National Advisory Council (NAC) on the
National Health Service Corps
Meeting Minutes

February 10–11, 2011

Summary of Action Items

- Dr. Pathman will get data for Ms. Spitzgo about the 1990s State programs for LRP during education—page 15
- Ms. Spitzgo will share demographic data during Day 2 of the meeting—page 18
- A call for agenda items will precede the next meeting—page 23
- A call will be planned to help with the next meeting, and a draft agenda will be distributed for comment and possible additions—page 23
- Ms. Edgman-Levitan will identify the person to contact at the Institute for Health Care Improvements Open School Program—page 27
- Discuss inviting George Rust to the Council's next meeting during the planning conference call—page 31
- Ms. Edgman-Levitan will send materials to Ms. Derwinski about the Disparity Solution Center at Massachusetts General—page 31
- Send copies of the new Scholar kit and the video to Ms. Edgman-Levitan—page 31
- Ms. Dillon will talk with Ms. Edgman-Levitan about a NHSC Community Connections Event in New England—page 32
- Create and distribute a press release about the Council members—page 43
- Dr. Rogers will send information about coaching—page 45
- Confirm the urban/rural mix of NHSC providers—page 47
- Confirm the guidance about applications, credentials, and timing—page 47
- Query Council members about possible dates and locations for the next meeting—page 49

Day-1 – Thursday, February 10, 2011 **1:00 p.m.**

Council: Mary Amundson, M.A.; Kristin Baird, RN, B.S.N., MHSA; Byron J. Crouse, M.D., FAAFP; John Everett, D.O.; Theresa V. Horvath, PA-C, M.P.H.; Tito Izard, M.D.; Michael D. McCunniff, D.D.S., M.S.; Donald Pathman, M.D., MPH; Norma

Martinez Rodgers, Ph.D., RN; Darryl Salvador, Psy.D.; Susette M. Schwartz, J.D.; Rueben Warren, D.D.S., M.P.H., Dr.P.H., M.Div.; Ronald Yee, M.D., M.B.A.

Federal: Kenneth Brown; Philip Budashewitz, RPH, M.A.; Kim Derwinski; Leyla Desmond; Beth Dillon, M.S.W., M.P.H.; Kim Huffman; Njeri Jones, M.P.H., CHES; Kimberly Kleine; Eeshan Melder; Dan Merrick; CAPT Sheila Norris; Cynthia Sego; Rebecca Spitzgo; Mark Wheeler; John White; CAPT Jeanean Willis-Marsh, D.P.M.; Tami Holzman

Seamon Corporation: Barbara Murdock; Taye Hailu, Sr.; Len Rickman

Guests: Teresa Baker, American Academy of Family Physicians; Mary Lynn Bender, American Association of Colleges of Osteopathic Medicine; Michael Duenas, D.O., American Optometric Association; Rodney Peele, American Optometric Association, Rachel Gupta

Welcome and Introductions—Byron J. Crouse, M.D., FAAFP; Chair, National Advisory Council on the NHSC

Dr. Crouse welcomed and thanked everyone for overcoming travel challenges. He noted the meeting is being recorded and transcribed. He asked members and other attendees to introduce themselves.

Byron Crouse, M.D., is pleased to have been reappointed to a second term on the Council. He is benefitting from a change in the Council where members formerly were not allowed a second term. Many former members would consider re-serving. It is an honor to be Chair. Dr. Crouse is from the University of Wisconsin School of Medicine and Public Health (and a Green Bay Packers fan). He served for 10 years as dean for Rural and Community Health, and has been interim senior associate dean for 2 years. His specialty is family medicine. He is hoping to return to his passion of rural programming.

Rebecca (Becky) Spitzgo is the director of the National Health Service Corps (NHSC or the Corps) and associate administrator of the Bureau of Clinician Recruitment and Service (BCRS or the Bureau). She has been with the Corps for just over 1 year, and while starting to do specific activities for the second time can reflect on progress. Ms. Spitzgo has been with the Health Services and Resources Administration (HRSA) for 5 years, and previously led the Grants Office, and the Office of Performance Review. Overall, she has served in the Federal Government for more than 30 years.

Cindy Sego is the senior advisor to the BCRS associate administrator. She has been with the Bureau for just over 1 year and with the Federal Government for 11 years. Previously, Ms. Sego was with a nonprofit soup kitchen for 5 years. She is vested in populations the Bureau serves and the work it performs.

Tito Izard, M.D., is chief medical officer and interim president and chief executive officer (CEO) at Milwaukee Health Services, Inc. He unexpectedly became CEO when the organization's former CEO passed away 5 months ago. The organization is an urban model Federally Qualified Health Center (FQHC) practice. It serves 120,000 patients per year.

Beth Dillon, M.S.W., M.P.H. is director of the Division of Regional Operations, located in Denver. She oversees 55 BCRS and NHSC staff in the 10 HHS regions, including Site visits, marketing, and any other support for NHSC.

Kris Baird, RN, B.S.N., MHSA is from Wisconsin. Her background is in nursing in public health and critical care. For the past 20 years, Ms. Baird has worked in marketing and business development, with an emphasis on customer service. She runs a consulting firm that works with health care organizations to transform culture and shape the patient experience, and make it a place where patients want to come for care, physicians want to serve, and employees want to work. This is Ms. Baird's second year on the Council.

Captain Jeanean Willis-Marsh, D.P.M. is director of the division of the NHSC. She has been with the Bureau for 3 years, first as a branch chief for 2 years, and in her current position for 8 months.

Darryl Salvador, Psy.D., is a psychologist and director of behavioral services at Molokai Community Health Center, a FQHC on the island of Molokai, HI. He is a new Council member.

Rueben Warren, D.D.S., M.P.H., Dr.P.H., M.Div., is director and a professor at the Tuskegee University National Center for Bioethics in Research and Health Care. He is a public health dentist. For the past 2 years, Dr. Warren has been in Tuskegee, where there are no public clinicians and no such thing as emergencies. This is his second year on the Council.

Michael McCunniff, D.D.S., M.S., is a dentist with a background in dental public health. He directs extramural rotations for junior and senior dental students at the University of Missouri Kansas City.

Ronald Yee, M.D., M.B.A., is chief medical officer and a family physician at a community and migrant health center in California called United Health Centers. In 2010, the United Health Centers saw 47,000 patients in 187,000 visits at seven Sites. It is a full-service facility, including dental, an X-ray lab, and a pharmacy. This year it added behavioral health. He has served on the Council for nearly one year, and it is a great experience, including building friendships among people with similar concerns.

John Everett, D.O., is a family physician in northern rural Michigan. He has enjoyed serving on the Corps and is looking forward to seeing what can be accomplished this year among the great, diverse minds.

Don Pathman, M.D., M.P.H., is from the University of North Carolina at Chapel Hill. He is residency director, and spends most of his time at the Cecil Sheps Center looking at rural workforce and Federal and State programs for practitioners for underserved populations. He is a former Corps Scholar.

Susie Schwartz, J.D., is chief executive officer at The Hunter Health Clinic in Kansas, a community health center for the homeless and an urban Indian clinic. She has been there for 18 years. Previously, she practiced law. She is a new Council member.

Mary Amundson, M.A., has a background in social work. It was a natural transition to the University of North Dakota School of Medicine and Health Sciences. Ms. Amundson has been there since 1989. She directs the Area Health Education Center (AHEC) and has recently received a workforce planning grant.

Theresa Horvath, M.P.H., PA-C, is a physician assistant (PA). She directs the PA program at Hofstra University in New York. She has completed 4 years on the Council. Ms. Horvath was recently elected to the Board of

Directors of the PA Education Association, and hopes to use that position to move PAs to embrace the workforce shortage issue.

Kim Derwinski is the director of the Division of External Affairs. She has been with the Bureau and the Federal Government for 6 months. Previously she was at a private agency doing communication outreach and education.

Kim Kleine is deputy associate administrator for BCRS. She started in late spring 2010. Ms. Kleine has been with the Corps for 1 year and has performed various roles, including as a communications and customer service representative. Formerly, she was in external affairs at the Centers for Medicare & Medicaid Services (CMS). Her career has been in broadcasting media and public relations.

Njeri Jones, M.P.H., CHES is with BCRS. She works with the Division of External Affairs and works with the Council.

Kim Huffman is branch chief for the Member Resources Branch. She oversees NHSC conferences, Council meetings, and focuses on retention.

Tami Holzman works on the NHSC conferences.

Mark Wheeler is director of the Office of Compliance in BCRS. He has been with the Bureau since its inception. Mr. Wheeler has had various positions in HRSA since 2000. Previously, he was an attorney.

John White is director of Business Operations. He has been with the Bureau for nearly 1 year. Previously, Mr. White was with the National Institutes of Health (NIH) for 28 years.

Rachel Gupta is a student intern in the HRSA Office of Rural Health Policy.

Dan Merrick is the chief medical officer for the HRSA Office of Rural Health.

Michael Duenas, O.D., is with the American Optometric Association (AOA). He has been with AOA for 2-1/2 years. Previously, he was with the Centers for Disease Control and Prevention (CDC) Division of Diabetes and Chronic Disease where he helped develop a model that includes pharmacy, podiatry, optometry, and dental. Prior to that, Mr. Duenas was an optometrist in a health provider shortage area in Florida for 23 years. He is pleased with the HRSA changes regarding optometry, such as expanded service awards that include optometrists as essential primary care, and starting in 2010 the UDS data set will include including FTE optometrists.

Rodney Peele is the assistant director for Regulatory Policy and Outreach at the AOA.

Captain Sheila Norris is director of the Division of Nursing and Public Health. She runs the Nursing Scholarship and Loan Program, the Faculty Loan Program, and the Native Hawaiian Health and Scholarship Program. She has been with HRSA for 13 years, including the past year with the Bureau of Health Professions (BHPr).

Philip Budashewitz, RPH, M.A., is director of the Office of Policy and Program Development. He joined BCRS in October 2010. He is a pharmacist by training, and previously worked at NIH and the U.S. Food and Drug Administration (FDA).

Theresa Baker works in Government relations for the American Academy of Family Physicians. She has been in that position for 4 years, and has worked on Capitol Hill for 27 years.

Leyla Desmond joined BCRS in November 2010. She works in administrative and management services.

Ken Brown is the Bureau's executive officer. He started 9 days prior to this meeting.

May Lynn Bender is with the American Association of Colleges of Osteopathic Medicine Government Relations Department. She has been there for 4 years.

NHSC Program Updates—Rebecca Spitzgo, Associate Administrator, BCRS; Director, National Health Service Corps

Ms. Spitzgo began by noting it is great to be able to provide this update. Much is happening, including the effort to find new opportunities to promote the message and engage physicians and retain them after their service. Another effort is to maintain the necessary infrastructure within the Bureau to be well positioned to execute changes.

The titles of Ms. Spitzgo's slides are listed below in italics, along with supplemental comments and discussion.
Agenda. Realignment has occurred. Modernization means to make the Corps meet providers' needs right as they start, and have the Corps be more nimble in meeting needs.

Meet the BCRS Leadership (org chart). There was no office of policy prior to Ms. Spitzgo's tenure at the Bureau, but she got it started based on a clear need. Previously, the Bureau had three divisions; now, it has seven. That represents the program's growth, and reconsideration of the most sensible combinations of activities and prevention of missing things, since the Bureau is more than just NHSC. Phillip Budashewitz's office is new. The Office of Legal Compliance existed previously, and it recently brought approximately 20 people back into service versus placing them in default. The part-time option makes it easier to have people return versus default.

The Regional Operations Office serves all 10 regions. It was kept in house to have them do cross-cutting functions, beyond only supporting the Corps or doing outreach. Its staff is in the field, and that boosts its ability to help, including bringing in intelligence about what is going on. Program Operations serves participants in service, including in the Corps, the Nursing Loan Repayment Program (NRLP), and the Faculty Loan Repayment Program (FLRP). It will also manage the call center. A Triage Branch and a Participants Branch will emphasize customer service for providers.

The Division of the NHSC includes Sites, the Loan Repayment Program (LRP), and the Scholarship Program (SP). Formerly, Sites were in a different division not connected with the Corps (the Division of Applications and

Awards for all programs, not just Corps), but as the Corps grew and other programs fell by the wayside, the Site piece still was not well established. Site issues often were the cause of slow application processing, and people were lost in the system and disconnected. Part of the problem was having Sites managed by a different division, since Sites play a major role in placement after award.

The Division of Nursing and Public Health will be better able to handle the large appropriation increase (doubled), versus last year when it was more neglected due to small staff and multiple duties. The Affordable Care Act (ACA) added support for nurse faculty. Some LRP programs have been authorized in the ACA, but are not yet funded, and will be in this division if funded. The Division has room to grow, if necessary.
The Office of Business Operations is the information technology (IT) office. It is developing systems for cross cutting activities. It is looking at electronic files and synchronization across systems and products. The goal is integration of systems to support the entire Bureau.

The Division of External Affairs is focused on communications and outreach, including conferences. Formerly, its functions were fragmented. The new effort started in September 2010.
Many Bureau employees started within the past year. It is an exciting and diverse team. Cindy (Sego) has served as many of the titles listed in the slide.

Affordable Care Act Builds on ARRA. The Bureau is nearly done with the $300 million. In the past 2 months, the last $56 million was spent to reach 4,100 LRP awards. The field strength has doubled since 2008. A big jump is due to the ACA, and it is a good accomplishment. The Corps was the only place in HRSA with recovery fund money left, but now the awards are made. Awards are now being made from the annual funding.
Affordable Care Act & NHSC (awards now and over 5 years).

Ms. Amundson. Will the dollars stay the same regardless of what happens in the president's budget about to be released?

Ms. Spitzgo. The number includes ARRA, and the appropriation and funding stream. However, the annual appropriation is not yet funded. These numbers are likely unless somehow rescinded. No word has emerged about being rescinded, but it is a challenging time and everyone must wait to see. The annual appropriation is targeted at fiscal year 2010: $140 million for the Corps.

NHSC Field Strength Projections (bar graph). Field strength means everyone under an obligated service commitment, across all disciplines funded in the LRP and SP. It includes Scholars placed in service, and a small group of Ready Responders working in underserved communities. The largest numbers are in the LRP. 500 Scholars are in the field. Approximately 740 are in the SLRP and the rest are in the LRP.

