

Meeting Minutes
National Advisory Council on the National Health Service Corps
Meeting June 22-23, 2021

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

Welcome and Opening Remarks

Designated Federal Officer Diane Fabiyi-King convened the meeting at 10:18 a.m. Eastern Daylight Time (EDT). She introduced herself, welcomed meeting participants, and conducted roll call. All members were present. LaShawn Marks gave instructions for meeting participation. Council Chair Dr. Keisha Callins thanked HRSA staff and the Council for their work. She announced that Patricia Pinto-Garcia will resign from the Council to pursue other opportunities, and welcomed new Council members Tara Brandner, DNP and Andrea Anderson, MD. Dr. Callins reviewed the meeting agenda as well as the charge for NACNHSC, which includes: 1) serving as a forum to identify priorities for NHSC, and anticipate future program issues, 2) functioning as a sounding board for proposed policy changes, and 3) distributing white papers and briefs on issues and concerns relevant to NHSC, and recommendations for addressing them. Dr. Callins read an inspirational poem about teamwork and invited meeting participants to participate in a moment of silence in remembrance of lives lost during 2020, and in recognition of frontline health workers.

Presentation: NHSC Updates

Israil Ali, MPA

Director

Division of National Health Service Corps, Bureau of Health Workforce (BHW), HRSA

Angela Hirsch

Director

Division of External Affairs (DEA), BHW, HRSA

Dr. Callins introduced Mr. Ali, who said the NHSC's primary priority is to mobilize a high-quality primary care workforce. Mr. Ali said the need for primary health care services has increased over the past several years. NHSC is a recognized resource for addressing the primary care shortage among vulnerable populations. The American Rescue Plan Act added \$800 million to NHSC's current budget.

Mr. Ali provided updates on the FY 21 NHSC application cycles. The Students to Service (S2S) Loan Repayment Program (LRP) received a record number of applications (n=384), partly due to making nurse practitioners and certified nurse midwives eligible to apply. This number reflects a 90 percent increase from the number of applications received in recent prior years. More than 20,000 scholarship and LRP applications were created, and nearly 10,000 were submitted. During the application process, NHSC staff learned that many site staff and scholars were not aware of the additional program funding or the likelihood that NHSC would spend it to support additional scholars and licensed clinicians serving Healthcare Provider Shortage Areas (HPSA). NHSC is likely to support all eligible S2S applicants, and is reviewing scholarship and other LRP applications to consider whether to fund additional applicants to these programs.

NHSC's priorities are to: 1) establish program linkages to the NHSC, 2) dedicate support to the NHSC pipeline, and 3) optimize data collection and utilization. NHSC aims to enhance data collection via program applications. The program is collecting more demographic and training data, including tracking residency and fellowship information, to improve understanding of providers who are committing to serving vulnerable populations, and rural and underserved communities. These data will inform marketing and outreach efforts.

BHW offers several programs that aim to cultivate the health workforce, including the Teaching Health Center Graduate Medical Education (THCGME) program, the Primary Care Training and Enhancement- Primary Care Champions program, and the Addiction Medicine Fellowship program. Participants who complete these programs are prime candidates for NHSC and have received preference for NHSC awards in recent competitions. A total of 80 people who completed training in these programs applied to NHSC in FY 21. NHSC plans to build on this modest beginning and eventually saturate the NHSC applicant pool with people who have completed training in BHW programs. NHSC program staff are interested in how education and training support the NHSC pipeline. This includes exploring how both BHW programs and other similar programs that are not administered by BHW contribute to the NHSC pipeline. NHSC staff are especially interested in the readiness of NHSC participants to provide care to underserved communities. The NHSC Pipeline Initiative aims to cultivate readiness and ensure that participants practice in underserved communities throughout their careers. The initiative also aims to ensure NHSC participants understand how population health management determines community health outcomes, and that NHSC participants are able to promote clinician resiliency and recognize symptoms of burnout. The initiative supports development of a resource repository and technical assistance to engage 1,500 NHSC participants at their approved sites.

NHSC will compare applications that were started but not submitted with those that were submitted. Approximately 8,000 applications were complete but not submitted. Data on these applications will inform future outreach efforts. NHSC staff plan to externalize more program data. NHSC field strength dashboard data have facilitated discussions about award disparities between States. The program aims to focus on health outcomes attained rather than number of people trained. The National Center for Health Workforce Analysis (NCHWA) currently is assessing health outcomes associated with the Substance Use Disorder (SUD) Workforce LRP and Rural Community LRP programs.

Angela Hirsch said that the additional NHSC funding from the American Rescue Plan Act charged the program with recruiting the largest group of participants in the history of the program. DEA's planning and implementation of its recruitment communication strategy is collaborative, creative, and comprehensive. DEA works closely with a cross-agency, cross-divisional, and cross-functional team from initial planning through development of after-action reports. Subject matter

experts offer support for initial communications planning and ongoing needs assessment. Teams employ adaptive prioritizing, which includes adjusting targets, messaging, and promotional activities in response to needs assessment results. Teams analyze metrics and develop after-action reports. Communication strategies aim to reach the right balance of applicants across disciplines and demographics, HPSA targets, rural and Tribal communities, and others that may be defined by a campaign.

DEA creative marketing efforts are intentionally inclusive. Program staff and stakeholders are involved throughout the campaign process. Previous successful efforts are tailored for new campaigns when appropriate. For example, images of pets and babies are generally successful at engaging social media audiences. Campaign images depict diverse health care providers, including actual NHSC participants. Teams foster creativity and include all members to share ideas. In some cases, ideas not applied in the campaign for which they were developed are applied in other campaigns. Teams gather input that allows them to develop campaigns that reflect the audience's perspective. Program applications and applicant questions during webinars provide information about the target audience's perspective regarding challenges and facilitators to applying to NHSC. Campaign steps include identifying the target audience, determining where they get information, and what messaging will be effective. Campaign teams assess the appropriate frequency for message delivery. DEA seeks partners who can amplify messages.

In response to the additional program funding for FY 21, DEA developed a national recruitment campaign that used earned media, paid media, website and social media, and stakeholder outreach. Earned media efforts included a radio media tour with Dr. Luis Padilla and Israil Ali speaking on more than a dozen stations, some based in rural communities. Earned media also included a prepared article on medication assisted treatment (MAT), a pre-recorded audio news release, and articles for organizations that represent and can reach key stakeholders. The messages in these media outreach efforts emphasized that new funding would allow increased NHSC awards, including to sites with lower HPSA scores that had not previously been able to compete successfully.

DEA also paid for media advertising to reach potential applicants. This year, for the first time, DEA advertised on podcasts. DEA placed advertisements on "Curbsiders," a podcast about clinical

care and practice management reaching approximately 50,000 listeners. DEA hopes to participate in podcast interviews in the fall of 2021. DEA also has paid for advertisements on Twitter, LinkedIn, and Google Keywords. Google Keywords advertisements aim to reach clinicians who do not use NHSC social media channels. The NHSC website and social media are key channels for outreach to future applicants, site administrators, and stakeholders. The website offers graphics that display how LRP programs compare as well as an application checklist, which was downloaded approximately 5,600 times during the first 2 weeks it was available.

NHSC Champions are members and alumni who provide content about the program on their own social media. DEA provides information for NHSC Champions to share. DEA hosted a Facebook chat with approximately 1,500 participants. DEA also has hosted question and answer, and technical assistance webinars. DEA monitors questions to identify those that are repeated frequently and sends e-blasts with answers to frequently asked questions. In 2021, for the first time, DEA hosted a Reddit Ask Me Anything (AMA) session.

