Meeting Minutes

National Advisory Council on the National Health Service Corps

November 15–16, 2022

Council Members Present

Keisha R. Callins, MD, MPH, Chair

Andrea Anderson, MD, FAAFP

Tara Brandner, DNP, FNP-C

Charmaine Chan, DO

Sandra Garbely-Kerkovich, DMD (*day 1 only*)

Kareem Khozaim, MD, FACOG

Monica Taylor-Desir, MD, MPH, DFAPA

Health Resources and Services Administration Staff Present

Diane Fabiyi-King, Designated Federal Official

Keisha Robinson, Management Analyst, Division of National Health Service Corps

Kim Huffman, Director, Advisory Council Office

Zuleika Bouzeid, Management Analyst, Advisory Council Office

Janet Robinson, Management Analyst, Advisory Council Office

Overview

The National Advisory Council on the National Health Service Corps (NACNHSC or Council) met November 15–16, via webinar. The NACNHSC is a group of health care providers and administrators who are experts in the issues faced by communities with a shortage of primary care health professionals. The Council serves as a key source of information to the National Health Service Corps (NHSC) senior management, the Secretary of the U.S. Department of Health and Human Services (HHS) and, by designation, the Administrator of the Health Resources and Services Administration (HRSA). The NACNHSC was established under 42 USC 254j (Section 337 of the Public Health Service Act), as amended by Section 10501 of the Affordable Care Act. The Council is governed by provisions of Public Law 92-463 (5 USC App.2), which sets forth standards for the formation and use of advisory committees. NACNHSC

responsibilities are specified under Subpart II, Part D, of Title III of the Public Health Service Act.

DAY 1

Opening and Welcome Remarks

Designated Federal Official Diane Fabiyi-King convened the meeting at 9:09 a.m., Eastern Time. She called the roll and summarized the agenda for the meeting. HRSA staff member Zuleika Bouzeid provided instructions for meeting participation.

Council Chair Keisha R. Callins, MD, MPH, welcomed the participants and expressed appreciation to the Council members for their continued commitment to the NHSC. She explained that the meeting focus on caregivers reflects the Council's interest in geriatric care. Dr. Callins suggested considering caregivers a vulnerable population because of the burden they absorb. She challenged the Council members to consider how to improve health and social systems to better work for caregivers and how strategies can be translated into the curricula for health professionals.

Dr. Callins called for a paradigm shift in how clinicians help caregivers maintain their own health. She urged clinicians to look, listen, and link; that is, look at patients who are caregivers, ask questions and listen to their concerns, and link them to appropriate resources. Dr. Callins read from President Joseph Biden's proclamation of November as National Family Caregivers Month, which recognizes that caregivers provide "a profound service to their families and to our Nation, but they are still too often unseen, undervalued, and unpaid."

Dr. Callins reminded the Council of its responsibilities:

- Serve as a forum to identify the priorities for the NHSC and bring forward and anticipate future program issues and concerns.
- Do this through ongoing communication with program staff, professional organizations, communities, and program participants.

- Function as a sounding board for proposed policy changes by using the varying levels of expertise represented on the Council to advise on specific program areas.
- Develop and distribute white papers and briefs that clearly state issues and/or concerns relating to the NHSC with specific recommendations for necessary policy revisions.

Introduction of the New Deputy Associate Administrator

Sheila Pradia-Williams, RPh, MBA

Deputy Associate Administrator, Bureau of Health Workforce (BHW), HRSA, HHS

Sheila Pradia-Williams, RPh, MBA, took on the position of Deputy Associate Administrator in June 2022 but has been with HRSA for 24 years in various roles. She noted that the NHSC is HRSA's flagship program, and she appreciated the work and advice of the Council. Ms. Pradia-Williams looked forward to the Council's recommendations on strengthening the workforce. She noted that HRSA has identified behavioral health, substance use disorders, maternal health, and health equity as priority issues.

Discussion

Dr. Callins asked Ms. Pradia-Williams to elaborate on how the Council can further address strengthening the workforce. Ms. Pradia-Williams pointed out that site visits bring to the surface the opportunities and challenges of providing seamless, team-based, coordinated care. Part of readiness to serve is ensuring that NHSC is well positioned to recruit clinicians with a team-based mindset who also have an understanding of the communities they will serve. HRSA is also looking at expanding the workforce by ensuring that licensed paraprofessionals and other support workers are part of the care team and can practice to the full extent that their licensure allows. Effectively implementing a team-based care approach can help make up for the shortage of primary care providers. Ms. Pradia-Williams said that in thinking about how to develop and distribute the workforce, it is important to pay close attention to how the NHSC infrastructure and sites can implement a team model.

Charmaine Chan, DO, asked whether HRSA has considered ways to assign foreign-trained medical providers to practice in underserved areas through the NHSC, and Sandra Garbely-Kerkovich, DMD, added that some states restrict foreign-born, trained and licensed dentists to a

limited license. Ms. Pradia-Williams said she would look into the policies around foreign-trained providers and their eligibility for participation in the NHSC. She added that HRSA does have a group looking at issues faced by foreign-born physicians.

Kareem Khozaim, MD, FACOG, pointed out that lack of access to reproductive health care affects maternal mortality. He asked whether HHS has any plans to address the issue. Ms. Pradia-Williams replied that there has been discussion of the issue, particularly on ensuring that clinicians have adequate training. She added that accreditation requirements play an important role.

Dr. Callins asked about current HRSA work to support clinician resilience. Ms. Pradia-Williams described recent grants awarded to tackle systemic factors that contribute to burnout or counteract resilience. Listening sessions in anticipation of the awards revealed that efforts should focus less on encouraging individuals to seek services and more on upstream and underlying factors, such as stigma and other barriers to getting help as well as the environments that contribute to burnout. Dr. Callins agreed that a systemic focus is key. She proposed that the NHSC set an expectation that sites support clinicians as a vital function of recruitment and retention.

Dr. Callins noted that the NACNHSC is eager to connect and collaborate with other HRSA advisory councils. Ms. Pradia-Williams appreciated the offer; she said Congress and BHW would both like to see more work across advisory councils.

