

## Meeting Minutes

# National Advisory Council on the National Health Service Corps

Meeting November 5, 2020

The National Advisory Council on the National Health Service Corps (NACNHSC) met on November 5, 2020 via webinar. NACNHSC is a group of healthcare providers and administrators who are experts in the issues faced by communities with a shortage of primary care professionals. The Council serves as a key source of information to the NHSC senior management, to the Secretary of the U.S. Department of Health and Human Services (HHS) and, by designation, the Administrator of the Health Resources and Services Administration. The National Advisory Council on the National Health Service Corps was established under 42 USC 254j (Section 337 of the Public Health Service Act), as amended by Section 10501 of the Affordable Care Act. The Council is governed by provisions of Public Law 92-463 (5 USC App.2), which sets forth standards for the formation and use of advisory committees. NACNHSC responsibilities are specified under Subpart II, Part D of Title III of the Public Health Service Act.

### Welcome and Opening Remarks

Designated Federal Officer Diane Fabiyi-King convened the meeting at 9:17 a.m. She welcomed participants, introduced herself, provided instructions for meeting participation, and conducted roll call. All members except Claude Jones were present. Ms. Fabiyi-King welcomed the new Council Chair, Keisha Callins, MD, MPH. Dr. Callins thanked HRSA staff for supporting the Council meeting, and thanked prior Chair, Adrian Billings, as well as former members Sodabeh Etminan and Dante Brown, who are now enrolled in the National Health Service Corps Loan Repayment Program and are no longer serving as Council members. She thanked former Council members Cindy Stergar and Gwen Witzel, whose Council terms expired since the Council last met.

Dr. Callins reviewed NACNHSC's charge, which is to provide information to NHSC senior management, the HHS Secretary, and Administrator of the Health Resources and Services Administration (HRSA). The Council's role is to provide input about NHSC priorities and policies, and to disseminate information about issues related to NHSC. She quoted Brian Stevenson: "Those closest to the problem are also closest to the solution." Dr. Callins said those providing healthcare to disadvantaged communities are responsible for being champions to ensure the best outcomes for those communities.

Dr. Callins said that the Council needs additional members. Ms. Fabiyi-King and Ms. Keisha Robinson currently are reviewing more than 60 applications and will make recommendations soon. Dr. Callins reminded Council members to submit their current contact and biographical information by November 10. Dr. Callins recalled that prior Council Chair, Dr. Billings, had encouraged members to share information resources with each other. Dr. Billings had recommended Eric Redman's *The Dance of Legislation*, a book by a Congressional staff member about the development and passage of the National Health Service Bill, S4106. Dr. Callins is reading the book and also recommends it. She invited additional reading recommendations from Council members, and suggested creating a resource depository or directory. Drs. Taylor-Desir and Piernot supported this idea. Dr. Piernot said resources could include podcasts and articles. Dr. Callins said it would be useful for members who recommend resources to include brief

summaries. Ms. Fabiyi-King said she and Ms. Robinson would support Dr. Callins in producing and sharing the directory.

## **The National Advisory Council on the National Health Service Corps**

*Luis Padilla, MD, FAAFP*

*Associate Administrator, Bureau of Health Workforce*

Dr. Callins introduced Dr. Padilla, who thanked the Council and HRSA staff for their work. Dr. Padilla said the NHSC is the Bureau of Health Workforce's (BHW) largest program, and an important mechanism for meeting underserved communities' healthcare needs. Dr. Padilla thanked Council members for their services to these communities during the COVID-19 pandemic.

Dr. Padilla said that BHW is assessing its priorities through fiscal year (FY) 2023. The Bureau's core program aims are to enhance access to culturally competent care, achieve health workforce supply equilibrium, improve distribution of the health workforce, and augment quality of the workforce and healthcare in order to improve population health. BHW is considering how to improve its operations in order to support more progress toward achieving its aims, especially in rural and underserved communities. The effort to align BHW strategy with community needs is referred to as BHWise. BHWise prioritizes reducing health disparities and improving health equity. This requires a better understanding of the needs of vulnerable communities. BHW aims to learn more about state and local workforce needs, then address these needs with a tailored program portfolio. BHW's budget last year was just more than \$1.65 billion, which is not adequate to achieve its objectives. The Bureau must collaborate with partners to maximize impact of its programs.

Many external factors currently affect healthcare delivery and workforce development. These include the COVID-19 pandemic, which disproportionately affects underserved communities and exacerbates disparities. Systemic inequity is another major influence on healthcare delivery and the workforce. Recent increased emphasis on consumer-driven and value-based healthcare affects several aspects of care delivery, including workforce development.

BHW is considering developing a behavioral health portfolio of programs to address needs for mental healthcare, and treatment for substance use disorder, particularly opioid use disorder. COVID-19 has increased need for these services. BHW is bundling programs to maximize impact, and intends to sustain this organizational change. The Bureau is interested in how it can best use data to define and assess community needs, and how needs assessment results can inform BHW priorities, programs, and strategies. BHW currently implements several initiatives to enhance its data collection efforts and to share data with stakeholders.

