

Meeting Minutes
National Advisory Council on the National Health Service Corps
March 29-30, 2022

The National Advisory Council on the National Health Service Corps (NACNHSC or Council) met on March 29-30, 2022, 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, to 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 Ms. Diane Fabiyi-King convened the meeting at 9:04 a.m. Eastern Standard Time (EST). She introduced herself, welcomed the meeting participants, and conducted roll call. Ms. Zuleika Bouzeid gave instructions for meeting participation. Council Chair Dr. Keisha Callins thanked Ms. Fabiyi-King and HRSA staff for their work to set up the meeting. She also thanked the Council members for their attendance. Dr. Callins spoke briefly on the meeting's main topic, health equity, and reviewed the meeting agenda.

NHSC 50th Anniversary Video

Mavis Carter

Public Affairs Specialist, Division of External Affairs

Bureau of Health Workforce (BHW), HRSA

Ms. Mavis Carter led the Council in the development of a video celebrating the 50th anniversary of the NHSC. Each member was recorded via Zoom reading a part of a previously developed HRSA script. The script's message focused on what the NHSC is, its history, role, goals, impact, and how others can participate in the program. The video will be subsequently edited and used to promote the 50th anniversary through HRSA's social media channels and other means.

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

Israil Ali, MPA

Director, DNHSC, BHW, HRSA

Mr. Israil Ali provided an update on the activities related to the NHSC. The NHSC is comprised of clinicians from a variety of specialties including behavioral health specialists (47 percent), nurse practitioners (19 percent), physicians (13 percent), dentists (9 percent), physician assistants (8 percent), registered hygienists (2 percent), certified nurses (1 percent), and other clinicians.

The American Rescue Plan Act of 2021 (ARPA) allocated significant resources to the NHSC, allowing HRSA to substantially fund more applications than in previous years. The NHSC was allocated \$858 million, including \$345 million in funding from ARPA. A total of 1,192 new awards were made for the Scholarship Program, 8,830 for Loan Repayment Programs, and 257 to the Students to Service Loan Repayment Program. In addition, awards were made to 41 State Loan Repayment Programs (SLRP). All of these efforts have increased the NHSC's impact. Currently, nearly 20,000 NHSC members are providing care to almost 21 million people in the U.S.

The NHSC has four priorities for FY 2022: 1) The NHSC SLRP, 2) Providing dedicated support to the NHSC Pipeline, 3) Optimizing data utilization, and 4) Establishing outreach to health professional pathways and pipeline programs. The NHSC SLRP provides grants to states and territories to operate their own loan repayment programs. These programs offer loan repayment to primary medical, mental/behavioral, and dental health care clinicians working in Health Professional Shortage Areas (HPSA). In FY 2022, \$100 million will be dedicated to operating the NHSC SLRP. For the first time, some of this funding will be available to states starting programs to support the hiring of personnel, travel, and/or marketing costs.

The NHSC has partnered with the Association of Clinicians for the Underserved (ACU) to build participant capacity for resiliency, increase their understanding of the social determinants of health, and provide access to in-depth resources and tools to better engage with the communities they will be serving. The goal is to improve clinician retention rates in the communities being served. The NHSC is also working to optimize data utilization. This will allow for the better evaluation of applicants who apply to NHSC programs and lay the foundation for NHSC outcomes.

Discussion

Dr. Michael Sein asked how long the American Rescue Plan (ARP) funding would last. Mr. Ali said the appropriation is considered “no-year money,” meaning it is available until expended. The ARP will hopefully be exhausted this year.

Dr. Sandra Garbely-Kerkovich asked if the SLRP monies go to primary care organizations or the state’s Department of Health. Additionally, she asked if the state reviews all applications and awards monies to the applicants.

Mr. Ali said that various entities representing the state can apply for funding and these entities do review applications to ensure they are in line with the federal standards of the LRP.

Dr. Kareem Khozaim asked what happened to those people who completed the program and how many of them continued in their community afterwards. Also, he asked if anything was known about those who were not accepted.

Mr. Ali said they have not analyzed all the data yet to be able to make any findings. Anecdotally, some providers who have not received an award in the past have still continued to apply.

Dr. Callins asked how mentorship of clinicians could be introduced into the model as there are more than 66,000 alumni and 20,000 current members. An ecosystem of mentorship could help to engage current individuals that are serving.

Mr. Ali said mentorship is something that has been infused into the NHSC Pipeline Readiness Contract. It is something that is being cultivated with ACU and other partners.

Dr. Callins asked Mr. Ali if he could elaborate on the collaborative relationship with the ACU, and if it would be appropriate for them to speak to the Council about their initiatives in the future? Ms. Fabiyi-King said that could be arranged.