Presentation: NHSC Updates

Michelle Yeboah, DrPH

Deputy Director, Division of NHSC, BHW, HRSA, HHS

Across the federal government, departments are focused on addressing COVID-19 and promoting health equity, said Michelle Yeboah, DrPH. Within HHS and BHW in particular, workforce issues around behavioral, community, and maternal health are of high priority. Cross-cutting themes are resilience, telehealth, and diversity and equity. Dr. Yeboah highlighted accomplishments from fiscal year (FY) 2022, noting that supplemental funding from the

American Rescue Plan allowed the NHSC to fund all eligible applicants in FY 2021 and FY 2022, which contributes to the health workforce pipeline. As of 2022, more than 20,000 NHSC participants serve more than 21 million people in the United States and its territories. Of those, 80 percent remain in the communities they serve. Dr. Yeboah pointed out that 47 percent of NHSC clinicians are behavioral health care providers. Over the past year, the NHSC has focused on services provided rather than disciplines to increase access to behavioral health care. BHW continues to make NHSC data transparent and to use data to drive policy decisions.

For FY 2023, the NHSC plans to implement the Maternity Care Health Professional Target Areas (MCTAs), which will allow it to better distribute maternal health professionals within Health Professional Shortage Areas (HPSAs). To better prepare clinicians in the pipeline to practice in the communities they serve, the NHSC embarked on a 5-year contract to establish mechanisms to support resiliency and facilitate transformative care among postgraduates and clinicians. It is also providing self-assessment tools for burnout and creating community spotlights and assessment guides to help clinicians better understand the communities they plan to serve.

Finally, the NHSC is taking advantage of its data. Analysis of the application process revealed that a number of potential individual applicants abandon the process at the point where they need their employer to verify their work status. Dr. Yeboah said the NHSC can use such information to improve its application guidance and eliminate barriers to applying. The overall aim of NHSC's efforts can be summarized as refinement; the NHSC will continue to listen, process information, and incorporate what it learns to improve its systems and ensure resources are available to support the next generation of clinicians.

Discussion

Dr. Khozaim asked Dr. Yeboah to elaborate on mentorship proposals. Dr. Yeboah said NHSC participants would like to get more information about the communities where they will serve but also want to hear from those who found themselves serving in a place where they had no experience. Dr. Yeboah added that she and her colleagues are delving into why applicants abandon the process at the point of employment verification.

Dr. Garbely-Kerkovich suggested reaching out to potential applicants to promote the NHSC much earlier. Dr. Yeboah agreed, noting that the NHSC is always trying to better understand how to reach more people, and looking at the application process more closely is one way to gather information. She said the NHSC is open to new ideas, and Dr. Garbely-Kerkovich suggested tapping NHSC alumni to serve as ambassadors. Dr. Yeboah hoped more NHSC alumni would be engaged in planning presentations (e.g., at conferences) as well as participating in job fairs and local, informal education opportunities to promote the NHSC. Dr. Chan said it is important to dispel myths about the NHSC program and to let even very young people and their families know that health care professional training can be an affordable option. Dr. Yeboah agreed, adding that any opportunity to reach students in small and informal settings would be optimal. Dr. Chan noted that community programs and clinics would benefit from knowing more about how they can become NHSC sites.

Dr. Callins suggested that the NHSC offer alumni a branded signature line that could be used in email correspondence, so that more alumni identify themselves in all their communication. She proposed asking the BHW Division of Regional Operations for advice on how to educate academic faculty about the NHSC, so that faculty members can support students in applying. Dr. Callins also suggested the NHSC consider setting up recruiting stations in shopping malls, just as the U.S. Armed Services do. It could also target information to academic financial aid departments. Dr. Chan recommended encouraging or requiring NHSC participants to engage in some form of outreach before they complete their academic training. Dr. Garbely-Kerkovich added that testimonials from alumni can be informative and influential. (She noted that the high level of debt incurred can drive some graduates to pursue private practice because they feel they have no other options.)

Recognition of the Outgoing Chair

Dr. Yeboah introduced a video from Luis Padilla, MD, Director of the NHSC, thanking Dr. Callins for her commitment to the NHSC and her remarkable leadership during her tenure as Council Chair (which expires in February 2023). Dr. Yeboah added that Dr. Callins embodies the spirit of community health and public service.

Panel: Collaborative Care: Improving Care for Patients, Families, and Caregivers

Moderator: Joan Weiss

Deputy Director, Division of Medicine and Dentistry (DMD)

To place the topic in context, Moderator Joan Weiss said the number of people over age 65 in the United States is increasing at a pace far faster than that of younger people. As of 2019, one in seven U.S. residents is 65 or older, and this population is more racially and ethnically diverse than ever before. Older people can be faced with cognitive decline, rising health care needs and costs, isolation, technology barriers, and challenges in access to transportation, housing, and food. Caregivers are crucial to helping people age in place and be as independent as possible for as long as possible. Older people want their caregivers to be part of their health care team, and they want the needs of their caregivers to be met.

The Recognize, Assist, Include, Support, and Engage Family Caregivers Act and the National Strategy to Support Family Caregivers

Greg Link, MA

Director, Office of Supportive and Caregiver Services

Administration for Community Living, HHS

Greg Link, MA, observed that caregivers are often family members who are called on to provide an extraordinary level of highly skilled care that rivals the capacity of nurses and even doctors in some cases, so caregivers should be considered an integral part of the health care team. About 53 million U.S. adults provide care to a family member or friend, and nearly 2.5 million grandparents are raising their grandchildren. The Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act called for creation of a Family Caregivers Advisory Council, a report to Congress on caregiver issues, and a National Strategy to Support Family Caregivers. Mr. Link noted that the RAISE Family Caregivers Act is the culmination of 25 years of federal advocacy, programs, and demonstrations to understand and address the needs of older people and their caregivers.

The September 2021 initial report to Congress presents 26 recommendations from the Family Caregivers Advisory Council and includes 26 videos from caregivers, resulting in a name and a

face that brings each recommendation to life. The recommendations form the basis of the National Strategy, which seeks to raise awareness, incorporate caregivers as partners in health care, increase services and support for caregivers, improve caregivers' financial and workplace security, and promote research, data, and evidence-informed practices.

