National Advisory Council on the National Health Service Corps (NACNHSC)

Health Resources and Services Administration
5600 Fishers Lane, Rockville, Maryland

Monday, September 17, 2018, 9:00 a.m.

Council Members

Adrian Billings, MD, Ph.D., NACNHSC Chair
Joni Adamson
Jackie Griffin, Ph.D.
Wilton Kennedy, DHSc, MMSc, PA-C
Joan Malcom, DMD
Daryl Salvador, PsyD
Cindy Stergar
Gwen Witzel, APRN, FNP, FAANP

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Vicky Noland
Sophia Russell
Sean Smith
Martha Vallier

Opening Remarks

Ms. Diane Fabiyi-King convened the meeting and welcomed everyone. She expressed gratitude for Council members' participation by Adobe Connect and telephone since staff thought it best to meet remotely versus in person due to weather and travel concerns. **Ms. Fabiyi-King** called roll.

Welcome and Introductions – Dr. Adrian Billings, MD, Chair, NACNHSC

Dr. Billings thanked everyone for coming together, especially for those early in the morning. He is excited about the agenda and opportunity to make recommendations to move forward for patients and NHSC. He expressed well wishes and prayers for people affected by Hurricane Florence, including NHSC providers working in difficult conditions and putting patients above their own families. He asked Council members to give a short biographical summary of themselves.

Dr. Billings is Chief Medical Officer of a federally-qualified health center (FQHC) called Preventative Care Health Services in southwestern Texas near the Mexican border. He is also an associate professor in pharma and community medicine at Texas Tech University Health Science Center, and supports the rural medical education efforts in the rural Big Bend area of Texas. Dr. Billings was an NHSC scholar.

Joni Adamson is the Manager of Recruitment and Workforce Development at the Missouri Primary Care Association. She works on recruitment services and workforce development initiatives, and works with smaller hospitals, critical access hospitals, certified well-health clinics, and more.

Joan Malcolm has been in private dental practice for the last several years. Prior to that, she worked at several FQHCs in southern New Jersey.

Jackie Griffin is a retired CEO for several community health centers. He retired twice from MedLink which covers the entire northeastern quadrant of Georgia, and was brought back as a Project Director to design and bring in new services, including at a new site near Athens. It will include rehabilitation services and integrated mental health and substance abuse services.

Wilton Kennedy (who currently has a houseful of Wilmington, North Carolina hurricane refugees) is on faculty at the Virginia Tech Carilion School of Medicine, and he works in private practice in Roanoke, Virginia. He is a former NHSC scholar physician assistant who spent eight years at a community health center in Hendersonville, North Carolina.

Darryl Salvador is a clinical psychologist by training, currently serving as an integrated behavioral health consultant at the U.S. Army Health Corps-Schofield Barracks in Hawaii in their primary care medical home. He also works at the Molokai Community Health Center. He also provides treatment via telehealth. He is a former NHSC scholar who worked at the Molokai Community Health Center.

Cindy Stergar is CEO of the Montana Primary Care Association. All members are FQHCs and other primary care providers, such as tribal health centers and urban Indian centers in Montana.

Gwen Witzel is a family nurse practitioner in North Dakota. She did primary care in a critical access hospital and rural health clinic for many years, and currently covers the emergency room in a critical access hospital. She also serves as adjunct faculty for the University of Mary in North Dakota where she develops the rural health curriculum for the DNP program. Also, at HRSA, she was involved in the NHSC SEARCH program several years ago.

Dr. Billings also asked federal staff to introduce themselves, and he thanked them for helping NHSC clinicians take care of patients on a daily basis and improve their lives and improve the nation's public health. **Dr. Billings** reviewed the meeting's agenda.

Minutes from NACNHSC meeting in May 2018

Ms. Stergar moved to accept the minutes as presented, and **Dr. Salvador** seconded. No discussion occurred. The minutes were accepted unanimously.

NHSC Update – Mr. Israil Ali, MPA, Director of Division of National Health Service Corps, Bureau of Health Workforce

Mr. Ali thanked everyone for taking time from their busy schedules to help shape and bolster the program. He is looking forward to meeting everyone in person.

Mr. Ali noted the staff additions of Senior Public Health Advisor, Captain Stacy Atkins, and a new Deputy Director, Dr. Michelle Ubella. Captain Atkins has much experience in public health, and mental and behavioral health, and will bolster efforts in substance use disorder and team-based care. Dr. Ubella comes from the Food and Drug Administration, and will focus on infrastructure building, evaluating program effectiveness, and ideas for moving forward.

Mr. Ali noted BHW's goals are to prepare a skilled workforce prepared for community-based training, improve workforce distribution specifically in rural and underserved areas, and advance modern healthcare, including through telehealth (a major topic across HRSA). He added NHSC is dedicated to building a healthy capacity of clinicians for underserved areas, enhancing development of its programs, being agile and responsive to the current healthcare landscape, and strengthening its academic and community partnerships. He noted the 2018 Budget Consolidation Act will help expand the focus on substance use disorder (SUD).

Mr. Ali is looking forward to hearing the Council's ideas and recommendations that will inform decisions. This is vital as NHSC will emphasize enhanced review of its effectiveness and impact in the next few years. He knows Council members have the experience to help leverage evidence-based practices and make great recommendations. Each member can help advance some of the things that the Corps is doing, and help remove barriers specific to locations or disciplines that are not apparent to headquarters. Clearly, Council members care deeply about NHSC and are vital to identifying ways the Corps can continue to grow its capacity and improve the healthcare landscape.

Dr. Billings thanked Mr. Ali for his leadership in helping clinicians everywhere they serve, and for the health of the nation. Academic partnerships are exciting, and they help solve clinicians' questions as they treat patients, and soften the isolation in rural areas.

Auto HPSA – Ms. Elisa Gladstone, Special Assistant, BHW

Dr. Billings noted a lot of people are nervous about automatic HPSAs. Ms. Gladstone began by saying she appreciates the opportunity to discuss this topic. The titles of her slides are listed below in italics, along with her supplemental comments.

Shortage Designation Modernization Project. No changes to the criteria will be made due to this project (in addition to none made thus far). Updates for existing HPSAs will be based on national standardized data sets, facility-specific data, and data provided by the primary care offices or PCRs at a single point in time. In November 2017 BHW did a national shortage designation update of geographic, population, and other facility HPSAs, and is now focusing on automatically designated HPSAs (auto HPSAs).

Automatically Designated Facility HPSAs.

Auto-HPSAs Compared to other HPSAs – Similar but not the Same. Facility requests for updates are emailed to HRSA. The current imbalance is based on when data were used to score auto HPSAs. Many communities have changed since 2002, as has technology and other things.

Year Auto-HPSAs were Updated (n-9,032). Auto HPSAs do not lose designation unless they are no longer a Section 330 grantee and would be proposed to be withdrawn.

NHSC and Sites Relying Upon Auto-HPSA Scores. The effort is to be transparent and accountable, and strive for parity with where national resources are going.

2019 National Shortage Designation Update: Auto-HPSAs. Surprises are not desired. BHW will provide a lot of technical assistance for how scores are done. There was not a lot of scoring transparency in the past, but going forward facilities will see all the data points. The September date might slip. Update results will not be published and only used for planning, and are subject to change based on PCO changes to provider data. BHW will continue to review and revise the data, and transparency will lead to broad confidence in how data are derived and revised, and in the process overall.

Data Sources Summary. The Working Group had to work within existing scoring criteria, despite some frustration with that. It is a challenge to balance data, and blend all the reporting processes. Five proposals are up for consideration, and this slide shows the data selected by HRSA. How data points are derived was discussed in a webinar, and the Bureau will do so again upon request. Scoring is organized at the facility level so all within a system will have same score. RHC and ITU rely heavily on census data.

Next Steps. The Bureau is working to ensure less confusion and concerns, and that people understand the process. The Bureau recognizes some will understand, and some will not be happy with the process. The Bureau is working to ensure the information is distributed and it is meeting participant needs, including by improving communications.

Resources and Contact Information. A single point of entry for questions, comments, etc., is part of the effort to increase communication and partnership between PCOs and PCAs in states.

Summary.

Discussion

Ms. Stergar said this has been an important topic for many years, and asked how facilities will be notified about status. **Ms. Gladstone** replied it will be a stepwise process beginning with state PCOs receipt of data since they are in a unique position to make changes. The Bureau will also reach out to organizations and facilities as needed. Next, PCAs will receive a list of facilities in their state, followed in one week by their current and projected scores; then facilities will receive an email. The Bureau will rely on the electronic handbook for contact information for health centers and FQHCs and lookalikes, and will email facilities one week in advance to give notice. Contacts for RHC and ITU will come from the BMISS Portal, and they too will receive an email one week in advance. The plan was to do a broader mass communication but the timeline shifted and the Bureau did not want people to think they missed the information.

Ms. Stergar asked whether the information will go out in September or October, since it already is mid-September. **Ms. Gladstone** said it is more likely to be October, or possibly November, and she will submit an updated timeline. **ACTION ITEM**. **Ms. Stergar** asked whether the Council will be notified when data are sent. **Ms. Gladstone** replied she will prepare a national summary of what the data will look like and will provide that to Council members. **Dr. Billings** said that was a great recommendation and he wants a preview to see and share with stakeholders. **Ms. Fabiyi-King** agreed to do that. **ACTION ITEM**.

Dr. Griffin asked for clarification about each site in a multi-site FQHC receiving the same score. **Ms. Gladstone** noted that if an organization has five sites and a primary care score of 17 each site will receive that score. **Dr. Griffin** added his organization has 16 sites, and the scores are uneven, and he asked how it will work for accurately portraying need in one site versus another. **Ms. Ryan** said that is how auto HPSA for health centers works now. Five years ago the Bureau proposed to give different scores to each site in an FQHC since vast differences could exist, but the health centers adamantly opposed that approach in favor of the flexibility that comes with one score for an entire network of sites. The method uses UDS data and that is done at the organization level with all sites. To disaggregate the data is either not possible or quite difficult.

Dr. Billings said his organization serves three clinics in two counties, and one has a HPSA score of 12 and one is a 17 auto HPSA, so sites that would have been a 12 are a 17 and that gives more flexibility for locating NHSC providers. However, he also has clinics in a lower score area so Dr. Griffin's perspective is valid. It is an advantage of being an FQHC to be allowed to have a system-wide higher score.

Ms. Adamson said she supports this project and appreciates that it has come further than in the past. As data are distributed sites should recognize unintended consequences of the project, including how federal regulations say scores must be decided based on number of sites and their HPSA scores but suddenly there will be more sites with high scores and that will drive up competition for scholars. Also, some sites who now think they are competitive will learn they are not next July, and it is important to let sites know about that potential. Many people do not understand how the Federal Government does scores, and this is about scholar placement and, possibly loan repayment. **Ms. Ryan** said that is more about the statute and not this project, and the statue says there must be at least one but no more than two opportunities for each scholar, and that is done by seeing the number of jobs posted in the health workforce connector at NHSC sites.

Ms. Adamson added that some sites post notices about jobs regardless of their site's score, while some never release their score because it is so low and is not competitive in a program with limited funds, but now a lot of sites are excited about their score and are adding and updating vacancies. The consequence

of that is the scores could potentially go higher and higher, but still be unattainable for some sites. A few years ago when the modernization included online submission of HPSAs and it became a little more automated the NHSC scores started to increase since more sites were entering. Sites need to recognize the other piece, for what it means to get certain scores and the unintended consequences. **Ms. Ryan** noted competitive score shifting is more likely for the Loan Repayment Program (LRP) than scholar placement.

