NATIONAL ADVISORY COUNCIL
ON THE
NATIONAL HEALTH SERVICE CORPS (NHSC)
MEETING SUMMARY

Thursday, January 10, 2013 – Friday January 11, 2013

Health Resources and Services Administration
Parklawn Building

Council: Jay Bhatt, D.O., M.P.H.; Adrian Billings, M.D., Ph.D.; Byron J. Crouse, M.D., FAAFP; Theresa V. Horvath, PA-C, M.P.H.; Tito Izard, M.D.; Mary Looker; Michael D. McCunniff, D.D.S., M.S.; Norma Martinez Rogers, Ph.D., R.N.; Darryl Salvador, Psy.D.; Cindy Stergar, M.A.; Rueben Warren, D.D.S., M.P.H., Dr.P.H., M.Div.; Gwen Witzel, M.S.N., FNP-BC; Ronald Yee, M.D., M.B.A.

Federal: CAPT Philip Budashewitz, RPH, M.A.; Tina Cheatham; Kim Huffman; Alexandra Huttinger; Njeri Jones, M.P.H., CHES; Kimberly Kleine; CAPT Sheila K. Norris; Katie Root; Cameline Toro; Cynthia Sego; Rebecca Spitzgo; CAPT Jeanean Willis-Marsh, D.P.M.

Day 1
Thursday, January 10, 2013

Welcome and Introductions
Byron Crouse, NAC Chair

Dr. Crouse opened the meeting by welcoming everyone and introducing himself and those in attendance. Ms. Rebecca Spitzgo (Associate Administrator, Bureau of Clinician Recruitment and Service) welcomed everyone then briefly shared changes to Agency and Department-level policies regarding restrictions on federal travel, a greater focus on webinars and virtual meetings, and utilization of federal space in an effort to reduce costs. Ms. Spitzgo noted that input and feedback from the Council will be very helpful to the National Health Service Corps (NHSC) as they begin to make these transitions.

NHSC Program Updates
Rebecca Spitzgo, BCRS Associate Administrator and NHSC Director

2012 Recap and Accomplishments

Ms. Spitzgo provided the Council with an update on NHSC programs, initiatives and accomplishments for the year. She began by sharing a recap of program changes and improvements that have taken place during FY 2012 such as improvements to award processing and revamping the NHSC Call Center, creation of a new online jobs center, and the completion of a long-term retention study and retention brief. (See slides)

A major accomplishment for the NHSC in 2012 was the launch of the NHSC Jobs Center in May, which also won the HHS Secretary's Innovation Award. The Jobs Center integrates Google Map technology and replaces the former Job Opportunities List. Some innovative highlights about the Jobs Center include the ability to search for sites within a particular HPSA, and for sites to upload site information such as mission statements, videos, brochures and photos. The NHSC has encouraged all sites to submit a profile and to date, there are 4,300 completed profiles.

Discussion

- Dr. Bhatt suggested integrating stories from the field from scholars, loan repayors or staff that deliver care on the Jobs Center site profile pages as a narrative of the experience and culture.
- Ms. Spitzgo expressed that the use of the Jobs Center has been very positive. The Corps was able to use the tool with scholars at the Scholar Orientation and Placement conference in July (2012) to query where scholars were interested in serving. Scholars were able to access the site and walk through how to take advantage of researching sites, not necessarily vacancies. Because many of the scholars are 6 to 18 months away from being in the field, the anxiety level can be high when searching for a site to work at. The NHSC can now encourage scholars to look for vacancies often, do rotations at sites of interest, or contact sites to see if there would be vacancies around the time they would be ready to enter service.

- Ms. Spitzgo also highlighted other tools of the Jobs Center including site visit functionality which allows users to view all the sites within a particular area in order to group together a site visit.