The nursing programs supported through the Bureau are not included in this. Nursing gets appropriation as a separate line item. Including nursing would add several thousand to the field strength. By the end of 2011, the Division of Program Operations will support approximately 1,300 under some form of service obligation.

NHSC Field Strength Discipline Distribution (two pie charts). Data were included back to 2004, based on a discussion with Dr. Pathman (Council member). The biggest gains are in mental health and NPs, and some in

PAs and dental. It is not clear whether this indicates a different way to deliver care, or illustrates the physician shortage, but either way the Corps supports Sites that need it. It is not just about providing a surplus. As data improves, analysis will improve and help determine whether or how to shift numbers.
The situation with HPSA vacancies, physicians, and primary care is complicated in general and in light of the negotiated rule making underway. Based on percentages, there are many more vacancies for physicians than other professions. Recent projections for ACA throughout HRSA looked at dollars from the ACA, annual appropriation, and the Recovery Act (ARRA) and included PAs, NPs, physicians, and nurse midwives (NMW). 56 percent of the funding is for those professions in the LRP and 80 percent in the SP where there are fewer disciplines. That is what is being monitored. It is important that people seek care when they need it, and have assurances they will get it.

Dr. Izard. Looking at the 2004 numbers with 45 percent of 3,900 being physicians, that is roughly 1,755; and going to today with 25 percent of 7,500 that is only 1,875. It is great that more disciplines are included, but to the Bureau is the physician participation disconcerting or a strategy?

Ms. Spitzgo. Modifications in the early 1990s broadened the disciplines included. Over time disciplines have been included and dropped. Currently included disciplines are specified in the legislation. It was narrower in the past. Numbers differ partly because 2004 included more Scholars. In the SP, 60 percent are physicians, and that helped drive the 45 percent, but now more money is put in the LRP, and there is no clear answer on whether the changing numbers are good or bad. An effort to reverse them would look at tiers, and more LRP money to physicians to attract more, but it is not clear what that would do. It also is possible that a new, integrated health model has reduced physicians' roles as NPs and PAs do more.

Dr. Izard. Is flat participation from physicians deliberate by the Corps or based on more inclusion of other disciplines?

Dr. Pathman. In a current study on a similar program, interviews with recruiters in 30 States included a lot about how they cannot find physicians. Most likely the Corps is doing a great job in getting out the money, and did not turn people down for the LRP, so there has not been much response by physicians for the LRP. The interviews noted incentives by competing programs, so more specific strategies are needed if the goal is to increase physician participation.
Dr. Yee. In discussion about the legislation and $1.5 billion to the Corps was Congress looking to fill some of the Medicaid expansion, with perhaps half of the needed clinicians?

Ms. Spitzgo. That is not clear. The combined funding for the Corps and CHC expansion indicates Congress saw the Corps as part of the way to staff the CHC expansion, though there was no specific direction to do so. Clearly, funding is needed for workforce programs to make the ACA work.

Dr. Warren. The public health question is whether program changes impact outcomes.

Ms. Spitzgo. It is not clear whether the Corps can measure that.

Ms. Amundson. Not enough clinicians are looking to serve in underserved areas. The University of North Dakota School of Medicine partially focuses on rural primary care, and creating a rural preference strategy. It is important to make an impact on physicians who choose rural, especially those for who service is 7 years in the future.

Ms. Spitzgo. It is necessary to influence primary care by reaching into schools, but the Corps has not done enough of that. More will be done in 2011, mostly through the regional offices, including presentations and visits by Corps members to encourage interest.
Dr. Crouse. In addition to direct funding to the Corps from the ACA, other incremental changes include CHCs and workforce planning, including the National Center for the Health Care Workforce. Other activities are trying to address shortages, and the Bureau should look at how to interface with other initiatives. The effort is in a bigger environment than just the NHSC.
[Back to Ms. Spitzgo's slides.]

2011 Loan Repayment Guidance. This is a first for NHSC. The ACA changed authority for part time service from a demonstration to permanent, and the Corps established a 2- and 4-year option. It is not a separate competition for full- or part-time LRP. It is one process open for the same amount of time. The small number of part-time applications was partly due to the short time the cycle was open. This year 10 percent of applicants are choosing part time, and among those two-thirds choose 2 years. That is not surprising. The demonstration indicated many people were hesitant to commit to four years. Even though 2 years is half the money, it is better for many applicants' needs. Part time means a person can do other things, including work in a hospital.

The award increase from $50,000 to $60,000 was well received. Continuations were increased from $35,000 to $40,000. Flexibility in the ACA included service credit for teaching, so everyone can do eight hours of teaching as part of the 32 hours of direct patient care. A policy bulletin to clarify the definition and requirements for teaching was issued the week prior to this meeting. It was the Bureau's first official policy bulletin, and Ms. Spitzgo is looking forward to issuing more. The term "continuation" is from the grants arena, and replaced "amendment" since that word is confusing.

The new IT system allows electronic versus manual tracking. This increases visibility into the status of applications. Last year six to eight months between application and funding was not unusual, while the month before this meeting (January) awards were made for applications submitted in November. The Bureau now publically notes turnaround in three months. Technology helps, such as letting people know the status rather than have applications fester due to Site issues. Plus, with the online versus paper application people can easily check the status, though some challenges remain.

More than 4,000 people asked for advance notice of the application. That signifies a lot of interest. The closing date was moved up. Last year it closed at the end of July, but was moved to not push awards too close to the end of fiscal year. Also, leaving it open late led to more applications than could be funded, and that left many disappointed people. An earlier date can be extended if not enough applications come in, but a late date cannot be moved up. Many applications now are complete and ready to be processed. This is better than before, and the eligibility rate is higher. The online application includes an eligibility screen up front to screen

out those who will not be eligible. That also prevents people from applying and then waiting to see if they are eligible.

NHSC LRP Award Activity (matrix). Part time has a question mark because they are part of the overall numbers. For ARRA funding, officials want to know how the money was spent, so the matrix separates categories. The SLRP is not on this matrix, but will be funded with $10 million for State partners, and an additional 285 awards. *State Loan Repayment Program.* This was in BHPr because it was awarded to organizations versus individuals. It is funded by the Corps, and it affects the field strength. Having it in two places was a disconnect. States are struggling with budgets. This has a one to one match, and some States returned the money due to not being able to match. Bringing it back into the Bureau helped States do it differently. Many were not considering changes. Now with the Corps' help some struggle to find enough applicants. There was confusion over how money can be used. The PCO conference in December 2010 presented ways to be flexible in conjunction with the General Counsel and other guidance. States were asked to look for alternative funding, such as foundations and others, beyond other Federal money.

The goal is to bring more States back into the SLRP. Thirty States now have grants. It is a great use of money, since for half the cost the Corps gets more people in the LRP due to the matching requirement. It is a great way to grow the field strength. The program is a great opportunity to target high need areas. The Bureau now gives more flexibility to target areas.

Modernization of the Corps. Dr. Wakefield (HRSA administrator) often says it is no longer mom's or dad's Corps. It is doing new things. However, since August 2010 much discussion has ensued about Sites' vital role in recruiting and retention, but not a lot has been done with Sites. Communication includes at schools, including minority serving institutions. The retention strategy is evolving, but is part of everything done, and needs to be part of every touch point. The new IT system called BMISS is well underway, and is much further along than Phase 1. It is adding efficiencies.

BCRS Management Information System (BMISS). The Bureau is starting to create case work files via BMISS. People who call for support often say the Bureau should know who they are since it gave a lot of money, but too often callers have to repeat information with every call. The new customer service portal is exciting. Its recent soft lunch was with 600 people. Users can change personal file information, and check everything. It also will be the welcome kit for new participants. The Scholars portion, including for nurses, allows them to see when payments and stipends go out. Soon, people can apply for continuation online and not have to start the information process again, or do it on paper. This will relieve pressure on the call center. Utilization numbers will be monitored, and the goal will be to drive more use. Within the first few weeks 450–500 people went to the portal. The call center has limited hours, and that is a problem for clinicians who are not easily reached by return call. Some contact is for simple matters, and the portal means no assistance is needed.

NHSC Customer Service Portal (screen shot). Helpful Resources will include FAQs.

BMISS. Data cleaning is necessary for centralized usage. CAPT Willis-Marsh staff also is cleaning data. The effort to confirm contact points began with more than 3,400 names, and 2,500 came back as not right person to contact. BPHC has good CHC data, so this effort does not have to start over. Tiger teams were formed and

will work hard on the new system over the next 2 to 3 months. PCOs and other partners will help clean data. The Bureau is getting more nimble and confident in responding to data requests. Another legacy system retired this month, and by the end of calendar 2011 they all will be down.

NHSC Initiatives. The AHEC contract was in awarded in September. The project began at the University of Connecticut. The idea was to replicate the model in five States, to get people exposed to and interested in underserved areas. Another goal was to have differences among the States, such as large and small, to see if the program can be replicated in different places, and see whether a best practice exists. It is an 18-month award.

A cooperative agreement with Morehouse College was signed in September 2010. Its three components are training, resources, and networking. It will strive to reduce the sense of isolation and increase connections among Corps members. It will add alumni as mentors. It will offer CE credits, including online. It will have a soft launch at the Awardee Conference this coming March in Nashville.

A long-term retention study was awarded to the Sheps Center in September 2010. The most recent long-term retention study was in May 2000, and needed to be updated. The new study will be smaller in scope and done faster, due to the need to get results sooner. A participant and partner survey was done in August 2010. The review was about how to perform better and better leverage money. It is a struggle to get school data. Some evaluation data are coming in, and more will arrive over the next month.

Caps will be added to the SP. No caps exist now. Full scholarships are awarded regardless of school, and that leads to a wide range of funding. It could be from $250,000 to $400,000 with the same obligation. The cap will not be about directing people to a specific institution, but is about balance. Using caps could allow additional scholarships. Some scholarships are quite expensive. Scholars finished with their placement can enter the LRP.

Ms. Amundson. The Bureau is doing a great job moving the Corps into the next century. The portal is a good idea. Many people talk about PCOs having access to State Scholars and others, and the disk helps, but is not enough. Is the portal coming soon for PCOs to track providers?

Ms. Spitzgo. It is on the list, and will be available relatively soon. Site partner and PCO involvement in recommending Site approval or disapproval will drive use of the customer service portal. The Bureau knows PCOs want standard reports and one goal is for them to be able to run the reports themselves. Data will come together or in sequence. Challenges include security, such as a PCO only running reports for its own State. Hopefully this will be ready by the fall of 2011, but perhaps sooner.

Dr. Warren. The progress is Impressive. However, while good things happen nationally, gaps exist at the regional level between what is being said at this meeting and what is being done. That frustrates clinicians and Sites.

Ms. Spitzgo. Ruben (Warren) and Beth (Dillon) can synchronize since she is working with the Atlanta office. Together they can figure out what is missing. She started leading that in October. The process is evolving.

Everyone is encouraged to share what is happening in the field, including alignment between national and regional efforts.

Dr. Warren. How does public health fit?

Ms. Spitzgo. That is how non-nursing programs are captured, including the FLRP and the Native Hawaiian SP. That is how programs are captured without listing each one. Thus far no public health role exists, but it can be considered.
Dr. Warren. Public health is all of the above.

Dr. Everett. It is encouraging to see the Council's ideas becoming reality. An acronym sheet would be helpful since it can be overwhelming to keep it all straight. More information is needed about retention strategies and virtual education opportunities, including connecting rural clinics with specialty care.

Ms. Spitzgo. Kim will cover the virtual piece. The Morehouse Site will happen in March during phase 1. The formal retention strategy is under development. It has multiple components. The struggle is how to make it visual. Retention rates can be measured, and it becomes the umbrella of all the sub- components being started. How to frame retention must be determined. It is needed, and some things will drive it, but what it will look like and what will be included is being sorted out. Various things will be added along the way. It is a key component, but no strategy exists yet. The long-term retention study and feedback from conferences will help craft strategy. Hopefully more specific strategies will be available for comment at the next Council meeting, though the Council should offer input along the way.

Ms. Kleine. An acronym sheet is in the meeting packet. A direct correlation exists between clinician customer satisfaction and retention. That is being developed and improved, including better communication.

Dr. Schwartz. HRSA's recent coordination with the Indian Health Service (IHS) is appreciated. The IHS Office of Urban Indian Health recently sent a letter encouraging applications to be NHSC Sites. That is a good start, so including them in data collection is a good idea.

Ms. Spitzgo. They are prequalified, like health centers. A small group will be the first in. They also are good candidates for data cleaning, and use of new data to move forward. The HHS Secretary is excited about it, so it is a cross HHS initiative.

Dr. Rogers. The NHSC SP has family NP eligibility on the flier, but other documents break down NP sub-specialties. Are there different eligible disciplines?

Ms. Spitzgo. The guidance should be checked for the answer, but SP disciplines are more limited. It is limited to family NP, but in the LRP other sub-specialties are supported.

Dr. Rogers. Based on AACN criteria nursing is moving into a doctoral of nursing practice. How will that affect it?

Ms. Spitzgo. That is being discussed. Currently the doctorate program is not supported under the LRP or SP. Whether to change that is being considered. Nothing in the legislation prohibits a change in that area. Information is needed about Sites who hire Corps providers, including whether Sites need to support doctoral graduates based on a higher salary. How all of that fits together is being considered.

Dr. Rogers. Universities have a time limit, after which NP programs will fall under the DNP.

Ms. Spitzgo. The word is it will be a choice, but not after a while.
Dr. Rogers. The curriculum is changing to look more at evidence-based for practice, and make programs stronger. It takes a couple of years to start a DNP. Some do it online. NP programs will be phased out.

Dr. Duenas (public visitor). For optometry, BHPr uses the primary care landscape for data. Will the same data be in the health landscape for visual tracking and mapping, and a geography specific tie in?

Ms. Spitzgo. That is not ready, but will be a goal after data cleaning and consolidation. It will be part of the analytics. BHPr has made significant strides in using that tool. Some months ago some mapping of Corps clinicians was done, but was not informative and was dropped in favor of higher priorities.