The Strategy describes key principles that should inform all efforts to improve support for family caregivers: centering the family and person in all interactions; addressing the impact of trauma; advancing equity, accessibility, and inclusion; and elevating direct care workers as family caregiving partners. The Strategy defines actions to be taken across 15 federal agencies and suggests actions that states, communities, and other organizations can take. As mandated by legislation, the Strategy will be updated every 2 years. The initial draft Strategy is open for public comment through November 30, 2022. Mr. Link said the RAISE Family Caregivers Resources and Dissemination Center provides useful information about federal and state initiatives and resources.

Healthy Brain Initiative: Public Health Approach to Advancing Brain Health

Lisa C. McGuire, PhD
Lead, Alzheimer's Disease Program
Centers for Disease Control and Prevention (CDC), HHS

Lisa C. McGuire, PhD, pointed out that caregivers can be crucial in preventing and managing the comorbidities that lead to preventable hospitalizations among people with Alzheimer's disease or related dementias. CDC's Healthy Brain Initiative provides funding to integrate brain health into public health. The Initiative developed a series of roadmaps geared toward public health professionals describing how to advance brain health (available on CDC's website on aging).

CDC's Building Our Largest Dementia (BOLD) infrastructure program provides funding to establish public health centers of excellence around Alzheimer's disease. Three centers of excellence have already received 5-year awards. The BOLD program helps public health departments (including tribal entities) build their public health infrastructure for dementia using the Healthy Brain Initiative roadmaps. Some entities are at the initial stages of developing plans and making community connections, while others are implementing existing plans and

advancing the work of current coalitions. The BOLD program also seeks to increase data analysis and timely reporting for relevant issues. The Healthy Brain Initiative Collaborative brings together the Healthy Brain Initiative awardees, BOLD centers of excellence, and BOLD-funded public health programs to gather data that will provide insights on long-term outcomes.

Healthy People 2030 expanded on its two 2020 goals for dementia and Alzheimer's disease and added a third that seeks to spark early discussion between health care providers and patients about confusion or memory loss. The National Plan to Address Alzheimer's Disease was updated in 2021 to include a new goal to accelerate action to promote healthy aging and reduce risk factors for Alzheimer's disease and related dementias. CDC will host a national summit on dementia risk reduction in May 2023. CDC recently kicked off a dementia risk reduction Prevention Research Center thematic network. The next BOLD program notice of funding opportunity will be released in December 2022. Dr. McGuire concluded that dementia and caregiving are public health issues, and she stressed that public health has a role to play in addressing Alzheimer's disease and dementia.

Enhancing Effectiveness of Care

Shari Ling, MD
Deputy Chief Medical Officer
Centers for Medicare and Medicaid Services (CMS), HHS

Shari Ling, MD, pointed out that most Medicare beneficiaries are age 65 and older, and many of them have multiple chronic conditions that become increasingly complex with age. CMS influences health care systems through its payment strategies, quality improvement initiatives, and performance-based programs. Some CMS services directly support coordinated care. For example, Medicare pays for chronic care management and complex chronic care management, cognitive impairment assessment, and caregiver assessment, among many other services. Medicaid covers certain home and community-based services, as well as care coordination. CMS also coordinates across Medicare and Medicaid for beneficiaries eligible for both programs.

Medicare recognizes the need to support caregivers. For example, the hospice benefit includes respite care services through a Medicare-certified inpatient facility. Medicare recognizes a billing

code for cognitive assessment and advance care planning that includes identifying caregivers and assessing their knowledge, needs, social supports, and willingness to take on caregiving tasks. It also recognizes a billing code for using standardized screening tools for health risks among caregivers. Medicare Advantage plans may offer supplemental coverage that benefits a caregiver, such as adult day care and transportation.

Medicaid services vary by state, but they generally include coverage for respite care, counseling, and case management. Each state selects a suite of services that best applies to the population of beneficiaries who reside in that state.

Collaborative Care: The Role of Area Agencies on Aging

Deborah Stone-Walls, MA
Chief, Programs and Services
USAging

Deborah Stone-Walls, MA, explained that the United States has more than 600 area agencies on aging (AAAs) tasked with responding to the needs of people age 60 and older, all of which provide at least the following core services:

- Supportive services, including a wide variety of home and community-based services
- Nutrition services, such as home meal delivery
- Health and wellness, which incorporates evidence-based programs addressing chronic disease self-management, fall prevention, and caregiver support, among others
- Caregiver support, including counseling, support groups, training, and respite care
- Elder rights, including abuse prevention and ombudsman programs to advocate for people in long-term care

A 2022 poll found that almost all AAAs are seeing increases in the number of people asking for services and the complexity of consumer needs. AAAs serve a broad range of consumers, sometimes coordinating with veterans services and programs funded by HHS' Administration for Community Living. Individuals choose the services they want and the level of care and intervention they need. Ms. Stone-Walls emphasized that AAAs can offer personalized solutions

by taking the time to identify underlying issues, such as physical barriers in the home that affect health and safety. They also recognize that addressing social determinants of health (SDH), such as housing, nutrition, and transportation, can protect individual and their caregivers.

AAAs create contracts to partner with numerous entities, such as Medicare and Medicaid programs, the Veterans Health Administration, health systems, and health insurers, and help individuals navigate these programs. Since COVID-19 began, 74 percent of AAAs have created new contracts or partnered with new health care entities, increasing collaboration across organizations.

Ms. Stone-Walls underscored the importance of addressing caregiver needs by reading from a letter she received. A caregiver wrote that she has been providing constant, one-on-one care for her mother with dementia for 645 days so far, amounting to 15,480 days without a day off or even a few hours off, which is equivalent 387 40-hour work weeks. Caregiving is a burdensome job, said Ms. Stone-Walls, and collaboration is critical for family caregivers.