FY 2013 Funding and Priorities

Ms. Spitzgo discussed plans for funding in FY 2013 as well as program priorities. (See slides)

Discussion

- Ms. Looker suggested that the Corps "refresh" the additional criteria for the disadvantaged. Disadvantaged could be considered economical, educational or environmental.
- A discussion took place on whether participants needed to be employed as of the application closing date. One concern was that a contract could be issued to a clinician before they secured employment. It was noted by Ms. Stergar that legislation is fairly rigid with regard to canceling or voiding a contract.
- Ms. Spitzgo indicated that there have been numerous conversations with general counsel to gain more flexibility with this issue and noted that clinicians would probably need to be employed within 60 days of the application closing date. It was suggested that perhaps the time period could be expanded from 60 to 90 days.
- Program noted that a legislative change has been put forth to give the Secretary more flexibility to cancel or void a contract, but at this time a participant has to ask to cancel a contract; NHSC cannot initiate a cancellation.
- Ms. Spitzgo highlighted other key initiatives for 2013 including expanding employment verification, automating scholar placement, and continuing application processing enhancements.
- Ms. Spitzgo also noted a site initiative to clean up site data including deletion of duplicate sites in the database.
- Retention will also be a key emphasis and was discussed in more detail later in the meeting.
- Shortage designation will also be a great area of focus for the Corps this year. (NOTE: The Bureau recently added the shortage designation responsibility to its function statement). The strategy is to develop a strong understanding of the current process to then be able to determine what can be improved to make the process more transparent to our providers.
- A HRSA-wide effort is underway to make sure that grant project officers are certified, and are monitoring and documenting consistently.

Analysis of NHSC Field Strength

CAPT Phil Budashewitz, BCRS/Office of Policy and Shortage Designation Director

Captain (CAPT) Budashewitz shared an update on the National Health Service Corps field strength which included the field strength report. He noted that there are multiple funding streams available to the NHSC, primarily discretionary funding, which Congress has appropriated historically (annual appropriations). In 2009, there was also the American Recovery and Reinvestment Act (ARRA) funding; and in 2010, ARRA and Affordable Care Act (ACA) funding. In 2011, the Corps had access to all three funding streams which led to very high investment in the NHSC. In 2012, the field strength was three times that of 2008. CAPT

Budashewitz noted that NHSC's programs are very funding-dependent and the Students-to-Service program was a good example of investing in someone during their academic phase and getting more leverage for that investment. (See slides)

Questions/Discussion

- CAPT Budashewitz expressed that he would like to hear from Council members regarding discipline mix, what they believe is the phenomenon based on experience or need versus job opportunities. A discussion took place including a reminder that when looking at shortage areas and uninsured populations there are ethnic demographics to consider as well. CAPT Budashewitz said that more analysis in terms of where placements are and racial/ethnic makeup may be helpful.
- Dr. Warren asked if there were projections for how the health professional shortage areas (HPSAs) would be impacted by the Affordable Care Act. CAPT Budashewitz explained that HPSAs look at patient-to-provider ratios, so it is a demographic look at the population and the clinicians there to serve them. Thus, the ACA and the expansion of insurance will allow more access, but the provider-to-population ratio will not change which is a major factor.
- Ms. Lindsey Toohey (Deputy Director, DPSD) stated that another challenge is one of primary population designations. To the extent that the Medicaid expansion provided under ACA creates more Medicaid individuals in a community, there is the potential to see more communities eligible for the Medicaid population designation if everything else stays the same. Ms. Spitzgo added that there is an effort underway called a "surge analysis" to look at what the results of people becoming insured will be and whether lack of insurance is really a factor in existing HPSAs.
- Ms. Horvath asked if the efforts to increase the number of physician assistants (PA) had been successful. Ms. Spitzgo responded that based on the last cycle, the percentage of applications received from physician assistants was low for loan repayment but very high for the scholarship program. It was determined that there are a lot of PAs and they are interested in working in underserved areas but the Corps has not been successful in finding places to place PA scholars, particularly in community health centers. Some of the obstacles could be State laws about supervision and the use of physician time, and readiness for practice (i.e., sites reluctance to hire someone right out of school). Examples of barriers and challenges regarding PA placement were discussed by a number of Council members.
- Dr. Billings asked if the NHSC is tracking within the clinical field strength the disciplines that have active hospital privileges and what the impact of that is, especially to Critical Access Hospitals. His opinion was that although it may not be in the NHSC's purview to get into the in-patient realm, for funding and credibility, NHSC clinicians (especially in rural areas) have a significant impact on the in-patient realm.
- Ms. Stergar suggested giving some consideration to whether a participant is in a residency that is patient-centered medical home certified or in process. She stated that hiring a resident out of a patient-centered medical home program is very different than hiring a resident from a non-team based program. It was explained that the number of patient-centered medical home residencies was minimal. Dr. Salvador asked, in terms of current field strength, if it was known what the largest loan repayment group was and had it changed in terms of applicants or the disciplines for which they apply. Ms. Spitzgo said that

the largest number of members in the field strength, if looking discipline by discipline, comes from physicians, particularly allopathic (MD) and osteopathic (DO) physicians being the largest group. Ms. Spitzgo said that they will look at comparing national numbers from an in-school perspective and then see if the Corps percentages are higher or lower.

