should precisely define the action recommended. Mr. Berry provided links to examples of previous NACNHSC recommendation letters and white papers. Letters may be addressed to Congress, possibly through the Chair of the Health Committee. Letters can be addressed to the HRSA Administrator. Another approach to submitting recommendations is through the US Office of Management and Budget (OMB) A-19 process, described in OMB Circular No. A-19. In this process OMB clears and coordinates agency recommendations regarding legislation. Mr. Berry said that the Health Care Safety Net Amendments of 2002 authorizing Loan Repayment Program participants to satisfy their service requirements through part-time work was a response to an NACNHSC recommendation made in a white paper.

Dr. Schmitz asked if it would be useful for the Council to comment on issues under the jurisdiction of other agencies, such as CMS, that are related to NHSC priorities, such as medical education and workforce development. Mr. Berry said CMS has its own advisory council. Previously, bureaus with multiple councils have convened all councils together. Dr. Schmitz asked if council reports are available to share and use to inform other councils’ recommendations and discussions between councils. Ms. Fabiyi-King said reports are available on agency websites. Dr. Bockwoldt asked if other councils would have access to NACNHSC recommendations, and how NACNHSC can solicit input from other committees and

stakeholders. Ms. Fabiyi-King said the Council can invite other committees' chairs and designated Federal Officers to meetings. Mr. Berry said Council meetings are announced in *The Federal Registrar*. Any member of the public can attend open meetings. Dr. Billings said it would be valuable to read about what other councils are doing and consider how councils can collaborate to be more effective.

Ms. Stergar requested a history of changes that have resulted from NACNHSC recommendations. Mr. Berry said this information was not available in one source, but that he would produce a summary for the Council.

Dr. Bockwoldt asked if the Council could obtain data on the reasons for declining applicants who were not funded. Mr. Ali said grant application scores are mostly determined by HPSA scores. Some applications do not meet eligibility criteria. Some are missing documentation. He said he would look into providing data about this to the Council. Dr. Etminan said it would be useful to determine how many rejected applicants serve HPSAs. It may be useful to consider granting a greater number of smaller awards to people who do not require an additional incentive to remain in high-need communities.

Mr. Ali said HRSA will begin studying service locations and migration patterns of applicants who did not receive awards as part of assessing NHSC program impact on where providers serve. Dr. Schmitz said research has been published about the relationship between community embeddedness and physician practice specialty, which should be considered along with HRSA-generated data when making NHSC policy decisions.

Dr. Billings agreed that it would be helpful for NHSC to fund more scholars and to know what rejected applicants do after being denied NHSC funding. He said it would also be useful to know how to encourage people to serve at NHSC. He asked Mr. Berry if the Council could recommend increasing NHSC's budget. Mr. Berry said the Council could write a letter to the chair of the House of Representatives Health Committee asking for a specific funding level¹. He

¹ The HRSA Advisory Council has advised NACNHSC members that this letter should be to the HHS Secretary, not to the Chair of the House of Representatives Health Committee.

added that HRSA and the Council do not know how many eligible applicants there are, or how many NHSC participants would be willing to serve HPSAs without an additional incentive, or how many would not serve HPSAs regardless of incentive, which would inform the amount to request. Dr. Billings said that there are data on number of applications received. He noted that staff at NHSC sites report losing clinicians who started service with expectations of being accepted into a loan repayment program, then leaving the site after being declined, resulting in lower retention and lower HPSA scores. Mr. Berry said the data of interest for potential NHSC participation is not total applications but total eligible applications. Ms. Stergar said the Council recently produced a white paper recommending increased NHSC funding in order to support health equity and primary care. She said the Council could make a recommendation for legislature supported by data, such as the number of qualified applicants. She said that NHSC would be able to expend any reasonable budget increase to address the health shortage. For example, additional funds could support paraprofessionals.

Ms. Witzel asked if the Council could recommend changing the definition full-time service to a minimum of 36 hours per week, so that more people could qualify. Mr. Berry said this is within the Council's purview.