In partnership with the Bureau of Primary Healthcare, BHW has allocated \$5.8 million in supplemental funding to 52 State and regional Primary Care Associations to provide training and technical assistance on a Readiness to Train Assessment Tool (RTAT), and to develop strategic workforce plans. BHW aimed for half of participants to complete the RTAT during the first year of the program, which has been accomplished. Assessment results will inform strategic workforce plan development. Community Health, Inc. developed and validated the Readiness to Train Tool, which assesses seven domains of an institution's readiness to increase workforce capacity through education and training. Results will support BHW in targeting investments and

identifying key partners that can support efforts to overcome barriers and develop community-based organizations' education and training infrastructure.

BHW aims to optimize data management and utilization by enhancing collaboration with other HRSA groups and external organizations; making data-driven decisions; and enhancing capacity for analytic work such as geo-coding and predictive modeling. Analytic efforts will support need measurement and development of programs to address community needs. On October 29, 2020, BHW deployed a new Field Strength Dashboard, which allows external stakeholders to view BHW's field strength at a glance, and to download data for their own workforce planning purposes. Current field strength is more than 16,000, which is the highest in BHW history. In 2019, BHW deployed the Clinician Dashboard, which shows the distribution of NHSC, Nurse Corps, Children's Hospital Graduate Medical Education, and Teaching Health Center Graduate Medical Education program alumni. The National Center for Health Workforce Analysis developed a new visualization interface for Area Health Resources Files, which facilitates downloading and data filtering.

BHW's Shortage Designation Modernization project began in 2013. Updates for automatically assigned Healthcare Provider Shortage Areas (HPSA) are complete. The project will complete updates for geographic and population HPSAs next year. Updates will facilitate data collection and sharing. In 2020, BHW issued a request for information about how to improve HPSA scoring.

BHW responded to the COVID-19 pandemic by mobilizing the workforce, leveraging funding to improve telehealth capabilities, developing a workforce framework, developing a COVID-19 Workforce Virtual Toolkit, exploring approaches to improving workforce well-being, assessing impact of COVID-19 on the workforce, and funding COVID-19 research projects. BHW's first priority was to ensure clinicians provided services during the emergency. One strategy was regulatory flexibility. BHW waived query fees for the National Practitioner Databank to facilitate users' credentialing providers.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act appropriated \$50 million to BHW to enhance telehealth. BHW awarded funds to 159 grantees. Efforts to enhance telehealth include using it for workforce training. Much training and education was halted to protect participants' safety. Telehealth supports continuing education while addressing safety concerns. The CARES Act also mandates the HHS Secretary to develop a workforce coordination plan by March 27, 2021, and an implementation report 1 year later. HRSA is leading plan development and seeking input from advisory councils.

Dr. Padilla requested NACNHSC input on how to define and assess community needs for healthcare. He reminded the Council that HRSA's mission is to improve health outcomes and reduce health disparities through access to quality services, a skilled workforce, and innovative, high-value programs. BHW's mission is to improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting providers to communities in need. BHW currently is focused on better understanding community needs through local, current, high-quality data, which will support program and policy planning.

## *Discussion*

Dr. Padilla invited discussion. Dr. Callins thanked Dr. Padilla for his presentation. She asked how the pandemic had affected deployment of the RTAT. Dr. Padilla said the pandemic had delayed deployment.

Dr. Callins asked whether BHW's Field Strength Dashboard, Clinician Dashboard, and Area Health and Resource Files are publicly available, and could potentially contribute to the CARES Act requirement to apply data and surveillance to identify barriers or gaps in ability to meet workforce needs. Dr. Padilla said the tools are publicly available and could be used for this purpose.

Dr. Callins invited Council comments on defining community healthcare needs. Dr. Taylor-Desir asked Dr. Padilla to comment on engaging paraprofessionals and non-clinical service providers, such as traditional medicine practitioners and community health workers, as liaisons between clinicians and priority communities. Dr. Padilla said BHW is interested in identifying and learning from these key stakeholders. He invited Council members to provide information about who these stakeholders are, how best to engage them, and how to apply their feedback to BHW's work.

Dr. Sein asked whether HRSA plans to make changes to the Teaching Health Center program structure or budget. Dr. Padilla said that the December 11 fiscal cliff will affect this program, which is not allowed to carry over money from previous years. The fiscal cliff will affect awards and field strength. Program plans will be halted or reconsidered if Congress does not provide funding. The program does have bipartisan support and is a model for education and training. BHW plans to continue support for Teaching Health Centers and is considering how to link the program to NHSC.

Dr. Schmitz asked Dr. Padilla what he thinks is the ideal approach for community health assessment and health improvement plans. These require community engagement and often are coordinated by State Offices of Rural Health. Dr. Padilla said BHW wants to take advantage of existing data sources and tools. The Bureau also aims to create a centralized database. BHW is always interested in learning about potential new data sources. Dr. Schmitz said these include the Rural Health Information Hub, which links to some community health needs assessments and disseminates information relevant to rural health. Another resource is the National Center for Rural Health Works, which disseminates information about how communities can set public health priorities and implement plans. The Colorado State Office of Rural Health generated a heat map to illustrate distribution of high priority public health needs, such as opioid use disorder. Dr. Padilla said State and regional organizations will need partners to help assess their data, and help identifying those partners.

