National Advisory Council on the National Health Service Corps

Teleconference – April 2–3, 2019

Health Resources and Services Administration

5600 Fishers Lane, Rockville, Maryland

Tuesday April 2 **9:00 a.m.**

Council Members

Dr. Adrian N. Billings, MD, Ph.D., FAAFP

Ms. Joni Adamson

Dr. Joan Malcom, DMD

Dr. Darryl S. Salvador, PsyD

Ms. Cindy J. Stergar

Ms. Gwen L.R. Witzel, APRN, FNP, FAANP

Federal Staff

Mr. Israil Ali, Director, Division of the National Health Service Corps

Ms. Diane Fabiyi, Designated Federal Official

Ms. Robin Alexander

Mr. Michael Arsenault

Ms. Monica-Tia Bullock

Mr. Michael Dembik

Ms. Kim Huffman

Mr. Jeff Jordan

Dr. Tory Mack, MD

Ms. Janet Robinson

Ms. Keisha Robinson

Ms. Melissa Smith

Contractor – Technical Writer

Mr. Len Rickman

Convening the Meeting – Diane Fabiyi-King, Designated Federal Official; Chief, Scholarship Program and Students to Service, Division of the National Health Service Corps

Ms. Fabiyi-King welcomed everyone, and called roll of Council members

Welcome and Introductions – Dr. Adrian Billings, MD, Ph.D., FAAFP, Chair, National Advisory Council on the NHSC

Dr. Billings thanked everyone for attending, welcomed everyone back, reviewed the agenda, and noted it has been a while since the last meeting. He also thanked federal support staff. **Dr. Billings** asked everyone to introduce themselves.

Dr. Adrian Billings is Chief Medical Officer with a federally-qualified health center in Texas along the Texas-Mexico border, and an associate professor at Texas Tech University Health Sciences Center. He currently helps direct rural medical education efforts, and is proud to have served in NHSC.

Ms. Joni Ms. Adamson is with the Missouri Primary Care Association (PCA).

Dr. Joan Dr. Malcom is a family cosmetic dentist in New Jersey in practice for 25 years and had quite a varied experience working in federally-qualified health centers and then eventually opening her own private practice.

Dr. Darryl Dr. Salvador currently is working with behavioral health and psychology at a U.S. Army Health Clinic in Hawaii, and once a week works in an FQHC. He also conducts a monthly all-islands visit, and does telehealth. He is a former NHSC loan repayor.

Ms. Cindy Ms. Stergar is the Chief Executive Officer at the Butte Community Health Center in Butte Montana.

Ms. Gwen Witzel is a nurse practitioner in rural North Dakota. She has practiced in different critical access hospitals and rural health clinics, and done local work with the Indian Health Service in South Dakota and worked in an emergency room in Texas.

Dr. Billings asked federal staff to introduce themselves.

Ms. Fabiyi-King is the Designated Federal Official for the National Advisory Council, and Branch Chief for the NHSC scholarship program (SP) and the Students to Service (S2S) Program. She is delighted to have

the Council together, though it is unfortunate that it could not be in person. A lot is happening in the Scholarship Program and in S2S, and the latter just closed officially and staff is sending confirmation of interest letters. To date approximately 150 have accepted the confirmation of interest. The next phase is to send awards that will total approximately 20,000 people and $20 million, but exact numbers will be available soon. Many dentists applied this year and it is good to see the S2S program has engaged them enough to be almost more than half the participants. It is NHSC's hybrid program that joins students in their last year of school with the loan repayment program, and it is good that a class is in service. While it seemed like a longer time before they went into service, it was only about five years and they are doing well, and staff is very happy about that expansion.

Dr. Billings noted his practice has a S2S participant, and another one is set to join the staff soon.

Ms. Kim Huffman is the Director of the Advisory Council Operations Team responsible for coordinating all five of the Bureau of Health Workforce (BHW) advisory committees. **Ms. Melissa Smith** is a Management Analyst in BHW's Division of External Affairs, and provides technical support at Council meetings. **Ms. Robin Alexander** is NHSC's liaison to the Council. **Ms. Janet Robinson** is also a liaison for the Council, and three other advisory councils. **Ms. Monica-Tia Bullock** is the SP and S2S Team Lead, and also works closely with Ms. Fabiyi-King on the Council's activities. **Ms. Keisha Robinson** is new to NHSC, and works in the Office of the Director.

Ms. Fabiyi-King noted the Scholarship Branch had an opening for a supervisory management team lead because Melissa Lewis became NHSC Loan Repayment Program Branch Chief. Ms. Bullock was hired to replace Ms. Lewis, after working for several years in other NHSC capacities. She is now the Scholarship Branch Team Lead Manager and has taken-on many more responsibilities, supervising directly up to seven people and will transition to a new role for the Council. Also, it is good to have Ms. Robinson on board. She brings a lot of experience and skills, and will transition into Ms. Bullock's former role.

Opening Remarks and Accept Minutes from September 2018 Meeting – Dr. Adrian **Dr. Billings**

Dr. Billings reviewed the meeting agenda. The meeting's main purpose will be to produce a draft letter to the HHS Secretary about what the Council thinks NHSC should engage over the next few years. **Dr. Billings** asked the Council to consider accepting or amending the September 2018 meeting minutes. **Ms. Stergar** moved to adopt the minutes as presented, **Dr. Salvador** seconded. No discussion occurred, and the Council unanimously approved the minutes as written.

Dr. Billings expressed appreciation for members to take time from their work to participate in the meeting, and the federal staff for supporting the NHSC and the 10,000+ field strength. NHSC cares for patients whose lives would be more difficult without it, and is important to the health of the nation.

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

Mr. Ali thanked the Council for allowing him to share NHSC updates. Staff continues to emphasize the priorities presented earlier to the Council. Good things are on the horizon for NHSC, and recently Dr.

Michelle Yeboah started as Deputy Director. She will be a resource for both the Division and the Council, including to answer questions about the program. NHSC will continue to comply with Congressional intent, as well as HHS and HRSA priorities and the BHW mission.

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

Program Priorities. The key is for NHSC to broaden its impact in underserved communities and be a catalyst to actual transformative care.

Opioid Investments. The program closed February 28. It was well received, and the Corps anticipates placing 1,000 clinicians who will provide evidence-based treatment in rural communities. It is good that rural communities will be a high priority.

FY19 Rural Community Loan Repayment Program. Staff is working closely with the Office of Rural Health Policy to ensure the workforce is substantiated in actual rural communities, and that a large number of providers support NHSC.

Telehealth: Improving Access. The Corps lifted the limit of 25% of a provider's time spent on telehealth, and is monitoring data to leverage how applicants and providers are practicing telehealth within their communities. The Corps considers both applicants and awardees as great sources of insights in how telehealth is practiced in urban and rural communities, and that will continue to inform plans for program improvements. The Corps will push for even more dedication to telehealth in FY '20. Staff has been discussing it with various stakeholders, including much discussion around Project Echo and similar models, and on issues such as tele-mentoring. All efforts will remain within Congressional intent and the Corps' legislation. Staff plans to present more information to the Council by the end of this fiscal year.

Value-Based NHSC Clinicians. The Corps is looking at Title VII programs to help identify the best clinicians, and persona, for the program to provide transformative care in underserved communities. A key goal is as the program expands it should become even more responsive to emerging health trends while continuing to place the right people in underserved communities. Staff is looking to update the formula for assessing applicants and program priorities. In addition to cultivating primary care champions, the Corps also is prioritizing growth in its substance use disorder (SUD) workforce. Another value-based change is the loan repayment program (LRP) award enhancement that offers an additional $5,000 for a one-year continuation for those with a data waiver who are providing medication assisted treatment (MAT). This clearly will substantiate the Corps' SUD response by ensuring that not only is the Corps making new awards to those providers but also looking back to the existing field strength to ensure covering SUD per a holistic approach to the entire program.

FY19 Scholarship Application. The impending opening of the cycle is exciting. This will be another opportunity to see the potential pipeline of health professionals, and think about how to influence their direction into primary care. The Corps has highlighted the opportunity for scholars to take the path into addiction medicine publishing, and this cycle will bolster the opportunity to build the SUD workforce in underserved areas.

<u>Discussion</u>

Dr. Billings thanked Mr. Ali for providing more clarity on value-based clinicians, including who they are and how they advocate for their communities. **Ms. Stergar** asked about the qualifications for the $5,000 LRP extension. **Mr. Ali** replied the extra loan repayment enhancement award is exclusive to those currently in the program, including providers eligible for a data waiver and who practice MAT. They can receive the extra award boost when they come-in for the one-year continuation. The Corps believes this is a deliberate way to influence the field strength to go back and receive additional education that will help better support communities.

Ms. Stergar asked whether NHSC scholars and loan repayors finished with their obligation but still at their sites and are practicing MAT will qualify for the extension since they are not in a continuation. **Mr. Ali** replied the extension is available only to those currently in the program. It must be capped if they have outstanding loans, but people can re-apply for a new award.