DEA is conducting outreach to stakeholders to notify them that sites with relatively low HPSA scores are eligible to apply to become NHSC sites. Primary Care Associations have communicated this message to sites in their States. DEA also reached sites through stakeholder webinars, and disseminated a stakeholder toolkit to 58 partners. The toolkit included prepared articles, social media posts, and other tools to amplify messages about the NHSC. Stakeholder outreach also included a letter to Tribal leaders to nurture relationships and inviting their help in reaching clinicians to practice at Tribal sites.

Communications in the next application cycle will focus on people who started, but did not submit, an application. DEA will work to encourage these people to submit applications, and to identify and overcome barriers to application.

Discussion

Dr. Callins asked Mr. Ali how the Pipeline Readiness Initiative will link mentorship to the NHSC pipeline. Mr. Ali said this is a factor that proposal reviewers will consider, but that he could not discuss the topic in more detail while the funding solicitation is active. Dr. Callins said mentorship would be a program strength; it is important for clinicians to know they are not alone when they practice at NHSC sites.

Dr. Callins asked Ms. Hirsch how communications campaigns inform audiences about the range of professional disciplines eligible to participate in NHSC. Ms. Hirsch said the LRP comparison infographic presents this information. Stakeholder organizations with established connections to newly eligible professions can help to disseminate messages to members of these professions. E-blasts also include messages about expanded eligibility.

Dr. Bockwoldt said the NHSC website asks which program an applicant is applying to. There are several programs; answering may be challenging for initial applicants who do not know the program most appropriate for them. She suggested instead offering a tool to help potential applicants determine the programs for which they are eligible. She reported that she had nearly completed an application for one program before finding out that she was ineligible, which was frustrating. Mr. Ali said he would call this to the website team's attention. He said most DEA messages drive audiences to information about a specific program.

Dr. Ellen Piernot asked whether the application portal prompts people who complete but do not submit applications to indicate why they did not submit, and whether it offers applicants assistance. Mr. Ali said the DEA currently is following up with this group of potential applicants to address these questions. The system does notify people that their applications are pending.

Dr. Andrea Anderson asked whether DEA is training the social media influencers it works with to apply evidence-based practices in messaging. Ms. Hirsch said she did not know. DEA is monitoring social influencers' content and following. The social influencers have been skilled and effective. DEA is interested in making the approach more effective and will consider Dr. Anderson's suggestion.

Panel Presentation: Mental Health Perspectives in Underserved Communities as We Emerge from the COVID-19 Pandemic

Joshua Morganstein, MD

Captain

U.S. Public Health Service

Chair

Disaster Committee, American Psychiatric Association

Associate Professor/Assistant Chair

Department of Psychiatry

Assistant Director

Center for the Study of Traumatic Stress, School of Medicine, Uniformed Services University

Altha Stewart, MD

Senior Associate Dean for Community Health Engagement

Director Center for Health and Justice Involved Youth

College of Medicine, University of Tennessee.

Patrice Harris, MD, MA

Immediate Past President

American Medical Association

Dr. Callins welcomed the presenters and thanked Dr. Taylor-Desir for recruiting them. Dr. Callins noted that addressing communities' need for behavioral health care providers is a high priority for NHSC. She reported that, in 2020, NHSC doubled the number of participating behavioral health clinicians who treat substance use disorder (SUD) to more than 2,800. During this time the number of SUD behavioral health care providers serving rural communities increased more than 270 percent. Mental and behavioral health total field strength increased approximately 40 percent. SUD behavioral health care provider professions include health service psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, and nurse practitioners and physician assistants with training in mental health and psychiatry. Dr. Taylor-Desir welcomed the panelists and introduced them.

Dr. Joshua Morganstein said he studies trauma in the context of all types of disaster. A major part of his work is translating military work on well-being and resilience in disaster settings for non-military communities. He has collaborated with colleagues to determine how best to adapt existing resources to respond to the unique needs associated with COVID-19. He noted that the psychological and behavioral impacts of disasters are nearly always more severe and long-lasting than their medical impacts. COVID-19's impact is likely to last even after society is fully vaccinated. Typically, some groups bear disproportionate mental health burden.

People may develop psychiatric disorders in response to disasters. The public is less aware of less severe mental and behavioral health issues that may result from experiencing disaster, although these issues are more common and cause significant public mental health burden. Less severe reactions include distress reactions, such as insomnia and decreased sense of safety, and risky health behaviors, such as substance use and interpersonal violence. These issues are of concern even if they are not severe enough to warrant a psychiatric diagnosis. People experiencing these problems typically do not seek services from mental health care specialists. They are most likely to seek care from primary care or emergency care providers. These types of providers also are the most accessible to vulnerable populations.

A large majority of people do recover from mental and behavioral health issues that result from experiencing disaster. That is an important message for the public to hear at this time. Stress occurs on a continuum. Appropriate interventions and care providers vary along the continuum. Many organizations considering how best to support health care providers' mental health focus on identifying mental illness and responding with clinical interventions. But most people do not seek clinical care. And, interventions designed to treat illness are not appropriate to address stress reactions at other points on the continuum. Organizations should offer resources and interventions that respond to needs.

Disaster response typically occurs in phases: a honeymoon with community cohesion, followed by disillusionment, then reconstruction. COVID-19 response has included these phases. But the initial response also involved conflict within communities, which has been stressful for health care workers. Understanding that response changes over time is useful for resource planning and intervention targeting. It also is important to know where risk is concentrated, such as which

communities experience most exposure to environmental toxins. Mental health care needs among health care provider are concentrated among those who experience most exposure to human suffering, especially exposure to human remains and death. Organizational leadership and support are critical for health care provider mental health and well-being during all crisis events. Empathy, encouragement, and communication are associated with better mental health care outcomes for workers.

Certain socioeconomic factors are associated with higher risk. For example, losing a job or home heightens risk for adverse health outcomes. Lower socioeconomic status is associated with living in communities at higher risk for disasters, and receiving care in systems that are less prepared to respond to disasters. Nearly everyone has been affected by COVID-19. Intervention efforts must consider people's strengths and resilience. For example, being homebound during the pandemic has been associated with social isolation, family conflict, and substance use for some people, and increased social connection with family and neighbors, and increase self-reliance for others.

There are five essential elements that protect health and sustain functioning in the wake of disaster: 1) enhancing a sense of safety, 2) calming, 3) self- or community-efficacy, 4) social connectedness, and 5) hope. These are the basis for psychological first aid, and an evidence-based framework for supporting resilience, enhancing well-being, and improving functioning after a disaster. Organizations should share a ranges of resources that can help workers with varied needs to cope after disasters. Examples include fact sheets, well-being assessments, wellness portals, and resilience training programs.

Dr. Altha Stewart said she was a NHSC scholar. She said it is critical to understand the experiences of people in underserved communities with mental health and mental health care access. Dr. Stewart's mentor taught her that providers should understand people in the context of their families and communities. She learned the necessity of understanding her patients' needs and experiences, and the values of their communities. It was important not to impose her cultural expectations on the communities she served. Dr. Stewart noted that community can mean not just people living in the same geographic area, but any closely connected social network. Underserved communities are vulnerable to racism, poverty, unemployment, and underemployment. Although Dr. Stewart identifies as African American, and acknowledges that this has helped her to better understand

some of the communities she has served, she has learned that her experiences and perspectives as an African-American woman do not always match those of people she has served even if there is racial or gender concordance. It is always important to learn communities' values rather than assume understanding. Health care providers must learn how social determinants of health affect the communities they serve.

Dr. Stewart said a positive outlook is essential for provider well-being. She emphasized that health care providers must not be defeatist when serving patients who experience many risk factors, but should address risk by strengthening presence of protective factors. Providers must learn how patients and communities handled stress prior to intervention efforts. Dr. Stewart advocated assuming that challenges can be overcome and “pursuing the possible,” focusing on resiliency rather than deficiency.