Retention and the National Health Service Corps
Kim Kleine, BCRS Deputy Associate Administrator

Ms. Kleine introduced herself and then shared that since 2010, an annual NHSC Service and Retention Survey has been prepared for Congress and therefore has fueled some of the initiatives that have been undertaken by the Corps. The results of the 2012 short-term retention and long-term retention surveys were distributed; consistent results have been received for three years (2010 - 2012). CAPT Budashewitz in turn shared information and data from the retention brief. He explained how the Corps defines retention as the percentage of clinicians who practice in underserved areas after the completion of their service obligation. It is measured when no additional financial incentives are provided. (See slides)

Regarding strategies for providers, there are three key areas Ms. Kleine addressed: (1) providing a meaningful match; (2) exposing the provider to different sites; and (3) talking to them about the practice model. Providers need a network so they do not feel isolated, and the NHSC needs to determine how to get them engaged in peer-to-peer relationships and networking. Providing professional development for providers, training opportunities and educational resources is also key. (See slides)

Questions/Discussion

- Ms. Stergar began by asking why sites do not have a culture of retention. Some reasons were understood to be: complaints about administration at sites, feeling being taken advantage of, and being treated differently because they are a part of the Corps. Ms. Kleine noted that in 2011, sites were asked if they had a retention plan. Out of the respondents, 56 percent said they had a recruitment and retention plan, 26 percent said they did not have a recruitment and retention plan, 4 percent said they only had a retention plan, and 14 percent said they only had a recruitment plan.
- Dr. Rogers suggested that providers need to be asked, "How do you define culture of retention?" Perceptions of culture of retention will look different between providers and it is important to have their input.
- Council members discussed strategies for developing a culture of retention for sites such as more effective communication with the sites regarding their role in recruiting and retaining providers. The Jobs Center, Virtual Job Fairs, retention calculator, webinars and technical assistance to sites provide technical support for the endeavor of recruiting and retaining providers. Council members and NHSC staff should be talking to sites about the financial benefits of having a retention plan and recognizing sites that are "Sites of Excellence."
- Further discussion by the Council took place regarding the strategies for sites and providers. It was stated that response time for answering provider questions has improved, but the goal is to get it consistently within 48 hours. The suggestion was made that it needs to be

stressed to providers that they have two contracts, one with the Corps and one with the site. Providers need to follow guidelines provided by both groups. This needs more emphasis in the area of retention policy and should include an explanation from the Corps that the employer agreement/contract supersedes the Corps agreement.

- Policy initiatives were also discussed, such as scholars being allowed to noncompetitively transition to loan repayment and Students-to-Service program participants being able to noncompetitively transition to loan repayment. The Corps is also trying to adjust policies to allow contemporary clinical practice. Policies have been enacted on telemedicine and home health, but more needs to be done.

Recruitment and Retention – Part I

Tito Izard, President and CEO, Milwaukee Health Services, Milwaukee, WI

Dr. Izard introduced himself and shared information about the organization where he works. He has recruited and hired about 30 different providers that have been either NHSC scholars or loan repayors. With regard to recruitment, Dr. Izard discussed the various factors that impact recruitment and retention at his site, such as expectations, culture, internal and external community, and compensation/benefits. (See slides)