Discussion

Monica Taylor-Desir, MD, MPH, DFAPA, highlighted the need to screen caregivers for health risks. Dr. Chan asked whether the BOLD centers of excellence are required to work with smaller community facilities that bear the brunt of caring for people with dementia, many of whom cannot leave their communities to get services in major health centers. Dr. McGuire responded that the centers of excellence do not provide direct care; rather, they are a resource for all communities, nationally.

Dr. Callins pledged to work with her local community health centers (CHCs) and federally qualified health centers (FQHCs) to ensure they are aware of their local AAA services, and she hoped others would help spread the word. She appreciated CMS recognizing billing codes that support caregiver assessment and noted that caregivers should be included in training and education. Dr. Callins also said clinicians should begin asking the right questions to identify caregivers and link them to available resources.

Dr. Callins asked whether the National Strategy to Support Family Caregivers recommends actions for clinicians in training. Dr. Link replied that education and curriculum development are expressly identified in the overarching goals of the Strategy, which includes ideas for actions and implementation.

In response to Dr. Garbely-Kerkovich, Dr. Link explained that the initial report to Congress defines and frames family caregivers in very broad terms, acknowledging that they can even be people younger than 18 caring for family members, for example.

Dr. Garbely-Kerkovich asked about the status of efforts to create comprehensive Medicare coverage for oral health. Ms. Fabiyi-King said she would follow up with Dr. Ling for more information.

Dr. Callins encouraged all the Council members to provide comments on the draft National Strategy to Support Family Caregivers by November 30.

Remarks from the Chair

Keisha R. Callins, MD, MPH

Chair, NACNHSC

Dr. Callins invited Dr. Taylor-Desir to offer a personal reflection on caregiving. Dr. Taylor-Desir pointed out that, even as a health care professional, she has faced challenges coordinating care for older family members. She described her own experience, noting that needs can arise suddenly, leaving a caregiver scrambling to find assistance.

Presentation: Division of Policy and Shortage Designation (DPSD) Policy Updates

Carla Stuckey

Director, DPSD, BHW, HRSA

Carla Stuckey observed that the BHW budget has increased slightly every year since FY 2018, with a huge boost of $1.5 billion in supplemental funding in FY 2021, which allowed the NHSC to fund all eligible NHSC applicants for FYs 2021 and 2022. The President's budget request for FY 2023 includes $2.1 billion, an increase of $324 million, to support health workforce

programs and a diverse workforce. The request includes $50 million to support the resiliency, mental health, and well-being of health care providers and $88.4 million for the NHSC Substance Use Disorder and Rural Communities Loan Repayment Programs and the inclusion of mental and behavioral health providers, such as peer support specialists and providers in crisis centers.

Within the context of the broad federal government-wide priorities of responding to COVID-19 and increasing health equity, BHW is focused on better meeting community needs for behavioral, community, and maternal health. For example, BHW is working to increase the supply of community health workers. Cross-cutting focus areas for the immediate future are provider resilience, telehealth, and diversity.

BHW will offer funding opportunities that address more than 20 community workforce needs. Additional funding could lead to even more funding opportunities. Ms. Stuckey noted that BHW will be focused on reauthorization of the NHSC in 2024. It also aims to maintain the field strength created as a result of the American Rescue Plan. On the basis of data gathered before COVID-19, HRSA's National Center for Health Workforce Analysis projected that by 2030, the United States will be facing significant shortages in the number of full-time health care providers, specifically a shortage of 41,050 primary care physicians, 12,530 psychiatrists, and 11,530 addiction counselors.

Discussion

Dr. Callins asked whether BHW's plans and projections recognize the large number of health care professionals who have left the field as a result of the pandemic. Ms. Stuckey pointed to the two major funding opportunities on resilience (described by Ms. Pradia-Williams), which address provider burnout from a systemic point of view. She recommended that Council members visit the National Center for Health Workforce Analysis website for more details on their workforce projections (https://data.hrsa.gov/topics/health-workforce/workforce-projections) to better understand the shortages in each state, including data on dentists.

Presentation: Shortage Designation Modernization Project Update: MCTA Final Criteria

Janelle McCutchen, PhD, MPH, CHES

Chief, Shortage Designation Branch, DPSD, BHW, HRSA

Janelle McCutchen, PhD, MPH, CHES, outlined the steps taken since the 2013 inception of the Shortage Designation Modernization Project to ensure that HPSA designations reflect current health care practices. She noted that HRSA is pushing to collect more data but cautioned that it takes years to clean and process the data for use. In 2021, HRSA completed a national HPSA update that included geographic and automatic HPSA designations at the same time. In May 2022, HRSA published the final MCTA criteria and began incorporating them into its systems.

Dr. McCutchen explained that MCTAs will be identified within existing primary care HPSAs, and the MCTA criteria apply only to OB/GYNs and certified nurse midwives (CNMs). Although HRSA recognizes that family practice physicians and others can and do provide the full scope of maternity care, for the purpose of accurately calculating the actual level of services available in a community, the criteria are limited to OB/GYNs and CNMs.

MCTA applications will be scored according to the final six criteria:

- Population-to-provider ratio, specifically the number of women ages 15–44 years and the number of OB/GYNs and CNMs
- Population with income at or below the federal poverty level
- Travel time and distance to the nearest source of care
- Fertility rate
- Social vulnerability index, created by CDC to identify vulnerable populations in terms of increased need for maternity services
- Preconception health index, which incorporates medical and behavioral health conditions that affect pregnancy

Dr. McCutchen outlined the scoring and weighting process. The criteria will be officially released to the public in late November 2022.

Discussion

In response to Dr. Garbely-Kerkovich, Dr. McCutchen clarified that the criteria will calculate all of the travel time required to reach services from remote areas. Dr. Chan pointed out that family medicine physicians are not included in the calculation of MCTA scores. Dr. McCutchen reiterated that HRSA recognized the valuable role of family medicine providers but added that the intent of the legislation supporting the MCTAs was to increase the number of OB/GYNs and birthing centers in underserved areas.