Dr. Piernot said that she has mentored multiple people who apply for NHSC support simultaneously. All serve the same HPSA. In some cases, some applicants have been accepted while others have been rejected. She asked why this would occur if the HPSA score is the main determinant of application acceptance. She asked if applicants can request application guidance or scoring debriefing. Mr. Ali said NHSC offers webinars on how to submit successful applications. Applicants can contact the call center to request debriefing about why an application was denied. One reason for one application being preferred over others from the same site is a preference for applicants from disadvantaged backgrounds. HRSA is available to debrief any applicants about how their application was scored. Dr. Piernot asked for HRSA to provide the Council with more information about the application scoring process. Mr. Ali said the process is described in the Application and Program Guidance. Dr. Billings asked Mr. Ali to share this documentation with the Council.

Dr. Etminan asked if the Council could recommend workforce pipeline programs to encourage high school students, especially those living in rural areas, to become healthcare professionals. Mr. Berry said the Council discussed the potential of a Junior Health Service Corps several years ago. The Council did not know how to implement the program and did not pursue the idea. The Council could recommend this now. He said that current legislation does not authorize prioritizing service to rural areas over service to urban areas. Scores are based on HPSA scores. Dr. Billings said research has demonstrated that secondary school students from underserved communities are most likely to practice in those communities.

Dr. Bockwoldt asked whether HPSA scores correlate with States' decisions to participate in Medicaid expansion. Mr. Berry said he did not know, but Dr. McCutchen might be able to answer this question. Dr. Billings said the clinician tracker potentially could provide relevant data to address this question. Ms. Stergar said HPSA scores are based on new data; so current data cannot address this question. It may be able to do so later.

Dr. Pinto-Garcia asked how the legislation defines eligible service. She said that she was required to serve in a hospital, which did not count toward her service requirement. She said this is particularly a problem for OB/GYNs and family medicine physicians who must provide surgical care. Not counting these hours is unfair to patients and providers. Mr. Berry said primary healthcare services are defined in Section 331 of the Public Health Service Act. The definition has been changed previously and could be changed again, potentially through an NACNHSC recommendation. The Application and Program Guidance provides more specific definitions.

Dr. Jones asked if data are available on applicants' geographic regions. These could be used to identify areas in which to recruit more actively. Dr. Billings said NHSC is working to increase awareness of the program in areas which have produced few applicants. Dr. Jones also noted that his organization's information is not correct on the NHSC website. He asked what the process is for ensuring these data are correct and current. Mr. Berry said that Mr. Jordan was the person best able to answer that question. Mr. Jordan was not present. Mr. Berry said site staff are responsible for updating information on the website. Ms. Stergar said it is difficult for staff

to find time to update website information. She added that this information is valuable for recruitment, so site staff have to prioritize the task. The website provides an opportunity to market service at one's NHSC-approved site. It is an opportunity to inform providers that service at the site can qualify applicants for scholarships or loan repayment. Dr. Taylor-Desir said there are rules regarding permission to update NHSC website data. Site administrators need to be aware of who is responsible for updates. She agreed that website information can support recruitment and emphasized that recruitment and retention should be priorities for the Council. Dr. Jones agreed that website information could be used to support recruitment and suggested including information that promotes quality of life in the site's community (e.g., natural beauty).

Dr. Billings said medical students are often unaware of NHSC programs until their 3rd or 4th year of medical school. Council members should work to increase awareness of NHSC. Dr. Billings noted that the Scholar Program is the most expensive NHSC program. It is also a long-term investment since it supports students throughout medical school. When ACA passed, the program prioritized getting clinicians into the field quickly. This was accomplished by expanding the loan repayment program.