Dr. Piernot said health workforce support staff, including front desk staff and medical assistants, have gotten sick or have had to care for sick family members during the pandemic. In addition, the patient load has increased, partially due to increased unemployment. Some patients who lost health insurance when they lost their jobs are using safety net providers. Some patients have more time to seek care while they are unemployed. The increased demand for services while staffing has decreased is challenging. This is a factor in community needs and should be addressed. Dr. Padilla said other people also have reported this concern, and thanked Dr. Piernot for her input. He said support staff needs are outside of BHW's purview. Dr. Padilla said BHW

is collaborating with the Bureau of Primary Healthcare to conduct a national survey of all health center staff, which will ask about staffing and workforce needs. BHW recognizes the importance of support staff to care providers' resiliency and effectiveness. Dr. Padilla asked the Council to consider how best to address support staff needs. Dr. Piernot said workforce resilience is a critical consideration as the pandemic persists, cases increase, and the course of the pandemic is uncertain. She said she would share links to resources related to workforce resilience with the Council and Dr. Padilla. She thanked Dr. Padilla for his work. Dr. Padilla said HRSA Administrator Thomas Engels prioritizes supporting frontline staff and preparing them for the next pandemic. Ms. Fabiyi-King thanked Dr. Padilla for his presentation.

## **NHSC Update**

*Israil Ali, MPA*

*Director, Division of NHSC*

Dr. Callins welcomed Mr. Ali, who welcomed and thanked the Council, and provided an overview of his presentation. As the NHSC approaches its 50<sup>th</sup> anniversary, it is planning its activities for the next 50 years. NHSC's first priority is to continue supporting NHSC participants in providing care while protecting themselves. NHSC has implemented regulatory flexibilities to address the public health emergency, including allowing pauses in service obligations, service at alternative sites for as much as 40 hours per week, and increased options for telehealth. The program helps support temporary emergency sites, and allows participants to earn service credit through volunteer services.

NHSC has analyzed program applicant characteristics, and which sites and communities received more applications than others. Initially, applications to the loan repayment program decreased 40 percent compared to FY 2019, probably due to the pandemic. Many scholarship applications were incomplete, probably due to college and university closures and difficulties obtaining signed letters of recommendation and other required documents. In response, NHSC allowed electronic signatures and implemented additional flexibilities. As a result, loan repayment program applications decreased only 4 percent and scholarship applications increased more than 20 percent compared to FY 2019. NHSC granted more than 8,700 awards across all programs in FY 2020. Scholarship awards increased 25 percent.

NHSC participants provide care to more than 17,000 people across the U.S. Most participants continue to serve high-need communities after meeting their service obligations. Currently about 60 percent of NHSC participants provide care in health centers and 33 percent serve rural communities. For the second year in a row, NHSC has funded all eligible applicants serving in urban Indian, Tribal, or Indian Health Service facilities, with a budget of \$15 million. In FY 2020 NHSC funded loan repayors serving sites with HPSA scores of 15 or more. NHSC prioritized awards for former participants in the Primary Care Training and Enhancement Fellowship program.

NHSC granted 204 award enhancements to providers who with Data 2000 waivers and training in integrating behavioral health counseling into their practice. This was an increase of 63 percent since FY 2019. NHSC collaborated with the Substance Abuse and Mental Health Services Administration to deploy three Medication Assistant Treatment training efforts.

NHSC's priorities for FY 2021 are to establish more program linkages, dedicate support to the NHSC pipeline, and optimize data collection and utilization. NHSC is especially interested in linkages with post-graduate training programs that prioritize preparing providers to serve rural and underserved communities. Program applications will collect more data to support tracking and program linkages. NHSC will track how many participants complete their training in HRSA-funded programs.

NHSC is considering making nurse practitioners and certified nurse midwives eligible for the Students to Service Loan Repayment Program. The number of physician applicants has declined slightly. Accepting nurses is a mechanism for the program to fulfill its goal of increasing availability of primary care services. NHSC also aims to increase women's health and maternal care providers in the workforce.

NHSC's efforts to increase participants' readiness to serve began with FY 2019 focus groups about participants' perceived readiness. Results showed that participants do not believe they are adequately prepared in the areas of cultural competence, population health, or resilience. NHSC is developing a plan to address these needs and others identified through focus groups.

NHSC's plans to optimize data collection and utilization include collecting and analyzing data on all applicants, not just awardees. Analysts will use predictive modeling to forecast program outcomes and trends to demonstrate how the program improves population health.

HRSA will celebrate the 50<sup>th</sup> anniversary of NHSC deploying services in the field in 2022. NHSC will continue to align its work with BHW program aims, including focusing on primary care services rather than primary care disciplines. The program will work to address demand for maternal care in target areas.

NHSC is monitoring the effects of telehealth on healthcare providers' business models and forecasting changes in practices such as hiring and eliminating brick and mortar sites. The program also is monitoring changes in education and training, such as medical school enrollment, the types of students seeking careers as healthcare professionals, and the factors that affect retention.

#### *Discussion.*

Dr. Callins thanked Mr. Ali for his presentation. She asked how many specialist physicians had received NHSC awards, and what their areas of specialization were. Mr. Ali said he would send this information to the Council after the meeting.

Dr. Callins asked how NHSC incorporates mentorship, a high priority for the Council, into training and education. Mr. Ali said NHSC focus group participants also emphasized the importance of mentorship throughout training. NHSC's readiness measures assess mentorship. Mr. Ali encouraged the Council to provide input about additional ways NHSC can support mentorship in its programs.