Dr. Patrice Harris said the field must focus on prevention, not just treatment. She emphasized the importance of Dr. Stewart's advocacy for health care providers being “pursuers of the possible.” Dr. Harris noted that health inequity and a declining public health infrastructure were problems prior to the COVID-19 pandemic. The pandemic only amplified these existing problems.

Dr. Harris said there are several definitions of behavioral health integration. The term usually refers to integrating behavioral health into primary care. As president of the American Medical Association, Dr. Harris prioritized: 1) integrating mental health into health care generally, 2) matching provider demographics to the communities they serve, with the purpose of achieving health equity, and 3) addressing trauma, especially childhood trauma. The COVID-19 pandemic has emphasized the importance of these issues. It also has increased the need for mental health services. It is critical to collect surveillance data and use these data to inform development of programs that offer prevention, promote resilience, increase awareness, and offer treatment. Dr. Harris described her own experience working in a clinic that integrated medical, mental, and oral health services and also worked to address social determinants of health such as access to housing, transportation, and childcare.

Collaborative care models cannot be implemented unless policy supports them. For example, Medicaid used to refuse to reimburse for treatment if a patient visited a primary care and mental health care provider on the same day. Stakeholders should review government, payer, and health

care provider organization policies to consider whether they support parity in coverage, access to care, and care provider competence. Data are necessary to assess progress toward achieving target mental health outcomes. The field must work to integrate data systems, which tend to be siloes. Training and education efforts should expand, train and diversify the health workforce, and prepare the workforce to serve on integrated care teams. Technology must be applied to solve problems, not worsen health inequity. During the pandemic, some burdensome restrictions on telehealth were removed. Stakeholders must work toward equitable access to telehealth, such as expanding broadband access.

The Behavioral Health Integration Collaborative comprises several health professional associations with a mission to “catalyze effective and sustainable integration of behavioral and mental health care into physician practices (with initial emphasis on primary care).” Activities include education and programming for health care providers, disseminating resources and tools, and testing practice approaches to support providers in developing integrated practices.

Discussion

Dr. Taylor-Desir asked Dr. Morganstein how best to prepare and support clinicians who have experienced moral injury, and those who will serve communities experiencing collective grief. Dr. Morganstein said it is important to distinguish these experiences from disorders. During disasters, clinicians are most likely experiencing moral distress. Clinicians vary in their responses to disaster. It is important to listen and understand individual experiences and perspectives. Addressing clinicians’ and communities’ needs is not only the responsibility of individuals affected, but also of organizations and leaders. Peer “buddy systems” can offer support during a crisis by offering opportunities to discuss and reframe experiences, and express empathy and appreciation for good work. Post-shift huddles are opportunities for leaders and peers to hear and correct distorted thinking that can worsen a sense of moral injury. Huddles are an opportunity to monitor team members and identify potential challenges.

Recognizing community grief is an important part of addressing that grief. Grief leadership facilitates faster and more thorough recovery from grief. Grief leadership includes leaders’ publicly acknowledging grief, helping the community to assign meaning to grievous events, asking community members what they need, working with communities to implement actions to recover,

and facilitating looking hopefully toward the future. People are responding to COVID-19 with grief over loss of loved ones, routine, and sense of certainty and safety. Health care providers should understand this grief and how to respond to it.

Dr. Taylor-Desir asked Dr. Stewart what community systems new NHSC clinicians should learn about and collaborate with to promote well-being in children and families. Dr. Stewart said she would start by advising new clinicians to give everyone, including themselves, grace as they adjust to new experiences. People need time to learn about a new person. They will inevitably say something awkward with no malice intended. It is important not to impose preconceived notions on communities that are new to the clinician. A clinician should have a humble and authentic demeanor, and be willing to ask for help to learn. Clinicians should seek to never condescend. Rather, they should learn about a community's history, geography, and demographics before practicing there. This will help clinicians to support communication with community members. Clinicians should be aware and become knowledgeable about who the community leaders are in their site location area and invite their guidance. They should learn about community needs, how they are being met, and collaborate to address these needs better. Clinicians should learn self-care and develop social support systems. These approaches will support clinicians in addressing community needs and having a sense of success, which is critical for avoiding frustration and burnout.

Dr. Anderson said many health care providers are frustrated by lack of time to address patients' grief and anxiety. She asked how providers can advocate for policy changes that will allow adequate time for this purpose. Dr. Harris said providers should advocate for payment models that support team-based care and allow clinicians the time necessary to address patients' grief and anxiety, or models that support referrals to other appropriate team members. Clinicians can join professional organizations' policy alert lists and contact their representatives to advocate change. They also can offer to advise political representatives on health issues.

Dr. Taylor-Desir asked Dr. Harris how integrating behavioral and primary health care promotes equity. Dr. Harris said practices must prioritize equity in all of their work. Clinicians should tell their representatives to prioritize equity in policy and contact their representatives to advocate for policies that promote equity.

Dr. Callins thanked panelists for their presentations and offered to share the Council’s policy recommendation report with them. She congratulated Dr. David Schmitz on publishing an article in *Family Medicine* on June 15, 2021 entitled, “The role of rural graduate medical education in improving rural health and health care,” and invited Dr. Schmitz to comment on the article. Dr. Schmitz said he hoped the article, which is part of a series on needs for training family physicians between medical school graduation and board certification, would be useful.

Presentation: Health Equity and Social Determinants of Health

Gem Daus

Public Health Analyst

Office of Health Equity (OHE), HRSA

Mr. Daus said that Office of Health Equity (OHE) “works to reduce health inequities so that communities and individuals can achieve their highest level of health.” OHE collaborates with internal and external partners, and works to integrate equity into all HRSA programs and policies. OHE has convened a Tribal Advisory Council and facilitates a course on “The Roots of Health Inequity.” The course includes discussion on how to address root causes of health inequity. It is publicly available. Participants report they find the training valuable for their work.

The Department of Health and Human Services defines health equity as, “Attainments of the highest level of health for all people. Health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.” OHE defines health equity as, “the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographic areas in health status and health outcomes such as disease, disability, or mortality.”

Achieving equity requires addressing social determinants of health, which the World Health Organization defines as, “the conditions in which people are born, grow, live, work, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” as well as “the fundamental drivers of these conditions.” Domains of social determinants of health include education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. Healthy People 2030 has produced briefs

summarizing literature relevant to each of these domains along with discussion of how Healthy People objectives can address social determinants of health. People in the United States tend to think of health as an individual responsibility. However, behavior patterns only account for 40 percent of premature death and other health outcomes. Genetic disposition is estimated to account for 30 percent of health outcomes, but is modifiable by environmental factors.

An upstream/downstream model of social determinants of health presents injury, disease, and death as “downstream” results of “upstream” causes such as social inequities and policies. For example, COVID-19 infection and deaths among people younger than 65 years are higher, testing and vaccination rates are lower among Black and Hispanic people. Pacific Islanders experience the highest rate of COVID-19-related mortality among people younger than 65 years. Causes for these disparities include different rates of being unable to socially distance at work and having to use public transportation. Public policies and programs can improve conditions to improve the social conditions that affect health.

HRSA’s *Health Equity Report 2019-2020* includes a special feature on housing and health inequalities. The report is available on HRSA’s web site. Housing status is a key social determinant of health. Mr. Daus presented maps displaying American Community Survey 2000 and 2013-2017 zip code-level data on the percentage of the population with a college degree, percentage of children younger than 18 years and adults aged 18-65 years without health insurance in 2013-2017, percentages of people with any disability and with cognitive disability, age-adjusted cardiovascular disease mortality rates in 1999-2003 and 2013-2017, home ownership rates and housing cost burden 2013-2017, severe housing problems 2010-2014, and number of social associations per 10,000 population 2015. He noted that burden varies geographically.