Dr. Callins made two recommendations. The first is that the program should consider the idea of sponsorship. For example, working with students to identify a potential student to serve on a board or participate in the chamber of commerce for the community. The second recommendation is to consider servant leadership. Many times when a clinician goes to a small community, they end up being asked to

engage as a leader or a contributor. In future planning, she wished to make sure that readiness to serve includes being able to assimilate into the community and becoming a leader, not just a leader of the health care team, but also a community leader.

Dr. Andrea Anderson said it would be important to highlight NHSC members who are on their local school board or performing some other activity in their local area. This could help build comradery. It is an investment in long-term retention for applicants to feel integrated into the communities where they are placed.

Joint Committee Telehealth Letter of Support Review

NACNHSC Members

The Council reviewed and approved a joint letter expected to be cleared by all five BHW advisory committees. Through the letter, the committees request that the Secretary and Congress urge the Centers for Medicare and Medicaid Services to make permanent payments for telehealth services at the same rate as allowed for in-person visits, just as it has been allowed during the public health emergency in order to:

- 1) Promote reimbursement parity for expanded patient care through telehealth, using either video or voice-only communications for health care visits, and
- 2) Support reimbursement parity for telehealth clinicians across disciplines and geography, especially in rural areas.

Panel: Opportunities to Apply a Health Equity Lens to Rural and Underserved Care

Andrea Anderson, MD, FAAFP (Moderator)

Member, NACNHSC

Benjamin Anderson, MBA, MHCDS

Vice President, Rural Health and Hospitals

Colorado Hospital Association

Al Richmond, MSW

Executive Director

Community-Campus Partnerships for Health

Maisha Standifer, PhD, MPH

Director, Health Policy, Satcher Health Leadership Institute

Morehouse School of Medicine

Mr. Benjamin Anderson said the Colorado Hospital Association (CHA) represents more than 100 hospitals and health systems throughout the state. Its mission is to support the members' collaborative commitment to advance the health of their communities through affordable, accessible, high-quality health care. The CHA's rural strategy has four components: 1) Leveraging data to inform system development and interventions, 2) Increasing leadership and workforce capacity, 3) Improving access to excellent and holistic care, and 4) Strengthening partnerships and collaborations.

One of the CHA initiatives helped to provide access to Personal Protective Equipment (PPE) during the pandemic. CHA was able to distribute 2,280 boxes of PPE during that time. They delivered the equipment to 32 rural Colorado hospitals through more than 100 flights. CHA partnered with Angel Flight, an organization with several hundred pilots, which donated their planes, gas, and time to deliver the PPE to the nearest landing strips next to rural hospitals. Using the same transport system, CHA worked on the Combined Hospital Transfer Center, which guaranteed that every admitted COVID-19 patient in Colorado would have access to inpatient care and would not have to be turned away. Angel Flight allowed for the transfer of these patients to and from rural and urban areas as needed. In addition, CHA also provides their members with a data dashboard that uses claims-based data to help rural communities understand what is coming into their community, what is leaving their community, and what is staying in their community.

Mr. Al Richmond said the mission of the Community-Campus Partnerships for Health (CCPH) is to promote health equity and social justice through partnerships between communities and academic institutions. Over the past 25 years, CCPH has been involved in various projects, from service learning to community-based participatory research. More recently, CCPH has been involved in patient and community engagement and been on the front line of mobilizing partnerships across the U.S. to address the global pandemic.

CCPH is part of the North Carolina Community Engagement Alliance Against (CEAL) COVID-19 Disparities. This initiative was initially mobilized across 10 states across the U.S. that were disproportionately impacted by COVID-19. Another initiative, called *At the Heart of the Matter: Building a Framework for Collective Action*, is a partnership between CCPH, the Morehouse School of Medicine, the American Heart Association, and The Center for Black Health & Equity. It convenes HBCUs in the southeast region and their community partners to address cardiovascular disparities using a patient-

centered outcomes research framework. CCPH also forms part of RADx Underserved Populations (RADx-UP), a consortium of more than 125 research projects studying COVID-19 testing patterns in communities across the US. The partnership collects data on disparities in infection rates, disease progression, health outcomes, and access to health care.