Dr. Piernot said that residents may train at Teaching Health Centers with low HPSA scores, making them ineligible for the Loan Repayment Program unless they leave the site that invested in their training. She asked if there were a way to support loan repayment and continued service at the training site for these students. Mr. Ali said NHSC does not fund Teaching Health Center residency programs. However, NHSC is considering prioritizing accepting applicants who have trained in Teaching Health Centers while continuing to prioritize service in HPSAs. NHSC does not have the statutory authority to give priority to Teaching Health Center trainees as they do with Scholarship Program participants, but is exploring the issue. Mr. Berry said ACA allows for up to 50 percent of an NHSC member's service to be delivered at a Teaching Health Center. However, this does not apply to residents. Dr. Schmitz said it is critically important to count faculty teaching time toward required service, particularly teaching that trains family medicine residents, because this helps to ensure continued program accreditation. Because faculty's salaries are often lower than community physicians' salaries, faculty recruitment can be challenging. Supporting an NHSC scholar in serving as a faculty member who is increasing the

local health workforce and who can provide critical hospital coverage for accreditation does more to promote NHSC goals than requiring that scholar to perform only direct patient care. Mr. Berry said that the law also allows 20 percent of service time to be spent teaching in settings other than Teaching Health Centers. Ms. Stergar said this change occurred during the past decade as a result of HRSA staff responding to input from the field.

Ms. Stergar said that scores and awards are based on HPSA scores, so it is critical for stakeholders to respond to the upcoming RFI about HPSA scoring and how it should be changed to address concerns, including those related to needs of special populations and rural communities.

Mr. Ali recommended that Council members become familiar with NHSC Application and Program Guidance, which defines programs and standards. Many applicants do not do so, which is a barrier to program participation. Mr. Ali said Council members should be familiar with this guidance in order to make informed recommendations about changes. Mr. Berry added that the Guidance is based on authorizing laws, so Council members should be familiar with those laws. He invited Council members to contact him with questions about laws and regulations related to NHSC. Dr. Billings asked for HRSA staff to send links to the Application and Program Guidance and authorizing laws to all Council members. Mr. Berry said that information would be provided.

Dr. Etminan asked if analysts were determining how NHSC funds should be distributed to maximize return on investment, and if results of these analyses could be available to Council members. Mr. Ali said analyses are focused on the costs and benefits of continuation. He said he could discuss expanding analysis to consider how best to allocate resources to increase field strength with the Division of Business Operations. Mr. Berry said HRSA does analyze default rates. Initially the penalty for default was to pay back the award amount. Nearly half of awardees defaulted. HRSA then required defaulters to pay three times the award amount. The default rate dropped to less than 2 percent. Dr. Schmitz said that, in addition, to studying return on investment data, NHSC should consider published research on how to recruit and retain practitioners to high-need communities.

Dr. Billings thanked Mr. Berry for his presentation.

Open Discussion of Council Members

Dr. Billings presented themes he had noted in the discussion so far. The first theme was that the NHSC needs an increased budget to support eligible applicants for loan repayment programs. Another theme was redefining full-time service from 40 to 36 hours per week. Council members also had discussed the potential value of communication and meetings with other councils at HRSA and other agencies, including CMS. Another theme was considering developing a program to recruit students from disadvantaged backgrounds and communities to pursue healthcare careers and to make them aware of NHSC as a possible source of support. Council members had discussed the possible relationship between HPSA scores and whether a State participates in Medicaid expansion, and the degree to which this decision is a barrier to healthcare access. Members had discussed advocating for continuing NHSC and the Teaching Health Center Program, which are facing a fiscal cliff. This could include advocating an increase in the Teaching Health Center budget. Another discussion theme was allowing faculty service to count toward NHSC service requirements. Dr. Billings opened the floor for discussion.

Ms. Witzel observed that themes in the current discussion were similar to those at the last NACNHSC meeting, which were documented in a white paper. She asked if the Council could review this paper. Ms. Fabiyi-King said this paper could be distributed. Dr. Taylor-Desir asked where Council members could find previous Council papers and recommendations. Ms. Fabiyi-King said this information is on the NACNHSC website. She requested that the most recent paper be presented on the conference room screen.

Dr. Callins said she also had noted discussion themes. She agreed that increased funding had been a theme, as well as recruitment and retention strategies and identifying factors associated with retention. Dr. Callins agreed that discussion had focused on the importance of a workforce pipeline and the potential value of the clinician tracker in identifying areas with highest need for services. She noted that there had been discussion about programs to prepare physicians to feel comfortable serving in rural areas, as well as the importance of ensuring that practitioners have

the skills and resources to serve high-need areas. Dr. Callins said the AHEC program has been successful supporting disadvantaged students in becoming medical students and offers a standard for other efforts to do so. Dr. Callins said data optimization was another discussion theme.