[Break]

Stakeholder Perceptions—Discussion Group Summary from Scholars, Awardees and Site Executives – Kris Baird, RN, B.S.N., MHSA; President, Baird Consulting Company

Ms. Spitzgo thanked Ms. Baird for donating her time and wealth of knowledge to do this through her organization. She also supports conferences. The research did not reveal huge surprises, but reinforced plans and the emphasis on specific issues to resolve. Bureau staff was required to read Ms. Baird's report, including seeing the extent of alignment between internal and external feelings about progress and needed changes. Ms. Baird began by noting it was a pleasure to do this. She is a strong believer in qualitative research, since other kinds of data can be too cerebral. Qualitative research is interaction with people and their impressions. It moves the information from the head to the heart. Much about the Corps is about appealing to the heart, including compassion among the kinds of people the Corps wants. A wealth of information is meaningful, but fortunately the Council's work makes a lot of the findings moot.

The titles of Ms. Baird's slides are listed below in italics, along with supplemental comments and discussion.

Goal.

Discussion Groups.

Discussion Format. This is a form of a gap analysis for excellence overall and the Corps. It included a letter grade for the Corps, and what respondents would change to make it a better experience. That shows opportunities for the Corps.

Making the Grade. Many comments underpin the low grades. Many similarities existed between the three focus groups.

Common Themes (two slides). The sense of it being an honor to be part of the Corps should be harnessed for better experiences. People become disengaged too quickly. All of this is known, and much of it is being addressed. The two to three day response is generous since other groups insist on shorter times.

Positive. One person with the program for nine years claims to never have heard from the Corps, while a new person reports a much better experience. The line of experience is clear based on time in the system. Camaraderie and being part of something comes across in several different ways. Approximately one-quarter of respondents know about the Corps' Facebook page, and they are frequent, excited users. Most likely, others in the group went to the page based on comments about it. NHSC should push its page.

Negative. The person who had only one conversation with the Corps had to initiate it, but that seems unlikely. The person was disillusioned and vocal, and is telling people not to join since they "get their hooks into you." Others did not have that experience, though one bad example can spread negative publicity. When the Corps knows a person's name, it generates good feelings. That should be considered when the Corps considers its message.

Opportunities. "Educate" is cerebral, while "engage" is in the heart. "Empower" came up around things already implemented in the customer service portal, and that is good. Stories about wrong addresses, etc., will stop.

Awardee Milestones and Needs (flow chart). Every step includes psychological needs the Corps should consider to keep people engaged.

Scholar Milestones and Needs (flow chart). To capture and promote the excitement mind set will boost recruiting and retention.

Recommendations (two slides). Many of these are underway or complete. Call backs and measures for quality should be used. Some asked why Sites cannot be like monster.com for posting CVs. Clear expectations are akin to patients in waiting rooms. Some Scholars do not know about changes in the HPSA landscape and the possibility of needing to move to another State. This message must be redundant to ensure reception, including through multiple encounters with the Corps.

Ms. Amundson. The Corps used to give plaques of appreciation for a specific number of years of service. What is the status of that? People liked it. The Scholars Conference discussed the Student Experiences and Rotations in Community Health (SEARCH) program, but how many programs participate in SEARCH. There are none in North Dakota.

Ms. Spitzgo. SEARCH is not for Scholars. It is about exposing new people to the Corps and the underserved. Scholars already are members of the Corps. Beth (Dillon) and Jeanean (Willis-Marsh) are working on ways to financially support Scholars in training to do a rotation. It could be a major effort, including finding Sites and

staying in touch with Scholars doing rotations during spring break or in the summer. It will be separate from SEARCH.

Ms. Dillon. Erica is working on it. She has spoken with the University of Colorado Medical School who says it is doable but a mechanism is needed for getting rural Sites and CHCs. Hopefully it will be done by this coming June.

Ms. Amundson. Perhaps the requirement to give Scholars priority should be scratched. More exposure means better preparation to serve. It is good to point Scholars to PCOs to help stay in touch with the Corps, including the regional offices.

Ms. Spitzgo. The New Scholar Conference in November 2010 was based on feedback from August about Scholars feeling abandoned and without communication. It showed the need to do better, including a support network via regional PCOs, PCAs, and AHECs. The idea is to keep people connected and exposed to the underserved. Also, people in training will have better contacts and engagement through the newsletter and other vehicles.

Dr. Rogers. Did the focus groups cover a large area of the United States?

Ms. Baird. The groups from the Scholars Conference represented multiple disciplines and locations.

Dr. Rogers. This generally is social media. The Mentor Program has 260 students and face-to-face is not possible. That could help retention.

Dr. Yee. The flow chart is a good visual. It would be good to include a "percent complete" progress bar on the application similar to what is used on surveys. That would encourage people who start the application to finish it. One couple who both were Scholars feared disliking where they would be placed, but service is years away, so is there the possibility to convert from the SP to the LRP based on HPSA score so they have more choice?

Ms. Spitzgo. The legislation would have to be reviewed for an answer. The SP and LRP are separate programs, and there is no mention of switching between them. Consideration is being given to a hybrid LRP. The legislation allows participation in the LRP during the last year of training, but the Corps has never done that. It would be a hybrid between the LRP and SP without the HPSA restriction. Also being considered is more flexibility in how to craft program amounts and service obligations. A report about the pilot will be submitted to Dr. Wakefield, but not until 2012. It would be the best of both worlds and would attract people prior to their choice of specialty.

Dr. Pathman. In the 1990s five States had programs to do a LRP in the last 1 to 2 years of training. However, surprisingly the outcome data were awful for retention. People fled from the practices. [**ACTION ITEM:** Dr. Pathman will get the data for Ms. Spitzgo.] Also, the NHSC pins have to come in the right setting. Among the current generation, those who are just finishing and did not have a good experience early on based on poor contact (including Dr. Pathman many years ago), the pin in the mail has the opposite of the intended effect. If the pin is a part of ongoing contact it will be good.

Ms. Spitzgo. The pins were given out at the conference. It was not certain whether people would care about the pin, partially because of the amount of material in the bags, but during the debriefing, many people expressed interest in the pin. One NP noted not wearing the nursing pin even though it has meaning, and the NHSC pin also has meaning. The new policy is to mail the pin to everyone, and distribute them at conferences. Certificates are lagging, and that is an opportunity.

Ms. Dillon. An effort is underway for getting Scholars into safety net rotations, regardless of specific school. The biggest challenge is getting Sites to agree to host rotations.

Dr. Crouse. Most medical schools work hard to identify places that will take students. Support directly to the student rather than Site, such as housing, would help. Students know what is required of them. Direct support to students will lead to creative ways to meet their needs.

Ms. Baird. For some, opportunities to see what frontier and rural medicine looks like are more motivational than credit.

Ms. Dillon. It is necessary to make more Sites available. The medical school in Denver would welcome this.

Dr. Crouse. The realty is underserved areas have unmet service needs, and they will be reluctant to add an education component.

Dr. Schwartz. As an NHSC Site there are various kinds of students and interns, but with residents the medical university prefers to have them in their own Sites versus a CHC to gain community experience. Anything to encourage them to partner with the CHC to gain experience is good.

Ms. Amundson. The experience with Sites, including CHC, is increasingly difficult since they turn down SEARCH students. Sites are underserved and understaffed, and not interested in students. Different thinking is needed. Sites have NHSC providers but will not take students. It is necessary to incentivize Sites, as they see fewer patients.

Ms. Spitzgo. The SEARCH meeting in October 2010 discussed that. It is surprising, since taking a student could be a major piece of recruiting. Site partnerships should include expectations of Corps Sites, including being part of training and pipeline development. This issue could be good for discussions and strategies to increase the number of Sites to be receptive, and to develop a good network of Sites taking students.

Dr. Izard. It is necessary to create a participatory vision for learners and Sites. Getting clinicians to take students is about leadership. Sites without strong clinician support and leadership are less likely to do training. Is support for medical directors and other leaders being discussed? Physician participation is a flat line, but does not have to be. An environment for leadership is needed. It is important for the Corps to help clinicians be leaders.

Ms. Spitzgo. What would support look like?

Dr. Izard. Part time is a good example. The Corps can carve a role for medical directors.

Ms. Spitzgo. Recently a part-time participant, who is a medical director, offered thanks for the opportunity to do part-time work, and the ability to provide direct care and get loan repayment for the first time. That is an example of supporting leadership development.

Dr. Izard. Medical directors should be informed about the good things like that.

Participant Survey—Kimberly Kleine, Deputy Associate Administrator, BCRS

Ms. Kleine began by noting while the focus groups yielded more personal insights, the survey is among a larger sample pool. It was a web-based survey among loan re-payers, Scholars, and partners, mostly Sites, but also PCOs and NHSC alumni. The survey and focus groups yielded many similar themes, especially about support and communications, and how timeliness and details in communications are missing. Another similar theme is difficulty reaching a Bureau representative to help resolve issues.

The titles of Ms. Kleine's slides are listed below in italics, along with supplemental comments and discussion.

Survey Key Objectives.

The Organization and ACSI Method. It is important to know the key drivers of performance.

Overview. Questions used a 1–10 rating scale, and then were bundled into a 0–100 scale. Overall, NHSC is in the 70s range.

Part 1: NHSC Partner Survey. A 20 percent response rate is the goal, so 19 percent is good.

Partner Survey – Key Findings (flow chart). Scores of 90 and 91 for "will promote and recommend the Corps" are the Corps' strongest ratings. The lowest score was for "enough support even though you call us a partner." Scores for training, orientation, and materials are good, but the score for support is a low 64. The 74 for information is average, and respondents want more timely and relevant information with sufficient details to make informed decisions. Preferred formats to receive information are e-mails and e-newsletters. The Bureau's partners are professionals, so social media is a push. They know how to reach the Bureau, especially the PCOs and Sites.

BCRS Partner – 2011 Priorities. After the PCO meeting 75 questions were collected to probe during a call in February. Participants were sent answers first so it will be a meaningful discussion. Partners have difficulty finding things on the Web site, and were quite critical about it. The online networking tool is the Morehouse piece. CE credits also will be exciting. The efforts to work with Sites should be major, including working with clinicians.

Part 2: NHSC Clinician Survey. The 21-percent response rate is good. Asian and Hispanic rates are much lower. Proximity will inform recruiting efforts.

How Clinicians Learn about NHSC (flow chart).

Clinician Experience with NHSC. The 82 percent for "resolve issues" needs to be reconciled.

NHSC Clinician Survey—Retention. The first and third factors listed for retention are quite related.

NHSC Clinician Survey—Satisfaction. The overall score for communication is 71, while it is 70 for detail and 63 for being timely. Ability to find information on the Web site scored a 69. Those are priority areas, as is the customer service score of 75. The score of 68 for reaching a representative, and 72 for timely response were the lowest under the customer service umbrella.

BCRS Clinician Priorities 2011 (two slides, including short and longer term priorities). The triage team will centralize the process as the first line for customer inquiry, and will enter information into a tracker for number of calls and best ways to handle them, including when and where to refer them based on easy or difficult resolution. That started 5 months ago. Personalizing includes video clips and media stories featuring clinicians. Regions will handle local networking events, including five this year starting on May 18 in San Francisco. There is much enthusiasm, including for the using the alumni house at the University of California at San Francisco. The events will include NHSC alumni.

The Bureau has baseline and Kristen's (Baird) information, but wants to know what else should be researched. Sites are not happy, and clinician recruitment and retention is tied to that.

Dr. Everett. What is included in the monthly update? One association does a daily update, including items of personal interest and legislative updates pertinent to practice. An email like that is sufficiently interesting to look at every day to keep connected. The association also makes it easy to contact its headquarters. Members feel connected and updated in real time. It is important to make Corps communication worthwhile and have people want to read it and feel connected.

Ms. Kleine. The monthly PCO call will drill into topics and offer tech support. Now, clinician communications are quarterly, but they also get just-in-time email about policy and other changes, and announcements.

Ms. Derwinski. The three newsletters are for Sites, clinicians in service, and students. They all have different information needs. The first newsletters were distributed in November 2010, and the next round will be several weeks after this meeting. Feedback is needed about communication. Based on time constraints, the newsletters are no more than two pages, but the goal is to include substantial articles of three to four paragraphs, and to include a quote or short story about people in the Corps. Another goal is to include information on resources for topics such as HIV-AIDS, and health information technology, and a calendar of events within and beyond the Corps. The e-newsletter is sent as an attachment, and can be printed or shared. The Bureau is not tracking click paths.

Dr. Schwartz. Does the information go to Site CEOs or human resource managers? Site leaders want the information, and want to be able to recognize Awardees. Not enough information is sent about Awardees' progress, service, etc.

Ms. Spitzgo. Sites are sent a letter when an award is made, but sometimes senior managers do not see the letter. That is part of Site data cleaning and improved communications.

Dr. Warren. How representative of the entire field are the demographics in the survey? How reliable are the data? The response among Hispanics and others is very low.

Ms. Kleine. That is a good question. Few demographic data are available.

Ms. Spitzgo. Based on other numbers the Bureau has, 75 percent female is about right. It will be important to see how well other data match, but it should be close.

Dr. Schwartz. American Indians often are put in other categories, but hopefully that is not the case here.

Ms. Spitzgo. The number seemed to be too high. [**ACTION ITEM**: Ms. Spitzgo will share demographic data during Day 2 of the meeting.]

Ms. Amundson. The AHEC Association sends an update every Monday, and it is very helpful. It ranges from 2 to 10 items, but it is easy to read more. It is a good way to stay in touch with a national organization.

Ms. Spitzgo. The Bureau is struggling with the right frequency of contact. People receive a lot of email, but a drought from NHSC is not good. One goal is for people not to instantly delete Corps email.

Ms. Amundson. Several nearly simultaneous listservs exist, and perhaps can be merged into one.

Dr. Salvador. Will PCAs be engaged? The Executive Board includes health center executives.

Ms. Derwinski. PCAs have asked to be on the PCO call, but that is not the right approach. Quarterly PCA update calls have been discussed.

Ms. Spitzgo. Material sent to PCOs also is sent to PCAs.

