

**Meeting Minutes**  
**National Advisory Council on the National Health Service Corps**  
**Meeting November 9-10, 2021**

The National Advisory Council on the National Health Service Corps (NACNHSC or Council) met on June 22-23, 2021, via webinar. The NACNHSC is a group of health care providers and administrators who are experts in the issues faced by communities with a shortage of primary care health professionals. The Council serves as a key source of information to the National Health Service Corps (NHSC) senior management, to the Secretary of the U.S. Department of Health and Human Services (HHS) and, by designation, the Administrator of the Health Resources and Services Administration (HRSA). The NACNHSC was established under 42 USC 254j (Section 337 of the Public Health Service Act), as amended by Section 10501 of the Affordable Care Act. The Council is governed by provisions of Public Law 92-463 (5 USC App.2), which sets forth standards for the formation and use of advisory committees. NACNHSC responsibilities are specified under Subpart II, Part D of Title III of the Public Health Service Act.

**Welcome Remarks**

Designated Federal Officer Diane Fabiyi-King convened the meeting at 9:10 a.m. Eastern Standard Time (EST). She introduced herself, welcomed meeting participants, and conducted roll call. All members were present, except for Dr. Claude Jones. LaShawn Marks gave instructions for meeting participation. Council Chair Dr. Keisha Callins thanked HRSA staff and the Council members for their work and attendance. She welcomed and introduced Dr. Luis Padilla. Dr. Callins reviewed the meeting agenda as well as the charge for NACNHSC.

**Presentation: BHW Update**

***Luis Padilla, MD, FAAFP***

***Associate Administrator***

***Bureau of Health Workforce (BHW), HRSA***

Dr. Luis Padilla provided an update on BHW's FY 22 funding and the allocation of supplemental funding through the 2021 American Rescue Plan Act. BHW's mission is to improve the health of underserved populations by strengthening the health workforce and connecting skilled professionals to communities in need. The 40-plus programs BHW administers focus on four key aims, each of which contributes to the goal of improving the health of people who need it most. The programs' aims are 1) Access (make it easier for people to access health care), 2) Distribution (improve distribution of the health workforce), 3)

Supply (balance the supply of health workers with the demand for care), and 4) Quality (improve the quality of the health workforce and the care they provide).

Since 2016, BHW has had a steady increase in its overall annual budget, going from over 1.2 billion in 2016 to 1.6 billion in 2021. In addition, the American Rescue Plan Act has afforded BHW to be allocated an additional 1.55 billion. These are additional funds that Congress provided as a part of the Biden-Harris administration's priorities around health equity.

The Teaching Health Center Graduate Medical Education (THCGME) program supports training in community-based care settings rather than in-patient hospital care settings. Such settings include Federally Qualified Health Centers (FQHCs), community mental health centers, rural health clinics, and health centers operated by the Indian Health Service (IHS) or tribal organizations. The training opportunities made available to these residents will help expand and improve the distribution of the primary care workforce in economically disadvantaged areas.

The American Rescue Plan Act appropriated \$330 million for the THCGME program. These funds are expected to support up to 1,088 new resident FTEs in FY 2022, with that number increasing to 1,375 new resident FTEs in FY 2023 (up from about 800 currently). This is one of HRSA's expansion programs supporting the development of new primary care, health psychiatry, and OB/GYN residency programs. It is expected that approximately 50 development grants will be awarded through this funding.

Four National Health Service Corps and one Nurse Corps loan repayment program are currently open. These programs typically launch their application cycles in the spring, but given the increased funding from the American Rescue Plan, HRSA is launching application cycles this fall to get those additional funds into the hands of the health workforce serving in high-need communities. There has been a slight increase in the applications (approx. 12%). This speaks to the fact that there is a need for more assistance in making sure that eligible clinicians apply for this funding.

Clinicians—including physicians, nurse practitioners, physician assistants, certified nurse-midwives, certified registered nurse anesthetists, and medical students—can complete the free training for medication-assisted treatment. Doing so will help improve access to substance-use disorder treatment within our communities and increase the number of clinicians with the DATA 2000 Waiver. The waiver allows clinicians to dispense or prescribe the narcotic medications used to treat opioid substance use disorder in settings other than an opioid treatment program.

One of BHW's new resources is the Health Workforce Projection Dashboard, developed by BHW's National Center for Health Workforce Analysis (NCHWA). The Dashboard helps public and private organizations understand how changes in population will affect future health care workforce demands. By estimating supply, demand, and distribution of health care workers, we inform public policy to help prevent shortages and surpluses. It allows the user to develop workforce projections for any state or region in the country.

We still have a significant undersupply of primary care providers. Data will be added for other disciplines as those data are acquired by HRSA. Data will also be added to better understand the impact of the pandemic. The visualization tool is available to researchers, the public, and other stakeholders.

BHW is working on expanding community-based training by helping health centers become training sites. The centers have responded to the Readiness to Train Assessment Tool (RTAT), which will help them develop targeted strategic workforce plans. Thus far, there have been 8,239 responses from 55 states/territories—a 73% national response rate.

The Health Professions Education and Training Initiative, launched in collaboration with the Bureau of Primary Health Care, will analyze RTAT results. This will help to identify areas of strength as well as where there is a need so that health centers can address their workforce needs. As a result of this initiative, HRSA expects to better understand the barriers that prevent health centers from advancing their own education and training programs.

Dr. Padilla went on to discuss new and expanded programs. The pandemic has placed an additional burden on our health care system and the professionals that work within it, especially the frontline workforce staff. To address this, BHW announced the availability of an estimated \$103 million late this past summer for a new program to reduce burnout and promote mental and behavioral health among the health workforce.

This funding, available through the American Rescue Plan, will fund three new programs that support the implementation of evidence-based strategies to help organizations and providers respond to stressful situations, endure hardships, avoid burnout, and foster healthy workplace environments that promote mental health and resiliency. A total of 405 applications have been received for 41 awards.

In addition, a \$6 million award will be made for a single recipient to provide tailored training and technical assistance to HRSA's workforce resiliency programs over three years through the Health and Public Safety Workforce Resiliency Technical Assistance Center.

The American Rescue Plan has also targeted \$100 million toward helping areas with relatively few medical professionals to attract and keep clinicians. The State Loan Repayment Program, which just launched October 14, makes grants to the 50 states, the District of Columbia, and the U.S. Territories to help them operate their own state educational loan repayment programs. These programs help primary care providers working in Health Professional Shortage Areas (HPSAs) repay student loans in exchange for service in underserved communities.

The COVID-19 pandemic has significantly challenged the health care workforce. Along with training the workforce in underserved communities using team-based models, there is a need to address health equity and community need and do more to integrate public health into care teams.