Dr. Sein said that NHSC and THC efforts overlap and their funding should be coordinated. He said FQHC service should count toward NHSC service requirements, and that FQHCs' investment in training should be recognized. NHSC scholars should be able to retain these scholars. He asked for clarification about THC funding support and processes. Mr. Berry said he believed the program was funded for about \$120 million annually through 2024. It is a separate appropriation and budget from NHSC, which is funded only through May 22, 2020. Dr. Sein said this uncertainty made it difficult to plan for the future. Mr. Berry said THC trains students to serve rural and underserved communities. NHSC supports health workforce development. He agreed it would be useful to consider how to link the programs to support progress toward their shared goals.

Dr. Schmitz suggested inviting the Chair of COGME to meet with NACNHSC to discuss COGME's 2017 report *Towards the Development of a National Strategic Plan for Graduate Education*. Dr. Schmitz agreed that THC funding is linked to NHSC program activities as well as the Rural Residency Planning and Development Program. Dr. Schmitz suggested that the COGME Chair may have insight regarding integrating program activities to support graduate medical education goals and objectives. Dr. Schmitz also said it would be valuable to obtain input from a CMS advisory council regarding approaches to funding graduate medical education. Ms. Stergar noted that there are several CMS advisory councils, and asked if Dr. Schmitz had a specific council in mind. Dr. Schmitz said he did not. He said he would like expert input regarding program financing. Ms. Fabiyi-King said the Council could invite COGME members to participate in the next NACNHSC meeting. Dr. Billings said he agreed with Dr. Schmitz's points. He asked if other Council members had comments on these points. Ms. Witzel asked if inviting others to the meeting would involve asking them to present on a topic. Dr. Schmitz said that was his intention. He volunteered to develop discussion points with Dr. Billings. One topic areas could be COGME's background and function. In addition, NACNHSC could share information about NHSC needs and the implications of THCGME and Rural Residency Planning

and Program Development funding for NHSC goals. Dr. Billings concurred that these were relevant discussion points. Ms. Stergar agreed that this was a good idea. Dr. Billings said it appeared that there was consensus that the COGME Chair and/or a CMS representative should be invited to the next meeting and that Council members should specify what points NACNHSC wants invited speakers to address.

Ms. Stergar said the Council should clearly identify priorities and planned actions for itself. Dr. Billings agreed. Dr. Callins said it would be useful to become familiar with Application and Program Guidance in order to identify priorities and recommend actions. Dr. Billings invited more open discussion followed by listing and voting on priorities.

Dr. Schmitz said that the Council's 2000 report recommended removing the requirement for a 3:1 vacancy to scholar ratio. He said he wanted to recommend assigning a minimum number of qualified sites within geographic regions. Ms. Stergar asked him to explain why. Dr. Schmitz said that lack of NHSC-approved sites within an area can present a challenge for recruitment and retention. Dr. Etminan asked in HRSA staff site visits could include engaging with and presenting to community schools to increase awareness of NHSC. Mr. Ali said that site visits require providing support to between six and ten sites within a few days. It is likely that site visitors would not have time to add academic institutions to their itineraries. Dr. Billings said every State has a NHSC Liaison, whose responsibilities include raising awareness of NHSC among students and faculty at healthcare training institutions. Raising awareness among people who have not yet started college is the responsibility of AHECs. It may be useful for NHSC to collaborate with AHECs to raise awareness of NHSC. Dr. Schmitz noted that federal funding for AHECs is contingent on matching dollars, often from medical or nursing schools. AHECs are sometimes located in State Offices of Rural Health. This could facilitate collaboration to address needs for rural health care.