Dr. Billings asked whether predictions or preliminary data are available about HPSA score trends. **Ms. Gladstone** replied she still is waiting for results, but expects older HPSAs will change since the communities have changed, though she does not know how scores will change. **Dr. Billings** said that is the cause of anxiety, and he is looking forward to seeing the data.

Dr. Billings asked whether critical access hospitals (CAC) meet some eligibility requirements other than as an auto HPSA. **Ms. Ryan** replied CACs are not part of the statute that created the auto HPSAs. **Dr. Billings** asked how UDS data affect FQHCs and auto HPSA scores, particularly whether UDS data that show a need for improvement have a negative or positive affect auto HPSA score. UDS data are quality metrics that every center must submit to the Federal Government annually, based on health conditions (e.g., diabetes h1c) so it is not clear whether uncontrolled patients help raise or lower the score. **Ms. Ryan** replied it is neither, because scoring criteria are not related to quality metrics. The three common criteria across all primary care are population provider ratio, percentage below 100% of the federal poverty line, and travel time to nearest source of care. Also considered are the infant health index (either low birth weight or infant mortality data), fluoridation rates for dental, prevalence of substance use disorder (SUD) for behavioral health (BH), and ratio of age cohorts (under 18, to 18-64, 65+). **Ms. Gladstone** said she will send data points and scoring criteria to the Council. **ACTION ITEM**.

Dr. Malcom asked for more detail about fluoridation rates as scoring criteria. **Ms. Ryan** said it is just one point in the dental HPSA score, and factors in if less than 50% of the population has access to fluoridated water, though those data are difficult to get since CDC data only cover county level and some states have large counties with varying water systems. The alternative is to rely on state PCOs or health sites to provide the information. Primary care and MH scores range from 0-25, while dental is 0-26 with the extra potential point for fluoridation.

Dr. Kennedy praised the due diligence taken to notify people who are concerned about how the auto HPSA update will affect them. **Ms. Gladstone** said her staff is dedicated to making sure stakeholders are involved.

Dr. Salvador asked whether auto HPSA scores are discipline specific. **Ms. Ryan** replied separate scores are given for primary care, dental, and BH. **Dr. Salvador** asked whether alcohol rates are self-report, or by diagnosis or screener measures. **Ms. Ryan** replied it is based on rate for an area and has to be among the highest quartile for the nation, region, or state. National data come from the Substance Abuse and Mental Health Services Administration (SAMHSA), but regional and state are more challenging. Each is worth one point, so the Bureau looks to state or site partners for information about qualifying when they are not qualified at the national level.

Ms. Stergar thanked HRSA staff and stakeholders for this effort, and noted it has been underway for 40 years. She appreciates the commitment to stakeholders despite some ongoing concerns. **Dr. Billings** agreed, and said he is eager to see the data.

How to Write Council Recommendations – Ms. Lauren Spears, Chief, Health Workforce Policy Branch, BHW

The titles of Ms. Spears' slides are listed below in italics, along with her supplemental comments.

Overview.

NHSC National Advisory Council Charge.

Committee Recommendations.

Type of Committee Documents.

Writing Strong and Precise Recommendations. It is important to specify what part(s) of a statute, guidance, etc. needs to be changed, and why. A focus on general items in communications can be included, but may not rise to the level of a recommendation.

Examples of Strong Recommendations.

Other Recommendation Examples. HRSA looked at the first one to consider what can be done, but it would be better if it clarified whether it is directed at legislative or policy change. The second one is good, but could be stronger because it is difficult for HRSA to implement based on being outside its scope, and it should be clear about Congressional action or something the Secretary could do through CMS (Centers for Medicare and Medicaid Services). It also needs to specify the audience. For the third one, the audience is licensing bodies, and they are outside HHS or Congressional influence, so it would be better to have this in a policy paper about how to work with licensing bodies.

Turning Recommendations into Action. Letters to Congress may be effective to show a committee's support for specific recommendations, and HRSA staff can reference them via the A19 process. It helps agencies coordinate their legislative proposals with the annual budget submissions to OMB. It gives agencies an opportunity to recommend specific proposals for Presidential endorsements, and it aids the President in developing the legislative program budget and special messages. In general, these proposals are extremely high level and significant. Strong recommendations from the Council support HRSA's efforts to get these proposals to move forward. For example, when drafting A19s, if they are specific to the National Health Service Corps, staff may reference committee recommendations in them to help support a position on moving a legislative change forward.

Turning Recommendations into Action – Policy. The Council is well positioned for these, but challenges include the lengthy process and the movement toward less regulations, though the most effective recommendations are related to driving funding priorities. Programmatic often includes adding more disciplines or direct funds to areas with emergency needs (e.g., Zika). Bureau staff are looking for recommendations from the Council. For funding priorities HRSA often consults with Council members on changes like telehealth, and writes policy papers that help craft policy that reflects Council input. Another example is about SUD and how more funding was provided to address it.

Discussion

Dr. Billings said he appreciates Ms. Spears' efforts, and is looking forward to working with her on recommendations.

{Break}

Project ECHO (Extension for Community Health Outcomes) – Dr. Sanjeef Arora, MD, MACP, FACG, Director of Project ECHO

Dr. Billings welcomed and introduced Dr. Arora, and summarized NHSC's history and mission. He noted the Project ECHO act passed unanimously through both houses of Congress and was signed by the President in December 2016. Dr. Arora is a distinguished professor of medicine and a gastroenterologist in the Department of Internal Medicine at the University of New Mexico Health Sciences Center. He developed ECHO as a way to dramatically improve both capacity and access to specialty care for rural and underserved populations. The legislation mandates and empowers both the U.S. Government Accountability Office (GAO) and HRSA to study the impact of ECHO on the U.S. health system. He also noted his center has been using the Project ECHO model for Hepatitis C treatment for the past four to five years, and it is a great example of bringing specialists to an underserved area.

The titles of Dr. Arora's slides are listed below in italics, along with his supplemental comments.

Mission Statement.

Logo.

HCV (ECHO project started with this). Overall in the world less than 4 million people are treated, and 15-20 million people will die without treatment. Treatment formerly was with Interferon and Ribavirin which was a chemotherapy-like agent, via weekly injections.

Goals of Project ECHO. People would drive 250 miles round trip to get treatment, but among the poor they often could not afford to do so.

The ECHO Model. All three specialties were needed. They meet via teleconference. 21 centers of excellence exist across New Mexico, 16 in an FQHC and five in a correctional facility. They must have either an NP, PA or primary care MD, but no one was willing to use the protocol that required chemotherapy. As a gastroenterologist Dr. Arora became an expert in HCV by using the training model for that to create specialists.

Steps.

Benefits to Rural Clinicians. 40 publications shows ECHO increases the joy of work for rural physicians.

Image of people involved in interactive video network to discuss patients one at a time for 45 minutes, to co manage. Learning was mostly based on experience, also called guided practice, versus just lectures and discussion.

ECHO vs. Telemedicine. Most specialists already have significant waits, at least when they are seeing Medicaid and poor patients, but ECHO trains teams of physicians who then treat many people, it is force multiplication.

Technology.

How Well has the Model Worked? Worldwide millions of credit hours.

Project ECHO Clinicians (2 slides). Self efficacy must be addressed before clinicians will treat HCV via ECHO. First, rural clinicians treated their own patients and then started accepting patients from referrals in town. They became specialists and the result for treating Hepatitis C was the wait fell from eight months to two weeks.

Clinician Benefits. It was clear that patients were benefiting but it also was important to know whether physicians benefitted as well.

Project ECHO Annual Meeting Survey. Rural FQHC physicians said access to specialists is a major challenge.

Outcomes of Treatment for Hepatitis C Virus by Primary Care.

Treatment Outcomes. This changed the world in 33 countries and 230 universities worldwide.

Disease Selection.

Bridge Building – Pareto's Principle. This shows a huge impact with minimal investment.

Force Multiplier. This was an exponential improvement in capacity, 10 times. NPs providing the same level of care as a specialist leads to 10x force multiplication.

Successful Expansion into Multiple Diseases. Most popular are antimicrobial stewardship and other system improvements, so it is not just care of individual patients but using systems as cases. Asthma could be a community where prescription rates are too low.

View of Participating Providers, Health Workers, and Educators (2 slides). 25% of the population suffers from chronic pain, so more experts helps.

ECHO-Age – Beth Israel Deaconess Boston.

Geriatric Mental Health ECHO – University of Rochester.

V SCAN-ECHO for Liver Disease – University of Michigan. Provider participation in ECHO led to a 46% reduction in mortality.

Peer Reviewed Publications – n=116.

ECHO Publications by Moore's Outcome Levels. Several abstracts for papers under review are showing ECHO helps with community health. Examples are from the nations of Georgia and India.

ECHO Hubs and Spokes: State of New Mexico.

IACP Clinic Participation Sites.

Chart showing buprenorphine-waivered physicians in New Mexico.

ECHO Shared Services Model.

HRSA Funded National Opioid ECHO Program.

What the Mind does not know the Eye cannot see. It is hard for physicians in rural areas to keep up with advances in knowledge. It is frustrating, as is not having access to specialists, and it leads to turnover. The knowledge gap is expanding, and it is important to help people learn.

Potential Benefits of the ECHO Model. A challenge is public health is disaggregated from the treatment arm. This causes dysfunction because so much money goes into end of life and advanced specialty care as opposed to prevention. ECHO allows some integration. The idea is to democratize knowledge so that everybody can benefit rather than just the few who can get to see specialists.

Map of New Mexico, and of the U.S. for the VA SCAN-ECHO.

Army and Navy Pain Management ECHO Clinics. This includes multiple other countries.

Map of "Indian Country."

ECHO Hubs and Superhubs: United States. The program will partner with anyone interested in democratizing knowledge. It is in 33 countries for 70 different disease areas. It also is now being applied in the field of education where school teachers are being trained for math, science, and career counseling, and school principals for leadership training.

Images of participants.

The "ECHO Act" Report Due to Congress in December 2018. If the Council wants input it should write a letter about the importance to its constituents, or contact the HHS Secretary. The Assistant Secretary for Program Evaluation is evaluating the program, and it is important to note the impact on doctors and how they should be given time away from patient demands to learn.

Co-Sponsors. This is bi-partisan, including the bill's co-sponsors.

Image of ECHO Team. In 2007 they received a $5 million award for the most disruptive innovation in health care from 307 applications from 21 countries.

What Makes ECHO Work? Most of the value of ECHO is about empathy, respect, kindness, relationships, and networks, and not just knowledge. Knowledge expansion is all-teach-all-learn. Specialists and primary care share knowledge, and customize knowledge to individual patient needs such as in primary care, and in a social, economic and demographics context. It includes implementation science for how to apply best practices in rural areas where resources and challenges are different than at major health centers. Job satisfaction and access to care increase, and costs decreases. This is a movement to change the world and improve care in the U.S. Dr. Arora wants to work with NHSC to bring the right care at the right place and time.

Discussion

Dr. Billings thanked Dr. Arora for his presentation, and said in 20 years in medicine this is the most transformative because it gets specialists to underserved rural and urban areas. It has a positive effect on patients and providers, and its impact is moving public health in a positive direction.

Dr. Malcom asked whether ECHO will include oral health. **Dr. Arora** replied that is one of the highest needs worldwide but not a lot of partners are available at this time. Harvard University has signed an agreement but its efforts have not launched, and they are looking for leadership. He is looking for an

oral health pioneer to start, and believes that will cause many more to follow. He will be glad to assist a dental start up and glad to respond to email inquiries. **Dr. Malcom** noted major needs for expanded dental services, including for its role in Hepatitis C.