Dr. Maisha Standifer said the mission of the Satcher Health Leadership Institute (SHLI) is to create systemic change at the intersection of policy and equity. She added that Political Determinants of Health Care (PDoH) create the social drivers—such as lack of transportation, neighborhoods that are not safe, and a dearth of healthy food options—that affect all other dynamics of health. PDoH can create structural barriers to equity for population groups that lack power and privilege. The institute’s PDoH Learning Laboratory equips participants with tools to examine the PDoH factors influencing their respective local communities and supports their development of a health equity initiative or proposal designed to address identified conditions unique to their local populations and communities. The Laboratory provides an opportunity for leaders and community champions to enhance their skills in policy and health equity. Its training fosters community partnerships between the participating officials and their partnering community-based organizations.

SHLI also works to inform policymakers on how to address climate justice and environmental political determinants of health. Additionally, the institute developed a webinar series that focused on advancing medical cannabis health equity. The first webinar explored “Informing, Educating, and Empowering” historically marginalized communities and people around the issue.

Discussion

Dr. Anderson kicked off the discussion with the question *What do you see as the emerging threats to health equity in rural areas and how can we address them?*

Mr. Anderson said that in many rural areas, especially in the rural Southeast, health outcomes have fallen behind even those in urban inner cities. One of the most glaring is maternal health outcomes, where a woman of color in the rural Southeast is three to four times more likely to die in connection with childbirth than a White woman in an urban area.

Mr. Richmond said there is an increase in diversity in rural communities. Previously, one thought of only Black and White, but increased diversity (e.g., Latinx) means understanding issues surrounding language and culture. Mr. Anderson agreed, saying that in his hospital they deliver babies from 20 countries.

Dr. Standifer said another issue is that, policy-wise, no one seems to be speaking for these populations. If no one advocates for them, they may not be considered.

Dr. Anderson then asked *In what ways could an increase in the utilization of community partnerships further advance health equity?*

Mr. Richmond said that, in response to COVID-19, some groups and community-based organizations have pivoted from worker rights issues, voter registration, and other work to addressing COVID-19. In terms of capacity building, some groups might need support if they choose to become a 501(c)3 organization. Others may need support around securing resources, funding opportunities, writing grants, etc.

Dr. Anderson asked *What policy initiatives have directly affected health equity and how can we continue to expand on what we know is working?*

Dr. Standifer said one of the policies that is working is the Affordable Care Act, which has reduced disparities, particularly concerning those who are underinsured. Also, the Black Maternal Health Momnibus Act of 2021 lists factors that contribute to disparities and inequity regarding maternal mortality rates in Black women. The Opioid Reduction Act also addresses some of the factors that can help reduce disparities.

Mr. Richmond said he believed public policy is needed on the accurate collection of data around race and ethnicity. It should be a mandate across all health care systems. If one does not fully have data, then it is not possible to know where all the disparities occur. Once we have the data, we can focus like a laser on those disparities.

Dr. Standifer agreed and said the director of the Satcher Health Leadership Institute has presented testimony to Congress about the need for data.

Dr. Callins said the roadmap for the journey to health equity includes pathways, partnerships, and policy—and how they intersect. She asked Mr. Anderson how he was mobilizing his family medicine providers in terms of improving maternal peer delivery.

Mr. Anderson said the hospital where he worked, Kearny County Hospital, partnered with the Kansas University School of Medicine to develop the Pioneer Baby Initiative, a program to improve pregnancy and birth outcomes. The region had twice the national average of women experiencing gestational diabetes, which can lead to respiratory problems due to early delivery and a higher risk of developing type 2 diabetes. The program engaged family physicians and mothers through telemedicine to get ahead of gestational diabetes. The program also involved specialized nurses that were the primary contact for the mom and helped monitor the mothers' health and change behaviors. Over time, the number of mothers delivering LGA (large for gestational age) babies dropped from about 80 percent down to less than 30 percent.

Dr. Taylor-Desir asked Mr. Richmond if he could highlight one or two of the principles of an authentic partnership. Mr. Richmond answered that conflict resolution is important as conflict is part of our lives. So in a partnership, there needs to be a plan to resolve conflict when it does emerge so that it does not result in the dissolution of the partnership itself.

Dr. Anderson said sometimes there can be a program champion at an institution but when the program ends, or the person leaves the institution, the program can die. He asked how that could be addressed.

Mr. Richmond agreed that this is a problem. He said there is an infusion of dollars to respond to the pandemic, but what will happen when these funds dry up? Because partnerships and collaborations oftentimes are brought together around funding, there is currently a need to be thoughtful and plan on how to address this and other issues, such as individuals leaving institutions.

Presentation: Climate Change and Health Equity: Introduction to the New Office of Climate Change and Health Equity (OCCHE)

John Balbus, MD, MPH

Interim Director, OCCHE

Office of the Assistant Secretary for Health

Dr. John Balbus presented on the newly formed Office of Climate Change and Health Equity (OCCHE). OCCHE was created on January 27, 2021, and falls under the direction of the Assistant Secretary for Health. Its mission is to protect the health of people throughout the U.S. in the face of climate change, especially those experiencing a higher share of exposures and impacts.