Dr. Bockwoldt suggested aligning Council priorities with the NHSC priorities described by Mr. Ali, such as enhancing data collection through identifying key data to collect. She asked Mr. Ali what would help NHSC achieve its goals for 2020. She also asked him to explain what his meant by "identifying workforce program linkages." Mr. Ali said BHW must analyze available

BHW data and other available evidence to determine how best to train providers to have a positive impact on rural and underserved communities. He asked the Council what kinds of data members think BHW should collect for this purpose. He said BHW is interested in what characterizes transformative clinicians and in what factors predict retention in underserved communities. Dr. Bockwoldt asked if BHW has collected data from NHSC alumni. She suggested program exit interviews. Mr. Ali said BHW would prefer prospective to retrospective data collection, especially with the rapidly changing landscape of healthcare delivery. He asked what data sources other than applications, including subject matter experts, other advisory councils, other agencies could support this effort. The Bureau is also interested in how to analyze rural versus urban providers' experiences.

Ms. Stergar said the capacity of Internet resources should be considered when deciding what qualifies as an eligible NHSC service site and the hours grantees are required to work. She pointed out that radiologists already deliver services remotely. She suggested collecting data on how scholars expect to use telehealth in their practice over the next 5 years, including whether they expect in to help them provide services in multiple locations. She asked if these data could be collected about scholars currently in the program. Mr. Ali said BHW is waiting for OMB clearance to do so. He said it is important to consider issues such as whether remote patient monitoring or reviewing patient data should count toward required patient care. Dr. Witzel said scholars working in rural clinics are sometimes required to take calls in the emergency department or make rounds in nursing homes. Some of this work is not counted toward service requirements because it is not considered face-to-face primary care. Dr. Witzel said it would be useful to broaden the definition to support loan repayers in practices where these services are essential. Dr. Schmitz concurred. Family medicine in rural settings often requires hospital care, emergency department care, and maternity care. Facilities in isolated areas that were not designed to provide these services are required to do so to meet community needs, in many cases to save lives.

Dr. Billings invited additional comments.

Dr. Callins said it may be useful to share information and collaborate with the National Association of Advisors for the Health Professions, which works with institutes of higher education. She said the Council should consider how to work with other organizations to maximize its impact. She said it is important to use existing information to inform decisions. Dr. Billings concurred. He said he would determine whether NHSC already has a relationship with the National Association of Advisors for the Health Professions. Dr. Callins said she is a member and would facilitate a connection if necessary.

Dr. Schmitz said it is important to consider the limits of telemedicine. Some safety net providers are not allowed to bill for telemedicine services. CMS requires physical presence in order to bill for some services. Rural doctors may be required to be present in an emergency department and provide remote primary care between emergency patient encounters. But CMS would not reimburse for service delivered remotely.

Dr. Schmitz said that understanding rural retention includes collecting data not only from providers who do serve in rural areas, but also from providers who choose not to. He said the University of Washington Rural Health Research Center specializes in workforce analysis and has data and results that could address BHW questions.

Dr. Billings asked Drs. Brown, Pinto-Garcia, and Jones if they had comments.

Dr. Brown said it is unclear whether people who serve in both NHSC and the military are eligible for loan repayment from both. He has asked for information, and no one has been able to answer. He said this issue should be clarified. Mr. Ali said he would inquire about this with the Office of General Counsel.

Dr. Pinto-Garcia asked how HRSA defines primary care medicine and dentistry. Mr. Ali said these definitions are provided in Application and Program Guidance and the Site Reference Guide. Dr. Pinto-Garcia said the definition in the field has changed dramatically in the past decade. People often get primary care in retail settings and are going to primary care settings for conditions that most people used to think required hospital care. Primary care is type of care

provided, not a place. Dr. Pinto-Garcia said that it appeared the current HRSA definition emphasized location of care in its definition and that this has resulted in problems. She said the Council should consider how to define primary care.