To address this, BHW is targeting \$239 million toward the development of a new program to train and expand the community health worker and paraprofessional workforce. In addition, \$42 million have been approved for a new scholarship program designed to encourage individuals to pursue careers in public health—both to address our response to COVID-19 and to prepare for other public health emergencies

Dr. Padilla summarized the work currently being done by HRSA and said that future goals include: 1) Advancing health equity and provider diversity in communities that HRSA serves; 2) Adding flexibility to training requirements; and 3) Expanding care teams and encouraging careers in public health. He added that the Biden-Harris administration wants to improve health equity across the country. Diversity encompasses race/ethnicity, educational background, or economic background.

#### *Discussion*

Dr. Elias Villareal asked if every state has a loan repayment program. Dr. Padilla replied that HRSA has 38 programs.

Dr. Andrea Anderson asked if territories and districts are also eligible for LRP. Dr. Padilla said that both States and territories are available for LRP.

Dr. Bockwoldt asked if the LRP programs are aligned with the health care workforce projections report that was just released. Dr. Padilla said the eligible disciplines are the same ones where there are shortages—for the most part in primary care. States have some more flexibility than the national program, so they have the ability to support some disciplines that are not supported through the national program.

A Council member asked if the THCGME program includes a strategy to increase the number of residency programs and whether it is different from CMS's program. Dr. Padilla said the THCGME program is separate from CMS's program and is poised to address primary shortages across the country.

Dr. Callins asked Dr. Padilla if he could expand on best practices related to workforce resilience which were discussed during his presentation. Dr. Padilla said that organizations can implement best practices that are evidence-based at the organizational level. The funding opportunity will provide \$10 million to organizations to address their organizational culture.

Dr. Callins asked if there is a loan repayment program for providers serving in the area of maternal health (e.g., trained family physicians willing to help in that area). Dr. Padilla said they are actively working in that area. A couple of years ago, Congress required HRSA to develop "maternal care target areas." These are areas within primary care HPSAs starting in FY 23. Once the process is complete, HRSA will be making awards in those areas, which means that HRSA will be supporting certified nurse-midwives in loan repayment efforts using NHSC funding.

Dr. Monica Taylor-Desir asked Dr. Padilla if he could expand on the Readiness to Train assessment tool, more specifically on the eight domains mentioned. Also, she asked if HRSA could share the assessment results at the next meeting. Dr. Padilla said the tool's methodology is now out in the public domain in a journal article. Some of the domains include leadership buy-in, financial infrastructure, partnership capabilities, and other domains.

Dr. Michael Sein asked how the America Rescue Plan would affect THCGME funding 2-5 years down the road. Is this short-term funding, or will it continue down the road? Dr. Padilla said that the America Rescue Plan funding is short-term funding that needs to be spent by the end of FY 22. He added that HRSA has made its stakeholders, as well as members of Congress, aware of the matter.

Dr. Denise Bockwoldt said that her FQHC lost 15 individuals as a result of the vaccine mandate, including a pediatrician, a dentist, and two PAs, which impacted their ability to serve patients. She asked

if the Community Health Worker initiative would allow individuals to work within the clinic to provide support or if they had to be out in the community. Dr. Padilla said that it would be a function of the organization as to how they want to utilize the health workers.

Dr. Anderson asked Dr. Padilla what concerned him the most in terms of what is on the horizon.

Dr. Padilla said there are many issues that are of concern, including maternal health, mental health, overdose deaths, health equity, and diversity among health professionals, among others.

Dr. Tara Brandner asked if there had been any conversations about retention and extending the participant's time at the facility for the NHSC program? Dr. Padilla said they have done analyses, and it seems that after 5 years, there is a drop-off because individuals are making decisions about their careers. Discussions on the matter will continue.

### **Presentation: Division of National Health Service Corps (DNHSC) Update**

*Michelle Yeboah, DrPH*

*Deputy Director*

*Division of National Health Service Corps, BHW, HRSA*

Dr. Michelle Yeboah provided an update on the DNHSC. She said the American Rescue Plan provided \$800 million in supplemental funding in March 2021. This funding will allow the program to support a broader workforce, including behavioral health professionals and substance use disorder treatment providers. The funding also provides the ability to optimize the awards of the Division's health care workforce pipeline. The Division anticipates that this year, the final bureau numbers will reveal that more than 1000 students were supported by NHSC to pursue their professional education.

Dr. Yeboah reviewed the following four NHSC priorities for FY 22: 1) The NHSC state loan repayment program (SLRP), 2) Preparing the NHSC pipeline for underserved communities, 3) Optimize data utilization, 4) Establishing outreach to health professional pathway and pipeline programs. A total of \$100 million will be dedicated to operating the NHSC SLRP, which will allow HRSA to provide grants to 50 states, the District of Columbia, and US Territories.

One of the other important areas related to NHSC programs is preparing the NHSC pipeline for underserved communities. Priorities include increasing the NHSC pipeline's readiness to serve Health Professional Shortage Areas (HPSAs). This will be done through various means, including

technical assistance, resources, and tools to address resiliency and prevent burnout. Another priority is to establish internal mechanisms to recognize BHW-funded, postgraduate trainings completed by the NHSC pipeline (e.g., scholars and students to services (S2S) participants). Finally, an additional priority is to expand disciplines for the S2S LRP program by including other professions, such as physician assistants.

The country's health care demands are outpacing the current need. The NHSC scholarship and S2S program serve as a pipeline to recruit professional students into careers at health centers, NHSC-approved sites, rural and urban communities, and frontier communities. So, in essence, the program works as a building block to ensure the capacity and longevity of a health care workforce.

There has been significant data collected over the years related to the NHSC and its participants. The goal is to optimize data utilization to better understand applicants, measure their characteristics, the migration patterns of NHSC applicants, and its influence on training and employment. Now that funding levels have been increased, there is an unprecedented opportunity to examine training and employment of providers and determine what variables may lead to greater retention. These data will also be available to the public and other stakeholders on demand through NHSC dashboards. Stakeholders have often asked HRSA to externalize these data, and this effort will allow them to see the data at a national level. The data will also be helpful in developing expansions, allocation of funding, and other decisions related to the NHSC.

In FY 22, NHSC will continue outreach to health professional pathway and pipeline programs. NHSC will continue to identify BHW program linkages, such as the Addiction Medicine Fellowship, the THCGME program, and Primary Care Champions. NHSC will also continue to link to programs that recruit providers that demonstrate an interest in caring for underserved communities.

### *Discussion*

Dr. David Schmitz said that Dr. Yeboah was "right on" with regard to trying to have an impact earlier on and then linking data to outcomes to both be able to intervene where the impact is and be able to align investments prior to placement.

Dr. Sandra Garbely-Kerkovich said that many of their students that come for residency programs do not know about the loan repayment or scholarship programs. She added that recruitment for specialty care had not been addressed (e.g., oral surgery care, periodontal care). Specialty care is hard to come by in rural communities. Dr. Yeboah thanked Dr. Garbely-Kerkovich for her advice and counsel. The Division

is currently looking at how they are targeting messages, so this is an important area in terms of getting advice and support from the Council.