OCCHE works with various federal agencies and stakeholders—including community-based organizations, nongovernmental organizations, academia, business, industry, and state, tribal, local, and territorial governments—to address the impact of climate change on the health of the American people. It also serves as a department-wide hub for climate change and health policy, programming, and analysis in pursuit of environmental justice and equitable health outcomes.

The Office’s priorities focus on 1) Climate and health resilience for the most vulnerable, 2) Climate actions to reduce health disparities, and 3) Health sector resilience and decarbonization. In the area of resiliency, OCCHE enhances the resilience of health systems and communities to climate change effects and builds on existing networks and will develop a national plan for health adaptation. In the area of decarbonization, it partners with the private health sector to develop an action plan for reductions via incentives, technical assistance, policy guidance, applied research, toolkits, training, and the use of regulatory authorities as needed. In addition, the Office coordinates with federal health system greenhouse gas accounting and reduction targets.

Dr. Balbus proposed some thoughts on a potential partnership with the NHSC. OCCHE might: 1) Support the development and delivery of training on CCHE, 2) Help identify and connect clinicians to resources to address climate resilience and the Social Determinants of Health, and 3) Connect NHSC staff and members to learning networks. In turn, the NHSC might be able to: 1) Help identify “adaptation gaps,” 2) Help connect OCCHE to communities and build health resilience narratives, 3) Conduct pilot interventions and be early testers of tools and supports, and 4) Conduct community-based research, especially implementation research.

Dr. Balbus presented various examples of the public health impacts of climate change. He added that climate change is compounding existing stressors and health disparities. Populations served by the NHSC are among those at greatest risk and the NHSC has a critical role to play in building health resilience to climate change at the community level.

Discussion

Dr. Denise Bockwoldt asked Dr. Balbus what he meant by the term “adaptation gaps.” Dr. Balbus replied that adaptation gaps are systematic gaps that leave individuals less resilient.

Dr. Khozaim said some of the health care environmental instability seems to happen in large facilities, like hospitals that use a lot of energy and sterile, single-use plastic. He asked what can OCCHE or the federal government do to incentivize or penalize health care facilities to improve their environmental sustainability.

Dr. Balbus replied that they are using the rubric of signaling, supports, and standards as a strategy to move the health sector from wasteful practices to sustainable ones. For example, signaling involves putting language into the Medicare-Medicaid rule-making process. OCCHE is also learning from the 19 members of the Health Care Climate Council, some of whom have implemented successful programs.

Dr. Charmaine Chan said some people, such as the victims of Hurricane Katrina, have given up waiting for the government to help them rebuild in a sustainable way and have taken matters into their own hands. She pointed out that some of those areas involve underserved communities. She then asked how OCCHE was partnering with government agencies that are just now getting some infrastructure funding to help with those disaster recoveries.

Dr. Balbus said their first-year focus is mostly internally within HHS in terms of identifying opportunities and resources. OCCHE also has a close collaboration with FEMA, which has significant resources and a new mandate to move beyond just response and recovery to do more about resilience.

Dr. Callins said sometimes when discussing the issue of climate and health equity, the feedback one gets is that it is too late, that we have we done the damage and cannot undo what has been done.

Dr. Balbus said it is important to convey the message about the inevitability of the human spirit to overcome adversity, rather than the inevitability of climate change.

Dr. Callins asked Dr. Balbus if he could provide more information on the report that came out this year on climate change and health. Dr. Balbus replied that the report was released by the Intergovernmental Panel on Climate Change (IPCC) in February 2022. It is titled [Climate Change 2022: Impacts, Adaptation, and Vulnerability](#). He added that the National Academy of Medicine has an [Action Collaborative on Clinician Well-Being and Resilience](#), which could be a good resource for the Council.

Presentation: Women's Health Services Workforce

Anne L. Stahl, PhD

Special Assistant

National Center for Health Workforce Analysis, BHW, HRSA

Dr. Anne Stahl's presentation focused on the capabilities and analyses performed by the National Center for Health Workforce Analysis (NCHWA) in the area of women's health services. NCHWA provides an extensive collection of information resources to the public, including reports, data tools, and health workforce projections. One of those data resources are the Area Health Resources Files (AHRF). Data from AHRF show that the current women's health workforce in the U.S. consists of: family medicine physicians (109,765), general internal medicine physicians (126,942), OB/GYN physicians (42,995), nurse midwives (12,925), and registered nurses in women's health (202,909).