Dr. Bockwoldt asked why any medical service is not counted as patient care. Dr. Billings said that it is usually a matter of a hospital being a separate site from the NHSC service site. Dr. Bockwoldt said any billable service, including telehealth should be considered care. Ms. Stergar said the site where care is provided is reimbursed. Sites are competing for workforce. NHSC is intended to provide primary care, and therefore limits allowing hospitals and remote sites to be reimbursed for services provided by a clinician supported by NHSC. NHSC repays loans but is not an employer. NHSC-approved sites will ensure loan repayers fulfill their service requirements but can also require additional services. So it is important for NHSC to clearly define primary care scope of practice and practice location. It is important to define the requirements of receiving money from the Federal government and to communicate them clearly to program participants. Dr. Jones said that it is also important to acknowledge that specialized services are often required in rural primary care settings. He said he thinks the current NHSC definition of primary care is clear and appropriate. Mr. Ali said the definition of primary care in the NHSC authorizing legislation refers to services “to” an underserved area, not “in” an underserved area, which suggests that telehealth services are eligible. However, it is unclear how to score applications for practitioners whose time is divided between HPSA and non-HPSA communities or communities with different HPSA scores. The HPSA community may have a very high score, but it may not be appropriate to prioritize that application over one for full-time service in a HPSA community with a lower score.

Dr. Billings asked Council members to consider how their priorities overlapped, what actions they would recommend for addressing those priorities, and which vehicles they would use for making those recommendations. Dr. Billings adjourned the meeting for lunch. After lunch Ms. Fabiyi-King conducted roll call. All Council members were present.

Next Steps: Roles and Responsibilities of Council

Dr. Billings reminded the Council that the next scheduled meeting is a teleconference on March 10 and 11, followed by an in-person meeting June 16 and 17, and a teleconference November 5 and 6. The Council can convene additional teleconferences as necessary to support report preparation.

At Dr. Billings' request, HRSA displayed two examples of previous NHSC recommendation letters to the HHS Secretary. Dr. Billings pointed out a 2019 letter to Secretary Azar recommending continued growth in telehealth and technology at NHSC-approved sites, a recommendation to promote the concept and presence of value-based clinicians at NHSC-approved sites, a recommendation to develop a mentorship program for NHSC students in training, and a recommendation to plan celebrations for the 50th anniversary of NHSC legislation enactment and the first NHSC clinician field placement. Dr. Billings also showed previous recommendations to establish a balance between field strength and provider retention in underserved communities, and one to provide mentorship and training throughout participants' service. He said these were to provide information about the Council's past efforts. Dr. Billings said the Council was not required to reach consensus on priority topics at the current meeting.

Dr. Billings asked each Council member to identify two topics they would like the Council to consider.

Dr. Piernot said she would like to advocate for increased funding, and to support this position with data, such as results demonstrating that scholars and loan recipients continue to serve HPSAs after completing their service requirements. She also recommended expanded collaboration between BHW programs.

Dr. Taylor-Desir said her first priority was a letter to Congress requesting an NHSC budget increase. She agreed with Dr. Piernot's suggestion to support the request with data on provider retention in HPSAs. Her second recommendation was to implement a mentorship program aimed at increasing provider retention. She expressed concern that mentorship programs have been recommended multiple times but have not yet been implemented.

Dr. Etminan also recommended writing a letter to Congress to request a budget increase so that NHSC can support more scholarships and loan repayers. She also recommended supporting robust and relevant mentoring.

Dr. Sein said he recommended integrating the NHSC and THC programs to better reach and serve HPSAs. He said that retention is easier than recruiting and he would recommend emphasis on retaining scholars in rural and underserved communities.

Dr. Brown recommended implementing mentorship for dental providers, with a focus on integrating primary medical and dental services at health centers. He said that dentists sometimes feel isolated, which reduces retention. Mentoring on successful integration into HPSA settings could improve retention. Dr. Brown reiterated his recommendation to clarify regulations regarding reimbursement through both military and NHSC programs.

Ms. Witzel agreed that the Council should recommend increased NHSC funding so that the program can support more applicants. She also recommended considering changing time constraints and the primary care services definition to acknowledge current primary care service requirements in the field.

Dr. Callins pointed out that Council members serve for 3 years. She suggested phased implementation of recommendations, and to have each phase include a recommendation for action that the Council could act on and another that would require outside parties to act. For Phase 1 Dr. Callins recommended advocating for an increase in the NHSC budget. Her second Phase 1 recommendation was for NACNHSC to conduct an in-depth review of NHSC Application and Program Guidelines and recommend updates as needed. For Phase 2, Dr. Callins recommended that the Council consider issues related to workforce pipeline, mentorship, recruitment, and retention. She also recommended developing recommendations for and promotions of curriculum and skill development.