Dr. Sein asked whether NHSC is likely to support more loan repayors in FY 2021 if the budget allows. Mr. Ali said NHSC would like to increase field strength, and confirmed this will depend on the program's budget.

Dr. Schmitz said there are unique factors in readiness to serve in rural communities. He asked whether focus groups or other NHSC participant assessments have yielded information about participants' readiness to serve in rural communities, and how to prepare NHSC participants to serve these communities. Dr. Schmitz said the Accreditation Council for Graduate Medical Education (ACGME) is collaborating with the American Board of Family Medicine to consider revising requirements. NHSC's input regarding lessons learned about readiness would be valuable. Mr. Ali said he will inquire about sharing focus group results, which are not public. He also expressed interest in what ACGME has learned about preparing healthcare providers to serve in rural communities.

Dr. Taylor-Desir said Medication-Assisted Treatment training and Data 2000 waivers are critical for addressing substance abuse in underserved communities. She encouraged prioritizing allowing time for addiction medicine fellowships for NHSC scholars. She said her community psychiatry fellowship prepared her to serve in an underserved community. Mr. Ali agreed with this suggestion.

### **Update on Shortage Designation Modernization Project**

*Janelle McCutchen, PhD, MPH, CHES*

Dr. Callins introduced Dr. McCutchen, who thanked HRSA staff for their work. Dr. McCutchen explained that State Primary Care Offices designate Health Professional Shortage Areas (HPSA) by examining availability of primary care, mental health, and dental care providers in geographic areas, geographic areas with high proportions of residents representing priority populations, and specific types of facilities. Eligible facilities include Federally Qualified Health Centers (FQHC), rural health clinics that meet NHSC criteria, facilities serving Indian, Tribal, or Urban Indian communities, correctional facilities, and State mental hospitals.

The Shortage Designation Modernization Project was initiated in 2013, with core principles of transparency, accountability, and parity. The project aims to increase data security and accuracy. The project has not yet made any changes to HPSA scoring criteria. Analysts have updated the data used to calculate scores. An initial project step was developing a Shortage Designation Management System for application data entry and analysis. The system utilizes Environmental Systems Research Institute (ESRI) geographic information system (GIS) software to support identification of geographic areas.

The project team issued a request for information (RFI) seeking input regarding HPSA scoring criteria, and collected data between May 27 and September 18, 2020. Many stakeholders have responded to say that the criteria are outdated. The current criteria often do not identify community needs or account for current ways to access healthcare. Dr. McCutchen said HRSA can only collect input and make recommendations about statutory requirements; it does not have the authority to make statutory changes, which require Congressional approval.

HRSA plans to update all HPSA designations by September 2021 using current standardized data. HRSA updates these data annually between January and March. The update scheduled for February 2021 will base calculations on U.S. Census data collected in 2019. In March or April, HRSA will notify State Primary Care Organizations of potential score changes. Automatically designated HPSA sites can directly access the data portal and update data at any time and request an updated score.

HRSA currently is analyzing RFI responses. The RFI asked respondents to identify potential data sources that would support implementing their suggestions, and to be specific regarding how to change scoring points and scales. HRSA would prefer for all data sources to be free of charge and publicly available, to support transparency and additional research. Data should be available for counties, sub-counties, and Census tracts, and be no more than 5 years old. HRSA is interested in comments regarding whether scoring criteria should include provider to population ratio, percentage of population living below the Federal poverty threshold, or travel time and distance to the nearest source of care. HRSA is interested in how these criteria, if retained, should be measured and scored. Current scoring criteria are required by statute. HRSA can determine how to measure and score criteria. HRSA requested comments on criteria specific to primary, dental, and mental healthcare, such as whether to continue using the Infant Health Index in primary care scores. Some respondents recommended replacing this measure with standard mortality. The American Academy of Dentistry recommended changing the weight assigned to access to fluoridated water.

The Maternity Care Act requires HRSA to establish criteria for Maternity Care Health Professional Target Areas (MCTA), which are geographic areas within primary care HPSAs that have shortages of maternity care professionals, who provide prenatal, labor, birthing, and post-partum care. HRSA is charged with developing designation scoring criteria and issued a RFI for input on issues such as whether care professionals should include certified nurse midwives. The Act requires HRSA to use MCTA designations in distributing maternity care health professionals, and to collect and publish data that support assessing availability of maternity care health services within HPSAs. After establishing MCTA scoring criteria, HRSA will develop software to identify MCTAs. BHW will update NHSC application and program guidance to reflect MCTA scoring criteria, then grant awards accordingly.

The RFI comment period on MCTA designation was between May and September 2020. HRSA currently is analyzing responses. A total of 36 respondents' submitted comments, including the American College of Obstetricians and Gynecologists, professional associations of certified nurse midwives, and university groups with a focus on maternity care access or provision. Academic groups submitted suggested potential data sources to analyze in scoring.

### *Discussion*

Dr. McCutchen invited questions. Dr. Callins thanked Dr. McCutchen for her presentation and asked whether HRSA had requested for any specific parties to answer the MCTA RFI. Dr. McCutchen said HRSA's Office of Communications announced the RFI to the general public and to its listserv, which includes individuals, practices, and professional associations. HRSA's Maternal and Child Health Bureau and the Federal Office of Rural Health Policy distributed the RFI to their contacts. HRSA requested input from the Centers for Disease Control and Prevention (CDC). HRSA's Office of Communications made the announcement monthly, then weekly during the last 4 weeks.