Dr. Billings asked about standardizing the process for resident and advanced practice clinicians to become MAT eligible before going into the field, and about people in the field getting a waiver. He also asked whether NHSC has a role in recommending training programs. **Mr. Ali** replied the Corps is working within BHW on how to bolster some residency programs to be more geared towards the continued learning that will impact communities, whether that is MAT or anything else that is emerging to make sure that they are prepared. The Corps is partnering with the Substance Abuse and Mental Health Services Administration (SAMHSA) to support and leverage training in this area under a cooperative agreement. This will help boost the SUD workforce, including through mentoring. Another aspect is to help dispel the stigma of SUD treatment and care through additional training and mentoring.

Dr. Malcom asked whether there is a breakdown of scholarship participants by professional discipline. **Mr. Ali** replied the application cycle will open soon, and those data will be available after it closes. **Dr. Salvador** asked for clarification on how a site becomes an NHSC-approved SUD facility. **Mr. Ali** replied there is a discipline criteria, but also a methodology for determining which sites are providing SUD treatment. New sites opening this year can apply, and those already in the repository of sites can do the opt-in process where they must show that they are providing this type of treatment by either demonstrating that they have providers in their facility who are practicing MAT or they have to provide some other general SUD treatment, including counseling.

Mr. Jeff Jordan (from BHW) noted staff releases a site reference each year, and is getting ready to put-out another one. The existing reference, with the criteria, is on the website. In general, staff looked at opioid treatment programs called OBOTs or Office-Based Opioid Treatment facilities, and general SUD treatment facilities. Each classification has different criteria, and it essentially was the behavioral health checklist, though also with other requirements, including for some, the NHSC site application process. It was a two-pronged process, starting with noting the NHSC sites providing treatment for SUD or opioids that used the opt-in process. It was similar to identifying existing NHSC-approved sites providing these services. In last year's application cycle the vast majority that came in had opted-in but some had not yet elected to provide SUD services. A smaller number, 400-500, came in as new sites. Overall, the site reference guide has a good listing of the requirements.

Ms. Fabiyi-King noted the link to the site reference guide was posted on the meeting screen.

{Break}

Bureau of Health Workforce Updates – Dr. Torey Mack, MD, Deputy Associate Administrator, BHW

Dr. Mack joined BHW in January. She is a pediatrician by training, and specialized in neonatology. She did a residency in Washington DC and fellowship in Houston Texas. She welcomed the Council, and acknowledged its hard work and dedication to advising HRSA and BHW on programs and policies. She also thanked BHW staff for making sure this meeting will enable coordination and interaction.

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

Bureau of Health Workforce Vision and Mission.

BHW FY2020 Priorities. BHW values include collaboration, innovation, and results-driven actions. The priority to transform the healthcare workforce will be met by creating training opportunities, and sustaining support for clinicians who receive BHW training, so the focus is on having some of that training in high-need communities. Research demonstrates that medical providers who train in those high-need areas are much more likely to stay and work in those same communities after they complete training, so grant programs specifically through the Division of Medicine and Dentistry give opportunities for clinicians to work and gain experience in those areas.

Improving Care in Underserved Communities. Teaching health centers are an example of how to operationalize this, and they are providing graduate medical education in 24 states. They expand the primary care residency training in community-based settings in underserved communities. Currently, among the 57 teaching health center sites 36 are based in an FQHC or a lookalike. In 2017 and 2018 the Bureau supported 847 residents, including 503 family medicine physicians, 206 future internal medicine physicians, and 54 psychiatrists.

Increasing Access to Behavioral Health Services.

National Health Service Corps Substance Use Disorder Investments. The $45 million is for an exciting partnership with the Office of Rural Health Policy to collaborate across systems and across agencies and offices to impact healthcare.

NHSC Substance Use Disorder Workforce Loan Repayment Program. The goal was to award around 1,000 recipients this go-around, and more than 1,500 applications were received.

Leveraging Health Workforce Data. This process includes a lot of innovation, and projection models and review of how the program is doing. Through the National Center for Health Workforce Analysis the Bureau can track national trends and examine specific issues that help develop responsive programs and helpful workforce policies. An example is being able to share data externally to facilitate data collection and sharing, hopefully by this coming summer. The National Practitioner Data Bank includes a wide array of healthcare practitioners as well as providers and suppliers, and this comes into play when providers move from state to state.

Emphasizing BHW's Core Values. These values guide BHW's approach to the program and funding opportunities to create a robust workforce to meet demand with supply.

For Awareness: Advisory Councils. The Advisory Committee on Interdisciplinary Community-Based Linkages looks at the area health education centers, geriatrics, allied health, chiropractic, podiatric, and social work as well as psychology. The Advisory Committee on Training and Primary Care Medicine and Dentistry looks at BHW's family medicine, general internal medicine, pediatrics, dentistry, and all of those primary care questions including dentistry and the physician assistant program. The Council on Graduate Medical Education provides an ongoing assessment of Division workforce trends, looking specifically at training issues and financial policies, who is being recommended, and whether the appropriate federal and private-sector efforts really impact those issues. The National Advisory Council on Nurse Education and Practice looks at Title VIII programs administered by BHW that include the nursing workforce supply, and education and practice improvements.

Discussion

Dr. Billings asked about collaborations with academic medical schools. His practice has hosted many medical students and residents, and there have been many benefits to patients and the practice, including the return of five former trainees after completion of family medicine residencies to work with the practice for at least one year and some up to five years. His practice is beginning to host master's degree students in social work, as a way to recruit one or more to return and practice after training. The teaching health center program is a great example of how HRSA has been able to tie together NHSC and academic health centers. He asked whether there are ways outside of the teaching health center programs to enable and encourage NHSC sites to consider opening to trainee students such as medical students, advanced practice clinicians students, or behavioral health students.

Dr. Mack replied BHW and the Bureau of Primary Care in HRSA are working together on how to leverage opportunities in FQHCs specifically around training, and use BHW's efforts to respond to emerging health needs by fostering that collaboration. The idea is to ensure clinicians in training and already in practice receive the appropriate training, especially for opioids and SUD treatment. **Mr. Ali** added the NHSC perspective is to guide its scholars to do more community based-training in FQHCs, including through its postgraduate bulletin and throughout the program's APG. That is part of the effort toward value-based clinicians. A goal is to align expectations with some of the trainings across programs. **Dr. Billings** agreed that is a goal for the future.

Ms. Stergar asked how the Bureau is avoiding duplicate training, including for MAT since some state primary care associations (PCA) and national organizations also are providing it. **Dr. Mack** replied that is a challenge, especially to both ensure being responsive to emerging needs but also knowing other opportunities exist to receive training and waivers. A key is to measure efforts in the Bureau's programs by capturing information from participants and grantees on the front end so the data can help determine what to provide and how to be responsive. **Ms. Stergar** asked if BHW is working with PCAs across states, and whether PCAs know what is being provided, especially in rural states. **Mr. Ali** replied the Bureau of Primary Health Care has a major connection to PCAs, and that bureau carries the message and helps leverage the program.

Dr. Billings asked about efforts to increase the impact of the teaching health center program by increasing the number of sites or increasing the capacity of existing ones. **Dr. Mack** replied BHW always is interested in expansion. It has great metrics from graduate medical education programs, but must comply with the budget while looking at how to expand. It is considering expansion of existing sites, including those that could house teaching health centers. It also is considering how to bring in other sites that are doing good work. Feedback from external partners is appreciated.

Mr. Ali noted the Health Workforce Connector used by NHSC-approved sites to offer additional training and placement to scholars. It is a platform that BHW supports to allow individuals to connect to community-based training. **Dr. Billings** wants to talk to students about medical equity and career paths such as NHSC or the Indian Health Service. He will explore the possibility of including teaching health centers in medical school curricula and discuss opportunities in residency programs at these sites. **Dr. Mack** noted the importance of considering program recruitment strategies, including by reviewing data for where people are coming from, and working with the Division of External Affairs on outreach and targeting. The Clinician tracker and Workforce Connector are innovative ways to connect trainees with opportunities, and seeing where people go after receiving the information helps BHW assess program impact during and after training.

Dr. Billings asked whether BHW is sending information to scholar students while they are in training to steer them toward teaching health center programs as a way to demonstrate the value of serving in underserved communities. **Mr. Ali** replied that will be looked at for the next cohort. **Mr. Jordan** said that is an excellent suggestion, but one challenge is the HPSA threshold keeps increasing. **Dr. Billings** added it would be a great recruitment tool, and **Dr. Mack** agreed.

Ms. Stergar said it would be good if 90% of LRP and SP placements went to community health centers (CHC). A lot of national resources are spent in them, and they are given many expectations, but more workforce development and support is needed. At least 50% go to CHCs, and it is in part a political issue. If CHCs are the primary care system then they need to be loaded with workforce, and at least 75% of NHSC participants should go to a CHC, though 90% would be better. **Dr. Billings** concurred.

Dr. Billings said questions remain about how to further include telehealth, and the definition of value-based clinicians. **Mr. Ali** noted many discussions are underway with telehealth resource centers at HRSA and with other stakeholders who believe that Project ECHO has been a great source of both primary care and continued education for many of primary care providers, particularly in rural settings. A key question is how that will fit with the NHSC model, and that is something that the Corps is continuously shaping, and is looking at how that can be implemented in the years to come. As for value based, that is really the crux of where the Corps is trying to go. The Corps has put many clinicians in the field over the years but as the need grows for a more responsive workforce the Corps needs to see how it can make sure awardees are properly trained to be impactful and transformative in communities. Even when there is not an emerging health need in a particular community, a key question is how to start to shape health outcomes within that population. A key goal is to make sure that comes to fruition in the Division.