Questions/Discussion

- Ms. Stergar asked Dr. Izard about the most successful retention strategies with either scholars or loan repayors and whether he has seen an increase in retention. Dr. Izard explained that he has been in his position seven years and has retained doctors he recruited with the goal for them to stay three to five years. He said if you want to have great providers you need to already have great providers and you do this by recruiting through the top quartile, however you define that for your community or organization. Once you have a good provider and support them, it is easier to get more good providers. Dr. Izard also talked about organizational change and how it comes from the middle, with the providers. If they wanted to see change, they needed to cause change, but with that comes responsibility. Once providers hold themselves to that standard, administration will listen and change can take place from both directions (top and bottom).
- Ms. Kleine asked Dr. Izard if he had a perspective, based on all the things the Corps is doing, about how the NHSC might be able to help more (or differently) regarding retention planning, and what did he see as NHSC's role. Dr. Izard responded that he liked the new technologies (Jobs Center and portal) and wanted to take more advantage of that. He felt that providers start doing their work and can get isolated. Getting like-minded people together and sharing through web-based conversations and topics to present would be good.
- Dr. Bhatt asked how does the community try to bring back tools and teaching, and how to make it easier for site leadership to be able to push forward. Dr. Izard suggested bringing mentorship opportunities for people, whether in their training, residency or early practice. The more we can provide that in underserved areas so that people who are new coming on board can see there are ways to overcome challenges and navigate issues, the better.

Recruitment and Retention – Part II
Ron Yee, Chief Medical Officer, United Health Centers, Parlier, CA

Dr. Yee introduced himself and gave a brief description about his organization. He thanked the NHSC staff for doing such a great job and shared some illustrations of the good work being done by the staff. His presentation included sharing various retention strategies that are utilized at his health center and retention data his organization generated.

Discussion

- Ms. Stergar said that the NHSC has clearly defined what they are doing and has defined the expectations and must stay consistent. NHSC has become much more customer service oriented and people are getting consistent messages now.
- Dr. Bhatt echoed Ms. Stergar's comments and added that it is the Corps' responsibility to share stories of what is going well and leave it up to the leadership at the various sites to implement and execute.
- Ms. Horvath noted that the NHSC leadership team needs to be developed either by site, State, or profession so that the staff does not become burnt out. The next step for the Corps is to understand how this program fits within a redesigned health care delivery system and to be as responsive as possible.
- Dr. Warren said that the health care system in this country is changing very quickly. This puts people in need of care and those providing the care at risk. NHSC can define what needs to be done because if they don't it will be defined for them. Dr. Izard explained that FQHCs are broken down in thirds: a third are having major troubles; a third are on the edge; and a third are doing well. If that is the case, that would mean half to two-thirds of these organizations that providers are going to are floundering and that is going to discourage providers from the Corps. Supporting management development will have a huge impact and help with retention.
- Ms. Stergar said the philosophical issue about service is really what this is about, talking about service in health care and that we are called to service. This is a role that the Corps has but how to do it is the question. Do you do it through residency programs, physician assistant schools, and medical schools? Partnership with Federal partners is the way to get to management, not through the sites. There are still opportunities with Federal partners. She stated the Corps needs to get patient-centered medical home or transformational teams as a piece of language in any communications that go out.
- Dr. Yee offered that partnering with groups such as the Bureau of Operational Issues (BOI) and National Association of Community Health Centers (NACHC) is important. There also needs to be partnership for each of the site types to help support the operational side. Therefore, NHSC would not be doing the actual work but instead collaborate with these partners on the operational side and leadership development.
- Dr. Bhatt concluded the discussion by saying there should be more consideration of different opportunities regarding the virtual model since there will be no in-person conferences.

Wrap Up

Ms. Spitzgo suggested that Council members think about the day's discussions and to share any new insights or questions when they reconvene the next morning.

As a follow-up, Ms. Spitzgo shared about osteopathic numbers and ratios related to licensed physicians and students preparing for practice. Practicing primary care physicians (MD and DO) were 10 percent of the total physicians currently in practice, but DOs make up 33 percent of the physician applicants for NHSC. About 23 percent of students studying to be physicians that are in school are DOs versus MDs. The number of students going to osteopathic school is growing and the training and philosophy of those attending such schools fosters the higher in-school numbers. Some announcements and logistics questions were answered and the meeting for January 10 was adjourned at 4:49 p.m.

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DAY 2
Friday, January 11, 2013

Friday's Focus and Review and Approve Minutes from January 2012
Dr. Byron Crouse, NAC Chair

Dr. Crouse opened the meeting by reviewing the focus for the day's agenda and making a motion to review and approve the meeting minutes from the January 2012 Council meeting.

Ms. Spitzgo reminded the group about taking a moment to come back to yesterday's discussion to see if there were any questions or comments. There were a few questions from Council members on efforts around promoting the NHSC in educational institutions and Students-to-Service program requirements as well as comments from Dr. Bhatt regarding Corps Community Day activities, and suggestions for building stronger partnerships with primary care specialty societies in lieu of there being no more conferences.