Dr. Andrea Anderson said there is the perception by sites of not wanting to engage in the process because they think it is cumbersome or too rigid. What kind of efforts are being undertaken to try to debunk that myth and advertise the program? Dr. Yeboah said that last week HRSA did a presentation with a potential site, and they had similar questions. Following the community-based practice model, HRSA is connecting with more sites to demystify these issues. The Division of Regional operations also has an excellent site reference guide and other types of support.

Dr. Charmaine Chan said she had gone back to her medical school to speak to first- and second-year students about the NHSC to promote the program.

Dr. Villarreal asked if HRSA and NHSC have plans to help educators and institutions with pipeline programs that focus on potential students from areas in high need that can then be funneled into careers such as, for instance, physician assistant (PA) education. Dr. Yeboah thanked Dr. Villarreal for the question. She said they partner with HCOP and AHEC programs and present the NHSC as an incentive after participants finish their education.

Dr. Anderson asked if there was a slide set that could be adapted and downloaded for individuals to present NHSC to various audiences. Ms. Fabiyi-King said there currently is no presentation on the website, but there is something coming forward that could be helpful for those individuals who are proponents of the program. She also said she would share her comment with the Division of External Affairs.



**Panel: Opportunities for Improvement in Maternal Health Care  
Outcomes for Rural and Underserved Communities**

*David Schmitz, MD (Moderator)*

*Member*

*NACNHSC*

*Mark Deutchman, MD*

*Director*

*School of Medicine Rural Track*

*Associate Dean for Rural Health*

*University of Colorado School of Medicine*

*Phil Johnson, MD*

*Litchfield Family Practice (Litchfield, IL)*

*Tim Putnam, DHA, MBA, FACHE*

*Member, COVID-19 Health Equity Taskforce*

*Former President and CEO, Margaret Mary Health*

Dr. Mark Deutchman, Dr. Phil Johnson, and Dr. Tim Putnam each gave a brief initial presentation and then answered questions. Dr. Deutchman said he had provided maternity care for over 10 years in a rural location and is now teaching students and residents who are destined for rural practice. He and his colleagues published a study in the journal *Birth* in 2021 on the impact of family physicians in rural maternity health. The study included 10 states, 185 rural hospitals, and 13,000 births. Results showed that family physicians delivered babies in 67 percent of these hospitals. Also, family physicians were the only physicians who delivered babies in 50 (27 percent) of these hospitals. Family physicians provided VBAC services at 18 percent of the rural hospitals and cesarean birth services at 46 percent of the rural hospitals. It was estimated that many patients would have to drive an average of 86 miles round-trip to access care if those family physicians were to stop delivering babies.

Dr. Deutchman said that family physicians provide essential access to maternity care in rural areas. Because of this, residencies in family medicine should make sure that trainees who intend to practice in rural areas have adequate maternity care training. Also, those in OB/GYN training programs can help by collaborating with family medicine training programs.

Dr. Johnson said he has been a family physician in Litchfield, IL for 30 years. In the Litchfield hospital, family practice physicians are the only physicians who deliver and take care of babies. Currently, the hospital handles 200 deliveries a year, whereas a few years ago, they were delivering 400 babies. While patients can drive to a city and get services, Dr. Johnson explained that he cares for a poor population with high public aid, and if a patient or friend does not have money for gas, it is less likely that women will seek services in the city. He said one of his concerns is the closure of hospital obstetrics units. In Illinois, there are only six left, and they are underfunded. Many of these units are losing money because it is very expensive to provide low-volume obstetrical care with a high public aid population.

Dr. Putnam said the way that critical access hospitals are being reimbursed is also a challenge. For example, the more Medicaid patients are treated, the lower the hospital's Medicare reimbursement. Therefore, it is a poorly incentivized program that works well if the hospital is only serving Medicaid patients. He explained that for most rural hospitals, it takes a team to support an obstetrics unit, including obstetricians (or family physicians), general surgery for backup, nursing staff, pediatricians (or family physicians) for coverage for the infant and anesthesiologists. He added that the Biden-Harris Administration COVID-19 Health Equity Task Force, of which he is a member, has completed its soon-to-be-published final report, which contains a series of recommendations for rural areas.

### *Discussion*

Dr. Schmitz asked each panelist the following questions: *How do you see the current state of maternal health care?* and *How could the National Health Service Corps best support and improve these services, particularly in underserved areas?*

Dr. Deutchman said that family medicine is the solution to the current rural maternity care. There certainly are OB/GYNs occasionally located in rural areas, but by and large OB/GYNs and midwives cluster in urban areas, and it is really family medicine that is the backbone of rural maternity care. The study he just published supports these assertions. The National Health Service Corps could recognize the value of full-scope family medicine and support their practice not only in ambulatory care but also in the hospital to care for a patient in the emergency department or deliver a baby. If we want to get rid of maternity care deserts, we need to have a viable workforce with family physicians in sufficient numbers.

Dr. Johnson that in Rockford, they have instituted a program for family physicians called STRETCH-OB. It is a federally-funded, four-year program where obstetrics is integrated over the course of 4 years for

residents. He recommended that physicians going into rural areas for maternity care should work in cities where there is a high volume of deliveries and where they will see more unusual cases and their complications. He added that midwives on their own cannot solve the problem in rural Illinois. A freestanding facility run by midwives is not going to have immediate surgical care.

Dr. Putnam said that, unfortunately, often, when obstetric services are lost in a hospital, patients also lose access to prenatal services. This issue needs to be addressed nationally, also as an issue tied to infrastructure.

Dr. Schmitz asked the panel: *How can we best prepare and support those clinicians who will be providing direct maternity health care services in underserved areas?* and *How can we support NHSC awardees who will be providing maternity care in underserved areas?*

Dr. Johnson said they invite high school students to shadow a doctor in their rural area. The office manager then keeps in contact with them via email throughout their education, and incentives are provided once they graduate from medical school to come to practice in the rural area. In terms of supporting NHSC awardees going into maternity care, the best thing we can do is to have them practice in a city where there is a high volume of deliveries so they can become familiar with a wide variety of cases.

Dr. Putnam said they have a formal program that brings in high school students into the hospital to rotate for a full semester. Upon conclusion, about one-third of the students do not want to pursue careers in health care, but the other two-thirds do, and they know why. Dr. Putnam said it sometimes makes his legal team nervous when they bring high school students and put them in the obstetrics unit to have them watch a delivery, but the students get a lot out of it, and the experience is memorable.

Dr. Deutchman agreed with Dr. Johnson that it is important that students going into rural areas have broad-based training. The University of Colorado has a rural track and places students for up to a year in rural communities for their core clinical experiences, so they can experience what rural practice is really like.

Dr. Deutchman said that if the goal is to have physicians practice in a rural community long term, they need work/life balance, which is important to new generations of physicians.

Dr. Schmitz asked what resources should be highlighted to physicians who are currently moving to new communities as they partner with their community in providing safe and effective maternity care?

Dr. Putnam suggested that physicians new to a community understand the local social services and the social determinants of health. For example, people can turn for social services at their local Churches, so getting involved with pastor networks and understanding what resources are available is always good. Another thing that might be helpful is for physicians to reach out to EMTs to be part of an educational session. Understanding regional partners and large health systems is also important.

