

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

Thursday, July 18, 2013

Health Resources and Services Administration (HRSA)
5600 Fishers Lane
Rockville, Maryland 20857

National Advisory Council on the NHSC:

Jay Bhatt, D.O., M.P.H.; Byron J. Crouse, M.D., FAAFP; Theresa V. Horvath, PA-C, M.P.H.; Tito Izzard, M.D.; Mary Looker; Norma Martinez Rogers, Ph.D., R.N.; Susetta Schwartz, J.D.; Cindy Sterger, 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.

Conference Call Speakers:

Becky Spitzgo
Tina Cheatham
Kim Kleine

Senior Staff Participating on Call:

CAPT Phil Budashewitz; Kim Huffman; Njeri Jones; Katie Root; Cindy Segó; CAPT Jeanean Willis-Marsh; Tracy McClintock; Jessica Harrison; Miriam Jordynne; Victoria Hux

Welcome and Introductions – Byron Crouse, M.D., FAAFP, NAC Chair

Dr. Byron Crouse opened the meeting by welcoming everyone to the National Advisory Council (NAC) on the National Health Service Corps (NHSC) conference call. There was a roll call of Council members present and federal staff introduced themselves.

Affordable Care Act (ACA): Outreach and Enrollment Activities – Discussion Rebecca Spitzgo, BCRS Associate Administrator and Director, NHSC

Rebecca Spitzgo opened the discussion with an introduction to the new conference call meeting format. She solicited feedback on the format from the attendees at the end of the meeting.

Ms. Spitzgo provided an update of the activities from the Health Resources and Services Administration (HRSA) and Bureau of Clinician Recruitment and Service (BCRS) since January 2013 concerning implementation and roll-out of the Affordable Care Act. Between January and now, BCRS has been preparing for enrollment by distributing emails, providing links to www.healthcare.gov, and to the HRSA ACA website. BCRS has also used social media platforms (i.e., Facebook and Twitter) to distribute ACA messages via www.healthcare.gov.

The third annual NHSC Corps Community Day will be held on October 10, 2013. Many events will focus on understanding the ACA and how to sign up for insurance. BCRS has also developed a series of tools called “Events in a Box” to assist NHSC partners with planning events. There are other resources such as a NHSC slide deck, badges and buttons that can be downloaded.

Ms. Spitzgo opened the discussion to NAC members by asking what types of questions they are hearing from colleagues and networks in reference to the new Health Insurance Marketplace.

Discussion

- Dr. IZard (Milwaukee, WI) works with an urban Federally Qualified Health Center (FQHC). Many of the questions he is hearing revolve around how the expansion of Medicaid will impact communities and states, and how the Marketplace will cover the potential challenges.
- Dr. Rogers (San Antonio, TX) said that since their Governor decided not to expand Medicaid or to accept money from the Federal Government, there are questions about what they are going to do with so many continuing to be uninsured.
- Dr. Warren (Tuskegee, AL) discussed the need to re-segment those states that are supportive, neutral, and negative, because the questions are very different. In Alabama, there is misinformation, which is hurting those who want to be engaged. Medicaid is not being expanded in Alabama and there are thousands who are eligible but are not utilizing it.
- Ms. Stergar works in Montana, and in Oregon and with Care Oregon. Montana did not expand Medicaid, and Oregon did. She anticipates that during 2014, there will be a lot of confusion on both the client and provider sides. It is going to be very confusing for the consumer, even with outreach funded through community health centers.