Evaluating Retention in BCRS Programs: the NHSC—Donald Pathman, M.D., M.P.H.; Professor, Department of Family Medicine, University of North Carolina

Dr. Pathman began by noting the retention of NHSC Clinicians study published in 2000 actually represents data from 1997. He presented the study at the Council's spring 2010 meeting and while it was well received it also was noted as being old. The discussion at this meeting has covered an Impressive set of activities, but questions remain about efficacy.

The titles of Dr. Pathman's slides are listed below in italics, along with supplemental comments and discussion.

Evaluation Goals. Council input will be timely and helpful.

NHSC Groups to be Surveyed. As Becky (Spitzgo) mentioned, the scope will be smaller to make data collection quicker. However, the focus will be sharper and the sample larger than in the previous survey. It will use a good stratified sample design, so it is not too large but still has strong statistical power. It is not possible to survey retention among people still serving, but they can be asked how long they intend to stay. The retention numbers are from 2005–2006 clinicians. Current providers can rate satisfaction and the reasons, and can be tracked to see the effect. Retention efforts are old news since the Corps is changing fast, but the important factors can be determined.

Model of Retention (flow chart). This is adapted from literature about typical job turnover. Everyone on the Council accepts the notion that satisfaction is an intermediate step in retention, but many people do not realize that. The analysis will look for factors statistically related to satisfaction and retention or departure. Guidance is necessary for the definition of retention, including whether it means specific Sites, the same community, another underserved population, or any rural area.

Sample Retention Display (fictitious data) (bar chart). This can be within any practice that cares for the underserved. The project's goal is to present findings in ways people understand, and is intuitive and used by various actors, including NHSC ambassadors.

Sample Retention Display (fictitious data) (line graph).

Data for NHSC Retention Policies. Familiarity with the region is an important factor, and it is important to use that in placement decisions. An important question is whether Site satisfaction is how the Corps experience is rated.

The survey is going through the Office of Management and Budget (OMB) clearance process required for a federal survey. Hopefully that will be done within a few weeks of this meeting. Preparations for the clearance process were a daily scramble. Hopefully the survey will be in the field in March, and the data reported in September. The target response rate is 65 percent. The last survey response was over 70 percent, but response rates in general are going down.

Dr. Warren. Urban is not in here. Is the assumption that rural is all the same?

Dr. Pathman. It is difficult to ask whether a person is serving in an urban underserved area since it is not reported that way. Urban CHCs are adjacent, but not necessarily in underserved areas. It is not possible to determine setting type with just one question. Also, the term "HPSA" is problematic since clinicians often do not know. That is a limiting factor. The most important outcome is a composite. It is good if a respondent identifies a specific community that the survey team knows is a HPSA. It also is possible to inquire about percentages of specific patient types, and whether the organization's mission includes serving the underserved since people can answer yes or no. An affirmative to any of those questions indicates an urban underserved area. For rural advocates it is common to look at how long a person stays in a rural area, while urban advocates do not want to lose urban practitioners to rural areas. To inquire about race requires two questions, including Hispanic or not.

Dr. Pathman. Is the Corps required to report length of retention within HPSAs?

Ms. Kleine. The legislation requires counting the number of clinicians who choose not to serve in a HPSA after their service obligation.

Ms. Spitzgo. That is part of the reason to survey retention and customer service. Over the long term people will be asked to do an exit interview via the customer service portal before they can receive their letter of completion. That will include questions relevant to retention of individuals. The legislation mentions the short term, but the plan is also to ask long-term questions.

Dr. Salvador. Does retention include plans to do a continuation?

Ms. Spitzgo. After completion the person does not have a commitment. Someone with an amendment no longer has to stay.

Ms. Amundson. Data can be skewed when the HPSA designation is lost during the time of service.

Ms. Spitzgo. That is true, but the Corps has not removed people from HPSAs since 2002 so that is not a problem. The negotiated rule making will be monitored. By definition a HPSA is an underserved area.

Dr. Warren. OMB clearance includes the requirement for the government to collect data among certain races and ethnicities.

Dr. Pathman. The criteria will be the same as for the application data.
[Back to Dr. Pathman's slides, about a different study.]

<u>Flux in Loan Repayment Programs in Healthcare with States Budget Cuts and NHSC Budget Increases</u>
This was driven by States' budget issues and growth in the Corps.

Education Loan Repayment Incentives.

Project Goals. NHSC is a Federal model for loan repayment. Many States offer the same kind of program, and most are State funded, though some receive support from foundations. They often, but not always, are managed by the PCO. It is important to encourage people to think about the five other programs.

Methods.

State Programs Found. Hawaii was developing a program but it did not happen. Thus far the response rate is more than 50 percent.

States' Perceptions of their Own Programs (two slides, including verbatims).

Perceptions of the NHSC (two slides including verbatims). They love the Corps.

State-NHSC Program Interactions (two slides including verbatims). State programs often build around what the Corps does not provide.

Anticipating the Future (two slides including verbatims).

Potential Strategies. The situation has changed, but staying the same is dangerous.

Preliminary Survey Highlights (three slides, bullets and matrix). "Other" includes pharmacist and physical therapist/occupational therapist. The funding increase in some States was due to Federal money in the SLRP. Day 1 adjourned at 5:10 p.m.

Day 2—Friday, February 11, 2011 **8:00 a.m.**

Council: Mary Amundson, M.A.; Kristin Baird, RN, B.S.N., MHSA; Byron J. Crouse, M.D., FAAFP; Susan Edgman-Levitan, PA; John Everett, D.O.; Theresa V. Horvath, PA-C, M.P.H.; Tito Izard, M.D.; Michael D. McCunniff, D.D.S., M.S.; Donald Pathman, M.D., M.P.H.; Norma Martinez Rodgers, Ph.D., RN; Darryl Salvador, Psy.D.; Susette M. Schwartz, J.D.; Ruben Warren, D.D.S., MPH, Dr.P.H., M.Div.; Ronald Yee, MD, MBA

Federal: Kenneth Brown; Philip Budashewitz, RPH, M.A.; Kim Derwinski; Leyla Desmond; Beth Dillon, M.S.W.,M.P.H.; Rachel Gupta; Kim Huffman; Njeri Jones, M.P.H., CHES; Kimberly Kleine; Eeshan Melder; Dan Merrick; Captain Sheila Norris; Cynthia Sego; Rebecca Spitzgo; Mark Wheeler; John White; Tammy Holzman.

Seamon Corporation (meeting planner): Barbra Murdock; Taye Hailu, Sr.; Len Rickman

Guests: Teresa Baker, American Academy of Family Physicians; Mary Lynn Bender, American Association of Colleges of Osteopathic Medicine Michael Duenas, D.O., American Optometric Association; Rodney Peele, American Optometric Association, Susan Walter, National Association of Community Health Centers, Angela Jeansonne, American Osteopathic Association

Friday's Focus—Byron Crouse, M.D., Chair

Dr. Crouse convened the meeting. He noted the enjoyable dinner with members and staff after the Day1 meeting, and how that creates a team environment. The Council appreciates staff taking personal time for it. Staff has shared a lot of information and positive exchanges at the meeting. Day 2 of Council meetings often include much discussion about roles as advisors.

Future Council Meetings (not on the original agenda)

Ms. Spitzgo. Discussions with Dr. Crouse, as Chair, include how to best use Council members' wealth of knowledge. At times, members appear uncomfortable discussing certain issues. Some parts of meetings can be closed to anyone not on the Council or BCRS staff, but that would have to be stated in the Federal Register. Things are changing quickly. The Bureau wants the right format for Council meetings, and has shortened them. Some councils meet for only one day. Member input is welcome about closed portions, format, timing, etc. As meetings approach, the specifics of what will be discussed in closed portions can be decided. Open discussion typically is at the end, based on the full range of information, but some must leave for travel and other plans.

Ms. Amundson. Air travel is a challenge, especially for people who live remotely. A full first day and shorter second day would be helpful.

Dr. McCunniff. One and a half days is good. A half day for Day 1 is preferable since it allows travel that first morning versus being away two nights. Avoiding Saturday is essential. It would be good to include service recipients in the conversations. They need to see the Council as transparent, and their input is important. That includes the community receiving services and those who would like to.

Dr. Rogers. Medicare Payment Advisory Commission (MedPAC) meetings are a full day on Day 1 and a half day on Day-2. That is good for long travel. Part of that meeting is open to the public, by invitation and RSVP, and a specific portion is scheduled for public questions.

Dr. Salvador. Any time schedule is fine to get oriented to serving on the Council. Can the Federal Register notice call for an executive session?

Ms. Spitzgo. Yes, it just needs to be spelled out.

Ms. Horvath. In past meetings the Chair or someone else called for executive session and asked visitors to leave. It would be good to have a planned portion that way.

Dr. Crouse. Flying from the west and getting here by noon means leaving very early in the morning, and a long day. A full first day is better.

Dr. Schwartz. For some, returning on Saturday is necessary based on no late afternoon flights. It is convenient to arrive a day earlier and get a fresh start on Day-1.

Dr. Everett. It is nice to come in early before a full-day meeting, and leave Friday after it is done.

Dr. Pathman. The current structure helps identify what to discuss, but there often is not enough time for Council members' agenda items. Members should be asked what to include in the agenda.

Ms. Spitzgo. A request for agenda items was sent, but few were submitted. The request always is a good idea. The schedule of meetings can be impacted by when new member packages are approved. This meeting was called prior to approval, but fortunately the packages were approved in time. **ACTION ITEM:** A call for agenda items will precede the next meeting because the Bureau wants to cover topics of interest to members.

Dr. Pathman. This is a polite group, and that can stop people from suggesting agenda items. People should contribute to the agenda, and staff should more aggressively seek input.

Ms. Spitzgo. Perhaps a conference call would help link what is happening in the field and preparations for the next meeting.

Dr. Crouse. That was done in the past. It helps invigorate Council members' roles between meetings. People have different personal approaches to suggesting agenda items.

Ms. Spitzgo. ACTION ITEM: A call will be planned to help with the next meeting, and a draft agenda will be distributed for comment and possible additions. That will help invigorate members' role.

Dr. Pathman. SUGGESTED ACTION: It would be good to have pre-set blank subheadings such as "future directions' or controversies and issues. That will prompt suggestions.

[Ms. Spitzgo distributed Corps race and ethnicity data from early February]. These are self-reported data. It looks different than conference attendees, and thus is questionable. Perhaps conferences are not a total reflection of the Corps. Perhaps some cultures do not value a conference, but it is not certain. A HHS diversity plan is being developed. Goals and milestones are being considered, including specific increases in diversity,

but first the current status must be known. Data sources for the various disciplines supported are not good. That makes it hard to compare with national averages per discipline. It is harder to increase in areas already ahead of the curve.

The Corps' current status is not clear. A source is needed for national data to help the analysis of health care disciplines. Part of the outreach plan is to reach out to minorities and increase numbers. Workforce diversity limits and the Corps are issues. The field strength is not close to matching the people served. As the portal comes up, staff will look for confirmation and possible adjustments. Data are self reported and people can select multiple categories.

Dr. Warren. What can be compared?

Ms. Spitzgo. It starts within specific professions such as Hispanic or Asian NMWs overall and in the Corps. It might or might not be a good story, including about how communications work. It is important to align the types of providers and patients, since that boosts comfort and the number who seek care.

Dr. Rogers. Hispanics are Caucasian, so both race and ethnicity is how to ask.

Ms. Spitzgo. Race and ethnicity both are asked, and then aggregated in the table.

Ms. Amundson. The Health Workforce Information Center has good data, knowledge, and staff that can help search disciplines.

Ms. Horvath. Perhaps Asians can be subdivided into underserved Asians.

Ms. Spitzgo. Data are collected based on government standards.

Ms. Horvath. The government makes that distinction in some data.

Ms. Spitzgo. This is the minimum, though it can go further. It might become worthwhile to do more, but not currently.

Ms. Edgman-Levitan. The Association of American Medical Colleges (AAMC) keeps similar data on medical students. Perhaps other data from professional societies can be shared.

Dr. Warren. Professions, schools, and associations have data, such as the American Dental Association and others. HRSA's definition of underrepresented minorities is more sophisticated than raw race and ethnicity data.

Dr. Pathman. In the 1980s the Corps was 30 percent African American, but the program only did scholarships. In the mid-1990s it was 20 percent or less. Numbers by the two programs should be reviewed since selection criteria differ. The number of Hispanics is impressive. It is better when people self-designate race and ethnicity, but that can lead to questions about the data.

Ms. Spitzgo. A column should be added for people who refuse to answer.

Ms. Horvath. This does not show the n for total number of respondents.

Ms. Spitzgo. This is anyone currently serving an obligation. The data are based on a field strength of 7,530 at the end of September 2010. At the end of December it was 8,025. When approximately 700 SLRP participants are pulled out this number (shared at the meeting) is higher than the current field strength. Some double counting occurs.

Dr. Rogers. The high number of Hispanics is surprising.

Ms. Spitzgo. The number is questionable, since that is not what is seen at conferences. It is the same thing for American Indians. Accurate numbers would be great, and the Bureau will continue to work on it. The good news is this reflects growth in data systems and the ability to have data that can be confirmed and analyzed, or see when collection methods should change. Overall, it is good to help clarify specifics about field strength.

Dr. Rogers. Only 49,000 RNs in the United States are Hispanic, and only approximately 5,000 have a master's degree, so these numbers are shocking.

Dr. Warren. It is encouraging that the data were distributed today, only one day after the Council raised questions about it.

Ms. Spitzgo. Dr. Salvador is interested in knowing the Corps members in Hawaii. Other members are invited to request similar data.

Ms. Amundson. The Bureau should work with PCOs. The lists are confidential.

Ms. Spitzgo. Quarterly distribution of lists to PCOs is based on their past frustration with not knowing the providers in their States. With the SLRP back in the Corps, and distribution of names to PCOs, double dippers can be identified. That shows the value of accurate and shared data. People apply to both programs in hopes of getting one or the other, and some get both but participation in both is not allowed. Lists are covered by data use agreements and should not be shared. The systems of records notice gives authority to share information with partners who help promote program, but the Bureau does not want to put PCOs in an awkward situation.