Dr. Deutchman suggested that physicians new to a community be knowledgeable of the behavioral health and social services resources available to the community. He agreed with reaching out to local clergy and the faith community. He also suggested getting to know people in the community by using their services (e.g., shop at local stores, get insurance with the local insurance agent, etc.).

Dr. Callins said her practice offers opportunities for fourth-year medical students to “sample” the community. She offers a rural maternal health elective, where students get immersed in a rural environment. She added that there are only two critical access hospitals in her state and that it would help to build a network that can support the physicians in those hospitals when they need help.

Dr. Deutchman said he had suggested the development of a regional health care network in his state. Physicians, nurses, and other health care professionals would work for a consortium and be deployed where they are needed within their region. The health professionals would work for the consortium serving communities in the region rather than working for not one hospital.

Dr. Putnam said that Wisconsin has been able to do something similar where physicians work for a group of hospitals.

Dr. Chan agreed it was a great idea and said they have an osteopathic consortium with medical schools working with consortiums of hospitals in each region that support each other in medical and graduate medical school education.

Dr. Deutchman said it is important to look into the unintended consequences that may be discouraging rural maternity care. He said that the idea of NHSC allowing locums is a great idea.

Dr. Johnson recommended that small communities create teams of five or six physicians to share calls (i.e., being on call). He also supported the idea of NHSC developing a cadre of professionals who can be deployed where there is a shortage.

#### **Remarks from the Chair**

***Keisha Callins MD, MPH***

***Chair***

***NACNHSC***

Dr. Callins thanked Dr. Schmitz for convening the panelist and laying out the foundation for the running theme for the Council meeting.

#### **Presentation: Division of Policy and Shortage Designation Update**

***Carla Stuckey***

***Deputy Director***

***Division of Policy and Shortage Designation (DPSD), BHW, HRSA***

Ms. Carla Stuckey provided an update on bills that impact the NHSC and are being considered by Congress. One of those bills is the *Strengthening America's Healthcare Readiness Act* proposed by Sens. Dick Durbin (D-IL) and Marco Rubio (R-FL). The bill is a bipartisan proposal for an additional \$5 billion appropriation for the NHSC program, with a 40 percent set aside for racial and ethnic minorities and students from low-income urban and rural areas. The bill would establish a demonstration program to mobilize the NHSC workforce to serve in emergency capacities via National Disaster Medical System (NDMS).

Another bill under consideration is the *Mental Health Professionals Workforce Shortage Loan Repayment Act* proposed by Sens. Tina Smith (D-MN) and Lisa Murkowski (R-AK), as well as Rep. John Katko (R-NY). This bipartisan, bicameral bill was reintroduced from the 115<sup>th</sup> and 116<sup>th</sup> Congresses. The bill proposes to amend Title VII of the Public Health Service Act to provide up to \$250,000 in eligible student loan repayment for mental health professionals who work in mental health HPSAs.

Another senate bill that has been recently proposed by Sens. Marsha Blackburn (R-TN), Richard Durbin (D-IL), Lisa Murkowski (R-AK), and Tina Smith (D-MN) is the *Rural America Health Corps Act*. The bill proposes to establish an NHSC LRP demonstration program for rural providers. Eligible participants would be required to complete five years of service in a rural HPSA in exchange for \$200,000 in loan

repayment. HRSA has provided technical assistance to this bill without providing a policy position. Technical assistance may include fundamental issues that may need correcting or fixing in the bill.

The *Public Health Workforce Loan Repayment Act*, supported by Reps. Jason Crow (D-CO), Michael Burgess (R-TX), Anna Eshoo (D-CA), and Brett Guthrie (R-KY), proposes to establish a Public Health Workforce Loan Repayment Program to promote the recruitment of public health professionals at local, state, and tribal public health agencies. Qualifying individuals must be in their final year of pursuing a public health or health professions degree or have graduated within the last 10 years. Individuals would agree to a three-year service commitment at a local, state, or tribal public health agency in exchange for up to \$35,000 of loan repayment per year of service.

Another house legislation being proposed is the *HIV Epidemic Loan Repayment Program (HELP) Act*, which was reintroduced from the 116<sup>th</sup> Congress (originally introduced by the late Rep. John Lewis (D-GA)). It authorizes a new LRP in Title VII of the PHSA, which will offer up to \$250,000 in loan repayment in exchange for five years of service. Eligible providers include physicians, NPs, PAs, pharmacists, and dentists who provide HIV treatment in HPSAs or Ryan White-funded sites.

The *Turn the Tide Act*, introduced by Sen. Jeanne Shaheen (D-NH)), is an appropriations bill that proposes to provide additional funding for programs under the SUPPORT Act. The bill proposes appropriating \$25 million for each FY 2021-2024 for the Substance Use Disorder Treatment Workforce (STAR) LRP.

Sens. Brian Schatz (D-HI) and John Barrasso (R-WY) have introduced the *Ensuring Access to General Surgery Act of 2021*. It is a bipartisan proposal to amend Title III of the PHSA to require the Secretary to designate general surgery shortage areas. Sens. Schatz and Barrasso introduced a similar bill in the 116<sup>th</sup> Congress. The *Physical Therapist Workforce and Patient Access Act of 2021* is a proposal to amend section 331 of the PHSA to alter the definition of primary health services to include physical therapy. The bill further proposes to amend the authority for the NHSC LRP in section 338B to include physical therapists. The bill was introduced by Sen. John Tester (D-MT) and Rep. Diana DeGette (D-CO).

The *Provider Training in Palliative Care Act*, introduced by Sen. Jackie Rosen (D-NV), is a bipartisan proposal to amend section 331 of the PHSA to allow participants in the NHSC SP and NHSC LRP to defer their obligated service in order to receive training in palliative care services. The bill would authorize the Secretary to grant deferrals for up to one year.

Ms. Stuckey also provided updates on the Build Back Better Act, which provides increases for the NHSC in the amount of \$2 billion. The updated version of the bill also has various palliative care provisions for up to \$90 million. HRSA's office of legislation has been working with the Budget Office to provide technical assistance as they have received inquiries from members of Congress.

#### *Discussion*

Dr. Schmitz said that in some rural places, such as Critical Access Hospital environments, general surgeons are incredibly valuable. With few exceptions, many states do not have their own community residing general surgeon. In North Dakota, a surgeon will spend a day a week in one hospital and perhaps a separate day in a different rural hospital for nonemergent care. One of the things discussed in medical education, particular around graduate medical education residency training, is to better prepare other physicians (e.g., family physicians) to be able to pre-operatively and post-operatively support services that are uniquely applied by a general surgeon (e.g., assist in surgery and recognize post-operative complications if the surgeon has already gone to the next Community).

Dr. Anderson said that having a general surgeon in an outpatient setting is helpful. They had a retired general surgeon at their FQHC. The surgeon would evaluate patients, help them with triage, post-op, and wound care.