A NCHWA report titled [Projections of Supply and Demand for Women's Health Service Providers: 2018-2030](#), projects that—despite a growth in the supply of other providers—there number of OB/GYNs is expected to decrease from 50,850 to 47,490 (7 percent) by 2030 while demand is projected to increase from 50,850 to 52,660 (4 percent) during that same time period. Other data have shown differences in the distribution of OB/GYNs throughout the country. For instance, in 2019, 10,140,674 women lived in U.S. counties that had no OB/GYN physicians. These projections do not take into account the effects of the COVID-19 pandemic.

On December 2020, HRSA published an article in the *Annals of Internal Medicine* using NCHWA data titled [Regional Variations in Maternal Mortality and Health Workforce Availability in the United States](#). The study found that maternal deaths per population had increased from 2009 to 2017. While no causality could be established, the study found that deaths varied by geographic region. Deaths were significantly higher in the South but lower in the Northeast when compared with the national average. The study also found that the South had the lowest availability in the nation for nearly every health occupation and category studied while the Northeast had the highest.

Discussion

Dr. David Schmitz said one of the things that can be challenged in the data presented is on-call time. Babies can come at any time. Time studies can be challenging because there could be one precipitous delivery that takes two hours while another could be a long labor. He asked if the provision of women's services involved obstetrical time.

Dr. Stahl said she was not sure if it was included in the report but would check. However, they are looking at that factor rather closely because of the high rate of attrition on OB/GYNs.

Dr. Chan said she trains residents in the Northeast in internal medicine. In that specialty, they do not always get enough women's health training. She asked, for the data presented for internal medicine doctors providing both outpatient and inpatient services, how does one break it down to evaluate their participation in women's health.

Dr. Stahl said it is part of the workforce simulation model. The projections only include those professionals in internal medicine who reported being qualified to deliver women's health services. That does not mean, however, they were actually delivering those services. It is also an estimation. The information is included in the report, and Dr. Stahl said she would be happy to share it with Dr. Chan.

Dr. Khozaim said one challenge for training new OB/GYNs is surgical training. There are fewer surgeries being conducted in the U.S. now compared to 30 years ago, so the number of OB/GYN residents trained in full-scope practice of surgery and obstetrics is decreasing. Therefore, it might be unrealistic to expect there will be a full-scope OB/GYN working in some rural communities.

Dr. Callins said that, as a practitioner, sometimes the hard work comes from preventing pre-term deliveries. The idea of cross-training is important because in some underserved communities the emergency room or internal medicine doctors are the only physicians available. Also, working in collaboration with internal medicine doctors in the management of pre-gestational diabetes and cardiovascular and pre-eclamptic disorders that happen in pregnancy is very important. Thus, women's health is much more than just delivering babies. Once the babies are born, there is also the need to keep the mothers healthy. Training is really expansive when one thinks about it from that perspective.

Dr. Stahl said one of the things that needs to be taken into consideration is the morbidity factors of the locale (e.g., obesity, diabetes, hypertension) when considering what kind of training is needed for someone to provide services in that particular locale.

Dr. Chan asked Dr. Stahl if they had done any research on the Accreditation Council on Graduate Medical Education's training programs for obstetrics and gynecology. Dr. Stahl replied they had not but would take back the suggestion to the group.

**Presentation: National Academies of Sciences, Engineering, and Medicine Report:
“Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care”**

Robert Phillips, MD, MSPH

Founding Executive Director

Center for Professionalism and Value in Health Care

American Board of Family Medicine Foundation

Dr. Robert Phillips provided an overview of the report by the National Academies of Sciences, Engineering, and Medicine titled [Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care](#).

The report was an update of the 1996 Institute of Medicine (IOM) report, [Primary Care: America's Health in a New Era](#). Primary care is the only part of the U.S. health care system that results in longer lives and more equity. Studies show that the ratio of every 10 primary care physicians per 100,000 people is associated with a 51.5-day increase in life expectancy. Even though primary care consists of 35 percent of the volume of visits for those seeking medical care, it only incurs 5 percent of the medical expenditures.

The report proposes five objectives for achieving high-quality primary care: 1) Pay for primary care teams to care for people, not doctors to deliver services, 2) Ensure that high-quality primary care is available to every individual and family, in every community, 3) Train primary care teams where people live and work, 4) Design information technology that serves the patient, family, and interprofessional team, and 5) Ensure that high-quality primary care is implemented in the US. Dr. Phillips reviewed the recommendations under each objective.