- Ms. Looker (Olympia, WA) stated that Washington is doing a state-based exchange, as well as Medicaid expansion. Both have been combined in one portal. She is concerned that they can set up systems that overwhelm the patient rather than empower them.
- Dr. Yee (Parlier, CA) said that in California they are undergoing a state health insurance exchange and the Medicaid expansion. He hears concerns, especially from the front line staff, that it is very difficult to understand the enrollments and what is and is not covered, etc. The patients at his center (United Health Centers) consists of seventy percent farm workers and their families and many of them do not have internet access and/or do not know how to access information on the internet. Their biggest challenge will be consolidating the information that patients need to know, and training of clinical and front line staff.
- Dr. Rogers noted that illiteracy is a problem in Texas where they have many people who only speak Spanish, and do not know how to read either in Spanish or English. Fifty percent of their children drop out of school, so they cannot help their parents or grandparents.
- Dr. Crouse is hearing questions about what an Accountable Care Organization (ACO) is. He is part of an Accountable Care Organization and does not understand what it means. He is also hearing questions about what the interface is going to be between ACOs and other entities, as they look at a more population-oriented approach to health care.
- Dr. Warren commented that it is important to distinguish between patients and people who are not patients because there is confusion.
- Dr. Izard said that in Wisconsin they did not expand Medicaid and are going to have a Federally led exchange. People who are not covered by Medicaid, will have a \$2,000 individual maximum out-of-pocket expense. He has asked if pharmacy medication costs are included in that maximum out-of-pocket, but has not yet received a response.
- Tina Cheatham (Division of External Affairs, BCRS) said that CMS envisions doing a series of state-by-state, and some regional, webinars and conference calls specifically targeted to providers. BCRS will be messaging clinicians and partners to advise them of these opportunities.

Ms. Spitzgo asked what else they could be doing to help inform their members and partners about ACA.

- Ms. Looker expressed her excitement about upcoming changes.
- Dr. Warren noted it is important that the HRSA expand the number of site designations. That can correlate with the expansion of access and the other things that are going on with ACA.
- Ms. Witzel (Langdon, ND) said that North Dakota is expanding Medicaid. One of her concerns is that she has heard the ACOs are not acknowledging nurse practitioners. Patients question, if their primary care provider is a nurse practitioner, if they go to an ACO, can they continue with their primary care provider, and how does the insurance exchange plan for that? She believes that Federal programs acknowledge all provider types, but questions whether that will carry over to the state-run programs.

Ms. Spitzgo moved on to the next topic, but invited participants to email with any issues that arise. Ms. Cheatham is the point person, and there is a group within HRSA that is working on ACA.

Retention Resources – Discussion
Kim Kleine, Deputy Associate Administrator, BCRS

Ms. Kleine opened the discussion with a recap of the conversation from January about the NHSC and their retention strategy, goals and activities in fiscal year 2012 and 2013, and the discussions led by Dr. Yee and Dr. Izard on their site perspective of CEOs around retention.

The NHSC conducts annual satisfaction surveys which yield results around retention of providers. Short-term satisfaction and return survey results were described. Survey results for June and July 2013 are anticipated in early August.

In creating the 2013 retention plan, BCRS developed strategies and activities directed at sites for raising awareness around a retention; to provide good business value to sites around recruitment and retention; and to create tools to do that, through webinars and TA. BCRS also looked at ways for providers to feel connected to the NHSC. A site retention questionnaire is being cleared in the OMB, which will generate more data.

There have also been discussions in previous Council meetings about policy, ways to look at policy in the NHSC differently and how this translates in the field. There will be a webinar in August around program guidelines that details what is expected of members of the NHSC with respect to recruitment and retention.

A lot of work has been done around preparing people for service, including a mentoring program that was created to foster relationships between scholars and NHSC providers in the field. (See discussion paper for overview).

Four virtual job fairs took place this year to help connect scholars transitioning to service and sites. The virtual job fair in March focused solely on tribal sites. BCRS have also ensured that all of their sites are well represented on the NHSC Jobs Center with a site profile and active posting of open positions. Non-NHSC providers are also going to the Jobs Center to look for job opportunities.

Stories from providers in the field and their experiences at NHSC have been posted on the NHSC website and Ms. Cheatham's team is working on a video record of a story on a site that is doing a great job and successfully retaining NHSC providers.

Ms. Kleine asked the Council if there is anything that the NHSC is missing and for suggestions for anything innovative and creative that they can be doing.