HRSA supports laws, policies, and regulations that create community conditions that support health. The American Rescue Plan Act funding to HRSA will support and expand community health center COVID-19 operations and capacity, support an increase in the number of community-based health care providers responding to COVID-19, develop a community-based workforce to increase vaccinations in underserved communities, and support rural response to COVID-19. HRSA manages distribution of the Provider Relief Fund, which reimburses health care providers for expenses or lost revenue attributable to COVID-19, including masks, and

vaccination and treatment of patients who do not have health insurance. Health centers collect data on social factors and provide referrals to “enabling services” that support access to health care, such as transportation and translation.

Telehealth use increased during the pandemic. During the week of May 28, 2021, 20.54 percent of health center visits were conducted virtually. Vaccine disparities are a challenging structural issue that HRSA is working to address. As of June 8, 2021, HRSA-supported health centers had delivered 11,922,395 COVID-19 vaccinations, 63.3 percent of which were to patients who were race/ethnic minorities. Mr. Daus referenced Daniel Dawes’ book *The Political Determinants of Health*, which emphasizes that the public health field should not strive to return to what was normal prior to the pandemic, but should consider how to improve.

Discussion

Dr. Callins asked Mr. Daus to confirm that OHE’s “Roots of Health Inequity” course is available to the general public, which he did. Mr. Daus added that the National Association of County and City Health Officials (NACCHO) created the course and is considering how to update the course, which discusses racism, sexism, and class issues. It discusses redlining, a policy from the 1930s and 1940s, which is associated with current high prevalence of poverty, crime, pollution, and current HPSA status. Many people do not know this history and have appreciated the opportunity to learn about structural racism from the course. Dr. Callins asked how many NHSC sites participate in the course. Mr. Daus said OHE offers the course to HRSA staff, some of whom recommend the course to the grantees they work with.

Dr. Callins asked whether HRSA’s *Health Equity Report 2019-2020* discusses climate change. Mr. Daus said he did not think this was the case, but that Healthy People 2030 does discuss climate change and has several objectives related to air quality. Communities with poor air quality are likely to have Federally Qualified Health Centers (FQHC).

Dr. Schmitz commended OHE for considering geographic factors associated with health equity, noting that BHW emphasizes ensuring the workforce is in places with greatest need. Dr. Schmitz said his focus is on health care providers meeting the needs of the communities they serve. Telemedicine is a factor that affects progress toward this goal. Telemedicine allows reach across geographic distance and changes what is needed from providers who are face-to-face with patients.

It is important for policy makers and systems to consider how to ensure people living in rural and remote communities have access to health services that cannot be delivered via telemedicine. Dr. Schmitz noted that several critical access hospitals have closed, and that it is important to avoid unintended negative consequences of telemedicine, such as inadequate capacity to deliver services that must be delivered in-person, including obstetrical delivery and traumatic injury care. In order to be available to offer these services, providers must have financial stability. Dr. Schmitz asked whether Mr. Daus believes community health needs assessments are adequate to indicate geography-related needs. Mr. Daus emphasized the need for access to broadband internet services, and said OHE published a report that discusses disparities in broadband access. Dr. Schmitz said telemedicine has the potential to undermine traditional models of place-based necessary health care.

Dr. Anderson asked whether participants in the “Roots of Health Inequity” course can earn continuing education credits. Mr. Daus said he will ask NACCHO for this information. Dr. Anderson said these credits would be an effective incentive for clinician participation in the training course.

Dr. Callins said the Council could discuss tailoring the “Roots of Health Inequity” course for NHSC site administrators and clinicians. She asked whether *Health Equity Report 2019-2020*, which is more than 200 pages long, includes an executive summary. Mr. Daus said the report includes a one-page abstract.

Dr. Callins pointed out that health care providers and systems developed innovations to respond to COVID-19. She invited group discussion on how to leverage these innovations, in domains such as outreach, access to care, and vaccination, to sustain improvements in health care delivery. Dr. Schmitz said it is important to consider the potential impact of policies on rural and frontier communities, and how to ameliorate potential unintended negative consequences. Dr. Bockwoldt said many support staff members have not yet returned to work, which is a challenge for operations. Large health systems are hiring these staff for wages and benefits with which small practices cannot compete. Dr. Brandner agreed with Dr. Bockwoldt’s comments and added that demand for services has increased as patients present for services they postponed during the pandemic.

Dr. Callins said providers in rural areas must be generalists in order to meet the needs of communities they serve. She observed that communities' needs can change over time. She said that her patient load had doubled during the pandemic, while support staff were less available for several reasons, including lack of childcare. Dr. Schmitz said it is important for rural health care providers to be "master adaptive learners," who are able to learn new skills and adapt in order to meet communities' needs. Dr. Callins said it is important to consider how to retain benefits from lessons learned and infrastructure built after a provider leaves a community. Dr. Anderson reemphasized the importance of focusing on what should be improved after the COVID-19 pandemic ends, such as health equity and payment models. Dr. Callins thanked Mr. Daus for his presentation.

Presentation: Legislative Update

Melissa Ryan

Director

Division of Policy and Shortage Designation, BHW, HRSA

Ms. Ryan reminded the Council that the American Rescue Plan Act appropriated \$800 million, an historic amount, for NHSC programs. The appropriation includes \$100 million set aside for State LRPs (SLRP), which will be allocated at \$25 million annually over a period of 4 years. The SLRP set aside does not include the usual requirement for States to match funds. SLRP recipients can use as much as 10 percent of their funds for program administration, which they are not normally allowed to do. The American Rescue Plan Act allocated significant funding for THCGME and Nurse Corps programs.

Recently proposed legislation includes the Strengthening America's Healthcare Readiness Act, which proposes a \$5 billion budget increase for NHSC, with 40 percent of funds set aside to support students who are racial or ethnic minorities, students with low-income urban backgrounds, and students from rural communities. If passed, the bill will establish a demonstration program to mobilize the NHSC workforce to serve in emergency capacities via the National Disaster Medical System. This bill has bipartisan sponsorship.

The Mental Health Professionals Workforce Shortage Loan Repayment Act has bipartisan and bicameral support. This legislation proposes to amend Title VII of the Public Health Service Act

to provide as much as \$250,000 for eligible student loan repayment for mental health professionals who work in mental health HPSAs.

Senator Schatz of Hawaii has previously proposed, and is proposing again, the Ensuring Access to General Surgery Act, which would amend the Public Health Service Act to require the Secretary to designate General Surgery Shortage Areas. The bipartisan Rural America Health Corps Act would establish a NHSC LRP specifically for rural health care providers. Recipients would be required to practice for at least 5 years in a rural HPSA to be eligible for as much as \$200,000 in loan repayment.

The Public Health Workforce Loan Repayment Act proposes to establish a public health workforce LRP to promote recruitment through local, State, and Tribal public health agencies, applying Section 330J of the Public Health Service Act. Eligible individuals are those completing their last year of health or public health professional training and those who have completed training within the last 10 years. Recipients must commit to at least 3 years of service at a local, State, or Tribal public health agency in exchange for as much as \$35,000 loan repayment per year of service.

The HIV Epidemic Loan Repayment Program (HELP) Act would offer as much as \$250,000 for loan repayment to physicians, physician assistants, nurse practitioners, pharmacists, and dentists in exchange for 5 years of providing HIV treatment in HPSAs or Ryan White-funded sites. The Physical Therapist Workforce and Patient Access Act would extend NHSC eligibility to physical therapists. The Turn the Tide Act proposes additional funding for programs created by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. This includes \$25 million annually from FY 2021 through FY 2024 for the Substance Use Disorder Treatment Workforce LRP.