[Ms. Spitzgo introduced Eeshan Melder, the director of the Division of Program Operations. She noted the responsibility among all in-service clinicians to answer questions and provide good customer service. Ms. Spitzgo also welcomed Council member Susan Edgman Levitan.]

The Modernization of the Corps—FY 2011 NHSC Strategic Communications Plan—Kimberly Derwinski, Director, Division of External Affairs.

Ms. Derwinski began by noting much of this topic was discussed in Day-1 of this meeting. The titles of Ms. Derwinski's slides are listed below in italics, along with supplemental comments and discussion.

Communication Goals. This was one of the first items discussed when Ms. Derwinski started with the Bureau. The goals are basic. Messages cannot be effective if people do not know about the Corps. The idea to recruit to retain underpins who to target. Research shows targeting people from communities served will boost the retention rate, so the targets are rural and racial and ethnic minority groups. A key goal is to keep people in the Corps and in primary care. Research also shows the need to maintain connections with members.

Refine Mission, Tagline, Logo. The August 2010 Council meeting included much discussion about the logo and tagline. Council feedback was incorporated. Focus groups were held in three cities in November 2010. One was with students eligible but not in the program, and one was with eligible clinicians not in the program. All respondents had education loans. Now a survey is underway among current members to get feedback on the logo and tag line. The survey has not closed, but strong preliminary findings are being presented today.

[Ms. Kleine asked whether what was being shown is closer to Council expectations, and received much non-verbal affirmative feedback.]

Ms. Amundson. Clinicians are considered professionals, though some do not seem themselves as professional.

Ms. Derwinski. Dental and medical professionals said using the term "clinicians" leaves out mental and behavioral health (MBH), but MBH providers say they are included. The term "providers" rises to the top more than "clinicians." Use of the term "professionals" will be considered. A consistent mission and tagline is the goal.

Refine Mission, Tagline, Logo (examples). Some were quickly discarded. Few rose to the top. Some equity is being developed based on recognition and appreciation. The current survey is looking at possible tweaks. Some feedback was to emphasize health and service, not the Corps. The blue and yellow theme, and the graphics likely will be kept. More specific and closer to final versions will be presented at the Council's next meeting.

Key Points of Communication (flow chart). Kristen (Baird) helped discuss the approach. People go through different processes with different needs, and that will guide future marketing. Scholars are different since it can be eight to nine years before they enter service.

Awareness and Investigation. Some of the materials are at this meeting. They will be refined. People want chronological listing of benefits.

[Ms. Derwinski showed the new marketing video. The Council applauded.]

Ms. Amundson. Since it can be hard to give presentations to NPs and other students who are not on campus, an electronic version of the video will help.

Ms. Baird. It should be available via Facebook and the Web site. That will increase its use.
Ms. Derwinski. Strategies for Facebook, YouTube, and the Web site are being tweaked since the goal is to drive traffic to the Web site. The video can be sent on disc and via links. The Web site is good for non-members, but it is important to know more about how current members use or want to use it. Hopefully the new Site will be launched in August or September of this year.

Another goal is better balance of information for prospective and current members. The 4,000 people who signed up before the cycle opened in November can be contacted. Limited contact via mail will be included. The exhibit schedule was scaled back, but still includes associations and conferences with rural and minority audiences. PSAs, speaking opportunities, and paid advertising will be included. The application and the call center will have better measurement of how people heard about the Corps. Regional staff will help coordinate visits, exhibits, etc. Many people are willing to visit schools, but the issue is whether a consistent message is delivered and tracked. A tool kit will be created for how to visit schools. It will recommend meeting with faculty, financial aid officials, and health professions counselors to maximize the value of visits. Presentations will be provided to ensure consistency.

Ms. Edgman-Levitan. The Institute for Health Care Improvements Open School Program is web based and involves thousands of health students interested in practice quality, safety, and other issues. It would be a good place for information about the Corps to help attract a broad array of health profession programs Don Berwick leads the program. [**ACTION ITEM**: Ms. Edgman-Levitan will identify who to contact at the program.]

[Back to Ms. Derwinski's slides.]

Awareness and Investigation (flow chart…Grassroots Outreach). A recent meeting with rural- and minority-based organizations discussed in depth how to work together. It must be two-way, so the Corps also has to offer help. An example of results was the meeting in January with the National Rural Health Association. That group noted a planned meeting with 53 residency directors, and requested the Bureau send information and a print PSA, and conduct a breakout session. Good, concrete activities are coming from the effort.
The Ambassador Program has 1,500 volunteers, and is a great opportunity. Organizations would pay millions of dollars for such a resource, but message consistency is an issue. Every conference includes ambassadors doing great work, but the Corps does not provide them enough support. More support is being developed. The title "ambassador" needs to have meaning. The ambassador database is being re-developed to record and list their activities, and a minimum number of activities will be required.

Ms. Amundson. A disconnect exists between PCO and ambassador roles. Some ambassadors try to act like a PCO, including Site processes. Ambassadors' roles should be clear.

Ms. Spitzgo. That needs to be clarified. It is about recruitment and promotions. It is not about recommending Sites, though ambassadors can help identify positive Sites. That should be included in a FAQ for ambassadors. Some do more than anticipated, some do less.

Dr. Crouse. PCOs are busy, but perhaps should engage at least once per year with ambassadors. Better connections are needed between PCOs and ambassadors.

Ms. Derwinski. The Bureau is trying to clarify the roles of ambassadors and other resources in every State. That includes PCOs, AHECs, etc. Alumni could do the same kinds of things as ambassadors, but the Bureau does not want alumni to feel obligated to continue to serve the Corps.

[Back to slides.]

Awareness and Investigation (includes photos). A sample of media clips is available to see. The Michigan Chronicle focuses on African Americans. Other publications have photos of clinicians and stories of how they got to the Corps and what it means to serve communities. Some great coverage is by trade publications such as for dental. Paid media includes minority-focused publications. The Bureau is outperforming the national rate for click through based on ads. Tracking will continue.

The Facebook following increased rapidly, per the plan to be smarter about use of social media. It was a generic strategy, but as it gained popularly it included a mix of things, including complaints, and it became hard to follow. Now, the first page is announcements about conferences, the call center, issues and responses, etc., and discussion threads are accessed via tabs. That is a better way to include posted policies. It is a great way to monitor confusion, concerns, etc.

Awareness and Investigation (includes U.S. map). The quarterly reports from States include 18 people who went through SEARCH and are applying. Maine has four people who were in SEARCH and now practice primary care. Only one received loan repayment from the Corps, so it is driving people to primary care even if not in by the Corps. The five States where the national AHEC organization awarded contracts for the Collegiate Health Service Corps (CHSC) are New York, Florida, Tennessee, Louisiana, and Utah. The program started in Connecticut. It exposes undergraduates to primary health care mostly through service learning projects and direct interaction. Since 2008, in Connecticut approximately 350 students have gone through the CHSC, and 65 percent have started health care careers. That is a high rate. The program will be carefully monitored over the next 18 months.

Application. Jeanean Willis-Marsh has been a great partner for working on the application piece. Tips and fact sheets were embedded based on knowing where concerns and questions arise. People want the timeline and process details up front. Next year's cycle will include better insight into where people are in the process so the Bureau can be more strategic with follow up, including emails, post cards, and links about what people need to know. E-blasts are being sent to the approximately 4,000 people who registered or started the application but not finish, to encourage them to finish.

Award. A welcome package was sent to the 2010 Scholar class. Something similar will be done for others. It includes important details and requirements. Materials will be on the re-designed Web site. The conferences were started to prevent default, but have evolved into major networking and training opportunities. The first webinar will be March 31 of this year. The Bureau continues to prefer people attend in person.

In-Service and Alumni Status. The 30,000 alumni are the best marketing tool. They know the experience and primary care, and they should be leveraged and kept engaged. These screen shots are early in development. A log-in for Corps members will be included. It is a dot.org Site open to all, but the goal is for it to also be a retention tool as a unique and valuable Site. Training will include webinars and a clinical focus to support practice. It will include CEUs and free training with no travel required. A cyber café will be key piece for 24/7 networking and retention. It will be password protected. HRSA has many resources and there are many beyond the agency, so connection via the Web site is good. Morehouse tends to be clinical, but NHSC also wants to do quarterly seminars on other topics of interest, such as business related issues.

Dr. Everett. Who decides what training is available, and who develops the Webinars and curricula? Clinicians are very diverse, with specific special needs.

Ms. Derwinski. It is via a cooperative agreement with the Morehouse School of Public Health and a clinicians' director network. A wide variety of topics is offered, but suggestions are welcome.

Mr. Budashewitz. Different roles for the Council could include training in leadership and other topics. Some requests are about a Site's business operations. That is not taught in health professions school.

Dr. Everett. Primary care is not the full range of what is done. Specific needs the Council can address can include training modules more specific than general primary care. CME offered through this training would be more incentive to use the Web site.

Mr. Budashewitz. These are issues to consider for future contracts. Training in leadership or around specific populations such as rural, or diseases, that offers CE would be a win-win for everyone.

Ms. Spitzgo. The subcontract with Morehouse and the Clinicians Directors Association already includes 600 CE accredited classes, and it could have more. Clinicians say that is a tremendous help for keeping the license. It can be a major tool for recruiting and retention. A former Scholar named George Rust is leading the effort at Morehouse. The goal is training for working in an underserved community since it is a unique talent not taught in school. The Council's suggestions can be shared. That would boost the Corps support and sense of engagement among members.

Ms. Kleine. Mr. Russ is connected in HRSA, CDC, and FDA, so he knows HHS training resources.

Dr. Warren. Morehouse has an outstanding medical school, but does not teach dentistry or nursing. How can they be incorporated?

Ms. Spitzgo. A mechanism can be found for that. The idea is to partner with organizations to use existing training materials rather than create new ones. A meeting with George Russ will include discussion about how to engage organizations.

Ms. Baird. Leadership training should include Site leaders. Webinars that combine providers and Site leaders would be good since they would hear the same messages.

Ms. Spitzgo. The goal is to get the word to clinicians and then Sites, and support clinicians at NHSC Sites. It also is important to retain non-Awardees at Sites. Tremendous opportunities exist to make a huge impact.
Ms. Baird. It is important to enhance the culture of those organizations to be a place where people want to seek care, providers want to practice, and employees want to work.

Dr. Yee. A corporate account for Hippocrates can help retain clinicians. Practical tools via easy links can be distributed at cost, or be donated. When clinicians keep open a Site while seeing patients they can see the Site all day, and that would be true for the Corps' Site.

Dr. Izard. It is important to set realistic expectations regarding culturally appropriate and compassionate care among minority and underserved communities. Providers can falsely believe they will know the community. They should know what to expect in new communities and at Sites. That will help prevent disappointment or disillusionment. Corps colleagues at Sites need to connect.

Dr. Rogers. The Corps should be careful to ensure it is culturally diverse among the many minority groups. Latino populations often are bilingual, and that is critical, especially in States like Texas, California, and Arizona. Many patients are documented for living in the U.S. but their primary language is Spanish. That needs to be gotten across better to new clinicians. It should not be assumed that someone from a Latino background speaks Spanish. As Dr. Warren said, Morehouse is medical, so other professions must be incorporated, including with offerings other than CME. Morehouse is culturally diverse, but predominantly black. The Corps' diversity needs to be broader to avoid the impression that the program only caters to one population.

Ms. Derwinski. That is a valid point currently being considered. A recent photo shoot had better representation, and that is included in the video.

Dr. Schwartz. The video did not include American Indians. Tribal clinicians do not work as closely with the PCO since they are self governing. Marketing could include a package specific to American Indians.

Ms. Derwinski. That is a great idea. The Bureau is collaborating with the IHS on joint programs.

Dr. Pathman. These are wonderful means of getting information to current clinicians, alumni, and others. This has been needed for a long time. Most connections have been with people in the DC area, but the Corps is a bigger group and success is better when people identify with the field rather than DC. Ambassadors need connections to support each other, not via a central office. Focus groups at a grantees meting years ago showed how clinicians want to meet with each other, not via DC. Infrastructure is needed to boost viral connections and sense of identity.

Ms. Baird. It is fun to encounter providers and see their pride; that is, untapped potential that should be emphasized and promoted. Corps Scholars at places like Georgetown University and the University of Georgia

expressed their pride. People on college campuses should be designated as NHSC alumni, and that will help promote the program. It would be good to map and track alumni.

Dr. McCunniff. The ambassador brief case generates recognition and comments from Corps-affiliated people, alumni, etc.
Ms. Derwinski. Blogs written by Council members would be great. Morehouse personnel will be invited to the conferences see what is relevant and up to date.

Mr. Budashewitz. The professional and other diversity in the Council will help engage multiple communities.

Ms. Spitzgo. Perhaps George should be asked to attend the Council's next meeting to hear this kind of discussion about the Sites, and share updates. There is nothing better than hearing it personally, so he needs to hear Council input first hand. **ACTION ITEM:** Discuss inviting George Rust to the Council's next meeting during the planning conference call.

Ms. Edgman-Levitan. The Disparity Solution Center at Massachusetts General has a Web-based program on quality interaction, with resources to include. **ACTION ITEM:** Ms. Edgman-Levitan will send materials to Ms. Derwinski. **ACTION ITEM:** Send many copies of the new Scholar kit and the video to Ms. Edgman-Levitan

Ms. Spitzgo. It is important to get it right. The Bureau always will target consideration of whether the investment is worthwhile. The goal was to get the video on Site by November 2010, but it has not yet received HHS clearance.

Ms. Derwinski. The message is changing. While the financial incentive remains up front, the message includes training and networking. Those are included in the video. Additional kits are being developed.

[Back to Ms. Derwinski's slides.]

In-Service and Alumni Status. The goal is to have five NHSC community connections events. The first is May 18 in San Francisco. It is informal, after work hours. It includes a 30-minute speaker, but the main purpose is connections among alumni, current Scholars, loan re-payers, and Sites, plus the support networks of PCOs, PCAs, AHECs, and ORHs. The purpose is to establish and support local connections. The first few events will be evaluated for possible changes. Another goal is for it to go viral where people connect on a regular basis.

Dr. Salvador. Hopefully that program will grow. Can HRSA sponsor connections by Web-X or other online methods?