Discussion

- Ms. Stergar asked if there has been any more development in establishing partnerships with residency programs, so that people are aware of primary care, as well as at the medical school site, or about scholar programs and loan repayment.
- Ms. Kleine stated that the NHSC is an over-subscribed program. They have more applications than they are able to fund. The Division of External Affairs has done substantial outreach.
- Ms. Cheatham in turn indicated that they have a number of schools that they are working with directly, and a large school list. There are 970 active Ambassadors who are doing a lot of school outreach. These Ambassadors are in every state and region. It was also noted that NHSC has reached over 10,000 likes on their Facebook page, so the social media arm of DEA's outreach efforts has been successful.
- Ms. Spitzgo added that part of the emphasis is getting physicians in the fourth year of training on the primary care track, keeping them there as they go into residency and providing incentives similar to the scholarship program. They are looking at applicants after the second year, and what is needed to help them get completed applications in to boost the numbers so they can hit the target numbers of awards for the S2S Loan Repayment Program.
- Dr. Crouse stated that the private sector is moving into recruitment and retention, doing increased activity and graduate medical education, and rotations in rural areas or underserved areas. There is a wonderful synergy between the Students to Service opportunity, teaching health center opportunities at FQHCs, and retention afterward. This educational opportunity applies to both recruitment and retention.
- Dr. Warren noted that it is important while focusing on primary care physicians to look at need and transfer some of that need into demand. There is a pool of interested young people that he does not want to be missed because they do not have scholarship opportunities. They need to figure out how to maximize where they have the greatest opportunities in terms of schools.
- (Action item): Ms. Spitzgo will pull the data on schools and examine where they are having the greatest success and discuss this item at the next meeting.
- Ms. Horvath said that as they make the call for primary care physicians, they need to include other clinicians, such as nurse mid-wives, nurse practitioners, PAs, and mental health workers.

Ms. Kleine had two additional questions: (1) can NHSC sites start to create momentum around retention being important, and add business value and retaining primary care providers, and (2) concerning the 2014 Application Guidance for Loan Repayment and how they can allow providers to have leadership roles in sites, the hours that they need to service patients versus the eight hours of administrative time. There will be 32 hours of clinical time. The eight hours of administrative time has been expanded to include other roles of providers, including leadership management. These changes arose from phone conferences in October and January. She asked the members what other policy changes they could consider, especially for sites that are not able to retain providers.

- Dr. Izard felt that recruitment and retention are major issues that they are always dealing with, especially with expansion of the various programs. There are other types of practices that are trying to take the “better providers” out of some of the under-served areas, and into different positions within the health systems, private practice, ACOs, etc. The issue is, how can the NHSC compete with others who offer more money and other benefits than the NHSC can?
- Mr. Stergar agreed that it is going to be very difficult to go forward when they are not competitive in some of those basic areas.
- Dr. Izard had been in discussions with some of his sister FQHCs, who are trying to aggressively expand their organizations; concern was expressed that over the next couple of years, physicians and providers are potentially going to demand a higher pay than the groups are historically accustomed to because of supply and demand. This is going to cause some significant internal problems in these organizations because if they hire a new doctor, and that person is making \$5,000-\$10,000 or more greater than established employees, that is going to create problems. If they have to increase their recruitment salary compensations, they need to start planning in the budget how to increase salary compensations of existing providers.
- Ms. Schwartz commended Ms. Spitzgo on the work she has done. Schwartz was nominated by the National Council of Urban Indian Health, and commended HRSA, NHSC, and Ms. Spitzgo’s team on their efforts to include tribal and urban Indian clinics and Indian health service sites.

Partnerships with NHSC – Discussion
Tina Cheatham, Director Division of External Affairs, BCRS

Ms. Cheatham opened the discussion with a recap of the January meeting, where they talked about partnerships. Two of the advisory members followed up with additional ideas about partners.

There are about 4,000 contacts that are national organizations that are part of the partners list, as well as academic institutions. Where there is a launch or posting on Facebook, the goal is for these partners to “like” it and in return, they share the partners’ messages that are helpful to the NHSC audience in that social media space.

In addition, NHSC is working closely with about 18 organizations that help them to continue to have a diverse applicant pool, in terms of racial and ethnic diversity, diversity of discipline, and geography. The rural organizations are part of that group. There are student organizations on the list.