Dr. Khozaim asked for more details on how HRSA defines an appropriate population-to-provider ratio. Dr. McCutchen said HRSA used national-level statistics, with data from urban areas and smaller communities. She suggested that communities look at the local fertility rate as well as the number of women of reproductive age as a starting point for identifying an appropriate ratio. Tara Brandner, DNP, FNP-C, asked whether coverage of infertility was part of the discussion. Dr. McCutchen responded that the topic was raised, but the legislation is focused on pregnant people. However, there may be an opportunity to revisit the issue in the future when more data are available.

Dr. Callins particularly appreciated the inclusion of the preconception health index in the criteria. She asked how NHSC sites might link recruitment to MCTA scores. Dr. McCutchen replied that every current HPSA (except correctional facilities) will be assigned a MCTA score, and efforts are underway to include the MCTA score in program guidance for 2023 site applications. She suggested following up with Israel Ali, Director of the Division of NHSC, for more information on how MCTA scores can be linked to recruitment. Dr. Garbely-Kerkovich suggested adding oral health to the preconception health index.

Presentation: HRSA's Geriatrics Programs

Joan Weiss

Deputy Director, DMD

BHW, HRSA, HHS

Ms. Weiss described HRSA's Geriatrics Workforce Enhancement Program (GWEP) and Geriatrics Academic Career Awards Program (GACA). GWEP seeks to develop a health care workforce that can provide value-based care that improves health outcomes for older adults by

maximizing patient and family engagement and integrating geriatrics and primary care. Awardees create partnerships with academia, primary care sites, health systems, and community-based organizations to educate and train the workforce, including developing or implementing curricula. These partnerships train geriatrics specialists, primary care providers, and health professional students, residents, fellows, and faculty in caring for older people. Specifically, education and training must address continuity of care, chronic care self-management, long-term care, and end-of-life care as well as mental health and SDH. Training must include individual, community, and population health approaches and must involve telehealth technology.

The goal of GWEP awards is to transform care environments into age-friendly systems that incorporate value-based and alternative payment models. Age-friendly health systems address four key elements of high-quality care for older people: what matters to the older adult, medication management, mentation, and mobility. So far, 48 GWEP awards have been granted to organizations working through partnerships to improve health and outcomes for patients, families, and caregivers. They are assessed against measures related to the four elements of age-friendly care as well as relevant CMS quality measures, such as dementia caregiver education and support, evaluation for opioid misuse, documentation of care plans, fall risk assessment, and screening for future fall risk. In recognition of priorities of HRSA's Bureau of Primary Health Care, other program measures assess rates of diabetes, hypertension, and colorectal screening among older people.

Regarding education and training goals, Ms. Weiss noted that HRSA partnered with other federal agencies to develop online training modules on Alzheimer's disease and related dementias for health professionals that remain available at no cost to anyone who wishes to use them. (See Train Health Care Workers About Dementia.) The modules address a broad range of topics for providers and caregivers and are written in plain English, so patients and families can also use them. The modules describe how providers can better incorporate caregivers in shared decision making and how to assess and address caregivers' needs. In addition, 40 of the 48 GWEPs and 9 of 21 GACAs provide training on elder mistreatment.

In 2020, through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, GWEPs received additional funding to train clinicians on using telehealth for screening, testing, case management, and outpatient care and to maintain primary care functionality away from physical sites. Some of that funding was used to purchase devices and internet access so that practices and patients could use telehealth. Providers and patients that took advantage of telehealth said it improved their sense of connection during a period of extreme social isolation. In 2021, HRSA provided $2.2 million in supplemental funding to GWEPs to expand education and training to nursing home workers, residents, families, and caregivers. The move aligns with President Biden's goal of increasing nursing home worker recruitment and retention.

GACA programs support the career development of junior faculty in academic geriatrics settings. The programs seek to educate and train the health care workforce in the context of an age-friendly health system to address dementia risk reduction, health disparities, and nursing home care, for example. The program is open to all disciplines, including, for example, behavioral health providers, clinical psychologists, and social workers. Institutions apply for GACA awards on behalf of an eligible individual.

Discussion

Dr. Callins was "pleasantly surprised" by HRSA's commitment to geriatrics but expressed disappointment about the exclusion of OB/GYNs. Ms. Weis said future awards could consider increasing attention to women's health. Dr. Callins said the NHSC should seek to use all available tools to increase knowledge about geriatrics care and caregivers, and the online modules on Alzheimer's disease and related dementia could be very helpful. Ms. Weiss described the mechanisms HRSA uses to disseminate information about the modules through the federal agencies that helped create them and through HRSA grantees and their partners. She noted that academic institutions in the United States and abroad use the modules in their curricula, and some states even require certified nurse assistants to complete the modules as part of their training.

Dr. Garbely-Kerkovich pointed out that older people often cite transportation as a key barrier to dental care. Ms. Weiss said providers are beginning to restore mobile programs to provide oral health care in nursing homes, which shut down with the COVID-19 outbreak.

Presentation: Preparing Clinicians to "RAISE" Family Caregivers

Cheryl Woodson, MD

Member, Board of Directors

National Council on Aging

Cheryl Woodson, MD, pointed out that family caregivers provide 80 percent of the care that individuals receive (at no pay), and health care professionals rely on caregivers to ensure the best possible outcomes for their patients. Clinicians may be the only touchpoint a caregiver has with the health care system, so clinicians must be ready to activate a cascade of support for those caregivers. Dr. Woodson outlined a practice management strategy that clinicians can use to activate support.

Caregiving can be defined broadly as regularly doing for someone something that person cannot do for themselves. Caregiving has often fallen to women in midlife, but now 25 percent of caregivers are men and 60 percent are millennials or Generation X. Another 13 percent are over age 65 and have their own chronic health conditions.

Dr. Woodson stressed that the health care system cannot keep assuming that family members will take on the burden of caregiving. Families now have fewer children (and thus fewer potential caregivers). They are more geographically disbursed, and more women work outside the home. At the same time, the population of older people far outweighs the number of younger people who can provide care, and older people are living longer with more complex chronic conditions. People with disabilities are living much longer now than in the past. Substance use and behavioral health issues complicate both caregiving and chronic conditions. More grandparents are caring for grandchildren.