Dr. Billings noted his work in Uganda, and how the ECHO model would help, similar to how massive open online courses transformed education for millions of people across the world that would not otherwise have access to the education.

Ms. Witzel asked how small communities connect to the project, including to address the huge need for mental health care in rural areas. **Dr. Arora** noted www.echo.unm.edu for information on all programs worldwide and how to connect. He said they all are looking for people to include. He also invited direct inquiries to his office.

Ms. Stergar said many places in Montana and throughout the northwest use ECHO, and the program is one of the best things for rural and frontier America. She asked about the capacities of the Hubs and Superhubs since sometimes it is a problem getting into ECHO for a certain disease since they are full or have difficult criteria to participate. One challenge is currently there is no university reimbursement system either for specialty or primary care clinicians.

Dr. Arora replied that one barrier is universities have to use their own limited resources but he wants to include more universities per the ECHO Act that is about improved health system functioning. Several factors are involved, including big data and artificial intelligence, human genome sequencing, computer aided drug design, proteomics, and the Internet. It all is creating revolutionary knowledge expansion and is leaving primary care clinicians to their own devices to capture and apply it. Incentives are needed for academic centers to share their knowledge. Also, it will be important for primary care practitioners to not get tagged for lost productivity due to time spent with an ECHO Clinic to boost their expertise since their added qualifications can reduce patient travel and discomfort, late diagnoses, and emergencies. A national financing system for ECHO is needed for every FQHC and other sites.

The Hubs help people in their local communities and Superhubs are defined as a Hub that is running ECHO projects but also has the authority to start new hubs. All of them are capacity constrained but in general many are still taking people. Also, every month five to seven ECHO sites are launched around the world.

Ms. Stergar said the Council should discuss whether being an ECHO participant can be included in the NHSC time requirements. **Dr. Billings** and **Ms. Fabiyi-King** concurred.

Dr. Billings asked how else the Council can assist. **Dr. Arora** cited a need for help with rural primary care, especially to allow very busy clinicians to participate in ECHO without fear of being punished for missing HRSA productivity metrics. This would help address their being overloaded and driven to leave. ECHO is creating value for primary care physicians in underserved areas to make their lives better, but HRSA should help remove the financial disincentive to working with ECHO. The Association of American Medical Colleges, the Association of Academic Medical Centers, and specialty colleges need to understand they are not just about training clinicians who will then fend for themselves, they need support for lifelong learning. It is important to democratize knowledge and train people in rural areas to work in teams. Value is not about the doctor doing everything. Medical schools do not teach the type of

teaming that ECHO helps with, and that kind of work should be valued. ECHO brings all types of clinicians together, but fee for service limits are a barrier. ECHO can help improve rural retention.

Dr. Billings suggested educators should expose trainees to ECHO as a force multiplier and a way to democratize healthcare in underserved areas. **Ms. Stergar** said she is strongly in favor of the Council recommending language for the NHSC LRP that time used for enhancing rural service in high needs areas can be credited, and time allotted to ECHO counted toward hours of service. Staff should determine how to do that. **Dr. Billings** said he agreed.

Dr. Malcom said this is perfect timing because of new funding and this shows how the delivery model is changing, and the Corps' requirements can change accordingly. The model is changing in general, and in different states. **Dr. Billings** asked how to change CFO and CEO minds to make them realize ECHO is a force multiplier that will bring patients into the practice, and whether changes in reimbursement for telemedicine and telehealth can help centers receive appropriate funding.

{Lunch}

Afternoon Session

Ms. Fabiyi-King re-took roll, and all from the morning's session were in attendance.

Substance Use Disorder – Ms. Paula Gumbs, MBA, Public Health Analyst, Division of the National Health Service Corps, BHW

The titles of Ms. Gumbs' slides are listed below in italics, along with her supplemental comments.

NHSC Combatting Opioid Epidemic.

Purpose and Update. Special thanks to the Drug Enforcement Division in the Division of External Affairs for help with communication to stakeholders, and HRSA's Division of Regional Operations who helped identify and recruit SUD treatment at NHCS sites. Thus far they have success at 111% of their goal with 1,672 sites recruited, and that will increase as they review additional updates. Another partner is the Division of Business Operations who manages program reports and requirements in the electronic system. Also, SAMHSA provides a lot of information about services and treatment to help shape practices and policies in the program guidance.

NHSC Strategic Overview. The $75 million for FY 19/20 expansion comes from the overall $105 million funding.

Award Enhancement – FY 19 LRP Continuation Awards. Includes NPs, PAs, and DOs sanctioned by Congress to provide MAT services.

FY19 New LRP Awards.

FY19/20 National SUD Expansion. Included primary and secondary research.

FY19/20 Rural Opioid Focus. People were identified in planning and implementation grants.

NHSC SUD Challenges. It was necessary to identify subject matter experts, including from SAMHSA, and those who monitor the MAT cooperative agreement. Staff met with four of the nation's leading bodies who determine what is a SUD counselor. When the APG is released the people can agree with what a

SUD counselor is. It is important to know the providers who will be treating the population. Three of the four initiatives will be rolled out for all of 2018, and the rule that helps focus on the initiative will be rolled out in 2019. It will be a busy time for award application submission and processing.

Accomplishments. This includes more partnerships than listed here to ensure meeting program and providers' needs.

Next Steps.

Discussion

Dr. Billings said this is a new and exciting development. **Ms. Stergar** agreed that this is important, and she is thankful to see the focus on rural health and partners. It is similar to a program with academic training institutions who partner with academic schools for training in the SUD field. Different states do different things regarding requirements for clinicians and for peer support, and controversy exists over whether a SUD counselor should be at the master's or bachelor's degree level.

Ms. Gumbs noted meeting with the International Reciprocity Consortium for Substance Use Disorder Counselors, the National Association of Addiction Specialists, and the National Board of Counselors. They are the three primary credentialing bodies for SUD professionals. They were asked to define a SUD counselor and the elements and criteria for certification. As for master's versus other degrees many professionals have a SUD certification rather than a master's degree, so the definition is two-pronged in terms of education and state licensure. A licensed professional could be an RN with a bachelor's or a Pharmacist with a SUD certification, and they could be Level 1 or Level 2, but they would be serving at an approved NHSC site.

Ms. Carson added SAMHSA condoned the planned training through their cooperative agreement with the Provider's Clinical Support System. The Bureau will program that into the application process so that it can lead and track clinicians eligible to take the training so the impact can be measured. Additional training will be available from the SAMHSA website, and there will be links for peer support.

Roger noted the activities being discussed are primarily under Section 338B of the statute, the loan repayment opportunity, and it will be individuals who have already received credentialing and are prepared to provide clinical interventions. Other training partnerships are being considered, including with internal health workforce programs such as the Behavioral Health Workforce Enhancement and Training Program that could possibly be leveraged in other programs within the NHSC. However, the FY19 investment will not include targeted academic partnerships.

Ms. Stergar said the American Society of Addiction Medicine (ASAM) and other accrediting bodies have provided MAT waiver training. Her state's primary care association has sponsored ASAM training for a year and a half. Other PCAs have done similar things. **Ms. Gumbs** noted ASAM is a part of the five entities Congress approved to provide the data waiver training. Her primary contact is the American Association of Psychiatry who is leading the cooperative agreement for the next three years, though all information has been in concert with the other four entities eligible to provide the training.

Dr. Billings asked for Dr. Salvador's input as the mental health expert on the Council. **Dr. Salvador** said it is a wonderful program, but SUD is a big problem. While the program is for those who already have education and training and will work in certain areas, a question is how to infuse or coordinate working

with other behavioral health clinicians who do not prescribe but work on the other components of SUD. **Ms. Stergar** noted the same concern exists in Montana, and since alcohol and meth are the biggest problems, the PCA calls it 'MAT+' training to supplement just MAT. This is a great step in training a workforce for this epidemic, though getting a MAT waiver does not mean you know all the ways to treat the problem. It is important to include other elements in the training, including peer support. It also is important for providers to be working at the top of their license, including care navigation. Workforce support goals have not yet been met, but this program is a good first step. **Dr. Salvador** agreed that good progress has been made, and going forward a multidisciplinary approach will be good.

Ms. Adamson said the program will help because there is a pool of people who have been providing needed services but are not eligible for loan repayment. The extra $5,000 incentive for continuation is exciting, and will help answer the many questions about LRP continuation and participation in SUD. However, how the $75,000, and any extra incentives will work needs further guidance before people can make decisions and officials can offer advice or answer questions. The program will also help with retention. A key question is how participation in this program will affect fulfillment of the 32 hours per week of patient care, especially since the delivery system can be different across states and regions. In some states many SUD and MAT providers do not do as much direct patient care because they are reviewing charts and medications. It is patient care, but not in person. This situation requires close monitoring for states to know whether providers can participate, and the effect that has on eligibility, and recruitment and retention. Overall, this is exciting information and a great program. It is a rare instance where the Corps opens up for different disciplines.

Dr. Billings said NHSC has faced pressure for years to add disciplines to expand care for patients. The recent expansion was made possible by enhanced funding from Congress, and that also will be a factor in any future expansion. While NHSC is historically about primary care, more needs to be done. **Dr. Griffin** noted how care sites vary but SUD is a common problem among many, and state support helps but often is not sufficient. Some solutions include using licensed clinical social workers but overall availability of SUD providers is a challenge and it is important help people get basic credentialing. The $75,000 is enticing, and will help with getting certified clinicians to deal with this major emergent problem. It will be interesting to see how the new information will make an impact.

Dr. Billings noted the challenge centers face with billing when they debut SUD treatment and new disciplines, and perhaps they need help with it to entice their interest. It is important to establish solid billing procedures to sustain these kinds of programs, especially if federal funding ever went away. He asked about current or future funds for SUD prevention, including for training of residents or emergency medicine colleagues. He asked whether to fund SUD efforts in oral health since it is another area where opioid disorders can result. And, he asked about funds to entice graduate medical education programs to offer MAT training and data 2000 waivers as part of their primary care curriculum.

Mr. Ali noted that flexibility ('notwithstanding language') in the Corps' appropriation bill, as well as the new funding, allowed the program more flexibility for this specific initiative, and the Corps has taken advantage of some of that notwithstanding language. The Corps has tried to be as inclusive as possible as it relates to the types of sites it invests in, and the types of providers that make up the care team. As for SUD prevention, the investment is about treatment, and the 2018 Consolidation Act focused on NHSC as being a response mechanism to make sure the focus is on treatment. As for GME, BHW has many GME programs that are expanding their focus to include SUD, and the effort is not just housed

within NHSC. As for the role of dental providers in treating SUD, the May 2018 Council meeting discussed that, including interest in seeing how the American Dental Association sees itself as being responsive to this epidemic. As for emergency medicine, it is important to reiterate that NHSC focuses on primary care and outpatient ambulatory services.

Ms. Fabiyi-King said she will ask her staff to check with the Council on Graduate Medical Education about the issues discussed at this meeting. **ACTION ITEM.**

Dr. Malcom added it is important to have oral health care providers included in the SUD team, since often opioid abuse accompanies oral health issues such as rampant caries that lead to infection and pain and the need for pain management. It is critical to have oral health care providers on the front line to make sure these individuals get over opioid abuse or disorder, and lead productive lives once finished with treatments. The mouth is an important part of treating the whole body and an important component of health. **Dr. Billings** added SUD treatment is multifaceted and should be multidisciplinary versus in silos. The additional funding and the efforts discussed at this meeting are exciting. Hopefully, the centers will soon see debuts of new SUD treatment counselors.