Dr. Callins asked what further actions the Council could take with respect to the legislative update. Ms. Stuckey replied that the Council could vocalize the needs of their Communities to members of Congress. The Council could also review language in a bill and help foster outcomes that would be helpful or make sure there are no unintended consequences.

Dr. Callins asked what was meant by public health professionals in the *Public Health Workforce Loan Repayment Act*. Ms. Stuckey said she did not have any specific details and would have to go back to the bill to see if any degrees were specified.

Ms. Stuckey asked if there was a definition of "Community Health Worker" that is universally accepted in the field. Dr. Ellen Piernot replied that generally, the definition of Community Health Worker is quite variable and can range from lay individual to those with degrees. The University of Arizona has done a lot of work around this, and they have arranged Community Health Workers into three categories.

Dr. Bockwoldt said that if Community Health Workers are defined as “non-degreed individuals,” they might not have a college education and thus no loans to repay, so the LRP would not apply.

So instead, perhaps the language should reflect salary support for the health centers to hire these individuals. Ms. Stuckey said according to the language in the bill that Community Health Workers would have to be pursuing a public health or health professional degree or have graduated in the last 10 years. So, it would be somebody paying back some form of an educational loan.

Dr. Callins asked if there was a dashboard that kept track of bills and their success/failure?

Ms. Stuckey replied that they do not have a dashboard but could come back and note in their presentation which previous bills have been reintroduced.

Dr. Chan asked if the Council could utilize data to determine the appropriateness of the bills for underserved communities. For example, supporting physical therapy vs. surgery vs. other specialties. Ms. Stuckey said HRSA had used data in some of the technical assistance provided to Congress. One common example is that sometimes Congress wants to introduce legislation to encourage greater retention for certain populations in certain areas. Still, the data may show there is already high retention in that area, so that the effort might be duplicative. She added that all the data provided to Congress is public and therefore also available to the Council.

Dr. Khozaim asked in what circumstances it would be better to provide loan repayment/scholarship funding vs. salary support to offset the cost of positions. Ms. Stuckey said salary support would be more useful when there is no loan to repay and in cases of apprenticeships to incentivize individuals to get the experience they need. For example, HRSA funds an apprenticeship program that reimburses costs for the student to get on-the-job training skills.

Dr. Sein said one of the bills mentioned up to \$2 billion for NHSC support. Does the bill already spell out exactly what the funding will be for? Ms. Stuckey said it does not, and it is a broad appropriation to NHSC.

Since student loans are not available to DACA students, Dr. Villareal asked if HRSA is considering the inclusion of DACA individuals for scholarship opportunities. Ms. Stuckey said this would have to be a statutory inclusion, as there is a citizenship requirement in the statute. To overcome this, Congress would have to make an exception in the law.



Dr. Bockwoldt said that in Illinois, DACA-designated individuals are allowed to pay Illinois state tuition rates in college, as they are considered residents. So, these individuals can accrue educational loans. She asked if it would be easier to develop an exception in state loan repayment program for nonresidents fulfilling a needed role, such as Community Health Workers or even physicians.

Ms. Stuckey said that states would still be subject to the citizenship requirement because it is in the federal statute, and states are required to follow federal regulation.

### **Presentation: NCHWA Overview**

***Dr. Michelle Washko, PhD***

***Director***

***NCHWA, BHW, HRSA***

Dr. Washko said the mission of the NCHWA is to support informed public-private sector decision making on a broad range of issues around the US health care and the health support workforce by expanding the evidence-base. NCHWA produces, funds, and disseminates research findings and data on the US health care and health support workforces.

NCHWA's has five primary activities, which are to : 1) Conduct intramural research on the US health workforce; 2) Fund extramural research on the US health workforce; 3) Determine the adequacy of the US health workforce; 4) Evaluate federal health workforce development programs; and 5) Disseminate data and findings on the US health workforce.

Dr. Washko described some of NCHWA's efforts including the Health Workforce Simulation Model (HWSM); the National Sample Survey of Registered Nurses (NSSRN); and the Area Health Resources File (AHRF).

The Health Workforce Simulation Model was established in 2013 and projects workforce estimates. The HWSM estimates workforce supply and demand for individual occupations at the national and state level. The model has enabled HRSA to project for many more individual occupations simultaneously, replicating the behavior and labor market patterns of the real-life workforce

The National Sample Survey of Registered Nurses is conducted by HRSA approximately every 4 years. Topics covered in the survey can include: states of current licenses, education and training in nursing, current and past nursing workforce participation, income and demographic characteristics, and professional nursing certifications.

The Area Health Resources Files includes data from over 50 data sources on the following: health care professions, health facilities, population characteristics, economics, health professions training, hospital utilization, hospital expenditures, and environment at the county, state, and national levels.

She added that one of NCHWA's biggest challenges is balancing the internal research with the external research. It is a constant push and pull to marry the external research and place it into context with HRSA's multibillion dollar programmatic investments. HRSA is continuously working to assist external stakeholders to better understand findings and data that are released so that it may be interpreted correctly.

### *Discussion*

Dr. Piernot said that the effect of the pandemic in 2020 and the impact it had on the health care workforce in terms of employment and burnout could change some of the predictions. She asked if they had considered that in their work.

Dr. Washko said that because of a data lag, that many national data sources will be available in December 2021. Recent results from the Survey of Occupational Injury and Illness released by the Bureau of Labor Statistics is showing a 4,000 percent increase in certain workplace illnesses. Data are just coming in and NCHWA is putting everything in place to get ready to analyze the data and get it out the door.

Dr. Schmitz said that these types of modelling can have confounders. He said he liked that HRSA defines access as not only by calculating where people work but also by patients getting the services they need. When one is discussing health care utilization by setting, two settings that cannot wait are maternity care and the ER (trauma services). Telehealth has been accelerated over the past two years and this trend is not likely be ending. Individuals will be able to access telehealth in a way that they had not been able to before moving forward, which will be a disrupter to geographic analysis. And while telemedicine can provide enhanced access to certain services, in other underserved communities—particularly rural communities—we may have to be attentive to the critically important, but unscheduled access to care that is necessary, such as maternity and the ER care.

Dr. Washko agreed that certain issues, such as telehealth, need to be factored into their projections. And that may mean tapping into experts to getting those assumptions right in the modeling. She added that

projection model changes over time, and NCHWA is constantly responding to changes in the health care environment.

**Presentation: Advancing Maternal Health**

***Kimberly Sherman, MPH, MPP***

***Chief***

***Maternal and Women's Health Branch, Division of Healthy Start and Perinatal Services, Maternal and Child Health Bureau, HRSA***

***Sandra Lloyd, RN, BSN, M.Ed.,***

***Maternal and Child Health Bureau, HRSA***

Ms. Kimberly Sherman provided the Council with an overview of the Maternal Child Health Bureau's (MCHB) maternal health portfolio as well as efforts and opportunities to improve maternal health outcomes.