Ms. Stergar said that a letter to Congress recommending an increase in NHSC mandatory and discretionary funding would have to be submitted before May 2020².

Dr. Jones recommended support for data analysis to determine whether loan repayers continue practice in communities where they fulfilled their HPSA service requirements, and where they go when they do leave. He also recommended determining characteristics of communities most in need of additional healthcare services. He emphasized the importance of using data to develop objective priorities. Dr. Jones recommended developing efforts to market and promote service in areas most in need, possibly in collaboration with national professional associations, such as the American Medical Association, and organizations focused on services to smaller communities, such as the Ohio Association of Community Health Centers.

Dr. Schmitz recommended collaborating with other advisory councils, including COGME and at least one CMS advisory council representative to discuss issues related to graduate medical education funding. He also recommended analyzing the process for determining scholar eligibility and number of NHSC-approved site vacancies for scholar and loan repayer service.

Dr. Bockwoldt said she also thought the Council should consider recommendations and promotion for curriculum and skill development. She recommended expanding collection of data on loan repayers after repayment is complete in order to learn about participants' perceptions and what lessons they had learned about needs for curriculum and skill development. She also supported the idea of reviewing Application and Program Guidelines and recommending changes as necessary.

Dr. Pinto-Garcia also supported recommending an increase to the NHSC budget. She said that the workforce pipeline cannot be increased without an increase in funding. Dr. Pinto-Garcia supported the recommendation for NACNHSC to review Application and Program Guidelines and make recommendations as necessary, with a focus on supporting current program participants.

² The HRSA Advisory Council has advised NACNHSC members that this letter should be to the HHS Secretary, not to the Chair of the House of Representatives Health Committee.

Dr. Billings also suggested submitting a letter to Congress recommending an increase to NHSC's budget in order to meet demand for participation and address the impending fiscal cliff. His second recommendation was to encourage BHW to increase funding for Teaching Health Centers and to expand training support to more healthcare disciplines.

Dr. Billings asked whether Council members had identified points of agreement. Dr. Taylor-Desir said members had agreed on the need for increased funding. Ms. Witzel suggested that the Council should develop a letter recommending a budget increase by the next Council meeting, which is scheduled for March, in order to submit it to Congress before the May fiscal cliff. Dr. Billings concurred. Dr. Callins said that previous letters include relevant information that could be included in the new letter. She added that new BHW data also could support the recommendation. Dr. Billings said that a working group could produce a draft letter for review and discussion at the March meeting. He said Congress should be aware of NHSC's work, its unmet financial needs, and the fact that the mandatory budget has been stagnant since 2014. Dr. Callins noted that other groups, such as the Association of Clinicians for Underserved, are working to address the fiscal cliff. She suggested that the Council should integrate its efforts with others to maximize momentum. Dr. Billings concurred. He said individual Council members should talk with their legislators, contact the news media, and otherwise advocate for NHSC and for patients in need of healthcare services. He asked if any Council members had additional comments in favor of or in opposition to writing a letter to Congress³ to advocate for increasing NHSC funding. Dr. Piernot made a motion for the Council to vote on whether to write the letter. Dr. Callins seconded. Dr. Billings called for a vote. The Council unanimously voted in favor of writing the letter.

Dr. Billings noted that other topics of interest included reviewing Application and Program Guidelines, supporting mentorship, and supporting data analysis. Dr. Callins suggested that reviewing the Application and Program Guidelines could be completed by the Council in relatively little time, so would be a reasonable next step. Dr. Taylor-Desir agreed, saying that the Council probably could complete this task within a year. Dr. Piernot asked if there were

³ The HRSA Advisory Council has advised NACNHSC members that this letter should be to the HHS Secretary, not to the Chair of the House of Representatives Health Committee.

restrictions on changes the Council could recommend to the guidelines. Mr. Ali said the Council should recommend what they think would be best for the guidelines. HRSA would be responsible for considering statutory limitations in responding to NACNHSC recommendations.