In November, the Office of the Assistant Secretary for Health (OASH) launched the Initiative to Strengthen Primary Health Care, which aims to develop a federal foundation for high-quality primary care for all, improve access/outcomes, and advance health equity. It is currently in the phase of landscape analysis and meeting with HHS partners, as well as external stakeholders, to determine priorities. It is expected that in June the initiative will propose an entity at the federal level for coordinating policy and strategy for primary care across HHS.

A scorecard for the health of U.S. primary care will be developed through a collaboration among the Milbank Memorial Fund, The Physicians Foundation, and the Robert Graham Center. The collaboration

is exploring the use existing data to produce important metrics, such as the percentage of adults and children without a usual source of care, the number of primary care physicians per 100,000 people in medically underserved areas, and equity of access to primary care. The group is expected to publish the first report and data visualization in January 2023.

Discussion

Dr. Callins asked how the NACNHSC could become a primary care champion. Dr. Phillips said the Assistant Secretary for Health has a leadership team that pulls individuals from several agencies within HHS and also has a broader authority to work across HHS to strategize how primary care could be an important part of the solution. The NACNHSC could be an external stakeholder that helps them with prioritization as well as an advocate for the initiative.

Dr. Chan asked what Dr. Phillips meant when he referred to public service loan forgiveness. Dr. Phillips explained it is a program not only available to health care professionals but also to people who become teachers, fire fighters, police officers, etc. It is a federal program where if individuals enter a public service job and they pay their loans off for the first 10 years, any loans they have beyond that are forgiven. It is an inducement for people to take careers in the public sector and stick with them long term.

Dr. Garbely-Kerkovich asked about the impact of value-based reimbursement and whether patient outcomes would improve using that methodology.

Dr. Phillips said when using that model, it becomes important what one is basing the value on. High-value functions of primary care need to be included in measurements. What is being measured and paid for drives behavior, so it is important to make sure that we are driving behavior to things that really matter.

Dr. Tara Brandner said that most rural health care facilities, especially in the Dakotas, are functioning off nurse practitioners with a physician visiting once a month. This makes collaboration with specialists is very important. Dr. Phillips agreed.

Dr. Elias Villarreal said it is important to advocate for hiring more physician assistants (PAs), especially in states where nurse practitioners can practice independently. There are various barriers for PAs to be able work in rural settings, especially in community health centers and Federally Qualified Health Centers

(FQHCs), because they tend not to want to hire PAs in preference for nurse practitioners who can work independently.

Dr. Phillips said that, across the board, the workforce (physicians, nurse practitioners, and PAs) is eroding. There is a need for nurse practitioners, PAs, and physicians in primary care, and there is a need for them working together to provide a broader scope of care than any one of them can provide independently. Teams need to be robust and should take advantage of what every health professional can bring to the table.

Dr. Callins said she spends about 40 percent of her time practicing medicine and the other 60 percent doing social work and home visits, which include a variety of things to help support care and overcome social determinants of health. She commented that peer coordination and patients being in a medical home is important, but the sites have to be prepared to support and sustain those efforts. She asked how can one perform HIPSA interventions to make sure that rural health clinics are ready for that.

Dr. Phillips said their data showed that FQHCs are more likely to have the components of a patient-centered medical home than academic health centers or even community-based sites.

Dr. Anderson asked what message could be created to recruit more students from all areas of medicine, rather than focusing on students who might already have additional challenges, such as being the first in the family to graduate, having high debt, etc.

Dr. Phillips said the focus should be in increasing the pipeline because studies show that students go back to their communities. In other words, they often have a personal mission to serve those communities in need. But it should not be the exclusive expectation. It would not be helpful to have an expectation of bringing in more people from those communities with the expectation that they will practice there. We have to make it hospitable and possible for them to make that choice, if it is their current mission.

Dr. Villarreal said Arizona has a good model for encouraging mental health care professionals to practice in underserved communities, which is part of the regular Area Health Education Centers (AHEC) umbrella. They have a special section and availability of money for training programs to send students off with more funding, more housing, more travel, and more stipends to do work in the field. The program he just left had 27 students sign up—out of a total of 50—to do rural care as well as underserved care in the inner city areas.

Public Comment

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

Discussion and Recap

Keisha Callins MD, MPH

Dr. Callins thanked Council members for their time, especially given their busy practices and other commitments. She also thanked HRSA staff for their support.

She encouraged Council members to explore the resources available at the American Medical Association's [Center for Health Equity](#). Lastly, Council members went around the room and shared their main takeaways before the meeting adjourned.

DAY 2

Welcome and Roll Call

Ms. Fabiyi-King convened the meeting and conducted roll call.