Ms. Stergar said one of the most interesting phenomena at HRSA is the large amount of money coming out in this field. SAMHSA sends a lot of money to states for prevention, and now NHSC money is funding addiction treatment as a chronic disease, even beyond just focusing on opioids. A challenge for the Council is to make it all connect, including with GME and residency programs. Since GME has strict guidelines on what to cover and limited space in curricula, her state's PCA has helped with MAT training. That is a kind of fascinating systemic problem. Also, the ADA has committed to including the issue in oral health training, but in the midst of everything else people are being trained for, it becomes just one of many things. It will be good, though challenging, for NHSC and the Council to help coordinate all of this. Money is pouring into rural states to address opioids but the workforce is way behind. There are just not enough qualified people, and to get people qualified at a master's level takes at least two years, and possibly four. Hopefully, the funding will continue, but the challenge is to catch up with it in terms of rural state workforce.

Dr. Billings asked about incentives for NHSC scholars to provide MAT and/or for health centers debuting MAT other than what Ms. Gumbs described. **Ms. Gumbs** replied the only initiatives are those she described. Scholarship Program participation would be something for the future, perhaps in 2019 or 2020. **Mr. Ali** added scholars who may be looking for placement in this upcoming year have every opportunity to apply for SUD funding as well.

Dr. Griffin asked when the guidance will come out that defines and outlines all of this. **Mr. Ali** replied it is going through the clearance process and when staff knows more and it has been cleared for release they will share it widely.

Ms. Stergar said she appreciates that the $30 million is for high-risk communities since that should be the focus. Data about overdoses are hard to get because of how it has or has not been defined in emergency rooms. Often, providers in rural frontier communities and critical access hospitals will note another chronic disease as first before an overdose, and hopefully as awareness of the chronic disease increases that problem will change. Some communities, especially Native American, might think they will not qualify for funding because of their low overdose rates as listed by the CDC. While overdose

data should be used, they are only as good as what is entered correctly, and an effort is needed to improve reporting from emergency rooms.

Dr. Billings said he sees a role for Project ECHO in SUD in communities where they have difficulty recruiting and retaining SUD counselors and treatment professionals. It also could help train providers in those areas that currently do not have the MAT or Data 2000 waivers to debut those programs with the existing workforce. **Dr. Salvador** added ECHO could provide supervision to force multiply as well. In many places people want to learn or do new things, but often no billing mechanism exists, like efforts to supervise over Telehealth. While that might not be within the Council's charge, it could be another area to explore in terms of fiscal reimbursement. **Dr. Billings** added that is about the kind of cross-discipline effort that is better than silos. Perhaps this Council can address that with its counterparts in other areas of HRSA.

{Break}

Summary of the Day: Next Steps

Dr. Billings again reviewed the meeting thus far. He said this is like practicing medicine outside the examination and hospital room, and this is increasingly important, to influence policy and be involved in the community and government bodies such as the Council. Members have on the ground experience in providing care to these populations, and those who see 20-25 patients per day know that is important, and patients agree. However, programs like NHSC and ECHO affect populations more than on a basis of 20-25 patients per day, and are more efficient ways to help the health of communities and the nation. It is exciting to be part of policy work, and though it can be a daunting challenge the more people involved the easier it is. The Council is helping programs that impact public health and make the lives of patients and providers better, including improved knowledge and access to care.

Dr. Billings asked what products, or directions, the Council wants to push forward. **Ms. Fabiyi-King** noted that this is the time to think about the meeting's presentations and discussions to determine how to make the Council's tasks and actions as robust as possible to hone in on success.

Dr. Billings said he sees at least two areas the Council can begin to effect, SUD and/or Project ECHO expansion at NHSC sites. Those two areas likely are intertwined and one probably facilitates the other, or at least ECHO can enable response to SUD. **Dr. Malcom** thanked Dr. Billings for chairing, and agreed with idea on priorities, but wants to ensure oral health is included in SUD and ECHO. She asked what formal actions the Council can take to advance oral health in both areas. **Dr. Billings** said that is a great idea, and noted Dr. Arora (Project ECHO Director) is open to it, and is looking for an oral health champion either from the Council or someone it connects with. **Ms. Fabiyi-King** reiterated the Council can make recommendations to the HHS Secretary, including to support ECHO, for what will benefit NHSC and HRSA.

Dr. Malcom said she would like to formalize a recommendation to explore inclusion of oral health care providers in SUD care teams.

Ms. Witzel noted the importance of addressing how involvement with ECHO affects the 32-hour patient care requirement, and the possibility of allowing time spent with ECHO to count in the 32 hours since it is both about provider education and reduced rural isolation. That would help expand ECHO to communities where it currently is not located.

Dr. Billings said ECHO is unique since telemedicine typically means linking with patients in different facilities but ECHO specialists never see the patients. With ECHO, the local provider diagnoses conditions, fills out paper work and sends it to an ECHO hub for review and advice. While the primary care provider presents the patient to the ECHO team, the patient is not there in person. Upon sufficient experience with ECHO, providers get comfortable with recommendations for treating diseases (e.g., Hepatitis C) and then calling the patient for a visit to discuss treatment and follow up. Often, part of the time presenting a patient to ECHO includes staying during the 15-30 minute lecture on an element of treatment. Therefore, a key question is if the Council recommends ECHO at its sites will it also have to be a proponent for providers to have their ECHO time count toward their required time with patients. **Ms. Fabiyi-King** replied that a recommendation can be provided, but it is policy driven so would need to be a recommendation to change the policy to the HRSA Administrator, for funneling to the HHS Secretary.

Ms. Stergar said the recommendation should say the time scholars or loan repayors spend in ECHO training, listening to colleagues, and attending or presenting at ECHO sessions should count as part of the 32 hours of required patient care. The learning that takes place helps boosts retention. **Dr. Billings** agreed, and added another important question is how to make NHSC sites places where providers want to practice versus just a place to fulfill LRP or SP requirements, and offering ECHO and time toward academics and expanding knowledge base will help make them the practice of choice. This will lead to improved patient care and getting patients into the clinic who might not have had access to it.

Ms. Witzel said ECHO is the go-to source for CME and improving practices, but expanding to other types of continuing education also will benefit sites. Whether site-based continuing education counts in the 32 hours would be worked out per site. **Dr. Billings** reiterated that attending ECHO lectures includes free CME or CEU credits.

Dr. Griffin said most clinics offer and pay for CME, and providers use that for licensure credits. He asked whether adding only ECHO would set a precedent for number of days or weeks providers get off for CME. That is the other side of the question regarding ECHO, and how that will impact competing programs who would want similar treatment. **Dr. Billings** replied that speaks to the practical impact, and the issue of provider productivity and the financial constraints for centers to remain viable. A key question is how to help sites make up for the financial impact of pulling providers out to learn and expand services. His center has added Hepatitis-C patients based on ECHO, versus losing patients due to the process. This is a long-term workforce strategy that will not financially harm centers.

Ms. Stergar said the sooner people understand the value of on the job training the better. Perhaps the recommendation can say the 32 hours of direct care can include ECHO or similar programs that address clinical knowledge and retention in underserved areas. CME will be addressed by the institutions that hire providers. **Dr. Billings** said that is a good idea that relates to expansion of care and services that would otherwise have resulted in a referral. He noted the danger of people traveling to referred services (e.g., a fatal motor vehicle crash), versus seeing the primary care provider. ECHO has the ability to expand services and improve the quality of care at health centers.

Dr. Salvador said the model of train the trainer is good, whether or not it is ECHO, so clinicians can better manage complicated patients. ECHO is validated with peer-reviewed research. It has bipartisan legislative support, and that is rare in recent times, and speaks to its credibility.

Ms. Adamson said a frequent question is what providers do in the eight hours between 32 of patient care and the weekly total of 40. It can be confusing given the many provisions for part-time service, or specific specialties (e.g., OB/Gyn) or settings (e.g., critical access hospital). Not all scenarios include 32 hours of direct patient care, and that must be considered in these discussions. A key question is whether time spent with ECHO should be considered administrative, even though it is related to patient care. Also, while ECHO is not the same as telehealth, the new language about telehealth and the LRP should be considered when considering the role of ECHO. **Dr. Billings** replied that ECHO participation is direct patient care, including the 30-60 minutes discussing specific patients, and some CFOs or CEOs do not see a problem with that. Primary care providers, and probably other specialists, define administrative burden as patient care tasks that are not face-to-face, such as signing orders. That is part of the administrative burden that the health care system is struggling with since it is part of the provider's day. A key question is how to recognize it as becoming more paperwork that requires more time and extends a provider's day in the office, and can lead to burnout.

Dr. Griffin asked Dr. Billings if he has a target number of ECHO presentations per week or month. **Dr. Billings** replied no, it depends on when patients arrive, and is not a significant part of the overall effort. He has treated only 60 patients over the years but has saved them more than 300 miles round trip to see a specialist, so it does not have a big financial impact and will attract new patients. It also helps recruit providers since offering Hepatitis-C treatment in a rural area makes his center look more credible.

Ms. Fabiyi-King noted the scenario Dr. Billings describes is valuable at some sites. However, NHSC does not govern sites for what work or training to do on site, and only allows the eight hours for administrative tasks, so the Council must be mindful of how a recommendation is written. NHSC has the ability to implement opportunities for clinicians going into service. **Ms. Stergar** reiterated that most heath centers must decide through the Medical Director and CEO whether they will participate in ECHO, and register in an ECHO hub, though not every site participates in every ECHO series. Perhaps the recommendation can say some time could be available for programs like ECHO since it helps with retention and improves patient care. If ECHO is specifically mentioned it will help sites look at it, but does not guarantee anything. **Dr. Billings** said he agreed.

Dr. Salvador noted Hawaii participates in ECHO through Tripler Army Medical Center and other military facilities, but not the community health centers. Time is an issue, and ECHO participation typically is during lunch and is not part of the productivity package. It would be good to not have productivity penalties for participation, and perhaps specific billing codes could be implemented to help fiscally sustain participation. **Dr. Billings** said he agreed, and noted there is no cost to the health care provider, or patient other than a co-pay, if applicable. It would be great for NHSC sites to recoup and bill for time away from direct patient care that still includes indirect care, since that could remove financial concerns about programs like ECHO.

Ms. Stergar noted the minimum of $250,000 to set up an ECHO hub, and often universities pay for it, but in some cases the health centers and other state resources pay when no academic health center is available. Agreement to pay includes discussion and review of patient cases and other logistics. **Dr. Salvador** said participation in Hawaii is limited to the Department of Defense and the University of Hawaii, probably due to the cost of start up. **Dr. Billings** said the ECHO hub typically is where the

specialists are, but there is no charge for accessing the program. This could be another example of how to tie NHSC sites with academic health centers.

Ms. Adamson questioned the wisdom of dabbling with the 32-hour requirement. It could be difficult to regulate an amount of participation since often it will not be a lot of time per day. While NHSC cannot mandate such a change, perhaps at a minimum the Council could encourage participation in ECHO to boost recruitment and retention. U.S. providers that participate in it appreciate having networks of support. However, perhaps providers would fear being out of compliance due to the time spent with ECHO. **Dr. Billings** replied that some sites may do it differently. At his site most providers present their own patients. At some centers it is possible that ECHO presentations would become the focus of one or more of their providers and a larger part of their practice. However, overall this is not likely to significantly impact operations except for those for whom it is their passion and calling. Those people would become their own internal referral specialist. This might all come to a relatively simple fix of just rewording the 32-hour commitment, especially for things like obstetrics or telemedicine presentations.