Ms. Adamson noted a key concern with Project Echo, telehealth, and similar models to increase the Corps' success is looking at how sites report six-month verification for in-service. Some struggle with

how to answer those questions, and it impacts recruiting and retention. It will be good to pay attention to national employment trends, especially with some female providers in relation to what they want to do in a week. Some sites are getting hung up on number of days on and off, and some allow three and one-half days or call 36 hours full-time. It might be good to consider a model with hours per year versus reporting every single day off because tracking hours can be hard for some types of sites or providers, and that makes them nervous. They answer to the best of their ability, and do things right and remain in compliance, but it makes them nervous because of how the provider works. Sites fear a Corps audit will find something wrong, and they need help to properly track provider hours. However, things like telehealth and Project ECHO are direct patient care but not in-person. Creating extra burdens on sites detracts from NHSC's intent. It is important to consider meeting needs, complying with the obligation, and work-life balance as factors in retention.

Dr. Billings added it also is important to consider what a patient visit will look like in the future, including how much of it will be virtual versus face to face. **Ms. Adamson** said much of it is black and white in terms of compliance, and there is not enough flexibility. **Ms. Stergar** agreed that those recommendations are important.

{Break}

BHW NHSC Clinician Tracker – Mr. Michael Dembik, BHW

Mr. Dembik noted the Clinician Tracker is part of the Bureau-wide data management initiative began approximately 18 months ago by Dr. Padilla to unlock the full potential of BHW data assets. It focused on four key principles: ensure transparency and access to data across the Bureau, provide the ability to analyze current data, build understanding of the data through governance, and create a culture of information sharing. As the operator of two high-value systems for HRSA this Division houses significant data on thousands of NHSC clinicians. In order to assess the true value of the programs the goal was to track the supported clinicians after completion of service, and formally identify the future state.

The Division identified crucial existing transactions data in the two major systems, BMISS and SCMS, and is currently working on all NHSC reporting needs and a Clinician Tracker prototype with additional data dashboards. The Division formalized the process so everyone would recognize that this is much more than just a dashboard to show data. Governance was crucial, as was Bureau-wide collaboration. The first goal was to know where clinicians are, what they are doing and when. The Division broke down all the potential data it could pull, and started confirming definitions and making assumptions. They gathered potential questions that could be answered, all focused on whether or not the supported clinicians continue to serve in medically underserved areas.

The Division then began constructing a prototype with a framework for the future and a focus on NHSC data initially, then expansion to the Nurse Corps. Over 10 weekly sessions they developed four major deliverables: the executive dashboard, master dashboard, custom dashboards, and an interactive map. Each dashboard serves a separate and unique purpose, and can be used for different types of analyses or questions. Because the initial prototype was built for expansion it was easy to add Nurse Corps data. The total data set includes 15,000 NHSC clinicians and 2,000 Nurse Corps clinicians who completed service between 2012 and 2017, all matched to the NPI.

The Division also is about to deploy applicant dashboards for awarded and non-awarded clinicians for NHSC and Nurse Corps programs, and ultimately will add additional data to meet the needs of other BHW programs. The initial prototype was geared toward overall retention, that is alumni who work in a HPSA or serve the same community where they completed their service.

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

BHW Data Strategy: Unlocking Potential. This houses data on thousands of NHSC clinicians.

NHSC Clinician Tracking Pilot: Governance. The Division is working on all NHSC data needs, and has formalized the process. That made governance crucial, including to define how the data will be used.

NHSC Clinician Tracking Analysis. Retention was the overall goal.

NHSC Clinician Tracker Demo. Executive-*level dashboard, managers' dashboard, custom dashboard: retention rate overall, field strength per state, retention by state; included map-based data and trends.* The goal is to export data and download pictures to tell the story of BHW and its programs.

Discussion

Dr. Billings complimented the amazing work. **Dr. Malcom** asked if Council members can access the retention data. **Mr. Dembik** replied it currently is only internal but will be available externally in the future. There will be working groups and all are invited to participate.

{Per Council members' requests Mr. Dembik showed data for Montana, New Jersey, Pennsylvania, and North Dakota.}

Ms. Witzel said they are great data and she will look forward to seeing the information when it is available. **Ms. Stergar** agreed it is wonderful data, and would like a snapshot of Montana based on all the discussion about auto HPSAs. She asked Mr. Dembik to let the Council know how it can facilitate data distribution and availability. **Dr. Salvador** reiterated that it was great work putting together the data and requested it for Hawaii. He asked if it goes further back than 2012. **Mr. Dembik** replied that is as far back as it can go, but the Division will be able to expand the analysis into timed snapshots and other additional functions. **Ms. Fabiyi-King** will work with Mr. Dembik to get data for each member's state to help them develop their story. **ACTION ITEM.**

Dr. Billings asked whether the data can be broken down by congressional district to demonstrate to representatives and senators the impact of funding. **Mr. Dembik** replied that is a good idea but thus far county is the smallest breakdown, though the Division is developing an interactive map that potentially could include congressional district, and perhaps HPSA boundaries.

Ms. Adamson asked where the data are coming from, beyond just alumni completing surveys. **Mr. Dembik** replied this is the first time using real data, and noted how governance included decisions about how to use actual data for tracking. While current data are accurate, it is missing where clinicians are now, but in conjunction with the NPI there could be matching to show community retention. A key was to use the same definition as the survey to remain consistent. It is looking at NHSC, and includes 15,000

out of 16,000, so that is a really high percentage of all of NHSC alumni. The Division also is analyzing other data sets on clinicians' locations after the service obligation, to ensure even more accurate data and get closer to 100% certain. The current Tracker is fairly accurate, but the Division is constantly working to improve it.

Ms. Stergar said it is nice to see this since it has been wished for. **Dr. Billings** added it would be great if these data could be published to show how NHSC retains providers in communities and is impactful.

Ms. Fabiyi-King introduced Mr. Michael Arsenault, Director of the Division that is creating the Tracker. **Mr. Arsenault** noted how Dr. Padilla has charged the Bureau to share more data and make it more assessable, whether it is grant related or about NHSC and the Nurse Corps. HRSA is focused on creating external data sets, and that will include grant data in the Clinician Tracker. A key goal is to secure help from external stakeholders. Having a lot of data is more useful if it can be used externally, and HRSA needs to see external players' data needs. That means the workgroups being assembled for this will include external stakeholders who will help show what the country needs. This means going beyond data for individual states and instead considering what colleagues across the country need. Invitations to participate or recommend others will be sent soon. Weekly workgroup meetings will guide development of the Tracker.

Ms. Fabiyi-King noted this is a key component for this meeting's discussions. **Mr. Arsenault** added external stakeholders were key to moving this forward. **Mr. Dembik** noted plans to deploy applicant dashboards to show retention-related behavior among NHSC applicants that were awarded versus people in the same disciplines in the same areas that were not awarded. Showing that gap in retention could help demonstrate the program's importance.

Dr. Billings asked if there is a way to track why, or how many, NHSC alumni leave HPSAs and go to into programs that are training the next generation of providers for underserved communities. **Ms. Fabiyi-King** replied those data might not be available, but would be valuable to further demonstrate the value of NSHC. That could be a part of the recommendations for the Council's letter to the HHS Secretary.

Review of Council Priorities – Dr. Billings

Dr. Billings shared a project he has been working on. He returned to school after 17 years since being a student, and he missed being a student and being mentored. He was accepted into a fellowship at George Washington University but still is practicing in Texas. It is an international and cross-disciplinary program with individual projects. It includes work on the primary care workforce pipeline similar to how the Council has approached that issue, and also is similar to the former NHSC Ambassador Program.

Mentorship is important for both recruitment and retention. His project focuses on developing a PowerPoint presentation about care for the underserved, especially for family physicians and medical students. Thus far it is only used in Texas, but hopefully it will be successful and can be replicated nationally and into other disciplines and programs.

Among the majority of medical students Dr. Billings has hosted over 10 years few can say who an underserved patient is, and fewer can say where they receive care even though they work at a CHC. The presentation shows who the patients are, who cares for them, and how training can encourage people

toward careers in underserved medicine via NHSC and other programs. Data show medical students' debt burden for medical school is approximately $200,000 to $300,000, and it is much harder to repay loans on a primary care salary versus other specialties that pay two to three times more.

Hopefully the presentation can be part of medical school curricula, and Dr. Billings has done presentations at schools in Texas. He has no desire to copyright the presentation and wants it to be used far and wide. He also wants to replicate the NHSC Ambassador Program, but not just for NHSC. It will be good to identify family physician faculty champions to serve as mentors for students and answer questions about underserved medicine. It also will be good to tie in the underserved medicine group with mentors. He is presenting these ideas this coming Saturday at the Commission on Academic Affairs at the Texas Academy of Family Physicians. He wants to see the program replicated, versus leaving it to chance that students will meet each other, and encourage colleagues and friends toward underserved medicine.