Dr. Sein asked when updated HPSA scores are released and how continuous data updates affect scores. Dr. McCutchen said designations are calculated annually.

Dr. Bockwoldt asked the purpose of MCTA designation, whether applicants would be existing HPSA sites or new entities, and whether the purpose was to support sites in hiring maternity providers. Dr. McCutchen said the purpose is to support placing NHSC providers in MCTAs. It



is available for existing HPSAs, not new entities. NHSC loan repayors and scholars will be eligible. Providers will be placed according to MCTA score rather than HPSA score. Mr. Ali said MCTA will allow NHSC to place maternal care providers where they are needed most. Dr. Schmitz asked whether family practitioners could qualify as maternal care providers. He said the ability to provide maternal care should be considered as part of readiness to practice. Dr. McCutchen said she would mention this issue to the MCTA workgroup.

Dr. Schmitz said he is conducting research at University of North Dakota on geography of mothers' residence and proximity of services. He expressed interest in comparing results to HRSA's MCTA designations. He commended HRSA for seeking input from the Federal Office of Rural Health Policy. Dr. McCutchen said the HPSA RFI elicited 225 comments, many of which discussed the specific needs of areas with low population density and how best to measure these needs. For example, standard mortality may be a better measure of need than the Infant Health Index in rural communities with older populations and infrequent births.

Dr. Bockwoldt said women with high-risk pregnancies seem to be disproportionately represented in HPSAs. These women often are referred to specialty care facilities. Dr. Bockwoldt asked how this would affect MCTA scoring. Dr. McCutchen said criteria are still in development and that she would mention this issue to the workgroup. Dr. Callins supported Dr. Bockwoldt's comment, explaining that not all HPSA facilities have maternal or fetal medicine specialists on staff. She said that only 79 of 159 counties in Georgia have at least one women's healthcare provider. She said maternal care has a major impact on communities. Dr. Taylor-Desir also supported Dr. Bockwoldt's and Callins' comments. She worked in a rural North Dakota community that is an hour and a half drive away from the nearest hospital. Local care providers can deliver prenatal care, but then have to transfer patients to another provider who can support delivery. Patients want post-natal care in their own communities. These issues should be considered when setting MCTA requirements and definitions of comprehensive maternal care. Dr. Schmitz agreed that it is important to consider how geography can necessitate collaboration between local and distant providers in order to provide the full-spectrum of maternal care from prenatal to postnatal services. Degree of collaboration is critically important for pregnancy outcomes. Some countries, such as Australia have organizational processes to support this type of collaboration.

Dr. Schmitz said quality metrics often are based on institutional rather than patient characteristics. They do not support analysis of how outcomes would change if the patient had access to care closer to home or to team-based care. NHSC's efforts to increase the maternal healthcare provider workforce should focus on patient-centered outcomes. Dr. Callins said maternal healthcare should include mental healthcare to prevent and treat post-partum depression and mental health issues that can be exacerbated by pregnancy. Dr. McCutchen thanked the Council for its input and invited them to contact her after the meeting with any further questions or comments.

### **HHS Strategic Plan for Health Workforce Coordination**

Dr. Callins said that participants in the meeting of BHW advisory committee and council chairs to discuss the strategic plan for health workforce coordination had developed a framework based on requirements in CARES Act Section 3402. Dr. Callins shared an illustration of the framework with the Council. She said the group has requested input from Council members by November 13, 2020. She asked Council members to provide input regarding the framework and the plan during discussion and to share additional written comments with her by November 9. Dr. Callins

said comments made previously during the current meeting indicate that care provider resilience behavioral health, and maternal health are important priorities. Dr. Piernot said developing and implementing the plan is urgent. Dr. Callins agreed.

Dr. Schmitz said it is important for the workforce to be competent in delivering telemedicine. It also is important to provide adequate support for services which cannot be delivered through telemedicine. Dr. Taylor-Desir said it is important to increase access to telehealth, especially for mental healthcare. She also said that the workforce should be culturally competent. Dr. Callins said providers should be prepared to deliver team-based care with a focus on optimal patient outcomes. She also asked Council members to consider whether the framework aligns with BHW's aims of optimizing healthcare access, supply, distribution, and quality.

Dr. Callins said the council and committee chair group had discussed linking the National Provider Index (NPI) database to other data in order to conduct forecasting and modeling analyses. She invited comments. Dr. Schmitz said that NPI data have important limitations. He suggested reviewing methods of rural health research centers, and possibly collaborating with them to consider how best to approach issues such as addressing NPI data limitations.

Dr. Callins suggested that the plan should consider the value of mentorship in increasing workforce supply. Dr. Schmitz agreed and suggested also acknowledging the value of community of practice in preparing the workforce.

Dr. Callins said the plan should include research. Dr. Schmitz said the framework mentions forecasting, modeling, and evidence-based practices, but not literature reviews. Dr. Callins agreed that literature reviews should be added.

Dr. Bockwoldt said it is important for the full range of healthcare providers, including physician assistants, nurse practitioners, and mental healthcare providers to provide input for the plan. Dr. Callins said this is why HRSA is seeking input from all five BHW councils and committees.