Dr. Kennedy said he recommends against the Council weighing in on whether the 32 hours is right, and it is important to remember that eight hours of administration is not a major burden. Perhaps, the Council should recommend further involvement with ECHO but not more administrative time.

Ms. Fabiyi-King said the Council can make a broad recommendation with some components of being more specific. It depends on what it wants to achieve for making the program more robust for sites across the country, and for clinicians to have an opportunity to participate.

Ms. Stergar said health centers understand NHSC's minimum requirements when they hire loan repayors and scholars, but they set actual number of hours required in the employment contract and it could be more than what NHSC requires for patient care and less for administrative. That is OK as long as the provider at least meets the minimum of what NHSC requires. Therefore, NHSC and the Council are limited in what they can do. **Ms. Fabiyi-King** agreed and reiterated the Council can recommend policy for the NHSC, but there could be clinicians who have to do more based on their contract with a site.

Dr. Billings said the two comments about sites help reiterate that the Council's focus is on trying to impact NHSC and its scholars and loan repayors. And, there is only so much that the Council can do with regard to the sites.

Wrap Up

Dr. Billings asked Council members and HRSA staff to think about the Committee Recommendations (guidance) slide for what to do regarding ECHO. It sounds like a majority of the Council supports doing ECHO for NHSC clinicians. **Ms. Fabiyi-King** reminded everyone that the agenda also included auto HPSAs and SUD, for further discussion.

Dr. Billings said he is impressed with the thoughts and energy on the part of Council members and HRSA staff. **Ms. Adamson** said it is refreshing to see the different partners and departments at NHSC working with others, such as the Office of Shortage Designation, and SAMHSA. It is hard to form those relationships, and even harder to keep and nourish them. This work has good repercussions outside of here. Thank you for taking the time to do that, and please keep it up. **Dr. Billings** said that is well deserved praise for our government.

Public Comment

No questions or comments were offered.

Dr. Billings thanked everyone for their participation and effort. He adjourned Day-1 of the meeting at 3:30 p.m.

Tuesday, September 18, 2018, 8:30 a.m.

Convening the Day

Ms. Fabiyi-King convened Day-2. She welcomed everyone back and called roll.

Charge of the Day – Dr. Billings

Dr. Billings also welcomed everyone back, and reviewed the day's agenda, and proceedings from Day-1. The idea is to formalize what the Council wants to accomplish, either at this meeting or going forward, including possible recommendations to put forward. A key question is what can the Council create that will impact patients, sites, and clinicians.

Council Business

Ms. Fabiyi-King said this segment is for discussion of the Council's immediate priorities, including dates for the coming year to meet on a regular basis, and possibly intermittent meetings by telephone. Setting dates allows staff to reserve rooms and let leadership know the Council's plans for the year. Another question is to set goals for new Council members who will replace the five rolling off at the end of February 2019. **Dr. Billings** added the exact amount of turnover can depend on whether members decide to extend. The Council can be up to 15 members, so openings exist. Members should submit names of potential new members to Ms. Fabiyi-King for consideration by the HHS Secretary. **Ms. Fabiyi-King** noted staff will explore extensions, but that would have to be approved by others. She reiterated Dr. Billings' suggestion for members to identify potential new members, including from among colleagues, and possibly current NHSC providers, who can provide guidance over the next year. Candidates should submit a resume, and other materials requested. It will be important to have a full Council of 15 members. **Dr. Billings** said the Council represents a great blend of disciplines, levels of professional responsibility, and site types and locations, and the goal is to not over weight on any. Also, people can nominate themselves.

Ms. Stergar asked what to tell prospective Council members about commitment for meetings. **Ms. Fabiyi-King** replied an important HRSA requirement, especially for this Council, is members have to attend Council meetings by adobe phone or in person, and the Council is required to meet up to four times per year. While in recent years that has been challenged by various circumstances all HRSA councils are going to push to hold their required number of meetings. As for NHSC scholars, several have served on the Council in the past 8-10 years.

Ms. Fabiyi-King showed a slide with proposed dates for the meetings in calendar 2018 and 2019: December 4-5, 2018; March 19-20, 2019; June 18-19 2019; September 17-18, 2019; and December 3-4,

2019. The actual number of meetings will depend on what the Council is doing and its ongoing priorities. June is a good time of year to get together in person based on members' schedules.

Dr. Billings said face to face meetings at least once, but perhaps twice per year are a tremendous value, even with members' busy schedules. The meetings reinforce members' commitment to serve on the Council. In person means synergy among members and with HRSA staff, along with the energy of the Washington, DC area. With the proposed dates the Council still has time to conduct additional business between meetings, including in smaller groups by teleconference.

Ms. Stergar asked about the March 2019 dates. **Ms. Fabiyi-King** replied the beginning of March is when the SP application cycle begins and that includes a lot of preparation so it would be good to allow for a week of preparation prior to the Council meeting. **Ms. Stergar** asked whether early April would work. **Ms. Fabiyi-King** said staff will consider that, while staying with Tuesday-Wednesday format. **Ms. Stergar** added it would be nice to have a report on the number of applications. **Ms. Fabiyi-King** said reports would be available but it would be while applications are continuing to be submitted. June is historically when the Council meets face to face, in conjunction with the scholarship meeting so Council members can meet the scholars. Also, June typically has good weather and fewer vacations versus July and August, while September is the end of the fiscal year and business has to be wrapped up, though a meeting prior to the end of fiscal year is good. December dates are easy to choose since people are not available by the middle of the month, including outside speakers.

Ms. Witzel said face to face is good to get to know each other, and perhaps March would be better for that since new members could be on board. **Ms. Adamson** said June is better for travel and for avoiding conflict with school schedules. **Ms. Fabiyi-King** said it also will be important to see what schedules will be good for new Council members. Also, in the summer there are not conflicts with schools, and people are more likely to want to add public comments per their own schedules, agendas, etc.

Dr. Billings asked whether the Council should convene face to face this coming December so it does not have to wait long to formalize recommendations if they are not done at this meeting and in light of members rolling off if not granted extensions. **Ms. Fabiyi-King** said she will submit that for clearance, and added a note of caution about the weather in December. **ACTION ITEM**. She added it is a good idea, but time is needed to vet the Council's ideas.

Ms. Fabiyi-King said perhaps the Council only has three, not four meetings, or December could be another Adobe conference meeting. **Dr. Kennedy** noted the importance of advance planning for any dates in December. **Dr. Salvador** added it would be good to meet again soon in person. He asked about the number of allowable extensions. **Ms. Huffman** replied extensions are limited, but due to the recent federal hiring freeze that prevents bringing on new members there is consideration of extending members until new ones come on board. However, it can take up to a year to vet new members on councils. It would be good to extend some current members, but the HRSA Administrator would have to approve additional extensions in the future.

{Note: the Council discussed various dates for upcoming meetings, and then decided to poll members sometime after this meeting about prospective dates and availability (including conflicts and the need to reschedule patients), including for in-person or video conference dates. Ms. Fabiyi-King will administer the poll. **ACTION ITEM**.}

No other Council business items were discussed.

Prioritize Council Recommendations

Dr. Billings asked each member to offer recommendations for discussion and possible consensus.

Ms. Stergar said the big picture issue is retention of scholars and loan repayors, and policies and incentives are needed to support retention in the field. She likes the additional work done to make more money available for loan repayments as a good incentive, and she supports the work discussed in Day-1 of this meeting.

Ms. Witzel noted 2005 legislation that allowed NPs to prescribe when using MAT. It was only a five-year authorization and Congress is considering extending that to a permanent change (Senate 2317, and HR 3692). If those privileges are not continued it will be a significant issue in rural and underserved areas especially since they have been doing providing that service. There should be support NPs and PAs as prescribers in MAT. She also agrees with incentivizing retention, and to continue looking into project ECHO, including how time spent with it could be counted as face to face working with patients.

Dr. Kennedy said project ECHO is a learning community that enhances the joy of work, and anything that does that pays big dividends for retention and recruitment. **Dr. Billings** added that was a good unintended consequence, or perhaps was intended. **Dr. Kennedy** said rural providers can feel isolated. **Dr. Billings** said it is good to have back up. **Dr. Malcom** said she agrees with the recommendation that hours spent with ECHO be counted as working hours for NPs in the field, and she would like dental practitioners to be included in national SUD efforts. She also agrees with incentivizing provider retention.

Dr. Griffin noted a project ECHO void in Georgia, though CDC is located there. Information about ECHO was pleasantly surprising, and NHSC should be leaders in rural health in Georgia but people there need to know about ECHO. Council support for ECHO or similar programs would be great.

{Ms. Fabiyi-King referred to Dr. Salvador's notes being shown on the screen.} **Dr. Billings** thanked Dr. Salvador for thoughtful input. **Dr. Salvador** noted some of his comments are questions, but he agrees with the importance of retention. He asked whether medical students pursuing careers that include treating addiction are eligible and can that be emphasized in recruiting. **Dr. Billings** replied that is a good question regarding all scholars and deferral of service for fellowships, and he asked whether addiction psychiatry should be allowed. **Ms. Stergar** said that is a great idea. **Ms. Fabiyi-King** noted all scholars can do a residency or fellowship, and NPs and PAs are asking for residency fellowship programs and HRSA has approved some of them based on being impactful for primary care. **Dr. Billings** added that should be allowed and would be an additional benefit, especially for sites looking for that. **Dr. Salvador** suggested perhaps incentivizing people to do it.

Dr. Salvador said while there are no expansion plans for the Students to Service (S2S) Program, but perhaps a multidisciplinary approach to the opioid problem can occur within the current S2S models. Psychologists are required to do a post-doctoral year prior to licensure in most states and that becomes a barrier to pursuing NHSC opportunities to work in rural areas and it would be good to help overcome that barrier to opportunities to provide care, especially to treat addictions. **Dr. Billings** asked whether post-doc psychologists are drawing salary or volunteering. **Dr. Salvador** replied it can be a mix. His fellowship was under a grant from Tripler Army Medical Center, where he stayed after being licensed.

Some do an hour per week of supervised care for a year, as a volunteer and then seek licensure. Perhaps that could also happen in other medical, MH, or dental fields. Also, perhaps changes should be recommended for reimbursement guidelines for things like telehealth or ECHO, and the effort can include collaborative partner agencies.

Dr. Salvador said perhaps within communities of learning and the joy of learning there could be a way to branch off the ECHO model and allow mentorship opportunities among current and former scholars and loan repayors to spend a small amount of time to talk with people to share experiences to minimize isolation and create community. **Ms. Stergar** agreed that is a great idea, and asked how scholars are kept connected, and whether that includes mentorships. **Ms. Fabiyi-King** replied the Division of External Affairs is revising the mentor program, but is not doing a deep dive into how the relationship is working out, it is just a review at the end of a quarter. The S2S and SP application does not have a section to request sharing contact information with others coming into the class, and since that has not been vetted the Bureau cannot provide PII to scholars to network together. However, webinars and online fora have allowed scholars to come together by discipline to network, ask questions, and generally connect. Those have been valuable to the small numbers of participants, but it is challenging is to get sufficient numbers from the overall population of eligible scholars to join despite efforts to find agreeable dates and times. The Division will continue to connect with people via information sent to them, but for technical assistance and connections among scholars and S2S participants the fora are the most robust opportunities provided. She also noted virtual job fairs scheduled approximately every six weeks and scholars and S2S participants are invited, as are providers working at sites to talk about their sites when they have job openings. **Ms. Stergar** said it is good to create communities through existing or new efforts, it will help with retention.