Ms. Fabiyi-King noted this is a concept from Dr. Billings, and the Council can discuss this as a recommendation and as a potentially informative program for NHSC. **Dr. Billings** said he is not suggesting that his presentation become a Council priority, but wanted to share it due to how the idea for it arose during his work with the Council.

Ms. Fabiyi-King reiterated the NHSC priorities outlined by Mr. Ali, and HRSA priorities outlined by Dr. Mack, and reiterated the goal is to have a letter of recommendation to the HHS Secretary. Issues of importance include: data and the Clinician Tracker presented by Mr. Dembik; telehealth and models like Project Echo, a program that includes universities to serve as champions for primary care, though different from the former NHSC Ambassador Program; and value-based clinicians and BHW's ongoing work on that in the sense that it speaks to who the clinicians are, and their mind, body, and purpose within the context of the communities served. At this point the Council's recommendation priorities do not have to be completely vetted and can be as robust as the Council wishes as long as they support the efforts to address current priorities.

Ms. Fabiyi-King added it will be good for the Council to have something by August 1 so that it can be vetted through a series of levels up to the Administrator, and eventually to the HHS Secretary Dr. Azar. By the beginning of the new federal fiscal year on October 1 the recommendation letter will have been approved and moved. During the work, the Council can engage subcommittees, conference calls, research, and other efforts to support the product, but no full Council meeting is planned in that time frame. The next in-person meeting is likely to be in September.

Dr. Billings cautioned about the need to be cognizant of members' professional responsibilities. **Ms. Stergar** said doing some of the work online is good, but the full Council should meet for two hours no later than July to review draft language prior to final decisions. **Dr. Billings** agreed, and suggested meeting during the evening or weekend to avoid interference with work responsibilities.

<u>Discussion on Priorities</u>

Dr. Billings reiterated the potential areas of priority are SUD, telehealth and Project ECHO, value-based clinicians, and the clinician tracker, but input on other priorities is welcome.

Telehealth

Dr. Billings asked what can be expanded in telehealth, whether Project ECHO should be more readily available for sites, and whether sites should be encouraged to allow providers to be more active in it as well as other telehealth programs. **Ms. Stergar** replied Project ECHO is being used in a variety of ways, so perhaps the Council should say it encourages its use for NHSC and all primary care providers, but not be too specific. It can be a training and listening service, versus discussing specific cases, or used more formally for consults. The idea would be for the Council to say it supports education resources such as ECHO but not only ECHO or any specific individual model. **Ms. Fabiyi-King** added it could be a part of clinicians' administrative hours as part of teaching and training, including tele-training.

Dr. Billings asked if a provider is doing telehealth and expanding services to other treatments such as for Hepatitis C would that also be a component of a value-added clinician because they are an innovator and an entrepreneur expanding services and increasing access to care via telehealth. **Ms. Fabiyi-King** said yes, the value-based clinician framework being developed incorporates training and delivery for positive impact on communities, and supporting that would be valuable. There could be a recommendation to continue that, but the Council may want to research what goes into the value-based clinician to see how it coincides with the recommendation about telehealth expansion as components that would support clinician training for growth and impact in the community.

Ms. Witzel asked if restrictions remain on the amount of time an NHSC clinician does telehealth. **Ms. Fabiyi-King** replied it depends on the location, and overall it still is being vetted. In general they are allowed eight hours of administrative time, and the site and the patient have to be connected within a HPSA. The Bureau is becoming more directive about the issue versus it just being accessible or an alternative. **Ms. Fabiyi-King** will ask for more insight from team addressing this. **ACTION ITEM**.

Ms. Fabiyi-King reiterated that recommendations can be high level, and then have their feasibility and likely impact analyzed. The Council's 2016 letter is on the website. It includes research and data that underpinned a robust document.

Dr. Malcom asked about data for how often clinicians use telehealth for a patient consult or working with other providers. **Ms. Fabiyi-King** asked would that be for NHSC, general medicine, or associations that have identified telehealth as a valuable tool. The letter does not have to be tied to current efforts, and instead can be based on research into new areas, activities, etc. **Ms. Fabiyi-King** will ask about current data. **ACTION ITEM**.

Ms. Stergar advised that the letter should be meaningful, and staff input and direction will be important for that. **Ms. Fabiyi-King** agreed and noted staff will support efforts for Council members' interaction, and will do some of the research, but it will be the Council's product. **Ms. Stergar** cautioned that members do not work daily in the Bureau, so will need help to avoid missing key points or other gaps for items or information that can that be presented to the Council as it deliberates the letter. **Ms. Fabiyi-King** agreed and said staff will share its perspective and knowledge.

Value-Based Clinicians

Dr. Billings noted a key goal is to provide transformative healthcare to underserved populations. As part of that, another goal is to establish a workforce linkage to other BHW educational and training programs to get students in training to come out and help care for the underserved and inspire, encourage, and enable them to go into careers in underserved medicine. Another goal is to educate trainees on health equity issues and challenges, as well as educate the workforce on new technologies. Another component is to activate primary care champions, to enable the success of NHSC clinicians at sites to be patient advocates and primary care champions for their communities.

Ms. Stergar noted value-based contracting, grants, etc., is a growing phenomenon, but clarity is needed on what it means, including whether it means dollar for dollar return on investment for program value for staffing across the U.S. and if so, what would that look like. **Ms. Fabiyi-King** added many different terms are used around value-based clinicians, and the definition remains a work in progress. Perhaps a clearer definition can start within NHSC and then grow to all of BHW. Key components are community engagement, practice models, prior training for post graduate work, and longitudinal training that includes telehealth, technology, and medical records. A key goal is to be transformative. Other components to include are possible based on input from Council members. Transformative includes improved patient outcomes, population health, and medical management. Additional research likely exists for Council members to refer to for how to define a value-based clinician.

Dr. Billings noted engagement can mean your own community and public health, but also can be for the clinician to be partners with training institutions to expand services and share the effort. Also, training where they came from needs to be more clearly defined, including geographic- and language-based. Longitudinal learning seems easy, with things like CME and/or hosting of trainees for learning and teaching. It would be good to have public health expertise as part of the clinic's services, including for community outreach.

Ms. Stergar advised that since federal funds are involved the definition of value has to be in the context of the needs of society at the time, including eradicating HIV, addressing childhood obesity and diabetes, and the opioid crisis. Also, it should include the ability to handle emergencies such as natural disasters and community engagement. It will be necessary to demonstrate the value of NHSC funding as aligned with national priorities. Value-based is interpreted to mean ROI on the money invested.

Dr. Malcom added patient compliance with testing, treatments, etc., is a major factor in better outcomes and could be a part of the value-based clinicians concept. **Dr. Billings** cautioned it is not clear how much of that is the role of the clinician, but perhaps the federal government can boost efforts and results in that area. **Ms. Fabiyi-King** added it will be good to have a far and wide perspective. **Dr. Billings** asked whether it would be good to ask administrators to look at UDS data regarding providers and outcomes as part of the value-based discussion.***SUD Enhancement***

Dr. Billings asked whether the recommendation to the Secretary should mention that advanced practice clinicians and physicians should come out of training already with MAT in hand, and what recommendation should be made to the Secretary for current providers who still need MAT training. Perhaps the recommendation should include creating a mentorship program for providers new to the

effort. He also asked whether providers seasoned in this area could be identified and asked to help. **Dr. Salvador** said the letter should include applause for efforts to expand SUD treatment and address the huge need in the communities as far as the opioid crisis. The Council should encourage clinicians who have the training, and should encourage others toward the effort as well. Perhaps the Council can recommend ways to incentivize or support clinicians to go back for training to be able to provide that service in communities. Also, the Council's last meeting discussed a multidisciplinary approach to providing care for SUD and addiction treatment, including medical care and behavioral and mental health providers. Perhaps that also can be in the letter.

Dr. Billings noted a family practice resident interested in incorporating addiction medicine into practice, and asked whether BHW would consider allowing clinicians to do more of that and less primary care due to the opioid crisis. **Dr. Salvador** agreed that would be good to consider and recommended continual exploration into expanding the NHSC program to meet more of the ebb and flow of the country's needs. **Dr. Billings** added it includes mental health, social work, and others. **Ms. Fabiyi-King** agreed the Council can consider whether SUD is becoming a component of primary care for many patients. **Ms. Stergar** noted in Montana it is being treated as a component of primary care but that is not the case everywhere.

Ms. Fabiyi-King asked whether the Council should recommend that as a post graduate training for rural health. **Dr. Billings** said that is a great idea and ties in with value-based clinicians. **Ms. Stergar** added many believe it should be a standard part of training since it is a chronic disease and thus is primary care and is related to public health. **Dr. Billings** added a specific recommendation could be to make it a standard part of training.

Dr. Malcom noted studies have shown that initial exposure to opioids often comes via a dentist for things like follow-up after wisdom tooth extraction and for some individuals, especially with OxyContin, begins a downward spiral toward SUD. It is not clear how to include a dental component with additional training for practitioners, but that can be an important part of this discussion. While some dental schools are addressing the issue, perhaps the Council can recommend additional training for dental providers when prescribing, or at least to give them further awareness that this sometimes is the gateway for SUD. **Dr. Billings** agreed with the need to think beyond primary care, including dentistry and emergency departments.