### **NACNHSC 2021 Priorities: Review, Assessment, Planning**

Before beginning the discussion, Council members participated in an "ice breaker" discussion about what they most miss and what they are doing more of during the pandemic. Dr. Callins reminded the Council that the priorities it set for FY 2020 were: securing NHSC funding, reviewing application program guidance, mentorship, collaboration, and training. To support these priorities, the Council sent a letter to the HHS Secretary to request more NHSC funding. She invited the Council to identify priorities for FY 2021 and how to address them. Dr. Sein said efforts to develop the national workforce coordination plan was an example of making recommendations about training. He asked whether the Council would contribute more to national strategic plan development beyond commenting at this meeting and in written remarks to Dr. Callins.

Dr. Schmitz said assessing NHSC awardees' readiness will be valuable. The Council should review and consider results, and disseminate lessons learned from the readiness assessment and similar studies in the field. Dr. Callins asked whether Dr. Schmitz was suggesting compiling information and disseminating a message about the Council's support for readiness assessment. Dr. Schmitz said this was the case, and that the Council's message also could emphasize the

importance of mentoring and community of practice as methods for increasing readiness. Dr. Callins concurred.

Dr. Taylor-Desir said the Council should continue to collaborate with other BHW entities. She suggested collaborating with the National Advisory Committee on Rural Health and Human Services to improve workforce recruitment and retention. She said the Council should consider topics for a white paper. Dr. Callins said the BHW council and committee chairs also had expressed interest in collaborating with the National Advisory Committee on Rural Health and Human Services.

Dr. Callins suggested forming a workgroup to develop a white paper about funding, application program guidance, mentorship and training, collaboration, or recruitment and retention with the technical writer. Another workgroup could develop policy recommendations for the National strategic plan for health workforce coordination, aligning NHSC with BHW priorities, and HSPA and MCTA designations. Dr. Callins invited Council comments on this idea. She said white papers can be brief and the Council should share them with other BHW councils and committees. Workforce readiness could be a white paper topic. Dr. Callins reminded the Council that it also can write formal letters, and that they have access to a technical writer. She asked Ms. Fabiyi-King to describe the technical writer's responsibilities. Ms. Fabiyi-King explained that HRSA has allocated a budget for the writer to produce summaries of all Council meeting proceedings and a limited number of workgroup meetings, and would support white paper development, including conducting literature reviews.

Dr. Pinto-Garcia asked how much progress the Council's workgroup had made in reviewing and making recommendations for updating NHSC application program guidance. Dr. Callins said the workgroup had made limited progress and should continue work on this task. Dr. Bockwolft said the workgroup plans to meet in May. Dr. Callins asked Ms. Fabiyi-King and Mr. Ali how the Council should submit recommendations. Ms. Fabiyi-King invited Michael Berry, from BHW's Division of Policy and Shortage Designation, to comment. Mr. Berry said regulatory flexibility would end when the public health emergency status ends. Changing statutory requirements will require legislation. Mr. Ali asked how the Council should recommend changes. Mr. Berry said the Council can make recommendations to the HHS Secretary via the BHW Administrator, who would make the recommendations via the HRSA Administrator. The Council can make recommendations via letter, white paper, or any other format it chooses. He recommended for the Council to ask Dr. Padilla's advice regarding the best format for submitting recommendations.

Dr. Callins shared workgroup recommendations for updating application program guidance. She said the Council should review these recommendations, then discuss them with Dr. Padilla and determine how to present them formally. Dr. Callins said these recommendations would be relevant to commentary regarding MCTA criteria.

Dr. Callins said the priorities the Council had identified would likely always be priorities. She asked how Dr. Schmitz recommended proceeding regarding NHSC participant readiness. Dr. Schmitz said he would like HRSA staff to provide input on which action would have the most impact. He volunteered to work on the Council's white paper or other document addressing this priority, especially with support of the technical writer. Drs. Sein and Taylor-Desir also said they would like HRSA input on the best approach to communicate the Council's input regarding this priority. Ms. Fabiyi-King said all Council formal communications regarding the health

workforce will have impact. Dr. Schmitz said white papers include references to supporting evidence, which can be useful to readers.

Dr. Schmitz supported the idea of two workgroups and volunteered to work on a white paper about offering mentoring and community of practice training experiences to increase awardees' readiness and retention in rural and underserved communities. He said the paper would support BHW efforts to increase readiness and retention. Drs. Taylor-Desir, Sein, and Piernot also supported the recommendation to form workgroups, and volunteered to join the white paper workgroup. Drs. Bockwoldt, Callins, and Pinto-Garcia volunteered to join the policy workgroup. Dr. Callins said she would ask Dr. Jones, who was not present, to join the policy workgroup.

Dr. Callins asked whether Council members had additional suggestions for the white paper topic, possibly related to the priorities they had identified for the Council. Dr. Piernot said it may be valuable for the Council to produce a white paper or formal statement about the importance of NHSC funding. Dr. Callins agreed and asked whether Dr. Piernot would be willing to work on this document. Dr. Piernot said she would, and also supported Dr. Schmitz' topic suggestion. Dr. Callins said both topics are important. Dr. Schmitz suggested developing the white paper on his suggested topic and an opinion statement on the necessity to continue funding. Dr. Piernot supported this idea.