By investing a small amount of time in helping caregivers, clinicians can reap a huge benefit, Dr. Woodson said. The clinician's office can contact local AAAs or departments of aging to create a

list of resources, contacts, and referrals. Lists of resources can be displayed in waiting rooms and examination rooms. Discharge personnel should have ready access to the list. Routine intake and update forms can include simple caregiver assessment questions (available from the Caregivers Action Network, the National Alliance for Family Caregivers, the Department of Veterans Affairs, AARP, the American Geriatrics Society, and others).

Clinicians should ask current patients whom they would call if they needed help with shopping, meals, or transportation, for example; who helps them with such tasks now; and how often they have help. They should also ask patients whether they are caregivers and, if so, what they do and how it affects them. Screening patients for depression (including caregivers) should be part of standard care. Dr. Woodson summarized questions to ask to define problems and outline a care plan. Clinicians can help caregivers become more confident in their own abilities to manage situations and become better partners in caring for the patient. Dr. Woodson emphasized that well-trained front desk staff should include clinicians who can provide information, conduct some basic screening and triage, and follow protocols.

Dr. Woodson described how to prevent caregivers from panicking should a concern arise. For example, caregivers should know whom to call for basic information and assistance (e.g., prescription refills). Clinicians should define and commit to a time for responding to pressing concerns and build time into their schedules to provide urgent care. Caregivers should be educated about changes in key conditions (e.g., blood pressure levels or glucose values) that merit an urgent response. Dr. Woodson will occasionally meet with families to discuss various issues; which might require payment out of pocket by the families but is always appreciated.

Clinicians can establish routine mechanisms for working with AAAs, community professionals, hospitals, and nursing homes, among others, to facilitate a team-based approach to care. Dr. Woodson encouraged clinicians to make connections with community organizations and providers and strengthen caregiver support by serving as a resource for health information. Moreover, clinicians should encourage caregivers to care for themselves. Dr. Woodson's website provides a wealth of tools to help clinicians and caregivers.

Discussion

Dr. Woodson reiterated that building confidence among caregivers helps allay their fears that they will not know what to do, which makes them better partners in care. She also emphasized that AAAs and other community resources are widely available. Dr. Taylor-Desir asked how to identify and assess informal networks of caregivers. Dr. Woodson suggested going where they are—e.g., churches, libraries, or bookstores—and even offering basic health screening as well as links to resources and information. She said AAAs can often identify someone in the community who can act as a caregiver when no one else is available (with costs adjusted on a sliding scale), and the Aging Life Care Association provides links to certified geriatric care managers. In addition, caregivers should reach out to others in the community for help with a family member. Dr. Woodson invited Council members to contact her directly with feedback or questions.

Public Comment

No public comments were offered.

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

Keisha R. Callins, MD, MPH

Chair, NACNHSC

Council members discussed key takeaways from the day. Several pointed out that almost everyone has a personal experience involving family caregiving. All were inspired to take some action to increase understanding and awareness about caregivers' health and resources available to support older adults and their caregivers. Dr. Callins expressed her gratitude for the Council's recognition of her tenure as Chair and said she greatly appreciated the opportunity to serve the NHSC, first as a scholar and then as Council Chair. The meeting recessed for the day at 4:49 p.m.

DAY 2

Welcome and Roll Call

Ms. Fabiyi-King opened the meeting at 9:06 a.m. and called the roll. She reviewed the agenda for the day.

Charge of the Day

Keisha R. Callins, MD, MPH

Chair, NACNHSC

Dr. Callins invited Dr. Chan to share her personal and professional experience related to family caregivers. Dr. Chan shared a story underscoring how important it is for clinicians to ask family members of patients about their caregiving roles and to support them with resources and information.

Presentation: Leading in Challenging Times … Creating the Future We Want and Our Communities and Patients Need

Margaret Flinter, APRN, PhD, c-FNP

Senior Vice President and Clinical Director, Community Health Center, Inc.

Senior Faculty Member and Founder Emeritus, Weitzman Institute

Margaret Flinter, APRN, PhD, c-FNP, described the efforts of a small group of clinicians in Middletown, CT, who were dedicated to providing health care for the underserved people in their community. They created the Community Health Center, Inc., in 1972, which Dr. Flinter joined in 1980 as a result of the NHSC. She acknowledged the NHSC's pivotal role in helping organizations like the Center move toward their vision of health care as a right, not a privilege. The Center currently has 108 NHSC participants. It provides comprehensive, patient-centered care at 174 locations across Connecticut, many of which are school-based health centers. It also uses mobile services to reach underserved populations, such as people who are unhoused and migrant farm workers.

Dr. Flinter described the confluence of events in the late 1970s and early 1980s that spurred the need for new ways of organizing and practicing primary care, particularly an integrated, team-based approach, which is key to supporting the most complex patient cases and reducing burnout and fatigue among health care providers. She pointed out that such care can be adapted for school-based settings, and the Center offers medical, dental, or behavioral services in 147 Connecticut schools. Increasingly, federal entities have called for more funding for health services in schools, specifically behavioral health services. Thanks to the Center, children living in communities most challenged by poverty in Connecticut have access to a full range of health

services with no financial barriers, and four more school-based health centers are opening soon. Dr. Flinter acknowledged the stress parents and caregivers endure when they are unable to access the health care that their children need.

The Center launched an offshoot, the Center for Key Populations, to provide training and support for all primary care teams across the Center on caring for people with HIV; people who are unhoused; members of the lesbian, gay, bisexual, transgender, and queer community (LGBTQ), and others who may require specialized care and services. The Center for Key Populations facilitates expert consultations and aims to help the next generation of health care professionals meet new challenges as they arise.

The Weitzman Institute launched in 2005 to enable the Center to conduct health care research within its patient population. The Institute provides training and mechanisms for health care providers in the field to lead research. Under a cooperative agreement with HRSA, the Institute hosts the National Training and Technical Assistance Partnership to promote team-based care in FQHCs. It adapted the Project ECHO model to facilitate virtual learning and collaboration, which allowed the Institute to respond quickly with training and information for health care providers when COVID-19 emerged. Dr. Flinter noted that extensive training creates opportunities for more health care providers to take on leadership positions, which increases their satisfaction and reduces burnout and stress.