Clinician Tracker

Dr. Billings asked whether the Council should recommend BHW partner with health workforce institutes such as the Rural Health Institute of the University of Minnesota, the University of Kansas, and the Health Workforce Institute at George Washington University to try and use academicians to mine, publish, and use these data for legislators. **Ms. Stergar** replied yes.

{Lunch}

Dr. Billings re-convened the meeting, and **Ms. Fabiyi-King** called roll.

Discussion of Council Recommendations and Draft Outline

Dr. Salvador asked how many of the Council's recommendations from 2016 were acted upon, including about value-added providers for NHSC-approved sites. **Ms. Fabiyi-King** replied that still is being vetted along with development of the value-based clinicians framework. It is the start of something great, and will become more of a robust program as it is vetted and gathers ideas and recommendations for the planning. That one was enacted based on the Council's recommendation. The second one was to establish a balance between field strength and provider retention in underserved communities throughout the NHSC service area. That tool was developed based on the request for the survey and the Council's recommendation, and for others who asked how to follow-up with clinicians to know the HPSA score at their sites and whether they stayed. It has taken a while but came to fruition based on the Council's recommendation.

The last recommendation in the 2016 letter was about mentorship and training throughout the service commitment experience. There was a formalized mentorship program at the time the Council submitted that, but it was getting increasingly difficult each year to find alumni mentors who had the time and space, so the formalized program was put into sunset. However, the Bureau sees some clinicians are seeking and finding multiple mentors, as a trend not just in NHSC but also in the world of mentoring. Mentoring means finding someone to discuss with you something specific, and can include speed mentoring for an opinion or a recommendation while in school or at a clinical site. Also, Project Echo is now an alternative for some mentoring on specific clinical issues.

Ms. Smith added the Bureau is looking into interest in mentoring and a definition for what it means. Often, it has meant interest in advice and tips on site selection, or finding a community that is a good fit for the clinician and their family. While it will not be called a mentor program 2.0, the goal is to determine what resources and recommendations the Bureau can provide to participants to help ease them into finding a job and reducing some of that anxiety. It will be good for the Council to identify resources or recommendations to help guide that discussion, though at this point no formal steps are underway.

Ms. Fabiyi-King noted the Council's previous recommendation indicated that HRSA or BHW should work to partner with sites and academic institutions to educate future providers about HPSAs and access to the programs. Perhaps that could be related to Dr. Billings' project and applied nationally. It does align with the Council's recommendation from 2017 regarding partnerships between NHSC sites and academic institutions. **Dr. Salvador** said it is great to see some of these things come to fruition.

{At this point, the Council split into two workgroups to discuss the four priorities. After some discussion, it was determined that none of the four issues naturally pair with another. Workgroup 1 discussed telehealth and value-based clinicians and included Ms. Stergar, Dr. Salvador, and Ms. Adamson. Workgroup 2 discussed SUD and the Clinician Tracker and included Dr. Malcom, Ms. Witzel, and Dr. Billings.

<u>Timeline for Letter of Recommendation – Ms. Fabiyi-King</u>

Dr. Billings re-convened the meeting and **Ms. Fabiyi-King** called roll.

Ms. Fabiyi-King noted the goal is to work on the letter over the next three months (May, June, and July) for an August 1 submission. It will be good to look at dates in those months that the two groups can get together, and when the full Council can convene to vet materials. Staff will then setup phone lines. There should be breakpoints in which each of the groups get together on their own to vet what they would like to write, and then everyone can convene to look at the material and work on it sometime around two weeks before the target submission date. Members should look for dates in May when they can get together to vet with each other and then send material to Ms. Fabiyi-King. Also, members should flesh out recommendations in draft sections of the letter, including with research or other work that will inform the recommendations. Staff will help set up an Adobe Connect meeting or conference line for member discussions.

Ms. Stergar said members are hoping that staff will help improve the initial drafts from the workgroups. **Ms. Fabiyi-King** replied the thoughts are for members to flesh out and clean up to ensure it is what is they want. It does not yet have to be fully vetted because the timing for that is later in the summer, but it will be more effective for each workgroup to go through the language, and consider any needs for additional research and deliberation. Staff will assist in locating research as needed.

Ms. Stergar agreed the smaller groups should work together by email on a rough draft, and then have a full Council meeting in July for each group to share their work and exchange feedback. **Dr. Billings** agreed that is a good idea, and said if staff has no objections the workgroups will share emails internally, and probably by the end of May the groups could share their work with each other as the beginning of formulating something together. Then perhaps in early June come together at a shorter, less than one-day meeting as a Council and come up with a good rough draft to send to staff for polishing.

Ms. Fabiyi-King asked for clarity on the proposed timeline of activities, including how and when the workgroups will work to vet materials to make them more robust, and when they would share materials with each other and with staff. One concern is when materials are assembled and when the full Council meets it has to be open and available to the public, but keeping materials within the smaller workgroups is fine.

Ms. Huffman affirmed that each subcommittee can meet and discuss recommendations, but once material is shared with the full Council, even if only by email, it has to be public. She suggested each subcommittee come together whether via email or a conference call to draft recommendations, and then the full Council convenes in a short two to four-hour meeting to discuss and finalize the draft. Then, the Council's technical writer can help finalize the draft.

Dr. Billings asked if each subcommittee should have its document done by late April, with the follow-up full Council meeting in mid-May. **Ms. Fabiyi-King** replied potentially the full Council could meet in late May, but would have to work around Memorial Day. {At this point the Council discussed various timelines and potential for conflicts with personal and professional schedules, and **Ms. Stergar** suggested a Doodle Poll among members for available dates for a two-hour meeting. **ACTION ITEM**.}

Dr. Billings suggested the workgroups share some of their ideas and make progress during day-2 of this meeting, and **Ms. Fabiyi-King** agreed. **Ms. Huffman** advised the further the Council gets on day-2 the less remains for later in the spring.

Public Comment

There were no public comments.

Recap of Day 1 and Plan for Day 2

Dr. Billings thanked everyone and said it is good to hear familiar and new voices. He reviewed the day-2 agenda, including sharing, reviewing, and building upon the subcommittees' work from day-1. Dr. Billings also said it is great to hear from federal staff, and the Clinician Tracker is especially exciting since it will produce good data and publications that will enhance public and provider awareness of NHSC. He appreciates everyone's efforts and time.

Ms. Stergar moved to adjourn, **Dr. Malcom** seconded, and Day-1 adjourned at 4:10 p.m.

Wednesday, April 3, 2019 **8:30 a.m.**

Council Members

Dr. Adrian N. Billings, MD, Ph.D., FAAFP

Ms. Joni Adamson

Dr. Joan Malcom, DMD

Dr. Darryl S. Salvador, PsyD

Ms. Cindy J. Stergar

Ms. Gwen L.R. Witzel, APRN, FNP, FAANP

Federal Staff

Mr. Israil Ali, Director, Division of the National Health Service Corps

Ms. Diane Fabiyi-King, Designated Federal Official

Ms. Robin Alexander

Ms. Monica-Tia Bullock

Mr. Michael Dembik

Ms. Kim Huffman

Ms. Janet Robinson

Ms. Keisha Robinson

Ms. Melissa Smith

Ms. Ann Venner

Contractor – Technical Writer

Mr. Len Rickman

Convening the Meeting

Ms. Fabiyi-King convened the meeting, welcomed everyone to day-2, and called role.

Charge of the Day – Dr. Billings

Dr. Billings expressed appreciation for members and staff for being here for day-2, and reviewed the day's agenda.

Council Business

Ms. Fabiyi-King reviewed housekeeping items for the Council, including members whose terms will end this coming summer: Ms. Adamson, Dr. Jackie Griffin, Dr. Wilton Kennedy, Dr. Malcom, and Dr. Salvador. She expressed gratitude for each member's service, and **Dr. Billings** agreed, noting their strong insights for this important work. He hopes everyone sees it as an honor to serve on the Council, as he does. **Ms. Fabiyi-King** noted the goal was to discuss departing and future members at the planned meeting in January 2019, but that session was canceled. She asked for recommendations for future Council members who staff will contact, in addition to people currently being vetted. **Ms. Witzel** asked about future meetings, and **Ms. Fabiyi-King** replied the next meeting is September 17-18, 2019, and will be in person.

Ms. Stergar asked for a printout of the new data mapping tool, and whether that would be sent via email. **Ms. Fabiyi-King** replied it will happen soon. **ACTION ITEM.**

Prioritizing Council Recommendations – Small Group Reports

Group-1 – presented by Ms. Stergar

Telehealth

Telehealth expansion is important, though for now the group is presenting concepts and not yet wordsmithing. It will be good to hear Council members' concerns. A key issue is flexibility within current legislative constraints for NHSC service requirements, whether to expand the definition of service time, and what is allowed. Another key is how telehealth can help address national health priorities such as improved access to high-quality care, including through advancement in technology for diagnostics, monitoring, and other activities. Also recent data show patients prefer telehealth, and it is effective, especially related to sexually transmitted disease.