Ms. Sherman said MCHB's mission is to improve the health and well-being of America's mothers, children, and families. The bureau's goals are to 1) Assure access to high-quality and equitable health services to optimize health and well-being for all Maternal and Child Health (MCH) populations; 2) Achieve health equity for MCH populations; 3) Strengthen public health capacity and workforce for MCH; and 4) Maximize impact through leadership, partnership, and stewardship.

The Maternal Child Health Bureau supports the following programs/initiatives: Title V MCH Services Block Grant to States, which covers 86 percent of all pregnant women and 99 percent of infants; the Maternal, Infant, Early Childhood Home Visiting Program; and the Healthy Start Initiative, which serves women, children, and families in 34 states, Washington, DC, and Puerto Rico.

Maternal mortality is a growing problem with around 700 fatalities each year from pregnancy-related causes. About 60 percent of these deaths may be preventable. In addition, studies show that black women are 3 to 4 times more likely to die from pregnancy-related complications than white women.

MCHB's maternal health portfolio includes a variety of programs and initiatives including the Women's Preventive Service Initiative (WPSI), State Maternal Health Innovation, and the Alliance for Innovation on Maternal Health (AIM).

WPSI identifies preventive services and screenings to improve women's health across the life course. The initiative provides clinical recommendations for preventive services for asymptomatic women that address health needs specific to women and fill gaps in existing guidelines. It also provides guidance to the insurance industry on preventive services for women. WPSI engages a coalition of health professional organizations to recommend updates to the HRSA-supported Women's Preventive Services Guidelines.

The State MHI Program assists states in collaborating with maternal health experts, and optimizing resources to implement state-specific actions that address disparities in maternal health and improve maternal health outcomes. The Maternal Health & Innovation Center provides 9 cooperative agreements per year, for up to \$2,072,222 million.

The primary objective of the AIM is to reduce preventable maternal deaths and severe maternal morbidity in the United States. It does so by: 1) Promoting safe care for every U.S. birth; 2) Engaging multidisciplinary partners at the national, state, and hospital levels; 3) Developing and providing tools for implementation of evidence-based patient safety bundles; 4) Utilizing data-driven quality improvement strategies; and 5) Aligning existing efforts and disseminating evidence-based resources. There are currently seven pilot sites around the country.

HRSA's Screening and Treatment for Maternal Depression and Related Behavioral Disorders (MDRBD) program helps address maternal mental health conditions that often affect women during and after pregnancy. A contract award has been awarded to Postpartum Support International to develop a maternal mental health hotline. The hotline will be available 24/7, 365 days a year. It will provide services in both English and Spanish via voice, text, and chat. The line's launch is expected in early 2022.

### *Discussion*

Dr. Khozaim said there is certain types of maternal morbidity that decreased during the pandemic (e.g. pre-term labor and pre-term delivery). Ms. Sherman said while there has been a reduction in some poor outcomes, there has been an increase in stillbirth. She added that MCHB has a call planned with its CDC colleagues to discuss this and other data issues.

Dr. Schmitz said many hospitals are closing their doors due to the number of patients or financial reasons. Ms. Lloyd said this is an important challenge and that HRSA's Federal Office of Rural Health Policy is looking into the issue.

Dr. Callins said it would be helpful to have a hybrid model forward that includes both in-person visits and telehealth. This model has made a difference in the quality of care of her patients.

Dr. Callins said if they had every considered marrying postpartum visits with pediatric visits. Ms. Lloyd said that one of their State Maternal Health Innovations is working on the mother/baby dyad. They are looking at how well the approach is received and whether it improves outcomes.

### **Public Comment**

Ms. Fabiyi-King invited public comment. No one offered public comment.

### **Discussion, Recap of Day 1, and Plan for Day 2**

**Keisha Callins MD, MPH**

*Chair*

*NACNHSC*

Given that the Thanksgiving holiday is a few weeks away, Dr. Callins asked each Council member to briefly share something that a colleague did that helped make a difference for them and for which they are thankful. Council members went around and shared a story of gratitude.

## DAY 2

### **Welcome and Roll Call**

Ms. Fabiyi-King convened the meeting and conducted roll call. She then provided instructions for meeting participation as well as an overview of the Advisory Council Operation Team and the Office of Information Technology.

### **Charge of the Day**

***Keisha Callins MD, MPH***

***Chair***

***NACNHSC***

Dr. Callins began with the quote of the day “Leadership is the capacity to change vision into reality.” She thanked Dr. Schmitz for moderating the maternal health care panel. She reminded Council members that they could suggest experts for the panels and/or volunteer to moderate one. Dr. Callins added that two focus areas for future panels are health equity and resilience. The NACNHSC meeting in March 2022 will be on health equity and the one in June 2022 on resilience.

### **Presentation: Council on Graduate Medical Education (COGME) Overview**

***Thomas Tsai, MD, MPH***

***Vice Chair***

***COGME***

Dr. Thomas Tsai said he is surgeon at Brigham and Women’s Hospital as well as professor of surgery at Harvard Medical School. In addition, he is the vice chair of the COGME.

Although GME part of COGME’s focus, the Council focuses on the overall support and development of the health care workforce. The charge of the council is to broadly provide advice to the U.S. Department of Health and Human Services and Congress on the overall health care workforce. COGME members bring a wide variety of expertise and represent various stakeholders.

In addition to reports, COGME issues rapid-response letters commenting on proposals and legislation in place. COGME is also developing three Issue Briefs that will provide evidence on a series of topics.

The 22<sup>nd</sup> report was focused on the role of GME in terms of a new health care paradigm. The 23<sup>rd</sup> report was titled *Towards the Development of a National Strategic Plan for Graduate Medical Education*. Over

the last three years, COGME has focused on addressing rural health care disparities. They have developed three Issue Briefs that will be consolidated into the 24<sup>th</sup> Report.

The first Issue Brief focuses on rural health care disparities. The two other briefs focus on the training needs of rural communities and additional financing to support new training for rural health care facilities.

The first Issue Brief provides two recommendations: 1) The need for a comprehensive assessment of rural health care needs to inform the implementation of programs, such as NHSC and other programs; and 2) The need to link funding to the populations' health needs.

The second Issue Brief provides five recommendations: 1) The importance of expanding place-based training; 2) Identifying financial incentives to innovate, create, and expand new GME programs; 3) Developing metrics to help measure the quality of care provided and assess return on investment; 4) Supporting the current workforce providing care to rural America by developing alternative payment models; and 5) Develop a strategic plan to pull together financing mechanisms across federal agencies to support both the training of the future rural health care workforce as well as current rural health care providers.

The third Issue Brief also provides five recommendations: 1) GME recommendations may not be specific enough to meet the rural health needs, and we may need to think of specific rural training paradigms; 2) There should be an emphasis on team-based care, 3) Preserving generalism in practice; 4) The need to invest in the recruitment and training of individuals from rural communities into the health professions; and 5) Focus on federal sources of funding, but also think of a comprehensive assessment to identify state and local sources of funding.