Medical Home and Clinician Retention
Jim Macrae, Bureau of Primary Health Care (BPHC) Associate Administrator
Suma Nair, BPHC/Office of Quality and Data Director

Jim Macrae was introduced by Ms. Spitzgo and he in turn introduced his colleague, Suma Nair. Mr. Macrae began by providing an overview of the health center program and some of the efforts taking place around patient-centered medical homes.

Mr. Macrae explained that quality strategies are anchored around the aims of better care, healthy people and communities and affordable care. It is critically important for people to have access and as a result there needs to be a full range of services, primary and preventative. The next step is how to integrate it by working with other providers to provide integrated services, specialty care, hospital care, etc. The final step, with Accountable Care Organizations,

is patient-centered medical homes and the integrated health system. Mr. Macrae explained what needs to be done to meet these objectives by outlining five key areas the Bureau of Primary Health Care (BPHC) would focus on. Suma Nair then continued with the presentation by discussing where BPHC stands with electronic health records, patient-centered medical home and some specific measures. Mr. Macrae also shared some important workforce data towards the end of the presentation. (See slides)

Questions/Discussion

- Dr. Warren asked if the projection of an increase in community health centers was real and if so how was it going to happen. Mr. Macrae responded in saying that the program is working on a new access point application which is an opportunity for organizations that are not health centers to come into the health center family, as well as for existing health centers to open new sites. The growth or expansion potential is really dependent on what is provided in appropriations. The ACA fund is growing but depending if that appropriation stays flat or increases will determine the ability to grow.
- In turn, Dr. Warren asked in terms of Healthy People 2020—considering that the goals are typically not met—how do you balance the reality of the measure being set with actually trying to succeed. Mr. Macrae replied that in looking at data, some areas are doing well. However, in terms of clinical performance, the program, looks at each health center and works with them to figure out where they are, where they want to go and how to get there. He shared that there is tremendous pressure to benchmark what is done against other providers, national statistics and other things but they try to adjust based on populations served.
- Dr. Bhatt asked how BPHC finds veterans and Mr. Macrae said this is a challenge and there are a variety of ways they are trying: state Primary Care Associations, government, and private foundations. He added that the program needs educate people to make them more familiar with the opportunity and suggested that the health centers could use a resource to remind them that there are many similarities between what people do in military service and what is done in health centers.
- Ms. Stergar asked how they align their policies now so that they are supporting patient-centered medical home and not putting people in centers with an unsuccessful start-off. Mr. Macrae said that with their investments they are reaching about 600 health centers that are involved in some type of network which includes electronic health records and quality improvement activities.
- Dr. Crouse asked where Mr. Macrae sees teaching health centers moving and the future of integration of education as another mission within community health centers. Mr. Macrae said that as a recruitment and retention tool, integration of education is invaluable. The challenges are the way reimbursement is set up; it is very visit and volume oriented. There would be some concerns that it would impact the bottom line if you take some of your providers' time away to teach students.
- Ms. Spitzgo asked if BHPC had enough data or just a benchmark to see any shift as a result of the patient-centered medical home or is it too premature to tell at this point. Mr. Macrae shared that the program had an uptick in the last six months but with the 2012 data, they will be able to look at it much better. They are doing a more formal evaluation with the

Centers for Medicare and Medicaid Services (CMS).

- Ms. Looker made two points about the need for BPHC to work more closely with the Bureau of Health Professions: (1) many training programs have not embraced the patient-centered medical home; and (2) the need to define the role of pharmacists in the patient-centered medical home. Mr. Macrae offered that the University of Minnesota was recently funded to do an interdisciplinary training team approach. A lot of work can be done on the front-end on curriculum development and other activities to make sure that while training providers (namely physicians and nurse practitioners) in their discipline, programs are building into the mix how to work in a team and how to work with other professionals.
- Ms. Witzel commented that nurse practitioners seem like the natural fit to be part of a patient-centered medical home team or leadership of a team since they have been educated and practiced as team-based care. However, some of the rules written by CMS are setting up restrictions that make it very difficult for autonomous practice for nurse practitioners. These rules make it difficult for frontier and rural areas to meet the requirements, but a lot of those restrictions could be eliminated.
- A Council member asked whether CMS was going to expand the Medicare patient-centered medical home pilot to include all community health centers. Mr. Macrae expressed that this was one of the projects he hopes will work out due to the pressure on his Bureau to show not just quality but cost. A major factor will be what happens with the current demonstration which will end in 2014, as well as evaluation.
- In conclusion, Dr. Bhatt asked how they train physicians and clinicians in community health centers to think about the social determinants of health. It was explained that a webinar was recently done with a group called Project Health Leads. College students' work at a health center and after a physician has a basic intake asking different questions about housing, employment and a variety of other things, they write a prescription for the patient who then talks to the Health Lead representative who then works to help the patient deal with housing issues, employment, etc. Mr. Macrae said to make headway on some of these issues you have to deal with these social determinants.