Dr. Billings noted scholars in training can feel isolated, and it is nice to connect with like-minded scholars and fellow NHSC participants on campus. It would be good to allow sharing of information among scholars to help them form communities, and also good to identify potential mentors at training institutions and in underserved communities. **Ms. Fabiyi-King** said the Council could recommend finding a way for S2S participants and scholars to connect with each other from the onset of involvement. A vehicle is needed for how and when to do it. HRSA cannot share personal information without consent, and the Compliance Office needs to say how to connect people who sign the consent.

Ms. Adamson said she supports all of the good ideas being discussed and the Council needs to consider its current and future role in advocacy, if any. It is important to recognize what is allowed or not in working with federal staff, and avoid putting anyone in a compromised position. The past Congressional session left many programs, including the Corps in a tough spot, but thankfully it was funded and it is good that additional funding is likely. However it is a concern that some people did not know about the Congressional negotiations and could not rally for it in their home states. A key question is whether the Council has a role, and if so, how to carry it out. Also, partnerships should be explored, including through the AHEC Scholars Program that could fit well with NHSC efforts for scholars. The Corps works well with many entities, but should also work with subject matter experts. **Ms. Fabiyi-King** said staff is consulting with ethics officials about the right position for the Council about advocacy, and hopes to soon gain clarification. **ACTION ITEM. Ms. Adamson** added advocacy means effective sharing of information, including about things like how close the Corps came to losing its funding.

Dr. Billings said Project ECHO has great value, and is the best model for telehealth. It is used worldwide and benefits the health of clinicians as well as patients. It will help with retention based on the joy of work. The Council should promote it to more NHSC sites, but the main barrier is the financial barrier to telehealth reimbursement. Perhaps the Council can send a letter to the HHS Secretary asking for removal of barriers to telehealth. Another important consideration is the future of medical visits that while not all will be virtual they increasingly are becoming so, and sites need to be modernized to the 21st century with virtual visits and reimbursement. This will require support from CEOs and CFOs, while currently providers support the idea. Also SUD money is available but more providers are needed for MAT and more waivers are needed. It is important to work with training institutions, though that is beyond the Council's charge. It will be important for the HHS Secretary to know how making SUD training for multiple disciplines more prominent will help address the opioid crisis

Dr. Billings also said a mechanism is needed for NHSC scholars in training to be able to share information among each other and among potential mentors to create communities that will decrease isolation. He noted the tenuous position of NHSC funding where it had expired for several months before it was renewed, and it received additional money for the opioid crisis. However $310 million stable over the past few years meant 11 applicants for every scholarship position, and that means turning away 10 potential primary care providers. Incredible demand exists for both the SP and LRP, but current budget constraints prevent NHSC from keeping up with it. Legislators should be asked to increase funding beyond $310 million, and find long-term solutions and funding for 10 years or so to avoid a fiscal cliff in the next 18 months. Similar to how care is now multidisciplinary, perhaps a summit among all HRSA councils can discuss plans for where each council can and cannot act.

Dr. Billings said he appreciates the ideas and passion expressed during this meeting.

{Break}

Group Discussion on Proposed Recommendations

Dr. Billings began by saying this is the most important part of this meeting. He summarized central themes from the discussion, including the importance of retention and how turnover hurts quality and efficiency; support for Project ECHO, including in relation to current policy on telehealth; importance of training for other disciplines; and incentivizing MAT training for providers. If recommendations are not finalized at this meeting a mechanism will be needed to carry forward, perhaps small group discussions.

Dr. Kennedy suggested staff clarify retention efforts and what works. He asked whether there was a report in 2013 about retention. **Ms. Fabiyi-King** replied yes, that was the last time it was formally addressed. **Dr. Malcom** asked whether NHSC dental practitioners could take part in MAT if they want to. **Dr. Billings** replied that is a good suggestion, but it will be important to see what the American Dental Association (ADA) thinks about the dental field's involvement in MAT. **Dr. Malcom** said it would be good for underserved rural and urban areas where the opioid crisis is ravaging patient populations. **Dr. Billings** agreed, and suggested reaching out to the ADA to gauge interest. **Dr. Malcom** said the ADA and the National Dental Association (NDA) should both be contacted since many dentists do public health and work in CHCs, and probably would be interested especially with an LRP incentive and as a way to do better for patients. **Ms. Fabiyi-King** said she will look into the ADA's position. **ACTION ITEM.**

Dr. Griffin said retention has many components, so it is important to target specific items that chip away at it versus trying to solve the entire problem. The Council's role needs to be defined. **Dr. Billings** added any recommendations should be focused and specific, and can be accomplished. Similar to how it is more effective to prescribe one medicine that treats two diagnoses, comments about retention need to see what efforts can address multiple components. Perhaps that is Project ECHO, though a key question is whether the Council wants to promote it, and if so, can it be accomplished, and how would it be done. The Council should review the 2018 telehealth guidance in case it wants to move forward with ECHO but doing so would not fit with the policy until it was updated accordingly. **Ms. Fabiyi-King** noted the current guidance has not received final approval for LRP and telehealth, but is in process at the Office of the General Counsel. **Dr. Billings** asked whether the Council has consensus on doing ECHO. Changes are coming for the 2019 guidance, to add a piece for S2S based on what was identified and approved for the LRP, but details are not yet available because it is going through compliance.

Dr. Billings asked whether the Council approves recommending ECHO for NHSC clinicians. **Dr. Griffin** replied that is OK as long as it is not just limited to ECHO but instead says ECHO or ECHO-like programs. **Dr. Billings** said he supports that. **Ms. Fabiyi-King** noted a concept of ECHO-like programs means a tool for clinicians to be involved in things beyond the guidance. **Dr. Kennedy** said telehealth means bringing clinicians to patient care, using a traditional model of care, and an important distinction exists between that and how ECHO works. **Ms. Fabiyi-King** added that affects what it means to recommend an ECHO-like program, and key questions are about impact on sites, clinicians, and NHSC as a whole. **Dr. Billings** said the main distinction with current policy would be the need to edit the requirement that telehealth requires one-on-one virtual patient visits. It would require consultation with a specialist for direction of treatment and expansion for the sites to provide services providers are not comfortable with, and that would help with the joy of work and retention, and would be impactful.

Ms. Adamson said she is a proponent of ECHO, but does not know how it would impact people in service. A key question is could someone spend 40 hours in a week doing ECHO and not see patients, since the Corps would not want that. However, it is not clear how to regulate it at that detailed a level. Current telepath policy makes sure patients and providers are at an approved site. It could be difficult to track hours doing ECHO and then do the six-month certification. It will be important to define the Corps' role in regulating ECHO participation. **Dr. Billings** noted the Council cannot control sites with whom providers work under contract. A key question is whether this is an opportunity for the Council to decrease barriers to providers having more autonomy to offer services they might otherwise have not been able to offer. It also can be about improved education and creating more value-based clinicians and centers of excellence at sites that offer new services. He noted NHSC can only control its own work requirements.

Ms. Witzel noted the policy is about providers and direct patient care, and perhaps a new policy or statement is needed about how care that includes consultation practices such as ECHO are part of the 32-hour requirement. **Dr. Kennedy** said technically it is not telehealth, it is about retention and joy of work. He asked what health centers say about ECHO and their own administrative policies. **Dr. Billings** said that is a great question for the National Association of Community Health Centers (NACHC), who could weigh in on adjustments to current policies or creating new ones. Providers frequently consult with specialists without extra reimbursement, and ECHO enables them to do so more often.

Ms. Fabiyi-King said it sounds like a statement could be made to recommend adding to the current telehealth guidance, and it sounds like the Council supports ECHO and that could be a definitive statement about its benefits without recommending changing policies. It could be good to recommend further consideration of ECHO at the HRSA or HHS level, as a supportive recommendation for something the Council believes in. **Dr. Kennedy** agreed that is a good idea, and added perhaps scholars at sites could be made more aware of ECHO since not all CHCs all are members of NACHC. It would be good to encourage sites to make scholars aware of ECHO.

Dr. Billings asked whether the Council should say it supports clinicians in training and service gaining exposure to ECHO and similar programs to improve access to specialty care and the education of NHSC trainees and clinicians. **Ms. Fabiyi-King** replied that recommendation could be done off line among Council members. Also, the Council might want to add a statement asking for a future look at the telehealth policy for 2020 since 2019 is already in the vetting process. It could suggest more opportunities for NHSC providers working toward ECHO or similar opportunities, including working with universities or medical schools.

Ms. Adamson said it is important to recognize why telehealth regulations are specific for patients and providers at NHSC approved sites, and it is not the same as ECHO, so rather than trying to add to current language the recommendation can be for involvement in it for patients without having clinicians out of compliance. **Dr. Malcom** added she agrees with the discussion about telemedicine, and since ECHO includes videoconferencing just between practitioners, the recommended policy should include a statement regarding how Echo helps practitioners who want to use those services.

Dr. Billings asked about the next step to craft a statement. **Ms. Fabiyi-King** replied it should it be a letter to the Secretary, with recommendations, or a report that includes more detailed research. Staff can facilitate smaller group work as needed to garner information and discussion to form recommendations. If the Council wants it sooner it would be with less detail. Mostly, the Council has written a letter to the Secretary, though in 2013 it submitted a white paper. **Dr. Griffin** said a letter of recommendation should contain experiences of Council members who have incorporated ECHO to show the value for decision makers to understand the message about it. It has to show how it impacts practitioners, patients, and communities. **Dr. Billings** agreed, and added a report in concert with ECHO staff would make it more effective since they have the data and experience to support its value. It also could include a Council member.

Dr. Malcom said she first heard about ECHO during Day-1 of this meeting, but she can see its value in rural areas that have no access to specialists. **Dr. Kennedy** and **Ms. Witzel** both said they had never heard of ECHO prior to Day-1 of this meeting, though **Ms. Witzel** had looked at the opioid management program at the University of North Dakota. **Dr. Salvador** noted his participation in ECHO as part of Tripler Army Medical Center's chronic pain management, and said it is valuable. A white paper would be good, but also needed is a supporting statement to make it reimbursable. **Dr. Billings** agreed, and noted two Council members have personal experience with ECHO. He asked whether the Council wants to pursue it, and if so, he and Dr. Salvador can work with ECHO staff to draft a white paper for consideration by the Secretary to make ECHO more known and accessible to sites and staff, and to consider reimbursement issues for telehealth. **Ms. Adamson** noted she knows people participating in ECHO, and can add personal stories.

Dr. Billings submitted a motion for the Council to look into action such as a publication or report for potential ECHO expansion for NHSC sites and clinicians, and to look further into reimbursement for telehealth. **Dr. Malcom** seconded. The motion passed unanimously 8 – 0. **Dr. Salvador** and **Ms. Adamson** agreed to work on follow up to the motion, in conjunction with Dr. Arora (ECHO Director) and his staff. They will put together a paper to be forwarded to the appropriate persons. **ACTION ITEM.**

Dr. Billings noted how practitioners can be challenged when they do not know what they do not know, and he stumbled upon ECHO when they reached out to him. It is increasingly exciting and it is good that the Council is aware of it. ECHO helps keep up with massive quantity of data, and will help serve underserved communities. It is worth the time and effort.