The NHSC is working with these partners to distribute information. These groups are asked to put up web badges and banners, and additional information for an application cycle, for their members and through their channels. The NHSC has also updated who their ambassadors are and where they are, and are trying to energize them to help spread information.

Ms. Kleine helps lead tribal efforts, specifically around the outreach and partnerships. NHSC has been providing monthly updates to the Indian Health Service on NHSC-approved sites, and the number of clinicians working at tribal sites. At the first virtual job fair, NHSC had 70 clinicians looking for jobs at tribal sites.

The NHSC Jobs Center website has experienced about 40,000 visits per month. This represents 20,000 unique visitors per month. Google analytics show that they are spending some time on the site. NHSC is trying to determine whether or not these people take the desired action.

The NHSC informed the Homeless Council of the availability of the NHSC Job Center as a source of behavioral health providers and encouraged them to complete their site profile. Ms. Kleine and Ms. Spitzgo have been working with tribal leaders to utilize the NHSC Job Center as a resource. Clinicians in Puerto Rico have also asked the NHSC to prepare more of their materials in Spanish. The NHSC has hired a bilingual staffer on their outreach team, who is part of their member resource team.

Ms. Cheatham asked the Council members to think about other expansions of partnerships that should be considered, and how can they better help the tribal partners. She also asked for input from the Council members who are physicians as to how the NHSC can strengthen a mutually beneficial relationship with their partners, when there is not a financial component to the partnership.

Discussion

- Dr. Warren has looked at the 18 target partners. He asks if any are in the area of education centers.
- Ms. Cheatham responded in saying that the National Association of Area Health Education Centers (AHECs) is not on that list, but the NHSC works very closely with the AHECs. AHECs are on the outreach list for launches, and NHSC works closely with them on Corps Community Day.
- Ms. Schwartz has been on the Advisory Council for the last couple of years, and thinks it is a good idea to have someone there to help answer questions related to tribal partners. She recommends that the National Council of Urban Indian Health, the National Congress for American Indians, and other organizations, continue to participate.

Additional Items – Discussion **Byron Crouse, M.D., FAAFP, NAC Chair**

Dr. Crouse opened the meeting to the members on other issues or topics.

Discussion

- Dr. Izard referred back to Ms. Kleine's conversation regarding recruitment and retention. He asked if a scholar comes to a site, and that site had an improved score for that scholar, if

that site score changes (i.e., becomes lower), would that scholar be unable to stay at that site?

- Ms. Spitzgo stated that if a scholar is placed at a site, they have a four-year obligation. If the score goes down, they do not have to move. They can complete their obligation at that site. Ms. Root added that if during that period the score went lower at the site, they would not be at the top tier. Ms. Spitzgo's understanding is that scholars who remain at the site where they completed their obligation, can go into loan repayment program non-competitively and they do not have to move to a site with a higher HPSA. If the site has completely lost their HPSA, the scholar would have to move to a high need site.
- Dr. Izard was referring to a situation where the scores have fluctuated, but it is still a HSPA. Ms. Spitzgo confirmed that in that case, they would be able to finish their obligation. If they leave and return, they would come in to the loan repayment application, and it would be ranked by HPSA for whatever the current score is of the site.
- Dr. Izard asked for improved communication on this subject so that people are not alarmed. Ms. Spitzgo suggested adding that information to the newsletter.
- Dr. Crouse noted that he thinks this is a retention issue for both scholars and loan repayors. If they sign off and commit at a site, in two or four years, do they have to move to maintain benefits from this Corps?
- A BCRS staff person said that there might have been some communications that went out to participants at sites where their HPSA score had been withdrawn, of the site became inactive because they did not take the necessary steps to retain an active NHSC standing. In those cases, the NHSC communicates to the participant that it does not affect their current eligibility, and they may stay at that site, but it would affect if they apply for continuation or for the Loan Repayment Program. She suggested that they review that message for clarity.
- Ms. Spitzgo said they will review the matter and try to clarify.

Public Comments

Byron Crouse, M.D., FAAFP, NAC Chair

Dr. Crouse asked participants on the phone for public comments.