Financial stability for providers is crucial, and it will be important to discuss billing and reimbursement policies with CMS for telehealth and other technology-supported models. It also will be important to support emerging models such as Project ECHO and similar models that enhance access to care, and should be given the same value as direct patient care. Often, patients see telehealth as the same as direct care.

Discussion

Dr. Billings said Ms. Stergar covered the breadth of telehealth, especially the role of ECHO, and financial stability since that is becoming a more prominent issue within and beyond the FQHC system, and it will be necessary to work in conjunction with CMS. **Ms. Adamson** noted LRP and S2S guidance allows a level of telehealth, and that should be built upon. **Dr. Salvador** noted guidance that should be reviewed and perhaps enhanced. **Ms. Witzel** said to move this forward, it will be critical to allow telehealth visits to count as face to face. **Ms. Stergar** noted studies that show patients prefer telehealth, especially for SUD and behavioral health care, and that should help boost support for telehealth recommendations.

Dr. Malcom asked if it is known why patients prefer telehealth versus in person with doctors or counselors. **Ms. Stergar** said patients report being comfortable and will be more compliant when seen via telehealth, and studies are underway about telehealth for dental care and the emerging tele-pharmacy model. **Dr. Billings** believes the American Medical Association has a telehealth committee, and a non-profit is documenting the telehealth model, including practitioners' experiences and trend data. NHSC probably should consider the trend as it reviews its program requirements. **Ms. Stergar** noted the National Telehealth Association whose conference is coming soon. It is a large conference with many organizations, and one element is helping providers with credentialing and license fees for multiple states. This boosts retention and recruitment for medical professionals, and can help NHSC maintain interest and field strength. Other research exists as well, including from Kaiser.

Dr. Salvador noted the American Psychiatric Association has a lot of data, especially for mental health disorders, including less anxiety during treatment. **Dr. Billings** noted telehealth improves care in rural and frontier areas, and decision makers should be advised of that. **Ms. Stergar** said the improved access should be emphasized, and **Dr. Billings** said it also will help improve providers' satisfaction and boost recruiting and retention based on professional growth and better patient outcomes. He asked whether Ms. Stergar can explore more about how specific populations and providers are using telehealth, and perhaps that could identify models for FQHCs, including to help reduce healthcare disparities.

Ms. Fabiyi-King asked whether the Council wants to create a policy statement about telehealth, though she cautioned that the NHSC legislation will not change. Clinicians must be at their site, with a HPSA score, and are limited to eight hours per week of administrative time. **Ms. Stergar** noted some Medicaid offices are releasing RFPs for telehealth for Medicaid populations. This would allow patients to use their existing provider, or telehealth, and might be a way for NHSC providers to do more telehealth. However it likely will become complicated, and perhaps telehealth should be counted as face to face as long as it is under the auspices of the site where they work. If it is just allowed during administrative time that will cause a loss of NHSC providers. **Dr. Billings** suggested the workgroup should continue to address these issues, especially to ensure NHSC stays current with developments.

Ms. Venner noted the most recent LRP application guidance included telehealth. It is considered direct patient care as long as it is provided and received at an NHSC approved site in a HPSA. It is increasingly recognized as a way to improve access for underserved populations, though restrictions exist about licensing across state lines, and the provider must be employed by the NHSC site versus self-employed. Also, some restrictions exist on the equipment used. **Ms. Stergar** noted it is complicated if a patient is in a location without a HPSA score. **Ms. Venner** added it does not include home-based care, but now the telehealth hours have fewer restrictions versus keeping it within the eight hours of allowed administrative time. **Ms. Fabiyi-King** noted new thinking about vetting HPSA minimums for both the patient and clinician sites, and she will contact other staff for more information. **ACTION ITEM**.

Dr. Malcom asked about tele-dental health and NHSC clinicians. **Ms. Venner** replied she does not have data about specific disciplines, but noted no restrictions on specific disciplines, and will look for relevant data. **ACTION ITEM.**

Ms. Witzel praised great progress on telehealth. However, due to the growth of patient self-monitoring it will be important to have a policy for when the originating site is in a HPSA designated clinic but the distant site is a patient's home. **Ms. Stergar** agreed that is a great idea, but perhaps rather than mentioning the distant site just say the originating site is in a HPSA. It is possible the patient is away in another state and could want care from their own physician, versus a local urgent care facility, and that is an example of how it gets complicated to include restrictions about distant sites.

Value-Based NHSC Clinicians

Ms. Stergar said an assumption is any NHSC clinician already is value-based, so no additional steps should be added for them to become one. They are high-achieving providers working in interdisciplinary teams committed to improved health for underserved communities and HPSAs, and helping with emerging public health issues. They are dedicated to a lifelong commitment to their profession by engaging in learning and teaching, and they should continue to be allowed to train future providers. The Council should recommend ongoing support for NHSC as the value-based workforce for rural and underserved areas across the U.S., and as the nation's primary care backbone. NHSC works to address the healthcare needs of the nation by significantly changing the management, treatment, and care of chronic diseases such as diabetes, STDs, HIV, childhood obesity, etc.

Dr. Billings agreed with the assumption that NHSC clinicians already are value-based, since they selected the program and were chosen to participate. It also is good to address teaching as a value-add, and a recruiting and retention tool, though teaching should not be mandatory since some providers will not want to do it. Including trainees in care improves productivity.

Ms. Witzel cautioned that in many clinics it is not clear how to measure value, and it can vary based on multiple factors such as outcomes, readmissions, etc. A key question is what to measure, including additional training such as for MAT or emergency management. **Ms. Stergar** replied that can be incorporated into ongoing education and learning, including with examples of how it meets national priorities such as MAT and HIV. Caution is needed when including productivity as a value metric, and it might be better instead to note providers are committed to the quadruple aim. **Ms. Witzel** said she does

not know of research articles about value and outcomes, but in underserved areas the populations often have serious health needs and it is false to use patient compliance as a metric for provider value.

Dr. Salvador noted it is difficult to define a value-based clinician, and multiple factors could be included. It is important but hard to measure value from the cost offset from utilization and prevention of additional care. **Ms. Fabiyi-King** noted value could be in part measured by cost data and the offset. **Dr. Salvador** said it could be site specific or a regional economic impact.

Ms. Stergar added NHSC is value-based because without it 27 million Americans would not receive care. NHSC providers give good care, as documented in UDS and clinical outcome data. Plus, as representatives of the U.S. Government they are the only workforce required to target national priorities such as emerging and public health issues. It is important to note how team-based care, including mental health, dentistry, pharmacists, and others can be cost effective even though different national organizations have their own perspectives on costs. All NHSC sites are trying to provide the best care possible.

Next Step

Dr. Billings requested Bureau staff send workgroup notes to the Council, and **Ms. Fabiyi-King** said first it will send it to each respective group for vetting in accordance with regulations for the Council, and then the full Council can provide feedback. **ACTION ITEM.** She added that improving health by providing culturally competent care is good language to include for value-based care.

{Break}

Dr. Billings re-convened the meeting and **Ms. Fabiyi-King** called roll.

Group-2 – Presented by Ms. Witzel

SUD

The opioid crisis is a federal priority. Perhaps all SUD providers could be allowed to participate in the LRP, and the program can include more disciplines such as licensed counselors or other therapists. It would be good to require MAT training in medical and nursing primary care programs, and have it expanded to include dentistry and emergency medicine. It should be subsidized, such as awards or subsidies to centers for MAT training. BHW should work with training and education partners. Thus far dentists are not included in SUD treatment because they provide preventive care, but perhaps they could receive awareness training, especially in rural areas, or perhaps in the future they could receive MAT training. Also, perhaps NHSC scholars can be allowed to do post-grad work in addiction medicine, including a fellowship.

Discussion

Ms. Stergar praised this great first stab at a difficult issue, and noted it is difficult because while alcohol is the top killer meth is second, and the Council should recommend MAT training for SUD treatment. New programs are likely, and the Council should keep encouraging that kind of training since there are

many opioid disorders. **Dr. Billings** agreed it is important to not forget about alcohol disorders, and there are newer drugs available for that, but providers need to be educated about their use. While primary care clinicians are available to be MAT certified and provide SUD treatment, dentists also can prescribe opioids so it will be important to see whether dentists are interested in MAT. Judicious use of opioids should be included in dental school curricula. Opioid addiction can begin in an emergency room so it also is important to teach judicious prescribing for emergency and advanced practice training.

Ms. Stergar noted the PCA in Montana is training teams for MAT, including behavioral health specialists and pharmacists, regardless of waivers. It is great to say this is a chronic disease so everyone in health care needs relevant training. **Dr. Malcom** agreed that awareness is key, especially among those who can prescribe medications and should be judicious and know how to recognize drug-seeking behaviors.

Dr. Salvador said including specialty care for SUD in the SP would be good, including fellowship training for chronic care management using multidisciplinary approaches, and exploring alternative ways to manage chronic pain other than prescription medicines. Psychologists and social workers are part of the LRP, but not the SP. **Dr. Billings** said it will be important to discuss providers who are no longer in training but who need MAT training, and how to encourage every NHSC site to have a MAT trained counselor.