{At this point, Ms. Fabiyi-King emailed Council members with input from ethics officials about Council advocacy.}

Dr. Griffin noted Day-1 of this meeting included a presentation about auto HPSAs and asked whether the Council is working on that. **Ms. Fabiyi-King** replied she will check with Ms. Gladstone, but she thinks it was just an informational presentation. She will check for opportunities for council input. **ACTION ITEM.**

Dr. Billings asked whether any other recommendations are needed. He noted the Council discussed improved access to MAT, promoting the availability of money to combat SUD, and mentorship program improvements including examining current policy about scholars knowing about each other and communicating. **Ms. Witzel** asked whether the Council can support legislation to allow NPs and PAs to continue participation in MAT. **Ms. Fabiyi-King** replied the council cannot advocate, however, individual members can do so as citizens. **Dr. Billings** noted Ms. Gladstone (during Day-1) talked about turning recommendations into action, and asked is this the vehicle where the Council can support pending legislation about MAT, via a letter to Congress after going through the A19 process. **Ms. Fabiyi-King** replied the A19 process takes a long time, and Ms. Gladstone noted individual letters to Congress versus one from the Council. The Council as a whole cannot advocate. **Dr. Billings** said since mid-levels are allowed to write prescriptions for opioids they should be able to write for getting people off of them. **Ms. Witzel** added a bill in the House would make permanent MAT prescription privileges among NPs and PAs as further support for patients and communities, but legislation pending in the Senate does not include that clause, and the Council should support the clause.

Dr. Malcom asked whether the Council can be made aware when important legislation that affects the Corps is underway, even though it cannot advocate as a group, so individuals can advocate. **Ms. Fabiyi-King** replied her staff is in touch with policy staff and can identify a time when they can do that but they need to be asked how and when. **ACTION ITEM. Ms. Adamson** asked if it is not allowed for staff to notify the Council perhaps individual members can email each other about legislation and sources of information.

{Ms. Spears joined the call.} **Ms. Witzel** reviewed legislation making MAT privileges for NPs and PAs permanent, and asked about support for it by the Council or individual members. The original legislation did not include advance practice providers, but they were added in 2015 and pending legislation is to make that permanent. **Ms. Spears** replied she is not sure whether the Council can support the legislation, and she will report back. **ACTION ITEM**. **Ms. Witzel** noted a House/Senate Conference Committee is looking at it, and she expects it will be will be passed prior to the next recess. **Ms. Spears**

said the Council probably can do a letter of support to Congress to support agreement on the final bill. She will get back as quickly as possible about supporting a pending bill. **ACTION ITEM.**

Dr. Billings asked whether the Council can request additional funding from Congress to support NHSC. **Ms. Spears** replied yes, for money for a specific purpose.

Ms. Huffman noted whatever the Council recommends or writes, a white paper or report, it is not vetted thorough HRSA because they are separate bodies. The Council can get a letter out quickly, and staff can help edit and format it, but the content needs to come from the Council who sends it to the Secretary or Congress, while staff sends it to HRSA leadership. **Ms. Fabiyi-King** cautioned if the Council wants to do just the letter about MAT and NPs she first needs to hear from Ms. Gladstone (about advocacy), but if desired the Council could move forward with a letter of recommendation about other items discussed at this meeting. **Ms. Witzel** said she will draft a letter.

Ms. Stergar said she would like the Council to set forth a plan for how to enhance NHSC retention. Important components include a provider survey and mentorship, but ECHO and ways to connect scholars and loan repayors into an existing leadership training program should be considered. **Dr. Billings** added communities in training is a component of retention, and perhaps something similar can be established for providers in service and alumni. Also, it would be good if LRP and SP applicants had the option to share contact information as part of creating community and laying the groundwork for retention among scholars in residency or service. **Ms. Fabiyi-King** said a definitive answer about sharing personal contact information is pending, but the Council can consider ideas. She noted mentor program staff will weigh in. The current program applications and guidance do not ask about opting in for sharing contact information so there really is no way for them to communicate with each other. However, the Division communicates extensively to update NHSC participants about the program, and hosts special events such as job fairs. Going forward, the Council can vet ideas to foster participant connections.

Ms. Stergar asked if the Council could schedule a strategic planning day around retention, including with more data about what is known, to generate more comprehensive ideas based on long-term trends, and also have speakers talk about best practices to help form recommendations. **Dr. Billings** agreed it is a great idea to review data and best practices, and talk to people about a holistic approach.

Dr. Salvador noted how Ms. Fabiyi-King said only a few scholars participate in efforts to stay connected. **Ms. Fabiyi-King** noted they typically will reply to an email blast but the most recent one was three years ago. That could be a recommendation as a vehicle to see any changes in the data, including by discipline, and perhaps more people would participate. **Ms. Stergar** asked whether waiting for a comprehensive strategy session about retention or talking action at this meeting would be better. **Ms. Fabiyi-King** suggested it could be the agenda for a future Council meeting, or discussed by small sub-groups prior to the next meeting, and either way should include data review. **Ms. Stergar** said she wants to discuss retention and current data at an in-person meeting. She noted a detailed report two to three years ago about scholar retention. **Dr. Billings** agreed it is important for the Council to know what the data show, including trends, and how to uptrend it. He said retention will be on the agenda for the next meeting, but HRSA staff should distribute current data for advance review. **ACTION ITEM.**

Ms. Stergar asked whether the Council can do a deep dive into non-responders on the surveys to see how to work with people who do not respond. Another question is whether staff or outside resources would conduct the study. **Ms. Fabiyi-King** noted the NHSC website has metrics and data on clinicians,

including how they access BMISS, and the Division does an annual customer service survey, alternating each year by scholars and loan repayors. Ms. Alex Huttinger is developing the new NHSC survey through the in-house statistical group. Typically in the past it was done around this time of year but its current status needs to be checked. **ACTION ITEM.** The schedule will affect when the Council can address it.

Dr. Salvador asked whether the Council should review a way to recommend continued exploration of current program success, and the possibility of expansion to other disciplines such as psychologists and dental. **Ms. Stergar** agreed that would be a great idea for discussion. **Dr. Billings** asked whether expansion would drive the need to ask for a higher budget, including more long-term funding versus frequently having to request it.

Ms. Spears noted the Council's statutory authority role is to advise the HHS Secretary and the HRSA Administrator. The Council writing a letter in an official capacity to Congress is outside the scope, but it can write to the Secretary. Specific recommendations about SUD legislation and permanent MAT participation would have to be communicated as private citizens and not as an advisory committee. This was confirmed by people familiar with the council, and by a review of the statute. Some advisory committees have authority to advise Congress, but this one is only allowed to advise the Secretary. **Ms. Fabiyi-King** thanked Ms. Spears and said it is good to confirm what the Council was thinking.

Dr. Billings asked whether the Council should write letter to the Secretary, or just contact legislators as private individuals. **Ms. Witzel** said a letter to the Secretary should be broader about how NHSC supports legislation that does not restrict advanced practice providers. Doing so would prevent the situation where people in rural areas are working at the top of their license but then they lose privileges they had in the past. That kind of broad language would be better than support for just one bill.

Working Lunch

Dr. Billings suggested staff should help generate a white paper for the HRSA Administrator to eventually be sent to the Secretary about Project ECHO and other NHSC directions. To do so likely will require additional meetings prior to the next full Council meeting. Perhaps additional letters, including for eventual communication with Congress, could address a robust mentoring program, and advanced practice providers being able to continue doing MAT. It also will be important to look at specific efforts to support retention. Overall, the Council should generate ideas about deliverables. **Dr. Billings** asked if any other areas need to arise or be discussed more fully.

Project ECHO

Dr. Kennedy said he would like to help on the ECHO project. **Dr. Billings** accepted his offer, and noted Council members can help with multiple areas but should not over extend themselves. He will email Ms. Fabiyi-King, Dr. Salvador, Ms. Adamson, and Dr. Kennedy, and will ask his contact at ECHO to begin gathering data and other information. **Dr. Malcom** said she wants to participate. **Dr. Billings** asked her to contact the ADA and NDA to gauge interest. **Dr. Malcom** agreed to do so, **ACTION ITEM** and added many NDA members work in rural and urban areas, and many were NHSC scholar recipients. **Dr. Billings** said NDA would be a good ally to move forward with ECHO.

Mentorship Program and Retention

Dr. Billings said this is good timing to discuss how to revise the mentor program that currently only provides an introduction between mentee and mentor based on criteria such as NHSC or Nurse Corps program, discipline specialty, and location. It can be a challenge when people do not want to be matched with someone from a different specialty. Much interest exists among potential mentees, but it is hard to get mentors. It also is hard to track interaction after introductions since that is determined by the participants. There currently approximately 300 mentees and 200 mentors. Interest in serving as a mentor is growing, but more robust recruiting is needed, including more with social media such as LinkedIn and Facebook chats among current participants based on how the mentor benefits.

Ms. Stergar asked about the incentive to be a mentor. **Ms. Hollis-Walker** replied the biggest incentive selling point is mentoring credentials look good on a CV, but it is a challenge to define tangible benefits. It is easy to sell the idea of being a mentee. Hopefully this conversation will garner recommendations to try new things. **Ms. Stergar** asked whether someone organizes mentors. **Ms. Hollis-Walker** replied it is not done by a particular staff person. She tries to match requests for mentors, but when the match is made the mentor and mentee work out how the relationship will develop. However, she wants to remain involved beyond just making the match, including tracking the benefits. **Ms. Fabiyi-King** noted some serve as mentors to give back, and having 200 mentors for 300 mentees is OK since a mentor can have more than one mentee. Also, some mentoring happens at fora where scholars dialogue about experiences, and perhaps that could become more of a formal program, though the mentorship is time consuming. Also, on some campuses people who were not NHSC clinicians have served as occasional or ad hoc mentors, and students appreciate having someone close by to ask questions.

Ms. Hollis-Walker said Facebook, Twitter, and LinkedIn are fora in a modern sense but it will be important to add value to being part of the program, including through special topics introduced for more interesting dialogue among mentees and mentors, and bringing in guest speakers. Also, more scholars than loan repayors participate in the mentor program since scholars are looking for career transition guidance while loan repayors are already in service, except in the S2S Program.

Ms. Stergar said the goal is for NHSC to be the primary care workforce in the U.S., with a robust retention program, so it will be important to do a deep dive on mentorship and retention. **Ms. Fabiyi-King** noted that is why Ms. Hollis-Walker was asked to join this meeting.

Dr. Billings said programs do not exist in silos, they interact, and so robust retention efforts should exist from providers' first day through the end of service. NHSC is looking for specific recommendations to make the current mentoring program more robust to help future retention. It will be important to identify the deliverables for recommendations about that, and perhaps the Council should create a sub-group to develop a letter to the Secretary.

Dr. Malcom asked whether individuals who sign up to be mentors and mentees are on board with using social media. **Ms. Hollis-Walker** said she is not sure, and noted LinkedIn is new for the program, as is social media in general. Most people find out about the program though the website. The Division added social media to increase value. **Dr. Malcom** said recent graduates and current students typically use social media, and it can be used to do surveys on hot topics. **Ms. Hollis-Walker** noted things like closed Facebook groups that increase engagement with mentors and mentees, versus a general email, will help with retention.

Dr. Griffin noted the Council also discussed mentorship and retention last year, and perhaps should assess the strength of that relationship and consider how to enhance it. Important questions are why intervene in the mentorship program, and at what point does the mentee get the most out of the program. Other questions are what do people look for when selecting a mentor, and when does the mentor come into the mentee's life. **Ms. Hollis-Walker** replied the goal is to pair it around the application opening and closing, based on who accepted the award and responded to a query about interest in being a mentee, but no deadline is set for that. Consideration is given to specific program, specialty, and location so both the mentor and mentee will benefit and it is easy to facilitate.