The Government Accountability Office released a report on NHSC on June 1, 2021. The report found that 14,000 primary care providers participated in NHSC in 2020. It also reported that 40 percent of program applicants were not funded because their designated NHSC site did not have enough need. Ms. Ryan said this is because funds are limited and priority is assigned according to need as indicated by HPSA scores. She encouraged Council members to read the report.

Ms. Ryan reminded the Council that the Improving Access to Maternity Care Act had passed in 2019. It requires HRSA to identify areas within existing HPSAs that have shortages of maternity care professionals, seek stakeholder input on how to identify these areas, collect and publish data in *The Federal Register* about availability and need for maternity health care services in HPSAs, and distribute NHSC maternity care professionals in these areas using scoring criteria. HRSA issued a request for information about criteria for Maternity Care Target Area (MCTA) scoring in May 2020, and currently is reviewing comments and other data sources to develop draft scoring criteria. It is a challenge to find data that are available across the U.S. and that describe small enough areas to designate a MCTA, which is generally a county or set of census tracts.

Discussion

Ms. Ryan invited comments on recently passed and recently proposed legislation. Dr. Sein asked how likely Ms. Ryan thought it was that all proposed legislation would be enacted. Ms. Ryan said she was uncertain. She noted that, if legislation to expand NHSC passes, this does not necessarily mean funding will be available to support additional participants. Authority and appropriations are distinct. The pandemic has increased awareness of the need for a public health workforce. Bipartisan and bicameral support increase likelihood of enactment.

Dr. Callins asked when HRSA would implement MCTA scoring, and how HRSA is working with professional organizations in developing the MCTA scoring process. Ms. Ryan said HRSA currently is reviewing comments from professional organizations. There are no funds allocated to support implementing the Improving Access to Maternity Care Act. Identifying data sources is challenging. Maternity morbidity and mortality data are not available to HRSA for regions smaller than States, due to privacy issues. Multiple HRSA and HHS reviewers will have to review the scoring process before it can be implemented. If the process is approved, HRSA will have to build an information technology (IT) system to support it and implement new data collection efforts. This process will take several years.

Dr. Piernot asked whether HRSA has a plan for documenting accomplishments supported by American Rescue Program funds in order to advocate continuing funding at increased levels. Ms. Ryan said NHSC submits annual reports to Congress. It will be a challenge to encourage participants at sites with lower HPSA scores to apply, since they have not been awarded in recent

years. NHSC will have to notify sites that these applicants are now likely to be competitive. It is important to show Congress what NHSC can do with additional funds, which is only possible if enough people apply to participate.

Dr. Schmitz said geographic access to maternity care is essential. Maternity care outcomes are documented according to where care is paid for, which is not always where care is delivered. For example, if a baby is delivered on the way to a hospital, outcomes data are associated with the hospital. Dr. Schmitz is working with colleagues to link birth outcomes to mother's residential zip code in order to assess geographical disparities. Dr. Schmitz said that the American College of Obstetricians and Gynecologists and other stakeholders are discussing how maternity care can be defined by multiple levels of institutions and providers necessary to meet needs. HRSA can make major contributions to this discussion.

Dr. Sein asked how HRSA expects the THCGME program to change as a result of additional funding from the American Rescue Plan Act. Ms. Ryan said the Act allocated \$330 million to support, expand, and develop the program through FY 2023, after which funds not expended will no longer be available. Development grants will be limited to \$500,000 each. Funds allow an increase in \$10,000 of support for each participating resident.

Dr. Callins asked when the best time is for HRSA to provide NACNHSC with legislative updates, and if the information can be presented in a manner that shows the progress of legislation over time, such as when legislation was first introduced, how often it has been reintroduced, barriers to enactment, and how the Council can support enactment of policies that benefit NHSC. Dr. Anderson supported this idea. Ms. Ryan encouraged the Council to consider which legislation would support NHSC's mission, and how to work with other BHW programs to support this mission. She said she will provide updates whenever the Council requests. Dr. Schmitz recommended that NHSC strategic planning include consideration of which services cannot be provided remotely as well as those that are time-sensitive.

Presentation: Celebrating Five Decades of Service

Angela Hirsch

Director

Division of External Affairs (DEA), BHW, HRSA

NHSC will celebrate its 50th anniversary in 2022. This anniversary will coincide with NHSC having the largest field strength in its history, and with unprecedented public attention to NHSC priority issues. DEA wants to tell a comprehensive story about NHSC's growth and development, who and where NHSC clinicians have served, NHSC's impact on health care delivery, and plans for NHSC's future. The celebration is significant for alumni, current participants, stakeholders, and partners. DEA is planning an inclusive celebration. Reasons to celebrate include NHSC's support for more than 63,000 primary medical, dental, mental and behavioral health care providers. NHSC clinicians have adapted to changing needs, and have served millions of people, in rural, urban, and Tribal communities. They have responded to public health crises including Zika, the opioid crisis, and the COVID-19 pandemic. DEA is using the anniversary milestone as an opportunity to call attention to health disparities that make NHSC more relevant and necessary than ever. DEA is seeking input on the celebration from NACNHSC, alumni, NHSC site personnel, and representatives from stakeholder organizations including other government agencies that have celebrated similar events.

The celebration theme is "Five Decades of Service." DEA is planning to produce a multimedia series, which may be a video and/or podcast or other media, shared via web site and/or social media. The series will focus on stories of individual NHSC members and alumni. DEA is considering the best way to capture these stories and share them as widely as possible. The celebration also will include a Stars of Service Profiles series to highlight individual NHSC members, which may extend beyond the anniversary celebration. DEA is working to develop engaging branded content, which will include a logo and web site content. DEA will provide partners, including the Secretary and other HHS operating divisions, and media outlets with content they can disseminate in order to amplify messaging. DEA will invite the Secretary to record a video congratulating NHSC. DEA is working with its Public Affairs team and stakeholders to plan outreach to a broad audience. Possible strategies include seeking celebrity endorsements and sharing reports on NHSC impact.

DEA is working to complete graphics and branding before the next NHSC application cycle, which will be later in 2021. DEA plans to use branded content in the field strength press release, which usually occurs in October. Campaign promotions will occur throughout 2022. DEA will reach out to alumni and current members to invite them to participate in celebration, to HHS and HRSA leaders in order to assess their interest in supporting the anniversary campaign, and to stakeholders to discuss celebration activities.

Ms. Hirsch invited input from the Council to ensure that the celebration recognizes every decade of service, geographical areas served, professional disciplines represented, and people served. She also invited Council members to share contact information for people and organizations that could help amplify messages about the anniversary. DEA would like to introduce younger audiences, such as secondary school students, to NHSC.

Discussion

Dr. Taylor-Desir asked whether DEA would produce wearable anniversary pins that could serve as conversation starters. Ms. Hirsch said people like physical mementos, but government regulations may make this problematic. DEA is exploring the possibility of stakeholders, such as alumni, producing promotional mementos. Dr. Anderson pointed out that physical displays of membership could help to connect NHSC participants with each other and remind them of shared experiences. This could be especially valuable to alumni who are not currently serving at a NHSC site. Dr. Piernot asked whether regulations allow government organizations to sell merchandise if the government does not profit from sales. She noted that this would be a strategy for promoting awareness of NHSC. Ms. Hirsch said she was unsure but did not think this was an option.

Dr. Anderson said Dr. Stewart's charge to be "pursuers of the possible" would be an appropriate theme for the NHSC's 50th anniversary. She also noted that Dr. Stewart had reported the musician Pharrell's song "Happy" was a personal source of inspiration, and suggested considering Pharrell as a celebrity to promote the anniversary. Dr. Anderson said communications about the anniversary should focus on the optimism and resiliency that have sustained NHSC.

