

# Meeting Summaries

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## May 20 - 22, 2010, Meeting — Bethesda Executive Summary — Bethesda, Maryland

### Opening Remarks:

Dr. Brand (HRSA Deputy Administrator) opened the meeting and stated that it is exciting that the HRSA budget and responsibilities have seen extraordinary increases, and President Obama personally chose Dr. Wakefield as Administrator. The American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA), plus a higher budget, have major implications. Clinician placement should double to help meet primary care workforce goals.

Council members are long-term HRSA experts, and their service will help HRSA and NSHC with the President's health care goals. The Council should review its structure and objectives (including communications), and consider coordination with other HRSA advisory councils. Members can advocate in ways not allowed for Federal employees, though as individuals versus representing the Council.

Ms. Spitzgo (Associate Administrator, BCRS) said the key takeaway from Dr. Brand is that new opportunities must replace old methods. She reiterated the Council's importance to NHSC, especially for guidance during fast-paced activities.

A copy of Ms. Spitzgo's presentation about BCRS staff and "NHSC Today: Historic Time & Opportunity" was included in the meeting packet. She highlighted NHSC placement and funding, accomplishments (e.g., culture shift, communications, streamlined application, reduced application and casework backlogs, access to NHSC data, redesigned conferences), the half-time pilot, plans (e.g., customer service, partnerships, marketing/branding), policy review, NHSC Forums, and the new information system.

Based on Council input, Ms. Spitzgo noted several things for BCRS to review or consider:

- Site technical assistance, including the role of national and regional offices
- Provider education requirements, to ensure inclusion of appropriate loans
- Handling of calls about issues, concerns, etc.
- Procedures for staff site visits (more friendly than a "checklist")
- Program eligibility (including state hospitals)
- Sites' roles in provider satisfaction, and decisions about removing Sites with serious problems
- Creation of education modules about Sites' populations, cultures, and types of patients
- Creation of a map to show NHSC's geographic coverage

### Outreach and Recruitment

The Academy for Educational Development (AED) is working on NHSC communications and branding. Its research found low public awareness of NHSC, and misperceptions about downsizing and inadequate service for poor people. Some optimism emerged over the new application as well as the President's focus on healthcare. The strongest benefit to NHSC is financial. Other benefits include multiple

professional opportunities, and underserved community health. Also, partners appreciate NHSC's support.

The need for enough applications to spend ARRA and other funds requires increased awareness of NHSC. BCRS is restarting its marketing (e.g., the new one-page summaries). Other marketing and outreach objectives are listed below.

- Strategic outreach and more efficient intake are needed.
- A compelling message is needed for multiple audiences. The message should include high-quality interdisciplinary care for underserved communities. It should emphasize a career versus temporary financial benefit.
- The term "Awardees" should replace "loan repayors."
- BCRS should help Sites' patient or provider satisfaction surveys, and recognition for providers' high-quality care for communities. This will increase visibility and interest.
- Clinicians who feel a part of something important, or are proud to serve, will spread the word.

Media stories such as the CNN piece shown at this meeting help. The ACA likely will drive increased media coverage. Media objectives are listed below.

- BCRS needs a strategic plan to help promote and control the NHSC message.
- Site staff should be trained to spot and promote stories. They should be given pre-written backgrounders, op-ed pieces, and letters to the editor.
- Successful Sites and individuals should be publicized, including press releases sent to providers' home towns and service communities.
- Council members should help identify and promote newsworthy stories.
- New media such as Facebook should be included.
- The value of specific communication strategies should be tracked.

### **Customer Service and Clinician Retention**

BCRS is reengineering customer service as a key to retention (and recruitment). Customers include Loan Repayors and Scholars, plus communities, Sites, patients, Primary Care Offices (PCOs), Primary Care Associations (PCAs), Area Health Education Centers (AHECs), Ambassadors, schools (professional and other), specialty societies, Congress, and State legislatures. Customer service objectives are listed below.

- Rapid identification and solution of issues, including familiarity with callers who seek help
- Enhanced provider contact (e.g., conferences with strong staff presence)
- Clinician and Site surveys to update data and benchmarks
- Enhanced partnering with Sites (scheduled to begin in August 2010)
- The clinician online community (scheduled to launch in September 2010)

BCRS defines "retention" as continued employment at any approved NHSC Site since they serve the underserved, and that enables accurate Government performance data. However, many believe retention means employment in the same, or any, underserved community, per the goals for primary care. A consensus definition remains a goal. Retention objectives are listed below.

- Retention should be a focus at the beginning and throughout a relationship with NHSC.
- Quality should be measured for each touch point.
- One hundred percent (100%) retention should not be the goal since it is unlikely. It also is not desirable since providers who are not engaged threaten high-quality care.
- Reasonable goals are 80 percent after 1 year and 70 percent after 5 years. The recent weaker emphasis on retention could mean lower rates. The new information system will help clarify and meet reasonable goals.
- BCRS and Sites should ensure early and comfortable community integration for providers and their families. This can include formal training and hands-on experience.
- AED's research found the strongest weakness is a sense of isolation and minimal connection to the Corps, so contact from NHSC should increase.
- Contact among providers makes it seem like being part of something important.
- BCRS should change its tone to emphasize exciting service rather than concerns about default.
- Regional offices and NSHC Ambassadors help retention but need clearer roles.
- Retention is linked to incentive and motivation, including continuation of Site or practice support and multidisciplinary resources. Other incentives could include easy contract extension, tax credits, IT support, and loans to practice in an underserved area. Centers of care excellence boost retention.
- Studies and anecdotes show a relationship between retention and practice near a person's home town or school. NHSC should increase Site development in Scholars' preferred areas.

**Don Pathman, M.D., Professor, Department of Family Medicine, University of North Carolina at Chapel Hill**

Council member Don Pathman presented a study on State scholarship and loan repayment programs. Copies of Dr. Pathman's slides were included the meeting packet. In sum, the study found satisfaction, retention, and community/Site contributions are better in the Loan Repayment Program (LRP) versus Scholar Program (SP); and during the 10 years prior to the study being published retention dramatically improved, especially due to the LRP. Based on Council input, Dr. Pathman agreed an updated study would be valuable, and noted the importance of provider/community integration, a clear retention definition, communications, and data.

**NAC Strategic Brainstorming**

The Council remains important to BCRS, though several suggestions emerged for the Council, including:

- More diverse membership (provider types, managers, race/ethnicity, alumni)
- Clarify and periodically review priorities and deliverables
- Meet in person three times annually, and continue Thursday evening through Saturday morning
- More advance notice and longer to prepare for meetings
- Overlap some meetings with provider events
- Coordinate with other advisory councils and professional organizations, academies, etc.
- Re-consider sub-committees (though review previous challenges)
- Ensure HRSA leaders know the Council appreciates seeing its recommendations implemented

Several suggestions emerged for BCRS, including:

- Faster distribution of Council minutes and products
- Create summaries from other events (e.g., Workplace Summit)
- Increase requests for Council support (e.g., feedback on ideas, drafts)
- Share more information with the Council
- Create a map to show where people are not being served