Ms. Derwinski. The Bureau wants to do that, starting in regional office cities since logistics are easier. But if anyone wants to host one, staff will help. **POSSIBLE ACTION**

Dr. Crouse. Is there a definition of alumni? It includes former Loan Repayors and Scholars, but should include others such as former Council members who are invested in the Corps, and ambassadors.

Ms. Derwinski. It is former loan re-payers and Scholars because their contact information is easily accessible due to the data overhaul last summer. Former Council members should be included, but updated information is needed.

Ms. Amundson. In the Dakotas alumni are geographically scattered. It is not clear how to get them together, though it is a good idea.
Ms. Derwinski. It will not work everywhere. People will not drive hundreds of miles, unless multiple events are tied together. The program is starting as an experiment, including the days of the week to include.

Ms. Dillon. A commuting radius was calculated, though it differs across regions. Denver could include Cheyenne and Pueblo. Tying these events to others people plan to attend will be an incentive.

Dr. Rogers. Regional breakouts are possible, similar to how universities work with alumni. In Texas, the drive from San Antonio to El Paso is 12 hours.

Ms. Edgman-Levitan. It would be good to do this in Boston and New England. Many questions exist about how to get more Sites. A new huge focus and interest exists in primary care. Three times as many students applied for primary care residencies versus the previous year.

Ms. Dillon. Boston is on the list. Attractive venues are needed. **ACTION ITEM:** Ms. Dillon will talk with Ms. Edgman-Levitan about a NHSC Community Connections Event in New England.

Ms. Derwinski. Clear goals are needed. The events will boost retention initially, and then will boost recruiting as people bring prospects.

Ms. Spitzgo. The emphasis for the program came from conferences. Many attendees said they want to stay connected in their communities, but travel and daily responsibilities are a challenge. The events are worth the Bureau's investment, and likely will be combined with other events such as Johnson and Johnson leadership programs, NACHC conferences, and others.

[Back to Ms. Derwinski's slides]

In-Service and Alumni Status. The Bureau is doing better with updates about events, polices, etc., including messages to PCOs, PCAs, ambassadors, and anyone who might field questions about this. A magazine subscription or discount could be an additional membership benefit.

Scholar Specific Communication. The Regional Division is doing great work at staying in touch and making personal contact with Scholars, including letting them know about PCOs, PCAs, and ORHs. The pre-conference Webinar will reduce anxiety about the conference, and boost the value of attendance.

Measurement and Evaluation. It is important to know the right balance for contact.

Ms. Baird. Databases should be used to help this work, including metrics that indicate engagement such as number of times emails are opened, and webinar attendance. Some existing software can help. Longitudinal measures of engagement can be predictors of retention, and help planning. Opt-outs should be measured to indicate overuse of-mail, and initiate thinking about other methods. **SUGGESTED ACTION**

Ms. Derwinski. Automation will be great to help ensure the program is moving in the right direction.
[Ms. Derwinski asked what Council members are hearing; is the program on the right rack; and are clinicians and Sites inundated. She asked for suggestions on directions.]

Dr. Everett. Sometimes it is best to just start an effort and then re-evaluate. It is not a onetime event. It is good to look for what people are using and what is helpful, and what changes are warranted.

Dr. Warren. How to reach minorities and different geographic locations are important. Audiences should be targeted based on what we know, versus sending the same old messages.

Ms. Baird. The amount of ground covered in a fairly short amount of time is impressive. Congratulations and thanks for the work.

Ms. Derwinski. The Bureau has a great team. Further suggestions are encouraged.

[Break]

Minutes from the August 2010 Council Meeting

No corrections were suggested to the August 2010 Council meeting minutes. Dr. Yee moved to approve the minutes, Ms. Horvath seconded the motion and approval was by unanimous vote.

Site Partnership Initiative Update October 2010—January 2011—Becky Spitzgo (substitute for CAPT Jeanean Willis-Marsh)

Ms. Spitzgo began by noting much discussion has occurred about this. The Site Branch moved into the Division of the NHSC in October, and is under CAPT Willis-Marsh. The goal is to mirror with Sites the progress made in the application. Sites are robust and valuable, and opportunities are being missed. The Bureau needs to keep them engaged and be a good partner with them.

The titles of Ms. Spitzgo's slides are listed below in italics, along with supplemental comments and discussion.

SPI Goals. It is an initiative because the old methods are not being completely discarded, though the same things have been done with Sites for 20−25 years and need review. Ms. Spitzgo's first chance to engage Sites was at a Scholar Placement Conference where 100 Sites were part of the recruiting piece. During frequent interaction with participants, the strong message was they need the Bureau to do what it is supposed to do right, before it makes changes. That includes the application, processing for loan applicants, and communications to participants. Sites want to help support participants.
The idea is to start with getting the basics right, and drive better Site relationships and more vacancies that attract people and increase access to care. While it is not clear why this will enhance retention, some survey

results indicate retention is based on employee satisfaction tied to support and other factors. Sites need to be good places to work. Within limits, they can do some things toward that while the Corps does others as a value added proposition. A CEO in California noted the first training in three or four years, since he left private industry. For the Site, any extra money is reinvested to serve the community versus, spending on staff.

SPI Objectives. Information on the Web site about how to be a Site can be confusing. It should be more straightforward for clinicians to speak to Site leadership about becoming an NHSC Site. It needs to be easier to become a Site, within the law. The old process was to apply, and receive approval for a 3-year period, and then apply for renewal. That process was reviewed, and it seems better to only require an annual online certification for being in compliance with requirements, versus the full renewal process. The term "renewal" will be jettisoned, because it represents the old method. Only recertification is needed. That is part of the overall simplification.

Communications have begun via newsletters. Data integrity will ensure vacancies are true, and Sites are actually posting vacancies when they claim to be active, or the Bureau can investigate why they are not posting. It takes a long time to get approved as a vacancy, and by the time it happens some Sites forget to post it. They will be able to post their own vacancies online. That is a customer service issue.

Ms. Edgman-Levitan. This is frequently asked. People say it is hard and cannot be done, even when they want to.

Dr. Schwartz. Can a Site increase the number of posted vacancies after it applies for one?

Ms. Spitzgo. The Federal Register has a notice about vacancy caps per discipline based on HPSA score. Review of that process is finding many issues with numbers of vacancies and Site knowledge about what they can do. Dr. Wakefield wants the situation improved. The system should tell a Site how many it can post, and how many it has posted.

Dr. Salvador. A monthly posting confirms the vacancy status. Several Sites have expressed interest, but want the clinician applicant to seek the approval.

Ms. Spitzgo. No data have been collected for UDS reports since 2008 for multiple reasons. The large volume of data made Sites look like CHCs. Submitting data without funding to do it was a good reason to not be a Site. This is part of the effort to check points of contact. This is about non-CHCs. Already, more Sites are being monitored. The regions did 500 Site visits last year. The effort to engage clinicians and determine areas of need will be doubled. The Bureau continues to monitor the purpose of Site visits. Multiple visits might be scheduled among Sites in close proximity. Visits are to be about support and engagement, and not a compliance review. Private practice Sites are part of NHSC, but some are problematic because it is not easy to run a business, including the major financial effort. Sites will be visited prior to approval.
Many mental health providers are in close proximity, but approving some Sites could set them up for failure because they are not ready, even when they have good intentions. Acceptance into the LRP prior to a Site being open is not good idea. Perhaps providers in that situation can be connected to other Sites. Site visits are gathering good information on how to assist.

Dr. Pathman. Some Sites experience rapid turnover, so visits could find out why, including the wrong selection or management issues and how Corps and other clinicians are treated. The Site visit goal should be to ensure proper use of valuable resources.

Dr. Izard. Perhaps Sites be rated by Corps participants, and the ratings publicized so it is taken seriously. Monitor means to take seriously. Do Sites receive feedback from clinicians who leave?

Ms. Spitzgo. Hopefully that knowledge will be obtained, based on good data and tracking. Some Sites assume people are there only for the LRP and will leave after the obligation so it is not wise to invest in them. Dispelling that reputation will help boost retention. It also is important to prevent Site leaders from thinking the clinician is automatically on board for 2 years so it does not matter how they are treated. Hopefully, attitudes like that are the exception, but that cannot be known without follow up. It is important to capture the rationale for why people transfer or leave.

Dr. Izard. The Corps can leverage its position with Sites as a three-way partnership between clinicians, Sites, and NHSC. If Sites value their ability to get clinicians they should not be allowed to burn them out and then get another. Perhaps a scoring system can be used to encourage Scholars to help set expectations about specific Sites.

Dr. Rogers. Is there an evaluation process for Site leaders?

Ms. Spitzgo. Nothing is in place now. That makes it hard to know what is behind comments. Exit interviews will help capture data about Sites. Perhaps Sites that are not a good place to go should not be an NHSC Site, though that might not have been done before. Bad experiences are followed up, including an invitation to talk about it by phone.

Dr. Schwartz. Awards for the highest retention and lowest turnover could be more valuable than a stipend. It boosts visibility in the community and among providers.

Ms. Spitzgo. Discussions are underway about how to capture and share best practices, and recognize good performers. Conferences are one way.

Dr. Yee. Problem Sites are an opportunity for cross-agency collaboration among project officers. It is beyond NHSC's reach to evaluate and change Site operations. The goal should be to help versus punish, and to boost retention and maintain access in the neediest communities.

Ms. Spitzgo. Preliminary discussions have occurred with Jim Macrae at the Bureau of Primary Health Care (BPHC) and Tom Morris at the Office of Rural Health Policy.

Ms. Amundson. Former technical assistance was excellent, including for management issues and challenges.

Ms. Spitzgo. The Bureau is going back to that.

Ms. Edgman-Levitan. The NSCQU has a contract with BPHC to provide technical assistance to FQHCs to be medical homes, and make them high-performing organizations for staff and patients. Perhaps that effort can be connected with Corps Sites having difficulty.

Dr. Pathman. Exit interviews is a great idea, but are too late for the individual practitioner. Perhaps an annual survey can identify and help correct problems so people do not leave. Site practice software is being used for that. Based on the question about whether people will speak honestly, the process does not include feedback at Sites with below a certain number of providers. With increased Corps placement, perhaps 50 percent of Sites will have enough providers to do the survey. Respondents should be given the option to say whether it is okay or not to share their input with the Site.

Ms. Spitzgo. The Corps teamed with the North Carolina ORH and a foundation to support a practice Site survey used by 30 States for recruitment and retention. One hundred fifty thousand people use it. For rural areas it is a great tool. Great retention efforts have been based on surveys. An effort is underway to integrate online posts. This can help the Corps craft and monitor efforts with clinicians.

Dr. Schwartz. The IPC effort to improve patient care among tribes can be incorporated.

Ms. Spitzgo. The Corps can try to leverage that. **POSSIBLE ACTION.**

[Slide] *Objectives*. The recruitment portion of the Site is ugly and hard to use. It will be replaced by something much more robust, and rolled out in stages.

Ms. Amundson. Peggy Hunt has a virtual living room Site, and could be a good source. **REFERRAL**

Ms. Spitzgo. Some of it is about providing a platform for people to use for their own interests and tools.

[Slide] *Reengineer NHSC Site Application Process* (two phases). Regional staff members are closer to Sites and have better insights than the national office. The need to apply will be eliminated. Sites will be invited to the Webinar. Site recruiting will be proactive, versus waiting for them to find it. IHS Sites are first in line, and since they are a smaller number, they are good for a pilot. CHCs and FQHCs will be next.

Ms. Amundson. PCOs should not have to rewrite everything on the application to the recommendation form.

Ms. Spitzgo. That will all be available already. The bottom of the page should be the approval field, but there will be no need to re-enter data.

Ms. Dillon. It will use a series of check boxes for approval and recommendation of a Site visit.

[Back to slides.]

Refresh NHSC Web site. The Web site seems like an afterthought. The value proposition is why a Site wants to participate, and how it benefits. The benefits should be listed, and Sites should be encouraged to strive for clinician retention. Sites also should be encouraged to help with training, including as preceptors since that would give them a recruiting advantage by knowing about people prior to other Sites. Mentioning training up front versus adding it later boosts receptivity. It helps Sites know they are part of something bigger than just the Site. The benefits of being a Site need better promotion.

Technical Assistance and Resources. Expertise can come from working at a specific Site, or at a Site that performs especially well. A new contract will recruit and deploy Site experts. Many good things are not new, but should be more widely shared. HRSA has resources such as grant workshops to encourage and support novice grantees, and the Bureau can use those presenters.

Enhance Communications. Not enough has been done, so the Bureau is working to do more. Vacancies must be posted, and the Bureau is helping with that. The customer service portal is all encompassing

Data Integrity and Collection. NHSC Site data survey was UDS, but now is more expansive. Vacancy data now has duplication. ARRA increased the caps significantly, but now the number of clinicians at a single Site is being reviewed, including the goal for that. Some have a fairly large number based on seeking the large amount of money, but now more focus is on the proper geographic spread of funding.

Site Monitoring. Risk-assessment tools are a new effort, and include technical assistance. Assessed risk includes financial solvency, and the payer mix. Also considered are the types of patients attracted within the radius of business, and a competitive market analysis. These tools are not yet developed.

Ms. Dillon. The Bureau is determining the most important Sites to help. Indicators are needed, such as turnover, and risks associated with seeing anyone regardless of ability to pay and whether the Site is doing so. In one case a Site was actually an apartment building. The risk of fraud is real.

Ms. Edgman-Levitan. The Primary Care Development Corporation in New York City provides technical assistance to Sites across the city and State. The North Carolina PCO helps communities determine if they can sustain a new Site. That includes self assessment prior to receiving technical assistance.

Ms. Horvath. PA training finds formal evaluation by Loan Repayors and Scholars helps assess Sites, since Sites are on their best behavior during visits. Student evaluation helps broaden the information.

Ms. Spitzgo. That has not been done, but perhaps an early assessment can provide data that can be cross tabulated to give good a picture of Sites. Indicators exist that can help reduce the number, or better target Site visits, and evaluate Site applications. Data will help track changes in indicators among specific Sites. The Bureau needs to be proactive, not reactive

Ms. Amundson. That could be a good tool for PCOs or whoever approves Sites. A checklist would help.