Charge of the Day

Keisha Callins MD, MPH

Chair, NACNHSC

Dr. Callins kicked off the meeting by wishing all doctors a happy Doctor's Day. She then informed the Council that the presentations would be compiled into one PDF and shared after the meeting.

HRSA Minority-Serving Institutions & Asian Americans, Native Hawaiians, and Pacific Islanders Engagement Framework

CAPT Elijah K. Martin, Jr., EdD, MPH

Senior Public Health Advisor

Office of Health Equity, HRSA

Dr. Elijah Martin provided an overview of the HRSA Office of Health Equity Minority and the 2021-2024 Engagement Framework for Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPI). The Office of Health Equity (OHE) was established in 1981 and works to reduce health inequities so that communities and individuals can achieve their highest level of health.

The OHE has four essential functions: 1) Be the principal advisor regarding health disparities, health equity, and minority and priority population health, 2) Provide technical assistance to HRSA bureaus and offices as well as external stakeholders on matters impacting health equity, 3) Increase the visibility of data and policies that may impact health equity, and 4) Develop partnerships with other government agencies and external stakeholders to increase the visibility of health disparities and health equity issues.

The Engagement Framework is designed to ensure that efforts are aligned across HRSA and external partners to support the PARTNERS Act and the Executive Orders signed by President Biden related to AANHPIs and Minority Serving Institutions (MSI). One of the expected outcomes of the Engagement Framework is to provide leadership and critical support to successfully implement the requirements of the Executive Orders and enhance the longstanding AANHPI and MSI relationships with HRSA through

partnership, targeted marketing, and technical assistance. The framework also aims to support the development of increased HRSA funding to AANHPIs and MSIs.

Discussion

Dr. Sein asked if the Executive Orders change with each administration. Dr. Martin said that, depending on the administration, they may change slightly, although they mostly have the same focus, which is challenging agencies to carve out resources to target opportunities for them to build capacity or increase the workforce.

Dr. Villareal said it would be helpful if HRSA made Notice of Funding Opportunities (NOFOs) easier to read. Larger institutions have grant writers that can produce wonderful proposals, but other institutions may not be able to hire grant writers.

Dr. Martin said that the new HRSA administrator is leading the charge to address this issue. The administrator wants to know how barriers can be eliminated to provide more opportunities for smaller schools and make it easier to reply to NOFOs.

Dr. Callins suggested that they consider reaching out to the National Association of Advisors for the Health Professions (NAAHP). Dr. Martin said he would follow-up on the matter.

Dr. Villareal said pipeline programs, such as the Health Careers Opportunity Program (HCOP), are important to attract students to practice in underserved areas. Dr. Martin said he would make a note to meet with the HRSA staff that manages that program.

Dr. Schmitz suggested that Dr. Martin review an article published on November 2020 in the *Journal of Health Care for the Poor and Underserved* titled [Challenges and Best Practices for Implementing Rurally Targeted Admissions in U.S. Medical Schools](#). He also suggested looking into the [Indians Into Medicine \(INMED\)](#) program at the University of North Dakota.

Dr. Callins said the NHSC is working on a pipeline program, and perhaps Dr. Martin's office can connect with Ms. Fabiyi-King to learn about a possible collaboration. There is also a campaign that will take place for the NHSC's 50th Anniversary. Dr. Callins suggested that there could be an opportunity to communicate messages through the campaign. She also suggested reaching out to AHEC to connect with scholars who may be starting their residency.

Presentation: NHSC History

Michael Berry

Senior Advisor

Division of Policy and Shortage Designation, BHW, HRSA

Mr. Michael Berry provided a historical review of the NHSC program since its inception. The 1970 Emergency Health Personnel Act authorized the placement of U.S. Public Health Services officers in areas with critical medical health workforce shortages. An amendment to the act in 1972 established the NHSC and the Scholarship program. The amendment provided the NHSC with its first appropriation, and by the end of the year there were nearly 200 personnel taking care of underserved populations. The 1976 Health Professional Educational Assistance Act required the National Health Service Corps to work in HPSAs.

The NHSC Loan Repayment program was authorized through a 1987 Public Health Service Act amendment. Initially, the focus of the NHSC was on medicine, dentistry, and nursing practitioners, but in 1995 the first mental health and behavioral health loan repayment awards were made. A provision in the law allowed the Secretary to add other specialties if a need was determined.

In 2001, the Economic Growth and Tax Relief Reconciliation Act made the NHSC scholarship program tax exempt. Prior to this time, the award was taxable, which was seen as a disincentive. The law allowed tuition and the other reasonable costs of attending school to be considered as tax exempt. The scholarship program's stipend, however, remains taxable. That same year, the NHSC was declared a presidential initiative by President Bush.