Ideas for the development of the 25<sup>th</sup> report include the following: 1) COGME's role in advancing recommendations related to health care equity; 2) The need to focus on behavioral and mental health care; 3) The future of telehealth both for GME and the health care workforce; and 4) Addressing issues around health care provider burnout.

### *Discussion*

Dr. Sein said that he works for an FQHC that is interested in starting a residency program in a rural setting. But obtaining long-term funding can be challenging. Is there anything on the works for funding residency programs long term? Dr. Tsai there are opportunities with the new funding to expand GME slots (1000 new positions), there is also new funding for America Rescue Plan to expand rural programs and teaching centers. He added that COGME has been discussing the issue and is open to discuss any ideas.

Dr. Chan asked if there have been discussions with CMS to loosen the restrictions on the CAP because of the pandemic? Dr. Tsai said this has come up in discussion at COGME's meeting.

Dr. Khozaim asked if there was a way to fund residents who come from tertiary settings to do a rotation per year in a rural setting and not hurt the hospital financially. He also asked if COGME could mandate curricula for federally-funded residencies.

Dr. Tsai said there is no mandate authority for COGME under that area as an advisory committee.

Dr. Taylor-Desir said it would be helpful to look for opportunities to create partnerships between tribal communities and academic centers. As a NHSC scholar, she did her service time mostly with the Navajo population. She said residents that visited the reservation usually had misconceptions about what the reservations and the patients were like. So it is helpful to provide opportunities for conversation and relationship building.

Dr. Tsai asked if the barriers to those partnerships were financial, in terms of supporting the residents, of regulatory nature, or related to accreditation.

Dr. Taylor-Desir said one of the barriers is mistrust and building trust between both the academic center and the communities. Providing housing to residents or medical students would also be very helpful.

Dr. Anderson said the FQHC where she did her residency also ran the health care in the local jail facility and was able to provide primary care for incarcerated patients and then help them follow-up in the clinic afterwards, so there was a seamless transfer of care. She said that compensating specialty rotations is a small incentive that brings forth huge dividends in terms of the workforce.



Dr. Piernot said that nurse practitioner and dental residencies are booming. She asked what will be the role of COGME in bringing all of these disparate advanced training programs into the fold. Traditionally GME is very MD/DO focused. Does the Council have a plan or vision for these advanced training programs?

Dr. Tsai said that COGME's focus on a national strategic health care workforce plan, the idea is to have an overall strategy across all individuals who provide health care. COGME needs to make sure that it is not falling down the silo of just thinking about MD and DO residency training programs. It is a constant tension between focusing and recognizing broader issues and tailoring recommendations.

**Presentation: Data Externalization**

*Elizabeth Kittrie*

*Senior Advisor to the Associate Administrator*

*BHW, HRSA*

*Michael Arsenault, MBA, PMP*

*Director, Division of Business Operations*

*BHW, HRSA*

**Discussion**

Ms. Elizabeth Kittrie and Mr. Arsenault gave a presentation on HRSA data and then held a listening session to obtain feedback from the Committee. Ms. Kittrie said that they are having listening sessions with all of BHW's HRSA Advisory Committees because each Committee provides an important perspective in terms of the organizations it represents the experiences that many of its members have had as scholars with the NHSC program.

Ms. Kittrie explained that HRSA is mandated by law and the Secretary to share data with the public. She explained that an effort is underway to improve BHW data on the HRSA Data Warehouse. The goals of the effort include: 1) Enhancing the findability and usability of BHW's health workforce data; 2) Presenting health workforce data more coherently across BHW programs; 3) Cleaning up data that are misaligned or outdated; and 4) Identifying data gaps and stakeholder needs.

To accomplish this, the Bureau will continue to hold a series of listening sessions from October to December 2021 in order to develop a strategy and roadmap. Implementation of the identified changes will be carried out from January to June 2022.

The HRSA Data Warehouse holds a significant amount of data on various areas, including data on clinician dashboards, training programs, practitioners, nurse corps, nurse surveys, shortages, workforce projections, and other data.

Some examples of data and tools include shortage designation data, which provides information on Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/P). The National Practitioner Data Bank is a national repository of medical malpractice and adverse actions related to health care practitioners, providers, and suppliers. The Health Workforce Project Tool is an interactive tool based on HRSA's microsimulation model that helps visualize the supply and demand of health professionals. Data on the clinician dashboards include retention and location data of the NHSC, Nurse Corps, and other program alumni. The Health Workforce Connector is an interactive tool that allows users to search and locate open job opportunities and training sites by a range of criteria (geography, HPSA score, clinician type). Data are also available on grant awards, health professions training programs, and other areas.

#### *Discussion*

Ms. Kittrie asked Council members two questions: *How are you using the HRSA Data Warehouse now, if at all?* and *What information are you seeking, and what are you trying to do?*

Dr. Piernot said that she personally does not use it, but the grant writer in her organization uses it to define HPSA scores and explain community needs.

Dr. Villareal said he uses the HRSA Data Warehouse quite heavily, and so does this staff. In all, about five individuals use it in his department on an almost weekly basis. The warehouse is used to obtain data and information for any HRSA proposal they submit. They also use it to determine HPSA scores, dental/behavioral scores, and other information to vet candidates for their rural health professions program. In addition, they use the information to follow graduates through their NPI numbers throughout their career to determine if their graduates are located in areas where they would be meeting the program's mission.

Ms. Kittrie asked Council members the following questions: *What is your awareness of the National Health Workforce Data Resources in the warehouse? How are you or your organization using these data?* and *What feedback do you have on these data or tools?*

Dr. Schmitz said the more tools are used and referenced, the more they will get used. He said that the team is on the right trajectory, but having workforce projections that are geographically sensitive, for example, by state, as the AAMC projections could be really helpful.

Ms. Kittrie said she would relay that information to Dr. Washko and her team.

Dr. Bockwoldt said she would be interested in learning about medical errors in the primary care setting from the viewpoint of the community health system. She said it would be helpful to map diagnoses to the location of health centers are and also look at quality of care. Ms. Kittrie said the warehouse is moving in the direction of integrating more data and being able to map it.

Dr. Garbely-Kerkovich asked where HRSA gets the data at the state and county levels. Also, how accurate are the data? Mr. Michael Arsenault said it depends on the specific tool. For example, shortage designation comes directly from the Shortage Designation Management System.

Dr. Anderson said that, with respect to awareness of the tools, she knew that HRSA collected data but was not aware that it was publicly available and searchable. In terms of using the data, she said she is not currently using the data and is not sure how the FQHC she is affiliated with is using the data. Lastly, with respect to feedback, Dr. Anderson said she liked the layout but thought it was a bit difficult to navigate without the direction sheet they were provided. She also liked the “how-to-use” tool. Dr. Anderson said she would suggest a navigation pop-up that would appear when the user hovers over the tabs, similar to the arrows on the direction sheet that was provided. Maybe something like “Click here to navigate to the data” or perhaps a separate instructional video tutorial. She also suggested more uniformity for the tabs. For example, the Nurse Corps and NHSC tabs link to information sheets, but the CGME and CHGME tabs link to a generic “How to apply for a grant” page. It would help if all the tabs linked to a uniform progression of information, and data about each program, like an information sheet on the THCGME or the CHGME. Ms. Kittrie said her feedback will help to provide the user with a better journey.