Center for Medicare & Medicaid Innovation: Program Overview and Workforce Efforts
John Rigg, Policy Advisor, Office of Planning, Analysis and Evaluation

Mr. John Rigg from the Office of Planning, Analysis and Evaluation works closely with the Centers for Medicare and Medicaid Services (CMS) Innovation Center, formerly known as the Center for Medicare and Medicaid Innovation (CMMI). Mr. Rigg presented an overview of the Innovation Center, the work they are currently doing, and their workforce efforts. He also explained and discussed the four models of the primary care transformation which include (1) Comprehensive Primary Care Initiative, (2) FQHC Advanced Primary Care Practice, (3) Multipayer Advanced Primary Care, and (4) State Demonstration to Integrate Care for Dually Eligible Individuals.

<u>Questions/Discussion</u>

- Ms. Stergar asked what the internal structure of CMS/Innovation Center was and if they had grant project officers. Mr. Rigg explained that they do have grant project officers and they

have relied upon other agencies within the government for technical assistance in getting operations set up. They have also relied on external validators and expertise for grant evaluation. The expectation is that they will turn around evaluations and quickly bring programs online.

- Dr. Bhatt asked if Mr. Rigg could speak to how much attention is being paid to the unique needs of vulnerable populations and the social determinants of health and were they being addressed in the demonstration phase and/or the rapid cycle evaluation phase. Mr. Rigg answered that it is very hard to quantify the social determinants of health, so to empirically prove cost savings, unless the evidence is clear and compelling, it is going to be a challenge for actuaries to produce. The evidence is not very clear and compelling so at this time there more than likely will not be a big innovation around it.
- Mr. Rigg concluded by saying that there more than likely would not be many more high level innovations. There are currently 109 innovations (several state-based models) and there will be additional opportunities to apply for Innovation Center funding that is not state-based. He offered that those who are interested to stay aware and pay attention to what is happening within their state. The Innovation Center will work more closely with the states in the future and delivery system transformations are going to be largely state-based. Under several of the funding opportunity announcements, the states are required or encouraged to engage with their provider and safety net communities as a condition of being successful.

Public Comments

No comments from the public were offered.

Open Discussion

The meeting transitioned to each Council member offering perspective from their work setting and background.

- Ms. Witzel began by suggesting that the NHSC should have a greater presence at national conferences. Ms. Witzel also asked if the nursing program (NURSE Corps) was directed towards registered nurses (RNs), advanced practicing nursing or both. Ms. Spitzgo responded in saying that it was directed to both and further explained that NURSE Corps made a big push last year towards advanced practice nurses and had a lot of RNs, but also have licensed practical nurses qualified for the program as well as faculty members. Ms. Cheatham added that there will be a NURSE Corps Loan Repayment and Scholarship opportunity coming soon.
- Ms. Looker commented that though the Corps is getting a lot of interest, she hopes they do not spread themselves too thin by not getting enough primary care providers in the field. The mental health profession is troubling because they are the hardest applications because of the variety and variation by state of what they can and cannot do. There is an uptick in mental health and there is a need to be mindful of it to provide access and parity as more and more people are looking for mental health services.