Discussion

- Mr. Overbeck is a primary care officer and oversees the Board. He commended Ms. Kleine for her presentation on retention efforts at the NHSC. He encouraged the NHSC to coordinate their efforts with primary care officers. A number of primary care officers have been funded through American Recovery and Reinvestment Act (ARRA) grants to expand retention. It makes sense to be able to coordinate the city-based efforts that are now being planned. He suggested that they could include a session with states, post ARRA grant, in September or October. He also thought a webinar from the NHSC would be very helpful. Other information sharing about these topics on the NHSC calls are also opportunities.
- CAPT Budashewitz agreed with Mr. Overbeck and has been thinking along those lines with the completion of the ARRA grants and final reports. In CAPT Budashewitz's office, they are thinking of analyzing final reports and doing a synopsis of all of the participants' final

- reports, and making that publicly available. He liked Mr. Overbeck's idea of doing a webinar.
- Ms. Forsome (Washington State Primary Care Office) had a question about the Affordable Care Act and the NHSC, specifically in regard to essential community providers. If a site is an NHSC-approved site, such as a community mental health center, would it qualify as an essential community provider. They do not appear on the list that Ms. Forsome checked. CAPT Budashewitz believed that there was no reason why they should not.
 - Ms. Spitzgo thought that there is a process that must take place to be deemed an essential community provider that has nothing to do with NHSC. She thought it is with the various insurance providers. The process may vary by state. She suggested that Ms. Forsome email Michele Goodman in BCRS' Office of Policy and Shortage Designation and she will answer the question.
 - Dr. IZard said there is a [website](#) where one can check for names on the list. The website makes reference to how they determined who would be on that list. Largely, if you are eligible for the NHSC through HPSA, then you should have qualified for that. One can also request that a name be added to the list on that website.
 - Ms. Spitzgo suggested that if you go to the www.healthcare.gov site, there might be links there for essential community providers. She also noted that she would be glad to help research this for Ms. Forsome.

Final Comments/Discussion

- CAPT Budashewitz added a comment on the issue of technical assistance to sites related to the question of ability to pay. As more people come into the exchanges or marketplace, the conversation regarding ability to pay and sliding fee scale is going to become more of an issue because of the maximum deductible that people have to pay. The sites are trying to figure out if they are allowed to offer people a sliding fee scale for their deductible, if they have their insurance through the marketplace. It may require some investigating on the part of NHSC to figure out what their position is going to be. Ms. Spitzgo said this is a great point and asked Dr. IZard if they have gotten any guidance from the Bureau of Primary Health Care on that. Dr. IZard responded that up to this point it is still the same position that the site fee is offered for everyone, but if a patient has a particular insurance, that contract with the insurance carrier might already dictate that the person is responsible for their co-pay, or a piece of it. At present, NHSC is not able to offer a discount on top of that. There is a lot of conversation around this issue because it is not clear. It may make more sense for the scholars to ask such questions, because their centers might be trying to figure that out. It would make more sense if the NHSC is stating the same case as the HRSA's position. It is going to become more important going into 2014.
- Dr. Bhatt had questions about whether they are plugging into state and city health department coverage plans concerning how they are going to deal with expansion and enrollment. He thought scholars and loan repayors and the Corps can plug into that, if that is not already in their plans.

Final Remarks

Rebecca Spitzgo, BCRS Associate Administrator and Director, NHSC

Ms. Spitzgo thanked everyone for their participation and noted that BCRS would follow-up with members asking for feedback on how the new conference call format worked for everyone.

The Council will revisit the ACA topic and may possibly have another call before September, even if it is just focused on the ACA. The input of what participants are hearing in the field was extremely valuable and will help to keep them very focused, and will be passed on.

Ms. Spitzgo noted that this was a very rich, insightful discussion of how they can continue to focus on the areas with the ACA, retention, and continuing to grow partnerships.

She asked that Council members send the events for Corps Community Day on October 10, 2013, and participate that day, or find someone who can help pull an event together. NHSC is happy to help. The enrollment kickoff is October 1, 2013 and that give all of them an easy event to help spread information.

Ms. Spitzgo thanked the Council members and participants and ended the call.

(Whereupon at 3:28 p.m., the NAC meeting telephone conference was concluded.)