[Slide] *NHSC Site Welcome Kit and Signage*. PCOs have not sufficiently been in the process. They are at the beginning, but are not notified about approval. That will change. Many Sites pay a lot for recruitment. The NHSC recruitment Web site is a huge opportunity for the Corps to make it worth accepting everyone and drive people to serve the underserved. The Corps has not done much of that, and if done right it will open access and influence career choices. It could be like monster.com.

Dr. Yee. It is good to redevelop the Web site so data can be updated. Sites are willing to help make it a good recruiting tool.

Ms. Spitzgo. It is to be a platform for Sites to use as they see fit. The Bureau will suggest how to attract people, using things like photos, but Sites should do their own efforts.

Dr. Everett. Recruitment is limited to Loan Repayors and Scholars, but in 4 to 5 years, a huge pool of clinicians will be interested in Sites like this if the incentives are sufficient. Experienced clinicians should be recruited to underserved areas. They are a much bigger pool than recent graduates.

Ms. Spitzgo. The term "volunteer" can be confusing. Now it means a Site can post vacancy and call it a volunteer position because it is a vacancy not tied to a LRP or SP offer. It is a recruiting tool, but no NHSC money is involved. Recruiting for non-NHSC vacancies is a good idea, but "volunteer" sounds like working for free.

Dr. Everett. "Volunteer" sounds like working abroad or disaster relief. It does not sound like a job.

Ms. Spitzgo. When all efforts are well underway there could be an opportunity to recruit experienced clinicians to serve the underserved. The current pool of money is for the LRP and SP.

Dr. Everett. The mission is to bring health care to those who need it. Limiting the effort to the LRP and SP limits the ability to treat people who are hard to reach and need care.

Dr. Schwartz. As many providers approach retirement and winding down a practice they want to see patients and pay back.

Dr. Warren. A cadre of clinicians wants to do this kind of work regardless of loan repayment or a scholarship, and some are frustrated by the limits of the private sector. A huge pool is waiting to serve.

Dr. Yee. Change the terms from "volunteer" to "non-NHSC clinician."

Ms. Spitzgo. No one is listed as volunteers in the data, so the term is not working. It is a good concept, but the terminology can be better.

Dr. Crouse. There needs to be a benefit to the service. A retirement plan can be a major incentive to stay at a current employer. Some people consider what to do in the last stage of a career, and for some that includes interest in underserved areas. However, for some, what would be lost is too much.

Ms. Spitzgo. People should be informed that work in these areas is rewarding, but incentives from the Corps are needed and do not yet exist. Perhaps the Bureau and Sites can work together on this.

Dr. Crouse. Some students are offered $200,000 for service, but perhaps that could be put into a retirement plan to entice physicians into certain areas, including near where they plan to retire. Many begin to think about being a health care consumer, not a provider.

Dr. Pathman. If Sites had to pay $250 for each vacancy posted they would pay closer attention to the process. That might help prevent false or old posting of vacancies.

Ms. Spitzgo. That could fall under the Economy Act and the prohibition of federal competition with the private sector. At a minimum it would need authorization.

[Slide] *Realign Customer Service Efforts.* Two call centers will be combined.

Ms. Baird. Much has been covered about Site support, and the Bureau should tell Sites it is responding to their stated needs. That is part of educate, engage, and empower. **SUGGESTED ACTION**

Ms. Spitzgo. Good point. It can be a struggle to engage Sites as a group. Suggestions are needed.

Dr. Izard. What percent of Sites participate in the recruiting fair?

Ms. Spitzgo. It is small. One hundred slots are allocated. They must be in a high HPSA where Scholars are placed, and that typically is a HPSA of 17 or higher. That is the annual Site gathering, and is only for Scholars.

Dr. Schwartz. To piggy back on events is a good idea. It would be good to have Ms. Spitzgo speak at the National Council of Urban Indian Health Conference, and at NACHC conferences.

Ms. Spitzgo. The Bureau is on the NACHC agenda, and Ms. Spitzgo recently spent 5 days with them to get re-engaged. However, that is part of a broader effort versus specific to Sites. Opportunities to be more specific to Sites are needed.

Ms. Edgman-Levitan. It will be critical to quickly send the message that the Bureau listened and acted upon Sites' needs. **SUGGESTED ACTION.** Webinars are helpful, including when they are recorded and used whenever convenient for providers. They are quite popular, and are cheap and easy for busy clinicians.

Dr. Yee. A multimedia approach is needed, based on available resources. It is good to show the Bureau is responding. A letter should be sent to Sites to summarize what is being done and invite them to webinars. The same message should be disseminated at conferences. **SUGGESTED ACTION**

Ms. Amundson. Sub-regional Site gatherings could be good.

Ms. Spitzgo. The Bureau shared the message at the PCO conference in December, and it was well received.

[Lunch]

BCRS Customer Service Strategy—Eeshan Melder, Director, Division of Program Operations, BCRS

Mr. Elder began by noting the effort thus far is at a fundamental level. He joined BCRS in February 2010. His background is in consulting for Federal agencies. He was interested in joining an effort with multiple parts. The titles of Mr. Melder's slides are listed below in italics, along with supplemental comments and discussion.

Key Drivers for Customer Service. These items are not outstanding now, and that has a negative impact.

Our Customers. Mr. Melder works with in-service people, but customer service touches all aspects, and needs a holistic approach. Questions arise about how people in troubled or default situations are handled. It has changed for the better in the past year.

The Big NHSC "Customer Service" Picture. This is an example of accountability. Traditionally, to leave a Site a participant needed an express written letter of permission, but that does not make sense and crates unnecessary paperwork. That was changed as part of being more accountable. Service requests such as changing Sites, deferment, waivers, maternity leave, and others sometimes took two years to process. The full new strategy is not yet in place.

BCRS In-Service Casework May 2010—Present (bar graph). It was 600 service request of indeterminate status.

Challenges. The industry perspective is a two to three year horizon for visible ROI. Outreach strategies are being developed. People are predisposed to talk about extremes, and people will tell others about bad more than good experiences.

What is Customer Service?

What is Excellent Customer Service?

General Customer Service Best Practices. IT support helps staff handle requests, and the sequence of necessary events. A bad example is when someone calls to seek an amendment, and the staff person knows the person is missing the 6-month verification so the caller gets shuffled around. Instead, it should be seamless, and technology allows that via personal histories embedded in files. The goal is a common, good outcome for everyone. Mr. Melder is working with Ms. Dillon and the regions to incorporate time-phase contact with providers at Sites. That could include Dr. Pathman's idea to seek feedback prior to a person's end of service. Mr. Melder uses "sucks" as a search term in Google to find negative comments about specific stores, vendors, etc., and he has gotten hits about NHSC related to customer service. Hopefully improvements will stop that.

Ms. Spitzgo. The Bureau recruited Mr. Melder to lead the re-engineering, but by time he arrived the backlog was discovered and that became his job.

NHSC Customer Feedback. This is anecdotal from multiple sources. Insincere responses do not show understanding that participants are humans, and not just numbers. Sometimes people will venue shop for finding the right staff person to help or to grant approval for something, but it all should be one voice. The portal will allow people to see what forms they already have submitted, and that will prevent redundancy. More caution is being taken to document exceptions, and ensure staff members are aware of them. That will make it more consistent.

General Solution Strategies (matrix). Hopefully within the next year all calls will be managed through a single system with the underlying data to track through every process. Too often the response is not as crisp as in the private sector. Becky (Spitzgo) said she never wants people to feel stuck. They need an out, and that led to development of gethelp@hrsa.gov as an alternative route to get attention. Mr. Melder gets reports twice per week on that. Training for handling callers' anger is pending. Call centers are challenged to know exactly what is happening when managers are not actually listening to the conversations, and that is why monitoring is important. The new IT system is a major improvement since this kind of program depends on good data. One goal is to be paperless. Staff is painstakingly going through each file, and eventually it all will be cleaned and online. Internal quality assurance includes spot checks.

Priority #1: Fix Our Call Center. There actually are more than two places handling calls. First call, first response is the major rule, versus sending people to voice mail.

Approach.

Priority #2: Empower the Providers we Support via an Internet Portal. Once online it is easy to have providers and others update their own information. The options to call or use paper remain, but hopefully most will do it online.

Customer Service Portal Vision of NHSC Participant. One goal is to make the 6-month verification a check in, versus just a check mark. Electronic systems give more flexibility versus asking a Site to sign, and worry about negative comments. This can be an alert system to reach out to investigate and pre-empt problems. The exit survey should be in place over the next six to eight months. The completion letter is the point obscured by the photo in the slide.

Portal Rollout Schedule. The goal is to start with 6,000 users. It will become the primary way people interact with the Bureau.

Priority #3: Policy & Process Definition. The vision is to make actions consistent. That will help modify efforts and train staff who can stop at any point in time and see if they are doing it accordingly. Mr. Budashewitz's group does more than policy. Answers for how to handle exceptions will quickly be entered in the manual for all to use going forward. Training will boost uniformity in implementing and following policy. An example is how to handle the economy and provider layoffs.

Summary/Other Issues. Positive experience is challenged when issues are major or complex.

Dr. Warren. Discussions about customers seem to stop at clinicians and providers, but the people served also are customers, and clinicians should understand they are not the end point. Patients are the ultimate goal.

Ms. Baird. This is great progress. Are you tracking things like time to completion from initial request to resolution, and setting a standard for time?

Mr. Melder. The goal is 30 days for completion if possible, but sometimes the requester does not send information soon enough. They will be contacted within 10 days for what is missing.

Ms. Baird. Some issues take more than 30 days, but some questions can be answered quickly. The focus group response was to expect a call back within two to three days. Is there a standard for that?

Mr. Melder. All communications tell people if they do not hear back in two days to escalate to Mr. Melder or another division leader. Simple inquires should take less than two days.

Ms. Baird. A response in less than two days will help exceed expectations, and repair the Corps' image and reputation. Social media chats include much about response times. Minor issues that do not need interaction from various departments should be resolved within two days. Brand marketing depends on the experience, which is the brand. The Corps phone experience needs to be a brand. Front end scripting is good.

Mr. Melder. Two days should be the outer limit.

Ms. Spitzgo. Realignment after the focus groups included a triage team for one place to handle calls. The triage team counts the percentage of inquires answered during the first call. It is important for people to get live person versus voice mail or no answer. Staff has basic knowledge of the situation. Some issues are easy. Some need the next level that can take several days and then bigger or more complex issues take longer.

Mr. Melder. Everything gets tracked as an inquiry unless it is a definitive request such as for a transfer. Usually the calls are about a person considering doing something. Often, answers are available quickly and the matter can be closed. However, many are about a bigger issue and include a trail of events, actions, etc., that require understanding of the full situation before a response can happen.
Ms. Baird. Is there a function to ask whether the person's question has been answered, and if not, that triggers more action? The system will track number of calls, but it also needs to track issues not resolved

Mr. Melder. That does not yet exist. Also, since calls are not monitored, enforcement is not yet done. It will be good to link to email addresses to send the survey about interaction.

Dr. Izard. How is staff trained and educated, and are you using new or re-trained people?

Mr. Melder. It is a mix. It is handled internally since it is foundational. It includes simple things like not saying BMISS is down because the caller will not know what that means. Vendors are being considered to do high-level customer service training across the Bureau.

Ms. Spitzgo. It is easier to train new staff. The existing culture was a backlog is necessary to the organization. It is job security, and staff convinced themselves is was not possible to keep up with the volume. That is changing. Bringing in new staff allows tipping that culture, including tracking and seeing a large majority of cases are closed in 30 days since timely attention makes that is possible for most. Dr. Wakefield says a case study can be done about this.

Dr. Pathman. It is good that people can update their own information in BMISS, but a problem can exist in the back end of data systems where fields can be overwritten with new information. Is old information saved? The specific dates information is changed should be stored.

Mr. Melder. The amount of old information kept is being looked at.

Ms. Edgman-Levitan. Congratulations on this progress. Many people familiar with the Corps advised Ms. Edgman-Levitan to decline the invitation to serve on the Council based on the likelihood that nothing will change, and it is a lot of trouble. It is a new day in Washington, and primary care is important. This material is addressing what must happen, and it is responsive to the focus groups. It is amazing what was done in a short time. Staff deserves a standing ovation. [The Council applauded.]

Ms. Spitzgo. It is a great team, and the goal for this meeting is for the Council to interact with the team. Hopefully the same team will be in place over the next two to three years to support the momentum and reach even higher accomplishments. The vision includes doing more, and it is difficult to wait for progress. It is great to see the Corps become what people have wanted for a long time. It is exciting, though challenges remain. Council input helps.

Dr. Rogers. Was a press release done about Council members? MedPAC did one, with a picture of all the commissioners. That triggered articles about MedPAC and it was a great way to advertise the new commission's view and mission.

Ms. Spitzgo. That has not been done, but is a great suggestion. **ACTION ITEM:** Create and distribute a press release about the Council members.

Ms. Baird. The press strategy should include mention of the organizations the Corps is involved with, since they will then pick up the press release.

Ms. Edgman-Levitan. Webinars or YouTube material with the graph about resolving the backlog would be enlightening.

Dr. Pathman. The Council is impressed with the changes, including how it will enhance the Corps' reputation. Perhaps advertising could show the changes and how the Corps is different. That would help generate positive word of mouth over the next 40 years.

Dr. Crouse. That is a good idea, but the message should not start with how the Corps was terrible. It should say the Corps is good and getting better.

Ms. Spitzgo. That is part of the reason to say "modernization" to show how major growth is being handled. Dr. Wakefield mentioned the Corps and its improvements in a recent speech, and she requested a two-page summary about the efficiencies and changes based on the Secretary's call for government efficiencies. It was hard to cover all the improvements in only two pages.

Dr. Rogers. MedPAC's Chair is careful about what is said in public. That is important. "Modernization" is better than saying trying to do better since that implies poor quality in the past.

Dr. Izard. Research has shown most people do not have an image of NHSC. Instead the Corps is more unknown. Some people have positive or negative impressions, but most do not know about the Corps. It is not clear whether going forward the past should be mentioned or ignored.