Dr. Callins invited the Council to discuss plans for completing the paper, opinion statement, and policy recommendations. The Council agreed to begin with discussions during the current meeting. . They agreed first to develop a white paper outline, then to discuss recommendations for BHW's strategic plan. Dr. Callins said all Council members were welcome to provide input about both the white paper and policies.

Dr. Schmitz said the white paper should summarize current NHSC strategies and the evidence regarding their effectiveness, then describe how NHSC could evaluate programs by utilizing new data and analytic tools. The first section of the paper would be about readiness for placement. This section would describe NHSC program's efforts to improve readiness to serve in priority communities, efforts to assess awardees' readiness, and recommendations for measuring readiness. Readiness comprises both competence and confidence. The second section of the paper would discuss support for awardees. This section would describe how awardees are supported at the time they are placed, how they are supported by mentoring and community of practice during placement, and how is preparation effectiveness measured. The third section of the paper would be about support for retention of awardees in priority communities. This section would discuss how retention is measured currently, which factors influence retention, and how best to measure impacts of retention. The white paper would include a review of current literature about health profession education, community of practice, recruitment, and retention. It would discuss how to prepare providers to reduce stress and burnout, and how to increase retention in priority communities.

Dr. Piernot supported Dr. Schmitz' suggestions, and emphasized the importance of defining provider readiness and successful placement. Dr. Callins agreed. Dr. Piernot said the paper should discuss the influence of training site and community stability on NHSC participants. Dr. Piernot believes stability eases transition. Dr. Schmitz concurred, but suggested the topic of how community factors affect recruitment and retention should be a separate white paper, since community factors are distinct from approaches to training scholars, and are equally important. Dr. Piernot said the white paper should state that its purpose is to demonstrate NHSC's value and

the importance of continued program funding. Dr. Schmitz concurred. He said the paper should define readiness both as preparation to complete trainees' service obligations in priority communities, and also as likelihood of continuing service in communities after completing service obligations. He emphasized that research shows self-efficacy and social support mitigate stress and prevent provider burnout, which hopefully leads to increased retention. Dr. Callins concurred.

Dr. Taylor-Desir said the paper should discuss current approaches to assessing readiness, and should discuss the importance of fellowship training. The paper should describe the types of sites trainees should be ready to serve, including urban, rural, frontier, and tribal. Dr. Schmitz agreed, and suggested that the paper should discuss what is necessary to prepare for service at all types of sites, and what is unique for each site type. Dr. Taylor-Desir said the paper should discuss readiness to deliver telehealth services. Dr. Schmitz agreed, and said it also should discuss readiness to deliver team-based care. Dr. Callins agreed, saying team-based care affects patient outcomes; and many practitioners who have not been trained to deliver it find it challenging. Dr. Callins said the paper should discuss the importance of training in priority communities in readiness to serve these communities. Dr. Schmitz agreed. Dr. Callins said the paper also should discuss importance of preparing NHSC participants to assess community needs and respond to needs by adjusting their approach to care deliver. For example, care providers can work with public transportation agencies to address transportation barriers, or they can develop community health education resources to meet community information needs.

Dr. Callins suggested asked the National Advisory Committee on Rural Health and Human Services to recommend resources or data to refer to when developing the white paper. Ms. Fabiyi-King said HRSA' Office of Rural Health Policy also could contribute in this regard. Dr. Callins said she would share an article in *American Family Physician* about retaining rural practice physicians. Dr. Schmitz said that he was the lead author for the article and would be able to address inquiries about content. Dr. Callins said that, while the writing workgroup will develop the white paper draft, the whole Council will review and provide input on the draft.

Dr. Callins asked Ms. Fabiyi-King how the workgroup should proceed with developing the white paper with the technical writer. Ms. Fabiyi-King said she would facilitate a meeting between the workgroup and the technical writer after the writer had submitted draft minutes for the current meeting. The workgroup and technical writer could develop a work plan at the meeting. Dr. Callins thanked the Council for its work on planning white paper development.

Dr. Callins read the following section from NACNHSC's charter: "Function as a sounding board for proposed policy changes by using the varying levels of expertise represented on the council to advice on the specific program areas." She asked members of the policy workgroup to provide recommendations in response to HRSA's presentations, starting with BHW's request for input on aligning NHSC with BHW's program aims. She reminded the Council that these aims are to improve workforce access, supply, distribution, and quality. Dr. Callins invited Mr. Ali to discuss NHSC's emphasis on primary care services versus primary care disciplines. Mr. Ali said BHW aims to link patients with providers trained to meet their needs. This includes ensuring that communities have the appropriate mix of providers. Needs assessments have indicated that this is best accomplished through ensuring providers can offer necessary services rather than deploying providers from specific disciplines. For example, if a community needs more mental healthcare services, it may not necessarily need a psychiatrist, but be served well by a psychiatric nurse

practitioner. Physician participation in NHSC's Students to Service program has declined. However, nurse practitioners can address many needs for primary care services.

Dr. Bockwoldt asked Mr. Ali to explain the relationship between BHW and NHSC. Mr. Ali said NHSC is one of 40 health profession education and training programs BHW administers. Dr. Bockwoldt asked in what ways NHSC is not aligned with BHW. Mr. Ali said BHW's goal is to establish links between its programs to optimize training for service in rural and underserved communities. For example, Primary Care Training and Enhancement Champion fellows have priority for participation in NHSC. Program linkages will provide opportunities for NHSC participants to receive training that prepares them to serve communities in need, and to continue their service after they have fulfilled service obligations.