A participant asked if there are data on applicants, both funded and unfunded. Mr. Arsenault said those data will be available at the end of the month.

A participant asked if migration could be examined by state as well as by rural and nonrural. Mr. Arsenault replied that it could indeed be examined in that manner.

A participant asked if he could look himself up on the site. Mr. Arsenault said the data are aggregated so that it is not individually identifiable.

Dr. Piernot said it is frustrating is that searching is different between different subgroups. It would be nicer if there were standardization across the search feature.

Dr. Callins suggested communicating the existence of the new data tools through various communications, such as notifications on scholarships opening up, site orientations, or other information sent to sites hosting NHSC clinicians.

Dr. Brandner suggested incorporating the tools into a nurse curriculum, especially those curricula funded by HRSA.

Dr. Villareal said they incorporate some of the tools, as well as the Health Workforce Connector, in their PA program. The tool is useful for both staff and students. He added that they also use data from the warehouse in admissions by determining the HPSAS score and other information tagged to the applicant's geographic location (this is disclosed in the application). Dr. Villareal said that for Arizona the results from the warehouse are skewed when compared with results from data from the Arizona Department of Health Services. He said retired physicians live in areas that are not designated as shortage areas but should be if they took into account the retired physicians.

Ms. Kittrie said that Council members could send any additional feedback to either Dr. Callins or Ms. Fabiyi-King. Dr. Callins thanked Ms. Kittrie and Mr. Arsenault and invited them to come back and present in 2022.

### **Presentation: NHSC 50<sup>th</sup> Anniversary Discussion**

***Angela Hirsch***

***Director, Division of External Affairs***

***BHW, HRSA***

Ms. Angela Hirsch said that 2022 will mark the 50<sup>th</sup> anniversary of the National Health Service Corps. A significant amount of activity has taken place to promote the anniversary, including the redesign of the

NHSC website. The website has been rebranded and includes more visuals, is easily accessible, and targets broad and specific audiences of applicants and members. It now includes an online new digital toolkit for stakeholders as well as potential applicant site information. The website is more visual, with three featured boxes on the main page as opposed to just one on the previous site. It is updated to provide the latest information on applications and the program.

The websites traffic and digital engagement have increased. Website engagement went up 9 percent, and the NHSC “About Us” page received 41,763 visits. Pageviews and sessions have increased, and the average time on page has remained steady. Graphics representations provide statistics on the program for those unfamiliar with it. This information can be used in social media with the goal of showing the program’s impact.

A 50<sup>th</sup> Anniversary digital badge has been created, and there will be an update to the NHSC 101, which is a slide deck used for senior staff and program presentations. The campaign will be rolled out in January 2022 and will be a year-long observance. It will include videos of current clinicians discussing the NHSC program. Another project being considered is “50 faces in 50 days,” which will highlight quotes from individuals connected to the Corps over the course of 50 days and which will be spread around the course of the year. HRSA will also release the *50 Years Across the U.S: Map of NHSC Impact Nationwide*, which would map the impact of the NHSC nationwide.

Central aspects of the campaign would live on a new web page that would be featured very prominently on the NHSC site and be a place to land for anyone who is interested in learning about historical content. The campaign will include many federal agencies and partners as well as earned media (e.g., podcast interviews, radio media tours, audio new releases, paid social media, etc.). HRSA will also be involved in a year-long release of social media content and e-blasts, related to the campaign.

One of the most compelling aspects of the campaign will come from NHSC members and alumni who will be able to talk about the impact they had on their communities as well as the impact that communities had on them and their careers. This will help reach new audiences for the Corps, get more support for the Corps, and also potentially increase the number of future applicants.

### *Discussion*

Dr. Callins asked whether the Council could post information about the anniversary on the NACNHSC website. Ms. Hirsch said she would make sure that the new site will link to the Council's webpage.

Dr. Garbely-Kerkovich suggested connecting with the National Network for Oral Health Access.

Dr. Khozaim said he loved seeing that the recruitment ads on the website include a diverse representation of health care providers. He asked if it would be possible to align the NHSC goals with some of the more recent millennial social issues since HRSA is currently trying to recruit millennials. For example, an ad that reads along the lines of "*Do you want to address systemic racism in our country? Join the NHSC*" or "*Do you want to help the LGBTQ community? Join the NHSC.*" Dr. Khozaim also suggested developing a one-page editorial for prominent journals such as *The Green Journal (OB/GYN)* or *The New England Journal of Medicine* or other journals targeting academically oriented providers so that they may encourage their students and residents to learn more about the NHSC.

Ms. Hirsch said they have a two-fold message when reaching out: one is a financial message, where the NHSC can make education affordable. But it is also important to emphasize social justice and health equity issues, as well as the service connection.

Dr. Chan suggested also suggested reaching out to medical schools and allied professional schools that have branch campuses in underserved communities.

Dr. Schmitz said that, with regard to an editorial in a journal, he is on the editorial board of the *Journal of Rural Health*. The *Journal of Rural Health* might be interested in a commentary with regard to the NHSC impact over 50 years. He said that HRSA could reach out to him if they need assistance with the matter.

Dr. Piernot suggested leveraging primary care associations, by making sure they get all the press releases since they have paid media to leverage. Ms. Hirsch said they have been working with associations very closely.

Ms. Fabiyi-King said during the last meeting the Council was considering writing a paper on the 50<sup>th</sup> anniversary of National Health Service Corps.

A participant said that NAC would be a great resource. Ms. Hirsch said they work closely with them on promoting the 50<sup>th</sup> anniversary and the loan repayment and scholarship programs. She said that members can share any additional ideas through [NHSCstories@HRSA.gov](mailto:NHSCstories@HRSA.gov).

### **Public Comment**

Ms. Fabiyi-King invited public comment. No one offered public comment.

### **Discussion, Closing Remarks, and Next Steps**

#### ***NACNHSC Members***

Dr. Callins thought that developing a publication on the 50<sup>th</sup> Anniversary of the NHSC was a good idea. She added that some of the data tools presented during the meeting could help in this endeavor. She also asked participants to think about priorities moving forward, and suggested reviewing NHSC priorities and recommendations over the past few years. She added that the recurring theme of interdisciplinary practice and professional development were important. The Council had a discussion about instituting a leadership curriculum for the NHSC scholars. Members will submit samples of developed curriculum for review.

Dr. Callins complimented HRSA staff for all their logistical efforts to have the virtual meeting. She also thanked Council members for the high quality of work being done. She wished everyone a happy Thanksgiving.

Ms. Fabiyi-King said she will resend out the dates of all future meetings as well as a new member roster as soon as it is completed.

### **Adjourn**

Dr. Callins adjourned the meeting.