Ms. Spitzgo. The past should not be ignored. Past frustrations, including with conferences, can be acknowledged. The situation turns over quickly since most providers are on a 2-year commitment. Many getting awards now will have a positive experience, but it helps to show improvements to people who were frustrated. It also is good to mention impending changes based on feedback. It helps people to know they have been heard. The Corps has a wonderful, forgiving group of people hanging in there based on passion for the service.

Dr. Rogers. Kudos to Becky for her great deal of positive energy.

Open Discussion

Ms. Spitzgo. The meeting has offered great suggestions, but what else needs to be addressed, now or in the future? It is a transformation period but it is important to consider the future and make plans.
[Dr. Crouse asked everyone to offer three things that should be considered.]

Dr. Crouse. One issue is expanding equity and resources. For example, representatives from Montana asked for assurance that someone from that State would receive a scholarship. Second, it is important to have periodic open discussions in the Council about the professions included in NHSC. At a recent National Rural Health Policy meeting, pharmacists, optometrists, and rural surgeons noted significant needs and suggested their inclusion in NHSC. The process needs to be reviewed, including demand by CHCs and outcomes, versus evaluation of professions. Third, it is a changing environment. Not only is NHSC modernizing, but uncertainty exists in primary care education and teaching health centers, and whether residents working in teaching health centers could be part time loan re-payers since that will attract students to the Corps. That would be similar to changes in rural training tracks. An overarching question is how the Corps will be linked to changes in education to serve underserved populations.

Guest's name not captured. Becky mentioned collaborative efforts with BHPr. The Office of Rural Health has a cooperative agreement for rural training tracks that include residency in rural areas. Research shows 75 percent say in a rural practice, and 60 percent stay in a HPSA. The collaboration includes efforts by Becky, Jim Macrae, and Tom Morris to get venues to work together on the pipeline. The Rural Assistance Center at the University of North Dakota has link to rural training information.
Dr. Izard. Scope of profession is huge issue, including whether to include podiatry. It would be good to align with the structure at FQHCs for reimbursable providers. Second, it would be good to leverage three-way relationships between NHSC, Awardees, and Sites. Sites should take more responsibility. They are getting a pass since they have a lot to do. Issues for practitioners can lead to a difficult environment, and NHSC is in a good position to advocate for them. Third, provider time should be measured differently. Now the six-month verification is worded based on being away for a limited amount of days, but that can be hard to measure. Some prefer to measure by hours or weeks or half days, and that all is not the same thing. More flexibility is needed for how Sites measure.

Ms. Baird. Metrics are needed for Site accountability, including how each is doing and who is best. Patient satisfaction is directly correlated to provider satisfaction. CMS has mandated hospitals report patient satisfaction as one way to hold people accountable. The Corps should do this before CG caps are a reality. That will help providers choose Sites. The next best thing to retention data are patient satisfaction data. Second, Council members that do not work with patients are inspired by the three- minute clip at each meeting to hear stories about why people are serving. Perhaps the meetings could include a live video or Skype connection with a provider to discuss what is like to serve.

Dr. Salvador. It is good to enhance the Corps. As changes are made, they should be revisited to monitor progress. The focus on professions to include should continue. Opportunities should be found to collaborate with other resources, including government agencies that manage residencies, rural practices, etc., and enforce Medicare rules.

Dr. Crouse. Past Council meetings have included Site visits.

Dr. Warren. It is necessary to explore how to fully integrate primary care, health services, and public health. It currently is at the edge but is not intentionally being integrated. "Not served" is not the same as underserved, and the former includes thousands of people. Second, the Corps should intentionally target Sites where there are no providers. Third, there must be some sense of how to evaluate or assess health services outcomes for the people served. The impact must be measured. It likely is good, but must be known.

Dr. Rogers. A coaching system similar to mentoring should be set up for providers, especially rural. That is a new concept to some, but it has been around a long time. Coaches can be remote from anywhere. That will boost retention. **ACTION ITEM:** Dr. Rogers will send information about coaching.

Ms. Spitzgo. Perhaps alumni being envisioned as mentors could be coaches. Examples from Morehouse should be considered.

Ms. Edgman-Levitan. The regional offices should publicize the Corps' impact, including on the health of the country. It would be good to engage Regina Benjamin in the publicity. Students often mention interest in global health, and while that is important they should be reminded that the same problems addressed in places like Africa and Asia exist close to home. Much needs to be done in the U.S., and that theme should be expanded in the Corps' marketing. People should be encouraged to use their passion to help solve problems at home.

Dr. McCunniff. New Council members are joining at the perfect time. Dr. McCunniff also heard stories about why to decline Council service. The meeting has been a great two days. It is important to tap this expertise. However, while members leave the meeting with passion, they quickly are subsumed in their routines. Perhaps the Council can have a listserv to sustain momentum. Second, it is important to explore education alternatives. Third, the epidemiology perspective is to claim making a difference, but impact on health must be measured. People need to see data on how the Corps is making a difference.

Ms. Spitzgo. That does not yet exist. The closest thing is a measure about how every clinician serves a certain number of people so the field strength serves "x" number of people and that grows as the field strength grows. However, that is not a quality of impact number.

Mr. Budashewitz. Perhaps the Council should discuss that, including the impact of expanded access. Measures must be chosen carefully.

Ms. Spitzgo. That is a good point. The Corps' measures are being re-worked. Current measures do not make sense, such as whether the average HPSA score is increasing for placements, but when making more placements of course it is not going up. Meaningful data are needed to help tell the program's story. An audience is needed to help re-work the measures, and that would be a good topic of conversation, including what is needed and how do it.

Dr. Crouse. Educators often ask how education affects outcomes, but it is not about care, though that is the start of the continuum. The Corps focuses on the workforce for patient care, and that is one step removed from measures of actual health outcomes.

Dr. Warren. Conversations are needed across HHS to establish collaboration versus new initiatives about health outcomes.

Ms. Spitzgo. BHPr funding for CHCs often is questioned about whether it is making a difference in health. BHPr collects data about that. Slightly more than 40 percent of Corps clinicians are in CHCs and contributing to the quality of care, and that is an easy measure. Digging deeper would reveal other connections.

Dr. Crouse. All pieces should be considered, not just public health.

Dr. Yee. Technology such as the UDS mapper helps health centers. The Bureau should identify holes where there are no NHSC Sites, and send an ambassador, and work with PCOs and the PCAs to help reduce mal-distribution. Second, Dr. Crouse is right about teaching health centers should start earlier to get people tied in

during their last year of training. That would improve distribution. Third, HRSA filming at conferences, and follow up calls are well received. Also, coaching is a good idea and perhaps can be done at Scholar Conferences that also include a short workshop about things not learned in school. That could include how to get through a day, provide good customer service, and handle angry customers.

Dr. Everett. Many clinics barely stay viable, and billing can be complicated. How does the Bureau support fiscal soundness, including with IT?

Ms. Spitzgo. That does not yet exist, but perhaps could be included in the technical assistance or information given at the conferences. That could include help understanding meaningful use and electronic health records. That kind of technical assistance would fit well with the Site initiative.

Dr. Crouse. The Department of Family Medicine hired two FTEs to shift the physician's role in billing. The goal is to stem losses. It is very complex and a challenge in primary care.

Dr. Everett. Dr. Everett's clinic lost nine of eighteen primary care providers that could not keep up with regulations, IT, and billing issues. They kept getting further behind. Billing is increasing but receipts are shrinking. The IT age is a curse and blessing. Proper payments will help FQHCs survive and thrive, and improve retention.

Dr. Pathman. The conversation about new disciplines to include should be expanded. That should include consideration of the strategic impact for different distribution of disciplines in the Corps. It will be a difficult conversation since all disciplines are valuable. The current split derived from professions asking to be on board. It is not as managed as it should be given the Corps' growth. However, recent Bureau improvements will drive more applications, and selection might need to be based on issues others than type of profession. Now, the Corps is two-thirds urban, but people outside the Corps remain concerned about the distribution of professions and the urban rural split.

Ms. Spitzgo. Rural could still more than 50 percent, but that needs to be checked. **ACTION ITEM.**

Dr. Schwartz. The role of ambassadors is not clear. Loosely speaking, everyone on the Council is an ambassador, and needs a toolkit or short message to promote, including to respond to media requests. Second, alumni should be given more attention. They can be mentors or coaches. They can help with the pipeline, including planting seeds about NHSC in elementary and middle schools. Third, a future presentation should include geographic information about provider distribution. Among the 120 employees at Dr. Schwartz's clinic is it not clear how many were, or are in the Corps.

Ms. Amundson. Integration of fields should be looked into, including pharmacists and physical therapists. Correctional licensed counselors are unique and part of the program but do not fit the mold. They do not provide 21 hours of direct patient care since they do group work, and work plans for inmates. It is in and out resident care, but they are a vital part of the Corps. Physical therapists provide 11 hours of direct client care. Second, the NLRP deadline is February 8, but a student who expressed interest will not have the credentials for

this year. The obvious answer is to apply next year, but is the deadline appropriate? If it is not changed, people will go elsewhere.

Mr. Budashewitz. The guidance includes a policy about showing credentials by the time of award. The Bureau is reviewing the practice, based on the statute, and will ask people who could be awarded to confirm their interest and documentation. However, the NLRP has more applicants than slots, and it is important to manage expectations. **ACTION ITEM:** specifics of the changed guidance should be confirmed.

Ms. Spitzgo. The idea is to stagger the work versus have applications all come at the end of the fiscal year. The Bureau will review the wisdom of that process.

Ms. Horvath. A research agenda is needed to identify what the Corps needs to know and the priorities. Second, several things arose at this meeting, such as ethnicity and race data for recipients, and the differences between urban and rural health and where people are practicing. That should be turned to look at where providers are most needed, and recruiting should emphasize those areas. The idea is to cast a wide net for serving in the corps. Third, when it appeared the Council term was ending it was good to continue to serve as an ambassador but not clear how. The Ambassador Conference in Kansas City was a fantastic introduction, but conferences are not practical based on the time to attend. Ambassadors should not have to carve lot of time to know what to do. Better outreach to them is needed.

The Corps can serve national needs if it is better focused. It needs to look at national health needs and find people to meet them in a targeted way. Ms. Horvath is excited to finally have a Scholar in her program, but the many challenges might cause her to leave. A support network for program directors would be good. Data about PAs and NPs having the highest default rate was actually reflective of mid-level providers with economic issues rather than defaults. They needed a strategy to handle the issues so they left, and were counted in default data. Support is needed for those kinds of people, to keep scholars in the program. The Scholars Conference was good, but during weekdays is a challenge.

Dr. Crouse. Scholars have many years before they practice, and often the financial aid person is the only one who knows they are a Scholar. That is a missed opportunity to capture the Scholar's passion.

Ms. Horvath. Scholar's names should be on the Web site.

Ms. Amundson. AHECs should be called upon for support during education.

Ms. Spitzgo. This meeting produced a wealth of great suggestions. Advice, but no true support mechanisms exist for Ms. Horvath's situation. The Bureau is considering how to push people to higher need areas, but a clear definition is needed for high need area. The Corps' definition is based on HPSA score thresholds, typically where Scholars are, but that omits some States entirely even when they have high need areas. The challenge is to define high needs in a way to help get people where they are needed. That was the intent of the HPSA designation, but it is not a perfect solution. The score is not the only way to define high need. The definition needs more flexibility to broaden the pool.

Ms. Amundson. A town whose HPSA score is nine has 1,500 people and it struggles to keep clinicians. States should be asked to help identify high needs areas.

Mr. Budashewitz. The goal is to link high need and hard to fill. That can be mutually exclusive in some States. HPSA tries to address the social determinants of health, but also important are the social determinants of practice, including isolation or no association with a major academic center.

Ms. Spitzgo. High need hard to fill is the new scope.

Ms. Amundson. Perhaps J-1 visas can help fill those areas.

Dr. Pathman. It is important to add "not their fault" to high need hard to fill. Literature shows one of the strongest reasons for need is high turnover, but Sites can be responsible for that. HPSAs include high turnover Sites.

Dr. Crouse. This issue could be the agenda for future Council meetings. Every topic mentioned at this meeting generated general agreement on importance. This touches many people, and their hearts. Respect for each other's perspectives is good. This has been one of the most productive Council meetings. Compliments to members and the staff.

Discussions will continue, perhaps via the new listserv. It will be important to prioritize focus points for the next meetings, including data needs for discussion, such as what Dr. Pathman and Ms. Baird did for this meeting. It is important to keep dialogue going as members get busy with their regular duties. The energy level should be maintained. Meeting dates should be set as soon as possible.

Ms. Spitzgo. The Council meets for a minimum of two days, two or three times per year. Four months rather than six might be better based on the amount of issues and momentum, and the pace of changes. [Members seem to agree.] **ACTION ITEM:** It is a good process to ask for input on dates and then lock in, and that will be done again.

Some Council meetings have been outside the DC area. **ACTION ITEM:** Staff will send a survey about what works best for members. Perhaps a meeting could be conjunction with the Awardee Conference in Chicago in May or Atlanta in July, or others.

The issue of high need hard to fill was discussed at the August 2010 meeting. The meeting also discussed the possibility of issuing papers, and maybe one can be done about the high need hard to fill issue, or other issues. A draft would be sent to the Council as a whole, and feedback would be invited, though it is understood that some will choose not to comment. Several ideas can be considered over the next few months.

Many members received the email from a distressed Scholar about the issue of returning from American Samoa to the mainland. That is being addressed toward a mutually agreeable solution. The imperative policy is to not be able to support the specific situation, and that is difficult when promises are implied. Staff has been addressing the situation since last summer, and found an opening and a way to support the person and

others who might be in that situation. The Bureau usually does not re-locate people after they finish service since that hurts retention. A conversation with Mr. Melder and the Scholar has shown the person is better off now. The Bureau appreciates the Council's support on the situation. It was resourceful for the person to reach out to the Council, and that is fine.

Dr. Crouse. Thanks to everyone, safe travels, and the Chair is looking forward to the next meeting.
[Njeri Jones of the Bureau said members' materials can be shipped so they do not have to be carried. She noted the reimbursement forms are in the meeting binder, and also will be emailed. Questions should be addressed to Njeri at the Bureau (njones@hrsa.gov).

The meeting adjourned at 2:35 p.m.