The Center is committed to training the next generation of health care professionals for a high-performance model of care that recognizes the complex needs of patients who are deeply affected by SDH. Inspired by the Affordable Care Act, the Center created a new model of postgraduate residency training for nurse practitioners who sought to provide primary care for patients with complex conditions in CHCs. The program has been replicated across the country for nurse practitioners and physician assistants. Another effort focuses on recruiting talented people who have not attended college to become medical assistants. The approach brings people from underserved populations into the workforce, increasing diversity and better reflecting the populations served in CHCs.

HRSA commissioned the Weitzman Institute to develop and validate a tool to assess the readiness of CHCs to offer training, and it has been distributed across the country. A national survey provided data that gives BHW and the NHSC a sense of readiness among centers that can be used for planning; the data also allow individual centers to measure their progress toward readiness to provide training.

The COVID-19 pandemic brought to the forefront the needs of vulnerable patients and the role of CHCs in education as well as treatment. It also raised awareness among policymakers and health care payers about the central role of primary care. The pandemic paved the way for rapid adoption of telehealth and virtual care for medical and behavioral health services, which will likely endure. It also renewed focus on health disparities and the impact of burnout on people in the health care field. The emergence of COVID-19 demonstrated how quickly people and institutions can move when there is no other option, Dr. Flinter observed.

More must be done to strengthen and improve primary care provision, Dr. Flinter continued. A team-based, integrated approach should include substance use treatment and social support, appropriate to the population served, with clear links and mechanisms for "closing the loop" through effective communication. Community care providers, telehealth, and information technology are all key components of team-based care. The field needs leaders who can help people get to a place where primary care practice is manageable and satisfying. Individuals need opportunities to participate in research and innovation, develop leadership skills, and advance their careers. Leaders must spend time with their employees, listen to their concerns, and address what they can; satisfaction surveys alone are not enough, said Dr. Flinter. What is good for primary care is good for the community, she emphasized.

Behavioral health services are vital for young people in school settings and for adults through other primary care settings. Moreover, racism and discrimination—among the root causes of mental and behavioral health problems among adolescents in particular—must be addressed. Primary care teams should frequently assess their own patient population to better understand how substance use is affecting overall health and lifespan, using the findings to inform new

approaches to care. Primary care cannot fix all the global problems that threaten health, but it can serve as a link to reach people most affected by SDH.

Dr. Flinter noted that the Council heard a presentation at its March 2022 meeting on the report from the National Academies of Sciences, Engineering, and Medicine (NASEM), *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. She suggested that the Council express support for the report, which advocates for giving primary care providers the structures, policies, and financing to achieve the goals of primary care broadly to address the needs of the workforce, patients, and communities. Dr. Flinter called for a funding mechanism that supports primary care providers and allows additional funding for team members who can provide comprehensive services. A primary care team should be available to every individual in every community. More outreach is needed to reach more people (e.g., through community health workers). More training is needed for the health care workforce in places where people live and work. Technology must be designed that works for providers and patients. Dr. Flinter called for every federal department to assign an official responsible for ensuring that the department is working toward making high-quality health care available for every individual in the United States.

Discussion

Dr. Chan asked how to disseminate the model of the Community Health Center, Inc., to other sites. Dr. Flinter recognized that organizations do not need to be told what to do; rather, they need tools to make changes. The skills can be learned, through coaching, collaboration, and a disciplined, stepwise process over time. For example, the nurse practitioners in the postgraduate residency programs were well prepared to care for complex patient conditions, but the program offered them tools and training on performance improvement to identify and solve problems. Such tools are not yet embedded in most training programs, and the Center has various mechanisms to disseminate them to other CHCs and sites.

Dr. Taylor-Desir appreciated the integration of behavioral health and the assessment of readiness to interact with training programs. Dr. Flinter said primary care providers have found that

incorporating behavioral health into care is invaluable. Telehealth may be ideal for offering behavioral health when having providers on site is not feasible.

Dr. Khozaim requested insight on managing a large entity with multiple service lines. Dr. Flinter noted that good leadership is crucial, as is confidence that the organization can overcome barriers to achieve its goals. She said the Center was tiny but deeply committed to expansion and created a culture of excitement about growth. Management and administrative staff grew alongside the providers. Dr. Flinter emphasized that having well-trained management staff is as important to success as a well-prepared clinical staff. The Center is open to change and fanatical about growth, recognizing that adding more sites and people means more resources to draw from.

Dr. Callins observed that great leaders create other leaders, so she appreciated Dr. Flinter's emphasis on leadership training as well as her focus on tools that providers can adapt to use in their work. Dr. Flinter urged Council members to seek out opportunities to collaborate with the Weitzman Institute on research and demonstration projects.

Presentation: Caring for the Care Collaborator: Building and Sustaining the Competent Team

Peter Hollmann, MD, AGSF
Chief Medical Officer, Brown Medicine
Chair, Board of Directors, American Geriatrics Society

Peter Hollmann, MD, AGSF, offered advice on how clinicians can care for caregivers. Dementia, multiple comorbidities, and functional impairment contribute to dependency among older people. More than other countries, America relies on families rather than social support systems, yet it spends more than other well-developed countries on health care than social support. A 2016 NASEM report pointed out that no single health care specialty or social service fulfills all the roles that a family caregiver does. Caregivers face emotional and physical difficulties, including the emotional pain of caring for someone with dementia.

However, Dr. Hollmann noted, caregiving can also be rewarding and contribute to confidence as an individual learns new skills to manage challenging situations. Caregiving not only affects

emotional health and physical well-being but also has a financial impact, especially for families managing long-term chronic conditions, and a social impact, as caregivers may be too busy to socialize or embarrassed by their circumstances. The least advantaged are most affected by these challenges, said Dr. Hollmann.