Dr. Bockwoldt said that some students in the nurse practitioner training program where she works have not been able to fulfill their direct care obligations during the COVID-19 pandemic. This is likely true for several education and training programs, and will affect workforce supply. COVID-19 also has discouraged some people from beginning health profession training. BHW should anticipate this and consider how to address a decline in trainees. Mr. Ali said BHW is considering this issue. Dr. Schmitz said that the American Association of Medical Colleges has reported a significant increase in medical school applications between 2019 and 2020. He said team-based care can help to address healthcare shortages. For example, training emergency care providers in basic and advanced life support obstetrics can save lives. Dr. Schmitz suggested that exposing groups underrepresented in health professions to career options while they are in high school could increase the future health workforce. Mr. Ali said this type of suggestion is helpful to NHSC and BHW.

Dr. Pinto-Garcia said the Council's discussion throughout the meeting should inform workgroup input about policy. She asked which format would be most appropriate for policy recommendations. Dr. Callins suggested developing a formal letter. Ms. Fabiyi-King said the workgroup could develop a letter or a recommendation paper, in which the workgroup could refer to research supporting their recommendations.

Dr. Callins said the workgroup could consider assessing how sites indicate their needs for NHSC participants. Current listings are for titles and positions, not ability to deliver particular types of service. In addition, NHSC participants should be trained to be aware of services available in the community and be able to make appropriate referrals. Dr. Bockwoldt said the program should support providers' collaborating across sites, with telehealth being one strategy for doing so. For example, specialists could provide telehealth consultations to avoid the necessity of referring a patient to a care site that involves burdensome travel. Dr. Callins said a network of consulting specialists can reduce provider stress and burnout, and improve retention. Dr. Callins suggested that placing at least one women's healthcare provider in existing community health centers could improve distribution. Dr. Schmitz suggested reviewing data about national distribution of OB/GYNs.

Dr. Callins said now is the time to recommend legislative changes necessary to maintain changes allowed due to the COVID-19 public health emergency. Dr. Bockwoldt said policies and programs should address how to increase workforce supply and stability. Some communities depend on one provider for behavioral health or maternal care services. If that provider leaves or becomes ill, the community has no access to these services. The Council and BHW should consider systemic changes to address this issue. Dr. Callins said this recommendation is relevant

for BHW's aims to improve access, supply, and quality. Mr. Berry said NHSC's Health Workforce Connector is a resource for matching underserved communities with providers. He also said some NHSC sites do form networks of providers.

Dr. Callins invited Council comments on how healthcare systems and delivery should change after the pandemic. Dr. Pinto-Garcia said training should emphasize cross-disciplinary collaboration and community of care approaches. Dr. Schmitz said it is critically important for NHSC participants to learn to leverage technology and deliver team-based care. These competencies will help trainees to deliver quality care and increase the likelihood that they continue service in rural and underserved communities. He said that telehealth can allow providers to offer consultation and guidance to other clinicians providing urgent or emergency care. Dr. Taylor-Desir said that single NHSC sites can include multiple clinics that are physically distant and burdensome to travel between, especially during harsh weather. She said telehealth is a valuable strategy for facilitating care delivery even within one NHSC site.

Dr. Callins said the workgroups could refer to the meeting minutes in preparing their recommendation document. She invited additional comments on policy recommendations. Mr. Berry reminded the Council to make recommendations relevant to NHSC's scope. Dr. Bockwoldt said it is important to prioritize increasing access to mental health and maternity care services.

### **Public Comment**

Ms. Fabiyi-King invited public comment. There were no callers with public comments. Margaret Kilman, Director of Federal policy matters at the Corporation for Supportive Housing sent comments via email that Ms. Fabiyi-King said she would distribute to the Council.

### **Closing Comments**

Dr. Callins thanked HRSA staff for their work to support the meeting. She thanked presenters and Council members for their time and effort. She requested written input regarding the national strategic plan for health workforce coordination by November 10. She invited Council members to contact her with suggestions for future meetings and additional questions or concerns. Council members thanked Dr. Callins for her work as Chair. Ms. Fabiyi-King thanked the Council for their work. Dr. Callins said shared the African proverb, "When you see a turtle on top of the fencepost, know that he did not get there on his own." NHSC's potential for impact depends on dedication to service and collaboration.

Dr. Piernot motioned to adjourn. Dr. Taylor-Desir seconded. Dr. Callins adjourned the meeting at 4:40 p.m.

## **Planned and Suggested Follow-up Actions**

- The Council will submit written comments on the national strategic plan for health workforce coordination.
- Council workgroup #1, with support from the technical writer, will begin working to develop a white paper on NHSC participants' preparedness to serve in rural and underserved communities.
- The Council will develop a statement recommending continued funding for the NHSC. This statement may be incorporated into the white paper on preparing NHSC scholars to serve rural and underserved communities.
- Council workgroup #2 will develop recommendations regarding BHW's priorities, aligning NHSC with BHW aims, and approaches to designating MCTAs. The technical writer will support this workgroup in developing written documents.
- Dr. Callins will share an *American Family Physician* article about retaining rural practice physicians.
- Dr. Piernot will share links to resources related to workforce resilience with the Council and Dr. Padilla.
- The Council may develop a directory of information resources for members' referral.