- Ms. Stergar said that with all the pressure and focus on health care, she hoped that the NHSC would continue to focus on their integrity of purpose. The NHSC needs to ensure that everyone aligns with the integrity of the program and stays with the purpose.
- Dr. Izard provided remarks by first suggesting to Corps members starting new jobs that they spend time, especially in the first 60 days, with their medical director, chief medical officer or CEO. Checking in with new providers around the 60-day mark may provide for checks and balances to make sure their interpretations of what they are experiencing are consistent with what the administration wants them to get. It is also important for providers to understand how their organization functions.
- Dr. McCunniff began his remarks by thanking the staff for a good meeting and complimenting the efforts made to improve the NHSC website. He noted that he spends a lot of time on the website, particularly when educating prospective students about the scholarship and loan repayment programs. Regarding the Students-to-Service program, Dr. McCunniff said he would propose making dental the next potential area of focus.
- Dr. Billings noted two things that he thought were important to be considered. One, aligning the NHSC with educational training programs, health science centers, nurse practitioner schools, and physician assistant schools because they represent the pipeline. It is important to "hit" them when they are early and impressionable. Secondly, from the rural perspective, all of the things coming down the pipeline will benefit our patients. The challenge for the rural/frontier community health centers will be daunting, so we need to align with larger community health centers to share their resources. The rural/frontier provider has something to offer as well; they have unparalleled experience in frontier areas. Perhaps the larger health center clinicians would be willing to come out and do low income relief and frontier providers could go to their community health centers and get to do some things they normally do not get to do.
- Dr. Warren commented that he hoped they could engage the health profession schools early because letting them know the NHSC exists now is beneficial. In addition, instilling the idea of coming in and not only getting loans repaid, but looking at it as a career and mission. He said that the Corps had to figure out a way to enhance and communicate with the federally funded community health centers. Dr. Warren also noted that the need and demand often precedes the science. The NHSC should not allow the science to impede the progress being made in the program. When the science and research people see providers working together they will eventually see that it works but the work must come first.
- Dr. Bhatt began his comments by asking "How do we build capacity in our community and give the work back to the people that are our Corps and our service community?" They are mission-driven and want to grow and help. He said he was happy about the way the Council is thinking about partnership. Being strategic about with whom they do or do not engage with is important. He suggested that if the Agency for Healthcare, Research and Quality (AHRQ) was still having one-day conference grants, the Corps could potentially use those regionally to talk about some of the issues happening around health reform and use it as a way to bring people together. Finally, Dr. Bhatt stated that he thinks they are in a position where the Corps can be out in the front lines of what is happening in health care, particularly around underserved communities.
- Finally, Ms. Horvath opened her comments by saying that Dr. Izard's and Dr. Yee's

presentations were spectacular in underscoring the basic principles of what it is the Corps is trying to do. She believes there is work to be done between meetings, and this group is particularly talented in being able to find ways to pick issues that are personally interesting and working on them so when the Council comes together, members will have more to contribute.

Final Business
Dr. Byron Crouse, NAC Chair

Dr. Crouse provided some final comments, first in saying that the desire has always been for the Corps to become a community and that is now becoming a reality. It is a time where there is substantial change taking place, such as with the CMS innovation efforts and patient-centered medical homes. He expressed how great an opportunity it is for the Council to be part of the great transformation that is taking place and also stated that he would champion the teaching health center concept and model. It is an opportunity for community health centers to showcase the issue of the public's misperception of them being free clinics to really becoming cutting edge of what is to be team care and integrated, comprehensive services. Lastly, Dr. Crouse expressed that the Council will be looking to the leadership to determine how they can be of service to senior leadership and participate in high-level discussions around program and policy initiatives.

Ms. Spitzgo began her final remarks by reminding the Council that there is a shift taking place in the agency and Department to do virtual advisory council meetings. The administration will come together to talk more about the virtual meeting concept but the NHSC values the face-to-face meeting format. The NHSC will also look into engaging the Council more regularly in between meetings through conference calls that focus on a specific topic or issue. Ms. Spitzgo also noted that a Federal Register notice will come out soon soliciting nominations for the Council.

A big meeting takeaway for Ms. Spitzgo was around making more room for policy discussions. The NHSC needs to be more deliberate about having these discussions from a “bigger picture” perspective. She mentioned that there will a priorities meeting within HRSA where each bureau will talk about their priorities for 2013. Ms. Cheatham said there is a perennial question about what is being done to reach out to veterans. One idea is looking for stories from Corps members who are veterans. The Council’s input and suggestions would be helpful.

Logistics about the next meeting were discussed and Day 2 of the meeting was adjourned at 11:44 a.m.