Dr. Piernot said NHSC has changed many clinicians' career trajectories. She suggested highlighting this during anniversary events. Ms. Hirsch said DEA hopes to do this in sharing NHSC clinicians' stories. Dr. Taylor-Desir said some people discourage NHSC participation as

detrimental to career achievement, yet participants have gone on to lead national organizations and teach at medical schools. She recommended sharing stories that illustrate alumni's career achievements. Ms. Hirsch invited members to send her contact information for potential alumni who could share these stories.

Dr. Callins recommended anniversary activities that illustrate the diverse professions included in NHSC, and how these professions have expanded in response to community needs. She also recommended developing messages to encourage youth to aspire to NHSC participation, with emphasis on the program's heroism. Dr. Callins suggested sharing patients' stories of how NHSC helped them. These stories could be more compelling than celebrity endorsements. Dr. Callins also suggested promoting the anniversary through news media. Local organizations often recognize community leaders and heroes. These community activities could be incorporated into anniversary events. NHSC participants often mentor students who become NHSC participants. This generational impact could be celebrated during anniversary events. Health profession schools that educate a large number of scholars could amplify communications about the anniversary. Dr. Callins said recruitment strategies of other service organizations, such as the military, could inform NHSC recruitment strategies. She suggested developing messages that illustrate how most NHSC participants grow to love service in high-need communities and remain committed to service after fulfilling their obligations. Ms. Hirsch said the military targets its recruitment efforts toward middle school students because they are idealistic and at the age when people are most likely to be inspired to commit to service. It is more difficult to recruit people who are older and dealing with practical considerations. This suggests it may be useful for NHSC to do the same.

Ms. Hirsch said sites will be very valuable partners in sharing messages. Dr. Callins suggested providing sites with a communications toolkit. She also suggested developing promotional materials that would not require purchase, such as an e-mail logo. Ms. Hirsch said the NHSC logo is downloadable and added that DEA could develop a Facebook picture frame. Ms. Hirsch and Ms. Fabiyi-King thanked the DEA team for their work in developing anniversary campaign ideas.

Public Comment

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

Closing Comments

Dr. Callins asked Ms. Fabiyi-King and Keisha Robinson to distribute biographical sketches of Council members to the Council. She facilitated an informal exercise to introduce members to each other. She said the day's presentations and discussions would inform the Council's papers, and invited closing comments. Dr. Schmitz welcomed and thanked new Council members. Dr. Callins and Ms. Fabiyi-King thanked HRSA staff for their work. Dr. Callins adjourned the meeting at 4:35 p.m. EDT.

DAY 2

Welcome and Roll Call

Ms. Fabiyi-King convened the meeting at 10:16 a.m. EDT and conducted roll call. All members were present. Ms. Marks provided instructions for meeting participation.

Opening Remarks

Dr. Callins reminded the Council that NHSC's mission is "to build healthy communities by supporting qualified medical, dental, and behavioral health care clinicians working in areas in the United States with limited access to care." She reiterated that the Council had agreed that their goal is to retain what worked well prior to the COVID-19, then work to improve rather than return to normal. Dr. Callins read an excerpt from "The Hill We Climb," read by Poet Laureate Amanda Gorman at the 2021 presidential inauguration, "We will rebuild, reconcile, and recover in every known nook of our nation and every corner called our country. Our people, diverse and beautiful will emerge battered and beautiful. When day comes we step out of the shade, aflame and unafraid. The new dawn blooms as we free it. For there is always light, if only we are brave enough to see it, if only we are brave enough to be it." Dr. Callins said these words are appropriate when considering the post-pandemic recovery.

Dr. Callins said that, in November 2020, the five advisory councils and committees supporting BHW provided input on a strategic workforce coordination plan required by the Coronavirus Aid, Relief and Economic Security (CARES) Act. These councils and committees include NACNHSC, National Advisory Council on Nurse Education and Practice (NACNEP), Advisory Committee on

Training in Primary Care Medicine and Dentistry (ACTPCMD), Advisory Committee on Interdisciplinary and Community-Based Linkages (ACICBL), and Council on Graduate Medical Education (COGME). NACNHSC has invited the other council and committee chairs to present at Council meetings and discuss shared goals. The Chair of ACTPCMD spoke at NACNHSC's last meeting. Dr. Callins said the Chair of ACICBL would address the Council today.

Presentation: ACICBL

Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP

Chair

Dr. Callins introduced Dr. Brandt. Dr. Brandt said ACICBL provides advice and recommendations to the Secretary regarding policy and program development, and other activities under the part of the Public Health Service Act under the Committee's purview. The Committee prepares and submits an annual report describing activities, findings, and recommendations to the Secretary, the Senate Committee on Labor and Commerce, and the House of Representatives Committee on Commerce. ACICBL develops and publishes performance measures for programs under its purview, develops and publishes guidelines for longitudinal evaluations of these programs, and recommends program appropriations levels. Dr. Brandt thanked Designated Federal Office Shane Rogers and Subject Matter Expert Joan Weiss for their leadership of ACICBL.

ACICBL comprises 14 members who are appointed by the Secretary. Members serve 3-year terms. The Committee currently includes five active members; three members recently completed their terms. New members will join in August, when the Committee will hold its next meeting. Dr. Brandt shared the ACICBL roster, which includes a physician, a dentist, and social workers, in addition to Dr. Brandt, who is a pharmacist. Members practice in rural and urban communities. Dr. Brandt invited ACICBL Vice Chair Sandra Pope to introduce herself to the Council, which she did. Dr. Brandt presented a list of programs under ACICBL's purview, noting that not all of these programs are funded currently. The Committee's next report will evaluate programs and their funding. Dr. Brandt described currently funded programs.

The Area Health Education Center (AHEC) program develops and enhances education and training networks within communities, academic institutions, and community-based organizations. These networks support BHW strategic priorities to increase diversity among health professionals

and improve distribution of health professionals, enhance health care quality, and improve health care delivery to rural and underserved areas and populations. AHEC awards grants in 5-year cycles. AHEC includes a Scholars program. Dr. Brandt suggested that ACICBL and NACNHSC could collaborate in developing recommendations for recruiting scholars to programs on which they advise.

The Geriatrics Workforce Enhancement Program (GWEP) supports development of a health care workforce that provides value-based care to improve health outcomes for older adults by maximizing patient and family engagement, and integrating geriatrics and primary care. GWEP collaborates with national organizations to enhance training and resources. GWEP grantees develop partnerships between academic institutions, primary care delivery sites, and community-based organizations, including AHECs, to train geriatric specialists, primary care providers, and health professions students, residents, fellows, and faculty to assess and address older adults' primary health care needs. GWEP grantees aim to transform clinical settings into integrated primary care and geriatrics systems to become age-friendly health systems. GWEP supports community-based programs that provide patients, families, caregivers, and direct care workers with knowledge and skills to improve health outcomes for older adults. GWEP grantees provide training on Alzheimer's Disease and Related Dementias across the educational continuum.

The Geriatrics Academic Career Award program supports geriatrics specialist career development of junior faculty in geriatrics at accredited schools of allopathic and osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, and allied health professions. The program supports clinical training in geriatrics, including interprofessional team training. The program currently funds 25 4-year awards to support training and stipends. Dr. Brandt said there is a need for training and curricula to focus more on geriatrics, and invited NACNHSC to consider how it can work with ACICBL on this issue.

The Behavioral Health Workforce Education and Training (BHWET) program develops and expands the behavioral health workforce serving populations of all ages, including those in rural and medically underserved communities. The program emphasizes establishing or expanding internships or field placement programs in behavioral health that include interdisciplinary training for students, interns, faculty, and field supervisors. The Graduate Psychology Education program

supports training for doctoral students and interns in health psychology, and post-doctoral residents to provide integrated, interdisciplinary behavioral health, opioid use disorder, and other substance use disorder prevention and treatment services for communities with high need or demand. The program fosters an integrated, interprofessional approach to addressing access to care with specialized training in opioid use disorder treatment and prevention. The program aligns with HRSA's mission to improve health and achieve health equity through access to quality services, a skilled workforce, and innovative programs.