Dr. Griffin added it not only is important to offer mentorship while in school. Providers assigned to a program outside of school like a CHC or other facility need a lot of support, and that means a lot of value for mentoring at that time that will affect satisfaction with a match and retention. **Ms. Hollis-Walker** said the Division is looking at requests for mentors after school, during job searches or when new in practice, but she is not sure where that will go in the program. It is a common theme in the S2S program, including among those who go from dental school directly into service.

Dr. Billings said the key to effective mentoring is time for face to face interaction, instead of virtual, though virtual is better than nothing. It would be good to have NHSC mentor champions at schools or sites, and robust communication with partners outside NHSC, like AHECs and PCOs who can identify high-yield mentors and practices. Schools are challenged in finding preceptors since increasingly education happens in the field, so it is important to offer incentives to NHSC mentors. Perhaps, mentoring can count as CME. Also, it could be good to send NHSC gear to help identify and recognize mentors.

Dr. Kennedy said after many years he has seen how it is hard to predict who wants a mentor, and whether a mentor will be good at it. He has never found clear predictive factors, though has found good mentors enjoy mentoring, and many incoming students say they do not need a mentor. **Ms. Fabiyi-King** added that is how mentoring happens in many professions. This program has had success with Facebook chats but it goes up and down, and that could be a component of a recommendation about retention techniques and models to promote it versus only a separate push related to mentorship. **Dr. Billings** said if the Council wants to do retention recommendations it can meet offline to discuss how mentoring fits and actions NHSC should take. **Ms. Fabiyi-King** said that is a good idea, and the topic could be on the agenda for the next Council meeting.

Ms. Stergar asked about offering monetary award for serving as a good mentor. **Ms. Fabiyi-King** said the Corps' funding is to provide care so additional money for mentors is not an option for the Corps. However, it will be important to strategize ways to build the mentorship program. **Dr. Malcom** added monetary incentive is not driving interest in mentoring, the challenge is more about time constraints so social media makes it easier including reaching out to past participants. 300 mentees and 150 mentors is a good ratio.

Dr. Billings asked for two Council members to volunteer to address retention and mentoring, who will work with **Ms. Fabiyi-King** and Ms. Hollis-Walker to develop a recommendation to the Secretary. **Dr. Malcom**, **Ms. Stergar**, and **Dr. Kennedy** volunteered. **Dr. Billings** suggested exchanging ideas by email and then follow up with **Ms. Fabiyi-King** and Ms. Hollis-Walker for agenda items for the Council's next meeting. Kennedy agree too. **Ms. Fabiyi-King** said she likes the idea and will set up a conference call.

ACTION ITEM. Dr. Billings said the Council's next in-person meeting will develop deliverables to share with the Council as a whole and to present to the HRSA administrator and NHSC staff.

MAT

Ms. Witzel read to the Council her letter regarding MAT and advance practice providers, though acknowledged the issue may be settled before the Secretary gets the letter. **Dr. Billings** said the number of areas with a dearth of MAT services means advance practice providers should be allowed to continue doing MAT. **Ms. Stergar** complimented Ms. Witzel's letter but said its introduction should talk about being in line with the Council's work on building and maintaining a quality workforce. Perhaps Division staff can help with wording.

Dr. Billings said this issue impacts NSHC clinicians and patients so the Council has purview, while other councils have the purview to suggest MAT training be included in residency and advanced practice training programs. The issue should not be in a silo. **Ms. Witzel** said it is a good idea to include that in the letter to the Secretary. **Ms. Stergar** said if only one letter will be sent for this issue it should also recommend the Secretary address the issue of graduate medical education (GME) with CMS and with accrediting bodies to encourage them to include MAT as part of training for all primary care disciplines. **Ms. Witzel** added GME funding is not given for advanced practice providers and PAs, so other language is needed, and the letter should address all of the issues being discussed.

Dr. Billings said he would be happy to work with Ms. Witzel on another draft to present to the Council and/or HRSA staff for eventual presentation to the Secretary. He asked if a draft could be ready to show to Ms. Fabiyi-King within a week after this meeting. It would be a quick turnaround letter to the Secretary versus a white paper or report. **Ms. Witzel** said perhaps two documents are needed, one about current MAT legislation, and one about funding for MAT education. **Ms. Fabiyi-King** said funding for MAT education is not an NHSC responsibility, so it is not clear whether that should go into the Council's letter to the Secretary. **Dr. Billings** asked whether this Council should write a letter about MAT in education to the HRSA council that works on clinician training. **Ms. Fabiyi-King** replied that would be the right council to contact, and she will talk to its Designated Federal Official about it. **ACTION ITEM.**

Dr. Billings noted Ms. Witzel will draft a letter supporting the MAT legislation, and Ms. Fabiyi-King will tell the Council how to work with councils that address GME and other education about the broader issue. **Ms. Witzel** acknowledged she will draft the letter and send it to Dr. Billings for distribution to whole council. **ACTION ITEM.**

Formalizing Recommendations

Ms. Fabiyi-King said initiatives for NHSC such as SUD expansion, value-based clinicians, and telehealth can be addressed in a letter to the Secretary, but it must address FY20 since activities for FY19 are already under review. She reviewed the Council's proposed recommendations on the screen, and noted retention is a side piece that includes mentoring and other ideas. The current retention rate is 93% but it is not clear how the Council wants to approach it. It will be good to look at the customer survey when it is complete. She also asked whether the Council wants to identify ECHO as something to support.

Dr. Salvador clarified adding more disciplines is about SUD. Going forward it will be important to continue to examine the success of existing programs such as an expanded S2S that include dental, and part of that review should be consideration of adding disciplines for things like SUD and opioids. **Dr.**

Billings added additional appropriations targeted at new disciplines and SUD shows how the program is dynamic, and perhaps the Council should send a letter of appreciation.

Dr. Billings asked Mr. Ali about how the Council should weigh in about deliverables and support for expansion of SUD. **Mr. Ali** said it looks like it has been a robust meeting. He looked at Dr. Salvador's email about the possibility of leveraging the S2S Program for more response to SUD. The Division is looking at exploring other programs to capture the workforce at the beginning of training when people are enthusiastic to serve in underserved communities. The bigger challenge is to see how S2S can play a greater role in being able to place providers, considering the training variance around the mental and behavioral health workforce. In some training programs, especially for BH workforce expansion training from the Division of Nursing and Public Health, a short gap happens between training and entry into practice, so a key question is how provide awards to MH and BH providers who are in training and are completing additional hours or a fellowship and allowing them to enter service when NHSC needs them and can plan accordingly. The Division can take proactive measures to hold on to those people and ensure they enter service versus a lot of them going into default. That is worthwhile for the Council to explore, as well as understanding the challenges related to the program's statutory requirements and how to be innovative. As for priorities, the Division set out what NHSC needs to do to move forward, and it wants the Council's input on how to implement the various initiatives. Telehealth is important, and staff thinks every day about the need to expand the SUD workforce but it also is important to see if anything is missing at this point. During Day-1 of this meeting Ms. Gumbs shared the Division's approach, but it is important to see if there are there any gaps that we can bolster or have oversight about for types of disciplines to include, and the number of hours they work.

Ms. Stergar asked whether the Council should discuss and possibly make a statement about CMS payment mechanisms as it looks at telehealth or ECHO, or just stick to workforce development. **Mr. Ali** replied it is always best when the Council focuses on where it can make most impact within the statute. That is part of the challenge. There are issues with reimbursement, work hours, and licensure with telehealth, so the Council should stay within what it can control. The 2018 telehealth policy is more flexible in not speaking to number of hours dedicated to it. The Division had been shortsighted when limiting telehealth to 20% of the work schedule, and after speaking with CHCs and other stakeholders it became clear that telehealth was being used a lot more where individuals were going across a network, so limiting it to 20% was not advantageous to many providers and it was necessary to change. The Council's input on workforce engagement is most important, including how to be flexible within the statutory framework.

Dr. Billings agreed the Council needs to consider flexibility with telehealth regulations, since isolated locations are challenged when trying to recruit people with specific SUD training. It will be important to consider flexibility and deregulation about face to face requirements. He asked whether licensed clinical social workers are allowed to offer SUD treatment and counseling, and if so, are they supported by the LRP. **Mr. Ali** replied yes, and added a majority of disciplines in the SUD expansion are NHSC eligible, though certified nurse midwives are not. Various MH providers can apply for SUD expansion, including licensed professional counselors.

Ms. Stergar said a master's level for any of those is a good start, and it will be important to see the new funding's impact over the next year. SUD requires a team approach, and at some point it may be necessary to allow non-master's level people with special training to participate to help in rural America.

Mr. Ali noted the recent report had language about expanding NHSC participation to include master's level SUD counselors, but it also is important to understand variances across states. Many SUD counselors and other allied health workforce providers do not have a master's degree but they still perform a critical part of the task. **Ms. Stergar** added it is a start but it will be important to remain alert to what else to do. **Dr. Billings** said he would love to see SUD training programs reach out to NHSC sites and health centers to see the need, and how they can help with workforce development, including for telehealth for isolated areas where there are not enough patients to support full-time providers so the face to face care requirements could possibly change. It would be like the ECHO hub and spoke model. **Mr. Ali** agreed.

Ms. Fabiyi-King noted the afternoon discussion has focused on what the Council discussed during the morning session, and it is good that smaller work groups are coming together, though it is not clear whether there should be a telehealth work group or whether the Council wants to address it as a whole. **Ms. Stergar** said she would like to see statistics or a presentation on telehealth to gauge its impact. **Ms. Fabiyi-King** said she would work on that. **ACTION ITEM**. She also asked whether the issue of reimbursement is about telehealth. **Dr. Billings** replied yes it falls under that.

Ms. Fabiyi-King said there are at least three areas (e.g., retention, expanded disciplines, and telehealth) where the Council can build a recommendation to the secretary. **Ms. Adamson** said it is hard to think about all the reimbursement models and factors. It is a great idea but it is not clear where the Council is in supporting that, and whether it has the necessary expertise. It is complicated, based on what the government, insurance companies, states, and Medicaid allow. It is good to talk about sites and reimbursement. **Ms. Fabiyi-King** asked whether the Council should form a workgroup to look into that before putting in the statement about telehealth. **Ms. Adamson** replied it depends on what a majority of the Council wants. **Ms. Stergar** said it is not clear whether the Council should discuss that yet, and it can add something about it to other statements. She noted Mr. Ali said it was not in the Council's scope of work so it should not be a separate statement. **Dr. Billings** agreed and said it is a bigger issue than what this Council is dedicated to.

Wrap Up

Dr. Billings said he is impressed with the insights heard at this meeting and the Council's desire to make a difference. There are many things now to do, but with a lot of people involved a lot will get done. He is looking forward to the poll among Council members for how to proceed, though the most timely item is the letter to the Secretary to support continuation of allowing advanced practice clinical colleagues to do MAT. **Ms. Fabiyi-King** reiterated Division staff can set up conference calls for workgroups, and she will send the poll about proposed meeting dates. She asked members to email her for additional administrative needs, and reiterated her request for names of prospective valuable members of the Council at any time prior to next meeting as staff continues to vet resumes and credentials. **ACTION ITEMS.**

Public Comment

No public comments emerged.

Closing remarks

Dr. Billings thanked HRSA staff and Council members for dedicating two days to important work and effort. He appreciates sharing thoughts, and looks forward to continued dialogue prior to the next in person meeting. Everyone together can affect positive change that patients depend on. This is like practicing medicine outside the exam room. It is impactful to keep doing this to help the patients being served.

[Just prior to adjournment, several Council members expressed much praise for the staff's work and arrangements made for this meeting.}

The meeting adjourned at 1:50 p.m.