Dr. Callins asked what, specifically, the Council would recommend regarding mentorship. Dr. Billings said the topic has been considered by the Council since 2016. He agreed that additional mentorship support is needed, and said the Council could address a letter to the HHS Secretary about this.

Mr. Ali agreed with Dr. Callins that the easiest priority for the Council to address is recommendations to update the Application and Program Guidelines. Dr. Billings said he would entertain a motion to vote on whether to review and update the guidelines. Dr. Bockwoldt made a motion. Dr. Pinto-Garcia seconded the motion. Dr. Billings asked if any Council members had comments on the issue. Dr. Taylor-Desir asked if the guidelines are the venue for a recommendation regarding the definition of full-time practice. Mr. Ali said NHSC's definition of full-time practice as 40 hours per week is provided in the authorizing legislation. Dr. Taylor-Desir asked if this definition could be reconsidered. Mr. Ali said the Council could recommend a change. Dr. Billings called for a vote. The motion to evaluate Application and Program Guidelines passed unanimously.

Dr. Billings suggested dividing into two working groups to act on the motions passed. One group would work on the letter to Congress recommending an increase in NHSC's budget and the other would review Application and Program Guidelines. Both groups would meet to prepare draft work to discuss at the March meeting. Dr. Bockwoldt asked how working group members would share documents. Dr. Billings said this would be determined after forming working groups. He asked members to volunteer for each group. Ms. Stergar had left to catch a flight. Dr. Billings said she would likely prefer to serve on the budget working group. Drs. Sein, Pinto-Garcia, Taylor-Desir, Etminan, and Piernot also volunteered to serve on this group. Drs. Jones, Schmitz, Buckwoldt, Callins, and Brown, and Ms. Witzel volunteered to review Application and Program Guidelines. Dr. Billings recommended that groups decide upon a point

of contact, initiate communication during the next two weeks, and schedule a conference call to begin work, with the goal of bringing draft products to the next Council meeting.

Dr. Piernot asked Dr. Billings to share the two previous Council letters to Congress presented as examples at the current meeting. Dr. Billings agreed to do so.

Public Comment

Dr. Billings invited public comment. Ms. Witzel said that CMS was soliciting public comments regarding scope of practice for nurse practitioners. The comment period was through January 17. Ms. Witzel said current CMS regulations prevents nurse practitioners from prescribing diabetic shoes, taking medical history and conducting an initial physical examination, admitting people to home care, or conducting initial home care visits. This has been a barrier to care access in her rural community, where physicians are not available to provide these services. Changing CMS regulations could eliminate this barrier, increase access, and reduce physician burden. Ms. Witzel invited meeting participants to share their opinions with CMS through public commentary.

Closing Remarks

Mr. Ali thanked the Council on behalf of BHW and the Division of NHSC.

Dr. Billings asked Council members to save the data for the Association of Clinicians for the Underserved's 50th anniversary gala for the NHSC to be held August 3, 2020 at the Mandarin Oriental Hotel in Washington, DC.

Dr. Billings thanked HRSA staff and Council members for their work, and expressed gratitude for family and staff who support HRSA staff and Council members. He emphasized the value of HRSA and Council work for underserved patients. Dr. Billings said that healthcare should be a right not a privilege. He invited final comments. Dr. Callins also thanked HRSA staff. Ms. Fabiyi-King provided information about reimbursement and wished Council members safe travels. Dr. Billings adjourned the meeting at 2:00 p.m.

Motions Passed

- Ms. Stergar motioned to adjourn Day 1. Dr. Witzel seconded. Dr. Billings adjourned.
- Dr. Piernot moved for the council to write a letter to the Secretary of HHS to support increased budgetary support for NHSC. Dr. Callins seconded. The motion passed unanimously.
- Dr. Bockwoldt moved for the council to review and recommend updates for the NHSC Application Program Guidelines. Dr. Pinto-Garcia seconded. The motion passed unanimously.