The four most recent ACICBL reports are: "High Value Health Care and Health Equity: It Takes a Team" (2020), "Promoting the Inclusion of Population Health at the Nexus of Primary Health Care Delivery and Public Health" (2019), "Preparing the Current and Future Health Care Workforce for Interprofessional Practice in Sustainable, Age-Friendly Health Systems" (2019), and, "Enhancing Community-Based Clinical Training Sites: Challenges and Opportunities" (2018). Dr. Brandt shared ACICBL's recommendations for the 2020 report:

- Recommendation 1: The ACICBL recommends that Title VII Part D grant recipients must develop academic/practice partnerships to educate the workforce on health information technology, cost and quality metrics, person-centered measures, and social prescribing strategies to provide high-value care.
- Recommendation 2: The ACICBL recommends that Title VII Part D grant recipients educate the health workforce on alternative payment models, including value-based payment models, and their impact on healthcare delivery systems and the health of communities.
- Recommendation 3: The ACICBL recommends that Congress fund demonstration projects that use social media to educate the healthcare workforce to improve health and healthcare delivery.
- Recommendation 4: The ACICBL recommends that Title VII Part D grant recipients provide didactic and experiential training experiences, conducted in collaboration with at least one community partner, on how social determinants of health, including housing status, food security, poverty, health literacy, and adverse childhood experiences, impact individual and community health.
- Recommendation 5: The ACICBL recommends that Title VII, Part D funding opportunity announcements include a requirement to prepare the workforce to address emergency

preparedness, response, and recovery in the context of how social determinants of health impact rural and underserved populations in healthcare emergencies.

Recommendations for the annual report currently in progress are:

- Recommendation 1: Congress should increase funding to Title VII, Part D programs by 25% to build and enhance telehealth capacity and capabilities, including, but not limited to, secure internet access, equipment purchase, increasing digital literacy, and other virtual services pertaining to remote patient monitoring to support telehealth training to the health care workforce to increase access to health care and community-based services for rural, underserved, vulnerable, and overlooked populations. This recommendation will set a foundation for addressing the current COVID-19 pandemic and future public health emergencies.
- Recommendation 2: BHW should educate and train the health care workforce on ways to increase public trust around public health initiatives, to include vaccinations, by partnering with communities to co-develop and deliver public health information and services to individuals who are rural, underserved, vulnerable, and overlooked. BHW should also educate and train the workforce on vaccine options, administration, delivery, storage, safety and side effects, and the impact on health disparities and population health.
- Recommendation 3: BHW should educate and train the health workforce on core interprofessional education competencies (IPEC) and Institute of Medicine (IOM) performance measures for interprofessional practice and education (IPE) that reflect the principles of diversity, equity, and inclusion, and align with the Quintuple Aim.
- Recommendation 4: BHW should require Title VII, Part D grant recipients to link their education and training activities to transform primary care practices and community-based organizations to become age-friendly eco-systems by linking education and training to improvements in patient health outcomes, specifically health plan performance measures.

ACICBL submitted a support letter regarding HRSA's Strategic Plan and Framework and is developing a letter regarding support for low Earth orbit satellites.

Discussion

Dr. Schmitz said it would be useful for BHS advisory committees and councils to share information about available resources. He serves as Dissemination Lead for the Collaborative for Rural Primary care, Research, Education, and Practice (PREP), which is one of six HRSA Academic Units for Primary Care Training Enhancement grantees. Research supported by Rural PREP is available on RuralPREP.org. Dr. Schmitz and collaborators recently published an article in a special edition of *The Journal of Healthcare for the Poor and Underserved* featuring articles by all six grantees. One article discusses K-16 education, primarily through AHECs. The authors concluded that AHEC best practices should be supported and funded. Dr. Schmitz noted that it has been challenging for the AHEC program to assess long-term outcomes for younger students. Another article presents analysis of medical school admission processes associated with diversity and other targeted workforce outcomes. Dr. Brandt said ACICBL has discussed challenges with tracking scholars. Dr. Schmitz said this is partly due to the broad range of training activities. He also said tracking outcomes provides evidence to support program funding. Dr. Callins said that several students of an AHEC she has worked with have gone on to medical school and residencies. She agreed that formal tracking is important.

Dr. Callins suggested that ACICBL and NACNHSC could coordinate to provide input to HRSA regarding a workforce pipeline program that NACNHSC is consulting on. She said it would be valuable for NHSC site directors and clinicians to be familiar with Title VII, Part D programs. Dr. Taylor-Desir suggested a central repository of program information.

Drs. Callins and Anderson expressed support for how ACICBL is promoting training in health equity, and lessons learned through these efforts. Dr. Callins offered to share a recording of the Day 1 mental health panel presentation with Dr. Brandt.

Workgroup 1 Report Update and Discussion

Dr. Callins explained that Workgroup 1 would make comments regarding Workgroup 2's report in order to ensure it achieves its goals. Ms. Fabiyi-King reminded the Council that both reports would be submitted from the entire Council.

Dr. Piernot said Workgroup 1 suggested considering reorganizing the policy report as a set of policy briefs in which each recommendation is presented with background and rationale

immediately following. She said the rationales were well done. Dr. Schmitz said the workgroup agreed that the report reflects good work. The recommendations are not necessarily interrelated. Dr. Callins invited input on how to organize the report. The Council decided to organize the report with separate sections for each recommendation, background, and rationale.

Dr. Schmitz said telehealth includes telemedicine, which is providing health care through technology. Telehealth also includes monitoring, sharing information asynchronously, and applying artificial intelligence. He said the recommendation about telehealth may be intended to refer only to telemedicine. He also expressed concern about unintended consequences of telemedicine, such as undermining economic models that support place-based health care. Dr. Schmitz suggested that the report should acknowledge this issue. Dr. Piernot suggested adding discussion about how lack of access to broadband internet is a barrier to telemedicine. When discussing telemedicine benefits, the report should specify which benefits are for patients and which are for providers.

Dr. Callins invited comments on the recommendation supporting HRSA efforts to modernize HPSA scoring and develop MCTA designations. Dr. Piernot asked whether strong support is merited, given the data limitations Ms. Ryan discussed during Day 1. Dr. Callins said the Workgroup made the recommendation to support ongoing efforts to make changes that respond to community needs, which is the aim of MCTA designation. She invited comments on whether it is too early to support MCTA efforts. Dr. Schmitz said it is very important for the Council to make comments on the MCTA process. He said comments should emphasize the importance of responding to community needs. He said it is difficult to obtain evidence about shortages of maternity care. However, stakeholders can collaborate to address this issue. Identifying shortage areas is an important step toward addressing shortages, and it is important for NACNHSC to comment on the issue. Dr. Callins noted that the report is about priorities and recommendations, and agreed with Dr. Schmitz's comments.

Dr. Callins said NHSC site applicants must submit recruitment and retention plans. Applicants can request example plans from their regional office. Workgroup 2 is considering recommending that application guidance include sample recruitment and retention plans, and that plans must address provider well-being and burnout. She suggested that applications should have a checklist for

compliance with this requirement. Dr. Brandner said a checklist would hold sites accountable for preventing burnout, and provide clear guidance for applicants. The workgroup will add this suggestion after reviewing guidance that HRSA currently offers. Dr. Taylor-Desir said her site had developed the recruitment and retention section without guidance about promoting provider well-being. This process was very difficult. She said it is important to provide applicants with guidance that addresses specific issues that may affect clinicians' well-being. For example, clinicians at Tribal sites often are not eligible to receive care from the sites where they practice because this care is only available for American Indians. Recruitment and retention plans for these sites should specify where clinicians can get health care and mental health services. Plans need to show how sites will help diverse clinicians thrive. Dr. Callins said organizations such as the American Medical Association have published information about how to support provider well-being. The report will mention these resources.