Mr. Ali discussed how to leverage training across all sites and the NHSC field strength. He noted a partnership with SAMHSA who has a cooperative agreement with several accrediting bodies and professional organizations focused on SUD training, and it is free. Specifically for NHSC providers there is an eight-hour training to become eligible to apply for a data waiver with the Drug Enforcement Agency. The Bureau is leveraging that throughout the NHSC field strength. **Dr. Billings** referenced training funded through a grant mandates a MAT provider at each site receiving the funding, and that is not tied to additional funding since it is a mechanism to receive training. While it may be peculiar for training to be free, people should know about it as a potential resource for sites and providers.

Dr. Billings asked whether SAMHSA training is in person so people can meet each other, or via distant learning the way others do it, and whether an effort is underway to expand that to other professional organization meetings. **Mr. Ali** replied he is not sure, but knows they offer mentorship around reducing the stigma of treatment.

Ms. Stergar said it would be great if they could mandate what national professional organizations do. In Montana the PCA did in-person MAT training for the American Academy of Family Physicians via a contract through SAMHSA, and that is an example of ample funding for this. The training used American Society of Addiction Medicine criteria, and many physicians attended. Another method is academic detailing which is basically peer-to-peer support, and grants exist for that as well, including from SAMHSA and HRSA. There is money out there and a lot going on in states and regions, so it would be good for national professional organizations to do this in addition to at the state level.

Dr. Billings noted being invited to in-person MAT training by the University of Texas Health System as a good example of cross discipline collaboration for promoting MAT training and to train the trainers. **Mr. Ali** cautioned it is not clear how many people receive training and then request the data waiver. **Ms. Stergar** noted some big grants require tracking that. It usually takes approximately one year from when

they receive training until they decide to provide that care. The PCA also trains on how to integrate, including how to overcome stigma around SUD, resistance to calling it a chronic disease, and dissention about needed training for prescribing MAT but not opioids. **Mr. Ali** added it is good to know how this is happening in the states. NHSC's goal is to use the award enhancement and other programs to see if it incentivizes people to seek training and the waiver. It will be good to monitor if people get the training under one application cycle and the waiver under the next cycle.

Dr. Billings cautioned that while it can be easiest to get the MAT waiver, the biggest challenge can be limited staff and number of participating disciplines. It is crucial to facilitate sites' efforts to treat patients with an integral team of disciplines. Clinical and non-clinical staff express concern about the logistics of addiction patients, including comingling with non-opioid addiction patients. That is a particularly difficult issue in small centers. It would help if other disciplines are allowed to be part of the solution. A key question is how to implement the new service model. **Ms. Stergar** noted those are the workforce challenges, and an opportunity for telehealth. Tools exist but workforce limitations are preventing progress.

Dr. Billings asked about webinars or other training to debut new service lines. **Mr. Ali** replied they are not specifically in NHSC but one division is doing something like a virtual grand round with one segment dedicated to SUD treatment, including speaking to them about how to treat this population and navigate the stigma that comes along with it. NHSC will cultivate that conversation as it develops its field strength approach to dealing with this population, either providing SUD treatment, general SUD services, or MAT.

Clinician Tracker

Ms. Witzel said an impressive amount of work went in to developing the Tracker, and it could have many uses. Tracker information should be widely published when it becomes public information, to stimulate ongoing support for NHSC. It should be used to show national legislators and policymakers that the program successfully provides access in underserved areas. It should be shared with academic researchers and the general public. And, it should be used to foster partnerships with other organizations that focus on rural health, the health workforce, and other issues. It also can provide information that boosts provider retention in HPSAs. Overall, the data can provide affirmation that the programs are valuable and have a positive impact on public health. Plus, it could provide support for expanded telehealth services and help remove barriers and restrictions to site-based reimbursement.

Ms. Stergar said it also is important to talk about the UDS mapper. **Dr. Billings** described UDS as annual reporting around specific diseases and events, so it would be good to see correlation between NHSC providers and better outcomes in the UDS data, though it would be complex. He asked about barriers to providing these data and tools outside the federal government, and how to reduce them so academicians can mine the data to produce papers about outcomes and the value of NHSC providers. **Mr. Ali** replied that in addition to standard barriers it is necessary to ensure BHW data are accurate, but at some point the Bureau wants people to use the data to justify academic curricula and evaluate primary care across the U.S. The Bureau's goal is to publish information through NCQA, but it first must ensure the data are sufficiently robust. **Ms. Stergar** added it would be nice once it is rolled out to have training on how to maximize its use.

Dr. Billings asked whether a combination of data from the Tracker and UDS could be used to identify areas that are even more underserved and help HRSA direct more human or financial resources to certain areas. **Ms. Stergar** added that is a great idea for a robust response to need.

Next Steps

Dr. Billings asked whether any of the four main issues the Council is deliberating can be combined with common themes for the workgroups to address over the next few weeks. For example SUD enhancement and telehealth blend together, so in May they can be tied together, especially for small centers that do not have a sufficient number of provider disciplines to expand lines of treatment. **Dr. Salvador** added the Tracker data and topic could be tied to the discussion of value-based clinicians in terms of improved health in areas NHSC providers serve.

Additional Thoughts

Dr. Billings asked whether the important topics have been sufficiently covered. **Ms. Stergar** replied no additional components seem necessary for the top four issues. **Dr. Malcom** agreed everything was covered for all the disciplines, including dental. **Ms. Witzel** said the discussion covered the important topics for rural health, but more time is needed to consider additional details and how to make it formal versus only bullet points. It will be good for the full Council to weigh in on finalizing thoughts and recommendations.

Dr. Billings said it will be good to discuss how to finalize the products in May, including next steps toward the August 1 deadline. **Ms. Fabiyi-King** said the next steps include conference calls or emails among the small groups to flesh out or vet recommendations and bullet points and prioritize recommendations for crafting a statement. The Council can convene in May or June, with the goal of final recommendations submitted by the end of June for review and tweaking by the end of July.

Ms. Adamson noted the importance of advocacy in general to support continued funding for NHSC, and said data from the data warehouse and the Clinician Tracker about amounts of money and people served, including per specific states, can support that. **Ms. Stergar** asked about a statement of support for continuing Bureau efforts to coordinate among all federal partners, and to support continued communication to all parties involved in NHSC and related services. **Dr. Billings** agreed and noted the administration of health programs is multidisciplinary and multi-departmental.

Dr. Billings asked whether any of the four priorities should not be brought forward and, if focusing on all four, whether there can there be a finished product by the end of June. The model is the 2016 Council letter, addressing three main topics, versus a white paper that includes many references, though even a letter should include some references to peer-reviewed publications. **Ms. Fabiyi-King** agreed the general scope of a letter would be three pages with citations from a limited number of publications. Each workgroup should identify a writer, and can meet as often as necessary, and then the full Council will review the material for a final letter. **Dr. Billings** noted the workgroups can develop and share drafts weekly through May.

Ms. Fabiyi-King noted two Council members were not able to attend this meeting, and each should be asked to join a workgroup based on their expertise. Dr. Kennedy is an educator and physician assistant,

and Dr. Griffin was an administrator and CEO of multiple health centers. Dr. Griffin could help team-1 (telehealth and value-based clinician), and **Dr. Malcom** agreed; and therefore Dr. Kennedy will join team-2 (SUD and Clinician Tracker). **Dr. Billings** will contact each to update them on progress and plans, though will need help with Dr. Kennedy's email address. **Ms. Fabiyi-King** will help with that. **TWO ACTION ITEMs.**

Dr. Billings asked whether any priorities are missing at this point, for general mention but not necessarily at the level of detail as the four already discussed. **Ms. Stergar** replied it is critical to note that the Council is committed to supporting the Bureau's efforts to make a difference by serving 27 million Americans and responding to emerging needs like SUD and MAT, including through team-based care. Perhaps a fundamental statement about the importance of team-based care is needed. **Dr. Billings** agreed that team-based care is another important topic for the Council.

Themes and Other Priorities

Dr. Billings noted the upcoming 50-year anniversary of the legislation that began NHSC, and perhaps the Council should ensure the Secretary is aware of NHSC's history, especially the 50-year milestone that should be celebrated. An association of clinicians for the underserved is discussing how to celebrate this, and whether to invite previous NHSC leaders to a celebration. Perhaps staff can document other milestones such as the 25-year anniversary.

Ms. Fabiyi-King mentioned being told by colleagues about celebrations at the 25- and 35-year anniversaries that included gathering alumni and prior directors. The celebrations were connected to the NHSC national conferences for scholars and loan repayors, and the Council was in attendance. Discussions are underway in HRSA for the 50th, including to commemorate NHSC's five-year anniversary in BHW. It is a very momentous time period in the history of the National Service Corps. **Mr. Ali** added discussions are underway about whether to celebrate enactment of the law or the actual first year of placement. It is a nuance. The National Service Corps was put into law in 1970, while the first funding for scholar placement was in 1972. It is very momentous, and should be celebrated in the very near future. **Dr. Billings** added the importance of ongoing promotion of NHSC, including multiple celebrations, and NHSC should not be the best kept secret. It should be just as visible as the Peace Corps since it is a domestic missionary program by the federal government.