Clinicians should assess whether their patients are caregivers. Even if the caregiver is not their patient, clinicians can provider general advice about managing the patient's condition, for example, and what to expect. Dr. Hollmann said caregivers face many of the same frustrations that primary care providers do: insufficient time, low or no reimbursement for care, difficulty with specialists, poor connections with social services, and lack of team members to assist with care. He outlined the following characteristics of effective care:

- Assessment of risks and needs
- Tailored interventions, including education, skills training, environment modification, care management and coordination, and counseling
- Goals that increase confidence and effectiveness

Assessment tools are available and can help the clinician delve into the caregiver's well-being, the challenges they face, and their capacity to manage the situation. Dr. Hollmann emphasized that providers should treat what they can and offer support. Clinicians can provide caregivers with the tools they need to provide the level of care according to the caregiver's abilities and capacity. Every caregiver has different capacities and resources. Clinicians can assist by helping families understand their options (including long-term care facilities), allaying fears, and clearing up misunderstandings about health conditions and resources for care. Dr. Hollmann recommended that clinicians provide caregivers with perspective, stay positive, emphasize self-care, and recommend ways to rally family members and take advantage of community resources. Clinicians can encourage caregivers to respect the patient's autonomy as much as appropriate and safe—for example, by helping the patient complete tasks rather than doing the task for the patient. Some patients pose special challenges for caregivers—such as those who were abusive to family members—and family members' perspectives on how to care for an aging relative can vary substantially.

Dr. Hollman outlined some of the services that Medicare covers, noting that some services associated with better health outcomes are not widely used. On a broad scale, Dr. Hollmann recommended building and sustaining competent teams for managing geriatric conditions—for example, by incorporating the geriatrics care approach into education and training for primary care and specialty providers and working toward an age-friendly health system. He called for better community-based long-term care services and supports and more effective implementation of technology in health care. In closing, he recommended the website HealthInAging.org as a good resource of information for caregivers.

Discussion

Dr. Callins said the Georgia state legislature is discussing funding for in-home care and asked whether other states are pursuing similar efforts. Dr. Hollmann said that Medicaid waivers exist to pay for in-home care, but they vary by state. He pointed out that more health care workers are needed who can treat patients in their homes, such as certified nursing assistants and home health aides. States save money when families provide care in their own homes, and home care also frees up space in institutions for patients who cannot be cared for at home.

Dr. Callins asked about the status of oral health care for older adults. Dr. Hollmann responded that Medicare is considering covering dental care, but such coverage would be very costly.

Andrea Anderson, MD, FAAFP, pointed out that community care programs and activities for older adults can be very helpful, but such services can be hard to find in some communities, and few cater to non-English speakers. Dr. Hollmann said some states support adult day care programs and caregiver respite programs. Medicare's Program of All-Inclusive Care for the Elderly combines adult day care and medical care for people with advanced health care needs. Dr. Hollmann noted that Medicare is taking SDH into account and recognizing the importance of community programs. He agreed that community programs can be very effective for helping people maintain social engagement.

Public Comment

No public comments were offered.

Remarks from the Chair

Keisha R. Callins, MD, MPH

Chair, NACNHSC

Dr. Callins reminded the Council of its responsibilities and purpose as a preface for considering next steps.

Discussion, Closing Remarks, and Next Steps

NACNHSC Members

Topics for Recommendations and Reports

Dr. Callins summarized the major topics the Council has addressed in its recommendations, letters, and white papers over the past two decades. She called for input on future topics. The Council can make recommendations on new and emerging issues or offer advice and support to HRSA and the NHSC on initiatives planned or underway. The following suggestions were offered:

- Health equity, including justice, equity, diversity, and inclusion
- Telehealth, recognizing the need to preserve the broad access that emerged in response to the COVID-19 pandemic
- Innovations in practice
- Interdisciplinary collaboration, including how the NHSC supports various disciplines and how to expand dental and surgical care services in rural and underserved communities
- Mentorship, training, and ensuring a robust pipeline of future providers, including the role of area health education centers
- Behavioral health
- Support for sites, such as providing performance improvement tools and other knowledge dissemination
- Access to women's health care

Dr. Khozaim asked how the Council could weigh in on implementation of the MCTA designation process. Ms. Fabiyi-King said the Council is welcome to offer advice or make recommendations on implementing or improving the MCTA designation process, but many

aspects may already be finalized. She agreed to ask Mr. Israel and Dr. McCutchen whether clinicians were involved in developing the MCTAs and whether Dr. Khozaim can contribute his insights to the effort.

Regarding telehealth, Dr. Callins suggested Council members review the letter to the HHS Secretary sent jointly from the BHW's five advisory councils to express support for legislation and policy that expands the capacity for telehealth services.

Dr. Callins proposed that the Council seek opportunities to collaborate with the other BHW councils so that reports and recommendations would carry more influence. She noted that the Council can position access to services as an umbrella topic, under which it could address telehealth, equity, surgical and dental care, behavioral health, and women's health services. Ms. Fabiyi-King suggested the Council also consider how to implement its recommendations within the NHSC framework. Dr. Callins said she would send the list of proposed topics to all the Council members and ask them to identify and rank their priority topics.

Ms. Fabiyi-King said the NHSC's application program guidance documents are revised annually, and she invited the Council's input. Dr. Callins suggested that the Council review the application program guidance documents on a regular basis and make recommendations.

Future Meeting Planning

Dr. Callins invited Council members to weigh in on topics for future meetings. Members expressed interest in two topics proposed at previous meetings but not yet addressed: substance use disorders and clinicians in training. Dr. Chan suggested adding leadership training for clinicians. Dr. Taylor-Desir added the Council could examine issues around health care for migrants and refugees.

Dr. Callins suggested that as relevant new publications are posted for public comment, the Council should review them and provide comments. She also proposed that the Council reach out to other advisory councils in HRSA to enhance communication and potentially stimulate collaboration. Dr. Callins said individual Council members could take turns sitting in on other

groups' meetings as a way to initiate engagement. She will work with the HRSA staff to determine the meeting dates of other advisory councils and let Council members know about them.

In closing, Dr. Callins invited Council members to reflect on takeaways from the meeting. Several were impressed by Dr. Flinter's extensive work to expand primary care. Others appreciated the many tips on how clinicians can better support caregivers. Dr. Callins thanked HRSA staff and the technical writer for their support of the Council.

The meeting adjourned at 1:42 p.m.