Dr. Sein said it would be helpful for NHSC to collect data on why clinicians leave or stay past their service obligation at NHSC sites. He said loan repayment is a recruitment incentive for community health centers, but it is difficult to retain clinicians when salaries are lower in community health centers than other settings.

Dr. Schmitz pointed out that rural health system boards that make decisions and hire executives are volunteers with little experience or expertise about system administration, although they are experts in community needs and priorities. These volunteers may benefit from training in how to recruit and retain clinicians. Dr. Schmitz emphasized that this comment was not a criticism of volunteer board members. Dr. Anderson asked whether sites are required to solicit input from clinicians when developing recruitment and retention plans. Dr. Callins said the Council has requested information about application requirements. She noted that having adequate support staff is a major factor in retention.

Dr. Piernot said recruitment and retention strategies can be effective for some sites but not others. It is important that requirements for developing them lead to real change and not be mere paperwork. Ms. Fabiyi-King reminded the Council that NHSC does not govern sites. Dr. Schmitz said it is important for the Council to advocate for retention strategies, and research to support

development of evidence-based retention strategies. Ms. Fabiyi-King said the Council can recommend, but not mandate, recruitment and retention strategies.

Dr. Taylor-Desir said the report should clarify that it is recommending collaboration with community health workers, not that NHSC participants should become community health workers.

Workgroup 2 Report Update and Discussion

Dr. Anderson said the paper is well-done and addresses an important topic. Workgroup 2 suggested adding more explanation of why provider readiness to practice in HPSAs is important. The report also should clarify that the intent is not to identify shortcomings in individual providers, but to consider how to ensure providers have what they need to serve communities with high need. The report could refer to “preparedness” rather than “readiness” as part of clarifying that the onus for preparedness is not on individual clinicians. Multiple factors including background and training contribute to preparedness. Participation in HRSA’s health equity course could increase clinicians’ preparedness to practice in HPSAs.

Dr. Callins said the report’s introduction could discuss NHSC’s current retention rates. She said adaptability is an important aspect of practice in HPSAs. The report’s description of HPSA site types is helpful.

Dr. Bockwoldt said the report should be clearer regarding whether it is discussing retention or recruitment and what the next steps should be for implementing recommendations. Dr. Schmitz said the recommendations are intended to apply across professions and settings. The recommendations are intended to inform efforts to increase the likelihood that NHSC participants will continue service in HPSAs. The field has not yet defined readiness, which varies across settings. Definition and operationalization are essential first steps toward increasing readiness. Recommendation 2, to identify education and training programs associated with readiness, will help inform efforts to ensure health professional education aligns with NHSC needs. Recommendation 3, to support efforts to develop measures of preparedness to serve, could be supported by HRSA research funding, possibly for rural health research centers. Recommendation 4, to support programs that improve preparedness, encourages investment in efforts that prepare the workforce to serve communities with high need. Recommendation 5 is to collect and analyze data about NHSC participant preparedness to practice in HPSAs, which will support continuous

policy improvement in the field. The recommendations as a whole are asking for investment in improving a broad range of workforce outcomes, including maternal health, HIV/AIDS, rural health, mental health, and Tribal health. Dr. Bockwoldt recommended starting the report with a call to action. Dr. Schmitz said the paper begins with the recommendations and could be formatted to emphasize them. Dr. Callins agreed that this would be helpful. Dr. Taylor-Desir suggested more clearly stating the urgency of the issue. Dr. Schmitz suggested using the term “call to action” in the beginning of the report. Dr. Piernot said the report’s main purpose is to encourage the field to make measuring preparedness a priority, not to prescribe how to do so. Dr. Schmitz said the NHSC would not do much of the work the report calls for, but would benefit greatly from the work when it is accomplished, which likely would take between 5 and 10 years. Dr. Bockwoldt said the Council could recommend that HRSA make defining and measuring preparedness a HRSA research priority.

Dr. Callins suggested linking the report’s mention of the requirement that applicant sites submit a recruitment and retention plan to the policy report discussion of this requirement. Dr. Schmitz supported this idea.

Dr. Callins said she liked the section on potential competency measures. She asked whether this section should discuss the importance of mentoring. Dr. Schmitz said the report could discuss available evidence for the importance of mentoring for preparing NHSC participants to serve HPSAs, as well as any gaps in this evidence. This could include research on qualities of effective mentoring. The report also could emphasize the value of implementing mentoring best practices.

Dr. Callins asked whether resilience is a measurable component of preparedness. Dr. Schmitz said implementation of Recommendation 1 would include studying factors that current evidence suggests are likely to contribute to preparedness. This evidence is necessary for making preparedness a training and education priority. Dr. Bockwoldt asked whether there is evidence that NHSC participants are not adequately prepared for practice. Dr. Schmitz said there is a lack of data to indicate level of preparedness prior to practice. These data would be used for continuous quality improvement. Dr. Taylor-Desir said comparing participants who leave early with those who remain in service for the long-term would provide information about what defines preparedness. The paper should acknowledge the high percentage of participants who continue

service for the long-term. Dr. Callins said Dr. Schmitz had clarified that the report offers a framework for addressing a high-priority issue. Dr. Schmitz said he expected evidence-based education that increases preparedness would contribute to reducing workforce shortages. Dr. Callins said her training and education had not prepared her to be a supervisor, collaborator, or instructor. The workforce may benefit from efforts to prepare members to assume these responsibilities.

Ms. Fabiyi-King said the Division of Regional Operations (DRO) had replied to a query about requirements for recruitment and retention plans submitted with NHSC applications. Plans must describe processes and policies for recruitment and retention that ensure staffing will meet community needs. Plans also must describe strategies for promoting resiliency and reducing burnout. Applications and recertification include plan documentation. DRO staff review plans during site visits.

Public Comment

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

Closing Remarks

Dr. Callins thanked the Council and HRSA staff for their work. She invited each Council member to describe a meeting highlight. Dr. Taylor-Desir said she appreciated the mental health panel and the presentation from OHE, especially information about training people in health equity and social determinants of health. Dr. Bockwoldt said she appreciated participants' passion for serving a wide range of communities. Dr. Schmitz said he is excited about the possibility of developing tools to increase clinician preparedness in the near future. Dr. Brandner said she appreciated reading the Council's papers and participating in Council work. Dr. Piernot said she appreciated learning about BHW's work. Dr. Sein said HRSA staff presentations had shared valuable information. Dr. Anderson said she enjoyed working with the Council, the mental health panel presentation, and the OHE presentation. Dr. Pinto-Garcia said she enjoyed reading both Council papers and working on a paper. She said she especially appreciated the technical writing support.

Dr. Callins said National Public Radio eulogized Supreme Court Justice Ruth Bader Ginsburg as resilient and relentless. Dr. Callins encouraged Council members to be resilient and relentless in

pursuit of healthy communities. Members should be “pursuers of the possible” and focus on equity and resilience.

The Council’s next meeting will be November 9-10 via Zoom. Ms. Fabiyi-King and Dr. Robinson are determining appropriate approaches for the Council to publish written recognition of NHSC’s 50th anniversary. The Council discussed “four Cs” at its previous meeting: competence and confidence in context and with compassion. These could inform development of the written statement.

Dr. Callins said Council members are clinicians, educators, and advocates, with opportunities to be transformative leaders and servant leaders. She encouraged members to take care of themselves, and their families, patients, staff, students, trainees, and communities. She reminded all meeting participants that their work is meaningful and makes a difference.

Dr. Callins adjourned the meeting at 2:08 p.m. EDT.