The 2002 Health Care Safety Net amendments required MDs and DOs to complete a primary care residency before going into service. Prior to this time, only a one-year rotating internship was required to work as a general practitioner. The amendments also mandated the creation of a demonstration project to place chiropractors and pharmacists in Health Centers and evaluate them over several years to determine their usefulness. The Students to Service loan repayment program was created in 2012. It was originally set up to make an award of up to \$20,000 to medical students in their fourth year of medical school to choose a residency in primary care. The money would be paid out over several years and require a three-year service obligation. In 2014, the Bureau of Health Workforce was created and the above referenced programs were moved to be under its umbrella where they have been since that time.

Discussion

Dr. Garbely-Kerkovich asked if there is a finite number of loan repayments or scholarships that can be distributed. She asked if they are broken down by discipline or HPSA or is it first come, first served.

Mr. Berry said the NHSC requirement is that the clinician must serve in the HPSA of greatest need. So in terms of loan repayment, applications are processed and qualified clinicians are ranked by the HPSA score of the facility where they will practice. The program then makes awards from the top highest score downward until they either run out of clinicians or out of money.

Dr. Khozaim asked Mr. Berry if he could provide any insight into how the penalty for non-fulfillers was proposed, how the amount was determined, and whether it has changed in the past or will change in the future.

Mr. Berry said in the beginning awards were given out annually and participants came back for another year's worth of scholarship. If they failed to finish school or failed to serve, the penalty at that time was to repay the amount of funds that were expended to support the scholarship. At the time, the default rate for those who were not serving was close to 40 percent. When those rates came out, there was a change in the law, and the scholarship penalty was raised to triple damages (three times the amount of funding that was given to support the scholarship plus an interest rate). The default rate after this change dropped precipitously. The 2002 reauthorization determined that the penalties were disproportionate. They were changed to the amount of funds awarded, plus the interest rate, plus \$7,500 a month for every month of unserved obligation.

Dr. Callins asked Mr. Berry what he would recommend highlighting in the 50th anniversary paper.

Mr. Berry said that the default rate for the programs as a whole is small. This means that either the applicants are highly motivated to work in underserved areas or the program is doing a good job in deciding who gets an award and who does not. The reason the NHSC was set up was to address the maldistribution of clinicians. This is why the NHSC and the designation of HPSAs were created. In the short term (within two years of completing the obligated service) 80 percent of NHSC clinicians are still working in an underserved area. In the long term (up to 15 years after completion of the obligation), studies show that roughly half of the NHSC clinicians are still serving the underserved. That is the success story of the NHSC.

50th Anniversary Paper

NACNHSC Members

The Council had a robust discussion on the paper. A few working titles were suggested. The one preferred was *Celebrating the Living Legacy of the NHSC*. Other titles discussed included *Celebrating Commitment, Compassion, and Community* and *Our Past, Our Present, Our Future*.

Ms. Fabiyi-King informed the group that the primary audience would be the Secretary. Secondary audiences would include certain HRSA divisions and the public. In terms of a timeline, Ms. Fabiyi-King said it would be at the pleasure of the Council. However, she said some NHSC celebratory activities will take place in August and there will be some time needed to go through the clearance process. The Council discussed whether the paper should be celebratory in nature or policy-based. The general consensus was that a celebratory (or impact) paper would make it more lasting into the future.

Two models were proposed for the structure of the paper. The first would be to cover changes over time in six areas: 1) Policy, 2) Program expansion, 3) Providers, 4) Patients, 5) Places, and 6) Projections. It would also cover three cross-cutting areas: diversity, equity, and inclusion.

The second model is to develop a brief impact paper that focuses on three areas: 1) Accomplishments (e.g., recruitment/retention); 2) Adaptations (e.g. substance abuse/critical access/professional fields), and 3) Aspirations (readiness/responsiveness).

Dr. Callins informed the Council that the other two papers have been completed and are undergoing clearance.

Public Comment

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

Discussion, Closing Remarks, and Next Steps

NACNHSC Members

The next meeting will be held on June 28-29, 2022, and will be a virtual meeting. Council members were asked to forward any suggestions for topics and speakers for future meetings. Some of the topics offered included: substance abuse, opioid response (from a health equity perspective), innovations in continuing medical education for trainees, the role of medical schools in recruitment (e.g., the revamping of the

Mercer School of Medicine process to accommodate a rural component), data on scholars and awardees (who they are, where they practice, what they practice, etc.), and a demonstration of HRSA's dashboard.

Adjourn

Dr. Callins adjourned the meeting.