Dr. Billings discussed the sunset of the Ambassador Program, and asked for thoughts about a recommendation for renewed interest in an NHSC mentorship program for students, potential, or current participants. **Ms. Stergar** replied it merits mention to say the Council supports leadership development, and use the Ambassador Program as an example. **Dr. Salvador** agreed. **Dr. Billings** added community and isolation are key themes, so mentorship can help create a sense of community and reduce barriers to recruiting and retention. **Ms. Fabiyi-King** agreed the Council should state its support for leadership development through mentorship, and refer to the Ambassador Program as an example. While the former ambassador and mentor programs had their sunset, perhaps the Council can make recommendations for how to fulfill the concept of mentorship in a different way, including with sufficient detail to move it forward.

Ms. Stergar asked about using social media to help create regional communities and peer support among NHSC. **Ms. Fabiyi-King** noted the Corps' presence on Facebook, LinkedIn, and Twitter, and the website, though other ways to interact could be options, and certain groups can be given specialized tools. Many NHSC service sites are on LinkedIn. **Ms. Stergar** said perhaps certain providers can be tagged as leaders in gathering connections among others, but they would need NHSC or Bureau recognition and support to promote it. It would be a low-cost and valuable type of mentorship. **Ms. Smith** replied the Division of External affairs does things like Facebook sessions, but overall it would be a grassroots effort led by alumni and others who do so on their own. The Ambassador Program was a form of mentoring but was more about promoting the program and encouraging applications.

Mr. Ali reiterated the Division of External Affairs is dedicated to building connections across new and seasoned providers in NHSC and underserved communities. Mentoring has evolved to more technology-based methods including social media messages and virtual job fairs that describe what it will be like to work in a rural health center. **Ms. Smith** added the Division of External Affairs will consider Council recommendations in this area.

Ms. Stergar said younger people do everything through social media, and will be attracted to regional support systems. **Dr. Malcom** said leveraging social media sites will help ensure younger professionals know about sites and professional networks.

Ms. Fabiyi-King noted the Bureau has tools for connections, but perhaps more promotion and awareness are needed, especially to encourage alumni and providers in service to participate. Social media is driven by those who want to be on it. The Bureau can encourage participation, but cannot share personally identifiable information (PII). **Ms. Smith** noted that after the Mentor Program was ended scholars and S2S participants were reminded about the connection tools available regardless of where they are in the process. There are videos from current providers that offer great advice on site selection and other points of anxiety that people asked mentors about, but the biggest challenge is sharing information since contact information cannot be shared without permission. Anyone can like the NHSC Facebook page, but perhaps that can be limited to alumni or current participants. **Ms. Fabiyi-King** added alumni and others already make comments but it is not a continuous social activity, and it is opt-in and occasional.

Mr. Ali praised the conversation but cautioned about the need to consider the partition between networking and mentoring. The former can give good information about sites, while mentoring is the cultivation of a provider and shaping the value-based model to be transformative in the community with the help of someone who has been there. Mentoring is more intimate than networking. **Ms. Stergar** said mentoring could be done through websites and coaching, but since funding is not likely for a mentoring program perhaps the Bureau can create a closed room on social media for mentors and mentees. **Ms. Fabiyi-King** replied that could be recommended in the letter to the Secretary.

Ms. Stergar asked about feedback from providers who joined NHSC in the past five years, whether they are using current technology-based communication tools, and what is the impact. **Ms. Smith** replied those data need to be researched in conjunction with the Division of External Affairs. **ACTION ITEM. Ms. Stergar** suggested continuing the discussion about new avenues for mentorship, including possible inclusion in a letter to the Secretary, when additional information is in hand, such as an analysis of all

Bureau virtual communications and their results and impact. **Dr. Billings** agreed that would be good data to see to help determine future use and expansion of communications and mentorship, including digital and in person. **Dr. Malcom** agreed that is worth exploring, especially in the virtual world. Posts can be sponsored and that can drive engagement and interaction with people connected to the members who may see that and may be interested in someday becoming an NHSC clinician or scholar. **Ms. Fabiyi-King** agreed to add that to the list of priorities. **ACTION ITEM.**

{Lunch}

Dr. Billings reconvened the meeting, and **Ms. Fabiyi-King** called roll. **Dr. Billings** reviewed the remaining agenda, including what the Council intends to produce and the process for doing so.

Next Steps: Process to Formalize Recommendations

Dr. Billings reiterated the letter should be three or more pages about the next few years of NHSC tasks for the Secretary to consider. The formal draft should be done by the end of June, for final polishing by staff for submission to the Secretary by August 1. This means a two-month window to produce a document to send to federal staff for polishing. He will contact the two Council members not in attendance at this meeting to invite their participation. **ACTION ITEM.**

Dr. Billings noted two options for workgroup activities. One would be a similar format to the Adobe process used for this meeting, but it would have to be between 8:00 a.m. and 5:00 p.m. Eastern time, and that could be a problem for some members. The other option is a series of email exchanges among the workgroups. **Ms. Witzel** suggested small group email exchanges for updating material, and then a webinar with the entire Council to produce the final product. **Dr. Salvador** agreed with that as a way to build the documents prior to presentation to the entire Council. Google Docs can be the tool. **Dr. Billings** agreed to use both Google Docs and MS Word. **Dr. Malcom** agreed with the exchange of emails and then a larger group meeting via Adobe Connect. **Ms. Adamson** agreed as well.

Dr. Billings asked how frequently members can commit to working on this, with mid- or late-May as the goal for merging the two documents. Perhaps it could be 30-60 minutes per week for the research and writing, as well as weekly contact, though less time will be required as the documents approach being final. He asked whether members can commit to that structure by one week from this meeting. **Dr. Malcom** agreed and noted it will be good to start working soon. **Ms. Witzel** agreed, and supported using Google Docs, including initiating it during this meeting. **Ms. Fabiyi-King** noted staff will have to confirm whether it can use Google Docs, but the members can do so while working together. **ACTION ITEM. Dr. Billings** asked for a copy of the current content in Adobe so each team's writer can copy it into Google Docs. **Ms. Fabiyi-King** said that will be done by COB today. **ACTION ITEM.**

Dr. Billings noted the Council's discussion of including celebration of the NHSC legislation, then two years later celebrating the 50th anniversary of the first scholar, and rekindling some form of mentorship. He volunteered to be the lead writer for those pieces. He asked for a volunteer from each group to serve as the initial writer for each groups' first draft, due Wednesday April 10. **Ms. Stergar** volunteered for team-1 (telehealth and value based clinician); and **Ms. Witzel** volunteered for group-2 (SUD and clinician tracker). **Dr. Billings** asked staff to email today's product in Adobe to the groups. **Ms. Fabiyi-King** agreed

and will also send the Council's 2016 letter as a frame of reference. **ACTION ITEM**. **Dr. Billings** requested staff send a Doodle Poll for dates for a two-hour meeting, sometime between May 15 and May 30, for the full Council to work on finalizing the documents.

Dr. Billings thanked everyone for volunteering, and noted how it is similar to practicing medicine beyond the walls of the center since this is important work for the communities being served. **Ms. Fabiyi-King** reiterated how staff will stand ready to support the plan and schedule as discussed. **Dr. Billings** noted being excited about the plan, and thanked everyone for their efforts.

{Break}

Public Comment

Dr. Billings reconvened the meeting. **Ms. Fabiyi-King** called roll.

Dr. Billings opened the telephone lines for public comments. No public comments were offered.

Closing Remarks and Next Steps – Dr. Billings

Dr. Billings thanked all staff who supported the meeting, and thanked HRSA, Adobe, and the conference line support. Council members and HRSA staff are impressive, and should be thanked for their efforts that impact daily care for patients and boost clinical and administrative or other support. This is a team, and many hands make a great task small. Many people are helping with this huge task and making accomplishments possible, and everyone pulls their weight without individual credit, toward reducing disparities, and is doing good work.

Dr. Salvador thanked Dr. Billings for his leadership, including exemplary and seamless transition from previous leadership when he first joined in 2010. He expressed deep appreciation and gratitude to HRSA staff for help with tremendous personal and professional growth made possible by serving on the Council. He noted being an NHSC clinician serving the underserved, and his continuing efforts to do so. He thanked NHSC for tremendous work over the years, including progress on specific issues such as now allowing part-time service, and in general seeing more branding and growth, including among mental health providers, and care provided across the U.S. He praised new efforts such as the Clinician Tracker. He expressed sadness at leaving the Council and not being able to say farewell in person, but he feels good to know the nation's health and care for the underserved are in good hands among HRSA staff and present and future Council members. Hopefully, people will continue to reach out to him and vice versa. **Dr. Billings** expressed appreciation for Dr. Salvador's service, and promised to say good bye at the Council's meeting in May.

Dr. Malcom thanked Dr. Billings for a great meeting, and thanked staff for their support. She said it is an honor to serve on the Council, and thanked everyone for patience with her, and for doing a great job representing the nation. It is great people working tirelessly on behalf of care for the underserved in America.

Ms. Stergar moved to adjourn, **Ms. Witzel** seconded. The meeting adjourned at 2:10 p.m.